University of Jaffna

Dr.Arunasalam Sivapathasundaram

Memorial Lecture - 2017

Tarnished Children of Northern SriLanka

by

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Kailasapathy Auditorum
University of Jaffna

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Message from Vice - Chancellor

We are thankful to Dr. (Mrs.) M. G Sathiadas for accepting to deliver the Memorial lecture of Dr.Sivapathasundaram, the well known paediatrician who lost his life due to attack. He was appreciated by all the people who took their children for treatment. He was always interested in the wellbeing of children. Being a paediatrician, and having similar interest to society, it is a rare opportunity one gets to pay tribute to such a great personality.

His dealings with colleagues, junior doctors, medical students and other staff were very friendly and treated all patients alike and followed them up kindly. He always stood up against injustice and unfairness.

The topic 'Tarnished children of Northern Sri Lanka' is very important today and I am very delighted to welcome all the participants to the valuable event.

Prof. R.Vigneswaran
Vice-Chancellor

Tarnished Children of Northern Sri Lanka

Manuscript for Dr. Arunasalam Sivapathasundaram Memorial Lecture : 2017

Dr. Gitanjali Sathiadas

Department of Paediatrics/Faculty of Medicine, Jaffna

It is my great privilege to deliver Dr Arunalsalam Sivapthasundaram memorial lecture and I thank the Faculty of Medicine, University of Jaffna for giving me this opportunity. Unlike many other memorial lectures, this lecture is dedicated to one, who had his date with destiny, at a relatively young age and in a violent manner. I regret that I only had a few opportunities to see him, and that also through the eyes of my parents, as I have had no opportunity to work with him. He was so dedicated to the field of paediatrics. I take this opportunity to bow my head for his dedication at a critical time, when the doctors in Jaffna were unable to go to the hospital during the October 1987 conflict with the Indian Peace Keeping Force in the heart of Jaffna where a heavy battle erupted. He was so determined to be in the hospital at such a needy time and went through the back entrance of the hospital while the hospital surrounding was being rained with all kinds of rockets and shells. His noble service as a medical person at this peak time was not only limited to see to the welfare of patients, but to the welfare of the hospital staff who were trapped in the hospital at that time. He was shot and killed by the Indian Peace keeping Force on the 22nd of October 1987 within the hospital building when he went with his hands raised up and shouting loud and clear 'we are innocent doctors and nurses'.

Dr.Sivapathasundaram was born to Somasundarampillai

Arunasalam (who was a school master) and Valliammai on the 23rd of November 1939, at Puloly, Point Pedro and was named after his grand uncle, the Late S Sivapathasundaram, a former Principal of Victoria College and popularly known as "Saiva Periyar". He had two brothers and three sisters, one brother Mr.A.Somasundarampillai was a well-known and successful accountant, and the other, Mr. A. Rajasundaram, was a successful Engineer. Of three sisters, the eldest is a house wife, the other, Dr Mrs.Maheswary, was the Head of the Tamil Department of University of Peradeniya. The youngest sister retired as a Graduate Teacher.

Dr.Sivapathasundaram had his primary education at Vadamaradchi Hindu Girls' College and Secondary Education at Hartley College. He obtained a number of prizes for oratory and took part in many dramas as well. His interest in drama and theatre was not confined to College. His skills were portrayed in Radio Ceylon with Prof. Sivathamby and later with others. He also inspired the Jaffna Hospital Staff Welfare Society to produce drama, him playing the chief role.

He obtained the Diploma in Child Health (Sri Lanka) in 1970, proceeded to London afterwards and obtained the Diploma in Child Health (London) in 1975 and the Membership of the Royal College of Physicians in 1977. During his career, he served in Ratnapura, Balangoda, Ragama, Kuliyapitiya, Matara, Lady Ridgeway Hospital for Children, Colombo and Chilaw before assuming duties as Consultant Paediatrician at Base Hospital Point Pedro on 1st of June 1974. Having served nine years at Point Pedro, he was appointed as a Consultant Paediatrician to the Teaching Hospital, Jaffna in February 1983. Sad to say, his period of service was interrupted by his exemplary qualities, paving the way for his demise.

As a Paediatrician, he was punctual disciplined, meticulous, kind and left no stone unturned in the treatment of his patients. His clinical skill was

good and his interests in his patient were such that, he would even go to the operation theatre to know all about the patients he referred to the Surgeons. His dealings with Colleagues, junior doctors, medical students and other staff were very friendly but if the occasion demanded, he would be stern with the staff for the sake of the patients. He treated all patients alike and followed them up keenly. He took an interest in the welfare of the Hospital and according to his colleagues that he always comes out with meaningful suggestions at staff conferences. During his time, he fought for the construction of a 1200 beds New Teaching Hospital in Jaffna. He always stood up against injustice and unfairness.

He took a great interest in the activities of the Jaffna Medical Association, often taking part in the clinical demonstrations and discussions. One could then discern the ample knowledge and clarity of the thought, he had. This was a great boon for the students who clerked under him. He was elected as the Secretary of the Jaffna Medical Association in July 1987 and functioned efficiently for a short period before his demise. He was also Secretary of the Parents Teachers Association of Vembadi Girls College and I was told that he never missed a meeting. Such was his interest in anything he undertook. He was a good chess player and used to beat many of his opponents.

As an individual, he was a highly religious person, who performed poojas every morning and evening. He was a highly principled, honest, sincere and forthright person, never afraid to express his opinion. He was energetic and always ready to fight for a cause. It was these qualities that earned him displeasure and criticism from just a few but he was untroubled by these comments because he knew that such baseless and false criticisms were made to stop him from his fights for justice. He was always ready to help anyone in distress or need.

As a loving husband and father of four daughters, he discharged his

family responsibility to their entire satisfaction. His tender loving care kept them happy. His wife Mangaleswary comes from an educated family. Her father is a retired Principal of Arunodaya College, Alaveddy. She was always a source of inspiration, help and support to him in all his endeavours. We have lost such a great personality but I am sure his grateful patients, their parents and the community will remember him forever.

Ladies and gentlemen, I Have tried my best to pay respect to a wonderful human being and let me start with a poem written by a child:

I was made shattered. A ruined soul now exists where a whole person once was.

I break plates and glasses, smashing them for release; The fractured pieces litter the floor and I can't help but relate to each broken fragment.

I'm the broken vase that lies on the floor, the spilled water decorating the tile with the tattered roses begging for life. The body is soft and supple, able to absorb blows. Identities are fragile and difficult to repair. My self is destroyed.

I've put the pieces back together with glue- that's progress- but the glue is still curing and the pieces don't fit together quite right. I'm not okay.

We work with available light to mend the fractured soul. Like plates, I am the product of human efforts.

You made me shatter.

Children are God's gift to planet earth and it is also said that if one keeps a child happy, they are keeping the almighty happy. The period of childhood is a phase in which the human being is more vulnerable because they have not finished developing physically or mentally. Furthermore, the child requires particular attention and protection.

