This issue of the JMAJ features the 28th Confederation of Medical Associations in Asia and Oceania (CMAAO) General Assembly and 49th Council Meeting held on September 12–14, 2013, in New Delhi, India under the host of the Indian Medical Association.

Of the 18 National Medical Associations (NMAs) of the CMAAO, 13 medical associations (Australia, Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Myanmar, Nepal, Philippines, Singapore, Taiwan, Thailand) took part in the meetings. The total number of participants in the General Assembly was about 150, with Dr. Mukesh Haikerwal, Chairman of Council of the World Medical Association (WMA), invited as an international guest, and the mayor of Delhi taking part as a guest of honor in the opening ceremony on September 12.

At the 11th Taro Takemi Memorial Oration, Dr. Rajeev Seth, Chairperson of the Indian Child Abuse, Neglect and Child Labour (ICANCL) Group, gave a speech titled “Protection of Children from Abuse and Neglect in India.” Each NMA gave their annual Country Report, and a Symposium under the theme “Be Human Stop Child Abuse” was held.

At this General Assembly meeting, there was no application for a new member to join the CMAAO.

New CMAAO President and Officers
Dr. Vinay Aggarawal (former president of the Indian Medical Association) was installed as the 31st President of CMAAO and received a Presidential medal from his predecessor, Dr. Ming-Been Lee (immediate past president of the Taiwan Medical Association). Dr. Jose Asa Sabili (former president of the Philippine Medical Association) was elected as President-Elect, and Khin Mig Aye (Myanmar Medical Association) was elected as 1st Vice President. Dong Chun Shin (Korean Medical Association) and Yeh Woei Chong (Singapore Medical Association) retained the posts of Chair and Vice-Chair of Council, respectively. Dr. Masami Ishii (Japan Medical Association) was reappointed as Secretary General.
Official CMAAO Resolution adopted

After a round-table discussion on Child Abuse, which was also the theme of Symposium and Takemi Oration, the CMAAO resolution committee developed the draft “CMAAO Delhi Resolution on the Prevention of Child Abuse.” The draft was adopted as an official CMAAO resolution at the General Assembly’s plenary meeting on September 14. The CMAAO will encourage the WMA constituent members to spread this message and to eradicate child abuse (Refer to page 296).

Future Meetings

The next meeting, the 29th CMAAO General Assembly, will be held in Manila, Philippines in September 2014, under the hosted of the Philippine Medical Association. Proposed theme of the symposium is “NCD and lifestyle-related diseases.”

The 30th CMAAO General Assembly will be held in Yangon, Myanmar in 2015.


President (2013–2014):
Vinay Aggarwal (India)

Jose Asa Sabili (Philippines)

Immediate Past President (2013–2014):
Ming-Been Lee (Taiwan, R.O.C.)

1st Vice President:
Khin Mig Aye (Myanmar)

2nd Vice President:
— ( — )

Chair of Council:
Dong Chun Shin (Korea)

Vice-Chair of Council:
Yeh Woei Chong (Singapore)

Treasurer:
Yee Shing Chan (Hong Kong)

Secretary General:
Masami Ishii (Japan)

Assistant Secretary General:
Hisashi Tsuruoka (Japan)

Councillors:
Steve Hambleton (Australia)
Sharfuddin Ahmed (Bangladesh)
Saly Saint (Cambodia)
Yee Shing Chan (Hong Kong)
Vinay Aggarwal (India)
Ihsan Oetama (Indonesia)
Yoshitake Yokokura (Japan)
Dong Chun Shin (Korea)
Nai Chi Chan (Macau)
Mary Cardosa (Malaysia)
Kyaw Myint Naing (Myanmar)
Sudha Sharma (Nepal)
Paul Ockelford (New Zealand)
Oscar Tinio (Philippines)
Yng Yng Bertha Woon (Singapore)
— (Sri Lanka)
Ching-Chuan Su (Taiwan, R.O.C.)
Wonchat Subhachaturas (Thailand)

Advisors:
Tai Joon Moon (Korea)
Yung Tung Wu (Taiwan, R.O.C.)
Wonchat Subhachaturas (Thailand)
Shinichi Murata (Japan)
Ajay Kumar (India)
Program

DAY 1: Thursday, September 12, 2013
—Opening/Inauguration Ceremony and the 49th CMAAO Council Meeting—

12:30–13:30 Committee meetings (if necessary)
13:30–14:30 Opening Ceremony and Inauguration of a New President of CMAAO by Chair
   1. Opening: Chair
   2. Roll Call: Secretary General
   3. Welcome and Opening Addresses:
      3.1 President of IMA, Dr. K. Vijayakumar
      3.2 President of CMAAO, Dr. Ming-Been Lee
   4. Congratulatory Remarks
      4.1 Chair of the WMA, Dr. Mukesh Haikerwal
   5. Installation of the 31st President of CMAAO for 2013–2014
   6. Inaugural Address by New President, Dr. Vinay Aggarwal
   7. Presidential Award to the Outgoing President, Dr. Ming-Been Lee
   8. Group Photo
   9. Adjournment

14:30–15:00 Break
15:00–17:30 Council Session
   1. Roll Call by Secretary General
   2. Opening Remarks
   3. Elections (Chair and Vice-chair) for the term of 2013–2015
   4. Appointment of Secretary General for the term of 2013–2015
   6. Report of Secretary General
   7. Approval of Minutes of the 48th CMAAO Midterm Council Meeting held in Macau
   8. Report of the Treasurer
   9. Venue and Dates of the 29th CMAAO General Assembly and 50th Council Meeting (2014)
11. Membership Applications (if any)
12. Report of the Committees (by the committee chairs)
13. Special presentation on “Health care in danger” by Dr. Bruce Eshaya-Chauvin, Medical Adviser/Health Care in Danger Project, International Committee of the Red Cross (ICRC)
14. Other Business
15. Adjournment

19:00 Welcome Reception

DAY 2: Friday, September 13, 2013
—The 28th CMAAO General Assembly—

09:00–10:00 The 11th Taro Takemi Memorial Oration Chaired by JMA officer
   1. Introduction of Orator
   2. Memorial Oration on Child Abuse
   3. Presentation of a Plaque to Orator from JMA officer
   4. Adjournment

10:00–10:30 Tea break
10:30–12:30 Symposium “Be Human Stop Child Abuse”: NMAs 10 minutes each
12:30–14:00 Lunch break
14:00–15:00 Round-table Discussion on Child Abuse
15:00–15:30 Tea break
   Develop a draft of the resolution on child abuse by the resolution committee
15:30–17:30  Country Report: NMAs 10 minutes each
19:00  Dinner hosted by the Indian Medical Association

DAY 3: Friday, September 14, 2013
—The 28th CMAAO General Assembly—
09:00–12:30  Plenary Session  Chaired by President
1. Approval of Minutes of the 27th CMAAO General Assembly held in Taiwan
2. Report of the Council Meeting by Chair
3. Approval of the Report of the Treasurer
4. Discussion and adoption of the proposed CMAAO resolution on child abuse
5. Approval of the Report of the Committees
   6.1 President-elect ... From the Philippine Medical Association
   6.2 Two Vice-Presidents ... 1st Vice-president from the host NMA in 2015
       2nd Vice-president, optional
6.3 Treasurer for 2013–2015
   7.1 Articles and By-Laws
   7.2 Nomination (Ad-hoc)
   7.3 Resolution
   7.4 Finance
   7.5 Membership
8. Venue and Dates of the 29th CMAAO General Assembly and 50th Council Meeting (2014)
10. Membership Applications (if any)
11. Other Business … Theme of the symposium for the CMAAO General Assembly in 2014
    and others
12. Closing Remarks
12:00  Adjournment
12:00–12:30  Press Conference
P.M.  City Tour hosted by the Indian Medical Association
19:00  Farewell Dinner

Conference hall of the CMAAO General Assembly
The Confederation of Medical Associations in Asia and Oceania
(Established since 1956)

Official Homepage  http://www.cmaao.org/

Current membership: 18 national medical associations
(As of December, 2013)

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Challenges are opportunities. The relevance and scope of CMAAO simultaneously present both. The super arching body for national medical associations of Asia—Oceania represents roughly one third of humankind. The responsibilities that we can shoulder borders on infinity. The question is whether we can take the huge strides worthy of the platform.

I am glad to take up the reins of CMAAO being only the second President from India. I bring in the rich experience of Indian Medical Association (IMA) in public health interventions (Tuberculosis), crusade for social causes (save the girl child), and rural healthcare initiatives (Aao Gaon Chalen/Let us go to the villages). IMA is also a strong defender of the dignity of medical profession and has been playing an active role in nation building. I should admit that it would be a different role that is my calling now. Nevertheless like our eastern culture and values; we share common challenges and destiny. I would like to embark upon partnership with our national Governments in all areas of health. From South Asia to North East Asia and Oceania millions of doctors provide clinical care. Involving them in national programmes and channelizing their energy and capacity, for public health strategies will be the thrust of my tenure.

Great men live eternally through the institutions they create. Human civilization would have been impossible without institutions. Institutions are platforms for team work with common goals. In this way CMAAO is an unique institution. It unites us in the name of medical profession across national frontiers. We have to set an agenda that befits the platform. I dream of a vision where the profession is able to uplift the health of our peoples. Synchronizing the profession across the semi circle of Asia and the Oceania can bring in great dividends in health. The true potential of the independent profession has never been harvested for larger public health goals. Holding hands across the borders sharing best practices and protocols and strategizing together, diseases defying solutions over aegis can be tackled. Clinical medicine and public health are two faces of modern medicine. They are not exclusive of each other. Structural linkages between the two can redeem humankind from many a scourge. It is the wont of medical associations to manage the contradictions for a larger cause. Endless are the possibilities for our intervention in health issues. Our concern for the health of our peoples is legitimate and genuine borne out of deep appreciation of field realities. There is no relationship sacred than the doctor patient relationship.

We also represent countries in different planes of development. We have countries with organized and structured healthcare at one end and countries which face huge challenges in meeting the
healthcare needs of their people. It is my desire that developed nations share their skills and expertise through exchange programmes. We should be able to facilitate such activities between the national medical associations. We should actively engage our national governments for enhanced budgetary allocations for health. Our expertise and co-operation would be available to them in evolving three tier structures of referral and providing universal health coverage. The disease profiles of our countries also vary from each other. While countries like India and Indonesia carry a huge burden of tuberculosis Australia and New Zealand are at the other end of the spectrum. I have to mention diabetes mellitus and coronary artery disease as emerging threats in all nations. While it is a matter of great satisfaction that poliomyelitis has been eradicated in our region, it requires continued vigilance at this front. Huge gaps do exist in maternal and child healthcare in some countries. Let us continuously strive to provide the best modern medicine could provide to our peoples.

Another area of challenge is decreasing levels of clinical skills in young medical graduates. This is an inevitable fall out of consumer culture in the society which has led onto high tech evidence based medicine as a response. I emphasize that clinical medicine is still very relevant in most of our societies and has the capacity to provide healthcare at affordable cost. Clinical skills and methodology are our common heritage and is patient friendly. Medical teachers have a special responsibility in imparting this live science to new generation doctors.

There has been increasing tendency on the part of national governments and international technical agencies to consider the independent practitioners of modern medicine as ‘for profit’ providers. This in turn has resulted in myopic policies and strategies. I have no hesitation to reiterate that doctors in any country are a national asset and not a national liability. Doctors in any sector respond to calls of professional duty than to any financial incentive. Peer pressure and peer opinions are better tools to reach out to doctors. I request the Governments and the agencies like WHO to factor in this reality. Nevertheless there are emerging trends to use Governmental regulations to contain medical science. Dissent and plurality of opinions are the strength of modern medicine. Regulations are often unrealistic in space and time and should be used with caution. Only self regulation through Medical Councils is acceptable to the medical profession.

Advances in medicine both in therapy and technology push the frontiers every day. Ways and means should be found that they are accessible and affordable to the poor sections of the society. States have a bounden duty to uphold the dignity of life. Right to healthcare is an essential component of right to life.

The central theme of this conference is child abuse. It is important to focus attention on this crime against humanity. We may still be touching only the tip of an ice berg. Nevertheless our efforts in this area should be relentless. I take this opportunity to thank my predecessor Dr. Ming-Been Lee a role model for others. His contributions in the area of public health specially suicide prevention are noteworthy. I also thank the Honorary Secretary General of CMAAO Dr. Masami Ishii for his pivotal role in holding together all the 18 national professional associations. My thanks are due to the Japan Medical Association, Korean Medical Association, Medical Association of Thailand and others for their stellar role in founding and maintaining the activities of this unique body.

I will be failing in my duty if I do not remind every doctor to adhere to the ethics and etiquette of medical profession. They should not be carried off their feet when hospitals have taken precedence in healthcare. Any industry which is centered on patient care should follow only medical ethics. There is no way to apply business or industrial ethics and practices.
CMAAO Delhi Resolution on the Prevention of Child Abuse

Adopted by the 28th CMAAO General Assembly, New Delhi, India, September 14, 2013

The Confederation of Medical Associations in Asia and Oceania (CMAAO), an organization consisting of 18 National Medical Associations (NMAs) in the Asia and Oceania region, is aware that children, as any other individual, have the right to be protected and respected and to be provided with the basic elements necessary in enjoying a healthy and happy life. Based on its awareness of the medical field’s responsibility to prevent child abuse, CMAAO hereby adopts the following principles and encourages individual physicians, NMAs, national governments and related organizations to practice them.

The World Health Organization (WHO) defined ‘child Abuse’ as a violation of basic human rights of a child, constituting 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 relationship of responsibility, trust or power. ‘Child Neglect’ is stated to occur when there is failure of a parent/guardian to provide for the development of the child, when a parent/guardian is in a position to do so where resources are available to the family or care giver. Mostly neglect occurs in one or more area such as health, education, emotional development, nutrition and shelter. All types of violence and cruelty could be detrimental to the health and normal development of children. The physical and mental damage from child abuse can impact the child in multiple ways throughout his/her life, which raises the importance of multi-agency and multi-disciplinary prevention.

Medical professionals stand on the very front lines of early detection and treatment of child abuse and have exerted great efforts over the past decades to its prevention. While meaningful progress has been made in raising the awareness on this issue among medical professionals and the general public, unfortunately, child abuse has not been reduced. The existence of various forms of child abuse such as oppression and exploitation depending on local culture and sentiment makes a comprehensive response difficult. In addition, social development and the resulting unraveling of family bonds have led to the increase of child abuse in the form of neglect. Accordingly, prevention of child abuse and the early detection and treatment of victims are still imperative social challenges.

International organizations have also established many policies for prevention of child abuse. The UN committee on the Rights of the Child proclaims children to be free from all forms of violence. The World Medical Association (WMA), the umbrella organization of NMAs, in its WMA statement on Child Abuse and Neglect, calls for the world’s physicians to be aware of their responsibility in the prevention and treatment of child abuse and for each NMA to raise the awareness of physicians and to provide necessary training and to closely cooperate with governments and related organizations.

Although protecting children from abuse is everybody’s responsibility, the following recom-
Recommendations are made to include multi-agency colleagues.

**A. Recommendation to all individual physicians and health providers**

1. When suspecting child abuse, the health practitioners and providers can intervene in the early prevention of abuse by notifying the facts to the appropriate authorities and social organizations and by providing direct support or information to the patient and the family.

2. The physician, who is in the position to perform a unique and special role in identifying and assisting abused children and their parents/care givers, must be aware of his/her responsibility regarding this issue; fulfill his/her duty to report cases of abuse and receive training necessary in identifying child abuse.

3. Also, the doctor/medical professionals and health workers must carefully observe the overall surroundings of the child suspected to be abused and consider the possibility of additional abuse victims because child abuse can occur not just in the family but under various circumstances such as child care facilities, kindergartens and schools.

4. Child abuse usually can be attributed to a combination of causes and requires a combination of multiple approaches to identify and respond to. Therefore, multi-disciplinary collaboration across fields such as medicine, nursing, law and social welfare is required to provide appropriate help to the victim and the family. CMAAO encourages physicians to collaborate with experts of various fields to address the issue of child abuse.

**B. Recommendation to NMAs**

1. NMAs must conduct active public campaigns to raise the awareness of child abuse prevention among doctors, health workers, other services and all other sectors of society. They must also cooperate with other groups that conduct such projects to raise the overall social awareness for child protection.

2. NMAs should recommend to the medical credential authorities of their countries to advocate necessary changes in curriculum and are encouraged to play an active role in promotional activities and the development, teaching, training and practices of medical/allied professional's bodies. In particular, NMAs must develop and conduct Continuing Medical Education (CME) programs that provide basic knowledge on child abuse and protection. The CME programs must include contents such as identification of the abused child, consulting the family and other care givers, medical evaluation, treatment and systematic protection of the abused child as well as knowledge and techniques for record keeping in all cases.

3. NMAs are encouraged to advocate and actively promote and participate to provide necessary advice as an expert group in legislation and public policies to address all aspects of child abuse including measures necessary in its anticipation, detection, confirmation, treatment, protection and rehabilitation to safeguard against repeated victimization.
4. NMAs must cooperate with the government and related authorities in preparing systematic measures to protect health professionals so that they can actively fulfill their direct duty of reporting cases of child abuse and of solving child abuse issues without being treated unfavorably or being exposed to various dangers due to such actions.

C. Recommendation to Governments

1. Each government must provide a basic framework to protect children from all forms of abuse. This includes regulations and legislation on reporting systems, treatment, protection and prevention of repeated abuse of the child. Each government must establish and operate a national child protection register and annually monitor and update this framework.

2. To provide appropriate assistance to the abused child, parents and all entrusted care givers in all settings, each government must create a system for collaboration of all agencies involved with or affecting children. It must also guarantee full rehabilitation and continuum of care.

3. Each government must continuously monitor and research international standards or conventions related with child protection and child abuse prevention and must maintain its national standards and systems in accordance with international and human rights standards through ratification of such if necessary.

4. Each government must have dedicated budgets allocated for child protection services.

5. Each government must have mandatory training of all personnel at all levels.

6. All governments should ensure that there are robust communication systems for timely referral and intervention across all sectors.

D. Recommendation to other professional bodies and organizations

1. CMAAO should work with other organizations to gain wide support and participation of the general public for the cause of preventing child abuse by conducting campaigns to raise the overall social awareness on children's rights as well as the organizational responsibility to protect the child from various dangers and threats.

2. All people working in child care sector must work together for better detection, continuous data collection and monitoring of child abuse in collaboration with the community. They must also monitor the government’s child abuse prevention policies and initiatives and present opportunities for improvement.

3. They must focus on the development and wide use of education programs and guidelines for children, parents, children related professionals such as teachers and care providers and the general public.

4. They must form a network with related entities such as the government, various expert groups
and child protection centers and agencies to exert efforts in sharing data cooperatively.

The 28th CMAAO General Assembly (September 12–14, 2013, New Delhi, India), hereby adopts this resolution and, pledges to exert every effort in collectively implementing the principles set forth in this resolution. It calls upon all NMAs to adopt and carry out a work plan and regularly report its implementation status.
Protection of Children From Abuse and Neglect in India

Rajeev SETH

Chair, Indian Child Abuse, Neglect & Child Labour (ICANCL) group, Indian Academy of Pediatrics Delhi

Dr. Seth (5th from right) and members of the National Medical Associations
Protection of Children From Abuse and Neglect in India

Rajeev SETH*1

Abstract

In India, child rights, protection from abuse and exploitation (street children, child labour, trafficking etc.) are intimately linked to poor socioeconomic conditions in a large population base. Whose responsibility is it to ensure the safe, protective and caring environment that every child deserves? The UN CRC does not absolve either family or community or society at large. But it firmly puts the onus on the State.

The paper discusses two community intervention efforts for protection of vulnerable children at urban & village levels, New Delhi India. In India, the key public health approach should be to prevent child maltreatment and to ensure that all children and families have access to school, basic health care, nutrition, besides supportive social welfare and juvenile justice systems. The families and the community must be educated, informed and empowered so that they can provide care and protection to their children. Awareness of their rights and information about governmental assistance would ensure proper utilization of various “schemes.” These child protection systems, community ownership and participation can contribute to break down cycle of inter-generational poverty & exploitation.

Introduction

The UN Convention of Rights of Child (UN CRC) (1989) is the most widely endorsed child rights instrument worldwide, which defines children as all persons aged 18 years and under.\(^1\) In the UN CRC, Article 19.1, Child Protection has been defined as “States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.\(^2\) Failure to ensure child right to protection adversely affects all rights. Child protection is critical to the achievement of Millennium Development goals (MDG). These MDGs can’t be achieved unless child protection is an integral part of program & strategies to protect children from child labour, street children, child abuse, child marriage, violence in school and various forms of exploitation.\(^3\)

Several well developed countries of the world have well developed child protection systems, primarily focused at mandatory reporting, identification and investigations of affected children, and often taking coercive action. The burden of high level of notifications and investigations is not only on the families, but also on the system, which has to increase it’s resources.\(^4\) In these contexts, the problems of child protection in India, with huge populations, and additional socioeconomic constraints, need serious and wider consideration.

India Country Experiences & Magnitude of Problem

In India, the number of children needing care and protection is huge and increasing. Uncontrolled families, extreme poverty, illiteracy result in provision of very little care to the child during

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This article is based on the 11th Takemi Memorial Oration made at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
the early formative years. Even services that are freely available are poorly utilized. The urban underprivileged, migrating population (a very sizable number) and rural communities are particularly affected. In large cities, there are serious problems of street children (abandoned and often homeless) and child labourers, employed in menial work. Children in difficult circumstances such as children affected by disasters, those in conflict zones, refugees, HIV AIDS need appropriate care and rehabilitation.5

For example in India, there are about 440 million children; about 40% of them are vulnerable or experiencing difficult circumstances. Twenty-seven million babies are born each year. A large majority these births are among the underprivileged section of the population, mostly unplanned and where the parents cannot provide proper care to their children. The situation of the newborn and the periods of infancy and early childhood are particularly critical and the morbidity and mortality rates continue to remain very high. Maternal under nutrition, unsafe deliveries, low birth weight babies and poor newborn care, neglect of early development and education are major issues that need to be appropriately addressed. Child rearing practices reflect social norms and very often adverse traditions are passed from one generation to the next, especially in illiterate and poorly informed communities, and are extremely resistant to alter. As per Government of India (2007) survey, the prevalence of all forms of child abuse are extremely high (physical abuse (66%), sexual abuse (50%) & emotional abuse (50%).6 In these contexts, India must also seek its own insights and way forward plans to protect their children.

