Child Maltreatment in Bangladesh

Like most low and middle-income countries Bangladesh have no prevalence data on Child Maltreatment (CM) and lack a reporting system. The overall aims of the thesis were to generate knowledge on CM in the Bangladeshi society and to estimate the prevalence and associated risk factors.

The thesis is based on four studies. An explorative interview study to get children's views on CM was the first study. A systematic analysis of newspaper content was then performed to get a societal picture of CM. The first two studies generated new research questions for the two successive studies. Study III and IV were population based cross-sectional surveys. The results show that CM was a common and painful experience with serious physical and emotional consequences but highly accepted by the society (Study I). Boys were victims of physical abuse to a higher degree, while girls were reported as victims of sexual abuse. One third of the newspaper reported cases resulted in death. The identity of the victims was often disclosed (Study II). Almost every child in Bangladesh has experienced either physical or psychological abuse. Neglect was less reported (Study III and IV). The studies incorporated in this thesis contribute to the knowledge on CM in the Bangladeshi cultural context.
Child Maltreatment in Bangladesh
Perceptions, Prevalence and Determinants

Md. Atiqul Haque
Child Maltreatment in Bangladesh - Perceptions, Prevalence and Determinants

Md. Atiqul Haque

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ABSTRACT

Background: Like in most low- and middle-income countries, Bangladesh has no prevalence data on Child Maltreatment (CM) and lacks a reporting system.

Objectives: The overall aims of the thesis were to generate knowledge on CM in the Bangladeshi society and to estimate the prevalence and associated risk factors.

Methods: The thesis is based on four studies. In Study I children’s experiences were explored, and 24 school aged children were interviewed. Qualitative content analysis was used for data analysis. In Study II 790 newspaper articles on CM from six national daily newspapers were selected during three months in 2014. Data were analysed through descriptive content analysis. Studies III and IV were cross-sectional population surveys. The International Society for Prevention of Child Abuse and Neglect Child Abuse Screening Tool for Children (ICAST-C) was translated for data collection. Face-to-face interviews were performed during March-April 2017 with 1,416 children aged 11-17 years. In Study III the prevalence and risk factors of child physical abuse (CPA) were estimated, while in Study IV the same for child psychological abuse (CPsyA) and neglect.

Results: CM was a common and painful experience with serious physical and emotional consequences but highly accepted by the society. Vulnerable groups were young children, girls, and poor children (Study I). Physical and sexual abuse were the most common types of CM covered in the news articles. One third of the reported cases resulted in death. Boys were victims of physical abuse to a higher degree, while girls were reported as victims of sexual abuse. The identity of the victims was often disclosed (Study II). Approximately all children reported experiences of CPA and CPsyA. Neglect was less reported (Study III and IV). Being a boy, younger, victim of family violence, and low maternal education were risk factors of CPA (Study III). Not living with parents, working, big family size and victim of family violence were risk factors of CPsyA or neglect. More years of schooling was a protective factor (Study IV).
Conclusions: The results show that almost every child in Bangladesh experience CM. The studies incorporated in this thesis contribute to the knowledge on CM in the Bangladeshi cultural context.

Keywords: Child Maltreatment, ICAST-C, Public Health, Bangladesh
The encounter with the topic child maltreatment and enrolment in the PhD program has indeed become a turning point of my life particularly for personal reasons. Being born in a family embedded with poverty, hunger and frustration, child abuse mingled with our daily lives inevitably. With glimpses of devastating memories of the war of independence of Bangladesh in 1971, I was compelled to pass critical times of 1974’s famine, economic hardship and serious political violence throughout my childhood. Corporal punishment was then a usual child upbringing norm both in school and at home, which continues until date in our society.

Even during my years at the medical school, I have never come across the subject of child maltreatment. Only in my early forties, I had lucked into this issue for the first time while having an opportunity of PhD in Sweden on child maltreatment. The topic child maltreatment is so ignored in the context of Bangladesh that it had also happened that on the first go; I even thought that I have wrongly heard it as child malnutrition but not child maltreatment.

However, as I went deep into this issue, I was only more amused and astounded, and thoughts often ringed by bells that why did I delay in learning this highly important public health issue? Other questions followed as why this topic is not covered in the medical curriculum or why the public are in general not aware of this sensitive issue. Moreover, to initiate betterment for children of Bangladesh and prevent them from being maltreated, I felt it was an opportunity for me as our generation has undergone similar experiences of child maltreatment.

However, this is just the beginning and I am optimistic enough that I will be able to do more for the wellbeing of the children and explore the other unexplored avenues of child maltreatment, a vital public health issue.
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THESIS DELIVERABLES


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STUDY CONTRIBUTION

Paper I. Bangladeshi school-age children’s experiences and perceptions on child maltreatment: A qualitative interview study

Study design  M. Atiqul Haque, Ulla-Britt Eriksson, Staffan Janson, Syed Moniruzzaman, Saidur Rahman Mashreky, AKM Fazlur Rahman

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Analysis  M. Atiqul Haque, Ulla-Britt Eriksson, Staffan Janson, Syed Moniruzzaman, AKM Fazlur Rahman

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Paper II. Child maltreatment portrayed in Bangladeshi newspapers

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Paper III. Children’s exposure to physical abuse from a child perspective: A population-based study in rural Bangladesh

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Paper IV. Children’s exposure to psychological abuse and neglect from a child perspective: A population-based study in rural Bangladesh

Study design  M. Atiqul Haque, Ulla-Britt Eriksson, Syed Moniruzzaman, Staffan Janson, AKM Fazlur Rahman

Data collection  M. Atiqul Haque, Saidur Rahman Mashreky, AKM Fazlur Rahman

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Manuscript writing  M. Atiqul Haque, Ulla-Britt Eriksson, Staffan Janson, Syed Moniruzzaman, AKM Fazlur Rahman, Saidur Rahman Mashreky
DEFINITION

Child  A person below the age of 18 years, according to the Convention of the Rights of the Child. Children Act 2013 of Bangladesh also endorses this definition.

The education system in Bangladesh
There are mainly two types of education systems in Bangladesh: formal and non-formal. Formal education takes place within educational institutions with primary and secondary level education, while non-formal education takes place outside of a school environment. The Ministry of Primary and Mass Education (MoPME) is responsible for primary education and non-formal education. The Ministry of Education (MoE) is responsible for all education after primary education including general, religious and technical education.

Primary education
Primary education lasts for 5 years (grades I to V) and is intended for children aged 6 to 11 years. Two types of education are available: a general (Bengali, Mathematics, English, Environmental Science, Religion, Physical Education, Arts and Crafts, and Music are taught) and a religious. Primary education is subsidised by the government.

Secondary education
Secondary education lasts for 7 years and comprises of two cycles: secondary (grade VI to X) and higher secondary education (grades XI and XII). After each cycle, a nationwide examination is held. At secondary level, pupils choose between three programmes of study: general, religious (taught at Madrasahs) or technical vocational education.

Higher education
Admission to the university for higher education is decided on the basis of results (grade point average, GPA) obtained in secondary and higher secondary certificate examination.
Schools

Public school
Public schools include all kindergarten, elementary, primary, secondary and higher secondary schools which are run by partial or full support of the government of Bangladesh. Most of the pupils attain public schools.

Madrasah
Schools following the Islamic education system. There are two types of Madrasahs. The Aaliyah Madrasahs are operated with government support, while the Qawmi Madrasahs are operated with voluntary labour and funding from both foreign and local charities.

Brac school
A non-formal education (NFE) program is run by BRAC (Bangladesh Rural Advancement Committee), one of the leading non-government developmental organisations in Bangladesh. BRAC operates more than twenty thousand one-room primary schools worldwide, especially for girls and offer quality, non-formal education to school dropout children and children who are not able to get admission to other schools. Brac schools provide four years’ non-formal education, which cover the five-year primary school curriculum, mainstreaming for secondary education.

Pupil
A child who is learning under the supervision of a teacher at school, a private tutor, or the like.

Private tutor
A person who teaches the pupil at home or in any setting other than school in exchange of cash incentive. This person may be a schoolteacher or a teacher without any school affiliation.

Head teacher/head sir/headmaster/headmistress/principal
A person who is a teacher and the focal person in the management of all administrative and academic activities of a school.
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ASK</td>
<td><em>Ain o Shalish Kendra</em> (a rights-based organisation of Bangladesh)</td>
</tr>
<tr>
<td>BBS</td>
<td>Bangladesh Bureau of Statistics</td>
</tr>
<tr>
<td>BLAST</td>
<td>Bangladesh Legal Aid and Services Trust</td>
</tr>
<tr>
<td>BRAC</td>
<td>Bangladesh Rural Advancement Committee</td>
</tr>
<tr>
<td>BSMMU</td>
<td>Bangabandhu Sheikh Mujib Medical University</td>
</tr>
<tr>
<td>CIPRB</td>
<td>Centre for Injury Prevention and Research, Bangladesh</td>
</tr>
<tr>
<td>CM</td>
<td>Child Maltreatment</td>
</tr>
<tr>
<td>CP</td>
<td>Corporal Punishment</td>
</tr>
<tr>
<td>CP MERG</td>
<td>Child Protection Monitoring and Evaluation Reference Group</td>
</tr>
<tr>
<td>CPA</td>
<td>Child Physical Abuse</td>
</tr>
<tr>
<td>CPsA</td>
<td>Child Psychological Abuse</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
</tr>
<tr>
<td>ERC</td>
<td>Ethical Review Committee</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>ICAST-C</td>
<td>ISPCAN Child Abuse Screening Tool Children’s Version</td>
</tr>
<tr>
<td>ICAST-P</td>
<td>ISPCAN Child Abuse Screening Tool Parent’s Version</td>
</tr>
<tr>
<td>ICAST-R</td>
<td>Child Abuse Screening Tool Retrospective Version</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
</tr>
<tr>
<td>ISPCAN</td>
<td>International Society for the Prevention of Child Abuse and Neglect</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MoE</td>
<td>The Ministry of Education</td>
</tr>
<tr>
<td>MoPME</td>
<td>The Ministry of Primary and Mass Education</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NSCAW</td>
<td>The National Survey of Child and Adolescent Well-Being</td>
</tr>
<tr>
<td>PsyA</td>
<td>Psychological Abuse</td>
</tr>
<tr>
<td>REDCap</td>
<td>Research Electronic Data Capture</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SES</td>
<td>Socio-Economic Status</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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</table>
UNCRC  UN Convention on the Rights of the Child
UNDP  United Nations Development Programme
UNESCO  United Nations Educational, Scientific and Cultural Organization
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
1. BACKGROUND

Child maltreatment (CM) is a universal phenomenon, with negative effects on the child, the family and the society (Almuneef, Alghamdi, & Saleheen, 2016). Children are maltreated in their homes, in schools and at workplaces. Through historical documents we know that whipping was common in the Sumeric schools (today’s Iraq) 4,000 years ago (Lucas, 1979) and that abuse was regarded as a valuable disciplinary and pedagogical help during the Roman Empire (McGrail, 2016). Children in ancient times had no rights of their own and were considered as properties of their family. Their wellbeing was largely dependent on their parental will. Physical punishment is still customary in many places around the world (Crosson-Tower, 2014).

In the 19th century Ambroise Tardieu, a French forensic physician tried to create awareness among physicians regarding medical effects of CM by describing classical features of almost all forms of CM, but he failed. Later, in 1929, Parisot and Caussade tried to attract attention to the phenomenon when they published a complete report on 1,768 cases of child physical abuse (CPA), but their paper went unnoticed (Labbé, 2005).

In late 40s and early 50s, CM started to get more recognition attributed to the works of the American radiologists, John Caffey and Frederic N. Silverman, who reported important findings on CM (Labbé, 2005). In 1962, Kempe and his colleagues described clinical features of physical abuse in their seminal paper “The Battered Child Syndrome”. This paper contributed to employ a mandatory child abuse reporting system in the United States, Canada, and several other countries (Roche et al., 2005).

Through the gradual socialization process, children’s status from viewed as a property has attained recognition that children have their own rights (Crosson-Tower, 2014). Several international organizations including the United Nations are working to ensure protection of the children.

Survey reports reveal the prevalence of CM ranging from 5-83 percent across different studies (Pereda, Guilera, & Abad, 2014; Tsuboi et al., 2015). The extent of such differences considerably depends on the operational definition of CM and methodology used in different studies.
(Jud, Fegert, & Finkelhor, 2016). Moreover, most low- and middle-income countries have no prevalence data or information on the risk factors of CM and they often lack a reporting system of CM (Stoltenborgh et al., 2015) where Bangladesh is not an exception.

2. DEFINITIONS OF CHILD MALTREATMENT

2.1 Global perspective

There is no universal agreed upon definition of CM. The lack of an agreed-upon definition of CM, a lack of mandatory reporting system and the frequent “invisibility” of the phenomena make research in this field particularly problematic (Pinheiro, 2006). The need for a consistent definition of CM has been recommended by many researchers because estimation and identification of victims is dependent upon how the term is operationalised as it may vary across countries and cultures (Leeb et al., 2008). Within these diversities, it is problematic to provide a reliable, useful and unique definition (Muela et al., 2012). There also lie obstacles related to contexts and different goals set by professionals in defining CM. For example, advocates, lawmen and therapists have their own agenda and way in defining a case as abusive or non-abusive (Haugaard, 2000).

A handful of literature has defined and conceptualised the term “child maltreatment”. In some literature, the term CM has been used in order to indicate violence against children. Although there is no universal definition of violence, the World Health Organisation (WHO) has defined it in the following way:

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” (Krug et al., 2002, p. 5)

By including the word “power” in addition to “physical force”, WHO has broadened the conventional understanding by describing violent acts as resulting from a power relationship, and state that the use of power should be understood as including neglect and all other types of
physical, sexual and emotional violence. WHO also created a typology of violence that makes distinction between four different types of violent behaviour: physical, sexual, psychological and deprivation/neglect. Based on the criteria above the subsequent WHO definition of CM is described as:

“Child maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power.” (Krug et al., 2002, p. 59)

Differing from the definition of violence, the definition of CM includes exploitation, which is a severe problem in many low-income countries, where children are exploited as workers from young age. It also points out the deleterious impact of maltreatment on children’s health and development as well as to their dignity.

Leeb views physical, psychological and sexual abuse as acts of commission and looks upon the two types of neglect as acts of omission:

“Any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child” (Leeb et al., 2008, p. 11).

The three subtypes of abuse are described as physical (e.g., hitting, kicking, shaking, or burning), sexual (e.g., rape or fondling) and psychological (e.g., terrorizing or belittling). The two forms of neglect are described as failure to provide (e.g., not providing nutrition, shelter, or medical or mental health care) and failure to supervise (e.g., not taking reasonable steps to prevent injury). Although this definition is aligned with the WHO definition, it adds detailed description of subtypes of abuse and neglect (Krug et al., 2002).

Child sexual abuse (CSA) is also defined in different ways. A useful and common definition is that CSA is an act that the child cannot comprehend, is not developmentally prepared for and cannot give consent to (Butchart et al., 2006). Accordingly, CSA is a sexual activity between a child and an adult, who is in a relationship of responsibility, trust or power. The activity further intends to gratify or satisfy the needs of the other person violating the integrity of the child. CSA thus violates the laws or social taboos of the society, which includes any completed or
attempted sexual act, sexual contact with, or exploitation of a child (Murray, Nguyen, & Cohen, 2014).
Child psychological abuse (CPsyA) is often described as a pattern of caregiver’s condescending behaviour towards the child that transmits to the child that s/he is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another’s needs. CPsyA may also involve “spurning, terrorizing, exploiting or rejecting” the child (Kairys, Johnson, & Committee on Child Abuse & Neglect, 2002).
The terms psychological abuse and emotional abuse are often used interchangeably (Hibbard et al., 2012). Some authors have argued to distinguish the two terms, but in absence of an empirical or theoretical basis on which to do so, such distinction is difficult to make (O’Hagan, 1995). The term psychological abuse is preferably used in the USA while emotional maltreatment is used in the UK, Canada and Australia (Barlow et al., 2013).
According to some studies child neglect is the most common but neglected form of CM (Stoltenborgh et al., 2013; Dubowitz et al., 1993). There is some confusion though over its definition. Miller-Perrin and Perrin (2013) stated that child neglect is the consistent failure of the child’s caretaker to meet the child’s basic physical and psychological needs, which may result in the child suffering chronic impairment in both health and/or development. Ben-Galim, Louis, & Giardino (2010) defined child neglect similarly but adding also when the caretaker fails for the child to develop their intellectual capacity.
WHO gives a more extensive definition of child neglect as:

“...the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child’s health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.” (Tobin & Cashmore, 2019, p. 700)

All definitions of neglect have emphasised it as an act of omission. Unlike physical, psychological or sexual abuse where the abusive acts are directed towards a child, neglect is defined by the absence of provision for a child’s basic needs (Gough, 2005). Each of the above definitions
provides a general understanding of the phenomenon of neglect but provides little guidance on the measurement of neglect for research. Greater detail is needed about what constitutes basic needs, avoidable suffering, adequate shelter, or safe living conditions, etc. (Moran, 2009). Identifying a specific event of neglect is problematic when conducting research as one has to rely on professionals working with children, to make a decision about the neglect event within the child’s family context (Appleton, 2012).