The maltreatment of children is a long-standing problem. Since ancient times, children have been viewed as property to be sold, given, or exploited by adults. Throughout history, children have been overworked, prostituted, and physically maltreated for a variety of reasons. Severe beatings administered with religious fervour were inflicted to gain the child's salvation and to exorcise evil. Employers used children to further their own economic interests. Despite the widespread sexual exploitation of children, the one taboo has been incest. The origins of this taboo seem to have been economic. An untouched female child was insurance for later barter with other tribes and cultures. (WHO 2012)

Charles Dickens used his own painful background to speak out against child maltreatment. (Hammond 2015) Then the case of Mary Ellen Wilson and crusader Henry Bergh set in motion a mechanism for the future protection of children.

Bergh's efforts on behalf of Mary Ellen gave birth to the SPCC in the UK, which provides help for children even now. (Watkins 1990) The discovery by radiologists of multiple, unexplained fractures and the coining of the phrase battered-child syndrome in the 1960s added impetus to the child protection movement. (Kempe 1962)

Children deserve attention and the superior interest is the necessity to protect children. All the decisions regarding children have to be taken in the exclusive interest of each child to ensure their immediate and future well-being and all the decisions and acts must imperatively guarantee the child's rights.

The principle of the superior interest of the child has the goal of promoting and assuring the wellbeing of all children, on physical wellbeing, ensuring good health and proper development of the child, mental wellbeing providing the opportunity to develop intellectually and social wellbeing ensuring the child the opportunity to flourish socially and spiritually.

In order to achieve this wellbeing and superior interest the state should establish a protection system for the children. Child protection must be ensured by the parents and the community which surround them. An effective system includes laws, politics, procedures and practices intended to prevent and fight against various problems of mistreatment, violence and discrimination that can damage a child's wellbeing. An efficient protection is essential to the children's well-being because, as vulnerable people, they are more exposed to problems of mistreatment, exploitation, discrimination and violence.

In order to set up an effective protection system, the States must first ratify the main principal international standards of protection of children's rights and then implement it in their legislation. The adults must have competencies, knowledge and motivation to provide effective protection for children. They must identify and react against possible cases of discrimination, neglect or mistreatment. (UN 1989)

International legislations:

The International Save the Children Union was a Geneva-based international organisation of children's welfare organisations founded in 1920. The intention was to create 'a powerful international organisation, which would extend its ramifications to the remotest corner of the globe'. It brought together organisations from various countries that were initially working to tackle child suffering around Europe after World War I. In 1923, it agreed, and then lobbied for, the Declaration of the Rights of the Child which was adopted by the League of Nations in the following year. Five aspects were endorsed. (Geneva declaration 1923)

1. The child must be given the means requisite for its normal development, both materially and spiritually.

2. The child that is hungry must be fed, the child that is sick must be nursed, the child that is backward must be helped, the delinquent child must be reclaimed, and the orphan and the waif must be sheltered and succoured.
3. The child must be the first to receive relief in times of distress.
4. The child must be put in a position to earn a livelihood, and must be protected against every form of exploitation.
5. The child must be brought up in the consciousness that its talents must be devoted to the service of its fellow men.

In 1959, the United Nations resolved to adopt the 1946 document, in a much expanded version, as its own statement of children's rights. Many different governments were involved in the drafting process. A slightly expanded version, with seven points in place of five, was adopted by the United Nations General Assembly as the Declaration of the 'Rights of the Child'. This Declaration was followed in 1989 by the Convention on the Rights of the Child adopted by UN General Assembly. Nations that ratify this convention are bound to it by international law. Compliance is monitored by the UN Committee on the Rights of the Child, which is composed of members from countries around the world. (UNICEF 1989)

The Sri Lankan Perspective:

Global ratification of the Convention on the Rights of the Child (CRC) occurred in 1989, and Sri Lanka soon followed suit in 1991. As a response to protection concerns, a presidential task force on child protection was established in 1996. The taskforce recommendations were adopted, and in 1998, the National Child Protection Authority was established as an Act of Parliament. A parliamentary bill was passed to strengthen compulsory education laws, primarily to reduce school dropouts. In 2005, Sri Lank agreed

to become a party to UN Security Council Resolution 1612 on children affected by armed conflict, and to report on progress regarding children affected by the conflict to the UN Secretary General. This entailed monitoring violations against children caught in the conflict, mostly undertaken by UNICEF, and other humanitarian agencies working in conflict affected areas. (NCPA 1998)

The innocence of Childhood becomes tarnished by losing their respect and value due to abuse and maltreatment. First part of my lecture will be mainly on epidemiological aspects of child abuse which will be followed by the knowledge, attitude and practices of child abuse, then I will concentrate a few aspects on corporal punishment and final part will deal with child offenders.

Child abuse in Northern Sri Lanka – a six year review

Introduction

Child abuse is a state of emotional, physical, sexual and economic maltreatment meted out to a person below the age of eighteen years and is a globally prevalent problem. It can be rooted in both cultural and religious history as well. In Sri- Lanka the magnitude and characteristics of this problem has not been clearly understood. Sri Lanka is a multi-ethnic and multi-religious country which was affected by a civil war between a Tamil separatist group and the Sri Lankan government forces for many long years. This ended in May 2009 after a major conflict especially in the Northern part of the country. It was evident that this civil conflict has targeted civilians including children and the infrastructure of the society resulting in scenarios which have never been witnessed before. The effect of this has led to the disruption of the medical, social, educational and public services in the area.

In these circumstances, the children suffer the most as their homes are destroyed, their families disrupted and their chances of becoming mature sensible members of the society is compromised. (Goldsone 1996) Children are exposed to situations of terror and horror during war which leaves lasting physical and psychological impacts. Severe losses and disruption in their lives lead to high rates of depression and anxiety which may be prolonged to further exposures of violence and abuse. Malevolence may cause children to suffer loss of meaning in moral and spiritual values leading to lie, steal and changed behaviour. Social and cultural losses also lead to disrupted behaviour both in adults and children. (WHO 2012)

Methodology

A hospital based retrospective study was done at the Teaching Hospital Jaffna among the children admitted or seen by the hospital child protection services from January 2009 to December 2014. Children less than the age of 18years with a suspicion of child abuse was considered. All records maintained at the Teaching Hospital Jaffna, of children admitted with a history of child abuse was sequentially considered. Records of children with a suspicion of child abuse are separately maintained at the office for child protection services. Records maintained at the Northern Province child probation office were also considered. Northern Province of Sri Lanka is one of the nine provinces which comprise the districts of Jaffna, Kilinochchi, Mannar, Mullaitivu and Vavuniya. The Teaching Hospital is the tertiary care Centre for this province and is situated in the district of Jaffna. A pre-tested questionnaire was used to collect the data from the hospital database. Data regarding the demography, social back ground, nature of the abuse, details of the incident, details of the perpetrator and the follow-up measures were taken from the hospital records. The efficiency of record keeping in the institutions

was also assessed. Data was also extracted from the database from the Northern Provincial child probation office to obtain the overall incidence in other districts. Details of abuse according to the districts, age and sex incidence were obtained from the provincial office.

