Child Abuse & Neglect: Prevention and Response by Pediatricians & Allied Medical Professionals

Report of Meeting of Expert Group on Round-Table Consultation to Develop IEC Material for Care givers, Front line workers & Parents

India Habitat Centre, August 5&6, 2018

Indian Child Abuse, Neglect & Child Labour (ICANCL) Group

Indian Academy of Pediatrics

UNICEF India

Background

The UN Convention on the Rights of the Child (UN CRC), ratified by India in 1992, urges states to ensure the right of children to protection from abuse, violence, neglect and exploitation (1). India is home to the largest child population in the world, with almost 41 per cent of the total population under eighteen years of age. The health and security of the country's children is integral to any vision for its progress and development.

'*Child maltreatment*' is therefore a violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. This child maltreatment has serious and often lifelong consequences. For instance, victims of child maltreatment are at higher risk of depression, anxiety, post-traumatic stress disorder and suicidal behaviour throughout their lives. Child maltreatment affects cognitive and academic performance starting early in childhood and extending into adulthood. Later in adolescence and adulthood, it can lead to behavioural and social problems such as violence against peers, delinquency and crime, high-risk sexual behaviour, and increased risk of subsequent re-victimization, and, once the survivor becomes a parent, to the perpetration of child maltreatment. In developing countries such as India, with its adverse socio-economic situation and large population base, child abuse & neglect is a serious, widely prevalent public health problem. Poverty, illiteracy and poor access to health and family planning services often result in multiple births per family, which in turn leads to considerable pressure on families particularly in the middle-to-lower income groups and consequently to low availability of resources for the care of children during their early formative years. It thus places a heavy strain on health and criminal justice systems and social and welfare services.

In this scenario, physicians, multidisciplinary professionals, care givers, front line workers, including parents, as first responders, have a critical role to play in identifying and managing cases of child maltreatment and providing relief to its victims. However, they often have a limited understanding on how to protect these vulnerable children. There is thus an urgent need for systematic training for medical and multidisciplinary professionals, care givers, front line workers and parents in preventing, detecting and responding to cases of child abuse and neglect in clinical settings. Such training would raise awareness and increase the capacity of physicians, allied medical professionals & parents to offer high quality services to children and to work together with professionals from other fields in maximizing the impact of a comprehensive multidisciplinary response to child maltreatment.

The Indian Academy of Pediatrics (IAP) was established in 1963 with the chief aims of developing excellence in curative and preventive services for children, education of pediatricians and other personnel. IAP has about 28,000 members across branches in various States of the country. It has several subspecialty groups & chapters, which have promoted

availability of highly specialized care to children with complex and chronic problems. One such group is the Indian Child Abuse, Neglect and Child Labour (ICANCL) Group that was established more than 20 years ago, in 1996, within the framework of the IAP. Recognizing the impact of socioeconomic, cultural and environmental factors on child health, development and overall welfare, the ICANCL Group specifically focuses on comprehensive child welfare, child rights, abuse, neglect, exploitation and rehabilitation. The ICANCL Group has adopted a multidisciplinary approach to address the problems of Child Abuse and Neglect with other agencies and community organizations interested in child welfare. The group has committed its efforts to reach out to neglected, deprived and abused children for their comprehensive needs, which include health aspects, education, rehabilitation, protection and prevention.

With this objective, IAP-ICANCL and UNICEF have forged a partnership to provide this much-needed training to medical and allied professionals as well as to parents, caregivers and frontline professionals involved in the care of children. The intended outcome is a curriculum that will enable prompt assessment, examination and management of victims of child abuse & neglect by medical professionals, which will eventually be used to impart ongoing education through conferences, webinars & video conferencing for further intensive training of committed paediatricians & medical professionals, in order to enable them to become local child abuse 'experts' in their regions.

In addition, the Project aims to come up with some informational materials for caregivers of children, with the objective of making them aware about child maltreatment, its signs, symptoms, and treatment, so as to equip them to prevent, identify, and seek support for affected children in their care. These materials will then be disseminated to paediatricians for further dissemination in the course of their practice.

