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Adolescent today

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From the Editor's desk

My Dearest colleagues of IAP Adolescent Health Academy,

At the outset I extend my sincere appologies for the inadvertant delay in bringing out Adolescent Today – our official mouth piece. But, honestly I feel happy that due to desire, love and affection of all members – we are here with the e-edition of Adolescent Today- with the promise by heart and soul that very soon that we would be trying our level best to ensure that you get a hard copy of the same soon.

Over the last few years the incidents of sexual abuse are on the steep hike, specially in teenage population. This makes us rather more responsible to enlighten our fellow members about the issues involved and also to empower the parents to protect their children.

Hence we have tried to provide you tips for sensitive, yet comprehensive care for our adolescents from sexual abuse. We understand it is multi-disciplinary approach and maintaining the dignity and integrity of our adolescents all the times, please judge our endeavour – the contributors have really contributed very meaningful and interesting articles – I am sure you will love to read it.

The Activity report of individuals and branches used to be a very interesting feature – Thanks to our dyanamic secretary and co-editor for helping us to gather the reports and the photographs.

Please pour in your suggestions to make Adolescent Today more meaningful and interesting. We are all ready to witness the AHA National Conference at Ludhiana - I am sure we would be having a great conference full of academics and fun.

I wish an excellent conference in Ludhiana.

Sincerely,

Dr C.P. Bansal
Editor in Chief, Adolescent Today
President, SAPA

Dear Esteem members,

It is matter of great pleasure that after a long unexpected delay in “Adolescent Today” is in our hand in e version. The present issue is on sexual abuse which is rampantly increasing in our country. It is the time when we all should actively involve ourselves to give sex education to our adolescent not only by the pediatricians but also by gate keepers of the society.

All articles are written by esteem faculties of Adolescent Health Academy-and real time has been devoted by them for the cause.

I hope you will praise all the esteem authors for their devotion and dedication to adolescents issues.

Best wishes and see you in Ludhiana for Adolesccon 2014 - a great event of AHA.

Yours in academy service,

Dr. J.S. Tuteja
Chairperson, AHA

Dear AHA Members,

It is a matter of great pride that Adolescent Today, the official publication of Adolescent Health Academy has been revived with a vibrant new editorial board under the dynamic leadership of Dr CP Bansal. The current issue focuses on the burning issue of 'Adolescent Sexual Abuse', its management, sequlae, predisposing factors and prevention. The largest ever national study on child abuse in 2007 revealed that 50% children were sexually abused. Maximum abuse was seen in the 12 to 15 years age group. Sexual assault was maximum amongst 15 to 18 yrs age group with a total prevalence of 5.69%. 50% of the children and adolescents were abused by persons known to the victim. We hope that this issue of Adolescent Today will fine tune clinical skills and aid in appropriate management of cases of sexual abuse. The issue also brings to you the annual report and activity report of AHA. Kindly give your feedback and suggestions at secretary@ahaiap.org

Yours in academy service,

Dr. Preeti M. Galagali
Secretary, AHA

Dear AHA Members,

Dear colleagues of Adolescent Health Academy,

I am delighted to present ADOLESCENT TODAY as e-magazine specially to take care of our adolescents. There are a lot number of sexual abuse incidences particularly 12 to 15 years.

Great efforts are put by Chief editor, co-editor , team of editors & specially dynamic secretary of Adolescent Health Academy.

National conference of AHA is being organised at Ludhiana. Organizing team are putting great efforts. I wish all the success of the conference.

I again convey my congrats to the successful release of the Adolescent Today. Hope the members will take advantage in solving day to day problems of Adolescents.

Dr. J.C. Garg
Treasurer, AHA

Dr Chhaya Sambharya Prasad
MBBS, DCH, DHR, PGDDN
Developmental Pediatrician,
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Clinical Presentation of Sexual Abuse in Adolescents

Adolescence is an energetic and a vibrant phase of life characterized by rapid growth and development. Children and adolescents are vulnerable to influences from the environment they live in. They are more affected than any other age group by the actions and inaction of their caretakers and guardians. Adolescents, due to their vulnerable age and risk taking behavior are more prone to being exposed to challenging situations.

Children should be allowed exposure to varied situations in order to experience challenges and to learn from the same but it should be within an environment that is safe, creative and stimulating. Provision of a safe environment is important so that children can be allowed free play, with protection from known dangers and identified hazards, with reduced need for adult intervention. With careful planning, parents ought to create an environment that is conducive to healthy growth and development of children and adolescents. Prevention of accidents / untoward incidents means ensuring that the environment they are in is safe and suitable for them. It is true that no one can keep a child / adolescent completely safe at all given times, and indeed in many ways it would be undesirable to try to do so always. In order to gain confidence in recognizing the untoward situations, they should be allowed to explore their environment. But they should be taught the right way of protecting themselves and should be allowed to settle their own boundaries based on experiences gathered. We may consider our homes as the safest environment for our adolescents but ensuring safety at home becomes a prime responsibility of every parent / caretaker. We must not forget that most of the cases of abuse occur at home.

Every child has fundamental right to be reared in a safe and secure environment. Parents / caretakers should help them to identify situations that can be harmful for their physical and / or psychosocial growth. Adolescents visit pediatricians for common health problems or for a health screening or for immunization. Adolescents may appear physically healthy but may have some psychological issues bothering them. They may not be aware that these issues need attention. Most of them don't even know that they can share their problems with a pediatrician and seek help. If the issues are left unattended and unaddressed, these psychological issues and or any form of maltreatment being can alter their perception of the world around them, about their own self and their future. Thus identifying the various distressing issues affecting an adolescent becomes the responsibility of a pediatrician who can help them realize the difference between wellness and illness.

Adolescents are exposed to great deal of unnecessary and distorted facts from media and also from friends / peers / seniors in high schools. They need to learn the true facts about human sexuality. As teenagers are 'hungry' for accurate, adequate information and sexual expression is a basic instinct and need, they may end up harming themselves in irreversible ways that may severely affect their psychosocial growth, mental functioning and stability. A very striking feature that has come to light recently is that the age of puberty is gradually decreasing whereas age of marriage has been on the increase. Due to a dire need of the sexual expression, few adolescents are indulging in unsafe sexual activities earlier in life without being aware of the consequences of their behavior.

Child and Adolescent Sexual Abuse in India

India is the country with the second highest rates of fatal abuse/child homicide in the world. The majority of child deaths in our country are not investigated or routinely autopsied, thus leading to misclassification of cause of death. The National Survey of Child Abuse commissioned by the Ministry of WCD in 2005 and conducted in 11 states across the country reported that 21.90% children face severe forms of sexual abuse and 50.76% other forms of sexual abuse in their lives, 5.69% were sexually assaulted. Children on street, children at work and children in institutional care face highest incidence of sexual assault. 50% abusers are persons known to the child or in a position of trust and responsibility. Mostly the children / adolescents did not report the matter to anyone.

A study among 189, 6-16 year old boys in an observational home in Delhi showed that 76% had suffered physical abuse (most commonly by father) and 38% sexual abuse. A study by Tulir-Centre for the prevention and healing of CSA, amongst 2211 class XI students of Chennai revealed that 39% girls and 48% boys had undergone sexual abuse in some form.

Important definitions

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused by adults or older children in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or career fabricates the symptoms or deliberately induces illness in a child.

Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child / adolescent such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or

unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, ensure adequate supervision including the use of inadequate caregivers, failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (for example, rape, buggery or oral sex) or non penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of,

pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Pediatricians need to understand the difference between Sexual Abuse and Sexual assault. Whereas sexual abuse is committed by a person responsible for the care of a child and which has a great potential for repeated occurrences and more likely to go undetected, sexual assault refers to the act committed by a stranger.

Clinical Features of Sexual Abuse

It is essential for a parent / professional to identify early any incident of abuse, especially sexual abuse, in a child / adolescent in order to provide support and allow a healthy physical and psychosocial growth. Research proves that children / adolescents, who are subjected repeatedly to episodes of sexual abuse early in their lives, face bigger challenge in developing normal peer relationships, facing greater risk of developing depression, internalizing or externalizing behaviors and / or suicidal tendencies. The Child Sexual Abuse Accommodation Syndrome is well described in literature. It includes the following psychological stages:

1. Secrecy from usually family members / friends
2. Helplessness: feels intimidated, stigmatized, isolated, helpless, fearful, also guilty
3. Entrapment and accommodation: gets 'adjusted' to ongoing abuse
4. Disclosure that is usually delayed, conflicting and unconvincing
5. Retraction: the victim denies the complaint and abuse continues

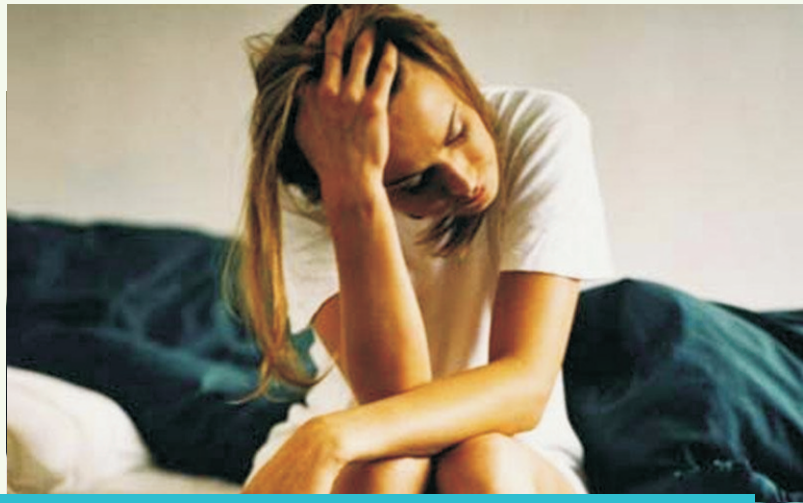
A detailed evaluation of the victim includes the following:

- Presenting symptoms
- Detailed medical history
- Social history
- Examination

An adolescent may present with history of physical abuse only, but one must keep a high index of suspicion for sexual abuse too when a child or an adolescent presents with the following symptoms. Signs and symptoms for physical, emotional and sexual abuse may be present in a child simultaneously; hence a careful evaluation of history is of utmost importance.

Symptoms to look out for include:

- Loss of appetite, and or sudden changes in eating habits like compulsive eating or dieting.
- Recurrent abdominal pain without identifiable etiology.
- Sudden appearance of age inappropriate behaviour such as bed-wetting and thumb sucking
- Internalizing / externalizing symptoms, sudden mood swings such as rage, fear, anger, or withdrawal.
- Self injurious behaviour, suicidal tendencies, use of drugs, alcohol and truancy.
- Difficulty in falling asleep
- Sexual promiscuity
- Fear of intimacy or closeness, fear of certain people or places.
- Inadequate personal hygiene
- Adult-like sexual activities with toys or other children, manifested during play, writing, drawings or dreams. May include sexual or frightening images.
- New words for private body parts.
- Shows resistance to bathing, toileting, or removing clothes even at appropriate situations.
- Refusing to talk about a "secret" he/she has



with an adult or older child.

- Talking about a new older friend.
- Suddenly having money, toys or other gifts for no apparent reason.
- Having a negative self image

Specific pointers towards sexual abuse are:

- Inappropriate sexual behavior
- Vaginal discharge/bleeding
- Vulvovaginitis
- Recurrent Urinary tract infection
- Recurrent abdominal pain with unidentifiable etiology
- Rectal bleeding
- Bites / bruises around genitals / anus / oral / breast / thighs
- Lacerations / tears around these areas
- Mutilation of genitals

Practical tips for physical and systemic examination in a suspected case of adolescent sexual abuse

- Consent is always essential
- A head to toe examination should be carried out.
- Growth & Development assessment
- Sexual Maturity Rating (Tanners Scoring)
- The examination should always be conducted in a well lit room with adequate lighting.
- All examination and procedures should be adolescent friendly and in their best interest.
- One should record resistance to examination or if the child goes into a state of dissociation.
- During general examination one should note the attitude, behavior, demeanor, body language, promiscuous behavior, apathetic, listless attitude, etc. A small child can be examined in the mother's lap.
- Look for an abnormal gait – broad based and painful
- If the adolescent allows, it is best to examine in the lithotomy / knee-elbow position
- Signs of violence / struggle should be looked for
- Examine the clothes for any blood stains, semen, hair
- Examine the nails for tags of epithelium, blood
- Look out for oral ulcers, warts, fungating lesions
- Age of injuries should be co related with the time of abuse

Genital Examination includes details of:

- Vulva – for any redness and or tenderness
- Distensibility of vagina/anal opening
- Hymen – intact or ruptured
- Hymen – edges, edematous, presence of hemorrhage
- Perineal tears/warts/ulcers
- Pubic hair – presence of matting due to seminal fluid, blood, foreign hair

It is important to remember that in 75-80% cases of CSA, the examination of genitals and anal areas will be normal.

The adolescent may present with sequlae of sexual abuse that are explained in detail in another article titled 'Sequlae of Sexual Abuse'.

