

Assessment of the Child Abuse Mitigation Project at the Bustamante Hospital for Children (C.A.M.P. Bustamante)

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EXECUTIVE SUMMARY

Three project objectives were set for CAMP Bustamante (Jan 12th, 2004 - Sept 30th 2008)

1. To develop and implement a hospital-based model to identify and refer victims of violence
2. To improve parenting skills and conflict resolution
3. To develop and implement an intervention model within the child's environment (home, school, church) through interaction with existing community based programmes

One of the world's leading experts on violence and author of the 2006 UN Study on Violence against Children, Professor Paulo Sérgio Pinheiro urged the Jamaican Parliament in February 2008 to do all it can to end the cycle of violence, noting that:

“In an environment where violence breeds more violence, the ways in which Jamaican children are subjected to violence are inextricably linked to the unrelenting levels of crime and violence affecting the island.”ⁱ (our emphasis)

Many experienced childcare and prevention practitioners feel that violence against children is not only escalating in numbers but, more disturbingly, in severity. Previously perceived appropriate disciplinary methods for children, such as use of belts, have changed to more serious injuries consistent with punching, kicking, assaulting with blunt instruments, machetes or other less common acts of physical and mental cruelty, such as placing a child in an ants nest, or branding them with a hot iron. Some parents in community discussions in the inner city have said that they have to “Mash up de rod on dem” while their children are young, between 4-11 years. Their perception is that this is the only chance they have of preventing them from taking up guns, drugs or sex in the extremely challenging social environment of their communities.

Child abuse is covered by Article 19 of the Convention on the Rights of the Child (CRC): “...all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.” Thanks to scientific data now available on the developing brain, we know of the immediate severe damage abuse

and exposure to external violence has on children and their well being, as well as the profound long-term damage it has on their physical and mental health as adults. The developing brain evolves in relation to environmental stimuli. When these stimuli present situations of abnormal stress, especially if repeated over a long period, there is “toxic stress” which can have a lasting negative effect on the “architecture of the brain”, resulting in a maladapted individual who can exhibit problematic behaviour both as a child and later as an adult. The brain’s development proceeds at a much faster rate than the rest of the body in the earliest years. Its neural circuits develop most rapidly in the first three years of life during which time the brain reaches 90% of its adult size. Brain development starts with lower level capacities. If this early foundation is impaired some higher level capacities may not be built, which is why the earlier the child experiences abuse, the more damaging its effects are likely to be.

From January 2004-June 2008 1,284 children who were suspected victims of physical abuse, sexual abuse or gunshot wounds came to Bustamante Hospital for Children (4 out of every 1,000 children who visited). The number of boys and girls were almost equal. Over half of the injured children (53%) were between 8-11 years, almost a third were 4-7 years (30%) and 16% were 0-3 years old. The majority (65%) had injuries from physical assaults (including use of a blunt object, pushing, stabbing), over a quarter (28%) had been sexually molested or assaulted (nine out of 10 being girls), and 7% had gunshot wounds. Almost half the victims (49%) were injured in their home surroundings, 16% at school and 14% on the street. Over two thirds of the perpetrators were people the children knew well: acquaintances, friends, parents, close relatives. The A&E Department began treatment of their injuries and referred all these children to CAMP Bustamante.

One third (34%) of these cases never received home visits or further assistance from CAMP Bustamante because they could not be located (some adults gave false contacts) or were police cases in which the catching of the perpetrator took precedence over assistance to the victim. 836 home, school and other visits made by CAMP Bustamante social workers were recorded, some clients receiving more than one visit, innumerable follow-up phone calls were made, and a number had follow-up referrals to the Child Development Agency, the Children’s Registry, Child Guidance Clinics, PATH, CISOCA,

Victim Support Unit, Family Court, Women's Crisis Centre, and Bethel Family Counseling. Over 100 children attended summer camps or Saturday activity classes (art, drama, music, personal development). Parents of some of these children participated in annual parenting forums to discuss their children's progress and their own parenting challenges and achievements, and to learn positive parenting techniques. However in both instances a number of problems prevented full attendance.

CAMP Bustamante also set out to raise awareness of child abuse through informative and educational printed materials targeted at the general public (a brochure), children (a small stand-up tent card with information on their rights and contact numbers, and colouring sheets on their rights), youth and adults (Find-a Word puzzles) and professionals (a brochure on recognition and response to child abuse). Staff were invited to visit schools and churches, ran booths at exhibitions, created a fabric mural on which over 80 men suggested what fathers can do to prevent child abuse, worked with students at Edna Manley College so that they could present a play and a musical on child abuse, assisted UTech to put on an exhibition of art and poetry by their clients, and organized a capacity-building seminar for child care professionals demonstrating the use of play therapy.

The impact of CAMP Bustamante as measured from the responses of parents/caregivers and childcare practitioners has been overwhelmingly positive. Parents and caregivers found the social workers' visits not always comfortable at first, but in the end experienced them as empowering, informative, and reaffirming. They were very appreciative of the information, the pointers for guidance in dealing with children who in the majority of cases had been abused by someone else, the counseling they received in helping the depression that many experienced after the incident, and for some simply the experience that someone cared about them and their child. The great majority of those whose children went to Summer Camps and Saturday classes and who attended the Parenting Forums found that as their children socialized, were exposed to new experiences, mastered some of what they were taught, they were more self-expressed and happier. Their camp and class guides saw real signs of personal development in many of them. Parents were also deeply appreciative of the counseling and parenting tips they received and most experienced positive changes in their approaches to their children: they

listened more, held conversations with their children for the first time, had more patience and shouted less, practiced encouraging their child rather than putting them down, began to feel more loving towards their child and good about themselves. They tried alternatives to beating.

Agencies praised CB for its work in advocating on issues of child abuse through the many awareness raising seminars and workshops CB had hosted and through the personal input of its Coordinator. They were emphatic that their organization had benefited from CB for a number of reasons:

- Increased identification and reports of children at risk
- Reduced case load
- Repeat injuries are few
- Increased awareness and advocacy on child abuse issues and the need for more strategic approaches
- Assistance with child abuse events and forums
- Referrals of children for activities
- Ability to respond quickly to vulnerable children when others can't
- The opportunity to interact with children that they may normally never see, which raises awareness of societal differences and discrimination
- Puts hospital services in Jamaica on par with health services in developed countries

The weaknesses of CB were in the areas of:

- Rapid response – its own perhaps overambitious target of a 72 hour response was hardly ever achieved and only about a third of the cases were visited within two weeks;
- The recording of vital case information on the database which has a lot of missing data and lacks the capacity, as programmed, to capture critical indicators such as repeat injuries, no. of counseling sessions held, socio-economic information on housing and so on;

- Few useful links with community based organizations, critical for developing a community intervention model, and strong links with only three NGOs.
- Governance. The effectiveness of the project could have been strengthened by a stronger governance system to oversee management and monitor quality assurance, as well as by a stronger multi-agency, multi-disciplinary approach to case management.

In terms of cost effectiveness, based on the lack of alternative violence prevention programmes for children in Jamaica, it is difficult to compare the effectiveness and efficiency of programmes. However looking at some hypothetical outcomes of the child abuse mitigation project, it would appear that the substantial benefits of such a programme to the child victim and their family, and the alternative cost to society in treatment, visits to the hospital and other health services, lost productivity, disability, decreased quality of life and premature death, as well as the cost to social welfare organizations, outweigh the additional costs.

The chief recommendations of this study are:

For CAMP Bustamante

1. Six months bridging financing be immediately found to continue the project at Bustamante Children's Hospital until final decisions are made.
2. The Child Abuse Mitigation Project be placed under the Office of the Children's Registry and piloted for eighteen months at Bustamante Children's Hospital and Cornwall Regional Hospital, working in collaboration with the primary health care clinics. Ultimately all hospitals with a CAMP would be linked to a Type V Health Centre where screening for the risk of child abuse would be implemented.
3. A National Coordinator is appointed to oversee CAMP development, advocacy, training and community development.

4. A multidisciplinary case management approach should be further developed in order to foster information sharing and monitor follow-up of complex cases of child abuse.
5. Community development needs to be given a much higher priority. CAMP teams should include a CD worker who links into SDC and other community based programmes in order to integrate clients into suitable programmes, monitoring their attendance and any challenges, and helping in the development and evaluation of the programmes. In addition the CD worker would coordinate the parenting forums.
6. Parenting Forums should be expanded to include all parents of victims, as this experience makes parents particularly receptive to sensitization and behavior change.
7. A 360 degree approach to counseling services be put in place, starting with siblings, especially if they are witnesses (e.g. through VSU) and continuing with the investigation, counseling and rehabilitation of child perpetrators of violence and sexual abuse, and finally ending with all perpetrators, starting with parents.
8. The CAMP database be modified to capture key indicators. Indicators must be reviewed and set at the start of the project.

For the entire Child Protection System

9. The TWG concept should be expanded and improved by establishing a terms of reference for a Child Protection Committee that should have at its core strategic and technical governance of programmes relating to child protection and include a wider remit than the child abuse mitigation programme. It is envisaged that senior level membership with powers of decision be sought to represent relevant stakeholders and at a minimum include: the Ministry of Health HPPD, Primary Health Care, the Hospital and CAMP, the CDA, OCA and the OCR, Ministry of Education/School governing body, Child Guidance Clinic and the Police. This group should meet and report once per quarter and should seek stewardship from the OCA.

10. Promote widely the Children's Registry hotline 1-888-PROTECT, for reporting suspected child abuse, stressing its confidentiality.
11. Re-start the Parents' Hotline, formerly run by the Jamaica Foundation for Children, which offered counseling, advice and referrals
12. Restart the 24 hr Children's Hotline, formerly run by the Jamaica Foundation for Children.
13. Integrate training on the recognition and response to child abuse in the training of medical doctors, nurses and nurses aides
14. Forums on sensitization on child abuse and alternative methods of discipline for staff of Children's Homes. Support for Teachers Forums on alternative methods of discipline and management of violence in schools. Development of a short accredited course on child abuse for professionals.

This assessment included a literature review, a review of secondary data, analysis of client records through the database, interviews with 19 staff from 11 childcare and protection agencies, 19 parents/caregivers from 18 randomly selected cases, 6 school staff members associated with these cases from 3 schools, and 2 focus group discussions with a total of 43 persons (8 male) from 2 of the communities with the highest incidence of child abuse cases reaching Bustamante Hospital for Children

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INTRODUCTION

The Child Abuse Mitigation Project at the Bustamante Hospital for Children (CAMP Bustamante) was established on January 12th 2004 and ended on September 30th 2008. There were three objectives set for the project:

1. To develop and implement a hospital-based model to identify and refer victims of violence
2. To improve parenting skills and conflict resolution
3. To develop and implement an intervention model within the child's environment (home, school, church) through interaction with existing community based programmes

CAMP Bustamante originally emerged from the Inter-Sectoral Working Group on Children and Violence and was developed by a multi-agency technical working group. For the first six months the project was funded by UNICEF and for the remainder of the period by the National Health Fund, with specific inputs such as the cost of establishing a database, from UNICEF. The aim of CAMP Bustamante was to develop a rapid hospital based response to suspected child abuse, by identifying and treating children between 0-12 years of age who attended the Bustamante Hospital for Children for injuries sustained as a consequence of violence. CAMP Bustamante was designed utilizing an ecological approach that addressed the needs of the family, the school and the community through the establishment of a multi-agency response that drew on the support and expertise of child protective services and community and non-governmental agencies in an effort to mitigate violence related injuries in children.

The definition of a violence related injury (VRI) that guided the development of CAMP Bustamante was in keeping with Article 19 of the Convention on the Rights of the Child (CRC), i.e. a child suffering “...all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse....” and draws on the definition in the *World Report on Violence and Health* (2002): “The intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting

in actual or potential harm to the child's health, survival, development or dignity."ⁱⁱ The 2006 United Nations Report on Violence Against Children notes in its opening statement that "In every region, in contradiction to human rights obligations as well as children's developmental needs, violence against children is socially approved..." and notes that for societies to prevent violence against children "...does not mean sanctioning perpetrators only but requires transformation of the 'mindset' of societies..." as well as the underlying social and economic conditions associated with violence.

In February 2008 Professor Paulo Sérgio Pinheiro, one of the world's leading experts on violence, urged the Jamaican Parliament to do all it can to end the cycle of violence. Prof. Pinheiro, author of the 2006 UN Secretary-General's Study on Violence against Children, said:

"In an environment where violence breeds more violence, the ways in which Jamaican children are subjected to violence are inextricably linked to the unrelenting levels of crime and violence affecting the island"ⁱⁱⁱ

According to the Violence Prevention Alliance:

"Homicide is the fifth leading cause of death and is the leading cause of deaths among young males. Over the years, homicide rates have been rapidly increasing. In 1970, the homicide rate was 8, and thirty-five years later in 2004, it reached 55 and is projected to increase to 64 or 65 per 100,000. According to the United Nations Children's Fund (UNICEF), in 2004 a total of 1,471 persons were murdered, an average of four murders being committed per day. Of that total, 119 were children, and the majority of these were boys (85.7%). In that same year, 430 children were victims of gun-shots. The majority of the violence related injuries occurred after school hours between the hours of 2:00 pm to 11:00 pm. Furthermore, the rates of children becoming perpetrators of violence has increased. In 2004, a total of 2,003 children were arrested for major crimes including murder (44), shooting (58) and rape (57)."^{iv}

CAMP Bustamante was developed and implemented as a component of the Healthy Lifestyles Project in the Health Promotion and Protection division (HPPD) of the Ministry of Health and the Environment, as part of the National Strategic Plan for the Promotion of Healthy Lifestyles in Jamaica 2004-2008. This included the launch of the Violence Prevention Alliance (VPA) as part of a global public health initiative to get all sectors involved in violence prevention. This alliance allows for the establishment of collaborative efforts to addressing the root causes of violence and simultaneously improving services for victims as well as mitigating the harmful effects of violence.¹ The project was part of the government's commitment as a signatory to the United Nations Convention on the Rights of the Child 1991 and in keeping with the United Nations Millennium Development Goal # 4, to reduce child mortality by two thirds by 2015. It also played a critical role in demonstrating a new approach to child protection, as required by the newly enacted Child Care and Protection Act 2004 that sought to restructure child protective services by:

- Establishing an Office of Children's Advocate to act in legal matters on behalf of children.
- Establishing a central Office of the Children's Registry for the reporting of abuse of children
- Formulating standard principles to be upheld in dealing with matters affecting children.
- Increasing parental responsibility and government support for the welfare of children.
- Increasing community responsibility for the reporting of abuses against children.
- Increasing penalties for violations of the rights of children and other offences under the Act.

Therefore the model aimed to identify children from the A&E Department of Bustamante Children's Hospital, that were identified in the Jamaica Injury Surveillance System (JISS), and screen them for levels of risk of abuse, using a screening instrument that would be developed by the project based on standard instruments. These children would

then either receive social work intervention or be referred to the relevant support agencies to reduce the risk of further harm. It was thought that such interventions would include after-school activities, conflict resolution and parenting skills and community development as a way of reducing the risk factors associated with violence and increasing the protective factors for these children at home and in the community.

Now that the project has concluded its first phase and the National Strategic Plan for the Promotion of Healthy Lifestyles 2004-2008 is being revised and the National Plan of Action for an Integrated Response to Children and Violence is being developed, the timely assessment of CAMP Bustamante aims to discuss its relevance, effectiveness, sustainability and replicability. This is particularly critical given that the model was implemented as a pilot in anticipation that the model be adopted by other hospitals across the island. Therefore the assessment, based on the clear evidence of its relevance and effectiveness, provides some recommendations for the development of the model, the role of key-stakeholders, the challenges that exist within the child protection system and the governing structures of a rapid response hospital based model.

The assessment was bound by the Terms of Reference developed by the HPP division that outlined the parameters for the assessment as follows:

- (i) The extent to which the original objectives of the project were met.
- (ii) The achievements against original progress indicators
- (iii) The strengths and limitations of the intervention model
- (iv) The areas of congruence/complementarity with existing child protection systems
- (v) Dissemination of findings and recommendations for information as a programme planning, prevention and a public education strategy

METHODOLOGY AND LIMITATIONS

Given the terms of reference the following methodology was developed to assess this project.

1. Literature Review of national and international research on the effects of violence on children's development, including reviewing best practice models and services similar to those offered by CAMP Bustamante in developing and developed countries.
2. Qualitative analysis from reports and database information as well as data collected in semi-structured interviews with:
 - a. CAMP Bustamante staff
 - b. Key stakeholders to whom cases were referred, including the Child Development Agency (CDA), Child Guidance Clinics (CGC) and the Office of the Children's Registry (OCR)
 - c. Other key state agencies such as the Centre for Investigation of Sexual Offences and Child Abuse (CISOCA) (Kingston) and the Office of the Children's Advocate (OCA)
 - d. NGOs whose activities the children were involved in, supported by the project, such as East Street Junior Centre, Institute of Jamaica, Multicare Foundation, Tomorrow's Children at the Centre for Arts, University of Technology
 - e. One-to-one interviews with randomly selected parents/caregivers of 20 children served by CAMP Bustamante.
 - f. Principals, guidance counselors and teachers in three schools which some of these children attended.
 - g. Focus group discussions with parents from two of the Kingston inner city communities with the highest incidence of child abuse cases reaching CAMP Bustamante.
3. Quantitative analysis of project in relation to client data and key project indicators, including stakeholder referrals and follow-up activities.

4. Risk analysis in relation to socio-economic/demographic factors, types of violence, instruments used (if data exists).
5. Cost effectiveness analysis.

Each section will also provide detailed methodologies regarding sample selection, data collection and analysis.

LIMITATIONS

Limitations to this assessment include:

1. The limitations of the quantitative analysis due to the lack of key indicators set at the start of the project, data gaps and by the design of the database, that is not able to generate socio-economic variables for analysis. Fields to capture critical epidemiological indicators are missing and this is most likely due to the absence of sufficient specification instructions.
2. Gaps in the data for about 300 cases, which were being entered in November 2008 while this assessment was taking place. There is particular concern about the quality of the data on referrals as after the first year the data shows a very low referral rate, particularly to the Child Development Agency, but it is not clear if this is the result of unentered data.
3. Failure to reach the target for the qualitative analysis of 20 case studies – only 18 were completed;
4. Failure to reach personnel from the 10 schools associated with clients from the 18 case studies - only three schools were contacted instead.

LITERATURE REVIEW: THE IMPACT OF VIOLENCE ON CHILDREN'S DEVELOPMENT

The 2006 United Nations World Report on Violence against Children uses as its definition of violence article 19 of the Convention on the Rights of the Child (CRC): “all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.”^v

Professionals who treat child abuse have identified many categories and sub-categories of abuse. The four main categories and their definitions in Table 1 are taken from the 2001 Health Canada framework for child maltreatment surveillance^{vi} and the 2004 Jamaican Ministry of Health guidelines for the management of victims of child abuse and neglect^{vii}.

Table 1: Categories of Child Abuse

Category	Health Canada	Ministry of Health Jamaica
Physical Abuse	The deliberate application of force to a child's body, including shaking, choking, biting, kicking, burning or poisoning a child, holding a child under water etc.	Any action which results in non-accidental physical injury.
Emotional Abuse/ Maltreatment	This involves an attack on a child's sense of self. Involves acts or omissions by parents/caregivers that have caused, or could cause, serious behavioural, cognitive, emotional or mental disorders. Can include verbal threats and put-downs as well as habitual scape-goating, belittling and name-calling.	The overt or covert direction of hostility towards a child by making repeated threats, withholding affection and/or belittling the child's capabilities, qualities and desires.
Neglect	Parents or other caregivers not providing the essential prerequisites for a child's emotional, psychological and physical development (including needs for food, clothing, shelter, cleanliness, medical care and protection from harm). Emotional neglect can range from the context in which the abuser is unavailable to that in which s/he openly rejects the child. Emotional neglect is considered to be as serious a risk to the child as physical assault.	Abuse through neglect is the gross or repeated failure to provide for a child's mental/physical health and welfare.
Sexual Abuse	Any sexual experience between a child and an adolescent or adult. Like all forms of maltreatment, sexual abuse is also emotionally abusive to the child's sense of self, trust and personal safety.	The exploitation of a child through violent or non-violent molestation. This includes a spectrum of behaviour ranging from violent rape, to inappropriate touching of the genitals or seduction.

There is increasing evidence of both the immediate deleterious effects of child abuse, and exposure to external violence, on children and their well being, as well as the long-term damage to their physical and mental health as adults. This is partly related to the scientific data now available on the developing brain, which evolves in relation to environmental stimuli. When these stimuli present situations of abnormal stress, especially if repeated over a long period, there is “toxic stress”^{viii} which can have a lasting negative effect on the “architecture of the brain”^{ix}, which in turn results in a maladapted individual who can exhibit problematic behaviour both as a child and later as an adult.

The Incidence of Violence against Children

Although statistics on violence against children are limited, globally child abuse seems to be an increasing phenomenon: “...what little is known about the incidence and prevalence of maltreatment would suggest that these phenomena are at epidemic proportions in both developed and less developed countries.^x US reports to the National Child Abuse and Neglect Data System show an incidence rate of 43 per 1,000 children⁷ (1996) and reports from the Province of Ontario in Canada are 21 per 1,000 (1994). Experts estimate 44% under-reporting of cases.^{xi}

In Jamaica an average of 0.4% of children 12 years and under attending Bustamante Hospital for Children were suspected victims of child abuse (2003-2007), suggesting an incidence rate of 4 per 1,000. This of course would not include cases which did not involve physical abuse or sexual assault. In a mid-1990s Jamaican study of 156 mothers visiting child welfare clinics, 71.4% reported experiencing some form of abuse as a child: 53% reported physical abuse, 47% neglect (38% physical and 9% emotional), 33% emotional abuse and 10% sexual abuse. 42% had experienced multiple forms of abuse^{xii}. In a recent study of 80 children between the ages of 7-11 years from a Kingston inner city primary school, 81.3% answered in the affirmative to the description “Been hit, whipped, beaten or hurt by someone”, 57.5% to “Been threatened by someone” and 7.5% to “Been tied up or locked in a small place”.^{xiii}

The World Report on Children points out that while the global extent of physical violence is known (see example of sexual assault and its consequences in Table 2), much less is known about the global extent of psychological violence except that it frequently accompanies other forms: a strong coexistence between psychological and physical violence against children in violent households has been established.^{xiv}

Table 2: Global burden of mental disorder attributed to child sexual abuse

Mental disorder	Percentage of global disease burden attributed to child sexual abuse (CSA)	
	Females (%)	Males (%)
Depression, alcohol and drug abuse	7–8	4–5
Post-Traumatic Stress Disorder	33	21
Suicide attempts	11	6
Panic disorders	13	7

Source: Andrews G et al. (2004). Child Sexual Abuse. In: Ezzati M et al. (2004). Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors, Vol 2. Geneva, World Health Organization, pp 1851–1940. (p. 65)

The WHO Report on Violence and Health points out the substantial financial consequences of violence against children (Table 3).

Table 3: Financial Consequences of Violence against Children

Direct costs:

Treatment, visits to the hospital doctor and other health services

Indirect costs:

Lost productivity, disability, decreased quality of life and premature death

Costs borne by criminal justice system and other institutions:

Expenditures related to apprehending and prosecuting offenders. Costs to social welfare organisations, costs associated with foster care, to the educational system and costs to the employment sector arising from absenteeism and low productivity

Source: Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). World Report on Violence and Health. Geneva, World Health Organization, pp 59–86.

The Impact of Stress on the Developing Brain

Just as the external body grows and changes shape from infancy to adulthood, so does the brain. However the brain's development proceeds at a much faster rate in the earliest years. Its neural circuits develop most rapidly in the first three years of life during which time the brain reaches 90% of its adult size. Brain development starts with lower level capacities. These are an essential foundation for building higher-level brain circuits and skills. If this foundation is impaired some higher level capacities may not be built.

One of the capacities the brain has to develop is the ability to cope with new or threatening situations. These events cause stress reactions through the body's chemical and neural responses. Where a child can learn to control and manage stress with the help and support of caring adults, this stress is beneficial because it builds capacity and control. However stress can be toxic if it is strong, frequent or prolonged. "Strong and persistent activation of the body's stress response systems (i.e., increases in heart rate, blood pressure and stress hormones such as cortisol and cytokines) can result in the permanent disruption of brain circuits in the sensitive periods in which they are maturing."^{xv} Extensive scientific study has indicated that:

- The neural circuits for dealing with stress are particularly malleable during fetal and early childhood. Toxic stress during this period can affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress-responsive systems that will be overly reactive when faced with stress throughout the lifespan.
- Frequent or sustained activation of brain systems that respond to stress can lead to heightened vulnerability to a range of behavioural and physiological disorders over a lifetime, including stress disorders affecting both mental (e.g. depression, anxiety disorders, alcoholism, drug abuse) and physical (e.g. cardiovascular disease, diabetes, stroke) health.
- Sustained or frequent activation of the hormonal systems that respond to stress can have serious developmental consequences, some of which may last well past the time of stress exposure. For example, when children experience toxic stress, their cortisol levels remain elevated for prolonged periods of time. Both animal and

human studies show that long-term elevations in cortisol levels can alter the function of a number of neural systems, and even change the architecture of regions of the brain that are essential for learning and memory.^{xvi}

“Common causes of such toxic stress include child abuse, serious neglect, and prolonged or repeated exposure to violence, which may be associated with deep poverty, parental substance abuse, or maternal mental illness, such as severe depression.”^{xvii}

The infant’s brain develops in the context of relationships, in the first instance with the mother: “The self-organisation of the developing brain occurs in the context of a relationship with another self, another brain.”^{xviii} Studies have also shown that “one of the critical ingredients that make (very) stressful events tolerable rather than toxic is the presence of supportive adults who create safe environments that help children learn to cope with and recover from major adverse experiences, such as the death or serious illness of a loved one, a frightening accident, or parental separation or divorce. In some circumstances, tolerable stress can even have positive effects. Nevertheless, it can also become toxic stress in the absence of supportive relationships.”^{xix} This information reinforces one of the potentially serious consequences of emotional neglect.

The Impact of Adverse Childhood Experiences on Health and Quality of Life

There is now strong evidence of the lifelong effects of violence against children, effects which provide some of the clues to the causes of ill-health and to risky behaviour and the social problems that arise from this behaviour. A foundation study for the investigation of the impact of stress in childhood is the Adverse Childhood Experiences (ACE) Study, undertaken by the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, U.S.A., between 1995 -1997^{xx}. Over 17,000 Health Maintenance Organisation (HMO) members undergoing a comprehensive physical examination agreed to participate by providing detailed information about their experiences as a child in relation to abuse, neglect, and family dysfunction. From this study a great deal of evidence, elicited by many separate analyses, has been obtained about the strong correlations between adverse childhood experiences and later physiological and mental ill-health, leading to a lowered quality of life. The categories

used were physical abuse, emotional abuse, emotional and physical neglect, sexual abuse and witnessing interparental violence.^{xxi} The survey data indicated that approximately two-thirds (64%: 66% females and 62% males) of the respondents had experienced at least one adverse experience as a child. Over one third of the respondents (38%: 41% females and 34% males) had more than one adverse experience.

The study counts the total number of adverse childhood experiences (ACE) that respondents reported. The ACE Score is then used to assess the total amount of stress during childhood. The study demonstrated that as the number of ACE increase, the risk for the health problems listed in Table 4 increases in a strong and graded fashion:

Table 4: Health problems linked to adverse childhood experiences (ACE study)

- | | |
|--|--|
| • Alcoholism and alcohol abuse | • Liver disease |
| • Chronic obstructive pulmonary disease (COPD) | • Risk for intimate partner violence |
| • Depression | • Multiple sexual partners |
| • Fetal death | • Sexually transmitted diseases (STDs) |
| • Health-related quality of life | • Smoking |
| • Illicit drug use | • Suicide attempts |
| • Ischemic heart disease (IHD) | • Unintended pregnancies |
- Source: www.cdc.gov/nccdphp/ACE

The UN report on violence against children gives a comprehensive list of the acute and long term physical and psychological consequences of violence against children taken from the WHO Report on violence and health (Table 5).

Table 5: Acute and Long Term Health Consequences of Violence against Children

- | | |
|-------------------------------------|--|
| <i>Physical health consequences</i> | <i>Psychological consequences (contd.)</i> |
| • Abdominal thoracic injuries | • Criminal, violent and other risk-taking behaviours |
| • Brain injuries | • Depression and anxiety |
| • Bruises and welts | • Developmental delays |
| • Burns and scalds | • Eating and sleeping disorders |
| • Central nervous system injuries | • Feelings of shame and guilt |
| • Fractures | • Hyperactivity |
| • Lacerations and abrasions | • Poor relationships |
| • Damage to the eyes | • Poor school performance |
| • Disability | • Poor self-esteem |
| | • Post-traumatic stress disorder |

Sexual and Reproductive Consequences

- Reproductive health problems
- Sexual dysfunction
- Sexually transmitted diseases including HIV/AIDS
- Unwanted pregnancy

Psychological consequences

- Alcohol and drug abuse
- Cognitive impairment

- Psychosomatic disorders
- Suicidal behaviour and self-harm

Other longer-term health consequences

- Cancer
- Chronic lung disease
- Irritable bowel syndrome
- Ischaemic heart disease
- Liver disease

Source: Runyan D et al. (2002). *Child Abuse and Neglect by Parents and Other Caregivers*. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, 59–86.

The Impact of Adverse Childhood Experiences on Behaviour

Major and complex behavioural problems are associated with adverse childhood experiences and it is imperative that their sources be understood so that their treatment is appropriate and the accompanying challenges for caregivers can be eased by understanding the profound developmental dysfunctions that have caused them.

Children are developing beings until they reach adulthood. Their development is based on species-specific processes that have evolved over generations, and will lead to successful adulthood unless this “is thrown off its normal course and becomes less predictable and adaptable.”^{xxii} Childhood experiences are the raw material for the brain’s development. It patterns its circuits based on its responses to the stimuli received from these experiences. These experiences must be “consistent, nurturing, structured and enriched”^{xxiii} for the child to develop into a flexible, responsible and sensitive adult. If the experiences are “neglectful, chaotic, even violent and abusive, the child could become aggressive, remorseless and intellectually impoverished.”^{xxiv}

Critical to healthy development are attachment and bonding, the regulation of emotions, and a positive view of self. In the field of infant development ‘attachment’ refers to the special bond in the maternal-infant or primary caregiver-infant relationship. Its special characteristics are: an enduring emotional relationship with a specific person; the relationship brings safety, comfort, soothing and pleasure; the loss or threat of loss of the person evokes intense distress.^{xxv} These “early interactions, in turn, lay the

psychobiological foundation for attachment”.^{xxvi} A solid and healthy attachment with the primary caregiver is associated with a high probability of healthy relationships with others during life. Poor attachment^{xxvii}, on the other hand, results in emotional and behavioural problems later.^{xxviii} How parents interact, bond and communicate with their young children is of core importance.

How individuals regulate emotion and its affective (or non-verbal) expression is called ‘affect regulation’. “(A)ffect regulation – the attempt to maintain, moderate, diminish or intensify affective states – has been termed a ‘central organizing principle of human development and motivation’”.^{xxix} There is increasing consensus that “this self-regulatory capacity is a central risk factor in a wide range of psychosocial difficulties.”^{xxx} Where families exist in circumstances of poverty, environmental deprivation and violence this capacity for affect regulation is challenged. Moreover styles of affect dysregulation tend to be passed on from one generation to the next. “Children developing in these families are likely to internalize ways of handling strong emotions that place them at risk for later psychopathology (Bradley, 2000). Many of these children develop with impaired ability to sooth themselves, modulate states of intense emotional arousal, respond adaptively to over- or understimulation by caregivers, or regulate aggressive and sexual impulses.”^{xxxi} Support for families in difficult circumstances can therefore have a direct impact on the mental health of their children.

Maltreatment affects children’s developing view of themselves and their world. Children who are sexually abused (almost one in four, 23.4%, of those seen at CAMP Bustamante) undergo pronounced interruptions: “Once the sexual barrier has been crossed, the child’s life is irreversibly altered.”^{xxxii} Maltreated children may attribute stressful, uncontrollable events to something about themselves rather than the external situation, leading to loss of self-esteem. This attribution may also extend to their families and their world in general including their community. Because the source of their stress and fear is often in the family they are especially challenged in finding ways to cope. Their coping mechanisms may include avoidance of an abusive caregiver which may later compromise their ability to form relationships. Involvement in episodes involving personal danger in which response was futile may lead to future helplessness, in which the victim believes there is

little they can do to gain control over stressful situations. If this is a persistent experience it may lead to chronic helplessness in an adult, a phenomenon familiar to social workers. Maltreated children may have a very difficult time adapting to any form of stress to the extent that they are deprived of positive adult relationships, effective models of problem-solving and a sense of personal control or predictability.^{xxxiii}

Despite the powerful negative impacts of violence, especially in child abuse the severity of which experts compare to war experiences, negative outcomes are not inevitable. Children have the ability to adapt and use whatever resources or opportunities are available to resist the harmful effects of these experiences. Therefore provision of these opportunities, through organized activities, art and music therapy and other recreational outlets can be very important.

