I.M.A.G.S.B. NEWS BULLETIN

GUJARAT MEDICAL JOURNAL
INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH
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Dr. Bipin M. Patel — Ahmedabad
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Dr. Jitendra N.Patel — Ahmedabad
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National President's Desk

MY APPEAL

Season's Greetings

Appeal to all Local Branch Presidents / Hon. Secretaries.

(1) PROACTIVE EFFORTS FOR MEMBERSHIP DRIVE.

(2) ACTIVE IMPLEMENTATION OF "AAO GAON CHALEN" PROGRAMME BY ALL BRANCHES.

(3) BLOOD DONATION CAMP.

(4) ACTIVE EFFORTS FOR STRENGTHENING OF YOUNG DOCTOR'S WING.

(5) STRONG BONDING WITH SPECIALITY ORGANISATIONS.

(6) "WELCOME THE GIRL CHILD..." DRIVE.

KINDLY COMPLY POSITIVELY.

Dr. JITENDRA B. PATEL
NATIONAL PRESIDENT, IMA

STATE PRESIDENT'S MESSAGE

Dear friends,

Summer is going, monsoon has established in south India and it will reach to Gujarat in few days. Many parts of Gujarat have received first rain of this season.

Friends, as you have again started your work after summer vacation and adjusted in your routine schedules, but let me tell you **to reserve the dates of last week of December for Indian Medical Association.**

Friends, it is proud moment for Ahmedabad and Gujarat that after the gap of 25 years, National conference of Indian Medical Association will be held in the city of Ahmedabad.

89th National Conference will be held **on 27th & 28th, December, 2014** at Gujarat University Convention Center. More than 2500 delegates from all parts of India are expected to visit the city as they have curiosity to see Gujarat model of health care, as in last few years Ahmedabad has emerged as premium destination of treatment not only in India but globally.

No corporate hospital can afford not to have its presence in Ahmedabad as Medical tourism is also flourishing here.

Ahmedabad as a city is developing very fast and there are many places to visit with historic and religious important as well as for shopping and eating.

I want to share some historic facts about the city of Ahmedabad,

There is a legend associated with Ahmedabad ('abad' means 'prosper').

At the beginning of the fifteenth century (1411 A.D), an independent sultanate ruled by the Muslim Muzaffarid dynasty was established in Gujarat. Sultan Ahmed Shah, while camping on the banks of the Sabarmati River, saw a hare chasing a dog. The sultan was intrigued by this and asked his spiritual adviser for explanation. The sage pointed out unique characteristics in the land which nurtured such rare qualities which turned a timid hare to chase a ferocious dog. Impressed by this, the sultan, who had been looking for a place to build his new capital, decided to found the capital here and called it Ahmedabad.

Ahmedabad is the largest city in the state of Gujarat. It is located in western India on the banks of the River Sabarmati. The city has been under different rulers since its creation and thus had a rich history. The city has been a former capital of Gujarat and has been the home to most important leaders of India like Mahatma Gandhi and Sardar Patel during the Indian independence movement. Ahmedabad is also the cultural and economical centre of Gujarat and the seventh largest city of India.

Organization committee is working very hard to make it memorable for you, I urge you all to register yourself at earliest for same and convey it to your friends also.

More detail about conference is given in this bulletin.

Hope to see you at Ahmedabad.

Long live IMA.

Yours Truly,

Dr. Bipin M. Patel
(President, G.S.B.,I.M.A.)

HON. STATE SECRETARY'S MESSAGE

Dear members,

This year we all have faced the kind of heat wave which we have never faced before. Almost every year it crosses the record of previous year. Don't you feel that same kind of scenario prevails in almost all fields.

Ok, let us start from our own field. Most of our members make new high in their practice in terms of either finance or turnover, or may be both? And whether it does happen or not, but one thing is certain that we all expect such thing to happen. Isn't it? It is true on reverse side also. Take stock market, whether we do or not but it certainly attracts & affects almost all. We are experiencing new range. Real estate, on other side facing huge difficulties. The people we consider (mota matha), are in huge trouble. Prices of almost all essentials are rising like never before. Number of vehicles sale touches new levels. Over all the world is passing through the phase of great recession.

But when it comes from nature, we all resist to accept it. And are we all not responsible by one way or other for such changes in the nature to happen? Of course we know everything & its solutions too. But I am very much sorry to say that when it comes as collective responsibility, then we take our own self deliberately out from that responsibility. We expect others to do something for that. But when there is something for our rights, then we are first to have it. Is it so or not? Just spare few minutes on it & think over.

Anyway, there is one good news that, this year AMA, branch & HQ of GSB is hosting IMA NATIONAL CONFERENCE-2014 after gap of almost

25 years with support of state branch. Dates are 26th,27th & 28th of December 2014. As its a event of our parent body IMA, & a huge event we are organising after so many years, we expect active participation from all of you. You may register as RC member or delegate whichever suits you. You may send your suggestions to make it a memorable one.

Once again invitation is always open for your freedom & self expression on this big platform.

Thanking & anticipating your partenership.

Truely yours,

Dr. Jitendra N. Patel
(Hon. State Secy., G.S.B.,I.M.A.)

* * * * *

For Kind Attention Please

We would like to add following section in our News Bulletin like.....

1. Sport Update
2. Politics Update
3. Humour
4. Movie Update
5. Finance Update
6. Recent advances in Medical Science
7. Use of Information Technology in Medicine.
8. Any other interesting matter which increase readership of our bulletin.

Members who are interested to write on any of the following should contact : **Dr. Jitendra Patel,** Hon. State Secretary, IMA-GSB on
E-mail : drjitendrapatel11@yahoo.com M. : 098253 25200

STATE PRESIDENT-HONY. SECY. & OFFICE BEARERS TOURS/VISIT

25/05/2014 Dr. Bipin M. Patel; President, I.M.A. G.S.B. attended Gastro-Enterology Seminar at Gandhinagar.

07/06/2014 Dr. Bipin M. Patel; President, I.M.A. G.S.B., Dr. Jitendra N. Patel; Hon. State Secretary, I.M.A. G.S.B., Dr. Kirtibhai M. Patel; Chairman NSSS, Dr. Yogendra S. Modi; Hon. Secretary, NSSS, Dr. Ashok D. Kanodia; Convenor, Family Planning attended Indian Medical Association & CMAAO in Collaboration with UNICEF - Symposium on - Child Sexual Abuse, Prevention & Response at New Delhi.

08/06/2014 Dr. Bipin M. Patel; President, I.M.A. G.S.B. attended National Working Group (RNTCP) meeting.

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Member's Information

Dear Members,

As you all know that in today's world, we all need quick & easy communication & data transfer from one to other place. And for that we should have precise destination address. We at GSB IMA have full details of very few members with us. So I request you all to fill up your full details on members information form which we have kept on our website www.imagsb.com. Also pass on this information during your each programme & continuously insist all members until we have information of all members. Expecting your huge support as this is very crucial for our effective communication with all members.

Thank you,

Dr. Jitendra N. Patel
(Hon. State Secy., G.S.B.,I.M.A.)

IMA GSB Students Wing Election

at IMA Hall, Muglisara, Surat (Gujarat)

Date : 24-5-2014 at 3.00pm

Reported by **Dr. Tony Nicholas,** Hon. Secretary, IMA Surat

Observers :

Dr. Pragnesh Joshi,	IPP, IMA GSB
Dr. Tony Nicholas,	Hon. Secretary, IMA Surat
Dr. Mahade Dalwadi,	V.P. IMA Surat
Dr. C. D.Lalavani,	Hon. Treasurer, IMA Surat

The following is the result :

POST	Candidate
1. National Secretary	**Dr. Dhairya Lakhani**
2. President	**Dr. Aayushi Choksi**
3. Vice Presidents	**Dr. Krutin Vyas**
	Dr. Rydham Patel
	Dr. Manthan Kanani
	Dr. Bansi Adroja
4. General Secretary	**Dr. Tarak Patel**
5. Asst. Secreatary	**Dr. Mohit Makwana**
6. Joint Secretary	**Dr. Asim Mansuri**
7. Finance Secretary	**Dr. Sagar Jani**
8. Joint Finance Sec.	**Dr. Himanshu Gadhvi**

Plus 15 executive members are to be selected from various medical colleges of State of Gujarat.

NEW LIFE MEMBERS

I.M.A. GUJARAT STATE BRANCH

We welcome our new members

L_M_No.	NAME	BRANCH
LM/23536	Dr. Ranpariya Ketan Manubhai	Surat
LM/23537	Dr. Shah Kalpeshkumar Kantilal	Surat
LM/23538	Dr. Shah Richa Dishankbhai	Surat
LM/23539	Dr. Chothani Dipak Karsanbhai	Junagadh
LM/23540	Dr. Khatri Mohmadtarek A.	Bhujkutch
LM/23541	Dr. Mistri Samira Ayubbhai	Bhujkutch
LM/23542	Dr. Patel Viranchi Jitendrabhai	Modasa
LM/23543	Dr. Agarwal Vivek Purushottambhai	Surat
LM/23544	Dr. Trivedi Kedar Ajaykumar	Bhavnagar
LM/23545	Dr. Someshwar Tejas Kantilal	Gandhinagar
LM/23546	Dr. Soni Chintan Sunilbhai	Mandvi-Kutch
LM/23547	Dr. Makwana Jignesh Mukeshbhai	Surat
LM/23548	Dr. Sanghani Toral Vasarambhai	Surat
LM/23549	Dr. Rangparia Hardik Ravjibhai	Morbi
LM/23550	Dr. Barasara Mehul Maganlal	Morbi
LM/23551	Dr. Samani Kushal Dhansukhlal	Morbi
LM/23552	Dr. Patel Dharmil Maheshchandra	Surat
LM/23553	Dr. Thakkar Dharitri Dineshbhai	Rajkot
LM/23554	Dr. Doshi Shrenik Rohitkumar	Rajkot
LM/23555	Dr. Sankhala Swastiksinh O.	Rajkot
LM/23556	Dr. Sankhala Shilpi S.	Rajkot
LM/23557	Dr. Patankar Amey Prakashbhai	Vadodara
LM/23558	Dr. Suthar Hetal Maganbhai	Vadodara
LM/23559	Dr. Mahajan Sanket Kaushikbhai	Vadodara
LM/23560	Dr. Patel Hiren Kanubhai	Vadodara
LM/23561	Dr. Vasava Rahul Ramanbhai	Vadodara
LM/23562	Dr. Patel Varsha Prabhubhai	Vadodara
LM/23563	Dr. Patel Rahul Yashvantbhai	Himatnagar
LM/23564	Dr. Patel Kazoomi Kantilal	Himatnagar
LM/23565	Dr. Patel Umang Prakashchandra	Surat

