University of Jaffna

Lady Leelawathy Ramanathan Memorial Lecture – 2026

titled

"Nurturing the Next Generation: Contemporary Perspectives on Child Health"

by

Professor Gitanjali Sathiadas,
Chair Professor,
Department of Paediatrics,
Faculty of Medicine,
University of Jaffna.

on

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05.03.2026

சீமாட்டி லீலாவதி இராமநாதன்

Lady Leelawathy Ramanathan

Message from the Vice Chancellor

Lady Leelawathy Ramanathan Memorial Lecture is an annual event which usually takes place following the Annual General Convocation. This memorial lecture is established through an endowment initiated by the Saiva Mangaiyar Sabai-Association of Hindu Women, funded by Sir Pon Ramanathan in 1924.

Lady Leelawathy Ramanathan originally from Australia, attracted by the theosophical moment in Australia, moved to Sri Lanka to quench her spiritual thirst. She got married to Sir Pon Ramanathan, a high Hindu intellectual personality. She exemplified the ideas of woman who embraced her husband's profound vision of knowledge and spirituality as her own. She was a devoted wife, who respected all the cultures and traditions of her second home land as her own motherland. She is none other than our Lady Leelawathy Ramanathan.

Soon after the demise of Sir Pon Ramanathan in 1924, Lady Leelawathy Ramanathan followed the Hindu tradition of wearing white saree and built Kurinji Andavar temple in loving memory of her husband. Her contributions to the Tamil-speaking community were significant and commendable. Her untiring efforts on publishing Sir Ramanathan's lectures and several books including Ramayanas in English version were Marvelous. We express our gratitude to those who established this memorial lecture, allowing us to celebrate her invaluable contributions to our Tamil community.

Speaker of Lady Leelawathy Ramanathan Memorial Lecture 2026, Prof.Gitanjali Sathiadas, is an eminent lady and famous researcher of our university. She was born in Badulla and moved to Jaffna and obtained her education at Chundikuli Girls' College, Jaffna. She completed her Bachelor's degree in Medicine from University of Aberdeen in the United Kingdom in 1997. She obtained her MD Paediatrics from PGIM, University of Colombo in 2007.

She joined the Faculty of Medicine of our university as a lecturer in 2003 and promoted to Senior Lecturer in 2010, and the Head of the Department of Paediatrics (2010-2016) and Clinical Coordinator (2010-2017). She was promoted as the Professor in Paediatrics from 2020 and currently she is the Chair Professor of Paediatrics at the University of Jaffna.

She has published books and journals, articles, abstracts on newspapers and Scientific Journals. She is an honorary Consultant Paediatrician to Teaching Hospital, Jaffna. In addition to her clinical contributions, she also contributes a lot on academic level as a multifaceted academician. She is a very active person in the community level and a gifted teacher and respected by all students.

On behalf of the University of Jaffna, I extended my gratitude to Prof.Gitanjali Sathiadas for graciously accepting our invitation to present the Lady Leelawathy Ramanathan Memorial Lecture this year, focusing on the theme "Nurturing the Next Generation: Contemporary Perspectives on Child Health".

I believe this is a suitable topic for those who are in the medical field to strengthen their engagement and expertise in the contemporary issues on Child Health and to enrich the future generations.

May the Almighty bestow upon her peace and prosperity.

Prof. S. Srisatkunarajah,
BSc(Hons), PGDE(Merit) OUSL, PhD (Heriot-Watt),
Professor in Mathematics,
Vice Chancellor,
University of Jaffna.

Leelawathy Ramanathan Memorial oration

Prof Gitanjali Sathiadas
Chair Professor of Paediatrics
Faculty of Medicine
University of Jaffna

Nurturing the Next Generation: Contemporary Perspectives on Child Health

It is my great privilege to deliver the prestigious Lady Leelawathy Ramanathan memorial lecture today. Lady Ramanathan was born Rosa Lilian Harrison in Victoria, Australia, to Frederick Drake Harrison and Mary Lloyd Poole, both of whom had emigrated from England as children. She was educated at Dryburgh House School in Adelaide and later at Queens College, an Anglican girls' school in Ballarat, where she distinguished herself by winning prizes in painting, music, recitation, and fancy work. In 1889, she was awarded a scholarship by the Commercial Travellers' Association to attend the University of Adelaide, enrolling in the Bachelor of Music degree program.

Her interest in Theosophy eventually drew her to Sri Lanka, where she met the distinguished statesman and scholar Ponnambalam Ramanathan, then Solicitor General. In June 1905, Ramanathan embarked on an international lecture tour accompanied by Harrison, who served as his secretary. Their travels took them first to London and then to New York and other parts of the United States, where Ramanathan delivered a series of discourses on "the unity of faith." He addressed diverse audiences, including Zionist groups in Boston, artists in New York, and students and faculty at leading universities such as Columbia University, Cornell University, Harvard University, Johns Hopkins University, and Yale University. In April 1906, the pair returned to London.

By this time, Harrison had adopted the name Ráma Lílávati, writing under the signature "R. Lílávati." She contributed a series of articles to prominent newspapers, including the Indian Mirror, The Hindu, and the Ceylon Independent.

Following her marriage to Ramanathan in 1907, Lady Leelawathy Ramanathan largely withdrew from public prominence, though she remained deeply engaged in educational and cultural work. In 1912, when Ramanathan founded Ramanathan College, she served for a period as its Principal. A scholar proficient in Tamil and Sanskrit, she made significant contributions to indigenous education and the preservation of Sri Lankan cultural traditions.

After Ramanathan's death in 1930, Lady Ramanathan adopted the white robes of a Hindu widow and spent periods in meditation at Kodaikanal. In 1931, she published a concise English retelling of the Ramayana, a copy of which she sent to Mahatma Gandhi. In 1942, the University of Ceylon conferred upon her the honorary degree of Doctor of Laws in recognition of her services to education.

Lady Ramanathan spent her final years living with her daughter and son-in-law on the campus of Ramanathan College. She passed away on 31 January 1953 at the age of about eighty, leaving behind a legacy of scholarship, cultural advocacy, and dedication to education in Sri Lanka.

Ladies and gentlemen, I Have tried my best to pay respect to a wonderful human being and let me walk you through some of the work that we did in this region regarding child health and the interference of factors that hinder the health of the future society.

Introduction

Children are the soft beginnings of every hope we dare to hold. They carry wonder in their questions, courage in their small steps, and an honesty that reminds the world how to feel without fear. In their laughter lives a kind of magic that heals tired hearts, and in their tears, a quiet trust that someone will come to make things right. They teach us, without trying, that love can be simple, joy can be loud, and tomorrow is always worth believing in.

Today's world is changing rapidly due to advances in science and technology. In such a situation, creating a resilient, responsible, and empowered generation is essential for the progress of society. This nurtured strong generation is one that possesses knowledge, moral values, discipline, and a sense of responsibility. It should not only have intellectual brilliance but also social responsibility. Such a generation can truly be called the future of a nation.