Important Do's and Don'ts while examining an adolescent with sexual abuse

Do's

- Report all cases of sexual abuse
- Document findings chronologically / with consistency
- Maintain objectivity / avoid subjectivity

- Authenticity of information should be ensured
- Age determination is a must, whether requested or not (especially in a case of trafficking)
- Comfortable, relaxed atmosphere for better cooperation
- Build “trust and confidence” with the victim
- Even minute details of examination should be recorded / reported

Don'ts

- Ally with individuals involved in investigation
- Get pressurized for false reports
- Get emotionally influenced by allegations
- Use words, of more than one meanings/ those that may be interpreted wrongly
- Disclose identity / findings to unauthorized persons
- Try to be investigator/ remain person of science
- Write very lengthy/ irrational history in report

It is pertinent to remember that the trial of the case is to be done by the Court, not by a medical professional and hence it is best not to be a detective and just carry out the medical examination scientifically and appropriately record the reports.

Failure to recognise abuse may be due to several reasons ranging from psychological barriers to gaps in clinical skills. For example, a professional may not actually recognise that a child has been abused due to an uncommon presentation. This leads to inappropriate management, and a subsequent postponement in diagnosis. However, a heightened awareness of the occurrence of sexual abuse, can lead to its more frequent recognition.

Adolescents should be supported, nurtured, informed and given the opportunity to live their lives to the fullest, safely and responsibly. It is the responsibility of the society at large to ensure a safe physical, emotional and social environment for our adolescents. Pediatricians can play a major role in managing cases of sexual abuse appropriately.

Recommended Reading

1. Hobbs JC, Wynne JM, Hanks HG; Forfar & Arneil's Textbook of Pediatrics 6th ed.2003
2. Working Together to Safeguard Children (HM Government 2006).
3. Child Rights and Child Protection Manual, CRPP, IAP 2007
4. Child Protection Companion RCPCH 2006, Evaluation of suspected Child Physical Abuse AAP Policy Statement Pediatrics 2007
5. Subgroup report Child Protection in 11th five year plan(2007-11) MWCD GOI
6. Adolescent's Care In Office Practice (AC-OP) How to Prevent Sexual Abuse

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Child Sexual Abuse: A Pediatrician's Perspective

While great awareness has been raised about sexual violence against women in India, much less is known about the problem of sexual abuse of children. Studies suggest that more than 7,200 children, including infants, are victims of sexual abuse (rape) every year;

As recent research has shown, it is not just within institutions that Indian children suffer from sexual abuse. A 2007 Indian government-sponsored survey (Study on Child Abuse © Ministry of Women and Child Development, Government of India, 2007), based on interviews with 12,500 children in 13 different states, reported serious and widespread sexual abuse, thereby putting the government on notice about the gravity of the problem. The study also showed that 50% abusers are persons known to the child or in a position of trust and responsibility and that most children did not report the matter to anyone.

Children are sexually abused by relatives at home, by people in their neighborhoods, at school, and in residential facilities for orphans and other at-risk children. Most of such cases are not reported. Child Trafficking for Sexual Abuse and Prostitution are the level of an unorganized industry. Many are mistreated a second time by a criminal justice system that often does not want to hear or believe their accounts, or take serious action against perpetrators.

What is important to understand is that, beyond the physical and sexual trauma of child sexual abuse, is the range of symptoms associated with child sexual abuse which includes anxiety, depression or complex post-traumatic disorder. Rape, as heinous as a crime against an adult woman, inflicts a trauma many times more on the developing brain of a 4 year old boy or girl. Consequently, the repercussions on this maturing brain are more myriad, difficult to elicit and even more difficult to heal.

The table below represents the most common signs and symptoms according to age:

COMMON SIGNS AND SYMPTOMS OF SEXUAL ABUSE ACCORDING TO AGE

Infants & Toddlers (0 – 5 years)

- Crying, whimpering, screaming more than usual.
- Clinging or unusually attaching themselves to caregivers.
- Refusing to leave “safe” places.
- Difficulty sleeping or sleeping constantly.
- Losing the ability to converse, losing bladder control, and other developmental regression.
- Displaying knowledge or interest in sexual acts inappropriate to their age

Younger Children (6–9 years)

- Similar reactions to children ages 0-5. In addition:
- Fear of particular people, places or activities, or ofbeing attacked.
- Behaving like a baby (wetting the bed or wanting parents to dress them).
- Suddenly refusing to go to school.
- Touching their private parts a lot.
- Avoiding family and friends or generally keeping to themselves.
- Refusing to eat or wanting to eat all the time.

Adolescents (10 –19 years)

- Depression (chronic sadness), crying or emotional numbness.
- Nightmares (bad dreams) or sleep disorders.
- Problems in school or avoidance of school.
- Displaying anger or expressing difficulties with peer relationships, fighting with people, disobeying or disrespecting authority.
- Displaying avoidance behavior, including withdrawal from family and friends.
- Self-destructive behavior (drugs, alcohol, self-inflicted injuries).
- Changes in school performance.
- Exhibiting eating problems, such as eating all the time or not wanting to eat.
- Suicidal thoughts or tendencies.
- Talking about abuse, experiencing flashbacks of abuse.

Pediatricians are the professionals most concerned and most empowered about the well-being of the child. Whenever child suffers sexual abuse, the pediatrician is most likely the first contact of the child. Therefore, pediatricians need to be knowledgeable about the available community resources.

Pediatricians across all 50 states in the USA have to statutorily (required by law) report ALL suspected cases of child abuse and neglect. They are protected by law in case of an erroneous reporting, as long as it was in good faith. Pediatricians are legally penalized in case they fail to report. They might also undergo medico legal proceedings for damages, for the additional burden faced by the child, for failure to have been reported earlier by the pediatrician. Indian Academy of Pediatrics (IAP) has been at the forefront for this battle for Child Protection.

A country wide Child Rights and Protection Program (CRPP) on Recognition and Response to Child Abuse was launched under the aegis of IAP Vision 2007 by Dr Naveen Thacker, President IAP 2007. The IAP released its guidelines “Recommendations on Recognition and Response to Child Abuse and Neglect in the Indian setting” (Indian Pediatrics, 2010 June; 47(6): 493-504). The Child Abuse and Neglect Chapter (CANCL) of IAP has been doing yeoman service in this area under the guidance of eminent IAPian and Past President IAP, Dr R N Srivastava.

A first of its kind Academic Program in India “The Post Graduate Diploma in Juvenile Jurisprudence and Juvenile Justice System” was offered by the University of Mumbai due to the efforts of Prof Dr Chandra Krishnamurthy, formerly Dean Faculty of Law, University of Mumbai and IAP member Dr Samir Dalwai, which offered detailed knowledge of Child Rights on the basis of Child Development and Psychology.

The International Rescue Committee (IRC), in partnership with the U.S. Department of State, the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation have dedicated resources toward developing a program model of care and guidelines for implementing the model of care for child survivors of sexual abuse across humanitarian settings. The program suggests that Health and psychosocial service providers responding to child sexual abuse cases should adhere to the following set of communication best practices while working with children who have been sexually abused:

1. Be nurturing, Comforting and Supportive.
2. Reassure the Child.
3. Be Careful not to traumatize the Child further.
4. Speak so children understand.
5. Help children feel safe.
6. Tell children why you are talking to them .
7. Use Appropriate People .
8. Pay attention to non-verbal communication.
9. Respect children's opinions, beliefs and thoughts.

Unfortunately in India, till date, there was no specific law aimed for safeguarding the children from sexual abuse. Sexual Abuse of the girl child was actionable under IPC Section 375, 376 (Rape) and of the boy child under IPC Section 377 (Unnatural Sexual Acts).

Thanks to the pioneering efforts IAP and many other like minded organizations and NGOs, 'The Protection of Children against Sexual Offences Bill' was passed into an Act of the Indian Parliament, in May 2012. On 14th Nov, 2012, this Act has been notified and is being implemented.

This brings us to the aspect of Judicial Proceedings, Mandatory Reporting and appropriate punishment.

Though it is obvious that perpetrators of child sexual must be punished, especially as a deterrent to other offenders, most survivors dread about the matter being reported. In a study reported by an NGO (http: // arpan . org .in/media-report-on-child-sexual-abuse/), of the 64 survivors, nearly 62 per cent strongly feel that they would never be okay with mandatory reporting, while the remaining favoured the clause. Under the Protection of Children from Sexual Offences Act (POCSO), if a citizen comes across the case of child sexual abuse, he is duty-bound to report the crime to authorities concerned. If a person chooses to keep silent, s/he can be punished.

For most survivors, it took time to make sense of what had happened, to figure out the vocabulary to describe the incident and to muster courage to talk to someone. Guilt and shame were two major stumbling blocks to disclosure.

A survivor said her mother wanted her to narrate the crime in front of her abuser. “Whether it was because she did not believe me or because she wanted to judge from the reaction of my abuser, I do not know. It made me feel traumatised.” Another male participant said, “It's nearly impossible to make anyone believe that I had been abused by another man. I once told someone about my experience and she laughed at it, telling me that I probably would have enjoyed it.”

Shreya Sen, a researcher, who took part in the study, said, “It is important to take into account the unique and specific environment within which each survivor is negotiating with the aftermath of their abuse. Mandatory reporting may not suit the needs of every survivor.” Pooja Taparia, founder and CEO of the NGO said safety education programmes with children and greater emphasis on therapeutic intervention with survivors and their trusted adults needs to go hand in hand with law.

As is clear from the above, Child Sexual Abuse is a social malady. Legislation serves to underscore a Government's commitment to its eradication. However, Justice Systems and Jurisprudence are no answer to a twisted mind; a Magistrate's Order is no match for public apathy and the circle of silence that surrounds the abuse. Child Sexual Abuse is a disorder in the social spectrum, and both, the prevention and punishment on one hand, and the healing on the other need to be rooted in public action and humanity. Pediatricians owe a responsibility on many counts; i) as the primary care givers and respondents for a child's mental and physical health, ii) as Advocates for All Children, iii) as Citizens of the State, and most of all, iv) as parents, aunts, uncles, grandparents, themselves.

What can a Pediatrician do? To quote Nelson Textbook of Pediatrics: "Children generally do better if they can get social support, either from family members or from a nonjudgmental adult outside the family, especially an older mentor or peer.'' Needless to say, there is a great deal that a Pediatrician can do, by way of recognizing, responding to and reporting child abuse.

We fail ourselves, our children and all humanity when we fail to act against Child Sexual Abuse.

Dr Kiran Aggarwal
Consultant Pediatrician Delhi

Etiology And Evolution of Sexual Abuse

Childhood sexual abuse is a complex life experience, not a diagnosis or a disorder. An array of sexual activities is covered by the term Child sexual abuse(CSA). This diversity in itself ensures that there will be a range of outcomes. Interestingly boys and girls are abused equally. Boys differ in that they do not tell, remain confused with what exactly happened with them, continue to behave with disordered mental health in their adult life which adversely affects even their married life. Some of the abused in childhood or as adolescents get caught in a cycle of repeated abuse.

Sexual abuse and Sexual assault continue to be major social problem. Finkelhor and colleagues (1990) studied the prevalence of sexual abuse in a national survey of adult men and women. 27% of all females and 16% of males surveyed, reported that they had been sexually abused prior to age 18.

Recent reports from media about India of emerging ugly trends of sexual abuse and a historical community protest, forced the laid-back policy makers in the Indian government to seriously consider the totally neglected issue of safety of women and children. Professionals, NGOs and the government need to work hand in hand with a political will.

National study on child abuse in 2007, the world's largest study in the country of that time, initiated by government of India (MWCD) had shocked the researchers of the study with the magnitude of the problem. Sadly it had never received any attention by the state, it being too difficult a task. Non existence of mapping of services, missing infrastructure and lack of knowledge and interest of medical professionals, ignorance and insensitivity of police and other allied professionals regarding the subject, were all contributory.

The study reported 53.22% children revealed facing one or the other form of sexual abuse. 21.90% child respondents reported serious form of SA. Among all the children reporting sexual assault 54.4% were boys and 45.6% were girls. The maximum percentage of children abused fell in 15 -18 age group.50% abusers were cousins, uncles, friends and class mates. 72.5% children did not disclose the abuse to any one! Maximum cases were reported from Assam, Andhra Pradesh, Bihar and Delhi. Children on streets, at work and in institutional care reported the maximum CSA.

MWCD was forced to initiate CA study to substantiate existence of CA in the country while initiating drafting of legislation on child abuse in 2005.This was the first landmark research work initiated by the Indian government on the subject which brought Govt allied,professionals and NGO together.

The CA study came out with several recommendations, but unfortunately child protection did not receive enough budgetary allocations as priority investment in the child. Very recently Protection of children against sexual offences Act 2012 and National Policy of Children 2013 emerged as one of those recommendations and has brought some hope for future policies on child welfare as “Right's based” and not only “need based”.

The process of disclosing childhood sexual abuse varies, it is often described as : purposeful or accidental; and as spontaneous or prompted. All published empirical studies on the disclosure of child sexual abuse indicate that a high percentage of victims who report their abuse to authorities delay disclosure of their abuse, and that a significant number of children do not disclose the abuse at all.

The delay between the initial happening and the subsequent disclosure of the abuse varies, depending on a number of factors such as the victim's age at the time of the events, the relationship between the perpetrator and the abused, the gender of the abused, severity of abuse, developmental and cognitive variables related to the abused, and the likely consequences of the disclosure. Consequently, child sexual abuse is significantly UNDERREPORTED. When victims do report that they were abused, they often do so years after the abuse occurred making the subject all the more difficult to deal with.