The present consultation was held with the aim of inviting child protection stakeholders and experts to provide their input in order to come up with these materials. The report below is based on the discussions and dialogue held over the course of the two-day consultation. The consultation was structured in a round-table format, with each session scheduled including a presentation of 10-15 minutes by the facilitator followed by a moderated discussion.

While it is impossible to summarize all the rich ideas that were shared at the forum, we have reproduced below some of the key outputs and learning that occurred.

List of expert participants

1. Dr. Rajeev Seth, President, ICANCL
2. Dr. Anjali Saxena, Joint Secretary and Treasurer, ICANCL
3. Dr. R. N. Srivastava, Adviser, ICANCL
4. Ms. Rupa Kapoor, Member, National Commission for Protection of Child Rights
5. Dr. Jagadeesh N. R., Professor of Forensic Medicine, Vaidehi Medical College, Bengaluru
6. Dr. Sangeeta Saksena, ENFOLD, Bangalore
7. Dr. Rajesh Sagar, Department of Psychiatry, AIIMS
8. Dr. Bipasha Roy, Member, Juvenile Justice Board, Kolkata
9. Dr. Sabina Ahmed, ICANCL Group, Guwahati
10. Ms. EnakshiGanguly, Co-founder HAQ
11. Dr. Yogesh Sarin, Director Professor, Maulana Azad Medical College
12. Ms. Deepa Das, Ex UNICEF Consultant
13. Dr. Monika Gupta, Associate Professor Gynecologist, Safdarjung Hospital
14. Ms. Neha Sharma , ARPAN
15. Ms. Heenu Singh, Childline India Foundation
16. Mr. Samrat, Childline India Foundation
17. Dr. Indra Taneja, ICANCL
18. Dr. Kiran Modi, Managing Trustee, UdayanCare
19. Dr.Latika Bhalla, Adolescent Pediatrician, AACCI
20. Ms Ankita Sharma, Psychologist , Expressions India, MoolChand Hospital
21. Dr. Om Taneja, Bal Umang Drishya Sanstha (BUDS)
22. Dr.Chhaya Prasad, ICANCL group
23. Dr Uma Agrawal, ICANCL group
24. Mr Yawar Qaiyum, Bal Umang Drishya Sanstha (BUDS)
25. Ms. Japreet Grewal, Child Protection Consultant, UNICEF

Summary of Discussions

Introductory Remarks

The consultation began with welcome remarks by **Dr. Rajeev Seth**, Chair ICANCL group and Convenor of the Project. Dr. Seth warmly thanked UNICEF for its support and gave an overview of the project activities, reiterating that the ultimate aim was to have a subsequent phase of the Project in which to conduct Trainings of Trainers (TOTs) in each region of the country so that those trained can in turn conduct further trainings and take the curriculum to more and more doctors. With this objective, Dr. Seth mentioned that there has been a previous workshop in June 2018 to collect ideas from experts and then to incorporate those in the curriculum for doctors. This particular workshop was being conducted to take a further step by calling upon medical as well as non-medical child rights & protection experts so as to come up with materials for dissemination to parents, caregivers and others entrusted with the responsibility of children. He mentioned the need to tailor our programmes to the Indian adverse socio-economic context of poverty and inadvertent neglect, child marriage etc., most of which has been normalised in our country. He also spoke briefly of the need to engage with and empower Anganwadi and ASHA workers who are the frontline workers who work on the ground in adverse conditions, and to be sensitised also about important recent child protection laws.

Dr. Seth's address was followed by a round of introductions from participants, which revealed the diverse backgrounds and experiences of those present; they included a forensic psychologist, paediatricians with different specialisations (developmental, surgical, etc.), Childline, and persons working with Child Care Institutions.

