JMAJ
Japan Medical Association Journal
Vol. 51 No. 6 November-December 2008

Message

Greeting

50th Anniversary of CMAAO

Conferences and Lectures

Message

On the Occasion of the 50th Anniversary of CMAAO

Yoshihito KARASAWA*1

This year marks the 50th anniversary of the establishment of the Confederation of Medical Associations in Asia and Oceania (CMAAO). This issue provides a record of the CMAAO 50th Anniversary Celebration.

A former president of the Japan Medical Association (JMA), Dr. Taro Takemi, and Dr. Rodolfo P. Gonzalez of the Philippine Medical Association are said to have played leading roles in the establishment of CMAAO.

The JMA joined the World Medical Association (WMA) in 1956 at the same time as the German Medical Association. Dr. Takemi served as president of the JMA for 25 years from 1957, becoming president shortly after the JMA joined the WMA. In 1959, the inaugural CMAAO Congress was held in Tokyo, Japan. Dr. Takemi believed that it was very important that the opinions of regions, particularly the Asia-Pacific region, be reflected within the WMA, and that this was imperative for the formulation of a foundation for the WMA, an organization representing medical associations around the world. Consequently, it is said that Dr. A.Z. Romualdez of the Philippines, who was then WMA Secretary-General, also became involved in the establishment of CMAAO in order to forge ties between the two organizations.

During the program of the 1st CMAAO Congress, Dr. Takemi said, "The emerging close and rapid connecting of people around the world today through scholarship and culture is unprecedented in the history of humankind. This could be called the 'birth of a new world.' I believe that this 1st CMAAO Congress will create a core for this 'birth of a new world.'"

Dr. Takemi emphasized the importance of taking an extremely global perspective. He stressed the need to realize that diseases occurring on one's own country do not exist in isolation and to unceasingly seek connections with other areas of the world as to the diseases' significance in terms of global healthcare. Dr. Takemi formulated this approach—which we apply to the problems we face today, such as avian influenza and other transnational medical issues and the impact of climate change on healthcare—more than 30 years ago. This issue contains a paper by Dr. Takemi that provides insight into his medical philosophy, so please take the time to read it.

It is my hope that this special CMAAO issue provides an opportunity to consider the future of CMAAO, an organization that was established as a foundation for the work and achievements of physicians in the Asia-Pacific region.

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Greeting

50th Anniversary of CMAAO—Congratulations by the World Medical Association

Otmar KLOIBER*1

When the Confederation of Medical Associations in Asia and Oceania (CMAAO) was founded fifty years ago, the world was deeply divided and actually at the brink of a nuclear catastrophe. What is normal today—to cooperate, act, even to legislate across borders—fifty years ago was no more than a vision requiring courage and eagerness to make a change for the better. Building bridges was the vision of a few for the benefit of all.

More than many other professions, medicine relies on collaboration and exchange. Physicians migrate to other countries to learn, teach and work. Patients migrate to, or seek advice in, other countries. As a human family, we not only share the same biology, we share the same pathology. Close international cooperation in medicine is more than useful, it is absolutely essential.

CMAAO and the World Medical Association (WMA) helped to pioneer this kind of cross-border cooperation, thanks to visionary leaders in the early days of our associations: Dr. Taro Takemi (Japan Medical Association), Dr. Rodolfo P. Gonzalez (Philippine Medical Association) and Dr. Romualdez of the Philippines. Today our partnership is more active than ever, with the strongest representation of the Asian and Pacific region in WMA in our history. Civil engagement in medical associations—both national and international—provides crucial advocacy opportunities to benefit both patients and their physicians. Together members of CMAAO and WMA have shown leadership in advocacy most recently with our Caring Physicians of the World Conference in Tokyo in 2006 and our 2008 General Assembly in Seoul. We look forward to visiting Asia again with our General Assembly in New Delhi, October 14–17, 2009. Our newest initiative—the Caring Physicians of the World Leadership Course—has been very well received by our members from CMAAO countries and we plan to bring this exceptional course even closer to the region.

The WMA offers its heartfelt congratulations to CMAAO, our steady and loyal partner for fifty successful years. We wish you a bright future in support of physicians and the patients you serve in your region and, indeed, across the world. We also hope this half-century of cooperation is also a good incentive for the few CMAAO members who have not joined WMA to do so now.

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Commemorative Lecture of the Late Dr. Taro Takemi

Characteristics of Man in a Life Cycle in the Development and Allocation of Medical Care Resources

JMAJ 51(6): 353–357, 2008

Taro TAKEMI*1

I have been involved with the work of the World Medical Association (WMA) since 1970. The duties assigned to me concerned primarily socio-medical affairs. When the World Medical Assembly was held in Tokyo in 1975 and I was appointed WMA president, I proposed that the WMA take up the question of "the development and allocation of medical care resources." Fortunately, my proposal was accepted, and it was subsequently decided that the socio-medical affairs committee alone would be inadequate to carry out this task. Therefore, it was decided that the Japan Medical Association (JMA) undertake to form a special committee to follow up on this theme. And the committee has met twice since then.

It has been recognized that the theme of "the development and allocation of medical care resources" is of utmost importance because it includes the most fundamental problems of medical care found in every country of the world.

It gives me great pleasure to be able to discuss one of what I have regarded as central problems. Both medical science and economics are the most important basic branches of learning to human survival and living.

I thought that a new survival order—which includes a new social order, economic order and medical care order—and a new ethics and science and technology must be developed, bridging these two disciplines. Human survival and living must be examined from every angle, and man must be grasped as an individual and groups and in his relationship with his environment. When man is grasped as an individual being, his economic life has a very important meaning. At the same time, medical care must be considered as something of great fundamental significance.

When we examine the mechanisms of human survival we must start with a consideration of in what form human beings are spread over the surface of the earth. I use the ecological approach and regard human life as a thin film covering the earth. During the age of agricultural society, very little development of natural resources was carried out. There, human existence was found in terms of metabolism occurring in the surface layer of the earth.

As industrialization progressed, however, man began extracting natural resources from the deeper layers of the earth. With further industrialization, we entered the age of mass production with these natural resources. The things produced in this mass production stage were not recycled back to the earth after they served the purpose for which they had been intended. This is the reason why we had the pollution of the environment.

The industrial society developed during the height of economic growth, and it is a fact that this brought about an elevation of the standard of living. It is also a fact that the allocation of industrial goods became a major economic issue.

In agricultural production, the metabolic cycle was very simple, and natural resources were recycled locally in a very natural manner. In the industrial society, however, the situation was totally different. There was absolutely neither

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This article was selected from a commemorative book "Socialized Medicine in Japan" published in 1982 which collects major articles written by Dr. Taro Takemi, past President of the JMA who served president for 25 years. The text remains unchanged.

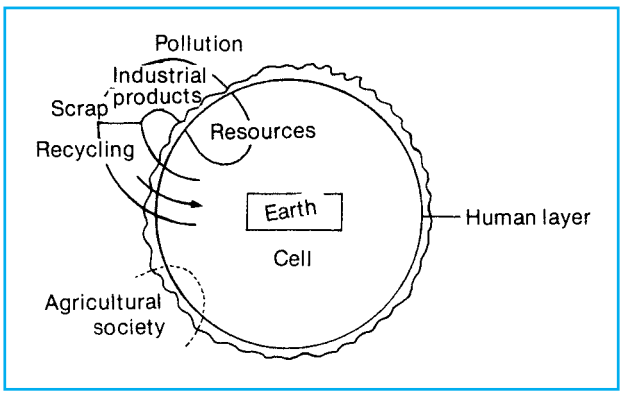

Fig. 1 Man in a metabolic process in 'cellular membrane' on earth's surface

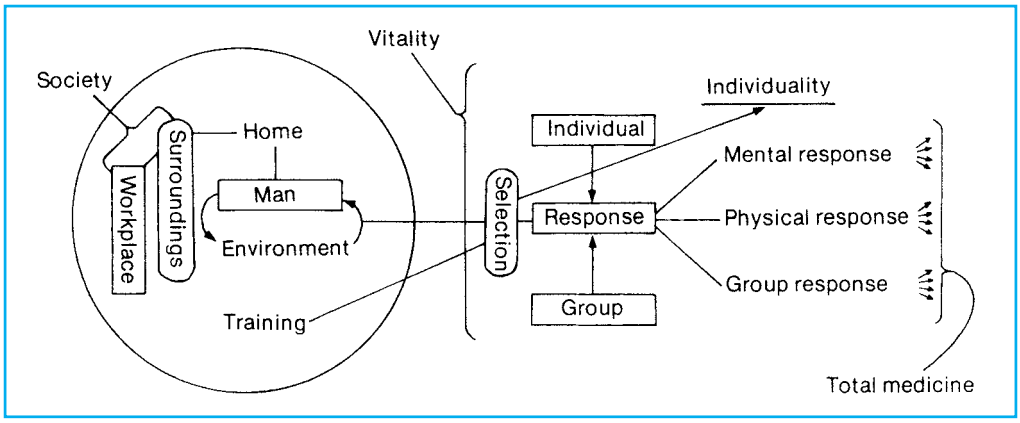

Fig. 2 Demand side of medical care

economics nor technology for the recycling of wastes—a fact responsible for a high degree of environmental pollution that occurred, threatening, in some local areas, the survival of man.

What is called the economics of pollution is an economics that came into being after pollution actually occurred. There was an element of prediction of industrial pollution in medicine and public health. But I don't believe there was an economics of prediction. Economics had a close relationship with ethics from its early stage of development. This is the reason why it has attained a major development in its relationship with the industrialized society as a survival order in term of air pollution, industrial accidents, changes in working conditions, and improvement in the standard of living. Yet, economics was essentially a science of labor and consumption and had very little to do with the development of natural resources.

In the case of medical care, the development of its resources is highly important, and I believe that interaction between the process of development centering on medicine and the process centering on economics is extremely important to the stable development of human survival and living. The improvement of economic life is inevitably accompanied by an increase in the demand for medical care. The proper and effective allocation of demand for medical care, I believe, is possible through cooperation between medical science and economics.

For this, it is necessary first of all to establish a goal in the development of medical care resources, but this must be done in both medical science and economics at the same pace.

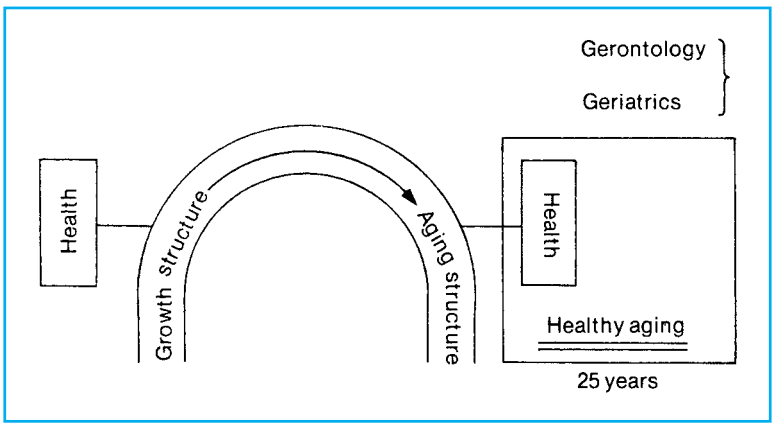

Fig. 3 Qualitative change in population structure by aging

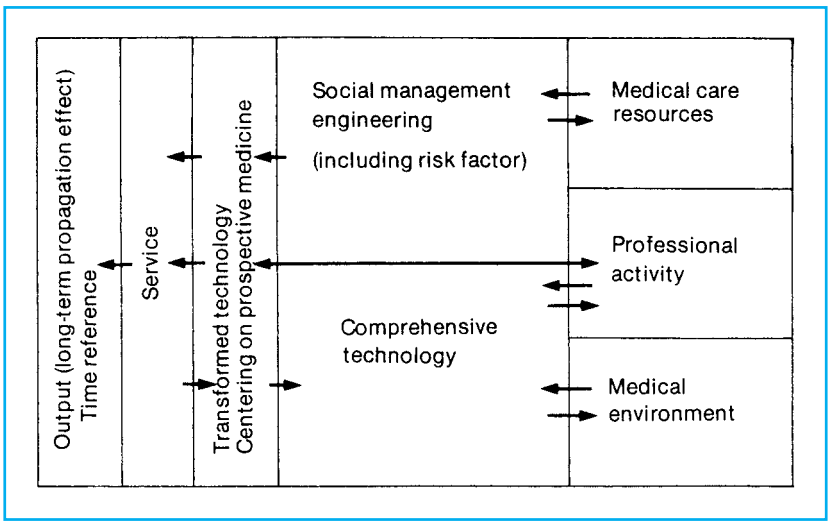

Fig. 4 Supply side of medical care

Medical care must be developed by both individuals and groups as I said earlier. This means, in a nutshell, the question of how an individual or a group responds to demand made by the human body. These may be mental, physical and group responses. And these three kinds of response must be considered in terms of total medicine.

Then there is the important question of the selection of what kind of responses to make. This is where the question of individuality comes in. There are also the questions of the environment, workplace and its surroundings, and the home and its surroundings. In every one of these questions, economics must become involved with both the natural and social environments. Participation by medicine also becomes necessary.

Demand for medical care must be considered in terms of the various periods in the life of man just as it is so with regard to health. For instance, health at the stages of growth in a person must be considered separately from health in the stage of his aging because of the qualitative changes that occur during the latter process. In the stage of aging, geriatrics and gerontology become involved.

As for the structure of aging, the ideal is "to age healthily" and therefore, demand for medical care in the aging period is totally different from that for the periods of growth.

The development of medical care resources must be carried out according to these demands. For this development of medical care resources, there could be such varied targets as development by age bracket, for health improvement, for the prevention of disruption of health, etc. For these purposes, economic rather than social, bases are extremely important, and this is where medical technology has a major role to play.

In short, the development of medical care resources, because it greatly differs from the social development of inanimate objects, must be conducted toward a target established according to the survival process of man. As for industrialization, development must be carried out from the standpoint of industrial medicine with regard to a large number of different types of occupations created by that process of industrialization itself. Here, the development of the environment for man as a group also has a great significance.

The setting of medical targets in the development of medical care resources and the methodology that makes this possible must anticipate many contributions from economics. Economics of today is a science concerned with the state of "completed development." And little attention has been paid to the combination of economics with the technology necessary for the development of the future. Through the systematic study of the development and allocation of medical care resources that has been conducted, however, I have keenly felt the need or this.

The allocation of resources requires a large number of processes. After the kind of development of medical care mentioned above has been achieved, it is to be supplied as a "professional activity" (Fig. 4). Because the medical environment is of extreme importance in this connection, medical care resources, professional activity and medical environment must be considered as parallel concepts. These three must be promoted by comprehensive technology.

Social management engineering, including the management of risk factors, and patient control also become necessary. Comprehensive technology includes medicine and the technologies surrounding it. Another important thing is that through this emerge prospective medicine and its surrounding technologies.

Prospective medicine today is still at a very infantile stage. To those who are on the side of supplying medical care, it is of great importance to establish prospective medicine because, for one thing, it is impossible to conduct an efficient allocation of medical care resources without it.