The concept of child neglect also suffers a number of criticisms. Zuravin (2001) and Dubowitz et al. (1993) mention two major difficulties on the agreed-upon terms and operational definitions of child neglect. The primary concern they lift up on what is considered neglect; whether an activity that can make possible harm or cause actual harm as a consequence. Another conceptual debate is raised on whether neglect should be seen as when children’s basic needs are not met. In the latter, even failure to provide adequate amount of food per day, support access in schooling and health services can be considered as neglect. Mistaking poverty for neglect contributes overrepresentation of CM cases for families in low income settings (Duva & Metzger, 2010). So, measuring child neglect is problematic in a country like Bangladesh where a large number of people live in poverty.

Kairys et al. (2002) have found that different forms of abuse often co-occur in the same setting. The aspect of psychological abuse is present in all cases of physical and sexual abuse, while neglect overlaps with abuse, at least regarding the failure to protect a child from harm. The existing broad definitions of maltreatment can also be categorised in groups to sub-groups in separate studies. Besides, the National Research Council (1993) proposed that the definition of CM should be guided by consideration of the specific objectives the definition must serve, division into homogeneous subtypes, conceptual clarity, and feasibility in practice.

Childhood exposure to intimate partner violence (IPV) is also included as CM in the WHO definition (WHO, 2016). In table 1, the definitions of CM subtypes are described.
Table 1 Definitions of CM Subtypes.

<table>
<thead>
<tr>
<th>Subtype of Maltreatment</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Physical abuse</td>
<td>The intentional use of physical force against a child that results in actual or potential physical harm for the child’s health, survival, development or dignity.</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>The involvement of a child in any sexual activity that they do not understand, are unable to give consent to, are not developmentally prepared for, or that it violates the laws or social taboos of the society. This includes any attempted or completed sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by an adult.</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>A repeated pattern of caregiver condescending behaviour towards the child. Psychological abuse may also involve “spurning, terrorizing, exploiting or rejecting” the child.</td>
</tr>
<tr>
<td>Neglect</td>
<td>The failure to provide for a child’s basic physical, emotional, or educational needs or to protect a child from harm or potential harm.</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been, intimate partners or family members, regardless of sex.</td>
</tr>
</tbody>
</table>

2.2 The Bangladesh perspective

The Bangladeshi legal system lacks a unique definition of CM like the one defined by WHO, but in different acts like “Penal Code, 1860”, “Children Act, 2013”, “Domestic Violence (Prevention and Protection) Act, 2010”, and “The Prevention of Oppression Against Women and Children Act, 2000”, there is a taxonomy of almost every abusive event against children as described in the WHO definition. Instead of using the term CM, the legal system often uses terms like ‘violence’ or ‘cruelty against children’, where neglect gets less emphasis.
In the above-mentioned laws, there is a manifold of actions considered as CM and many of the expressions used in different laws seem to cover the same or similar concepts. Thus, to the international audience, expressions like child stealing, kidnapping, abduction and, selling and buying minors, describe similar acts. In addition, there is a detailed specification of many acts, for example psychological abuse includes verbal abuse (insults, ridicule, humiliation or threats of any nature), harassment or controlling of behaviour. Sexual abuse is also exemplified and described in different ways such as selling and buying minors for the purpose of prostitution, rape, sexual oppression and exposing children in an obscene way. Economic abuse or exploitation is dealt with, in terms of slavery and child labour. Child abandonment and forsake are obvious acts of neglect, even if the term as such is not used. Other acts mentioned are acid violence and assaults. Disclosing the identity of the child victim in the media, is also considered as an offense in “The Prevention of Oppression Against Women and Children Act, 2000”.

Child marriage has not been regarded CM in the customary laws of Bangladesh. However, it has been mentioned as CM in the “National Action Plan to Prevent Violence Against Women and Children 2013-2025” of the Ministry of Women and Children Affairs of Bangladesh. The Bangladeshi legal system does not clearly define child neglect, but the term “neglect” has been mentioned as an abusive event in the “Children Act, 2013”.

In the Bangladeshi context, neglect has been overshadowed by different social factors notably poverty. Poor Bangladeshi families lack ensuring basic needs for their children and do not consider poverty as child neglect. The children therefore have difficulties to recognise neglect in this local context.
3. THE PREVALENCE OF CHILD MALTREATMENT

CM is a global phenomenon affecting millions of children (Stoltenborgh et al., 2015). However, the prevalence of CM varies widely in different countries due to definitional inconsistencies, methodological variations in conducting research, varied types of maltreatment, children’s status and reporting methods (Jud et al., 2016; Pinheiro, 2006). Despite these discrepancies, it is evident that CM is a serious social and public health problem especially in low-income countries (Akmatov, 2011; Jud et al., 2016).

A recent report highlighted that South Asia is the third highest region for violence against children after Western and Central Africa and Eastern and Southern Africa (Know Violence in Childhood, 2017). The South Asian countries Bangladesh, India, Pakistan, Nepal, Bhutan, Sri Lanka, Maldives and Afghanistan share commonalities in different demographic, socio-economic and human development indicators. Approximately 45 percent of the girls in this region are married before the age of 18 years, almost 17 million children are involved in child labour and 32 million children remain out-of-school making this region having the highest rates of child marriage and child labour, and the second highest for the number of out-of-school children after the sub-Saharan region (Khan & Lyon, 2015; Unicef, 2014; Unicef South Asia, 2018). All of these factors make the children of this region subjected to a growing problem of violence and abuse. In consideration of these facts, it can be presumed that Bangladesh also has a high rate of CM (Rahman, 2017). However, Bangladesh lacks CM data. Most of the information is revealed either by newspaper reports or by governmental and NGO reports. These reports also indicate CM as a major public health and social problem in Bangladesh.

The subtypes of CM are described separately below with the knowledge that many children are victims of several types of CM.
3.1 Physical abuse

Stoltenborgh and his colleagues (2015) combined and compared the results of a series of meta-analyses on the prevalence of different types of CM and reported that the overall estimated prevalence rate of CPA of self-report studies was 22.6 percent. Gilbert et al. (2009) reported that the prevalence of CPA ranges from 4 to 16 percent annually in high-income countries, where 80 percent were perpetrated by their parents or guardians. An Indian study revealed that approximately 80 percent of the school-going children were physically abused during their lifetime, and boys experienced more CPA than girls (Kumar et al., 2017). Studies conducted in other South Asian countries revealed both higher and lower rates of CPA and the rate was 76 percent in Sri Lanka (de Zoysa, 2013), 68 percent in Afghanistan (Central Statistics Organisation & Unicef, 2012), 67 percent in Nepal (Neupane et al., 2018), 67 percent in Pakistan (Planning & Development Department, Government of Gilgit-Baltistan & Unicef Pakistan, 2017), 64 percent in Bhutan (Unicef, 2018), and 38 percent in the Maldives (Unicef Regional Office for South Asia, 2016).

Very little evidence is available on CPA in Bangladesh. An opinion poll by Unicef (2008) estimated that 91 percent of the children experienced physical punishment in school while 97 percent were punished at home. The most common forms of physical punishment at school were reported as hit in the palm (76%), forced standing in the classroom (63%), hit on other body parts (60%), and slapped (49%). At home the most common forms were being beaten or kicked (40%). Approximately 90 percent of the children reported experience of physical punishment at home, while 82 percent adults reported punishing their children at home (Ministry of Women and Children Affairs, 2013).

3.2 Sexual abuse

Around 15 million adolescent girls aged 15 to 19 were reported having experienced forced sex during their lifetime globally (Unicef, 2017). In a meta-analysis, Barth et al. (2013) found that the prevalence of child sexual abuse (CSA) ranged from 8 to 31 percent for girls and 3 to 17
percent for boys, where nine girls and three boys out of 100 were vic-
tims of forced intercourse. In another meta-analysis, Stoltenborgh et
al. (2011) showed that the prevalence rate of CSA was around 13 per-
cent, where the number of female victims were significantly higher
than male victims. In the light of methodological differences, the prev-
ance of reported CSA varies from 2 to 62 percent globally (Andrews
et al., 2004).
Pereda et al. (2009) reported that an estimate of 10 percent of the men
and 20 percent of the women experienced sexual abuse globally prior
to the age of 18, where the highest prevalence rate was reported in Af-
rica (34%) and the lowest (9%) in Europe. America, Asia and Oceania
had prevalence rates between 10 and 24 percent.
Across South Asia, little scientific work has been done on CSA. Social
tabooS about disclosure also make it difficult to find information in this
regard. In a meta-analysis though, Choudhry et al. (2018) stated a vari-
ed range of prevalence of CSA in India, where 4 - 41 percent of the girls
and 4 - 57 percent of the boys below 18 years were found to be sexually
abused. In Pakistan, there is no reliable data on CSA, but unofficial
studies suggest that 15-25 percent of the children have endured some
forms of sexual abuse (Government of Pakistan and Unicef Pakistan,
2017). In Nepal, Neupane et al. (2018) reported that 11 percent and 13
percent of the children had experienced at least one form of sexual
abuse during the past year and lifetime respectively.
According to a report of a rights-based organisation in Bangladesh, in
total 588 rape cases were recorded in the first nine months of 2017 with
100 child victims (European Asylum Support Office, 2017). Another
rights-based NGO conducted a survey in five districts in Bangladesh
and found that 68 children were sexually abused online between 2011
and 2018 (Irani, 2018). Meanwhile, a multi-country study reported
that 1 percent of the girls in rural Bangladesh were sexually abused be-
fore the age of 15 years by someone other than an intimate partner
(Garcia-Moreno et al., 2005). A study conducted by Fattah and Kabir
(2013) revealed that nine percent of all rape victims were children and
of them, 83 percent were abused by non-family-members.
3.3 Psychological/Emotional abuse

In a meta-analytical study, Stoltenborgh et al. (2012) revealed that self-reported estimated prevalence rate of childhood psychological abuse was 36 percent, whereas in informant-reported studies, the prevalence rate was 0.3 percent around the world. Studies conducted in the South Asian countries showed a varied rate of CPsyA. High prevalence rates of CPsyA were reported in Sri Lanka (89%) (de Zoysa, 2013) and in Pakistan (84%) (Wasif, 2018). The past year and lifetime prevalence rates of psychological abuse in the educational setting of India were reported 84.5 percent and 86 percent respectively (Kumar et al. 2017). At the home setting of Nepal, the rates were 75 percent and 76 percent respectively (Neupane et al., 2018). Lower but still high rates in an international perspective were also reported from Afghanistan (50%) (Ashrafi, 2017), and Bhutan (48%) (Kulkarni, 2016).

There is no study solely representing the prevalence of CPsyA in Bangladesh. However, some studies revealed statistics of CPsyA in combination with all types of abuse. According to the Child Well-being Survey-2016, a total of 72 percent of the children (1-14 years) in Bangladesh experienced psychological aggression during the last month (Bangladesh Bureau of Statistics and Unicef Bangladesh, 2016). A national study conducted by the Bangladesh Legal Aid and Services in 2012 revealed that 77 percent of the students encountered physical, psychological or financial punishments in their schools (Global initiative to end all corporal punishment of children 2018). Unicef (2008) reported that almost all children in Bangladesh experienced scolding, rebuking, and censuring in their school and at home.

3.4 Neglect

Studies reveal neglect as a prevalent form of CM (Stoltenborgh, et al., 2013). Stoltenborgh et al. (2015) estimated that the global prevalence of self-reported child physical neglect and child emotional neglect were 16 percent and 18 percent respectively.
There is little evidence available on child neglect from South Asia. Prevalence rates of neglect reported in different studies conducted in India, were from 35-60 percent (Charak & Koot, 2014; Daral, Khokhar, & Pradhan, 2016; Zolotor et al., 2009). In Nepal, it was reported that 46 percent of the children were neglected during their lifetime, and 45 percent in the past year (Neupane et al., 2018).

So far, no study revealed the actual scenario of child neglect in Bangladesh. It is difficult to estimate the prevalence of neglect in Bangladesh as it has been overshadowed by a number of social factors such as poverty and low school attendance.

3.5 Child labour and exploitation at the workplace

Child labour is a global problem and is considered CM by the International Labour Organisation (ILO), which defines child labour as “depriving children of their childhood, their potential and their dignity, and is harmful to children’s physical and mental development” (International Labour Organisation, 2018). According to ILO, one in every ten children around the world is a child labourer and there are around 152 million working children globally. Nearly half of these children are also involved in hazardous work that directly endangers their health, safety and moral development (International Labour Organisation, 2017).

Unicef South Asia (2019) estimates that 12 percent of the children aged 5-14 years are involved in child labour in South Asia and they are commonly exploited financially and sexually. Children are often used as bonded labourers, child soldiers, and for trafficking.

The general situation of child labour in Bangladesh is such that children work for long hours, with low wages, and in hazardous conditions (Hadi, 2000). Unicef reported that disabled children, street children, orphans and working children are high-risk groups facing all forms of maltreatment. According to a 2008 children’s opinion poll, one-quarter of all working children were physically punished at their workplaces, where girls received higher rates of serious injuries (Unicef, 2008). The Baseline Survey on Child Domestic Labour in Bangladesh-2006 revealed that about 60 percent of the children in domestic work experienced physical abuse, such as scolding or slapping (Associates

3.6 Child marriage

Child marriage is a human rights violation which places children at high risk of violence, exploitation, and abuse. Globally, one in every five girls is married before the age of 18, while this number is doubled in the least developed countries (UNFPA, 2019).

Globally, South Asian countries in general have the highest rates of child marriage where almost 45 percent of women aged 20-24 years are reported to have been married before the age of 18 years (Unicef South Asia, 2018).

Bangladesh has the highest rate of child marriage in Asia and the fourth highest rate in the world (Unicef South Asia, 2018). An estimate of 60 percent of the girls in Bangladesh are married by the age of 18 (Fattah & Kabir, 2013) leaving them vulnerable to sexual and physical abuse. Rahman et al. (2014) found that child brides in Bangladesh experienced more physical abuse in comparison to later-married women. Yount et al. (2016) found that approximately 50 percent of the women had experienced IPV and among them around 70 percent had been married before the age of 18.

3.7 Intimate partner violence (IPV)

Childhood exposure to IPV is often considered as CM (WHO, 2016). Globally, almost 30 percent of the women aged 15 and over have experienced physical and/or sexual violence by their intimate partners (Devries et al., 2010). So, there is a belief that children witness violence within the family milieu. Moreover, IPV and violence against children often occur together and share many common risk factors (Coulter & Mercado-Crespo, 2015).

In the countries of South Asia studies revealed that IPV ranged from 33 to 62 percent (Samuels, Jones, & Gupta, 2017; Das et al., 2013). In
Bangladesh, 87 percent of the married women have experienced some type of violence by their husband (Hossen, 2014). Scarcity of studies could not establish the relationship between IPV and CM in the Bangladeshi context. However, a few studies reported that detrimental health effects of children are related to IPV (Silverman et al., 2009). Conticini and Hulme (2007) argued that street migration of children in Bangladesh is the consequence of different social factors like violence towards children within the household. Reza (2016) also pointed out poverty, abuse and family disorganization as the causes for street migration.

4. CONSEQUENCES OF CHILD MALTREATMENT

Globally, CM is one of the most important causes of suffering and death of children, which leads to approximately 57 thousand deaths of children yearly around the world (Jenny and Isaac, 2006). This number is however only a representation of a fragment as a large number of deaths are incorrectly attributed to falls, burns, drowning and other causes (WHO, 2016). Children who have suffered maltreatment show a range of immediate and long-term adverse health and developmental consequences (Lazenbatt, 2010).

4.1 Health and developmental consequences

4.1.1 Physical health consequences

Empirical studies show strong associations between CM and health problems in children and adolescents (Flaherty et al., 2006, 2009). Flaherty et al. (2006) found that children’s exposure to one adverse experience of CM doubled the risk of overall poor physical health and, if children had experienced four or more adverse experiences the risk of illness tripled. Another study by Hussey, Chang, and Kotch (2006) revealed that each type of maltreatment was associated with 8 out of 10 adolescent health risks.
The immediate physical consequence of CM can be minor (e.g. pain, bruises or cuts) or major (e.g. broken bones, haemorrhage, or even death). In a UK study, Chester et al. (2006) showed that 10 percent of admissions to paediatric burns and plastic surgery units were related to CM. WHO (2016) estimated that approximately 41,000 children aged under 15 years have homicidal deaths annually throughout the world. Another report by WHO estimated that the rate of death is double among 0-4-years children than that of 5- to 14- years (Butchart et al., 2006).