Wider implications of “protection”

The term “protection” readily relates to protection from all forms of violence, abuse, and exploitation. However, from India’s perspective, the Indian Child Abuse Neglect & Child Labour (ICANCL) group has strongly propagated the view that “protection” must also include protection from disease, poor nutrition, and illiteracy, in addition to abuse and exploitation. The 9th ISPCAN Asia Pacific Conference of Child Abuse & Neglect (APCCAN 2011) conference outcome document “Delhi declaration” re-confirmed & pledged a resolve to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination. It urged and asserted the urgent need to integrate principles, standards and measures in national planning process to prevent and respond to violence against children.7

Effective Child Protection Systems

Whose responsibility is it to ensure the safe, protective and caring environment that every child deserves? The UN CRC does not absolve either family or community or society at large. But it firmly puts the onus on the State. Governments are the ultimate duty bearer. In India, the State should ensure that all vulnerable children have access to school, basic health care, nutrition, besides social welfare and juvenile justice systems.8 These child protection systems can contribute to break down cycle of inter-generational poverty & exploitation.

Experiment models of Child Abuse & Neglect

(a) Child protection for urban poor

In India, rapid urbanization is a challenging problem. The present urban population of India is close to 285 million. Preventive social services are abysmal, with high prevalence of abuse & neglect. It is estimated that every year about 2 million children are born amongst urban poor, all needing care and protection. The ICANCL group members volunteer their services for health care & rehabilitation to these vulnerable children at drop in centers (DIC) managed by PCI, a NGO in various slums of the New Delhi. The group also looks after health of street children at one short stay home (Shelter home) in outskirts of the city.9 The group has served more than 14,000 street children since year 2000. A shelter home was started in year 2005, where 347 children have been rehabilitated; provided with formal education, vocational skills & job placement. Home repatriation has been achieved in 350 children.10 The group assists in the following community services to protection of these vulnerable children:

(1) Street & Working Children

In Urban metropolitan cities, street children are migrants from underserved states and have no formal education or job skills. They are subject
all forms of abuse, including substance abuse & exploited as child labourers. The DIC provide non-formal education, free medical care, vaccinations, counseling against substance abuse/HIV/AIDS etc., mid day meals and vocational courses. Moreover, crèche and day care services are provided to these orphan and vulnerable children.

(2) Education & Health Services for Urban Poor
The group runs an ongoing campaign to put “Every Child in School,” to promote child protection and optimum development. Advocacy efforts made to retain children in school within the framework of Government programs, such as sarva shiksha abhiyan & Right to Education (RTE) Act (2009). Health services were provided at DIC, as loss of daily wages & lack of transport prevents them to go to avail facilities at government hospitals. Health education and monitoring, nutritional screening, vaccinations, basic sanitation, hygiene & counseling services were provided.

(b) Protection of children in underserved rural village
The ICANCL Group has developed a model for protection of children in an underserved village Bhango, district Nuh-Mewat, Haryana, which is primarily focused on provision of primary education and basic health care. Village Bhango is situated about 70 km from New Delhi; has a Population 1,300. [Adults: 592 (M 311 & F 281) and Children: 708]. Before the group started work, the only Government Primary School had low enrollment rate, high school drop outs, poor infrastructure, no toilets, teacher absenteeism and irregular administration of mid day meals. For the past 6 years, the ICANCL group volunteers have monitored the school program on an ongoing basis with the help of local village panchayat (local self government) education committee, which comprised of sarpanch (head man) and some senior community members. An extra English remedial teacher was hired. Repair of building, safe water and regular mid day meals were administered. The government administration was approached to report teacher absenteeism and effective implementation of their program. The group managed health care clinic for sick children and immunization at the village chawpal (meeting point). In a period of 2 years, the school had enhanced enrollment, no drop outs, and improved school performance. The key to the success of this initiative was due to a clear responsibility and accountability of Panchayat officials, teachers, community ownership and participation.

What we have learnt?
In the process of voluntary service in underserved regions of our country, we learnt some important lessons from the vulnerable families and communities. The most important lesson was that public awareness about child abuse & neglect has to be raised & society attitudes have to change. Children should have knowledge regarding life skills, child rights and participation. Moreover, Governments should encourage public discussions on child maltreatment. The media has an important role to play in this regard. Legislation alone will not bring sufficient impact unless awareness and public attitudes are changed! Nevertheless, adequate Legislative framework and their consistent implementation & enforcement are very important. Beyond rationalization of existing laws, the main challenge in India remains their enforcement and the fact that there is a certain degree of impunity for those violating the law. For instance, if one compares the prevalence of child marriage in India (43% of women aged 20–24 were married before they were 18) and the numbers of people prosecuted for violating the anti-child marriage law (a few hundred per year, at best), it is evident that the law is not enforced.

Child Protection: Assigning responsibility
Ideally, the parents should be responsible for proper care and protection of their child. Every birth should be planned and all births registered. However, the child must not suffer in case the parents can’t provide care and protection. It is the duty of the proximate community and the Government at large to address the issues of care and protection.

Education and empowerment of families
The magnitude and seriousness of the problems of underprivileged children are too great to be tackled through “external” measures. The child must be the responsibility of the parents, the family and the proximate community. The families and the community must be educated, informed and empowered so that they can provide care
and protection to their children. Parenting skills, alternative forms of discipline and basic support to vulnerable families must be expanded. In India, the Government cannot afford to separate children from their vulnerable families and place them in institutions. Such approaches are also being challenged in more developed countries as well. What most families need is some extra support to cater for their children, in the form of sponsorship schemes, social protection programs. Awareness of their rights and information about governmental assistance would ensure proper utilization of various “schemes.”

**Role of the community**

Wherever the parents are unable to take care and protect the child, the proximate community and their elected representatives must take up that responsibility. Thus, in the village, *panchayat* officials (local self government) and in the urban areas, the elected members must ensure that every child is in school, receives basic health care (particularly immunizations, nutrition) and protection from child abuse & neglect.

**Role of Non Government Organizations (NGO’s)**

A large number of NGOs are working in the field of child welfare and child protection. However, because of the huge numbers of children requiring protection, their efforts can make only a marginal impact. However, they should coordinate their child welfare activities and need to work together. They also need to oversee implementation of various government measures that are already in place. The crucial ones include basic right to health, education, infant and young child development and prevention of child abuse & neglect.

**Role of Government**

The ultimate responsibility to protect its nation’s children lies with the Government. By ratification of International instruments such as UN CRC & UN General comments #13, the Government’s should commit appropriate legislative, administrative, social and educational measures to prevent and protect children from maltreatment. In 1992, India accepted the obligations of the UN Convention on the Rights of the Child (CRC). In the last two decades, the government has taken several steps towards practically advance children's rights. These include the Juvenile Justice (Care and Protection) Act 2000 (amended in 2006), Prohibition of Child Marriage Act (2006), the formation of the National Commission for Protection of Child Rights (2005), a National Plan of Action for children (2005), Right to Information (RTI) 2005, the Goa Children (amendment) Act 2005, the Child Labour (Prohibition & Regulation) Act, 1986 (two notifications in 2006 & 2008), expanded the list of banned and hazardous processes and occupation), Integrated Child Protection Scheme (2009) and advancing various legislations such as Right to Education Bill (2009) & Prevention of children from Sexual Offences (POCSO Act 2012) to protect, promote and defend child rights in the country. However still, there is a wide gap between policy & implementation/practice & outcome, and millions of children fall through the gaps.

**The Juvenile Justice (Care and Protection) Act 2000 (amended in 2006)** was a key step in the right direction by Government of India. It established a framework for both children in need of care and protection and for children in contact with the law. However, further harmonization is needed with other existing laws, such as the Prohibition of Child Marriage Act 2006, the Child Labour Prohibition and Regulation Act 1986 or the Right to Education Act 2009. Important contradictions exist among these laws, starting with the definition and age of the child. Conflict with personal laws should also be addressed, ensuring universal protection of children, regardless of the community they belong to.

**National Commission for Protection of Child Rights (NCPCR)** was established by the Government of India in March 2007 by an Act of Parliament, with a wide mandate and considerable powers. The Delhi Commission for protection of child rights was started in July 2008. Similar bodies at State level have been pursuing various matters concerning child rights and protection. Telephonic help lines (CHILDLINE 1098) and Child Welfare Committees (CWC) have been established, where reports of child abuse or a child likely to be threatened to be harmed can be made and help sought.

**Integrated Child Protection Scheme (ICPS)** The Ministry of Women and Child Development, Government of India has launched an Integrated Child Protection Scheme (ICPS) (2009), which
is expected to significantly contribute to the realization of State responsibility for creating a system that will efficiently and effectively protect children. It is meant to institutionalize essential services and strengthen structures, enhance capacity at all levels, create database and knowledge base for child protection services, strengthen child protection at family and community level and ensure appropriate inter-sectoral response at all levels and raise public awareness. The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society. The document “The integrated child protection scheme (ICPS)—A centrally sponsored scheme of Government—Civil society partnership” gives detailed accounts of this scheme.

**Prevention of children from Sexual Offences (POCSO Act 2012)**

The Protection of Children from Sexual Offences Act, 2012, specifically address the issue of sexual offences committed against children, which until now had been tried under laws that did not differentiate between adult and child victims. The punishments provided in the law are also stringent and are commensurate with the gravity of the offence. Under this act, various child friendly procedures are put in place at various stages of the judicial process. Also, the Special Court is to complete the trial within a period of one year, as far as possible. Disclosing the name of the child in the media is a punishable offence, punishable by up to one year.

The law provides for relief and rehabilitation of the child, as soon as the complaint is made to the Special Juvenile Police Unit (SJPU) or to the local police. Immediate & adequate care and protection (such as admitting the child into a shelter home or to the nearest hospital within twenty-four hours of the report) are provided. The Child Welfare Committee (CWC) is also required to be notified within 24 hours of recording the complaint. Moreover, it is a mandate of the National Commission for the Protection of Child Rights (NCPCR) and State Commissions for the Protection of Child Rights (SCPCR) to monitor the implementation of the Act.

**Public Health Approach**

Given a large population and socio-economic constraints in developing countries, a public health approach/system response to primary, secondary and tertiary prevention of child maltreatment is urgently needed. More vulnerable groups with greater poverty, unemployment, migrant workers, parents with mental health problems, substance abuse, domestic violence, children with chronic health problems and disabilities are at greater risk. In order to make a social & public health impact, the Government should integrate its social welfare policies and child protection scheme; ensure their proper implementation and effective convergence at the grass root levels. Universal prevention services also need to have the ability to identify vulnerable families early enough to change risky behavior and pathway to abuse. Use of maternal & child health (MCH) services, integrated child development schemes (ICDS) can broaden the pediatric surveillance role of community workers in the community. The children subjected to maltreatment should be quickly assessed and provided treatment and appropriate secure placement to avoid further damage in situation where it is unsafe for children to remain at home.

In India, there is also a big need for appropriately trained human resources and adequate child protection budgets. The analysis of Indian child budget data revealed only 0.3% of child budget is allocated to child protection. The officials should also ensure that Governmental funds are properly utilized.

**Role of professionals, corporate sector, religious institutions**

The professionals, all educated persons, corporate sector and religious institutions must help in child protection and child welfare. A major attitudinal change in civil society is called for. The “child’s voice” must be heard by the policymakers! Attitudes, Traditions, customs, behavior & Practices refers to social norms and traditions that condemn harmful practices and support those that are protective.

Many protective traditions and practices exist, such as strong family values. However, certain stereotypes, attitudes and social norms that violate the rights of the child also persist, such as the use of corporal punishment as a way to discipline children or the social acceptance of child labour. Other harmful practices associated to gender roles, such as child marriage or gender-biased sex selection, are deeply rooted
and manifest a patriarchal and hierarchic attitude towards girls and women, who are still seen by many as a liability or as *parayadhan* (*someone else’s wealth* or property of the marital family). A better understanding of those norms and attitudes, are necessary to promote social change in the best interest of the child.\(^{13}\)

**Monitoring, Data collection, Research & Evaluation**

Monitoring effective systems of data collection, routine monitoring, research and evaluation are necessary to assess progress in the protection of children. In most countries, as well as in India, there is limited data on child protection. Existing national census and surveys can give data on birth registration, child marriage, child sex ratio etc. However, Data is difficult to find in many forms of violence, such as sexual abuse, exploitation, trafficking, etc., which thrive on secrecy. It is important to have reliable data in order to promote inter-sectoral and regional strategies and best practices in child protection and their evolution over time.

**Recommendation**

In India, child rights, protection and exploitation (street children, child labour, trafficking etc.) are intimately linked to poor socioeconomic conditions in a large population base. Survival, early child health care, nutrition, education, development and child protection are most crucial child rights. Illiterate parents are ignorant of their children rights. They must be made aware of child rights, must demand and fight to obtain them. Multidisciplinary child professionals should work together and monitor the government efforts in protection of child rights. They should be able to collate available national child health indicators, address key issues and concerns in their region, involve children in research and facilitate their participation in projects and policy development. There is an urgent need to assign responsibility and accountability to Government, elected representatives, policy makers, proximate community and education and empowerment of families. In any case, a child must not suffer, if the parents can’t provide care and protect.

**References**

2. Committee on the Rights of the Child, 56th session General Comment No.13 (2011) Article 19: The right of the child to freedom from all forms of violence.
The following member NMAs presented their country reports.

- Australian Medical Association
- Hong Kong Medical Association
- Indian Medical Association
- Indonesian Medical Association
- Japan Medical Association
- Korean Medical Association
- Malaysian Medical Association
- Myanmar Medical Association
- Nepal Medical Association
- Philippine Medical Association
- Singapore Medical Association
- Taiwan Medical Association
- The Medical Association of Thailand

(Listed in alphabetical order of the country name)
Country Report: Australia

Dr. Mukesh Haikerwal AO
General Medical Practitioner
Immediate Past President
Australian Medical Association
Chair of Council, World Medical Association

This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.

*1 Chair of Council Member, World Medical Association; Immediate Past President, Australian Medical Association, Kingston ACT, Australia (ama@ama.com.au).
Thank You!
With the continuous efforts of our colleagues, the Association’s membership has grown steadily over the past year. The tie between colleagues at community level and the Council continued to be strengthened through various activities—including but not limited to the countless continuous medical education (CME) programmes, public education events, community projects, research projects and social and recreational activities.

With the unfailing support from our members, we continued to speak for the profession and safeguard the health and welfare of the public. We worked closely with the Government, the Hospital Authority (HA) and the Department of Health (DH) on important issues relating to the Policy Address, legislation on medical devices, public-private partnership (PPP), revamp of HA, medical manpower planning, the Health Protection Scheme (HPS), Formula Milk and H7N9 influenza. We also worked with The Medical Council of Hong Kong on issues of lay representation in the Council and quotable appointments.

On the educational front, the 14th Beijing/Hong Kong Medical Exchange on “Dermatological problems” was successfully held in Hong Kong. Numerous CMEs, certificate courses and training courses were organized with practical topics on influenza vaccination, diabetes management, chronic pain, medico-legal issues and many others. To improve doctor’s communication skills, we organized series of Risk Management workshops. To help doctors become expert witness for inquiries, courts and tribunals, a two-day training course was held on a September weekend. Series of exercise for health training courses for various Community Networks were organized to teach participants different types of exercises for different chronic diseases so that they could later apply in their daily practice and teach their patients. We also organized an exchange visit to Beijing and Inner Mongolia for young doctors and medical students.

At the same time, important and useful health messages were promoted to the public via public education day on Early Detection and Treatment of Hypertension and Kidney Disease. We also promoted the Dietary Approaches to Stop Hypertension (DASH) Diet. Medical check stations and free consultation were arranged for the public.

On social and recreational events, just like previous years, we arranged countless activities for our members. Sports events included the many ball games and matches—football, basketball, volleyball, badminton, tennis, table-tennis, squash, bowling, snooker and golf etc. We also had bench pressing and power-lifting, not to mention the usual dragon boat, trailwalker, hiking activities. On top of the annual swimming gala and family sports day, the Recreation Sports Club for Professional Bodies (RSCP) was formally established to foster friendship amongst different professions and their members. Besides, the Hong Kong Medical Association Photographic Society successfully held a photo exhibition at Hong Kong Cultural Centre and then tour around various hospitals. Tours to Jiuzhaigou and Luoyang in Mainland China were also well-received.

Our professional choir and orchestra continued their expertise in performing for various fund-raising activities, including our annual Charity Concert. Some members also participated in the Hong Kong Coalition of Professional Services’ charity concert in June 2013 to raise funds for the rehabilitation of the victims of the Yan’an, Sichuan earthquake.

Internationally, we attended the 63rd WMA
General Assembly in Bangkok, Thailand and the CMAAO luncheon in October 2012, and participated in the 48th CMAAO Council Meeting held in Macau in November 2012.

Under the concerted efforts of all, the HKMA will continue to serve our profession and the public in all areas related to our health care system.
BEIJING/HONG KONG MEDICAL EXCHANGE
- 3 & 4 November 2012 in Sheraton, Hong Kong
- Theme: From Medical to Cosmetic Dermatology

CONTINUING MEDICAL EDUCATION (CME)

CHARITY
# Annual Charity Concert
# Ya’an, Sichuan Earthquake

MEMBER WELFARE AND ACTIVITIES
# HKAMA Chair
# HKAMA Orchestra
# Annual Social Function
# Sports
  1. Team Professional Tournaments
  2. Ball games
  3. Family Sports Day
  4. Swimming Gala
  5. Dragon boat, treasure hunt, family hiking
  6. Bench press, body building
# Recreation
  1. Photo competition, singing competition
  2. Wine dinner
  3. Dinner party
  4. Trip to Macau
  5. Career talks
END
~THANK YOU~
Indian Medical Association (IMA) is a well established pan-India voluntary organization of modern medicine doctors. It has a membership of 2.3 lakh doctors spread over 1,600 branches in almost all the districts of India. IMA is reaching to approximately 33 crores of people every month and ensuring affordable & quality treatment.

Born in 1928, mainly out of the burning need to organise the medical professionals of the time for the national freedom struggle, IMA eventually reached an agreement with the British Medical Association (BMA), which had opened a few branches in India to cater to the local needs, that they will have no branch in India and got mutually affiliated. This relationship continues till today. This was as a result of the select few stalwarts of the medical professionals in the country at that time.

In the year 1946, IMA was one of the founder constituent members of the world body, World Medical Association (WMA). IMA has been and continues to play an important role in the deliberations of WMA. In 1966, we hosted the III World Conference on Medical Education under the joint auspices of WMA and IMA in New Delhi followed by the WMA General Assembly in 2009 in the national capital.

Vision of Leaders of IMA

IMA went started from where we left last year. The new team of office bearers took over the office with new vigour and dedication. Our National President, Dr. K. Vijayakumar gave a clarion call for a “Vibrant IMA” with the Hony. Secretary General, Dr. Narendra Saini promising it by “Building Partnerships in Healthcare.”

We have strived hard and taken effective steps to involve IMA State/Local Branches, Government Authorities, other National Medical Specialist Organizations, National and International Agencies, Media and Residents’ Welfare Associations etc. as partners in Healthcare. Various MoUs have been entered into by us during a short span of 8 months of this year with many stakeholders for the benefit of the doctors and society alike.

To make IMA “Vibrant,” many programmes have been started by IMA for the benefit of its members. A few to name:

- **IMA Privilege Card**: A card to be issued to members of IMA which will entitle them to facilities like subsidized Tickets for Travel, Transport, Hotel Accommodation etc.

- **IMA Pension Scheme for Members**: Steps have been initiated to work out an attractive Pension scheme for IMA members in collaboration with the leading Insurance providers of the Country.

- **IMA Family Protection Scheme**: It has been decided to start a Family protection scheme at HQs. for the families of deceased Doctors wherein the family members will be given a sum of Rs.15 lakhs to 20 lakhs on his death. IMA is working out an exhaustive scheme for the benefit of the families of our members.

Alliance of Health Association of India (AHAI)

A professional health alliance has been formed involving all the medical stakeholders involved in providing Health to the nation. The ultimate goal of the Alliance is to develop a mutually beneficial relationship for all health care providers. It will result in delivery of the highest quality care to all citizens.

At its first meeting held at New Delhi on April 21, 2013, it was resolved:

- **Core Committee should be formed.**
• Policy/white paper of the Alliance be drafted and released.
• Common Minimum Programs be finalised.
• Harassment and violence against the healthcare professional to be stopped.
• Alliance should come forward against all forms of quackery.
• Campaign for Save the Girl Child launched.
• Social Security Scheme to be started for the doctors of AHAI
• Ethical and Moral Issues should also be included.
• Representative in state and central legislative bodies such as Rajya Sabha membership from the AHAI
• Continuing Medical Education and Research in all pathies.
• Referral system between healthcare specialties and other domains
• Insurance schemes for AHAI members
• Issues related to immigration of all health care providers.

We started a signature campaign under this initiative where we have collected signatures of more than one lakh medical professionals endorsing the IMA viewpoint—“I can’t imagine a world without women. No family is complete without a girl. I pledge to save the Girl Child.”

Academic Activities of IMA and Its Wings

IMA College of General Practitioners, one of the academic wings of IMA organises many courses for our members. To name a few:
1. Fellowship Course on Cancer Palliative Medicine
2. International Post Graduate Paediatric Certificate Course
3. P.G. Course in Emergency Medicine
4. P.G. Course in Family Medicine
5. Fellowship Course in Diabetology
6. Fellowship Course in Nephrology
7. Fellowship Course in Echocardiography
8. Fellowship Course in Practical Oncology
9. Fellowship Course in Sexual Medicine
10. Fellowship Course in Practical Endocrinology

IMA Academy of Medical Specialities, the Specialists’ wing of IMA, publishes its Annual publication, the Annals of IMA AMS every year, which is an important publication for specialists. Moreover, the following courses are being organised by this Wing:
• Infertility
• Fluorescein Angiography
• Laser Photocoagulation in Retinal
• Excimer, Laser & Lasik Surgery
• Phacoemulsification
• Training in Laparoscopic Surgery, Noninvasive Cardiology, Echocardiography, TMT, etc., Critical Care in Cardiology, Advance Microear Surgery
• Functional Endoscopic Sinus
• Laser in ENT
• Tracho-Bronchial. Rhinoplasty Joint Replacement
• Orthoscopic
• Spine Surgery

IMA AKN Sinha Institute of IMA, the wing of IMA involved in Distance Learning Courses, is organising a large number of Distance Learning Certificate courses for the members of IMA e.g.
• Family Planning
• Lactation Management

Partnership With Medibiz TV

As a part of our “Partnerships in Healthcare” initiative, IMA has entered into an Understanding with MediBiz TV to provide TV programmes on medical ailments and treatment for the benefit of the common man. They shall also organise TV programmes to provide CME activities for the benefit of the medical professionals.