Today's children are tomorrow's leaders. It is the duty of all of us to identify their talents and guide them so that they do not stray from the right path. We can create a strong generation by properly guiding and nurturing them through education, skills, discipline, and culture. Such a generation will protect the environment, speak out for social justice, work for the welfare of fellow human beings, and strive for the development of the nation. However, today we see that the environment needed to create such youth is being eroded, and the society carefully built and protected by our ancestors is declining. This could be the long term effects of a war-torn society.

War does not end when the guns fall silent, it quietly reshapes society for generations, turning lost childhoods into fragile futures and passing unseen wounds from one heart, one family, and one generation to the next.

Long-Term Impacts on Children Growing Up in High-Risk Environments

- Psychological Effects: Mental stress, fear, and sleep disturbances are common. Children may suddenly become frightened by small noises, darkness, or news about death. Persistent insomnia, lack of concentration, and anxiety can continue over time.
- Reduced Self-Confidence: Due to unsafe environments and lack of affectionate care, children may grow up with low self-esteem. As a result, they may fall behind socially and academically.
- Educational and Cognitive Impact: School dropouts increase, opportunities to attend school decrease, and parents may be forced to send children to work to support family livelihoods. This disrupts learning and skill development.
- Impaired Cognitive Functioning: Continuous stress, hunger, and insecurity affect brain development. Decision-making ability, memory, and attention span are weakened. When children grow up without normal childhood opportunities, their natural talents may never surface and may be permanently lost.
- Social Exclusion and Marginalization: Children who lose parents due to war may be neglected or excluded by society. As close relationships disappear, children may grow up lonely and without hope or trust. When children live as refugees in other countries, they may lose their native language and cultural identity.
- A lack of education and skills can negatively affect their future livelihoods and economic stability
- Normalization of Violence and Risky Behavior: Some youth grow up perceiving violence as a normal part of life. As a result, their behaviour becomes harmful, such as habitual

lying, substance abuse, reckless driving, engagement in high-risk sexual behaviors leading to infections, and frequent school absenteeism. Additionally, due to poor emotional regulation, they struggle to manage emotions like anger, jealousy, and rejection. They find it difficult to resolve conflicts peacefully and often face challenges in forming and maintaining healthy social relationships.

Emotional wounds carried from childhood can affect their own family life later. They may struggle to show affection to their children. In relationships, love, marriage, and parenthood, they may lack trust, responsibility, and emotional generosity, leading to ongoing difficulties within the family.

Nurturing children is the most profound responsibility a parent or caregiver can hold. It is not enough to merely provide food, shelter, or basic care; a child must be guided, taught values, and empowered to grow into a capable, compassionate, and responsible adult. Effective nurturing combines firm guidance with love, ensuring that children understand boundaries while feeling supported and valued. Through consistent encouragement, education, and moral mentoring, parents and teachers shape not only a child's skills and knowledge but also their character, resilience, and ability to navigate the world with confidence. The way a child is nurtured today determines the quality of their future, the strength of their relationships, and the health of the society they will help build tomorrow.

Nurturing the preschool child

Preschool age (2 to 5 years) is a period of rapid physical, motor, social, cognitive, and emotional development. During this time, children begin to form habits that are flexible and adaptable, yet these early patterns can have a lasting influence on their lifelong behaviors. In particular, habits related to eating, physical activity, and overall health, established during these formative years, play a crucial role in shaping a child's future well-being and lifestyle.

Providing a balanced diet rich in essential nutrients proteins, vitamins, minerals, and healthy fats supports brain development, strengthens immunity, and fuels the energy required for learning and exploration. Proper nutrition not only enhances physical growth but also lays the foundation for cognitive abilities, emotional regulation, and social skills. Habits formed during this early period, whether healthy or unhealthy, tend to persist into later childhood and adulthood, making it essential for caregivers to ensure children receive consistent guidance and access to nutritious food.

Economic Challenges, Poverty, and Child Nutrition in Sri Lanka

Following the severe economic crisis of 2021, the Sri Lankan economy began to stabilize by mid-2023. Years of poor economic management, structural weaknesses, and external shocks intensified the situation, leading to a depletion of foreign reserves and difficulty in servicing public debt by 2022. Amid rising unemployment and inflation, real household incomes fell, pushing poverty rates up by 10 percentage points between 2021 and 2022.

Interventions under the IMF's Extended Fund Facility (EFF) helped stabilize the economy, containing the contraction in gross domestic product to 9.5 percent between 2021 and 2023. Inflation, which peaked at 69.8 percent in September 2022, dropped to 4 percent by December 2023. However, fiscal reforms including adjustments to utility pricing and new revenue measures reduced household disposable incomes.

Despite signs of economic recovery, a significant portion of the population approximately one in three people, remains in poverty or at risk of falling back into it. Families struggling with high living costs often resort to coping with strategies that are harmful in the long term: reducing essential consumption, taking on excessive debt, limiting nutrient-rich food intake, or withdrawing children from educational activities. These strategies disproportionately affect child nutrition.

The Sustainable Development Goals (SDGs) prioritize the elimination of hunger, achievement of food security, improved nutrition, and promotion of sustainable agriculture. Progress toward these goals is monitored through four key nutritional indicators for children under five:

- Stunting (low height for age)
- Wasting (low weight for height)
- Overweight
- Anemia during early childhood

Poverty and malnutrition are deeply interconnected, creating a self-reinforcing cycle. Families living in poverty cannot afford nutrient-rich foods, leaving both children and adults deficient in the nutrients essential for physical growth and cognitive development. Children who grow up undernourished face higher risks of infections and other illnesses, which further impair brain and body development.

Malnutrition also affects educational outcomes. Undernourished children struggle to concentrate in school, leading to poor academic performance. In the long term, these children are likely to obtain lower-paying, unstable jobs, perpetuating a cycle of poverty that can span generations.

The root causes of poverty-related malnutrition include lack of access to essential, affordable foods such as protein-rich legumes, whole grains, fruits, and vegetables. This food insecurity has profound consequences for physical and cognitive health. The most visible effects are stunting, wasting, and general nutrient deficiencies. Early childhood undernutrition also increases the risk of chronic conditions in adulthood, including heart disease, high blood pressure, and susceptibility to infections.

Achieving the Sustainable goals

Globally, from 2012 to 2020, 84 percent of low birthweight infants were born in low-income countries. The prevalence of stunting among children under five rose from 21 percent in 2012 to 26 percent in 2022. During the same period, wasting increased from 14 percent to 17 percent, while the proportion of stunted children in these countries rose from 88 percent to 90 percent. Additionally, overweight prevalence among children in low-income countries increased from 49 percent to 53 percent between 2012 and 2022. Though these shifts appear small, they signal growing concerns about both undernutrition and overnutrition among vulnerable populations.

The prevalence of stunting (reduced height-for-age) among children under five years of age declined from 26.3% in 2012 to 22.3% in 2022. However, to achieve a stunting prevalence of 13.5% by 2030, the prevalence in 2022 should have reached 18.2%. Although there has been strong progress, the 2030 target is not likely to be achieved. To make up for this gap, substantial investments in appropriate policies and interventions will be required.