Research found that 28 percent of children had a chronic health condition due to CM (Administration for Children and Families, 2007). Maltreatment causes significant impairment of brain development during infancy. Such alterations have long-term effects on children’s cognitive, language, and intellectual development in connection with mental health disorders and learning difficulties/poor academic achievements (Hunter, 2014).

Adverse experiences in early childhood may shape the experience-dependent maturation of stress-related pathways underlying hypothalamic-pituitary-adrenal axis and sympathetic nervous system, leading to a long-lasting altered stress responsivity and elevated inflammation in adulthood (Su et al., 2015). Such alteration has links to higher risk for non-communicable diseases like diabetes, cardio-vascular diseases, systemic hypertension, stroke etc., in later life (Child Welfare Information Gateway, 2019a).

4.1.2 Psychological/mental health consequences

The immediate psychological effects of maltreatment are isolation, fear, feelings of powerlessness and undermining the ability of trust in caregivers, which may lead to lifelong psychological consequences, including low self-esteem, depression, and relationship difficulties (Child Welfare Information Gateway, 2019b).

In a meta-analysis, Norman et al. (2012) found that abused children have a higher risk of developing depressive disorders than non-abused children, and also found association with later age drug abuse, suicide attempts and risky sexual behaviour. Messman-Moore, Walsh, & DiLillo (2010) mentioned that negative effects on the development of
emotion regulation may persist into adolescence or adulthood, due to 
CM. Stress due to maltreatment during childhood has effects on emo-
tional regulation, somatic signal processing, substance abuse, memory, 
arousal and aggression, which in turn predisposes to psychiatric vul-
nerability during later life (Anda et al., 2010). 
Children living in shelter homes are often neglected and several studies 
from Bangladesh found negative psychological consequences. Rahman 
et al. (2012) for example revealed that approximately 40 percent of the 
children living in orphanages had behavioural and emotional disor-
ders. 
Afifi et al. (2008) suggested that CM is associated with later life suicidal 
ideation and suicidal attempt. They found that childhood physical 
abuse, childhood sexual abuse, and witnessing domestic violence were 
associated with a substantial proportion of suicide ideation and suicide 
attempt in the American general population among men (21% and 
33%, respectively) and women (16% and 50%, respectively). 
In Bangladesh, media reports revealed that the reasons behind female 
children committing suicide were sexual depredation by local thugs, 
parental rebuke and nude pictures uploaded in social media (Tithi, 
2018).

4.1.3 Developmental consequences

Children’s emotional and social development largely depends on the 
patterns of caregivers’ attachment. However, Hunter (2014) stated that 
very young children exposed to maltreatment are more likely to expe-
rience insecure attachment problems with their primary caregiver. This 
insecure attachment makes the primary caregiver a source of danger 
opposed to that of being a source of safety. 
The normal development process of children becomes altered due to 
early-life insecure attachment, which subsequently affects a child’s 
ability to communicate with others. In a study from Romania, Zeanah 
et al. (2005) found that maltreated children had rates of disorganised 
attachment as high as 90 percent, and children in orphanages had rates 
of secure attachment with their institutional caregivers as low as 19 
percent. Trickett et al. (2011) found CM associated with problematic 
peer relationships in childhood and adolescence in a study from USA.
In a review paper, Gilbert et al. (2009) stated that CM is associated with children’s long term problematic academic performance and/or learning difficulties. In a Saudi Arabian study, Altamimi et al. (2017) found that abused children had poor school performance. Maltreated children in Bosnia and Herzegovina exhibited significant deficits in total working memory capacity, verbal recall and attention ability in later life (Dodaj et al., 2017).

4.2 Economic and social consequences

Maltreatment has long-lasting economic consequences to the children and the society as well, but they are difficult to measure (Gilbert et al., 2009). If maltreatment of children stopped, they would be less punished, humiliated or killed and healthier as adults, which will help making them productive and bring wealth to the society. Lower academic achievement, adult criminality and mental health problems are difficult to measure economically (Ferrara et al., 2015). Direct costs related to CM include hospitalization, mental health care, welfare and residential services, foster care, professional social work, and juvenile justice, while indirect costs also include child special education, adult and juvenile crime, adult health care, and loss of productivity (Ferrara et al., 2015).

In countries of East Asia and the Pacific region, an estimate of USD 209 billion is spent annually due to CM, which is equivalent to 2 percent of the gross domestic product (GDP) of these countries (Whiting, 2015). Fang et al. (2012) estimated that the average lifetime expenditure of a case of fatal CM is USD 1.27 million and this cost is mainly due to the loss of productivity.

Studies have found that CM has an association with the increased risk of later life committing of crime and violence (Gilbert et al., 2009). In a study on the children of Chicago, Topitzes, Mersky, and Reynolds (2012) reported that maltreated children had higher rates of delinquency and adult crime in comparison with their non-maltreated peers. Neglected children also exhibited more antisocial behaviour and were more likely to become arrested in adult life (Widom, 1989). Studies have also showed associations between antisocial behaviour of adult women with their childhood experiences of physical and sexual abuse.
(Belknap & Holsinger, 2006). However, CM does not necessarily lead to adverse consequences. McGloin and Widom (2001) showed that 16–33 percent of maltreated children were resilient from becoming delinquent when they grew up.

5. A PUBLIC HEALTH PERSPECTIVE ON CHILD MALTREATMENT

The strong negative impact of CM on child development and health has posed the international community to account it as a leading public health problem (Krug et al., 2002). After the adoption of the Convention on the Rights of the Child (CRC) in 1989, there has been growing recognition that CM is a public health problem, and that a public health approach can remediate CM (Child Welfare Information Gateway, 2017).

A public health approach to safeguard can provide effective protection for children. The need for a public health approach is aimed at reducing the risk factors for maltreatment but there remain several issues such as defining the problem and develop effective intervention programmes (Woodman & Gilbert, 2013). Barlow and Calam (2011) stated that the widespread nature of CM, the problem of managing the existing rate of referrals due to the pressure on the available resources of child protection agencies, inaccurate risk assessment process, adverse effect of CM on early brain development and the economic cost related to prevention programmes are the reasons to consider the public health approach in remediating CM. According to Mercy et al. (1993), a public health approach helps defining CM, determine the risk factors, develop interventions to address the risk factors and thereby reduce its frequency, and finally facilitate implementing intervention programmes and measure the prevention effectiveness.

Gilbert, Woodman, and Logan, (2012) stated that the public health approach to CM is a preventive approach as it focuses on reducing the risk factors of maltreatment, rather than on the occurrence of maltreatment. So, a public health approach can act on the risk factors at all levels of the ecological model of CM (Sidebotham, 2001). Depending on
the risk factors being addressed, the preventive interventions may be through legislation and/or parental training.

CM got more emphasise as a public health problem or a protective issue in medical literature than as a violation of child rights. However, Reading et al. (2009) argued that a child-rights-based approach to CM needs to be implemented for the provision and participation of children in the society, and the right of protection from harm. The strength of a rights-based approach lies in providing a legal instrument for policy implication, ensuring social justice and accountability, hence enhancing public-health responses to CM.

Along with the public health approach, awareness should be built among the population changing attitudes towards CM. The Scandinavian countries are good examples of reducing CM by creating awareness in the society together with enacting laws.

CM is in Bangladesh considered as mostly a medical, judicial or criminological issue. However, different organizational reports reflect CM as a common occurrence and its unequal distribution among the child population. Male children seem to be abused physically more while female children are reported to be more neglected and more abused sexually (European Asylum Support Office, 2017). Only immediate negative health effects of CM like injury, death, hospitalization, psychological upset and committing suicide have been surfaced in Bangladeshi news media. Different international studies reveal the long-term health consequences of CM, which is yet to be explored in Bangladesh.

Thus, Bangladesh needs to implement a child wellbeing policy emphasising CM as a public health problem rather than focusing it as medico-legal or criminological issues. If NGOs and GOs are putting CM in a public health perspective, there is scope for prevention programmes. It is necessary to measure CM accurately and repeatedly for designing prevention models. Formulating a standard definition alone with development of a measurement tool is a priority. In Bangladesh, there is no reliable data on CM, so conducting a national survey is needed to estimate the prevalence of and risk factors for CM to formulate a prevention model. Ward et al. (2016) recommended key informant interviews and small-scale surveys for quick and cost-effective estimation of prevalent risk factors for CM in poor resource setting countries.
The prevention of CM by a public health approach can be conceptualised according to the following three-tiered model. The primary prevention comprises of techniques which are designed in preventing the target behaviour from ever occurring. These include programs of parental interventions and home-visit programs for parents (Stagner & Lansing, 2009). Parent support programmes may be effective for low- and middle-income countries as this type of intervention have the potential to mitigate the effects of poverty (Ward et al., 2016). The second model focuses on treating the existing problem and its early detection by targeting the individuals or groups at risk of CM. For instance, programs could be designed to prevent CM through education programs targeted to communities where there are higher risks of child neglect and abuse. Lastly the third prevention method is designed to families where abuse has already been identified to reduce their existing abusive behaviour (Stagner & Lansing, 2009).

6. BANGLADESH COUNTRY PROFILE

Bangladesh is a young nation. It got its independence from Pakistan in 1971 after a violent war where some three million people were killed and 0.2 million women were raped (Mookherjee et al., 2006). The country is situated in South Asia, bordering India in the west, north and east, Burma in southeast and the Bay of Bengal in the south. Bangladesh with its 163 million population is the 10th most densely populated country in the world. The majority of the population are Muslims (89%) (World Population Review, 2019). Around 40 percent of the population are under 18 years old (Unicef, 2019).

Over the last ten years, Bangladesh has met several Millennium Development Goals (MDGs), especially in reducing the poverty gap ratio (56.7 percent in 1991-92 to 24.8 percent in 2015). The gender parity at primary and secondary education has been achieved. The under-five mortality rate has decreased to 41 children/1000 live births in 2013 from 151 in 1990 and more than 90 percent of the children under five were sleeping under insecticide-treated bed nets in 2014 as a malaria prevention measure. Further, tuberculosis detection and cure rate have
improved. A remarkable progress has also been made in lowering the prevalence of underweight children, in increasing primary school enrolment, lowering the infant mortality rate to 32 per 1,000 live births in 2013 from 94 in 1990. There has also been a 40 percent decline of maternal mortality ratio in nine years from 2001 to 2010. Immunization coverage has improved, and the incidence of communicable diseases has been reduced. The life expectancy at birth has increased to 72.8 years in 2017 (UNDP, 2018; General Economics Division, 2015). In 2017, Bangladesh was placed among the countries considered to have achieved medium human development, ranking at 136 among 189 countries (UNDP, 2018).

Despite this progress, 1 in 4 people still live in poverty and 13 percent of the total population live in extreme poverty (BBS, 2017). The major concerns for the development are bringing down the poverty, creating jobs, enhancing the rate of primary school completion, better preventive health care for pregnant women, and reducing childhood stunting since approximately 40 percent of all the children under five are stunted (Centre for Research and Information, 2014; Rezvi, 2017).

Moreover, the Bangladeshi women are still facing barriers and disadvantages in nearly every aspect of their lives, including access to health services, economic opportunity, political participation, and control of finances. The patriarchal social system is said to be the root cause of these discrepancies (Sultana, 2010-2011).

Besides, in recent years in Bangladesh, there are some serious human rights violations reported in the media and law enforcers are repeatedly blamed for forced disappearances of opponent political activists and for extrajudicial killing. Killing of freethinkers and foreigners by Islamic activists in recent days has also made concern to the public in general and the international community as well (Human Rights Watch, 2019).
7. CHILD PROTECTION AND THE BANGLADESHI LEGAL SYSTEM

The Bangladesh government has enacted different acts and policies to ensure child rights and wellbeing since its independence in 1971. A description of different laws and policies related to children has been summarised in Table 2, which reveals that Bangladesh has ample legislative measures to ensure child rights and protection. For example, it is stated in article 35(4) of the constitution that no person shall be subjected to torture or to cruel and inhuman or degrading punishment or treatment, and Article 28(4) empowers the State to make special provisions for the benefit of children. Despite having all these legal measures, the rights of children are often violated because of weak law enforcement.

Table 2 Acts and policies related to child protection in Bangladesh.

<table>
<thead>
<tr>
<th>Acts/Policies</th>
<th>Features and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penal Code, 1860</td>
<td>Child abuse includes abduction, kidnapping, sexual exploitation, slavery and forced labour, and selling and buying minors for the purpose of prostitution.</td>
</tr>
<tr>
<td>The Suppression of Immoral Traffic Act, 1933</td>
<td>Prohibition of prostitution of women below 18 years of age.</td>
</tr>
<tr>
<td>The Children Act, 1974</td>
<td>Deals with juvenile justice system; child considered below the age of 16 years; provision of penalty for caregivers who abuse children. Replaced by Children Act, 2013.</td>
</tr>
<tr>
<td>The Compulsory Primary Education Act, 1990</td>
<td>Compulsory primary education for children aged 6-10 years; fail to address primary education as a constitutional right.</td>
</tr>
<tr>
<td><strong>Policy</strong></td>
<td><strong>Description</strong></td>
</tr>
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</tr>
<tr>
<td><strong>The National Children Policy, 1994</strong></td>
<td>Addresses the issue of child labour, promotes and protects children’s rights and ensures the overall development of children; define children under the age of 14 years.</td>
</tr>
<tr>
<td><strong>The Prevention of Oppression Against Women and Children Act, 2000</strong></td>
<td>Deals with violence against women and children with outline of punishment for rape, death caused from rape, child trafficking, acid violence and deaths from inflammatory object; does not include non-physical sexual harassment, incest, spousal rape, etc.</td>
</tr>
<tr>
<td><strong>Birth and Death Registration Act, 2004</strong></td>
<td>Compulsory birth registration within 45 days of birth but no provision of registration without a permanent address.</td>
</tr>
<tr>
<td><strong>The Mobile Court Act, 2009</strong></td>
<td>Provision for action to prevent girls and women from sexual harassment.</td>
</tr>
<tr>
<td><strong>Domestic Violence (Prevention and Protection) Act, 2010</strong></td>
<td>Define “domestic violence” as physical, sexual and psychological abuse, and financial exploitation to women or children by any family member; does not address to what extent parents can exercise their customary right to punish their children for upbringing.</td>
</tr>
<tr>
<td><strong>National Child Labour Elimination Policy, 2010</strong></td>
<td>Aim at changing the lives of children by withdrawing them from child labour, providing incentives to bring them back to education and raising people’s awareness regarding the harmful effects of child labour.</td>
</tr>
<tr>
<td><strong>Circular regarding the Ending of Corporal Punishment on Students in Educational Institutions, 2010</strong></td>
<td>Prohibit CP in all educational settings issued by the Ministry of Education of Bangladesh.</td>
</tr>
<tr>
<td><strong>National Children Policy, 2011</strong></td>
<td>Aim at ensuring child rights by eliminating all forms of discrimination and child abuse.</td>
</tr>
<tr>
<td><strong>The Pornography Control Act, 2012</strong></td>
<td>Provision of imprisonment with fine for filming child pornography.</td>
</tr>
<tr>
<td>The Labour Act, 2013 (amended)</td>
<td>Determine the minimum age for admission to work as 14 years, 18 years for hazardous work; does not include domestic work or give any definition of non-hazardous labour.</td>
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<td>-------------------------------</td>
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<tr>
<td>The Children Act, 2013</td>
<td>Define children under the age of 18 years and prescribe punishment against child violence.</td>
</tr>
<tr>
<td>National Action Plan to Prevent Violence against Women and Children 2013–2025</td>
<td>Provide definition of different forms of child abuse along with neglect; consider child marriage as child abuse.</td>
</tr>
<tr>
<td>The Child Marriage Restraint Act, 2017</td>
<td>The minimum legal age for marriage for girls and boys have been set at 18 and 21 years respectively. However, a court can allow child marriage in “special cases”.</td>
</tr>
</tbody>
</table>

### 8. THE CONCEPT OF CHILD

The concept of child, which we understand today, is historically and culturally conditioned (Matthews & Mullin, 2015). Throughout the history of Western civilization, a child has been regarded as a little adult, a miniature adult, an angel, an empty vessel, an unformed animal, an exasperating parasite, and a source of amusement (DuCharme, 1995). The concept of child is different from how it was previously depicted. Children are nowadays recognised with full respect by different international organisations and are protected by the legislation of countries. According to the UN Convention on the Rights of the Child (UNCRC):

“.. a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier” (Children’s Rights Alliance, 2000, p. 9).
8.1 The concept of child in the Indian subcontinent

The Indian subcontinent including Bangladesh, Pakistan and India have a common history of many cultural traditions for some millennium years (Naqvi & Mohmand, 2012). The concept of child and childhood in the Indian subcontinent was largely shaped with religious beliefs and practices (Sitholey, Agarwal, & Vrat, 2013).