LM/23566	Dr. Patel Jignesh Bhavsingbhai	Surat
LM/23567	Dr. Patel Vipul Amrutbhai	Surat
LM/23568	Dr. Patel Nilesh Chunilal	Surat
LM/23569	Dr. Kordawala Smita D.	Surat
LM/23570	Dr. Iyer Indumati R.Subramania	Bhavnagar
LM/23571	Dr. Chokshi Utsav Dineshchandra	Godhra
LM/23572	Dr. Dani Ankit Krushnavadan	Godhra
LM/23573	Dr. Patel Yashdip Dineshbhai	Himatnagar
LM/23574	Dr. Shah Monil Bharatbhai	Bhujkutch
LM/23575	Dr. Algotar Gaurang Nathubhai	Ahmedabad
LM/23576	Dr. Shah Shrenik Mountkumr	Surat
LM/23577	Dr. Enginner Kishan Rameshbhai	Surat
LM/23578	Dr. Mahadik Mitali Devendrabhai	Surat
LM/23579	Dr. Patidar Arvind Shivprakash	Surat
LM/23580	Dr. Ganeshwala Gaurav M.	Surat
LM/23581	Dr. Ganeshwala Grishma G.	Surat
LM/23582	Dr. Patel Siddharth D.	Vapi
LM/23583	Dr. Mahendra Manpreetkaur G.	Vapi
LM/23584	Dr. Detroja Paresh Govindbhai	Anjar-Kutch
LM/23585	Dr. Prajapati Banshi Kanubhai	Ahmedabad
LM/23586	Dr. Raval Ronakkumar Kantilal	Ahmedabad
LM/23587	Dr. Sureja Samir Jayantibhai	Ahmedabad
LM/23588	Dr. Chauhan Hardik Prahladbhai	Ahmedabad
LM/23589	Dr. Chavada Dharmendrasinh D.	Ahmedabad
LM/23590	Dr. Patel Juhi Amitkumar	Ahmedabad
LM/23591	Dr. Gadi Shabbir Saifuddinbhai	Ahmedabad
LM/23592	Dr. Raval Mrudang Sanjaybhai	Ahmedabad
LM/23593	Dr. Mehta Shaile Pareshbhai	Ahmedabad
LM/23594	Dr. Shah Keshavi Nayanbhai	Ahmedabad
LM/23595	Dr. Vaghela Chirag Prafulchandra	Ahmedabad
LM/23596	Dr. Chauhan Mehul Amrutlal	Ahmedabad
LM/23597	Dr. Chauhan Hansa Mehulbhai	Ahmedabad
LM/23598	Dr. Patel Monil Ramanbhai	Ahmedabad
LM/23599	Dr. Patel Neha Monilbhai	Ahmedabad
LM/23600	Dr. Khandekar Archan Abhaybhai	Ahmedabad
LM/23601	Dr. Patel Anant Jitendrabhai	Ahmedabad

LM/23602	Dr. Aliraza Khunt Ramzanali	Ahmedabad
LM/23603	Dr. Bulsara Jignesh Sureshbhai	Ahmedabad
LM/23604	Dr. Agrawal Pawan Suganchand	Surat
LM/23605	Dr. Shah Krunal Shirishbhai	Surat
LM/23606	Dr. Shah Ruchi Gunvantraybhai	Surat
LM/23607	Dr. Kothari Swati Pareshbhai	Surat
LM/23608	Dr. Dodia Bhooshan Valjibhai	Surat
LM/23609	Dr. Davda Dipti Kishorchand	Surat
LM/23610	Dr. Kapadia Shukan Nitanjkumar	Anand
LM/23611	Dr. Parekh Mihir Manojbhai	Anand
LM/23612	Dr. Vaghela Malti Rasikbhai	Mehsana
LM/23613	Dr. Saxena Sanjay Manubhai	Mehsana
LM/23614	Dr. Salvi Alpesh Shankerbhai	Mehsana
LM/23615	Dr. Patel Viral Kantilal	Patan
LM/23616	Dr. Patel Sachin Chandubhai	Unjha
LM/23617	Dr. Patel Niti Mukundkumar	Unjha
LM/23618	Dr. Bhavsar Mrugank Mayankbhai	Mehsana
LM/23619	Dr. Bhavsar Mansi Mrugankbhai	Mehsana

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OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Jayantilal C. Gandhi

(22/03/1941 - 08/06/2014)

Age : 74 years

Qualification : M.B.B.S., D.P.H.

Name of Branch : Ahmedabad

* * * * *

Dr. Anil Bhaskarrao Mehta	02-03-2014	Ahmedabad
Dr. Bharat Surendrabhai Jamusaria	23-03-2014	Vadodara
Dr. Jatin Shantilal Bhagat	22-04-2014	Ahmedabad

We pray almighty God that their soul may rest in eternal peace.

CONGRATULATIONS

GUJARAT STATE H.S.C. BOARD

Name : **SHAH ANVAY SUMANTBHAI**
Percentile Rank : 99.92 (A1)
Date of Birth : 23/08/1997
School : St. Xavier's Loyela, Navrangpura, Ahmedabad
Hobby : Cricket, Reading,
Line of Interest : Medical
Father Name : Dr. Sumant R. Shah
Mother Name : Dr. Urvashiben S. Shah

Name : **SHAH RIYA JIGNESHKUMAR**
Percentile Rank : 99.85 (A1)
Date of Birth :
School : N. R. School, (GLS), Ahmedabad
Hobby : Dance
Line of Interest : Medical
Father Name : Dr. Jignesh C. Shah
Mother Name : Dr. Jigisha J. Shah

Name : **SOLANKI DEVANSHI JAYESHBHAI**
Percentile Rank : 99.83 (A1)
Date of Birth : 24/04/1997
School : Shanen School, Vadodara
Hobby : Badminton, Reading
Line of Interest : Medical
Father Name : Dr. Jayeshbhai T. Solanki
Mother Name : Vaishali Jayesh Solanki

Name : **GEVARIA VISHWA CHANDRESHBHAI**
Percentile Rank : 98.77 (A1)
Date of Birth : 09/05/1997
School : P. U. Modi School, Rajkot
Hobby : Music, Drawing, Reading
Line of Interest : Medical
Father Name : Dr. Chandresh Gevaria
Mother Name : Smt. Harshaben C. Gevaria

Name : **PATEL SHASHANK MAHESHBHAI**
Percentile Rank : 98.37 (A1)
Date of Birth : 08/06/1996
School : Sahjanand School, Naroda, Ahmedabad
Hobby : Reading
Line of Interest : Medical
Father Name : Dr. Mahesh K. Patel
Mother Name : Dr. Meena M. Patel

Name : **KOTHARI KAIVAL SHAILESHKUMAR**
Percentile Rank : 99.15 (A1)
Date of Birth : 22/01/1997
School : M.K. Higher Secondary School, (GLS) Ahmedabad
Hobby : Cricket
Line of Interest : Medical
Father Name : Dr. Shailesh Kothari
Mother Name : Dr. Priti Kothari

Name : **PANDYA RUTVI MANISHBHAI**
Percentile Rank : 99.09 (A1)
Date of Birth : 07/12/1996
School : Sardar Patel School, Surendranagar
Hobby : Music, Reading
Line of Interest : Medical
Father Name : Dr. Manish R. Pandya
Mother Name : Dr. Nehal M. Pandya

* * * * *

GUJARAT STATE S.S.C. BOARD

Name : **PATEL NEEL KALPESHBHAI**
Percentile Rank : 99.94 (A1)
Date of Birth : 30/08/1998
School : Nootan Sarvavidhyalay, Visnagar
Hobby :
Line of Interest :
Father Name : Dr. Kalpeshbhai R. Patel
Mother Name : Bhavnaben K. Patel

Name : **CHAUHAN YASHKUMAR DILIPBHAI**
Percentile Rank : 99.88 (A1)
Date of Birth : 26/06/1999
School : K. K. Shah High School, Wankaner
Hobby : Cricket, Music
Line of Interest : Medical
Father Name : Dr. Dilip Chauhan
Mother Name : Dr. Kalpana Chauhan

Name : **PARIKH BANSARI KALPESHBHAI**
Percentile Rank : 99.76 (A1)
Date of Birth : 06/11/1998
School : St. Xavier's School, Hansol
Hobby : Reading
Line of Interest : Medical
Father Name : Dr. Kalpesh R. Parikh
Mother Name : Dr. Bela K. Parikh

* **Dr. Vishwanath S. Shukla; Ahmedabad**

"Critical Analysis of PIM2 Score Applicability in a Tertiary Care PICU in Western India" International Journal of Pediatrics, Vol. 2014

* **Dr. Piyush Bhansali Ahmedabad**

Elected as President Shree Choksi Mahajan

Business (Mahajan) Category of Gujarat Chamber of Commerce and Industries.

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DISCLAIMER

Opinions in the various articles are those of the authors and do not reflect the views of Indian Medical Association, Gujarat State Branch. The appearance of advertisement is not a guarantee or endorsement of the product or the claims made for the product by the manufacturer.

COMMUNITY SERVICE

MORBI

06/05/2014 World Asthma Day

06/05/2014 Free spirometry camp at Sanjivani Hospital. Total 25 patients had taken advantage.

18/05/2014 Free diabetes camp and measurement of RBS by glucometer at Sarvad PHC. Total 45 patients have been examined. Out of them 20 patients were known case of DM and 3 patients were detected DM for the first time.

31//05/2014 'No Tobacco Day' celebration by presenting video of tobacco related diseases among students of Awesome classes.

RAJKOT

31/05/2014 World No Tobacco Day. Total 66 children participated

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BRANCH ACTIVITY

AHMEDABAD

18/06/2014 Scientific Programme

15/06/2014 Scientific Programme

1/06/2014 Medical Camp - Dani Limda

DHORAJI

14/06/2014 "Acute Pancreatitis - an overview IC care in Acute Pancreatitis" by Dr. Gunjan Joshi

JASDAN

24/04/2014 "Update on thyroid disorder and recent advances in diabetes management" by Dr. Pankaj Patel

JETPUR

03/05/2014 "Practical guideline on fluid line therapy" by Dr. Sanjay Pandya

"Hospital Management of diabetic patients" by Dr. M.A. Karmur

09/05/2014 "Role of calcium chennal bloeker" by Dr. Gurunath

"Opthalmic infection" by Dr. Chotalia

KALOL

27/05/2014 "Management of Viral Hepatitis" by Dr. Shravan Bohra

MORBI

06/05/2014 "How to tackle gram negative infection in ICU" by Dr. Sanket Mankad

06/05/2014 "Survival sepsis campaign 2012" by Dr. Dhaval Vaghela

27/05/2014 "Do's and DON'T of private practice" by Dr. Mayank Thakker

"Nonresolving pneumonia" by Dr. Tushar Patel

PALITANA

21/05/2014 "Trauma and management of head injury" by Dr. Dijesh Shah

RAJKOT

13/04/2014 "Cardiac Surgery, Kidney transplant and dialysis" by Dr. Hasit Joshi, Dr. Shamaik Shah and Dr. Nitin Jain

31/05/2014 "Breast Cancer management" by Dr. Divya Kantesariya, Dr. D.G. Vijay, Dr. C.B. Koppike, Dr. Manohar Chari and Dr. V.K. Gupta

Family Planning Centre, I.M.A. Gujarat State Branch

Respected Members,

Indian Medical Association, Gujarat State Branch runs 9 Urban Health Centers in the different wards of Ahmedabad City.

These Centres performed various activities during the month of May-2014 in addition to their routine work. These are as under :

01-05-2014 to 31-05-2014 : Intra domestic house to house survey by the centers of Ahmedabad

Rander - Surat : Children, Iron : 1000 tablets Calcium -1000 tablets were distributed.

Nanpura - Surat : Vitamin 'A' Solution - 40 Children, Iron : 4500 tablets Calcium -4500 tablets were distributed.