Between 2012 and 2022, there has been only modest change in the prevalence of wasting (low weight-for-height) among children under five. It declined from 7.5% to 6.8%. To meet the 2030 target, it should be reduced to 3%, but it remains at around 6%. These findings indicate the need to increase access to essential interventions for the prevention of wasting. To ensure the achievement of global targets, actions such as early detection, appropriate treatment, and the monitoring and delivery of effective services for child wasting must be scaled up.

Achieving the 2030 target of reducing overweight among children to 3% will require multiple changes at the global level. The prevalence of overweight was 5.5% in 2012 and 5.6% in 2022. To address overweight and obesity among young children, it is crucial to invest in effectively

promoting and adopting positive behaviours, including healthy dietary practices, avoiding easy access to foods high in sugar, salt, and fats, and encouraging active play and other forms of physical activity.

According to studies conducted in Sri Lanka in 2020, among children aged 6–59 months, the prevalence of stunting (low height-for-age), underweight (low weight-for-age), wasting (low weight-for-height), and overweight/obesity was 13.7%, 19.8%, 22.7%, and 1.7%, respectively. Severe acute malnutrition (SAM) was observed in 2.5% of the sample population. Hemoglobin (Hb) levels were also assessed in this age group, revealing that 14.6% of children suffered from anemia (Hb < 11 g/dL), with female children being disproportionately affected.

The Jaffna District

Preschool children

A cross-sectional study was conducted in all 13 Medical Officer of Health (MOHs) areas of the Jaffna District of Sri Lanka among 6-59month children in 2023. A two-stage stratified random cluster sampling technique was used. Interview of the child's mother or the main carer as a respondent using a structured questionnaire was used to collect general socio-demographic characteristics, information on breastfeeding, feeding habits, dietary diversity, illness history, and the socio-economic status of the households. Measurement of food insecurity was done using the Household Food Insecurity Access Scale (HFIAS) guideline version 3. Household hunger score was assessed using the scale of household hunger scale a subset of the HFAIS. Anthropometric assessments were taken by the trained investigators using the standardized scales used in the community.

A sample study of 351 children (190 rural, 161 urban). Age distributions are comparable, with 1-3 years dominating both (25.1% rural vs. 24.2% urban), though rural has a higher proportion in the >3-5

years category (14.0% vs. 8.0%). Health indicators show rural advantages in exclusive breastfeeding for 6 months (49.6% vs. 39.3%) and immunization completion (53.3% vs. 44.2%), alongside marginally lower recent hospital admissions (3.7% yes vs. 4.6%). Maternal education peaks at GCE O/L level for both (31.1% rural vs. 24.5% urban), with higher education scarce. Family income and socioeconomic status align closely, centering on 25,000–49,999 rupees (23.1% rural vs. 24.8% urban) and upper middle class (29.3% rural vs. 29.6% urban), though rural exhibits lower middle SES (18.5% vs. 8.8%).

Analysis of malnutrition indicators across age categories reveals distinct patterns of association with age. Growth faltering, observed in the CHDR weight-for-age charts over the previous six months, affected 29.6% of the total population (104 cases), with the highest prevalence in the 1-3 years group at 16.8% (59 cases), compared to 4.8% (>1 year, 17 cases) and 8.0% (3-5 years, 28 cases). This distribution showed a significant association with age, as indicated by a chi-square statistic of 11.2697 and p-value of 0.003571 ($p < 0.05$).

Wasting impacted 16.5% overall (58 cases), peaking in the 1-3 years group at 7.9% (28 cases) and 6.5% (3-5 years, 23 cases), while lowest at 2.0% (>1 year, 7 cases), the p-value of 0.0002 confirmed a highly significant age-related link ($p < 0.05$).

Underweight prevalence reached 27.0% total (95 cases), highest in 1-3 years at 12.5% (44 cases) and 10.5% (3-5 years, 37 cases), versus 4.0% (<1 year, 14 cases), with p-value < 0.00001, underscoring a strong age association.

In contrast, stunting affected 27.9% (98 cases) without significant age variation, 8.8% (<1 year, 31 cases), 11.7% (1-3 years, 41 cases), and 7.4% (3-5 years, 26 cases) as the chi-square statistic of 3.2249 yielded a non-significant p-value of 0.199395 ($p > 0.05$). Overall, acute

malnutrition forms (growth faltering, wasting, underweight) significantly clustered in toddler and preschool ages, while chronic stunting appeared more evenly distributed.

Analysis of food consumption habits reveals no significant difference in dietary diversity between rural and urban areas, with 69 rural (19.7%) and 67 urban (19.1%) households reporting dietary diversity and121 rural (34.5%) and 94 urban (26.8%) reporting no dietary diversity.

Mean score for HHS in rural area was 204.9±65.8, in urban area was 141.3±122.8 and for HFAIS in rural was 204.9 (std. deviation 65.8), in urban area was 141.3 (std. deviation 122.8) for the population.

An independent samples Welch's t-test showed a significant difference in mean HHS scores between rural and urban households, $t(235) = 5.90$, $p < 0.001$. Mean HFIAS scores were significantly higher in rural households compared to urban households ($p < 0.001$), indicating a greater overall burden of food insecurity. However, categorical food insecurity status ($p = 0.83$) and categorical hunger scales ($p \approx 0.09$) did not differ significantly by place of residence. These findings suggest that while overall hunger intensity differs significantly, categorical severity differences may require larger samples or targeted subgroup analyses to detect statistically significant effects.

Analysis of the binary logistic regression results underscores strong protective effects from socioeconomic factors against malnutrition. Economic status exhibited, with crude odds ratio (OR) 0.529 (95% CI: 0.411-0.680, $p<0.001$) and adjusted OR 0.740, indicating substantially reduced household food insecurity in better economic conditions. Maternal education showed even stronger protection (adjusted OR 0.432, 95% CI: 0.316-0.590, $p<0.001$), while monthly income reinforced this trend (adjusted OR 0.808, 95% CI: 0.751-0.871, $p<0.001$), highlighting their consistent inverse associations. Nutritional risk factors displayed varied significance, with dietary

diversity significantly reducing household food insecurity (Crude OR 2.479, 95% CI: 1.578-3.895, p<0.001). HFIAS has a significant positive correlation with poor consumption of egg/flesh frequency (r = 0.124, p < 0.02), suggesting that higher food insecurity links to reduced consumption of nutrient-rich animal proteins.

In conclusion the socioeconomic crisis has significantly worsened household food insecurity in Jaffna District, reducing families' ability to secure adequate and nutritious food. Among children under five, food insecurity is linked with increased prevalence of growth faltering, underweight, wasting, and stunting. These findings underscore the compounded vulnerability of children in low-income households during economic hardship and highlight the need for targeted food security policies.

School going children

A community based cross-sectional study was carried out using multistage stratified proportionate cluster among healthy children attending schools in the Northern part of the country. Height and weight were measured, and Body Mass Index (BMI) calculated [weight (kg)/Height (m) 2]. BMI-for-age z-score (BAZ) and Height for age Z (HAZ) scores were determined and WHO growth references were used to categorise the nutritional status. Correlation between various nutritional problems with Maternal education, household income, number of family members and the residential area was assessed.