Moreover children are different – some are resilient to some specific stressors and not others, while resiliency may vary over time. Clearly the younger the child the more profound can be the impact of stress. In addition not all attachment problems stem from abuse. It has been estimated that as many as one in three persons has an avoidant, ambivalent or resistant attachment with their caregiver.^{xxxiv} Despite this these individuals can form relationships, although not with the ease that others can.

Findings from Jamaican Research

Exposure to External Violence

In a country with one of the highest murder rates in the world, the exposure of Jamaican children of all ages to external violence is exceptionally high. In recent years this has been well documented. A 1999 all island study of 245 randomly selected pre-school and primary school children of all social classes (48% male) between the ages of 4.8 - 7.7 years revealed that almost three in four (70.4%) had seen somebody being beaten up, over half (53.5%) had heard guns being shot, over one in three (38.4%) had seen a dead body (other than at a funeral), over one in three (36.5%) had seen somebody get stabbed and one in four (24.5%) had witnessed somebody get shot.^{xxxv} A comparative study in the same period of 202 boys (100 identified as aggressive and 100 as pro-social) in Grades 5-6 (average age was 11.7 years) in 10 randomly selected schools in the urban

areas of Kingston and St. Andrew indicated that over three in four (77.2%) had seen fighting on the street, over one in three (37.6%) had seen fighting with knives or guns, and almost half (47%) had seen a dead body killed by gunshot or knife.^{xxxvi} A more recent study, carried out between 2002-2003, of 410 older children aged 10-18 years (56.5% male), half in-school and half out-of-school, 80% poor and 6% near-poor, living in Spanish Town and other urban areas of St. Catherine, indicated that over half (58.3%) had seen someone stabbed, half (49.7%) had witnessed someone shot by a gunman, and one in three (35.6%) had witnessed someone shot by the police.^{xxxvii}

Child Experiences of Violence and Child Disciplinary Methods

Corporal punishment is a broadly accepted disciplinary method for children in Jamaican homes and schools, often under the mantra “Spare the rod and spoil the child”, although the 2008-9 school year commenced with the banning of corporal punishment in schools by the Minister of Education. Psychological punishment is also widely used in home and school situations. The World Report on Violence Against Children notes that corporal punishment is a predictor of depression, unhappiness and anxiety, and feelings of hopelessness in children and youth.^{xxxviii}

The 2005 Multiple Indicator Cluster Study of a nationally representative sample of 4,767 households found that in a population of 2,243 children between the ages of 2 – 14 years three out of four (74.8%) boys received minor physical punishment (shaken, spanked, hit or slapped on bottom with bare hand and/or hit anywhere on the body with a hard instrument and/or hit/slapped on arm, leg or hand) and one in ten (9.5%) severe physical punishment (hit or slapped on the face, head or ears and/or beat with an instrument over and over as hard as one could). Among the girls the respective figures were just under three in four (70.8%) and one in twenty (5.4%). Psychological punishment in the form of the child being shouted, yelled or screamed at and/or called dumb, lazy or a similar name, was received by the same proportion: just over three in four (77.2%) boys and just under three in four (73.2%) girls.^{xxxix} These punishments were delivered by mothers/caretakers or other household members and were reported by them. Some of the qualitative data from the St. Catherine study of adolescents gives a feel for the severity of some of the beatings: “I see a boy get beating with hose, cutlass, stick, name it.”; “I feel dat some of

the parents only need now to eat the children. The way dem beat dem is must kill dem intend fi kill dem and eat dem.”; “Mi mother tell me bad words and beat me till me can’t see.”; “Mother beat me and cut me bad and then she ask me brother to beat me too.”; “Father broke my nose for nothing. He quarrels for nothing.”; “Him beat me and me piss for days and blood come out.”; “Father beat me til me pass out. Me nuh even know if him did stop.”; “One boy of only 14 years was whipped repeatedly by his mother, and in one extreme case he was convinced she wanted to kill him. ‘She burst mi head wid a pot and den throw hot water pon me.’ Another 15-year-old boy was whipped so badly that neighbours had to intervene to save his life more than once.”; “Him say mi not to turn on de light but me don’t remember. Him get up and start beat me. When him finish me bruise up and me hand broke.”; “Him just get mad, when him finish me chin and above me eye dem cut, plus me two mouth corner tear from de slap dem wid him hand. Him use de mop stick when him hand tired” (the last two speakers are girls).^{xi}

The comparative study of aggressive and pro-social boys, in which 30 school administrators and 185 teachers were also interviewed, found that 87% of teachers reported that they beat children for misbehaviour. Beating by hand was carried out by only 10% of teachers but 81.1% of teachers used a belt, strap, ruler, board or book. 87.3% of children reported that they had been beaten by a teacher with an implement. Some of the other punishments received by the boys were making them stand and hold their ears or feet or hold out hands (36.2%), making them stand in the sun (8.9%), and making them kneel (6.8%). Half of the boys (49.9%) had been quarreled with or shouted at by teachers. A study published in 1999 on violence in school found that, while teachers had a difficult time controlling the fighting among the boys at lunch break and the bullyism, the students pointed out that teachers were almost as likely to emotionally abuse the children as parents. They reported teachers ridiculing students, showing favouritism and taking their own frustrations out on the class.^{xii} This information is reinforced by an unpublished 2007-2008 social assessment by UWI graduate social work students of the enabling factors and challenges to the readiness of young people 15-18 years to make the transition to work or further education, carried out in a working class community in St. Andrew. The study found a poor relationship between teachers and students. Of the 109 youths who participated in this study, nine out of ten reported negative experiences with teachers

at both primary and secondary levels: “Teacher treat yu like dawg”; “Teacher call we names like skettel and whore”; “Beat yu wid light wire and fan belt.”; “Sometime teacher mek yu feel like yu don’t even want come back a school”. One parent explained, “teacher do not treat the students right.....teacher call mi son a monkey...now him get silent and don’t talk or respond in class”.^{xliii}

The Role and Situation of Parents

A key finding of the research into the Jamaican pre-school child has been the level of stress among Jamaican parents of all social classes, chiefly mothers, who “experienced a much greater level of parenting-related stress than did American parents.”^{xliiii} The study found that near to half (45%) of Jamaican parents experienced high levels of parental stress compared to just over a third (37%) of American parents. Against the background of the following information, support for parents becomes a key issue:

- The quality of parent-child interaction and parental involvement are both associated with academic achievement among children.^{xliv}
- Children of dysfunctional families have higher rates of psychiatric illness, poor self-esteem, poor academic performance and problem behaviour.^{xlv}
- In a study of pre-school children outside Jamaica the parent child interaction, as measured by the Parental Stress Index, was found to be the most powerful predictor of behaviour problems, when considered with child temperament and child health.^{xlvi}
- In the study of 202 Jamaican boys the variables which were significant predictors of aggression were the children’s experience of and attitude to violence, physical punishments at home and at school, crowding (no. of adults in the home – aggression significantly correlated with less adults), school achievement and socio-economic status.

Societal Response

Children are vulnerable to stressful experience. The impacts can last a lifetime and result in heavy costs for society. As the United Nations World Report on Violence has pointed out, “Thus, the opportunity to prevent violence against children promises to address a

host of longer-term problems that impose a substantial social and economic burden on the nations of the world^{xlvi}. These problems include the violence which has traumatized so many and of which society is weary. A network of support is needed to address the impacts of violence not least of which is support for at risk families and vulnerable parents. The recognition of the sensitive family situation is captured in the introduction to the Ministry of Health guidelines for management of child abuse victims: “Child abuse occurs as a consequence of interaction between a vulnerable parent and a vulnerable child, especially when stressors such as poverty, single parenthood, social isolation and young parental age are present.”^{xlvi}

For children whose stress has been particularly severe, chronic or pervasive (widespread, permeating, spreading throughout their environment) there will be difficulty overcoming their persistent physiological and psychological responses to earlier stressors (related to how the brain is wired – especially when forming). “Lingering symptoms of post-traumatic stress disorder (PTSD) or disrupted attachment can present as difficulties with sleep, anxiety, oppositional behaviour, violent behaviours, and school failure.”^{xli} Problematic behaviour may continue long after abuse or neglect have ceased and loving attention has been given by foster, adopted or birth parents who have successfully changed their behaviour. “...the child’s unsatisfactory response to stress may have originated as a biologically based adaptation to the child’s abnormal world and persisting problem behaviours are the consequence.”¹ Several different types of interventions may be needed to assist the child in resuming a normal development trajectory. The advice of the experts is that the investment here will save much more down the road and that, worse still, in a later time the developmental path may close.

Camp Bustamante was developed and initiated in 2004 by the Health Promotion and Protection division of Ministry of Health, as a hospital-based response to an increasing awareness of the plight of Jamaican children and violence. The project supported by UNICEF aimed to identify children at risk of violence from hospital injury surveillance data and to intervene by way of case management and referrals to minimize further harm. Therefore as part of a comprehensive assessment of this project, this review of the current

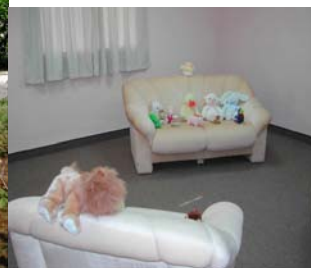
literature provides an important framework in which key stakeholders, governments and funding bodies may consider the issue of child protection in Jamaica.

BEST PRACTICE EXAMPLES OF CHILD ABUSE TREATMENT CENTRES



The Philippine General Hospital, Manila (Child Protection Unit)

The Chadwick Centre for Children and Families at Rady Children's Hospital, San Diego, California



The Centre for the Protection of Children and Adolescents, Havana, Cuba

The Child Abuse Mitigation Project at the Bustamante Children's Hospital (CAMP Bustamante) appears to be the only hospital-based child abuse centre in the Caribbean. Cuba does however have a state-of-the-art centre for the forensic video interviewing of abused children, usually victims of sexual abuse. It also provides support for all abused children and their families who are referred to the centre or who drop in. It is not, however, hospital based. Generally there are very few hospital based centres for the treatment of child abuse victims in the developing world. This short review of best practice models looks at one best practice model in a developing country and one in a developed country as well as the Cuban model which is of particular interest. The first is the Child Protection Unit in Manila, capital of the Philippines, a country with a much larger population than Jamaica but similarly positioned economically and socially as a country with Medium Human Development on the Human Development Index². The second is the Chadwick Centre for Children and Families, a best practice model in San Diego, California, in the United States of America, a country with High Human Development on the HD Index³ (see Table 6 below for further details). While staff numbers were only obtained for CAMP Bustamante (at peak staffing periods) and Chadwick, they bring out the resource gap which must impact outcomes however well qualified and committed the staff. The ratio of the former is 1: 70 children, the latter 1:10. The information on the Philippine centre suggests that the staff:child ratio would certainly not be as low as CAMP Bustamante.

The Child Protection Unit (CPU) at the Philippine General Hospital, Manila

This Unit developed with the assistance of a Washington based NGO, CityBridge Foundation, following their research in 1994 on street children in Manila which found that unidentified child abuse was a significant cause of homelessness for children. CityBridge worked with model programs in the United States and local experts in Manila

² In the latest report (2007-08) the Philippines is at 90 and Jamaica at 101 out of 177 countries

³ At 12th position in the latest report. However some key health indicators among black and ethnic minorities in the US (HIV/AIDS, infant mortality, life expectancy) are on par with developing countries.

Table 6

Country Population GDP per capita (US\$)	Centre Hospital where it is based Date started	Av. # seen per yr	# Prof. Staff
Jamaica 2.6m (2007) \$4,104	Child Abuse Mitigation Project (CAMP Bustamante) Bustamante Hospital for Children 2004	275 Cases	4
Cuba 11.2m (2006) ----	Centre for the Protection of Children and Adolescents Not hospital based 2005	450 Cases	----
Philippines 88.5 m (2007) \$4,321	Child Protection Unit (CPU) University of the Philippines College of Medicine/Philippine General Hospital 1997	972 Cases (2005)	----
USA 305.2m (2005) \$37,562	Chadwick Centre for Children and Families Rady Children's Hospital 1976	1,200 child and adult victims	120
Sources: Official statistics; GDP from Human Development Report 2005 UNDP	Sources: Cuba: Child Protection Development Trust www.cpdtrust.org/assets/media/havana-project-brief.pdf ; Philippines: UN World Report on Violence and www.citybridgefoundation.org/index.html ; USA: Chadwick Centre for Children and Families www.chadwickcenter.org and Report on Participation at Institute of Violence, Abuse and Trauma (IVAT) Conference 2007 by Rose Robinson- Hall, Project Coordinator, CAMP Bustamante		

to design a state-of-the-art full-service treatment center for abused children at the Philippine General Hospital, a public university teaching hospital with some of the lowest fees in the entire country. Today there is a network of 25 child protection units at hospitals all over the country with staff that have been trained and/or certified at the unit in Manila.

The CPU provides comprehensive medical and psychosocial services for maltreated children and their families, aiming to prevent further abuse and to start the process of healing.

“In 2005, the CPU cared for 972 new cases of maltreated children, 81% of whom had been sexually abused...(It) provides quality care using a multisectoral approach which coordinates the actions of the health, legal and social sectors through CPU’s case management system. The CPU provides legal and police services, judicial hearings, medical services, guidance and support to the child and next of kin, as well as therapy or referral to other specialised medical services, when necessary. The CPU also provides other

social services to very poor families, including grants for the child's school-related costs and interest-free loans for livelihood assistance. Parenting classes help parents manage their expectations of their children, help them to better understand their children's behaviour, and adjust their methods of discipline accordingly. Each child has a CPU case manager to coordinate all services received by the child and the family, and to facilitate and monitor child safety placement, legal assistance and mental health care. Case managers work with the children and families for as long as is necessary."

The Chadwick Centre for Children and Families at the Rady Children's Hospital, San Diego

The Chadwick Center is one of the largest child abuse centres in the world, attached to a large children's hospital in San Diego, California, which serves approximately 8,000 children each year. The Chadwick Center employs over 120 professionals and para-professionals from the fields of medicine, social work, psychology, psychiatry, child development, nursing and education technology. "The staff is committed to family centered care and a multidisciplinary approach to child abuse and family violence." The services at the Centre include medical forensics, professional education, research, trauma counseling, family therapy and education technology. Their programmes treat child and adult victims of violence.

The centre also operates 15 satellite services across the county where staff members work with community agencies, law enforcement and the District Attorney's office. "The Chadwick Center provides a continuum of services with an integrated, multidisciplinary approach to healing intervention and family support. Outcome evaluation is an integral component of all services. " Programmes include:

- Family Support Programme. This operates both as an early intervention and prevention service including material help to families under stress and hence at risk for abuse and neglect.
- Family Violence Programme. This allows for treatment of victims of domestic violence with a special emphasis on how this affects the children in such situations.

- Forensic Medical Services. This includes a Sexual Abuse Response Team (SART) which is on call for 24 hours, every day of the week. Home visits are conducted by para-professionals in conjunction with the state Child Protection agency and screening of risk and safety are done according to standard instruments.
- Specialist Trauma Counseling Centre. Services in this area include Parent Child Interactive Therapy (PCIT) and Parent Child Attunement Therapy (PCAT).
- Kids and Teens in Court. This prepares children who are required to attend court and assists in facilitating safe and successful evidence by reducing the stress and anxiety of being in court.
- Professional Education Services. Major educational activities include the annual week-long San Diego International Conference on Child and Family Maltreatment; the Clinical Training Program conducted on and off site (professionals from Africa, Latin and South America have benefited from this module), the weekly multidisciplinary Child Protection Team Case Conference, and various local, county, and state trainings funded through contracts.

The Centre for the Protection of Children and Adolescents in Havana

Like the other best practice models in this review, this centre has a multi-agency approach and focuses on the welfare of children and families. It has state-of-the-art video recording facilities for forensic interviews of child victims to be used in court, avoiding the trauma of secondary victimization⁴, and was set up in 2005. These facilities use standard UK court video recording equipment and procedures and were set up through the UK Child Protection Development Trust, whose consultant, Dr. Tony Butler, undertook a Child Protection Audit in Jamaica in June 2008 under the auspices of the Family and Parenting Centre, a Montego Bay-based NGO, and the Office of the Children's Advocate. The Centre, however, is deliberately situated in a pleasant house (with rooms equipped with toys, computers etc.) in a residential district, quite unlike an official building, to create a friendly and reassuring atmosphere.

⁴ The trauma of secondary victimization can happen when children have to recount their sexual or other abuse in formal, non child-friendly situations (police stations, court in the presence of the perpetrator etc.) or when they have to recount their experiences to a string of professionals: police, doctor, social worker, psychologist, prosecutor, judge and so on.

The Centre is staffed by child protection specialists including psychologists and social workers. An out-of-uniform specially trained police officer carries out the videoed forensic interview once all the preparatory background work has been undertaken. If the child wishes their mother to be present she can sit beside her/him on the settee which faces the camera (see photos above). This interview should now be the only occasion on which the child has to relive the details of the experience of abuse. Others can watch the interview live, or later, on video. The interviewing officer can also be spoken to on a hidden microphone. Afterwards the police investigation continues while the child and their family receive counseling and support from the centre for as long as is required. The child may also be referred to other specialists. The Centre is unique in the Caribbean and Central America.

QUANTITATIVE ANALYSIS OF CAMP BUSTAMANTE DATA

Data collection method and sources

Data were extrapolated from the Camp Bustamante (CB) Data Management System (CB/DMS). Initial data that were recorded on visits by children 0-12 years to BHC for suspected violence related injuries and characterized as such by information given at registration, were obtained from the Jamaica Injury Surveillance System (JISS) at Bustamante Hospital for Children (BHC). Reporting was for the purpose of investigation and intervention by CB. Data was exported to Excel for graphical presentations and to Stata Intercooled 9, Statistical software package for statistical analyses.

Summary

For the period January 2004 to June 2008, 321,615 children attended the Accident and Emergency Department (A&E) at Bustamante Children's Hospital and 1,284 VRI cases were identified, representing an average of 0.40% of the total A&E intake for VRI over the period (See Table 7 and Fig 1).

Table 7: Visits to A&E and VRI

Year	A&E	VRI	%
2004	68,787	343	0.49
2005	60,009	211	0.35
2006	67,289	268	0.40
2007	76,777	276	0.36
Jan-Jun 2008	48,753	186	0.38
Total	321,615	1,284	0.40

For the period January 12, 2004 and June 2008 in which cases were recorded there was a total of 1,284 suspected violence related injuries reported to CB in children 0-12 years (clients). The burden of morbidity was approximately equal among females and males. There appears to be a reduction in cases between 2004 and 2007 (See Table 8 and Fig. 2). Data in 2008 only captures January to June 2008 and of the total 1284 cases, 300 cases have not been fully entered in the CB/DMS which may affect the data on referrals.

Fig. 1

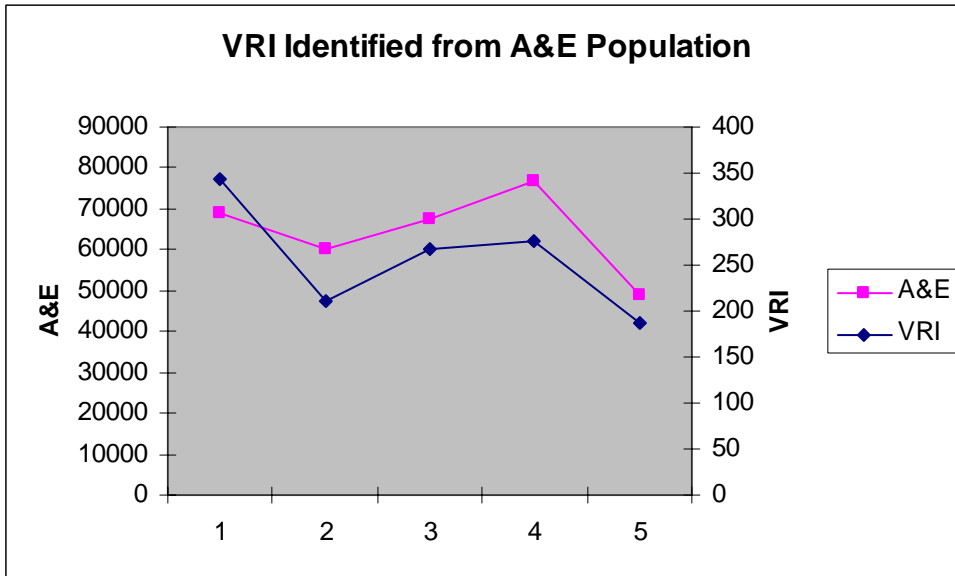
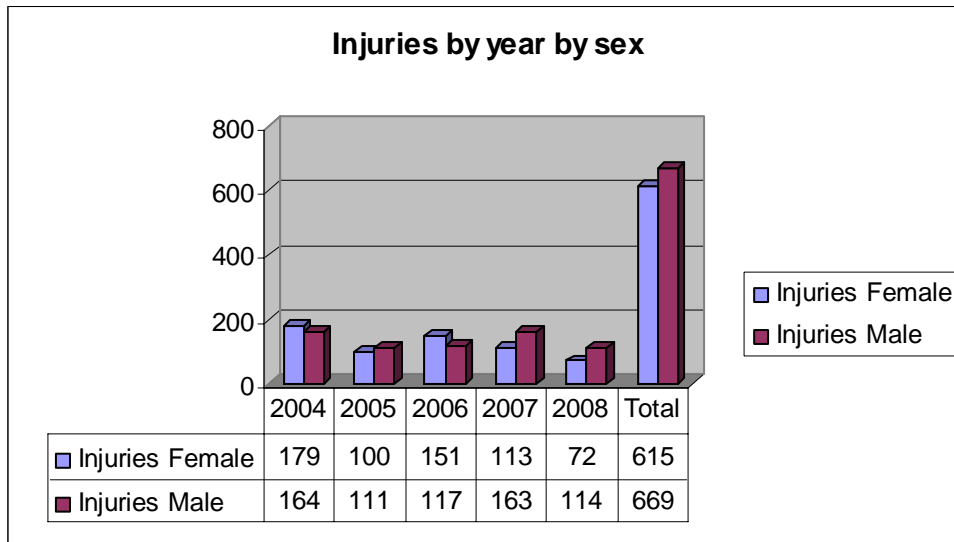


Table 8.

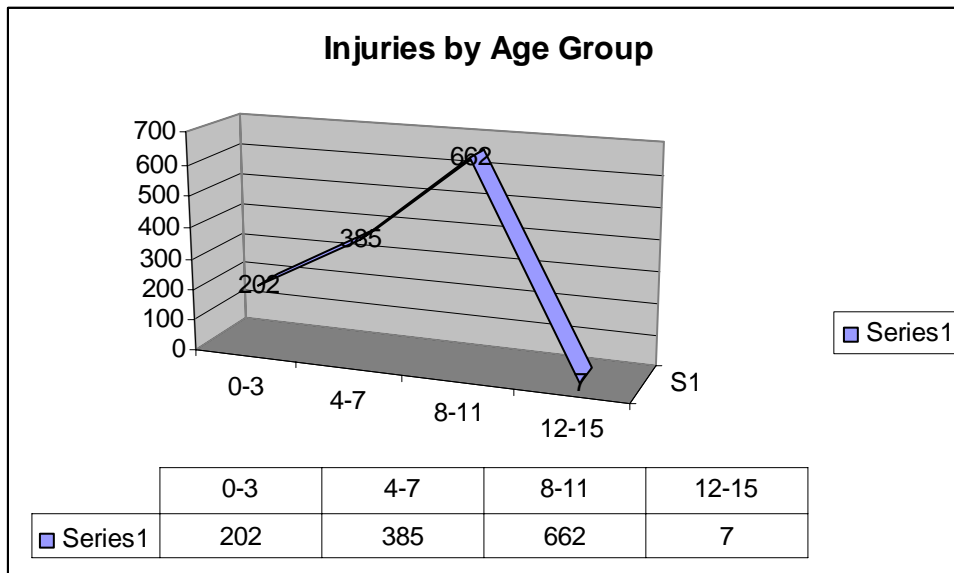
Total Intake						
YEAR	Female	% of total	Male	% of total	Total	% of total
2004	179	29.1	164	24.5	343	26.7
2005	100	16.3	111	16.6	211	16.4
2006	151	24.5	117	17.5	268	20.9
2007	113	18.4	163	24.4	276	21.5
Jan-Jun 2008	72	11.7	114	17.0	186	14.5
Total	615	47.9	669	52.1	1,284	100

Fig. 2



In relation to 1,256 recorded injuries according to age, the majority (52.7%) took place in the 8-11 age group, followed by 30.7% (4-7 yrs), 16.1% (0-3 years), and 0.5% (12-15 yrs) (BCH serves children 0-12 yrs) (see Fig. 3.)

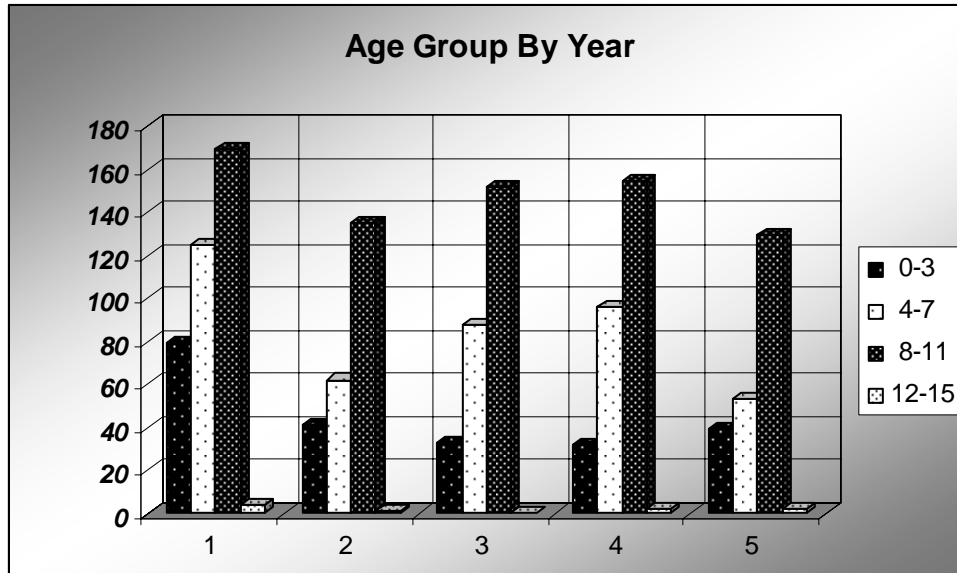
Fig. 3



It would appear that injuries increase significantly with advancing age and this is also reflected in the views and rationale of parents in focus group discussions (See page 98)

There appears to be an encouraging downward trend in the incidence of VRIs among the youngest and most vulnerable age group (0-3 years) from 2004-2007, but this needs to be investigated further (Fig. 4) to eliminate data artefact or reduced health seeking behaviour for VRI due to the passing of the Child Care and Protection Act in 2004.

Fig. 4



Clients Reached

Of the total number of cases reported to CB during the life of the project (LOP) out of 1,622 planned visits entered in the CB/DMS, 836 visits were made (n=836, 51.5%) to either the home, school, hospital or others venues and it is not clear whether these visits were to individual clients or the data includes follow up visits. Inconsistencies in the data make it difficult to assess the percentage of total clients seen by CB as various fields in the database show different total intake numbers as follows:

- *Sex by perpetrator 1269*
- *Age by injury type 1256*
- *Injury type 1269*
- *Age of child by perpetrator type 1269*
- *Location by gender 1392*
- *Sex by injury 1366*

- *General Queries 1384*

However calculating an estimate of clients seen by CB based on the most frequently calculated figure of 1,269 with 836 visits, it appears that 65.9% of clients received at least one visit and 34.1% were either not seen or lost to follow up due to insufficient locating information, inclement weather conditions, police interventions or community violence. This is consistent with the CB Annual Report 2007⁵, which reports that approximately one third of clients in 2007 could not be located.

Response Time

From a random sample of 50 cases and information recorded in the CB/DMS, the response time in relation to the target of 72 hours is as follows (see also Table 9 and Fig 5.):

- 5 (10%) of cases were unable to be located (UTL) which raises questions about the need to improve collection and verification of locating information for vulnerable children on attendance to hospital.
- 4 (8%) were police cases in which CB could not intervene which has implications for the well being of the victim, when pursuing the perpetrator becomes the primary focus of the investigation.

After removal of police and UTL and Police cases, the following is found:

- Only 1 client (2%) was contacted within the 72 hour target.
- 9 (22%) were contacted between 4-7 days
- 3 (7%) were contacted between 8-10 days
- 2 (5%) were contacted between 11-15 days
- 1 (2%) was contacted between 16-20 days
- 1 (2%) was contacted between 1-2 months
- 7 (17%) were contacted between 3-6 months

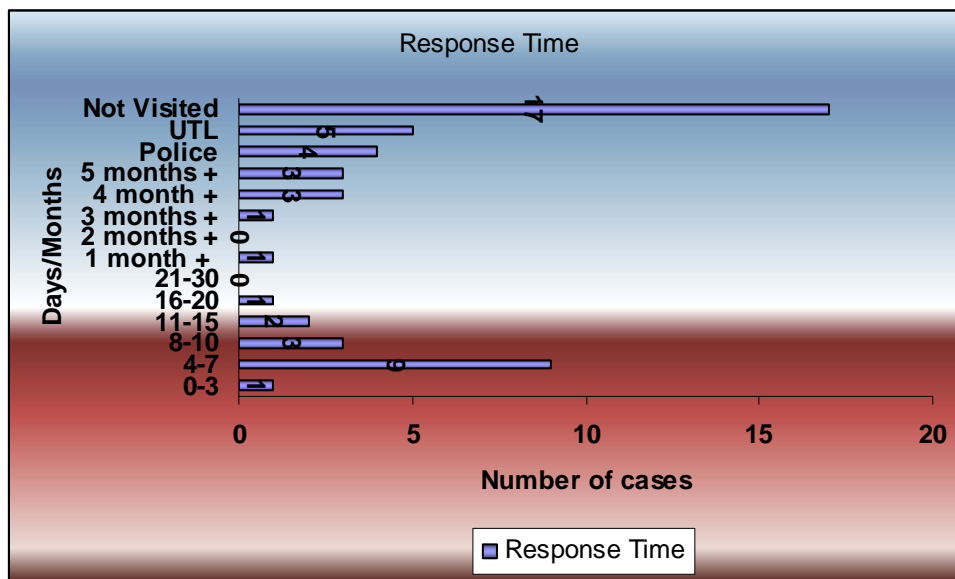
⁵ Camp Bustamante Annual Report 2007

- 17 (41%) clients were not visited and many had not been assigned to a social worker. Individual case files on the database did not contain any information to explain this.

Table 9: Response Time

Days	Response Time	Percentage	Summary
0-3	1	2%	<i>32% of cases were seen within 30 days</i>
4-7	9	18%	
8-10	3	6%	
11-15	2	4%	
16-20	1	2%	
21-30	0	-	
1 month +	1	2%	
2 months +	0	-	
3 months +	1	2%	
4 month +	3	6%	
5 months +	3	6%	
Police	4	8%	52% of cases were not seen by CB
Unable To Locate (UTL)	5	10%	
Not Visited	17	34%	
Total	50	100%	

Fig. 5



On further cross referencing of the information to ensure that completeness of data was not affecting the results, individual case files were requested for manual examination. Of 50 files requested, only 30 files could be located. After confirming that manual case files for UTL contacts were opened, it appears that 20 of the 50 case files requested had been mislaid. The following was found:

- Response times for visits were consistent with the database in 24 out of 26 cases that were locatable (92%). In two cases the dates for receipt of cases were incorrect altering the response time from 6 days to 4 days in one case and from 10 days to 15 days in the other.
- A total of nine cases out of the 30 cases were not visited because:
 - Six cases were unable to be located and this information was a difference of one with the database that recorded 5 UTL
 - Three cases were in the hands of the police which was consistent with the database and possibly a GSW case, although the cases files, like the database, do not explain why this case was not visited.

Clients Referred

In relation to referrals it would appear from the available data that CB referred very few cases (164) to other agencies and the CDA and this has implications for statutory requirements for child protection and adequate intervention, as most clients appear to have received only one visit in which a social investigation took place. However because there are approximately 300 incomplete cases, with referral data known to be missing in many, this picture is almost certainly incomplete. Referrals to other agencies include the Children's Registry, Child Guidance Clinic (CGC), PATH, CISOCA, Victim Support, Family Court, Women's Crisis Centre, and Bethel Family Counseling among others.