Rajkot : Vitamin 'A' Solution - 77 Children, Chlorine : 2000 tablets

The total number of patients registered in the OPD & Family planning activities of Various Centers is as Follows :

MAY-2014

No.	Name of Center		New Case	Old Case	Total Case
(1)	Ambawadi	(Jamalpur Ward)	825	417	1242
(2)	Behrampura	(Sardarnagar Ward)	905	253	1158
(3)	Bapunagar	(Potalia Ward)	1335	518	1853
(4)	Dariyapur	(Isanpur Ward)	595	117	712
(5)	Gomtipur	(Saijpur Ward)	1277	411	1688
(6)	Khokhra	(Amraiwadi Ward)	1708	471	2179
(7)	New Mental	(Kubernagar Ward)	153	63	216
(8)	Raikhad	(Stadium Ward)	340	680	1020
(9)	Wadaj	(Junawadaj Ward)	727	173	900
(10)	Khambhat		—	—	—
(11)	Junagadh		----	----	----
(12)	Rander-Surat		----	----	----
(13)	Nanpur-Surat		----	----	----
(14)	Rajkot		508	423	931

MAY-2014

No.	Name of Center		Female Sterilisation	Male Sterilisation	Copper-T	Condoms	Ocpills
(1)	Ambawadi	(Jamalpur Ward)	31	—	52	12660	565 P
(2)	Behrampura	(Sardarnagar Ward)	19	---	57	8900	1325
(3)	Bapunagar	(Potalia Ward)	37	---	34	18504	417
(4)	Dariyapur	(Isanpur Ward)	25	—	26	6875	283 P
(5)	Gomtipur	(Saijpur Ward)	17	---	33	17000	583 P
(6)	Khokhra	(Amraiwadi Ward)	54	01	42	5700	112
(7)	New Mental	(Kubernagar Ward)	11	---	29	9090	276 P
(8)	Raikhad	(Stadium Ward)	25	01	40	7280	806 P
(9)	Wadaj	(Junawadaj Ward)	11	01	58	12000	1421
(10)	Khambhat		---	—	14	---	03
(11)	Junagadh		27	—	29	---	249
(12)	Rander-Surat		36	—	45	1500	15 P
(13)	Nanpura-Surat		38	—	77	3000	70 P
(14)	Rajkot		23	—	64	---	260

ATTENTION PLEASE !!

The office has received back News bulletins of the following members from Postal department with note as "Left", "Insufficient address" etc. The concerned member / friends are requested to inform the office immediately with change of address, L.M. No. & Local Branch.

L_M_No.	NAME	BRANCH
LM/23297	Dr. Gandhi Rozil Jayeshbhai	Ahmedabad
LM/23298	Dr. Gandhi Aditi Rozilbhai	Ahmedabad
LM/09097	Dr. Nayak Ghanshyam C	Ahmedabad
LM/04889	Dr. Shah Abhay K	Ahmedabad
LM/04890	Dr. Shah S A	Ahmedabad
LM/04171	Dr. Shah Kavita S.	Ahmedabad
LM/10464	Dr. Sheth Parag M.	Ahmedabad
LM/18648	Dr. Vyas Bhavesh Mansukhlal	Ahmedabad
LM/18649	Dr. Vyas Monika Bhaveshbhai	Ahmedabad
LM/04749	Dr. Doshi Vinodkumar C.	Bavla
LM/00978	Dr. Jain P.H.	Dahod
LM/17681	Dr. Parwani Chandra Udharam	Dahod
LM/15682	Dr. Memon Zakir A.	Himatnagar
LM/09441	Dr. Pansuria Jethalal K.	Jamnagar
LM/05733	Dr. Amin Narendra K.	Mansa
LM/22723	Dr. Prajapati Tejas Thakorbhai	Nadiad
LM/17525	Dr. Kotak Kaushik Jethalal	Rajkot
LM/14765	Dr. Mehta Pravinkumar H.	Rajkot
LM/13339	Dr. Vyas Meghana Uttam	Surendranagar

CONGRATULATIONS

Top 10 Tuberculosis Notifiers in Gujarat State - May 2014

Sr. No.	Name of the Doctor/ Clinic/Laboratory Address/Branch/City	Number of Notifications	I.M.A. District Co-ordinators	D.T.O./ City T.B. Officer
1.	Parinbanu TB Clinic Hirabaug, Surat	134	Dr. Vinod C. Shah	Dr K. N. Sheladia
2.	Action Research in Community Health Rajpipla, Narmada	048	Dr. Umakant C. Sheth	Dr. S. A. Arya
3. (a)	Doctor House Mehsana	043	Dr. Anil Nayak	Dr. D. C. Nayak
3. (b)	Dr. N.P Suthar Mehsana	043	Dr. Anil Nayak	Dr. D. C. Nayak
5.	Sundram Surgical Hospital Jhalod, Dahod	041	Dr. Alpesh Amin	Dr. P. R. Suthar
6.	R. B. Kothari Poly Diagnostic Centre & Hospital, Rajkot	036	Dr. Atul Pandya	Dr. S. G. Lakkad
7. (a)	Dr. J. M. Vaghamshi Rajula, Amreli	029	Dr. Haresh Yadav	Dr. C. J. Butani
7. (b)	Vardan Hospital Khedbrahma, Sabarkantha	029	Dr. Bhupendra Shah	Dr. A. K Patel
9.	Sparsh Chest Disease Center, Ahmedabad	027	Dr. Jitendra Shah	Dr. R. M. Leuva
10.	Navjivan Hospital Veraval, Junagadh	025	Dr. Jayesh Vaghasia	Dr. C. A Mehta

Mandatory Tuberculosis Notification in India

This is a giant step towards furthering TB care and control in our top priority country world-wide. It has many implications especially when it comes to the coordination with the non-state sector. GoI is to be highly congratulated for having addressed this major issue. WHO at all three levels stands ready to support implementation of the new policy.

Frequently Asked Questions

(Tuberculosis notification in India)

1. What is TB notification?

Reporting about information on diagnosis &/or treatment of Tuberculosis cases to the nodal Public Health Authority (for this purpose) or officials designated by them for this purpose.

2. Who is expected to notify TB cases?

Every healthcare providers meaning clinical establishments run or managed by the Government (including local authorities), private or NGO sectors and/or individual practitioners.

3. Are the public sector health facilities expected to notify the TB cases?

Yes. All Tuberculosis cases diagnosed &/or treated; whether under DOTS strategy or not.

4. To whom TB cases should be notified?

Nodal Public Health Authority (for this purpose) or officials designated by them for this purpose. State/UT & district-wise contact details are available on www.tbcindia.nic.in

5. **When TB cases can be notified?**

On diagnosis or initiation of anti-TB treatment of a Tuberculosis case. Such reporting to the nodal public health authority to be done at least on monthly basis

6. How TB cases can be notified?

- Hard copy by post, courier or by hand to the nodal officer

- Soft copy by email from persons / institutes authorized for this purpose to the nodal officer
- Using authorized mobile numbers by phone call, IVRS or SMS *
- Uploading of information directly on to the Nikshay portal http://nikshay.gov.in*
- Direct online information transmission from newer diagnostic machines like CB- NAAT or MGIT etc. *
- Will be available in future

7. Why should private health facilities notify TB?

Notification gives an opportunity to support private sector for better practices in terms of Standard TB Care which include helping the patients to get right diagnosis, treatment, Follow up, Contact Tracing Chemoprophylaxis & facilitates social support systems.

Complete and accurate data obtained from notification will allow continuous evaluation of the trend of the disease with better estimation of burden/impact.

8. **How do I know the contact details of the nodal officer for TB notification in my area?**

The list of Nodal Officers is available on http://tbcindia.nic.in/.

In States/UTs or districts where the bilateral understanding is established between the Health Establishments and the local public health authorities for convenient local TB notification, the information on TB Notification can be submitted to the local public health authorities (e.g. Medical Officer of the Primary Health Center) as designated by the district nodal authority for TB notification. However, this should be done only in consultation with the concerned district nodal officer for TB notification.

In case, health care provider is not aware about the contact details of the nodal officer for TB Notification in the district the same may be obtained from the respective District TB Officer / State TB Officer for the updated contact.

9. **What do I do when I am unable to contact the nodal officer for TB Notification?**

You may contact respective District TB Officer / State TB Officer. In case of any grievances, the same may be sent to tbnotification@tbcindia.nic.in & issues regarding electronic reporting data update may be sent to helpdesk.nikshay@tbcindia. nic.in mentioning the name and complete address of the individual and the health care facility.

10. **I am a medical practitioner but I neither diagnose nor treat TB cases. Do I still have to submit the TB notification report to the nodal officer?**

Health establishments and medical practitioners not routinely diagnosing / treating TB patients may give an undertaking regarding the same while agreeing to submit the information in future, in case they diagnose or treat any TB case.

11. **What is a TB case?**

Microbiologically-confirmed TB case – Patient diagnosed with at least one sputum specimen positive for acid fast bacilli, or Culture-positive for Mycobacterium tuberculosis, or RNTCP-approved Rapid Diagnostic molecular test positive for tuberculosis

OR

Clinical TB case – Patient diagnosed clinically as tuberculosis, without microbiologic confirmation and initiated on anti-TB drugs.

12. **What are the different types of TB cases?**

New TB case – Patient who has never been treated with anti-TB drugs or has been treated with anti-TB drugs for less than one month from any source

Recurrent TB case – Patient who has been treated for tuberculosis in the past and been declared successfully treated (cured/treatment completed) at the end of their treatment regimen.

Treatment change – Patient returning after interruption, and patients put on a new treatment regimen and due to failure of the current treatment regimen.

13. **How Site of disease can be defined for TB cases?**

Pulmonary TB case – Patient with TB of the lungs (with or without involvement of anyextra-pulmonary locations).

Extra-pulmonary TB case – Patient with TB of any organ other than the lungs, such as pleura, lymph notes, intestines, genito-urinary tract, skin, bones and joints, meninges of the brain, etc, diagnosed with microbiological, histological, radiological, or strong clinical evidence.

14. **Which TB diagnostics are endorsed by RNTCP?**

Smear Microscopy (for AFB) using Zeil-Nelson Staining or Fluorescence stains and examination under direct or indirect microscopy with or without LED.

Culture for MTB on Solid(Lowenstein Jansen) media or Liquid media (Middle Brook) using manual, semi-automatic or automatic machines e.g. Bactec, MGIT etc.

Rapid diagnostic molecular test for MTB using conventional PCR based Line Probe Assay for MTB complex or Real-time PCR based Nucleic Acid Amplification Test (NAAT) for MTB complex e.g. GeneXpert

Note: Diagnosis of TB based on radiology (e.g. X-ray) will be termed as clinical TB

15. **What can be the Rifampicin resistance status of TB patient?**

Rifampicin resistant – Patient with a drug susceptibility test result from a RNTCP- certified laboratory or WRD (WHO approved Rapid Diagnostic) drug susceptibility test report showing resistance to rifampicin.

Rifampicin sensitive – Patient with a drug susceptibility test result from a RNTCP- certified laboratory or WRD (WHO approved Rapid Diagnostic) drug susceptibility test report showing sensitivity to rifampicin.

Not available – Patient without a drug susceptibility test result from a RNTCP certified laboratory

16. What if, I do not notify a TB case?

As per MCI code of Ethics – Rules & regulations 2002, Chapter 7, Point 7.7, a registered medical practitioner giving incorrect information on his name and authority about Notification amounts to misconduct and such a medical practitioner is liable for deregistration.

17. How can I share the information about TB patient, as it is a professional secret between a doctor and his patient and needs to be kept confidential?