Service in terms of the allocation of medical care resources based on data obtained by predictive medicine must be provided in such a way as to secure the maximum propagation effect in the long term. Unless the service is given on the basis of metabolic processes varying according to age groups, it would be wasteful. The concept of timing in relation to this service must be thought of as "time reference." When the service is given just before it becomes necessary, it is likely to have a long-term propagation effect.

We have accumulated a large amount of knowledge in relation to the problem of medical care costs for the aged. What we have learned is that when medical attention, including that in mental hygiene, is given to individuals from the time when they are about 35 years old, medical care costs for the same individuals as they become aged are very small—about one-tenth of what is normal.

This seems to suggest that it is possible to think of the provision of medical services for human beings as an investment. In the past, medical care was considered a form of consumption. But when medical service is incorporated into a metabolic system, it makes now development within that system, raising expectations in a long-term propagation effect.

In other words, we must not think of countermeasures after a problem has arisen. Take the case of the prevention of contagious diseases, for instance. If all the countermeasures have been put into effect, prevention could be achieved at a very low cost. When there are no countermeasures in force, on the other hand, there is even the danger of a mass outbreak of a disease with a serious threat to human life, and medical care costs would be enormous. Measures in prospective medicine must be said to have long-term propagation effects.

Therefore, the supply side of medical care does not only include hospitals, clinics and physicians. It requires many new branches of learning, for which it is necessary to select the most effective points of action. Welfare location theory, for instance, which considers welfare in terms of where to locate facilities, may be also important. This means that when a medical care facility is to be established, we must think in terms of

what is to be built where for a long-term propagation effect.

On the other hand, early detection and diagnosis make major contribution to the preservation and promotion of health, and its relationship with social production deserves a serious assessment.

As seen from the above, it is obviously necessary to think anew of the supply side of medical care. Its development and allocation must be considered simultaneously; placing emphasis only on allocation is not adequate.

The health insurance system as a form of allocation of medical care has expanded enormously throughout the world. Essentially, however, insurance is a system based on the idea of compensation for damages. In it the insurer collects premiums to have the insured pay part of the damages while he pays the remainder. Economic measures of this kind, dealing with inanimate matters are rather simple. But when we apply this idea to human society, we are compelled to think of human life, not of inanimate things. As I said earlier, human survival and living has many extremely complex conditions and relationships with the natural and social environments.

Yet, the health insurance system regards disease as a form of damage. As far as I have observed so far, this signifies the fact that medical care resources have been thrown into the metabolic process through medical service. They are therefore, not a form of consumption nor a redress for damages.

Unless we consider the human body in its context of the environment by ecological thinking and also in terms of age bracket, the health insurance system must be thought of as representing an entirely new mode of thinking and a health insurance plan must be formulated primarily on the basis of the concept of life.

This is what I call bio-insurance, which, to be sure, is not a system for compensation for damages. Its supply system must be considered as a form of investment. And effective investment in this system would be maximize its propagation effect.

The development and the allocation of medical care resources are the two sides of a coin. Only when they are considered in terms of life cycle will new bio-insurance become possible.

In order to translate into reality the concept of bio-insurance, it is necessary to think of the development and allocation of medical care resources in highly rational terms. At the base of this rationality, there must be bioethics and biomedicine. To the evaluation of bio-insurance, economics will make a major contribution.

In the scheme of bio-insurance, the insurer is people themselves, and the insurer under the present health insurance system will become unnecessary. The Burden to each citizen in this scheme will be figured out by computer through the successive administrative levels of local government, prefecture and state. Bills by physicians checked by the examination machinery of the medical association will be paid by the bio-insurance center at each city, town or village. When any of these local governments is short of funds for payment, state funds will be used. If the state center is in deficit, additional premiums will be collected from the insured.

Details are to be worked out by the government of each country. In this system, the physician and the patient operate an insurance plan without the intervention of a third party, constantly improving the system of allocation of medical care resources.

Of course, we cannot expect a conclusion on such a large problem as this in a short time. But I have served as chairman of the socio-medical affairs committee of the WMA, and I am also president of the Japan Medical Association, which is in charge of this committee.

In lieu of greetings to you today, I have stated my views on the basis of what I have learned in these capacities. This matter, however, will require further studies in the months and years ahead because it includes many areas that will move forward through the progress of medicine and its collaboration with economics.

Special Contribution

CMAAO's Role and Future Tasks

JMAJ 51(6): 358–361, 2008

Tai Joon MOON*1

The 50th anniversary of Confederation of Medical Associations in Asia and Oceania (CMAAO) is a momentous occasion for all national medical associations in Asia and Oceania. To best mark this significant event, I would like to reflect upon my long time involvement in CMAAO and to summarize CMAAO's history and share suggestions for an even more meaningful future.

Birth and Development of CMAAO

After World War II, ethics and social responsibility of physicians became a topic of serious discussion by physician groups in Europe and North America. This led to the launch of the World Medical Association (WMA) in Geneva in 1947. WMA quickly gained widespread attention for its noble cause and impressive achievements, which generated a consensus in Asia for the need to establish an umbrella organization of medical associations in the region that strive for similar goals. In 1950, the 43rd Congress of the Philippine Medical Association (PMA) first officially discussed the idea of an international medical organization devoted to the Asia and Oceania region. In 1954, the name of this organization was decided to be the Asian Confederation of Medical Associations but in 1956, the 3rd Meeting of the South East Asian Medical Confederation revised the name to the current CMAAO and adopted its Constitution and by-laws to complete the process of officially launching the new organization. CMAAO's historic first Congress was held in Tokyo in 1959 with 11 member associations attending including Japan Medical Association (JMA) and Korean Medical Association (KMA).

CMAAO's foundation purpose is similar to that of the WMA. It is dedicated to topics such as medical ethics, alliance and friendship building among medical associations in Asia and Oceania and other medical issues common to the region. It aims to discuss and develop policies necessary to protect the health of people in this region, as stipulated in its Constitution. Cooperation with other international organizations such as WMA is also included in its Constitution.

From its very start CMAAO was fortunate to enjoy the outstanding leadership of Presidents Dr. Taro Takemi of Japan, Dr. C. Wu of Taiwan and Dr. Rodolfo P. Gonzalez of Philippines. These competent and respected leaders successfully formulated and developed CMAAO's systems and procedures.

Structure and Operation of CMAAO

According to CMAAO's Constitution, the President, Vice President, President-Elect and Treasurer/Secretary are to be appointed through election. Each member association is to dispatch a councilor to the Council. Council meetings are to be presided by the Chair and the Vice-Chair. The term for officers is 2 years with the possibility of re-election. The president of the national medical association hosting the Congress has been elected automatically as the President of CMAAO. The Congress has been hosted by different member associations in the region with almost all members having had the honor of hosting the Congress at least once, which demonstrates the strong unity among members. Currently, CMAAO has 17 member associations from Australia, Bangladesh, Cambodia, Hong Kong, India, Indone-

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Table 1 Past secretariats & secretary generals

1956–1993	Manila, the Philippines (Secretary General: Dr. Primitivo D.Chua, PMA)
1993–1997	Malaysia (Secretary General: Dr. Applanaidu Krishnamoorthy, MMA)
1997–1999	Thailand (Secretary General: Dr. Wonchat Subhachaturas, MAT)
1999–2000	New Zealand (Secretary General: Dr. Stephen Phillips, AuMA)
2000–present	Tokyo, Japan (Secretary General: Dr. Hokuto Hoshi, Dr. Nobuya Hashimoto, Dr. Masami Ishii, JMA)

sia, Japan, Korea, Macau, Malaysia, Nepal, New Zealand, Philippines, Singapore, Sri Lanka, Taiwan and Thailand. CMAAO funds itself through contributions from its member associations and the amount is determined by its Congress based on each member association's financial situation. While WMA allocates voting rights in proportion to a member association's financial contribution, CMAAO allows equal voting rights to all members regardless of the amount of contributions.

According to my experience of CMAAO Congresses and Council Meetings, CMAAO Congresses meet amidst a warm and relaxed atmosphere and actively exchange information and opinions on major issues through country reports. Medical insurance, traditional medicine related problems and medical education have been addressed as some major topics. The 2005 Congress in Seoul adopted the Resolution on the Rights of the Patient.

Distinguishing Features of CMAAO

CMAAO prides itself for its strong bond among participants, who share common cultural and historical experiences. It has also emphasized promoting the health of the region's people. Even though Asia and Oceania encompasses widely dispersed diverse areas, its common bond and shared mission has enabled CMAAO to function smoothly without particular complications. Determining the amounts due by each member association required great wisdom and reflected various factors such as the economic situation and number of member physicians of each organization. Currently, JMA shoulders the highest contribution followed by KMA, Australian Medical Association (AuMA) and Taiwan Medical Association (TMA), which are also contributing relatively high amounts.

Suggestions for a Brighter Future

Even though CMAAO has devoted huge efforts in discussing medical issues common to the region, its response to newly emerging threats such as avian influenza and SARS has been somewhat delayed. In addition, it was not able to effectively communicate a strong message to the people or governments. To respond nimbly to changing medical environments and to establish a system that can efficiently produce agendas, CMAAO would benefit by holding meetings more frequently, which would enhance its internal communication. The current meeting routine is roughly once a year at either the Congress or mid-term Council Meeting, which does appear to limit communication among member associations. The luncheon meeting organized for CMAAO members during the WMA General Assembly in Seoul this year was an excellent way of providing an additional opportunity to meet and I hope this luncheon meeting is repeated every year in the future. Smaller gatherings such as work groups devoted to specific topics could be organized for even more frequent meetings. Of course, to make this a reality, issues such as how to finance travel expenses would require further study.

Lastly, I would like to urge all members to take greater interest in fully utilizing the wonderful resources offered by the secretariat. CMAAO's secretariat was first operated by PMA for a long

Table 2 List of presidents and congress hosting cities

Year	Congress numbering	Place	President numbering	Presidents	Country
1956	—		1	Rodolfo P. Gonzalez	Philippines
1959	1	Tokyo	2	Taro Takemi	Japan
1961	2	Quezon	3	Heraldo del Castilo	Philippines
1963	3	Tokyo/Osaka	4	Hideo Yagi	Japan
			5	Angus Murray	Australia
1965	4	Perth	6	Taro Takemi	Japan
1967	5	Tokyo	7	Tsung Ming Tu	Taiwan
1969	6	Taipei	8	Choo Wan Myung	Korea
1971	7	Seoul	9	Prof. A.A. Sandosham	Malaysia
1973	8	Kuala Lumpur	10	Raman R. Angeles	Philippines
1975	9	Manila	11	Sir Geoffrey Newman-Morris	Australia
			12	Taro Takemi	Japan
1977	10	Tokyo	13	Taro Takemi	Japan
1979	11	Taipei	14	Chi-Fu Wu	Taiwan
1981	12	Seoul	15	Tai Joon Moon	Korea
1983	13	Genting highland	16	Say Man Lim	Malaysia
1985	14	Sydney	17	H. Lindsay Thompson	Australia
1987	15	Bangkok	18	Songkram Supcharoen	Thailand
1989	16	Jakarta	19	Azrul Azwar	Indonesia
1991	17	Hong Kong	20	Peter C.Y. Lee	Hong Kong
1993	18	Malacca	21	R.P. Lingham	Malaysia
1995	19	New Delhi	22	V.C. Velayudhan Pillai	India
1997	20	Bangkok	23	Kachit Choopanya	Thailand
1999	21	Wellington	24	Brian Linehan	New Zealand
2001	22	Taipei	25	Yung Tung Wu	Taiwan
2003	23	Tokyo	26	Eitaka Tsuboi	Japan
2005	24	Seoul	27	Jae Jung Kim	Korea
2007	25	Pattaya	28	Somsri Pausawasdi	Thailand

period and then by New Zealand Medical Association (NZMA) followed briefly by Malaysian Medical Association (MMA) and Medical Association of Thailand (MAT). In 2000, JMA decided to take over responsibility of Secretary General. Thanks to JMA's effective leadership, CMAAO's financial situation has stabilized and its administrative services have been seamless. Personally, I would like to see our members fully utilizing the functions and the abilities of this capable secretariat. I recommend smoother communication between member associations and the secretariat so that various medical information, suggestions or experiences collected at the national level is shared through the secretariat with the global medical community. Operational problems of each

nation's medical system in Asia and Oceania and possible solutions or research results on topics such as medical education, traditional medicine, medical insurance, physician rights, medical accident disputes, issues of environment or human rights could be accumulated and distributed through the CMAAO secretariat. This would further enhance the role and importance of CMAAO. Another matter requiring CMAAO's greater attention is the cooperation with international organizations such as WMA.

I have been entrusted with the role of advisor due to my long involvement in CMAAO. I do believe that I have done my best supporting the secretariat and member associations whenever an issue arose, but I also am aware that further efforts to cooperate with the secretariat operated by JMA is necessary for CMAAO's brighter future.

Special Contribution

The Role of Medical Organization in Health Care Service

JMAJ 51(6): 362–364, 2008

Somsri PAUSAWASDI*1

As the president of the Confederation of Medical Associations in Asia and Oceania (CMAAO), I would like to take this opportunity to remind all members about the history of the CMAAO which was founded 50 years ago. It was firstly proposed by Dr. Rodolfo P. Gonzalez of the Philippine Medical Association and officially established in 1956 at the third Southeast Asian Medical Confederation meeting.

The first CMAAO Congress was held in Tokyo in 1959. At that time, there were 11 country members including Australia, Burma, the Republic of China, Iran, India, Indonesia, Korea, Japan, Pakistan, Philippines and Thailand. All of which attended the meeting. The official CMAAO headquarters was established in Manila. The CMAAO Congress Meeting takes place every other year rotating among the country members.

Dr. Taro Takemi, the President of Japan Medical Association (JMA) at that time, became the second CMAAO president. He served for four successive terms and actively contributed to the organization. In honor of Dr. Takemi, the Taro Takemi Memorial Oration was established at the 16th CMAAO Congress held in Indonesia in 1989. Subsequently, it has been held at each Congress. In 1991, the Takemi family and the JMA each donated ten thousand US dollars to establish the Takemi Memorial Fund at the 17th CMAAO Congress held in Hong Kong.

The CMAAO Congress and Midterm Council Meetings are held in alternate years and hosted by each member medical association. The objectives of CMAAO activities as stated in its constitution have been to promote academic exchange and cultivate ties of friendship among member medical associations.

The 18th CMAAO Congress held in Malacca, Malaysia in 1993 was the major turning point in the history of confederation. Based on a growing awareness among the member medical associations of the need to strengthen the overall activities of CMAAO, a special committee in charge of planning and finances was established. The committee reviewed the confederation's role in medical ethics, health care quality, the physician exchange program, and submitted a report on measures to strengthen the institutional aspects of the confederation. Based on this report, activities were launched and measures to address the financial difficulties of the organization were implemented. Specific measures included moving the secretariat from Manila to Malaysia.

The 20th CMAAO Congress took place in Bangkok, Thailand in 1997. The offices of Chairperson, Vice-Chairperson, and Treasurer were newly created and the secretariat was moved to the Medical Association of Thailand (MAT). The 21st CMAAO Congress was held in New Zealand in 1999. The secretariat was then proposed to move to Australian Medical Association in view that the Secretary General will be working closely to the President but the idea did not work.