Save the Girl Child and Empowerment of Females

IMA launched its Save the Girl Child and empowerment of the females initiative in continuation of its many earlier programmes related to Gender equality. Due to our old social beliefs, there exists a gender inequality in our society which is not good for its development.

To ensure that no medical professionals are involved in Sex determination and as a part of its social commitment, IMA made two of Indian celebrities of International fame as its Brand Ambassadors for this issue of immense social importance, namely:
1. Mr. Sunil Gavaskar, the famous former Indian Cricketer and
2. Mrs. Hema Malini, the world renowned, Indian cine personality & social worker.
Increase in Membership

Envisioning that our strength is in numbers, a special effort has been made to increase the membership of our Association through a Special Membership Drive. We have since started receiving good results and expect a spurt in Membership by the end of this year. IMA is the largest professional organisation around the globe, with a membership of more than 230,000 members.

Medical Students and Young Doctors Networking: Bringing our younger ones into the mainstream

We have taken proactive steps this year to attract our younger medical professionals and medical students into the mainstream of the Association.

We have formed the Medical Students Wing of IMA in all our branches to involve them into the various activities of the Association so as to eventually enrol them as members of IMA after their Graduation.

Besides the Medical Students, extreme attention has been paid to initiate the process of enrolment of those young medicos who have graduated within the last 5 years through attractive discounts in Life Membership of IMA for them.

IMA Hospital Board of India

In India, where 87% of healthcare expenditure is outside the Government system, it is important to have institutions to give direction to the growth and activity of the non Governmental players. The leadership in healthcare delivery has been slowly and steadily passing into the hands of entrepreneurs of all backgrounds. It is important to moor the industry strongly on the ethics and dynamics of the medical profession. To achieve the political objective of maintaining the benign influence of the medical profession on the healthcare industry, IMA stepped in with the initiative of IMA Hospital Board of India (IHBI). The IHBI is working very hard to achieve its aims and objectives:

1. To assist and equip healthcare institutions in non Governmental sector to provide quality healthcare to people.
2. To protect and sustain non Governmental sector in health to play its effective role in public health.
3. To represent and safeguard the interest of the non Government health care institutions and their personnel irrespective of their affiliation.

It has recently taken action to work out the minimum standards for health providers for implementation through its affiliated institutions.

Antibiotic and Hospital Infection Control

A special committee has been formed on rational use of Antibiotic and Hospital Infection Control Programme. With increasing antibiotic resistance and no newer molecules being discovered, it has become important that we should use Antibiotics judiciously. In this regard, IMA has taken a number of steps; an important one being, creating awareness among medical professionals on this issue. A book on rational use of Antibiotics is being prepared. A Committee has been formed on Hospital Infection Control to give recommendations on minimum standards to be adopted in healthcare settings on this issue.

IMA Activity Related to Autonomy of the Medical Profession

For effective working of any professional regulatory body, its autonomy needs to be ensured for its enhancement and promotion. Since the year 2010, no election were held in the Medical Council of India (MCI), the regulatory body for medical professionals in India.

Due to the efforts of IMA, the elections of MCI have been announced and the democratic structure of this regulatory body is expected to be restored soon.
Bachelor of Rural Health Course

There is a shortage of doctors qualified in modern system of medicine for serving the rural population of the country. To offset this shortage, the Government proposed a short term Course of 3 1/2 years for students who will be required to essentially serve the rural population only. These students would be allowed to prescribe medicine to the above population just like the other MBBS doctors. However, IMA strongly objected to this course and felt that such a Course will amount to discrimination towards the health of the rural folk. Also, it will not be possible to devise a mechanism to ensure that such professionals will only work in rural areas in future. In accordance with our objections and observations on the issue, the Indian Parliamentary Standing Committee on Health rejected the above Course.

Consumer Protection Act and Medical Profession

In our country, the medical profession has been brought under the ambit of Consumer Protection Act (CPA). However, IMA has formed a Committee against the implementation of CPA on the medical profession. We have proposed to the Government and the Judiciary that a Medical Tribunal be formed consisting of some designated medical professionals also, to assist the Judiciary to adjudicate the CPA cases related to medical profession. Efforts are on to get this approved and implemented at all levels.

Anti Quackery Activities

The menace of Quackery, a procedure of medical practice by a person in a system of medicine for which he is not qualified, is extremely widespread in our country. This causes a huge danger on the lives of the common man. In the absence of an exclusive law dealing with Quackery, this menace goes on increasing day by day. IMA has initiated steps to try and get a Central law against this menace against humanity so that the same can be effectively implemented all over the country.

Implementation of Service Tax Laws on Medical Profession

There have been many proposals to apply Service Tax laws on all medical procedures. This will increase the cost of medical treatment to the poor patients. IMA fought tooth and nail and succeeded in waiving off any such taxes on the regular medical treatment and keep the essential medical services out of the ambit of Service Tax.

IMA Activity Related to the Safety of Medical Practitioners in the Country

We have worked immensely to ensure that more and more State Governments come out with effective laws for prevention of assaults and attacks on medical professionals and their clinical establishments.

At present, sixteen States have enacted laws for prevention of assaults and attacks on medical professionals and their clinical establishments. Efforts are also being made to make a Central Law regarding this important issue.

Crisis Management Committees have been formed at IMA HQs., State and Local Branch levels to immediately deal with crisis situations arising out of sudden assaults on medical professionals and their clinical establishments in the area.

IMA Activity Related to Ensuring Speedy Rape Case Trials and to Make the Laws of Rape Cases More Effective

The country observed the New Year on a sad note with the unfortunate rape of a para medico in the Capital of India. It was followed by a huge outburst of the society which made the Indian Government to frame proper laws against this ghastly act of mankind.

IMA provided its set of recommendations for speedy rape case trial and to make the laws for rape cases more effective:

1. More Forensic Labs to be made in the country
   The numbers of forensic lab in the country are very less as compare to work load. The report of examination of rape victim from forensic lab takes lots of time and the trial gets delayed. Justice delay is justice denied. If the labs are increased in the country, the report can be
available expeditiously and would help to expedite the trial of the case.
2. Forensic reports along with other medical reports for forced sexual intercourse should be accepted as conclusive proof for rape.
3. Medical test for rape should also be done on the request of the victim and not only on the request of the police, and, if possible, should be done within 24 hours of the sexual assault.
4. Fast track trial Courts should be made compulsory for rape cases.
5. Identity of unsound person and minor as is with the major cannot be disclosed in any condition not even with the consent of parents/guardians.
6. Testing including HIV and Follow up for sexually transmitted diseases should be made compulsory. At present prior consent even of the accused is required for HIV test. Seeing the gravity of disease and antisocial habits of the accused, HIV and other tests should be mandatory for them even without their consent in rape cases.
7. Prophylactic HIV medicine for the victim: In view of the antisocial behavior of sexual assaulters, they are more prone to sexually transmitted diseases. (STDs) HIV is a serious disease which is transmitted sexually. So the victim should be given the course of prophylactic medicine immediate after the crime.
8. Chemical castration is not an answer. It is not effective as rapes are not linked only to increased desire but also involve people with criminal mind and high hormone levels does not mean that a person will have sexual deviations. Chemicals are not medically safe and require an informed consent. Their effects are reversible.
9. For Molestation & eve teasing, laws should be stringent and strictly implemented. Preventive measures should be taken by Govt. E.g. CCTVs/security guards at public places & in public transport.

Activities Related to Disaster Management

This year, India witnessed one of the worst natural disasters when most of the hilly terrains of Devbhoomi (The God’s own land), i.e. the State of Uttarakhand, were washed away due to huge landslides as a result of cloud bursts during the Monsoon season. A large number of unsuspecting pilgrims and local residents were buried alive or were left stranded with no food or shelter. The Uttarakchal State Branch of IMA reached the disaster hit areas before any other help could reach there and started providing medical relief immediately to the survivors. It was followed by many other members from other States like Punjab etc.

It has been decided by IMA to start rehabilitation work in Kedar valley, one of the worst hit areas and construct a well equipped New Health Center at Gupt Kashi for disaster victims.

The IMA HQs. has prepared an extremely informative Manual for Disaster Management for medical professionals which is updated on a regular basis. Recently we have prepared a booklet on dealing with Disaster due to floods. Regular training workshops are being held to train our members on disaster management.

IMA Trauma Care Committee

Identifying the need of primary medical care during the “Golden Hour” of an accident on highways, IMA has formed an IMA Trauma Committee which shall look into registration of medical establishments alongside the highways which can arrange medical and paramedical professionals to reach an accident site immediately and provide the most needed medical attention to the victims(s). IMA has also approached the National and State Governments to create such Trauma Care centres along the highways.

Feasibility of Generic Drugs

IMA has resolved that it is concerned and is committed in providing cost effective quality drugs to the patient. Seventy percent of the expense of a treatment is on drugs. IMA is negotiating with the Government to evolve a mechanism to reduce the cost of drugs.

1. Major concern for medical professionals is to evolve a mechanism so that a quality and affordable drug can be given to the patient.
2. IMA believes that the Govt. should control the MRP of drugs, generic or branded so that benefit reaches the common man. At least the price control of MRP of all essential drugs is of paramount importance and their list should
be published and revised regularly.
3. Government of India should undertake measures to strengthen the monitoring system of medicines for quality control of all batches of drugs and it should also cover the Bioavailability aspect.
4. Supply of quality generic drugs, in different stores of the country.
5. The IMA members should maintain the rational use of drugs while choosing a drug and ensure it qualifies the criteria: quality safe drug and yet affordable.
6. The so-called nexus between doctor and chemist or a pharma company, where a doctor is writing a particular brand, a costly brand or a brand only available with particular chemists should be considered unethical.
7. Since in our country, patients have very limited access about the information of drugs and even persons employed in chemist shops are also not qualified, proper checks and balances are essential to ensure that patients get the best medicine on physician prescription.
   Doctors along with Govt. monitoring and price control are the only mechanisms to ensure patient getting proper medicine in the present circumstances.
8. The web site of Drug Controller of India should mention the names and addresses of manufacturing and marketing companies authorized by them to ensure the traceability of the product. It should also mention the MRP of drugs.

**Medical Tourism**

Non availability of quality medicare services in developing countries and Long Waiting Lists & Expensive treatment in the developed ones, the Wellness and Medical Tourism is growing at a rapid pace in our country. At the estimated annual growth rate of 30 percent, it is expected to make it a Rs.10,000 crore industry by the year 2015.

The metropolitan cities of Delhi, Chennai, Bangalore and Mumbai cater to the maximum number of the health tourists and are fast emerging as medical tourism hubs. The low cost personlized quality healthcare services of international class made available in near real time, coupled with the rich cultural heritage of our country, makes India one of the favoured nations for medical tourism.

We have conveyed some of our observations on this issue to the concerned authorities, which include:

- Medical Tourism can only succeed if state proactively assists the healthcare providers with Affordable real estate, infrastructure, good governance and continuous energy.
- Financial incentives such as tax rebates/holidays, special financial assistance in the form of low interest loans and active PPP collaborations and active promotion through dedicated cells by the government tourism bodies and Embassies.
- Fast track Visas clearance for such cases.
- Environment safety, Infection control practices, qualified, trained & experienced staff, regulatory compliances and better Infrastructure are other key areas in promoting health tourism.
- Indian judicial redressal system needs to be refined and recalibrated to address concerns related to typical delays in India’s Civil Courts & consumer forums as well as difficulties in securing expert testimony and accessing medical records, so as to build confidence in the inbound patients.

**IMA Activities Related to Control of Tuberculosis in the Country**

**IMA-GFATM-RNTCP-PPM-Project**

Our Understanding with the Global Fund Against Tuberculosis, AIDS and Malaria (GFATM) through the Government of India in connection with the Government’s Revised National Tuberculosis Control Programme (RNTCP) has gone stronger every passing year since its starting in 2007.

**Monitoring & Evaluation:**

A National Working Group (NWG) formed at the IMA Hqs. level has been monitoring and evaluating the progress of the project.

**Achievements as Per Project Indicators:**

Since 2007, the project has successfully achieved all its Project Indicators, the salient achievements being as **Table 1**.

We have added another Project Indicator this year—TB notification. All new TB cases shall be notified by our members on the national register.
Pain is the most common symptom of any illness. The physicians’ task is twofold: to find the cause and treat the pain. Sometime whether or not the underlying cause is treatable, to provide relief and reduce the suffering caused by pain.

In this regard IMA has conducted a series of CMEs on Management of Pain during the year 2012–2013. A total of 250 CMEs will be conducted in selected districts all over India.

Total 165 CMEs have been successfully conducted in various States and more are to follow.

Care of Elderly Project of IMA

Due to increase in better health facilities, the elderly population of the country is increasing. IMA Care of elderly project to give better health care and social support to elders is an ongoing project of the Association. The National President Dr. K. Vijayakumar and Hony. Secretary General, Dr. Narendra Saini are taking keen interest for the continuous implementation of the project.

This year our aim is
1. To observe the World Elders Day on October first in National level, State level and Branch levels.
2. To organize workshops and CME programmes for our members.
3. To request the government:
   a) to help IMA to start training programme in geriatric care for doctors by financial and other technical help. (We have prepared a project submit to the Government)
   b) To implement National Policy on elder persons. Preference to be given to:-
      Financial security
      Health care
      Shelter
4. Protection against abuse and exploitation
5. Health insurance policy to all senior citizens
6. Old age pension scheme

World Elders Day will be celebrated on October 1, 2013 all over the country by most of the Branches of IMA. Necessary information has already been sent to all the branches of the Association.

Project on Prevention and Treatment of Childhood Diarrhoea

A project on Prevention & Treatment of Childhood Diarrhoea supported by UNICEF was successfully completed. The project covered 13 States and 44 Districts. Medical practitioners were trained on revised diarrhoea control guidelines. The objective of the project was to promote use of ORS and Zinc for the treatment of diarrhoea and to advocate rational use of drugs for the treatment of diarrhoea. The overall aim was to reduce the deaths due to diarrhoea.

The National Advisory Group formed for this project has conducted its meetings and finalized the study material and project outline. The same was effectively implemented and Workshops organised in this regard. More than 3,000 practitioners trained in various States.

IMA Project on Defining Minimum Standards for Health Providers to Govt. of India

IMA conducted a survey of clinical establishments in all districts (61 in number) of the 4 States of Arunachal Pradesh, Himachal Pradesh, Sikkim and Mizoram and 7 Union Territories with an objective of:

Phase-1 Listing of all types of Clinical establishments in the 61 districts.
Phase-2 Detailed survey of at least 40 selected clinical establishments in each district to collect information in relation to the parameters under the template of Standards.
The project started in April 2012 and have completed both Phase-1 & Phase-2 survey. We have since submitted our report and recommendations on the basis of the data collected and are soon going to initiate our own system of Registration of Clinical Establishments owned by our members based on the above Minimum standards. This is a step towards self regulation.

**Liaisons With International Bodies**

It is my proud privilege to inform the august gathering that the National President of IMA, Dr. K. Vijayakumar has been elected as the Vice President of Commonwealth Medical Association (CMA) (2013–2016) at its recently organised 23rd Triennial Conference and Council meeting held on July 4–7, 2013 at Trinidad and Tobago, Port of Spain.

As already informed above, the IMA is actively participating in the activities related to the WMA. IMA attended the 194th Council Session of WMA held at Bali, Indonesia from 4–6th April 2013. Dr. Ajay Kumar, Past National President, IMA and IMA Council Member to WMA attended the same alongwith Dr. Vinay Aggarwal, President-Elect, CMAAO, Dr. K. Vijayakumar and Dr. Narendra Saini. Apart from other matters, there was a discussion for voting on “Abolishment of Capital Punishment.” IMA and American Medical Association (AMA) voted against the motion of “Abolishment of Capital Punishment.” The motion was passed with majority votes.

Dr. Narendra Saini attended the Annual Representative Meeting (ARM) of our affiliates, the BMA on June 23–27, 2013 at Edinburgh, U.K.

We are well involved with the American Association of Physicians of Indian origin (AAPI) and British Association of Physicians of Indian Origin (BAPIO).
ININDIAN MEDICAL ASSOCIATION

- Born in 1928.
- IMA has a membership of 2.3 lakh doctors spread over 1600 branches in almost all the districts of India.

VIBRANT IMA

BUILDING PARTNERSHIPS IN HEALTH CARE

EFFECTIVE FUNCTIONING OF IMA

- IMA Office Bearers Orientation & Training workshop.
- IMA State President & Secretary Orientation & Training workshop.
- Hand Book for IMA Office Bearers.
- IMA Office workers workshop.

ACADEMIC ACTIVITIES OF IMA AND ITS WINGS

- IMA College of General Practitioners.
- IMA Academy of Medical Specialities.
- IMA AKN Sinha Institute of IMA.

MEDICAL STUDENTS AND YOUNG DOCTORS NETWORKING

- IMA Medical Students Wing.
- Young Doctors Wing at subsidized membership Drive (50%).
MEDICAL COUNCIL OF INDIA

- MCI
  - Restoration of Autonomy of MCI (Separate Committee, formed for Restoration & Achieved).
  - Non Medical Secretary Appoint objected / MCI replied as only a temporary arrangement.
  - Went to court against an advertisement of MCI to appoint Non Medical Secretary.

RURAL MBBS COURSE – OBJECTED & SUCCEEDED

MBBS (R) → BRMC → BRHC → BSC Community Health → made to be rejected by Parliamentary Standing Committee.

ACTIONS INITIATED

- Clinical Establishment Act – Made Doctor friendly.
- Consumer Protection Act → Fight started to form Medical Tribunal Instead of CPA.
- Anti-quackery Act - Demanded at National / State level.

ASSAULT ON DOCTORS

- Hospital Protection Act
- Rape of a Medical Student
- Murder of a Medical Student
- Many attacks on Doctors / Hospital.

MEMBERS BENEFIT SCHEMES

- IMA Privilege Card → Subsidized Tickets for Travel, Transport, Hotel Accommodation for our members.
- IMA Pension Scheme for Members (LIC)
- IMA Family Protection Scheme → Helping the family of deceased Doctors family with Rs.15 to 20 Lakhs.
- IMA National Social Security Scheme.
- IMA National Professional Protection Scheme.

DOCTOR - PUBLIC RELATIONSHIP

- Partnership with Biz TV to enhance Doctor – Public Telecasting & Web learning for Doctors.
- IMA Trauma Care Committee at all levels.
- Disaster Management Committee at all levels.
- Village Adoption Project
- School Adoption Project.
- PPP Clinics (Public Private Partnership Clinics).
DOCTOR - PUBLIC RELATIONSHIP (CONT...

• Care of the Elderly.
• Save the Girl Child and Empowerment of Females.
• Control of Tuberculosis of the Country.
• Polio Eradication.
• Other Govt. Health Schemes.

TRADE UNIONIZED IMA

• Action Committee for Agitations & Protests formed.
• Indian Health Professional Alliances Partnership with Speciality, Super Speciality Association, other pathies, Dental Association Nursing & Para-medicals.
• Crisis Management Committee, HQRS, State, Local Branch to deal with Crisis situation of the Hospital / Doctors.

THANK YOU
INDONESIAN MEDICAL ASSOCIATION

Mahesa M. PARANADIPA

COUNTRY REPORT OF INDIAN MEDICAL ASSOCIATION

28th CMAAO Congress & 49th CMAAO Council Meet
New Delhi - India, 12th - 14th September, 2013

CONSTITUTION OF THE REPUBLIC INDONESIA

In Preamble:
One goal of Indonesian state is "to protect all the people of Indonesia and the entire homeland of Indonesia and to promote the general welfare..."

In Article 26 H:
Every person has the right to social security in order to develop himself fully as a human being with dignity

Law No. 40 Year 2004 on National Social Security System (SJSN) is determined by the main considerations to provide a comprehensive social security for all Indonesian people.

POPULATION DISTRIBUTION MAP OF INDONESIA (2010)

251.85 million
Source: Ministry of Home Affairs, 2012

INDONESIAN DOCTORS SPREAD MAP (2013)

111,574 doctors
Source: data center and information services of IMA 2013

NATIONAL HEALTH INSURANCE PROGRAM

The program will begin in January 2014 targeting a universal coverage for all citizen to access healthcare services by the year 2019. Today, stakeholders such as ministry of health, health insurance providers, as well as IMA have been preparing all supporting instruments for the success of the program.

*1 Deputy Secretary General, Indonesian Medical Association, Jakarta Pusat, Indonesia (pbidi@idionline.org).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
The critical success factors of national health insurance

- Every Indonesian citizen must have access to the same qualified point of care (POC). It is mandatory to have a qualified doctor in every single POC to ensure the implementation of national health insurance otherwise the service will be hampered.
- The availability of POC and reliable primary care physicians as a Gate Keeper. The public acceptability to national health insurance is based on the reliability of the primary health care physicians and the availability of POC. The higher the reliability the better the acceptability.
- POC is the basic unit held by the primary care physician with multi-disciplinary team member.
- In accordance to the law of medical practice, IMA plays a role in equally distribution of physician (via recommendation to issue medical practice license) and improving physician competency (certification, CPD).

Recommendation of IMA

- Horizontal and vertical integration is needed to overcome overlapping and unstructured healthcare facilities to be in lined with national health insurance. In the era of national health insurance,
- Every citizen is allowed to choose one of the nearest basic healthcare unit to his neighborhood in order to utilize the service.
- Each basic unit is designed to be able to overcome most common daily health issues that is faced by individuals / families. All of the services should be therefore be given by a multi-disciplinary team (doctors, dentists, midwives, nurses, pharmacists, etc.) according to local setting.
- A referral system should be started from the chosen basic unit that is visited by the needy.
- Need a new classification based on the function of health facilities and competence. The classification for outpatient facilities and inpatient.