The opening session was conducted by **Dr. (Prof.) R. N. Srivastava,** who touched upon the National Policy on Children (NPC) and National Plan of Action for Children (NPAC), and challenges in their implementation. He emphasised that the problems of children must be comprehensively considered. Neglect can be defined in many ways, but in India the denial of health care and nutrition are most important because it seriously impairs child growth & development. He pointed out that in India, 40 per cent of children are born in vulnerable conditions and experience difficult circumstances; homelessness and street children, child labour, etc. are intractable issues in our country. Their families do not see immediate benefits of schooling in the face of the many adverse socio-economic factors. The NPC envisages a long-term multisectoral integrated approach for development and protection and engenders a participatory approach to child rights, with room to hear the child's own views. It makes the best interest of the child the main consideration. It accords the highest priority to survival and health. It ties together education and development and gives universal and equitable access to education and early childhood care and development (ECCD). It also designates child protection a priority and makes special mention of children with disabilities. The NPAC, based on the NPC, emphasises stakeholder convergence to achieve the objectives of the NPC. The NPC takes into account the SDGs and focuses on families to develop their capabilities to protect children. It also notes the need to identify and address challenges as they emerge.

However, there are limitations. Funding for children still remains at low levels (decreased from 5.7 to 3.3 percent from 2008 to 2018). The implementation of NPAC will have to be through existing programmes. The National Coordination and Action group(NCAG) under the Ministry of WCD is to monitor progress, with SCAGs at state level. However, this is a cumbersome and impractical process. Various other mechanisms are also in play such as other ministries. Civil society has a role to play and private multidisciplinary stakeholders can contribute especially in a supervisory capacity. There is a lack of health information amongst common people; something as basic as vaccination is not as institutionalised in public consciousness as it should be, and has to be taken up at a door-to-door level to see results. In light of all this, Dr. Srivastava urged doctors and multidisciplinary professionals to act as agents of change for children.

Dr. Srivastava's session was followed by discussion amongst participants, wherein they agreed that there is an urgent need for making child rights and protection committees functional at all levels It was pointed out that migrant populations need special attention as there is no social or community structure even to take care of their children; resources are not available and children are often left alone when parents go to work, leading to a high risk for

child abuse. Anganwadi workers have to be trained to address child rights to protection under these circumstances.

Dr. Seth pointed out that the government has now started a computerised programme connected to ICDS, to improve record-keeping. However, the demand for better services has to come from community levels, so that services can be made accessible.It was also pointed out that anganwadi workers are overburdened. There is a lot of agitation and turmoil and this naturally affects their performance. Also, they are also underqualified and underpaid and this has bearings on their commitment. The experts also agreed that parents have to be informed of various government schemes and made accountable, for instance in the case of vulnerable street children.

This session was followed by an overview of Child Abuse and Neglect by **Dr. Rajeev Seth.** He reiterated that the issue needs to be seen in the Indian context. Neglect has to be distinguished from poverty-related inability to provide for the child. All adverse maltreatment in childhood leads to development severe consequences for adult health. Therefore investment in child health and development is extremely important. In the Indian context, it is important to ensure that the child is not deprived of health and education and not exposed to child labour and abuse/exploitation. He gave a brief overview of the clinical manifestation of child physical, sexual & emotional abuse, diagnosis, history-taking, and treatment, and the importance of appropriate referrals; there is also a need for development of parenting programmes for primary prevention. Children need to be taught to personal safety and privacy information, as early as 3 years or whenever, they are developmentally ready to protect themselves. Underserved children need to be given access to these government services and be given assistance to achieve social justice objectives. Caregivers and frontline practitioners need to be taught to advocate for the children rights in their care. Child protection services need to be comprehensive and integrated. There has to be convergence amongst care givers, frontline workers, stakeholders, and parents so as to give the child comprehensive protection, taking into account their specific vulnerabilities.

This was followed by a session by **Ms. Deepa Das** on corporal punishment. She began by stating that although the Right to Education Act of 2009 clearly states that no child is to be subjected to physical or mental "harassment", in practice it continues. The problem lies with our implementation; corporal punishment is a socially-accepted notion; 'spare the rod and spoil the child' is the basis of the problem. We have to change our way of looking at it, social norms are not the determining factor here. She pointed out that we take physical abuse into account but not mental abuse; children are made to clam up about it and not talk about it unless it becomes evident and/or unbearable. Parents need to have an open relationship with their child. There has to be dialogue and engagement and the child has to trust the parent. At school, the teacher may make a disparaging remark in passing without realising the effect on the child; this has to stop. There has to be an attitudinal change and this is a long-term plan. She noted that in spite of laws, there is no system of monitoring their impact or effectiveness,

and this is a weak link, without which we will never have reliable data and never know the way forward. She mentioned the important role of the health sector, especially in identifying the age and physical capacity of the child, which can make or break the child's life. Also, it has to be communicated to the caregiver that maltreatment is detrimental to the growth of the child, it stunts their development. Children are also exposed to mental violence in the form of discrimination and these are root problems in society that need to be addressed so that children are given the opportunity to grow into positive adults.