Figure 6 shows the proportion of all cases that were reported to other agencies based on the data available at this point:

Fig.6

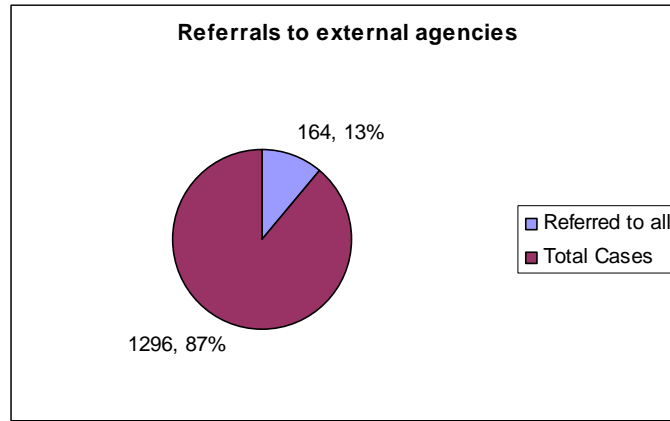


Figure 7 shows the percentage of clients referred to the Child Development Agency (CDA) over the LOP.

Fig.7

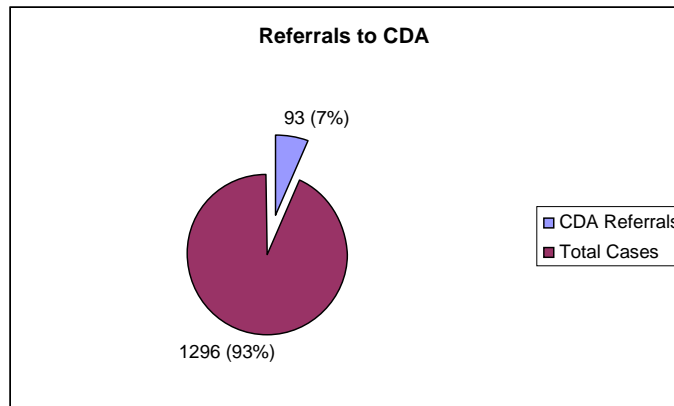
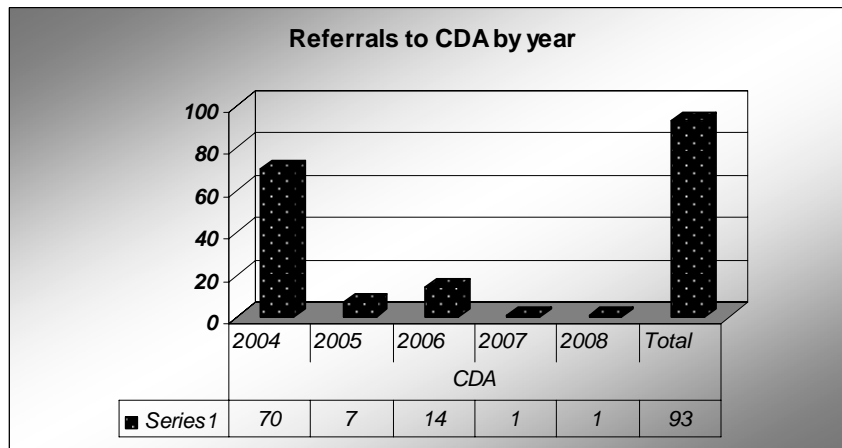


Fig. 8: Referrals to CDA by year 2004-2007 and Jan-Jun 2008



Injury Types and Methods

Injuries were recorded under 19 categories as follows (Table 10), with significant categories highlighted by percentages:

Table 10

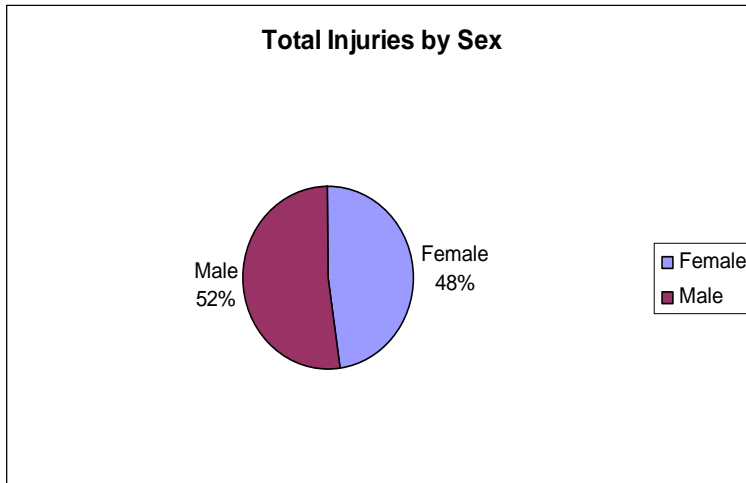
Injury Types	Number	%
Blank	104	8.3
Accidental blunt	8	
Accidental burn	1	
Accidental laceration	5	
Animal related	4	
Blunt object	279	22.3
Chemical burn	2	
Choking/strangulation	1	
Falls	18	
Gunshot	71	5.6
Other	45	
Poisoning	1	
Push	240	19.2
Sexual Assault	293	23.4
Skin lesions	2	
Stabbing/sharp object	183	14.6
Thermal burn	15	
Unconscious	1	
U/K	94	7.5
TOTAL	1253	

The highest prevalence of all injuries was sexual assault (23.4%), followed by an injury caused by a blunt instrument (22.3%) and pushing and stabbing (19.2% and 14.6% respectively).

Accidental injuries are recorded by CB, when injuries are found to be unintentional consequences of violence.

There appears to be an equal chance of becoming a victim of a violence related injury among females and males 12 years and under with a slighter higher prevalence seen among males (see Fig. 9).

Fig. 9



Gunshot Wounds

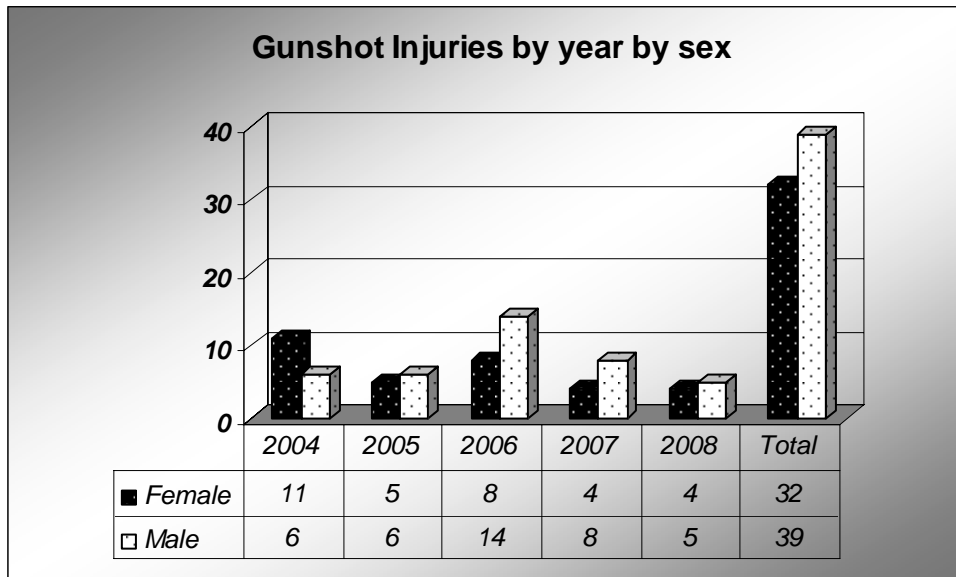
Gunshot wounds (GSW) represent a disturbing trend (5.6%). However these figures do not include ‘dead on arrival’ to hospital cases, that the JISS does not capture. Therefore these cases do not get reported to CB and the extent of this problem is not reflected in the data presented (Table 11).

Table 11

Gunshot Wounds by Year & Sex	Female	Male	Total
2004	11	6	17
2005	5	6	11
2006	8	14	22
2007	4	8	12
Jan-Jun 2008	4	5	9
Total	32	39	71

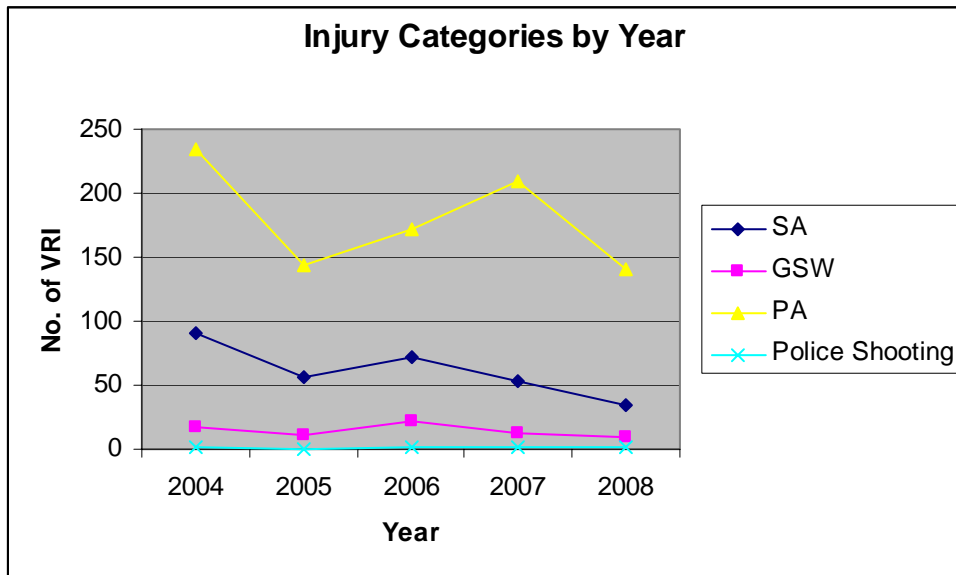
It is evident that vulnerability to GSW is similar among males and female 0-12 and this can probably be explained by the random nature of these events with children in this group (see Fig. 10).

Fig.10



The following Figure 11 shows injuries by type. Note the 2007 spike in physical assaults which is continued in the 2008 projection (Fig. 11).

Fig. 11



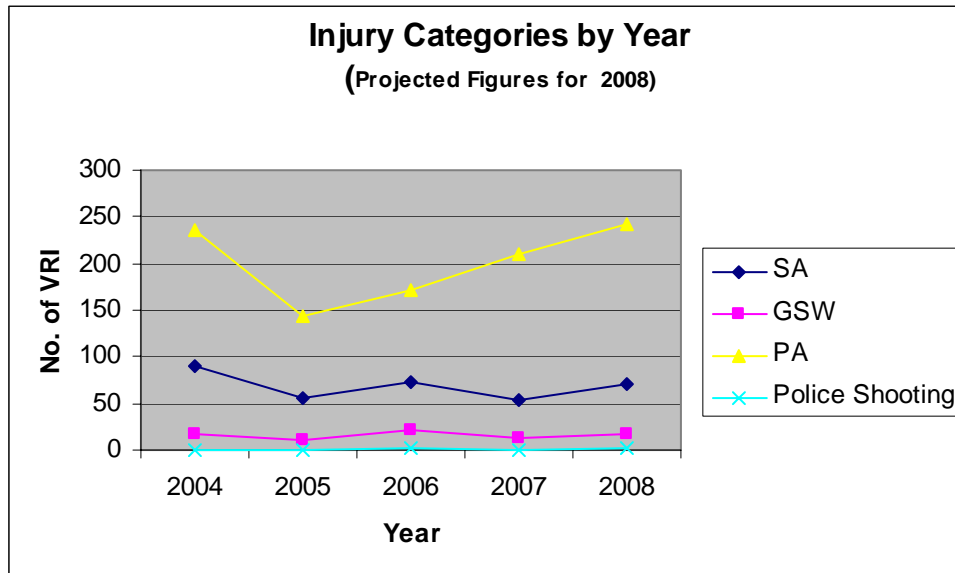
If a projection is made for 2008, based on a doubling of the figures for the first six months of the year, injuries as a result of physical assault will be the highest in four and a half years (Table 12 and Figure 12). However caution must be used since there are

seasonal patterns, one of which is a lower number of visits to A&E during the summer months and this will certainly result in a reduction in VRI taking place in schools.

Table 12: Injuries with Projected figures for 2008 (Half yearly figures doubled)

	SA	GSW	Police Shooting	PA	
2004	90	17	1	235	
2005	56	11	0	144	
2006	72	22	2	172	
2007	53	12	1	210	
2008	70	18	2	242	

Fig. 12



Sexual Assault

Over the past five years reports show young females are disproportionately vulnerable to sexual assault, as shown in Figures 13 & 14 with a total of 306 reported sexual assaults to CB, 87% of which were committed against females. However between 2004 and 2007 there appears to be a 41% reduction in reported sexual assault to CB among males and females.

Fig. 13

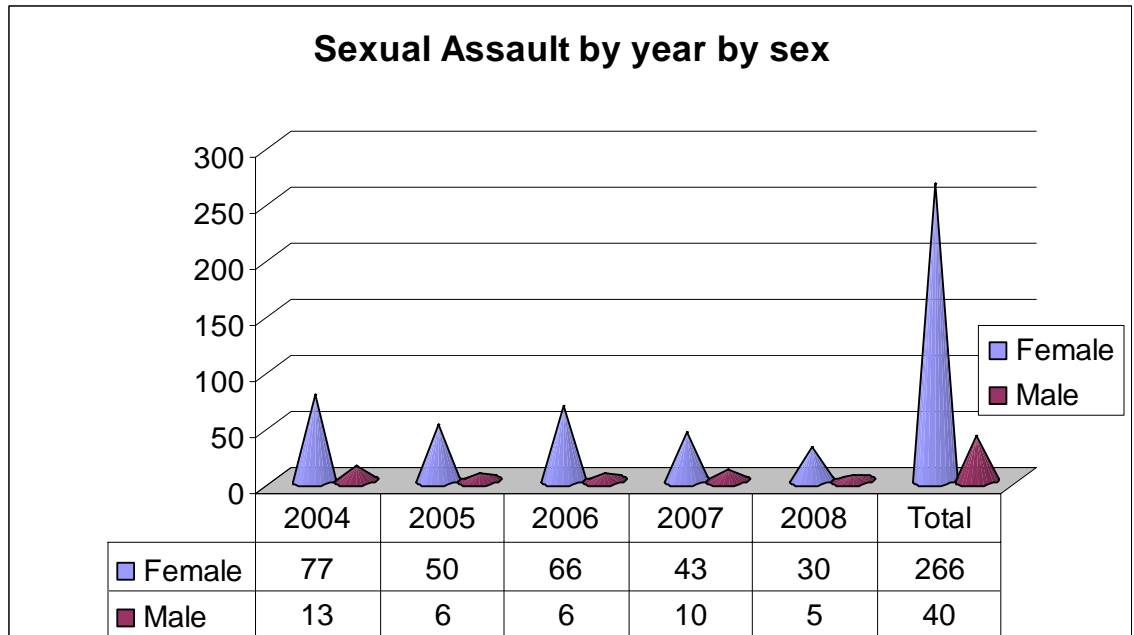
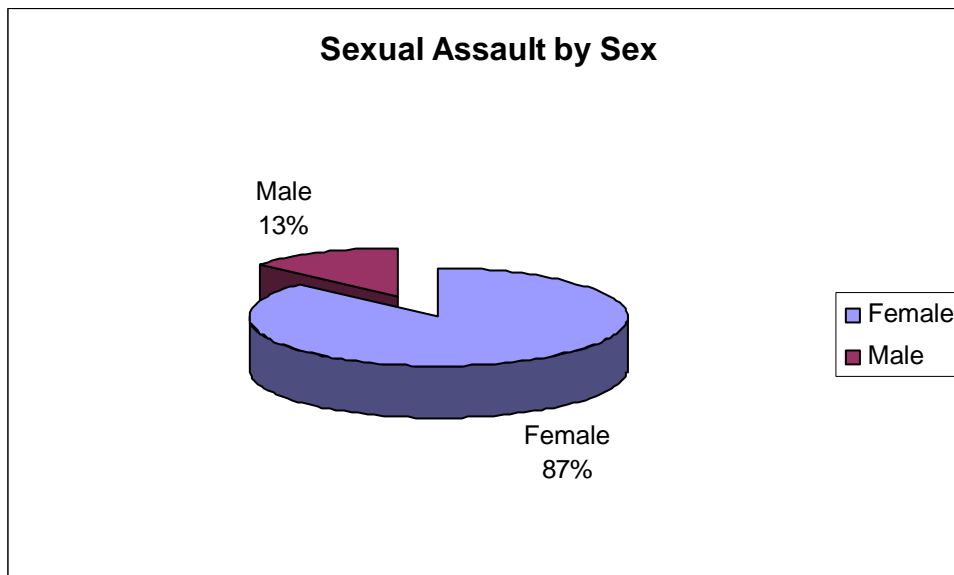


Fig.14

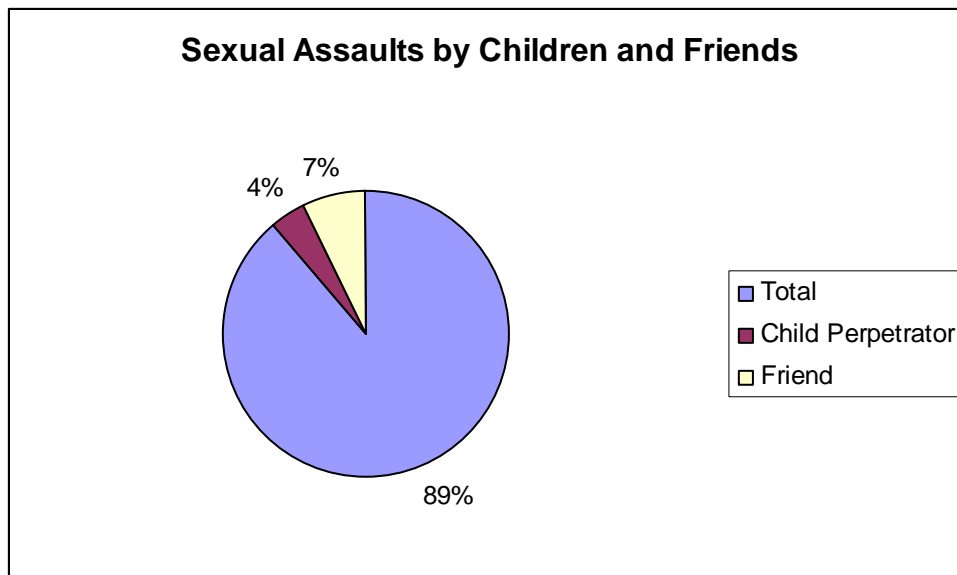


There are no fields in the CB/DMS to capture referrals by injury type; therefore it is unclear how many sexual assault cases were referred to the CDA or the Office of the

Children's Registry. Moreover since the data is incomplete no further work can be carried out until the data is entered.

An extremely disturbing trend is the number of sexual abuse cases that are perpetrated by children on much younger children. Of the total number of sexual assault cases 4% are committed by children and 7% by friends. It is unclear however whether child perpetrators may also be categorized as friends or, acquaintances, which may mean that this proportion is much higher (see Fig. 15) (see also case studies in Table 14, p. 78).

Fig. 15



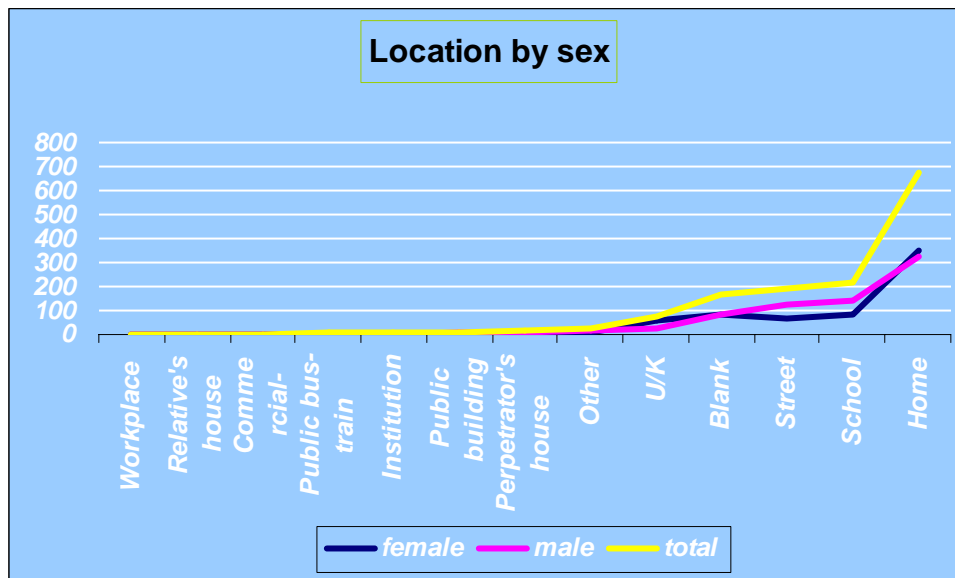
Location of violent episodes

Almost half of violence related injuries took place in the home (48.6%) followed by the school (15.8%) or the street (13.6%). Localities were not recorded in 13.9% of cases. There was no difference between the location of injury and sex of the child (see Table 13, with significant categories highlighted by percentages, and Fig 16).

Table 13

Location	Number	%
Home	677	48.6
School	220	15.8
Street/Highway	189	13.6
(Blank)	163	13.9
Unknown	79	
Other	22	
Perpetrator's House	15	
Institution	8	
Public building / Recreation / Cultural	8	
Public bus / train /parking lot	5	
Commercial area / shop / market	3	
Relative House	2	
Work place	1	
Grand Total	1,392	

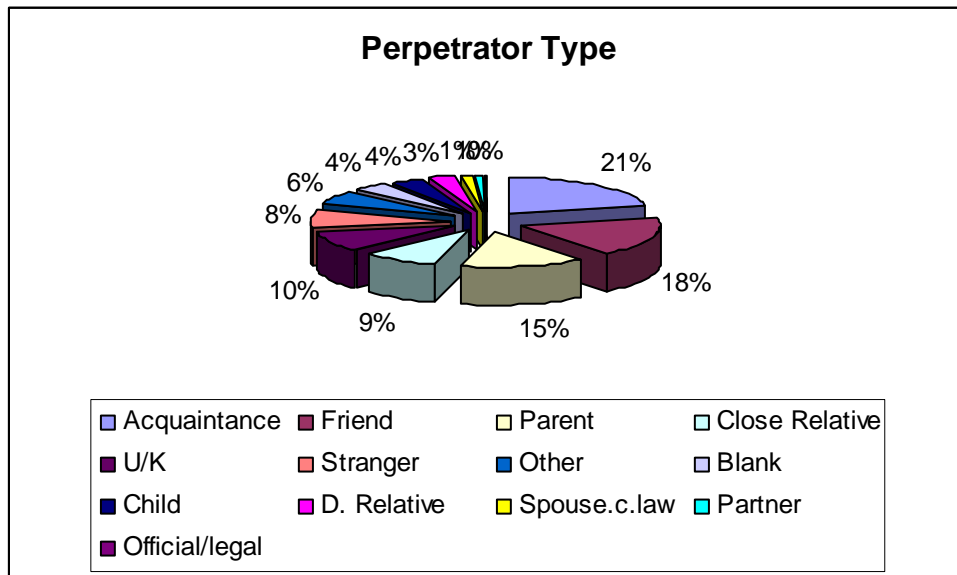
Fig.16



The disturbing trend of children receiving serious injuries requiring hospitalization when at school, raises grave concerns about the supervision of children in school settings, the events that trigger these violent attacks, the carrying of weapons into schools, and the teachers' capacity to control these types of events.

It appears that children are at the most risk from people they know well. The main perpetrators of violence were acquaintances (21%), friends (18%), parents (15%) and close relatives (9%). Perpetrator type was unknown in 17% of cases and in 4% of cases the perpetrator was another child (see Fig. 17). Again with regard to the latter percentage, in the 18 case studies and 30 pulled files the percentage of child perpetrators involved was much higher, raising questions regarding the mutual exclusivity of categories, e.g. do the categories relating to close and distant relatives include children?

Fig. 17



Comparing risk by sex of child and perpetrator type, the odds ratio of 0.88 (CI .534, 1.24) (Stata) suggests a 12% lower risk of violence among females than males for all categories combined. However as the confidence interval contains 1, this may not be significant.

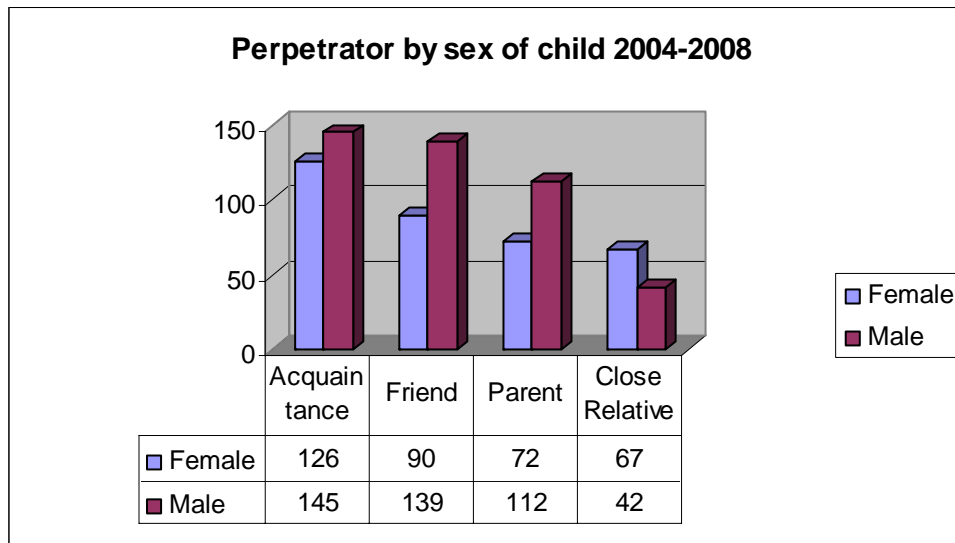
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|           Linearized
|           Ratio  Std. Err.  [95% Conf. Interval]
-----+-----
| _ratio_1 | .8805147  .1347211  .5342031  1.226826
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In relation to perpetrator type and sex of child from VRI inflicted by acquaintances, slightly more male than female victims were reported in this category (11.4% and 9.9% respectively). Similarly for friends - 10.9% male compared to 7.0% female victims, and for parents - 8.8% for male compared to 5.6% for female victims (see Fig. 18).

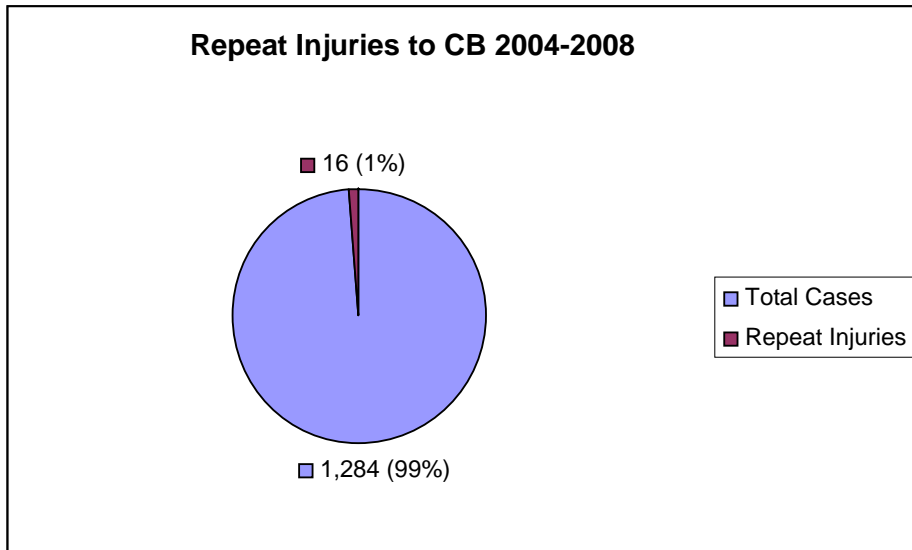
Fig.18



Repeat Injuries

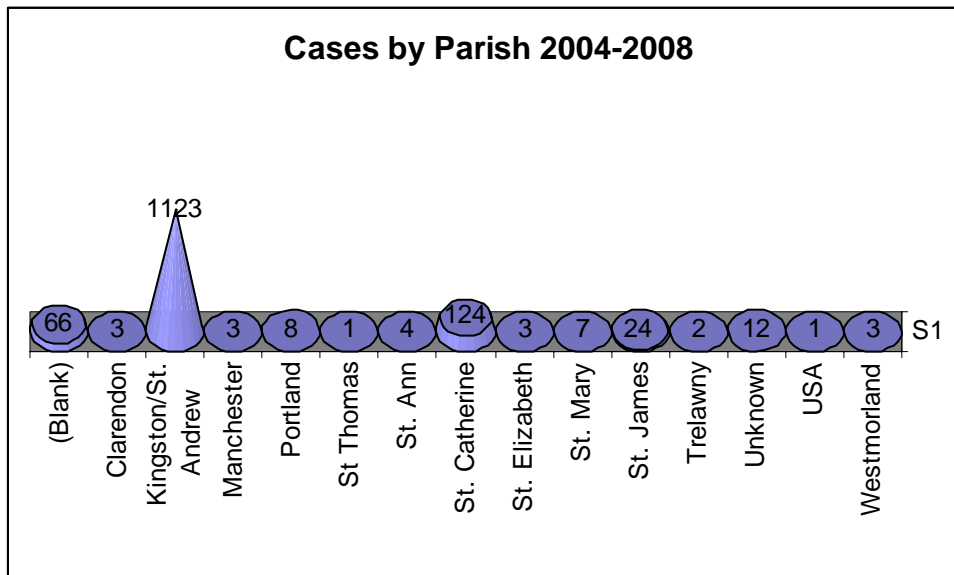
It appears that there were a small proportion of repeat injuries to CB. However although the database includes a field to record previous injuries, it cannot generate a report on these and there is no field to capture repeat injuries, therefore these were calculated from double entries to the database. Of 28 double entries to the CB/DMS, 16 of these were found to be repeat injury cases and 12 were data entry errors. Therefore it would appear that 1.25% of children returned with repeat injuries (See Fig. 19).

Fig. 19



The majority of VRI to Camp Bustamante took place the parish of Kingston and St Andrew, with cases also coming from St Catherine, Clarendon, Portland and St James. There are also a number of cases where the parish is recorded as blank (See Fig. 20).

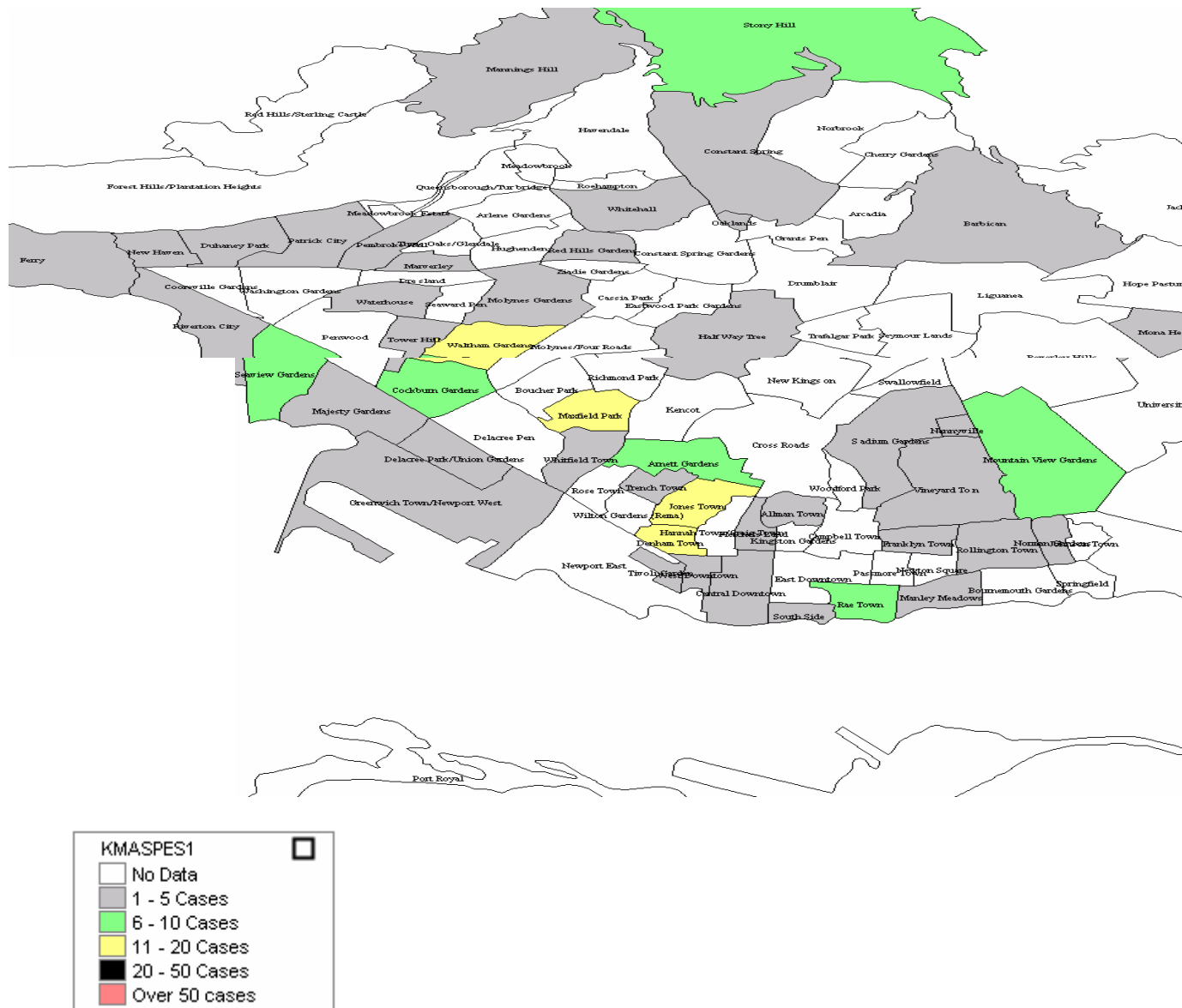
Fig. 20



Demographic and Socio-economic Factors

Geographical and socio-political risk factors in relation to VRI in children are in need of careful examination. The map in Figure 21 was generated from CB/DMS and transported to GIS mapping. It shows a distribution of cases between 2004 and 2007. It is noteworthy that with the exception of Stony Hill the communities with the highest number of VRI in children, shown in keys green and yellow, occur in the following inner city communities

Fig. 21: GIS Distribution of Cases by Communities 2004 - 2007



most of which have been classified as political garrisons, either currently or in their recent past: Waltham Gardens, Maxfield Park, Jones Town, Hannah Town, Denham Town, Arnett Gardens, Cockburn Gardens, Seaview Gardens, Mountain View and Rae Town. The communities that do not appear in the cases are noticeably those communities of higher socio-economic status and non partisan persuasions. Population density must also be considered as a possible risk factor as overcrowding and sub-standard housing contribute to family tensions and domestic violence.