A total of 1012 children were recruited, and the mean age and standard deviation were 11.12±1.77 yrs. Girls in the age ranges of 9-14 were heavier and taller when compared to the boys compatible with the pubertal growth spurt. Stunting based on the height for age was seen in 10.9% of boys and 11.8% of girls. Wasting based on BMI for age WHO standard (WHO 2007) was seen in 30.6% of boys and 29.1% of the

girls. The prevalence of overweight was 11% and Obesity was 6.3% of the population. Obesity was predominantly seen in boys (4.2%) and it was significantly higher when compared to the girls (2.1%) ($p < 0.001$). Obesity in older boys (> 10 years) was significantly more than the younger ones ($p < 0.01$). Maternal education and family income had a significant impact on the prevalence of wasting, stunting and obesity whereas the family size contributed to the wasting and obesity ($p< 0.001$).

Mean haemoglobin was 12.31±1.51g/dl and mean ferritin was 21.31ng/ml 95%CI 18.99-23.63 respectively. The prevalence of anaemia was 27.9% (n=324), prevalence of iron deficiency anaemia was 16.8. Females had higher prevalence (30.6%) of anaemia when compared to males (25%) ($p <0.01$). Prevalence of iron deficiency was 52% adjusted after excluding population with high CRP. Haemoglobin level of study population significantly correlated with height (r-0.243, $p<0.01$), weight (r-0.256, $p<0.01$) and BMI (r-0.2, $p<0.01$). Prevalence of anaemia was significantly higher in children aged 12-16yrs ($p<0.001$) and among children from Thenmaradchi zone ($p<0.003$).
These findings suggest that stunting, wasting, overweight, obesity and anaemia causing a triple burden are prevalent among 6-16-year-old leading to concerns in public health. Nutritional status significantly varies according to the geographical location, maternal education and the household income.

A range of these challenges continues to affect our population, posing significant risks to the health and well-being of future generations. While numerous policies, programs, and interventions have been implemented at the global level to address these issues, questions remain regarding their effectiveness in reaching target populations, the fidelity of their implementation, and the rigor of impact assessment mechanisms used to evaluate their outcomes and long-term effects.

Short- and long-term effects of malnutrition

Malnutrition has extensive and long-term consequences that transcend early childhood, impacting health outcomes across the life course. Consistent with Barker's Hypothesis, undernutrition during critical windows of fetal and early postnatal development induces permanent structural, physiological, and metabolic adaptations, which increase susceptibility to chronic non-communicable diseases, including cardiovascular disease, type 2 diabetes, and hypertension, later in life. The UNICEF Conceptual Framework further highlights that malnutrition is the result of complex, multilevel determinants, encompassing inadequate dietary intake, recurrent infections, suboptimal caregiving practices, and broader socio-economic and environmental constraints. These interacting factors contribute to stunting, wasting, and micronutrient deficiencies, which in turn exacerbate cognitive and physical developmental deficits. Effective mitigation of malnutrition therefore requires an integrated strategy: targeted early-life nutritional interventions to prevent immediate deficits and promote optimal growth, combined with comprehensive social, economic, and policy measures to address underlying and structural determinants, thereby disrupting the intergenerational cycle of poor health and developmental disadvantage.

Nutritional status directly influences physical growth, illness susceptibility, and physical activity. These factors, in turn, affect brain development and function. Caregiver behavior and parent-child interaction also play a crucial role by shaping brain development and the child's level of interaction with the environment. Ultimately, these interconnected pathways influence a child's cognitive, motor, and socio-emotional development.

Considering this we designed and experimented with a community-led intervention to improve the nutritional status of children in Poonery area. A feasibility study in the Ariyalai area of the Jaffna District

showed promising results. The overall feasibility assessment indicated that the program was highly viable, with strong community engagement and system support. Community readiness and caregiver response showed high interest. Infrastructure readiness, and availability of nutrition resources were also favorable, with most foods accessible locally and Public Health Midwives (PHM) and community health centers positioned to provide support. Cultural acceptability and legal compliance were present as minor challenge. Additional training for health workers, external funding support, and transportation costs for fieldwork was addressed to ensure smooth and sustainable implementation.

Project Amuthasurabi

This community led intervention is by using the care group approach. The Care group approach has been acknowledged for building stakeholders' capacities to contribute actively to health and nutrition development initiatives, promoting local ownership and empowerment. It is noted as the best strategy to share new information and transfer skills at a large scale and act as a central point to integrate various complementary interventions. In general, the care Groups approach has decentralized a key aspect of health service provision to the grassroots level, by equipping the common mother/father with crucial competencies to positively impact on his/her community's health status. This will create ownership of services delivered at the community level and empower communities to organize themselves for action and to request services from the government.

Key Components of the Intervention: Project Amuthasurabi

1. Nutrition Education & Affordable Recipe Development

A tailored training manual guides preparing nutrient-rich, cost-effective meals using locally available ingredients. Participants learn to optimize dietary diversity, address malnutrition, and adapt recipes to cultural preferences while staying within budget constraints.

2. Hygiene and Sanitation Practices

Interactive workshops emphasize the importance of personal and household hygiene, safe food handling, and disease prevention. Training includes practical demonstrations (e.g., handwashing techniques, and water purification) to reduce preventable illnesses, particularly among children.

3. Positive Parenting Strategies

Caregivers are equipped with evidence-based tools to nurture child development, including emotional regulation, age-appropriate communication, and non-violent discipline. Sessions also address stress management and foster secure caregiver-child relationships.

4. Financial Literacy and Resource Management

Modules focus on budgeting, savings strategies, and income-generating activities to improve household financial stability. Through networking and collaboration facilities are made aware to form community savings groups, participants learn to prioritize expenses, access microfinance opportunities, and mitigate economic shocks.

5. Behavioral Change Techniques

Peer-led discussions and role-playing activities encourage the adoption of healthier habits. Techniques include goal setting, social accountability, and problem-solving to address barriers to change, such as entrenched cultural practices or resource limitations.

A total of 13 clusters with each cluster having ten households with children under five years of age was selected using a multistage cluster sampling method. The selected households participated in baseline data collection, followed by a structured training program. The training was conducted over six weeks, comprising a total of twelve sessions, each lasting two to four hours. Upon completion of the training, two weekly household follow-up visits were conducted to assess and reinforce adherence to recommended practices.

Of 178 families, 154 (86.5%) completed 6-month follow-up. Mean child age at recruitment was 25.4±11.6 months, and most (n=148) were from lower-middle socioeconomic households.

Post intervention Household hunger improved, with mean HHS decreasing from 0.55±0.43 to 0.43±0.93, with little to no hunger rising from 83.1% to 88.3%. HFIAS scores changed slightly from 3.11±4.5 to 3.37±4.98, reflecting income loss during flooding. SAM dropped from 10.4% to 1.3%, MAM from 10.4% to 7.1% and growth faltering fell from 60.4% to 27.9%. Severe wasting declined from 5.2% to 1.3% and moderate wasting from 18.8% to 13.0%; moderate stunting decreased from 25.3% to 20.8%, while severe stunting remained unchanged. Consumption of vitamin A-rich vegetables (48%→69%), green leafy vegetables (50%→60%), eggs (52%→80%), and organ meat (8%→17%) increased, whereas fried foods (92%→88%), bakery items (60%→47%), and sweets (86%→36%) decreased. Fish Consumption gradually increased from 59.1% to 62.1% and 78.8%, and the change was statistically significant ($p = 0.033$). Sweets/Sugar/Honey intake decreased markedly from 89.4% at the 1st visit to 86.4% at the 5th visit and 36.4% at the 8th visit, showing a statistically significant reduction ($p < 0.001$).