Roadmap in 2013–2014

- IMA involvement in national health insurance
- Mapping and formation of primary care physicians and specialists
- Model of primary care centers
- Recommendation guidelines for primary care physicians (involved system)
- Practice guidelines for primary care physicians
- Standardizing guidelines for primary care physicians
- Index of primary care physicians competence
- Completed NAP-CPT (Current Procedural Terminology)
- Programs to improve primary care physician competence

EXTERNAL

- Advocacy system of primary care-based health care
- Advocacy of bill medical education
- Advocacy & equitable distribution of doctors district
- Advocating quality medical care
- Physician advocacy as a strategic profession

Public – Private Partnership

1. the era of independent physician / entrepreneur doctor
2. mono-loyalty era
3. era one source of income

IMA involved in draft development of medical education law

Cooperate and coordinate with the national family planning body and ministry of health related family planning program

Gallery

Gallery
in commemoration of the day consecrated Indonesian doctors, IMA doctors launched a movement to plant trees

avoid smoking and drug campaigns and campaigns to limit sugar and salt intake

IMA’s building targeted in 2014 to accommodate all the activities of the organization

We seek to unite all physicians and develop the common interest of intellectual and professional

Thank You...
The 30th Anniversary of the Takemi Program in International Health: Harvard School of Public Health

The Takemi Program in International Health at the Harvard School of Public Health (HSPH) is an interdisciplinary program established in the HSPH in 1983. The program is named after Dr. Taro Takemi, a former president of the Japan Medical Association (JMA) and the World Medical Association (WMA), in recognition of his achievements and in admiration of his vision in pointing out the global need to enhance and improve health services along with the worldwide problems arising from limited resources and his advocacy for the development of new, effective health resources and improvement of their methods of allocation.

Dr. Takemi’s concept was to invite current and future leading health professionals in government, academia, and industry from around the world, with the purpose of facilitating the effectiveness and global development of health services integrating all manner of natural and social sciences through research and training programs, making use of Harvard University faculty and related programs. The point of research is to study the science of the development, distribution, and use of new health plans and medical resources and the objective is to train health care policy leaders from countries around the world.

There are seven principles that underline the concept and practice of global health, as developed over the past two decades in the Takemi Program. The principles are: research emphasis, policy orientation, interdisciplinary perspective, mutual respect, individual freedom, community spirit, individual capacity building.

The Takemi Program started in the HSPH in September 1984 with five Takemi Fellows. Since then, 242 people (including 52 Japanese) connected to local universities, public and private research institutes, government health authorities, NGOs, and international organizations from 52 countries have conducted research at the HSPH as Takemi Fellows, and their international network now extends around the world. Geographically, the majority of Takemi Fellows have come from Asia (including CMAAO member countries), Africa, and South America.

This October, Harvard University will hold the 30th anniversary of the Takemi Program commemoration in Boston followed by a commemorative symposium organized by the JMA in Tokyo in November, in order to further develop the program’s accomplishments over the past 30 years. Moreover, since Fellow candidates from low-income countries have been abandoning hope of joining the program for economic reasons, a new scholarship program has been established to invite two Takemi Fellows each year.

Today, Takemi Fellows are active in a wide range of global health fields around the world, and it is hoped that they will continue to reinforce their network and cooperate in many ways in the future.

The Japan Pharmaceutical Manufacturers Association financially supports the core administrative costs of the Takemi Program. Furthermore, the JMA has supported the Takemi Program since it was first established, and since 1994 it has further strengthened its involvement through the screening of Japanese Takemi Fellows and the provision of scholarships. Marking the program’s 30th anniversary, the JMA is committed to more actively supporting the Takemi Program together with CMAAO member associations and hopes to contribute to international health by making effective use of Takemi Fellows.

*1 Executive Board Member, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Country Report
Japan Medical Association

The Takemi Program in International Health
Harvard School of Public Health

Masami Ishii, MD
Executive Board Member
Japan Medical Association

The Takemi Program in International Health
Harvard School of Public Health (HSPH)

Dr. Taro Takemi, a former president of the Japan Medical Association (JMA)

pointed out the global need to enhance and improve health services along with the worldwide problems arising from limited resources, and advocated the development of new, effective health resources and improvement of their methods of allocation.

The Origins of the Takemi Program
Harvard School of Public Health (HSPH)

in recognition of Dr. Takemi's achievements and in admiration of his vision,
established the Takemi Program in 1963, which became the first program in HSPH bearing the name of a Japanese.

From left: Prof. David B. Bell, Dean Wanda Hill, and Dr. Taro Takemi (A photo taken in Dec. 1963)

The Concept of the Takemi Program

Dr. Takemi's concept was

- to invite current and future leading health professionals in government, academia, and industry from around the world
- with the purpose of facilitating the effectiveness and global development of health services integrating all manner of natural and social sciences through research and training programs, making use of Harvard University faculty and related programs.

- The point of research is to study the science of the development distribution, and use of new health plans and medical resources, and the objective is to train health care policy leaders from countries around the world.

Seven Principles of the Takemi Program

There are seven principles that underpin the concept and practice of global health in the Takemi Program:

7 Principles
- Research emphasis
- Policy-oriented
- Interdisciplinary perspective
- Mutual respect
- Individual freedom
- Community spirit
- Individual capacity building

Taro Takemi Professor & Program Director
Michael Reich

Takemi Fellows (1984-2014)

September 1984
The first group of five Takemi Fellows arrived at the HSPH

1984—2014
Since then, 242 people (including 52 Japanese) connected to local universities, public and private research institutes, government health authorities, NGOs, and international organizations from 52 countries have conducted research at the HSPH as Takemi Fellows.

- Many Fellows emerge as leaders of national institutions and occupy leadership positions in the front line of global health.
- Their international network now extends around the world.
The first Takemi Fellows (1984)

- HONRATA Ijiro, INDONESIA, deceased in 1991
- LEUNG King-chung, CHINA, Deputy Dean, School of Graduate Studies, Shanghai Medical University
- Prakash C. Gurav, INDIA, Managing Director, Sethurama Institute of Public Health
- VEDO, Ilia Cheong, KOREA, Vice President for Public Service & Dean of Graduate School, Yonsei University
- TANAKA, Koji, JAPAN, Chair, Board of Regents, Tokyo Medical University Education Foundation

The group photo of Takemi Fellows 1990-91 (above)...

Dr. Nafidah Mofid was named Minister of Health in Indonesia in June 2012 (left).

Takemi Fellows: Leaders in Global Health

After the Takemi year, Fellows are encouraged to continue their relationships with other researchers met at Harvard on the basis of mutual respect.
Community spirit is an impossibly asset in global health.

Geographical Distribution of Takemi Fellows, 1984-2014

242 Fellows from 51 Countries

JMA delegates visit the Program every year.

Financial Support to the Takemi Program

- The JMA has supported the Takemi Program since it was first established.
- Since 1994 it has been involved in the screening of Japanese Takemi Fellows and the provision of scholarships to them, sending two Fellows each year.
- Since 1994, the Japan Pharmaceutical Manufacturers Association supports core administrative costs of the Program.

30th Anniversary of the Takemi Program (2013)

2013 marks the 30th anniversary of the Takemi Program
- Commemorative symposiums Oct. 11-12, Harvard University, Boston, USA Nov. 23, JMA Building, Tokyo, Japan
- Establishment of new scholarship program for Fellows candidates from low income countries invite two Takemi Fellows each year for 10 years.
- MDU was entered by JMA and HSPH

(From Left) Prof. Michael Reich, Dean of Academic Affairs Dr. Masahiro Ihara [JMA]

The Takemi Program in the Future

- Marking the program's 30th anniversary, the JMA is committed to more actively supporting the Takemi Program and hopes to contribute to global health by making effective use of Takemi Fellows.
- Furthermore, the JMA proposes that Takemi Fellows in the CMAAO member countries and their global network be utilized to improve the health status of the people living in the Asia and Oceania region.
**Medical Personnel License Reporting System**

The medical personnel license reporting system, which requires all medical personnel to report his/her status and employment situation to the Minister of Health and Welfare every 3 years, was implemented last April. Professional organizations such as KMA have been delegated with the work of receiving the reports on behalf of the Ministry.

Anyone who does not report could have his/her license suspended until reporting requirements are met. Basic personal information, employment situation, place and area of work and whether continuing education requirements are fulfilled are some of the specific facts to be reported.

The reporting system is expected to improve qualification management as well as continuing education rates, which will improve quality of medical service and raise public trust upon medical professionals. KMA also will benefit by obtaining more up-to-date information regarding members and gaining a stronger position as the continuing education management body.

**Law to Prevent Violence Against Medical Professionals**

The so-called “Law to Prevent Violence against Medical Professionals” was proposed last December in the National Assembly and is currently on a review process. This bill demands that violence or threats against medical personnel be punished with a jail sentence of 5 years or less or a fine of 20 million won or less.

Once the law is adopted, we expect violence against medical personnel and violence in places like the emergency room will decrease significantly. The purpose of the bill is not to treat medical personnel differently from others. The aggravated punishment is intended to ultimately protect the public.

This law needs to be adopted quickly not just for the sake of all medical personnel exposed to violence everyday without proper protection, but also for everyone who use hospitals and receive treatment from medical personnel. I hope the National Assembly adopts it as soon as possible.

**Supports “Rice of Love” to the Visually Challenged**

KMA signed an MOU with the Korea Blind Union last May and agreed to provide rice to support the visually challenged facing economic difficulties.

As reported in last year’s country report, KMA has been leading the “Good Hands” campaign to encourage physicians to take the initiative in creating a bright and healthy society by eliminating negative aspect of society and by leading a social reform movement. This relationship with the Korea Blind Union is a part of this larger campaign.

In Korea, the custom is to send tall elaborate flower arrangements to congratulate various events and ceremonies. KMA has encouraged its members and relevant organization to receive rice donations instead of flowers and was able to deliver about 500 kg of rice collected from its members to the Korea Blind Union. The rice will be distributed to those in need in the Seoul area through the Korea Blind Union. KMA plans to continue to collect rice donations from its members to support KBU.
KMA hopes that by donating rice instead of flower arrangements, physicians become better aware of those in need and motivated to do more in terms of the “giving and sharing” movement. It is very encouraging that many medical organizations in Korea have agreed to also join the rice donation movement.
1. Medical personnel license reporting system

- Reporting rate for this year: as of April 28, 2013 (reporting deadline), a total of 93,446 physicians (87.6% of the total license holders of 106,659) completed reporting.
- For the remaining 14%, who did not report, KMA is working with the Ministry so that they will not be penalized by having their licenses suspended.

2. Law to prevent violence against medical professionals

The bill demands that violence or threats against medical personnel be punished with a jail sentence of 5 years or less or a fine of 20,000 dollars or less (aggravated punishment)

It was proposed December 2012 in the National Assembly and is currently on a review process.

3. Supports “Rice of Love” to the visually challenged

Signing an MOU with the Korea Blind Union (May 2013)
- Provision of rice to support the visually challenged facing economic difficulties
3. Supports “Rice of Love” to the visually challenged

KMA's “Good Hands Campaign” (starting from 2012)

- Encouraging physicians to take the initiative in creating a bright and healthy society by
- Eliminating negative aspect of society
- Leading a social reform movement

“Rice of Love” donation

- In Korea, the custom is to send tall elaborate flower arrangements to congratulate various events and Ceremonies
- KMA is encouraging giving and receiving rice instead of this custom by using so-called “rice flower arrangement”

- KMA was able to deliver about 500kg of rice collected to the Korea Blind Union
- Many medical organizations have agreed to also join the rice donation movement

KMA staff are delivering “Rice of Love” to a visually challenged

Thank you.
MALAYSIAN MEDICAL ASSOCIATION

N.K.S. THARMASEELAN

Objectives of the Malaysian Medical Association

• To promote and maintain the honour and interest of the profession of medicine in all its branches and in every one of its segments and help to sustain the professional standards of medical ethics.
• To serve as the vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large.
• To participate in the conduct of medical education, as may be appropriate.
• To promote social, cultural and charitable activities in building a united Malaysian nation.

Executive Committee 2013/2014

Dato Dr. N.K.S. Tharmaseelan—President
Dr. S.R. Manalan—Immediate Past President
Dr. H. Krishna Kumar—President-Elect
Datuk Dr. Kuljit Singh—Honorary General Secretary
Dr. Azizan Abdul Aziz—Honorary General Treasurer
Dr. Koh Kar Chai—Honorary Deputy Secretary
Dr. Rajan John—Honorary Deputy Secretary
Dr. Azhar Amir Hamzah—SCHOMOS Chairman
Dr. Ganabaskaran Nadason—PPS Chairman

MMA Council 2013/2014

The MMA Council comprising of 31 members includes the key office-bearers who are also members of the Executive Committee; as well as 21 branch representatives from the 14 states in Malaysia.

We Have Two Sections in Our Association, Namely:

Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS)

Its objective is to identify, address and seek the cooperation of the government to resolve issues relating to the welfare, pay, and allowances and working conditions of all grades of doctors in government service.

SCHOMOS over the years has evolved into a powerful Section of the MMA which conducts periodic meetings with the Director General and other top Ministry of Health officers and has achieved many notable successes in its ventures.

The issues discussed periodically includes: clinical allowance for medical officers, review of specialist allowance, overtime pay, promotion prospects for medical officers and specialists, housemen issues, etc.

The Private Practitioners Section (PPS)

Private Practitioners Section of MMA was established to look after the needs of the private practitioners.

PPS continues to be the negotiating arm of the Association in all matters relating to private practitioners. Currently, the PPS Section is concerned on issues related to:

• Pharmacy Bill—Dispensing rights to pharmacist worrying the GPs because many GPs who are dependent on the consultation fees fear losing their income to Pharmacists who are prescribing medicines;
• FOMEMA—(Examination of Foreign Workers)
• Managed Care Organisations—Low consultation fees paid to GPs;
• National Health Financing Scheme;
• 1Care—restructuring of the Malaysian Health System: worrying the GPs as its going to affect their income also.

*1 President, Malaysian Medical Association, Kuala Lumpur, Malaysia (info@mma.org.my).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.

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The 4 Societies Under the Umbrella of MMA Are:

- Public Health Society
- Society of Sports Medicine
- Society of Occupational and Environmental Medicine
- MMA Society of Medical Students

We also have 26 Committees and MMA is represented on 36 External Bodies, Government and Non-Governmental Organizations (NGOs).

**MMA Membership**

Currently there are over 42,778 registered medical practitioners in Malaysia but only about 8,519 are active MMA members.

The total number of doctors in Malaysia about two-thirds are in government sector and one third in the private sector.

The MMA has been in the forefront in promoting and looking after the welfare of doctors including non-members who reap the benefits;

The MMA believes that we can play an even greater and more meaningful role because we continue to have within our means, very interested members and experts who sacrifice huge personal time and effort to study, research and understand healthcare issues, which we believe we can share with the regulatory authorities.

**Membership by Category** (Fig. 1)

- Ordinary members 39.36%
- Life members 55.80%
- Honorary members 0.06%
- Associate members 0.01%
- Exempt members 4.77%

**Membership by Employment** (Fig. 2)

- Private 4,536
- Government 3,555
- Universities 359
- Retired 69

Total 8,519 members

**Membership by State** (Fig. 3)

- Johor 834
- Kedah 463
- Kelantan 186
- Melaka 314
- Negeri Sembilan 385
- Penang 677
- Pahang 266
- Perak 1,039
- Perlis 97
- Sabah 408
- Sarawak 713
- Selangor 1,461
- Terengganu 87
- Wilayah Persekutuan 1,589

Total 8,519 members

**Student Membership**

The total number of Student members in benefit is 2,478. The Students have a Society under the MMA. Unfortunately, many students do not continue as MMA members after graduation.
We Have Two Publications

Medical Journal of Malaysia (MJM)
The first medical journal publication in the country originated in 1890 as the Journal of the Straits Medical Association and it is stated that it could be found in the archives of medical libraries in many parts of the world.

Soon after the founding of the Malayan Medical Association 1960, the Medical Journal of Malaya was recognised as an official publication of the Association.

The MJM is listed in Index Medicus.

Is a multi-specialty journal with established international recognition, providing a publication medium for Malaysian doctors as well as for contributors from all over the world.

Members can submit articles for publication in the MJM free of charge; non members are charged a fee. All articles are accepted online and the published articles made available online.

Berita MMA
The Berita MMA began as a Newsletter in 1960.

Since 1969, the Berita MMA made its regular monthly appearance and developed into an important medium to keep members informed of activities of the Association and its various committees, developments in the healthcare services in the country and general news and feature article of professional interest.

Continuing Professional Development (CPD) Committee

- The continuing education of doctors is a vital component in the ultimate delivery of quality healthcare to our people and in recognition of this adage, the MMA launched the CME Committee and in 1994, MMA was appointed by the Malaysian Medical Council (MMC) to administer the MMC-CME Grading System and the accruing of annual credit points by doctors leading to the issuance of a certificate by the President of MMC.
- MMA dedicated itself with enthusiasm on this project and spared no expenses in making it a nation-wide success through purchasing of computer hardware for all state Branches and engaging secretariat staff.
- This service is provided free for all MMA members.

Next MMA Annual General Meeting

53rd Annual General Meeting on 23–26 May 2013
• Dato’ Dr. N.K.S. Tharmaseelan—President
• Dr. H. Krishna Kumar—President-Elect

International Affairs

MMA were participating the International Affair:
- CMAAO—Confederation of Medical Associations of Asia and Oceania
- MASEAN—Medical Associations of South East Asian Nations
- CMA—Commonwealth Medical Associations
- WMA—World Medical Associations

The 27th CMAAO General Meeting & 47th Council Meeting

Held in Taipei, Taiwan from 10–12 November 2011, at the Grand Hyatt Taipei, Taiwan.

MMA was represented by eight (8) Exco members:
President: Dr. Mary Suma Cardosa,
President-Elect: Dr. S.R. Manalan,
Immediate Past President: Dr. David K.L. Quek,
Honorary General Secretary: Dato’ Dr. N.K.S. Tharmaseelan,
Honorary General Treasurer: Dr. Ravindran R. Naidu,
Honorary Deputy Secretaries: Dato’ Dr. Sarjeet Singh Sidhu, Dr. Harvinder Singh and
SCHOMOS Chairperson: Dr. Rosalind Simon.

The Theme of the Scientific Meeting was “The Role of Physicians in Suicide Prevention.”
The 14th MASEAN Mid Term Council Meeting
The 14th MASEAN Mid Term Council Meeting was held at the Savoy Homann Hotel, Bandung, Indonesia on 14–16 June 2011.

The theme for this meeting was “The Role of Primary Healthcare Towards Population Health in ASEAN.” MMA was represented by the President: Dr. Mary Suma Cardosa, President-Elect: Dr. S.R. Manalan, Honorary General Secretary: Dato’ Dr. N.K.S. Tharmaseelan and Honorary General Treasurer: Dr. Ravindran R. Naidu.

The “Dr. M.K. Rajakumar Oration” is sponsored by the Malaysian Medical Association.

WMA Instead Leadership Development Programme
WMA Caring Physicians of the World Leadership Course was held in Instead, Singapore from the 21–25 November 2011.

MMA, Dr. Ravindran R. Naidu, Honorary General Treasurer, Dr. Rosalind Simon, SCHOMOS Chairperson and Dr. Selasawati, MMA Kelantan Chairperson attended leadership course.

The MMA hopes to conduct the same leadership course for its Council members and other members interested in June 2012.

Current National Problems
MMA has been working with the Ministry of Health (Fig. 4) so that the views, concerns and welfare of all sectors of doctors are represented and taken into consideration in the implementation of new laws, policies and practices.

The Ministry of Health is encouraging:
- Doctors to specialize in order to raise the quality of healthcare;
- GPs to become Family Medicine specialists to enhance primary care services in the country.

1Malaysia Clinics to include/utilise GP Clinics
The setting up of 1Malaysia clinics manned by Medical Assistants and Nurses by the Government in aid of the urban poor in the country. MMA had opposed because of our fear of subtle task-shifting and a possible reduction of standards or quality of medical care for the most indigent and marginalised in the urban areas (Fig. 5).

General Practitioners’ Woes Mounting
1Care for 1Malaysia is the name given to the transformed healthcare system of the future, which is going to be based on a social health insurance scheme (SHI) i.e. a compulsory health insurance scheme which every contributes to with primary care physicians as “gatekeepers.”

The Ministry of Health will play a more regulatory and policy making role while health services will be run by both public and private sector healthcare providers.

Care for 1 Malaysia health reform plans were the main concern of General Practitioners;

Every GP was annoyed and felt that they were the target of every new Medical Act and
Regulations, being unfairly micromanaged, their livelihood and professional status being put under the microscope.

GPs feel policies are made with disregard for their welfare.

Glut of Medical Doctors
By 2020, we expect that we might have as many as 87,000 doctors, which would mean that we cannot Sustain their training even for their houseman ship years or retaining them in the public sector.

Too many local medical colleges with too few experienced clinical teachers, training material or clinical experience.

Too many graduates also are returning from poorly monitored foreign medical schools.

The private sector could also be very crowded and doctors could become unemployed, underemployed, and unemployable even.

This would be a sad scenario because Malaysian parents and the government would have spent so much money sponsoring these students, at huge costs!

We are urging the government to quickly establish a moratorium on medical schools and programmes and enforce more stringent quality assessment of these schools and beyond.

The Ministry of Health has set a target ratio of one doctor to every 400 people by 2020.

Lynas Rare Earth Plant
A company by the name of Lynas is currently building up the world’s largest rare earth refining factory in Gebeng about 25km from Kuantan, Pahang.

The plant will import raw rare earth from Western Australia to be processed here before exporting to other countries.

Lynas’s explanation on why they are bringing the rare earth plant to Malaysia instead of processing it in Australia, claims that the skills and engineering requirement cannot be met by the human resource in Australia.

• The long-term management of the enormous quantity of radioactive waste is the major factor concerning environmental and public safety;
• The MMA in its role to defend the people’s health has made several press statements to stop the operation.
• The government and Ministry of Health is also probing into this issue for the safety of the nation.
Founded in 1949, Myanmar Medical Association (MMA) is the only professional organization of qualified medical doctors in the Republic of Union (ROU) of Myanmar. It is registered, Non-political, Non-governmental, Non-profitable organization and operates with its own budget, generated from its activities and membership fees. MMA has its own policy, constitution, bylaws and regulations with legal framework.