The “child Sexual abuse accommodation syndrome”, proposed by Summit (1983) has been supported by a number of researchers (Elliot & Briere 1994, Faller 1988, Sorensons & Snow 1991, Lawson & Chaffin 1992, Elliot & Briere 1994) to explain why children's disclosure is sometimes delayed, a theory that proposes children's responses to child sexual abuse comprise five stages 1) Secrecy, 2) helplessness, 3) entrapment and accommodation, 4) delayed,unconvincing disclosure, and 5) recantation.

The typical pattern of events is as follows : the child is forced to keep the sexual abuse a secret and initially feels trapped and helpless. These feelings of helplessness and the child's fear that no one will believe the disclosure of abuse, leads to accommodative behavior. If the child does disclose, failure of family and professionals to protect and support the child adequately, augment the child's distress and may lead to retraction of disclosure.

Historicaly earlier it was believed that those responsible for sexual abuse and assault in the society were adult males .Recent data indicate that sexual abuse and sexual assault are perpetrated by adult males as well as females, by female adolescents as well as juvenile males.

Albert, Mittelman and Becker (1985) found that of more then 400 sex offenders interviewed 58% reported the onset of their deviant sexual interest patterns prior to age 18. In regard to literature on characteristics of juvenile offenders, motivators for sexually abusive and aggressive behavior, assessment of juvenile sex offenders and treatment issues and modalities, most of it focuses on juvenile male offenders and very little on females sex offender. World literature reports adolescents represent a significant proportion of all individuals, 1/3 rd of all sex offences against children .

Contrary to common assumption most juvenile sex offenders have not been victims of childhood sexual abuse,the self reported rates of sexual victimization range from 20% to 55% (western literature). Juveniles who sexually offend are a diverse group ranging from well functioning families to highly chaotic or abusive background.

Why men sexually abuse children has been one of the foremost questions guiding research on sexually deviant behavior in the twentieth century. As with most forms of deviant behavior, there are various explanations as to the etiology and maintenance of sexual offending. Within the multispeciality literature, biological, psychological and sociological theories have been designed to explain the onset of deviant sexual fantasies and behavior.

Understanding the etiology and maintenance of sexual offending is important in order to implement policies that are appropriate for all types of sexual offenders. Section below summarizes the theories on deviant sexual behavior.

SUMMARY OF THEORIES EXPLAINING CHILD SEXUAL ABUSE

Biological Theory

Concernes with organic explanations of human behavior; physiological factors (e.g., hormone levels, chromosomal makeup) have an effect of sexual behavior; androgens promote sexual arousal, orgasm, and ejaculation, as well as regulate sexuality, aggression, cognition, emotion and personality; abnormal levels of androgens lead to aggressive sexual behavior.

Psychodynamic Theory

Sexual deviance is an expression of the unresolved problems experienced during the stages of development; the human psyche is composed of three primary elements: the id, the ego and the superego; sexual deviancy occurs when the pleasure principle is overactive.

Behavioral Theory

Deviant sexual behavior is a learned condition, acquired through the same mechanisms by which conventional sexuality is learned; it is acquired and maintained through basic conditioning principles.

Attachment Theory

Humans have a propensity to establish strong emotional bonds with others, and when individuals have some loss or emotional distress, they act out as a result of their loneliness and isolation.

Cognitive-behavioral Theory

Addresses the way in which offenders' thoughts affect their behavior; focuses on the way in which sex offenders diminish their feelings of guilt and shame by rationalizing it through excuses and justifications.

Integrated Theory

There are preconditions to child sexual abuse, which integrate the various theories about why individuals begin to participate in sexually deviant behaviour.

Theories On Abuse By Clergy

No clear consensus as to why some priests molest children and others do not, though many theories address the stunted psychosexual development of the priest; the psychodynamic model addresses the way in which the experiences of shame interact with unrealistic, moral expectations conveyed through church teachings that have been internalized, resulting in the creation of a shame cycle that stunts the individual's psychosexual development and contributes to sexual misconduct; experience of celibacy interacts with past traumas (e.g., childhood sexual abuse) and may stunt the priest's psychosexual development at a preadolescent/ adolescent stage leading to sexual misconduct.

THE OFFENSE CYCLE

When sexually abusing a child, the abuser must make a series of decisions prior to committing the deviant act .There are two types of child molesters: the fixated offender and the regressed offender.

Fixated, or preferential, child molesters are exclusively attracted to children. They are likely to have many victims as a result of their failure to have developed a sexual attraction to their age mates.

In contrast, the regressed offender is sexually attracted to age mates, but the abuse is triggered by some type of stressor in the environment. These offenders are less likely than fixated offenders to have multiple victims as the abuse serves almost as a means of them coping with the stressful situation. Regressed offenders display greater guilt and shame and exhibit a positive treatment prognosis.Since regressed offenders are influenced by external stressors in the environment, it is possible to teach them to identify their high-risk situations. Most importantly, it is possible to identify a series of Seemingly Unimportant Decisions (SUDs). These decisions place the offenders in a position

where they are likely to reoffend.

The key feature of the offense cycle involves the interaction of thoughts, feelings and behaviors. Essentially, negative thoughts will cause the offender to experience negative feelings, prompting the use of certain behavioral measures to overcome these feelings. There are multiple determinants involved in this cycle, but the core point is that sexual abuse is not a random act. These determinants may include situational factors (i.e., the opportunity to offend), affective states (depression, anger, isolation), past learning, biological influences and prevailing contingencies of strengthening (current, unforeseen support or back up).

There are several steps involved in the offense chain. The offender will first have negative thoughts. Thoughts may be characterized by themes such as “Nobody likes me” or “I'm no good.” These thoughts then lead to feelings such as anger, frustration, sadness and inadequacy. The thoughts and feelings then interact in such a manner as to influence the offender's behavior. At this point the offender likely to make poor decisions (SUDS) and withdraws from people around him. Isolation results in a lack of communication that causes the thoughts and feelings mentioned earlier to go unsolved.

Then the pro-offending thinking causes the offender to progress to the point where he starts to experience deviant sexual fantasies also referred to as lapse fantasies. These fantasies lead to masturbation, and the offender begins to feel better about the negative thoughts and feelings experienced earlier in the cycle. Through fantasizing and orgasm, the offender has now found a way to quiet the painful feelings, but he is placing himself into more unsafe situations. It is not uncommon at this point for the offender to take steps short of committing a sexual offense such as targeting a victim and engaging in a fantasy rehearsal of the future abuse. Once the offender has engaged in the fantasy rehearsal, he reaches a point in the cycle where he decides to give up. In a sense, he is saying to himself, “Why not? I've already gone this far. I may as well do it.” It is at this point when the offender begins to “groom” his victim and plan the abusive act. This planning causes the offender to experience a sense of excitement that further motivates him until he is at the point of committing the offense.

After adequate grooming has taken place, the offender sexually abuses the victim. The act itself serves as a back up of the original fantasy. However, once the act has occurred, new anxiety provoking thoughts emerge. Examples of some of the thoughts the offender may be contemplating include, “What have I done? I might get caught.” These thoughts lead to new feelings of guilt and fear despite the release of tension achieved through the recent abusive act. These feelings of guilt, fear and remorse cause the cycle to come to a stop during which the offender tries to regain a sense of normality. By refusing to acknowledge the thoughts and feelings associated with the abuse, the cycle begins once more as the original issues had never gets addressed.

GROOMING

Those offenders who take time to plan the deviant act are known to indulge in what is termed “grooming” behavior. Grooming is a pre-meditated behavior intended to manipulate the potential victim into complying with the sexual abuse. Based on a survey of tactics used by abusers to groom their victims, Pryor (1996) describes several methods by which offenders approach and initiate sex with their victims.

These methods include verbal and/or physical intimidation, seduction or the use of favors such as candy, money or other gifts. The tactics used by offenders depend somewhat on the potential victim's response to the tactic. If an offender encounters little to no resistance from the potential victim, he will continue to use the same tactic repeatedly. If some resistance is encountered, the offender may either change the tactic and/or may become more forceful in his endeavor.

One common tactic noted by Pryor is the seduction and testing of a child. This tactic is used when there is an existing relationship with a child and the child is accustomed to the affectionate expression of the offender. The offender gradually extends the affectionate touching to include sexual behavior, all the while “testing” the child's response. If no overt resistance is observed, the sexual abuse continues.

A less frequent tactic that is mentioned by Pryor may be the offender catching the victim by surprise. In this instance, the offender may plan a situation to distract the victim or seize the opportunity to abuse when it arises. The latter is most common and is usually a result of the offender's frustration from waiting for the right time/opotunity to initiate contact.

A third and more scary tactic used by offenders may be garnering victim compliance through the use of either verbal or physical force. In this situation, the offender either commands the victim to perform sexual acts and/or physically forces the victim to engage in sexual acts. This tactic is more common in more serious, repeat offenders.

Pryor found that emotional manipulation and verbal force were the most common tactics used by offenders to groom their victims. This occurs in various ways, such as doing favors for the victim in exchange for sex and/or emotionally blackmailing the victim into compliance. Even though it may appear that there is room for negotiation on the part of the victim, the outcome always favors the offender. Offenders who have ongoing contact with their victims often utilize this tactic (i.e., incest offenders).

Another tactic used by offenders in order to groom their victims entails disguising sexual advances in the context of playing a game. For example, the offender will begin by tickling the victim and gradually progress to fondling. While this approach may appear spontaneous, it has been well planned by the offender, yet planned in a rather secret manner.

The most methodical and deliberate tactic of engaging a victim in sex involves a process of initially introducing the victim to the idea of sex and then gradually engaging them in sexual activity. Pryor describes this tactic as turning the victim out. For example, the offender will begin by displaying himself in the nude or introducing the victim to pornography. Then there is a period of rationalizing that sex is okay. This may be followed by fondling the victim or having the victim fondle him, all the while rationalizing that sex is okay and possibly verbally praising the victim for his/her efforts. This exchange slowly builds up to more serious sexual acts and possibly to the point where the victim is being rewarded with gifts for his/her participation. Over time, the victim becomes groomed to the point that engaging in sex with the offender is more or less automatic. While most grooming tactics are premeditated, this tactic is more methodically planned and the offender is willing to wait months or possibly years to accomplish his task. When offenders set out to groom a victim, they will usually use tactics that have previously proved successful in gaining their victim's compliance. However, given that offenders attend to their victim's response, they are open to changing their tactics if an approach proves unsuccessful.

TYPOLOGIES OF CHILD SEXUAL ABUSERS

In the ongoing effort to develop an understanding of characteristics that would allow for classification of sex offenders into specific groups, many researchers have proposed typologies of offenders.

Groth proposed the fixated-regressed dichotomy of sex offending.

Fixated offender:

The fixated offender is characterized as having a persistent, continual and compulsive attraction to children. They are usually diagnosed with pedophilia, or recurrent, intense, sexually arousing fantasies of at least six months in duration involving pre-pubescent children (American Psychiatric Association,

1999). Finkelhor (1984) classifies these offenders as exclusively involved with children and points out that they are usually not related to their victims and are attracted to children from adolescence. According to Holmes and Holmes (2002), the offender has not fully developed and shows characteristics of a child.

The fixated offender's actions are typically premeditated in nature and do not result from any perceived stress. In addition, this type of offender is often unable to attain any degree of psychosexual maturity and, during adulthood, has had virtually no age appropriate sexual relationships. The fixated offender is more likely to choose victims who are male and not related to him (Abel and Rouleau, 1990; Simon et al., 1992; West, 1987). It is the fixated offenders who are most dangerous to society, constituting “a public health problem” (Abel, Lawry, Kalstrom et al., 1994) as well as a “criminal problem” (Freeman-Longo, 1996).

These offenders develop relationships with vulnerable children (vulnerable in either an emotional or situational sense), they typically recruit, groom and maintain the children for a continuing sexual relationship (Conte, 1991). The offenders make themselves believe they have established a caring, supportive role with the child and that the child is able to derive pleasure and educational experience from the interaction (Abel and Rouleau, 1995; Marshall and Barbaree, 1990b). They are dangerous as their offenses mostly go unreported, and get convicted for fewer offenses than they actually committed (Abel and Rouleau, 1990; Abel et al., 1994; Elliot, Browne and Kilcoyne, 1995). Abel and Rouleau's (1990) study of 561 male offenders who voluntarily sought treatment showed that the non-incestuous offenders in the sample who assaulted young boys averaged 281 offenses with an average of 150 victims. It is the strongly fixated offenders who have the most victims and should consequently be considered the highest risk to the community.

Regressed offender

The regressed offender's behavior, on the other hand, usually emerges in adulthood and tends to be precipitated by external stressors. Gebhard et al. (1965) touched upon the role of external stressors as precursors to sexual offending. In this early classification system, the researchers state that sexual offending is the product of environmental stressors and disordered childhood relationships. These two variables intersect in such a manner as to render the offender powerless to control his behavior, thus culminating in an offensive act.