During the ensuing discussion, it was pointed out that corporal punishments exists even outside the school environment, and that preventive laws exist outside the RTE, in the Juvenile Justice (JJ) Act which has a provision on cruelty. There is a need to distinguish discipline from punishment, not just for teachers, but also within the child's home.

Some best practice model examples were provided by discussants: the Jammu and Kashmir model, which has a nodal officer for grievances related to corporal punishment in schools; Telangana, which has personal safety rules in govt textbooks from class 1 to 10, as well as manuals for parents; and Karnataka, where school police cadets have interactions with children to make them aware of systems like birth registry; as well as inclusion in the Bachelor of Education curriculum about personal safety education so teachers are equipped to teach children; as well as in , media and television serials on puberty, and even about transgender rights.

This session was followed by that of **Dr. Jagadeesh,** who presented the legal aspects of the issue through case studies that touched upon reporting on corporal punishment and neglect in institutional settings; legal dilemmas around mandatory reporting under the Protection of Children from Sexual Offences (POCSO) Act 2012, such as in the disclosure of sexual relations by a minor girl to doctor, before disclosing to her own parents; issues that may arise in the case of an underage pregnancy; revelation of child sexual abuse after the victim has become an adult; etc. He gave an overview on the need to mandatory report under the POCSO Act, which also makes failure to report punishable. He also pointed out the other important questions to consider:

- Within what time gap should the report be made? Is there a limitation period after the disclosure?
- Should one verify the facts before making the report?
- Does the information have to be given in writing or in any particular form?
- Does the report have to be recorded in any particular form?
- Should a third person wait for the parent or caregiver to arrive before making a report?

In addition, he pointed out the problems inherent in mandatory reporting:

- Treatment is affected and often delayed due to fear of mandatory reporting

- Trust, confidentiality and privacy are also affected – Right to Privacy is a fundamental right.
- The interplay with other laws like the Medical Termination of Pregnancy(MTP) Act is often fraught with conflict e.g. mandatory reporting and consent under the MTP act.
- Consensual sex – when one of the parties is underage it is still criminalised.
- There are also false cases, including in the above scenario.
- Whether a person should be tried for failure to report only after the main offence is proved?

In addition, he gave insight into the interplay of mandatory reporting and child rights:

- Right to health – being healthy vs. control of healthy body; access to health care including contraception
- Right to information – including on health care, also including STIs, contraception and sexual behaviour
- Right to privacy – medical information and counselling are private spaces
- Right to be heard – are the child's own wishes not to be taken into account in disclosing the information he or she shared in confidence?

Finally, he touched upon the attendant medico-legal issues:

- Age estimation – If there is a suspicion as to age, only then can medical age estimation be ordered. If the child has been to school there is no need for bone age estimation test, school records are enough. Documentary proof removes need for age estimation by medical procedure (Section 94 JJ Act). This also applies in the case of a child in conflict with the law, for whom there is also a margin of error of one year in favour of an accused child (although the same benefit is not given to the victim child).
- Teenage pregnancy where girl is married: if girl is a minor under 15, there will be mandatory reporting. If not, therapeutic care will be enough.
- Adoption – those working with children need to be aware of the rules and laws; e.g. adoption should not be a legal way of trafficking. Doctors are to screen for health issues, this should be done ethically.

His session was followed by a panel discussion on recommendations and good practices. This was commenced by **Dr. Monika Gupta,** who spoke about history-taking and interviewing in One-Stop Centres (OSCs), and of the need to evaluate the body language and non-verbal cues of the child; she pointed out that as the Safdarjung Hospital, New Delhi OSC is in the casualty wing of the gynaecological department, only sees girls and women. She spoke of the difficulty of having a dedicated space within hospital premises, and mentioned that while the room is a simple one, there are charts and some toys. She also mentioned that there was an NGO that supported the staff at the OSC and served as a bridge between medical and other caregivers such as those providing legal assistance.