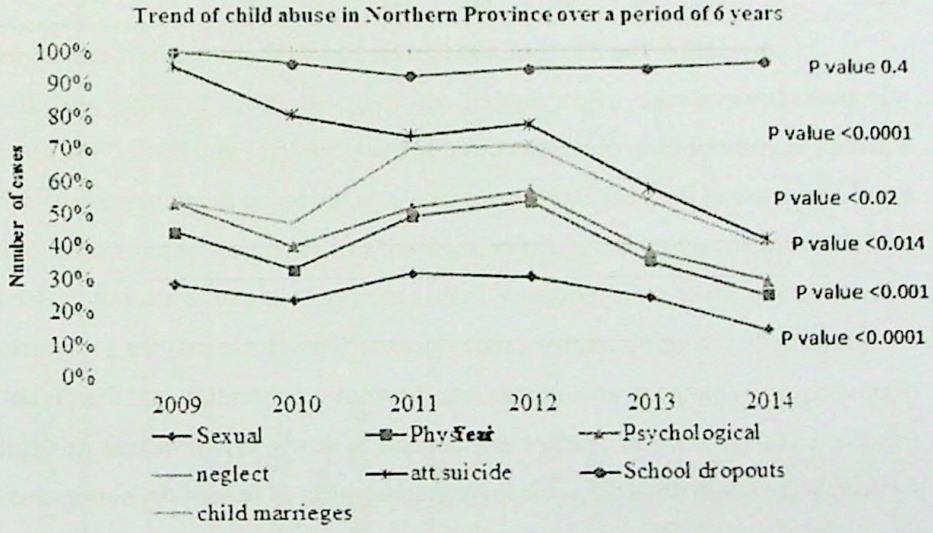
The following case definitions were used in identifying and categorizing different types of child abuse. Child abuse was defined as the intended, unintended and perceived maltreatment of the child, whether habitual or not, including any of the following: Psychological and physical abuse, neglect, cruelty, sexual and emotional maltreatment, any act, deed or word which debases, degrades or demeans the intrinsic worth and dignity of a child as a human being. Physical abuse was defined as inflicting physical injury upon a child. This may include hitting, shaking, kicking, beating, or otherwise harming a child physically. Emotional abuse (also known as verbal abuse, mental abuse, and psychological maltreatment) includes acts or the failure to act by parents, caretakers, peers and others that have caused or could cause serious behavioural, cognitive, emotional, or mental distress/trauma.

Sexual abuse is inappropriate sexual behaviour with a child. It includes fondling a child's genitals, making the child fondle an adult's genitals, sexual assault (intercourse, incest, rape and sodomy), exhibitionism and pornography. Child neglect is an act of omission or commission leading to the denial of a child's basic needs. Neglect can be physical, educational, emotional or psychological. Psychological neglect includes lack of emotional support and love. The collected data was entered and analysed using Statistical Package for the Social Sciences (SPSS) version 21. Trend analysis of proportions was calculated using stata 14 statistical packages.

Results:

A total 4270 incidences were extracted from the database of the Northern province child probation office from 2009 to 2014. Majority (68%) of the children were falling in the age range of 14-16 years. Females were affected more when compared to the males, the ratio being 1:1.7. Majority of the children were resident in Jaffna district (45%), followed by Vavuniya (32%), Mullaitivu (18%) and Kilinocchchi (12%).

Figure 1 : Trend of different types of abuse and the analysis



A total of 843 cases were reported during the study period to the Teaching Hospital Jaffna. Major details were missing in the records in 123 cases (14.5%) hence a total of 720 cases were further studied and analysed.

Table 1 Types of abuse seen at the tertiary centre and the trend analysis over the years.

Type of abuse	2009	2010	2011	2012	2013	2014	Tot	X^2 for trend	P-value
Sexual abuse	48	45	68	75	61	55	352	0.275	0.6
Child marriages	45	28	54	46	39	33	245	4.4	0.03
Physical abuse	4	3	3	8	12	10	40	4.94	0.02
Neglect	2	2	8	11	10	12	45	7.2	0.007
Attempted suicide	0	0	2	3	8	8	21	14.1	0.0002
Conflict with law	3	3	2	2	3	4	17	0.008	0.9
Total	102	81	137	145	133	122	720		

Considering the trend of abuse over the years in the immediate post war period prevalence of attempted suicide, was more in 2009 and 2010 whereas the school drop outs, was more in the year 2011 and 2012. There was a rapid increase in the year 2014, most likely cause being the education and the probation departments being more vigilant and reporting school drop outs. Education was given an importance in this society over centuries, but the trend is noticed to be changing over the recent years. This again may be a reflection of poverty and change in attitude among the young generation and the parents. (Radford 2009) Further studies are needed to study this problem in depth. Actions were taken regarding this increased number of school dropouts, and in the year 2014, 53% of the school drop outs re-joined school according to the district child probation office in the Northern Province.

Some of the socio-demographic risk factors were compared mainly between sexual abuse, physical abuse and neglect. (Table 2)

Table 2: Characteristics of the study population in the main forms of abuse

Feature	Sexual Abuse			Physical Abuse			Neglect		
	Count	OR (95 % CI)	*p* value	Count	OR (95 % CI)	*p* value	Count	OR (95 % CI)	*p* value
Age									
<5	3	0.0088 (0.002–0.029)	**<0.0001**	5	1.28 (0.47–3.44)		37	222 (78.74–625.86)	
5–10	72	0.29 (0.18–0.48)	**<0.0001**	32	15.85 (7.03–35.72)	**<0.0001**	8	0.60 (0.27–1.33)	0.203
>10	277	100.95 (31.01–328.54)	**<0.0001**	3	0.04 (0.01–0.12)	**<0.0001**	0		**0.0001**
Sex									
Male	123	0.60 (0.37–0.98)	**0.04**	19	1.59 (0.83–3.06)	0.161	21	1.54 (0.83–2.87)	0.170
Female	229	1.66 (1.03–2.67)	**0.04**	21	0.63 (0.33–1.21)	0.1	24	0.65 (0.35–1.21)	0.17
Religion									
Hindu	308	0.8 (0.39–1.78)	0.63	36	1.2 (0.41–3.57)		40	1.11 (0.42–2.97)	0.82
Christian	42	1.14 (0.53–2.45)	0.72	4	0.83 (0.66–1.13)		5	0.92 (0.34–2.43)	0.86
Reported to Authority									
Family	188	0.69 (0.43–1.13)	0.14	23	1.11 (0.58–2.14)	0.75	30	1.72 (0.90–3.29)	0.10
Other	164	1.45 (0.89–2.35)	0.137	17	0.61 (0.32–1.17)	0.133	15	0.58 (0.30–1.12)	0.100
Family Structure									
>6 members	105	0.54 (0.35–0.84)	**0.005**	28	2.83 (1.39–5.760)	**0.002**	45	1.26 (0.78–2.05)	0.342
Single parent	70	2.24 (1.28–3.93)	**0.004**	8	0.78 (0.34–1.75)	0.537	11	0.39 (0.20–0.78)	**0.006**
Unemployment	71	1.10 (0.68–1.78)	0.698	4	0.25 (0.09–0.73)	**0.007**	30	1.51 (0.90–2.53)	0.11

Bold are statistically significant

The form of abuse was sexual in majority and 83.8% (295) children lived with their parents. The perpetrator was known to the victim in 302(86%) occasions. 70% (247) of the time, the perpetrator coerced the victim into a relationship before abusing. Fourteen children living with their parents were abducted and abused. Penetrative injury was seen in 15% (53) and none of the children tested positive for sexually transmitted disease. Fondling was seen in 270 (91.5%) cases. The details regarding pornography was not reported in the hospital data. In the sexually abused group, school dropouts before GCE O/L was seen in 30.6 %(108), which has shown an increasing trend over the years. Reason given for school dropout was mainly poor socio-economic status. 201 children (57%) belong to the poor socio-economic status getting a monthly income of less than Rs. 10,000/=. Unemployment, at least in one parent, was seen in 71 (20%), and abuse with alcohol in parent was seen in 80 (22.7%) of the cases. None of the victims reported alcohol or drug abuse. 78% (274) of the parents indicated they feared stigmatisation in the community thereby wanted to change schools or put the children into hostels/children's homes. Intelligence Quotient was tested using Raven's in 52 (14.7%) victims of child sexual abuse and out of that, 20 (38.4%) had IQ of less than 90. None of the victims had neurodevelopmental disability.