Stressors

There has been extensive research evaluating the nature of stressors. These stressors can be situational, such as unemployment, marital problems and substance abuse, or can be related to negative affective states such as loneliness, stress, isolation or anxiety. These stressors, according to Schwartz (1995), often lead to poor selfconfidence and low self-esteem, undermining the abusers confidence in themselves as men. Sexual involvement with children is not fixed, but is instead often a temporary departure from the offender's attraction to adults (Simon et al., 1992). This type of offender is more likely to choose victims who are females.

Regressed offenders tend to victimize children to whom they have easy access, and as such, they often victimize their own children. It is difficult to establish accurate patterns of arousal for regressed offenders, and researchers (Freund, McKnight, Langevin et al., 1972; Quinsey, Steinman, Bergerson et al., 1975) have found that they have similar arousal patterns to “normal” men. Arousal is generally measured

through a penile plethysmograph (PPG) as the male is shown erotic material. The control group generally shows some level of arousal to photos of young children in erotic poses, and it is difficult to differentiate between the two groups. This indicates that, as with rapists, the offender is not necessarily motivated by sexual needs alone.

Sex-pressure/sex-force offense

A distinction is made between a sex-pressure offense and a sex-force offense. In a sex-pressure offense, the offender either entices or entraps his victim. In his pursuit for sexual gratification, the offender would prefer his victim to cooperate. However, if his victim resists, the offender usually will not follow through with the sexually abusive behavior. In contrast, a sex-force offense is one wherein the offender uses either terrorization or physical aggression. When terrorization is used, the offender may be drawn to his victim primarily because the victim is easily overpowered and may present less resistance than an adult. The offender is using his victim purely as a means of sexual release.

Those offenders who use physical aggression to overpower their victims, commonly known as "sadistic" offenders, must inflict pain in order to achieve sexual gratification. Fortunately, this type of offender is the rarest.

SEXUALIZED BEHAVIORS

There is growing body of research on sexualized behavior in children and its relationship to sexual abuse. Although majority of sexually abused children do not engage in sexualized behavior, the presence of inappropriate sexual behavior may be indicator of sexual abuse and problematic when it occurs at a greater frequency or at a much earlier stage than would be developmentaly appropriate. (kindly note before trying to understand Sexualized behavior in children and Adolescents, Its crucial to understand age appropriate development of sexuality in Children and Adolescents from 0-18 age)

WHAT IS SEXUALITY?

"Sexuality is a central aspect of being human throughout life and encompasses sex,gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behavior, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economicpolitical, cultural, ethical, legal, historical and religious and spiritual factors".

(WHO draft working definition 2002). It is our genes that dictate sexuality and therefore our sexuality is genetically programmed within us at the earliest stages of foetal development said Harner.

Scientists highlight the importance of several factors for normal sexual development. The emotional radar of babies is already greatly developed before birth, they respond not only to the obvious emotions such as love and hate, but are capable of much finer emotional instincts. Even in the womb, babies need to feel wanted and loved in order to thrive best.

We are all sexual from the day we are born to the day we die. Sexuality is an essential, lifelong aspect of being human, and it needs to be celebrated with respect, openness and mutuality. Sexuality is much more than having sex. It involves a wide range of feelings and emotions at all ages. Sexual instinct is natural in children. Our child's sexuality does not need to be uncomfortable topic. Sex and sexuality are good and positive aspect of life. Children should experience their sexuality as a natural part of their development and not as a topic not to be talked about or to be avoided for as long as possible (as the usual trend in India is).

What does sexuality actually mean? Sexuality is not just a nine-letter word. It is an integral part of our life and is instrumental in the way we

think and behave. Our sexuality influences our personality and determines our physical, social and emotional behaviour. It affects our relationship with people. It is about who we are and how we view ourselves, how others view us, how we think others view us and how we behave and conduct ourselves in a given situation. It is not just about how we walk and talk and dress or make love. It is much more complex and includes every aspect of our life. Simply put,it is about our needs, desires, hopes, fears, ambitions, values, attitudes as well as conflicts, pain and problems. Finally it is about how we face life and resolve conflicts and deal with difficult situations.

All that we are, as parents, will mould our children too. Children learn a lot about relationships, bodies, affection, and communication from the beginning. If parents tell the truth and take it to their child at his developmental level, they can help the child grow up safe, self-aware and sensible. It is now accepted that, from the early months of life in the womb, the unborn child is an aware, remembering, feeling and reacting being. So it is now that the baby's sense of self begins to emerge? Perhaps. It is also widely accepted that we may be deeply affected by our early experiences during birth and even in the womb. The unborn baby experiences his first sensations through the skin, before he can see or hear. In the early weeks of development, sensations and feelings are centred on the skin. It is through the skin that, as unborn babies, we become aware of the relationship between our bodies and our surroundings, and this gives us our earliest sense of self.

THE MESSAGE OF TOUCH

Learning about sexuality begins at BIRTH. Touch is the beginning of sexuality. As a mother kisses her baby's toes and fingers, massages his legs, strokes her baby's head and cheeks, the baby receives a lesson in the language of sensual pleasure. Parents begin teaching their child about sexuality at birth. Often unknowingly, in most of our interactions, we give sexual messages to our children. The earliest message is Touch. The concept relating to a sense of self, of being wanted and valued is largely rooted in the feelings of human warmth and security that a baby receives from others early in life.

SEXUALITY AS SECURITY

In the foetus, sexuality is experienced as total security – From the moment we are born, we learn, about love, about touch and relationships. It is both amazing and interesting that when one mentions the words sex or sexual or sexuality, there is a mixed reaction, often of interest but some times of embarrassment. This is true even in the most educated of homes and among the most progressive of people.The basic problem lies in the fact that one tends to club the three together without realising that while the first two – sex and sexual are an integral part of the third, the third sexuality is a word that is so much larger and encompasses everything from birth to death.

SEXUALITY EDUCATION

Each day children receive sexuality education by the way their parents talk to them. How they cuddle and play with them or teach them new words including body parts. It is comfortable or awkward? It will then make them comfortable about their bodies or again awkward about it.Without even being aware we pass on some attitudes and values to our children through how we think, what we say and in the way we behave. The child will pick up nuances from our conversation and body language. Among children who feel they are not loved, there is a great craving for physical nearness in terms of cuddling and hugging and kissing. This is certainly desirable with parents, but not with others. We have to be very cautious especially with girls. A lot of sexual abuse is rampant these days in society and within the family circle.

Gradually, sexuality education continues as the child grows and picks up values. Although parents continue to be the main sexuality educators, gradually others come in:

neighbours, teachers, friends, television, books, advertisements, toys and even the internet. Although sexuality education does include sex education, it is only a part of it.

Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions from the cognitive domain. This includes the information component, through the affective domain of feelings, attitudes and values and the behavioural one of communication and decision-making skills. Today sex education programmes have become an integral part of the education system throughout the world.

Through sex education programmes attempts are made:

- to impart knowledge about physical, mental and emotional process of growing up.
- to build moral values in making rational decisions.
- to help each person understand how to use one's sexuality effectively and creatively as a student, as a son/daughter, as a sibling, as a spouse, as a member of the family, the community and as a citizen.

In India, girls are given some sex education in the specific area of menstruation and about being careful, but normally boys are left to fend for themselves. We must try and change this. Parents can change the trend. It is important that we keep ourselves informed to be able to impart information. Learn the technical terms. Have diagrams ready to explain. Be vigilant and anticipate what the children will ask or want to know. One's own comfort level, tone of voice and factualness will convey more than words.

Children are quick to sense parental discomfort or unwillingness to discuss sexual topics. If they sense discomfort, many children inhibit their interest and curiosity (at least in presence of parents) or they may reserve the topic for peer discussion. If parents are not open to such discussions, they forego awareness of the child's sexual development and possibly will not have any influence in the later years when sexuality is a primary developmental task. For the parents, the best course to take,is to strike a balance between being too open in approach and being too repressive or too judgemental.

DEALING WITH MASTURBATION

Expert advice : If you are clever, most masturbation can be handled as a matter of manners rather than morals.

Masturbation is normal among young children. They often use it to work out something that has upset them. Experts should counsel parents to realise that their child is not, in fact, masturbating for erotic purposes. The reason genital fondling bothers adults is that we tend to view the child's actions through adult eyes. Children touch their genitals simply because it feels good and it's comforting – some children suck their thumbs, some twirl their hair, some boys hold their penis, some children touch their genitals at naptime or bedtime as a way to calm themselves. For him, it is pleasure. It is not 'wrong' or 'dirty'. Only, if the child hears these terms from adults (or picks up on their anxieties) does he become worried or confused.

MESSAGES ABOUT SEXUALITY

How children view their gender reflects their self-esteem and contributes to it. Low self-esteem is likely to carry over in to unhealthy sexuality; problems with sexuality are likely to weaken self-esteem. A girl needs to be glad she is a girl, a boy needs to enjoy being a boy. It is important to tell parents to convey to their children that they are happy about their gender. Children are more likely to become adults with unhealthy sexual identities if they are confused and dissatisfied with their gender as a child.

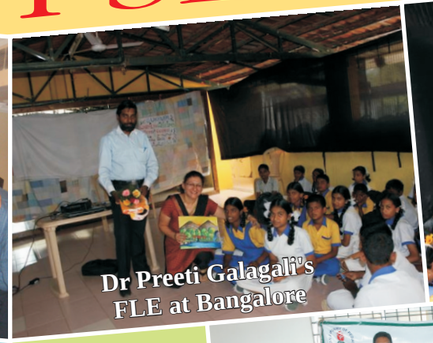
Acknowledgements

1. National study on child abuse 2007(initiated by Govt of India MWCD)
2. Review of literature by eminent world researchers on Sexual abuse

GLIMPSES


Dr Beena Johnson conducting
FLE at Calicut


Dr Tuteja & Dr Prajapati
at Adolescent CME by AHA Agra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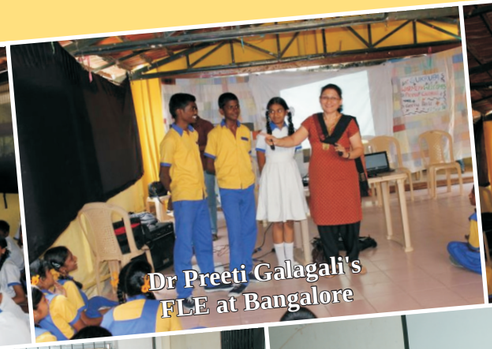
FLE at Bangalore


Dr Preeti Galagali's
FLE at Bangalore


Dr Preeti Galagali's
FLE at Bangalore


Dr Somashekar conducting
FLE at Bangalore


Dr Somashekar conducting
FLE at Bangalore


Adolescent Health CME at
Ambedkar Medical College Bangalore


Dr Prema, Dr Vanita Rao, Dr Preeti Galagali
in a Role play at CME in Bangalore


Dr Vaishali Deshmukh's
FLE at Pune


Dr Venkiteswaran's
Parenting Session at Kerala

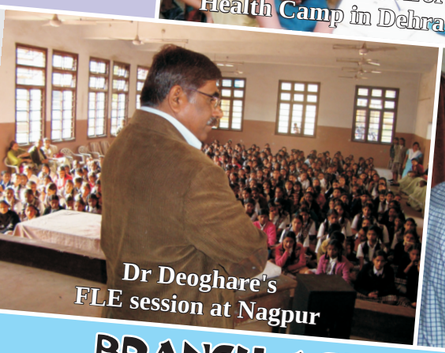

Dr Latha at Adolescent Health
CME at Chennai

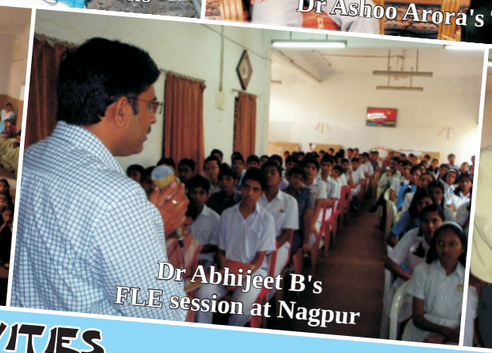

Dr Yamuna at Adolescent
CME at Chennai


Dr Ashoo Arora's
Health Camp in Dehradun Slums

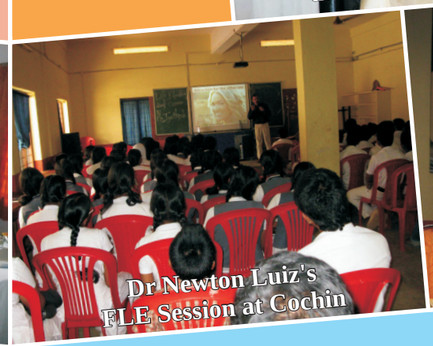

Dr Ashoo Arora's TV Talk


Dr Sushma Desai
at Parenting Session at Surat


Dr Deoghare's
FLE session at Nagpur


Dr Abhijeet B's
FLE session at Nagpur


Dr Rajiv Mohta's
FLE session at Nagpur


Dr Newton Luiz's
FLE Session at Cochin

BRANCH ACTIVITIES

BRANCH ACTIVITIES

ADOLESCENT HEALTH ACADEMY 2014 Activity Report

In 2014, Adolescent Health Academy (AHA) reached out to over 25000 adolescents, 4000 parents, 120 teachers, 250 community health workers and counsellors, 100 nurses and 700 medical professionals throughout the country. AHA members conducted 100 school family life education sessions, 25 parenting sessions, 14 training sessions for teachers, counsellors, health workers and teachers and 14 academic sessions for medical professionals including paediatricians. They participated in 15 television shows related to adolescent health issues, 1 radio show, 1webinair and published over 100 articles in print media. They also organised health camps, rallies, quizzes, essay and drawing competitions for adolescents with special focus on underprivileged adolescents.