Review of Database

The database has the capacity to generate important data as previously shown and is designed in the user friendly Access programme (Visual Basic for the graphical user interface and MS SQL server as the back end)⁶, which is familiar to many Microsoft Windows users and does not require specialist training in its use. However the limitations of the database are that fields to capture critical epidemiological indicators are missing and this is most likely due to non specific DB specification instructions as outlined in the consultant Terms of Reference (TOR). This TOR includes six objectives as follows:

1. To develop an electronic database management system to process data from case management forms, referral forms and other client encounter forms and reports.
2. To generate a standard set of local and national summary reports
3. To create ad hoc local reports
4. To be compatible with demographic reporting requirements for GIS mapping
5. To incorporate the health GIS in the production of an inventory of maps
6. To allow fast retrieval of client records

The request for reports in the TOR include four areas:

1. Design monthly and ad hoc VRI reports, including injury type, disaggregated by gender, age, victim-perpetrator relationship and risk category.
 - a. The report should be designed to allow comparisons of injuries using time-trend series analysis where year/month to date comparisons are plotted and presented in a table format
 - b. A GIS hot spot map should be included in monthly/quarterly reports for types of intentional and unintentional VRI
2. Provide monthly report of cases separated in high, moderate and low risk
3. Provide monthly report of cases that have been referred, segregated by organization to which cases were referred:
 - Child Development Agency
 - Child Guidance Clinic
 - Police

⁶ Electronic Database Management System Proposal for Camp Bustamante

4. To train support staff to generate reports

Whilst Objectives 1-6 have been met, only number 1, 3 and 4 of the specified reporting requirements were met. Some fields capture important demographic determinants existing within the DB, e.g toilet facilities, water source and light, but these fields are qualitatively designed and would benefit from quantifiably coded data entry fields to facilitate evaluation of these variables.

It may also be the case that given the dynamic nature of the project and increased knowledge about risk factors in relation to children and violence, the reporting requirements changed over the LOP and the database has not been kept apace. However some of the initial reporting indicators outlined in the UNICEF project document (2003-2004) as follows were not captured anywhere in the database and therefore for process indicator evaluation purposes could not be assessed from the DB. They are as follows:

1. Number of affected children correctly identified from JISS
2. Number of children at risk identified by screening tool
3. Level of risk (high, moderate, low)
4. Number of children treated in a public hospital for physical and sexual abuse in the past year and repeat visits.
5. Children integrated into stable after school activities
6. At risk children showing increased levels of resiliency, demonstrated by participation of supervised after school activities, decreased hours watching TV and decreased deviant behaviour
7. Increased help seeking behaviour among parents
8. Number of handouts distributed
9. Number of counseling sessions held
10. Number of parents demonstrating enhanced coping skills and improved interaction with their children

Another limitation in terms of data entry, completeness, and the ability to analyse and use data effectively and respond to emergent needs, was the capacity of CB staff who were

often in short supply, did not possess the knowledge or skills to use the database effectively, and received minimal training at a very late stage in the project (late 2007) which contributed to its lack of efficiency. Therefore the database should be modified to make it more efficient and relevant to reporting needs and staff should receive adequate instruction and supervision in its use.

The Screening Tool

A considerable amount of research, time, effort and consultation went into the development of a locally approved screening tool, which was an expected output of the project. Several versions of the tool were developed, drawing on elements of internationally approved instruments such as the Child Abuse Potential Inventory (CAPI) and the Trauma Assessment Protocol (TAP) and the Child Abuse Behaviour Checklist. However the processes for developing and approving screening tools are extremely complex and expensive, requiring tests for validation, reliability, sensitivity and specificity. The Technical Working Group spent considerable time in trying to achieve this, including inviting experts to assist with the process. However as local experience and expertise to develop and validate a screening tool, as well as resources, are limited in Jamaica the task was not concluded. Therefore doctors who were expected to use the screening tool rejected its use on these grounds that it was not a scientifically tested instrument. An attempt was then made to develop a non-clinical screening checklist instrument that could be used by nurses. However although the nurses were willing and open to the suggestion, this was not implemented as planned. However the nurses did attempt to use the checklist as a guide for two awareness raising sessions with patients in the waiting areas (see Table 17, p. 93 below).

Elements of screening tools that were adopted for use by the Case Workers were the Ecomap and Genogram, that should enable the CW to capture environmental and family risks and protective factors as part of an in-depth assessment process. However as this was incorporated in the social work intake form the data was qualitative in nature and did not follow prescribed screening tool methods that allow scoring to eliminate subjectivity. Therefore the assessment of levels of risk was still based on the skills and intuition of the social worker. Thus, despite social workers being trained on how to use them, these tools were rarely used or captured in the database and case files.

Therefore a screening tool to accurately identify children at risk and the subsequent levels was not met. If such a tool is desirable and practical in the context of the health care setting then careful consideration must be given to the added value that a screening tool

can bring in the present context and where and when the instrument should be used. An ideal, given the public health approach of CAMP Bustamante, would be to develop preventive screening methods that are administered before children attend hospitals with injuries.

INTER-AGENCY INTERVIEWS

Objective of Agency Interviews

- To identify the strengths and limitations of the CB intervention model
- To identify areas of congruence and complementarities with existing child protection systems
- To assist in the development of recommendations for the design and implementation of violence prevention services for child victims by key social service stakeholders

Selection of Agencies

The agencies selected for interviews, were identified as key child protection stakeholders and partners by Health Promotion and Protection Division as outlined in the Ministry of Health Terms of Reference.

Selection on Representatives

Interviewees were selected based on knowledge of and collaboration with CAMP Bustamante by Ministry of Health (MoH) and Consultants (see Appendix 1)

Methodology – Semi Structured Interview Guide

A semi-structured interview guide was developed and approved by the HPPD, MoH (see Appendix 2). Interviews averaged 45 minutes each. Written notes were recorded at interview and summarized for clarification on interpretation with interviewees in the summing up of the interview.

Analysis

Thematic analysis in accordance with the semi-structured interview guide was conducted for recurrent and conflicting themes.

Violence Risk and Perpetrators

There was a shared sadness and concern about the nature of violence in society and its effects on children by all interviewees. These concerns were not solely about obvious acts of violence that result in violence related injuries at hospitals, but the pervasiveness of violence witnessed by children in their daily lives. In their view this has reached tragic proportions with adverse psychological effects on the developing minds of children. Many interviewees talked about children coping with the loss of loved ones, being unable to go to school because of violence in their communities, the school's themselves being unsafe and unable to protect the children and in one person's words "...a society in which children are submerged in violence..."

There was a general feeling that violence against children was not only escalating in numbers, but more disturbingly in severity. Many said that previously perceived appropriate disciplinary methods for children, such as use of belts have changed to more serious injuries consistent with punching, kicking, assaulting with blunt instruments, machetes or other less common acts of physical and mental cruelty. One such example was a child that was placed in an ants nest.

Concern about the number of sexual assault cases and the fact that many of the perpetrators are both child victims and perpetrators of violence was shared among agencies. This highlighted the inability of child protection services and a general lack of available expertise and facilities to address the dual needs of such children.

Many learned and experienced childcare practitioners expressed sentiments of genuine shock and feelings of inadequacy with the spiraling levels of violence in society, the harsh socio-economic conditions underpinning communities where the most vulnerable children reside and their capacity to minimize the effects of multiple risk factors.

The most frequently cited risk however was seen to be the lack of and/or changing nature of the family. Mothers and in turn grandmothers tended to be younger, so the extended family support was often lacking as grandmothers who may once have been the mainstay

of childcare support were now often working to continue raising their own young children. Therefore supervision of children is often haphazard, left to older siblings or is arranged by convenience rather than to meet the needs of the child. More often there is not a stable father figure in the child's life, and reliance is usually on a single mother who may have several children, is unemployed or is working or hustling to survive. One person reported that they are beginning to see some changes as more women work and fathers are assuming the main parenting role, which has both benefits and risks depending on the circumstances and the father. There is also a belief by some parents that there is nothing wrong with leaving a child at home unattended. Don-manship is the way of life in many communities and vulnerable children provide easy criminal and sexual fodder for these powerful men, who they may seek out for parental guidance and support.

Other risk factors discussed were the paucity of safe and supervised community-based activities, green spaces or access to extra-curricula activities, often because they do not exist in many communities. If they are available often they are unaffordable or inaccessible for the most vulnerable children for a variety of reasons. One interviewee talked of a situation where some children were invited from Camp Bustamante to a summer school activity and were shocked and delighted to get the opportunity to play on grass.

One interviewee felt that the impact of the media is grossly underestimated and played a critical role in the shaping of young minds. She felt that the media, through its local and cable stations was providing material that assists young people to perfect the art of crime. She was also concerned about media callousness towards grieving family members of victims, who are often exploited in their most vulnerable moments and this is shown on prime time news when children are viewing.

In relation to interviewees' views on the perpetrators of violence against children there was no particular consensus on an adult perpetrator type. Males and females alike were seen to be perpetrators of violence against children, including those employed to work with children in institutions and schools. However there was a growing concern that

violence between children appeared to be escalating and the reasons for this were thought to be a direct result of their level of exposure to violence in society. Examples of children having witnessed murders and having to be hidden for their own protection, provides an insight into the fear that many children are facing.

Therefore in summing up the general view it would seem that it is the multiplicity of factors - violence, crime, poverty, hunger, fear and the lack of support and family structures - resulting in a collective societal desperation that frequently implodes on the most vulnerable members of society, children.

The Legal Child Protection Framework and the Capacity of Services to Protect Children from Violence

The majority of agencies felt that the enactment of the Child Care and Protection Act 2004 (CCPA) was a much needed and overdue piece of legislation that demonstrated the country's commitment of 1991 to the Convention for the Rights of the Child. The majority also felt that the legislation itself was adequate in relation to legislative process and recourse and enabled the restructuring of child protection services. There were also discussions about the further strengthening of the legislative framework, through the revisions of the Offences against the Person Act and the Sexual Offences Act that will offer greater protection to children. One such example is the introduction of a Sex Offenders Register and pre-employment screening for sexual offences for adults working with children. The strength of the CCPA as one person put it is that "...the act makes us all mandatory reporters" - therefore intrinsic to its design is collective responsibility. However everyone acknowledged that the act itself cannot protect children from violence without the commitment of society to enact the law and without the resources to implement it. With an overburdened police force and 'informer fears' (see pp. 98-9) this makes it difficult to really exercise the fullness of the law and affects not only lay people, but also the willingness of professionals to hold their colleagues accountable when mandatory reporting requirements are not followed. It was also acknowledged that if

some of the barriers to implementing the law were removed, then the capacity of government agencies to prosecute, protect and intervene would be severely tested.

In relation to the capacity of the Child Development Agency to protect children, all agencies including the CDA acknowledged the severe limitations of the agency to protect children, given an overwhelming number of reports of children at risk and the complexities of such cases, which have increased since the introduction of the CCPA. CDA receive approximately 15,000 referrals per year. This is a major barrier to effectively carry out its mandate given an insufficient Social Worker cadre of 75 island-wide, each carrying a caseload of approximately 80 cases at any given time. The CDA however were encouraged by the strides they have made in tackling child abuse in places of safety and children's homes, through enhanced identification and monitoring systems and as a result there are fewer reports of abuse in homes now.

Like other agencies, CDA also raised the need for more preventative programmes, particularly at the community level to reduce children's vulnerability, as most of the child protection services including CAMP Bustamante were responsive after the fact. Most agencies, however, noted that there is more involvement now and acknowledged the role that civil society and the private sector have been playing to assist in this regard. Grace Kennedy and Staff, Cable and Wireless, the ICD Group of Companies and the Cement Company of Jamaica were given as examples of corporate social responsibility initiatives that have been successful.

Camp Bustamante

Awareness

All agency representatives were aware that Camp Bustamante (CB) is a hospital based child abuse mitigation model that identifies violence related injuries in children attending Bustamante Children's Hospital. This was usually followed by the comment that they have heard that the project is closing down.

The majority of interviewees praised the CB Coordinator in the role she has played in advocating on issues of child abuse and bringing the problem closer to the surface. In their view she succeeded in raising the awareness of parents and staff, particularly at the hospital, to identify suspected child abuse cases by increasing their recognition of the signs. Many agencies felt that this was an invaluable contribution of CB and the majority said that they received very good advice and support from the Coordinator on child abuse related matters. Most frequently cited comments were “She’s very knowledgeable”, “She opened my eyes to what’s going on”, “She is very passionate about this issue and is always willing to assist”. They also talked about attending several awareness raising seminars and workshops hosted by CB during the life of the project and that CB had helped them to coordinate events, such as a Child Month activities at BCH, facilitated training and awareness raising sessions for staff and were instrumental in securing training for doctors and nurses at BCH in forensic investigation of child sexual abuse.

Governance

In relation to project governance, it was evident that the governing framework was not clear to most agencies. Some thought it was part of the Child Guidance Clinic at BCH, others thought it was a department of the BCH and others thought it was part of the Health Promotion and Protection Division of the MOH. Some persons were surprised that the hospital itself had no technical or management responsibility for the project. It was also evident that the Technical Working Group of the project was not immediately recognized by most interviewees until prompting led persons to recall meetings that were held, in their words “quite often in the early days” of the project. Therefore the governance role of the TWG and the input from stakeholders appeared to be limited beyond the developmental stage of the project. The few that were more familiar with the concept of TWG offered some insights as to why there were so few meetings and why the group did not function as originally intended. This included lack of clarity of purpose with no terms of reference for the group. Meetings took on more of a conceptual and technical role with the main focus being on the development of a screening tool which was at odds with perceptions that the TWG would play a management, monitoring and quality assurance role. Therefore one opinion offered was that those who felt unequipped

to contribute to this highly technical process may not have seen the purpose of attending these meetings. There was also acknowledgement that competing priorities also played a part in attendance.

Impact/Reporting

In relation to the service and its impact the general view from the agencies was that the service was good and this was based on general impressions, discussions at meetings and observation of children that CB had referred. On this basis they believed that CB has had a positive impact. However most agencies admitted that although they received annual reports, they did not have any hard data on the outputs of the project and progress on cases that CB had dealt with, therefore a definitive conclusion on its impact would be difficult to say.

Referrals and Reporting

With the exception of the Office of the Children's Advocate, all other agencies had received referrals from CB. However apart from Tomorrows' Children and the Office of the Children's Registry, other agencies were not able to provide accurate numbers of referrals at the time of interview and some of the larger agencies like the CDA do not have access to disaggregated data on referees. However the general impression was that referral reports from CB were appropriate, detailed and timely. The Office of the Office of the Children's Registry noted CB as one stakeholder that adheres to the standard format resulting in minimal follow-up to clarify details. CDA noted that since the initiation of CB reports of violence related injuries to them have increased, which in their view demonstrated that prior to this initiative these cases were largely missed as hospitals were not routinely reporting these cases. So they concluded that in the worst cases of violence the primary respondent is Health and the secondary respondent is the police, but these cases may never receive any social work intervention. Therefore CB has demonstrated that by having a hospital based model to identify violence related injuries in children attending the accident and emergency department it has effectively closed this gap. However it was noted that with the introduction of the OCR and mandatory reporting of these cases, this will effectively be altered to some extent and therefore

proper integrated reporting mechanisms will need to be established to avoid parallel reporting.

Duplication and Joint Working

In relation to identification of VRI in children, it was felt that there was little chance of duplication, given that CB is the only hospital based child abuse mitigation project in Jamaica. However the identification of cases comes directly to CB from reports from the Jamaica Injury Surveillance System (JISS) which is based at the nine major public hospitals. CB then enter this information into their Case Management DB for assignment to a social worker for an investigation of risk.

In relation to case management and approaches, several persons felt that communication, collaboration and possible integration with the hospital medical social work department is necessary when the service operates out of the hospital. They thought that this would reduce the likelihood of duplication and foster a more uniform approach to working with families, which is critical when dealing with serious cases, such as sexual abuse.

There was also concern that CB may not always be cognizant of the tremendous constraints of other child protection providers and this perceived lack of empathy has possibly strained collaborative relationships between different parties.

It was evident from interviews with agencies that whilst CB referred cases to other agencies, agencies still operated independently of each other and a truly multi-agency approach to child protection based on a shared philosophy and inter-dependency is yet to be achieved. The current practice does not involve multi-agency/disciplinary case management meetings, joint planning initiatives, the sharing of reports or regular child protection forums. Also social work case notes are not integrated into patients' medical docket, therefore there is no system (unless it is a violence related injury) to alert CB or doctors of repeat visits to the hospital for possible child abuse related complaints.

From these discussions it is clear however that the role of CB does not conflict with or duplicate the roles and functions of the Child Guidance Clinic, the CDA, the OCR or OCA but plays an important complementary role in mitigating violence against children. When agencies were asked whether they thought their organization had benefited from CB, all were emphatic that they had for a number of reasons as follows:

- Increased identification and reports of children at risk
- Reduced case load
- Repeat injuries are few
- Increased awareness and advocacy on child abuse issues and the need for more strategic approaches
- Assistance with child abuse events and forums
- Referrals of children for activities
- Ability to respond quickly to vulnerable children when others can't
- The opportunity to interact with children that they may normally never see, which raises awareness of societal differences and discrimination
- Puts hospital services in Jamaica on par with health services in developed countries

After-School and Summer Programmes

As part of the rehabilitative package that CB offers for children, providers of these services spoke highly of CB because it was evident that children referred were in great need and that inclusion in their programmes appeared to have a positive impact on their lives. Children are referred by CB through a formal process that includes parental consent. The types of activities offered are sports, the arts and Saturday schools through three providers (see also pp. 83-4 below).

1. Tomorrow's Children-UTECH reserved 6 places for CB students that normally attended the summer school and have been doing so since 2005.

2. The Multicare Foundation said that CB students normally occupy 20% of its Saturday school 'art on the street' classes which usually have between 30-50 children.

3. The Junior Centre-Institute of Jamaica said that attendance at the summer school has varied over the years of the project, but that the average number of children from CB attending each year from 2005-2007 was between 6 and 10 children. They noted that CB children never attended the after school activities because cost was prohibitive and attendance at the summer school was also affected by cost of bus fares, even though they are reimbursed at the end of the summer school.

Issues about the attendance of some CB children at these activities and concerns that due diligence on the part of CB to ensure follow-through was raised. One agency felt that CB should have been more proactive in identifying and placing children in these programmes. In their view this weakness may have resulted in lost opportunities for some children. Another agency felt that while the CB strength was in identification of children at risk of abuse, the restorative and rehabilitative processes that they expected CB to carry out, particularly in cases where a decision is made to avoid children going through the formal statutory system, was weak.

Another interesting view that was that while the protective benefits of after-school and other type extra curricula activities is understood, experience with the CB children highlighted a need to infuse social work or counseling psychology skills into some of these activities, which they expected CB to do. The rationale for this suggestion was that the placements themselves might be even more effective for the children, with inputs on some of the more complex behavioural and psychological needs of the children that cannot effectively be met by activity coordinators and staff. It was also noted that follow-up on children's attendance and progress by CB was lacking and it appeared that the relationships between CB and the families were not sufficiently developed to motivate and convince families of the benefits of engaging their children in these activities as part of a rehabilitative process. Therefore after the children left relatively short-term activities, as they were rarely enrolled in activities the following year, there was no evaluation of

their impact or follow-up to ensure the child's ongoing progress. Some case examples and evaluation reports given by one agency effectively illuminated the benefits of these activities for the children, against a backdrop of issues such as lack of parental support, lack of hygiene, psychological, behavioral and learning difficulties, that may largely continue unchecked when these interventions end. Therefore the general view is that you are left with the hope that something positive happened for the child as a result of attending an activity and, in one person's words, "they leave seeing their lives differently."

All agencies noted the severe lack of after-school and summer activities for children from lower socio-economic communities, given the multitude of constraints and lack of formal community infrastructure in these areas. This means that children's entertainment and extra curricula activities are part and parcel of adult pursuits and activities that shape their development. Many persons felt that it was essential that investments be made in these children and communities if we are to succeed in reducing violence between children and giving children a window of opportunity and hope of something more.

Community Development

In relation to interventions at the community level it was felt that networking with community based organizations to assist in developing social capital was lacking. One person also commented that they would have liked to see more sensitization programmes for parents carried out at the community level. It is apparent from the interviews that apart from home-visits to clients for assessments, the work at the community level and with other agencies was not developed.

Acceptability to Parents

Agencies were asked whether they believed CB was acceptable to parents. The response in general was that they believed it was acceptable to parents based on their interactions with parents and no one was aware of any complaints about CB. It was also noted that perhaps the benefit of CB was that it is perceived as a less threatening or punitive process

than the CDA which parents sometimes perceive as frightening, given their power to remove children from their homes.

The Way Forward

All agreed that the concept of a child abuse mitigation project that could provide a rapid response was a good one and that there was a great need for this. Most persons said that they thought that every hospital should have such a service or at least all the regional hospitals or hospitals in areas with high levels of child violence. Kingston Public Hospital, in particular, was given as an example of where many violence related injuries in children are seen. The reason they gave for believing that the hospital was the right setting for this service was the fact that when children come to hospital you have more control in eliciting correct information and securing follow-through than in other settings.

However the way in which the service should be structured and its governance were in need of reviewing. It was felt that CB may benefit from the support of a more formal arrangement and as such suggestions were that it could be integrated with the medical social work department at hospitals. In fact BCH said that they had made a submission to the Ministry of Health in 2007 for 4 additional Social Workers in anticipation of the project coming to an end. However this was not granted. There was also discussion about possibly utilizing vacant nursing posts to recruit these staff, as it was felt that it was critical to maintain the service.

Another discussion was a possible integration with the Office of the Children's Registry, but with services still based at the hospital. The benefits of this would be that the service would benefit from the formal child protection system that could provide the necessary guidance and technical supervision, whilst extending the role of the OCR in identification of VRI in children at hospitals and bridging the gap between the OCR and the OCA to do the preventative work necessary to avoid referrals to the CDA. This would also reduce time lapses and duplication by the OCR and CB who effectively carry out the same initial functions when cases are identified.

There was also a suggestion that in addition to, or as part of, CB a trauma facility be established given the number of children experiencing post traumatic stress from violence related incidents.

In relation to questions about improvements to the effectiveness of CB, the following suggestions were made:

- Greater follow-up on cases
- Improved documentation
- Improved monitoring and evaluation
- Increased and stable staffing
- More specialist training for staff
- More family conference approaches
- Removal of number of home visit limitations which currently stand at one-three visits per clients, so that service is more responsive to the individual needs of the family
- Infusion of specialist skills in children's activities
- More focus on preventative strategies and community development

INTERVIEWS WITH CAMP BUSTAMANTE STAFF

This section will report on the experiences of four members of staff in delivering CB. Staff include the Project Coordinator, two social workers and a case manager and raise some issues in relation to case management processes, documentation and administration.

Technical Working Group

The technical working group was at the helm of the development of CB and played an instrumental role in the first year of the project. However it did not begin with a terms of reference and attempts to do this came half-way through the project in 2006, but the process was never concluded. It would appear that the roles of key stakeholders were largely perceived to be advisory as the name would suggest. However in the original project document that was funded by UNICEF, a project management structure proposed a multi-agency management structure that defined the roles of:

- Bustamante Hospital for Children – Health service activities
- The Child guidance Clinic - Psychiatric counseling activities
- The CDA - Social work supervisory activities, linking with government agencies
- The HPPD/MOH - Operational activities
- Multicare Foundation - Supervised after-school activities

Whilst all the above agencies played a critical role in supporting CB, the management of the project and coordination of all activities was almost exclusively carried out by CB under the HPPD/MOH. Apart from the Technical Working Group, there was no clear strategy to develop a multi-agency management structure for CAMP Bustamante with defined areas of responsibility and accountability. At one stage in the project a draft Memorandum of Understanding between CAMP Bustamante and the CDA was developed and this was an attempt to formalize the role of these two partners in the implementation of the project. However this process, despite being referred to the legal department of the MOH, was never concluded.

Therefore the multi-agency approach to the management of the project was not achieved and it may be questioned as to whether stakeholders were aware of this expectation. Hence apart from the addition of CB, where joint working in relation to referrals between agencies took place, they continued to operate separately and this placed an undue burden of responsibility on CB and the HPPD of the MOH.

Training and Staffing

Specialist training in child abuse and neglect, while essential, is not yet available in Jamaica. CAMP Bustamante attempted to narrow this knowledge gap through on the job training sessions at fortnightly team meetings. Staff members fully appreciated these sessions and felt were essential to ongoing quality improvement in their work. However the inadequacy of training to manage complex child abuse cases, in particular sexual abuse, was raised by all staff members.

They believed that perhaps the difficulties in handling these types of cases, that require specialist training, placed some staff members under extreme stress, contributing to the high turnover of staff at CAMP Bustamante. In a five year period CAMP Bustamante employed a total of seven Social Work staff that covered case work and three Case Managers. In addition to this 10 Social Work Practicum Students were used over the LOP to also conduct assessments. Social workers also said that due to gaps in service delivery, when staff posts were vacant, they inherited large backlogs of cases, which were difficult to catch up on with visits and assessments and interventions being prioritized over documentation.

Case Management

Social workers were concerned that the CAMP Bustamante model, which was limited to 1-3 visits per client, did not allow them to be responsive to the needs of individual children and families. So when they assessed the need for family conferencing approaches and follow up visits, limitations were placed upon them often preventing them from carrying these out.

Administrative/Resource Challenges

One of the administrative challenges was accessing patients' medical docket from the hospital. The time it took to access docket delayed response times and also prevented the social workers from building up a case history of the child and whether there were repeated episodes of VRI. This approach was later dispensed with in an attempt to deliver a rapid response. However this meant that information from social work case files and medical records were not integrated. This would have provided a more detailed picture of the child's experiences in relation to violence for all parties involved in the care of the child.

There were also severe limitations in contacting clients given the ceiling on cell phone calls and traveling expenses. This meant that the bulk of the calling costs to contact clients fell on individual staff members, especially in the first 18 months when CAMP Bustamante did not have a telephone line to make cell phone calls, which most clients gave as a contact number.

Violence

Staff said violence also delayed response time as there were many times that they could not visit clients because communities were at war or cases were difficult and an intervention could be dangerous.

CLIENT SATISFACTION

18 Case studies

One measure of the effectiveness of CAMP Bustamante (CB) would be client satisfaction. Clients of CAMP Bustamante are the child victims of abuse. The team did not have the competencies to interview the clients themselves, and the wisdom of even experts undertaking this would need careful consideration in terms of the danger of reliving the trauma. However caregivers were taken from a random sample of 20 clients attending CAMP Bustamante between January 2004 and July 2008, as well as a few teachers from associated school visits. Parent satisfaction is therefore taken as a proxy for client satisfaction as well as providing some evaluation of one of CAMP Bustamante's objectives which is the improvement of parenting skills.

The number of clients chosen was dictated by the limitations of time and resources. It was felt, however, that a sample of 20 could provide a valuable insight into how parents experienced CAMP Bustamante. The total number of clients seen from the records in CAMP Bustamante's log book is 1,394. The yearly totals were used to weight the sample chosen from each year which is why six cases were chosen from 2004, which had the greatest proportion of overall cases. The overall sample was equal in terms of genders since this is almost the same in the client population (52% F, 48% M). However with regard to age the proportions of the population, 53% of whom fall in the 8-11 year age group, were not followed. Because in general terms the consequences of child abuse can be said to be greater the younger the child, the sample was weighted more heavily towards the younger group so that two thirds (67%) of the cases had children in the under-8 group. In the final sample of 18 case studies (but 20 children because of a pair of sisters and a pair of brothers, both sets abused by parents), 6 are from the 0-3 year group, 6 included a child from the 4-7 year group and 6 are from the 8-11 year group (see Table 10) (see Appendix 3 for a comparison of the proposed and actual samples).

Due to time and other constraints only 18 case studies were completed. Fifteen mothers, two fathers, two grandmothers, two form teachers, one principal and one guidance

Table 14: Sample of 18 cases (There are 18 cases and 18 perpetrators but 20 children)

Age	Gender	Injury	Perpetrator	Comment
0-3 yrs	Female	Physical assault	Mother	3 mth baby 'fell' off bed and later 'beaten' by another child. Highly stressed young mother.
		Gunshot wound	Unknown	1 yr old. Stray bullet came through house window in Portmore
		Sexual assault - unsubstantiated	Unknown	2 yr old. Blood on pamper after left with friend and her many children
	Male	Physical assault	Father	3 mth baby hit with machete during domestic quarrel
		Gunshot wound	Off duty policeman	9 mth baby in stroller on street during chase of a robber
		Physical assault	Neighbour and babysitter	2 yr old badly beaten while left with neighbour while mother in country
4-7 yrs	Female	Sexual assault	15 yr old cousin	4 yr old. Child perpetrator had been molested when younger.
		Sexual assault	15 yr old family friend	4 yr old. No penetration as older brother came and took child off lap.
		Sexual assault	20 yr old cousin	5 yr old. No penetration as child made alarm. Cousin already on similar charge.
	Male	Physical assault	Older boy in lane	5 yr old
		Physical assault	Older boy in tenement yard	6 yr old
		Sexual and physical assault	Mother (with HIV)	6 yr old
		Alleged physical assault	Cousin	7 yr old. After investigation found to be a genuine accident
8-11 yrs	Female	Physical assault	Father	Sisters 8 and 10 yrs old
		Physical Assault	School peers	10 yr old at school bus stop
		Physical Assault	School peer	11 yr old
	Male	Physical Assault	25 yr old pregnant neighbour in yard	8 yr old. Woman threw scissors at him while he & her son were in a quarrel
		Sexual and physical assault	Mother (with HIV)	10 yr old brother of 6 yr old (above)
		Physical assault	Peer in tenement yard	11 yr old

counsellor were interviewed face to face, and one principal and one form teacher were interviewed over the phone (See Appendix 4 for outline of semi-structured interviews).

The interview with caregivers attempted to explore their views on the following (see Appendix 4 for outline):

- Effectiveness of case worker (referred to as the social worker in the interviews) in explaining their role and the reason for the interview
- Assistance provided by case worker
- Assistance provided by other agencies to whom client was referred
- Area(s) causing upset or discomfort in relation to the services of CAMP Bustamante or of other agencies
- What was most helpful in the service of CAMP Bustamante or other agencies
- Impact of Saturday classes and summer camps on children who attended
- Impact of Parenting Forums on those who attended
- Impact of CAMP Bustamante on caregivers' behaviour
- Openness to advice and help from others (individuals or organizations)
- Advice they might wish to give CAMP Bustamante or any other agency

There were less interviews with school staff than originally intended as time constraints intervened. In the end two inner city primary/all age schools were visited and the principal and a form teacher from another inner city school were interviewed over the phone. These interviews asked specific questions in relation to specific cases, for example discreetly probing in one instance why a form teacher had not provided a letter for his pupil to the Child Guidance Clinic (which was the reason given by her mother for not taking her – the mother's report was that he remarked that "R does not need it").