Physical abuse was seen in 40 (5.5%). Majority (85%) of the children belonged to the age group of 5-10 years. Unexplained bruising on the face and back was the common form followed by ruptured ear drum and fracture of long bones. The perpetrator in 23 occasions was the step father or close friend and regular visitor to the house. There were 8 (20%) occasions where the child had received corporal punishment.

Neglect was seen in 45 (6.2%) of the children and they belonged to the age group of less than five years. Poor nutrition was seen in 30 (66%) children and ten children failed to seek medical care in time.

Poverty, inaccessible health care, inadequate nutrition, unavailability of education etc. are the contributing factors identified so far (WHO 2009, Radford 2009). Our study also shows poverty, large family sizes, unemployment and alcohol abuse in a parent has contributed to child abuse. Large family size had a significant association in sexual and physical abuse (p-value<0.001). Single parent family contributed significantly to sexual and physical abuse whereas unemployment contributed to physical abuse (Table 2)

All forms of abuse in childhood are associated with poorer mental health, elevated delinquent behaviour and developmental disorders (Rinke 2015). Strong associations are found between sexual abuse, physical violence, poorer emotional well being, including self-harm and suicidal thoughts (Rinke 2015). The children have shown problems with relationship, trust, behaviour and development, hence we need to take urgent steps to control this problem (Colomboge 2012, Harlow 1999). This problem is reflected in our study by the number of children dropping out of school and facing educational problems.

Referral and reporting:

Victims and perpetrators of child abuse will not typically self-report to the child protection services. Therefore responsibility of detection and reporting falls onto the first contact person, usually the health care personal (Warner 1994). The reporting of incidents of child abuse and violence must connect with access to services. This should include therapy/counselling as well as child-friendly law enforcement and legal processes. The child's age and maturity need consideration when collecting evidence and questioning children in court. Legal delays must be avoided where child victims are concerned. A child-friendly Juvenile justice system and the development of child-friendly courts for judicial proceedings involving children are among the many progressive steps taken by Sri Lanka.

Ninety two per cent of the time the child was admitted to hospital purely for judicial reason. The rest got admitted for other clinical reasons and the maltreatment was noticed.

In our study on the victims seen at Teaching Hospital Jaffna, Multidisciplinary case conferences were held in the hospital in 352 children (49%). The rest were seen by the judicial medical officer and discharged. Follow-up for the children who had multidisciplinary case conferences were advised to all children and 23 (6.5%) attended one follow-up clinic and thereafter lost for follow-up.

One hundred and twenty-three records (14.5%) were rejected due to major deficiency in the records. 183 records (25.4%) lacked the details of family, mainly the details of siblings. Medical details were satisfactorily filled in all records. 580 (80%) records did not have details of follow-up.

The deficiency in the management and poor record keeping led us to do the second study on Knowledge attitude and experience of medical professional and allied health professionals involved in child protection.

Child abuse and neglect in the Jaffna District of Sri Lanka - Knowledge Attitude practices and behaviour of health care professionals

Introduction:

In Sri Lanka, Reports of increasing child abuse, neglect and exploitation are on the rise. Out of about 15,000 legal trials pending nationwide, more than 4,000 (27 per cent) involve some form of violence toward a child. Over 1500 cases related to children are reported per year. According to figures tabled in Parliament in April 2013, there were 1,750 cases of child rape, 5,475 cases of child molestation and 1,194 cases of child abuse in

2012 (UNICEF 2013). The number reported is much less than the actual incidence because large number of children suffer in silence (Reiniger 1995).

The "wall of silence" which surrounds sexual abuse in particular to shyness, stigmatization, fear and shame, lack of access to communication systems are all relevant. Younger children may not be even aware they are being abused. Some are afraid to deal with law enforcement authorities and an adversarial legal system (Deshapande 2015). It is rare for children themselves to report abuse and it is usually done through a family member, neighbour or other adults. Complaints of abuse are also made to the Women and Children's Police Desks, but again, only a few among the many report such abuse (May-Chahal 2005). Thus the known cases of child abuse and exploitation are only a small tip of the iceberg. Although those who report abuse are slowly increasing, with more awareness programmes and media focus, available statistics do not in any way reflect the true picture. The first responders coming into contact with abused children are in an ideal position to report abuse allegations. Hence it is exceedingly important for medical officers to be thoroughly acquainted on medico-legal aspects of child abuse (Kirankumar 2011).

Methodology:

This study included random sample of medical and dental officers (includes consultants, senior registrars, registrars, senior house officers, resident house officer and intern medical officers), nursing officers attached to the Teaching Hospital Jaffna, and community health and social workers attached to the department of Probation and child health, Northern Province. Study period was from March 2016 to October 2016. An anonymous self-administered questionnaire was used as study instrument. A 24-question survey was constructed in the native language using multiple choice or true

false format based on the literature, case vignettes and Likert chart to assess the attitude. The questionnaire included questions to assess the Knowledge, Attitudes & Experiences and questions to assess the socio demographic factors of medical, nursing and social workers. A field test was conducted with 10 experts in the field of child abuse to measure the content validity. Content Validity Ratio (CVR) was calculated using Lawshe's formula (1975) CVR=(N_e - N/2)/(N/2), in which the N_e is the number of panellists indicating "essential" and N is the total number of panellists. The content validity ratio for the whole questionnaire was 0.80.

Attitudes scores: Each respondent was asked a 10-item questions related to his/her attitude towards child protection. Responses were recorded as strongly agree or disagree, or somewhat agree or disagree, or don't know/can't say. Depending on whether it was a proper attitude or not, scores from 1 to 4 were allotted. A score of '0' was given for don't know/can't say. Six items had negative statements and they were awarded the reverse scores. A total of 40 was then divided into sub scores which were defined as 0-9 Very Poor, 10-18 considered as there are many issues which need changing, 19-27 more positive attitudes and 28-40 had a good feeling overall

To assess the experiences of participants, some questions were given and the responses were expressed as percentage. Each respondent was asked if they undertook any particular action in the previous year that would help towards having better practices.

The data is described using frequencies and percentages. Chi-square test, t test, ANOVA was used to examine significant statistical differences between the socio demographic factors and Knowledge, Attitudes & Experiences. P value of <0.05 was considered as statistically significant. Data was coded and entered in SPSS version 20.