As per MCI code of Ethics – Rules & regulations 2002, Chapter 7, Point 7.14, it is the duty of the registered medical to divulge this information to the authorized notification official as regards communicable and notifiable diseases. It further states that in case of communicable / notifiable diseases, concerned public health authorities should be informed immediately.

18 .Is there a provision for punitive / legal action if I do not notify TB cases in Constitution / MCI rules?

Yes.

19. How will the TB notification information be used by the National Programme / Government?

For undertaking Public Health measures like contact tracing of infectious cases, counseling support for treatment adherence and follow-up. Also, the surveillance system will be helpful in estimating the burden of TB disease in the country.

20. What if I notify a TB case and later on I found it not to be TB?

Information on such rare cases may be intimated to the nodal officer for TB notification

21. What will happen to the TB cases I have notified?

Support system for treatment initiation, adherence, follow-up, default retrieval, contact tracing will be extended to such patients by public health staff. Though patient may opt to seek care from providers outside national TB control programme

22. Is a medical practitioner starting treatment of a TB patient expected to notify the case even if already notified by a Laboratory?

Yes. As the public health measures are additive.

Monthly Report

Reporting Format

Period of reporting. From ...../...../..... / To ...../...../.....

Name of the health facility / practitioner / Laboratory: .....

Registration Number ..... Telephone (with STD)..... Mobile number.....

Complete Address. .....

Sr. No.	Name of TB Patient ID of patient	Age (yrs)	Sex (M/F/O)	GoI issued identification number (Aadhaar, etc.) if available	Complete residential address	Patient Phone Number	Date of TB Diagnosis	Date of TB treatment initation

Signature ..... Date .....

2 Pin Code, father name, Centre referred, date of sample collection, DST results

Model Prescription Format as proposed by MCI

Doctor's Name

Qualification (eg. MBBS, MD)

Regn. No. : ..... (ALLOPATHY)

Full Address, Contacts : (Telephone No. E-mail etc.)

Name of the Patient .....

Address* .....

Age & Sex ..... Weight ** .....

1) Name of Medicine ***
Strength, dosage instruction, duration & total quantity ***

2) - do -

3) - do -

Doctor's signature

Stamp

Stamp of Medical Store

*Postal address/E-mail/Mobile Number

**for Paediatric Patients

***in capital letters only

Minimum size of the prescription blank should be (a) 14 x 21 cm (A5 size) & (b) XI x XI cm size.

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH
A.M.A. House, Opp. H.K. College, Ashram Road, Ahmedabad -380009
PHONE & FAX: (079) 265 87 370 Email: imagsb@gmail.com

Dear Branch Secretary

I hope that this circular finds you in the best of health and spirit. In continuation of my circular **A-11/HFC/LM/2014-2015**, further tabulated information is given below for the revision of fees effective from **1/7/2014.** Herewith I am sending the copy of I.M.A. H/Q fee schedule regarding revised fees.

ORDINARY MEMBERSHIP FEES

CATEGORY	HFC	GMJ	GSB	ADM.FEE	TOTAL TO BE SENT TO GSB.IMA
Annual Single:	391-00	25-00	10-00	20-00	446-00
Annual Couple:	586-00	38-00	20-00	30-00	674–00

Local branch share to be collected extra as per individual branch decision/resolution Kindly note that fees at old
Rates will be accepted up to **30/06/2014** only at State Office. Thereafter the new revised rates will be applicable.

LIFE MEMBERSHIP FEES

CATEGORY	TOTAL FEES	BR.SHAHRE	ADM.FEES INCLUDING GSB. IMA	TO BE SENT TO GSB. IMA
Single	7995-00	740-00	{ 20-00 }	Rs. 7255-00
Couple	11950-00	1180-00	{ 30.00 }	Rs. 10770–00

Kindly send fees of old annual member, which should reach this office before 30/4/2014. Membership Fees by a D.D. drawn in favour of G.S.B. I.M.A

I.M.A. COLLEGE OF GENERAL PRACTITIONERS

College of G.P Rs. 2000-00
Life Membership
Membership Fees along with Life Subscription of Family Medicine DD in favour of "IMA CGP HQ"
Payable at Chennai and send to us

Kindly send annual membership fees before **30/4/2014** so as to avoid deletion. The above increase of fee Rs. 50.00 in Life Member every year is computed as per the resolution passed in 41st State Council at Nadiad on 12/05/1989.

Yours Sincerely

(Dr. Jitendra N. Patel)
Hon. State Secretary

IMA NATCON 2014

89th National Conference of INDIAN MEDICAL ASSOCIATION

27th & 28th December, 2014

It is proud achievement of Ahmedabad & Ahmedabad Medical Association as after the gap of 25 years, Ahmedabad is hosting the 89th National Conference of Indian Medical Association, 'IMA NATCON 2014' on 27th & 28th December, 2014. On 26th December, 2014 there will be preconference workshops at various places. Detail will be published in due course.

Conference Details

Date	:	**27th & 28th December, 2014**
Venue	:	**Gujarat University Convention Centre** Nr. Helmet Circle, Drive-in Road, Ahmedabad.
Pre Conf. Workshop	:	26th December, 2014
Venue	:	will be declared in due course

Salient features of conference are,

1. Eminent National & International faculty as speakers.
2. Multiple Preconference Workshops on various different topics.
3. Scientific Papers and Posters are invited from Resident Doctors.
4. AMA has applied for GMC accredition.
5. Entertainment Programme with Gala dinner.
6. Programmes for spouse & accompanying persons.
7. Lucky draw & many more.

- Kindly register yourself as earliest and encourage others for registration.
- You can download registration form from imagsb.com Website or get from AMA Office.

IMA NATCON 2014

89th National Conference of INDIAN MEDICAL ASSOCIATION

27th & 28th December, 2014

HOSTED BY : AHMEDABAD MEDICAL ASSOCIATION

REGISTRATION FORM

To :
Conference Secretariat :
Dr. Kamlesh B. Saini / Dr. Jitendra N. Patel / Dr. Dilip Gadhavi
AMA HOUSE, First Floor, Opp. H.K Arts College,
Ashram Road, Ahmedabad - 380009.
Ph.: 079-26588775 (2.00 pm to 6.00pm)
Email : imanatcon2014@gmail.com

For Office Use Only
Reg. No. :
Receipt No. :

Please Fill in BLOCK LETTERS

Name : .....

Membership Detail LM/AM No.: .....

Branch ..... State .....

Mailing Address : .....

.....

.....City : ..... Pin Code : ..... State : .....

Telephone, STD Code : ..... (R)..... (O/H).....

Fax : ..... Mobile : .....

Email : .....

Member CWC / CC .....Branch : ..... State : .....

No. of the accompanying person (s) : .....

Please attach Photocopy of your Govt. approved Photo ID / Driving Licence.

Delegate Fees	Up to 31-10-2014	From 1-11-2014 to 20-12-2014	Spot Reg.	No. of Person	Total
R. C. Member	₹ 5,000/-	₹ 5,000/-	_		
IMA Member, Spouse & Other Family Member	₹ 2,000/- each	₹ 2,500/- each	₹ 3,000/- each		
Non IMA Member, Spouse & Accompanying Person	₹ 2,500/- each	₹ 3,000/- each	₹ 3,500/- each		
				Total	

Please find enclosed herewith a Demand Draft / Cheque No.: .....
dated ..... for INR .....
drawn on (name of bank) ..... City .....
in favour of "IMANATCON 2014" payable at Ahmedabad.

Date : .....
Place : .....

.....
Signature

IMA NATCON-2014

Gujarat State Branch IMA & Ahmedabad Medical Association are privileged to host IMA National Conference on 27th & 28th December-2014 at Ahmedabad.

We are thankful to the following members for registering as Reception Committee (R.C.) members.

Sr. No.	Names	Branch / City
1.	DR. DESAI MAHENDRA B.	AHMEDABAD
2.	DR. DESAI PARTH MAHENDRA	AHMEDABAD
3.	DR. GADHAVI DILIP B.	AHMEDABAD
4.	DR. FADIA BIREN AVNISHKUMAR	AHMEDABAD
5.	DR. NAYAK LALIT ISHWARCHANDRA	AHMEDABAD
6.	DR. NAYAK VIXITA L.	AHMEDABAD
7.	DR. MEHTA MUNJAL PRAFULCHANDRA	AHMEDABAD
8.	DR. SANGHAVI KIRTI R.	AHMEDABAD
9.	DR. SHARMA GEETENDRA B.	AHMEDABAD
10.	DR. MODI MADHUR YOGENDRA	AHMEDABAD
11.	DR. CHENWALA SUNIL B.	AHMEDABAD
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13.	DR. PATEL PARTH N.	AHMEDABAD
14.	DR. KANODIA ASHOK D.	AHMEDABAD
15.	DR. SACHDE JAYESH P.	AHMEDABAD
16.	DR. PATEL ASHOK M.	AHMEDABAD
17.	DR. PANCHAL DIVYESH N.	AHMEDABAD
18.	DR. GADHAVI KIRITKUMAR C.	AHMEDABAD
19.	DR. ANAND JITENDRA SOMESHWAR	AHMEDABAD

IMA NATCON 2014

89th National Conference of
INDIAN MEDICAL ASSOCIATION
27th & 28th December, 2014

Hosted By : AHMEDABAD MEDICAL ASSOCIATION

AMA House, First Floor, Opp. H. K. Arts College, Ashram Road, Ahmedabad-380009.
Phone : 079-26588775, Fax : 079-2658 7498
E-mail : imanatcon2014@gmail.com

DR. JITENDRA B. PATEL
National President

DR. NARENDRA SAINI
Hony. Secretary General

* * * * *

President (IMA-GSB)
Conference Chairman
DR. BIPIN M. PATEL

Organising Chairman
DR. VIDYUT J. DESAI

Chairman Reception Comm.
DR. KIRTI M. PATEL

* * * * *

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(M) 098253 25200

DR. KAMLESH B. SAINI
(M) 096019 49252

DR. DILIP B. GADHAVI
(M) 098980 47505

* * * * *

Hon. Finance Secretary

DR. DEVENDRA R. PATEL

* * * * *

Conference Co-Chairmen

DR. MAHENDRA B. DESAI
DR. PRAGNESH C. JOSHI
DR. DHANESH A. PATEL
DR. CHETAN N. PATEL

* * * * *

Organising Co-Chairmen

DR. BHARAT V. TRIVEDI
DR. ANIL J. NAYAK
DR. PRAFUL R. DESAI

PATRONS IMA NATCON-2014

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M.S. (Ortho.)
National President (IMA-HQs)
Mansi Hospital (Ahmedabad)

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Sanjivani Hospital (Ahmedabad)

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Disorder & Critical Care Specialist
Sparsh Chest Diseases Centre (Ahmedabad)

DR. PIYUSH BHANSALI
M.B.B.S.
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DR. PRAGNESH V. PATEL
M.S., M.Ch. (Urologist)
(Ahmedabad)

DR. R. G. PATEL
M.D. (Gynaec)
Infertility & IVF Specialist
Sunflower Women's Hospital for IVF
(Ahmedabad)

DR. CHAITANYA NAGORI
M.D., D.G.O.
Dr. Nagori's Institute
Infertility, Endocrinology IVF Centre
(Ahmedabad)

PLATINUM PATRONS IMA NATCON-2014

WALKFIT ARTHRITIS CLINIC & TRAINING CENTRE

SAVIOUR HOSPITAL

DR. HARESH P. BHALODIYA M.S. (Ortho.)