CAMP Bustamante

Effectiveness of Case Worker (CW) in explaining their role and the reason for the visit

It should be noted that the 18 cases had been spread across six case workers: one case worker was responsible for six cases, one for five, one for three, one for two and the other two for one each. Therefore it can be deduced that when a level of unanimity is found among respondents with regard to the performance of case workers, whether positive or negative, this reflects some institutionalization (or lack of it) of standards, training and procedures among CAMP Bustamante staff.

All the interviewees except two women said the case worker's explanation of the reason for the visit was clear, and they then explained what they understood this reason(s) to be. Two said they could not remember and volunteered that they were under great stress at the time⁷.

All interviewees were clear that the social worker's first interest was the child. One father said that while you felt they were your friend, you knew that they were first and foremost the friend of the child. Several parents at the time found the interview uncomfortable, even in some aspects frightening, but they said that afterward they realized, and indeed appreciated, that the social worker and the state had come in to ensure that the environment the child was living in was safe, to see if the injury had been caused by child abuse, "questioning the kid to find out if what we said was the same as what happened", and in cases of sexual assault to make caregivers aware of dangers, including that the perpetrators are often close to the family. "Both her father and I understood that they needed to do this (investigation) and that it actually could be someone we trusted."

Assistance and Advice provided by Case Worker

All but two answered in the affirmative when asked if the visit helped them to understand the problem better. Some found it empowering: the mother whose common-law husband

⁷ One was the mother of a three month baby hit with a machete by the father during domestic violence and the other was a grandmother whose daughter was under investigation for child abuse of a 3 month baby with a fractured skull (who seems to have suffered permanent damage – now aged 4 and is not talking).

stopped physically abusing his two daughters after the family conference, out of fear of the consequences; the mother who was so grateful when the CW made a visit to the young woman who had thrown a scissors which stabbed her eight year old son while he was in a quarrel with *her* son and who expressed remorse, paid all the medical bills and explained she was pregnant and could not contain her anger and frustration which had nothing to do with the child; “He gave me courage”, said the mother whose five year old daughter was sexually assaulted by her 20 year old male cousin, “He explained to me what would happen: my child would drop back in school. He also explained that sometimes when they are touched it feel good to them and they might start feeling their genitals.” She found this happening and was able to prevent this pattern of behaviour and to guide her daughter.

Others found that the visit educated and informed them about the seriousness of what had happened and the possible consequences. A father said that the visit gave them “a lot of pointers” - informed them that if their child even got a fall again it would be investigated. Another commented that the CW was “basically saying I needed to be careful of where I left the child. I would be accused of being reckless if the same situation occurred by leaving her in the same place.” “He said ‘Don’t abuse the child’ meaning if I look a babysitter, check them out; don’t just give him to any and anyone.” Parents seemed to appreciate that boundaries were set in relation to the treatment of children, even if they sometimes felt defensive during a visit.

Some were grateful that the CWs “explained at length”, as one mother said, how incidents of sexual abuse or gunshot wounds might affect the children, so that the parents would know what to look for and know how to handle it.

A number of the mothers, especially those dealing with sexual abuse of their daughters, emphasized the value of the CW’s assistance in helping them to cope with their stress and in answer to a question mentioned this was the *most* helpful service, a service which was often continued by phone calls after a visit: “She talked to me and counseled me when I was down and stressed out.”; “When they called on the days I was depressed – giving me

tips on how to cope.”; the advice, “Be patient, she will come round. He also told me I must not let her see me crying. If she did, she would break down.”

For some, notably the very poor, the visits and calls also affirmed that their children were worthy of love and attention. A father from one of the poorest homes visited commented: “I didn’t expect this. Shows they really care about the kids. To see a stranger come check up on the kids – if you were not having enough love, now you know you have to love them.” One mother from the other poorest dwelling, a one-room in a dark leaking downtown warehouse full of similar one-rooms, in a telling answer to what helped her most simply said: “Calling on the phone to ask if the baby is all right. (Q: Why?) At least somebody cares...”

The one mother who had nothing to say in answer to the questions on what help came from the CW, had only had an interview at CAMP Bustamante, not a home visit, and her 11 year old son was immediately referred to the Child Guidance Clinic (CGC). She was clearly stressed out from a failing relationship and a previous history of domestic violence, from having to cope with four children with no family support (she was thrown out by her mother during her first pregnancy) and a 12-hour job, and from being, in her own words, “at wit’s end with C (although) he is not a bad child”. However she thinks he may have Attention Disorder Deficiency, he resents her other children (he is the eldest) and is hurting from being treated differently by his step-father. His one outlet is football at school but he is “constantly not allowed to play because he is disruptive in class.” She thinks the CGC has helped him – “They get him to talk” – but she gets no advice as to how to deal with him, although she admits she does not ask, “I just respond to their questions and listen.”

Area(s) causing upset or discomfort in relation to the case worker or CAMP Bustamante

Interviewees were asked “Is there anything in the services that were offered to you by CAMP Bustamante that particularly upset you or made you feel uncomfortable?”. Some answered immediately, some thought first, but all but two answered “No” to this question. One mother felt that in the interview the CW was “unprofessional”, acting as

though there was definite evidence of sexual abuse to her two-year old daughter (who she had left with her close friend's mother while she went to a gym class) when at the time it was not clear. However in answer to what was most helpful she said the fact that the CW asked the father to attend the interview and had brought across the point that he also had a responsibility to the child and if something had happened he would be held responsible too.⁸ The other caregiver was the grandmother of two brothers, physically and sexually abused by their HIV positive mother, who were taken away from the grandmother to be remanded in a home until they were 18 years old while the mother has never been arrested or questioned. She was deeply upset that the CDA Officer had not in fact visited her home as requested by the judge (fear of the volatile area was indicated) to talk to the community who she feels would have given her very good credentials. She felt that the CWs from CB could have spoken on her behalf to the judge. However when asked to score CAMP Bustamante she gave 10 out of 10: "When the pickneydem see them, them deal with them totally good. They drive them out. Every time they visit them (in the Place of Safety accompanied by a play therapist) they call me. Bring me too. Bring them toys. Them know how to deal with children...Children them addicted to them."⁹

Scoring of Case Workers and CAMP Bustamante

14 interviewees felt they had had sufficient interaction to score the performance of the case workers. On a scale of 1-10, 13 scored between 8-10 with an almost even distribution of each score (8 x 4, 9 x 4, 10 x 5), while the mother who was critical of the CW's "unprofessionalism" gave her a score of 4. Thus the average score was 87%.

Most caregivers did not feel they could score CAMP Bustamante as a whole since most only experienced its services through the Case Worker, although they knew where the CW had come from and some had visited the office. This was not the case with the two who had attended Parenting Forums while three others also felt they could score it. Scores received were 10, 10, 10, 9, and 6.5, giving an average of 91%. It was not clear

⁸ This CW was the one who had visited the most interviewees (six)

⁹ This was in 2007. Since then the boys escaped while at school, walked to their grandmother and have never returned – they are with their fathers. She says it was not until 3 days later that she was rung up and asked if she had them.

why the last score was so low, since the same mother gave 8/10 to the CW who she praised especially for the assistance given in calls to her while she was depressed as well as in the way she and other staff interacted with her daughter “My daughter was really scared. They were really gentle with her”. However she was extremely critical of Bustamante Children’s Hospital staff with the exception of the doctors (see below).

The Impact of Saturday Classes and Summer Camps on Children who attended

Clients of CAMP Bustamante were offered the opportunity to attend Saturday Classes and Summer Camps if they were seven years or older and if the CW thought that this would help the client. The institutions were Multicare Foundation and East Street Junior Centre, both located downtown, and Tomorrow’s Children at University of Technology at Papine. Seven of the case study clients were eligible and four were offered places (including two sisters from one case); three went to Saturday classes at Tomorrow’s Children and one went to a two week summer camp at the Junior Centre.

The parents’ responses make it clear that the children loved these activities and that they had a very positive impact. The activities at Tomorrow’s Children were described by parents as poetry, singing, beating drums, recorder and shows on TV and at the Little Theatre. The sisters appeared on TV and the eight year old boy was “in all of their shows”. The girls who had suffered several years of physical abuse by their father had become very aggressive, especially the younger one. “Now they are always smiling. Every day they cry to go back!” The boy’s mother noted that he is more outgoing and plays the drum “like a real musician”, never having played it before. The summer course at Junior Centre included drama and a trip and the mother says it helped her 11 year old to be able to mix more with children. In addition she was greatly relieved of her own anxiety at her job during the day as the incident had just happened during the summer holidays in the tenement yard in which they lived. She wished that he could attend something more regularly. (See next section for a description of the activities and feedback from parents of all the CB clients involved in these activities)

Impact of CAMP Bustamante on Parenting

Fifteen of the interviewees (82%) remembered advice they had been given by the CW and had implemented it. Some of this impact has already been spoken of above. For some this experience clearly had a significant impact on their parenting and they parent differently now. One mother, who had also attended Parent Forums (see p. 88-9), related that “They tell me what I should do and what not” and gave examples: children must come in early, go to bed early, one is not to send them out on the road, and not to abuse them by beating. “And that is what I am doing!” she announced proudly. A father also described the advice: “Tek time to hear what they have to say. When them come from school, sit with them and look at their books. Teacher alone cannot teach them. They grow what they learn... Yes, I did follow it. Sometimes they give a lot of talking. I used to be rough but yu have to ‘low them more, tell them yu love them.” Another mother explained that she treated her son “in the same loving way” she had always done (“no bad treatment”), but what she did differently was that now “I talk to him more than I used to.”

For mothers and fathers whose daughters had suffered sexual abuse (four of the nine girls) understandably their prime focus was on protection. Two mothers expressed the concern that indeed they might have become overprotective. One mother, whose four year old daughter was molested in July of this year, follows the CW’s advice of reassuring her that she has done nothing wrong but “[I] counsel her every evening not to accept gifts.” The mother who was critical of the CW says she is “a bit more protective – you know something is out there – a body that reports these things.” For the mother whose one-year old daughter was hit in the arm by a stray bullet, “I, and especially her father, became more attentive. It was a result of the visit. She told us if anything else happened to the child the State might intervene – we did not want that to happen.”

For some the advice they remember is specific actions they were advised to take in relation to an incident: change the glass door panels which had caused the accident, move the stove away from the door so that the pot handles do not stick out into the entrance, ensure bathroom and other chemicals are stored away from the reach of children, do not take this child back to a specific location for a specific period etc.

Parenting forums were held for parents whose children attended activities as a way of evaluating the impact of these activities on the children and as an opportunity for teaching parenting skills. Two of the three mothers whose children attended activities attended at least one forum. It is clear from their comments that they had an impact, especially bearing in mind that both parents' children were served by CAMP Bustamante in 2004. "They help me a lot. Parents, don't shout at them - children don't like it. And when you are sad, don't let them know – just rub them down and be nice to them. And not because they look big, you tell them to go out and look something. No! You are the parent, that is your responsibility! You is here for your children." "Yes, they help a lot. Show me how I must help the children. If they are having a temper, help them get out of it, love them more. I try to tell A not to get into trouble and not to argue with people."

What was most helpful

Parents' responses to "What was most helpful?" with regard to CAMP Bustamante's services reflected the multi-faceted nature of what CAMP Bustamante offered:

- Showing me how I must treat my children
- Talking to me and counseling me when I was depressed (2 mothers)
- The first day I was really tense but with the way she spoke to me I became more at ease and flexible
- The way the social worker dealt with the situation in the (tenement) yard. I had been very scared and frightened (that the State would take away the child)
- The advice on how to deal with my daughter (who had been sexually abused)
- The things she pointed out to me. Don't take any chances as far as T is concerned. You never know what is in people's mind.
- Summer school for my son. I also liked when he checked on my son. I feel good that someone is checking on him.
- By coming here – she visited us. The attention given to my son. He felt good about it and so did I (another parent expressed similar views)
- The intervention of the social worker in getting the children to say sorry to each other.

- The counseling and treatment of the children by the play therapist and the social workers
- The guidelines they gave about the need to care for my children. My baby mother knows there are guidelines and that she cannot break them without them coming back
- The social worker pointing out to the father that he is responsible for the child too and for what happens to her.
- When she looked in the bathroom for the chemicals and explained why. It helped me – put me on my guard.
- He sent me to the Ministry of Education and he visited the school. I appreciated that.

Other Agencies

Views were also sought on the level of satisfaction with the services of the agencies to which CAMP Bustamante had referred some clients (Table 15). Ten clients (50%) were referred to other agencies. Where caregivers felt able, they scored the agencies. Also included in this section are the comments and scores of a mother whose 11 year old daughter had been a client, visited by a CW at home and at school in relation to an incident of violence from a classmate. It was later discovered by the guidance counselor at her new school that throughout this time the client was also being sexually abused by her father. Her comments and scores are included because they are on agencies in child protection area but her input is not included under the “No. referred” column.

In addition to the agencies in Table 15, this mother took her daughter to Mico Counselling (\$200 per session), which she found very good, only leaving for VSU when the Counsellor seeing her daughter left. She scored them at 9 out of 10. For herself she used Bethel Baptist (\$500 per session), recommended by a legal aid lawyer. She found their assistance invaluable when “I was going crazy - gone next door to Bellevue.” They got a score of 10 out of 10.

Table 15

Agency	No. referred	Comments	Score out of 10
Child Guidance Clinic	4	<ul style="list-style-type: none"> • Did not help much because child (5 yrs – SA) associated it with hospital & injections and was always fearful of going • Helped. Saw a change in child’s attitude to school (4 yrs – SA). Gave very good advice on how to deal with her in terms of being firm and sticking to what I say – it works. • Talked to the child and got him to talk (11 yrs – PA). He felt he was ugly and I did not love him. I fear he has ADD. But they do not help me. I just respond to their questions and listen. • They gave her a long appt. – about 3 mths - and said I must bring a letter from her form teacher. He said “R don’t need it” and never gave me a letter¹⁰. So she has never been. • (UWI CGC) Very good. 	<p style="text-align: center;">–</p> <p style="text-align: center;">8</p> <p style="text-align: center;">7</p> <p style="text-align: center;">10</p>
Victim Support Unit	2	<ul style="list-style-type: none"> • Provided counseling for my child and myself. Went 3 times. Were very good. Child opened up there and afterwards was able to talk to me (same child in 1st bullet above under CGC). • Have not been there yet. I want to forget about it now (4 yrs – SA by 15 yr old family friend from next door whose family deny it). Had a call last month from Office of the Children’s Registry urging me to go for the child and myself. • She got counseling and went on a field trip. They gave her presents. No-one went on as if they were better. She has low self-esteem and is easily put down so this was very good for her. But score is low because they have stopped calling. She still needs assistance! 	<p style="text-align: center;">9</p> <p style="text-align: center;">–</p> <p style="text-align: center;">6</p>
Child Development Agency	3	<ul style="list-style-type: none"> • CDA remanded baby (abused by father during domestic violence) and took him to court. Mother escaped with baby and went to parents in Westmoreland • CDA took mother to court and she was sentenced to one year for child abuse • CDA Officer did not follow judge’s instructions to visit the grandmother’s concrete block home, where the two brothers had been staying (all the evidence in the docket suggests they were strongly bonded to her). Grandmother was deeply hurt when they were remanded yet nothing was done to deal with their HIV positive mother, the perpetrator of physical and sexual abuse 	<p style="text-align: center;">–</p> <p style="text-align: center;">–</p> <p style="text-align: center;">0</p>
CISOCA	2	<ul style="list-style-type: none"> • Son did not make a statement. (Q. Afraid?) No, he is a Christian. He is trying to get him to come to Church. • Mixed experience. Policewoman who was first working with 	<p style="text-align: center;">–</p> <p style="text-align: center;">0</p>

¹⁰ Teacher remembered this in the interview but said he was swamped with work.

Agency	No. referred	Comments	Score out of 10
		<p>me was slow, lazy – when I set up the father she did not turn up to arrest him. I was frantic, called the station and Sgt. Gowdie came and arrested him. Took him through court to the finishing line. A stalwart.</p> <ul style="list-style-type: none"> • Police did not follow up on cousin (15 yrs – previously sexually abused) although reported to police and to rape unit. After a year past someone rang to ask if we were still interested in pursuing it. We said yes but then discovered he had gone to America to his parents¹¹. 	<p>& 10</p>
<p>PATH</p>	<p>1</p>	<ul style="list-style-type: none"> • Did not go because they had turned me down before yet had taken on others I sent. Who really need PATH not getting it. People who have cars getting it. Look like a friend and friend thing. Should visit the homes – that would make a difference. 	<p>–</p>

Area(s) causing upset or discomfort in relation to other agencies

Three persons responded with problems they had with other agencies. One mother said she found the general treatment by Bustamante Children’s Hospital staff from security to receptionist to nurse was “heartless” and it upset her four year old daughter (it was an SA case). “They handle people roughly. People are about to break down and they order you to ‘sit down and wait’. I suppose it is because they are a public hospital.” She was the most affluent of all the interviewees.

The case of the grandmother whose grandsons were remanded in a home has already been described elsewhere. It is noteworthy that in this instance, as in one other instance from these 18 case studies, the Judge removed the children from one home to another because of their complaints of physical abuse.

The grandmother, whose daughter was incarcerated for child abuse in relation to her baby said the following about a medical social worker: “One little thing – the person who came with the baby from the (BCH) ward to Court said ‘M a wicked – she fi go a prison’.”

¹¹ The file on this case records 14 calls made to CISOCA over a period of four and half months. It took 8 calls to reach the officer in charge of the case (who did not seem to return calls) who then told the CW that the case had been transferred to another station. When this station was contacted the CW was told the case was not at this station. After several months there is another note in the file after another call repeating that the station says the case is not there. The last entry records that the case has been found at the station.

The case of this young woman “M”, who was 21 years old at the time, is considered worth recording because it highlights a young adult perpetrator who has, three and a half years later, never received any professional counseling although there are two persons in her story, her Probation Officer and a woman who worked in a green uniform at Fort Augusta, who she says were extremely helpful to her. Her mother (interviewed initially because of the sensitivity of the case) described her daughter’s early life. For several years, from the age six years, she had to stay at home to look after her two younger sisters. “She was the eldest – she look after the two babies. I left at 8am and got back around 8.30pm¹². From she was six she had to do this - took real good care of them. That is why I tek care of hers now. Through my neglect. But nothing wrong with them and we never mek them hungry – that is the greatest part.” Then at 12 years old M was gang raped by 5 men, with no counseling afterwards. “All of that put M where she is now.” At the end of her own interview M, who is presently being physically abused by one of her babyfathers, described her everyday experience: “It’s like after all I have been through, when I decide to do something one day, the next day I forget.” (hand makes a gesture of fingers closing in around something to express what is happening in her head).

Her journey through the criminal justice system can only be described as abusive and victimizing. When the police came to the community to look for her (she was at BCH), they told the community that the baby had died. At Central Police Station where she went to be finger-printed she described the woman constable as “very aggressive”. She had pulled her skirt at the waist so tight her underwear outline was clear. “When I complained she called me ‘Criminal’”. She was then taken to a room with other police there who were also told the baby had died and they taunted her as ‘baby killer’. “I started crying and told them ‘Nothing like that’”. The police who carried her over to Ft. Augusta discussed among themselves in the car plans to rape her. At Ft. Augusta (where she went everyday to the computer lab), some of the warders “teased” her and called her ‘babykiller’. Asked what she did in response, she said she would go to the dormitory. She never complained to anyone. For the first two weeks she was so scared, she said, she did not sleep. Her advice in response to the final question was: “I would like the warders at

¹² Security guard job

Ft. Augusta to stop teasing because it causes war between warders and inmates. Wish the Warders were like Miss Bailey (in green uniform) who was very nice to me.”

The principal of an inner city primary school where she says over 60% of the students have fathers who have had violent deaths, or are in prison or abroad, is very concerned about her experience of responses from the Child Development Agency. She has concluded that they must be seriously understaffed. She described the three cases she has called them about in the last two years:

1. 2007 - in first half of the year. A parent took an iron and branded her daughter three times. It was on the weekend and the child came to school the next week with the sores clearly showing. CDA was called immediately. An officer came almost three months after the incident.
2. Later in 2007. Another parent branded their child with an iron. The Principal called the CDA. They told her to take the child to CISOCA so that they could place the child in a home. She refused because she felt this would lead to the parents and community saying she had taken the child and put them in a home. Nothing was done. She called in the parent and the grandparent and told the parent off very severely. She felt this this was all she could do in the circumstances.
3. 2008 - May/early June. Reported to CDA a case of sexual molestation by a stepfather. When she called CDA, she says they gave her a file number and told her she could follow it up if she wanted to. She called the mother and father in, although the father was not told the full story for fear he would retaliate violently. Separately she advised the mother to put the man out of her home since the residence is hers. However the mother has instead taken the child out to stay somewhere else, despite the Principal pointing out to her the message that this primary school child is receiving from this action. Moreover it is not clear that the abuse has stopped.

At another inner city school both the Principal, who formerly acted as the Guidance Counselor, as well as the present Guidance Counselor, had some concerns about cases referred to Child Guidance Clinics (CGCs). In the case of the Principal her concerns were that first appointments were to far ahead, the space between appointments was too long

(around three months) and she was also concerned about the quality of some of the counseling. In an instance where a 10 year old schoolboy was found fondling a schoolmate to the extent of putting his hand in her underwear, she said the advice was that the parent needed to show more love to the child but, she claims, there was no sensitization of the child as to the inappropriateness of what he was doing. She contrasted present experiences to the work of two former counselors at the CGC at the Comprehensive Clinic, Mr. Hepburn and Mrs. Daley. They would visit the school, make home visits, make referrals, prepare care plans and call to check on the progress of the child. There was follow-up until all were satisfied that the child had settled. With them gone, however, she sends all her cases to the CGC at Bustamante Hospital as she has found their service better. The Guidance Counsellor was upset because he had referred a child to the CGC (the same child who was a client of CB) because of his disturbed behaviour, which was causing concern to children and staff alike. He was involved in the practice known as 'jooking' where the penis is displayed and 'jooked' against another child. This was frequent behaviour and the Principal and Guidance Counselor became even more concerned when they found he had a sore on his penis. However when the Counselor wrote a referral letter to the CGC, suggesting possible molestation being involved (the child has a bad relationship with his stepfather and visits a local ice-cream vendor's house quite often) he received a call from the CGC "chiding" him ("I felt so ashamed") for suggesting sexual molestation might be involved (the child's mother was also upset at this suggestion).

Openness to advice and help from others

Of the 13 interviewees who were questioned on this topic, only two did not seek advice or help from anyone either on problems with their children or on their own problems. One was a father and the other a highly stressed mother. The other father said he sought advice on both issues through acquiring knowledge by watching documentaries. Another two mothers seek help and advice on problems with their children but not for themselves. One was the formerly imprisoned mother, M. Of the remaining nine most turn to family or friends, two consult their pastor or church, one a guidance counselor for her children and another a policeman she has always turned to. One will seek advice for herself

anywhere and everywhere, including friends and family, but will always weigh it in her mind before making a final decision. One said she is definitely more open since her very positive experience with the CAMP Bustamante social worker, while another said if she did not have her Church, she would turn to CAMP Bustamante.

Advice for CAMP Bustamante and other Agencies

Ten caregivers (55%) spoke of the need to “reach out” to more parents and children, one specifying “inner city children”. Five used the word ‘social worker’ in giving their advice. There seems to be considerable esteem for the ‘Social Worker’. “They tremble when they hear ‘social worker’” (‘they’ being the child abusers and the wrong doers). Another said “We need more social workers and more supervision (because) they are overwhelmed with work – she showed me the amount of files.” This mother, who is presently doing her teacher’s degree in early childhood, has decided to do her masters in social work as a result of this experience. One father had this to say: “We need social workers to talk to parents, show them the guidelines – it keeps them on the straight path. Sometimes people do crazy things with their children. They just need someone to talk to. They take out their frustration on their kids. But they love them. Just a talk – give a warning – will often be enough.” Another commented that “We need more social workers like Miss A. A lot of people in the community where I live need help with their children.”

Others in expressing their concerns gave advice on how to find out what is really happening on the ground, clearly alluding to social workers and agencies when they spoke. One mother recommended that “agencies go into the classrooms. You will get more from the children – if they’re away from parents and in a group setting. There is a lot of physical abuse.” Others recommended “random visits” because “Sometimes mothers lie” (a mother), another noting “Parents can tell you anything and the child is helpless.”

Other mothers focused on parental education, stressing that “There are a lot more mothers out there who need help. They need to know they must listen to their child. Don’t rush them (like) ‘Go on – I don’t want to hear nothing from you!’ Maybe when it is something

you need you hear, you will never hear it!” The grandmother interviewed, along with her sister, both of whom look after M’s child who is four and not talking, now have their Level 1 and Level 2 qualification as Early Childhood Practitioners from HEART and want to do Level 3, all as a result of this experience. She advised that “If you counsel parents early it would rub off on the children.” It needs to start early, she says, so that parents can be good role models. On prompting about whether parenting should be taught in school she responded “Yes, you should teach it at school from age 12 because these children now have babies.” She expressed concern that parents “don’t hold their children’s secrets again.” When that happens the children don’t trust them again. “Dem something deh lower children’s self-esteem.” One mother suggested that the Child Guidance Clinic needs a number that persons can call to get help without a referral.

The Principal of one primary school would like to see more follow-up. She suggested that in cases of child abuse not only the child but also the parents and siblings need counseling and that the school guidance counselor is often not the best person to undertake this. People often “open up more to strangers” than to persons they see on a regular basis.

**CHILDREN'S ACTIVITIES AND
PARENT EDUCATION**



Saturday Programmes and Summer Camps

The involvement of clients in structured after school activities, in the form of summer camps and Saturday classes, began in the middle of the first year in July 2004. The activities were centred mainly on the visual and performing arts and the overall goal was “to effect the building of life skills and create a healing space for clients” (Project Coordinator’s Interim Monthly Report July 24-Sept 3, 2004, pg. 1). One of the indicators to measure the objective of implementing a hospital-based model was “Children integrated in stable after-school activities” (UNICEF Project Proposal Nov 1, 2003 – Aug 31, 2004¹³). One of the main aims of CAMP Bustamante outlined in the orientation for new staff was “Develop a plan for care that links a child to services and support as well as structured after school activities.” (Orientation Handout) The literature on child abuse indicates that, despite their vulnerability, children have the ability to adapt and use whatever resources or opportunities are available to resist the harmful effects of abuse. The culturally appropriate activities organized by the institutions that CAMP Bustamante engaged provided resources and opportunities in music, art, dance and other areas that can create positive internal arousal, alter negative feelings and provide avenues of expression to help children to talk, or otherwise express feelings about maltreatment, grief and loss. This has a therapeutic effect, helping them to overcome some of the negative impacts of their experiences.

The criteria for attendance were that the child had to be aged seven years or over (age of sufficient depth perception to cross the road) and would benefit from participation. Data obtained for attendance from 2004-2008 were incomplete¹⁴ but give some idea of clients invited and those who participated (Table 16). It indicates that there were attendance difficulties which will be elaborated later in this section

¹³ In fact the project eventually started on Jan 12, 2004

¹⁴ The data should be in the MOH Accounts Department, attached to the institutions’ invoices, but retrieval did not prove possible.

Table 16: Attendance in Summer Camps and Saturday Classes

Programme	Organisation	2004	2005	2006	2007-8
Summer Camp <i>Nos. of clients whose parents agreed to send them are in ()</i>	Multicare Foundation	7 (21)	8 (25)	<i>Incomplete data</i>	<i>Incomplete data</i>
	Tomorrow's Children, UTech	8 (23)	13 (20)		
	Junior Centre, Institute of Jamaica	-	<u>5 (13)</u>		
	Total Attendance	<u>15 (44)</u>	<u>26 (58)</u>		
Saturday Classes	Multicare Foundation	<i>Incomplete data</i>	<i>Incomplete data</i>	1 (4)	
	Tomorrow's Children, UTech			5 (13)	
	Junior Centre, Institute of Jamaica			<u>4 (8)</u>	
	Total Attendance			<u>10 (25)</u>	

The original intention was that these structured activities be ones located in clients' communities since one of the objectives of the project was "to develop and implement an intervention model within the child's environment (home, school, church) through interaction with existing community based programmes". Six organizations were contacted: two located downtown (Multicare Foundation and Junior Centre), two community-based NGOs, including one on Spanish Town Road, the YMCA, a popular location for children from all over Kingston and centrally based, and Tomorrow's Children. The three chosen were those who responded first (Table 17). Further investigation in the first year revealed that not many communities could be found offering summer or term-time activities. After this the focus on managing cases within the targeted time left little time for further searching.

The programme activities outlined in Table 17 below indicate the focus on the visual¹⁵ and performing arts, activities through which children in general are able to process experiences, especially traumatic ones, which might otherwise remain repressed. These creative recreational activities can also contribute to building a sense of personal control, so important for abused children who may have experiences of devastating powerlessness.

¹⁵ Some of the artwork is shown at the beginning of this section

Impact of Structured Activities on the Clients

The impact of these programmes on the clients was assessed by CAMP Bustamante staff through three mechanisms: reports from the Institutions (these tended to be occasional except for Tomorrow’s Children), two focus groups held at two of the institutions in 2005, as well as five annual half-day Parent Forums held at CAMP Bustamante between 2004-2007 to gain feedback from the parents and caregivers of children participating in these programmes.

Table 17

Institution	Venue	Activities
Multicare Foundation	DaCosta Building Institute of Jamaica 1A Central Avenue (off North St.) Kingston	<ul style="list-style-type: none"> • Art and Craft • Environmental Photography • Dance • Storytelling • Personal Development • Field Trips
Tomorrow’s Children	Centre for the Arts, University of Technology Papine Kingston 7.	<ul style="list-style-type: none"> • Integrated Arts • Photography • Drama • Music • Drumming • Dance • Culinary Arts • Personal Development • Field Trips
Junior Centre, Institute of Jamaica	Junior Centre Institute of Jamaica 19 East Street Kingston	<ul style="list-style-type: none"> • Art and Craft • Speech and Drama • Music • Drumming • Dance • Storytelling • Guest presentations • Field Trips

The 2005 report from the Junior Centre (the only one available) indicated that two of the five CAMP Bustamante children on the summer camp were “very comfortable in the

programme from the start” with an 11 year old boy writing several poems and taking the lead role in a final day presentation skit, while “J, S and C appeared very shy and reserved at the start of the Workshop but it was rewarding to observe that by the end of the programme they had made friends and were able to perform on stage in the respective activities.” There were no exceptional behavioural or other problems.

The first report from the Centre for the Arts at UTech on Saturday Classes in 2004, attended by four CB clients, noted that three of the clients (all repeat participants from the Summer Camp) excelled, one being the most outstanding in the integrated arts project, one leading in a quiz and the third being the most outstanding in personal development and consideration for others. The new participant showed performance ability and recited a poem in a performance they staged in Sculpture Park at UTech. One parent commented to the staff that her child was far more outspoken and less introverted and shy. The second report on the 2005 Summer Camp, attended by 13 clients, gave a detailed report on each client. This report indicates the value of continuing to send clients to these activities, even when at first there seems to be no positive impact. One outstanding example is quoted:

“In previous sessions K approached the Centre as it she was being forced to be part of something terrible. She did not participate in most of the classes as her attitude suggested they were not interesting or important. She would come late in the afternoon and in general would not relate well to her peers. There were activities which sparked her interest, in which she would participate as much as she would allow herself to. This summer period was wonderfully different. She began the session with more or less the same attitude but this changed dramatically. She was particularly impressive in drama classes especially as the teacher was principally motivational and interested in her and her talent as a dramatist. In addition, she became close to one of the assistants as well as to another student in the group. The latter had a profound impact on her behaviour and general attitude on a whole. She was exceptionally beautiful in her mannerism, which exuded from her throughout

the course of the session. It was duly noted to her, which she accepted with good grace.”

A selection of other notable comments follows:

“S does not like to work with her peers (in groups). She however tries to please, especially if it is someone she expresses affection and respect for. This fact helped us in our methods of approach to rectify the situation.”

“At first D exhibited introverted tendencies; however these diminished as the programme progressed...He spends a lot of time trying not to be seen, yet he was particularly noticeable in the final production.”

“J was an eager individual who tried to accomplish the tasks at hand (and) participated well in all exercises...When reprimanded he usually expressed his regrets and sincere desire to do better next time. This, I believe, stemmed from the deep respect he had for members of staff. He was very helpful and conscientious. J nevertheless was suspended for one day because he was involved in a fight with another student. He did not acknowledge the punishment as he turned up for class the following day, accompanied by his brother; they fought...I had to intercede and send both of them home, especially as their presence was being observed and commented on by the rest of the children. He later apologized for his behaviour.”