**Main Functions**

1. Education and Training towards the CME accreditation.
2. Clinical and Public Health Research with ethical and professional needs and standard.
3. Community Healthcare including public health projects, health promotion including reproductive health.
4. Maintain high professional and Ethical standard among members.
5. Collaboration and coordination with medical societies in the region as well as outside the region.
6. Partnership approach with allied medical societies, INGOs, NGOs inside the country.
7. Encourage and support total capacity building of the association at all level with professional aspiration.

**Activities in 2012–2013**

1. Annual Meeting together with Annual Academic Conference in every January. 59th Conference in 2013 was held in Mawlamyaing, the fourth city of the ROU of Myanmar.
2. 19th Surgeons’ Conference was held in November 2013 at Mandalay, the third city of the ROU of Myanmar.
3. 10th O&G Conference was held in February 2013 at Yangon, the second city of the ROU of Myanmar.
4. 21st ENT Conference was held in January 2013 at Yangon.
5. 21st Eye Conference was held in November 2012 at Yangon.
6. 14th General Practitioners’ Scientific Conference was held in November 2012 at Lashio, Northern Shan State.
7. 9th Rehabilitation Medicine Conference was held in October 2012 at Yangon.
8. 2nd International Pain Seminar was organized by the ROU of Myanmar and was held in January 2013 at Yangon.
9. There are 3 Academic Projects, and 18 Public Health related Projects funded by various International Donor Agencies including MMA itself, covering 80 townships in the ROU of Myanmar.
10. Support Group for Elderly Doctors (SGED), care about doctors over the age of 70 with sick support, social visit, regular medical check-ups, social gathering, support in cataract operation, and at funeral.
11. Lady Doctors’ Section also organized in paying homage to the elderly doctors residing in Yangon in every December of the year (recent data is 340 doctors above 75 years of age).
12. Emergency Ambulance Service has been established and initiated and has an appreciable performance in Yangon by MMA with charity supports.

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*1 Joint Secretary General 2, Myanmar Medical Association, Yangon, Myanmar (drkhinesoewin@gmail.com). This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Country Report (2012-13)

Myanmar Medical Association

- Founded in 1949
- Only professional organization of qualified medical doctors in the Republic of Union (ROU) of Myanmar
- Registered, Non-political, Non-governmental, Non-profitable organization
- Operates with its own budget, generated from its activities and membership fees

Main Activities

1. Education and Training towards the CME accreditation.
2. Clinical and Public Health Research with ethical and professional needs and standard.
3. Community Healthcare including public health projects, health promotion including reproductive health.
4. Maintain high professional and Ethical standard among members.
5. Collaboration and coordination with medical societies in the region as well as outside the region.
6. Partnership approach with allied medical societies, INGOs, NGOs inside the country.
7. Encourage and support total capacity building of the association at all level with professional aspiration.

Activities 2012-13

1. 59th Annual Conference in 2013 was held in Mawlamyaing, the fourth city of Myanmar.
2. 19th Surgeons' Conference was held in November 2013 at Mandalay, the third city of Myanmar.
3. 10th O&G Conference was held in February 2013 at Yangon, the second city of Myanmar.
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7. 9th Rehabilitation Medicine Conference was held in October 2012 at Yangon.
8. 2nd International Pain Seminar was organized by the ROU of Myanmar and was held in January 2013 at Yangon.
9. 3 Academic Projects, and 18 Public Health related Projects funded by various International Donor Agencies including MyMA itself, covering 80 townships in the fields of Reproductive Health, Youth, Malaria, TB, Statics & Mobile Health Care Services, etc.
Health education and health promotion (public talks, hand on training)

Health information dissemination for doctors as well as public

Youth Training Programme

Clinical competency skill (PTC, Surgery, Ortho)

10. Support Group for Elderly Doctors (SGED), care about doctors over the age of 70 with sick support, social visit, regular medical check-ups, social gathering, support in cataract operation, and at funeral
11. Lady Doctors’ Section also organized in paying homage to the elderly doctors residing in Yangon in every December of the year (recent data is 340 doctors above 75 years of age).

12. Emergency Ambulance Service has been established and initiated and has an appreciable performance in Yangon by Myanmar Medical Association with charity supports.

in collaboration with
- United Nations for Population Fund (UNFPA)
- World Health Organization (WHO)
- United Nations Office for Program Services (UNOPS)
- Three Diseases Fund (3D)
- Global Fund (GF)
- German Fund
- Population Services International (PSI)
- Bill Gate & Melinda Foundation (BGMF)
- The Nippon Foundation, Japan
- United States Aid International Development (USAID)
Nepal Medical Association

Dr. Anjani Kumar Jha
President
Nepal Medical Association
nma.org.np

Nepal at a Glance

• Nepal is a landlocked country between India and China.
• It has great variation in languages, religions, ethnic groups, culture and traditions.
• This is the country where Gautam Buddha was born in Lumbini and World’s highest peak the Mt. Everest.
• It has the population 28 million.

Nepal Medical Association

• Nepal Medical Association (NMA) is the largest, non-political and not-for-profit professional organization of Nepalese Doctors.
• It was established on 4th March 1951.
• The main aim of NMA is the unity, fraternity and service to medical and dental professionals in the country.

*1 President, Nepal Medical Association, Kathmandu, Nepal (info@nma.org.np).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Nepal Medical Association

- It helps government to formulate Health Policies, Act & its amendments and their effective implementation.
- NMA advocates "health for all" in Nepal.
- NMA has 14 branches all over the country and has granted affiliations to more than 30 subspecialty Societies.

NMA Achievements

- Establishment of Nepal Medical Council through 1963 ANEMECON
- Establishment of Department of Drug Act through 1963 ANEMECON
- Various health policies, act and regulations

NMA Central Office

NMA Activities

- NMA is conducting various academic activities all over the country through its 14 NMA Branches
- It conducts interactions and discussion programs with different organizations on various health issues.

NMA Activities

- Scholarship program for Under Graduate and Post Graduate Medical students.
- Scholarship for late Life Members children.
- NMA has guest house for its members.

Journal of Nepal Medical Association

- Journal of Nepal Medical Association (JNMA) is an official publication of NMA since 1963.
- JNMA is the first and oldest medical journal from Nepal and freely available online.
- It has been indexed in the MEDLINE/PubMed since 2005.
- JNMA is being published quarterly and distributed freely to its members.

www.jnma.com.np
Current NMA’S Activities

NMA Consultative Meeting on Revision of NMC Act and Regulation

NMA Welcomes New Health Minister
Current Proposed NMA Activities

- Digitalization of Journal of Nepal Medical Association of last 50 years
- Regular trainings for Medical Journal editors, authors, peer reviewers, authors & researchers
- Implementation workshop for Health Professional Protection Act
- Advocating various health challenges and health equity in the country
Current Proposed NMA Activities

- Workshop on The Importance of District Coverage and Primary Health Care Services
- Workshop on Medical Waste Management
- Construction of new NMA building
- Interaction with Health Journalist to improve health reporting
- Advocacy for implementation of CME/CPD system for doctors in Nepal
PHILIPPINE MEDICAL ASSOCIATION

Leo O. OLARTE

My dear colleagues in the medical profession, allow me to report on the various undertakings and thrusts pursued by the Philippine Medical Association.

The PMA is the umbrella organization of physicians in the country with a current membership of 70,000 of which 34,000 are in good standing. It is the only Accredited Professional Organization in the field of medicine recognized by the Philippine Professional Regulation Commission.

It consists of 17 regions, each headed by an elected regional governor, organized under them are 118 component societies scattered all over the nation. At present, there are 8 specialty divisions, 74 specialty and subspecialty societies and 38 affiliate societies.

However, not all of the doctors in the Philippines are members of the Association. PMA’s membership at present consists of about 65–70% of the total number of physicians registered with the Professional Regulation Commission, which still include those who have died, retired or migrated in other countries.

Of the members who are in good standing, 50% of our membership has not been actively involved in the activities of the Association.

As physicians, our main priority is our patients whom we have sworn to serve; but as leaders of our associations, our main priority is to take care of our members and safeguard their interests.

In order to be relevant in the eyes of our members, the PMA Board of Governors developed programs that focused on making each physician feel the importance of being a member of the PMA. At the same time, make them proud again as Filipino physicians who are regarded by his patients with the highest level of respect and dignity.

- Membership Benefits and Professional Development
- Continuing Medical Education
- Legislative and Political Agendas
- Socio-Civic Activities and Advocacies

Membership Benefits and Professional Development

We want the members to have a sense of belonging to the Association taking care of their needs, and protecting their interests.

The Mutual Aid Benefit Program (Death, Disability, and Legal Aids) has been increased for the members and their beneficiaries.

The PMA is doing all it can to remind our members to take care of their health and that of their families. “We can never keep the Nation healthy unless we are healthy ourselves.”

The PMA and all its specialty divisions have also worked hard to negotiate with our National Medical Insurance System or Philhealth to increase the benefits it gives to our physicians for professional services rendered to their members.

The Association has made improvements to our Doctor’s Inn. It provides a decent and affordable place for our physicians to stay while in Metro Manila. Our auditorium and meeting rooms are also made available to our members and their friends for social gatherings and business meetings at very affordable costs.

The PMA Code of Ethics was amended to strengthen further the ethical conducts of physicians and put a stop to the commercialization of the practice of medicine, a controversy that has tainted the good image of the Filipino physician here and abroad.

The code prohibits a physician from commercially endorsing any health products to maintain his independence and integrity.

The Code also protects fellowship among physicians by prohibiting Filipino doctors to charge

*1 President, Philippine Medical Association, Quezon City, Philippines (info@philippinemedicalassociation.org).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
professional fees to fellow physicians and the immediate members of their family who are financially dependent on them.

**Continuing Medical Education (CME)**

It is one of the backbones of activities of the PMA. As a main provider of CME units, the PMA sees to it that it provides various avenues in updating the skills, knowledge and competencies of our members.

The various specialty divisions and all the specialty societies under them also hold their own regular scientific activities to update their members relative to their specialties.

All of these are being done to ensure the global competitiveness of the Filipino Physician.

**Legislative and Political Agenda**

Our LEGISLATIVE AND POLITICAL AGENDA is focused on ensuring that good legislative bills beneficial to the health of our people as well as the practice of medicine are passed in Congress.

1. Together with the allied health professionals, civil and religious societies, we have successfully worked for the approval of the Sin Tax Bill, a tax that is levied on activities or goods considered physically or morally harmful, such as cigarettes, gambling and liquor.

Many believed it was impossible to pass the sin tax bill as those blocking its passage were strong, noisy, and organized.

But it was ultimately hard work and unity that prevailed and made the day for the sin tax measure. The bill will significantly increase the prices of cigarettes and liquor in the country.

2. The PMA together with various medical associations called for a total ban on the manufacture and sale of electronic cigarettes or e-cigarettes, which allegedly deliver unwanted chemicals into the body and could cause cancer and other deadly diseases. E-cigarettes, are now flooding the market and even sold by sidewalk vendors such that the government should take drastic action to protect non-smokers, particularly children.

3. Passage of Physicians Act 2013 to amend the Medical Act of 1959, making it more relevant to the demands and needs of the present time. It also contains the Integration of the PMA, which will make it mandatory for physicians to become members of the PMA before they can practice medicine in the country.

**Socio-Civic Activities and Advocacies**

Our country was recently devastated by a series of typhoons. The PMA took the lead in organizing relief operations and medical missions in different parts of the country alongside with other government agencies.
Membership

The Singapore Medical Association (SMA) currently has 6,589 members and is growing. There are approximately 11,000 registered medical professionals and about 1,700 medical students in Singapore. As membership is voluntary, it is a constant challenge for SMA to recruit and retain members. To attract new members, some strategies SMA has adopted include increasing the suite of courses available to membership, increasing the number of professional and social engagement activities, and waiving membership fees for medical students and spouses (who are doctors) of current members.

Events

SMA aims to create tangible benefits and refresh professional competency for members through the events it organises. These events focus mainly on professional ethics, while others are related to medical practice or lifestyle activities. Events held in 2013 include the SARS 10th Anniversary Symposium, 44th SMA National Medical Convention: Staying in the Pink of Health, SMA Lecture 2013: Developing Singapore as an International Medical Centre, Medical Experts Training Course, Workplace Safety and Health workshops, and Annual Golf Tournament.

SMA Centre for Medical Ethics and Professionalism (CMEP)

SMA CMEP aims to develop and promote the art and science of medical ethics and medical practice for the betterment of patient care and public health. The teaching faculty includes doctors from various specialties and lawyers with experience in medico-legal cases. CMEP organises courses on medical confidentiality and consent, medical negligence, professional misconduct and dispute resolution.

Publications

SMA’s two monthly publications, the Singapore Medical Journal (SMJ) and SMA News, have each undergone improvements. For example, SMJ has implemented an article processing charge (waived for members and invited articles) to manage the cost of administering peer reviews. Meanwhile, SMA News has new columns like From the Heart, which provides charitable organisations with complimentary advertising space to promote volunteerism among members and match volunteers to volunteering opportunities available.

SMA Charity Fund (SMACF)

SMACF, an entity separate from SMA, was set up in 2013 to consolidate SMA’s charitable activities and spearhead new initiatives, in order to make a positive impact in the healthcare landscape. The SMA Medical Students’ Assistance Fund, which is under SMACF’s umbrella, will support students of all three local medical schools. SMACF also aims to provide support for public health education, mentorship in medical research, exposure of needy medical students to overseas education and elective programmes, and volunteerism amongst the profession and students.

*1 Council Member, Singapore Medical Association, Singapore (sma@sma.org.sg).

This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
COUNTRY REPORT

SINGAPORE MEDICAL ASSOCIATION

MEMBERSHIP

- 6,689 members and growing!
- Approximately 11,000 registered medical professionals in Singapore and about 1,700 medical students.
- Total membership of the Singapore Medical Association (SMA) represents approximately 50% of all registered medical practitioners in Singapore.
- Waiver of membership fees for medical students.
- Waiver of membership fees for spouse of members if they are also doctors.
- Challenge: Recruitment & retention as membership is voluntary.

84th SMA COUNCIL (2013-14)

President: Dr Virin Poon Nang
1st Vice President: Dr Lai Kwong Soon
2nd Vice President: Dr Lai Kwong Soon
Honorary Secretary: Dr Koh Wei Jia
Honorary Treasurer: Dr Lim Kheng Gin
Honorary Asst Secretary: Dr Lai Kwong Soon
Honorary Asst Treasurer: Dr Lai Kwong Soon

The current SMA Council is made up of a mix of doctors, in public and private practice, doctors-in-training and experienced doctors, general practitioners and specialists.

ACADEMY & EVENTS

- Aim: Refresh professional competency and creating tangible benefits for members.
- Focus on ethics, SMA Centre for Medical Ethics and Professionalism (SMA-CME) - practical issues, e.g. taxation, workplace safety & health, healthcare assistant course.
- Member-centric lifestyle activities, e.g. sports, leisure events.
- Partnering with other organisations, e.g. Medical Protection Society, Medico-Legal Society.
- Challenge: Staying relevant to needs of doctors and changing landscape.

MAJOR EVENTS

- 9 Mar - SMA Lecture 2012 - "Euthanasia: A Matter of Life or Death?" Chief Justice Sundaresh Menon
- 11 May - Annual Dinner - Guest of Honour, Minister for Health
- 31 May - SAMS 10th Anniversary Symposium
- 31 Aug - Medical Convention for doctors and public: "Staying in the Pink of Health, a Convention for Women and All Who Love "Thems"
- 20 Oct - SMA Lecture 2013 - "Developing Singapore as an International Medical Centre"
- May 2014 - MASEAF meeting in Singapore

OTHER EVENTS

- Ethics course for doctors-in-training [compulsory for all doctors training to be specialists].
- Risk Management Workshops, in partnership with the Medical Protection Society (MPS)
- Medical Experts Training Course [medical reports, expert witness in court, etc].
- CPR & AED Courses.
- Tax Obligations of a Medical Practice.
- Workplace Safety & Health Workshops.
- Lifestyle events: Like Annual Golf Tournament, Social Dance Night, Wine Chapter Dinner.
SMA CENTRE FOR MEDICAL ETHICS AND PROFESSIONALISM (SMA CMEP)

- To develop and promote the art and science of medical ethics and medical practice for the benefitment of patient care and public health
- Domain knowledge: Professionalism, Medical Ethics, Health Law, Medical Practice
  - Medical Confidentiality & consent
  - Medical Negligence & Professional Misconduct
  - Dispute resolution
  - Medical Report Writing, expert witness
  - Death Certification
- Teaching faculty: doctors from various specialties and lawyers with experience in medicolegal cases
- Resource articles on SMA website, and dedicated column in monthly newsletter

PUBLICATIONS

Singapore Medical Journal (SMJ) — scientific journal

- New features
  - Article processing charge – manage cost of administering peer-review
  - CrossRef membership and article DOIs – enhance online search of published articles
  - Subscription to CrossCheck powered by iThenticate – curtail scholarly plagiarism and duplicate publications
  - E-pub ahead of print – ensure timely publication of authors’ research findings

SMA News — members’ newsletter reporting on current local medical landscape
- Both published monthly
- Special themed issues focusing on specific topics throughout the year
  - E.g. SMJ – Pediatrics
  - E.g. SMA News – Doctors-in-Training
- Challenge: coordinating print costs and keeping publications in public domain

PUBLICATIONS

SMA CHARITY FUND (SMACF)

- Separate entity, newly set up in 2013 to consolidate charitable activities of SMA and to spearhead new initiatives
- SMA Medical Students’ Assistance Fund under the SMACF will be supporting students of all 3 medical schools: Needs-centric rather than school-centric
- Currently at fund-raising stage
- Over the horizon:
  - Research project; cost of living expenses
  - Promote volunteering amongst members and matching to opportunities available
- Challenge: making a positive impact in the healthcare landscape

THANK YOU
TAIWAN MEDICAL ASSOCIATION

Ming-Been LEE,¹ Ching-Chuan SU²

Contents
1. Beijing Liaison Office Open
2. TMA to Host 2016 World Medical Association General Assembly
3. Research Projects Commissioned by the Government in 2013
4. Holistic Care
5. Medical Error Mediation and Compensation Act
6. Preparation for Long-term Care in an Aging Society
7. Professionalism in the Community towards a Safe and Quality Healthcare Environment

The 28th CMAAO Assembly & 49th Council Meeting
- Country Report -

Ming-Been LEE, M.D., Immediate Past President
Ching-Chuan SU, Ph.D., President
Taiwan Medical Association

Beijing Liaison Office Open
Date: 28th January, 2012
Place: Beijing Formosa Women’s Hospital
Purpose:
● To enhance academic exchange.
● To effectively improve medical technology and service in China.
● To foster positive development through cooperation between Taiwan and China and in turn benefit the patients.

TMA Host the World Medical Association of 2016 General Assembly

Date: 19th ~ 22nd Oct., 2016
Place: Taipei City, Taiwan

¹ Immediate Past President, Taiwan Medical Association, Taipei, Taiwan, R.O.C.
² President, Taiwan Medical Association, Taipei, Taiwan, R.O.C. (intl@tma.tw).
This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Research Projects Commissioned by the Government in 2013

- Food and Drug Administration:
  Prescription behavior and drug use attitude of sedative drugs, a research on improved system of controlled drug management

- Council of Labor Affairs: 
  Physicians’ Work Stress Inventory Development and Survey

Holistic Care

Article 44 of the II National Health Insurance Act

The major reformation of NIH Payment System:
- The family physician system
- Based on capitation payments

Purpose:
- To be Achieved by the Expanded Project of Integrated Family Physician Care
- provision of patient-centered care

Medical Error Mediation and Compensation Act

- The have been prepared by the Executive Yuan on 13 December, 2012 and All articles have gone though the first round review by early 2013.
- Reference on “No-Blame Patient Injury Compensation System” (New Zealand and Scandinavian countries) and fit in the local context. “Medical Error Mediation and Compensation Act” (draft)

Preparation for Long-term Care in an Ageing Society

TMA organized the Long-term Care (LTC) CME Courses:

<table>
<thead>
<tr>
<th>Year</th>
<th>Course of CME</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Level II</td>
<td>Training 577 physicians</td>
</tr>
<tr>
<td>2011</td>
<td>Level I</td>
<td>Training 2,435 Health workers</td>
</tr>
<tr>
<td>2012</td>
<td>Level II</td>
<td>Training 600 physicians</td>
</tr>
</tbody>
</table>

Plan:
TMA plan to organize the LTC CME Courses 2013 in order to train more medical professionals in long-term care

Professionalism in the Community towards a Safe and Quality Healthcare Environment

“Safety & Quality in Health Care Series” Workshops
- 559 conferences were held by July 2013.
- More than 100,000 participants over 5 years.
- Including the web-based CME and correspondence CME through Taiwan Medical Journal, the participants are more than 200,000.

감사합니다
THE MEDICAL ASSOCIATION OF THAILAND

Wonchat SUBHACHATURAS*1

In 2012–2013, the Medical Association of Thailand conducted its activities in 4 levels.

1. **Within the Medical Association**
   1) The Medical Association acts as a mediator for the integrated collaboration of the 5 leading healthcare agencies, composes of:
      • The Ministry of Public Health
      • The Thai Medical Council
      • The Medical Association
      • The National Health Insurance
      • The Institutes of Medical Training
   2) Development of the monthly e-medical Journals of the Medical Association which is one of the oldest Journals published in Thailand (96 years old)—**Medassocthai**
   3) Outreaching programme on the Medical Ethics for the medical students and newly graduates (19 Medical faculties).
   4) Granting awards and funds for best practice doctors, researchers, and post graduate study abroad.
   5) Supporting the Thai Health Professional Alliance against Tobacco (THPAAT network with 21 health agencies) to perform their activities and campaigns.
   6) Providing support to members with a legal advisor.
   7) Performing public advocacy through public media.