Professor & Head of Unit, Orthopaedic Department,
B. J. Medical College & Civil Hospital

Joint Replacement & Arthroplasty Surgeon

* * * * *

ESTD: 1985

Dev ART ivf
Test Tube Baby Center
Shachi
women's hospital

DR. B. I. PATEL M.D., D.G.O., F.I.C.M.U.

Hon. Secretary (IMA-GMJ)

3D - 4D Sonography & Fetal Medicine Expert

Director of Dev ART ivf & Shachi Women's Hospital

PLATINUM PATRONS IMA NATCON-2014

APEX HEART INSTITUTE™
(A Unit of TCVS Pvt. Ltd.)

DR. TEJAS PATEL M.D.,D.M.,F.C.S.I.,F.A.C.C., F.E.S.C., F.S.C.A.I.

Chairman & Chief Interventional Cardiologist, Apex Heart Institute, Ahmedabad

Professor & Head, Dept. of Cardiology, Sheth V.S. General Hospital, Ahmedabad

Professor of Medicine (Cardiology), Department of Internal Medicine, Virginia Commonwealth University Medical Center, Richmond, USA.

* * * * *

SIDDHI VINAYAK HOSPITAL

DR. ABHAY KHANDEKAR M.B.B.S., M.S., M.Ch. (Urology)

Director & Consultant Urologist : Siddhi Vinayak Hospital, Ahmedabad

Ex- Head of Urology Department, V. S. Hospital, Ahmedabad

Indian Medical Association & CMAAO in Collaboration with UNICEF - Symposiumon - Child Sexual Abuse, Prevention & Response

National Working Group (RNTCP) Meeting & Nikshay Training Programme New Delhi (HQs)

IMA Delegation under the Leadership of National President Dr. Jitubhai B. Patel meets Dr. Harsh Vardhan, Health Minister of India

Kindly update your following data on our Website : www.imagsb.com and submit

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH

2nd Floor, AMA House, Opp. H. K. Collge, Ashram Road,
Ahmedabad-380009. Fax /
Phone : 079-2658 7370 E-mail : imagsb@youtele.com

Photo

BIO-DATA FORM DIRECTORY OF I.M.A. GUJARAT STATE BRANCH MEMBER

LMGUJ :

IMA HQ No.

Name of the Member : _____

_____

Branch : _____

City : _____

Address (Resi.) _____

_____

_____

Telephone No. _____

Address (Clinic/Hospital) _____

_____

_____

Telephone No. _____

Mobile : _____

Email : _____ Fax : _____

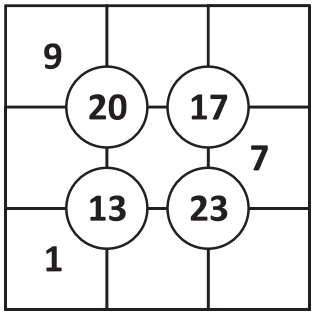
Blood Group _____

Signature _____

Games Corner

Dr. Chandresh Jardosh
Surat

Chhota Sudoku



"Place the numbers 1 to 9 in the spaces so that the number in each circle is equal to the sum of the four surrounding spaces."

7 BR OK EN Words

By using following keys, join the broken words & find out the 7 currencies of different countries.

Key	Words
4 Letters	3
5 Letters	3
6 Letters	1

AR	RU	RI	DO
EU	KA	PO	NAR
DI	LL	AL	PEE
UND	TA	RO	X

Sudoku

3	6		7					1
	2			9			7	
	4							
6		2		4				
	3		6		8		5	
				5		9		3
							2	
	7			6			9	
4					5		8	6

The objective of sudoku is to enter a digit from 1 through 9 in each cell, in such a way that:
Each horizontal row contains each digit exactly once
Each vertical column contains each digit exactly once
Each 3 by 3 square contains each digit exactly once

KEN KEN PUZZLE

4+		11+		
9+	9+	5+		1
		1	5	3
	3+	5	1	10+
5		3		

1 write down 1 to 5 in each row and each column in such a way they come only once, in each row and column.
2 The heavily-outlined groups of squares in each grid are called “cages.” In the upper-left corner of each cage, there is a “target number” and a math operation (+, –, x, ÷).
3 Fill in each square of a cage with a number. The numbers in a cage must combine—in any order, using only that cage’s math operation—to form that cage’s target number.

FOR EXAMPLE

3+ 1	2		
6x 1	2	3	

4 The number written in the cage of one square, will be the answer for the cage.
5 Important: You may not repeat a number in any row or column. You can repeat a number within a cage, as long as those repeated numbers are not in the same row or column.

Answer Page No. 87

Symposiumon of IMA & CMAAO in Collaboration with Unicef Child Sexual Abuse Prevention & Response

Introduction

India is home to the largest child population in the world, with almost 41 per cent of the total population under eighteen years of age. Needless to say, the health and security of the country's children is integral to any vision for its progress and development. However, there has been a steady increase in sexual crimes against children, and according to a study conducted by the Ministry of Women and Child Development in 2007, over half of the children surveyed reported having faced some form of sexual abuse.

Doctors, nurses, and other health sector professionals are important stakeholders in the prevention and response to sexual violence against children. According to the Adverse Childhood Experiences (ACE) Study, a major American research project examining the effects of adverse childhood experiences on adult health and well-being, a powerful relationship has been established between emotional experiences during childhood and physical and mental health during adulthood. Sexual abuse is an extremely traumatic experience that can affect the body as well as the mind, and the reaction of the body and the mind to such an occurrence could leave a lasting impact on the health conditions for any person at any age. Studies have consistently demonstrated that sexual abuse suffered in childhood is associated with a broad range of behavioral, psychological and physical problems that persist into adulthood; these include anxiety, depression, Post-Traumatic Stress Disorder (PTSD), self-destructive behavior, dissociation, substance abuse, sexual maladjustment, and a tendency towards revictimization in subsequent relationships. Adult survivors of childhood physical, emotional, or sexual abuse are not only at increased risk for depression and other mental health disorders, but new evidence suggests they are increasingly more likely to suffer from heart disease, obesity, and other potentially fatal physical conditions. Thus, it is imperative that the right kind of intervention and opportunity for recovery be provided at the right time. This is why the role of the health sector is such an important one.

This booklet provides a brief overview on child sexual abuse (CSA). It offers key information to health professionals (doctors, nurses and mental health professionals) on how to prevent, detect and respond to abuse. It provides insights on the Indian law for the protection for child victims and specifies the role for the medical sector. Finally, it gives inputs to health professionals on how to manage cases of child sexual abuse. A bibliography is available for further reading.

What is meant by sexual offences against children?

Definition

Sexual abuse refers to the involvement of a child in any sexual activity that:

- the child does not understand;
- the child is unable to give informed consent to;
- the child is not developmentally prepared for and cannot give consent to; and,
- violates the laws or norms of society.

Under the Protection of Children from Sexual Offences (POCSO) Act, 2012, any sexual activity with a child below 18 years, whether boy or girl, is a crime.

As defined by the Act, sexual offences include penetrative sexual assault (Section 3), sexual assault (i.e., non-penetrative) (Section 7), sexual harassment (Section 11), and use of a child for pornography (Section 13).

Sexual offences under the Act include:

- actual or attempted penetrative sexual intercourse with a child;
- non-penetrative sexual activity, e.g. rubbing the penis between the child's thighs or genitals;
- fondling a child's sexual parts, i.e. genitals, breasts or buttocks;
- oral sex with a child, i.e. mouth to sexual parts;
- forcing a child to masturbate another person;
- masturbating a child;
- the adult showing his or her private parts to the child;
- inappropriately watching a child undress or using the bathroom;
- photographing a child in sexual poses;
- the exploitative use of a child in prostitution or any other unlawful sexual practice;
- the exploitative use of children in pornography;
- showing pornography or any pictures of a sexual nature to the child that he or she does not want to see; and
- letting the child watch or hear an act of sexual intercourse.

Prevalence of Child Sexual Abuse

Data on CSA is difficult to obtain as it is often based on reporting and is associated with social taboos and a culture of silence that prevents victims from disclosing. The table below provides data across regions in the world for females and males, based on surveys conducted around the globe. On average, Asia has a prevalence rate of 11.3% for females and 4.1% for males.

Findings on the prevalence of child sexual abuse by region from 2 meta-analyses, Stoltenborgh et al 2011

Region	Lifetime prevalence in females	Lifetime prevalence in males
Africa	20.2%	19.3%
Asia	11.3%	4.1%
Australia	21.5%	7.5%
Europe	13.5%	5.6%
South America	13.4%	13.8%
USA & Canada	20.1%	8.0%

Data on child sexual abuse in India is scarce for the same reasons outlined above. The table below provides a few snapshots.

The Statistics on CSA in India

- In 2007, the Government of India published its first (and so far, only) report on CSA. This Report reveals: Of the children interviewed, over 53% reported having faced some form of CSA
- Over 57% of these were boys.
- 72% said they did not report the abuse to anyone.
- Only 3% reported CSA to the police.

In 2005, the international organization Save the Children and the Indian NGO, Tulir - Centre for Healing and Prevention of Child Sex Abuse, surveyed 2,211 school-going children from different backgrounds in Chennai.

- 48 percent of the boys and 39 percent of the girls interviewed said they had faced some form of CSA
- 15 percent of these children had faced severe forms of abuse, defined in this study as “oral sex, sexual intercourse, making the child touch the offender's private parts, or making the children take off their clothes and looking at them or taking their pictures.”

Where does CSA take place?

Child sexual abuse can occur in a variety of settings, including home, school, or work (in places like India, where child labor is common).

Who are the perpetrators?

Child sexual abuse can take place in the family - by a parent, step-parent, sibling or other relative. It is almost always by someone the child knows ... friend, neighbor, childcare giver, teacher, etc. The Study on Child Abuse conducted by the Ministry of Women and Child Development of the Government of India in 2007 found that in most cases, the perpetrator was known to the child. For example, 31 percent of sexual assaults were committed by the victim’s uncle or neighbor.

Offenders come from all walks of life and cannot be picked out or identified by appearance. It is therefore essential to pay attention to behaviours (and patterns) and situations that present risk rather than focusing on an individual’s character. Young people can also sexually abuse younger children or their peers but the dynamics of offending may slight vary.

Vulnerabilities of children

Due to their age and being experientially immature paired with the fact that children are still developing socially and emotionally, children can be easily confused, controlled & coerced. Most of them would not be able to interpret or understand an adult’s intent. Children give unconditional love and seek attention and affection. In addition to this, socio-cultural norms mandate that children respect and listen to adults. A person who intends to commit a sexual offence against a child, or to groom so as to abuse that child sexually, would be able to take advantage of all these factors.

If the child is an adolescent, his or her vulnerability increases as they are curious, rebellious, and easily aroused.

Some of the higher risk factors for a child to become a victim o f a sexual offence include isolation (such as children in institutions, children living on the street, working children, children of families in transition, children with disabilities, and children from dysfunctional families).

Grooming

Grooming is a method of building trust with a child and adults around the child in an effort to gain access to the child and increase the chances that the child will not consider the sexual advances of the perpetrator untoward or improper. However, in extreme cases, offenders may use threats and physical force to sexually assault or abuse a child.

