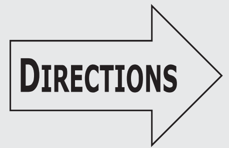

Reflections of a Fulbright-Nehru Scholar: The need for physician action in India's child maltreatment challenge

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Physicians should seed and support social change to address India's child maltreatment crisis

ARTICLE INFO

Article history:
Available online 26 September 2015

As I traveled from the tropical southern state of Kerala to a quaint hillside town at the base of the Himalayan mountain range, I first thought to myself, "I'm living an 'Incredible India' tourism commercial." However, I quickly, and sadly, realized that there are facts about India that are not told in tourism commercials. For example, India is home to over 440 million children, with an estimated additional 26 million babies born annually. According to UNICEF and non-governmental organization (NGO) statistics, approximately 50 million children are engaged in child labor, approximately 20 million are

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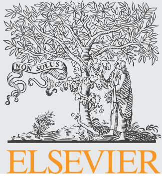
http://dx.doi.org/10.1016/j.chiabu.2015.08.014
0145-2134/© 2015 Published by Elsevier Ltd.

Child Abuse & Neglect 50 (2015) 26–32



"street children," and hundreds of thousands are trafficked annually in the commercial sex trade. India's own National Child Abuse Study and other NGO studies have demonstrated alarming prevalence data on physical and sexual abuse. For example, a quarter to one-half of India's children are victims of physical and sexual abuse. Desmond Runyan and colleagues have confirmed high rates (20–40%) of harsh discipline (e.g., kicking, choking, burning/branding, or hitting over and over again with an object or a fist) by Indian mothers. The numbers are staggering. How does the birthplace of the non-violent political philosophical movement reconcile itself with such maltreatment and violence toward its own children? It is a question India is grappling with right now.

The acceptance in the past two decades that child maltreatment is a very real concern in India has precipitated the government to promulgate both policies and legislation. The more notable of these actions include the Juvenile Justice (Care and Protection) Act of 2000 (amended in 2006), which provides a framework for child protection; the Right to Free and Compulsory Education Act (2009); and the Protection of Children from Sexual Offences (POCSO) Act (2012). India's Ministry of Women and Child Development has only recently conceptualized a centralized child maltreatment response scheme, referred to as the *Integrated Child Protection Scheme of 2009* (revised 2014). This scheme aims to institutionalize essential child protection and welfare services, to create a database and knowledge base for child protection services, and to organize appropriate inter-agency child protection and welfare responses at all levels. However, its implementation thus far has been variable and incomplete, and future funding is minimal at best (less than 50 paisa, or half a rupee, of every 100 rupees pledged for social development).

The lack of a meaningful central government response has left a child protection and welfare vacuum, which social NGOs have only partially been able to fill. Although many have tirelessly endeavored, the magnitude of the problem has, unfortunately, had only a marginal impact. As Narendra Saini, Honorary Secretary General of the Indian Medical Association, stated at his presentation at the 28th Confederation of Medical Associations in Asia and Oceania General Assembly in September 2013, this is a job for ". . .the State. It is for the State, as well, to bring together different professions and disciplines to make common cause in defense of children's safety and security." W*ho will compel the State to action?* Although multiple professionals are involved in and vital to the progress of child protection, I would submit that physicians are uniquely positioned to lead social change to address India's child maltreatment crisis.

Why Physicians?

Historical Precedent

One need look no further for the necessity of physician action than history. The history of modern era child protection is replete with physician activism. From the French forensic physician, Auguste Ambroise Tardieu, who penned the first detailed medical description of child abuse in 1860 which led to the revision of French child labor laws, to John Caffey (widely recognized as the Father of Pediatric Radiology), whose initial descriptions of subdural hematoma's and long bone fractures helped identify hidden trauma as the diagnostic basis of Abusive Head Trauma, to pediatrician C.

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