“R is an extremely bright and dedicated young man. Sometimes, however, he demonstrated issues of self-acceptance with respect to his skin tone...Sessions were held which focused on self-acceptance and self beauty. In addition tutors tried to be affirmative in as much as was possible in such instances.”

“O & K (brothers) have developed tremendously during the time they had spent with us. They are much calmer. It is clear that the activities experienced

and the places explored have had dramatic impact on their level of socialization.”

Of this group of 13 seven of the CB clients received certificates for outstanding achievement in helpfulness, congeniality, creativity, improved behaviour, dance, music, and culinary arts.

The report from the Multicare Foundation on its 2005 Summer Camp was a general one but indicated that the eight clients participated as well, and gave no more behavioural problems than the rest of the 110-120 children in daily attendance.

Feedback documented from 52 parents and caregivers from the focus groups and four annual Parent Forums (April 2005, January and December 2006, and November 2007) suggested they saw a positive impact on their children in all but six cases, in two of which the child was still facing problems, such as beatings from stepfather or return of the perpetrator to the community. While the reports from the institutions bring out the achievements in mastery of the subject areas, the experience of success and its assumed impact on self esteem and self confidence, as well as some of the healing processes, it is the parental feedback that gives most insight into the healing impact that they perceived. Many noted how much the children enjoyed the programmes and some actually referred to them being happier. Very concrete impacts were noted: “He used to talk about the stab him get when him was two and the one recently, but not so much now”. The most common impacts were talking more, expressing themselves more clearly and confidently, and being less aggressive. An example was given of a child now willing to speak to the Case Worker where before she had been unwilling – the caregiver volunteered that drawing had helped the child to express herself. Five referred to their children as now able to forgive more – “She change – used to want to hurt. Now she help with her baby” (baby of perpetrator who stabbed client, subsequently attributing this to the stress of pregnancy). Parents would also notice the improvement in relating to other children. Commonly mentioned was achievement in school with more interest and focus shown on school work and better behaviour, a more centred child - “calmer”, “more aware of

surroundings”, “more responsible”, “more polite in speech”, “speak different, talk softer now. Used to talk vulgar”.

Impact of CAMP Bustamante on Parenting

The parenting forums also provided the opportunity to build parenting skills. The second of the Project’s three objectives was “To improve parenting skills and conflict resolution”. The parenting forums included interactive exercises on parenting which allowed parents to explore and learn more about positive parenting. Each forum would focus on a particular topic: the difference between discipline and punishment, stress management, emotional intelligence, positive parenting. It was not unusual to have emotive points in these sessions “as some parents disclosed the stresses and challenges of managing discipline and not knowing what to do apart from administering beatings.” (Project Coordinator’s Monthly Report August 2005, pg. 4). In another forum two of the fathers who were perpetrators were involved in a similar session where persons became emotional as they shared their own stress points around parenting. The experience of CAMP Bustamante staff supports the findings of research which has found a much greater level of parenting-related stress among Jamaican parents than their American counterparts (see p. 27 above). The comments of caregivers in the 18 case studies on the impact of the entire experience of using CAMP Bustamante’s services has already been described above. Most of the parents attending the forums were equally positive and in answer to the questions: “What changes have you noticed in yourself since CAMP Bustamante’s intervention?” and “Are you doing anything differently” usually answered very concretely. Some were aware of increased motivation, feeling more self-pride, feeling as though they are getting somewhere with the child, more interested in their child’s welfare, feeling proud of their child. Many referred to feeling more loving towards their child. Their parenting skills had clearly developed as they spoke of being more attentive to their child, holding conversations with their child, learning to bring themselves to the child’s level, encouraging and not ‘putting down’ their child, structuring time to facilitate their child. Finally a number had made changes in their mode of disciplining their child by stopping beating, opting to hold conversations when their child does something wrong, shouting less and listening more. A few parents still

remained unable to deal with their negative experiences, complaining of “stubborn children”, of a daughter who “doesn’t care” and pays more attention to father and aunt, while one parent vented that her babyfather “should be shot” because he refused to go for counseling.

Their comments and suggestions for CAMP Bustamante included:

- The best thing the hospital has done for the children
- The hospital accommodated the development of children
- Continuing with the childrens’ classes
- Wanting more visits from Case Workers and to be able to take children to see them at CB (the children ask for them)
- Facilities and programmes for older children
- Training on how to deal with adolescents
- The forum creates practical exchange of ideas
- The forum is a relaxed environment where they were able to assess self and learn more
- Each parent should bring another parent to the forum
- More parenting sessions

The Attendance Problems for the Children’s Activities and the Parenting Forums

Table 16 above indicates the attendance problems with the children’s activities. Whereas the majority of parents and caregivers accepted the invitation for their child to participate, the percentage who actually benefited from these programmes was less than half, ranging from 34-45%. At the parenting forums, where this problem was discussed, parents said that the greatest challenge was finding funds for busfare, which had to include funds for the adult busfare of the parent or caregiver who had to accompany the child. Even though busfares were reimbursed this was not done until the end of the programme so it could not impact the cash flow problem. Because of this problem the cost of hiring transportation to pick up children was investigated in early 2006 but the costs were prohibitive.

The contract with the parent included the stipulation that the child must be delivered and fetched by a parent. Apart from the additional busfare this also caused a problem if the parent was unavailable. Later this stipulation was changed to the parent informing CB of who was undertaking this task, and finally no stipulation was imposed and the parent simply accepted responsibility for how the child reached.

The attendance problem for parenting forums, also attended by less than 50% of those invited, was partly due to the time it was held (Saturday mornings). Bus fare was also a problem for some. It is also likely, however, that given the numerous problems that many parents have to deal with, these events were not always given the priority they deserved in terms of the long-term benefit. The records show that a lot of time was spent by the Administrative Assistant initially calling parents and then following them up if their child did not turn up. The obstacles presented by the phone situation in the first two years not only made this arduous but also limited the number of calls. The strategy in situations like this has to be a combination of persuasion and reminding, which takes up a lot of staff time.

EDUCATION AND ADVOCACY



Students of Edna Manley College perform “Sworn to Secrecy”, a musical on child abuse written and produced based on research they undertook through CAMP Bustamante.



Training workshop for Bustamante Children's Hospital staff



Child shows Skip a book on how to raise children to resist violence (while checking his beak)

The original proposal for the design of CAMP Bustamante envisaged the provision of educational material (posters, handouts, audiovisual aids) for parents & caregivers in the waiting area of Bustamante Children’s Hospital as an activity contributing to the improvement of parenting skills and conflict resolution, CAMP Bustamante went beyond this by also targeting young people as future parents, as well as health professionals and the general public, becoming advocates for its clients, abused children, raising awareness of this often hidden issue in Jamaican society. Many agency interviewees identified this as an invaluable contribution of CB. However the original and primary target group, the Bustamante Hospital clientele, while served in 2004 were never fully exploited as a captive and key target audience (see Table 19, p. 108).

Educational Materials

The educational materials produced were specifically targeted for different groups including the general public, children and health professionals (Table 18).

Table 18: Educational Materials produced by CAMP Bustamante

Material	Target group	Year Produced	Approx. No. Distributed
Informational Brochure	General public	2004	2000
Small stand-up ‘Tent’ cards with information on their rights and where to call if they were being abused	Children	2005	1000
Find-a-Word puzzles	Children and adults	2005	?
Colouring sheets with Skip, the Healthy Lifestyles mascot, with child rights messages like “It’s my right to be safe”, “It’s my right to be healthy” etc.	Children	2006	?
Brochure for professionals on the recognition and response to child abuse	2008		Not yet in print

CAMP Bustamante also used other available materials which they distributed during their educational work including:

- Raising Children To Resist Violence (Health Promotion & Protection Division, MOH)
- Train Up A Child (3D Projects)

- Violence prevention pamphlet (Health Promotion & Protection Division, MOH, and the Violence Prevention Alliance)
- Posters
- Booklet for children on the Child Care & Protection Act (Child Development Agency)

Outreach to target groups

CAMP Bustamante has reached out to a wide range of target groups using many different communication techniques as Table 19 clearly shows. Some of the methods used were highly innovative, such as the fabric mural on which over 80 men visiting Emancipation Park wrote their suggestions as to “What Fathers Can Do To Prevent Child Abuse”. In fact interactive methods were extensively used, seemingly with great success, by the CAMP Bustamante project in all its educational activities including the parenting forums described in the previous section. Other innovative approaches that stand out are the exhibition of clients’ art and poetry, revealing the perceptions of the abused children themselves to the public. The involvement of Edna Manley College drama students, most of whom will be teaching drama in our high schools, in scripting and performing a play in 2007 and a musical (see photo) in 2008 about child abuse is also another high point. These students had to visit CB for hours of orientation in order to produce this material.

Table 19: Selection of Main Educational Events involving CAMP Bustamante

Year	Target Group				
	Children	Parents	Health Professionals	General Public	Other
2004	<ul style="list-style-type: none"> • School visits with presentations 	<ul style="list-style-type: none"> • On 2 occasions, nurses present 30 min health education session “Protecting Your Child From Abuse”, inc. 15 mins discussion & feedback, to parents in BCH waiting areas. Very well received. Plan to present it on a fortnightly schedule but only happens twice. 	<ul style="list-style-type: none"> • Project presents summary of home visits to BCH A&E doctors – well received as gives insight into what has happened to some of their patients 	<ul style="list-style-type: none"> • Distribution of posters “Keep Our Children Free from Violence” at all activities. • Booth at Kiwanis pre-Father’s Day Parenting Summit at Emancipation Park. Create a fabric mural where male visitors could write under the heading “What Fathers Can Do To Prevent Child Abuse”. Over 80 did so. 	
2005	<ul style="list-style-type: none"> • School visits inc. Mona Prep school for Girls Empowerment Day 		<ul style="list-style-type: none"> • Child Month Awareness child abuse prevention campaign at BCH under title “Love Grows a Child’s Brain – 100 ways go grow it”. Focus on principles of neurobiology – series of activities with public launch 	<ul style="list-style-type: none"> • Presentation at a Church Men’s Fellowship • Presentation to Optimist’s Club • Presentation to Church Women’s Group • Guest on Family Life Ministries radio Programme 	<ul style="list-style-type: none"> • Presentations at Early Childhood Conference • Child Abuse Workshop at Training workshop for Roving Caregivers • Presentation to 210 basic school teachers • Training for 25 basic school teachers • Presentation to Assocn. Of Carib. Social Workers • Presentation at strategic mtg of Girl Guide’s Association Executive

Year	Target Group				
	Children	Parents	Health Professionals	General Public	Other
2006	<ul style="list-style-type: none"> • School visits • Children's activity booth at "Celebrating Health Festival" Emancipation Park. Colouring sheets on their rights and a balloon. Booth continuously full 	<ul style="list-style-type: none"> • UWI practicum student continues what nurses started in April 04 for several sessions, all well received. 		<ul style="list-style-type: none"> • "Through our own eyes, in our own words" – exhibition of clients' art and poetry mounted at Junior Centre. Good media coverage inc. TV • Workshop on child-parent relationships for Church group 	<ul style="list-style-type: none"> • Exhibition of clients' art and poetry also displayed at annual training conference of Ja. Assocn. Of Social Workers • Presentation to new staff at Child Development Agency
2007	<ul style="list-style-type: none"> • Presentation at Annual Children's Expo 		<ul style="list-style-type: none"> • One-day capacity building seminar among child care professionals and practitioners. 76 participants from psychiatry, psychology, social work, nursing, research, social policy and child advocacy. Very well received. Play therapy presentn. aroused particular interest. 	<ul style="list-style-type: none"> • Drama on child abuse "Hope for Hope" scripted and acted by Edna Manley College Drama School students following sensitization sessions at CB. Videoed. 75 audience • Ran Healthy Lifestyles Day at BCH. • Presentation at a Church Service 	<ul style="list-style-type: none"> • Facilitated workshop on "Securing Children's Rights in Cmnty Devmt" at EC Commission Conference
2008	<p>School visits inc. Central Branch Primary School for girls/boys day</p>		<ul style="list-style-type: none"> • Lecture on child abuse to nurses doing paediatric training course 	<ul style="list-style-type: none"> • Musical on child abuse 'Sworn to Secrecy', put on by students of Edna Manley College. Videoed. Over 300 persons. Media cov 	<ul style="list-style-type: none"> • Workshop on children affected by violence at a workshop put on by UNICEF & CDA

COMMUNITY CULTURE AND ‘MINDSET’

The 2006 UN Report on Violence Against Children notes that for societies to prevent violence against children requires not only the sanctioning of perpetrators but also the “transformation of the ‘mindset’ of societies...”^{li} as well as the underlying social and economic conditions associated with violence.

In order to gain some insight into the values and attitudes of the communities from which many of the cases of child abuse seen by CAMP Bustamante come, a focus group was carried out in two of the four communities identified from the CB database as having the highest incidence of child abuse (see Fig. 21, p. 54). Both are garrison inner city communities with a long history of violence, but associated with different political parties. Two of the families in the 18 case studies resided in Community A. Participants were mobilized through the Social Development Commission (SDC). Their ages ranged from 20 to over 50 years, attendance was 21 and 22, with five and three men respectively¹⁶, the participants were parents or grandparents and there was animated discussion in both with good participation. However the second suffered from a room with poor acoustics, a number of crying babies both inside and outside the room, and excessive ‘cross-talk’ and was therefore a less rich discussion (see Appendix 5, p. ??? for Focus Group Discussion Outline and Appendices 6 & 7, p. ??? and p. ??? for Focus Group Notes for Communities A and B).

Greatest Challenges in Raising Children Today

Both the groups identified the social environment of their communities as a tremendous challenge. Community A specifically referred to gangs and the associated violence, drugs, consumption of alcohol, and the high rates of teenage pregnancy as the main challenges in raising children, along with the frustration and stress accompanying situations of single parenting and/or unemployment. To these issues Community B added music and the electronic media. They spoke of combating peer pressure and trying to provide a good environment for their children’s growth. They felt that in order to save

¹⁶ The aim was for a maximum of 15 with at least six men

their children from a path of destruction it was critical to influence them while they were young and the overwhelming majority felt that corporal punishment was an essential tool in achieving this. However most identified excessively severe physical punishment as abuse.

Keeping Children Safe – What does it mean?

Both groups said it meant protecting children from danger, such as keeping them away from gunshots, drugs, gang violence, sexual abuse, rapists, physical abuse, swimming/drowning, as well as “bad company”, while teaching them to be “street smart”. For toddlers in the home dangers such as fire, chemicals, kitchen activities were also mentioned. After much discussion in Community A, gang violence, sexual abuse, and drugs were ranked in that order as the top three dangers.

The participants identified factors in the environment that contributed to making children unsafe within specific age ranges:

Age	Unsafe environmental factors	
0-3 years	Fire	Physical abuse (from within the family and on the street)
	Water	Gang violence (not mentioned/avoided by Cmnty B)
	Chemicals	Sexual abuse
	Kitchen	Street
4-6 years	Same as above	
7-11 years	Gang link-up, peer pressure/friends who are a negative influence, sexual abuse (Community A) and physical and verbal abuse (Community B)	
12-18 years	Drugs (“ dem just love build up pure spliff”), alcohol, sex especially without protection, “hold a gun”, dance, loitering on the street (both communities).	

Both communities agreed music influenced behavior, especially “the gun lyrics, lewd music, sex inna de music”. Artiste Movado was singled out. There was a split over whether cable was as influential, most feeling it is not and, moreover, it is more controllable.

In Community A, by a show of hands, it was determined that it was only a small minority of participants who really discussed issues with their children (this discussion did not arise in Community B). It is noteworthy that holding conversations with their child was one of the things a number of parents in Parenting Forums said that they now did as a result of the CAMP Bustamante intervention (see p. 102).

Attitudes to Discipline

The approach to discipline varied among community members. When the Facilitator asked for responses to the saying ‘Spare the rod and spoil the child’, in both communities a man gave the first answer: one response was, “Yu have to mash up the rod on ‘im...at certain age yu start reason with them” while in the other community the eldest man in the group immediately commented, “I do not believe in it (i.e. sparing the rod) - they have to get beating.” In a structured discussion by age there was considerable agreement on the appropriate discipline for each age group, as indicated in Table 20 below. The majority felt beating was absolutely necessary to prevent children falling into the dangers outlined above and there was a clear minority who approved of a severe level of beating that the majority, however, saw as physical abuse.

Community B spoke of what they saw as a “new culture” emerging in which some pregnant mothers were “prophesying” negative careers for their future children. So in response to “Sharon, yu pregnant again?”, the answer might be, “Yes, me a bring another whore!” or “Me a bring a gunman!”. Community child rearing practices also came up for some discussion in Community B when it was agreed that some parents regard the use of bad words and cursing/tracing by their toddlers as being “cute” and rewarded it with attention and laughter.

Table 20

Age	Appropriate Form of Discipline
0-3 years	Slap with hand
4-10 years	For some, this is the period of childhood when there is no sparing of the rod. “Mash up de rod pon dem”, meaning severe beating with anything that comes to hand. ¹⁷ This is the time to “ben’ the tree when it young”. Overall, however, the view was that while beating was highly appropriate to ‘ben the tree’, ‘mashing the rod’ amounted to abuse.
	Verbal harshness, even indecent language, but not physical abuse – “mi discipline by mi mouth; I don’t beat kids” (a mother). Community A felt that mothers verbally abuse their children more than fathers, saying things like “Hey, batty bway” and “Yu ugly like yu pupa”.
	Reduce lunch money or send to school with no money at all (but must go to school). This was said only in Community B.
	Withhold privileges: <ul style="list-style-type: none"> - No ice-cream - No school trip - No games - No TV Community A was very clear on withholding privileges as a particular approach to discipline.
11-14 years	Continue with the beating.
	‘Tapping up’ (occasional physical discipline combined with reasoning). Mentioned only by Community A who felt that as children became adolescents there should be less physical punishment.
	Withhold privileges: <ul style="list-style-type: none"> - No school trip - No games - No TV - Curfew
15 years up	Reasoning
	Rough talk (expletives, threats)
	Curfew
	Straight reasoning (“if im no waan hear, den im de pon im own”)

¹⁷ These remarks recall the severe beatings referred to in the St. Catherine Study (endnote xxxvii)

Community Social Capital

Both communities valued the approach “It takes a village to raise a child” but both felt it could not be implemented except by a few. Children are too disrespectful, while many of their parents would quarrel: “Parents abuse other parents if you scold dem child”; “Some parents a go a school go beat teacher, much less”; “Children go home an tell dem parents lie on you”. Nevertheless Community A felt that some children are more likely to respond to elders and some elders do “...reprimand children on the street and part fight regular”. Community A felt that children tend to be more disrespectful to women. Both communities at different times in the discussion agreed that parents could do more to keep their children safe, especially with the help of the state:

1. Set up programmes like these to educate parents. “Who come now, will bring others next time”
2. Talk to your kids more
3. Provide counseling for parents “Nuff a de parents need counseling demself”

Knowledge of Child Care and Protection Act

Very few persons knew of the Child Care and Protection Act – 5% in Community A (saw it on TV) and none in Community B – and no-one could say anything about it. An overview of the Act by the Facilitator elicited the most caring remarks of the evening in Community A, comments like:

- “Once you love your child, you will do everything to see that they are protected”
- “Some children out there don’t get loved”
- “Sometime a jus waan dem waan yu fi notice dem”
- “Some parents never hug dem child yet”
- “Some parents defend child or give material things - but don’t hug”
- “Big hairstyles, rings etc...to show love”
- “Nowadays children don’t enjoy dem childhood”

In both communities there was a strong aversion to reporting cases of physical abuse to the authorities. In none of the situations were the police an option, for two main reasons: because of the repercussions that might come from “informing” and also because justice

is often not associated with those in authority, whereas it is quickly administered by ‘jungle justice’ and the don. Persons from Community A said if they had contacts with “people who have backative” they might ask them to report it. Persons from Community B had little time for the authorities. They gave the example of a women who beat her three-year old son very badly with a shovel. The community was outraged and she was taken to the police. However, when her friend pleaded with the police and gave excuses of excessive stress etc. they released her. She went back home with her child. There was no awareness that there was any alternative to going to the police. The Children’s Registry phone number was completely unknown.

Community B was also critical of the nearby hospital who, they claim, could not report the under-age mothers they receive since they never see the babyfathers questioned or arrested. Persons were not aware that they were supposed to inform the Child Development Agency or, more recently, the Office of the Children’s Registry regarding concerns they may have about suspected child abuse.

Protective Factors

In Community A the following structured activities, all widely used by the children, are available:

- Homework programme at the Community Centre
- Sunday school at Church
- The Youth Empowerment Programme (YEP)
- Summer school
- GSAT classes

In Community B the following structured activities are available:

- Homework Programme
- Sunday School - about 50% of the parents send their children to Church.

Community A were considering a child curfew and Community B had already put an 8 o’clock one in place. However there were clearly tensions around this as some participants expressed displeasure at the approach of the enforcers who were “abusing the children” by using indecent language to them when sending them off the streets. An

example was given: Enforcer approaches child “Weh de *+#@!! yu a do pan de road?”
Child answers back. Enforcer punches child.

Knowledge of CAMP Bustamante

No-one in either community had heard of CAMP Bustamante. Community A expressed their full support and requested that it be introduced to KPH and the Comprehensive Clinic on Slipe Pen Road. In Community B the fall of a baby in the audience was used to further explain in practical terms the mandate of CAMP Bustamante. This resulted in requests that it be introduced at the Glen Vincent and local clinics. When probed as to why they would want to see the project introduced at these sites, one participant remarked “It would cause parents to be more cautious.”

Recommendations

The following recommendations came from the groups:

1. Form a Parenting Group (Community A discussed this with the SDC officer present; Community B already had such a group)
2. Continuous parenting sessions/Monthly or quarterly parenting workshops (Both groups)
3. Alternate workshops in different sections of the community (Community B)
4. Convene a special workshop for 16 year olds - “to deal with a child, you must be mentally ready” (Community B)
5. Learn more about the Child Development Agency (Community A)
6. Skills training programme (Community A)
7. Employment for females (Both groups)

COST EFFECTIVENESS ANALYSIS

In framing a cost effectiveness rationale for CAMP Bustamante, the issue of establishing a standard outcome measure for effectiveness was explored. This could have included a reduction in number of children being seen at BCH for a VRI, a reduction in repeat violence related injuries to hospitals, reduction in number of children being placed in state care as a result of a VRI or social work response times. However as baseline data and indicators of effectiveness, or a comparison group, were not established at the start of the project, the project has no reliable data to capture the majority of these outcome measures except for a reduction in the numbers of children seen at BCH for VRI, which apart from reductions in the first two years of the project has not been sustained in common with murder and other indicators of violence in the society. The usefulness of establishing measures of effectiveness at the start of the project can not be overstated, in particular given that the current assessment of Camp Bustamante will inform policy and financial decisions regarding the implementation of critical child abuse mitigation interventions in the country. In the absence of this information and the capacity to establish effectiveness the following cost effectiveness scenarios are based on assumptions, hypothetical scenarios and data not collected for the purpose of this review.

Analysis will cover costs to implement the programme for one year, based on costings from 2007. Data has been derived from the Camp Bustamante Database and the finance department of the Healthy Lifestyles Project. Attempts to gather unit costs for hospital admissions for VRIs for comparison of the standard intervention (hospital visit) versus Camp Bustamante were not successful as currently BCH do not have that information although the hospital is working on developing these costings. The MOH also confirm that such costings are not currently available. However some comparisons will be made using average costings of hospital stays for VRI, based on a study carried out at Kingston Public Hospital^{lii}. Therefore Table 1 shows the direct costs of delivering Camp Bustamante in 2007 to 276 children who attended the accident and emergency department of BCH for a VRI.

Financial Costings 2007- Description	Amount	Annualized (*One off /4 years)
Capital Costs		
Telephone (3 cell phones & 1 land line)*	186,000.00	46,500.00
Capital equipment (2 desktops, 1 printer, 3 desks & chairs* Staff	431,364.00	107,841.00
Personnel (Salary & Travelling allowance and emoluments for : Project Manager Administrative Assistant Social Worker X 2	6,675,285.00	6,675,285.00
Consultants		
Consultancy (Screening Tools & Development of Model)*	2,250,000.00	562,500.00
MIS Database design/training*	345,000.00	86,250.00
Stationery supplies	130,400.00	130,400.00
Case visits (UNICEF)	900,000.00	900,000.00
Transport costs for w/shops etc.		
Training (4 training sessions)	750,000.00	750,000.00
Children's Activities	(Estimated)300,000	300,000
Material development	(Estimated)300,000	300,000
Utilities\		
Donations (cash & kind)		
Building /Space		
TOTAL		9,858,776.00

Unit Cost of Camp Bustamante per child in 2007 = J\$35,720.00 (9,858,776.00 /276)

Cost of cases successfully intervened based on 30% of children lost to follow-up in 2007= J\$51,082.00 (9,858,776.00 /193)

Hypothesis: If Camp Bustamante prevents repeat hospital episodes for VRI of those successfully intervened, the following scenarios might be appropriate:

Cost	Saves Repeat injuries	Cost of injury prevented
9,858,776.	193 (Ix1)	<u>J\$51,082.00</u>
9,858,776.	386 (Ix2)	<u>J\$25,540.00</u>
9,858,776.	579 (Ix3)	<u>J\$17,027.00</u>

NB. Figures subject to rounding

If we compare the costs and the effectiveness of an average hospital stay (\$11,000)^{liii} for VRI, the following Cost Effectiveness Ratios (CER) might be considered.

Camp Bustamante	Prevents VRI	CER
9,858,776.00	579 (163x3)	<u>J\$17,027.00</u>

Standard Hospital Intervention

3,036,000 (276x11,000)	193	15,730.00
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Therefore the difference in costs of the standard intervention and the CB intervention is (17027.00-15730.00) = \$1,297.00

The marginal difference therefore of J\$1,297.00 might be considered the cost of the marginal benefit between a child being treated at the hospital for a VRI with no specialist intervention or a child receiving treatment and specialists help. This however only accounts for the direct costs of the intervention, although and does not take into account the indirect and societal costs of a VRI in children, therefore the impact and savings to the health system and society will be much greater. However it must be reiterated that this is a hypothetical exercise.

ANALYSIS OF FINDINGS

Camp Bustamante succeeded in developing a hospital based model to identify and refer children who were victims of violence, evidenced by the analysis of quantitative data taken from Camp Bustamante data management system (CB/DMS). According to quantitative data from the Bustamante Children's Hospital and Camp Bustamante an average of 4 children per 1000 were victims of violence related injuries requiring treatment at the hospital over the LOP. However it must be noted that according to US reports, as seen in the literature review, child abuse and neglect are more likely to be at least 10 times higher than this (43 per 1,000) and therefore the VRI recorded represent only the tip of the iceberg and should be viewed as a window to undetected child abuse and unmet needs. It should also be borne in mind that the hospital caters to children from 0-12 years old only and that cases of emotional abuse and neglect may not be identified unless they are associated, as they often are, with physical or sexual abuse.

It is also noteworthy that VRI increase according to the age of the child and therefore this has implications for developing age appropriate parenting and disciplinary guidelines. The need for this is clearly brought out by the focus group discussions in two communities with a relatively high incidence of cases of child abuse reaching CB. In these communities corporal punishment is seen as a critical tool in the four to eleven year old age group in their parents' frantic efforts to prevent them being absorbed into the culture of gun, drugs and random sex, which is so much a part of the social environment of the inner city communities. It also emerged from these groups and from the Parenting Forums run by CAMP Bustamante that the majority of parents do not discuss issues or hold conversations with their children and do not therefore appreciate their value and influence. It is antithetical to an authoritarian approach, which is the only approach to which many parents have been exposed. The focus group discussions included recommendations for continuous parenting training workshops and special workshops for teenage parents. These discussions and feedback at parenting forums reinforce what is already known, that corporal punishment, including severe beating, is standard discipline for children. As noted in the literature review (p. 25), the World Report on Violence Against Children states that corporal punishment is a predictor of depression,

unhappiness and anxiety, and feelings of hopelessness in children and youth. The focus group discussions on age appropriate forms of discipline indicate that beating with implements (as opposed to slapping with the hand) increases between ages four to around 11 years (Table 20, p. 113). The CB/DMS indicates that cases of abuse received at Bustamante Children’s Hospital increase by age, with the highest number in the 8-11 year old group (Fig. 3, p. 38). When the cases are disaggregated by category, the data also show that while the incidence of sexual abuse and gunshot wound cases has remained at about the same level since 2005¹⁸, the incidence of physical abuse has been steadily rising (Fig. 12, p. 47). This suggests there may be a link with the increased stress parents say they are under due to the social challenges they are facing in the inner city communities. It will be noted that the majority of CB cases (over 80%) come from Kingston and St. Andrew with heaviest incidence of VRIs clustered for the most part in inner city communities (Figure 20, p. 53).

Although almost one third of clients were lost to follow-up during the LOP, this appears to be consistent with other CP services locally and internationally and therefore is not viewed as a weakness of the project. Nevertheless a target of 100% follow-up should not be compromised. So the locating information collected at first contact should be treated as a critical function of a child abuse mitigation programme and a more rigorous approach must be employed, to minimize the likelihood of receiving false information and losing the child after they leave the hospital.

No staff members were satisfied with the inability of CB to fulfill its target of a 72 hour response time. There are constant references to this in the PC’s monthly reports and to the backlog of cases that existed in the first two years. The only Case Manager interviewed felt that in the present scenario this was an “impossible” target. Certainly factors such as:

1. the length of time it took to find dockets (abandoned halfway through in favour of a one-page summary sent immediately to CB),

¹⁸ There was a drop in all categories between 2004, when CAMP Bustamante began, and 2005, raising the question as to whether the publicity around the passing of the Child Care and Protection Act early in 2004 had an impact.

2. the severe lack of a proper phone infrastructure (even when partially corrected CB still had only one dedicated phone/fax line – which is inadequate),
3. the limitations of using part-time social workers who are not so flexible in terms of their availability, and
4. violence in communities

all worked against this. Given that very few children were visited within 72 hours, it is important to review the mechanisms that resulted in this failure, whether this target is indeed realistic and how the constraints faced can be minimized, as the need for a rapid response is critical to child safety.

Another concern given the seemingly low referral rate to the CDA (although this could not be finally confirmed due to incomplete data entry) and the serious nature of many of the injuries is that whilst preventing the child from becoming a ward of the state is desirable, this must be based on finite parameters, otherwise interventions run the risk of inadvertently colluding with perpetrators resulting in children remaining in abusive situations.

Whilst no modifications were necessary to the standard injury surveillance system (JISS) in order to extrapolate suspected violence related injuries of children seen at the accident and emergency department, the surveillance system itself was strengthened by the generation of these reports which fed into the CB intervention model which takes a public health approach to violence mitigation. Therefore children once identified are assessed by CB for their risk of violence and risk reduction strategies are applied accordingly. CB generates statistical reports. However standardization and regularity of reporting was not sufficiently developed and this is in need of review. Although there is always a difficult tension between the immediate demands of responding to the children's urgent needs and the time spent on recording and documentation, it is critical for long term impact that focus also be put on the latter by management, as it is this evidence that can influence policymakers and public opinion and will certainly play a critical role in contributing to improving policies and programmes. In the original project document there was also the

expected output of a link between the JISS system and JAMSTATS, but this was not achieved.

The challenge of evaluating this system is the lack of critical indicators in the CB/DMS. No fields were created to identify the percentage of children who were correctly identified as being at risk for violence and this information was also not captured by screening methods. This is particularly important in order to test the effectiveness of the identification process at the A&E department, as cases of violence related injuries (VRI) are classified by the information that the parent or guardian gives on registration, after the child has been triaged. So the critical identification process that routinely determines whether the child gets onto the VRI list is subject to the interpretation of hospital administrative staff if parents are vague about the causes of injury, which is a potential weakness. The only other route is if something is picked up by the examining doctor or, if the child is admitted, on the ward. Also in terms of examining the true burden of VRI in children, cases that die on the way to or on arrival at the hospital are not recorded in the JISS and therefore these cases do not show up in the injury surveillance statistics nor are picked up by CB. This is a potential weakness in the system that also needs to be reviewed as this may result in unattended needs for the other children in the family of the deceased that are also likely to be at risk of violence.