8.1.1 The ancient period (before 10th century)

In Indian archaic epic texts and law books such as the “Veda”, “Ramayana”, “the Mahabharata”, “Dharmaśāstras” and the Laws of “Manu” childhood was thought to begin before birth and end during late adolescence (Menon, 2017), but the end of childhood of a girl involves menstruation, marriage and the move into her husband’s home (Bhakhry, 2006).

The different developmental stages of childhood were marked by several rites and rituals (samskaras) like “namakarana” (naming ceremony), “mundane” (tonsure ceremony) and “upanyana” (initiation into the religion and wider community) where girls and children of lower castes had no rights to perform these rituals (Kakar, 1982).

A male child was generally preferred with the expectation of their parent’s old age financial support and upholding family values, which is still deeply rooted in patriarchal and patrilineal Indian family structure. A family without a male child was considered accursed (Grewal & Singh, 2011). According to Hindu law books, female children had no right of inheritance or right to gain ancestral property. They were considered as financial burdens since the parents had to pay for dowry of their marriage (Halder & Jaishankar, 2008). The ancient society though was positive regarding child development, education and future independence, adult role, and contribution to the society (Sitholey et al., 2013). Children were considered precious where their loyalty and obedience were regarded as both moral and esteemed behaviours (Sitholey et al., 2013; Bhakhry, 2006).
The accessibility of being educated under “guru” (a wise man) was mostly limited to the boys of upper castes (Bhakhry, 2006). Female children from the beginning of their childhood were trained to be a docile daughter-in-law, and a skilled wife being able to do all the household activities (Bhakhry, 2006).

Children got protection from the society through a “protective indulgence” and were mildly punished to be disciplined (Raj, 2011). Scolding, imposing atonement, or being sent away for a while were the common forms of punishment for disobedient and misbehaving students. Only in extreme cases, the teacher could use thin ropes or canes for punishment but only on the back of the body. Beating with anything else was considered a crime for which the teacher faced punishment by the king. However, some brutal forms of CM were evidenced in the ancient times (Bhakhry, 2006).

8.1.2 The medieval period (10th-18th century)

The Mughal (1526-1858) period was the most influential regime of medieval India when significant changes took place in the formal schooling system where the Islamic system of education became predominant. During this period, access to quality education was limited to children based on their gender, caste and social class (Grewal & Singh, 2011).

“Satidaha”, a practice of widow immolation was observed only in the Hindu community after the death of their husband, which was a brutal abuse against child widows in the ancient and medieval India. During the Mughal period, several attempts were taken to ban Satidaha and finally in 1829, this practice was outlawed in British India (Bagchi, 1993). Social discrimination against girls was also visible in the Muslim community and still prevails today. In case of the birth of a male child, two animals were sacrificed as opposed to one in the birth of a female child.
8.1.3 The British colonial period (1858-1947)

British rulers introduced the colonial model curriculum with English as a medium of instruction, largely ignoring the access to education of rural children (Mohite & Bhatt, 2008; Grewal & Singh, 2011). During the British colonial rule, the wellbeing of the girl child emerged as a major concern. The Hindu community has been practising early child marriage since ancient times but in the nineteenth-century, movements concerning the banning of child marriage gained momentum. In 1929 “The Child Marriage Restraint Act” (Sharda Act) was passed, where the marriageable age was made 18 years for boys and 14 for girls. Under protests from the Muslim organisations, the Muslim Personal Law (Shariat) Application Act, 1937 (“the Shariat Act”) was passed in 1937, that allowed child marriages with the consent from the girl’s legal guardian.

8.1.4 The post-colonial Bengal period (1947-1971)

In 1947, after the British colonial rule, India and Pakistan emerged as two independent nations, based on Hindu and Muslim majority. The then Pakistan had two separate states, West Pakistan (now Pakistan) and East Pakistan (now Bangladesh), however without having any common geographical boundary. Pakistan was largely following pre-independence Anglo-Indian law although there are laws of Islamic Shariah (Munir, 2008). Besides, several changes have been made to ensure child wellbeing in the legal system of post-colonial Pakistan. The then Pakistani government repealed “The Child Marriage Restraint Act, 1929” and raised the marriageable age from 14 to 16 for girls and 18 to 21 for boys in order to reduce the child marriage rate. The government also imposed a monitory fine for any violation of this Act. However, this law was seldom enforced in the rural Bengal, due to lack of an effective birth registration system and the age of girls (especially in rural areas) were determined by their physical look and growth.
In comparison to West Pakistan, the children of East Pakistan were less privileged in education where the number of primary schools and teachers were low (Asadullah, 2010). The child labour scenario was also worse in East Pakistan with 38 percent of the children aged 10-14 years working, while the corresponding rate was 23 percent in West Pakistan (Haroon & Jan, 1964).

8.2 The concept of child in the Bengali society

In the Bengali society, the notion of childhood or a child is marked indistinctly, and in the Bengali language, the word “child” who is 0 to 18 years, does not exist (Blanchet, 1996). The Bengali word “Shishu”, chosen to translate the word “child”, has a meaning quite different from that spelled out in the CRC, to most Bengalis. There are several words representing the different developmental stages of children like, “shishu” (baby or child), “balok-balika” (pre-adolescent) and “kishore-kishori” (adolescent). The Bengali culture and language describe these stages but does not define them with clear-cut age demarcation (Blanchet, 1996). Beside this, the definition of a child is not uniform in the legal system of Bangladesh. Different legislations provide different upper age limits, but all of them are within 12-18 years of age (Ferdousi, 2012). However, in line with the CRC, in “Children Act, 2013” of Bangladesh it is mentioned that “Notwithstanding anything contained in any other law existing, all persons shall be considered as children until the age of 18 (eighteen) years for the purpose of this Act”.

9. CHILD-REARING PRACTICES AND THE BANNING OF CORPORAL PUNISHMENT

Child-rearing practices are influenced by various factors such as culture, generation and social class (Fontes, 2005). Aggressive disciplinary practices accepted in one culture are seen as shocking and abusive in another culture. Today, in several Western and Latino-American societies, punishment at home, at school or at workplaces is forbidden.
However, these practices are still accepted and regarded as a part of the child development process in many countries. As societies differ widely, understanding the cultural differences of child rearing practices is very important to fight CM (Fontes, 2005). It is in line with child rights to influence all countries to ban corporal punishment (CP) of children. Even though some Asian countries have committed to introduce the ban of CP, almost all the Asian countries have been reluctant to ban it in all settings (Freeman & Saunders, 2014).

By September 2019, 56 countries have prohibited all types of CP including only four Asian countries (Israel, Turkmenistan, Mongolia and Nepal). Sweden was the first country in the world to ban CP in schools, homes and workplaces in 1979 (Global initiative to end all corporal punishment of children, 2019).

Banning of CP often starts by banning CP in school. In 1928, the Swedish government amended their “Education Act” to forbid CP in secondary schools. In 1966, parental right to use CP was removed from the “Parent’s Code” and in 1979 CP was banned by the amendment of the following clause in the “Parent’s Code”:

“Children are entitled to care, security, and a good upbringing. Children are to be treated with respect for their person and individuality and may not be subjected to physical punishment or other injurious or humiliating treatment” (Durrant, 1999, p. 436).

Sweden is a welfare state and is regarded as a benchmark country in preventing CM. In the last few decades, there has been a radical change in child rearing practices in Sweden with a gradual decline of parental practice of CM along with changed attitudes (Jernbro & Janson, 2017). This attitudinal and behavioural changes in parents along with the banning of CP in 1979 helped Sweden to reduce CM remarkably.

CP in school is still legally permitted in 67 countries (Global initiative to end all corporal punishment of children, 2019). Studies indicate that countries who banned CP have a lower rate of CM. A newly published study found that also youth violence is lower in countries that have prohibited CP (Elgar et al., 2018). Punishment is thought to be more accepted by lower socio-economic classes than higher classes, which is evident both in inter and intra country comparisons (Hanna, 1988; Bealmear, 2006).
9.1 Child-rearing practice in the context of Bangladesh

Bangladesh has a cultural heritage and strong family bonds, where parenting practices mainly follow traditional norms. Children are brought up within a family, where a mother is the primary caregiver, while the upbringing practices mainly focus on ensuring food and education (Hamadani & Tofail, 2014). Lusk, Hashemi, and Haq (2004) found that the upbringing rarely focuses on recreation activities like playing. Besides, there are around one million children in Bangladesh, who live in the streets. These children are deprived of the care of the family and are more vulnerable to all forms of CM (BSS, 2019).

Aggressive disciplinary practices like CP in both schools and homes are common in Bangladesh. Moreover, the “Code of Criminal Procedure, 1898”, “Prisons Act, 1894”, “Children Rules, 1976”, “Whipping Act, 1909”, “Railways Act 1890” and “Penal Code 1860” endorse CP by incorporating provisions of handing out CP. For instance, Rule-24 of the Children Rules, 1976 has provision for canning up to ten strips to children for infringements of discipline. There are also provisions of whipping to boys in the Prisons Act, 1894 and Railways Act, 1890.

According to Siddiqui (2001), the cultural acceptance that parents, guardians, teachers and elders “can do no wrong” for the betterment of the children, is a reason behind aggressive disciplinary practices in the Bangladeshi society. Punishment is often inflicted on the children to secure a better academic performance and to enforce obedience. A recent study of the Bangladesh Legal Aid and Services Trust (BLAST) showed that approximately 70 percent of the parents considered CP as a useful tool to maintain classroom discipline, 55 percent considered it as an effective way to children’s proper development and 27 percent thought that children might be derailed unless parents used physical punishment. Only one percent of the guardians regarded hitting a child without any specific reason as a violation of child rights (Hasnat, 2017).
10. THEORETICAL FRAMEWORK

Several theories try to explain the CM phenomenon (Thomas et al., 2003; Cicchetti & Carlson, 1989). Among those, the ecological model, social learning theory, emotion theory, equity, human rights and child rights constitute the theoretical framework of the thesis.

10.1 The ecological model

The ecological model can be used as a theoretical frame in describing risk factors as well as protective factors for CM due to its comprehensive view (Smart, 2017). Adoption of Bronfenbrenner’s ecological model of child development was a scientific breakthrough in the understanding of CM (Sabri et al., 2013). Bronfenbrenner stressed the importance of studying the context of ecological systems since he believed that children’s development was affected by their surrounding environment. His ecological model organises the context of development into four distinct concentric systems of influence. The systems are categorised from the inner most intimate level, the micro level, followed by the meso and the exo levels, to the external macro level and the levels inevitably interact with and influence, directly or indirectly, each other in every aspect of the child’s life (National Research Council, 1993). Preventive strategies can also be developed from this model (Woodman & Gilbert, 2013).

Belsky (1980) applied Bronfenbrenner’s ecological model to conceptualise the risk factors of CM and added the ontogenic level in the ecological framework which was borrowed from Tinbergen. According to Belsky’s (1980) ecological model, risk factors for CM are divided into four interrelated, mutually embedded levels. He is naming them the ontogenic, the micro, the exo and the macro systems and they are further explained below.
10.1.1 The ontogenic system

The first level consists of individual factors related to the child and the parents’ ontogenic development. Factors related to the child include prematurity, temperament, age and gender, low birth weight, physical or intellectual disabilities and behavioural problems (National Research Council, 1993).
Parent’s ontogenic development is concerned with parental history of being abused during childhood, the style of parenting, feelings toward the child and parental mental health (Zigler & Hall, 1989). This category could explain the intergenerational effect of CM. In a Bangladeshi study, Islam et al. (2017) found that men who had witnessed father-to-mother violence were more likely to perpetrate IPV, suggesting an intergenerational transmission of violence.

Attachment is one of the issues in the ontogenic development. Studies show that maltreated children are found more likely to have an unsafe attachment with their caregivers and these children have a higher risk of become abusive in later life (Hunter, 2014).

### 10.1.2 The microsystem

The microsystem includes the family context which is the child’s immediate environment where CM takes place (Scannapieco & Connell-Carrick, 2005; Sidebotham, 2001). Family dynamics, parenting styles, parental developmental histories and their psychological resources are all incorporated in an analysis of microsystem influencing CM (Cicchetti, Toth, & Maughan, 2000). As the child grows, the microsystem gradually includes friends, peers and other significant adults (Sidebotham, 2001).

In this system, Cicchetti et al. (2000) addressed that good marital relations, consistent employment, positive family relations, good parental mental health and positive child rearing skills within a family serve as protective factors for child development.

Salzinger et al. (2002) demonstrated family stress, partner violence, and caretaker’s stressful work as potential risk factors of child abuse. Though there is a lack of data in support of interaction between family factors and child abuse in Bangladesh, a few studies revealed that family violence made children vulnerable by forcing them to leave home (Conticini & Hulme, 2007; Reza, 2016). Daisy et al. (2001) showed significant association of child burn with parental lack of awareness, illiteracy and lower economic status.
10.1.3 The exosystem

The exosystem is the greater social system within which the individual and the family are embedded. Belsky (1980) primarily focuses on the influences of work and neighbourhood. Other social structures like school, formal and informal support networks, socioeconomic status and social services have also been included in this stratum. This level includes Bronfenbrenner’s mesosystem, which comprises the interconnection between exosystem structures (Scannapieco & Connell-Carrick, 2005).

10.1.4 The macrosystem

In the macrosystem, the influences of an individual’s cultural values, customs, and laws can be found. The interconnected social drivers, such as cultural practice, gender inequality, unequal access to essential services, inequity, poverty, high rates of unemployment, substance abuse, high incidence of violent crime, natural calamity, war, and famine contribute to children’s experiences of violence (Mathews & Benvenuti, 2014; Thomas et al., 2003). In the ecological model, the macrosystem appears to be the least researched as the risk factors in this level often are difficult to determine (Thomas et al., 2003). Child protecting laws such as laws banning CP, equal access to education for boys and girls and gender equality are addressed as protective factors in the macrosystem.

The practice of CP is deeply rooted to the Bangladeshi culture. Around 67 percent of Bangladeshi parents endorse the use of physical punishment in school as it is considered as an effective measure to discipline children (Hasnat, 2017). Most teachers also believe that poor parenting and lack of punishment are causes of inappropriate behaviour of children (Malak, Deppeler, & Sharma, 2014). In a multi-country study, Elgar et al. (2018) revealed that countries that prohibited CP have less youth violence.

Wilkinson and Pickett (2018), and Pickett and Wilkinson (2015) suggested that children become more hostile in countries where economic inequality is high. Studies also showed the positive relationship be-
tween poverty, inequality and CM (Featherstone et al., 2017; Eckenrode et al., 2014). In Bangladesh economic inequality is high and increasing. A study conducted by the Centre for Policy Dialogue showed that in 2016, the top five percent of income-earners earn 121 times more than that of the bottom five percent, jumping from 31.5 times in 2010 (Editorial, 2017).

Since its independence in 1971 after a violent war with three million killed, Bangladesh witnessed violence between political parties, forced disappearance and extra-judicial killings by law enforcers which is a serious human rights concern. In recent days, Bangladesh has been passing through a security challenge due to attacks by Islamic militants and several people have been killed between 2013-2016, where most of them were foreigners, religious minorities, writers, bloggers, and gay rights activists (Human Rights Watch, 2019). Besides, thousands of people die every year due to natural calamities. Within this violent and disaster-prone society, high rates of poverty, IPV and violence against women increase stress on the whole family, which act as vulnerable factors that serve to potentiate CM in a larger scale (Cicchetti, 2000; Haider, 2016).

10.2 Social learning theory

Social learning theory of CM suggests that behaviour is accounted for by the continuous reciprocal interaction of personal and environmental determinants (Bandura, 1977). According to this theory, abused children absorb their parents’ negative behaviour into their own behavioural patterns through observing the role model thus continuing this behaviour into their adulthood as an intergenerational transmission of violence (Schelbe & Geiger, 2016). Renner and Slack (2006) stated that adults who had been reported experiencing physical abuse during childhood, were more than two times more likely to engage in IPV than those who hadn’t. Although several studies support the notion that abuse is cyclical, there are many factors like financial stability and social support that diminish the risk of abuse being transmitted across generations (Kaufman & Zigler, 1987; Dixon, Browne, & Hamilton-Giachritsis, 2009).
10.3 Emotion theory

In the 1970s, emotion theory again started to attract attention in public health research. Emotions can be looked upon as a link between the micro- and the macro systems in the ecological model and between the individual and the society, which can help explain causes to health and ill health. Emotions also describe the development of human relations and social processes (Dahlgren & Starrin, 2004).

