# Participative Model of Child Protection in Northern Thailand

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**Abstract:** This community-based, participatory research was undertaken with the aim to develop a model for promoting child protection in Northern Thailand. Semi-structured interviews, focus group discussions, participant activities and observations, group meetings and brainstorming were conducted among children, parents, villagers and key community leaders of one rural community in Chiang Mai province, Thailand. Content analysis was utilized for analyzing qualitative data.

The model demonstrated three levels of protective factors for child protection. At the individual level, both children and parents needed to be equipped with the skills and knowledge of child protection. At the family level, the focus was on promoting family warmth and applying sufficient economy. At the community level, the emphasis was on promoting public awareness, encouraging a child protection network, and developing a community child protection master plan. Community mobilization supported the sense of belonging and sustainability of the project.

The participation evaluation indicated change outcomes in terms of more network interest, raising public awareness, improving capacity, disseminating knowledge, and committing and implementing community child protection policy. The study outlines implications for nursing research, education and practice regarding child protection. Culturally appropriate activities and programs also were encouraged.

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**Key words:** child protection, participative model, Northern Thailand

## Background and Significance

Children have rights to special protection because of their powerlessness against maltreatment. The United Nations (UN) Convention on the Rights of the Child (CRC), to which Thailand became a signatory, addresses survival, protection, development and participation rights.[1] Child protection refers to protecting children from violence, exploitation, abuse and neglect.[1, 2] Violations of children's rights to protection are massive, under-recognized and underreported obstacles to child survival and development. According to the World Health Organization's (WHO) Global Burden of Disease, some 875,000 children and adolescents, under the age of 18 years, died as result of an injury or violence in 2002.[3] Most child victims are abused by their parents.[4]

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In Thailand, the available statistics of child victims who need help has been increasing almost every year.[5, 6] The statistics from the Health Care Service Development Office, Ministry of Public Health,[7] revealed, in 2007, there were 19,068 cases of abuse, which involved women and children, for an average of approximately 52 cases of abuse daily. Of the child abuse cases reported between 2004 and 2007, the majority involved sexual abuse (60-70%), followed by physical abuse (20-30%), mental abuse (3-7%) and neglect (2-4%).

Review of the literature, regarding Western culture and Thai research, reveals child abuse prevention research has focused on improving a protective environment, parenting and children's life skills. Most of the studies have used a quasi-experimental design, when examining families at risk.[8, 9, 10, 11, 12] Although positive changes have been reported in most of the studies, limitations in design, including: small sample sizes, few common characteristics being evaluated among the studies, the use of similar methodology, and inadequate formal and rigorous evaluations have been noted. Therefore, the design of new studies should take these limitations into account.[11, 13] In addition, the impact of the findings from previous studies, on children's life skills and knowledge, remains unknown.[14]

Prevention is the priority, which also supports and advocates for mitigating the effects of abuse. The quasi-experiments and randomized control trials, which were examined, can neither be used to confirm nor refute questions about one's values or beliefs. The content of the studies also does not indicate how children and parents retained skills, learned during the studies, or maintain modified behaviors, if they were not supported within their own homes or communities. Additionally, child abuse is a problem, which is influenced by the norms, customs, values and beliefs of the people in a specific geographical area. Therefore, taking cultural and ecological context into account, encouraging participation from individuals within a specific community, encouraging general respect for the rights of the children and raising awareness that all forms of violence against children are taboo is needed.

Community Based Participatory Research (CBPR) increasingly has been applied in violence related fields, especially in child abuse prevention efforts.[15, 16] All reviewed studies confirmed the CBPR approach engaged local knowledge, and encouraged the enhancement of cultural relevance, on the respective issue under examination.[15, 16, 17, 18] In order to protect children from being abused, it would be helpful when trying to understand the perception of people, in a specific geographical area, regarding their cultural beliefs on child physical abuse and corporal punishment, to have accomplished a community based participatory assessment. This is significant since the concerns, beliefs, and cultural values and norms, mentioned by the community members, need to contribute to the development of proper child protection programs and activities that fit within the local culture.

Therefore, the purpose of this study was to develop a child protection model based on the participation of community members. The following questions were posed: How does the community participate in developing a culturally appropriate model of child protection? What is a culturally appropriate model of child protection in Northern Thailand?