Dr TP Jayaraman, Dr Ashok, dr Shaji John, Dr Venkiteswaran, Dr CP Bansal, Dr Preeti Galagali at Kerala Adolescon

Report from AHA Branches

Delhi AHA

- Delhi branch of AHA was installed on 11 May 2014 at Kalawati Saran Children's Hospital. Dr JS Tuteja, Dr Swati Bhave, Dr Sangeeta Yadav, Dr Harish Pemde, Dr Anjali Saxena and other eminent faculties participated in an update on Adolescent Health attended by 99 pediatricians.
- On 13 July 2014, a workshop was conducted at BLK speciality hospital that was attended by 85 delegates.
- Dr Harish Pemde, Dr Ravi Gupta, Dr Srikanta Basu and Dr K Sharada are resource persons for National Level Training of Trainers on Adolescent Friendly Health Services under Rashtriya Kishor Swasthya Karyakaram

Chennai Branch

- In July 2014, Dr Latha Ravichandran conducted a session on 'Approach to Adolescents' for 24 post graduate students at Sri Ramachandra Medical College.
- In July and August 2014, Dr Manu took 3 interactive sessions for over 200, 7th to 10th std students on common health issues and study skills through games, quiz and role plays.
- Dr Rajmurali conducted a life skill program for 10 adolescents of an orphanage.
- On 31 July 2014, Dr Latha and Dr Padmasani conducted an orientation program for 1200 1st year MBBS graduates and 40 faculty members on common teen issues.
- On 1st August, Dr Latha took a life skill session

for 240 undergraduate students of Chettinand University. Dr Babu conducted a health camp for 159 teenagers of Krishna Matriculation School.

Pune Branch

- Dr Pramod Jog and Dr Vaishali Deshmukh took 4 parenting sessions for over 100 parents of teenagers called 'Palakancishala' (School for Parents) tackling different issues like growing up, stress, study skills and discipline.
- In January, February and March 2014, Dr Vaishali Deshmukh took 4 school sessions on teen issues for 300 adolescents and 100 parents.
- Dr Vaishali has been writing a weekly column called 'Open Up' on teen issues since January 2014 in Loksatta Marathi Daily. Her paper titled 'Knowledge and Attitude about growing up changes- An intervention study' was published in Pediatric Oncall journal in July-September 2014 issue.
- Dr Shailaja Mane is the course coordinator for a 1year post doctoral course in Adolescent Pediatrics recognised by DY Patil University. She conducted many health camps and awareness talks for adolescents in schools and community health centres along with Dr Sharad Agarkhedkar and other faculty members of DY Patil Medical College in Pimpri reaching out to over 500 adolescents. She has also published 2 articles on adolescent health in a leading Marathi daily.

Agra Branch

- On 26th April 2014, Dr JS Tuteja and Dr NC Prajapati took a session for 40 pediatricians on Adolescent Sexuality and Spirituality and Suicidal tendency respectively. This meet was extensively covered by the press.

Gwalior Branch

- From February to September 2014, AHA Gwalior reached out to over 800 adolescents, 450 parents and 27 teachers of 3 schools in Gwalior. Dr Mukul Tiwari took 5 sessions, Dr Rashmi Gupta 3 sessions, Dr PV Arya and Dr Sneha Gadker 2 sessions each, Dr Rahul Sapra and Dr Praveen Mittal 1 session each. Topics included common adolescent issues, counselling, hygiene, basic life support and positive parenting techniques. The sessions were covered extensively by the local media.

Surat Branch

- On 6th June 2014, Dr Sushma Desai took a session on adolescent health issues for 20 AHA members.
- On 19th and 20th July 2014, Dr Sushma Desai, Dr Kamlesh Parekh, Dr Salim Hirani and Dr Ketan Bharadva participated as faculty in a very successful conference called 'Parenting for Peace' organised in association with local police department. They reached out to hundreds of parents, NGOs, psychologists and social workers.
- Interactive family life education sessions were taken for over 1000 adolescents and 450 parents in 4 schools in August 2014 by Dr Sushma Desai, Dr Salim Hirani, Dr Swati Vinchurkar and Dr Premal Shah.

Nagpur Branch

- On 17th July 2014, Dr Tejas Golar from Australia addressed 40 AHA members on adolescent psychiatric disorders.
- In April and May 2014, Dr Abhijit Bharadwaj, Dr Rajan Patil, Dr Shubhada Khiwardkar, Dr Gawande, Dr Manjugiri and Dr Deoghare conducted sessions for 90 health workers working in tribal areas on life skills and also trained them in counselling skills.
- Dr Rajiv Mohta, Dr Abhijit Bharadwaj, Dr Tejas Golar, Dr Patil, Dr Kotwal, Dr Deoghare, Dr Shivalkar, Dr Manju Giri, Dr Kaduskar, Dr Upadhya and Dr Uday Bodhankar conducted interactive sessions for 1850 students, 31 parents and 70 teachers in 9 different colleges, schools and orphanages. Topics included drug abuse, media addiction, depression, suicide, life skills, road safety, relationships, lifestyle disorders and media literacy.
- The Nagpur AHA branch also conducted a drawing competition on road safety and a quiz on nutrition for teenagers.

Bangalore Branch

- On 7th March 2014, Bangalore AHA branch in collaboration with Dr SM Prasad of Ambedkar Medical College conducted a CME on Adolescent Health that was attended by 200 doctors.
- It also conducted 3 academic meetings in 2014 on acne, sports injuries and eating disorders respectively. Each meeting was attended by 15 to 20 AHA members.
- Dr Preeti Galagali, Dr Chandrika Rao, Dr Somashekar, Dr Prema, Dr Vimochana, Dr Sumitha Nayak and Dr Geeta Patil reached out to

3500 adolescents and 50 parents in 14 schools (both private and government), colleges and residential homes. They conducted interactive sessions on stress management, life skills, common adolescent health issues, menstrual issues, nutrition, suicide and personal hygiene.

- Dr Preeti Galagali took a session on Adolescent Counselling for 50 counsellors.
- 3 school sessions were conducted by Dr Hema Sharma for 60 teachers on adolescent health issues.
- Dr Prema conducted an essay competition for 200 teen girls on advantages of breast feeding. Health camp was conducted by Dr Prema for screening 200 teenagers of a residential school for underprivileged for anemia and mental health disorders.
- Bangalore Adolescent Health Academy has adopted 2 schools for the underprivileged at Bangalore for conducting Life Skill Education Sessions throughout the year for high school students.
- On 31 October, Dr Preeti Galagali, Dr Chandrika Rao, Dr Chitra Dinakar, Dr Anuradha and Dr Prema conducted a very successful pre-conference workshop at Karnataka Pedicon at Mysore for 60 health professionals
- Dr Anuradha published 35 articles related to common teen issues in a weekly column in Bangalore Mirror newspaper. Dr Preeti Galagali was the faculty on a webinair on adolescent health that was transmitted to 4000 pediatricians. Dr Chandrika Rao discussed adolescent issues on a premier TV channel, Uday TV and Dr Prema spoke over FM radio on teen issues. Dr Preeti Galagali's articles on adolescent health and study skills were published in 2 medical books respectively. Dr Vimochana's article on government school health programs was published in Sikshana Varthe. Dr Sonia Kanitkar's case report on pornography was published in Current Medical Journal.

Lucknow Branch

- On 9 November, Dr Ashutosh Verma organised a successful panel on Adolescent Health at NARCHI conference attended by pediatricians and gynecologists. Dr Roli Mohan, Dr Piyali Bhattacharya and Dr Preeti Galagali were the faculty. Dr Piyali and Dr Ashutosh also conducted a FLE session for 200 high school boys and girls.

Kerala State Branch

- On 2nd January 2014, Mission Kishore Uday was successfully conducted for 288 adolescents, 95 parents and 33 doctors at N.Parur. The faculty included Dr Venkiteswaran, Dr Jeeson Unni, Dr Newton Luis, Dr Yamuna and Dr Ashok.
- Dr Venkiteswaran took 11 sessions in schools to cover over 1000 adolescents on life skills, personal hygiene and other teen health issues.
- The adolescent friendly school project was stared jointly with Sadgamya project under MLA VD Satheesan and 9 schools were identified for conducting monthly FLE classes. Dr Venkiteswaran, Dr Ashok and Dr Vineetha take these classes.
- Teen Club was inaugurated at SN Institute of Technology by Dr Venkiteswaran.
- Dr Venkiteswaran took 2 sessions on adolescent parenting for 200 parents and on premarital counselling for 40 girls. His article on life skills was published in Malayalam daily Mathrubhumi. He also appeared on TV for a program on teen health issues.
- In 2014, Dr Beena Johnson reached out to 2350 parents in 11sessions . She covered topics like role of parents in personality development, effective parenting, teen conflicts and managing specially abled teens.
- Dr Beena took interactive sessions for 1300 adolescents in 8 schools and colleges on study skills and teen issues. She also addressed NCC cadets on life skills. She took a session on autism for 100 nursing students.
- 2 articles written by Dr Beena on study skills and learning problems were published in the IMA Malayalam weekly.
- In 2014, Dr Newton Luis conducted 7 school sessions for 1350 adolescents covering topics like sexuality, teen health, lifestyle disorders and hygiene.
- Dr Newton addressed 100 pediatricians on 'masculinity'. He took public lectures that were attended by 350 delegates on sexuality and sleep issues in adolescents. He also trained 90 counsellors as a part of Nirbhaya project.
- Dr Newton has 8 publications in local newspaper and monthly magazines in 2014 on various teen

issues.

- On 28th September 2014, Dr TP Jayaraman and his team conducted the 10th Kerala State Adolescon. It was a well organised conference with reputed national faculty.

Report from AHA Members

Dr Himabindu

In association with Government of Andhra Pradesh, Dr Himabindu, nodal officer YUVA, conducted many academic training programs for public health professionals on various adolescent issues. She also organised rallies, health camps and community awareness programs at YUVA, the premier centre for adolescent health at Niloufer Hospital, Hyderabad.

- 74 outreach activities were conducted in various places such as communities, slums, schools from Jan 2014 to May 2014 in which 6191adolescents participated.
- Dr Himabindu conducted training and awareness programs on anemia in association with Nandi foundation (NGO).
- Adolescents from St. Josephs High school were addressed on sexuality issues from 15th April to 26th April 2014. 1258 adolescents participated in 6 batches. This program received a good feedback from adolescents, teachers and parents. Special activities and competitions were conducted at various schools, community health centres, slums and at YUVA. 865 adolescents participated in these activities in March 2014. Senior Pediatricians namely Dr.P.S.Murthy, Dr. Devraj, Head of the institute ICH and Dr.Ravi Kumar, Dr Sri Krishna, secretary IAP TCB graced the occasion.
- State level rally was conducted on raising awareness regarding adolescent health on 14th February 2014. Nearly 400 Adolescents participated in this rally. District level rally was conducted on 24th January 2014 at Karmikanagar slum in which 400 adolescents participated to create awareness in the community about the importance of girl child and rights of the girl. The rally was flagged of by Project Director Mrs. Laxmi, WDCW and other local community leaders.

Dr Atul Kanikar

Dr Atul Kanikar organised an elaborate and extensive peer educator program at the West zone YUVA-FOGSI conference (11th-14th September 2014) at Nasik, Maharashtra. In 2014, he also took sessions for teachers and 'rescued' trafficked adolescent girls on various adolescent health issues. He also contributed to a discussion on Sexuality Education as an adolescent health expert in a leading Marathi daily.

Dr Sulekha

Dr Sulekha reached out to over 1500 high school and pre university students of 4 schools and colleges at Puttur, Karnataka on various adolescent mental and physical health issues. All her sessions were well appreciated by the students.

Dr Manju Lata Sharma

Dr Manju Lata Sharma conducted many community health related activities in Bikaner, Rajasthan. She celebrated World Health Day, International Breast Feeding Week, Save the Girl Child Day and conducted family life education classes in schools and community health centres reaching out to 220 adolescents, 110 parents, 30 doctors and 20 teachers. She also addressed the media on importance of adolescence and published an article on adolescent health in a leading Hindi daily, Dainik Jagran. Her poem 'Teen Diary' was published in Academy Today.

Dr Ashoo Arora

Dr Ashoo Arora conducted 2 public health talks at Dehradun, Uttarakhand for over 150 adolescents covering topics like puberty, menstrual issues, HIV, hygiene. 12 interviews on various adolescent health related topics featuring Dr Arora were telecast on DD1. He also conducted health camps and talks for adolescents living in slums. He addressed the DRDO officials on adolescent immunisation. He is actively involved in the ARSH helpline set up by the Government of Uttarakhand. He presented a paper on high risk behaviour in adolescence at UP Pedicon. He conducted a drawing program for adolescents featuring their common health concerns.