Scheff (1990) suggests that the ability to experience emotions create strong relations and the emotions pride and shame thus measure the quality of these relations. Being valued negatively can arouse feelings of shame while a positive treatment can awake pride. What treatment that arouses positive or negative emotions is also influenced by cultural norms and can be changed over time. To be able to understand and explain human behaviour such as CM, emotions like shame must be taken into consideration (Dahlgren & Starrin, 2004). Emotional processes elucidate how the experiences of maltreatment affect the development of psychological distress and behavioural problems in children. Shame belongs to the class of self-conscious emotions which is a means for understanding how maltreated children are at risk of poor adjustment (Feiring, 2005).

The shaming of children is believed to be a core aspect of CM (Loader, 1998). Shame is an emotional state, which affects the whole person relating to negative self-appraisals and devaluation in relation to perceived public exposure, or disapproval that leads to the desire to hide or escape oneself from certain experiences (Tangney, 1998). Phenomenologically, shame is a painful emotional experience following exposure to sexual abuse, physical abuse, emotional abuse, and neglect, linking to negative adjustment (Bennett, Sullivan, & Lewis, 2010).

Shame may be affected by maltreatment and by authoritarian parenting (Bennett, Sullivan, & Lewis, 2005). Severely maltreated children are likely to believe that they are unwanted and unlovable (Burhans & Dweck, 1995). Such negative self-beliefs induce intense feelings of shame and increases the likelihood of poor adjustment (Lewis, 1992). How this poor adjustment will be manifested, depends on a person’s response to shame.
Gold, Sullivan, and Lewis (2011) posit expressive and conversive types of responses to shame. Expressed shame is associated with negative attributions that are internal, stable, and global. Studies suggest associations between expressed shame and internalizing problems, such as withdrawal, depression, low self-esteem, anxiety, and feelings of worthlessness. Alternatively, feelings of shame may be converted into external attributes like blaming others, anger, aggressiveness or other emotions.

A shamed person is likely to blame others for their own shame-inducing behaviours resulting in insulating themselves from their own intensely negative feelings (Dutton, van Ginkel, & Starzomski, 1995; Ferguson, Eyre, & Ashbaker, 2000; Tangney & Dearing, 2002). Hence, shame proneness is associated with both externalizing and internalizing problems, which are commonly observed among maltreated children.

Bangladesh is a country embedded with religious, social and cultural conservativeness. In such a context, the exposure of private and personal issues is of hesitation where media reports often reveal grave consequences of child sexual abuse. Female rape victims are found to become stigmatised in such a male dominant social system as in Bangladesh and sometimes commit suicide due to the culture of shame (Tithi, 2018).

10.4 Equity, human rights and child rights

Health equity is a concept based on the ethical principle of distributive justice to ensure human rights by reducing the social inequalities of health. Health inequalities raise concerns about equity as they are systematically linked with social disadvantages leading to worsening health among the disadvantaged groups (Chapman, 2010; Braveman, 2010). Wilkinson and Pickett (2009) mapped the impacts of the rise in inequality and suggested a strong link between ill-health, social problems and inequality. They also argued that inequality within a society obsesses individuals with a feeling of being unvalued and inferior thus making them feel ashamed (Wilkinson & Pickett, 2018; Pickett & Wilkinson, 2015).
Human rights are linked to equity, equality, public health and child well-being. The human rights framework offers a context for addressing the broad range of social determinants of health and health inequalities. The major development problems of health are inequalities, discriminatory practices and unjust power relationship of different segments of the society, where a human rights-based approach is needed to be addressed for a better and sustainable development (WHO, 2019).

Since the early nineties, a growing body of work has been demonstrating the importance of human rights approaches within public health, seeking the reduction in health inequities (Taket, 2012). CM has been considered as a public-health problem or an issue of harm to individuals. However, in the scientific literature, it is less frequently reflected as a violation of children’s human rights.

The 1989 UN Convention on the Rights of the Child (UNCRC) was the first instrument to incorporate civil, political, economic, social, health and cultural rights of children. UNCRC constitutes a list of obligations for its member states’ child welfare. The human rights-based approach is derived from the principles of accountability, universality and non-discrimination, indivisibility, and participation that underlie the UNCRC.

Article 19 and 32 of the CRC can be the basic tools in CM research, where article 19 acknowledged child protection from all kinds of violence, abuse, neglect or ill-treatment. Moreover, article 32 is significant in the current context as it addresses protection of child rights from economic exploitation or hazardous working environment.

Since its independence in 1971, Bangladesh has endorsed laws and acts to promote child rights and to ensure child protection. However, a special judiciary system and a separate directorate for children are yet to be set up. Major policies and plans concerning child rights and protection have been adopted after the ratification of UNCRC in 1990 (Ferdousi, 2013).

Article 19 of the CRC requires states to protect children from “all forms of physical or mental violence” and consistently states that CP is incompatible with CRC. In 2011, Bangladesh High Court issued a ruling to ban CP in schools, while the Directorate of Primary Education and the Ministry of Education issued Circular and Guidelines prohibiting all types of punishment in schools. However, no measures have been
taken to transform this ruling into legislation or prohibit CP in homes and other settings. On the contrary, CP remains lawful at home, alternative care settings, and penal institutions, and the Children Act 2013 does not prohibit CP (Global initiative to end all corporal punishment of children, 2018).

11. AIMS OF THE THESIS

11.1 Overall objectives

The overarching objectives of the thesis were:
− to generate knowledge and understanding about the perceptions of child maltreatment in the Bangladeshi society
− to provide useful information about the magnitude of child maltreatment and associated social factors of child maltreatment

11.2 Specific objectives

The specific objectives of the empirical studies included in the thesis were:
− to explore the perceptions on and experiences of CM by school-age children in rural and urban Bangladesh in order to understand maltreatment in the local context and from a child perspective (Study I)
− to assess news-media reported CM cases by types of CM, and the socio-demographic characteristics of perpetrators and victims (Study II)
− to estimate the prevalence, risk and protective factors of physical abuse in rural Bangladesh from a child perspective and its association with demographic and socio-cultural factors (Study III)
− to estimate the prevalence, and determine demographic and socio-cultural risk and protective factors of child psychological abuse and neglect in rural Bangladesh from a child perspective (Study IV)
12. METHODS

12.1 Qualitative and quantitative methods

Both qualitative and quantitative research methodology was used to answer the questions arising during the period of study. The research departure was to conduct a qualitative study (Study I) as there is little knowledge regarding CM in Bangladesh. This methodology has been proven appropriate for comprehending a phenomenon that has not been previously explored (Starrin et al., 1997). The interview method adopted in Study I helped to understand the interviewee’s point of view unfolding the meaning of their life experience of maltreatment, prior to further scientific explanations (Brinkmann & Kvale, 2015). In Study I, children from different parts of the society were interviewed to explore their perceptions and experiences of maltreatment, and to understand what it meant for children in the local context of Bangladesh.

A systematic analysis of news media reports seemed to be a useful approach to get a societal picture of the CM pattern. Media content analysis is a technique for gathering and analysing the content of text to make valid inferences using a specific set of procedures (Macnamara, 2005). In Study II, newspaper contents were analysed to assess how the different types of CM cases were portrayed, along with the characteristics of the victims and perpetrators, where quantitative content (only manifest) analysis was employed. The main resulting theme of Study I was children’s subordinate position, which helps to explain CM in the Bangladeshi society. Study II revealed that physical and sexual abuse got a lot of coverage in print media with frequent reporting of cases of fatal abuse.

These two studies provided basic knowledge to go on with quantitative epidemiological studies to get a description of CM in a general population (Study III and IV). Based on the knowledge derived from Study I and II, questions arose to what extent CM (physical abuse, psychological abuse and neglect) is prevalent in the Bangladeshi society and what the determinants for CM are. These became the research questions for Study III and Study IV. In Study III, child physical abuse was addressed, while in Study IV, child psychological abuse and neglect were addressed. The studies were performed through a community-based
cross-sectional survey. A rural area was selected as approximately three-fourths of the total population of Bangladesh reside in rural areas.
Furthermore, the sub-district was selected since it is an injury-based surveillance area where every individual has a unique identification number. Based on these numbers, the desired sample was selected by a simple random sampling procedure. The methodological interconnectedness of the four studies is illustrated in Figure 2.

12.2 Overview of methods
An overview of study design, population, data collection and analysis methods of the four studies is presented in table 3.
Table 3 Overview of methods used in the four studies.

<table>
<thead>
<tr>
<th>Study name</th>
<th>Study design</th>
<th>Population</th>
<th>Data collection</th>
<th>Analysis</th>
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<tr>
<td>I. Bangladeshi school-age children’s experiences and perceptions on child maltreatment: A qualitative interview study</td>
<td>Qualitative interview study of children of school-going age from both urban and rural communities</td>
<td>24 children (13 boys, 11 girls), of them 11 were school-going and 13 non-school going</td>
<td>Semi-structured individual interviews in July 2013</td>
<td>Qualitative content (manifest and latent) analysis</td>
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<tr>
<td>II. Child maltreatment portrayed in Bangladeshi newspapers</td>
<td>Newspaper articles on CM in six daily national covered newspapers for three months of 2014</td>
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<tr>
<td>III. Children’s exposure to physical abuse from a child perspective: A population-based study in rural Bangladesh</td>
<td>Cross-sectional population survey</td>
<td>Children aged 11-17 years from a rural community (n=1,416)</td>
<td>ICAST-C instrument; face to face interviews during March-April 2017</td>
<td>Descriptive analysis</td>
</tr>
<tr>
<td>IV. Children’s exposure to psychological maltreatment and neglect from a child perspective: A population-based study in rural Bangladesh</td>
<td>Cross-sectional population survey</td>
<td>Children aged 11-17 years from a rural community (n=1,416)</td>
<td>ICAST-C instrument; face to face interviews</td>
<td>Descriptive analysis</td>
</tr>
</tbody>
</table>
12.3 Data collection and analysis

12.3.1 Study I

Study design

Individual qualitative semi-structured interviews were performed with both school-going and non-school-going children. The interviewees were strategically recruited to get a population of gender balance, in different ages, from different settings, and with varied experiences. In this regard, Dhaka city (the capital of Bangladesh) was purposively selected as the urban area, and a sub-district of Sirajganj district (Raiganj) situated 150 km north-west of Dhaka was selected as the rural area.

A pre-developed thematic interview guide with three themes was used. The interview guide was discussed at length between Bangladeshi and Swedish colleagues and then translated into Bengali from the original English version prepared by the Swedish research group familiar with this methodology. The three themes of the interview guide were upbringing methods, children’s own experiences, and children’s feelings and attitudes towards CM. The first theme focused on the upbringing process of the child and if CP was a part of the upbringing. The second theme concerned on the child’s personal experience of maltreatment and the child was asked to give examples preferably with detailed descriptions of the different types and settings of abuse, and of the perpetrators. The third theme dealt with the child’s feelings and attitudes towards CP and if the child knew about laws banning CP. Prior to finalising the interview guide in the Bengali language (the native language of Bangladesh), two pilot interviews were conducted to assess the feasibility of the study, clarity of the language and the appropriateness of the questionnaire to the participants.

Data collection

Two experienced interviewers conducted the interviews. The interviews were conducted in the natural settings close to the children’s homes, schools or working places in July 2013. Eleven school-going (six boys and five girls) and thirteen non-school-going (seven boys and six girls) children aged 9 to 17 years were interviewed. All the school-going
children went to formal education schools. All the non-school going children had left school and were working. Four children had left school for job before the age of ten. Of the working children, nine were manual labourers, of which five children worked in garment related industries, three were unemployed and the job nature of one child was unknown. One of the interviewed children, a girl aged 17 years, was married. The interviewees were encouraged to talk in their own way about the three themes included in the interview guide.

**Data analysis**

All the interviews were audio taped. The length of the interviews was between 15 to 45 minutes followed by immediate verbatim transcriptions in Bengali. The author cross-checked the audio recordings for accuracy of the transcripts. A number of 18 purposively selected transcriptions were translated into English giving the Swedish research group the possibility to take part in the analysis. Qualitative content analysis was used for analysis, since it has great opportunities for interpretation of the text. It can focus on the manifest content describing the visible and obvious elements of the text or on the latent content analysing the underlying meaning (Graneheim & Lundman, 2004). Both manifest and latent contents were objects for analysis.

The analysis started by reading the transcriptions to obtain an overview of the collected data. If difficulties to understand a few contexts arose, the research team got back to the audio tapes for cross-checking the information until a uniform level of understanding was reached. Thereafter, the meaning units, that are the phrases relevant to the aim of the study, were chosen from the text. In subsequent steps, all condensed meaning units were coded, and grouped into subcategories. The subcategories were then accumulated into main categories. Finally, a theme emerged. To ensure credibility, the whole research group was involved in the analysis process. Quotes from the interviews were included in the presentation of results in the journal article to illustrate and verify the interpretation.
12.3.2 Study II

Study design
Newspaper articles on CM in six daily national newspapers were collected for analysis. Newspapers were selected considering the criteria of having broadsheet publication, national coverage and at least 16 pages per issue.
The top circulated four Bengali and two English newspapers were selected (Department of Films and Publications, 2014). The selected Bengali newspapers were “Prothom Alo” with 501,750 circulation/day, “Kalerkantha” with 250,600 circulation/day, “The Daily Jugantor” with 221,125 circulation/day and the “Daily Ittefaq” with 194,500 circulation/day. The English newspapers were “The Daily Star” with 41,150 circulation/day and “The Independent” with 28,670 circulation/day. The English newspapers were selected despite having less daily circulation in comparison to Bengali newspapers, as they are read by the highly educated segment of the society.
The study design was outlined in a workshop with experienced mass media and journalism researchers, anthropologists, epidemiologists and public health researchers from Bangladesh and Sweden at the Bangabandhu Sheikh Mujib Medical University (BSMMU) in Dhaka.

Data collection
Newspaper articles reporting cases of CM were collected between October and December 2014. Duplicate articles i.e. articles with the same story printed in other sampled newspapers were eliminated, and simple random sampling process (lottery method) was followed to select unique cases from duplicate articles. Finally, 790 unique cases out of 1052 articles were identified. News articles, where the alleged perpetrator was a child only, were excluded.
The spot (immediate and up to date) news, features, pictures/photos, editorials and commentaries were considered for coding and analysis. Information relating to the perpetrator (gender, relation to the victim, number of perpetrators, occupation), the victim (gender, age, occupation), the place where the incident took place (urban or rural area, at home, outside the home, controlled area like educational institution, office, etc.), and the standard of reporting—regarding any disclosure of victim’s identity (name, address etc.), were collected.
Data analysis
This study was based on Berelson’s quantitative content analysis technique and only manifest content was analysed (Bengtsson, 2016). In a predesigned data (code) collection sheet, details from the newspaper stories were documented. Six coding categories were developed for the CM classification (Hove et al., 2013) as follows: (1) Child abuse in general, when there is no mention of a specific type of abuse. (2) Sexual abuse, including sexual exploitation or exposure, rape and sexual oppression. (3) Physical abuse, including all forms of CP, assault and acid violence. (4) Neglect, including child labour, abandoning of children, selling and buying of minors, and negligent behaviour of government agencies. (5) Verbal abuse, including insults or threats of any nature. (6) Emotional abuse, when causing mental derailment.
Three persons graduated in mass media studies were assigned for coding and they were trained through multiple sessions. An iterative process of coding was used until reaching satisfactory inter-coder reliability. The coding procedure of the sampled news articles was performed in the same setting and frequent consultations were made to remove ambiguities.
Data were recorded and analysed using Statistical Package for the Social Sciences (SPSS) for Windows, Version 24.0. All continuous variables were analysed to estimate measures of central tendency (mean), measures of dispersion (standard deviation [sd]) and categorical variables were analysed to determine the distribution frequency. Krippendorff’s alpha inter-coder metric was adopted to evaluate inter-coder reliability and found acceptable (80.0-100.0%).

12.3.3 Study III and IV
Study design
Both Study III and IV were population based cross-sectional surveys. The injury-based surveillance area at Raiganj Upazila (sub-district) of Sirajganj District, an agro-based rural area, was selected as study area. It is situated in the north-western part of Bangladesh, approximately 150 km from the capital city, Dhaka. This surveillance area has been maintained by the Centre for Injury Prevention and Research, Bangla-
desh (CIPRB) since 2006, with periodic updating of socio-demo-
graphic and injury-related data of all the residents twice a year. In 2017,
the total population and number of households in this area were
146,828 and 35,071 respectively. Every individual of this surveillance
area has a unique identification number, and this number was the base
of our sampling frame.

A total of 1,547 children aged 11-17 years were selected as study sample
using simple random sampling procedure. The sample size was esti-
mated based on a prevalence of CM 82.4 percent from a previous study
(Bangladesh Bureau of Statistics and Unicef Bangladesh, 2016), an ab-
solute precision of 2 percent and a confidence level of 95 percent, ac-
cording to the methodology described by Lwanga and Lemeshow
(1991), considering 90 percent response rate. A list of household ad-
dress of all sampled children was prepared before the data collection.
Children over 11 years were selected, as at this age they are considered
to understand concepts and elaborate their own life situation. It is also
an age when they normally understand informed consent (Runyan et
al., 2015; Hein et al., 2015).