Results:

Total number of responders was 246. Among them, 156 (63.4%) were medical officers, 59 (24%) were nursing officers and others were social workers. Mean age of the subjects was 34.7±7.9yrs. Male female ratio was 1:1.2. Most of them (60.6%) were married and had experience less than 5 years in their respective fields (43.7%). (Table 3)

Table 3: Demographic details of the study population

Feature		Medical officers (N=156)	Nursing officers (N=59)	Social and probation (N=31)
Age (years)	26-30	73(46.8%)	26(44.1%)	2(6.4%)
	31-35	36(23.1%)	11(18.6%)	11(35.5%)
	36-40	21(13.5%)	4(6.8%)	10(32.3%)
	>40	26(16.7%)	18(30.5%)	8(25.8%)
Gender	Male	77 (49.4%)	18 (30.5%)	12 (38.7%)
	Female	79(50.6%)	41(69.5%)	19(61.3%)
Experience (years)	0-4	76(48.7%)	22(37.3%)	10(32.3%)
	5-9	36(23.1%)	16(27.1%)	10(32.3%)
	>10	44(28.2%)	21(35.6%)	11(35.5%)
Marital Status	Single	67(42.9%)	23(39%)	7(22.6%)
	Married	89(57.1%)	36(61%)	24(77.4%)
Having children	Yes	62(39.7%)	26(44.1%)	19(61.3%)
	No	94(60.3%)	33(55.9%)	12(438.7%)
Experience in paediatrics and	Yes	69(44.2%)	21(35.6%)	0(0%)
judicial work	No	87(55.8%)	38(64.4%)	0(0%)

All groups of professionals were able to identify the forms of child abuse correctly and there were no significant differences between the groups except seeking timely medical advice. (Table 4)

Table 4: Frequency of identifying the type of abuse.

Type of child abuse or neglect	Medical officers (N=156)	Nursing officers (N=59)	Social workers (N=31)	P
Failure to seek needed medical treatment	148(94.9%)	39(69.6%)	30(96.8%	0.001
Neglect of child education	147(94.2%)	53(89.8%)	31(100%)	0.153
Beating causing injury	139(89.1%)	55(93.2%)	31(100%)	0.120
Non-injurious spanking	110(70.5%)	39(66.1%)	16(51.6%)	0.121
Verbal humiliation	139(89.1%)	54(91.5%)	31(100%)	0.150
Sexual abuse	148(94.8%)	57(96.6%)	31(100%)	0.400

Unexplained bruising, bite marks, burns, child refusing to go home after a period of hospitalisation and sexualised behaviour were identified correctly as physical evidence in majority of the instances. (Table 5)

Table 5: Knowledge of the physical indicators

Question	True	False	Not responded
Bruising over bony prominence is an indication of abuse	142(57.7%)	98*(39.8%)	06(2.4%)
Burns are associated with abuse	148*(60.1%)	90(36.5%)	08(3.25%)
Bite marks on the shoulder be investigated for child abuse	107*(43.49%)	79(32.1%)	60(24.3%)
Child expresses fear of going home after a period in the hospital	213*(86.5%)	31(12.6%)	02(0.8%)
A history that is vague and defers each time tells it is a possible indicator of abuse	172*(69.9%)	72(29.2%)	02(0.8%)
Torn frenulum indicates child sexual abuse	76(30.9%)	68*(27.6%)	102(41.4%)
Sexualised behaviour in the child may be due to sexual abuse	146*(59.5%)	97(39.4%)	03(1.2%)

**correct answer*

The three case vignettes were mainly of child sexual abuse, physical abuse and seeking delayed medical help. All categories of people identified the type of abuse correctly except delay in seeking medical help. This had a significant difference between the groups. (P value <0.001)

"Many abused children cling to the hope that growing up will bring escape and freedom. But the personality formed in the environment of coercive control is not well adapted to adult life. The survivor is left with fundamental problems in basic trust, autonomy, and initiative. They approach adulthood by establishing independence and intimacy burdened by major impairments in self-care, in cognition and in memory, in identity, and in the capacity to form stable relationships. The child is still a prisoner of its childhood; attempting to create a new life, to re-encounter the trauma." They end up traumatised and an outlet is to become perpetrators.

According to literature It is a known fact that those who have been abused as children end up perpetrators when they are adults and they are known to the family (Glasser 2001).

Table 6: Knowledge of Characteristics features of the perpetrator

Characteristics of perpetrator	Medical officers (N=156)	Nursing officers (N=59)	Social workers (N=31)	p
Known to the family	113(72.4%)	45(76.3%)	24(77.4%)	0.762
Psychiatric background	84(53.4%)	51(86.4%)	17(54.8%)	0.001
Been abused as a child	93(59.6%)	41(69.5%)	19(61.3%)	0.409

The knowledge on the fact that the perpetrator is known and has been abused as a child was not satisfactory, but the professionals thought they had a psychiatric background.

The attitude of professionals to Child protection

Mean attitude scores were 20.16±3.3, 20.25±4.04, 23.84±5.3 for doctors, nurses and social-workers. (F=12.546 p=0.000) Even though the majority of the professionals showed a more positive attitude, there are many issues that need changing. (Table 7)

Table 7: Attitudinal scores among the professionals:

	Medical officers (N=156)	Nursing officers (N=59)	Social workers (N=31)	Total	p
Mean attitude score	20.16±3.3	20.2±4.0	23.84±5		0.001
Issues need changing (10-18)	51(32.7%)	17(28.8%)	8(25.8%)	76(30.9%)	0.001
More positive attitudes (19-27)	101(64.7%)	41(69.5%)	15(48.4%)	157(63%)	0.001
Good feeling overall (28-36)	4(2.6%)	1(1.7%)	8(25.8%)	13(5.3%)	0.001

Majority (76.4%) were confident in reporting child abuse and 24% said they would defer reporting until firm evidence was present. 60.5% were confident in giving evidence in a court of law and 45% were not familiar with the legal issues. Only 24.3% were satisfied with the local child protection services.

The stigma on the child, parents and society is overwhelming when child abuse is considered. Talking about child abuse is difficult. Perhaps, on some level, we believe if we do not talk about it, it does not exist. The secrecy of child abuse contributes to the inability of victims to move on and to realize they were not at fault. To be able to move from victim to survivor, someone who has suffered childhood abuse has to understand the trauma, process it, and turn it into a memory. The parents, healthcare professionals and the society have to play a major role. Our findings are also compatible to maintain secrecy

to the event and promote removing the victim from the family and school. The perception is not to safeguard the child but to overcome the social stigma that has come over to the family and school. 23% of the professionals in our study felt removing the child from the home and familiar surrounding will be one form of therapy. 35.7% even said to change the school of the victim.

As a society, we need to be more aware of childhood sexual abuse and demand that religious institutions, schools, etc., are held accountable when it comes to protecting and reporting abuse. We can all effect change in these institutions by starting with critical self-reflection drawing connections between individual acts of abuse and systemic forms of oppression. By analyzing the strict gender roles contribute in a systemic way to the abuse, we can begin conversations that envision egalitarian, non-exploitative relationships.

Practices adopted by the professionals:

Majority of the professionals (62%) suspected child abuse in children and 64% had reported it to the authority. All the cases suspected were not reported and the difference is mainly due to no concrete evidence and the fear of stigmatisation to the family.