2. **At the National Level**
   1) Preparedness for the coming ASEAN Economic Community (AEC) in 2015 concerning healthcare provision.
   2) Moving medical services to a pay for performance system (the ministerial policy)
   3) Increase the health warning signs on cigarette packaging to 85% (the ministerial policy)

3. **At the Regional Level**
   1) Visited and attended the National and International Medical Association Conferences
   2) Visited and attended the National and International Medical Association Conferences

4. **At Global Level**
   1) October 10–13, October 2012: Hosted the WMA GA 2012 and 192 & 193 Council sessions
   2) January 13–18, 2013: Attended the WMA Leadership Course at INSEAD institute, Singapore.
   3) February 27–March 2, 2013: Attended and Chaired the Revision of Declaration of Helsinki, Tokyo, Japan
   4) April 2–7, 2013: Attended the 194 WMA Council Meeting in Bali, Indonesia
   5) June 15–19, 2013: American Medical Association

**Next Steps Activities**
   1) August 17–22 2013: 10th Asia Conference on Tobacco and Health (APACT 2013) Chiba, Japan
   2) September 3, 2013: APEC Healthcare Stake Holder Awareness, High Level Workshop, Bali, Indonesia
   3) September 12–14, 2013: 28th CMAAO General Assembly and 49th Council meeting in New Delhi, India
   4) September 17–20, 2013: Leadership and Negotiation Skill Training Course at Sampran Riverside, Thailand
   5) October 10–13, 2013: Midyear MAT Scientific Meeting at Khon Kaen, Thailand
   6) October 15–19, 2013: 64 WMA GA and 195 & 196

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This article is based on a presentation made as the Report of Activities by each NMA at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Council Sessions at Fortaliza, Brazil
- January 2014: AGM of the MAT when the New ExCo. will be elected.

COUNTRY REPORT
THE MEDICAL ASSOCIATION OF THAILAND
28th GENERAL ASSEMBLY & 49th COUNCIL MEETING
CMAAO
NEW DELHI, INDIA
SEPTEMBER 12-14, 2013
WONCHAT SUBHACHATURAS M.D.
PRESIDENT OF THE MAT

Country Report
2012-2013

The Medical Association of Thailand
Under Royal Patronage

Activities
Integrated collaboration amongst the 5 leading health agencies has been implemented. They are

The Ministry of Public Health
The Thai Medical Council
The Medical Association of Thailand

Key contact persons of the Medical Association of Thailand:
Integrated collaboration amongst the 5 leading health agencies has been implemented. They are

The National Health Insurance

The Institute of medical Training

Outreaching Programme on the Medical Ethics for the medical students and newly graduates.

Organizing the MAT AGM on January 19, 2013

I. Award Presentation to the best practice doctors

II. Award Presentation to the Researchers

Organizing the MAT AGM on January 19, 2013

III. Granting funds for post graduate study in Japan sponsored by the Takeda Foundation and the MAT
THAI HEALTH PROFESSIONAL ALLIANCE AGAINST TOBACCO (THPAAT)

Supporting the Network of the Thai Health Professional Alliances against Tobacco (THPAAT) to perform its activities.

- Cover dance step-up contest 2013 on September 15th, 2013

Supporting the Network of the Thai Health Professional Alliances against Tobacco (THPAAT) to perform its activities.

- Antismoking Campaign Awarding to Fah Sai (Clear Sky) Clinics

Cover Dance Anti Smoking
Top of the World, June 8th, 2013
Cover Dance Anti Smoking
Top of the World

Provide support to members with a legal advisor
Public Advocates through public medias

At the National level
Preparedness for the coming ASEAN Economic Community (AEC) in 2015 concerning Health care Provision
Moving medical services to a pay for performance system for doctors
Increase the health warning sign on cigarette packaging to 85%

At the Regional Level
Visit and Attended the National Medical Association Conferences
c. Visited Wu Han University in China, March 21-24, 2013

At the Regional Level
Attending Australian Medical Association National Conference, Sydney, 24-26 May 2013

May 24-26, 2013

At the Global Level
Attending American Medical Association Annual Meeting in Chicago, June 15-19, 2013

At the Global Level

October 10-13, 2012

At the Global Level
Attended the WMA Leadership Course at the INSEAD Institute in Singapore January 13-18, 2013

January 14-18, 2013

At the Global Level

27 February – 2 March, 2013

At the Global Level
Attending the 194th WMA Council Meeting in Bali, Indonesia, April 2-7, 2013

April 2-7, 2013
Next Step Activities

- 17-22 August 2013: 10th Asia Conference on Tobacco and Health (APACT 2013) Chiba, Japan
- 3 September 2013: APEC Healthcare Stake Holder Awareness, High Level Workshop, Bali
- 12-14 September 2013: 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India

Next Step Activities

- 17-20 September 2013: Leadership and Negotiation Skill Training Course: Sampran, Thailand
- 10-13 October 2013: Midyear MAT Scientific Meeting at Khon Kaen, Thailand
- 15-19 October 2013: 64th WMA GA and 195 & 196 Council Sessions at Fortaleza, Brazil
- January 2014: AGM of the MAT with the New Ex Co
Symposium

“Be Human Stop Child Abuse”

The following member NMAs made their presentations.

Hong Kong Medical Association
Indian Medical Association
Indonesian Medical Association
Japan Medical Association
Korean Medical Association
Singapore Medical Association
Taiwan Medical Association
The Medical Association of Thailand

(Listed in alphabetical order of the country name)
Be Human—Stop child abuse and life style disorders

Alvin Yee Shing CHAN*1

In Hong Kong, statistics show a decline of child abuse cases.1 The Social Welfare Department and the Department of Health work hard to prevent child abuse and violence at different levels, such as strengthening families value through publicity campaigns and public education programs, supporting children with psychological, child care and residential child care services, and educating parents-to-be and parents of infants and small children with information on parenting, child health and positive discipline.

Non-government organizations in Hong Kong also contribute to provide quality child protection programs of both remedial and preventive in nature, for example, establishing hotline services, providing counseling services and community empowerment.

Even with our extensive preventive measures and awareness programs organized in Hong Kong, there are still cases of child abuse that doctors have the duty to diagnose, being alert of all the clues. The children diagnosed of child abuse have to be admitted to public hospitals, reported to the police, and ordered to be separated from the suspected abusers. The abusers would be prosecuted according to the law if there is evidence. Responsible doctors need to assist in the process, to rehabilitate, testify, and even act as witness in Court.

Speaking of life style disorders, drug abuse and alcoholism are issues of every country and city, which are also related to the occurrence of child abuse cases.

Different strategies are adopted to fight against various life style disorders in Hong Kong.

In order to beat drugs, the Hong Kong Medical Association has organized many certificates courses for family doctors in various districts to help patients with drug abuse problem, public education programs, including road shows, video and slogan competitions, and publication for educational flyers to promote a drug free community.

Alcoholism is not a huge problem in Hong Kong. A Working Group on Alcohol and Health has been drawn up in the government to create a sustainable environment to reduce burden of alcohol-related harm.

Latest statistics show that the daily cigarette smoking prevalence dropped to 11.1% in 2010, the lowest rate recorded since 1982.2 With the effort of Tobacco Control Office of Department of Health, and Hong Kong Council on Smoking and Health, Hong Kong aims at a smoke-free culture.

Different strategies are adopted in accordance with the World Health Organization Framework Convention on Tobacco Control. They include monitoring of tobacco use, prevention policies, clinics to quit tobacco use, increasing tobacco taxes, legislations on smoke-free indoor environments, and prosecuting smokers against the law, etc.

To manage life style disorders, such as hypertension, obesity and diabetes mellitus, the Department of Health promotes health educations in family, school, workplace and community settings, and publishes relevant Hong Kong Reference Frameworks for patients to raise public awareness.

The Hong Kong Medical Association has organized community service days and cooperation with the Hospital Authority to promote Dietary Approaches to Stop Hypertension, aiming at better health in community, through health talks and medical check stations; launched

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This article is based on a presentation made at the Symposium "Be Human Stop Child Abuse" held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Healthy 8000 Steps Campaign to encourage daily exercise, and with the Department of Health, implemented the exercise prescription project training doctors and aroused public awareness. I have written theme songs\(^{3-5}\) to promote public health educations in these areas.

The Hong Kong Medical Association will continue to fight against child abuse, and do our best to prevent life style disorders.

References

Introduction

The UN Convention on the Rights of the Child (UN CRC) (1989) is the most widely endorsed child rights instrument worldwide, which defines children as all persons up to the age of 18 years.1 Defining violence and children protection rights, the Convention declares “States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.”1,2

The World Health Organisation (WHO) has defined ‘Child Abuse’ as a violation of basic human rights of a child, constituting 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. ‘Child Neglect’ is stated to occur when there is failure of a parent/guardian to provide for the development of the child, when a parent/guardian is in a position to do so (where resources available to the family or care giver; distinguished from poverty). Mostly neglect occurs in one or more area such as: health, education, emotional development, nutrition and shelter. ‘Child maltreatment’ sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity. Within this broad definition, five subtypes can be distinguished—physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.3 Failure to ensure child right to protection adversely affects all rights. Besides, Child protection is critical to the achievement of Millennium Development goals (MDG). These MDGs can’t be achieved unless child protection is an integral part of program & strategies to protect children from child labour, street children, child abuse, child marriage, violence in school and various forms of exploitation.

Child Abuse & Neglect (CAN) is a worldwide social and public health problem, which exerts a multitude of short and long term effects on children. The consequence of children’s exposure to child maltreatment includes elevated levels of post-traumatic stress disorder, aggression, emotional and mental health concerns, such as anxiety and depression. A well designed epidemiologic, Adverse Childhood Experiences (ACEs) Study4 revealed a high risk of heart disease in adult survivors of maltreated children, after correcting for age, race, education, smoking & diabetes.

Several developed countries of the world have well-developed child protection systems, primarily focused on mandatory reporting, identification and investigations of affected children, and often taking coercive action. The burden of high level of notifications and investigations is not only on the families, but also on the system, which has to increase it’s resources.5 In these contexts, the problems of child abuse and neglect in India need serious and wider consideration, particularly among the underprivileged rural and urban communities, where child protection systems are not developed—or do not reach.

Magnitude of Problems, Challenges & Types of Child Abuse

India has about 440 million children; they constitute

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This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
more than 40 percent of the population. Each year, 27 million babies are born. Many face unsafe birth, and many do not survive them. Many more struggle through childhoods of privation and risk, and fail to reach their full potential. As the poor vastly out-number the non-poor, a large majority of these births are among the underprivileged section of the population, where the parents cannot provide proper care to their children. The situation of the newborn and the periods of infancy and early childhood are particularly critical and the morbidity and mortality rates continue to remain very high. Maternal under-nutrition, unsafe deliveries, low birth weight babies and poor newborn care, lack of adequate immunizations, poor nutrition and unsafe water, neglect of early development and learning opportunities are major issues that need to be appropriately addressed.

One can argue that many of these deficits are of under-development rather than of safety, but this is debatable: childhood rights must include protection against neglect and negligent treatment, and the denial of services is negligence. Social and cultural defaults in child-rearing practices reflect social norms and very often adverse traditions are passed from one generation to the next, especially in illiterate and poorly informed communities, and are extremely resistant to change. As guardians of health, the Indian Medical Association (IMA) has to plan and manifest its effort to address child abuse in this reality. The declaration to 'be human and stop child abuse' is not for a single conference, but for an honest professional effort to try out and evolve an approach that can actually change children's prospects of safety and well-being. This effort must compete with many entrenched problems. It must apply professional skill and ethical determination, to bring forward offer viable solutions for this national challenge.

**An obvious challenge is that of magnitude**

The numbers in need of care and protection are huge and increasing. Extreme poverty, insecurity of daily living, illiteracy and lack of education, result in very little care to the child during the early formative years. Even services that are operating nation-wide, and are mandated to offer free or virtually free services are poorly run and often poorly utilized. The financial allocation for health care is far too small, despite some increases. The allocation of attention to health surveillance and to the social aspects of public health seems even smaller.

The urban under-privileged, large migrating populations and neglected rural communities are particularly affected. In large cities, there is more physical infrastructure and availability of basic services, but major inequalities in access and genuine coverage. Pavement communities, including street children on their own, and child labourers employed in menial and un-protected work are especially at risk and without support. Migrants and their children seem invisible to services that require the so-called “client” to produce proof of a location address. Other children in difficult circumstances such as those shut away in institutions, those affected by disasters, those in conflict zones; refugees, HIV/AIDS-affected, and children with disabilities need appropriate care and rehabilitation.

The Central budget allocation for child protection has never even reached 50 paisa (half a rupee) of every 100 rupees pledged for social development. This grave resource challenge calls for re-examination. It also calls for stronger voices from the public and medical constituencies.

Absence of monetary investment and lack of economic capacity are important concerns. But child abuse knows no class or livelihood barriers, or age buffers. It threatens and afflicts children up and down the economic ladder, and up and the 0–18 age spectrum. The IMA recognizes the need for diagnostic detection of children at risk—and the importance of finding ways to act to help children who appear to be at risk.

A Government of India, Ministry of Women & Child Development (2007) survey showed that the prevalence of all forms of child abuse is extremely high (physical abuse (66%), sexual abuse (50%) and emotional abuse (50%). A more recent study by the National Commission for Protection of Child Rights (NCPCR), conducted amongst 6,632 children respondents, in 7 states; revealed 99% children face corporal punishment in schools.

**Indian Medical Association Perspective**

The term “protection” relates to protection from all forms of violence, abuse, and exploitation. This underlines the importance of anticipating and averting what might happen to damage and demean a child—not just response to hurt
inflicted. Moreover, it calls for a deeper and wider comprehension of what protection means. Based on our understanding, the Indian Child Abuse, Neglect & Child Labour (ICANCL) group and IMA has strongly propagated the view that “protection” must also include protection from disease, poor nutrition, and lack of knowledge, in addition to action against abuse and exploitation. This infers that the denial of such safeguards does constitute negligence or neglect, both of which are included in the internationally recognized definition of violence.

The 9th ISPCAN Asia Pacific Conference of Child Abuse & Neglect (APCCAN 2011) conference outcome document “Delhi Declaration” re-affirmed and pledged a resolve to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination. It urged and asserted the urgent need to integrate principles, standards and measures in national planning processes, to prevent and respond to violence against children.

The concept of a ‘caring community’ as children’s right, conceived by eminent Indian public health expert Dr. Eric Ram a generation ago, argues that every sectoral entity, every service or infrastructure touching a child’s daily life—and every person in any of these—every arm of the State and its institutions—has the potential to be a ‘caring community’ for children. It is an issue of attitude, of not just giving care to the child, but caring about what happens to a child, and thus honouring the ethics that should guide any dealings with any child.

India’s Approach to Promotion & Protection of Children

The Government has assigned focal responsibility for child rights and development to the Ministry of Women and Child Development (MWCD). The sectoral management of schemes by this and other central ministries has not given children the convergent attention they deserve. Health care services are in one sectoral portfolio, child development and nutrition in another, youth services affecting older children in another, and education in yet another, and services for children with disability parked in yet another, and projects for children rescued from labour in yet another. The focal point ministry has not so far managed holistic coordination of planning, programming and monitoring very effectively. The National Commission for Protection of Child Rights, set up in 2007, enquires, investigates, and recommends but lacks autonomy and any authority to act. The same limitation holds for State-level commissions.

NGOs and civil organizations and forums

India has a strong presence of non-governmental bodies, networks, community-based organizations, civic forums and peoples’ campaigns. In recent years, these organizations and platform have sharpened their focus on protection issues. The news media are also increasingly alert in playing a watch-dog role.

Having accepted the treaty obligation of implementing the UN Convention on the Rights of the Child in 1992, the Government of India has reported thrice to the UN on national effort to realize these rights. Its latest (2011) report lists some welcome forward-looking legislations and actions, but unfortunately lacks information on impact of laws and programmes and actual benefits. The official routing of services and communications to the family as the receiving unit fails to address the need to reach children placed in any situation or setting other than a family or household location. Children must be sought and reached where they are, not where they should conventionally be. The IMA can see this as a working challenge in trying to access children in need—in institutions, in street groups, in work-places, on the move, or even in prisons. Linkage with NGOs connected to such kinds of settings may be considered as an outreach option.

General Measures of Implementation

To address national child right commitments, several policies, laws and programmes have been introduced. The core commitment is still the one that India enshrined in the Constitution: to safeguard children ‘against exploitation and from moral and material abandonment.’ A new National Policy for Children (2012) has just replaced the 1974 policy. That hallmark expression of commitment recognised children to be ‘a supreme national asset’ and accorded ‘paramount importance’ to their best interests in all situations of dispute. The new policy also expresses firm commitment to children’s rights, but gives their
interests ‘primary’ rather than ‘paramount’ status. The past decade has produced some positive official assertions of commitment. (See Note to the report). The challenge predictably lies in translating policy into programmes, and then carrying programmes into practice. The State’s development enterprise in India also urgently needs good monitoring and regular reporting. Much of the data given in official national reports is old, and some of it is consequently not representative of existing realities. This must improve.

**Effective Systems for Child Protection**

Whose responsibility is it to ensure the safe, protective and caring environment that every child deserves? Ideally, the parents should be responsible for proper care and protection of their child. Every birth should be planned and all births registered. However, the child must not suffer in case the parents cannot provide care and protection. It is the duty of the proximate community and the Government at large to address the issues of care and protection. In this responsibility, the State and its institutions must function pro-actively at all levels of governance and service.

The UN CRC does not absolve either family or community or society at large of care and protection of children. But it firmly puts the onus on the State. Governments are the ultimate duty bearer. In India, the State should ensure that all vulnerable children have the assurance of the best anticipatory, preventive and restorative protection of their right to life, survival, well-being and dignity. India’s new National Policy for Children reaffirms the promise of the original 1974 policy in pledging protective care to children “before, during and after birth and throughout the period of growth.” In practical terms, this must include access to comprehensive health care and nutrition, learning and play, social welfare and the protecting hand of law. Integrated child protection systems can contribute to breaking the cycle of childhood insecurity and exploitation.

**Role of Government**

India should not need to be reminded that the ultimate responsibility to protect a nation’s children lies with the State. The Constitution of India recognised and affirmed this in 1950, by pledging to safeguard children against “exploitation, and moral and material abandonment.” By ratification of international instruments such as UN CRC, by recognising international standards such as UN General Comment #13, the Government should commit appropriate legislative, administrative, social and educational measures to prevent and protect children from maltreatment. In 1992, India accepted the obligations of the UN Convention on the Rights of the Child (CRC). The National Commission for Protection of Child Rights (NCPCR) was established in 2007 with a mandate of enquiry and investigation. However, there is a wide gap between (i) policy and implementation and between (ii) practice and outcome, and millions of children fall through the gaps. Government should assign adequate child protection budgets and its officials should also ensure that Governmental funds are properly utilised. The “child’s voice” must be heard by the policymakers! Both the State and professional bodies must also give more attention to the need for services and schemes to be more than reactive, and become proactively preventive. There may be design faults as well as delivery faults: both require detection and correction. Otherwise health attentions as well as safety attention are only in ‘response’ mode. For many children, this may be too little, and too late.

**Role of Non Government Organisations (NGOs)**

A large number of NGOs are working in the field of child welfare and child protection, and many have created valuable models of prevention, intervention and rehabilitation. However, because of the huge numbers of children requiring protection, their efforts can make only a marginal impact. The larger and central responsibility falls on the State. It is for the State, as well, to bring together different professions and disciplines to make common cause in defense of children’s safety and security. Professional bodies can highlight this potential by taking the initiative to make connections and to converge efforts. This the IMA has set out to do, and the 2013 CMAAO conference is a signal of this resolve.

**Role of the community**

Wherever the parents are unable to take care and protect the child, the proximate community and their elected representatives must take up
more caring responsibility, with due diligence and also due benevolence. Thus, rural panchayats (local self government) and urban local councils can ensure that every child is safely born, receives basic health care and nutrition, and protection from abuse or neglect—and can feel secure throughout childhood. India’s policy assures this. But in practice, even the first moment of survival can fall prey to abusive neglect. This is where the medical professional must be available, aware and attentive.14,15

Education, Empowerment and Enabling Mechanisms: Families and the community must be educated, informed and enabled so that they can provide care and protection to their children. All those entrusted with the child’s upbringing and development must learn that the best approaches are non-violent. Parental guidance and basic support to vulnerable families must be expanded. In India, the Government cannot afford to separate children from their vulnerable families and place them in institutions. Such approaches are also being challenged in more developed countries as well. What most families need is some extra support to cater for their children, in the form of sponsorship schemes, social protection programmes. Awareness of their rights and information about governmental assistance would ensure proper utilization of various “schemes.”16,17

Role of Multi-disciplinary professionals, the private sector, religious institutions: In India, there is also an urgent need for appropriately trained multi-disciplinary professionals and human resources to make services for children viable and effective. Besides these professionals, all educated persons, the private sector and religious institutions can do more for child protection and child welfare. Children are not someone else’s responsibility.

Attitudes, Traditions, Customs, Behaviour & Practices: There is need to understand social norms and traditions and their effect on children and their right to safety—and to condemn harmful practices and support those that are positively protective. A major attitudinal change in civil society is called for. Any institution that senses this should make the first move.

Many protective traditions and practices exist, such as strong family values. However, certain stereotypes, attitudes and social norms that violate the rights of the child also persist, such as the use of corporal punishment as a way to discipline children or the social acceptance of child labour. Other harmful practices associated to gender roles, such as child marriage or gender-biased sex selection, manifest a patriarchal and hierarchic attitude towards girls and women, who are still seen by many as a liability or as paraya dhan (someone else’s wealth or property of the marital family).18 The traditional acceptance of caste and occupational divisions, and the perception that they represent a justified socio-cultural ladder has been legally questioned and limited or banned—but it persists, and imposes an identity-based restriction on many children’s fair access to rights and opportunities. This constitutes abuse. A better understanding of those norms and attitudes, are necessary to promote social change in the best interest of the child.

Recommendations & Plan for a Way Forward

Professional organisations and their infrastructures must not be found wanting in efforts to make India safe for children. IMA is a nationwide entity, with a large membership of trained professionals not only trained to save and safeguard lives, but pledged to do so. The Hippocratic Oath is already a promise made by every medical practitioner, carrying a pro-active commitment to be healers.

Survival, early child health care, nutrition, education, development and child protection are most crucial child rights. In India, child rights, protection and exploitation are intimately linked to socio-cultural and economic inequalities. The deprived sections of society may not know all their rights, and may not have high expectations. But the State does know, and so do professional bodies that all children have equal rights and entitlement to priority attention and care. Multi-disciplinary professionals should step forward and work together to make such attention and care a reality accessible to every child.19

It is important for professionals and their institutions to monitor the government efforts in protection of child rights. They should be able to collate available national child health indicators, address key issues and concerns in their spheres of operation, and promote and support necessary research. They must also monitor their own performance of their own chosen duties and responsibilities. We can be proud of our service to the nation. But there is always
more for us to do. What we now propose is in keeping with our pledge to be the best medical professionals possible.