Data collection using Child Abuse Screening Tool for Children
(ICAST-C)

The survey was conducted from March to April 2017. The interviews
were made in the homes of the children with a face-to-face approach.
Face to face interview technique is well feasible in countries like Bang-
ladesh, where the illiteracy rate is high (UNESCO Institute of Statistics,
2018; United Nations Department of Economic and Social Affairs,
2005). This technique also renders higher response rate in surveys
(Groves et al., 2004). In total, 1,416 children from separate households
were interviewed with a response rate of 91.5 percent.
The interviews were performed by six experienced interviewers (five
females and one male). In the context of Bangladesh, criminal records
of data collectors were not feasible to check, so references of earlier as-
signments were relied upon instead. A three-day training session was
also organised, where the data collectors and supervisor were trained
to introduce themselves, explain the purpose of the study, obtain in-
formed consent, administer the data collection tool, ask about abuse in
a non-judgmental way, preserve confidentiality, recognise possible
negative reactions and respond properly. During the data collection
process, the responsible researcher debriefed the team of interviewers weekly.

The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) Child Abuse Screening Tool for Children (ICAST-C) was used for data collection. ISPCAN has been working together with Unicef in developing three questionnaires, one for parents (ICAST-P), one for young adults (ICAST-R) and the other for children (ICAST-C) since 2004. ICAST-C was updated in 2014 and made into a single tool by combining the previously used Institutional and Home versions (Runyan et al., 2015). It has been successfully serving as a common tool to measure the prevalence of different forms of CM globally, where it is possible to compare CM data across cultures, time or between research groups.

There are several well-performed studies globally using ICAST-C (Al-Eissa et al., 2016; Kumar et al., 2017; Ribeiro, et al., 2015). In the Asian context, this tool was found reliable and valid in different cultural settings (Chang, et al., 2013; Usta, Farver, & Danachi, 2013).

In the socio-cultural context of Bangladesh, 17 questions of ICAST-C were found related to CPA, 19 questions to psychological abuse (PsyA) and 6 questions to neglect. These questions were posed to the respondents with reference to the past year. All questions had multiple choice responses: “once a week or more often” (≥7 times a week), “several times a month” (2-3 times a month), “about once a month” (6-12 times/year), “several times a year” (3-5 times/year), “once or twice a year” (1-2 times/times), “not in the past year, but it has happened before”, “never in my life” and “no answer”. The children were asked to select only one of these options. If the children would respond positively, they were asked to identify the offender as “adult male”, “adult female”, “child/adolescent male”, and “child/adolescent female”. In this study, only adult offenders were considered. Besides, the participants were asked about their safety feeling, bullying and family violence.

Further, the participant’s living situation, birth order, educational status, marital status, occupation, parental education level and household assets such as table, chair, watch, computer, electricity supply, refrigerator, television, radio, mobile phone, bicycle and air conditioners were collected. These questions followed the original ICAST-C questionnaire and all additional questions were numbered in a distinct way.
The original English ICAST-C tool was translated into Bengali and back-translated for comparison where standard translation procedure was followed. The Bengali version was tested on two male and two female children aged 11-17 years and was found understandable. Focus Group Discussions (FGDs) with professionals, rural parents, male and female children aged 11-17 years were organised to sensitise the vocabulary and thinking patterns of the population and accustom with the content area of the study as suggested in ICAST manual. The FGDs were audiotaped, transcribed verbatim and necessary modifications were made in the data collection tool. The ICAST-C tool was finalised after pre-testing and 17 children outside the study area aged 11-17 years were interviewed in this regard.

An interviewer manual was developed in the local language to be used for implementation of the study with attention to consent, ethics, data collection technique in electronic devises and training.

The questionnaire was designed in REDCap (Research Electronic Data Capture), a web-based, secure, reliable free software application designed for collecting and managing research data, developed at Vanderbilt University (Harris et al., 2009). The collected data were exported to SPSS version 24 for analysis.

**Data analysis**

Any abusive form of CPA, CPsyA or neglect occurring in the past year was counted as 1, if any of the following: “once a week or more often”, “several times a month”, “about once a month”, “several times a year”, and “once or twice a year”, was reported. The lifetime exposure was counted as 1 if any of the above response or “not in the past year, but it has happened”, was reported (Study III and IV).

The past year prevalence and lifetime prevalence were estimated as the proportion of children who have experienced maltreatment during the past year and during their lifetime respectively. The past year prevalence rate was calculated by dichotomizing all forms of abuse based on any vs. no exposure in the past one year. For lifetime prevalence, forms were dichotomized based on any vs. no exposure in the past year or ever. Prevalence was shown in percentage with 95 percent confidence interval (CI).

All 17 forms of CPA were categorised into “frequent” (≥3 occurrences/year) and “none to less frequent” (none to ≤2 occurrences
/year) groups. The “frequent” category was based on the following responses: “once a week or more often”, or “several times a month”, or “about once a month”, or “several times a year”, and “none to less frequent” category was based on the followings “once or twice a year”, “not in the past year, but it has happened before” or “never in my life” (Study III).

Further, a seven-point scoring system for all questions related to PsyA and neglect was developed (1=never in my life, 2=not in the past year, but it happened before, 3=once or twice a year, 4=several times a year, 5=about once a month, 6=several times a month, 7=once a week or more often) to estimate the PsyA and neglect scores. Total scores of PsyM and neglect were produced by adding the scores of all 19 items of PsyA and 6 items of neglect respectively. The score range of PsyA was 19-133 and neglect was 6-42 (Study IV). This type of scoring system has been used in a previous study (Lakhdir et al., 2017).

Descriptive analysis was performed on participants’ socio-demographic variables, family characteristics and family violence. Frequency and percentage were calculated as summary measures for the categorical variables, arithmetic mean and the standard deviation was used to describe the continuous variables.

Principal component analysis (PCA) was adopted to construct wealth index based on household assets as described by Filmer and Pritchett (2001).

To identify independent risk factors (expressed in adjusted OR) for the occurrence of “frequent” CPA, independent variables that demonstrated a significant (p<.05) risk factor (expressed in crude OR) in the bivariate model, were selected for further analysis in a binary logistic regression model. In this regard, all significant variables among gender, age, education, living arrangement, safety feeling at home, parental education, socio-economic status (SES) based on wealth index, bullying by siblings and witnessing family violence among adults like shouting, physical violence and using weapons, were entered simultaneously in the adjusted model (Study III). Full models for containing all predictors were statistically significant, indicating that the model was able to distinguish between respondents who experienced and did not experience frequent CPA (≥1 forms) \( \chi^2 (10, 1416) =114.55, p<0.001 \), and who experienced and did not experience frequent CPA (≥2 forms), \( \chi^2 (11, 967) =151.07, p<0.001 \).
Multivariate linear regression analysis was used to determine to what extent the independent variables explained neglect and PsyA, and which variables were the most important explaining factors. Child PsyA scores and neglect scores were considered as outcome variables. Explanatory variables included: age of the child, occupation, marital status, years of schooling, living arrangement, number of children in the family, safety feeling at home, parental education, SES based on a wealth index, bullied by siblings and witnessed family violence among adults included shouting, physical violence and use of weapons. All explanatory variables that showed a significant (p<.05) association with outcome variables were entered into regression model. These associations were evaluated by the Pearson correlation coefficient, independent t-test and one-way ANOVA. Our sample size was large and acceptable for regression analysis. No multicollinearity among variables was seen (correlation under .6; Tolerance-values .489-.961; VIF-values 1.04-2.044). Normal P-P Plot of regression standardized residuals of the dependent variable was acceptable (Study IV).

Data were analysed using SPSS for Windows, Version 24.0. A p-value less than 0.05 was considered as a level of significance.

12.4 Ethical considerations

To gather data on children’s experiences of CM is a sensitive issue with ethical and methodological challenges (Study I, III and IV). The sensitivity of the research subject and the safety of the interviewees have to be taken into consideration during the recruitment of interviewees, the consent to participate and the participation itself (Brinkmann & Kvale, 2015). There has been a reluctance to ask children directly about potential experiences of CM for fear of awakening unpleasant memories and causing distress. Few studies though have found any evidence of negative mental health consequences (DePrince & Freyd, 2004). It is also of importance that all the interviewers who take part in the research have basic training in ethical matters, which was included in the preparatory training of interviewers. In addition, the interviewer ended every interview by asking how the child felt and the children were encouraged to talk to a person they trusted, if the interview led to any unpleasant feeling (Study I, III, IV).
A possible positive aspect of taking part is, that the children can get the opportunity to express their views and experiences of the matter. Researchers also consider asking children to self-report their experiences of CM using tools as the ICAST-C as a valuable method for assessing CM, since they are considered to provide more accurate estimates than reports by caregivers or other third parties (Stoltenborg et al. 2011; Devries et al., 2015). The recruitment of respondents is facilitated and is justified if the study is aimed at promoting health within the group the child represents (World Medical Association, 2013).

Important issue when children are interviewed is the developmental capacity of children to understand the questions being asked and their ability to provide informed consent for participation in research. Before a decision of the age of the informants was made for studies I, III and IV such discussions took place within the research group.

By ensuring that participation was voluntary, they had the right to withdraw from the study at any time, and they could leave out questions they did not want to respond to the risk of discomfort feelings can be considered to be minimized.

A three-tiered consent process was followed during the data collection: First, it was the ethical application followed by permission, then consent from parents and assent from children. Parents were duly informed that the survey was about violence against children and included some sensitive questions, which might upset their children. They were also informed that they had the opportunity to withdraw their children from the survey at any time or not to give permission to participate (Study I, III, IV).

It is an assumption that it is complicated to obtain consent from abusive parents for their child’s participation in research, as there is fear of disclosing parents’ abusive behaviour. However, obstacles were not faced to obtain informed consent (Study I, III and IV).

There is no consensus in the literature about the benefit of reporting child abuse cases where reporting is not mandatory by law (Devries et al., 2015). It is often argued that in cases when it is unclear that the reporting of the abusive events would be beneficial, the principle of confidentiality and autonomy should precede. On the other hand, in cases where reporting is mandatory by a legal environment, there are arguments that the reporting should be ethically bounded by the principle of beneficence and that the disclosure would bring out positive
outcomes to the child rather than making them stigmatised (Devries et al., 2015). In Bangladesh, physical punishment of children is common and the law enforcement to protect children is weak. Since it is not clear that reporting would improve outcomes and also given the sensitive nature of CM and the issue of confidentiality, the research team decided not to report any child abuse they could come across (Study I, III, IV). This decision is in line with ethical principles given by Unicef (CP MERG, 2012).

In Study II news media-reported CM stories were analysed to assess types of CM and characteristics of victims and perpetrators. The area of research was newspaper reports with public and open access. The population was not human subjects although individuals were mentioned in the articles. This type of research does not require formal ethical clearance.

Ethical permissions were taken from the Ethical Review Board of CIPRB (Study I: Memo no. CIPRB/ERC/2013/01, for Study III and IV: Memo no. CIPRB/ERC/2016/1) and from the Institutional Review Board of BSMMU (memo number: BSMMU/2017/3228 (A) for Study III and IV). Ethical permission was also obtained from the Regional Ethical Review Board in Uppsala, Uppsala University, Sweden (Dnr 2016/520, Regionala etikprövningsnämnden i Uppsala) for paper III and IV.

13. SUMMARY OF RESULTS

13.1 Study I

The study explored the understanding of CM in Bangladeshi local context and children’s subordination emerged as the main theme in the analysis. The theme pervaded into the five categories: 1) Perception of children’s situation in society, 2) Understanding children’s development and needs, 3) CM associated to school achievement, 4) Negative impact of child maltreatment, and 5) Emotional responses (see Table 4). In addition, the study developed two to four subcategories. The subcategories were developed from the codes generated from the stories narrated by the children.
CM was a common and painful experience with serious physical and emotional consequences but was found accepted by the society. Young children, girls, and children from poor families were found as vulnerable groups to CM. The children’s voices were not heard due to their low status in their families, schools and working places. This constituted the main theme: Children’s subordination (see Table 4). We did not see any obvious differences in perception and experiences of CM between the urban and the rural children.
Table 4: Presentation of the main theme, categories and subcategories.

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Children’s subordination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Categories</strong></td>
<td></td>
</tr>
<tr>
<td>1. Perception of children’s situation in society</td>
<td>2. Understanding children’s development and needs</td>
</tr>
<tr>
<td>3. CM associated to school achievement</td>
<td>4. Negative impact of child maltreatment</td>
</tr>
<tr>
<td><strong>Subcategories</strong></td>
<td></td>
</tr>
<tr>
<td>CM as a common experience</td>
<td>Role of playing</td>
</tr>
<tr>
<td>Consequences of poverty</td>
<td>CM at school</td>
</tr>
<tr>
<td>Exploitation at work</td>
<td>Lack of protection</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Negative feelings</td>
</tr>
<tr>
<td>Views/hopes for good parenting</td>
<td>Teacher’s belief in beating</td>
</tr>
<tr>
<td>Views/hopes for good teaching</td>
<td>Exertion of power</td>
</tr>
<tr>
<td>Ambivalence towards punishment</td>
<td>Ambivalence education/unfriendly school environment</td>
</tr>
<tr>
<td>Ambivalence towards punishment</td>
<td>Intergenerational transmission</td>
</tr>
</tbody>
</table>
13.2 Study II

In total 1052 news articles related to CM were collected from six national newspapers and 790 articles were analysed due to duplicates. The results showed that approximately twelve articles focusing on CM were published daily during the study period, which estimates around two articles per day in each sampled newspaper. The most common type of CM covered in the news articles was physical abuse (26%) closely followed by sexual abuse (22%) and neglect (17%).

Further, among the 151 articles where multiple types of maltreatment were mentioned, of which sexual abuse counted for 34 percent and physical abuse for 32 percent. Thus, these two types of CM were the dominating types of maltreatment reported in the daily newspapers. Emotional abuse and verbal abuse were seldom reported (0.9% and 0.6% respectively).

Approximately 32 percent of the abuse cases had resulted in death and most of them reportedly due to physical abuse (57%). Some of the fatal cases were related to sexual harassment, rape, dowry, family violence, abduction and ransom demand, and parental rebuking. Almost half of the victims of physical abuse were male while 90 percent victims of sexual abuse were female. About three fourths of the victims were below 13 years of age. The mean age of the alleged perpetrators was 29 years. Victim’s identity (name and/or address) was reported in about 40 percent of the news articles. Further, a total of 13 percent of the articles concerning sexual abuse, the identity of the victims was disclosed and of them 91 percent were females. A total of 63 percent of the news articles reported the alleged perpetrator’s gender, of them more than 90 percent were males. In 58 percent of the articles on sexual abuse and in 50 percent of the articles on physical abuse perpetrators were identified and reported.

Only in 3 percent of the articles, mostly in editorials, the societal consequences of CM or how CM could be prevented were discussed. In some news articles, it was reported raped girls committed suicide. The percentage distribution of different types of CM is presented in Table 5.
Table 5 Percentage distribution of different types of child maltreatment with or without fatal consequences.

<table>
<thead>
<tr>
<th>Types of child maltreatment</th>
<th>Total (N=790)</th>
<th>Abuse with fatal consequence (n=251)</th>
<th>Non-fatal abuse (n=539)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>25.7</td>
<td>57.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>22.2</td>
<td>4.8</td>
<td>30.2</td>
</tr>
<tr>
<td>Multiple type</td>
<td>19.1</td>
<td>23.1</td>
<td>17.3</td>
</tr>
<tr>
<td>Neglect</td>
<td>17.1</td>
<td>12.4</td>
<td>19.3</td>
</tr>
<tr>
<td>Child abuse in general</td>
<td>14.4</td>
<td>-</td>
<td>21.2</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>0.9</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>0.6</td>
<td>2.0</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

13.3 Study III

The study population consisted of 1,416 interviewed children aged 11 to 17 years. The median age was 14.4 years (14.5 for boys and 14.2 for girls). Most of the interviewed children were pupils (86%) at the time of the interview while more than 10 percent were working. Almost 12 percent of the interviewed children were married (10% girls, 1.7% boys).

The past year prevalence rates of at least one form, at least two forms, and three or more forms of CPA were about 93 percent, 79 percent, and 57 percent respectively, while these rates over the lifetime were 99 percent, 95 percent and 83 percent respectively.

Table 6 shows the percentage distribution of reported physical abuse experienced by children. Female children experienced severe forms of physical abuse like pulling hair, being shaken, choked, burned or scalded. Although male-female differences were statistically non-significant, female children were more subjected to other severe forms of physical abuse like kicked, beaten-up, and slapped in head or face.
Table 6 Percentage distribution of children’s reported experience of physical abuse by gender.