The purpose of grooming is:

- To reduce the likelihood of a disclosure.
- To reduce the likelihood of the child being believed.
- To reduce the likelihood of being detected.
- To manipulate the perceptions of other adults around the child.
- To manipulate the child into becoming a cooperating participant/feeling complicit, which reduces the likelihood of a disclosure and increases the likelihood that the child will repeatedly return to the offender.

Grooming Behaviour

- Although not all child sexual abuse involves grooming, it is a common process used by offenders.
- It usually begins with subtle behaviour that may not initially appear to be inappropriate, such as paying a lot of attention to the child or being very affectionate.
- Many victims of grooming and sexual abuse do not recognize they are being manipulated, nor do they realize how grooming is part of the abuse process.
- Often, the abuser actively encourages the child to keep their interaction a secret.
- He/she may also try to isolate the child from persons to whom he or she is close, by saying that person wouldn't understand their "love".
- The touching may start in a way that feels vaguely confusing for a child, like tickling or hugging. For example, they may use touching as a game or introduce sexual touching as "accidental".
- They are likely to blur the boundaries of ordinary affection so the child confuses this with the abuse. This often occurs around the child's normal bathing, dressing and bedroom routines.
- The objective of grooming is to ensure that the child will not protest, and will keep the secret.

Behaviours that may suggest a potential perpetrators:

- An adult who seems overly interested in a particular child.
- An adult who frequently initiates or creates opportunities to be alone with a child (or multiple children).
- An adult who becomes fixated on a child.

- An adult who gives special privileges to a child (e.g. treats, gifts, etc.).
- An adult who befriends a family and shows more interest in building a relationship with the child than with the adults.
- An adult who displays favouritism towards one child within a family.
- An adult who caters to the interests of the child, so a child or the parent may feel emotionally dependent on the offender.
- An adult who displays age and gender preferences.
- An adult who tests the child's boundaries (and the child's ability to protect him/ herself) through the telling of sexual jokes, playing sexual games(non-sexual touching to 'accidental' sexual touching, so the child may not identify it as purposeful, inappropriate touching) in an attempt to see if s/he is at risk to tell someone.

Consequences of child sexual abuse

CSA leads to a range of physical as well as emotional/ mental health consequences. These depend on a number of factors, such as the duration of abuse, the age of the child, and the type and availability of support. Below are some of the symptoms and indicators that should raise an alarm if detected by a medical professional.

Physical Symptoms:

- Sexually transmitted diseases,
- Pregnancy,
- Complaints of pain or itching in the genital area,
- Difficulty in walking or sitting,
- Repeated unusual injuries,
- Pain during urination and/ or defecation, and
- Frequent yeast infections.

Behavioural Indicators:

It is important to pay attention to changes in a child's behaviour as children communicate how they are feeling through their behaviour. If an adult notices any of manifestations, he/ she should not automatically conclude that she has been victimized — this may be one of several possibilities. Rather, he/she should provide support and assistance to help determine what could be the cause of them. **It is important to note that change in a child's behaviour should be further explored, regardless of whether sexual abuse is believed to be the reason or not.**

Look out for :

- Abrupt changes in behaviour,
- Refusal to undress for physical examination,
- Report of sexual involvement with an adult or child,
- Excessive Fear of specific places, men or women,
- Fearful or startled response to touching,
- Recurrent physical complains without physiological basis,
- Tendency to self-harm,
- Wearing many layers of clothing regardless of the weather,
- Recurrent nightmares or disturbed sleep patterns and fear of the dark,
- Regression to more infantile behaviour like bed-wetting, thumb-sucking or excessive crying,
- Poor peer relationships,
- Eating disturbances,
- Negative coping skills, such as substance abuse and/or self-harm (in older children),
- An increase in irritability or temper tantrums,
- Fears of a particular person or object,
- Disrespectful behaviour and aggression towards others,
- Poor school performance, and
- Advanced sexual knowledge. This means the child knows more about sexual behaviour than is expected of a child of that age.
- Other behaviours may include:
  - The child may hate his/her own genitals or demand privacy in an aggressive manner;
  - The child may dislike being his or her own gender;
  - The child may use inappropriate language continuously in his or her vocabulary or may use socially unacceptable slang; and/or
  - The child may carry out sexualised play (simulating sex with other children).

How does sexual abuse affect children emotionally?

Children who have been sexually abused often continue to suffer even after the abuse has ended. Some of the psychological harms will be obvious to family

members, others may remain hidden. The effects of abuse may take these forms:

- **Confusion.** Children may have many mixed feelings a bout what happened to them and about what happened after they told, depending on the reactions of family and friends.
- **Guilt.** Children may feel guilty, believing they are in some way responsible for the abuse.
- **Shame.** The guilty secret may make them feel worthless.
- **Fear.** If the abuser has threatened that something terrible will happen if they reveal the secret, they may be afraid.
- **Grief.** Children may stop seeing the world as a safe and friendly place. They may mourn the loss of their sense of innocence and freedom. They may also mourn the loss of the relationship with the abuser if there had been a close bond between them.
- **Anger.** They may feel intense, and often uncontrollable anger. Because they can't strike back at the abuser, they may lash out at another person or they may hurt themselves, others or a pet.
- **Helplessness.** Because they felt helpless at the time of the abuse, they may feel unable to resist sexual abuse in the future.
- **Depression.** They may seem sad and less playful. They may lose interest in school, friends and activities. Depending on how serious the abuse is, and on the child's nature, these feelings may show up in several ways, for example, physical complaints, problems in sleeping and eating, irrational fears, an inability to concentrate in school, macho or seductive behaviour and/or sexual aggression. Even if there are no symptoms, it doesn't mean that the child doesn't need help – it just means that there are no immediate or outward signs of the abuse.

How Children Disclose Abuse

"Disclosure" refers to when a child opens up and says that he or she has been sexually abused. A child's capacity to disclose is impacted by several factors, including the child's age, sense of safety, available resources and other factors relevant to the particular context.

Often, disclosure of sexual abuse is a process; thus, a child may first give hints about the abuse to see how an adult reacts before he or she is able to give full disclosure.

Disclosure can be direct, i.e. when the child tells someone about the abuse; or indirect, when the abuse is discovered as a result of the child becoming pregnant or contracting a Sexually Transmitted Disease. How the abuse was discovered can impact the child's willingness to share information about it; some children may be ready to talk, share and receive help while some children may be afraid to do so.

Why a child may not disclose abuse

- He/she is embarrassed
- The child blames himself/ herself and thinks the abuse is their fault
- He/ she does not know if what is happening to them is normal or not
- The abuser is a known person and the child does not want to get them in trouble
- The abuser told the child to keep it a secret
- The child is afraid that no one will believe him/ her
- The abuser bribes or threatens the child
- He/ she thinks you already know
- The child is very young and is not aware that he/she is experiencing sexual abuse.

Believing and supporting the child are two of the best actions to start the healing process. Appropriate and helpful responses to disclosures are as follows:

"I am glad you told me, thank you for trusting me."

"You are very brave and did the right thing."

"It wasn't your fault."

"I am proud of you for telling me."

Preventing Child Sexual Abuse

Doctors and other medical professionals can help to prevent CSA by delivering messages on personal space and privacy to their young patients and their parents. They can do this by:

- Talking to parents about the importance of teaching their children about their personal space and privacy by 3 years of age
- Encouraging parents to teach their children the concept of "OK and NOT OK" touching and the need to tell if anyone touches their "private" parts for a reason other than to provide care.
- Encouraging parents to teach their children not to keep secrets.
- Telling parents that they should limit the individuals who provide genital, perianal and bathing care to those who they trust to reduce risk.

- Letting parents know that it is best to ensure the children become independent in taking care of their own genital/perianal care.
- Encouraging parents to teach their children the appropriate names for their private parts so they have the language to communicate.
- Looking out for signs that a child is being abused and take necessary action.
- Talking to other colleagues in the health care sector about CSA.

The Law on Child Sexual Abuse :

The Protection of Children from Sexual Offences Act, 2012

- The POCSO Act came into force in November 2012 to provide for the protection of children from the offences of sexual assault, sexual harassment and pornography.
- The Act defines a child as any person below eighteen years of age. It includes childfriendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts.
- It defines different forms of sexual abuse, including penetrative and non-penetrative assault, as well as sexual harassment and pornography.
- It deems a sexual assault to be "aggravated" under certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by a person in a position of trust or authority vis-a-vis the child, like a family member, police officer, teacher, or doctor.

Mandatory Reporting

The Act provides for mandatory reporting of sexual offences, so that any adult, including a doctor or other health care professional, who has knowledge that a child has been sexually abused is obliged to report the offence, failing which he may be punished with six months' imprisonment and/or fine **(Sections 19 and 21 of the POCSO Act)**.

When reporting, the doctor or other health professional should describe the nature of the abuse and the involved parties (if he/she is aware of them). He or she should be prepared to give the name, address, and telephone number of the child and also the name of the parent or caretaker if known. However, he or she is not expected to investigate the matter, or even know the name of the perpetrator. This should be left to the police and other investigative agencies.

The report may be made to the Special Juvenile Police Unit, or to the local police station. Alternatively, a call can be made to the Childline Helpline at 1098 and they can then assist the reporter in making the report.

"***Child sexual abuse is a preventable health problem that has been allowed to spread unabated due to scientific and social neglect.***"

- PAUL FINK, SCIENCE, VOL 309, AUGUST 2005

The Act does not lay down that a mandatory reporter has the **obligation to inform the child** and/ or his parents or guardian about his duty to report. However, it is good practice to let parents/guardians know that action to report will be taken. This will help establish an open relationship and minimize the child's feelings of betrayal if a report needs to be made. When possible, the medical professional should discuss the need to make a child abuse report with the family and with the child if in his/best interest, according to the age and maturity of the child. However, be aware that there are certain situations where if the family is warned about the assessment process, the child may be at risk for further abuse, or the family may leave with the child.

Role of Health Professionals under the Act

Doctors have a dual role to play in cases of CSA. They are in a position to detect that a child has been or is being abused (for example, if they come across a child with an STD); they are also often the first point of reference in confirming that a child has indeed been the victim of sexual abuse.

Under Section 27 of the POCSO Act, the doctor must conduct a medical examination as per the provisions of Section 164A Criminal Penal Code. Where the victim is a girl, the medical examination is to be conducted by a woman doctor. It is to be conducted in the presence of the parent of the child or any other person in whom the child reposes trust or confidence; if such person cannot be present, the examination is to be conducted in the presence of a woman nominated by the head of the medical institution.

Under Rule 5 of the Act, emergency medical care is to be provided by any medical facility, private or public; and no magisterial requisition or other document is to be demanded as a precondition to providing emergency medical care. Such care includes:

- treatment for cuts, bruises, and other injuries including genital injuries, if any;

- treatment for exposure to sexually transmitted diseases (STDs) including prophylaxis for identified STDs;
- treatment for exposure to Human Immunodeficiency Virus (HIV), including prophylaxis for HIV after necessary consultation with infectious disease experts;
- possible pregnancy and emergency contraceptives should be discussed with the pubertal child and her parent or any other person in whom the child has trust and confidence; and,
- wherever necessary, a referral or consultation for mental or psychological health or other counseling.

Further, Rule 7 of the POCSO Act provides that expenses incurred in providing medical care to the child may be recovered in the compensation awarded to the child.