Dr.Yogesh Sarin added that there was an OSC in LNJP Hospital New Delhi, but noted that it is not equipped to handle boys, as a result of which they get pushed around from one department to another, making the experience particularly traumatic for them; he stated that while boys who are 12 and below at least go to paediatrician, those older than this face a lot of difficulty in obtaining even emergency assistance. Dr. Sangeeta mentioned that this highlighted the need for a multidisciplinary approach, which would ensure that the team is better equipped to work with each other. It then reduces trauma for the child and allows best practices to emerge over a period of time, contributing to overall amelioration of an already very traumatic experience. Dr. Jagadeesh pointed out that the OSC should be a place where a victim can walk in without a police referral. Even now the majority of cases are those that the police brings in; the victim does not approach the medical professional unless the legal mechanism kicks in. Thus any OSC has to be government-owned and govt-certified.

Ms Ankita Sharma, psychologist spoke of her experience at Moolchand Hospital, where she stated that the effort was to make the environment child-friendly, with an Occupational Therapist room with availability of age-appropriate games and toys. She mentioned that their process allowed the therapist to build a rapport with the child through games, stories, etc and then do the interview. These sessions are video-recorded to ensure that the evidence is available for legal purposes.

During the panel discussion, **Ms. Kiran Mody** of Udayan Care, spoke of her experience with Child Care Institutions (CCI). She mentioned that there are many factors for children being out of family settings; while these children are already victims of trauma and neglect, this is often aggravated during the experience of being in an institution. It is therefore important to make the place as close as possible to home. She stated that Udayan Care had set up community-based small homes with up to twelve children, where children live in a family setting. It is difficult to integrate them with children from "normal" families and in that sense it is a slow process, thus there is a need for a trauma-informed approach to be adopted by all organisations working with children. **Ms. Neha Sharma,** who spoke of Arpan's experience of working with schools on CSA and personal safety education. She mentioned that their module included information on how to handle disclosure and build a supportive network within the schools and families.

<u>This closed the discussion for the day.</u>

The second day commenced with a presentation by **Dr. Indra Taneja** on Early childhood Care and Development (ECCD). She noted that while early childhood is a time for rapid development, maternal health is necessary for a good start to this and the environment plays an important role in influencing early development. She pointed out that ICDS has aspects of maternal health and education. Inadequate nutrition in children due to poor maternal nutrition causes problems for their survival. Safe delivery and breastfeeding are also important and for this awareness is needed as home births are still common. Also important

is the fostering of caring interactions so that a nurturing relationship is developed. Caregivers have to be made aware of health and safety aspects of living in order to prevent injury and avoid disabilities and fatalities, as well as access to safe water and sanitation. Anganwadis have the idea that they are only to feed the children rather than provide comprehensive holistic care (early stimulation, nutrition, pre-school education, health, development and child protection); this mindset has to be changed. They are also in a position to identify signs of neglect and abuse, be it malnourishment or bruises, and to make children and families aware and make appropriate referrals. She also gave an insight into the interaction of child rights vs. parental capacity – illiterate & parents living in poverty are not equipped to raise children; they are not even aware of their own rights. Neglect in early childhood is irreversible and the only way is to focus on how to prevent child neglect and abuse.