In 2001, Dr. Hoshi of the JMA was selected as the secretary general and the secretariat has remained at the JMA until present. Currently, the CMAAO has 17 member medical associations including Australian Medical Association, Bangladesh Medical Association, Cambodian Medical Association, Hong Kong Medical Association, Indian Medical Association, Indonesian Medical Association, JMA, Korean Medical Association, Macau Medical Association, Malaysia Medical

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Association, Nepal Medical Association, New Zealand Medical Association, Philippine Medical Association, Singapore Medical Association, Sri Lanka Medical Association, Taiwan Medical Association, and the MAT. We try to invite countries in Southeast Asia such as Myanmar and Vietnam to join us as a member.

It was a great pleasure for me to have received invitations from Singapore Medical Association, Australian Medical Association and Malaysia Medical Association to participate in their annual meetings in 2008. In addition, I was invited to be the keynote speaker at the 101st Annual Convention of Philippine Medical Association in Manila.

I had an honor to serve as the 47th president of the MAT under the patronage of His Majesty the King during 2004–2005. Over the years, changes were made to improve the quality of the association. Its regulation and organization were largely changed in 2002–2003 when Professor

Joint Meeting between MASEAN Meeting and 84th Anniversary of the Medical Association of Thailand (November 17, 2005)

CMAAO President Prof. Somsri Pausawasdi had been the Keynote speaker in 101st Annual Convention of the Philippine Medical Association in Manila (May 22, 2008)

PHILIPPINE MEDICAL ASSOCIATION CONVENTION. Somsri Pausawasdi (3rd from right), president of the Confederation of Medical Associations in Asia and Oceania, leads ribbon-cutting rites opening the 101st Annual Convention of Philippine Medical Association at the historic landmark Manila Hotel May 22, 2008. Others from left: Dr. Martini Ventura, chairperson, closing ceremonies; Dr. Rey Melchor Santos, PMA vice president; Dr. Jose Asa Sabili, PMA president; Dr. Ramon Rabago Jr., PMA governor, Southeastern Mindanao; Dr. Monalisa Cosme, PMA national treasurer; and Dr. Oscar Tino, PMA secretary general. (Ramon I. Samson)

CMAAO President and Philippine Medical Association President Dr. Jose Sabili did the opening of 101st Annual Convention of Philippine Medical Association of Manila Hotel

Arun Pausawasdi was the president. He invited the president of the Royal Colleges and regional representatives of every medical specialties in the country to be council members of the MAT. As a result, the MAT network has expanded and the number of memberships has increased dramatically. We currently have more than 20,000 members. Under the support of the Crown Prince Vajiralongkorn and the leadership of Professor Arun Pausawasdi, a twelve-floor building was built to serve as the MAT, the Royal Colleges, and many medical societies offices.

In the era of IT, knowledge and cultural exchanges should occur in national and international levels. For national level, I would like to use the MAT as an example. The objectives of MAT are the followings;

1. To encourage and improve the standard of code of ethics and morality in physician practice.
2. To encourage the unity among members.
3. To encourage medical education, research and health care services.
4. To provide members benefits.
5. To work with other local medical organizations in developing national standard of practice to meet international standard.
6. To improve the general public's basic knowledge in medicine and healthcare so that people can take better care of themselves.
7. To collaborate with medical organizations of other countries.

We have set up 15 subcommittees to work on different projects. The council members meeting is held every 4th Wednesday of the month. We invite the past presidents and secretary general to participate in the meeting regularly. We have multiple fund raising projects including distributing the replica of Buddha image to general public in exchange for donation, arranging golf tournaments and hosting scientific meetings.

The office of the Medical Association of Thailand

Special Lecture

Confederation of Medical Associations in Asia & Oceania: Past, present and the future*1

JMAJ 51(6): 365–371, 2008

Keizo TAKEMI*2

The 44th CMAAO Midterm Council Meeting is a special meeting because it marks the 50th anniversary celebration of CMAAO. CMAAO held its first Congress in Tokyo with an eleven-country membership in 1959, at about the same time that the Asian Medical Journal, an official English journal of the Japan Medical Association (currently JMA Journal) published its inaugural issue. This year is also the 30th anniversary of the Alma Ata Conference and the revival of the primary health care approach, whose key principles are universal coverage and the effective delivery of basic care that promotes and protects communities. The conjunction of these three anniversaries provides a context for this meeting.

CMAAO was created to ensure that the opinions and ideas of medical professionals in Asia are reflected within the World Medical Association; and to cultivate academic and professional exchanges, building closer ties and friendship among the national medical associations in Asia and Oceania. The establishment was a group effort of regional medical leaders during the post-war years, born out of strong mutual trust and respect. CMAAO strives for the highest professional and ethical standards in medical practice and education, and it promotes and advocates for access to health care for all people in Asia and Oceania, which make up nearly 60% of the world population.

In the early years, CMAAO's discussions centered on regional themes, such as research on Japanese encephalitis, the eradication of malaria and military medicine in the Philippines. However, since the 10th Congress in 1977, the organization's perspective has become more global in response to the globalization of diseases and the evolution of health care to combat them. CMAAO has also addressed such critical issues as population aging, effects of pollution and waste, environmental changes, and the burden of healthcare on government finances. Moreover, new forms of collaboration and networks are growing with globalization to improve prevention, as governments work with civil societies, non-government organizations, and private physicians to promote public health. For example, CMAAO created the SARS network office in 2001 within the JMA office to deliver appropriate information about SARS and other serious communicable diseases in these regions to the world.

In the word of the Nobel Laureate, Amartya Sen, "Over thousands of years, globalization has shaped the progress of the world, through trade, travel, migration, and dissemination of knowledge." We are now in the new era of global health, with common health agendas that stretch across national boundaries. Individual countries can no longer focus on their own geopolitical issues. Health is vital to human livelihood, dignity, and, indeed, survival. It is a basic human right that has to be secured and protected. To secure health means to enhance our human security.

Human security entails a comprehensive approach that is community driven, across sectors, to address major societal challenges. It offers a useful conceptual framework for strengthening health systems. It focuses on individuals and communities, allowing the architecture of health systems and global health issues to be seen from the perspectives of their ultimate stakeholders.

*1 This lecture is a summary of speech made at the 50th Anniversary Celebration of CMAAO on November 23, 2008 during the 44th CMAAO Midterm Council Meeting held in Manila, Philippines.

*2 Research Fellow, Harvard School of Public Health, Boston, MA, USA. Senior Fellow, Japan Center for International Exchange, Professor, Research Institute of Science and Technology, Tokai University, Tokyo, Japan (jmaintl@po.med.or.jp).

This human security framework requires more integration among the various sectors of society, the multiple levels of decision-making (global, national, and community), and the many building blocks of a health system. Furthermore, Japan adopted this dual strategy of including both a top-down and a bottom-up policy for strengthening health systems after World War II, which achieved remarkable results in health development.

Looking ahead, CMAAO should rededicate its mission to strengthen its regional human and information networks, making the best use of the JMA Journal to promote the principles of Alma Ata as the foundation for its development strategy for the 21st century.

This approach is consistent with the vision of the late Dr. Taro Takemi, one of the first presidents of CMAAO: "We must not only work within our own country but must think and cooperate beyond national borders, and . . . focus on community health and health system development."

I would like to extend my sincere congratulations to CMAAO on its 50th anniversary, and wish everyone continued prosperity and success in the next 50 years.

Prof. Takemi speaking at the Opening Ceremony of the CMAAO Midterm Council Meeting

Confederation of Medical Associations in Asia & Oceania: Past, Present and the Future

Keizo Takemi
Research Fellow, Harvard School of Public Health
Senior Fellow, Japan Center for International Exchange

The 44th CMAAO Mid-term Council Meeting
50th Anniversary Celebration of CMAAO
Sunday, 23 November 2008

Manila, Philippines

Today's Discussion

1. Origins of CMAAO
2. CMAAO strategic framework
3. Globalization and health
4. Health as a human right and human security
5. Health system strengthening
6. The importance of CMAAO in global health

The Origins of CMAAO

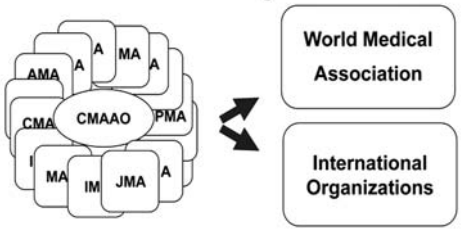
- circa 1956: CMAAO was established
  - proposed by Dr. Rodolfo P. Gonzalez of the Philippine Medical Association and officially established at the 3rd Meeting of the Southeast Asian Medical Confederation
  - Dr. A. Z. Romualzez, World Medical Association
- 1959: first CMAAO Congress in Tokyo
  - 11 country membership: Australia, Burma, the Republic of China, Iran, India, Indonesia, Japan, Korea, Pakistan, Philippines, and Thailand

Asian Medical Journal

- Inaugural edition: October 1958 to commemorate CMAAO
- Person letter from Dr. Schweitzer in the first edition of Asian Medical Journal

"I believe sincerely that we physicians bound to make the utmost effort for maintenance of life must inspire people with regard for dignity of life, and thereby we have a special mission to improve humankind mentally and ethically. And I am also firmly convinced that this higher spirit will lead up to possibilities of humankind to understand and solve many difficult problems of contemporary times."

CMAAO's Objectives



Represent the CMAAO at the World Medical Association and other international organizations

CMAAO's Strategic Framework

Networking Objectives

- Ensure Asian perspectives within World Medical Association
- Connect national medical associations in Asia and Oceania through academic and professional exchanges

Humanitarian Objectives

- Maintain highest professional and ethical standards in practice of medicine and education;
- Promote access to health care for all in Asia and Oceania

World Population

Estimated at 6.7 billion (as of Nov. 2008)

World Population

World historical and predicted populations (in millions)[7]

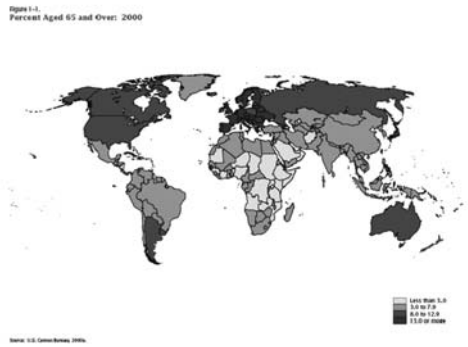
Region	1750	1800	1850	1900	1950	1999	2050	2150
World	791	978	1,262	1,650	2,521	5,978	8,909	9,746
Africa	106	107	111	133	221	767	1,766	2,308
Asia	502	635	809	947	1,402	3,634	5,268	5,561
Europe	163	203	276	408	547	729	628	517
Latin America and the Caribbean *	16	24	38	74	167	511	809	912
Northern America *	2	7	26	82	172	307	392	398
Oceania	2	2	2	6	13	30	46	51

World historical and predicted populations by percentage distribution

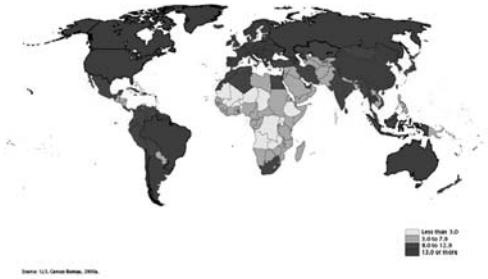
Region	1750	1800	1850	1900	1950	1999	2050	2150
World	100	100	100	100	100	100	100	100
Africa	13.4	10.9	8.8	8.1	8.8	12.8	19.8	23.7
Asia	63.5	64.9	64.1	57.4	55.6	60.8	59.1	57.1
Europe	20.6	20.8	21.9	24.7	21.7	12.2	7.9	5.3
Latin America and the Caribbean *	2.0	2.5	3.0	4.5	6.6	8.5	9.1	9.4
Northern America *	0.3	0.7	2.1	5.0	6.8	5.1	4.4	4.1
Oceania	0.3	0.2	0.2	0.4	0.5	0.5	0.5	0.5

(Source: wikipedia)

World Population 65+ yrs, 2000



World Population 65+ yrs, 2030



Globalization

The subject of globalization itself arouses passion - both in defense and in opposition. It is not, of course, a new phenomenon. Over thousands of years, globalization has shaped the progress of the world, through trade, travel, migration, and dissemination of knowledge. The opposite of globalization is persistent separatism and relentless autarky.

- Amartya Sen
Harvard University
Nobel Laureate

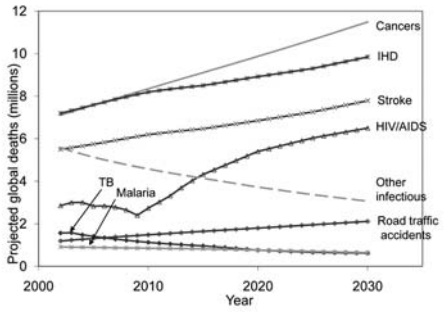
Globalization and Health

Globalization affects health in various ways, not only individual behaviors, but broader aspects such as social, cultural, environmental, political, and economic context within which health and disease occur

Globalization has shifted the concept of 'international health' to 'global health' and to think of health beyond national borders

Globalization and health issues means that common agendas stretch across national boundaries, so individual states cannot only focus on own geopolitical issues

Projected global deaths (millions) for selected causes of death, 2002–2030



(Source: WHO, 2007)

Globalization and Causes

Increased international travel

- spread of diseases to non-endemic parts of the world

Air Travel

- Air travel in Asia and the Pacific continues to flourish
- 3% increase in intra-Asia Pacific flights (15,975 flights/month)
- 4% increase in seat capacity in 2008 (80 million seats within Asia Pacific)
- Asia Pacific has the largest increase of new order for planes

(source: Official Airline Guide 2008)

Globalization and Policies

Asian **labor migration** across national boundaries in search of economic opportunities

Asia and Oceania asserting control over the flow of **illegal and counterfeit drugs** across national boundaries

Multi-national, cross-sectoral policy making is required

Prevention Matters

Metabolic syndrome increasing in Japan

- hypertension
- insulin resistance
- coronary heart disease
- Stroke
- Type 2 diabetes, etc.

To secure health means to enhance our human security

What is Human Security?

Definition

To **protect people's survival, dignity and livelihood** --"the vital core of all human lives in ways that enhance human freedoms and fulfillment" -- especially ***freedom from want*** and ***freedom from fear***, targeting people and defining the **community** as the unit of policy making

Strategies

Empowerment

- enable people to develop capacity to cope with difficult conditions

Protection

- set up by states, international agencies, NGOs, and the private sector to shield people from critical and pervasive threats

Why Health System Strengthening?

- Disease-specific programs showing results, but continued progress will depend on strong health systems
- Imbalance among MDGs 4, 5, and 6
- Changing structure of disease and health expenditure

Japan adopted a dual strategy for strengthening health systems after WWII

Top Down

Strong commitment by central government

– Promoting good practices as a way to scale up interventions

Integrated approach for Maternal & Child Health (now MDG 4 & 5))

– Maternal and Child Health handbook as a tool for integrated services.