Dr Kiran Agarwal

Dr Kiran Agarwal participated as a faculty in the International Conference on HumanTrafficking on 3rd and 4th February 2014. She talked on Problems of 'Common Data base and SOPs' in the session on repatriation, rehabilitation and social reintegration of Rescued Tafficking Victims among SAARC countries. She also actively participated in the session on Recommendations to the Government'.

Dr Sushma Kirtani

Dr Sushma Kirtani from Goa is contributing a weekly article on adolescent health issues in a leading local daily.

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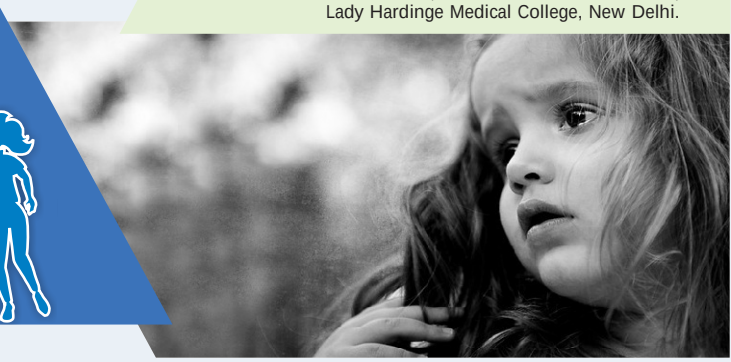
Prevention of Sexual Abuse in Adolescents



Sexual abuse is common in India. A national study on child sexual abuse found that almost every other child is abused sexually at least once in a life, including adolescents. Consequences of abuse have far reaching implications on body and mind. Early intervention will help reduce trauma. Pediatricians and Adolescent Health Practitioners should be alert to the possibility of sexual abuse while evaluating the history of the adolescent, especially when unexplained features are present.

This article focuses on prevention of sexual abuse in adolescents and describes briefly features, identification, management, and prevention .

Dynamics of sexual victimization and disclosures

To master a physical disease it is important to understand its pathogenesis. Similarly to understand sexual abuse it is necessary to understand the dynamics of sexual victimization and disclosures.

The Perpetrator (1) is mostly known to adolescent (the abuser looks like any friend or family member, not an ugly monster) (2) is obsessed with the victim and snares every opportunity to abuse (3) has easy access to adolescents or creates opportunities for easy access, (4) intends to involve the adolescent repeatedly and more aggressively over time, (5) uses rewards and/or threats, (6) lives in the same community, uses same roads, shops, parks, buses, and trains, (7) can be found at home, school, play ground, and neighbourhood. Adolescents and parents may know them socially, but may be unaware of their personal lives or interest in children and adolescents.

Secrecy plays a vital role in execution and repetition of sexual abuse and is an essential dynamic. It removes accountability and promotes victimization. Secrecy is maintained by (1) targeting the adolescent who is non-verbal or has poor communication skills or who would not be believed in, if he chose to disclose the abuse. (2) bribing (gifts, favours, money) or threats / intimidating remarks directed at adolescent or his near ones such as parents, siblings or friends, (3) inflicting adolescents with shame, guilt or embarrassment, or (4) a combination of these.

Disclosures or failure to disclose determine the course of abuse. Adolescents either fail to disclose the abuse or are very late to disclose. Various reasons are responsible for it like fear of stigmatization, threats, embarrassment, of not being believed, and feeling of culpability for their experience. Disclosures by the adolescent may be planned, accidental or elicited. It is important to know the method of disclosure, as planned disclosure may mean the conscious decision of the adolescent to speak out about the abuse, having reached her limit of putting up with it. Accidental disclosures may be found by parent or teacher or others through her diary or SMS or email or social networking sites etc. Eliciting a history of sexual abuse is the responsibility of physician and should be looked for when a behaviour or statement warrants suspicion.

Recantation is a phenomenon which must be known to physicians. The purpose of disclosure by adolescent is to STOP the abuse. Adolescents often blame themselves for whatever was happening to them, even when they were forced into it. The longer the duration of abuse, the stronger the sense of culpability, as is the guilt, when the perpetrator, close to the victim in relationship, is prosecuted. In such scenarios, the adolescent may retract the initial accusations. However, this may unfortunately restart or escalate the severity of sexual abuse.

Sexual abuse or assault should be suspected when following features are present-

1. Excessive Nightmares
2. Extreme fear
3. Sudden change in personality
4. Significant changes in eating, studying, play activities, and interactions with family and friends
5. Return of bed wetting and thumb sucking
6. Psychosomatic symptoms like stomach acheor headaches
7. Unexplained or unusual possession of money or gifts or privileges
8. Self harm
9. Suspicious use of mobile/internet
10. Unexplained trauma

Management of sexual abuse is complex and needs to be dealt with a lot of sensitivity and professionalism. It involves the following-

1. Assessing the physical and emotional safety of the victim
2. Examining for any trauma to genitals and other parts of body
3. Evaluating the need for post-exposure prophylaxis for sexually transmitted diseases including HIV
4. Collection of forensic evidence and ensuring that no potential forensic evidence is destroyed.
5. Evaluating for prophylaxis against pregnancy in female victim
6. Assessing the mental status including risk of suicide by victim
7. Arranging counseling of the victim including trauma focused cognitive behavioral therapy
8. Providing support to the family
9. Keeping the identity of the victim secret, and
10. Dealing with the media tactfully.

Detailed management can be found in the books mentioned at the end of the article.

PASS Test

It is difficult to assess whether the relationship between two adolescents is abusive or simply innocent exploration of body or harmless behavior. This test detects the sexual abuse of an adolescent by an adolescent. Ask these questions during evaluation.

Power: Is one adolescent using tricks, threats, bribes, physical force or blackmailing the other adolescent?

Ability: Is one adolescent more able (in terms of mental, emotional or physical abilities) than the other adolescent? Whether probable victim is developmentally immature or disabled? Status: Is one adolescent in a more powerful situation like owner-servant, team leader, etc. Size: Is one adolescent much larger in physique, age or strength than the other?

If none of the answers to these questions is yes then the adolescents pass this test and sexual abuse is unlikely. If any answer is yes then such adolescents should be evaluated for sexual abuse.

Prevention of Sexual Abuse

Considering the prevalence and consequences of sexual abuse in adolescents it is imperative that ALL adolescents are protected from it.

Primary Prevention

This is the action taken for preventing the first (and subsequent too) incidence of sexual

abuse. Education of caregivers, parents and adolescents themselves is the key to primary prevention. Ideally this education of children should begin much before the adolescence begins. Parents should master the art and skills of "How to protect the child" and should transfer these to their child and adolescent to empower them to protect themselves. Adolescent must be told in very clear unambiguous terms that what constitutes abuse and sexual abuse, what should they do if someone tries to abuse or assault, and to report anything and everything that happens without their consent and which makes them uncomfortable. Parents must be told to give credence to such complaints by adolescents and they should investigate every single such reported incidents.

Adolescents must also be told about high risk situations and to avoid these. Clinical interactions for minor illnesses and health checkup visits should be utilized for such health education. Every adolescent need this education.

Identification of potential perpetrator is an important part of prevention. A person may be an abuser if he/she-

- Tries to break social, physical or emotional limits and makes adolescent uncomfortable by this behavior.
- Insists or does tickling, kissing, touching, or holding the adolescent in a socially inappropriate manner.
- Often brings sexual references or incidents in routine talks especially when adolescents are there.
- Interacts with adolescent excessively through phone, email or through social networking sites.
- Behaves "too good to be true" e.g. gives gifts, offers excessive benefits or privileges.
- Helps adolescent to get away from any inappropriate behavior or 'crime' committed by adolescent.

Such a person may be an adult or adolescent too and at times it becomes very difficult to identify him/her. But when such a potential abuser is identified then such a person should be kept away from adolescents in every situation and at any cost.

Physicians should include the following points as anticipatory guidance-

- Identify different forms of abusive controls like physical force, social coercion, abusive role models, etc. and emotional blackmail
- Explain problems of violence in relationships especially when meeting in isolated places or very private places like rooms
- Establishing respect to the rights of others
- How to apply preventive skills in high risk situations like yelling, asking for help, not surrendering, forceful physical resistance, trying to injure the perpetrator, using chili spray, informing parents and friends, taking photographs of perpetrator, fleeing the scene, etc. It has been found that above methods lead to avoidance of rape and mere requesting not to harm, pleading, crying or offering no resistance at all is associated with a higher incidence of completed rape.

Secondary Prevention

This involves immediate response once the abuse has been reported or has occurred. Appropriate actions to identify the perpetrator may act as deterrent for repeat of abuse. This is also important to reduce the harm inflicted on the victim by treating physical trauma appropriately, providing adequate prophylaxis, and by extending the access to psychological counseling including cognitive behavior therapy. Parents have a critical role here not only in protecting their adolescents from getting abused but also in preventing their teen to become an abuser. Physicians should support such parents by providing appropriate health education and by referring the adolescent to mental health professionals for counseling and psychotherapy.

Tertiary Prevention

Prevention of consequences of sexual abuse is more important when the victim is an adolescent as they face greater consequences. Here too parents and family are important as they constitute the immediate support system. Physician has to coordinate the care by various experts like psychologists, psychiatrists, medical social workers, gynecologists, and STI experts. Schools and teachers are the other important components in life of adolescent and they should also be taken into confidence. As establishing the routine of adolescent as early as possible is the immediate goal the support of peers and same age relatives cannot be undermined. Ultimately concentrating on study and/or work will help the adolescent in leaving behind the episode of sexual abuse and to move forward in life.

Key Points

Sexual abuse is not uncommon and adolescents present in diverse ways when they face or have experienced sexual abuse. Physicians need to understand subtle signals and must have skills to take history, conduct examination following the law of the land, manage the victim, and empower the victim and the family in stopping further abuse.

Suggested Reading

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Finkel MA, Lind ME. Sexual abuse and assault. In Fisher MM, Alderman EM, Kreipe RE, Rosenfeld WD Eds, American Academy of Pediatrics Textbook of Adolescent Health Care, AAP 2011; pp 1702-08.

Stop It Now. Prevent Child Sexual Abuse: Facts about sexual abuse and how to prevent. 2010. www.stopitnow.org

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Sequlae of Adolescent Sexual Abuse

Adolescent sexual abuse has devastating effects on health and emotional, mental and social well being of the victim. Sexual abuse results in increased mortality and morbidity in adolescence and later in adulthood. There can be immediate, short term and long term ill effects on health. It can even lead to intergenerational effects on health and psychological well being.

All sexually abused adolescents do not suffer from these adverse consequences. Family and peer support and individual resilience act as valuable protective buffers. A few adolescents may initially report little or no psychological distress from the abuse but may suffer from its 'sleeper effects' i.e poor physical and mental health later in life. These children are unable to express their true emotions due to fear in childhood. Children suffering from penetrative sexual abuse at frequent intervals at a young age and with multiple forms of maltreatment have more severe consequences on their health. Severe forms of adolescent sexual abuse and maltreatment can even lead to death.

Immediate and Short Term Sequlae

Short-term effects of sexual abuse may include regressive behaviors (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, performance problems at school, or sexualised behaviour. Symptoms may be externalised such as show of aggression or bullying or internalised like social withdrawal or complaints of recurrent generalised aches and pains .

Physical health may also be affected with complaints of recurrent genital discharge, dysuria, abdominal pain and urinary tract infections. (Most of these issues are explained in detail in the article on 'clinical presentation of adolescent sexual abuse'.)

Long Term Sequlae

To understand the long term consequences of child sexual abuse, it is important to understand a few key points regarding Finkelhor's conceptualisation of the traumatogenic effect of child sexual abuse and latest neurobiology research on effect of toxic stress on the brain.

Finkelhor's Conceptualisation of Traumatogenic Effect of Child Sexual Abuse:

Finkelhor has divided the sequlae of child sexual abuse into four categories i.e betrayal, powerlessness, stigmatisation and traumatic sexualisation. As the perpetrator is usually a known trustworthy figure, the child feels betrayed when he/ she fails to protect. This leads to lifelong feeling of distrust and poor interpersonal relationships. The child may feel weak and powerless to stop the abuse and this would result in either despair and depression or aggression later in life. Due to stigmatisation, the child feels 'dirty', guilty and responsible for the abuse. This leads to poor self esteem, drug use and self harm. Traumatic sexualisation includes aversive feelings about sex, overvaluing sex and sexual identity problems. Child and adolescent sexual abuse can lead to either sexual aversion

or promiscuity later in life. All these effects are especially pronounced in adolescence as it is a phase of identity crisis, sexual exploration and personality development. An adverse event in the form of sexual abuse may leave lifelong 'scars' on the brain.

Effect of Toxic Stress on Brain

Long term toxic stress on the developing brain in the form of sexual abuse can have an impact on learning, behaviour and physical health by disrupting the neural pathways in the hippocampus, orbitofrontal tracts and prefrontal cortex. It leads to changes in the neural circuitry of the hippocampus that further impairs linguistic, cognitive, and social emotional skills. Disruption of the obitofrontal tracts occurs that leads to maladaptive responses to stress. Toxic stress also leads to changes in the prefrontal cortex that result in a hyperresponsive or chronically activated stress response. This causes stress related lifestyle diseases of the cardiovascular and immune system. These changes may be permanent and can even be transmitted from one generation to another.