<table>
<thead>
<tr>
<th>Forms of abuse</th>
<th>Lifetime Total</th>
<th>Lifetime Female</th>
<th>Lifetime Male</th>
<th>Past year Total</th>
<th>Past year Female</th>
<th>Past year Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit elsewhere except on the buttocks with object</td>
<td>89.8</td>
<td>87.7</td>
<td>91.9*</td>
<td>78.0</td>
<td>75.8</td>
<td>80.2*</td>
</tr>
<tr>
<td>Slapped in head or face</td>
<td>78.2</td>
<td>78.3</td>
<td>78.2</td>
<td>56.1</td>
<td>55.1</td>
<td>57.0</td>
</tr>
<tr>
<td>Stand /kneel for punishment</td>
<td>74.1</td>
<td>71.9</td>
<td>76.2</td>
<td>60.6</td>
<td>58.0</td>
<td>63.1*</td>
</tr>
<tr>
<td>Ear twisted</td>
<td>39.8</td>
<td>25.9</td>
<td>53.0*</td>
<td>26.1</td>
<td>16.5</td>
<td>35.3*</td>
</tr>
<tr>
<td>Kicked</td>
<td>23.2</td>
<td>23.6</td>
<td>22.9</td>
<td>8.2</td>
<td>7.2</td>
<td>9.1</td>
</tr>
<tr>
<td>Hair pulled</td>
<td>22.5</td>
<td>26.1</td>
<td>19.1*</td>
<td>14.3</td>
<td>16.2</td>
<td>12.5*</td>
</tr>
<tr>
<td>Hit on the buttocks with object</td>
<td>18.4</td>
<td>13.3</td>
<td>23.3*</td>
<td>10.3</td>
<td>6.1</td>
<td>14.3*</td>
</tr>
<tr>
<td>Spanked</td>
<td>16.5</td>
<td>16.8</td>
<td>16.1</td>
<td>7.9</td>
<td>7.8</td>
<td>8.0</td>
</tr>
<tr>
<td>Shaken</td>
<td>15.7</td>
<td>18.0</td>
<td>13.6*</td>
<td>4.9</td>
<td>4.8</td>
<td>5.1</td>
</tr>
<tr>
<td>Hit on the head with knuckles</td>
<td>12.1</td>
<td>8.1</td>
<td>15.8*</td>
<td>6.4</td>
<td>4.2</td>
<td>8.4*</td>
</tr>
<tr>
<td>Choked</td>
<td>11.7</td>
<td>13.6</td>
<td>9.8*</td>
<td>0.6</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Locked up</td>
<td>8.7</td>
<td>4.9</td>
<td>12.3*</td>
<td>3.2</td>
<td>1.6</td>
<td>4.7*</td>
</tr>
<tr>
<td>“Beaten-up” repeatedly with object or fist</td>
<td>7.8</td>
<td>8.0</td>
<td>7.6</td>
<td>2.5</td>
<td>2.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Burned or scalded</td>
<td>4.6</td>
<td>7.2</td>
<td>2.1*</td>
<td>1.6</td>
<td>2.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Pinched in</td>
<td>4.5</td>
<td>5.5</td>
<td>3.6</td>
<td>3.5</td>
<td>4.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Given drugs or alcohol</td>
<td>0.4</td>
<td>-</td>
<td>0.8*</td>
<td>0.1</td>
<td>-</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*p-value <.05

Male children, younger age groups, witnessing adults using weapons at home, bullied by siblings and low level of maternal education were found to be significant risk factors for both at least 1 form and at least 2 forms of frequent CPA. In addition, adult shouting in a frightening
way was found as a significant risk factor for at least 2 forms of frequent CPA.

13.4 Study IV

The prevalence rates for psychological abuse were very high, and there were hardly any differences between the past year and lifetime experiences. Of the 1416 interviewees, 97.5 percent had experienced at least one form of psychological abuse during the past year and 98.4 percent had experiences over the lifetime. Despite lower rates in comparison, there were still higher rates for repeated forms of PsyA (three or more) during the past year (71.6%) and lifetime (85.9%). Experiences of PsyA showed no significant difference between girls and boys separately. The prevalence rates for neglect showed a kind of different pattern. At least one event experienced for the past year was 58.4 percent and 78.1 percent for lifetime. On the other hand, the rates for repeated events were lower. For the past year, the rate for repeated events (≥3) was 3.5 percent and for lifetime 16.3 percent. In addition, experiences of neglect showed very small differences between girls and boys separately and no statistically significant differences were found in this regard. The most commonly reported psychological abuse cases and neglect during the past year and the lifetime is shown in Table 7. Regarding psychological abuse, a significantly higher number of the female children was maltreated by calling them dumb or lazy, forbidding them from going out, and referring their skin colour/gender/religion or culture in a hurtful way. On the other hand, the male children were maltreated significantly more by being cursed, locked out of the home, and having their food taken away. The male children were significantly more neglected by keeping them hungry and/or thirsty than that of the female children.
Table 7 Percentage of past year and lifetime prevalence rates for each psychological abuse and neglect-related items in total.

<table>
<thead>
<tr>
<th>Psychological abuse</th>
<th>Past year</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forbidden from going out</td>
<td>76.0</td>
<td>81.4</td>
</tr>
<tr>
<td>Shouted, yelled or screamed at</td>
<td>66.7</td>
<td>73.2</td>
</tr>
<tr>
<td>Threatened to invoke harmful people, ghost or evil spirits against the child</td>
<td>42.7</td>
<td>65.5</td>
</tr>
<tr>
<td>Insulted by being called dumb, lazy</td>
<td>32.5</td>
<td>40.5</td>
</tr>
<tr>
<td>Threatened of being abandoned</td>
<td>25.2</td>
<td>37.8</td>
</tr>
<tr>
<td>Cursed</td>
<td>20.6</td>
<td>34.6</td>
</tr>
<tr>
<td>Privileges or money taken away</td>
<td>20.1</td>
<td>27.8</td>
</tr>
<tr>
<td>Embarrassed publicly</td>
<td>19.2</td>
<td>33.8</td>
</tr>
<tr>
<td>Food taken away</td>
<td>14.3</td>
<td>31.7</td>
</tr>
<tr>
<td>Locked out of the home</td>
<td>13.3</td>
<td>27.8</td>
</tr>
<tr>
<td>Ignored</td>
<td>11.0</td>
<td>21.0</td>
</tr>
<tr>
<td>Blamed for misfortune</td>
<td>9.3</td>
<td>23.7</td>
</tr>
<tr>
<td>Wish that the child had never been born, or were dead</td>
<td>6.4</td>
<td>19.6</td>
</tr>
<tr>
<td>Hurtful prejudiced (gender, skin colour, religion, and culture)</td>
<td>5.4</td>
<td>8.1</td>
</tr>
<tr>
<td>Stolen from or braking of belongings</td>
<td>4.7</td>
<td>10.5</td>
</tr>
<tr>
<td>Stopped from being with other children</td>
<td>4.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Threatened of being hurt or killed</td>
<td>3.7</td>
<td>6.4</td>
</tr>
<tr>
<td>Threatened with bad marks not deserved</td>
<td>3.5</td>
<td>8.3</td>
</tr>
<tr>
<td>Embarrassed the child because s/he is orphan</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet medical needs</td>
<td>41.1</td>
<td>55.8</td>
</tr>
<tr>
<td>Went hungry or thirsty</td>
<td>11.9</td>
<td>25.1</td>
</tr>
<tr>
<td>Inadequate clothing</td>
<td>10.5</td>
<td>16.1</td>
</tr>
<tr>
<td>Felt not cared for</td>
<td>5.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Hurt or injured due to inadequate supervision</td>
<td>5.2</td>
<td>15.4</td>
</tr>
<tr>
<td>Felt unimportant</td>
<td>4.9</td>
<td>16.8</td>
</tr>
</tbody>
</table>
Living separately from the parents posed children to significant high-risk levels of being neglected and psychologically abused. Being a working child and having a big number of siblings in a family were risk factors for neglect, whereas witnessing family violence and being bullied were risk factors for psychological abuse of children. It was found that education acts as a protective factor for not being neglected or abused psychologically. Children with more years of schooling experienced less neglect and psychological abuse. The mean scores of psychological abuse and neglect decreased by 6.1 percent and 7.4 percent respectively with the child’s each year academic promotion (p value < .05).

14. DISCUSSION

14.1 Results discussion

The present study shows that CM is frequently prevalent in Bangladesh. The common scenario of CM is also similar for other countries of South Asia. The little knowledge about CM in Bangladesh gathered earlier was mostly based on official reports or studies with weak methodologies and conducted in small populations. The studies incorporated in this thesis therefore contribute to the knowledge on CM in the Bangladeshi cultural context. The qualitative study (Study I) provides deepened knowledge about the child’s perspective of CM whereas the study on the newspaper content (Study II) reflects the societal perspective. These studies formed the base for the further quantitative studies (Study III and IV). The population-based survey conducted in this regard using a well-known and well-validated instrument with a sound methodology, makes these studies the first of this kind in Bangladesh. The studies found CM as a common and painful experience which leads to serious physical and emotional consequences, although highly accepted by the society. Children’s subordinate position in the social hierarchy hinders them to express themselves in the family, at school or working place (Study I). The societal reflection of CM was revealed in Study II which found CPA and sexual abuse as frequent forms of CM. Almost all children in Bangladesh are abused physically and psychologically. Neglect was, however, less reported (Study III and IV).
14.1.1 The high prevalence of child maltreatment in Bangladesh

CM is one of the most inevitable challenges to overcome to ensure child rights and child safety in Bangladesh. Results of the cross-sectional survey presented in this thesis (Study III and Study IV) show that physical and psychological abuse among rural children of Bangladesh is extremely prevalent. Almost every child has experienced either physical or psychological abuse during their lifetime. ICAST-C, an internationally well validated tool was used in the studies of this thesis which helps to bring comprehensive results of CM. Studies using this tool have also showed high prevalence rates of CM elsewhere in the world. However, the prevalence in the present studies are much higher than in most of the other studies across the world. Ribeiro et al. (2015) reported 85 percent and 62.5 percent prevalence rates of physical abuse and psychological abuse respectively among school-going children in Brazil using the ICAST tool. Kumar et al. (2017) found that 78.5 percent of the school-going children in Kerala, India, were physically abused, and 85 percent were psychologically abused during their lifetime. Similarly, 75 percent of the children in Saudi Arabia experienced psychological abuse and 58 percent experienced physical abuse in the past year (Al-Eissa et al., 2015).

High prevalence of CPA and PsyA have also been found in studies of other South Asian countries using other methodologies. The prevalence of CPA in other South Asian countries ranges from 38-80 percent (Kumar et al., 2017; de Zoysa, 2013; Central Statistics Organisation & Unicef 2012; Neupane et al., 2018; Planning & Development Department, Government of Gilgit-Baltistan & Unicef Pakistan, 2017; Unicef, 2018; Unicef Regional Office for South Asia, 2016), while PsyA ranges from 50-90 percent (de Zoysa, 2013; Wasif, 2018; Ashrafi, 2017; Kul-karni, 2016).

Stoltenborgh et al. (2013) stated that studies using multiple CM related questions tend to bring out the highest prevalence rates of CM and a high tolerance of CP in Asian culture might also lead to these higher rates. The comprehensive nature of the ICAST tool and the cultural acceptance of physical punishment to discipline children seems to have shown high prevalence of CPA and PsyA in the present studies. A
Southeast Asian study revealed that punishment is considered as an effective measure for managing children’s behaviour and helping them to become responsible adults (Beazley et al., 2006). According to a survey conducted by BLAST, every schoolteacher and around 70 percent of the parents endorsed CP as a useful tool to discipline children at school (Hasnat, 2017).

14.1.2 Children’s subordinate position

The prevalent and varied nature of CM against children in Bangladesh as found in the qualitative study of the present thesis (Study I) is probably the result of children’s subordinate status in the society, the power imbalance and the cultural acceptance regarding the use of CP. CM has also been found to have an association with unreasonable expectations of the child’s academic achievement. Power and trust in adult-child relationships in the society traditionally remain hierarchical in nature where the child belongs to a subordinate group and an adult holding the power exercises authority over the child. The child remains obliged to obey the power holder’s commands’ trusting that the powerful individual will protect their well-being (Velayo, 2006). Deb and Modak (2010) explained that the cultural influence and an elder’s domination over children are additional risk factors for CM in the Bengali society in Tripura, India.

14.1.3 Poverty and neglect

Study IV of this thesis revealed the prevalence of child neglect in Bangladesh. Although neglect is said to be the most prevalent form of CM as revealed by different empirical studies (Child Welfare Information Gateway, 2019b; Dubowitz, 2013, Dubowitz, Giardino, & Gustavson, 2000), the present study estimated lifetime prevalence of neglect as 78 percent, which is far less than the rates of CPA and PsyA. Using ICAST-C tool, Neupane et al. (2018) reported that approximately 45 percent of the Nepali children experienced neglect, while Charak and Koot (2014) employed Childhood Trauma Questionnaire in their study in In-
dia and found that approximately 60 percent of the children had experienced neglect. de Silva (2007) suggested that the countries of South Asia are slow to recognise neglect as CM where the Bangladeshi society is not an exception. In Bangladesh, child neglect has been overshadowed by different social factors, notably poverty. Child neglect is often defined as parental inability to provide basic needs, including health care, nutrition and safety, to their children (Dubowitz, 1993). Dubowitz et al. (2000) stated that families experiencing poverty are likely to fail to ensure basic needs and adequate supervision to children. The findings of comparatively low prevalence rates of neglect in this study may reflect the fact that the rural Bangladeshi families lack ensuring basic needs of their children due to poverty not considering it as child neglect. Neglect is yet to become a recognised concept in the local context of Bangladesh.

14.1.4 Child maltreatment reflected in news articles

The societal view of CM was reflected in the findings of Study II of this thesis. The most common type of CM covered in the news articles was physical abuse followed by sexual abuse. The accurate prevalence of CM cannot be estimated through media reports (Saint-Jacques, 2012) as newspapers do not report all types of abusive events. However, media studies have the strength in understanding what message is spread to the public about a social issue as news media has the power to influence the readers’ perception (Willis, Kim, & Willis, 2007).

The high proportion of child sexual abuse (CSA) coverage as found in our study (Study II) is similar to the analyses of newspaper coverage in different studies conducted in the United States (Hove et al., 2013), in Malaysia (Niner, Ahmad, & Cuthbert, 2013) and in the UK (Davies, O’Leary, & Read, 2015). CSA, mostly against girls, is widespread in the Bangladeshi society but obtaining reliable data in this regard is extremely difficult due to the culture of shame and social stigma (Fattah and Kabir, 2013). In Bangladesh, social practices emphasise the need to hide any source of shame (like CSA) which coerce victims and their family members to remain silent. As a result, the stories surfaced by news media may be just a hint of the real scenario. Low conviction rate
and out of court settlement might be causes of low disclosing or reporting rate (Naznin & Sharmin, 2005).

14.1.5 Risk factors

Findings from Study III and IV indicate that being a male child, belonging to a younger age group, having witnessed family violence, being bullied by siblings and a low level of maternal education were significant risk factors for CPA, whereas living separately from biological parents, family violence and being bullied by siblings were significant risk factors for child PsyA. Similar findings were also observed in studies conducted in other countries of South Asia and around the world (Lakhdir et al., 2017; Deb & Modak, 2010; Zolotor et al., 2009).

In Study IV, child neglect was found to be significantly associated with child work, living separated from biological parents and having greater number of siblings in a family. The study also found that children with higher education levels experienced less neglect. Öncü et al. (2013) found that children at workplaces are more vulnerable to experience all forms of CM. This is in line with the findings of Study I of the present thesis where working children faced all types of abuse and neglect. However, most parents seem to be aware of their children’s needs and do not neglect them intentionally (Dubowitz, 2013). Literature support that children living with a single parent or at foster care are neglected more often (Dufour et al., 2008). This is consistent with the study result (Study IV) which shows that children living with anyone else than their parent, were at increased risk of being neglected along with becoming psychologically abused.

The results of Study III suggest that boys experience significantly more physical abuse than girls, which is similar to findings of studies in China (Chen & Wei, 2011), Cyprus (Theoklitou, Kabitsis, & Kabitsi, 2012) and India (Deb & Modak, 2010). Further, the findings suggest that female children are subject to severe forms of physical abuse. Unicef (2008) revealed that girls in educational institutes of Bangladesh received less physical punishment (81%) than boys (98%). However, a world meta-analysis of Stoltenborgh et al. (2013) did not find gender differences for CM. One of the reasons behind more physical abuse against male children in the Bangladeshi society could be, that
there are more disciplinary problems with boys than with female children. Boys are presumed to respond better to physical than verbal intimidation as reported by Benbenishty, Zeira, and Astor (2002).