Bottom Up

Expand services to communities through health workers

– Training public health nurses, midwives, as well as private physicians

– Face-to-face communication through outreach activities

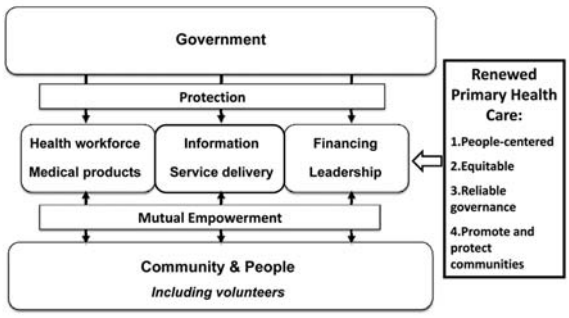
Health workers' activities supported by community volunteers

–Child Rearing Associations by community volunteer groups (AIIKU groups since 1936)

–Women's Anti-Tuberculosis Association (since 1950)

Maternal & Child Health Handbook

Health System Strengthening
A dual strategy



30th Anniversary of Alma Ata Conference

- World Health Report 2008 and the revival of PHC
  - Universal coverage reforms (health equity)
  - Service delivery reforms (people-centered care)
  - Leadership reforms (good governance)
  - Public policy reforms (communities where health is promoted and protected)
- Private practitioners are providers of (primary) health care

Private Physicians & Global Health

Public health organizations are insufficiently equipped and under funded to independently achieve their accomplishment. Therefore, collaboration across the health care delivery industry of public and private providers is essential in addressing the complex health problems.

Source: Healthy People 2010 goals: public and private sector involvement

Private Sector Provision of MCH Services in Developing Countries

Region	% treated in private facilities for:			Delivery in private facility (%)
	Fever	Pneumonia	Diarrhoea	
East Asia and Pacific	21	25	20	12
Latin America and Pacific	11	10	7	9
Middle East and North Africa	12	22	16	18
South Asia	26	30	25	7
Sub-Saharan Africa	7	8	5	6

(Source: Gwatkin et al. 2007)

Future Vision

Looking back to look forward

...we must not only work within our own country but must think and cooperate beyond national borders

...we need to focus on community health and health system development

- Taro Takemi
Japan Medical Association, President (1957-1982)
CMMAO President (1959-61; 1965-67; 1976-79)

Importance of CMAAO

- CMAAO's Regional network
  - Information and human network
- Asian Medical Journal's revival→JMA Journal
- CMAAO can contribute to health as a human security with respect to global health and health systems strengthening
- Partnerships
  - South-South collaboration
  - Public-private collaboration
  - Private-private collaboration

I look forward to discussing these ideas with you!

Memories of CMAAO's 50-year History

Dr. T. Takemi addressing
at the JMA office, Tokyo, 1959

Dr. R.P. Gonzalez making a congratulatory
address at the JMA office, Tokyo, 1959

Delegates of the 3rd Congress, Tokyo, 1963

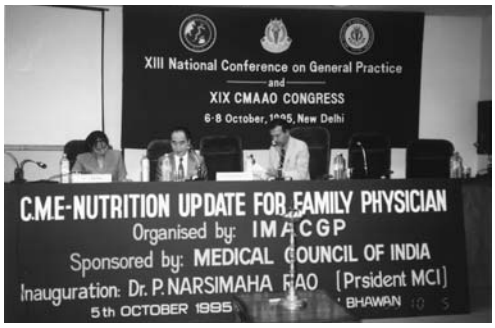
The 5th Congress, Tokyo, 1967

Opening session, Seoul, 1971

The 12th Congress, Seoul, 1981

Mrs. Takemi donating the fund for the Taro Takemi Oration, Hong Kong, 1991

Opening session, Malacca, 1993



Symposium, New Delhi, 1995

The 21st Mid-term Council Meeting, Wellington, 1999

The 22nd Congress, Taipei, 2001

Dr. Y.T. Wu and Dr. E. Tsuboi, Tokyo, 2003

Dr. T.J. Moon at the Takemi Oration, Seoul, 2005

Dr. J.J. Kim and Dr. Somsri, Handover of a Presidential Medal, Pattaya, 2007

The 44th CMAAO Midterm Council Meeting: COUNTRY REPORTS and SYMPOSIUM

—50th Anniversary Celebration of CMAAO—

EDSA Shangri-La Hotel, Manila, Philippines
November 22–24, 2008

The 44th Confederation of Medical Associations in Asia and Oceania (CMAAO) Midterm Council Meeting was held in the Philippines from November 22 (Sat.) to 24 (Mon.), 2008. This issue of JMAJ features the Country Reports on the activities over the past year of each of the member National Medical Associations (NMAs), which were presented on November 23, as well as the symposium held on November 24 themed "Global Warming, An Alarming Phenomenon, What Shall We Do?".

CMAAO Officers and Councilors

This Midterm Council Meeting was attended by about 40 representatives from 12 CMAAO member NMAs. The application for membership submitted by the Myanmar Medical Association, whose representatives participated in the meeting as observers, was approved and it was decided to refer the matter to next year's General Assembly.

This year marks the 50th anniversary of the holding of the 1st General Assembly in Tokyo, Japan, in 1959, and a special lecture on the history of CMAAO was presented (see page 365). Furthermore, CMAAO member countries met during this year's WMA Seoul General Assembly for a discussion and exchange of opinions, and the importance of communicating the voice of the Asia-Pacific region to the world was reaffirmed.

The following were the main items discussed.

(1) Establish a special committee to consider the future direction of CMAAO
(2) Form a sub-committee, if necessary, in standing committees (Committees of Constitution and By-laws, Finance, Membership, Nomination, and Resolution)
(3) Hold discussions during the WMA General Assembly held prior to the CMAAO meeting and/or on the day before the opening of the CMAAO meeting
(4) Utilize more efficiently the CMAAO website (http://www.cmaao.org/) as a tool to provide important information to the world
(5) Establish standing committees to continuously discuss specific topics such as the anti-smoking issue

Upcoming CMAAO meetings will be held in the following venues.

2009 26th CMAAO Congress
Bali, Indonesia
2010 46th CMAAO Midterm Council Meeting
Kuala Lumpur, Malaysia
2011 27th CMAAO Congress
Taipei, Taiwan

HONG KONG MEDICAL ASSOCIATION

Alvin Yee Shing CHAN*1

With the conjoint effort of members, partners, staff and council members, the Hong Kong Medical Association has made significant progress in the path of betterment for the medical and healthcare services of Hong Kong in the year 2007–2008. Twelve Council Meetings were held last year. Members were invited to attend our council meetings, and opportunities were used to meet important guests in the dinner before the meetings. Critical issues affecting the local health care scene and our members were carefully deliberated. Press meetings and releases were arranged wherever necessary. Rapid communication emails, notices, and newsletters were employed at the first instances to keep our members updated on the recent developments.

This year, healthcare reform and healthcare financing were of great concern for all parties in Hong Kong, especially for the medical profession. The Association expressed its views on the Bauhinia Report published in June 2007. After the Healthcare Reform Consultation Document "Your Health Your Life" was released in March 2008, the Council was invited by the Secretary for Food and Health to a briefing session during which views on the consultation paper were exchanged. The Association then organized a forum in May to allow interested members to meet the Secretary so that they could raise concerns and clarify issues. Only through active participation could we ensure that the voice of the medical profession be heard and our motto "Safeguarding the People's Health" upheld.

To safeguard the interest of our patients and the public at large, the Association held a number of meetings with the Consumer Council and other parties on nutrition labelling. Our stand was clearly put forward to the government and the Legislative Council. Among many other important issues, the Association also raised concern on influenza vaccination, safe dispensing, laser safety, air pollution and drug abuse. The Beat Drugs Seminar was successfully held in January in collaboration with the Hong Kong Council of Social Service. A resource booklet on drug abuse was published afterwards. We also completed a number of surveys—Hong Kong's political reform, Asthma management and HKMA sports activities. Regarding political reform, we submitted our views in response to the Government's Green Paper on Constitutional Development. Our Association has also been actively promoting healthy life style to the public. To promote healthy dining, the project on serving chopsticks and spoons was revived. With the support from various parties, the Slogan and Trailer Design Competition was successfully conducted. A prize presentation ceremony, acknowledging the efforts of the winners and participants, was held. Plans were underway to reinforce the message and impact of healthy dining amongst all walks of life in Hong Kong. The 4th and 5th Exercise Prescription Certificate Courses were successfully carried out in September 2007 and April–May 2008 respectively whereby exercises were actively promoted through our colleagues in order to benefit their patients.

We fully supported the front-line doctors in their fight for better conditions of services. We urged the government and the Hospital Authority to provide reasonable remuneration packages and work-hour arrangements to motivate and retain their valuable medical staff. In our continuing effort to promote public-private collaboration, we continued our collaboration with the Hospital Authority on Public-Private Interface through the Electronic Patient Record Sharing Pilot Project (PPI-ePR). Information technology efforts were also made in the areas of web content improvement and CMS enhancement. The Tao Yuan Project on open source clinical management softwares is now at its full swing. With regard to the Closer Economic Partnership Arrangement (CEPA), there have been some promising

*1 Vice-President, Hong Kong Medical Association, Hong Kong (yvonnel@hkma.org).

developments on the issue of Hong Kong doctors practising and setting up clinics in the Mainland as a result of repeated dialogues through various channels with relevant officials and parties in the Mainland.

The Association attended the 58th WMA General Assembly held in Copenhagen, Denmark, in October 2007. We also participated in the 43rd CMAAO Council Meeting held at Pattaya, Thailand in November 2007. To celebrate the 10th Anniversary of the establishment of the Hong Kong Special Administrative Region, the Association took part in the joint-professional forum and celebration dinner. With the coming Beijing Olympic Games, the Association also nominated two of our sporty colleagues to participate in the torch-bearer election conducted by a sponsoring company in Hong Kong. A wide range of sports activities were also organized for our members, including family hiking, Joint Professional Tournaments in Bowling, Football, Table-Tennis and Golf, Family Sports Day, Swimming Gala, and the First Guangdong, Hong Kong & Macau Sports Meet.

Our Association actively promoted continuing medical education by multiple means. Forums and seminars have been organized either by our Association alone or in conjunction with the other organizations. These educational programmes covered a broad spectrum of topics, including but not limited to vaccines, infectious diseases emergency, mental health and medico-legal issues (with Medical Protection Society). We continued academic exchanges with the Chinese Medical Association. The 9th Beijing and Hong Kong Medical Exchange Meeting, with the theme of "Psychological Medicine in Community," was successfully held at Presidential Plaza Hotel, Beijing last year. Structured CME seminars were continued with the Hong Kong Sanatorium and Hospital and the Queen Elizabeth Hospital. Under the efforts of many colleagues, the HKMA Community Network has been very active in a number of districts—Yau Tsim Mong, Tai Po, Shatin, Tin Shui Wai and Hong Kong East. Nearly all of them liaised with allied health professionals in one way or another and provided many educational programmes, like Safe Dispensing, the Kidney Disease Awareness and Management Programme, the Certificate Course on Practical Psychiatry, and Medical Ethics Issues in Clinic Practice. We also published 12 monthly HKMA News and 12 monthly CME Bulletins, and continued to publish the bimonthly Hong Kong Medical Journal jointly with Hong Kong Academy of Medicine.

Last but not the least, the Association continues to promote various charity activities. After the occurrence of the devastating 512 Sichuan earthquake, we immediately launched an appeal for monetary donations to assist in frontline rescue efforts and for voluntary relief work in the disaster-stricken areas. Our Orchestra was engaged in fund-raising street performances and candle-light concerts. Frequent dialogues with the Department of Health, charitable organizations like Red Cross and World Vision, and Mainland officials were maintained to seek every chance of assistance and contribution. Before these, the HKMA Charitable Foundation organized a charity concert with donations to the Hong Kong Alzheimer's Disease Association. The Orchestra, on its own, conducted charity performances in Tin Shui Wai ("City of Sadness") and at Grace Nursing Home in Lam Tin. It was also involved in the fund-raising concert for the Hong Kong Mucopolysaccharidoses & Rare Genetic Diseases Mutual Aid Group, Lifeline Express and Mary Rose School. Our Choir performed in a charity concert to raise funds for education development in Western China. To promote organ donation for the benefit of the needy, we continued our joint effort with the Department of Health and the Hospital Authority in the establishment of the Centralized Organ Donation Register whereby the data in our organ donation registry will be transferred to the Government system after obtaining consent from the registered willing organ donors.

REPORT ~ THE HONG KONG MEDICAL ASSOCIATION

For Year 2007-2008

Dr. CHAN Yee Shing, Alvin
Vice-President
The Hong Kong Medical Association

Healthcare Reform and Healthcare Financing

- Bauhinia Report published in August 2007
- "Your Health Your Life" released in March 2008
- Forum in May 2008

Public Health

- Nutrition labelling
- Beat drugs – seminar & booklet
- Serving chopsticks and spoons
- Exercise prescription
- Vaccination

10th Anniversary of the establishment of the Hong Kong Special Administrative Region

- joint-professional forum and celebration dinner

HA Junior doctors Sit-in

- Fight for equal pay
- Staff exodus
- Pay-rise
- Increase in intake of medical students
- Supporting their sit-in on 23 June 2007

Medical Students Intake Increase

- Meeting with Secretary for Education in August 2007
- Secretary promised to look into the matter from the perspective of overall supply and demand of medical manpower

Continuing Medical Education (CME)

Beijing/Hong Kong Medical Exchange

- Co-organized with Chinese Medical Association, Nov. 2007
- Theme: Psychological Medicine in Community

Health Maintenance Organizations (HMOs) and Medical Insurance

- Professional autonomy
- Customer service
- Patient care and choice
- to work on core elements of good medical insurance scheme

Cultural & Sports Activities

- HKMA Orchestra
- HKMA Choir
- Organ Donation Register
- Sports

1. Family hiking
2. Joint Professional Tournaments in Bowling, Football, Table-Tennis and Golf
3. Family Sports Day
4. Swimming Gala
5. First Guangdong, Kong Kong & Macau Sports Meet

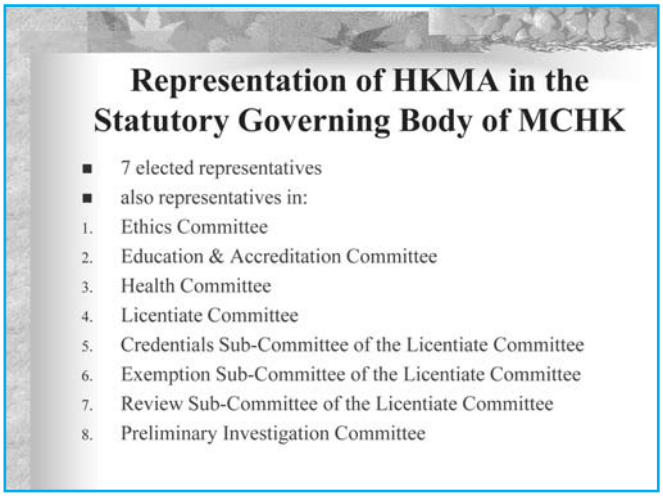
Charity

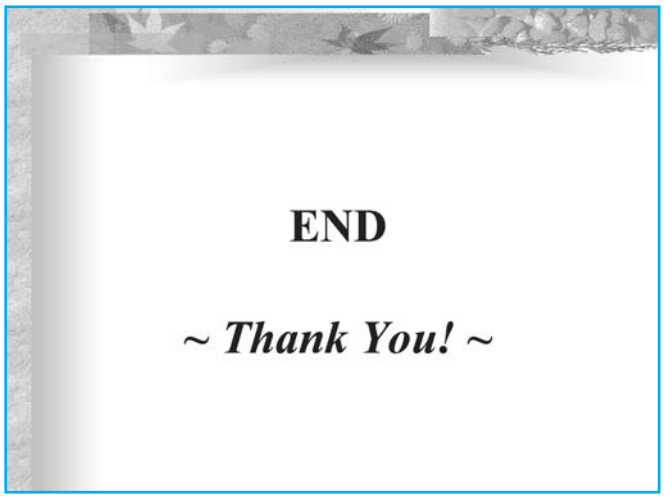
- Snow Concert
- 512 Sichuan earthquake
  - monetary donations
  - street performances and candle-light concerts
- charity concert with donations to the Families of Spinal Muscular Atrophy Charitable Trust