All the professionals indicated that education on child protection is essential, but only 52(21%) had attended a training workshop on child abuse. (Table 8)

Table 8: Practices adopted by the professionals

	Medical officers (N=156)	Nursing officers (N=59)	Social workers (N=31)	P value
Suspect CAN	96(61.5%)	28(47.4%)	28(90.3%)	0.001
Report CAN	74(47.4%)	23(39.0%)	27(87%)	0.001
Aware of process of reporting	114(73.1%)	38(64.4%)	28(90.3%)	0.031
Awareness of Sri Lankan laws	92(60.0%)	22(37.3%)	23(74.2%)	0.001
Importance of child abuse education	156(100%)	58(98%)	31(100%)	0.315
Attended training on CAN	13(8.3%)	16(27.1%)	23(74.2%)	0.001
Self-satisfaction of knowledge	45(28.8%)	21(35.6%)	18(58.1%)	0.007
Wish to improve the knowledge	150(96.2%)	54(91.5%)	25(80.6%)	0.010

CAN: Child Abuse and Neglect

Mandated training of professionals – a means to improve reporting

The above findings led to improve the care provided to the children involved in maltreatment. The Sri Lanka College of Paediatricians with the other colleges formulated a guideline and mandated training on these guidelines is being undertaken in various parts of the country. In this region, several training and awareness programmes have been conducted among doctors, nurses, probation department and public health personal. The training includes statutory reporting system, the clinical manifestation, the legal protection to those report and consequences of failing to report. Even though this training was one time the content will be included into the standard curricula of the designated professionals. The questions raised by the

mandated training by the participants, were concerns about their liability, their potential involvement in court procedures and their contact with the child protection services. Greater awareness can reduce these liabilities and hence improve reporting (Reiniger 1995).

Self-awareness of the level of knowledge on Child Abuse and Neglect (CAN) is important for further improvements in knowledge. Our study states that 65.8% of the responders were not satisfied with their knowledge and 93% of them indicated they wanted some form of CME on CAN. In our study, the preferred methods of updating the knowledge was by having continuing education and workshops on child abuse (70.3%) followed by issuing an information booklet (48%) and online self-study (28.5%). Outcome of the education has to be assessed on a regular basis and constant improvements must be made according to evidence. Professional education programmes must sensitise all health care professionals of the occurrences and instruct them on how and when to report a suspected case of CAN.

Ladies and Gentlemen, let me move on to the next most important aspect of child maltreatment in the name of corporal punishment.

Corporal punishment:

The subject of discipline has always been controversial. Many methods used in early Western culture would certainly be open to censure today. The philosophies of our forebears, however, differ from those of most modern-day societies. Not only in the home, but in the classroom, corporal punishment was a means to mould children into moral, God-fearing, respectful human beings. Parents were expected to raise religious, dedicated, morally sound, and industrious contributors to the community. Obedience was the primary virtue to develop in children. Disobedience often carried significant

fines; even older children were subject to such rules. The schoolmaster or mistress was accorded the same right to use corporal punishment.

In colonial Boston, the school masters were conscious of the need to maintain the great English tradition of "education through pain" (Inglis 1978). During the eighteenth century, the treatment of children improved. Philosopher Jean-Jacques Rousseau spoke of children as inherently good and encouraged educational methods that would enhance their positive development not break their spirit (Lenoir-Degoumois, 1983).

Corporal punishment in the name of "discipline" still continues in homes, schools, childcare institutions and juvenile detention centres. Worldwide, the pace at which states have realised and acted upon the human rights imperative to give legal protection to children from all forms of corporal punishment has accelerated since Sweden became the first country to achieve full prohibition in 1979. Corporal punishment in the family is still lawful in some countries, but parliaments are increasingly passing laws which protect children from corporal punishment.

- 95.0% of the world's total child population live in countries where they are not legally protected from all forms of corporal punishment by parents: 29.3% of these live in South Asia
- 54.7% of the global child population live in countries where they are not legally protected from corporal punishment in schools: 44.7% of these live in South Asia
- 55.7% of children worldwide live in countries where they are not protected by law from corporal punishment in penal institutions: 50.0% of these are in South Asia
- 93.4% of children worldwide live in countries where corporal punishment in all forms of alternative care is not prohibited, 29.8% of which are in South Asia

- 39.7% of children across the world live in countries where for committing an offense under criminal, traditional and/or religious law, they can lawfully be ordered to receive corporal punishment: 68.0% of these are in South Asia.
  (UNICEF 2017)

With this introduction we did a study on corporal punishment in children studying in schools in Jaffna district.

Methodology:

A cross sectional observational study was undertaken to assess corporal punishment in schools in Jaffna district. Multistage stratified proportionate cluster sampling technique was used in student aged 16-19yrs studying in GCE A/L classes in both private and government schools. A pre tested questionnaire was administered to school students. The questionnaire had forty questions to assess the students' perception and their response to corporal punishment.

A scoring system was used to assess the knowledge maximum score of 17 with >13 being good knowledge. Each correct response was awarded with +1 and incorrect with 0. The attitude was assessed with Likert scale. Scoring system for attitude was calculated awarding +5 for both strongly agree for positive attitude and strongly disagree for negative attitude. A total score of 110 was given. An attitude score of >85 was the considered as an overall good attitude, 60-85 considered as having a more positive attitude and <60 considered as needing a change in the attitude. Result were coded and entered into SPSS version 22.

Results:

A total population of 1130 with the mean age of 17.58±0.51yrs and male female ratio of 1:15 were considered. Majority (298, 30.0%) of the student were in the Maths stream followed by Arts stream. Mean score for the knowledge was 11.1±3.4 and 241(39.9%) had a score above 13 indicating good knowledge. Majority knew that corporal punishment was illegal (824, 75.7%), it was a punishable offence (798, 73.3%) and that it affected the future wellbeing of the child (791, 72.6%). A total of 660(60.6%) supported the law against corporal punishment. There was no significant relationship between age, sex, A/L section, family type, number of siblings and CP incidence (p value>0.05). Participants with good knowledge favor legal action, will take legal action against corporal punishment and supports complete prohibition of CP (p value<0.005).

687(63%) of the students received some form of corporal punishment during the student period and 82(7.5%) needed medical treatment for their injuries. Majority (62.2%) of the students indicated that they received some form of corporal punishment at least once a week and 7.3% indicated that they received it daily.

The children received the punishments both in school and home in equal incidences, but the teachers showed a slightly increased preponderance (597 times) when compared to the parents (511) in inflicting the punishment. The children received various forms of punishments. (Table 9)

Table 9: Form of corporal punishment received by the students

Type of punishment	Number of incidences
Ear pulling	339 (31.1%)
Slapping (beating on cheeks)	367 (33.7%)
Asked to kneel-down	340 (31.2%)
Sit ups	244 (22.4%)
Beating with hands	442 (40.58%)
Beating with a stick, cane	527 (48.39%)
Twisting the head	115 (10.56%)
Pinching	235 (21.57%)
Stand on the table	129 (11.8%)
Standing on one leg for a long time	94 (8.6%)
Hands-above-the head	163 (14.96%)
Stand outside the class	457 (41.96%)
Chair positions	113 (10.37%)
Extra home work	368 (33.8%)

Majority (91.4%) preferred an alternative way of discipline and felt corporal punishment had a detrimental effect on their future development. 451(44.8%) said it was a method used to discipline students and accepted it with reluctance. 600(55.09%) of the participants answered yes to "will you take legal actions against CP" and 552(50.68%) supported complete prohibition of corporal punishment.