### 14.1.6 Family violence

Study III and IV both acknowledge that CM and family violence co-exist among the rural families in Bangladesh. The co-occurrence of CM and family violence might be adult’s intentions to coerce, control and create fear within a family relationship significantly affecting family harmony (Chen & Wei, 2011). Perpetrators of family violence use a range of violent and controlling behaviours including physical, sexual and psychological abuse, abusing children to control their spouse, financial exploitation and social isolation (Government of Western Australia & Department for Child Protection and Family Support, 2005). The estimated risk factors for CPA, PsyA and neglect of the present studies have addressed two levels of Belsky’s ecological model, i.e. individual level (gender, age, and parental educational level) and family level (different types of family violence and history of being bullied by siblings) (Belsky, 1980). In accordance with this model, it is expected that societal and cultural factors at the macro-system level also have significant associations with the high rate of CM in Bangladesh.

### 14.1.7 Domestic work and maltreatment of girls

Some 420,000 children in Bangladesh, mostly girls aged 6 to 17 years old, are domestic workers (Mohajan, 2014). The majority of these working children are from impoverished rural families, who have migrated to urban areas. Indiscriminate violation of their rights is frequently reported in media. The girls often experience severe forms of inhumane physical torture like being hit in the head against the wall, burnt by lit cigarettes or hot metal objects, severely beaten by sticks or metal rods (Huda, 2017). This aligns with the findings of Study III, where female children were more severely abused than male children.
14.1.8 A violent, poor and disaster-prone society

Bangladesh got its independence from Pakistan in 1971 after a violent war in which some three million people were claimed to have been killed and 0.2 million women raped (Mookherjee, 2006). Since its independence, Bangladesh witnessed violence between political parties and government forces, while extra-judicial killings are frequently reported in the media. A new dimension of violence was added by several incidents of violent attacks in 2016 against secular writers and bloggers, academics, foreigners, gay rights activists and religious minorities. Moreover, almost every day there are reports in the national dailies of several violent cases with fatal consequences as found in Study II.

Thousands of people in Bangladesh die every year as a result of natural calamities, while millions are affected by arsenic contamination. This violent and disaster-prone society with high rates of poverty, IPV and violence against women contributes to increased level of stress on the whole family resulting to potentiate CM in a larger scale (Cicchetti et al., 2000). Bangladesh also holds an uneven record of human rights violations with its colonial experience, violent post-colonial and post-independent past. Thus, the people are accustomed to witnessing violence and this tolerance may be a contributing factor to the high prevalence of CM.

Bangladesh is one of the most densely populated countries in the world with a population of 163 million where approximately 41 percent are children (World Population Review, 2019). As a developing country of South Asia, Bangladesh has made significant contributions in poverty reduction, lowering the prevalence of underweight children, increasing primary school enrolment, lowering the infant mortality rate and maternal mortality ratio, and improving life expectancy at birth over the last decade (UNDP, 2018; General Economics Division, 2015). Despite this progress, it is reported that Bangladesh fails to ensure child rights in most domains and children are exposed to several forms of maltreatment at home, in the workplace, in educational institutions and other places as shown in the current study (Study I). Moreover, Bangladesh
has high rates of child marriage. Children are also victims of child labour and trafficking, both of which are treated as the most severe forms of child exploitation in the world.

14.1.9 Child rights

Although Bangladesh signed the UNCRC in 1990, little development has been achieved in ensuring child rights over the years. The National Children Policy 2011 and Children Act 2013 of Bangladesh have provisions for legal protection of children against violence, but CP is still lawful at home, alternative care settings, and penal institutions (Global initiative to end all corporal punishment of children, 2018). In 2010, the Supreme Court of Bangladesh gave a ruling to ban CP in schools, but this ruling is yet to be confirmed in legislation. The occurrence of CP at school was also shown in the results from Study I, where the children interviewed reported witnessing and experiencing severe punishments at school as well as at home and at working places. Even if the government of Bangladesh has made commitments at different international forums to ban CP against children in all settings including home, this is yet to be realised.

Beside this, family crises and stressful circumstances resulting from financial hardship might lead to violence across family dyads (Smith Slep & O’Leary, 2001; Stith et al., 2009). The rate of poverty is considered high in rural areas as approximately 35 percent of the people live under the poverty line ($2USD). In addition, high unemployment and underemployment rates, low standard of living, scarcity of health care facilities and lack of job opportunities make the rural people to live a stressful life (Ministry of Planning & Bangladesh Bureau of Statistics, 2011; Rezvi, 2017).

Since independence, the Bangladesh government has endorsed several laws and acts to promote child rights but as the results from the studies indicate with little implementation and awareness among the population. After the ratification of UNCRC in 1990, the government took more than two decades to promulgate a child act in 2013. The government is yet to enact laws banning CP and CM to ensure child rights and wellbeing.
CP is used to discipline children, but it repeatedly violates children’s rights to personal integrity, human dignity and protection from all forms of violence as guaranteed under CRC. The Convention states that the elimination of CP is a “key strategy for reducing and preventing all forms of violence”. In this aspect, prohibition of CP in Bangladesh might help to protect children from harm and support their social development. Legal bans on corporal punishment are closely associated with decreases in support of and use of CP as a child disciplining technique. Elgar et al. (2018) found an association between CP bans and decreased adolescent violence in a multi-country ecological study. Social learning theory partially explain this association as children and adolescents learn from being punished that physical violence is a measure of settling conflicts. This explains the intergenerational transmission of abuse from early childhood experiences to later violent behaviour. In Study I, children also acknowledged this intergenerational transmission of abusive behaviour.

Meanwhile, multi-year trend data on CP revealed that the rate of CP decline prior to the ban on CP and continue to decline after the ban (Janson, Svensson & Långberg, 2011). This brings the idea that legislative ban of CP does not solely rely in decreasing CP but is part of a dynamic national cultural background. Enough support from the public is needed for the lawmakers in order to ban CP. Legal bans can then be used to push the public sentiment as long as there is sufficient momentum. Thus, only banning is not enough to prevent CP. For instance, the Delhi High Court of India issued a decision stating that CP should be outlawed in schools in 2000. However, even after declaring the CP outlaw, 99 percent of Indian students either witnessed or experienced CP ten years after the ban (Tiwari, 2019). In Sweden, before banning CP in 1979, a declining trend of both CP and positive attitude toward CP was observed and this decline continued after the ban (Janson, 2019).

14.1.10 Child sexual abuse

Several acts of Bangladeshi laws have provision of tough punishment and even capital punishment against sexual abuse. However, these legal provisions are not enough to protect children and women from being sexually abused which can be seen from our results. The existing
legal system giving support to a sexually abused victim has obviously several loopholes. The Bangladesh Penal Code promulgated in 1860 during the British colonial period and its section 375 defines rape as sexual intercourse by a man with a woman without her consent and when consent is obtained through fraud, threat of hurt or death. This definition has mostly remained unchanged. The existing definition of rape is far too narrow, hinders access to justice and excludes men, boys and transgendered persons. There is also no provision for marital rape. The Prevention of Oppression against Women and Children Act of 2000 upgraded the punishment for rape without upgrading this inappropriate and gender-biased definition. Besides, a victim seems to be dishonoured as the section 155 (4) of the “Evidence Act, 1872” might consider a raped female of having an immoral character (Surur & Chaity, 2017).

In the social context of Bangladesh, a girl who is raped is stamped as a “dhorshita” meaning the woman who was raped. This stereotype is a humiliating tag on the victim (Sourav, 2017). At times, the social pressure on the victim is so intense and serious, and a recent study revealed that less than two percent of the women report rape or any other sexual assault (Ariff, 2017). Besides, the conviction rate of rape cases is less than one percent and such low conviction rates are mostly due to lack of evidence, undue influence of perpetrators to the authority, out of court settlements, reluctance of the police to record rape cases and the existence of Section 155 (4) of the Evidence Act, which favours the rapists (Surur & Chaity, 2017). The number of cases settled outside the courts is 10 times more than the cases filed. A few cases, especially in rural areas, are settled by village arbitration like “Shalish”, where the girls usually do not get guarantee of proper justice. Shalish is a Bengali practice based on patriarchal beliefs about gender roles, which is deeply rooted with informal dispute resolution mechanisms of Bangladesh (Khair et al., 2002). These reports are aligned with the findings of our study, where female children were found to be illegally punished by Shalish (Study II) and a female child left her residence due to shame and lived elsewhere after being sexually harassed at the workplace (Study I).

Therefore, in order to ensure child protection from sexual abuse, the existing legal framework of the country needs to be amended and proper support needs to be given to the victim. Social awareness should
be built in order to support the rape victims to prevent social stigmatisation. Addressing procedural barriers to accessing justice for raped persons, redressing rape by ensuring punishment, deterrence, and reparation are steps to be taken to ensure child protection from sexual abuse.

14.2 Methods discussion

14.2.1 Strengths of the study

A major strength of the studies was that it directly reached out to the children and brought in their voices (Study I, III and IV). Although the studies presented in this thesis focused on different objectives, it was unique in nature because of the existence of methodological interconnectedness among them.

Most of the people of Bangladesh live in rural areas and these areas have almost similar lifestyles. Study III and IV were conducted in a rural setting of Bangladesh, while Study II covered stories from all over the country. So, the result of these studies can be considered generalised for the whole population of Bangladesh.

In Study I, the latent content of the text was also analysed along with the manifest content in order to decrease the risk of reliability threat. Physical punishment is an accepted disciplinary measure in child upbringing by caregivers in Bangladesh. Revealing and talking about this matter has not been a taboo (Study I, III and IV).

The participants for Study III and IV were obtained from a rural injury-based surveillance area where every individual had a unique identification number. Based on these identification numbers, a simple random sampling procedure was employed to collect data. The study thus worked with a large sample size, which was a strength. Moreover, software-based data collection helped to keep the missing data negligible. The high response rate in Study III and IV was also a strength of the study.

The use of internationally validated ICAST-C tool was challenging but much worthy to assess CM in a low-income country context like Bangladesh. Its comprehensive nature allowed respondents to respond to
the various forms of abuse culminating in a high prevalence of both CPA and PsyA in Study III and IV.

The sampled six newspapers of Study II covered approximately 25 percent of the total nation-wide daily circulations (Department of Film and Publication, 2014).

Confidentiality was maintained with no identifying information on the questionnaire and keeping the data restricted for all other than the members of the research team, which was a strength of these studies (Study I, III & IV). All data collectors got training about how to debrief the children in case of emotional upsetting questions, but no psychological upsetting situation during the data collection was faced.

14.2.2 Limitations of the study

There were several limitations while conducting the studies presented in this thesis. The data collection methods used in these studies were retrospective in nature. When we collected the data on the occurrence of maltreatment, there might have been chances to arise recall bias (Study I, III, IV). However, it is known that memories of incidents that raise strong emotions are well kept in mind (Gilbert et al., 2009). Responses of the study might have implied social desirability bias due to the sensitive nature of the questions used in the data collection (Study I, III, IV). In the Bangladeshi local context, children seemed to have difficulties in understanding the neglect questions of ICAST tool, which might have caused response bias (Study IV). The ICAST-C tool used in this study was too insensitive to measure neglect in a country like Bangladesh, where most of the population live in poverty. Therefore, considering this context, this tool needs to be updated.

Interview studies often face risks of reliability when only the verbal meaning is included (Jeffner, 1997). However, in Study I, the latent meaning (Graneheim & Lundman, 2004) was also analysed to decrease such a risk.

In Study II, only six newspapers were selected which may not represent all national dailies and the selection of only three months’ news might have limited the generalisability of the findings (Study II). Moreover, a lottery method was employed to exclude duplicate news stories without
considering the news content. Therefore, some background information regarding the perpetrators and victims might have been missed (Study II).

In Study I, III and IV the data were collected in an isolated place for ethical reasons, but absolute confidentiality was not always possible to maintain due to overcrowding surroundings and parental interference in the interview. Inclusion of parents in consent taking procedure of these studies meant limited control over how the study initially was presented to the child, posing a problem of external influence (Study I, III, IV).

The data on the prevalence of CM were collected in a cross-sectional study and can therefore only indicate potential associations between CM and other demographic and socio-contextual variables which cannot provide evidence of cause and effect relationships (Study III, IV).

15. CONCLUSION

All the studies presented in this thesis revealed that Bangladesh is highly burdened with CM, but this issue is poorly managed. The interview study revealed that CM is a common and painful experience with serious physical and emotional consequences for the children. However, CM is highly accepted by parents, schoolteachers, and employers of Bangladesh. The children’s subordinate position in the society was found as the circumstantial cause of maltreatment. Despite the prevalent nature of CM in the Bangladeshi society, the media tend to report physical and sexual abuse more, while neglect and emotional abuse get less coverage. Finally, the cross-sectional survey revealed extremely high prevalence of physical and psychological abuse but neglect as a less addressed issue in the Bangladeshi rural society.

16. POLICY IMPLICATIONS

The result shows that almost every child in Bangladesh experienced CM. However, there are practically few initiatives to curb this highly
concerning issue from the government. Moreover, CM is considered as a medical, legal or criminological issue in the Bangladeshi society, which fails to emphasise its short- and long-term negative health effects. Considering CM as a public health priority, a policy should be adopted to protect children from any kind of CM which complies with the 1990 ratification of CRC, where Bangladesh is committed to ensure child health, safety and wellbeing. A public health approach to protect children from CM should be chosen to ensure maximum protection of children from harm.

Awareness campaigns should be taken to improve adults’ attitudes and practices towards CM, where the civil society, NGOs and developing partners like WHO, World Bank, Unicef and others may play a significant role.

Several risk factors of CM are revealed in this study, which might help researchers to adopt and evaluate intervention programs, and policymakers to enact protective laws and implementing programs. Education has been found as a protective factor for CM, so the government should ensure quality education for all children.

Steps should be taken for poverty alleviation and the government needs to extend its support to families with maltreated children. The high levels of CM make it imperative for the Bangladeshi society to install and enforce a CM ban at schools, homes and workplaces. A regular track on the prevalence of different forms of CM needs to be kept.

A political consensus is needed for implication of protective law and the government should speed up banning CM. Programmes should be taken to make people understand the obvious connection between family violence and CM.

According to CRC, all signatory states are committed to prohibit early child marriage and child labour, which should be implemented in Bangladesh the soonest.

The medical curriculum of Bangladesh covers little information about CM. Thus, a revision is needed to include this important public health issue. Besides, the government should take initiatives to educate professionals like teachers, law enforcers, journalists, etc. about the detrimental health and developmental consequences of CM.

Sweden is a welfare state and is regarded as a benchmark country in preventing CM. In the last few decades, there has been a radical change in child rearing practices in Sweden with a gradual decline of parental
practice of CP along with an increase of negative attitudes towards CP practices (Jernbro and Janson, 2017). This attitudinal and behavioural changes in parents along with the banning of CP in 1979 helped Sweden to reduce CM remarkably. In this regard, collaboration experiences with Sweden will help improving child rights situation and the CM scenario in Bangladesh.

17. FUTURE RESEARCH

Our study findings put forward some key questions for further research.
In the thesis, we explored children’s experiences of and perceptions on CM. So, additional research can be carried out to explore the adult’s/caregiver’s experiences of and perceptions on CM in the Bangladeshi context.
To prevent CM, a public health approach is an effective measure. In order to develop a public health model of CM prevention, we need to know the prevalence and risk factors of CM across the country. Besides, periodic follow up studies can be conducted to analyse the trend of CM prevalence and its risk factors.
A culturally accepted public health prevention model needs to be formulated and tested to prevent CM in Bangladesh.
The finding of the population-based survey presented in this thesis failed to address child neglect properly. So, a neglect questionnaire needs to be developed in order to measure the prevalence of neglect in a poor-resource setting country like Bangladesh.
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Child Maltreatment in Bangladesh

Like most low and middle-income countries, Bangladesh have no prevalence data on Child Maltreatment (CM) and lack a reporting system. The overall aims of the thesis were to generate knowledge on CM in the Bangladeshi society and to estimate the prevalence and associated risk factors.

The thesis is based on four studies. An explorative interview study to get children’s views on CM was the first study. A systematic analysis of newspaper content was then performed to get a societal picture of CM. The first two studies generated new research questions for the two successive studies. Study III and IV were population based cross-sectional surveys. The results show that CM was a common and painful experience with serious physical and emotional consequences but highly accepted by the society (Study I). Boys were victims of physical abuse to a higher degree, while girls were reported as victims of sexual abuse. One third of the newspaper reported cases resulted in death. The identity of the victims was often disclosed (Study II). Almost every child in Bangladesh has experienced either physical or psychological abuse. Neglect was less reported (Study III and IV). The studies incorporated in this thesis contribute to the knowledge on CM in the Bangladeshi cultural context.