This was seconded by the Guest of Honour and Member National Commission for Protection of Child Rights (NCPCR). Government of India, **Ms. Rupa Kapoor,** who noted that a standardised model was not viable as there are regional variations in education, development, and even natural and geographical factors; for instance, training people in an arid area to wash hands frequently is impractical and will not find any resonance. Also, if there is a lack of basic infrastructure Anganwadi workers etc cannot be expected to fulfil their deliverables. In most places parents who have to work etc don't have an option, they have to leave the child and go to work; there has to be a system of alternative care where their basic needs including food are met. She also pointed out that the focus is always on the mother to be the caregiver, but little thought is given to her rights or her emotional health. She often has to take care of the financial aspects as well as raising the family. Thus, other proximate front line worker & caregivers also have to be made aware that they can contribute with her parenting needs. Awareness building has to start at adolescence, which brings forth the need for sexuality education, health care and mental health counselling, so that when these youths become parents they are not ill-equipped for the job, forcing them to descend into a vicious cycle of poverty and lack of awareness. Ms. Kapoor pointed out that there are instances of good parenting models, even in adverse situations and it is important to take this as best practice. When a pool of such caregivers come together and help the Anganwadi worker, they boost her capacity also. The *Panchayat*/ Block officials also need to rally behind the Anganwadi worker and this is how to make a lasting change . The approach has to be practical and rooted in the community's values and community cultural influencers have to be involved in spreading this message for it to find resonance. Village-level child protection committees need to be made functional; members need to be given training. She revealed that NCPCR is conducting a safe childhood programme with *Panchayats* to address this. Thus, all these local structures have to be mobilised. Bal Panchayats are made functional by local NGOs, but these need to be brought into the government system. ASHA front line worker are local women and they find it difficult to talk on difficult topics like sexual health; they also have to overcome their cultural biases. Ms Kapoor pointed out that the police is also an important frontline practitioner. They have to be made sensitive how to deal with children and so that

the child can also approach them. Special Juvenile Police Units (SJPU) have to be set up and operationalised. There has to be an accountability and protection mechanisms in place for which monitoring systems also have to be developed. The community will only learn from repeated iteration. There has to be consistent outreach to the community to encourage them to demand and then utilise services. Primary Health Care systems have to be strengthened and staffed to meet the needs of the local community rather than compelling people to take the child to the district level hospital. She agreed that while IEC materials are important in reaching the community, they should be tailored to local needs and local leaders, including religious leaders have a great role to play in reaching the message to the community. She reiterated that parents need to be supported in looking after their children.

This was followed by a presentation by **Dr. Sabina Ahmed**, who mentioned that any curriculum must include pointers for a risk factor assessment for neglect and abuse in children with disabilities. She noted that there was very little research as disability is talked of as an aggregated problem whereas each disability has its own specific vulnerabilities and is distinct from other types of disabilities; for instance, motor disabilities are very different from intellectual disabilities. Disability has to be taken as a health disorder and not have a reason for exclusion from government health and child development schemes. It could be an impairment that leads to a functionality problem, and because of this the performance is affected and that is the handicap. It has to be placed in contextual terms. Society has to provide the facilities so that the disability does not become a handicap. The maltreatment occurs because the disability is seen as a problem and this has to be eliminated. She quoted a 2012 WHO report that these children are four times more likely to suffer abuse. In India, we don't have figures; we have extrapolated data which is not accurate and does not give any idea on incidence of abuse. If there is abuse the child may exhibit behavioural problems and understanding of that by caregivers and frontline workers is limited as a result of which the causes do not get picked up. The common misperception is that disabled child is not at risk of abuse as he is always supervised; this is not true as often the child is abused by those in his immediate vicinity. The misperception is that the child is not capable of feeling trauma or reacting to it. In truth, the child is less capable of resisting abuse and thus more vulnerable to it; he may be unable to communicate enough to express what is happening to him; behavioural changes may go unnoticed as signs may be incorrectly attributed to disability; the child may have little privacy or access to keep-safe strategies; and less likely to be consulted in matters affecting him. Disabled children living away from home are particularly vulnerable to over medication, poor feeding and sanitary arrangements, and therefore neglect and abuse. She reiterated that there has to be a developmental approach; otherwise the child will be unable to even achieve the developmental milestones, which may be possible with early diagnosis, intervention and multidisciplinary therapies. Policies for children must be all inclusive. Every child matters – this has to be understood.

Dr. Chhaya Prasad, the next expert on neuro-disabled children, wholeheartedly seconded her predecessor and added that the introduction of media to newborns should count as abuse in urban centres as it can lead to speech and language deficiencies; there is a need for guidelines to mention this risk. There is also a need for emphasising breastfeeding and maternity leave, both of which aid attachment and bonding between mother and child and thus prevent the child from developing anxiety disorder and other behavioural problems. She agreed that children with disabilities and health problems are already compromised and there is a lot of non-evidence-based therapy, which leads to a waste of time for the child's development and rehabilitation. Caregivers should be made aware of early diagnosis and intervention to promote holistic development and prevention of neuro – development delays and adverse health consequences.