Mean score for attitude was 54.97±14.29 and 57% indicated an overall attitudinal change. (Table 10)

Table10: Distribution of attitude scores

Attitude score	Frequency (%)
Overall good feeling (>85)	22(1.9%)
More towards a positive attitude (85-60)	462 (40.88%)
Attitudinal change is needed (<60)	646 (57.1%)

608(60.7%) of the students considered that corporal punishment disgraced them and it had a detrimental effect on their behaviour. (Table 11)

Table 11: Student perception of Corporal punishment

Statement of perception	Number(%)
CP disgraces you	608(60.7%)
CP causes pain and is detrimental	587(57.9%)
Increases the antisocial and illegal behaviours	464(45.9%)
CP stimulates aggressive behaviour	576(56.7%)
Increases the conflicts between husband and wife in future	386(38.3%)

The students indicated that CP promotes antisocial, aggressive behaviour and illegal activity. As the students them selves indicated the behaviour change, we considered to analyse the children in detention at a state house.

Children in Care:

There is a dual system of care, one run by the state and another run by non-governmental organizations (NGOs). According to the survey findings of the Department of Child care and Probation, currently there are 14,179 children in 414 institutions located in all nine provinces in Sri Lanka. Out of the total number of children residing in institutions at the time of the survey, 8,538 were females (60.2 per cent) and 5,641 were males (39.8 per cent) indicating an overall sex ratio of 153.4 girls for every 100 boys. It was revealed from the family situation of the children in the Child Care Institutions (CCI) that 50 per cent of the children had a single parent whilst 32 per cent of them had both parents. However, 18 per cent (2,562 children) of children in CCIs had no parents and therefore were orphans. It was revealed that the main reasons for institutionalization of children were unfavourable conditions at home due to divorced parents, alcoholism, mother migration and insecurity at home particularly for female children as they are the targets of sexual abuse by neighbours and even by their close relatives including their own fathers. Moreover the mental stress caused to children by feuding parents, lack of love and care at home and unacceptable life styles of parents also caused this. (UNICEF 2015)

Child Offenders

'Somebody has to polish the stars. They are looking a little bit dull. The eagles and gulls have been complaining they are tarnished and worn. They say they want new ones which we cannot afford, so take the rags and polish the tarnished stars'.

Our children are also tarnished due to our own mistakes and misguidance. They have been abused and involved in crime. I like to say a few words on children institutionalised in Certified school in Northern Province.

Introduction

Detention in institutions can be imposed on youths aged 13 to 18 years when the Juvenile Court considers that a penal sanction is necessary to deter them from re-offending. However, young adults are also held in these facilities if they had committed an offence before the age of 18 and are tried later, due to administrative delays, or for the purpose of completing a vocational programme (Spinellis and Tsitsoura 2006). Studies which may add to the understanding of such youths are needed (Robertson et al., 2004) to assist the development of effective social policy programmes and adequate mental health services, but in Sri Lanka the prevalence and types of mental health problems within this population have not yet been adequately determined.

The aims of our study were to describe the demographic and family characteristics of young males held in the juvenile detention centre, to determine their nutritional status and to determine the prevalence of anger and aggressiveness in this population.

Methodology

This study was conducted in an institution where young boy offenders were remanded. A pretested twelve itemed questionnaire was administered to the young offenders to collect their demographic details, family background and offending reasons. LEVEL 2-Anger-Child Age 11–17 PROMIS Emotional Distress questionnaire was administered by the principal investigator. Anger scores were determined based on the validated scores (PROMIS 2008). Scores Less than 55 = None, 55.0—59.9 = Mild, 60.0—69.9 = Moderate 70 and over = Severe. The nutritional status was assessed using the Inbody 230 apparatus and Haemoglobin was assessed by HemoCue® Hb 201apparatus. Permission was obtained from the child and probation department.

Results:

A total of 67 boys aged 13-18 years were assessed. Mean age was 15.52±1.57 years and the duration in detention was 8.33 months (95% CI 6.32-10.34). Theft and delinquent behaviour were the common reasons for being in remand (Table 12). Forty four children (65.6%) demonstrated a high aggressive score and 23 (34.3%) of them had self-harming behaviour. The children with high aggressive score had a significant association with crimes related to alcohol and drug abuse. (p value<0.001)

Table 12: Crimes committed and the high aggressive scorers

Type of Crime	Number (%)	Positive aggressive score
Theft	22(32.8%)	12 (54.5%)
Drug/Alcohol abuse	09(13.4%)	09 (100%)
Delinquent	18(26.9%)	12 (66.6%)
Aggressive behaviour	08(11.9%)	08 (100%)
Child abuse	01(1.5%)	00 (0)
Ran away from home	06(9.0%)	04 (66.6%)
Others	03(4.5%)	01 (33.3%)
Total	67(100%)	44 (65.6%)

The use of aggression may serve different purposes for different offenders (Smallbone and Milne, 2000). Aggression has traditionally been conceptualized as being either instrumental, an act of aggression that intends to hurt someone, but as a means to causing pain or injury. Anger has been cited as a motivator for criminal activities and reoffending. The juvenile offenders in the detention centre have mild anger scores. (Table 13)

Table 13: Distribution of anger scores

Classification of anger	Number (%)
No anger <55	22 (32.8%)
Mild 55-59.9	38 (56.7%)
Moderate 60-69.9	05 (7.5%)
Severe >70	02 (3%)
Total	67 (100%)

74.5% indicated they were misled by their friends and 44.5% indicated that they spent more than 5 hours per day with their friends. There was a significant association with the time spent with the friends and crimes related to drug and alcohol abuse. (P value<0.001). 54.2% indicated that their village was high in crime rates, 10.4% indicated a close relative was also involved in crime and 29.9% said they had easy access to drugs and alcohol. The offenders also felt they were humiliated by others (32.8%) and that led to the crime.

70% of the kids belonged to low and middle income families and the 20% that belonged to the high income families had committed crimes related to alcohol and drugs. 63% of the children belonged to disrupted family background with either parent dead, living abroad or separated.

Thirty children (44.8%) indicated they were abused as children mainly physical abuse, psychological and sexual abuses. The ability to read and understand some of the questions in the questionnaire was difficult in 38 (57%) and it was confirmed by the carers in the home. 60% of the children were engaged in vocational training and 40% attended a nearby school.

The children indicated they were looked after well at the detention centre and it was supported by two non-governmental organisations. Nutritional status was satisfactory in majority of the children. (Table 14)

Table 14: Nutritional status of the children

BMI status (IOTF criteria)	N (%)	Anaemic status (WHO criteria)	N (%)
Under nutrition	12(17.9%)	None	31(46.3%)
Normal	52(77.6%)	Mild	31(46.3%)
Overweight	02(3.0%)	Moderate	05(7.5%)
Obese	01(1.5%)	Severe	00

These children who are in care are likely to be poor and socially excluded even after they leave. They all need stability and support.

Ladies and Gentlemen, it is time we took necessary steps to prevent harm towards children. These children involved in abuse and crime are like the tarnished stars in the sky. They have to be polished and taken care of by the state, family, health care professionals and society. Before I conclude, I would like to tell a few steps to prevent child maltreatment.