Among participants the mean dietary diversity scores showed an increase from the baseline of 4.42±1.10 to 4.88±0.80 at the end of six months post intervention. Correct handwashing rose from 64% to 82% and hospital admissions reduced from 12% to 8%.

This pilot intervention showed early improvements in child growth, dietary habits, and hygiene at six months, supporting the scale-up of this integrated, culturally adapted, family-centered model with longer-term evaluation.

Although nutritional problems such as undernutrition, micronutrient deficiencies, and overweight remain well established determinants of

morbidity and developmental outcomes in children under five years of age, the risk profile of early childhood is expanding.

Physical activity not only reduces the chances of overweight and obesity it is associated with improved motor and cognitive development, psychosocial and cardiometabolic health. It has been well proven by randomized and non-randomized intervention studies. Moderate to vigorous-intensity, vigorous-intensity and total physical activity were beneficially associated with several health indicators.

WHO recommendations for 24-hour physical activity, sedentary behaviour and sleep for children under 5 years of age.

For the greatest health benefits, infants and young children should meet all the recommendations for physical activity, sedentary behaviour and sleep in a 24-hour period. Replacing restrained or sedentary screen time with more moderate- to vigorous-intensity physical activity, while preserving sufficient sleep, can provide additional health benefit.

Infants (under 1 year) should be physically active several times a day in a variety of ways, especially through interactive, floor-based play. For infants who are not yet mobile, this includes at least 30 minutes of tummy time (prone position) spread throughout the day while awake. Infants should not be restrained for more than one hour at a time (e.g., in prams or strollers, highchairs, or while strapped to a caregiver's back). Screen time is not recommended. During sedentary periods, caregivers are encouraged to engage in activities such as reading and storytelling. They should have 14–17 hours of good-quality sleep (for those aged 0–3 months) or 12–16 hours (for those aged 4–11 months), including naps.

Children aged 1–2 years should accumulate at least 180 minutes of physical activity at any intensity throughout the day, including some moderate- to vigorous-intensity activity—the more, the better. They

should not be restrained for more than one hour at a time (e.g., in prams, strollers, high chairs, or while strapped to a caregiver) or sit for prolonged periods. Sedentary screen time is not recommended for 1-year-olds; for 2-year-olds, it should be limited to no more than one hour per day (less is better). During sedentary time, reading and storytelling with a caregiver are encouraged. These children should have 11–14 hours of good-quality sleep, including naps, with consistent sleep and wake-up times.

For children aged 3 and 4 years, the WHO guidelines recommend, spending at least 180 minutes in a variety of physical activities (Total Physical Activity- TPA) of which at least 60 minutes in moderate-to-vigorous intensity physical activity (MVPA), not to be restrained for more than 1 hour (Restrained seating- RS) and sedentary screen time (ST) of not more than 1 hour and 10-13 hours of good quality sleep. WHO further states that young children should meet all the recommendations for the greatest health benefits.

One of the key problems encountered in children these days is excessive digital medial use. Digital media use in children should be guided by age, content quality, and balanced daily routines. Excessive screen time has been associated with reduced physical activity, disrupted sleep, and potential impacts on attention, language development, and social skills particularly in younger children. Establishing clear boundaries such as screen-free meals and bedrooms supports healthy development while allowing children to benefit from the educational and social opportunities digital media can offer.

Executive functions such as attention control, working memory, planning, and self-regulation require active engagement, problem-solving, and real-world interactions to strengthen. When children spend long hours on screens, they often experience fragmented attention, overstimulation, and limited opportunities for physical play, which are crucial for cognitive growth. Over time, this imbalance can

lead to difficulties in focusing, managing impulses, organizing tasks, and adapting to new challenges, ultimately affecting academic performance and social development.

Motor Skills and executive functions in preschool children

Motor skills and executive function are closely interconnected in preschool children and play a critical role in early development and school readiness. Motor skills include gross motor skills (e.g., running, jumping, balancing) and fine motor skills (e.g., grasping, drawing, manipulating small objects). Executive function refers to higher-order cognitive processes such as working memory, inhibitory control, and cognitive flexibility, which enable children to plan, focus attention, regulate behavior, and adapt to new situations.

Emerging evidence suggests that well-developed motor skills are positively associated with stronger executive function in early childhood. Physically active play, particularly activities that require coordination, sequencing, and rule-following can stimulate brain networks involved in both motor control and cognitive regulation. During the preschool years, rapid brain development makes this a sensitive period for strengthening these interconnected domains. Supporting structured and unstructured movement opportunities may therefore promote not only physical competence but also attention, self-regulation, and early academic readiness.

Excessive sedentary screen time hinders active play, which is essential for developing gross and fine motor skills. When children spend long periods on passive activities such as watching videos, they have fewer opportunities to practice balance, coordination, object manipulation, and hands-on exploration. Fine motor development may also be limited if screen interaction replaces activities like drawing, building, or puzzle play.

Executive function can also be affected. Fast-paced or highly stimulating digital content may tax attention systems and reduce opportunities to practice self-regulation, problem-solving, and sustained focus. Overuse of digital media has been associated with difficulties in inhibitory control and attention in some studies. However, high-quality, age-appropriate, and interactive digital content especially when used with caregiver guidance can support certain executive skills, such as working memory, turn-taking, and simple problem-solving.

We conducted a study to determine the factors associated with adherence of preschool children (ages 3-4.9 years) to WHO movement guidelines. Children were recruited from preschools in the Northern province.

A total of 224 children from all 5 districts were selected from 12 preschools. A pretested questionnaire was used to collect the data, anthropometric measurements were taken and activities regarding gross motor and fine motor were assessed. Standing long jump was used to assesses lower body strength and mobility, Supine-timed up and go (STuG) assessed mobility and posture, One-legged standing balance test assessed posture and balance. Handgrip dynamometer (TKK5825, Grip-A, Takei, Tokyo) assessed upper extremity strength and the 9-hole pegboard test assessed the dexterity and manipulation. Dexterity is a central component of hand function and relates to both the speed and accuracy of hand movements. Executive functions such as Inhibition and working memory were measured using the validated Early Years Toolbox (EYT), which is a set of iPad-based games that were used to assess the working memory and to assess the inhibition.

Electronic Device Use, Bedtime practices and quality of sleep in Children - Northern Province

Mean daily screen time was 81.7 ±70.5 minutes, with 82.1%reported spending 30 minutes or more on-screen time more than the WHO

recommended screen time.