This session was followed by a panel discussion moderated by **Drs. Sangeeta Saksena,** and featuring **Dr Latika Bhalla, Dr Chhaya Prasad, and Ms. Deepa Das.** Dr. Saksena spoke about ENFOLD's work in Bengaluru on life skills education and communication tips for parents and caregivers on sexuality education. She noted that lack of vocabulary for sexuality education and the difficulty of broaching the topic is due to an engendered gender bias and shame about naming private body parts. Parents have to be given culturally-accepted vocabulary and this has to be age-appropriate. However, the conversation has to be initiated by care givers, frontline workers and physicians with the parent, otherwise the child will not know that it is

ok to talk about personal safety and privacy information. Personal safety rules have to be taught in a matter-of-fact way and a safe person has to be designated. Children also have to be taught to respect others' privacy in the same way. Sexuality has to be a part of a normal and ongoing conversation rather than a taboo topic. Children and then adolescents have to be taught to experience it without guilt and express it without shame and with responsibility. **Dr. Monika Gupta** mentioned that when a child who has been maltreated approaches a doctor, appropriate language has to be used; there should be an understanding that it has to be done without confusing and frightening the child; questioning has to be non-judgmental and open-ended rather than prejudiced and leading. If the child is not comfortable with the accompanying adult the child should be spoken to privately with appropriate support persons.

Ms. Deepa Das spoke of strategies for developing positive discipline, including:

- Friendly classroom environment – children should feel safe to express their views, teachers should address children by name and greet them, promote activity-based learning; give equal opportunity to all children; make her/himself a role model; build trust and create an environment for free communication with teacher.
- Collaborative rule-making – for class behaviour and discipline; this will help children feel empowered.

- Constitute children's groups – give them responsibilities for their own well-being in everyday tasks
- Organise regular children's activities – festivals, independence day, exhibitions etc – this will help teachers connect with parents also
- System of anonymous complaints and thoughts – resolve class disputes with the help of children through a consultative process so that children can participate in decisions that affect them and be more likely to adhere to them
- Assign responsibilities to difficult children so that they are engaged in the well-being of their peers

This very informative panel discussion, Dr Latika Bhalla spoke on positive parenting**.** Dr Bhalla pointed out that children have stressors in their everyday environments and parents have to be considerate towards this. Older children also face peer pressure and academic pressure, as well as adolescence issues around their reproductive, emotional health and sexuality . Parents have their own stresses, and together these come together to lead to a high-stress environment, where both feel that the other is not responding to them. Thus, they need to be given skills and information to navigate this phase. Parenting should be authoritative rather than authoritarian or on the other end of the spectrum, permissive, where the child starts to rule over the parent. She listed the characteristics of authoritative parenting as follows:

- Daily routine
- Informal Talk
- Parents have to set limits
- Parents have to be consistent
- Minor misbehaviour should be ignored
- Positive encouragement for good behaviour
- Unconditional love
- Don't label the child
- Empathy and Education
- Effective communication – demonstration by example – teach them to respect others' opinion; teach them to say **NO**
- Love – limit - latitude

Dr. Chhaya continued with the consequences of permissive parenting – such a child has no motivation to perform, is low on confidence, therefore a bully, maladjusted to the outside world. She also spoke of other types of parenting, which created problems resulting from the lack of attention to the child's emotional needs secure attachments. She mentioned the red flag signs in child's behaviour, which parents need to be told and watch out for, ,as about half of depression starts in adolescence.

Dr. Prof Rajesh Sagar then spoke on the mental health consequences of Child sexual abuse (CSA), and of the need for any approach to be centred on ***respect, warmth, genuineness, empathy, and unconditional positive regard.*** He spoke of the appropriate stand of health professionals, breaking it down into ***do's***: be the child; go with the flow of conversation; convey genuineness; convey acceptance through friendly non-verbal gestures; and ***don'ts***: sympathy reactions; rush for obtaining information by badgering with questions; desperation to help; over-friendly gestures; blaming the child. He also spoke of the triad of history – observation – testing as cardinal to therapy and introduced a few evaluation tools used in psychiatric practice, such as the child trauma questionnaire and the revised child impact of events scale as well as cartoon-based assessment scales, anatomical drawings, FACES pain rating scale, and mood charting. He noted that the more simple amongst these could be used by amateurs including caregivers of children to identify the need for and provide mental health first-aid as well as to take necessary action when there was a need to make a mental health referral.