## Method

Community Based Participatory Research (CBPR) was employed as the research method in this study. Motivation for this research arose from expressions of interest and concern regarding the issue by stakeholders in the Northern Thailand rural community used as the research setting.

**Sample:** Participants were: community leaders (Chief Executive of the Sub-district Administration Organization [SAO]; Community Abbot; Sub-district and Village Headman; Assistant Village Headman;

Chair of the Public Health Center; and, Director of the primary school in the community); community members, including a group of 10-13 year old children (both low and high risk) and their parents; local organization personnel, both formal and informal community leaders; and, other interested villagers. Also contributing to the study were volunteers of the Community Network on Child Protection committee (CNCP); child protection experts; and, two local research assistants.

**Research Instruments:** The primary instruments for data collection were personal interviews conducted by the primary researcher. In addition, the primary researcher provided interview guidelines for focus group discussions, semi-structured interviews and an observation guide. Tools included tape cassettes and tape-recorders. Two research assistants were trained regarding the data collection procedures, and provided assistance as note takers, facilitators and co-coordinators for the research activities, as well as interviews transcribers.

**Research Procedure:** The research procedure for model development was based on the concepts of Community Based Participatory Research (CBPR). The strategies used involved people, capacity building, taking culture into account, working partnerships, power sharing and community change. The free participation in the model development process, among the participants, generally, began with community preparation, problem identification, capacity building, planning, collaborative community assessment, and reflection and sharing of the findings. The desired child protection model was tailored via validation and review of child protection experts, and reflection and consensus among community members. This was followed with planning for implementation of a policy driven model, including participative evaluation for project monitoring and further improvement.

**Data Collection:** Data were collected via focus group discussions, semi-structured interviews, group and public meetings, brainstorming, participative activities, participative observation and field notes. The interviews lasted one and a half to two hours each. During each interview, note taking, clarification of questions and eliciting of elaboration of responses was accomplished by the primary researcher and research assistants. The primary researcher played the role of facilitator, consultant and participant observer when conducting group and public meetings, including group brainstorming sessions. Upon completion of data collection, the researcher reflected on the observations, interactions and discussions, impressions from the field notes, as well as transcribed the interviews verbatim from the audio tape-recordings.

**Trustworthiness:** To ensure trustworthiness of the study, criteria for developing an effective evaluation of qualitative research was employed.[19, 20, 21] Credibility of the study was established by prolonged engagement with the participants, triangulation of information from the multiple data sources, member checking and use of peer debriefing processes. Transferability of the study to other contexts was established by providing a data base with sufficient information and detailed descriptions of the means utilized. Dependability and conformability, in this study, were established by providing enough information and an audit trail.

**Data Analysis:** Data analysis of statements and opinions voiced by the target groups during the focus groups and semi-structured interviews was based on content analysis.[22] This process allowed the researcher to analyze and classify words and/or statements. Data then were interpreted for the induction analysis, so as to answer the research questions.

**Human Subjects Protection:** Prior to implementation, the study was approved by the Human Subjects Review Board of the Faculty of Nursing of the researcher's university. Informed consent was obtained from all participants. Data collection procedures were designed to cover all aspects of protecting the human subjects. Participants'

names were not disclosed, and all other information was kept confidential. The audio-tapes, from the interviews, were erased, and written transcripts were destroyed upon completion of the study.

## Results

**Team building:** The study began with introduction of child abuse issues to the community, and community discussion was encouraged regarding the situation, causes and consequences of child abuse. As a result, community awareness was raised and a community child protection team, comprised of volunteers, was established. They later were named the "Community Network on Child Protection committee" (CNCP). A team building activity then was conducted, to facilitate community members in getting to know each other and in learning to work together as a team.