Prevention of child maltreatment

There is sufficient evidence, including in the scientific literature, to state with full confidence that child maltreatment can be prevented. Despite this, little attention in terms of research and policy has been given to prevention. Many existing prevention efforts consist of the early identification of cases of child maltreatment and interventions to protect the children involved.

This strategy is indeed a form of prevention and may well be beneficial to individual children and families. It will not, however, lead to a large-scale reduction in the incidence of child maltreatment that is possible using strategies that address the underlying causes and contributing factors. An effective prevention programme is one that reduces the incidence of child maltreatment in the intervention population, or at least lowers the rate at which incidence is increasing. The National Child Protection Agency and the Ministry of Health have developed policies on child protection and all districts have organisations to prevent child maltreatment. The effectiveness of these in preventive strategies must be reviewed for better services.

One of the main strategies for preventing child maltreatment is to aim to reduce the underlying causes and risk factors and to strengthen the protective factors, and in so doing prevent the occurrence of new instances of maltreatment. Counselling and family therapy is one important strategy.

Child maltreatment flourishes in societies with social inequalities, social and cultural norms that support the use of violence, ineffective or non-existent policies on children and the family, poor preventive health care, inadequate social welfare and weak systems of criminal justice. Table 15 indicates some strategies that can be adopted in prevention.

Table 15: Strategies for preventing child maltreatment at community level

Strategy	Sub Strategies
Implementing legal reform and human rights	Translating the convention on the rights of the child into national law
	Strengthening police and judicial systems
	Promoting social, economic and cultural rights
Introducing beneficial social and economic policies	Providing early childhood education and care
	Ensuring universal primary and secondary education
	Taking measures to reduce unemployment and mitigate its adverse consequences
	Investing in good social protection systems
Changing cultural and social norms	Changing cultural and social norms that support violence against children and adults
Reducing economic inequalities	Tackling poverty
	Reducing income and gender inequalities
Environmental risk factor reduction	Reducing the availability of alcohol and drugs

Setting up shelters and crisis centres for maltreated children has shown some prevention and these children should be supported and supervised for better results.

Training health care professional in identifying such likely future perpetrators and referring them to the appropriate therapeutic services could help to break the cycle of violence and reduce the number of new maltreatment cases.

It is sad to see so many broken families and relationships. These promote inadequate parenting, including the failure of any infant-parent attachment, unrealistic expectations of child development by the parents and teachers, a belief in the effectiveness and social acceptability of harsh physical punishment and an inability to provide for high-quality child care when the parent is absent are some of the risks leading to child maltreatment. Some strategies that can be used to overcome these are home visitation programmes and training in parenting.

Home visitation and social support is needed to families with low-birth-weight and preterm infants, children with chronic illness and disabilities, low-income, unmarried teenage mothers and a history of alcohol and substance misuse. Training programmes for parents to educate them about child development and help them improve their skills in managing their children's behaviour. The programmes can be delivered in the home or another setting, such as schools or clinics where parents-to-be and new parents can be reached.

Reducing unintended pregnancies, increasing access to postnatal and prenatal services, access to contraceptives, training children to prevent potential abusive situations are some individual strategies that can be promoted.

Early detection of child maltreatment and early intervention can help to minimize the likelihood of further violence and the long-term health and social consequences. Frontline health care workers in contact with the families must be watchful of the early warning signs that indicate children and families who may need assistance, and they must be able to act on these signs.

When a suspicion of maltreatment arise, a physical and mental health assessment is necessary for the sake of the child's well-being. An Integrated healthcare and forensic assessment is needed. In legal systems that are oriented towards adults, do not take into account children's developmental and mental health needs that must come before those of the forensic investigation. To avoid further victimization of the child, the medical and forensic examinations and the forensic interview should be coordinated and conducted by professionals specially trained to work with child victims. Services should be harmonized in a way that minimizes the number of times a child is asked to relate what took place.

All forms of child maltreatment can have significant and lifelong adverse effects on the child's mental health and development. Psychosocial support is therefore critical for the child's recovery. A child's experience of maltreatment may cause great stress and disruption in the family. The child and other siblings may be afraid of what is going to happen or feel guilty about what has already occurred in the home. Other family members may also have been abused or neglected. Service providers must recognize the importance of particular interventions in helping the family cope, providing reassurance and supporting the rehabilitation of those affected.

Where care is delivered by a team made up of representatives from a range of agencies or sectors, it is essential to have a well-developed plan for following up, with the roles of each member of the team clearly defined. This has been a problem in our region and the introduction of the primary health care system in the future can help to overcome this as the follow-up can be organised at the primary health care level.

Let me conclude this with a quotation from Dave Pelzer, in his book called "A child called It"

"Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul."

Acknowledgment:

Alone we can do little; together we can do so much' Helen Keller

It is my duty to thank all the patients who have been tarnished by abuse, putting up with the questioning and helping in gathering the information.

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Gitanjali Sathiadas was born in Badulla and moved to Jaffna and received her primary and secondary education at Chundikuli Girls' College, Jaffna. She entered Faculty of Medicine, University of Jaffna and was compelled to move to the UK during her final year of her MBBS due to the disruption of the faculty and completed her medical bachelor's degree from University of Aberdeen in the United Kingdom in 1997. She obtained Diploma in Child Health (2005), MD Paediatrics (2007) from PGIM, University of Colombo, MRCPCH (UK-2009) and PGDip in Medical Education (2016) from University of Dundee, United Kingdom. She was trained in Paediatrics at Royal Aberdeen Children's Hospital, United Kingdom (2008-2010).

She joined the Faculty of Medicine, University of Jaffna in 2003 as a lecturer and promoted to senior lecturer in 2010. She was the Head of the Dept. for Paediatrics from 2010 to 2016 and also as the Clinical Coordinator from 2010 to 2017. She is an honorary Consultant Paediatrician to Teaching Hospital Jaffna.

Dr. Sathiadas has authored a book on Cerebral Palsy and also member of the editorial board of Jaffna Medical Association. She has an extensive portfolio on research and a recipient of National Research Grant (NRC) in 2014. She has delivered more than 50 guest lectures, published many articles on newspapers and scientific journals. She also has more than 20 journal articles and more than 50 abstracts with more than 100 citations.

Dr. Sathiadas is a very active person at the community level where she works very closely with Northern region Child Care and Probation Department and contributed a lot on identifying child abuse cases, protecting and preventing child abuse in the region. She has also initiated and currently executing community reach programmes for special need children, especially for Cerebral Palsy and Autism. She is also a senior trainer at national level, training Paediatricians and other intensive care practitioners on Advanced Paediatric Life Support run by Sri Lanka College of Paediatricians, where she has been a council member for the last three years.

In addition to her clinical contributions, she also contributes a lot on academic level. She has been a long standing member of the Board of Study in Paediatrics in Sri Lanka. She is also the Acting Head of the Medical Education Unit of Faculty of Medicine in Jaffna.

She is in the core group of the curriculum revision body of the faculty which is responsible for the entire course revision.She is also in the University Quality Assurance group,which is a body across all Faculties of Jaffna University that is responsible for initiating, establishing and maintaining Quality Standards of the degree programmes in all aspects.

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