A screening tool was developed for CB and partially fulfills the requirements under the project; however the tool was not validated and was not implemented as intended. The screening tool that was developed was qualitative and did not follow prescribed screening tool methods that include a scoring system to eliminate subjectivity and provider intuition as far as possible, although these factors may still influence scoring of a standard instrument. Therefore this could be considered a weakness in the ability of the tool to accurately identify children's levels of risk and put in place adequate preventive measures to guard against further abuse. It is also suggested that if such a tool is developed, then perhaps child protection agencies give some consideration to adopting preventive screening methods that can be administered before children attend hospital with injuries, preferably at the primary health care clinics, either as part of the ante-natal visits or

integrated into the child health clinics, immunization programmes or community health programmes, as all suspicious injuries in children attending clinics, A&E and hospitals should be followed up. Decisions about instituting mass or targeted screening for child abuse need to be weighed carefully against VRI statistics to quantify the extent of the problem and the particular types of VRI that may benefit the most from early screening, e.g. child sexual abuse, and whether identification of risk can alter the course of subsequent violent events, which according to the literature, it can. Any screening tool considered, however, needs to be tested and scientifically validated before it is widely adopted. The ethics of screening parents for child abuse also requires thorough examination, as with all screening programmes, as the patient or in this case the parents must be given enough information to make an informed decision and to weigh up the benefits and the risks of participating in screening. These must also be considered in relation to the benefits and risks to society. Therefore policies and guidelines must be developed before mass or selected screening is implemented and an analysis of the costs must be conducted to inform decisions. Pilot screening could also take the form of a Randomized Control Trial to evaluate the effectiveness of screening on reducing child morbidity and mortality.

Based on client satisfaction responses, it would appear that CB has been very successful in beginning the process of assisting abused children to overcome their trauma and in assisting parents and caregivers to cope with their own stress surrounding these events so that they can better care for their children and keep them safe. The evidence also suggests that its strengths and solution based interventions, although relatively brief, have had considerable success in improving parenting skills and conflict resolution. It is evident from interviews with parents that CB Social Workers did far more interventionist work via follow-up telephone calls to families than is documented in either the database or the files, and this was one of the services that parents found most helpful. The parents that engaged in the parent forums also found that these helped them to reframe the way they interacted with their children and to recognize that they needed to change some of their negative behavioural patterns in relation to discipline and communication and in this

regard this combination of three approaches (visits, telephone follow-up, parent forums) could be considered an effective interventionist strategy.

Client responses also revealed concern at the plight of parents in general, many of whom clients identified as needing the counseling and guidance interventions provided by social workers. They felt that this positive support, combined with the knowledge that the state would apply sanctions, including the removal of their children, if child abuse was perpetrated, would help to protect children. Both focus groups recommended CAMPs be placed in other hospitals and clinics to protect more children. It is clear that most are unaware of the Children's Registry and feel that reports of child abuse have to be made to the police which, except in the most extreme cases, they are not prepared to undertake.

In relation to the original objectives and indicators, collection of key information to assess how far these objectives were met by quantifiable data is not possible as baselines or criteria to measure increased resiliency were not clearly defined at the start of the project. The indicators of success that were set, such as reduced TV viewing hours, greater participation in after school activities, reduced involvement in conflict, or increased help seeking behaviour by parents, were not measured or reported on quantifiably over the LOP so any conclusions must be drawn from the sample of 18 cases, the data on children who were referred for activities, and the agency interviews, all of which are limited in scope.

The project fulfilled its objectives in developing and disseminating educational materials for the parents. However apart from the parent forums the project documentation did not capture the effectiveness of the material used in other settings. There is also no documentation on the testing of education materials and the clarity of messages inherent in the materials or modifications made as a result of this, which need to be verified. There is also no quantifiable data on the number of parents whose parenting skills were enhanced.

From the assessment of CB through agency interviews it is evident that implementation of a model within the child's environment (home, school, church) through interaction with existing community based programmes was limited to three agencies (1. Multicare Foundation, 2. Tomorrow's Children, 3. The Junior Centre). Whilst from all reports these programmes were very beneficial to the children and parents alike, the capacity of these few agencies to meet the demands of children seen by CB is severely limited with approximately 50 places in total for summer activities and 15 for Saturday programmes during term time. It could be argued that all 863 CB children identified at risk and visited by CB would have benefited from such opportunities; therefore the current programmes over four years could only meet 30% of the demand. Moreover less than half this number attended due to problems associated with busfare and having to travel with an adult. Thus a substantial challenge remains with regard to not only engaging more community based programmes, but developing and monitoring the necessary community infrastructures to deliver these programmes effectively, especially in the high risk geographical areas (see Fig. 21).

Apart from the number of home visits, the project did not collect data on other project indicators in relation to number of children heading households, number of children living in households with a parent/guardian as head of household, the number of children engaged in after-school activities (apart from those referred), the number attending church activities, or the number of children receiving benefits from PATH. Although there are qualitative fields within the database to capture this information, data was often incomplete in these fields and it would be unlikely that a manual tabulation of these indicators would produce reliable results.

The establishment of CB and the recruitment of staff was successfully completed and housed at the expense of BCH who gave CB invaluable support throughout a tenure that lasted almost 5 years, but was originally intended only for 6 months. Part of their support rested on the fact that they very quickly saw the benefits of CB within the hospital given their previous difficulties coping with VRI, and this was also an indication of the professionalism of the CB team. However the space that they occupied was too small to

house all staff, resulting in the Project Coordinator splitting her time between the HLP/MOH and CB, not found to be the most productive arrangement. There also was no access to a confidential meeting room, hence staff would use whatever space was available when seeing parents. In the first year and a half the project did not have access to a landline and relied solely on cell phones, which resulted in limitations in contacting clients given monthly call limits. When the hospital added CB to its service network they were also required to go through the hospital's switchboard, which also severely impacted their ability to reach clients quickly. However staff retention was a particular problem at CB with only the Project Coordinator and the Administrative Assistant¹⁹ being employed throughout the LOP. Perhaps views of the staff, as it relates to difficulties in coping with such stressful child abuse cases, explain this repetitive phenomenon. In addition the decision taken in 2007 to only employ full time case workers also contributed to the turnover. Therefore CB was at times without its complement of two full-time Social Workers (or the equivalent in a combination of part and full-time) resulting in backlogs of cases that would put an additional strain on incoming staff, who were in periods of orientation and adjustment. Therefore in reviewing this model, staff recruitment criteria needs to be reviewed along with supporting mechanisms for staff supervision and support as an integral part of a child abuse mitigation programme. A governance system, in terms of a structure that would oversee management and play a monitoring and quality assurance role, would also need to be better established so that the project could receive the benefit of ongoing advice and guidance.

In relation to case management, efforts at taking a multidisciplinary approach, which could have been facilitated by the Technical Working Group, did not reach very far. For this area of public health such an approach is critical. This ensures a coordinated approach, using synergy to achieve results and at the same time helping to guard against clients being exposed to repeated short-term contacts with different specialists which has been found to be ineffective.^{liv} The BCH Medical Social Workers and CAMP Bustamante worked together, for example, but their work would have been strengthened

¹⁹ Present Administrative Assistant employed in 2005

in the context of a multidisciplinary team where overall philosophies and practical approaches are shared outside the immediacy of on-the-spot work.

CB made strides in relation to uniformity and produced a project protocol for CB that includes a conceptual framework and a protocol for case management, although this was late in the project (August 2007). The project also produced a Training Resource Manual to guide the roll out of child abuse mitigation programmes in other hospitals and this will be an invaluable resource if the decision is taken to continue and expand this initiative.

Training was a strong and ongoing feature of project team meetings and a range of topics were covered geared to improving the quality of interventions and adherence to the CB Model. From meetings with staff it was evident that they found these sessions extremely insightful and instructional and they felt that this enhanced their SW practice. They endorsed the CB focus on a strengths-based approach that seeks to focus on caregivers' strengths rather than their deficits, seeking the triggers for motivation and focusing on solution-based counseling. However they still felt that they would have benefited from specialist training in dealing with sexual abuse cases with a greater emphasis on strategies to personally cope with such troubling issues and in order to prevent premature burn out. Also the effectiveness of sticking rigidly to a model of short-term intervention, focused entirely on the victim, when the demands of service users appear to require more counseling and contact time and some focus on perpetrators when they are family members, must be assessed in the continuation of CB and subsequent modifications of the model.

CONCLUSION AND RECOMMENDATIONS

Camp Bustamante successfully developed and implemented a hospital based child abuse mitigation project at Bustamante Hospital. One strength of the approach, highlighted by the CDA, was the ability to identify children at risk of violence, that may have previously attended the hospital for an injury but were not followed-up on discharge or referred to other agencies. The capacity of Bustamante Hospital to manage this problem, like most hospitals, is severely limited due to under-staffing in medical areas and a shortage of social workers, who deal with very large caseloads and a multiplicity of issues. The other strength is that it would appear that the presence of a specialist team to intervene in VRI cases, with the primary objective of protecting the child and breaking the cycle of violence, is critical and it is evident that the interventions of CB have succeeded in preventing many children going through the court system and being ordered to stay in children's homes (which also accommodate child offenders and children with severe behavioural problems), or simply remaining in an unprotected environment. Also with such a service available at hospitals, health professionals are much more likely to report on these cases, when they are confident that they will receive follow-up and it has also raised the awareness of health staff in recognizing the signs of abuse in cases that are not initially identified as VRI. Jamaica can in fact become a pioneer in the area of child protection with a regional centre of excellence for the identification, assessment and treatment of abuse-related trauma in children.

The essence of the effectiveness of CB seems to lie in the quality of the interaction with the parents, especially when delivered by highly trained and skilled case workers. Many parents commented that knowing that there are agencies out there that care about children and intervene where abuse or neglect of their children is suspected is critical and in itself can prevent some of the abuse. It is clear that CB has focused on client and family welfare and treatment, has begun to explore critical specialist interventions such as play therapy, and has been able to escape dealing with some of the punitive perpetrator focused issues that other agencies have to confront. However as the value of its intervention has emerged so has the short-coming of an intervention model that deals so successfully only with the victim and his/her immediate caregiver(s). Siblings, who can

be deeply traumatised by what has happened, need to be systematically assisted. There is also urgent need for assistance for the child perpetrator like the school or lane bully, or the 15 year old cousin, guilty of sexual assault but who was himself molested at an earlier age, or the aggressive schoolgirl who herself is a silent victim of sexual abuse. Then there are the abusive fathers, who may or may not be remanded but who will certainly not be treated, and who will later continue the cycle of violence with new baby mothers and new children. In the long term the only way to halt this cycle is a 360 degree approach to treating cases of child abuse.

The role of a hospital based child mitigation project should also be linked to the primary health care clinics and the child guidance clinics where screening for child abuse would be ideally placed with subsequent counselling.

The issues of violence in society are complex and interwoven into every aspect of daily life, therefore it is important that a multi-agency, multi-sectoral approach to this problem is taken with CB being just one element of a holistic child protection strategy. As measures to prevent violence in schools are being adopted, a similar emphasis must be placed on community development and the provision of services for children, so that they are able to meaningfully engage in structured activities, especially in the poorest communities. This investment will not only be good for child development in Jamaica, but can also act as a preventive strategy to avert children away from anti-social behaviour that leads to child and adult perpetrators involved in crime and violence later down the road. Research is revealing that parents are highly stressed. Those who have received help are acutely aware of the needs of others in their communities. Poverty is an underlying concern for a number of affected families. The literature has shown that support for families in difficult circumstances can have a direct impact on the mental health of their children and is therefore an important aspect of child protection (see p. 22).

Given the serious nature of the majority of the cases identified by CB, the governance of this initiative must be given careful consideration. Some of the delays in response to

some of these cases are based on the fact that agencies work separately and communication and information sharing is not standardized. So changes in agencies handling cases sometimes result in no one knowing exactly what has happened to assist the child, if anything at all, after the case has been passed on. In considering where CB should be placed, it is suggested that negotiations with the Office of the Children's Registry (OCR) are held to explore whether CB can be situated under this Office, strengthening its identification role of child abuse and assisting its own planned expansion into emergency response, but continuing to work out of the hospitals. This not only would result in more rapid reporting to the Registry as this would be immediate, but provide the project with the necessary legal protection of a child protection service integrating hospital surveillance with the functions of OCR. If the present statutory regulations governing these two bodies do not pose an insuperable problem, it is therefore envisioned that CB pilot this approach for one year under the auspices of the OCA and under the direction of a National Coordinator, at the Bustamante Hospital for Children as well as the Cornwall Regional Hospital, where they have begun to adopt similar strategies for VRI in children. This should be done with a view to rolling out this initiative more widely, based on prevalence data from JISS and evidence of effectiveness and efficiency that must be established by definitive indicators that are set at the start of the project and accompanied by stringent reporting requirements.

It costs approximately 10 million Jamaican dollars per year to implement CB and J\$600,000 per year to keep a child in a state sponsored home. Therefore if CB prevented approximately 300 cases ending up in a children's homes for one year each over the LOP, this represents a saving to the government of J\$180 million for that period. Therefore an investment in child abuse mitigation programmes at hospitals will be money well spent.

Recommendations relating to CAMP Bustamante

1. Bridging funds for six months be immediately sought to ensure the continuation of CAMP Bustamante at the Children's Hospital until final decisions are taken and implemented.
2. The Child Abuse Mitigation Project be placed under OCR and piloted for eighteen months at Bustamante Children's Hospital and Cornwall Regional Hospital and this should be established through a short-term working group (see Figure 22 below).
3. The CAMP at the hospital work in collaboration with the primary health care clinics, so all hospitals with a CAMP are linked to a Type V Health Centre where screening for the risk of child abuse will be implemented.
4. Hospitals must provide space/utilities/services and other benefits of being in the hospital to CAMP.
5. A National Coordinator be appointed to oversee CAMP development, advocacy, training and community development.
6. Community development must be given a much higher priority. CAMP teams should include a CD worker who links into SDC and other community based programmes in order to integrate clients into suitable programmes, monitoring their attendance and any challenges, and helping in the development and evaluation of these programmes. In addition the CD worker would coordinate the CAMP parenting forums, again helping to deal with challenges parents may have in attendance, as well as seeking out school and community based parenting programmes that parents can join.

7. Each CAMP employ one Case Manager, 2 Social Workers, 1 Community Development Worker and an Administrator/Data entry clerk
8. As many clients as possible attend structured weekly and summer programme activities identified and monitored by the CAMP Bustamante Community Development Officer
9. In order to develop holistic case management and in accordance with best practice child protection models, a multidisciplinary case management approach should be further developed in order to foster information sharing and monitor follow-up of complex cases of child abuse. Representatives at this forum should be front-line multidisciplinary case workers who have responsibility for delivery of interventions and interfacing with other stakeholders. Such a forum should also include the development of care plans for children and result in improved monitoring of child abuse reduction strategies and outcomes.
10. A 360 degrees approach to counseling services be put in place for siblings, especially if they are witnesses (e.g. through VSU)
11. A system be put in place to investigate, counsel and rehabilitate child perpetrators of violence and sexual abuse (e.g. PC's June 07 report, page 4 – client lost an eye when she was intentionally and repeatedly hurt by another child who is known to have serious conduct problems. Where is the intervention for this child, who is almost certainly also a victim?)
12. Quality assurance and data protection must be put in place to ensure proper recording storing and retrieval of client information and to enhance confidentiality.
13. The CAMP database be modified to capture key indicators. Indicators must be reviewed and set at the start of the project.

14. JISS and CAMP databases be modified to capture repeat cases of VRI injuries.
15. JISS and CAMP databases be modified to capture VRI cases that die on the way to or on arrival at hospital.
16. The extent of VRI in children needs to be pulled from JISS for all major hospitals in last 5 years and this information should inform roll out and priority locations for expansion of the model.
17. A Randomized Control Trial or Cohort study be considered to test effectiveness of a validated screening tool.
18. A system of tracking must be established to minimize repeat visits to different hospitals either by requesting the parent/guardians TRN number at the time of registration or some other form of identification.
19. Parenting Forums should be expanded to include all parents of victims, as this situation makes parents particularly receptive to sensitization and behavior change.

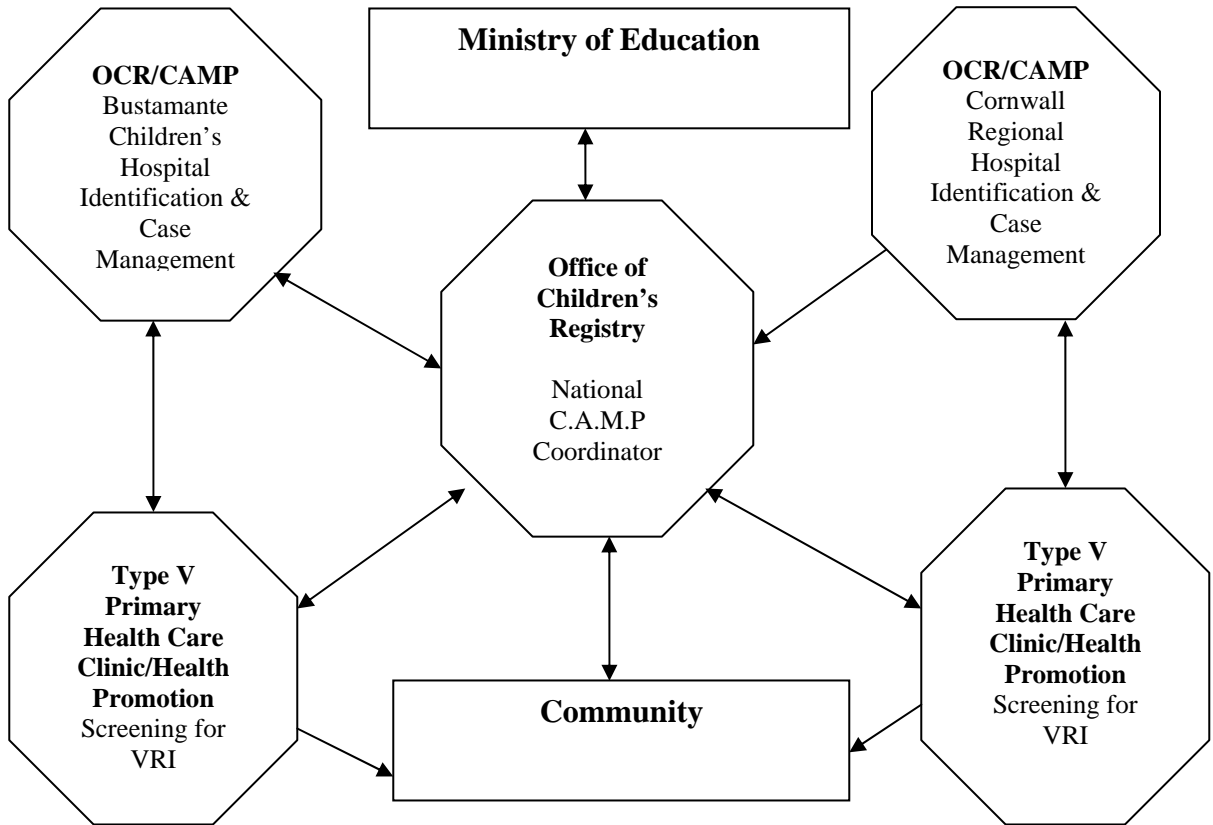
Recommendations relating to the entire Child Protection System

20. The TWG concept should be expanded and improved by establishing a terms of reference for a Child Protection Committee that should have at its core strategic and technical governance of programmes relating to child protection and include a wider remit than the child abuse mitigation programme. It is envisaged that senior level membership with powers of decision be sought to represent relevant stakeholders and at a minimum include: the Ministry of Health HPPD, Primary Health Care, the Hospital and CAMP, the CDA, OCA and the OCR, Ministry of Education/School governing body, Child Guidance Clinic and the Police. This group should meet and report once per quarter and should seek stewardship from the OCA.

21. Promote widely the Children's Registry hotline 1-888-PROTECT, for reporting suspected child abuse, stressing its confidentiality.
22. Re-start the Parents' Hotline, formerly run by the Jamaica Foundation for Children, which offered counseling, advice and referrals.
23. Restart the 24 hr Children's Hotline, formerly run by the Jamaica Foundation for Children.
24. A 360 degrees – ideally counseling services/restorative justice - approach for all perpetrators of abuse. At a minimum this needs to be introduced into the Correctional Services system, especially for parental abusers who are likely to be very conflicted.
25. Employ more social workers in appropriate places in the public sector.
26. Forums on sensitization on child abuse and alternative methods of discipline are needed for Children's Homes' staff (Out of the 18 randomly chosen case studies in the only two cases sent to Children's Homes, abuse was experienced in both - leading the judge in each instance to change the Home. In one case abuse was also perpetrated in the second one).
27. Support Teachers Forums on alternative methods of discipline and management of violence in schools. (There have been about 8 cases over the 4¾ years of CB where the perpetrators have been teachers administering corporal punishment. It is known that many teachers like parents are equally limited in applying non-physical disciplinary measures).
28. Integrate training on the recognition and response to child abuse in the training of medical doctors, nurses and nurses aides

29. Develop a short accredited course on child abuse for other professionals.

Fig. 22: Model of Intervention



National Coordinator will have responsibility for strategic oversight and development of child abuse mitigation programmes under the Office of the Children's Registry.

**Appendix 1: SEMI STRUCTURED AGENCY INTERVIEW TOPIC GUIDE:
CAMP BUSTAMANTE**

Good morning/afternoon. I am _____ and I am a member of a team carrying out an assessment of CAMP Bustamante for the MOH. We will be interviewing several agencies as a part of this. I'm aware that your time is limited so the interview should only take about 45 minutes, is that OK?

I have some particular areas that I would like to hear your views on, but I am interested to hear anything else that you think is relevant to the evaluation. Do I have your permission to proceed with the interview?

1. What are your views on violence against children in Jamaica?
2. What are the main factors that you think put children at risk for violence?
3. Who do you think are the main perpetrators of violence against children in our society?
4. Do you think the legal framework in Jamaica is adequate to protect children from violence?
5. What in your view is the capacity of the CDA to protect children from violence?
6. Please tell me what you know about CAMP Bustamante?
7. What are your views on the service it provides?
8. Did CAMP Bustamante make any referrals to your organization? (If yes) How many?
9. Where the referral reports adequate?
10. Was your agency involved in any regular joint activities with CB, such as case discussions (is this the right word?), training etc.?
11. Was your agency ever involved in any occasional joint activity with CB?
12. In your opinion do you think CAMP Bustamante has had an impact on mitigating violence against children? (If yes) Please explain.
13. Would you say that your organization has benefited from CAMP Bustamante? (If yes) How?

Semi Structured Agency Interview Topic Guide: CAMP Bustamante (contd.)

14. Do you think the hospital is the right place for this service to be placed? If not, where do you think the service is best placed and why?
15. Do you think CB is acceptable to parents?
16. How do you think that this service can be improved?
17. Is there anything else in your view that you think is important with regards to CAMP Bustamante that should be considered in the assessment?

Thank you for taking the time out to be interviewed.

Appendix 2: AGENCY INTERVIEWS

Agency	Representative/Position	Date of Interview
1. Camp Bustamante	1. Rose Robinson Hall/Programme Manager 2. Uki Atkinson/ Social Worker 3. Sheldon Simon/Social Worker 4. Paulette Laing/Social Worker	23/9/08 6/10/08 7/10/08 30/9/08
2. Bustamante Hospital for Children	5. Beverley Needham/CEO 6. Dr. Sonia Henry/SMO 7. Mrs. Garrick/MSW	24/10/08
3. Child Development Agency	8. Alison Anderson /Executive Director 9. Winston Bowen /Director of Programmes 10. Claudette Hemmings/Regional Director South East	30/10/08 24/10/08
4. Office of the Children's Advocate	11. Mary Clarke/Children's Advocate	7/10/08
5. Office of the Children's Registry	12. Carla Edie/Registrar	30/10/08
6. Child Guidance Clinic-BHC	13. Dr. Pauline Milbourne Pediatrician	6/10/08
7. Child Guidance Clinic-UHWI	14. Dr. Lowe/Coordinator	31/10/08
8. Multicare Foundation	15. Elizabeth Campbell/ Actg Coordinator	7/10/08
9. Institute of Jamaica-Junior Centre	16. Jacqueline Bushay/ Director of Programmes	7/10/08
10. Tomorrow's Children, Centre for the Arts UTECH	17. Pat Ramsay/Director 18. Trudy-Ann Barratt/Programme Coordinator	31/10/08 30/10/08
11. CISOCA	19. Inspector Gordon NB. A brief telephone interview (Head, Supt. Herfa Beckford, on study leave)	22/10/08

Appendix 3: PROPOSED SAMPLE AND ACTUAL SAMPLE FOR CASE STUDIES OF CLIENTS

Proposed sample of 20 cases/clients

Year	No. female	Female ages	No. male	Male ages	Ages	Total
2004	3	0-3	3	0-3	0-3	2
Yr 1		4-7		4-7	4-7	2
		8-11		8-11	8-11	2
2005	2	0-3	1	4-7	0-3	1
Yr 2		8-11			4-7	1
					8-11	1
2006	2	0-3	2	4-7	0-3	1
Yr 3		4-7		8-11	4-7	2
					8-11	1
2007	2	0-3	2	0-3	0-3	2
Yr 4		8-11		4-7	4-7	1
					8-11	1
2008	1	4-7	2	0-3	0-3	1
Yr 5				8-11	4-7	1
					8-11	1
Total	10	4 x 0-3	10	3 x 0-3	0-3	7
		3 x 4-7		4 x 4-7	4-7	7
		3 x 8-11		3 x 8-11	8-11	6

Actual sample of 18 cases/20 clients

Year	No. Female	Ages	Injury	No. male	Ages	Injury	Total cases
2004	3	3 ms	PA	3	3ms	PA	6
Yr 1		4	SA		6	PA	
		11	PA		8	PA	
2005	4	1	GSW	1	5	PA	4
Yr 2		2	ASA				
		8 & 10	PA				
2006	1	5	SA	1	7	PA	2
Yr 3							
2007	1	10	PS	3	9ms	GSW	3
Yr 4					6 & 10	PA & SA	
2008	1	4	SA	2	2	PA	3
Yr 5					11	PA	
Total	10	3 x 0-3		10	3 x 0-3		6
		3 x 4-7			3 x 4-7		6
		4 x 8-11			4 x 8-11		6

Appendix 4: SEMI-STRUCTURED PARENT INTERVIEW GUIDE: CAMP BUSTAMANTE

Hello. I'm _____ and I'm a member of the team carrying out an evaluation for the Ministry of Health on CAMP Bustamante. I understand you agreed over the phone to have a discussion on the services you received from CAMP Bustamante? Here is the actual letter requesting your assistance.

I am going to be writing notes while we talk. No-one else will see the notes in this notebook but I will be using them to help me in the overall evaluation. Everything we discuss is completely confidential. Your name will not be used in the evaluation – you and 19 others will be giving your opinions but none of them will be linked to anyone's name.

Do you have anything you want to ask me before we start?

CAMP Bustamante Services

1. Did you get a visit from a CAMP Bustamante social worker?
2. Did the social worker explain clearly why s/he was visiting you?
3. What did you understand from what s/he said?
4. Did the social worker help you to understand the problem better?
5. Did you get advice from the social worker?
6. Did you follow this advice? (probe for explanation of answer)
7. Did the social worker organize any further action to assist your child? (if they refer to referrals, do not proceed but say you will follow up in a minute – Q21 on)
8. Did they attend regularly? (If no) Why?
9. Did it help them? (probe for explanation of answer)
10. On a scale of 1-10, with 10 being the top score, how would you score overall the help from the CAMP Bustamante social worker?
11. Did you as a parent (or caregiver) attend any other CAMP Bustamante activity(s)? (probe which ones, e.g. the Parent Forums)
12. Was this helpful? (probe)

13. Do you do anything differently now as a result of the social worker or the CAMP Bustamante intervention? (probe behaviour towards children and behaviour towards others)
14. On a scale of 1-10, with 10 being the top score, how would you score overall the help of CAMP Bustamante?
15. If you have problems with your child(ren) now, who do you go to for advice or help?
16. Is that what you have always done? (probe if answer is no)
17. If you have other problems in your life, who do you go to for help?
18. Have you always done this? (probe if answer is no)

Referral Agency Services

19. Did CAMP Bustamante refer you to another agency (or agencies) to further assist your child and yourself?
20. (If yes) Which one(s)?
21. What services did it offer your child or yourself?
22. Were they helpful? (probe for explanations)
23. On a scale of 1-10, with 10 being the top score, how would you score overall the help of _____?

(Repeat 23-25 if more than one agency)

Other

24. Is there anything in the services that were offered to you by CAMP Bustamante or any other agency that particularly upset you?
25. What was most helpful?
26. Is there any advice you would like to give CAMP Bustamante - or any of the other agencies - that you think would help to improve what they are doing?
27. Is there anything else you would like to say?

Thank you very much for taking the time to have this discussion. It was very helpful.

Appendix 5: COMMUNITY FOCUS GROUP DISCUSSION GUIDE

Good morning/afternoon/evening! Welcome to our discussion group. My name is _____. We are carrying out an evaluation for the Ministry of Health on CAMP Bustamante, which is a service for children that have suffered injuries as a result of violence and we would like to hear your views on the issue of violence and children.

Everyone's contributions are valuable and we are interested in all your opinions, attitudes and suggestions. There are no right or wrong answers. You may disagree with one another and that is ok. Just think of this as a conversation and don't wait for me to call on you speak.

Just so we don't miss anything that you say during our discussion we will be taking notes. All your comments are confidential and will only be used for this evaluation and to make recommendations to the Ministry of Health. Your names will not be used, and therefore I will not record any names but just general information about the group such as age range and sex. However it would be nice if we can refer to each other by first name or 'pet name', so can we just have a brief round of introductions. Please say your name and one thing that you would like everyone to know about you.

At the end of the sessions I will be happy to clarify any questions that might come up in during the discussion. Can we begin the group discussion now?

INTRODUCTION

1. What do you enjoy doing most in your spare time?
2. What would you say are your biggest challenges in life?

KNOWLEDGE AND PERCEPTION ABOUT VIOLENCE AND CHILDREN

3. What would you say are the greatest challenges of raising children today?
4. What does keeping a child 'safe' mean?
5. What situations would you say are unsafe for children at different ages?
6. Where do you think children experience violence most? (and that can means witnessing violence or actually being hit themselves)
7. What do children do that sometimes provokes a violent reaction from others - whether other children, parents, relatives, neighbours...? (probe by age group if possible)

8. Do you think it is appropriate to behave with physical force if a child behaves in any of these ways?
9. Do you think that television can influence children's behaviour in the wrong way?
10. Do you think that popular music can influence children's behaviour in the wrong way?

COMMUNITY SOCIAL CAPITAL

11. Have you even heard the African proverb "It takes a village to raise a child"? How much do people look out for other people's children in this community?
12. Do you think the community could do more to keep its children safe?

ATTITUDES ON DISCIPLINE

13. What are your views on the following statements?
Spare the rod and spoil the child?
Bend the tree while it young'
14. Do you think these statements are good principles to go by in raising children?
15. What are the different ways people in this community discipline their children?
16. Who in the family is usually responsible for discipline? Is it one or more than one person?
17. What types of discipline do you think work best for children?

KNOWLEDGE OF CHILD CARE AND PROTECTION ACT

18. In 2004 Jamaica introduced the Childcare and Protection Act. Have you ever heard of this? What have you heard? *(if they don't know give brief overview)*
19. If people think a child in the community is being abused, would they report it to the Children's Development Agency, the CDA??
20. Do you think that services to protect children from violence are needed in Jamaica?
21. What types of service do you think can assist parents?

ATTITUDES ON PROTECTIVE FACTORS

22. What services and activities are there in your community for children? (Prompt if necessary e.g. homework programmes, Sunday School at church, sports)
23. How many children use these? (If they are not used much probe why this is the case)
24. What services or activities for children would you like to see in this community?
25. What services do you think can protect children from violence?

KNOWLEDGE OF CAMP BUSTAMANTE

25. Have you ever heard of CAMP Bustamante?
26. What have you heard about it?
27. (*At this point give a brief overview of where CAMP Bustamante is located and its purpose*) Do you think this is a useful service to be attached to a hospital?
28. a. (*Where the group or any individual[s] answer yes*) Why? Do you think it should be anywhere else too?
 - b. (*Where the group or any individual[s] answer no*) Why?

OTHER COMMENTS

29. Is anything else that you think is relevant to children and violence?

Thank you for taking the time out for this discussion.

N.B. Information on the Child Care and Protection Act will be distributed at the end of these sessions. Refreshment will also be provided.

**Appendix 6: REPORT ON FOCUS GROUP DISCUSSION HELD IN
COMMUNITY A ON THURSDAY, OCT 30, 2008**

Facilitator: Angela Stultz
Note Taker: Calvert Barclay
Observer: Nicole Kellyman, Community Development Officer,
Social Development Commission

Participants began arriving at 5:14 pm and at approximately 5:34 pm the discussion commenced with some 17 persons in attendance (5 males & 12 females).

INTRODUCTION

The facilitator, Ms. Angela Stultz, commended the participants for coming out in spite of the rain, and introduced herself and the Notetaker as representatives of the Ministry of Health, and the Observer, already known to them as the SDC CDO for the area.

She then outlined the purpose of the FGD to be an evaluation of the Camp Bustamante programme (a programme designed to provide a service for children who have suffered injuries as a result of violence), and stated that we were interested in getting their views on the issue of violence and children, so that the relevant recommendations could be made to the Ministry of Health.

