children \( \leq 18 \) years. Children constitute a vulnerable group in society and a systematic approach is required to reduce the burden of childhood sexual abuse and the accompanying physical and emotional sequelae. Overall, strangers were most commonly identified as the perpetrator of sexual abuse in our study. It is possible that a pre-existing relationship with the assailant influences a victim’s likelihood of disclosing sexual abuse. Therefore our finding may not accurately reflect the relationship between the victim and the assailant.

The large number of major offences involving the victim’s current intimate partner in girls aged less than 16 years suggests a need for education and discussion about Sri Lanka’s penal code on sexual offences. This can be based on the approach in the United Kingdom on sexual offences in minors within a consensual relationship [8].

The main limitation of our study was its reliance on data from sexual abuse cases reported to Police stations in Ampara District. This excludes all unreported sexual abuse and as a result it is likely that we have significantly underestimated the actual burden of sexual abuse in the district. Further research should be conducted in order to determine the countrywide significance of sexual abuse among the female population and establish a baseline from which to develop and implement effective strategies to prevent this serious human rights violation.

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To the Editors:

**Education in psychiatry: wider reforms needed – a reply**

K Walsh

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Kuruppuarachch and de Silva have clearly outlined the problems facing psychiatry in Sri Lanka. [1] There is a heavy burden of mental illness and a lack of services for patients. As they outline, there is a clear need for better undergraduate education in psychiatry. However delivery of such education may not be enough in itself to make significant improvements to the system. Other strategies may have to be developed to deliver a psychiatric service that the population needs.

All too often those who wish to improve medical education look to the education of medical students. However the healthcare workforce that we have now will by and large continue to be our workforce for the next ten, twenty or even thirty years. Educating this existing workforce in psychiatry will have short and long term positive effects. The priority for education of the existing workforce must surely be general practitioners (GPs). Much mental illness presents in primary care, can be
diagnosed in primary care, and can be managed in primary care. Delivering psychiatry training as part of the continuous professional development programmes of GPs would surely make a significant impact.

Secondly more attention needs to be given to the retention of the existing mental health workforce. Educating medical students and engendering an interest in psychiatry among such students is laudable and will likely encourage some to take up psychiatry as a career. However if working conditions and ongoing opportunities are not available to those who do enter the specialty, then these people will leave psychiatry for other specialties or stay in psychiatry and leave the country. Adding more resources into undergraduate education in current circumstances is akin to trying to fill a leaky bucket – you can pour lots of water in but this will not work unless you fix the leak.

Thirdly and lastly giving more attention to medical education on its own will probably not be enough. We will need to consider wider education for healthcare professionals. Psychiatry is a team based endeavour – even the best psychiatrists on their own will have limited impact without the support of a fully functioning multidisciplinary team of nurses, allied healthcare professionals and social workers. These team members will also need to be educated and recruited and retained. Ideally interdisciplinary education would take hold – interdisciplinary team members would thus learn together before they started to practice together. This form of education might turn out to be not only more effective but more efficient as well. Delivering medical education at lower cost would surely be attractive to a range of stakeholders [2].

References

To the Editors:

Platelet recovery in dengue – a reply

S Yasri¹, V Wiwanitkit²


The article on platelet recovery in dengue is interesting [1]. Gooneratne et al. concluded that “the platelet recovery rates of patients from the 2011 outbreak were found to be slower than the platelet recovery rates of patients from the 2010 outbreak” [1]. This finding is interesting and requires further assessment. The difference might be due to several factors such as underlying haematological condition of the patients, age group, severity of dengue infection, strain of virus and it can also be an accidental finding.

For example, it is obviously noted that “platelet recovery was significantly slower with increasing grade” among the patients with bleeding presentation [2]. The cases with dengue shock syndrome usually have longer recovery periods [3]. Also, if the patient has underlying white blood cell malignant problem, the recovery time will be significantly delayed [4].

References

¹Primary Care Unit, KMT Center, Bangkok Thailand and ²Hainan Medical University, China.
Correspondence: SY, e-mail: <sorayasri@outlook.co.th>. Competing interests: none declared.