General

- Council Meetings
- 43rd CMAAO Council Meeting held at Thailand in November 2007
- 58th World Medical Assembly held in Copenhagen, Denmark, in October 2007
- The Ninth Beijing and Hong Kong Medical Exchange Meeting focusing on "Psychological Medicine in Community" was successfully held in Beijing, China, last year
- 12 monthly HKMA News
- 12 monthly CME Bulletins
- bimonthly Hong Kong Medical Journal


Surveys
Current Practice and Opinion on Asthma
Survey on New CME Online and Bulletin
Opinion Survey on Political Development of the HKSAR
Survey on Health Care Reform


Representation of HKMA in the Statutory Governing Body of MCHK
7 elected representatives
also representatives in:
1. Ethics Committee
2. Education & Accreditation Committee
3. Health Committee
4. Licentiate Committee
5. Credentials Sub-Committee of the Licentiate Committee
6. Exemption Sub-Committee of the Licentiate Committee
7. Review Sub-Committee of the Licentiate Committee
8. Preliminary Investigation Committee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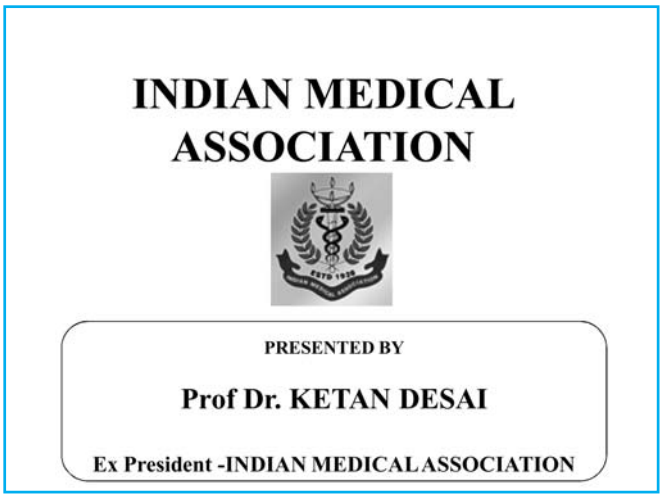
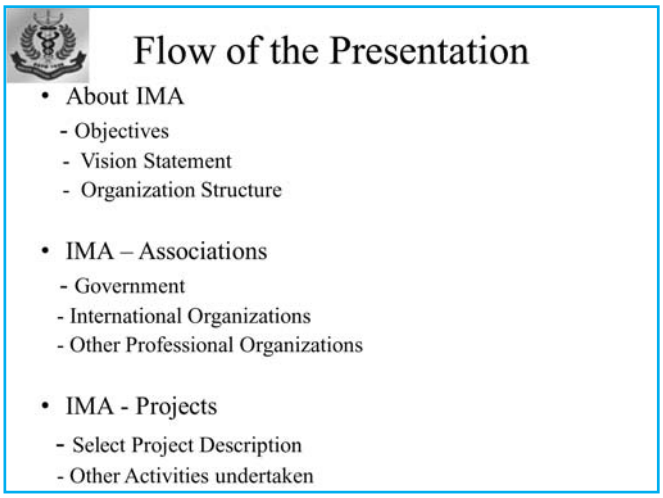
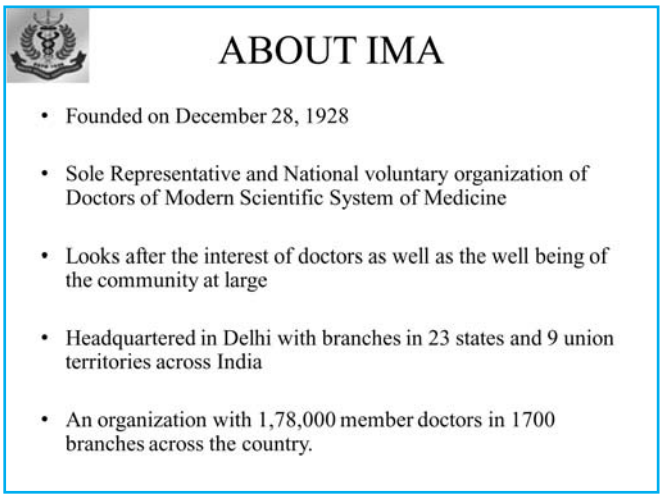
~ Thank You! ~

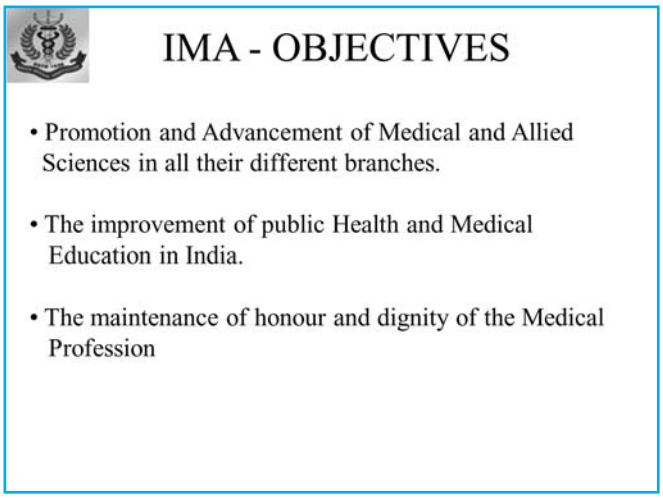
INDIAN MEDICAL ASSOCIATION

Ketan DESAI*1









*1 Past President, Indian Medical Association, New Delhi, India (inmedici@ndb.vsnl.net.in).

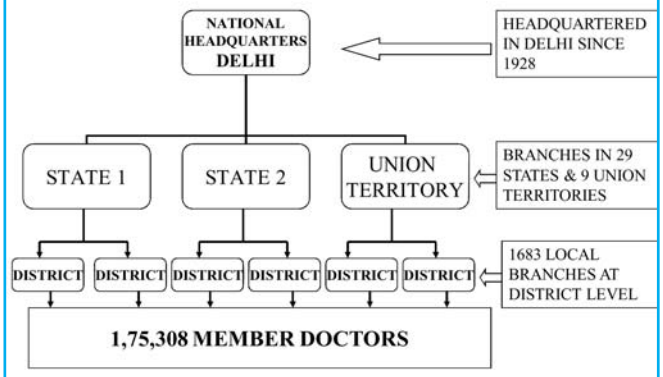
IMA – VISION STATEMENT

SARVE BHAVANTU SUKHINAH
SARVE SANTU NIRAMAYAH

IT STANDS FOR

HEALTH AND HAPPINESS FOR ALL

IMA –ORGANIZATION STRUCTURE



IMA - ASSOCIATIONS

GOVERNMENT ORGANIZATIONS

- Ministry of Health and Family Welfare
- Ministry of Women and Child Welfare
- Ministry of Human Resources
- Department for Consumer Awareness
- National Inst. of Communicable Diseases

IMA - ASSOCIATIONS

INTERNATIONAL ORGANIZATIONS

WORLD HEALTH ORGANIZATION | UNICEF | UNFPA

PATH | JOHN HOPKINS UNIVERSITY | IRCT | CLINTON FOUNDATION

IMA - ASSOCIATIONS

STRATEGIC ASSOCIATIONS WITH OTHER PROFESSIONAL ORGANIZATIONS

- Indian Academy of Paediatrics - (IAP)
- Federation of Family Physicians' Association of India - (FFPAI)
- National College of Chest Physicians (India) - NCCP (I)
- Association of Physicians of India - (API)
- Indian Chest Society - (ICS)
- Indian Radiology and Imaging Association – (IRIA)

PROJECTS UNDERTAKEN

Family Welfare Program by the Govt.of India

- Non Scalpel Vasectomy (NSV)
- Promotion and Distribution Oral Contraceptive pills
- Promotion of other contraceptive material through district branches
- Educational Workshops and Adolescent Health Programs organized
- Awareness Programs on motherhood & upbringing of girl child organized
- Uterine Devices amongst other things promoted

PROJECTS UNDERTAKEN

IMA-GFATM-RNTCP-PPM Project with the Govt.of India – A classic example of Public Private Mix (PPM)

- Collaborated with Central TB Division (CTD) of Govt. of India
- Implemented Revised National Tuberculosis Control Programme (RNTCP)-
- The first ever Public Private Mix in the country
- Sensitized and trained 16500 medical personnel to implement Direct Observation Treatment for TB
- 231 DOTS centres have been created in private sector.
- Being implemented in 5 states and 1 union territory

PROJECTS UNDERTAKEN

Fight against Child Trafficking, Sexual abuse and standardisation of procedures for medical examination of victims of rape

- Collaborated with UNICEF
- Training Medical Professionals on issues related to Child Trafficking & Sexual Abuse
- Organizing Regional & District level workshops
- Created a standardized examination kit for victims of rape
- Received wide appreciation from the Govt.of India (GOI), Ministry of Health and Family Welfare and Ministry of Women and Child Development.

PROJECTS UNDERTAKEN

Fight against Sex Selection and Sex selective procedures and implementation of the Pre Conception-Pre Natal Diagnostic Techniques (PC-PNDT) Act

बेटी बचाओ
save the girl child

- Passed a resolution to work against Sex Selection and Sex Selective abortions
- Implemented Pre Conception Pre Natal Diagnostics Techniques (PC-PNDT) Act.
- Several members sensitized & trained to educate society
- Members now ambassadors of IMA for this cause
- Stand against any member of medical fraternity executing the shameful act.

PROJECTS UNDERTAKEN

IMA Disaster Management Cell

- Well trained Disaster Management Cell
- Performed exemplary work during the unfortunate Gujarat Earthquake & Tsunami
- Always on the forefront to organize medical relief for victims
- Voluntary donations contribute to the IMA Disaster Management Fund for victims

OTHER ACTIVITIES

- Trained 50000 members to create awareness about HIV/AIDS in collaboration with the Clinton Foundation
- Public Awareness Campaigns about Oral Rehydration Therapy in cases of Diarrhea and Dysentery
- Creation of Baby friendly Hospitals who promote Exclusive Breast feeding
- Organizing regular Blood donation camps and promoting the same
- Regular health check ups and remedial cures offered in schools
- Organized Several Pulse Polio Immunization Programs
- Adoption of villages under AAO GAON CHALE to provide medical relief to remote vilages
- Creating awarness about breast feeding to reduce infant mortality and morbidity rate
- Worked closely in programs by National Institute of Communicable Diseases, Govt. of India to prevent Malaria, Leprosy and Kalazar.

SARVE BHAVANTU SUKHINAH
SARVE SANTU NIRAMAYAH

THANK YOU

INDONESIAN MEDICAL ASSOCIATION

Prijo SIDIPRATOMO*1

Country report 2008
THE INDONESIAN MEDICAL ASSCOSIATION
(IMA)

Presented by
Dr. Prijo Sidipratomo, Sp.Rad (K)

IMA Executive

- President : DR. Fahmi Idris, MKes
- President Elect : Dr. Prijo Sidipratomo, Sp.Rad (K)
- Secretary General : Dr. Zainal Abidin
- Treasurer : Dr. Wanarani Aries, Sp.RM
- Board of Collegiums : Prof. DR.Dr. Biran Affandi, Sp.OG
- Board of Ethics : Prof. DR.Dr. Agus Purwandianto, Sp.F
- Board of Prof.Dev : Prof. DR.Dr. Zubairi Djoerban, Sp.PD

IMA Branches

- Provincial branches : 31
- District branches : 336
- Specialist associations : 33
- Common interest groups : 37

Memberships

- Active members 77,601 physicians
- New members ± 5,000 physicians per year

*1 President-Elect, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).

Activities

The Doctor's Day

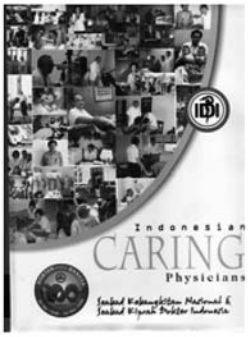
- IMA has declared 20 May become the Doctor's Day
- In that day, Indonesian physician will
  - Provide free services to their patients, or
  - Donate their earnings on that day to IMA and this fund will be used to run community development program
- As part of Professional Social Responsibility of Indonesian physician

Activities

INDO MEDICA EXPO

- IMA has conducted the first Indo Medica Expo on 29 May – 1 Jun 2008 in Jakarta
- To show the progress in medical education, technology and sciences
- This event will be held annually

Activities



INDONESIAN CARING PHYSICIANS BOOK

Consist of 112 Indonesian physicians who is nominated by their colleagues

HONORED PHYSICIANS

- 3 Physicians have been selected because their quality, long dedication and achievement
- Role model for young physicians

Activities

ONLINE CPD

- IMA has launched Continuing Professional Development program through internet
- To give opportunity to all Indonesian physicians, especially who live in remote area, to access CPD program

Activities

CHILD DOCTOR AWARD

- IMA has launched Dokter Kecil Award (Child Doctor)
- To promote healthy life style among elementary school students in Jakarta
- This award will be proposed nationally every year

Activities

"DOCTOR HEROIC" FILM

- IMA has launched a documentary film about history and roles of Indonesian physicians in developing our nation since 100 years ago
- As part of celebration of one hundred years of the National Reawakening Day that has pioneered by founding father of Indonesian physicians

Activities

- The IMA National Workshop has been held on 30 October – 2 November in Bandung

International

- **Attending World Medical Association General Assembly in Seoul, Korea on October 15-18, 2008**

Thank you

JAPAN MEDICAL ASSOCIATION

Kazuo IWASA*1

Participation in the Medical Congress Commemorating the Centennial Anniversary of Japanese Immigration to Brazil

Japanese people first immigrated to Brazil exactly 100 years ago, in 1908. In commemoration of this, various exchange events in Brazil were planned with the cooperation of the Japanese Government. Taking this opportunity, the Brazil Medical Association, led by President Dr. José Luiz Gomes do Amaral, held a medical conference commemorating the 100th anniversary of Japanese immigration to Brazil and invited executives of the Japan Medical Association (JMA) to participate. The JMA was represented by myself, acting on behalf of President Dr. Karasawa, and Executive Board Member for International Relations, Dr. Ishii. At the conference I provided an outline of Japan's healthcare system, while Dr. Ishii spoke about the JMA's Continuing Medical Education (CME) program. The conference brought together many medical professionals and, with various questions asked and answers given, enabled us to deepen our exchange with Japanese-Brazilian physicians.