The role of the doctor may include:

- Obtaining a medical history of the child's experience in a facilitating, non-judgmental and empathetic manner;
- Meticulously documenting historical details;
- Conducting a detailed examination to diagnose acute and chronic residual trauma and STDs, and to collect forensic evidence;
- Considering a differential diagnosis of behavioural complaints and physical signs that may mimic sexual abuse;
- Documenting all diagnostic findings that appear to be residual to abuse;
- Assessing the child's emotional and physical well-being and making appropriate referrals;
- Formulating a complete and thorough medical report with diagnosis and recommendations for treatment;
- Testifying in court when required.

Medical History

It is important to obtain a detailed medical history before examining the child. The medical history will serve to guide the physical examination. Its objective is not to obtain information for forensic purposes but for treatment and diagnosis and to ensure the safety of the child.

Taking Medical History

- The interview should begin by assessing the child's competence. This can be done by asking questions unrelated to the abuse, such as favourite colours, school activities, and likes and dislikes.
- The interview should not be an investigative one (this should be left to the police and courts), but relevant questions should be asked to obtain a detailed pediatric history and a review of systems.
- The questions asked and the child's responses verbatim, as well as their body language, demeanor and emotional responses to questioning should be documented.
- One can begin the conversation by talking about less threatening subjects.
- Overall medical history, past incidents of abuse or suspicious injuries, and menstrual history should be documented.
- It is best to avoid leading and suggestive questions; instead, maintain a "tell-me-more" or "and-then-what-happened" approach.
- It is best to avoid showing strong emotions such as shock or disbelief.

The following should be addressed in the medical history:

- A familial psychosocial history;
- A detailed medical history of the child with a review of systems focusing on any anogenital complaints such as bleeding, discharge, pain, or past genital injury;
- The child's history of sexual abuse, ideally obtained without the parent/caregiver present; and
- An adolescent medical history should include age of menarche and date of last menstrual period.
- Additional information to obtain includes changes in the child's behavior, specifically sexualized behaviors, and especially in young children the names the child uses for body parts (e.g., breasts, vagina, penis, and anus).
- The child and the parent should be informed and reassured that the pediatric forensic exam is not invasive or painful and does not routinely include the use of internal instrumentation or speculum insertion.
- The child should be prepared for the physical examination[6].

Child sexual abuse is most often a diagnosis based on history, as opposed to physical findings.

Examining the Child

Consent

According to the Indian Penal Code, where the child is over twelve years old, consent for the medical examination should be sought from the child himself or herself7 . Where he or she is below the age of twelve, a parent or the guardian may be asked for such consent.

Consent should be taken for the following purposes: examination, sample collection for clinical and forensic examination, treatment and police intimation.

Informed consent

Consent should be informed, i.e. the person giving the consent should be told about the purpose, expected risks, side effects, and benefits of the examination, and the amount of time it will take. This information should be given before the examination is conducted, in a form, language and manner that the child and his parent/ guardian can understand.

A child that has suffered abuse and his/her family may approach a health facility under three circumstances, and informed consent must be taken in all:

a) on his/her own only for treatment for effects of assault;

b) with a police requisition after police complaint; or

c) with a court directive.

- If child (and family) has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age).
- If child (and family) has come on his/her own without the First Information Report (FIR), she may or may not want to lodge a complaint but may require a medical examination and treatment. Even in such cases the doctor is bound to inform the police as per law.
- However neither the court nor the police can force the survivor to undergo medical examination. In case the survivor does not want to pursue a police case, an MLC must be made and s/he must be informed that s/he has the

right to refuse to file FIR. An informed refusal must be documented in such cases.

- If the child (and family) has come with a police requisition or wishes to lodge a complaint later, the information about medico-legal case (MLC) number & police station should be recorded.
- Police personnel should not be present during any part of the examination.

Physical Examination

The general approach to the physical examination follows the standard head-to-toe approach. Elements of the examination include the following:

- Determination of structures of interest – Mons pubis, labia majora and minora, clitoris, urethral meatus, hymen, posterior fourchette, and fossa navicularis in case of girls and penis, scrotum, and testes in case of boys
- Choice of positioning for optimal exposure of prepubertal genital structures – Frog-leg supine position, knee-chest position, or left lateral decubitus position
- Calming the child during examination
- General observation and inspection of the anogenital area, looking for signs of injury or infection and noting the child's emotional status
- Visualization of the more recessed genital structures, using handheld magnification or colposcopy as necessary
- Collection of specimens for sexually transmitted disease (STD) screening and forensic evidence collection
- Evaluation of any observable findings – Although most individuals who have been sexually abused present with essentially normal examination findings, observable findings may include (1) those attributable to acute injury or (2) chronic findings that may be residual effects following repeated episodes of genital contact.

It is important to remember that the results of a physical examination will be within normal limits in the vast majority of cases of child sexual abuse. The absence of physical findings can be explained by several factors:

- Many forms of sexual abuse do not cause physical injury. Thus, the sexual abuse may be non-penetrating contact and may involve fondling, oral-

genital, genital or anal contact, as well as genital-genital contact without penetration.

- Often, the child and family typically know the perpetrators, and physical force is not often a major component as in adult sexual assaults.
- Mucosal tissue is elastic and may be stretched without injury, and damage to these mucosal surfaces heals quickly.
- Finally, disclosure of abuse is often delayed; many victims of sexual abuse do not seek medical care for weeks or months after the abuse, and superficial abrasions and fissures can heal within 24 to 48 hours.

Diagnosis

- Gram stain of vaginal or anal discharge
- Genital, anal, and pharyngeal culture for gonorrhea
- Genital and anal culture for chlamydia
- Serology for syphilis
- Wet prep of vaginal discharge for Trichomonas vaginalis
- Culture of lesions for herpes virus
- Serology for HIV (based on suspected risk)

Other tests that may be considered include the following:

- Collection of forensic evidence preferably with a rape kit, wherever available; and
- Urine toxicology screen (if the abuse or assault was substance-facilitated).

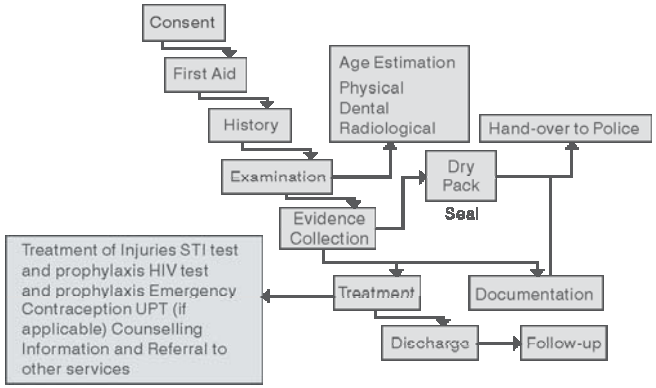
Management

Medical treatment of CSA follows the diagnosis. Recommendations include the following:

- Treat STDs with appropriate medications
- In post-menarchal children, consider the possibility of pregnancy and the need for emergency contraception
- Recognize the overriding need for emotional support and attention
- When sexual abuse is seriously suspected or has been diagnosed, ensure that it is reported to the appropriate authorities

- Keep well-documented medical records; these are essential in legal proceedings, which may occur over long periods
- A referral to a mental health specialist should be made in all cases. Mental health consultation is warranted to evaluate and treat acute stress reaction and, later, posttraumatic stress disorder (PTSD).

The following are the components of a comprehensive health care response to sexual violence and must be carried out in all cases :



Forensic Examination

- Forensic evidence includes blood, semen, sperm, hair or skin fragments that could link the assault to an individual person, as well as debris (e.g., carpet fibers) that could link the assault to a location.
- Evidence collection should be performed if sexual contact occurred within 96 hours of the physical examination.

What is the purpose of a forensic examination?

It is to ascertain:

- Whether a sexual act has been attempted or completed. Sexual acts include the slightest genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching. However, the absence of injuries does not imply consent.
- Whether such a sexual act is recent, and whether any injury has been caused to the child's body.

- The age of the survivor, in the case of adolescent girls/boys.
- Whether alcohol or drugs have been administered to the child.

Table indicative of type of evidence to be collected9

History of sexual violence	Type of Swab	Purpose	Points to Consider
Peno-vaginal	Vaginal	▪ Semen/ sperm-detection ▪ Lubricant ▪ DNA	▪ whether ejaculation occurred inside vagina or outside ▪ use of condom
	Body	▪ semen/sperm detection ▪ saliva (in case of sucking/licking)	▪ if ejaculation occurred Outside
Peno-anal	Anal	▪ Semen/sperm detection ▪ DNA ▪ lubricant ▪ faecal matter	▪ whether ejaculation occurred inside anus or outside ▪ use of condom
	Body	▪ semen/sperm detection ▪ saliva (in case of sucking/licking)	▪ if ejaculation occurred Outside
Peno-oral	Oral	▪ Semen/sperm detection ▪ DNA ▪ saliva	▪ whether ejaculation occurred inside mouth or outside ▪ use of condom
	Body	▪ semen/sperm detection ▪ saliva (in case of sucking/licking)	▪ if ejaculation occurred Outside
Use of objects	Swab of the orifce (anal, vaginal and/or oral)	Lubricant	Detection of lubricant used if any
Use of body parts (fngering)	Swab of the orifce (anal, vaginal and/or oral)	Lubricant	
Masturbation	Swab of the orifce or body part	▪ Semen/sperm detection ▪ DNA ▪ lubricant	▪ whether ejaculation occurred or not ▪ if ejaculated in orifce or body parts

Role of Mental Health Professionals

Throughout the process, mental health professionals play a key role in assisting the child and his/her family, as highlighted below:

- **Assessment of Lethality:** Usually victims of sexual abuse are vulnerable to considerable psychological distress and hence may tend towards self-harming behaviour. Such indicators should be duly noted by professionals not only for warning family members but also in providing immediate help to the child regarding this.

- **Catharsis:** Professionals can help the child narrate the incident and undergo complete catharsis to reduce the burden of trauma. Also they can provide help in handling range of emotional conflicts experienced.
- **Psychological Debriefing:** this is done by providing emotional and psychological support to the child following trauma to prevent development of PTSD and other forms of negative sequelae.
- **Normalize the Feelings of Victim:** Professionals should let the child know that it's absolutely okay to feel the way he or she is feeling. This helps to validate the child's feelings and unconditionally support them. This will also encourage them to emotionally express themselves completely.
- **Instilling Hope:** It is important to instil hope and attempt a positive resolution of the traumatic experiences of child. This also helps in reducing obsessive deterioration of self-respect when child come to believe and trust that a change is possible.
- **Interviewing Skills:** To begin interviewing the child, it is important to create a safe therapeutic environment where the child feels accepted and validated in herself/ himself. The session flows with the child's expression of inner feelings.
- **Assessment of Psycho-social Issues:** it is important to take a detailed history of the family background with specific emphasis on parental practices and type of family interactions. This helps in assessing any dysfunctional family boundaries and communication pattern which may be responsible for CSA.
- An assessment of the child's relative strengths and weaknesses may be significant for further building one's coping strategy in therapy.
- Enquiry should be done in gentle, casual, non-confrontational and non-threatening manner.
- An assurance of safety, security and confidentiality should be provided to the child as otherwise the child's fear of further harm consequent to disclosure would impede revelation.
- Professionals should validate and affirm that she/he did the right thing to reveal the truth.
- It is best to void barging the child with too many questions.
- It is important to avoiding trying to gather all the information in one session itself and thereby unnecessarily pressurizing the child

Who else is involved?