Impact on Physical Health

Prospective longitudinal research studies have reported strong associations between child sexual abuse and obesity. Middle-aged women who were sexually abused as children were twice as likely to be obese when compared with their non-abused peers. Large cross sectional studies indicate relations between child sexual abuse and ischemic heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, irritable bowel syndrome, fibromyalgia and chronic pain in adulthood.

Impact on Mental Health

Child sexual abuse can lead to childhood depression, post traumatic disorder, aggression and criminal behaviour. It can also lead to high risk behaviour like gambling, sexual promiscuity, running away behaviour and drug abuse. Adult survivors have 2-3 times more chances of developing depression, suicide ideation, criminal behaviour, personality

disorders, drug addiction and even psychosis than those who had not been sexually abused. They have problems in maintaining intimate relationships and in parenting. Children who have been sexually abused are at increased risk of 'revictimisation ' in childhood and adolescence. Most victims do not go on to offend others in adulthood although the chance compared to non victims is higher. Sexually abused boys experience more internalising symptoms including guilt and shame compared to girls. Prospective studies have identified that sexually abused children do poorly in schools and as adults have lower rates of skilled employment

Impact on Sexual Health

A few retrospective studies have reported strong association between sexual abuse and sex trading in adolescence and adulthood. Few other studies have noted an increase in rates of teen pregnancy, abortions, early onset of sexual activity, greater number of sexual partners and increased risk of sexually transmitted diseases. Male sexual abuse survivors have twice the HIV-infection rate of non-abused males.

Protective Factors

Familial support, family stability and positive parental relationships are important factors that can reduce the adverse consequences of adolescent sexual abuse. Positive peer and intimate partner affiliations in adolescence and adulthood are also protective influences. A few studies have shown that living in communities with strong social cohesion also has a protective

effect. Empathetic, non judgmental and caring response of the health care providers and parents towards the abused child results in a positive outcome.

Role of the Pediatrician

As sexual abuse may have effects over the entire life span of the individual it is important for pediatricians to respond appropriately to a case in a medical setting, to keep the child safe and lastly to closely follow up the physical and psychological health of the child. The paediatrician should consider working with a multidisciplinary team comprising of a gynaecologist, psychiatrist, psychologist, social worker and police (child protection agency) to ensure physical, psychological, emotional and spiritual well being of a victim of adolescent sexual abuse.

Suggested Reading

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Medico Legal Issues in Adolescent Sexual Abuse

This article includes Medico-legal aspects (including age estimation & examination of the victim), step-wise action plan for medical professionals, and immediate and long term management of the victim.

The Objectives of Medical and Forensic Medical examination are :

1. Mandatory verification of age and toxicological analysis .
2. Ascertaining whether sexual act has been attempted/ completed or not/ was it forcible/ recent.
3. Ascertaining whether there is e/o non penetrative sexual assault (i.e. indecent assault).
4. Providing treatment and appropriate referrals for the patient

1. MEDICOLEGAL ESTIMATION OF AGE

Medicolegal estimation of age is most important.

The Forensic medical age is the mean of physical age, dental age and radiological age. The physical age is estimated on the basis of factors concerned with physical growth like height, weight, chest circumference and secondary sexual characteristics. Tanner's staging is used to assess secondary sexual characteristics.

The dental age is determined by an OPG (Orthopantogram) which is the best x ray view of the third molar. One should be aware of important dental milestones to interpret it. In case of third molar, the crown is fully developed by the age of 15 years in girls and 16-17 years in boys. Half roots are formed by 16-17 years in girls and 17-19 years in boys. The root formation is complete by 18-19 years in girls and by 19-21 years in boys. Root apex closure is seen between 20-23 years in both boys and girls.

Age is also determined by X-rays of various joints. Following are tables showing Xrays to be advised.

X rays to be advised	Age group
Region to be x rayed	1-14 years
Elbow and wrist	14-16 years
Shoulder, elbow, wrist, dentition, pelvis including upper end of femur and iliac crest	16-18 years
Shoulder, elbow, wrist, dentition, pelvis including upper end of femur and iliac crest, chest x ray showing medial end of clavicle and sternum	18-22 years

Important at various ages in various joints visible radiologically - Age

12 yrs	Hip joint (centre for lesser trochanter appears 10 to 12 years)
	Elbow joint (centre for lateral epicondyle appears 11 to 12 years)
	Wrist joint (centre for pisiform appears 10 to 12 years)
14 yrs	Hip joint (centre for iliac crest appears 14 years)
	Elbow joint (centre for radial tuberosity appears 14 years)
16 yrs	Hip joint (centre for ischial tuberosity appears 16 years)
18 yrs	Shoulder joint (all the centres of upper end of the humerus fuse with shaft)
	Wrist joint (all the centres of lower end of

radius and ulna fuse with shaft)

Hip joint (centre for iliac crest fuses with ilium)

21 yrs Hip joint (centre for ischial tuberosity fuses with the ischial body)

Ossification around the wrist joint

The lower end of radius appears at 2 years and that of ulna at 6 years. Both unite with the shaft at about 19 years. The order of appearance of ossification centers in the carpal bones is:

Capitate 2 months; Hamate 3 months; Triquetral 3 years; Lunate 4 years; Scaphoid, Trapezium and Trapezoid 4-5 years; and Pisiform 9-12 years.

APPEARANCE OF CENTRES OF OSSIFICATION AND UNION OF BONES AND EPIPHYSES

AGE	Appearance of centre of ossification
5th yr	Head of radius, trapezoid, scaphoid
6th yr	Lower end of ulna, trapezius
6th-7th yr	Medial epicondyle of the humerus
9th yr	Olecranon
10th-11th yr	Trochlea of humerus
11th yr	Pisiform
13th yr	Separate centres in triradiate cartilage of acetabulum
12th-14th yr	Lesser trochanter of femur
14th yr	Crest of ilium, head and tubercles of ribs
15th yr	Acromion
16th yr	Ischial tuberosity
18th-19th yr	Inner end of clavicle

Newer methods

Newer imaging methods like ultrasound, echocardiography and computed tomography may be used in controversial cases.

2. ASCERTAINING WHETHER SEXUAL ACT HAS BEEN ATTEMPTED/COMPLETED OR NOT

This is done by physical examination after consent. The preparation and conduct of the physical examination of sexually abused children requires 'time, patience and a gentle manner...' [Horowitz, 1987].

a) Consent

Consent is most important, as neither Court nor police can force the alleged victim of sexual assault, to undergo examination.

Informed consent : After explaining about the examination, collection of evidence, information to police and treatment, informed consent should be obtained from the victim of sexual assault if she is above 12 years. If the victim is below 12 years of age, consent of the guardian should be taken. However it must be remembered that if the guardian himself happens to be an accused, consent of Superintendent or RMO must be taken. Consent includes acceptance for Medical examination, sample collection for investigations and treatment and photographs. All of the above must be explained in a language understood by the patient and in a sensitive manner.

Signature of uninvolved witness and doctor are also essential. If victim is below 12 or mentally unsound, consent of parents/ guardian is required.

If victim of sexual assault refuses to give consent for any of the act/ procedure, a detailed informed refusal mentioning consequences of such act.

b) Physical Examination

The examination should be in a private room after having made the child comfortable. Children may be anxious about giving a history, being examined, or having procedures performed. Time must be allotted to relieve the child's anxiety .Examination should not be forced. Examination can be done by a paediatrician or a gynaecologist or forensic physician and should be done once and not repeated by other team members. Findings can be noted by the doctor.

The physical examination of sexually abused children should not result in additional emotional trauma.A complete head-to-toe examination is mandatory.

The issue of sedation or anesthesia for the examination remains controversial. General anesthesia is usually required in cases of acute bleeding anogenital injuries [Harari and Netzer, 1994; Rogers and Murdoch, 1994; Sury, 1994; Hogan, 1996; Leventhal, 1998]

c) Position

The child may be examined in 3 positions,

namely:supine, lateral, or knee to chest.The genital examination begins in the most comfortable and least frightening position, the supine position with abducted legs ('frogleg position').

Especially younger children may prefer to be examined on the caretaker's lap. The separation technique of the labia majora allows an overview over the external genital structures. The traction improves visualization and opening of the hymenal orifice.Most examiners agree to routinely include the prone knee-chest position except in those cases when visualization in the supine position is satisfactory.

The inspection of the anus is mandatory and can be performed in the prone knee-chest position or in the left lateral decubitus position. The latter is preferable in boys who tend to be abused anally [Horowitz, 1987; McCann et al., 1990a; Emans, 2000].

Pubertal children are preferably examined in the lithotomy position.

4) Presence of Nurse /attender :It is of paramount importance that a nurse and/or an attender is present at time of examination

ACTION PLAN for medical professionals, Immediate and long term management of the victim

The responses of a paediatrician to a child abuse case can be broadly classified into:

A. URGENT RESPONSE : in case of death or serious injuries requiring hospital admission where the report should be ready within 24 to 72 hrs. Such cases are best managed in a hospital setting.

Admission to the hospital is needed in all cases of serious injuries. A child may be admitted if a safe place is required for some time

B. EXAMINATION ON SAME DAY

- The child should be seen as soon as possible. The child should not bathe or change clothing prior to the examination.
- The child is in pain, is bleeding, or is having other serious physical symptoms.
- The child is suicidal or threatening to harm him / herself.
- The child was assaulted / abused within the last 72 hours by a perpetrator with HIV or hepatitis.

C. EXAMINATION AFTER A FEW DAYS

- The child is having less serious symptoms such as discharge, pain with urination, or itching.
- The child or family is unwilling to wait because of anxiety, stress or other reasons.
- The child could be pregnant as a result of the abuse.

D. EXAMINATION IN A FEW WEEKS

- Exclusion of the above indications.

When more than 72 hours has passed and no acute injuries are present, an emergency examination usually is not necessary. An evaluation therefore should be scheduled at the earliest convenient time for the child, physician, and investigative team. Planned response is the best. Here a planned interview and examination are performed in a child-friendly atmosphere and by a multidisciplinary team(social worker, psychologist, gynaecologist, paediatrician and police officer if needed) in a confident setting.In India,The child is brought to hospital usually after case has been filed in police station by the police.

In OPD setting -Social Services like Child Welfare Committee (CWC) and Child Helpline (Phone No.1098) or local NGOs may be contacted if physician perceives threat to the child taken back to similar surroundings, or parents refuse to cooperate with the treatment or in any case where child rights are violated like neglect, child labour, corporal punishment at school, child marriage etc.

GENERAL PHYSICAL EXAMINATION

General principles in the management

- Multi disciplinary management
- Take history separately from child & each parent/care-giver
- Pre-examination consent
- Examination setting -- calm, pleasant and colourful, with pictures and toys for appropriate gender and age
- Child centered
- Examination done in private (female attender while examining girls)

Documentation should be accurate, objective and scientific. After obtaining written consent, FIR No., date and time and place of examination, witnesses present during examination and recording, details of informant and relation with the child must be noted. Demographic information, brief History and an account of Assault should be taken.

Emotional and Mental status-Best assessed by psychologist or psychiatrist.

If child is calm,one can go ahead with the examination.

Vitals – pulse, BP, respiratory rate, temperature, consciousness

Height and weight, Sexual Maturity Rating for adolescents

Examination of clothes (if same as those worn at the time of assault). Ask the victim to stand on the major brown paper provided to collect loose foreign bodies from cloth and body surface, which is folded and kept in a paper envelope. This procedure only done if victim has not changed her clothes, and or taken bath.

For evidence of tears, loss of parts, stains, other foreign materials etc.

Stains / foreign materials on body (including Pubic hairs & fingernails)

Signs of intoxication by drugs & / or alcohol Systemic examination

- Abdominal examination with special reference to pregnancy.
- Condition of Fingernails- intact, broken, foreign body under the nails

INJURIES ON BODY

The injuries on body may be due to various causes and of different types. The same injuries so entered can be marked on the body diagrams.

Following is the body region wise information of the injuries which may be seen in the course of sexual assault.

a. *Head Neck Face:* Scalp hematomas, black eyes, petechial haemorrhages in eyes, abrasion, contusion, laceration of jaw lips, buccal mucosa, gums, bite marks on cheek, laceration of frenulum and fracture tooth, bruising of ears. General or imprint bruises due to strangulation.

b. *Breasts:* Bite marks, Contusions, discoid forceful fondling resulting in fingertip bruises and cresentric nail scratches.

c. *Upper limbs:* Contusions on shoulder and upper arms, contusions of wrist, defense injuries on palms and forearms fingertip bruises and cresentric nail scratches..

d. *Buttocks:* Contusions, fingertip bruises and cresentric nail scratches and graze abrasions in the event of dragging.

e. *Inner aspect of thighs:* Abraded contusions and fingertip bruises and cresentric nail scratches.

f. *Other areas of body:* Sometimes graze abrasions on back, elbow and scapular regions in the event of dragging. Situations are not uncommon when injuries like head injury, incised injury, multiple fracture and stab wounds are seen.

LOCAL EXAMINATION OF GENITALS: It is important to know that in 70-85% of documented sexual abuse, the physical examination is normal.