WMA General Assembly in Seoul

The WMA General Assembly was held in Seoul, Korea, from October 15th to 18th, hosted by the Korean Medical Association (KMA). The arrangements made by the KMA, including meeting details and social events, were excellent, making the general assembly a highly memorable one. At the instigation of Dr. Moon, during the general assembly a lunch for CMAAO member countries was also held, and the discussions there, too, were very meaningful.

I would like for such gatherings of CMAAO member countries at WMA general assemblies to continue in the future, and at this general assembly, too, on various occasions I was keenly reminded of the importance of the solidarity of the CMAAO member countries, as well as the significance of the existence of this organization boasting a 50-year history.

Participation in Centennial Anniversary Celebrations for the KMA

This was also related to the KMA, which is celebrating its centennial anniversary this year. In commemoration, the KMA held an academic conference in May this year, to which I and Dr. Ishii were invited and which we were honored to attend.

Establishment of a Global Health Study Committee

The menace of SARS and new avian influenza is a huge problem facing not one country but the entire world. Moreover, as medical professionals it is only natural that we think of some means of providing support for African and other developing countries to resolve their healthcare problems. Amidst this globalization of health issues, a Global Health Study Committee was set up this year within the JMA with the purpose of considering what basic stance the JMA should take in its involvement in global health issues. Committee members predominantly comprise specialists in global and international health, and already the first committee meeting has been held and discussions carried out. High expectations from both inside and outside the association are held for such a large organization as the JMA, and in future we intend to consider more specific themes with the aim of contributing even in some small way to global health.

*1 Vice-President, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp). Vice-Chair of Council, World Medical Association.

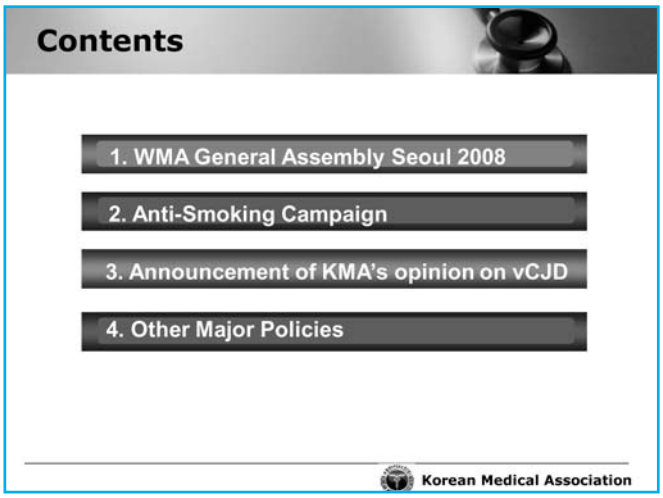
Revision of Medical Fees

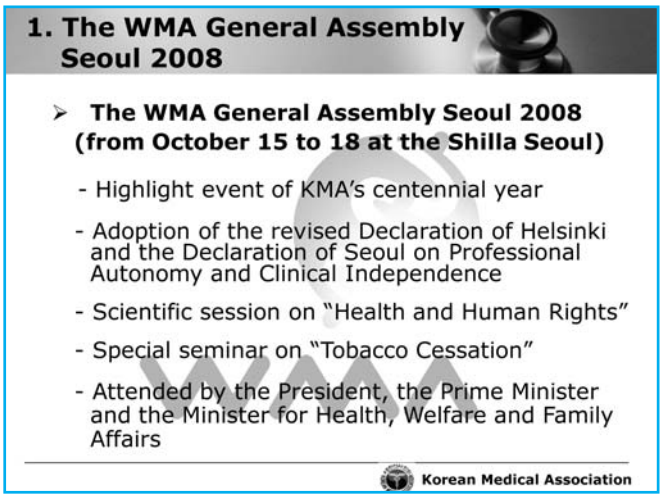
In accordance with proposals made by the Council on Fiscal and Economic Policy, which has strong influence over national fiscal management policies, controls on social security expenditure in Japan—particularly on healthcare costs—had continued. Consequently, one after the other medical institutions have gone bankrupt or closed down some of their hospital wards, which has in turn impacted the healthcare provision systems in each region. In order to escape from this situation, the JMA has since last year been proactively lobbying the national government to ensure funding for healthcare expenditure under the revision of medical fees implemented in April 2008. As a result, medical fees were overall reduced by 0.82%, but an upward revision of 0.42% in technical fees—the first increase in 8 years—was achieved. However, this is hardly sufficient for improving healthcare as the situation now stands. The Japanese Government has said that it intends to examine the current state of Japan's medical system, particularly with regard to emergency and obstetric medicine, and in drawing up the budget for the next fiscal year newly establish a 330-billion-yen or 3 billion US$ for "Important Issue Implementation Frame" to funnel funding into important issues such as social security.

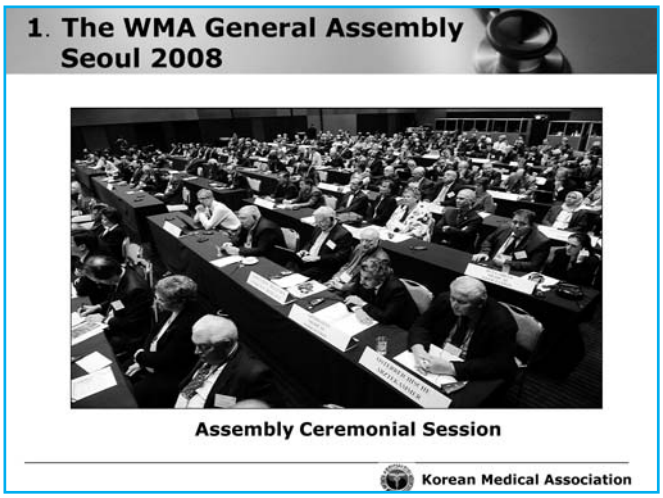
Finally, last April the JMA held elections for its new board, and Dr. Yoshihito Karasawa was reelected as president. In future, the JMA intends to continue to participate proactively in international activities through CMAAO and the WMA.

KOREAN MEDICAL ASSOCIATION

Dong Chun SHIN*1







*1 Executive Board Member, Korean Medical Association, Seoul, Korea (intl@kma.org). Professor, Department of Preventive Medicine, College of Medicine, Yonsei University.

1. The WMA General Assembly Seoul 2008

Voting for the revision of the Declaration of Helsinki and a scene from plenary session

Korean Medical Association

1. The WMA General Assembly Seoul 2008

Commemorative photograph with the President of Korea, Mr. Myong-Bak Lee

Korean Medical Association

1. The WMA General Assembly Seoul 2008

Welcome Reception hosted by the President of Korea

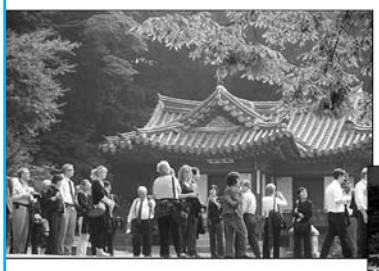
Korean Medical Association

1. The WMA General Assembly Seoul 2008

Scientific sessions on Health and Human Rights

Korean Medical Association

1. The WMA General Assembly Seoul 2008



Cocktails and dinner hosted by KMA at the Walkerhill Hotel

⇩

Official Tour to Changdeokgung, Royal Palace of Seoul

Korean Medical Association

2. Anti-Smoking Campaign

- Operation of Stop Smoking Help Line
- Provision of stop smoking treatment programs and information on clinics to our members
- Cooperate with the Military Medical Command

Korean Medical Association

2. Anti-Smoking Campaign

➢ **A Stop-smoking Declaration Ceremony (May 26, 2008)**

Korean Medical Association

2. Anti-Smoking Campaign

➢ **Advertisements for stop smoking**
(Through TV, daily newspapers, etc.)

Korean Medical Association

3. Announcement of KMA's Opinion on vCJD

➢ Concern among the Korean people reached extreme level after the agreement of resuming US beef imports

➢ KMA announced its opinion on this to provide accurate academic information about the vCJD

US beef tasting event by leaders of Korea's medical field

Korean Medical Association

4. Other Major Policies

(1) Development of Claiming Software

➢ Problems in the current claiming software caused loss of consultation data, incompatibility with other claiming software and other disruptions

➢ KMA is developing its own claiming software to provide members with a stable alternative

Korean Medical Association

4. Other Major Policies

(2) Diversification of Business

➢ KMA is actively developing new businesses to generate additional income to reduce the dependence on membership fees and to enhance financial stability

- An agreement with NAVER (NHN: Korea's top search portal) to provide medical consultation and contents

⇒ provision of accurate health information to the public

- Opening an Internet Shopping mall "Physician's Market"

⇒ to facilitate the smooth supply of various consumables necessary at clinics (about 25,000 clinics and increasing by 5% every year)

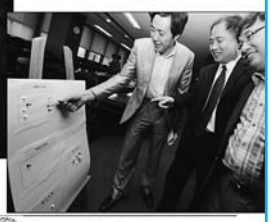
Korean Medical Association

4. Other Major Policies

(2) Diversification of Business

Agreement with NAVER to provide medical contents

Voting for deciding the name of the shopping mall



Korean Medical Association

4. Other Major Policies

(3) Long-term Care Insurance

- **Launch of Long-term Care Insurance**
  - launched from July 2008
  - Features as a program to support those taking care of elderly family members combined with strong medical care component

- **Beneficiaries**
  - those 65 or older and those under 65 but suffering geriatric diseases
  - Approval from the Long-term Care Needs Certification Committee necessary

Korean Medical Association

4. Other Major Policies

(3) Long-term Care Insurance

- **Long-term Care Insurance Benefits**
  - in-home services
  - institutional services
  - cash benefits for families
  - special cash benefits

- **Major sources of Financing**
  - contribution + government subsidy + co-payment of users

Korean Medical Association

4. Other Major Policies

(3) Long-term Care Insurance

- **Contribution for Long-term Care Insurance**

  - Persons entitled to pay a contribution: The insured persons with National Health Insurance (including overseas Koreans and foreigners with NHI)

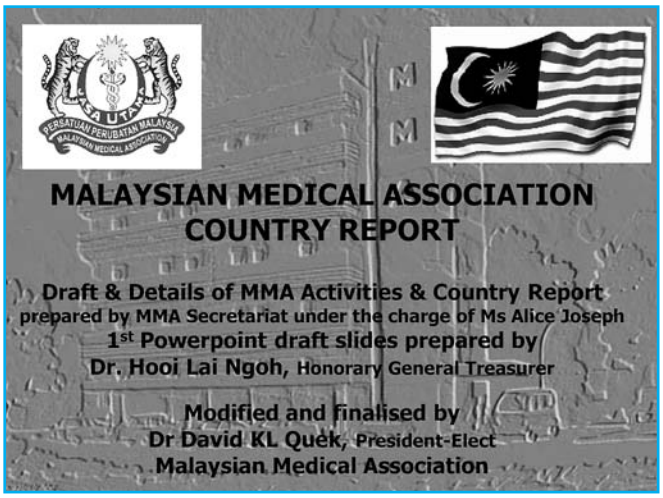
  - Contribution for Long-term Care Insurance

> **Contribution for National Health Insurance × Rate of Contribution for Long-term Care Insurance (4.05%)**

Korean Medical Association

MALAYSIAN MEDICAL ASSOCIATION

David KL QUEK*1



OBJECTIVES OF MMA

To promote and maintain the honour and interest of the profession of Medicine in all its branches and in every one of its segments and help to sustain the professional standards of medical ethics

To serve as a vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large

To participate in the conduct of medical education, as may be as appropriate

To promote social, cultural and charitable activities in building a united Malaysian nation

MMA Council 2008-2009

President	Dato' Dr Khoo Kah Lin
President Elect	Dr. David Quek Kwang Leng
Immediate Past President	Datuk Dr Teoh Siang Chin
Honorary General Secretary	Dr Mary Suma Cardosa
Honorary General Treasurer	Dr Hooi Lai Ngoh
Honorary Deputy Secretary	Dr Kuljit Singh
Honorary Deputy Secretary	Dr Sarjeet Singh Sidhu
Chairman, Private Practitioners' Section (PPS)	Dr S R Manalan
Chairman, Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS)	Dr Mastura Hj Ismail

plus 19 representatives from 14 Branches

MMA's Sections, Societies and Committees

2 Sections: Section Concerning House Officers, Medical Officers & Specialists (SCHOMOS) and the Private Practitioners' Section (PPS)

5 Societies: Public Health Society, Society of Sports Medicine, Society of Occupational and Environmental Medicine (SOEM), MMA Ophthalmological Society and MMA Society of Medical Students

MMA has 31 Committees and,

Representatives on 29 external bodies i.e., government and non-governmental organisations (NGOs)

*1 President-Elect, Malaysian Medical Association, Kuala Lumpur, Malaysia (mma@tm.net.my).

MEMBERSHIP

As at 21 April 2008, membership stood at 7,897
- 4,331 Ordinary Members
- 3,376 Life/Joint Life Members
- 178 Exempt Members
- 5 Associate Members and
- 7 Honorary Members

In addition, there were 3,114 student members

MMA members comprise only 44% of the total 17,904 registered medical practitioners in the country
It is hoped that the number of members will increase since there is a life membership promotion till end of this year

Malaysia's population = 26.5 million
Bumiputera = 60%, Indians = 9%
Chinese = 25%, Others = 6%

Profession	2005 (%)			2007 (%)		
	Bumiputera	Chinese	Indian	Bumiputera	Chinese	Indian
Accountant	21.5	73.0	4.9	23.5	71.4	4.9
Architect	45.3	53.1	1.4	46.2	52.1	1.5
Doctor	38.1	31.2	27.4	43.8	28.2	20.2
Dentist	44.4	35.3	18.4	46.5	34.5	16.9
Engineer	46.0	47.6	5.4	46.2	46.0	5.3
Lawyer	38.0	37.1	24.1	39.0	36.5	23.5
Surveyor	48.2	47.0	3.2	50.5	44.7	3.2
Veterinary Surgeon	39.0	32.2	24.8	43.3	34.1	22.5

Health Personnel: Population Ratio, 2005 and 2007

Type of Personnel	Number		Ratio to Population	
	2005	2007	2005	2007
Doctors[1]	20,105	23,738	1 : 1,300	1 : 1,145
Dentists[1]	2,751	3,163	1 : 9,497	1 : 8,586
Pharmacists[1]	4,012	5,730	1 : 6,512	1 : 4,742
Nurses[1]	44,120	48,196	1 : 592	1 : 556
Medical Assistants[1]	6,709	7,948	1 : 3,894	1 : 3,419
Dental Technicians[2]	655	684	1 : 39,889	1 : 39,728
Dental Surgery Assistants[2]	2,355	2,632	1 : 11,094	1 : 10,324
Community Nurses[2]	15,618	16,883	1 : 1,673	1 : 1,610
Dental Nurses[2]	2,071	2,319	1 : 12,616	1 : 11,718
Occupational Therapists[2]	301	405	1 : 86,802	1 : 67,096
Physiotherapists[2]	468	576	1 : 55,828	1 : 47,177
Radiographers[2]	1,156	1,375	1 : 22,602	1 : 19,763
Medical Laboratory Technologists[2]	3,302	3,684	1 : 7,913	1 : 7,376

Notes: [1] Includes public and private sectors.
[2] Refers to the ratio in Ministry of Health.