**Need identification:** The model development process began with need identification from the CNCP and other community members. There was community concern that child abuse causes long-term negative consequences, both for individual children and society, as a whole. The CNCP and other community members, therefore, decided to instill prevention measures, rather than wait for serious cases to occur in the community. They equated protection measures to vaccines for communicable diseases, and expressed the belief the proverb 'spare the rod, spoil the child' should be adjusted and carefully applied for more appropriate child rearing practices. The participants stated:

> "Waiting for a case to happen is just like shutting the stable-door after the cow has been stolen" "Voey haey leaw loom koo (วัวหายแล้วล้อมคอก)"

> "Protection is the vaccine" "Kan pong kan preab sa muan kan ceet vaccine" (การป้องกันเปรียบเสมือนการฉีดวัคซีน)

**Problem Identification:** The child abuse situation analysis was suggested and the data collection methods were raised from individual observations or what is called "detective inquiry activity." Information was collected from the CNCP and focus groups, composed of children, parents and villagers. In addition, semi-structure interviews were conducted with key informants. Information for the situation analysis was gathered, by the researcher, research assistants and volunteers, from the CNCP.

Risk factors, suggesting the need for child abuse action in the community, included community conflict, social isolation, communication problems, pilfering, presence of gangs, broken families, family violence, alcohol abuse, stress, gambling, economic problems and materialism. It was determined that this was an at risk community (see **Figure 1**). Despite the presence of these risk factors, no indication of serious child abuse cases was found in the community.

**Model development:** The child protection concepts, gained during focus group discussions and semi-structured interviews, were used as the first draft for the community child protection model. This was then presented, to the community members during a public meeting, in order to get feedback and suggestions. The CNCP was given the responsibility of revising the model to more comprehensively reflect the community concerns. The model then was reviewed by external child protection experts, and presented to the community group for consensus. This resulted in the final draft of the primary prevention model for child protection in the community.

The child protection model emphasized participation among local organizations and community members, in order to protect children from all kinds of abuse. This included improved surveillance of children and families at risk. Details of the community child protection strategies are portrayed in **Figure 2.**