The largest proportion of respondents (36.9%) never use devices for teaching children. A smaller percentage use them most days (18.2%) or every day (6.4%), suggesting occasional but not predominant reliance on devices for educational purposes. 42.8% never use devices for calming, while 11.9% use them most days, and 6.8% use them every day. This shows that most caregivers rarely rely on digital devices for emotional regulation, but a subset uses them regularly. 38.1% never use devices to keep the child active, while 16.5% use them once a week, and 14.8% use them most days. Devices are less commonly used as tools for physical engagement, though some moderate use exists. Smart phones are regularly used during mealtime to distract the child nearly 40.4% never use smartphones during meals, but 26.4% use them most days, and 11.1% use them every day. Child's device use before sleep is seen in 53.4% of children within 2 hours of sleep, while 46.6% do not.

Nearly 51.3% of children get engaged in less than 180 minutes of daily physical activity, while 48.7% met or exceeded the recommended 180 minutes per day. According to World Health Organization guidelines, children under five years should accumulate at least 180 minutes of physical activity throughout the day. On a typical weekday, children spend an average of 172 ± 104 minutes outdoors. During weekends, the average outdoor time decreased to 137 ± 106 minutes. Overall outdoor play: In the last three spend 81.4% of children went outside to play, while 18.6% stayed indoors.

The most frequent locations were gardens (66.1%) and relatives' or friends' houses (52.6%), indicating that children often play in nearby or familiar spaces and less common locations: Parks or playgrounds were visited by only 20.2% of children, and very few children played near roads (4.2%), pools or rivers (2.6%), or natural/forest areas (0.5%).

Regarding sleep, 84.3% of children slept between 10 and 13 hours per day, which falls within the WHO-recommended range for preschool-aged children. However, 8.1% slept 10 hours or less, and 7.6% slept more than 13 hours.

Only 7.2% of children met all three recommended movement behavior criteria (adequate physical activity, appropriate sleep duration, and limited screen time), whereas the vast majority (92.8%) did not meet the combined recommendations. This indicates the adherence to the combined 24-hour movement guidelines is considerably low. This imbalance suggests that achieving an overall healthy daily movement pattern remains a challenge.

Analysis of Physical Performance of preschool children in Northern Province

Children maintained balance for slightly longer on the right leg, but the high standard deviations indicate large variability in balance ability. Right leg: 7.27 ± 8.14 s and Left leg: 6.58±7.00s Standing long jump performance was consistent across trials, with a small improvement in the second attempt, suggesting reproducibility and moderate lower-limb strength. Standing Long Jump (cm) Trial 1: 49.81±19.05cm and Trial 2: 50.90±19.69 cm. Grip strength was slightly higher in the right hand, and performance remained stable across trials, indicating moderate hand strength with minimal fatigue effect. Children completed the task faster with the right hand, suggesting dominant-hand advantage and slightly better fine motor coordination on the right hand: 40.32±10.6 s and the left hand: 46.16 ±12.70s.

Executive Function and Digital Media Use in 3–5-Year-Olds of Northern Province

In children aged 3 to 5 years, the Go/No-Go task shows moderate executive function development: Go accuracy was 70.99± 20.40%, No-Go accuracy was 65.53 ± 22.94%, and the impulse control score

averaged 0.45± 0.21. These values indicate that while most children can successfully execute a response, inhibiting impulses remains more challenging, which is typical for this developmental stage.

Similarly, iPad game performance in this age group (mean point score = 1.12±0.87; number of trials = 3.06±2.45) suggests limited engagement and low task mastery, likely due to short attention spans, emerging cognitive skills, and novelty of digital devices. These findings are consistent with other studies showing that 3–5-year-old children benefit more from structured, interactive play rather than unstructured screen-based activities.

Excessive use of digital media increasingly replaces outdoor play, sports, and active recreation. Beyond physical health, excessive digital media use can negatively affect overall well-being by contributing to reduced social interaction, impaired emotional regulation, decreased academic performance, and increased risk of anxiety and attention difficulties. When screen time displaces movement, face-to-face relationships, and restorative sleep, it hinders balanced development.

Next, I present the extent of the influence of digital media on children in these parts of the country.

Digital media use and Cyber Safety

In the current digital era, children increasingly use the internet. However, spending time online without adequate safety measures exposes them to various risks. The adverse effects of excessive use of communication devices often become apparent only years later. Overuse can negatively impact physical health, psychological well-being, education, and social development.

Western studies emphasize the harmful effects of excessive exposure to electronic media. Research indicates that children who watch television

for two hours before the age of three have a 20% higher likelihood of attention deficits during adolescence. In contrast, children who spend one hour in storytelling or library activities before the age of three show a 30% reduction in attention problems later in adolescence. Excessive use of communication devices is associated with impaired cognitive functioning, behavioral changes, reduced comprehension ability, attention deficits, hyperactivity (ADHD-like symptoms), and diminished problem-solving skills.

As the proverb states, "அளவுக்கு மிஞ்சினால் அமுதமும் நஞ்சு Even nectar becomes poison in excess," overuse of communication devices may lead to dependency. This can progress to problematic usage and eventually addiction. Warning signs include inability to complete routine tasks due to phone use, preoccupation with social media even during study hours, wrist and neck pain, carrying the phone everywhere, anxiety when the phone is not in hand, phantom ringing sensations, continued use despite interference with daily activities, frequent and excessive checking of social media, and complaints from others about excessive use.

A 2025 study conducted among 240 school students aged 15–16 years in the Jaffna district reported that the prevalence of Nomophobia was 39.17% (n = 94). It was highest among Grade 10 students (41%) and was significantly more prevalent among female students ($\chi^2 = 8.93$, $p = 0.03$).

Behavioral factors significantly associated with nomophobia included non-participation in academic activities ($\chi^2 = 12.056$, $p = 0.007$), frequent checking of mobile phones ($\chi^2 = 61.15$, $p < 0.001$), sleeping with the device ($\chi^2 = 9.986$, $p = 0.019$), and carrying chargers or power banks ($\chi^2 = 9.173$, $p = 0.027$).

Possessing a personal mobile device ($\chi^2 = 13.748$, $p = 0.03$) and using a mobile phone for more than one hour daily ($\chi^2 = 16.436$, $p = 0.001$) were

also significantly associated with nomophobia. Additionally, social media use ($\chi^2 = 9.578, p = 0.023$) and taking selfies ($\chi^2 = 11.41, p = 0.01$) were related factors. Parents should model healthy digital behavior, increase interactive playtime with children, designate device-free zones at home, and implement the 20-20-20 rule (every 20 minutes, take a break and look at an object 20 feet away for 20 seconds).

Cyber threats can occur anytime and anywhere via websites, social media platforms, chat/text messaging, email, and online video games. These threats include harassment, cyberbullying, psychological abuse, sexual exploitation, and sharing or coercing explicit content (sexting/pornography).

A preliminary regional study conducted among 740 students in grade 10 of the Jaffna District found that all participants used online platforms, and 13.92% had experienced cyber-related violence.

Most students correctly identified forms of cyber violence: sending humiliating messages (80.4%), sharing sexually explicit images/videos (79.3%), spreading violent or false information (77%), cyberbullying (76.7%), and cyber extortion (78.4%). Overall, 73.3% correctly identified all listed forms of cyber violence.