While describing injuries it is necessary to note down their exact site, size, shape, color for age, direction, margins, depth and evidence of any foreign material.

a. *Labia majora:* Examine for evidence of swelling, tenderness, bleeding

b. *Labia minora:* type of injury.

c. *Clitoris:*

d. *Fourchette & Introitus / vagina:* The examination needs to be done with the help of vaginal speculum. Examine for evidence of swelling, tenderness, bleeding and type of injury. If the injuries are not visible but suspected Toluidine blue test must be performed.

e. *Hymen:* Examination of hymen may give valuable information related to penovaginal sexual intercourse. This includes whether it is intact or torn /contused, position of the injury and its age. Look for evidence of redness, bruises, bleeding and tears. Presence of intact hymen should be documented but it does not rule out vaginal penetration. Type of the hymen may be noted if relevant.

f. *Evidence of perineal tear:* E/o swelling, bleeding and degree must be mentioned.

g. *Urethra:* Swelling /edema, discharge, bleeding and injuries.

h. *Physical signs of STDs:* Look for s/o HIV/Syphilis/Gonorrhea, etc.

i. *Anus:* Look for injuries/bleeding / discharge/ swelling/stains/warts. Per rectal examination may also be done to find out deeper injuries stains / fissures / haemorrhoids.

Any other important and relevant finding which not covered above must be entered.

(Note: PS/PV examination is not warranted in children, but this examination needs to be done at least in case of adults, to identify and document internal injuries accurately)

Pediatric examination

Assessments of developmental, behavioural, mental, and emotional status.

Assesment of growth and sexual development of the child.

Examination for age determination (if needed) is a must.

Investigations

Urine routine and urine culture

STD screening, including low and high vaginal (in post pubertal girls) swabs and urethral swabs in boys, and serology for HIV, hepatitis B and syphilis

Pregnancy test should be done in an adolescent girl.

Forensic samples maintaining the chain of evidence include skin, hair, nail clippings, clothing, saliva, and, oral and genitourinary secretions in acute sexual assault.

Skeletal survey is done in a case of multiple injuries, and in all cases if a child is below 2 years.

Multiple bruising - a detailed hematological profile, including bleeding and coagulation profile.

Neuroimaging and ultrasonography of abdomen are indicated in a case of head and abdominal injury, respectively.

COLLECTION OF SAMPLES OF FORENSIC EVIDENCE MATERIAL

Indian law is procedural. So in all cases of victim of sexual assault evidence should be collected as per guidelines.

All samples must be sealed & labelled to avoid tampering.

1) Properly filled requisition form is handed over to concerned police. It is the responsibility of examining doctor as regards to collection, labelling, sealing and forwarding them through police to FSL.
2) Clothes worn at the time of assault
3) Examine the sanitary napkins, panty, diapers, tampon and tissues for stains, blood group and DNA profiling.
4) Fingernail scrapings/clippings of both hands separately
5) Approximately 10 to 15 loose combed pubic hairs are to be collected in a clean paper underneath.
6) One swab and smear from labia majora on a sterile swab and glass slide respectively.

TREATMENT AND FOLLOW-UP CARE

Assess for pregnancy.If not pregnant, prescribe pill if within 48 hrs.

STIs, HIV and hepatitis B; counselling and social support; and follow-up consultations.

When appropriate, patients should be offered testing for chlamydia, gonorrhoea, trichomoniasis, syphilis, HIV and hepatitis B.

Health workers must discuss thoroughly the risks and benefits of HIV post-exposure prophylaxis.

All patients should be offered access to follow-up services, including a medical review at 2 weeks, 3 months and 6 months post assault, and referrals for counselling and other support services.

Management

Management should be child friendly and should aim at achieving the short term and long term goals.

The physical injuries should be treated. Hepatitis B vaccination should be considered if the

sexually abused child is not vaccinated, and if the child presents within six weeks of the last assault (schedule 0, 1, 2, 12.)

DPT/DT vaccination should be given in unvaccinated children.

Tetanus immunization status should be confirmed and updated, if necessary.

STD prophylaxis and emergency contraception is to be given to an adolescent with acute sexual assault. STD prophylaxis should be offered in cases of oral-genital, genital-genital, or anal-genital contact by the abuser. HIV prophylaxis may be indicated in specific cases: it should be considered for every case that presents within 72 hours of the most recent abuse, if unprotected anogenital penetration has occurred, taking into consideration risk factors.

Counselling of the child and family forms the cornerstone of the management. The immediate counselling of the child that can be done by the pediatrician and should focus on the following:

- Believe the child, reassure and absolve feelings of guilt/ blame
- Explain about the existence of a medical, family and social support system.
- Listen carefully to all fears and concerns associated with disclosure.
- Teach coping and assertive skills.

Referrals to appropriate specialties should be made according to the need of the child. These will include psychologist, psychiatrist, orthopaedic surgeon, surgeon, social services and police. The family members may also need counselling and treatment from mental health professionals.

Follow up

Follow up after 2 weeks, or earlier if necessary, is essential to reassess the child and evaluate for development of sequelae.

A repeat serology for syphilis at 4-6 weeks and for HIV at 3-6 months is required.

The long term after-effects of abuse on the physical and mental health is influenced by the following factors: nature, extent and type of abuse, age of child, temperament and resilience of the child, relationship of abuser to the child, and family's response to abuse and medical management.

The key points to be kept in mind include:

1. Seriousness of abuse: Serious abuse requires urgent intervention and long term follow up
2. Safety of the child: If the child is not safe at home, help from non-offending family members for a change in residence is sought for. CWC, Child Helpline and local NGOs may also help in this situation. If the home continues to be unsafe, safer options like foster care and adoption of the child need to be considered.
3. Importance of counseling and follow up of the child are important issues. Counseling of the parents, if they are the abusers, is also necessary. All abuse, especially sexual abuse, needs to be reported to the police.

The pediatrician's response must always be in accordance with the existing law of the country, as highlighted in these guidelines.

Advise to Caregivers of an Abused Child If a child discloses that he/she has been sexually abused or exploited:

Support the child and explain that he/she is not responsible for what happened.

- Believe the child and don't make her/him feel guilty about the abuse.
- Be empathetic, understanding and supportive.
- Consult a doctor and consider the need for counseling or therapy for the child.
- Don't criticize the child or get angry with her/him.
- Don't panic or overreact, with your help and support, the child can make it through this difficult time.
- Don't ignore the abuse. Voice your fears to responsible NGOs or individuals.
- Lodge a complaint with the police and ensure that the abuse stops immediately.

Guardians should be made to understand that their first responsibility is to the child – to protect him/her and to ensure that there is no breach of privacy or confidentiality.

Consequences of sexual assault –are physical,psychological,rape trauma syndrome,

scholastic and personal

Physical health consequences – are abdominal pain,burning micturation, sexual dysfunction, dyspareunia, urinary tract infection, unwanted pregnancy, STD, PID, miscarriage of existing fetus and unsafe abortion.

Psychological health consequences could be short term or long term.

Short term psychological effects are fear and shock, physical and emotional pain worth lessness, intense self disgust and power lessness, apathy, denial, numbness, inability to function normally in their daily lives .

Long term psychological effects are depression and chronic anxiety,emotional distress, nightmares, self blame, mistrust,avoidance and post traumatic stress disorder, chronic mental disorder,suicidal tendencies .

RAPE TRAUMA SYNDROME:

Symptoms appears in two stages

Phase 1: *Acute / phase of disorganization*

Victim feels shock and disbelief regarding rape. They may initially react in two ways – a) in the expressed style in which patient display anger, anxiety, fear and often cries. b) in the controlled style in which patient remains calm and controlled and displays little outward emotion. This phase can last from 6 weeks to few months.

Phase 2: *The reorganization phase*

It is a long term process in which the victim develops certain coping mechanisms. It includes outward adjustment, personal integration

Short term and long term effects of child abuse

- Scholastic performance: Refusal to attend school or fall in grades
- Physiological Effects: bed-wetting, sleep and appetite disturbances.
- Physical Symptoms: aches and pains, not feeling well
- Emotional Reactions: fear, anxiety, depression, suicidal thoughts
- Behavioural Manifestations: withdrawal, avoidance, sexualized behaviour or distinct psychiatric syndromes
- Self Perceptions: negative self-esteem, feeling dirty, different and damaged
- Interpersonal Problems: conflicts, lack of trust, being either people pleasing or hostile and socially withdrawn

Rehabilitation

- Following interviews a child will be in better position making assessment of her needs
- Talk about their experiences, and children grieve and mourn
  - Must be at child's pace.
- Unsafe environment makes the child feel insecure and healing in complete as an adult.
  - Secure environment should be provided
  - May be achieved through liaison with family or through legal support, if necessary.
- Child displaying symptoms of psychological distress should be referred to therapeutic intervention without delay
- Use of art, play and music helps children to explore emotions and traumatic memories
- Older children prefer talking therapy (counsellor) Dolls/painting
- Refer to gender-specific group (‘Girls Group') so a child can explore his/her feelings with peers (that experienced similar trauma)

Protection and prevention

Sex education –

Important sex education topics according to age are as follows:

4-7 yrs	Awareness of own bodies, good touches and bad touches
8-10 yrs	Understanding of the changes in our bodies, how to tell, etc.
10-15 yrs	Assertiveness.

Children should practise these methods through the use of role-play and examples for optimal safety.

ADOLESCENT HEALTH ACADEMY

2014 was a very eventful and happening year for AHA. In 2014, 62 new members joined AHA taking the membership to 1496. One new AHA branch, Delhi city branch was installed in May 2014. Currently there are 9 city branches and 1 state branch.

In 2014, AHA reached out to over 25000 adolescents, 4000 parents, 120 teachers, 250 community health workers and counsellors, 100 nurses and 700 medical professionals throughout the country. AHA members conducted 100 family life education sessions in schools, 25 parenting sessions, 12 training sessions for teachers, counsellors and health workers and 14 academic sessions for medical professionals including paediatricians. They participated in 15 television shows related to adolescent issues, 1 radio show and 1webinair and published over 100 articles in print media. They also organised health camps, rallies, quizzes, essay and drawing competitions for adolescents with special focus on underprivileged adolescents. For the first time, branches reported their activities to the AHA secretariat. We also received individual reports from Dr Himabindu Singh, Dr Manjulata, Dr Atul Kanikar, Dr Ashoo Arora, Dr Sulekha, Dr Kiran Agarwal and Dr Sushma Kirtani. On 9th January 2014, I represented IAP at the launch of Government of India's Rashtriya Kishor Swasthya Karyakaram and updated the delegates regarding the achievements of AHA. We appreciate and applaud the dedicated work of all AHA members. We request you to regularly send your activity reports to us.

Under the charismatic guidance of our chairperson, Dr JS Tuteja, we made intense efforts to streamline the office of AHA and ensured transparency at all levels. Until last year, AHA accounts were handled by the Secretary. For the first time, the Treasurer was given complete charge of the accounts. Dr JC Garg, AHA's diligent and sincere Treasurer, will present the financial report in the GBM. The advisors, EB and office bearers of AHA branches were updated regularly regarding all AHA issues and their advice was sought. Oration committee to formulate rules for AHA oration was formed.

All AHA members will receive new membership certificates under the banner of Adolescent Health Academy that is now a registered society.

AHA website (www.ahaiap.org) with technical expertise of our dynamic webmaster, Dr Amit Shah was revamped. Many new features were added to the website. These include interactive web based case discussions, discussion forum, clippings, blog section, parenting section, forthcoming events and exclusive academic downloads for members. The AHA constitution, guidelines for branches and guidelines for organising Adolescon were also uploaded on the website. We shall launch a public health forum for adolescents, teachers and parents during Adolescon 2014.

Adolescent Today, the official publication of AHA is relaunched with a new vibrant editorial board with Dr CP Bansal at the helm. The electronic version will be available on the website.

We also initiated the AHA facebook page where members can directly upload their activity reports and share articles of public interest.

To acknowledge the immense contribution of our members and branches, we have initiated new awards this year namely, AHA award for outstanding services, Best branch award and Best emerging branch award.

Senior members of AHA with their sterling achievements have always been a source of inspiration and have made AHA proud! We congratulate them and seek their continued support and guidance. Dr MKC Nair was appointed as the Vice Chancellor of Kerala University of Health Sciences. Dr CP Bansal as President South Asia Pediatric Association, Dr Sachidanand Kamath as IAP President elect 2015 and Dr Pramod Jog as IAP President elect 2016. Dr Pukhraj Bafna was honoured with three World Records by Golden Book of World Record. Dr Tuteja was felicitated by his residential society for his dedicated Social Work in adolescent health across India and Dr Rashmi Gupta was honored at Tashkent, Uzbekistan with 'international women excellence award'.

Organising committee of Adolescon 2014 lead by Dr Ajit Singh Chawla and Dr Harmesh Bains have worked round the clock to bring to us this wonderful conference. Adolescon 2014 received a record 30 papers for paper and poster competitions. We thank all presenters for their keen participation and hope in the future their numbers will increase. We also thank Dr Atul Kanikar, Academic Coordinator for creatively drafting the conference program. We wish that Adolescon 2015 at Mangalore will be equally successfully. We invite you to register for the same.

In the end, I would like to place on record, AHA's warm gratitude to all AHA members, AHA branches, advisors, office bearers and executive board members for their whole hearted cooperation and encouragement for all our activities in 2014.We hope that the enthusiasm will continue in the coming years!

ANNUAL REPORT 2014

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