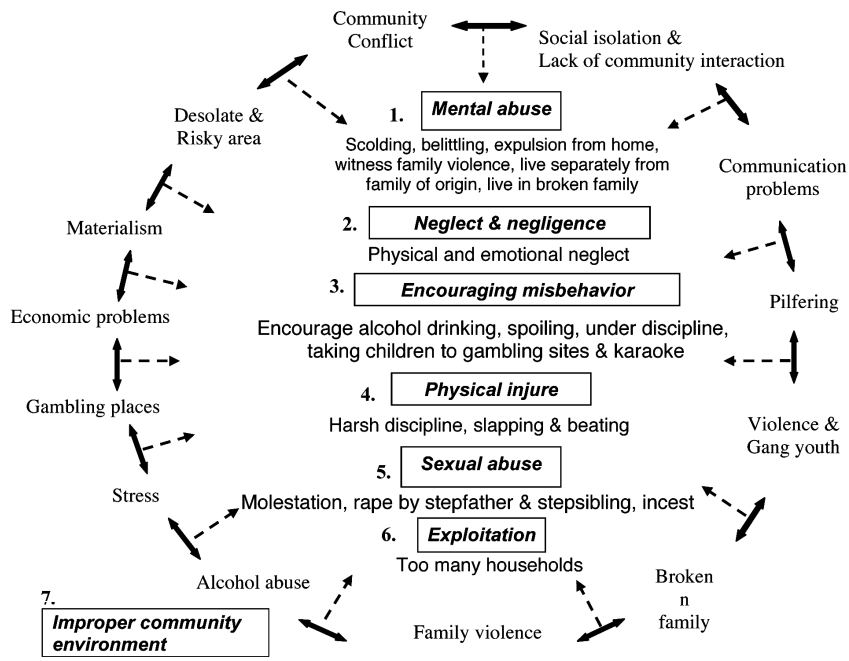


**Figure 1** Problem identification

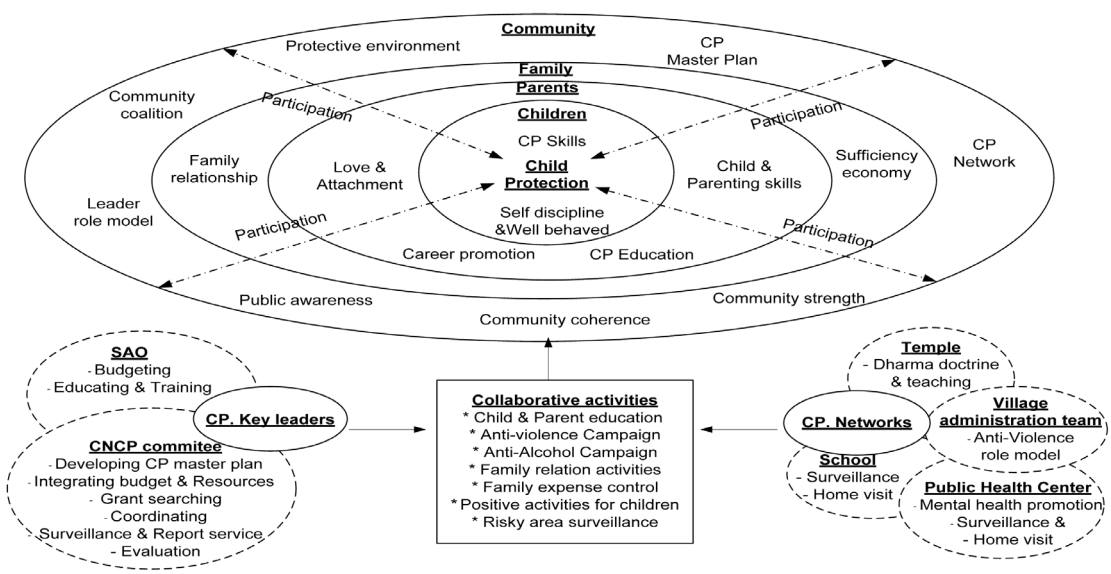


**Figure 2** Primary prevention model for child protection

***1. Child protection at the individual level:*** Protection at the individual level included children as victims and adults as perpetrators. Protection for children focused on promotion of protective factors, in order to reduce 'triggers' and the chance of a child becoming a victim. This included promoting the child's social immunity by: increasing awareness of children's rights violations; promoting desired behavior and self-discipline; promotion of their morals and virtue; and, increasing life skills. Developing children's life skills, included: teaching critical thinking, refusing, avoiding, protecting oneself from harm and asking for help; and, providing instructions on how to be safe in risky situations.

For protection from adults being a child abuser, focus was on placed on helping adults reduce the chance of their becoming a perpetrator. This involved adult education about child rights, child protection laws and the minimum standard treatment of a child, as stipulated in the ministerial regulations. In addition, the adults' education involved promoting knowledge, attitudes and skills on non-violence; positive child discipline; and, rearing practices. Thus, the promotion of good relationships, love and bonding between parents and children was emphasized.

***2. Child protection at the family level:*** Protection at the family level focused on promoting happiness and a good environment within the family, in order to reduce the chance of a child becoming a victim, due to stress within the family. Strategies included promoting: warm and healthy relationships among family members; non-violence in the family; and, economization, by applying the sufficiency economy concept initiated by His Majesty the King.

***3. Child protection at the community level:*** Protection at the community level focused on promoting awareness among community leaders and public education for community members, in order to continue promotion of child protection as a system. Creating a protective community environment for children involved: promoting safe areas and non-violence; development of a security system; and, discouraging gambling, and drug and alcohol use. Additional activities focused on providing growth opportunities for children, such as sports and alternative recreation for children and youth. Finally, a committee was established to develop a community network on child protection. The committee organized protection surveillance and coordinated assistance when required. The development of the community network involved: arranging continuous child protection activities; developing sincere involvement among local organizations; integrating child protection into local activities; and, promoting social cohesion and unity in the community. Promoting participation of a variety of community groups served to build community strength, and raised consciousness among community leaders, to be good role models for non-violent problem-solving.

***4. Key leaders on community child protection:*** The key leaders on community child protection were composed of two main sectors, the: SAO and CNCP. The SAO was the main local organization to provide budgetary support and integrate other local resources. The SAO also was set as the key leader in academic and education support, including educating community members about child protection laws. The CNCP was set as the key leader in coordinating and running child protection activities. The CNCP's responsibilities included: conducting child protection surveillance and case reporting service; running public hearings and consensus; and, developing and proposing the child protection plans to the SAO. The proposal to the SAO was necessary in order to put the plan into local policy and integrate it with local budgets and other resources. In addition, this allowed the two groups to search for and write grant proposals, and run and evaluate projects together.