In cases of child sexual abuse, it often happens that the child does not receive adequate legal assistance as well as proper medical support and counseling, causing the redressal process to be ineffective and traumatic while heaping

physical and mental distress upon the child and his/her family. There is therefore a need for action that can protect the child from further abuse and help him deal with his/her trauma and prevent revictimisation. The POCSO Act envisages a multi-sectoral approach that will be conducive to the justice delivery process, minimize the risks of health problems, enhance the recovery of the child and prevent further trauma. This is to be achieved through coordination and convergence between all the key players. It would therefore be very useful for hospitals and medical professionals to maintain links with their local police station, Special Juvenile Police Unit, Child Welfare Committees and District Child Protection Units.

The key organizations and professionals involved in the pre-trial and trial stages to assist the child are:

- Special Juvenile Police Unit or local police: Under the Juvenile Justice Act, each district has to have police officers especially trained to deal with children's issues. They form the Special Juvenile Police Unit.
- Health professionals, including those who render emergency medical care, conduct the medical examination and provide any other medical assistance. In some cases, the doctor or health care worker may be the first person who detects that the child has been sexually abused, for example when a child is taken to a paediatrician with a complaint which the latter then diagnoses as a sexually transmitted infection
- Mental Health professionals, such as counsellors, psychologists and psychiatrists to whom the child is referred for trauma counselling and long-term psycho-social support
- Interpreters, translators and special needs educators who may assist the child at various stages of the process.
- Child development experts.
- Social workers, support persons and NGO workers who may assist the child through the process
- Members of Child Welfare Committees before whom a child may be presented for assessment of protection needs (Rule 4[3] of the POCSO Act, 2012).
- Advocates, including legal aid lawyers and public prosecutors, involved in prosecuting the offender.
- Judges and staff of Special Courts.

The Model Guidelines under the POCSO Act, published by the Ministry of Women and Child Development, contain descriptions of the functions of each of these professionals under the Act, and also lays down guidelines for how these duties are to be discharged.

Myths and misconceptions about child sex abuse

- **The abuser is usually a stranger:** In most cases, the abuser is a person known to the child. The people most likely to abuse a child are the ones with the most opportunity, most access, and most trust.
- **Incest, i.e. sexual abuse by a person related to the child, is not common amongst well-educated or well-off people:** Incest happens in all kinds of families, including families like ours. It does not depend on class, socio-economic status, education, etc.
- **Sexual abuse never happened and the child is making it up or exaggerating:** Children rarely make up stories about things that traumatise them. In fact, research shows that children often minimize and deny, rather than embellish what has happened to them.
- **No damage is done by the abuse unless the child is visibly physically harmed:** Some acts, like fondling and oral sex, leave no physical traces. Even if the child has not been physically abused, any kind of sexual abuse causes psychological trauma to the child.
- **Many children do not reveal sexual abuse because they are enjoying it:** The reason children do not report it is because they are afraid, ashamed, or have been bribed or threatened.
- **He looks normal and acts normal, so he can't be a child molester:** Sex offenders are knowledgeable about the importance of their public image, and can hide their private behaviour from their friends, neighbours, colleagues, and even their own family members. Some child molesters appear to be charming, socially responsible, caring, compassionate, morally sound, and sincere and parents and other responsible adults trust these individuals.
- **Child molesters molest indiscriminately:** N ot e veryone w ho c omes i n c ontact with a child molester will be abused. Sex offenders tend to carefully pick and set up their victims by “grooming” in which the perpetrator skilfully manipulates the child into participating.
- **A child says that they have been sexually assaulted and then later says that it didn't really happen. This clearly means that they are lying:** Children may retract an allegation because of enormous pressure placed on them to make it go away. Disbelieving adults give the child the idea that if they say it was a lie things will return to normal. However an offender will not stop abusing and often becomes more aggressive knowing that if the child says something again people will not believe them.

- T**he victim is always a girl:** Just as women can be sex offenders, boys may be victims of abuse. Unfortunately, child sexual abuse with male victims is underreported due to social and cultural attitudes: boys are taught to fight back and not let others see vulnerability. Boys are aware at an early age of the social stigma attached to sexual assault by another male, and fear appearing weak to others. All of these attitudes make male child victims less likely to tell of their abuse.
- **Children are abused because their parents have neglectful style of parenting and fail to supervise their child properly.** T hough s ometimes a bsence o f s ex e ducation i n childhood makes a child an easy traps, however, usually offenders are quite tactful in manipulating both the caregivers and the child and they are to be essentially blamed for.
- **Sexual abuse victims are "damaged goods" and their lives are ruined forever:** While sexual abuse is incredibly damaging, victims are not "damaged goods." Healing is easiest when the intervention is immediate and appropriate therapy is provided. For adults who have repressed memories, the recovery process can be lengthy. However, all victims of abuse can become fully functioning, healthy children and adults.

- Courtesy : UNISEF

Answers

Chhota Sudoku

9	5	3
4	2	7
1	6	8

20	17
13	23

7 BR OK EN Words

1 EURO
2 TAKA
3 RIAL
4 POUND
5 RUPEE
6 DINAR
7 DOLLAR

Sudoku

3	6	9	7	8	2	5	4	1
1	2	5	4	9	3	6	7	8
8	4	7	5	1	6	2	3	9
6	5	2	3	4	9	8	1	7
9	3	1	6	7	8	4	5	2
7	8	4	2	5	1	9	6	3
5	9	6	8	3	7	1	2	4
2	7	8	1	6	4	3	9	5
4	1	3	9	2	5	7	8	6

KEN KEN PUZZLE

4+ 1	3	11+ 4	2	5
9+ 4	9+ 5	5+ 2	3	1 1
2	4	1 1	5 5	3 3
3	3+ 2	5 5	1 1	10+ 4
5 5	1	3 3	4	2

ROLE OF PATHOLOGIST IN CLINICAL MEDICINE

Pathology is the mother of all branches in modern medicine. Modern Medicine has been able to glorify itself and take the credits of having understood human body due to all the advances in Pathology which has made understanding of the diseases better. In fact it is the wing of pathologist who decoded human genome to make wonders in the field of modern medicine and therapeutics. The world utilizes pathologist for stem cell therapy to cure leukemia and Thalassemia. Organ banks and artificial organ banks have now started booming in the country which with the help of pathologist design knee cartilages, blood vessels, tissue valves of heart to help aid better treatment. Modern surgical treatment like across the blood group liver transplant have become possible today due to revolutionary leaps in Pathology.

Clinical medicine as a subject is amalgamation of Pathology and Pharmacology. Pharmacology in turn is amalgamation of Physiology and Pathology with biochemistry. Hence Pathology forms the nidus of modern medicine.

Today a practicing physician or surgeon is lame and helpless without Pathologist. It is pathologist who guides clinician about the changes of milieu interior which helps clinician to save life by arriving at correct diagnosis, as no treatments are possible without correct diagnosis.

The verdict of Final diagnosis “The confirmatory test” is always on shoulders of Pathologist. Clinician through his clinical skill suspects the disease and puts multiple possibilities as differential diagnosis. It is pathologist who through his microvision under the microscope and skillful understanding helps arrive at a pin point diagnosis which enables clinician to treat the ailment.

Hence Pathologist world wide plays a vital role in diagnosis and management of any disease. Pathologist is the hero behind the screen who guides the philosophy of treatment. Hence all treatments are based on pathologist's assistance.

When we understand so well the role of pathologist then how can handful of clinician be so callous in ignoring this fact and take such a risk by relying solely on technician's reports ? Technicians are staff working under pathologist, like compounders under clinician and OT assistants under a surgeon or nurse in a nursing home. Can you entrust your compounder or OT assistant or nurse to carry the job in your place? This is crime because technician would know the mechanics of machine and the test but would not know the principle, Physiology, Pathologenesis and variable factors in the test.

The essence of disease and dialogue with the clinician suggesting some more test or follow-up of tests to treat the disease which may otherwise become deadly are of utmost importance for the success of Physician's treatment. Good Physician is one who engages himself in dialogue with pathologist towards diagnosis and progress of the disease. Physician is evaluated and ranked in the society from the results he produces and from the successful treatment that he delivers. For this his right and left cerebral hemispheres are Pathologist and Radiologist. If it was machine only which could furnish a clinician with a biochemical report then likewise you even have ECG technicians, Echo TMT technicians, Sonography technicians, Robots to perform surgery .Then what is the need of surgeon or Physician or Radiologist?

The above mentioned facts need to be understood by some of our clinician friends who think that pathologist means operating set of automatic machines. This is not true. Do you know that a cell counter can make blunders and can not diagnose leukemia? It may miss true Platelet count? It may miss Megakaryocyte. No technician has any education of Human physiology or pathology. Then how can a knowledgeable clinician base his treatment on the report delivered by a technician run laboratory?

Simple case of Anemia needs to undergo microscopy to know the type of anemia. All anemias are not nutritional or iron deficiency. There may be megaloblastic anemia, hemolytic anemia, leukemia, myelodysplastic syndrome, chronic blood loss etc etc. These guidelines to clinician are of utmost importance as missing any of the important diagnosis in these days of ultra awareness by well informed patients means inviting trouble even on legal front. Labs run by technicians are illegal. Since there is relative scarcity of Pathologist in periphery, probably government gives deaf ear to these labs which mushroom all over the country.

Pathologist's report is documentation which protects clinician from legal hurdles. E.g. Patient aged 37 years with acute severe chest pain with non specific changes in ECG hospitalized and died in 1 hour. It was difficult time for Physician to label it as Acute Myocardial infarction with cardiac arrest as blood for Trop I, CK MB, GOT, LDH was not sent to pathologist. Physician would have shared the responsibility with pathologist had he sent all these reports to a qualified pathologist and not a technician. Honourable court takes notice of such cases as medical negligence.

Patient underwent surgery in a small surgical nursing home. Few months later patient was reported HIV positive by another pathologist. Patient blamed surgeon for using soiled instruments and injectables. Blood transfusion was not given to the patient. Surgeon had ordered pre operative investigations which were done in his "So called Lab" run under his supervision by a technician. Honourable court took a serious note of the fact and set an inquiry by experts comprising of pathologist and clinician. Negligence on the part of the surgeon was alleged strongly as surgeon could have got preoperative reports done by qualified pathologist. Pathologist is aware about the Window period in high risk patients and can perform Westernblot test or category III or Category IV tests to detect patients who are otherwise reported as HIV negative with screening tests.

Hence today practicing clinical science has become a great responsible job where one always needs documentation of having done correct diagnosis and correct treatment with the help of qualified personals as team by sharing responsibility. Today X rays are taken by radio technicians but we do not rely on their reports, likewise how can we rely on reports of technicians who have no educational basis???? Is it worthwhile risking our practice and reputation to unauthentic reports generated by unqualified?

Today pathology has advanced by leaps and bounds. In good old days Histopathology reports were relied on; based on grey hair of pathologist. The controversy of benign vs malignant lesion was a day to day affair. Now a days it is no longer opinion based histopathology reporting based on seniority and whims of Pathologist. Even pathologist needs to document Histopathology report and confirm whether benign or malignant by IHC (Immunohistochemistry) tests. IHC tests in fact guides cancer therapy too. If there are hormone receptors then it means that tumor is hormone therapy sensitive and will respond to hormone therapy. Likewise FISH technology, Flow Cytometry has revolutionized oncopathology.
Pathology is a head to toe subject where blood biochemistry makes only a small component of pathology. Let us not pollute our medical science with quacks and paramedicals whose job is to assist a pathologist and not be a pathologist. Machines always need man behind the machine……

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