***Registered doctors; actual number of practising doctors around 18,140**

Commitment
Health
▪ Reducing infant mortality rate to 4.9 per 1,000 live births
▪ Reducing maternal mortality rate to 2.5 per 100,000 live births
▪ Reducing incidence of TB to 59 per 100,000 population
▪ Reducing incidence of malaria to 19 per 100,000 population
▪ Improving doctor:population ratio to 1:763
▪ Improving dentist:population ratio to 1:6,855
▪ Improving pharmacist:population ratio to 1:3,267

Key Results, 2006-2007

Commitment	Output
Health	
▪ Expanding primary care services	▪ 34 health clinics and 72 rural clinics built, bringing the total to 824 health clinics and 2,073 rural clinics
▪ Increasing health promotion and education activities	▪ *MyHealth* portal launched as an Internet-based health education channel. Screening and early detection of risk factors were integrated into services provided at health clinics
▪ Implementing and consolidating the provision of secondary and tertiary care	▪ 21 hospitals completed, bringing the total to 130, while 61 hospitals provided secondary care and tertiary care was provided on a regional basis
▪ Addressing health needs of specific target groups	▪ Health care for the elderly was provided in 600 clinics or 73% of the total, while health care for children with special needs were provided in 214 clinics or 26% of the total
▪ Meeting human resource needs of the medical sector	▪ Number of doctors increased from 15,421 in 2005 to 18,140 in 2007. Number of specialists increased from 2,014 in 2005 to 2,413 in 2007

MMA's concerns are that there are fairly adequate infrastructural development within the country's health sector, the mal-distribution and the private-public discrepancy, adequacy, equity, standards of public/private health provisions remain less than optimum

LIAISON WITH MINISTRY OF HEALTH

MMA's representatives attended various meetings with the Ministry of Health during the 2007/2008 term

There were two meetings with the Minister of Health:

- the first in December 2007, and

- the second (with the new Minister) in April 2008

SCHOMOS ISSUES
(Public Sector Doctors)

Issues affecting government doctors which were discussed included:

- **the effect of extending the duration of housemanship to 2 years**
- **continuing professional development**
- **entry into the postgraduate training programme**
- **insurance for government doctors**
- **allowances and,**
- **remuneration for working after office hours**

Human resource development and retention of skilled and trained personnel remains problematic, with constant attrition to the private sector

PPS ISSUES
(Private Sector Doctors)

Issues affecting private sector doctors which were discussed included:

- regulation of Managed Care Organisations (MCOs) -
- outpatient clinics in private hospitals
- *implementation of the Private Healthcare Facilities and Services Act 1998 and Regulations 2006*
- dispensing of medicine by private doctors and,
- medical examination for commercial vehicle drivers

Discussion with the Ministry of Health to amend the Private Healthcare Facilities and Services Regulations 2006 are ongoing

MEDICAL ASSOCIATION OF SOUTH EAST ASIAN NATIONS (MASEAN)

The 12th MASEAN Mid Term Council Meeting was held in November 2007 in Hanoi, Vietnam

MMA was represented by:
- Datuk Dr. Teoh Siang Chin, Chairman of MASEAN
- Dr. P Vythilingam, Honorary General Treasurer and,
- Dr. N. Athimulam, Chairman of MASEAN Committee on Medical Education

CONFEDERATION OF MEDICAL ASSOCIATIONS IN ASIA AND OCEANIA (CMAAO)

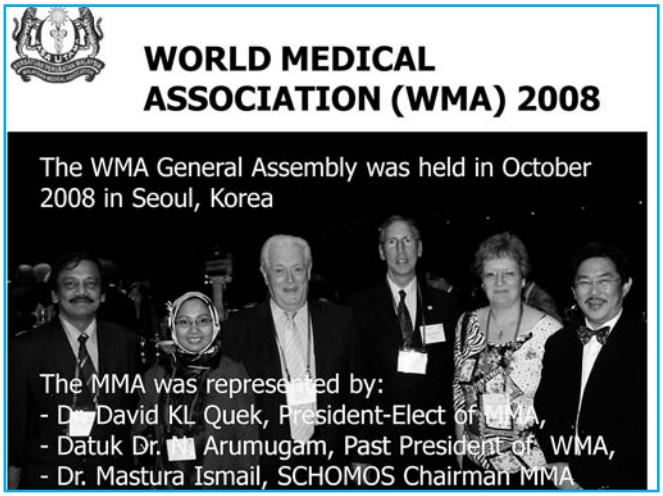
The joint 51st Annual Scientific meeting of the Medical Association of Thailand and the 25th CMAAO Congress with the 43rd CMAAO Council meeting was also held in November 2007 in Pattaya, Chonburi, Thailand

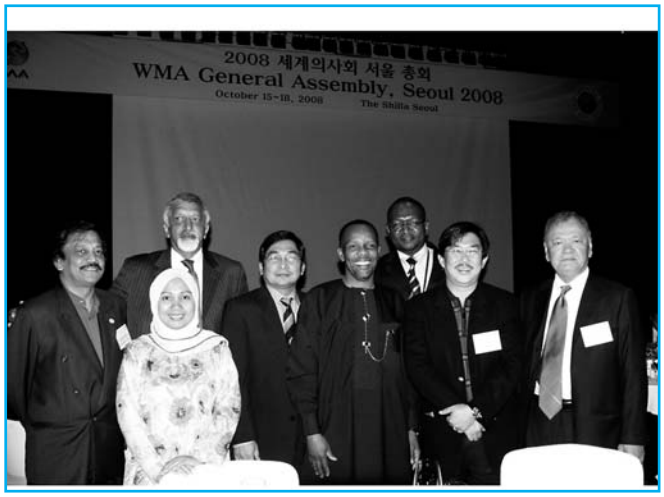
The MMA was represented by:
- Datuk Dr. Teoh Siang Chin, Immediate Past President of MMA, and
- Dr. S R Manalan, Chairman, Private Practitioners' Section of MMA

WORLD MEDICAL ASSOCIATION (WMA) 2007

The WMA General Assembly was held in October 2007 in Copenhagen, Denmark

The MMA was represented by:
- Dato' Dr. Khoo Kah Lin, President of MMA, and
- Datuk Dr. N. Arumugam, outgoing President of WMA, who delivered his presidential valedictory address during this Assembly





OTHER INTERNATIONAL MEETINGS

The 21st Triennial Conference of the Commonwealth Medical Association and Annual Academic Conference of the Indian Medical Association was held in Chennai, India, in November 2007

MMA was represented by:
- Dr. P. Vythilingam, Honorary General Treasurer and,
- Dr. Kuljit Singh, Honorary Deputy Secretary

Dato' Dr. Khoo Kah Lin, President of MMA, represented the MMA at the annual representative meeting of the British Medical Association in June 2007

SEMINAR ORGANISED BY MMA

International Federation of Health and Human Rights Organisations (IFHHRO) Regional Training (December 2007)

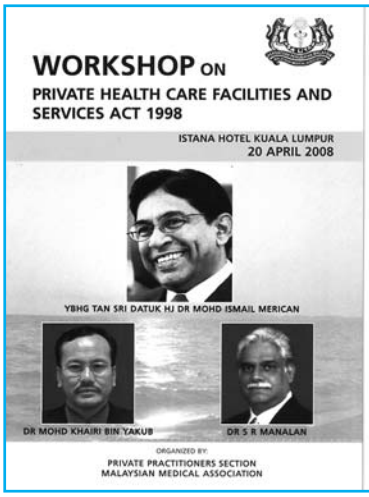
This training workshop brought together doctors, medical students, social activists, lawyers, academicians and NGOs with an interest in health and social policies from eight countries from South and South East Asia, namely India, Pakistan, Bangladesh, Nepal, Thailand, Vietnam, Philippines and Malaysia
Participants gained an overview of the international covenants and conventions, their significance in promoting health service provision, the ethical basis for right to health movement and how this is applied in real life situations

IFHHRO Regional Training

Meetings organised by PPSMMA

Forum for General Practitioners and Specialists (March 2008)
Among the issues discussed were the gatekeeper's role of the general practitioner, fee schedule for general practitioner, regulatory Act governing private practice, quality improvement programme for general practice clinics, development of Malaysian clinics' accreditation standards, healthcare system governance in Malaysia, regulating managed care organisations and National Health Financing Scheme

Workshop on Private Healthcare Facilities and Services Act 1998 & Regulations 2006 (April 2008)
The topics deliberated upon were "Private Health Care in a Developed Malaysia 2020" and "Challenges in the Enforcement of the PHFSA"



Workshop On PHFSA April '08
Attended by Director-General of Health and Director, Medical Practice Division, Ministry of Health Malaysia

Meetings organised by Society of Occupational and Environmental Medicine

Seminar on Occupational Health for Healthcare Professionals (July 2007)

Medical Fitness for Work Workshop (August 2007)
Organised in collaboration with MMA Sabah Branch and the Social Security Organisation (SOCSO)

Third Regional Conference on Occupational Health (April 2008)
Organised in conjunction with SOCSO and other stake holders

3rd Regional Conference on Occupational Health April '08

Meetings organised by Committees

Seminar on Victims of Violence for Medical Students (July 2007) Organised by Committee on Rehabilitation of Victims of Violence
4th Symposium on Medical Education (September 2007) Organised by Committee on Medical Education
6th National Symposium on Adolescent Health (March 2008) Organised by Committee on Adolescent Health in conjunction with other stake holders
GP Training Programme on HIV care (March 2008) Organised by AIDS Action Committee & Malaysian Society for HIV Medicine
Symposium on Evidence Based Complementary Medicine (April 2008) Organised by Committee on Evidence Based Complementary Medicine

6th National Symposium on Adolescent Health

Meetings organised by Branches

10th Penang Scientific Conference for General Practitioners (September 2007) and, Conference on Clinical Emergencies (April 2008)
Organised by MMA Penang Branch (25th Anniversary celebrations)

Seminar on Medical Law and Medical Ethics (March 2008)
Organised by MMA Perak Branch

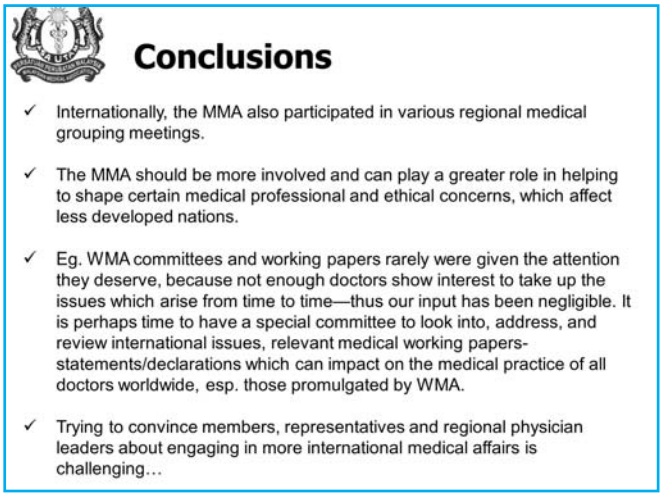
10th Penang Scientific Conference for GPs – September '07

25th Anniversary Dinner MMA Penang Branch April '08

Scientific Conference for GPs, Penang MMA, 18-19 October 2008

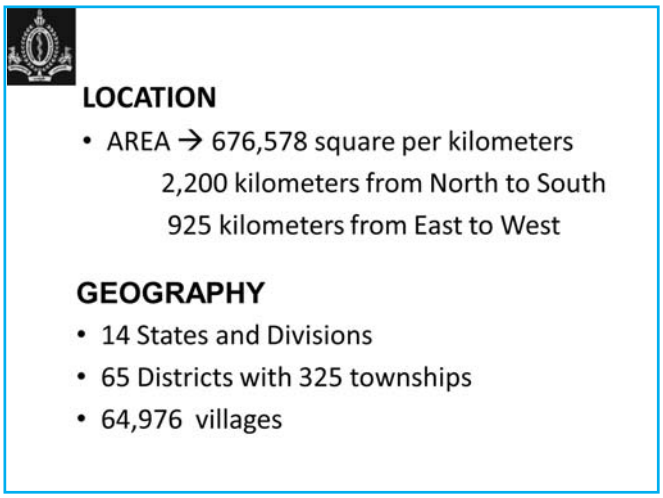
Conclusions

- ✓ It was an active year for the 47th MMA Council especially the key office-bearers who had many meetings to attend with the Ministry of Health and other external organisations to help solve problems faced by the profession
- ✓ The Sections of the MMA focused on resolving problems faced by their respective members in meetings with the Ministry of Health and in other forums
- ✓ The Committees and Societies were also active participating in and organising various meetings and conferences. The state Branches diligently carried out their activities, particularly continuing professional development /continuing medical education programs; community projects and recruitment of new members


Conclusions
✓ Internationally, the MMA also participated in various regional medical grouping meetings.
✓ The MMA should be more involved and can play a greater role in helping to shape certain medical professional and ethical concerns, which affect less developed nations.
✓ Eg. WMA committees and working papers rarely were given the attention they deserve, because not enough doctors show interest to take up the issues which arise from time to time—thus our input has been negligible. It is perhaps time to have a special committee to look into, address, and review international issues, relevant medical working papers-statements/declarations which can impact on the medical practice of all doctors worldwide, esp. those promulgated by WMA.
✓ Trying to convince members, representatives and regional physician leaders about engaging in more international medical affairs is challenging…

MYANMAR MEDICAL ASSOCIATION

Kyaw Myint NAING*1



*1 President, Myanmar Medical Association, Yangon, Myanmar (profkmnaing@gmail.com).