Ms. Enakshi Ganguly spoke on the multidisciplinary approach. She recommended the adoption of as holistic approach based on three principles: best interest of the child, non-discrimination and child's right to be heard. She warned that it was always advisable to approach each case individually, rather than a one-size-fits all one. Multi-disciplinary teams work on two verticals: preventive and protective. The role of the team in the first is different from that in the second, and the interventions required are also different. Prosecution occurs after abuse and the objective of the multidisciplinary assessment (MDA) is to prevent re-traumatisation and ensure that the child is facilitated in her recovery. The social worker has a role to play as the connecting factor between the various professionals. Every disclosure may or may not result in a legal case and the curriculum must take account of the environment in which we all function. This MDA team has professionals from: law enforcement, medical and mental health services, legal professionals, social workers, public prosecutors, forensic experts. The team also has to identify special needs and support persons. The child protection team works on prevention and civil action. Community education and social planning help to identify gaps in service delivery and also at research and data collection and analysis.

Childline's **Ms. Heenu Singh** then gave a brief overview of the important role her organisation plays in supporting affected children as well as their caregivers. She mentioned that they had modules for child protection training for police etc., as well as a skill-based curriculum for teachers. She also mentioned that Childline adopts a participatory and consultative approach in tailoring its programmatic interventions and this gives it more credibility with children themselves. Later, **Dr. Bipasha Roy** presented on the issue of justice to the survivor through case studies, where she highlighted the problems related to infrastructure, language, and personnel needed to facilitate the process.

Dr. Rajeev Seth then gave an insight into prevention and promotion of the child's well-being. He mentioned that prevention could be primary, secondary or tertiary, with the aim ranging from the prevention of recurrence to prevention of long-term effects. He spoke of the public health approach, which revolves around defining the problem, identifying causes, developing and evaluating interventions, and disseminating results in the form of interventions and is based on addressing the social determinants of health, which in turn has to involve parents and caregivers. The health sector has good resources and can provide leadership, and can also focus on primary prevention and also link science with prevention. Home visiting programmes can play a very important role. It can lead to an improvement in parenting skills, pregnancy outcomes and detection of abuse.

Recommendations

1. Provide **simple and clear definitions of child abuse and neglect** in Indian setting
2. Reiterate that child maltreatment is a **public health problem and a medical emergency** rather than a societal or family problem, and encourage parents and other caregivers to identify and seek assistance for their wards.
3. Educate parents on how to encourage their children to confide in them, and inculcate **positive parenting** techniques.
4. Inform teachers and other caregivers on **signs and symptoms of abuse and neglect** that they should be vigilant for.
5. Clarify to parents, teachers as well as other caregivers that corporal punishment, while socially accepted, is legally prohibited, and give them tips on **positive discipline strategies.**
6. Include specific guidelines on early diagnosis, intervention and **communication with children with disabilities** and/or special needs.
7. Include a component on **Early Childhood Care and Development** and guidelines on how to detect, prevent and treat neglect and abuse in very young children, particularly targeted at Anganwadi and ASHA workers.
8. Draw attention to the **influence of information & online technology** in the commission of violent crimes against children and educate caregivers on how to be vigilant in this regard.
9. Give parents and caregivers some basic information on how to talk to their wards about **personal safety**, and what materials (including apps) they can refer to for this.
10. Give parents an overview of their **legal obligations and protections** available under various laws.
11. Make the material **user-friendly and easy to understand** rather than curriculum-based.
12. Have materials **targeted to specific cultural regions and audiences**, such as parents, teachers, and child care institutions.

Conclusion

The consultation concluded with a broadening of the participants' understanding of the issue of child abuse and neglect and a consensus on the issues that must be incorporated in the IEC materials. Most importantly, participants agreed to continue to commit their time and efforts to this very important project and agreed to send academic and practical materials for incorporation in the curriculum.