goals. Further, these questions should be addressed through the collection of contextually appropriate measures that align with this theory of change. These measures should reflect not only child outcomes, but also more proximal targets of the interventions (eg, changes in responsive care practices) and subgroup differences. Given that intervention success also relies on implementing the program as intended, measurement systems should also incorporate fidelity monitoring to track variations in both the quantity and quality of protocol implementation. Such systems are critical for making sense of intervention impacts, helping to explain, for example, whether null effects may reflect an ineffective program vs poor fidelity to the intervention protocol. Evaluations should also allow for the potential identification of both positive and unintended negative program impacts. The exploration of iatrogenic effects is especially important when evaluating ECD interventions that encourage the replacement of "traditional" approaches to responsive care (which may be appropriate in the local context) with those found to be effective in high-income, Western settings (on which most of developmental science is based).

Finally, we advocate for greater transparency in the processes used to adapt, contextualize, implement, and evaluate ECD interventions around the world. Although the rising popularity of reporting standards (eg, CONSORT, TIDieR tables) has improved the consistency and transparency of ECD intervention publication, these standards are still not common in many outlets for ECD work (eg, education or psychology journals, gray literature). Furthermore, there are currently few systematic opportunities for interventionists to track, publicize, and get feedback on the decision-making processes they have used to set goals, select intervention approaches, adapt interventions to local contexts, develop theories of change, select and adapt measures, etc. Centralized public repositories of such information (eg, similar to clinical trial registries) could facilitate scale-up of successful approaches, as well as prevent unnecessary duplication of failed efforts.

Conclusions

The global community is currently facing an unprecedented opportunity to invest in the developmental well-being of the world's children, 90% of whom live in LMICs. Nevertheless, the potential impact and sustainability of existing ECD programs has been severely limited by the field's historic lack of consideration for local goals and approaches, coupled with the absence of detailed documentation regarding intervention design and decision-making processes. Successful and sustainable large-scale ECD programs are sorely needed. We argue that the best practices described above can support the development of a new generation of contextualized ECD programs that are more directly aligned with the specific needs and values of diverse LMIC communities and, in turn, are better equipped to promote the take-up and impact of these critical services.

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Published Online: December 28, 2021. doi:10.1001/jamapediatrics.2021.5351

Conflict of Interest Disclosures: None reported.

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VIEWPOINT

Child Physical Abuse Did Not Increase During the Pandemic

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Rates of child abuse appear to have fallen in 2020. Nevertheless, some experts, including physicians, have offered their opinions that child abuse must be on the rise because of the COVID-19 pandemic, even explicitly waving away evidence to the contrary.[1] Recognizing the paradox of declining rates amid increased risks points to important lessons for prevention: perhaps a combination of family strengths, community resources, and government assistance has prevented many cases of child maltreatment.

A review of available data suggests that there was not a significant rise in child abuse related to COVID-19. Child welfare reports dropped, emergency department (ED) visits declined, and hospitalizations were stable.

The total number of child abuse reports to state child welfare agencies plummeted up to 70% during the pandemic.[2] Decreased monitoring by educators due to school closures cannot explain the full decline: National Child Abuse and Neglect Data System data showed that educators made 21% of reports and childcare professionals, 0.7% of reports in 2019.[3] Instead, reduced reporting by schools may have diminished the disproportionate reporting of families of color, one example of bias that has led to widely acknowledged racial disparities in child welfare reporting.[4]

Further, if the dip in reports resulted from the loss of monitoring of schoolchildren, we would not expect to see a corresponding decline in cases that required medical attention. In fact, as shown in the **Figure**, Swedo and colleagues[2] at the Centers for Disease Control and Prevention reported a decline in the number of ED visits for suspected child abuse and neglect. The number of children hospitalized following ED visits for child abuse and neglect remained relatively constant.

Some individual centers did see increased child abuse admissions.[5] These reports did not include population rates and may have instead reflected diversion of ED visits from general hospitals to pediatric facilities when general hospitals were inundated with patients with COVID-19.