Risk factors for cyber victimization included having multiple social media accounts ($\chi^2 = 8.22, p = 0.004$), early initiation of internet use ($\chi^2 = 7.88, p = 0.019$), and using the internet outside the home ($\chi^2 = 8.07, p = 0.005$). While 84.7% of students expressed willingness to report incidents if victimized, only 2.6% were aware of proper reporting procedures.

Given the increasing severity of cyber threats, schools and private educational institutions must implement awareness programs and educate students on reporting mechanisms.

In Sri Lanka, government institutions such as the Sri Lanka Computer Emergency Readiness Team and the Women and Children's Bureau accept complaints related to cybercrime. Reports can also be made through the police online crime division. Victims should preserve evidence (screenshots, messages, emails) and report promptly to authorities to facilitate legal action and prevent future incidents.

Research indicates a growing prevalence of Gaming disorder among school students, and this trend is observed in our region as well. Major contributing factors include excessive smartphone use, lack of parental supervision, academic stress leading students to use gaming as a coping mechanism, and peer influence.

Preventive strategies include parental monitoring of daily digital device use, implementation of digital literacy and well-being programs in schools, and provision of alternative recreational activities such as sports, arts, and music.

Ladies and gentlemen, I have explained the importance of nutrition, physical activity and the problems of screen time on early childhood development. Parents and preschool teachers play a pivotal role in overcoming some of these problems. Parenting tactics, role modeling by parents and teachers along with educational reforms will help nurture our children to become the future society that solves problems, creates and nurtures the future.

Parenting and early stimulation of cognitive functions and child development

Early development plays a crucial role in shaping later cognition because the brain undergoes rapid growth and organization in the early years of life. During this period, experiences strongly influence the formation of neural connections that support attention, memory, language, and problem-solving. Early childhood also includes sensitive periods when the brain is especially receptive to learning, particularly in areas such as language and emotional regulation. Positive early

experiences, including responsive caregiving and rich language exposure, help build executive functions like self-control and working memory, which are essential for academic success and everyday decision-making. In contrast, early stress or deprivation can disrupt cognitive development, making later learning more challenging. Although development remains flexible across the lifespan, early experiences establish foundational cognitive structures that shape how efficiently individuals learn and adapt later in life.

Just as a sleep-deprived person stumbles through night and day, harming without awareness, a society that neglects education and moral nurture creates an even deadly danger an ignorance that destroys lives, erodes values, and scars generations. Raising a child is not simply about meeting their needs, it is a solemn duty to shape their minds, instill values, and nurture their potential. The responsibility of parents and teachers in guiding and safeguarding a child's future is absolute and cannot be delegated.

The Role of Parents and Impact on child health

The life of elephants provides a remarkable example of good parenting. In the wild, elephants live in highly structured family groups, led by an older female, known as the matriarch. Using her experience and wisdom, she protects the young elephants, guiding them to food, water, and safety. The calves learn life skills by following her example. From the moment a calf is born, the entire herd takes responsibility for its care. Until the young elephants can survive on their own, the adults nurture and guide them. They learn where to find food and water, how to identify danger, and other essential survival skills primarily through observation.

Humans are no different. Children learn behavior, civility, values, and responsibility by observing their parents. Just as elephant calves imitate the herd, children imitate the words, gestures, and actions of their caregivers. In a family, when one child faces danger, all family

members act together to protect them. Similarly, parents constantly work to shield their children from harm and ensure their education, health, and moral growth, shaping their future.

Elephants also remember their family members for years and approach them with affection even after long separations. In the same way, a parent's love transcends age and time, leaving an enduring impact across generations.

In human life, the role of parents is crucial. A child's physical, mental, intellectual, social, and moral development is profoundly shaped by parenting style.

Parenting Styles and Their Impact

1. **Authoritative Parenting**
   Parents balance love with discipline. They listen to the child's opinions but firmly enforce necessary rules. Children raised this way develop responsibility, self-confidence, and strong relationships. Encouraged to explore their independence, they strive to achieve goals on their own and generally grow with self-respect and academic success.
2. **Authoritarian Parenting**
   Parents exercise strict control and expect obedience without question. Children raised in this environment often develop fear and low self-esteem. They may harbor resentment, struggle with anger management, and lack decision-making skills.
3. **Permissive Parenting**
   Parents give excessive freedom with few rules or limits. Children may grow up undisciplined, irresponsible, and struggle with boundaries in life.
4. **Neglectful Parenting**
   Parents show little concern for a child's needs, emotions, or education. While children may have freedom, they often

experience loneliness, lack trust, and face difficulties in social interactions. They may struggle to cope with challenges and maintain healthy relationships.

5. **Helicopter Parenting**
   Parents go to great lengths to protect children from harm, disappointment, or failure. Though well-intentioned, such intense oversight shielding children from mistakes, constantly controlling their world, or over-involvement in conflicts can limit independence, hinder resilience, and obstruct healthy development.

Raising a child is one of the greatest responsibilities a parent can undertake. A balanced approach, combining love with discipline, nurtures children into good human beings and responsible citizens. The guidance parents provide shapes not only the child's personal life but also the future of society. When parents nurture children with patience, understanding, and care, they raise individuals who will illuminate both their own lives and the world around them.

Strategies for parenting

Healthy child development depends on the integration of different parts of the brain. In early childhood, the emotional right hemisphere, brainstem and limbic system while the logical left hemisphere and the prefrontal cortex are still maturing.

The cerebrum known as the "upper brain" is responsible for reasoning, problem-solving, empathy, self-control, and decision-making. In child rearing, this is the part that helps a child pause, think, and choose appropriate behavior.

The "lower brain" manages basic survival responses such as fight, flight, or freeze. In children, this part activates quickly during tantrums, fear, or frustration. When a child throws a tantrum, they are overwhelmed and react, not reasoning. In these moments, logic does not work well. Effective parenting focuses first on calming the lower brain through soothing tone, physical comfort, or quiet space before

engaging the upper brain with discussion or teaching. Supporting children in moving from lower-brain reactions to upper-brain responses helps them build emotional regulation over time.

This neurological reality explains why children often react with intense emotion before they are capable of reasoned thought. When a child is overwhelmed, the amygdala activates a stress response that temporarily limits access to the prefrontal cortex, making lectures or punishment ineffective. Supportive, attuned responses from caregivers help calm this stress reaction, allowing higher-order thinking to reengage. Over time, repeated experiences of co-regulation strengthen neural connections between emotional and rational centers, fostering self-control, empathy, and resilience. By helping children name their feelings, reflect on experiences, and feel securely attached, adults actively shape the architecture of the developing brain, promoting integration that underlies emotional stability and social competence.

Apart from raising kind children, I guess one thing that parents (and teachers, caregivers, guardians, etc.) continue to struggle with is discipline. What do we do when our children become difficult? Many parents and adults go through tantrums and blow ups on survival mode it's either you endure it or you end up losing it as well. Instead of simply focusing on what to do (ex. affirmation and consequences), we must ask ourselves: How do we engage and connect with them during these moments? And by shifting our perspective, we can stop being in survival mode and turn a disastrous moment into an experience where our children can thrive.