After assuring all as to the confidential nature of the proceedings and the need for each to respect the others' opinion/s (irrespective of whether you agree or not), she invited all to introduce themselves, state the name they would like to be called during the discussion, and tell one thing that they liked about themselves. She also assured participants that although notes were being taken, no names would be recorded, but we would need to have a rough estimate of their different age groups.

The following responses were recorded:

- Tek care of kids... mek sure dem go school....mek sure dem ok right through.
- Have to be very careful due to rape of children.
- I am a strict father and grandfather
- Disciplinarian...discipline goes a far way. Like to work with children, respect them. If you don't show them respect, dem won't respect you.
- Respect elder people
- Love to protect children. Mi love mi daughter.... Don't want anything happen to har. Mi a strict mother, always tek care.
- Love everybody pickney. Love everybody else children.

(At 5:45 pm two more females arrived).

KNOWLEDGE AND PERCEPTION ABOUT CHILDREN AND VIOLENCE

At this point the Facilitator sought to solicit the participants' perception about violence and children. The question was posed as to what are the greatest challenges of raising children today.

The first response was one of a mother (20-30 age range) commenting "I would like you to show me how to deal with my child... He is very rude.... How can I curve him?" One other mother voiced the same concern.

One 37 year old mother of seven children underscored the need for showing love for children and providing security for them.

One other stressed the need for children to "grow up right"

Other challenges were reported to include:

- Environment
- Peer pressure
- Unemployment > frustration > physical abuse
- Single parenting

Challenges were then broken down with respect to age cohorts as follows:

0-3 years

- Physical abuse
- Fire

4-6 years

- As above

7-11 years

- Gang link up
- Peer pressure
- Sexual /carnal abuse
- Movement restricted (due to violence)

12-16 years

- Gang violence
- Drugs
- Alcohol (guinness, magnum, rum etc),

(At 5:50 pm two females in their early 20s joined the group)

Facilitator asked the group, “What does keeping a child safe mean?”

Response: Protect from danger, i.e. keep young ones them away from gunshot, drugs, gang violence, sexual abuse, rapist, physical abuse, swimming/drowning, and fire. During this discussion a fire cracker exploded loudly on the outside providing a light moment for the proceedings based on the “knee jerk” reaction of some of us.

After much discussion wherein children were defined as being in the 0-18 age cohort, gang violence, sexual abuse, and drugs were ranked in that order as the top three dangers.

The greatest challenges in growing children were identified to be combating peer pressure and providing a good environment for their growth.

The participants then sought to identify factors in the environment that contributed to making children unsafe, and listed them within age ranges thus:

0-3 years: Fire (leaving children alone unprotected), physical abuse, gang violence, and sexual abuse. One member of the group (47 yr. old male) contested the inclusion of sexual abuse as this was not really a problem in the community. It was agreed that the 4-6 year age group would be also affected by the above mentioned.

6-11 years: Gang violence (prevent free movement, hamper school work); start having friends (may have negative influences); gang link up; peer pressure; sexual/carnal abuse.

12-18 years: Gang violence; drugs (mostly ganja, alcohol i.e. guinness, magnum, rum etc.).....relates to both male and female.

In response to a question related to what children do to put themselves in the way of violence/violent situations, participants remarked:

- Company they keep
- Peer pressure....wanting to be part of the gang
- Lack of parental guidance
- Negligence

Although television was identified by some to be a major factor influencing children’s behavior in the wrong way, a minority view was expressed (female mid 40s) that “nothing can force you to do anything you do not want to do.” The impact of cable television was downplayed however as most participants reported that they did not subscribe to “certain stations”, and in the words of one “if him going see it, mek him see it somewhere else...not at home”

In discussing the impact of music on children’s behavior, it was agreed unanimously that music did in fact influence behavior, especially “the gun lyrics, lewd music, sex inna de music”. Artiste Movado was singled out. Carnival and soca music also came up in the discussion with respect to the presence of “slack songs”. It was posited, however, that the

impact was not as great, as most children did not really understand what was being said or implied, but in the case of Kartel and Movado it was different as children “tek on to dem quicker”. All participants however bemoaned the fact that “you can’t stop that... it ever on the road..or even inna the bus dem.”

At this point the Facilitator proceeded to solicit the participants’ views on “Sex or gun, which is more harmful to the children?” Responses included:

- Both of them harmful
- Dem walk hand in hand
- Can’t stop that
- Come down to parental guidance

A lively discussion ensued with participants positing:

- Parents should be open enough and let their children understand about sex
- Parents should discuss sexuality with children

With a show of hands it was determined that it was only a small minority of participants who really discussed issues with their children. One participant pointed that “sometime when police cum a yu gate yu frighten, as yu neva know yu child involved”.

Another remarked (with respect to bad behavior) that “a dem waan do it.....no music nor fren can’t tell dem fi do it”. This position was disputed by another participant who posited “a no him really want do it, but him no waan look soft mongst him fren dem”

COMMUNITY SOCIAL CAPITAL

All agreed that “it takes a village to raise a child” but reported that this was not really the practice in their community:

- some people do not want you to talk to dem pickney
- children go home an tell dem parents lie on you
- parents abuse other parents if you scold dem child
- want come beat you up
- gooda get some box and kick
- have to jus ‘low dem wen yu see dem a misbehave
- some parents a go a school go beat teacher, much less

Some participants remarked however that irrespective of the above mentioned challenges they still:

- reprimand children on the street , and part fight regular
- run dem home all the time
- wild dem up all the while but dem say mi miserable
- tell their own children “anyone waan fight yu, go tell yu teacher”

On probing whether age was a factor, respondents posited that while children were more likely to respond to elders:

- some a dem no tek no talk
- some know how dem parent will react and therefore yu can't talk to them
- some kids jus don't care.....whether yu young or yu old

It was also posited that children tended to be more disrespectful to females more than males:

- women caan manage dem
- child don't respect the woman dem

They concluded that more could be done to keep the children safe, and suggested:

- Setting up programmes like these to educate parents and “sensitize them on parenting”. “Who come now, will bring others next time”.
- Talking more to your kids
- Providing counseling...nuff a de parents need counseling demself

NB. It was also disclosed that the community is predominantly made up of single parent/female headed households.

ATTITUDES TO DISCIPLINE

The Facilitator then asked participants to share their views on the statement “Spare the rod and spoil the child.”

The first and almost immediate response came from a male participant (40+) who exclaimed “no man, you have to mash up the rod on him....at certain age yu start reason with them.” He identified the beating age to be from about 3 years old.

This however turned out to be a minority view as others remarked:

- a physical abuse dat
- at age 3 dem understand demself

He nevertheless received some support – “Mi tink yu can weigh the beating thing still, yu know man...low de beating ting.”

The point was also made that due to the fact that many parents are ‘financially embarrass’, this is another challenge which causes frustration and stress, and results in parents physically and verbally abusing their children.

The group then proceeded to outline different disciplinary procedures utilized for different age cohorts as follows:

3 – 10 years

- Withholding privilege
- No ice cream
- No school trip
- No games
- No TV
- No sparing of the rod

“Yu have fi talk to dem ruff to yu know...tek weh certain privilege like no ice cream fi all one month”

“No television ... if yu have any...every body have TV”

The above point was disputed as it was contested as to whether all homes have television sets.

10 – 14 years

- Tapping up (some physical disciplining combined with reasoning)
- Reasoning
- Withhold privileges
- No school trip
- No games
- No TV
- Curfew

15 years up

- Rough talk
- Curfew
- Straight reasoning - “straight reasoning...if him no waan hear, den im de pon im own

In discussing who was primarily responsible for discipline in the home the following comments were made:

- mother will talk two time and say mi caan badda.....but the father nah give up (male view)
- de mothers rougher than de fathers.....my mother nuh play (female view)
- most of the mothers are single parents
- yu have to instill discipline at a tender age
- yu know how much time mi de a hospital an see parents a try discipline dem chile?
- in a both parents situation, vice versa

By a show of hands, 13 voted mothers & 5 voted fathers.

A probe of the reasons for single parenting in the community revealed:

- father dead
- don't own child
- deadbeat, don't care father

What type of discipline works best?

- No privileges...depends however on the circumstance
- Depends on what age...also depend on the child
- Some children bend dem mind fi tek de beating.....beating nuh really work
- Beating and punishment a two different tings
- Depend on the nature of the 'crime'

KNOWLEDGE OF CHILD CARE AND PROTECTION ACT

When asked about the Child Care Act, 16 persons confessed that they did not know about it, while 3 said they had seen it on TV. One young female participant (mid to late 20s) commented, "Mi believe them (children) have too much right".

The Facilitator then gave an overview of the Act, and in the ensuing discussion the following comments were made:

- once you love your child you will do everything to see that they are protected
- some children out there don't get loved
- sometime a jus want dem want yu fi notice dem
- some parents never hug them child yet
- some parents defend child or give or give material things...but don't hug
- big hairstyles, rings etc..to show love
- nowadays children don't enjoy dem childhood

Participants were then asked whether they would report cases of physical abuse to the authorities:

- no sah...dem a go sey yu a informer
- mi nah report nuttin
- sometime wen yu see tings yu don't talk because likkle more yu eye will shut an caan open back
- report it or we use jungle justice
- report it only if yu have backative
- can use people who have backative to report it

A hypothetical case of a 15 year old sleeping with older men was then presented by the Facilitator and resulted in the following mixed responses:

- mi a tell yu de truth....if a man rape my daughter, mi nah go no police yu know...mi a deal wid it - jungle justice straight (female participant –late 30s).
- mi willing fi put mi head pon de block fi dis one
- will report it, but you have to be discreet
- parents talk to them, them tell dem man, man kill parent
- some parents too likky likky....dem put up wid it

PROTECTIVE FACTORS

Services and activities available in the community for children include homework programme at the Centre, Sunday school at church, Youth Empowerment Programme (YEP), summer school, GSAT classes, JSIF programme – all widely used by the children.

Services/programmes to protect children from violence

- form a curfew ting...after certain hours dem have fi come off a de road.. this working well in Fletchers Land and Tivoli
- parents talk to them, them tell dem man, man kill parent
- some parents too likky likky....dem put up wid it
- we a cut out the don ting too, yu know

KNOWLEDGE OF CAMP BUSTAMANTE

Not one participant was aware of the Camp Bustamante programme, but after hearing about it from the Facilitator, they unanimously heaped high praises on it, and expressed their full support for such an initiative. They even requested that it be introduced to KPH and Comprehensive Clinic (Slip Pen Road). The Facilitator had explained that CAMP meant Child Abuse Mitigation Project and that the focus of CAMP Bustamante was the safety and security of children. It operated through the Bustamante Hospital for Children whose doctors would refer any child who they felt had been exposed to hazard – whether emotional, sexual or physical abuse – to the team at CAMP Bustamante. The social workers from the CAMP would make home and school visits to assess if the child was in a risky situation and to try to ensure that any risky situation was dealt with. They wished the child to remain with the parents and caregivers who they had bonded with but if the child was in a situation of danger or high risk, as a last resort they would remove the child in order to protect them.

OTHER COMMENTS

On the invitation of the Facilitator to comment on anything else relevant to children and violence, they responded:

- de environment add to the violence
- all de gunshot dem to; it affect the children
- need to build a library in the community
- dem call de youth 'fish', him get violent

Mothers verbally abuse their children more than fathers e.g. “hey batty bway” and “yu ugly like yu puppa”

The following recommendations were made:

8. Form Parenting Group
9. Continuous parenting sessions
10. Skills training programme
11. Learn more about the CDA
12. Camp Bustamante programme at KPH and Comprehensive
13. Employment for the females

CLOSING

Refreshments were served at approximately 7:00 pm and copies of CDA booklet –“Act Right, Treat Me Right” handed out to all.

On the insistence of one participant a contact list was compiled of persons interested in forming a parenting group, and the SDC Community Development Officer volunteered to assist with formation.

The discussion was terminated at 7:14 pm with the Facilitator, Notetaker, and Observer thanking all for their participation and lively, robust discussion.

At 7:20 pm one female who was not present at the FGD came into the room and requested a copy of the CDA booklet. Request was granted.

Team exited the community at approximately 7:35pm.

Composition of Participants (at highest point)

Age Cohort	Male	Female	Total
20 – 30 yrs	2	1	3
31 – 40 yrs	0	11	11
41 – 50 yrs	3	3	6
51 – 60 yrs	0	1	1
Total	5	16	21

**Appendix 7: REPORT ON FOCUS GROUP DISCUSSION HELD IN
COMMUNITY B ON WEDNESDAY, NOVEMBER 19, 2008**

Facilitator: Angela Stultz

Note Taker: Calvert Barclay

By 5:15 pm 8 persons had arrived, and at approximately 5:21 pm the discussion commenced with some 10 persons in attendance (3 males & 7 females).

INTRODUCTION

The Facilitator, Ms. Angela Stultz, commended the participants for coming out, and expressed her appreciation to the mobilizers for getting at least 10 persons to start with. She then introduced herself and the Notetaker stating that although each worked with different projects individually, today we were representing the Ministry of Health who were very concerned about the violence happening across the island, especially against children.

She then outlined the purpose of the FGD to be an evaluation of the Camp Bustamante programme (a programme designed to provide a service for children who have suffered injuries as a result of violence), and stated that we were interested in getting their views on the issue of violence and children, so that the relevant recommendations could be made to the Ministry of Health.

The Facilitator implored participants to respect each person's opinion during the discussion, as all were considered to be valid; turn off all cell phones or put them on silent/vibrate; and reassured them that all comments and information given would be held in the strictest confidence.

She then invited persons to indicate what name they would like to be called during the discussions, pledging that although we were documenting the proceedings no names would be recorded. Name tags were then produced using masking tape and placed on each person on the initiative of one young male participant.

By 5:30 another four persons had joined the group and the Facilitator then asked all to indicate by a show of hands what age cohort they belonged to.

Age Cohort	Male	Female	Total
20 – 35	1	4	5
36 – 50	0	3	3
50 +	2	4	6
Total	3	11	14

After introducing themselves, participants were then asked to state one thing that they liked about themselves. The following responses were recorded:

- Don't pretend
- Don't tell lie (evoked much laughter)
- Positive person
- Loving and kind
- Love tek care of children
- Like to be punctual
- Take care of people ... elders and children
- Very strict person
- Consider about things in life

KNOWLEDGE AND PERCEPTION ABOUT CHILDREN AND VIOLENCE

At this point the Facilitator proceeded to solicit the participants' perceptions about violence and children. The question was posed as to what are the greatest challenges of raising children today. These were deemed to be the social environment (guns, drugs, unsafe sex), communication, music, and the media (electronic). "Younger generation think you are old, and don't know or understand what they are going through." "Keeping child safe" was also a stated challenge.

Facilitator asked the group, "What does keeping a child safe mean?"

Response: Protect from danger, keeping them away from bad company, ensuring that they are in the house by 7 pm, teaching them to be "street smart" i.e teach them "survival tactics."

The participants then sought to identify factors in the environment that contributed to making children unsafe, and listed them within age cohorts as follows:

0-3 years

- Fire
- Water
- Street
- Chemicals
- Kitchen

4-6 years

- all of the above plus child molestation (sexual), affecting both boys and girls

7-11 years

- all of the abovementioned plus abuse (physical and verbal)

12 years +

- drugs
- sex
- sex without protection
- “dem just love build up pure spliff”
- “hold a gun”
- “pure bad company”
- “deh a dance all 1 o’clock a nite”
- “on the street, hustling, loitering

In response to a question related to what children do that sometimes provokes a violent reaction from others, participants posited:

- Being stubborn
- Don’t want leave bad company
- Repeat offences
- Disrespectful to parents and adults Even their peers

All participants were of the view that television can influence children’s behavior in the wrong way. One parent outlined a recent experience when, on attempting to reprimand her daughter for telling a lie, she was promptly told, “Mommy, lie no kill nobaddy”. This line is taken from a television commercial promoting a popular local play. They were also of one accord in agreeing to the negative impact of popular music on children’s behavior.

After a lively discussion as to the relative impact of television and popular music, where comments included, “No sah, de both a dem a de same ting”, “Wen yu talk bout cable, yu ha fi talk bout DVD too”, “Not everybody have cable”, some 75% of participants agreed that popular music had a greater impact as it was more accessible to children than cable TV, and was “more far reaching.” Of note is that all three males were of the view that cable had greater impact.

It was agreed that the community could and should do more to keep its children safe, but parents needed to be “educated”, in other words “sensitize them on parenting.”

COMMUNITY SOCIAL CAPITAL

At this point the Facilitator proceeded to solicit the participants’ views on the African proverb “It takes a village to raise a child.”

While extolling the virtues of this construct, participants posited that this used to happen a long time ago, but was no longer the practice as “most parents believe is only dem mus raise dem kids.” In addition the view was expressed that “if mi can’t control my child, how can I then talk to another person’s child?” Moreover if a family member in the community, even a distant one, was known to have any antisocial behaviour it was held

against the person who intervened. They were of the view, however, that a small minority of residents (less than 5%) still operated within this paradigm.

ATTITUDES ON DISCIPLINE

The Facilitator then asked participants to share their views on the saying “Spare the rod and spoil the child.”

The eldest participant in the group (male, 60+) immediately commented, “I do not believe in it... they have to get beating.” One female participant (50+) enquired as to the meaning of the statement, and the Facilitator explained that it essentially spoke to the view that abstaining from corporal punishment and allowing the child to have their own way resulted in them being “spoilt.” One participant said: “No way! Kick down first before spoil the child!” Another participant responded, “A physical abuse dat!”

A heated discussion ensued when participants were asked to outline the different ways that people in the community discipline their children. Comments like “withholding lunch money, but sending child to school same way”, “straight pick axe stick”, and “kick them down” brought immediately reprimand from the majority, who said this was not true.

Disciplinary practices as per different age cohorts were then highlighted as follows:

0 - 3 years

- Slap

4 - 6 years

- Start beating
- No television
- No go outside
- Verbal harshnessbut not physical abuse – “mi discipline by mi mouth, I don’t beat kids”
- Indecent language

7 - 10 years

- Reduced lunch money, but still have to attend school
- Thump dem up
- Indecent language
- Kick dem down (kicking is identified as abuse and sparked reprimand from group)

11 – 14 years

- Same as above
- No party
- No pretty clothes
- No lunch money, but still have to attend school
- Reduced lunch money

15 years +

- “Throw dem out” - no difference whether boy or girl (counteracted by some members and identified as a contributing factor to teenage pregnancy and gunmanship)
- “Can’t lick dem”
- “Some times the girls worse than the boys”

Interestingly, at this point, one participant (community leader, female, mid 40s) drew attention to the fact that all the information written the flip charts was confirming what was known to her to be true, “B is high on cases of child abuse.”

Approximately 50% of the group indicated that they headed single parent households and were therefore solely responsible for discipline. The remainder of the group (3 males included) reported that the responsibility for discipline was shared by both parents.

When asked what types of discipline worked best for children, they were unable to answer.

Another parent remarked that she usually talk down to her daughter, telling her that “Yu nah come out to nothing good”. This effectively, she said, motivated her daughter to do well and prove herself. She was mindful of the fact however that in many cases it works the other way. In the ensuing discussion on this issue, one participant posited that “Some people prophesy what the child is going to be from in the belly. Dem don’t try uplift dem children.” They gave the following as examples: “Sharon, yu pregnant again?”, the answer might be, “Yes, me a bring another whore!” or “Me a bring a gunman!”.

KNOWLEDGE OF CHILD CARE AND PROTECTION ACT

When asked about the Child Care Act, all 22 participants confessed that they did not know much about it. The Facilitator then proceeded to give an overview of the Child Care and Protection Act, stating that it was effectively intended to ensure the protection and care of children. This Act, she informed, covers three types of children rights, namely: protection rights; provision rights; and participation rights. Participants were informed that each would receive a copy a booklet produced by the Child development Agency outlining the details at the end of the session. Persons also said that they did not know much about the Child Development Agency and its mandate.

Participants were then asked whether they would report cases of physical abuse to the authorities. The first responder (elderly male) answered yes, as it was only last week that one such case was reported. This was contested by other members of the group, who posited, “No sah, not just so... something else cause dat.” Further probing revealed that the “authority” to which the report was made was the area leader.

One case was shared wherein a 3 year old had been beaten with a shovel by his mother and the matter was reported to the local police because it was felt to be extreme. Another parent went to the station and reported that the mother was suffering from extreme stress. It all ended there as the police took no action at all and mother and child went home. Participants were not aware that a case like this should have been reported to the Children's Registry or the Child Development Agency.

The majority of the parents felt that services to protect children from violence are needed in Jamaica, and identified continuous parenting workshops as a service that could greatly assist parents in the community.

PROTECTIVE FACTORS

Participants volunteered that a Homework programme and Sunday school is operated in the community centre. Approximately 50% of participants send their children to church.

Services/programmes to protect children from violence

The Parenting Association has initiated a "8 o'clock curfew" for children in the community. Some participants expressed some displeasure about the way things were going as "enforcers were abusing (verbally) the children" by using indecent language to them when sending them off the streets and gave an example.

Example

Curfew enforcer approaches child "Weh de ****===+++##@@!!!! Yu a do pan de road?" Child answers back. Enforcer punches child. "Some parents are vexed." "Some parents have no interest in their children at all anyway."

Participants underscored the need for "clean recreation" for children i.e. "no slack thing (eg. types of music sometimes played at Fun Days) and "No abuse of children entering the gate of an activity."

Community child rearing practices also came up for some discussion. There was agreement when one participant commented that some parents regard bad word cursing and tracing by their child as "being cute". One person said: "Is the way you grow your child", while another disagreed: "Sometime is not the way yu grow yu child, but is the environment and the exposure to all kind of things that dem not seeing at home."

KNOWLEDGE OF CAMP BUSTAMANTE

Only one participant had any knowledge of CAMP Bustamante and this was based on her daughter having gone there on a trip from her school. The Facilitator then proceeded to explain what it was all about and stated that CAMP meant Child Abuse Mitigation Project and that the objectives of the Project included the safety and security of children. It operated through the Bustamante Hospital for Children whose doctors would refer any

child who they felt had been exposed to hazard – whether emotional, sexual or physical abuse – to the team at CAMP Bustamante. The social workers from the CAMP would make home and school visits to assess if the child was in a risky situation and to try to ensure that any risky situation was dealt with. They wished the child to remain with the parents and caregivers who they had bonded with but if the child was in a situation of danger or high risk, as a last resort they would remove the child in order to protect them. The fall of a baby in the audience was then used to further explain in practical terms the mandate of CAMP Bustamante.

This resulted in a greater understanding of the Project on the part of the participants, who requested that it be introduced at the Glen Vincent and their local clinic. When probed as to why they would want to see the project introduced at these sites, one participant remarked “It would cause parents to use more caution.”

One parent pointed out that she knew of cases where “Abused children go a children’s hospital an mi no see no report mek against the parent.” The view was also expressed that at Jubilee Hospital the authorities did not inform the police when under 16’s turned up.

The following recommendations were made:

1. Monthly or quarterly parenting workshops
2. Alternate workshops in different sections of the community
3. Convene special workshop for teenage parents - “to deal with a child, you must be mentally ready”.
4. Skills training programme
5. Reintroduce Camp Bustamante programme
6. Employment for the females

CLOSING

Refreshments were served at approximately 6:20pm and copies of CDA booklet –“Act Right, Treat Me Right” handed out to all. Two community announcements were made.

Composition of Participants (at highest point)

Age Cohort	Male	Female	Total
20 – 30 yrs	1	1	2
31 – 40 yrs	0	10	10
41 - 50 yrs	0	4	4
51 - 60	0	4	4
61 +	2	0	2
Total	3	19	22

**Appendix 8: FEEDBACK ON RECOMMENDATIONS AT
STAKEHOLDER DISSEMINATION WORKSHOP
THE TERRA NOVA HOTEL, WEDNESDAY NOVEMBER 26, 2008**

GROUP 1: Scenario A

1. *The Child Abuse Mitigation Project be placed under OCA/OCR and piloted for 1-1½ years at Bustamante Children's Hospital and Cornwall Regional Hospital.*
2. *A National Coordinator be appointed to oversee CAMP development, advocacy, training and community development.*

FEEDBACK

- The Child Abuse Mitigation Project (CAMP) has been shown to positively affect the outcome of children exposed to all types of violence. Hence this programmes should be continued.
 - CDA and OCR are set up by Cabinet by statute with specific responsibilities and mandates. OCR is primarily a reporting agency with little powers of implementation. Investigation is not its mandate. The MOH is mandated by Government to implement policy and therefore has overall responsibility for children. Hence its mandate includes Prevention, Curative and Programme Development. This would therefore require legislative changes. 45% of persons in this group thought disagreed with this conclusion and thought the change to OCA/OCR could begin now rather than much later (as per the final bullet point).
- We propose that:
 - the CAMP be an independent unit under Family Health Services in the MOH with its role of policy and coordination. This will be better for planning across primary and secondary health care. Hence both 0-12 and 13-17 abuse will be seen and dealt with.
 - No more pilots are necessary as Camp Bustamante has proven to be effective
 - A National Coordinator be appointed to oversee CAMP development, advocacy, training and community development.

- Important links will remain with CDA, OCR, OCA, VSU. Work will continue through Bustamante, Cornwall Regional Hospital, Child Guidance Clinics and Health Centres and be replicated elsewhere.
- In the future with legislative changes and change of mandate this proposal for joining with OCR can go through.

GROUP 2: Scenario B

1. The Child Abuse Mitigation Project be placed as an arm (Acute Service/Rapid Response Team) of the Child Guidance Clinics and piloted for one year at the CGC at Bustamante Hospital and at the CGC at Cornwall Regional Hospital.

FEEDBACK

Discussion:

- CAMP Bustamante should continue as a hospital and health clinic-based programme.
- The study reveals that the perception of clients is that health based care is more attractive than other agencies and there is more cooperation and openness from clients and parents/caregivers
- Health institutions are usually the first response or gateway
- We need to have both horizontal and vertical linkages across sectors and agencies and ensure that they function effectively and efficiently
- If CB is incorporated into the Child Guidance Clinics will its focus be maintained or will it get lost on the CGC?

Proposal:

- CAMP Bustamante be a programme component, instead of an 'arm', of the Child Guidance Clinic, under the Regional Health Authorities (with a distinct focus on child abuse)
- This will ensure:
 - ownership of mental health/child abuse issues
 - having another voice (advocacy)

- more acceptability by all
- there is a response to the crisis we are facing based on the statistics reported (children at risk)
- sustainability

GROUP 3: Alternatives

- More social workers in the health systems islandwide, i.e. hospitals, CDA, CGC etc.
- CAMP Bustamante could be:
 - a unit under the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA) (would allow for both clinical and forensic investigation to be expedited)
 - An autonomous body such as the National Council on Drug Abuse (NCDA)

Role of the Public Health Clinics and the Prevention Strategy:

- Home Visits to communities (training of PHI, CHA, CPE, PHN etc. in the detection of child abuse/families at risk; development of checklist for health personnel)
- Public Health Campaign in all media. Each of the groups below should be separately targeted as there are specific messages for each:
 - Parents
 - Children
 - General Public
- Public Education (ongoing)
 - Radio programme
 - Performing Arts
 - TV (with JIS and others)
- Specific sensitization/education session for National Security and Justice
- Multi-agency involvement in prevention strategies
- Ensure that emphasis on prevention of child abuse is placed in Health and Family Life Education curriculum
- Establish a hotline

GROUP 4: Strengthening Child Protection in Communities

1. *What can we learn from some of the current role models for child protection in the communities?*

We can learn from models such as:

- Children First and Hope for Children, which involve the community and victims of violence themselves, an approach which should be adopted more widely
- Institute of Jamaica, which has guidelines and frameworks and uses trained professionals
- The 3Cs (Children and Communities for Change) which uses targeted interventions
- Faith-based groups, which train facilitators to go into the community, make home visits, establish groups dealing with issues such as literacy and parenting, and are thus very sustainable.
- Their interventions are culturally appropriate, using poetry, dance, drama and other methods of the contemporary arts to bring across their message.

2. *What can the state do to facilitate community organizations and NGOs providing after school activities in the communities?*

The state can:

- Create safe green spaces, e.g. the inner city project of the Housing Trust where the complexes are equipped with playgrounds and walking track, Ministry of Health's Healthy Zones which are equipped with walking and running trails and large field for sporting activities, Heroes Circle Playground which has an adult supervisor to reduce possible aggression/violence
- Ensure housing scheme designs include playgrounds and sports facilities
- The state and NGOs can provide financial and technical assistance for community start-up groups to help empower community efforts, legitimize persons and activities, and train individuals, e.g. as supervisors of playground facilities for children. This creates an 'ownership' of plans and efforts by communities and ensures sustainability with projects and assets like playfields, community centres etc.

- Facilitate multi-sectoral or ‘umbrella’ approaches to development to increase efficiency, pool resources, direct expertise through identifying stakeholders, funding, technicians as well as providing evaluations of approaches. Active community groups and others who are helping them need to be more **VISIBLE!**

3. *Is outreach from different sporting fraternities, perhaps funded by SDF, one possibility?*

JSIF (state) and the Jamaica National Foundation (private sector) and the Peace Management Initiative (state/civil society partnership) currently work in the area of sports with vulnerable communities, sometimes with the assistance of other organizations such as Whole Life Ministries (training of coaches and players in violence prevention), introducing sporting infrastructure, such as basketball facilities, and organizing cross community activities. The group was uncertain about the work of the Sports Development Foundation.

4. *What more can the SDC do?*

5. *What more can the private sector do?*

6. *What more can the churches do?*

The SDC and organizations from the private sector and the churches need to strengthen and widen their outreach to more communities and to collaborate in their activities to minimize duplication, to maximize resources and to share best practices.

7. *How can they be linked in to the child protection system – is there a network?*

The Assessment Report suggests that the system does work. It is important to have a multi-sectoral network that can advise, mobilize and assist.

**Appendix 9: LIST OF PARTICIPANTS AT STAKEHOLDER DISSEMINATION
WORKSHOP, TERRA NOVA HOTEL, NOVEMBER 26, 2008**

Dr. Barbara Gunske	Family Therapist	British High Commission
Dr. Colin Abel	Consultant Surgeon	Bustamante Children’s Hospital
Andrene Gorfu Garricks	Medical Social Worker	“ “ “
Matron Marcia Lyn Cook	Director of Nursing	“ “ “
Uki Atkinson	Former Case Manager	CAMP Bustamante
Sheldon Simon	Former Case Worker	“ “
Angela Stultz	Former Case Worker	“ “
Michelle Brooks	Counseling Psychologist	Caribbean Graduate School of Theology
Dr. Sandra McDermott	Play Therapist	“ “ “ “
Camille Rowe		Children & Communities for Change (3 Cs)
Warren A. Thompson		“ “ “
Alison Anderson	Executive Director	Child Development Agency (CDA)
Claudette Hemmings	Regional Director	“ “ “
Delicia Thomas	Children’s Officer and former Case Manager at CAMP Bustamante	“ “ “
Carol Daley	Counseling Psychologist	Child Guidance Clinic
Ceceile Minott	Director	Dudley Grant Memorial Trust, UWI
Maureen Watson		Family Life Ministries
Frances Madden	Coordinator	Grace Kennedy and Staff Foundation
Jacqueline Bushay	Director of Programmes	Institute of Jamaica
Linda Craigie Brown	Executive Member	Jamaica Association of Social Workers and Parenting Partners
John McClean	Head, Community Policing	Jamaica Constabulary Force (JCF)
Faith Aljoe	Healthy Lifestyles Proj.	Ministry of Health and the Environment
Melissa Beckles	Health Promotion	“ “ “
Joi Chambers	Project Manager, Adolescent Repr. Health	“ “ “
Dr. Sonia Copeland	Actg. Director of Disease Prevention & Control	“ “ “
Takese Foga	Director, Health Promotion Education	“ “ “
Raharah Khan	Violence Prevention Alliance	“ “ “
Dr. Judith Leiba	Director, Child & Adoles. Mental Health	“ “ “
Dr. Eva Lewis-Fuller	Director, Health Promotion & Protection	“ “ “
Joseph Pearson	GIS Cartographer	“ “ “
Hank Williams	Director, Epidemiological Rsrch.	“ “ “

Claudette Cooper	Assigned to CAMP Bustamante	National Youth Service (NYS)
Cruiz Holness	“ “ “	“ “ “
Mary P. Clarke	Children’s Advocate	Office of the Children’s Advocate
Georgia Garvey		“ “ “
Walter James		Planning Institute of Jamaica (PIOJ)
Janet Cupidon Quallo	Child Protection Specialist	UNICEF
Donald McFarlane		Victim Support Unit (VPU)
Karen Breakenridge	Parent	
Dr. Tony Butler	Consultant	
Dr. Pauline Milbourne	Consultant Child Psychiatrist	
Rose Robinson-Hall	Project Coordinator	CAMP Bustamante
Arlene Tempral	Administrative Assistant	“ “
Audrey Brown	Consultant for Assessment	
Jennifer Jones	Consultant for Assessment	

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