The Institute for Family Studies national survey of youth also suggested that child abuse may have decreased rather than increased. The Institute for Family Studies survey data show that more family time due to the COVID-19 pandemic had a positive association with mental health outcomes when compared with prepandemic data.[6]

If the social and economic risk factors for child abuse and neglect increased because of the stressors of COVID-19, why did child abuse rates not increase? We have reported anecdotal evidence collected during the course of training thousands of child- and family-service professionals nationwide.[7]

Together with the American Academy of Pediatrics, Prevent Child Abuse America, and the Centers for Disease Control and Prevention, we surveyed parents in the US about their experiences during COVID-19. The resulting Family Snapshots: Life During the Pandemic can be found on the American Academy of Pediatrics website.[8] They suggest that family support systems may have helped prevent child maltreatment. The risks were real: household finances worsened for 40% of families, driven in part by changes to employment status—43% of men and 52% of women reported reduced hours, layoffs, furloughs, or terminations. At the same time, enhanced unemployment insurance and other assistance buffered that financial distress. Half of families received assistance other than unemployment.

It is impossible to ask parents, even anonymously, if they abuse their children. However, when surveyed in late 2020, positive discipline strategies were nearly universal and 85% of parents reported that they had not used corporal punishment in the past week. These results align with other reports showing a steady decline in corporal punishment, which is a potent risk factor for child abuse.

The missing epidemic of child abuse tells an important story about prevention: (1) government assistance to families in financial distress may be protective, (2) increased parent presence in the home may promote attachment, (3) parents and children may build stronger relationships by collaborating on schoolwork, and (4) positive parenting practices are widespread, reducing a substantial risk factor for child physical abuse–corporal punishment.

Additionally, decreased reporting by school personnel was not associated with more severe abuse requiring medical attention. This observation may provide an opportunity for school personnel (among others) to enhance antibias training in their child abuse and neglect assessment, monitoring, and reporting practices.

We want to conclude with our own observations, from an admittedly nonrandom sample of adults. Many professionals worry about increased child abuse due to the pandemic. At the same time, they tell heartwarming stories about bonding with their own children. We believe that all of us—health care professionals and those we serve—have experienced a complex combination of challenges and resilience during the pandemic. Those of us who promote child abuse prevention should use the data to learn about prevention. How did so many families—despite hardship and disruption—continue to raise their children with love? The systematic supports developed this year seem to have worked; we might do well to sustain and expand the kinds of family support that prevent abuse and neglect.

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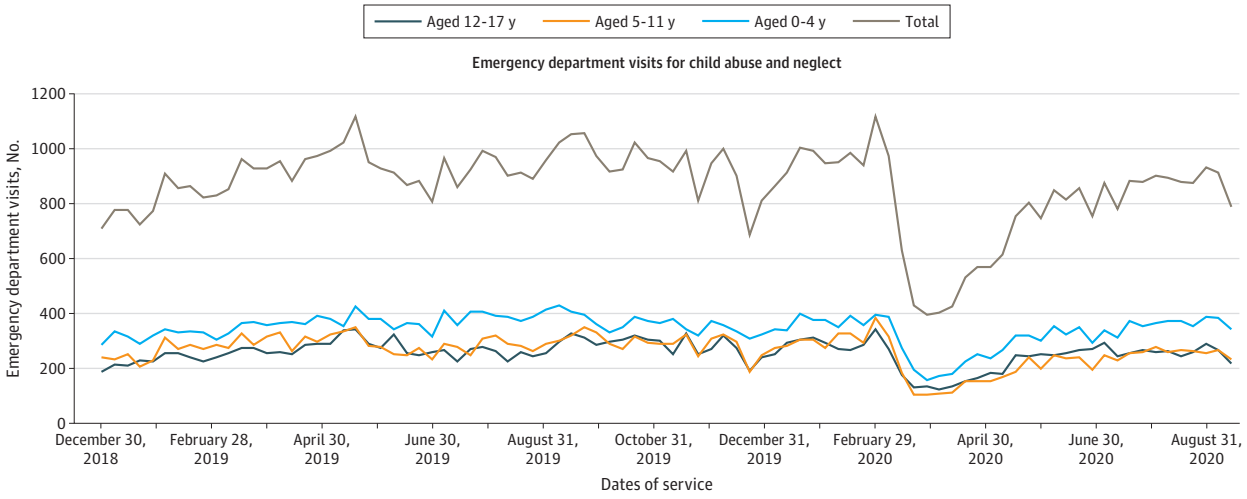
Figure. Emergency Department Visits for Child Abuse and Neglect, 2019 and 2020



Weekly number of children seen in US emergency departments for child abuse and neglect. Emergency department visits plotted by age and overall, based on age at the date of visit. Data provided by Swedo et al.[2]

ARTICLE INFORMATION

Published Online: December 20, 2021. doi:10.1001/jamapediatrics.2021.5476

Conflict of Interest Disclosures: None reported.

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