The prevention of sickness, the relief of injury, the service of relieving pain and suffering, and of both preventing the loss or breakdown of health and well-being, and of restoring them, is already our chosen vocation. The protection of human dignity in facing and overcoming hurt is a part of medical service.

Addressing the underprivileged, vulnerable families and communities as a priority

In the process of voluntary service in under-served regions of our country, some of our IMA members’ learnt some important lessons from the vulnerable families and communities. The most important lesson was that public awareness about child abuse & neglect has to be raised & society attitudes have to change. Children should have knowledge regarding life skills, child rights and participation.

Consistent implementation & strict enforcement of laws

Adequate Legislative framework and their consistent implementation & enforcement are very important. Beyond rationalization of existing laws, the main challenge in India remains their enforcement and the fact that there is a certain degree of impunity for those violating the law. For instance, if one compares the prevalence of child marriage in India (43% of women aged 20–24 were married before they were 18) and the numbers of people prosecuted for violating the anti-child marriage law (a few hundred per year, at best), it is evident that the law is not enforced.18

Medical Professionals: Training on Child Rights and Protection

Medical professionals are specially mandated to report cases of child sexual abuse, under the “The Protection of Children from Sexual Offences Act (POCSO), 2012.” However, the Indian Academy of Pediatrics (IAP) & IMA is aware that hardly any training is imparted to medical students, doctors and allied child health professionals in India on Child Rights and Protection and how to report cases of Child Abuse.21

Therefore, the IAP & IMA has decided to recommend to the Medical Council of India (MCI) (statutory body with the responsibility of establishing and maintaining high standards of medical education and recognition of medical qualifications in India) to advocate necessary changes in curriculum, teaching, training and practice of medical professionals, undergraduates as well.

Medical Professionals to take a stand against Child Abuse

To take a stand against child abuse is not outside our existing mandate. Children are already at our door, silently asking us to recognize them as the persons most vulnerable to the loss of well-being, and the least able to avoid it. We have a job to do.

We—as an association and as a very large number of people who know their job—intend to take up the task we have chosen. Our theme was not an idle or forgetful choice. Our next report should be able to tell how we worked to live up to it.

INFORMATION NOTE TO THE REPORT:

New National Policy for Children (2013). It establishes 18 years as the ceiling age of childhood, and details many of the 1974 policy commitments, adding an affirmation of India’s acceptance of the UN CRC, thus recognising the UN Convention at policy level.

National Policy for Persons with Disabilities (2006). The policy recognises that a majority of persons with disabilities can have a better quality of life if they have access to equal opportunities and effective rehabilitation measures.

Policy Framework for Children and AIDS in India (2007). This policy seeks to address needs of children affected by HIV/AIDS, by integrating services for them within the existing development and poverty reduction programmes.

National Rehabilitation and Resettlement Policy (2007). Under this policy, no project involving displacement of families can be undertaken without detailed assessment of social impact on lives of children.

National Urban Housing and Habitat Policy (2007). The policy seeks to promote sustainable development of habitat and services at affordable prices in the country and thereby provide shelter to children from disadvantaged families.

National Plan of Action for Children (2005). The action plan was adopted in response to the UN
General Assembly Special Session on Children (2002). It lacked specific activities, and implementation fell short of most stated goals and targets. A new national plan is presently being drafted.

National Legislations
The legislative framework for children’s rights is being strengthened with the formulations of new laws and amendments to existing laws. These include the Food Security Act (2013), The Protection of Children from Sexual Offences (POCSO) Act, 2012, Right to Free and Compulsory Education Act (2009), Prohibition of Child Marriage Act (2006), the Commissions for Protection of Child Rights Act (2005), Juvenile Justice (Care and Protection of Children) Act 2000, amended in 2006, Right to Information Act (RTI) 2005, the Goa Children’s (amendment) Act 2005, the Child Labour (Prohibition & Regulation) Act, 1986 (two notifications in 2006 & 2008), expanded the list of banned and hazardous processes and occupation) and the Information and Technology (Amendment) Act 2008. In addition, there are new legislations are on anvil, such as HIV/AIDS bill. The two most important legislations meant to exclusively protect children are the following:

The Juvenile Justice (Care and Protection) Act 2000 (amended in 2006) was a key national legislation. It established a framework for both children in need of care and protection and for children in conflict with the law. This law is presently being reviewed for substantive changes, and may be replaced by a new law.

Harmonisation is needed with other existing laws, such as the Prohibition of Child Marriage Act 2006, the Child Labour Prohibition and Regulation Act 1986 or the Right to Education Act 2009. Important contradictions exist among these laws, starting with the definition and age of the child. Conflict with personal laws should also be addressed, ensuring universal protection of children, regardless of the community they belong to.

Protection of Children from Sexual Offences (POCSO) Act 2012
The Protection of Children from Sexual Offences Act, 2012, specifically address the issue of sexual offences committed against children, which until now had been tried under laws that did not differentiate between adult and child victims. The punishments provided in the law are also stringent and are commensurate with the gravity of the offence. Under this act, various child friendly procedures are put in place at various stages of the judicial process. Also, the Special Court is to complete the trial within a period of one year, as far as possible. Disclosing the name of the child in the media is a punishable offence, punishable by up to one year.

The law provides for relief and rehabilitation of the child, as soon as the complaint is made to the Special Juvenile Police Unit (SJPU) or to the local police. Immediate & adequate care and protection (such as admitting the child into a shelter home or to the nearest hospital within twenty-four hours of the report) are provided. The Child Welfare Committee (CWC) is also required to be notified within 24 hours of recording the complaint. Moreover, it is a mandate of the National Commission for the Protection of Child Rights (NCPCR) and State Commissions for the Protection of Child Rights (SCPCR) to monitor the implementation of the Act. Telephonic help lines (CHILDLINE 1098) and Child Welfare Committees (CWC) under the Juvenile Justice Act (2000) have been established, where reports of child abuse or a child likely to be threatened to be harmed can be made and help sought.

National Programmes
The Government of India is implementing several programmes on social inclusion, gender sensitivity, child rights, participation and protection. The approach is based on UN CRC and Millennium Development Goals (MDGs). These programmes include: Integrated Child Development Services (ICDS), SABELA Scheme for Adolescent Girls, and Saksham project for adolescent boys; Rajiv Gandhi Crèche Scheme for children of working mothers, scheme of assistance to home for children (Sishu Greh) to promote in-country adoption, Dhanalakshmi-conditional cash transfer schemes for girl child, Programme for Juvenile Justice, Child Line (24-hour toll-free telephone helpline (No.1098), Integrated Child Protection Scheme (ICPS), Integrated program for street children, Ujjawala (scheme for prevention of trafficking and rescue, rehabilitation, reintegration and repatriation), Sarva Shiksha Abhiyan National programme for school education, National Rural Health Mission (NRHM), Mid Day Meal Scheme, Jawaharlal Nehru National Urban Renewal Mission
services and strengthen structures, enhance capacity at all levels, create database and knowledge base for child protection services, strengthen child protection at family and community level and ensure appropriate inter-sectoral response at all levels and raise public awareness. The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society. The ICPS is an important initiative, but is still in its infancy.\(^{22}\)

References

2. UN Committee on the Rights of the Child, 56th Session General Comment No.13 (2011) Article 19: The right of the child to freedom from all forms of violence.
Child Abuse in Indonesia: Commitment, implementation, and current situation

Retno SUTOMO*1

1 Member of the Yogyakarta Branch of the Indonesian Medical Association, Java, Indonesia (pbidi@idionline.org).

This article is based on a presentation made at the Symposium "Be Human Stop Child Abuse" held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
CHIlD ABuSe IN INDONeSIA:  COMMITMeNT, IMpleMeNTATION, AND CurreNT SITu ATION

JMAJ, September/October 2013—Vol.56, No.5

The burden of problem

- Indonesian population: 237.6 million
  - ± 34.26% (81.4 millions) children
    (Indonesian CBS, 2010)
- ± 3% children experienced violence
  (CBS & Ministry of women’s empowerment, 2006)

Implementation

- National action plan for elimination of violence against children
- National campaign to stop violence, bullying, and physical punishment at any places
- Guidelines for prevention of child abuse
- Guidelines early detection, reporting, management, and referral of child abuse for health professionals
- Minimum standard service for management of the violence victims
- Training kit of case management of child abuse

The data until 2012

Current situation

- Reported cases
  - 2010 2,426 cases
  - 2011 2,509 cases
  - 2012 2,637 cases
  (Commission for child protection, 2013)
- 58% cases are of sexual abuse
- Under-reported

Child violence by type of violence and gender
(Central Bureau Statistics, 2006)
The role of medical profession and association

- Promote the awareness – prevention, early detection
- Advocate – community, policy maker
- Taskforce for child protection
- Resource expert – guidelines, etc
- Care provider – management of the victims

Future challenges

- Awareness all stakeholders
- Sociocultural barrier
- Intersectoral collaboration
The Child Abuse Prevention Act of 1933 was repealed with the enactment of the Child Welfare Act of 1947 in Japan. However, subsequently child abuse worsened and became a social problem. In response, the Child Abuse Prevention Law was enacted in 2000 with the aims of encouraging measures to prevent child abuse and protecting the rights and interest of children.

Given these circumstances, the Japan Medical Association (JMA) published the Physicians’ Manual for the Early Detection and Prevention of Child Abuse in July 2002, distributed it to all JMA members, and strove to promote it in an attempt to help medical institutions with the early detection of the signs of child abuse and to facilitate its prevention.

Recognizing that countermeasures to Japan’s falling birth rate would be one of the top priority issues in the 21st century, the JMA announced its Child Support Declaration in May 2006 with the aim of supporting the healthy growth of children by promoting the development of medical, health, and welfare environments for mothers and children. The declaration states the necessity of the prevention and early detection of abuse. Meanwhile, according to statistics from the Ministry of Health, Labour and Welfare (MHLW), child consultation centers nationwide responded to 66,807 consultations about child abuse in fiscal 2011, up 11.5% year on year; and the reality is that the number is nearly 2.8 times more than 10 years ago.

Additionally, a fiscal 2008 report on deaths from child abuse compiled by an expert committee at the MHLW points out the increasingly younger age of abused children, especially the high ratio of abuse deaths among babies under the age of one and babies less than a day old.

The JMA thinks that the early involvement of medical institutions is necessary as a way of supporting women from the early months of pregnancy, in order to improve the current situation in which newborns and infants who cannot even call for help are robbed of their lives by their birth mothers and others close to them. Accordingly, the JMA has been co-sponsoring Child Support Forums four times a year together with local medical associations and the SBI Children’s Hope Foundation since fiscal 2011 in an effort to spread and increase awareness of such responses.

*1 Executive Board Member, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Child Abuse Prevention Measures by the Japan Medical Association

CMAOA 28th General Assembly & 49th Council Meeting Symposium “The Human Stop Child Abuse”
New Delhi, India
13 September 2013

Takashi Komori
Executive Board Member
Japan Medical Association

Laws Related to Child Abuse in Japan

1933 Child Abuse Prevention Act
1947 Child Welfare Act
(abolition of the Child Abuse Prevention Act)
in order to prevent increasingly serious child abuse and establish response measures
2000 Act on the Prevention of Child Abuse
2004 Revision of the Act on the Prevention of Child Abuse

Child Abuse Prevention Measures by the Japan Medical Association (JMA)

1. Laws related to child abuse in Japan
2. Definition of child abuse in Japan
3. Current situation regarding child abuse in Japan
5. JMA preventive measure (2): JMA Child Support Declaration
6. JMA preventive measure (3): Child Care Support Forum

Definition of Child Abuse in Japan

Physical abuse
Beating, kicking, throwing, violently shaking, burning, or strangling a child, tying a child up in a room with rope, etc.

Sexual abuse
Sexual acts with a child, showing a child sexual acts, touching a child’s genitals or making a child touch a adult’s genitals, taking pornographic photographs of a child, etc.

Neglect
Shutting a child away in the house, not feeding a child, allowing extreme lack of hygiene, leaving a child in a car, not taking a child to the doctor when he/she is seriously ill, etc.

Psychologic abuse
Verbally threatening or ignoring a child; treating siblings differently; violent behavior against the family in front of children (domestic violence (DV)), etc.

Number of Child Abuse Consultations at Child Guidance Centers Nationwide in 2012

66,807 (preliminary figure)

<table>
<thead>
<tr>
<th>Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of cases</td>
<td>26,569</td>
<td>33,486</td>
<td>34,472</td>
<td>37,823</td>
<td>46,619</td>
<td>42,664</td>
<td>44,215</td>
<td>56,384</td>
<td>59,919</td>
<td>66,807</td>
</tr>
<tr>
<td>No. of child cases (%)</td>
<td>111.9</td>
<td>125.7</td>
<td>103.2</td>
<td>108.2</td>
<td>108.9</td>
<td>105.0</td>
<td>103.6</td>
<td>—</td>
<td>—</td>
<td>111.8</td>
</tr>
</tbody>
</table>

Notes: (1) Due to the effects of the Great East Japan Earthquake, the figure for 2010 does not include the figure for Fukushima Prefecture.

Number of Child Abuse Consultations at Child Guidance Centers Nationwide in 2012

The 9th Report of the Ad Hoc Committee on Verification of Cases of Children Requiring Protection Due to Child Abuse, Etc.

The report focuses on the 85 cases (99 children) of child deaths due to abuse occurring or coming to light during the 12 months between April 1, 2011 and March 31, 2012 that were identified through surveys of prefectural governments conducted by the MHLW of Japan.

<table>
<thead>
<tr>
<th></th>
<th>9th Report</th>
<th>(Reference) 8th Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child deaths due to abuse other than murder-suicide</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Child deaths due to murder-suicide (including attempted murder-suicide)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>Child deaths due to abuse other than murder-suicide</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Child deaths due to murder-suicide (including attempted murder-suicide)</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>82</td>
</tr>
</tbody>
</table>

No. of cases | 56

No. of children | 58

Deaths of Infants Aged under 1 Year Due to “Abuse Other Than Murder-Suicide” (the 9th Report)

- Seven of the infants were aged under 1 day old and 4 of the infants were aged under 1 month old, making a total of 11 (44.0%). This was the largest age group.
- In previous reports, the largest number of deaths of infants aged under 1 year was also amongst infants aged less than 1 month.

Types of Child Abuse (the 9th Report)

(1) Physical abuse ⇒ 38 children (65.5%)
(2) Neglect ⇒ 16 children (27.6%)

- The trend of physical abuse comprising 70% and neglect comprising 30% of cases of child abuse death remains unchanged.
- The cases of child abuse death due to neglect occurred amongst young children aged 5 years or under.

Types of Neglect (multiple responses allowed) (the 9th Report)

<table>
<thead>
<tr>
<th>Category</th>
<th>April 2011 - March 2011</th>
<th>April 2011 - March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of children</td>
<td>Percentage</td>
</tr>
<tr>
<td>Neglecting to pay attention to the child’s health and safety</td>
<td>9</td>
<td>64.3</td>
</tr>
<tr>
<td>Not responding to the child’s necessary emotional demands</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Not providing the child with food or otherwise neglecting the child’s care</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Abandonment</td>
<td>6</td>
<td>42.9</td>
</tr>
<tr>
<td>Overlooking abuse by grandparents, siblings, etc.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Medical neglect</td>
<td>3</td>
<td>21.4</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Main Perpetrators of Child Abuse (the 9th Report)

(1) Biological mother ⇒ 33 cases; 56.9%
(2) Biological father ⇒ 11 cases; 19.0%
(3) Biological mother and father ⇒ 5 cases; 8.6%

For infants aged under 1 month, the “Biological mother” was the main perpetrator in all of the cases (13 cases; 100%), with the percentage of main perpetrators other than the “Biological mother” increasing for children aged 1 month or older.
**Problems of Biological Mothers (1)**  
*(the 9th Report)*  
Problems with the pregnancy period/peri-natal period of biological mothers (multiple responses allowed)  
(1) Mother did not receive prenatal care ⇒ 36.2%  
(2) Unwanted/unplanned pregnancy ⇒ 31.0%  
(3) Pregnancy at a young age (teens) ⇒ 24.1%  
  
Of the cases where the child was aged under 1 day, there were 3 mothers (33.3%) to whom both “Mother was not issued with a maternal and child health handbook” and “Mother did not receive prenatal care” applied.

**Problems of Biological Mothers (2)**  
*(the 9th Report)*  
Mental and emotional problems of biological mothers in cases of child death due to abuse (multiple responses allowed)  
(1) Low nurturing ability ⇒ 41.1%  
(2) Child-rearing anxiety ⇒ 19.6%  
(3) Impulsiveness ⇒ 17.9%  

How much support can be provided to mothers from the early stages of pregnancy?  
⇒ Importance of intervention by medical institutions

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**Recommendations of the 9th Report to the National Government and Local Public Authorities (Extract)**  
1. Preventing the occurrence and/or escalation of child abuse  
   - Improve and publicize systems for counseling regarding unwanted pregnancies  
   - Improve support for households requiring child-rearing support from pregnancy/soon after birth through coordination and cooperation with medical institutions and related organizations  
   - Provide publicity and education about child-rearing and child abuse aimed at young people  
2. Responding early and appropriately to child abuse and improving support  
   - Coordination and cooperation between relevant institutions in areas with different jurisdiction  
3. Preventing reoccurrence through implementation and utilization of verification processes

---

**JMA Child Abuse Preventive Measures (1)**  
July 2002  
- Publication of the “Physicians’ Manual for the Early Detection and Prevention of Child Abuse”  
- Published because of the increasing importance of the responsibility of physicians in the early detection of child abuse due to the rapidly increasing incidence of child abuse  
- Summarizes the results of surveys and analysis of the 573 cases of child abuse reported by medical institutions in 1999  
- Distributed to all JMA members

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**“Physicians’ Manual for the Early Detection and Prevention of Child Abuse”**  
Useful checklist for discovering child abuse early  
- The parent/child does not want to show problem to the physician  
- Explanation for the problem is vague and does not make sense  
- The parent behaves strangely  
- Child is not attached to the parent

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**JMA Child Abuse Preventive Measures (2)**  
May 2006: JMA Child Support Declaration  
- Purpose: To provide support for the healthy growth of children by promoting the improvement of the medical, health, and welfare environments, etc., of mothers and children based on awareness of this being an issue of paramount importance for countermeasures to the falling birth rate in the 21st century.  
- A declaration leaflet was prepared and distributed to all JMA members
THE EffORTS OF THE JAPAN MEDICAL ASSOCIATION ON CHILD ABUSE PREVENTION

JMA Child Support Declaration
Adopted in May 2006

1. We shall endeavor to provide support to those who desire to become pregnant.
2. We shall endeavor to improve the medical environment to enable safer pregnancy and childbirth.
3. We shall endeavor to improve the social environment to enable satisfaction in pregnancy and childbirth.
4. We shall endeavor to improve the medical environment to make child-rearing easier.
5. We shall endeavor to improve the social environment for child-rearing.
6. We shall endeavor to improve school health.
7. We shall provide support for children with disabilities, etc.
8. We shall lobby various government organizations regarding policies for supporting children and child-rearing.

JMA Child Abuse Preventive Measures (3)

- In order to prevent the deaths of children due to abuse, together with early discovery of and response to child abuse through child guidance centers, as in the past, measures are required to prevent abuse from occurring.
- It is essential that society overall works together to prevent child abuse, with schools, government agencies, and medical institutions cooperating to, with regard to unwanted pregnancy, provide sex education and raise awareness; and with regard to pregnancy and after childbirth, publicize and spread information about prenatal care and maternal and child health handbooks, establishing counseling services, and popularizing perinatal visits.

- **Hold “Child Abuse Prevention Forums”**

JMA Child Abuse Preventive Measures (3)

In 2012, the name “Child Abuse Prevention Forum” was changed to “Child-raising Support Forum”

Forums are held 4 times a year with the aim of educating and raising awareness as well as providing information regarding child-raising support and preventing child abuse.

Child-raising Support Forum in Ishikawa

Held on June 1, 2013

In order to prevent child abuse, the assistance system needs to be improved to enable people to easily seek counseling regarding their concerns about pregnancy and/or child-rearing, including coordination amongst various consultation organizations. The forum therefore called for the strong support of the national government and more active involvement by local government authorities. There was also lively discussions of the issue of child abuse.

Thank you for your attention.
Since South Korea ratified the U.N. Convention on the Rights of the Child in 1991, Korean government has enacted laws to protect children from all kinds of abuse. However, recently child abuse has become an important social issue nation-wide after a series of physical and sexual abuse incidents became known. Still, there is controversy over the definition of child abuse, given the differences between eastern and western culture.

The current statistics in 2012 showed that a total of 8,979 cases of child abuse were reported last year. Eighty-seven percent of child abuse occurred in the home, 84% of abusers were the child’s parents, and 41% happened every day. Multiple abuses accounted for 47%, followed by negligence (27%), emotional abuse (15%), physical abuse (7%) and sexual abuse (4%).

The reports of child abuse have been increasing every year. Some causes are thought to be a rise in weak family structures resulting from divorce, remarriage, and poverty-stricken households.

Because there are still a lot of cases that are hidden, there should be more effort put forth in getting better results regarding prevention, early detection, and in setting up well-managed reporting systems of child abuse. First, citizens and the community should all pay attention to neglected children and report abuse in their neighborhoods. This can be done through an educational campaign. Second, inadequate reporting systems should be revised by setting up a mandatory section on EMR so that all doctors can record suspicious cases which will then be reported to the child protective center automatically. Third, the legal limits in restricting parental rights and the monitoring system of high-risk families should be strengthened. Lastly, there must be more facilities to provide care and shelter for the victims. With the enactment of these initiatives society overall can be made better. This will result in the protection of children, and their rights as human beings, against all forms of violence. It is the most important investment we can make for the upcoming generations, and the future of all throughout the world.

*1 Department of Family Medicine, Yonsei University, Severance Hospital; Communication Director of JDN, WMA; Member, Executive Committee of International Affairs, Korean Medical Association, Seoul, Korea (intl@kma.org).