Daniel J. Siegel and Tina Payne Bryson explain how to nurture a child's developing brain through practical, research-based approaches. The authors emphasize the strategy "Connect and Redirect," which means first responding to a child's emotional state engaging the right brain before introducing logic or consequences through the left brain. For example, acknowledging a child's disappointment or anger before explaining why a certain behavior is unacceptable helps the child feel understood and more receptive. They also propose "Name It to Tame

It," encouraging adults to help children narrate overwhelming experiences; putting feelings into words activates the logical brain and reduces emotional intensity. "Engage, Don't Enrage" reminds caregivers not to demand reasoning when a child is emotionally flooded. Instead, they should wait until the child is calm, ensuring that communication supports integration rather than escalating distress.

The prefrontal cortex responsible for decision-making, empathy, and self-control requires intentional practice. Their strategy "Use It or Lose It" emphasizes giving children regular opportunities to make choices, reflect on consequences, and consider others' perspectives so these higher-order skills become stronger through repetition. "Move It or Lose It" highlights the powerful connection between body and brain, noting that physical movement can help regulate overwhelming emotions by calming the nervous system and restoring balance. "Use the Remote of the Mind" encourages teaching children to revisit memories in manageable ways pausing, rewinding, or fast-forwarding like a movie so they can process fear or anxiety without becoming overwhelmed. Together, these strategies help integrate emotional impulses with thought control, building resilience and emotional regulation over time.

Healthy development requires integrating memory, self-awareness, and relationships. Under "Integrating Memory," they encourage parents to "Remember to Remember" by helping children revisit and discuss past experiences so events become coherent stories rather than confusing emotional fragments. Teaching children to "Let the Clouds of Emotion Roll By," helping them understand that feelings are temporary states that can be noticed without being overwhelming. In "Integrating the Many Parts of the Self," the SIFT practice invites children to pay attention to their Sensations, Images, Feelings, and Thoughts, fostering internal awareness. Closely related is "Exercise Mindsight," which develops the ability to understand one's own mental states and those of others, strengthening empathy and emotional regulation. Finally, in "Integrating Self and Other," highlight the importance of increasing the family fun factor, as shared joy deepens

connection and resilience, and viewing conflict as an opportunity to teach empathy, responsibility, and collaborative problem-solving rather than relying solely on punishment.

Edcuationnal reforms and its impact

Educational reforms for preschool children in Sri Lanka focus on improving quality, equity, and consistency in early childhood education through the introduction of a unified national preschool curriculum, known as the Early Childhood Education Curriculum Framework. This reform replaces the previously fragmented system where preschools followed different syllabuses with varying standards, and it emphasizes holistic child development through play-based, child-centred learning rather than rote memorization. The new curriculum covers key developmental areas such as physical health, social and emotional development, language and early literacy, numeracy, environmental awareness, and creative arts, while also promoting school readiness for a smooth transition to primary education. Alongside curriculum reform, the government is strengthening teacher training and professional development, setting national quality standards for preschools, and encouraging parental and community involvement. These changes aim to ensure that all children, regardless of region or socioeconomic background, receive a strong and equal foundation in early learning, supporting their overall development and future educational success.

The impact of these preschool education reforms in Sri Lanka is expected to be significant and long-lasting, as they help create a strong and equal foundation for children at the very beginning of their educational journey. A unified national curriculum reduces disparities between urban and rural preschools, ensuring that all children enter primary school with similar basic skills and readiness. The emphasis on play-based, child-centred learning supports not only academic development but also social, emotional, and physical growth, leading to more confident, curious, and adaptable learners. Improved teacher training and clear quality standards enhance the overall learning

environment, resulting in better classroom practices and more meaningful interactions between teachers and children. Additionally, greater parental and community involvement strengthens learning beyond the classroom. Overall, these reforms are likely to improve learning outcomes in later grades, reduce early learning gaps, and contribute to a more skilled and balanced generation in the future.

Conclusion

Children are the future of society. Protecting their physical, mental, emotional, and intellectual development is a primary responsibility of parents, teachers, and educational institutions. Children live in environments where they face risks, including physical violence, mental stress, sexual abuse and exploitation, and online threats. Protecting the next generation from these dangers is our foremost duty. Parents are the first protectors of a child. It is their responsibility to guide and nurture children by creating a trustworthy environment filled with love and care. By listening to and understanding a child's needs and ensuring awareness of good habits and the consequences of harmful actions, parents play an irreplaceable role in a child's development.

Teachers play a key role in creating a safe environment in schools. They observe changes in children's behavior, provide support during emergencies, and take part in preventing harmful actions. Beyond teaching the curriculum, teachers must also help students recognize their rights, responsibilities, and potential risks.

Education in Life Skills such as decision-making, self-confidence, relationship building, problem-solving, and coping with stress help students live safely, identify dangers, make correct choices, and seek support must be imparted to the young minds. Education should move beyond mere exam scores and competitive achievement, which foster rivalry, to programs that promote child well-being. Curricula should include management of one's own safety, life skills, digital safety, and more.

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Prof. Gitanjali Sathiadas is a distinguished paediatrician, academic, and child health advocate whose career spans more than two decades of service, scholarship, and leadership. She was born in Badulla and moved to Jaffna and received her primary and secondary education at Chundikuli Girls' College, Jaffna. She entered Faculty of Medicine, University of Jaffna and was compelled to move to the UK during her final year of her MBBS due to the disruption of the faculty in 1995 and completed her medical bachelor's degree from University of Aberdeen in the United Kingdom in 1997. She obtained Diploma in Child Health (2005), MD Paediatrics (2007) from PGIM, University of Colombo, MRCPCH (UK-2009) and PGDip in Medical Education (2016) from University of Dundee, United Kingdom. She was trained in Paediatrics at Royal Aberdeen Children's Hospital, United Kingdom (2008-2010). She was awarded the fellow of the Sri Lanka College of Paediatricians in the year 2022.

She joined the Faculty of Medicine, University of Jaffna in 2003 as a lecturer and promoted to senior lecturer in 2010. Currently she is the Chair Professor of Paediatrics at the University of Jaffna. She also serves as the head of the department and is an honorary Consultant Paediatrician to Teaching Hospital Jaffna. She is also the chairman for the Board of medical science at the Faculty of Graduate studies of the University of Jaffna.

Professor Sathiadas has authored several books, including chapters in textbooks, and also serves as the chief editor of the Jaffna Medical Journal. She has an extensive portfolio on research and a recipient of National Research Grants. She has delivered more than 50 guest lectures, published many articles on newspapers and scientific journals. She also has more than 50 journal articles and more than 100 abstracts with more than 400 citations.

Prof. Sathiadas is a very active person at the community level where she works very closely with Northern region Child Care and Probation Department and has contributed a lot to identifying child abuse cases, protecting and preventing child abuse in the region. She has also initiated and currently executing community reach programmes for special need children, especially for Cerebral Palsy and Autism. She is also a senior trainer at national level, training Paediatricians and other intensive care practitioners. She has initiated and executed a nutrition intervention programme in the community called Project Amuthasurabi.

Her research interests are in the fields of Child nutrition, Childhood body composition, obesity, and Metabolic syndrome. Her life's work reflects an unwavering commitment to safeguarding childhood, strengthening medical education, and building a healthier future for the next generation.

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