***5. The community network:*** The community child protection network was comprised

of local organizations and resources; temple, village administration team, school, and public health center. The temple was set as the key leader in applying dharma doctrine and teaching for family life during weekends. The village administration team was the network leader in promoting community awareness and also serving as a role model for non-violence. As the school was the community network closest to the children and their families, it was set as the leader for surveillance and home visits. The public health center was considered the leader in mental health promotion, and promoted stress management for families and community members and performed home visits to families considered at risk. The purpose of the home visits was to reduce the risk factor of adults becoming perpetrators, by visiting those who were more likely to abuse children.

***6. Collaborative child protection activities:*** Some of the activities required the cooperation and involvement of key leader groups, community network groups and community members, in order to proceed and integrate child protection activities with existing local programs. In addition, some of the programs offered overlapping services and activities, i.e. reducing alcohol assumption in the community; parent education; children and youth education; local risk area surveillance; promoting positive recreation activities for children (sports, family activities); and, promoting sufficiency economy.

**Impact of model development:** The model development process brought about change to promote the protective environment for children in the community. The community meeting for both assessment and model reflection showed increasing community concern and awareness on child abuse as a public issue. This could be seen with the presence of interested parties from adjacent communities and provincial organizations, as well as from community suggestions, feedback, and questions posed, by community members, to the project coordinator. The sub-district's quarterly journal was utilized to educate community members on child protection activities. Outreach discussion regarding networking and policy implementation at higher levels were supported. The child protection master plan, to be implemented, was another evidence of change in the community. The community members also came up with the vision, mission, strategies and priority setting for each year.

## Discussion

The results showed an acceptance of corporal punishment, the embed belief of the Thai proverb of "Spare the rod and spoil the child," and a view of children as a possession among community members. This supports the findings of Bhikkhu,[23, 26] and Natamongkonchai *et al.*[24] who mentioned that corporal punishment is likely to be acceptable as a normative belief regarding appropriate parenting behaviors. It also supports the studies of Wechayachai,[25] Amornvivat *et al.*,[26] Phuphabul *et al.*,[27] and Natamongkonchai *et al.*[24] who indicated Thai parents use verbal aggression, along with physical punishment by spanking, hitting and pinching, to discipline their child.

When the beliefs mentioned above influenced the consideration of corporal punishment, as the common discipline for child rearing practice among parents, child physical abuse in the community was not considered as abusive. Even though Thailand became a signatory to the Convention on the Rights of the Child (CRC), in 1992, and the Child Protection Act was enacted in 2003, these concepts are relatively new for the Thai culture. In addition, Thais, traditionally, believe that family violence is a private issue and it is better for others to stay out of family issues.[28, 29, 30] Thus, others are reluctant to intervene when child abuse takes place in the family. Similarly, this study found that the community viewed spanking or verbal aggression as the parents' right and not an abusive behavior. Rather, these actions, often, are viewed as way for

parents to show love to their children. Physical aggression becomes abuse when it is unfair, undeserved, done for no good reason and is excessive.

Abuse was defined in terms of harm done or maliciousness. Therefore, the model proposed increasing child protective factors and decreasing risk or 'trigger' factors at all levels. At the individual level, protection was focused on increasing child protection knowledge and skills, in order to decrease the likelihood of the child becoming a victim or being the 'trigger' for abusive action. This is in accordance with Belsky's[31] results, wherein children's own behavior was found to elicit or maintain child abuse action.

At the family level, the model focused on promoting happiness and a good environment within the family. This included promoting career and side jobs, thereby applying the concepts of sufficiency economy. Reducing family stress would, in turn, reduce the chance of a child becoming a victim. This was supported by the studies of Sawyer et al.,[32] Wongsamari,[33] Krongyuth,[34] Katz and Woodin,[35] and Thyen,[36] who indicated that families, in which child abuse occurs, have poor relationship patterns, more conflict and less cohesion. Straus & Smith[37] mentioned that poverty causes the highest rate of child abuse. This was supported by the Transitional Model of Wolfe[38] who pointed out that child abuse occurs when parents fail to manage their life stressors.

At the community level, focus was on promoting public awareness activities and education on child rights and child protection law. The expectation was that this would deal with those parents who believed that family violence is a private issue. Creating a protective environment for children in the community and promoting community coherence in the model would be the significant protective factors. This idea is supported by Belsky,[31] who discussed ecology of child abuse and mentioned that maltreating parents often lack significant social connections to others in their neighborhoods and communities. Therefore, community coherence would help family members contact with others in the community. This could provide role models for acceptable parental behavior and influence parents to conform to a better standard of the rearing and treatment of their children. It also might maximize the use of community resources on child abuse protection and child rearing practices.