This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Case Reports

Case 1: Physical Abuse to Death
- In 2011, a father beat his three-year-old son to death and dumped the body in a garbage site
- The neighbors said they heard the boy crying almost every day because of the father’s violence.
- If they had reported it to the police, the boy may not have died.

Case 2: Sexual Violence
- In 2005 an 11-year-old girl was murdered.
- The man murdered the girl after he attempted to rape her but failed.
- The man had previously served time in prison for sexual molestation

Case 3: Sexual Violence
- In 2008 a man choked and raped an 8-year-old girl
- The rape was so severe that the victim’s internal organs were exposed externally

Case 4: Child Abuse on Disabled Children
- In 2005 a large scale system of sexual, physical and mental abuse was discovered at a school for students with hearing impairment
- Based on a true story, the movie “Silenced” shed new light on the case

Why is child abuse prevention important?
- Human Beings
- Violence Cycle
- Huge Economical Impacts

Recurrence
Prevention
Dogani Law
**Total Estimated Cost of Child Abuse and Neglect in the United States**

<table>
<thead>
<tr>
<th>Cost Type</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Cost</td>
<td>$33,193,273,133</td>
</tr>
<tr>
<td>Indirect Cost</td>
<td>$70,652,715,359</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>$103,754,017,492</strong></td>
</tr>
</tbody>
</table>

**Hospitalization**
- Mental health care
- Child welfare service
- Law enforcement

**Special education**
- Lost productivity to society
- Mental health
- Health care
- Juvenile delinquency
- Adult criminal justice system

**The Statistics**

**Child Abuse in Korea**

**Child Abuse Increases**
- Increased by 9.9%
- Increased by 10,000

**Rise in**
- Weak family structures
- Poverty-stricken households

**Gender of Victim**
- Male: 54.6%
- Female: 45.4%

**Age of Victim**
- Under 2: 2.4%
- 2-5: 12.5%
- 6-11: 53.0%
- Over 12: 32.1%

**Gender of Abuser**
- Male: 87.7%
- Female: 12.3%

**Age of Abuser**
- Under 2: 0.2%
- 2-5: 2.0%
- 6-11: 1.3%
- Over 12: 96.5%

**Relation between Abuser and Victim**
- Father: 21.4%
- Mother: 18.8%
- Other: 60.0%
History

- 1981 Korean Child Welfare Act
- 1989 Korea Association for Prevention of Child Abuse and Neglect
- 1998 Child Abuse Neglect Prevention Act
- 2000 The first Revision of Korean Child Welfare Act
- 2011 The second Revision of Korean Child Welfare Act

Nationwide Reporting System

1577-1381
24-hour Hotline in the Child Protection Agency
Organizations

Public
- Ministry of Health and Welfare
- National Child Protection Agency (NCPA)
- Local Child Protection Agency
- Ministry of Gender equality and Family
- Salvation child protection center for sexual abuse

Private
- One-stop supporting center
- Korea Association for Prevention of Child Abuse and Neglect
- Good neighbors (resource center of child abuse)
- ChildFund Korea (Group Home)

Efforts and Activities

KMA’s efforts
- Cooperation with child protection agency since 2003
- Hospital-based child protection team
- Guidelines and Manuals

KMA’s efforts
- 24 hour hotline call center
- Training for the experts
- Collaboration with Korean Bar Association for amendment of law
The Changes

Case 1: Physical Abuse to Death

- In 2011, a father beat his three-year-old son to death and dumped the body in a garbage site.
- The neighbors said they heard the boy crying almost every day because of the father’s violence.
- If they had reported it to the police, the boy may not have died.

Case 2 & 3: Sexual Violence of students

- In 2005 an 11-year-old girl was murdered.
- The man murdered the girl after he attempted to rape her but failed.
- The man had previously served time in prison for sexual molestation.

Current the law requires brutal sex offenders to wear a GPS enabled electronic anklet and the disclosing of personal criminal information.

Electronic anklet with GPS http://www.xoffender.go.kr/

“Dogani Law”

- Called “The Unbreakable” in English

The National Assembly passed “Dogani Law”

- Prison terms for those raping the disabled or young children will increase, up to life imprisonment.
- All teachers and doctors with a history of sexual assault are restricted from working in their profession for 10 years.
But still...

Social-Cultural barriers

- Traditional thoughts
- Confucianism
- Familiarism and Paternalism
- Saranged marked (whip of love)

Child Protection Law

- Expansion of family court intervention
- Clear guidelines and criteria for child abuse
- Independent legislation of child abuse and juvenile justice systems

Summary

- The number of child abuse reports has been increasing.
- Most abuse cases are committed by parents at home.
- The rate of isolation and prosecution is too low and most victims are sent back to their own family.
- The current law, public awareness, and the independent legislation should be promoted more vigorously.

Thank you!
Child Abuse and Related Issues in Singapore

Bertha WOON*1

Status of International Instruments


Local Legislation

The Children and Young Persons Act provides the legal basis for the protection and intervention by relevant authorities if a child (below the age of 14) or young person (from 14 years to below 16 years of age) is found to be abused or neglected. Child abuse includes: physical abuse, sexual abuse, emotional abuse and psychological abuse.

For example, under this Act, all Children and Young Persons’ Homes must be licensed. This is to enhance the welfare, care and protection of children and young persons in residential care. The relevant authorities will ensure that these Homes provide these children with safe and conducive living environments, and also that there are proper care plans in place to meet their long term needs.

Reporting of Suspected Child Abuse

The police and Ministry of Social and Family Development will investigate and intervene to prevent further harm to abused children. They will also provide professional assistance to abused children and their families. KK Women’s and Children’s Hospital (KKH) and National University Hospital (NUH) are the hospitals designated for the management of child protection cases.

The Role of Doctors

In a publication titled “Responding to Child Abuse and Neglect,” the Ministry of Health (MOH) acknowledges that it is not easy to diagnose child abuse. Doctors must obtain a combination of evidence like medical findings, history obtained, injury patterns and behaviour of the children and their families. Appropriate medical and social investigations are then required to confirm or elaborate on the diagnosis. MOH therefore suggests that doctors should continue to upgrade their skills in recognising child abuse and neglect.

*1 Council Member, Singapore Medical Association, Singapore (sma@sma.org.sg). This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Status of international instruments

- Note: some reservations made to CRC
- Also a contracting state of the Hague Convention on the Civil Aspects of International Child Abduction

Definitions

- Child abuse is defined as any act of commission or commission by a parent or guardian which would endanger or impair the child’s physical or emotional well-being or that are likely to induce a marked state of continuous anxiety and frustration to be irremediable.
- Child abuse includes:
  - Physical Abuse
  - Neglect
  - Sexual Abuse
  - Emotional and Psychological Abuse
- The Children and Young Persons Act provides the legal basis for the protection and welfare of children and young persons. It makes provision for the care and supervision of children and young persons, the prevention of child abuse, and the appointment of guardians of the person and estate of children and young persons.

Local legislation

Children & Young Persons Act

- Amended in 2011
- Provides for the appointment of children and young persons’ guardians
- Enhances the welfare, care, and protection of children and young persons in residential care
- All children in need of care and protection will be reviewed by a Review Board to ensure that there are proper plans in place to meet their long-term needs
- Members of the Review Board will also conduct visits to the homes to ensure that children have a safe and conducive environment that meets their care and rehabilitation needs
Reporting of suspected child abuse

- Reporting of suspected child abuse is the first positive step in helping to prevent further abuse. Appropriate investigation and intervention will be conducted to prevent further harm to the child.
- At the same time, professional expertise will also be provided to the abused child and the family. For further information or for reporting of child abuse, please contact:
  - Child Protection Unit, 1900-779-0000
  - Welfare Services, 555-377-8888
  - Child Protection Unit, 555-349-1999
  - Child Protection Unit, 555-377-8888
  - or the Police at any police station near where the child was found.
- KK Women’s and Children’s Hospital (KWC) and National University Hospital (NUH) are designated hospitals for the management of child protection cases.

The role of doctors

2005 Ministry of Health publication “Responding to Child Abuse and Neglect” [con’t]

- The diagnosis of child abuse is not easy. It requires a high index of suspicion by the professional who sees the child. It is based on a combination of medical findings that are unexplained, implausible, and inconsistent with the history obtained. Patterns of injury that suggest they have been caused by abuse rather than by accident, and certain characteristics and behaviour of the child and the family. Appropriate medical and social investigations are required to confirm or rule out the diagnosis, and a period of observation of the child’s response may be necessary in non-organic failure to thrive. Medical professionals should continue to upgrade their skills in the recognition of child abuse and neglect.”

The role of doctors [con’t]

2005 Ministry of Health publication “Responding to Child Abuse and Neglect” [con’t]

- Neglect
  - Emotional or Psychological Abuse
  - Sexual Abuse
  - Munchausen Syndrome by Proxy (MSP)

Statistics

Links

- Ministry of Social and Family Development
- Singapore Children’s Society
  - http://www.childrensociety.org.sg/
Children are our valuable national asset. A progress country undoubtedly has to guarantee children free from violence and fear. Since year 2000, the crude birth rate of Taiwan had fallen, from 41.7% in 1958 to 7.21% in 2010. However, news of child abuse is still often heard, one after another. Taiwan part in bulletin of “2010 Country report of human rights practices” by United States mentioned that child abuse is still a common problem. A credible NGO stated that cases of sexual abuse is more frequent than the public perception, with an estimated annual number of 20,000 victims, but only about 3,000 people annually reported.

Official registration data revealed that there is about 0.15% of child, a total number of 7,387 victims encountered abuse at 2004, rising to 0.40% at 2010, a total number of 18,331 victims. Most of the cases were physical abuse, around 35%. About 75% of the abusers were parents. Most of them were 30–50 year-old male with educational level at junior school. The experience of child abuse were brought short-term or long-term physical and mental consequences and pay for great medical and social costs; hence child abuse is not only a social phenomenon, but also an important public health issue.

Effective child abuse prevention strategies which involve different levels, different cultures, different standards of the problem of child abuse, should be conceptualized and quantified using statistical description of abuse in order to understand the overall outlook, to identify the risk and protective factors of child abuse. Effective implementation of child protection services must be based on these knowledge of risk and protective factors. Regardless of what intervention, follow-up assessment is required to determine its effectiveness.

*1 Taoyuan Psychiatry Center, Department of Child and Adolescent Psychiatry, Taipei, Taiwan, R.O.C. (intl@tma.tw).

This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.

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### Definitions of Child Abuse

* The lowest standard of child care in a society.
* “Any recent act or failure to act on the part of a parent or carer, which results in death, serious physical or mental harm, sexual abuse, or exploitation, or an act or failure (to act) which presents an imminent risk of serious harm”

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1. 吳漢維, 兒童虐待--現象檢視與問題反省 (增訂版) ; 皇冠文化公司; 1996.
3. 兒童虐待防治策略─醫療人員教材及關鍵議案委員會報告, 養育虐待及疏忽: 修況人員工作指引 ; 對策法人在親職法研究會 ; 1998.
Table B.1.1 The various types of child abuse*

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Physical harm or injury</td>
</tr>
<tr>
<td>Neglect/maltreatment</td>
<td>Failure to provide for a child's basic needs and development in all spheres</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>Failure to provide a developmentally appropriate, supportive emotional environment which results in impairment of a child's emotional development or sense of self-worth</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>The involvement of a child in sexual activity below the legal age of consent</td>
</tr>
</tbody>
</table>

Exploitation

The use of a child in work or other activities for the benefit of others, for financial gain, e.g., child labor


Table B.1.2 Features of risk factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
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<tr>
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</tbody>
</table>

General Information of Taiwan

- Area: 36,000 square kilometers
- Population: 23 million
- Language: Mandarin, Taiwanese, Hakka, Indigenous Languages
- Religion: Buddhism, Taoism, Christianity, Islam

Age Distribution of Population (2012)

- 0-6 Year-old: 11%
- 7-17 Year-old: 15%
- 18-64 Year-old: 70%
- 65 Year-old and above: 6%

Major Events and Laws related to Child Abuse

<table>
<thead>
<tr>
<th>Year</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>113 protection hotline established, entrusted by social bureau of ministry of interior to World Vision Taiwan.</td>
</tr>
<tr>
<td>1999</td>
<td>Child welfare bureau, Ministry of interior established.</td>
</tr>
<tr>
<td>2001</td>
<td>112 hotline established.</td>
</tr>
</tbody>
</table>

Major Events and Laws related to Child Abuse

<table>
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<tr>
<th>Year</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Conventions on enforcement of child and youth welfare act.</td>
</tr>
<tr>
<td>2005</td>
<td>Hegans of high-risk families monitoring program.</td>
</tr>
</tbody>
</table>
Manpower to intervene
Child and Adolescent Mental Health Allied Professionals in Taiwan

Professionals
- Pediatrician (Board certified): 973 (2013)
- Child psychiatrist (Board certified): 141 (2010)
- General psychiatrist (Board certified): 1,466 (2010)
- Psychologist (Board certified):
  - 649 (2007)
  - 412 (in medical system)
  - Social worker (licensed):
    - 2,200+ (2007)
    - 100~150 (in psychiatry)
  - 55 (in NGO for the youth among 926 colleagues)
- Psychiatric Nurse (Board certified): < 50 (2006)
- Occupational therapist (licensed):
  - 1,000+ (2007)

Child & Adolescent Psychiatric Facilities in Taiwan (2011)
- 67 available child & adolescent psychiatric facilities: 58 hospitals, 9 private clinics.
- Provide totally:
  - 10 inpatient wards (total: 1,857 beds)
  - 14 Day hospitals (total: 473 beds)
  - All have outpatient clinics.

Child Psychiatrists in Taiwan
- Locations: 55% in northern Taiwan, only 20% in the middle, 17% in the south and 6% in the east.
- 3 distant island counties (out of total 18 counties and 2 Special municipalities) have no qualified child psychiatrists.

Fact sheet of Child Abuse in Taiwan

Age distribution of abused child and youth (%)
Chen C-T

Educational level of abusers (%)

Attribution factors of abused victim (%)

Parental factors associated with child abuse

- Unemployment
- Poverty
- Family and marital conflict
- Domestic violence
- Drug or alcohol use
- Trouble with the law
- Previous involvement with child protection services
- Parental exposure to physical abuse or family violence in their childhood

Attribution factors of abuser (%)

Placement of the abused child (%)

Treatment provided at home (%)

112
Prevention strategies

- Educate adults to better protect children
- Galvanize communities to develop support systems for children
- Teach all children appropriate protective behaviors
- Teach high risk children how to use support systems
- Teach abused children who are too afraid to tell that what abuse was not their fault and help with other emotional health issues to minimize long-term negative effects of the abuse
- Prevent child abuse victims of today from becoming offenders of tomorrow.

The role of the physician

- To identify any injury (including ano-genital, extra-genital trauma, other physical signs of abuse or neglect)
- To detect the presence of STD, pregnancy (pregnancy prevention may be indicated in some countries)
- To consider post exposure prophylaxis for HIV
- To identify any other forensic evidence that may corroborate the existence of abuse (e.g., body fluids)
- To accurately record any physical findings and the result of investigations (e.g., through photographs)
- To explain and initiate any necessary treatment
- To rule out psychiatric emergencies (e.g., suicidality).

Thank you for your attention

"It is easier to build strong children than to repair broken men."

Frederick Douglass (1817-1899)
Since 1992, Thailand had ratified the Convention on the Rights of the Child (CRC), both GOs and NGOs have focused on strengthening child protection system to diagnose and prevent repeated abuse. The Police General Hospital aimed to develop both medico-legal investigation and medical management for child abuse, which includes sexual abuse, physical abuse, and mental abuse. Among the three categories of child abuse, sexual abuse is the most traumatized and taboo subject. In the 1990’s, the hospital treated 200–300 cases of sexually abused children between 10 to 14 years old annually. On the other hand, there were only around 10–20 cases of physically abused children annually. Hence, the hospital paid more attention in management of sexually abused children. In 2000, Police General Hospital set up One Stop Crisis Center (OSCC) to develop and integrate medico-legal examination, diagnosis, management, and protection of child abuse more efficiently. The protocol for medico-legal examination, evidence collection, and chain of custody was developed to support police investigation. OSCC set up the protocol of physical examination, diagnosis, treatment, and prevention of sexually transmitted diseases (STD) that covered Gonorrhea, Chlamydia, HIV, and Syphilis. Police General Hospital was the first institution to set up criteria of HIV post-exposure prophylaxis (HIV PEP) and to prescribe anti-retrovirus drugs for sexual assault cases. OSCC could manage STD within 2 hours from investigation. After medical treatment, psychological evaluation and prevention of repeated attack would also be provided by social workers and a multi-disciplinary team. In order to encourage co-operation and standard practice, OSCC established many training courses for physicians, nurses and social workers in examination, diagnosis, treatment, and prophylaxis for STD, especially HIV PEP, and for officers in child interrogation and multidisciplinary team management. Case conferences among a team in the hospital, law makers, officers, and NGO were conducted regularly. Within a decade, the Thai government enacted the Child Protection Act in 2003 and the Domestic Violence Act in 2008. The amendment of the Criminal Code and Criminal Procedure Code was completed in 2008 to further protect children and women. Nowadays, OSCC of the Police General Hospital managed 800–1000 children and youth under the age of 18 (400–500 of which were under the age of 15) annually. Nevertheless, child abuse cases reported to officers are only the tip of an iceberg. The multi-disciplinary team of OSCC will further develop a surveillance and management system and effectively provide both medical and complete forensic evidence for prosecution to stop child abuse.

*1 Chief of International Relations, The Medical Association of Thailand, Bangkok, Thailand (math@loxinfo.co.th). This article is based on a presentation made at the Symposium “Be Human Stop Child Abuse” held at the 28th CMAAO General Assembly and 49th Council Meeting, New Delhi, India, on September 13, 2013.
Stop Child Abuse by
One Stop Crisis Center of the
Police General Hospital
Bangkok, Thailand


Women and Children who came to verify sexual assault
1996-2000

Sexually Abused Children

Defined as the involvement of dependent, developmentally immature children in sexual activities that they do not fully comprehend and are unable to give informed consent

Children = 0-18 years old (CRC)

Problem Tree

Objectives Tree

System of women and child abuse protection

Thai’s Child Protection Law

IL is working in Thai

Victim get proper holistic care

Efficient OSCC

Good police processes

Good coordinate law maker, Pol., OSCC

Early diagnosis

Rapid verification

Pol. Interrogation is not standard

Pol. procedures are fast

Law enforcement was used
Early diagnosis and Rapid verification

Sexual Assault Evidence Collection Kit

Chain of custody

Sexual Transmitted Diseases

<table>
<thead>
<tr>
<th>STD</th>
<th>Diagnostic test</th>
<th>Incubation period</th>
<th>Sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>Urine or swab and culture</td>
<td>3-5 days</td>
<td>diagnostic</td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>Cervical or rectal and urethral culture</td>
<td>5-7 days</td>
<td>diagnostic</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>Vaginal swab and culture of vaginal discharge</td>
<td>5-20 days</td>
<td>very suspicious</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td>Biopsy of lesion</td>
<td>4-7 weeks to 1 year</td>
<td>suspect</td>
</tr>
<tr>
<td>Neisseria gonorrhoea</td>
<td>Specimen from urethra of male</td>
<td>2-3 days, 1 week</td>
<td>specific</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>Smear, stain, Culture</td>
<td>5-20 days</td>
<td>non specific</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Blood for VDRL</td>
<td>10-90 days, 6 M</td>
<td>diagnostic</td>
</tr>
<tr>
<td>HIV</td>
<td>Blood for HIV Ab</td>
<td>3-6 M</td>
<td>diagnostic</td>
</tr>
<tr>
<td>HBV</td>
<td>Blood for HBsAg, HIVAb</td>
<td>3-6 M</td>
<td>non specific</td>
</tr>
<tr>
<td>HCV</td>
<td>Blood for HCV Ab</td>
<td>3-6 M</td>
<td>non specific</td>
</tr>
</tbody>
</table>

Chlamydia Quick Test
Immunochromatographic

Detect Chlamydia trachomatis Antigen

Cervical Smear and Gram’s stain

Gram negative diplococci, intracellular
Diagnosis: Gonorrhoea Infection

Psycho-social support.
Prevent repeated attack

Counseling

Blood testing for HIV VDRL HBV HCV
Child’s protection Law Development

- 2003 Child Protection Act
- 2008 Domestic Violence Act
- 2008 Child Interrogation in Criminal Procedure Code
- 2008 Criminal Code (Option 276)
- 2008 Thai Constitution
Age of pregnant victims in 2009

- Pregnancy test positive: 85 cases
- Minimum age of Pregnant Victims: 12 years old
- Average age of Pregnant Victims: 16.5 years old

OSCC Police General Hospital

Conclusion

UN goal

"Best interest of the child must be primary concern."

Perpetrator of sexual assault children 15-year-old 2010

- Friend
- Boyfriend
- Acquaintance
- Stranger
- Family member
- Teacher, boss, monk, not notify

Perpetrator of sexual assault children 15-year-old 2009

- Friend
- Boyfriend
- Family member
- Neighbor
- Stranger
- Acquaintance
- Teacher/boss, not notify

Criteria for HIV prophylaxis

1. Status HIV Ab negative
2. Verify sexual assault
3. Come to the hospital within 72 hours
4. Rapist's status HIV Ab positive, high risk profile
**Risk of HIV transmission**

1. Virus (Viral load, Virulence, Resistant strain)
2. Route (Anal, Vaginal, Oral)
3. Ulcerative or Inflammation
4. Trauma, Bleeding
5. Times
6. Others; Menstruation, IUD Circumcision

**Probability of transmission of HIV from single exposure**

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous Exposure</td>
<td>0.0032</td>
</tr>
<tr>
<td>Receptive anal</td>
<td>0.008 - 0.032</td>
</tr>
<tr>
<td>Insertive anal</td>
<td>0.006</td>
</tr>
<tr>
<td>Receptive vaginal</td>
<td>0.0005 - 0.0015</td>
</tr>
<tr>
<td>Insertive vaginal</td>
<td>0.0003 - 0.0009</td>
</tr>
<tr>
<td>Receptive fellatio with ejaculation</td>
<td>0.0004</td>
</tr>
</tbody>
</table>

**Triple drugs prophylaxis should be considered in**

- HIV infected rapist
- Anal exposure
- More than one attacker
- Seriously injured victims