The collaborative activities among community resources on child protection were composed of two majors sectors: child protection key leaders and a child protection network. This supported the idea of capacity-orientation proposed by Kretzmann and Mcknight[39] who mentioned that connecting local resources could multiply their power and effectiveness for the project. This also supported the concept of a community network for child protection response proposed by UNICEF.[40]

## Conclusions and Recommendations

The community child protection model emphasized the participation of local organizations and community members in creating child protective factors from all kinds of abuse. Community health professionals need to play a role in identifying and treating victims, as well as preventing the occurrence of abuse. Prevention should be implemented in a child-focused, family-centered, community-based and culturally adapted manner. Review of the protocol and the role of community and school health nurses on child protection should be promoted.

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# รูปแบบการมีส่วนร่วมเพื่อส่งเสริมการคุ้มครองเด็กในประเทศไทยภาคเหนือ

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**บทคัดย่อ:** การศึกษาครั้งนี้ใช้กระบวนการวิจัยแบบมีส่วนร่วมโดยชุมชนเป็นฐาน โดยมีวัตถุประสงค์เพื่อพัฒนารูปแบบเพื่อส่งเสริมการคุ้มครองเด็กในประเทศไทยภาคเหนือ การเก็บรวบรวมข้อมูลใช้วิธีการสัมภาษณ์แบบกึ่งมีโครงสร้าง การสนทนากลุ่ม กิจกรรมการมีส่วนร่วม การสังเกต การประชุมกลุ่มและการระดมสมองกับกลุ่มตัวอย่างในหมู่บ้านชนบทแห่งหนึ่งในจังหวัดเชียงใหม่ โดยกลุ่มตัวอย่างประกอบด้วย กลุ่มเด็ก กลุ่มผู้ปกครอง กลุ่มประชาชน และกลุ่มผู้นำชุมชน การวิเคราะห์ข้อมูลเชิงคุณภาพใช้วิธีการวิเคราะห์เนื้อหา รูปแบบการคุ้มครองเด็กแสดงให้เห็นถึงปัจจัยป้องกันเด็ก 3 ระดับ ในระดับบุคคลทั้งเด็กและผู้ปกครองต้องการการส่งเสริมความรู้และทักษะในการคุ้มครองเด็ก เพื่อเพิ่มปัจจัยป้องกันสำหรับเด็กและลดความเสี่ยงในการกระทำสำหรับผู้ใหญ่ ในระดับครอบครัว การคุ้มครองเน้นที่การส่งเสริมความอบอุ่นในครอบครัว รวมถึงการประยุกต์ใช้แนวคิดเศรษฐกิจพอเพียง สำหรับในระดับชุมชนเน้นการสร้างความตระหนักในปัญหา ส่งเสริมเครือข่ายคุ้มครองเด็ก และพัฒนาแผนแม่บทเพื่อคุ้มครองเด็กในหมู่บ้าน การเคลื่อนไหวของชุมชนในการป้องกันปัญหาการทารุณกรรมเด็กก่อให้เกิดความรู้สึกเป็นเจ้าของซึ่งมีผลต่อความยั่งยืน ของโครงการต่อไป

ผลการประเมินแบบมีส่วนร่วมพบการเปลี่ยนแปลงคือ มีเครือข่ายเพิ่มขึ้น ตระหนักถึงความสำคัญของปัญหาในชุมชนที่มากขึ้น มีศักยภาพที่สูงขึ้น มีการกระจายข่าวข้อมูล ข่าวสารด้านการคุ้มครองเด็ก มีข้อตกลงร่วมกันในการบังคับใช้ และดำเนินงานตามแผนคุ้มครองเด็กชุมชน ผลการศึกษาได้ให้แนวคิดในการพัฒนางานวิจัยด้านการพยาบาลการศึกษาและการปฏิบัติงานด้านการคุ้มครองเด็กและส่งเสริมให้มีการจัดกิจกรรมหรือโปรแกรมการคุ้มครองเด็กที่เหมาะสมกับวัฒนธรรมต่อไป

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