POPULATION

- Total population estimate 55.40 million in 2005
- Population growth rate 2.02 %
- 70% reside in rural areas
- Population density varies
- 390 per square kilometers in Yangon city

NATIONALITY

- 135 national groups with over 100 languages and dialects
- About 89.4% Bamar and others such as Kachin, Kayah, Kayin, Chin, Mon, Rakhine, Shan (10.6%)

NATIONAL ETHNICS

HEALTH STATISTICS

Vital Statistics

Health Index	1988	1999	2000	2001	2002	2003	2004▲
Crude Birth Rate (per 1,000 population)							
- Urban	28.6	24.5	24.2	23.9	21.2	19.9	19.1
- Rural	30.5	27.1	26.4	26.3	24.6	22.4	22.0
Crude Death Rate (per 1,000 population)							
- Urban	8.9	6.0	6.3	6.2	6.1	5.6	5.5
- Rural	9.9	7.8	7.3	7.1	7.0	6.5	6.4
Infant Mortality Rate (per 1,000 live births)							
- Urban	47.0	55.1*	48.5	48.3	48.4	45.3	45.2
- Rural	49.8	62.5*	50.2	50.1	50.7	47.1	47.0
U5 Mortality Rate (per 1,000 live births)							
- Union	-	77.77^	-	-	-	-	-
- Urban	72.9	65.12^	73.5	73.1	72.6	72.2	70.1
- Rural	-	85.16^	-	-	73.5	73.2	71.4
Maternal Mortality Ratio (per 1,000 live births)							
- Urban	1.0	1.8*	1.1	1.0	1.1	1.0	1.0
- Rural	1.9	2.8^	1.9	1.8	1.9	1.5	1.5
Population Growth Rate	1.96	2.02	2.02	2.02	2.02	2.02	2.02
Average Life Expectancy							
- Urban (Male)	59.0	61.0	61.1	61.5	61.8	62.1	62.4
(Female)	63.2	65.1	65.1	65.6	66.0	66.2	66.5
- Rural (Male)	56.2	60.3	60.4	60.8	61.3	61.5	61.8
(Female)	60.4	62.7	62.8	63.3	63.8	64.0	64.5

Source: Statistical Year Book, CSO, 2004
▲ Planning Department, Ministry of National Planning and Economic Development
▲ National Mortality Survey, 1999

Health Manpower Development

Health Manpower	1988-89	2002-03	2003-04	2004-05	2005-06	2006-07▲
Total No. of Doctors	12268	16570	17081	17564	18584	20501
- Public	4377	6180	6331	6473	6941	7250
- Co-operative & Private	7891	10390	10750	11091	11643	13251
Dental Surgeon	857	1227	1285	1365	1594	1732
- Public	328	517	543	580	625	707
- Co-operative & Private	529	710	742	785	969	1025
Nurses	8349	15502	16382	18123	19776	21075
Dental Nurses	96	109	123	159	162	165
Health Assistants	1238	1728	1739	1771	1771	1778
Lady Health Visitors	1557	2559	2679	2796	3025	3137
Midwives	8121	14097	15130	16201	16745	17703
Health Supervisor (1)	487	529	529	529	529	529
Health Supervisor (2)	674	1144	1199	1339	1359	1394
Traditional Medicine Practitioners	279	563	649	819	819	812

▲ Provisional actual

Health Facilities Development

Health Facilities	1988-89	2002-03	2003-04	2004-05	2005-06	2006-07▲
Government Hospitals	631	780	790	824	826	832
Total No. of Hospital Beds	25309	32770	33683	34654	34920	35544
No. of Primary and Secondary Health Centers	64	84	84	86	86	86
No. of Maternal and Child Health Centers	348	348	348	348	348	348
No. of Rural Health Centers	1337	1413	1424	1456	1456	1463
No. of School Health Teams	80	80	80	80	80	80
No. of Traditional Medicine Hospitals	2	12	14	14	14	14
No. of Traditional Medicine Clinics	99	213	237	237	237	237

Myanmar Medical Association

- One and only professional body recognized by government, non-profit, non-political organization representing all medical doctors in the country
- Over 9,000 member doctors
- 76 branches of MyMA through out the country
- 27 specialty societies

History of MyMA

- Founded in 1949
- First founder was Dr Shwe Thwin
- Lt Col Ba Thaw was first MyMA President
- In 2006, Prof. Kyaw Myint Naing was selected as President and Prof. Myint Thaung as Secretary General

MyMA building in 1950

Main Functions

1. Organization and Administration at all levels
2. Academic (Education) for member doctors as well as general public
3. Incorporate into National Health Care Delivery System by execution role for "10" public health project activities
4. Emergency medical relief for natural disasters
5. Extending the fraternal ship with medical associations in neighbouring countries as well as outside the region

Working committees

1. Academic committee
2. Disaster Relief committee
3. Editorial committee
4. Ethical and Research committee
5. Office of labor affairs committee
6. Social and sports committee
7. Lady doctors section
8. Buddhist section
9. Support group for elderly doctors
10. Golfers' club
11. Doctor Writers' Section
12. Health Projects Central Supervising committee
13. Peer review committee

Role of MyMA in (2008)

- Increasing more publicity and identity in local and INGOs
- Appreciated and well supported by the Ministry of Health
- Achieving commitment and public empowerment
- Developing human resources, capacity building at all managerial level
- Enhancing professional rights for MyMA members
- Developing professional skills
- Binding global and regional network through professional activities

International Relationship

- Member of MASEAN in (1997)
- Proposed member of CMAAO (Confederation of Medical Associations in Asia and Oceania)
- Member of International Foundations and Societies in relation to medical specialties
- Professional Relationship with neighbouring countries as well as outside the region
- Partnership with INGOs, social and funding agencies, disaster management teams, and other civil societies

Our Current Interest

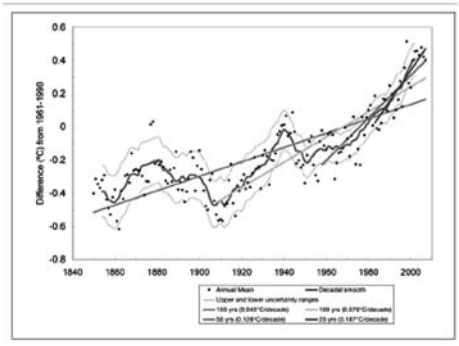
- Improving advocacy and educational program in upgrading ethics and profession by forming Central Ethical Peer-review Committee.
- Development of Master Plan for Disaster Management and Role of medical association
- Role of Civil Society in ASEAN countries particularly emphasizing on Trade in Health
- Improving Total Personal Professional Development of new member doctors
- Recruitment of new generations for career development in association
- Strengthening the health promotion strategies
- Developing a new organization infrastructure in our association

Our Current Interest in consequences of climate change

The role of Myanmar Medical Association in development of Master Plan for Disaster Management

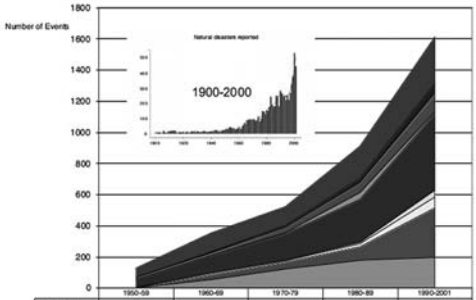
Storms and Hurricanes including the deadly Nargis, mainly due to climatic changes are consequences of the well-publicized "Global Warming"

Strengthening evidence for past and future warming



WHO; Protecting health from climate change. Based on IPCC

Figure 1.6 The Frequency of Weather-Related Disasters



	1950-59	1960-69	1970-79	1980-89	1990-2001
Wind storm	59	121	121	207	300
Wild fire	0	4	11	25	54
Wave/surge	2	5	2	3	12
Slide	11	15	34	63	114
Insect infestation	0	1	6	43	13
Flood	50	110	170	276	489
Famine	0	2	4	11	45
Extreme temp	4	10	9	19	70
Epidemic	0	31	44	86	317
Drought	0	52	120	177	195

Growth and changing composition of natural disasters. Sources: CRED / Center for Research in the Epidemiology of Disasters (CRED) "Natural.xls" Intl database of Disasters http://www.emdat.net and US Census Bureau's International Database (http://www.census.gov/ipc/www/idbagg.html). From analysis completed by Radco's Climate Change Solutions Group for USAID's Global Climate Change Team.

Global data for the Frequency of water-related diseases

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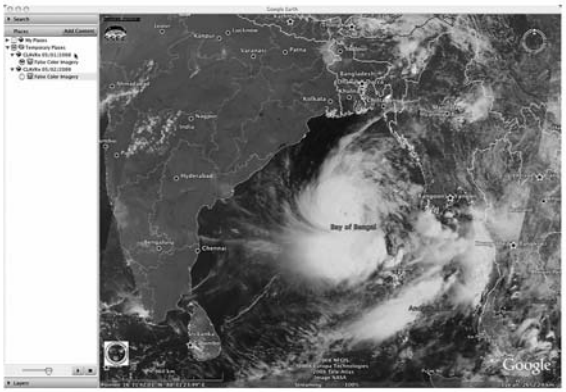
Nargis on 3rd May 2008 in Myanmar Delta



Nargis Storm Destructions

Flooded area in Delta of Myanmar after Storm Nargis

Table 2.2 Direct and Indirect Health Effects of Floods

Direct effects

Causes	Health Implications
Stream flow velocity; topographic land features; absence of warning; rapid speed of flood onset; deep floodwaters; landslides; risk behavior; fast flowing waters carrying boulders and fallen trees	Drowning Injuries
Contact with water	Respiratory diseases; shock; hypothermia; cardiac arrest
Contact with polluted water	Wound infections; dermatitis; conjunctivitis; gastrointestinal illness; ear, nose and throat infections; possible serious waterborne diseases
Increase of physical and emotional stress	Increase of susceptibility to psychosocial disturbances and cardiovascular incidents

Indirect effects

Causes	Health Implications
Damage to water supply systems; sewage and sewage disposal damage; insufficient supply of drinking water; insufficient water supply for washing	Possible waterborne infections (enterogenic *E. coli*, shigella, hepatitis A, leptospirosis, giardiasis, campylobacter), dermatitis and conjunctivitis
Disruption of transport systems	Food shortage; disruption of emergency response
Underground pipe disruption; dislodgement of storage tanks; overflow of toxic-waste sites; release of chemicals; Rupture of gasoline storage tanks may lead to fires	Potential acute or chronic effects of chemical pollution
Standing waters; heavy rainfalls; expanded range of vector habitats	Vector-borne diseases
Rodent migration	Possible diseases caused by rodents
Disruption of social networks; loss of property, jobs and family members and friends	Possible psychosocial disturbances
Clean-up activities following floods	Electrocutions; injuries; lacerations; skin punctures
Destruction of primary food products	Food shortage
Damage to health services; disruption of "normal" health service activities	Decrease of "normal" health care services, insufficient access to medical care

Source: Menne et al., 2000. Floods and public health consequences, prevention and control measures. UN, 2000. (MP.WAT/SEM.2/1999/22)

MyMA Activities after Nargis Storm in Myanmar, May 2008

- After forming the working committee, as requested by the Ministry of Health to conduct relief medical tours in Delta region.
- MyMA Volunteer groups of twenty doctors lead by two physicians and two paediatricians went to Pyinkhayine village track and Magibin village track of Ngapudaw township to provide free medical care for ten days.

Management Activities Categorization

- Emergency relief free medical care including surgery if need and referral to hospital
- Base and mobile field Clinic services
- Free distribution of food and utensils
- Logistic support
- Health Education
- Communicable disease surveillance and prevention

Activities Categorization

- Counseling including psychological training for volunteers
- Peer Review and Education
- Regular activity on disaster preparedness by the central committee
- Short term project implementation in collaboration with UN agencies

Current Activities

- Short trips and long trips made by volunteer medical teams that were equipped with
- essential medicine,
- medical equipments,
- donated foods,
- utensils,
- clothes etc.

- Travelling to the disaster areas, villages by coach, or boat, with own arrangement.
- Divisional Committees are also implementing activities for disaster relief.

Current Activities (Cont:)

- Social support to healthcare providers who are victimized by Nargis
- Support to the health infrastructure in the field
- Provision and chlorination of water supply and continuation of standard latrine in some village tracts
- Donation of tractors for agriculture use in some villages
- Support for monasteries

Current Activities

- Members of district branches throughout the country also took part in Nargis relief activities in kind or cash.
- Members of district branches like Mandalay, Mawlamyine, Taunggyi, Pathein, Pyay, Laputta, Shwe Bo, Magway, Hinthada, Pha Khant, Bago and other branches also enthusiastically took part in relief medical teams of Central Relief Works.

Capacity Building Trainings

Altogether 695 doctors have attended the capacity building courses for volunteer medical doctors and Psychosocial support trainings are also conducting.

Association Women's Section activities in Nargis Relief Work

Medical Team to Pyin Ka Yine for second time Ngapudaw township in Ayeyarwaddy

Activities implemented by MyMA (18.11.2008)

- Total 54 trips, 7 GP clinics, 4 Projects were done up to 18.11.2008. Total 860 doctors looked after more than 157,968 patients.

The role of MyMA in Development of Master Plan for Disaster Management

- MyMA is now implementing Development of Master Plan for Disaster Management in collaboration with
- MAMS (Myanmar Academy of Medical Science)
- MRCS (Myanmar Red Cross Society)
- and some consultants from UNICEF (Myanmar)

THANK YOU VERY MUCH

NEW ZEALAND MEDICAL ASSOCIATION

Peter FOLEY*[1]

New Zealand is a country of four million people in the South Pacific. In November 2008 a new Government was elected, headed by Prime Minister John Key, who replaced the Labour-led Government of the past nine years which was headed by Helen Clark. The new Government is centre-right, and plans to largely keep existing health structures in place while making a number of changes.

Health expenditure in New Zealand as a proportion of GDP (9%) is similar to that in most other OECD countries. Expenditure on health in real terms has risen consistently over the last decade. In addition, 43% of discretionary extra budget funds have gone to health. Over the last decade there has been an increase in the number of health professionals, including the numbers of doctors and nurses, although there are still many shortages. Life expectancy has risen over the last half century. However, there remain disparities in life expectancy and health status based on ethnic and socioeconomic differences. There have been significant increases in life expectancy, and much of this has related to improvements in cardiovascular risk profile—and this has been particularly evident amongst Maori men. For each year, they are gaining a quarter of a year greater life expectancy than the general population gains.

Obviously, a reduction of 100,000 smokers has assisted, but we still have over 600,000 still smoking!

The way that health and disability support services are organised in New Zealand has undergone a number of changes in the last two decades. These have ranged from a 'purchaser/provider' market-oriented model introduced in 1993, to the more community-oriented model that is currently in place.

The current system was implemented through the New Zealand Public Health and Disability Act 2000 which allowed for the creation of District Health Boards (DHBs), which are responsible for providing, or funding the provision of, health and disability services in each region. There are 21 DHBs in New Zealand and they have existed since 1 January 2001.

Of much interest outside New Zealand is our ACC system of no-fault accident cover. ACC provides universal accident insurance cover, injury prevention services, care management, and medical and other care and rehabilitation services.

The Primary Health Care Strategy was released in early 2001. The intention of the strategy is to improve health and reduce health inequalities in the population for all New Zealanders. Primary Health Organisations have been set up as local structures for delivering and co-ordinating primary health care services. This strategy has seen more resources placed in primary (non-hospital) care, but the need to realign secondary services remains in the "yet to do" basket.

About the NZMA

The NZMA is the largest medical professional organisation in New Zealand with approximately 4,500 members. It is pan-professional in that it represents member doctors from all disciplines within medicine, including medical students. It was established in 1886.

The key roles of the NZMA are:

- To advocate on behalf of doctors and their patients
- To develop of health policy initiatives
- To provide services and support to members
- To publish the New Zealand Medical Journal
- To publish and promote the Code of Ethics

The NZMA has strong and effective working relationships with other medical organisations and often acts as a "peak" organisation for major issues affecting the profession or large groups within the profession. We also have working relationships with other professional organisations within the health sector and with government agencies, including the Ministry of Health, ACC, Department of Labour, Ministry of Social

*1 Chair, New Zealand Medical Association, Wellington, New Zealand (nzma@nzma.org.nz).

Development and Ministry of Transport.

Main Issues of Concern to NZMA

Workforce

For more than a decade, the NZMA has had grave concerns about the viability of the medical workforce. Like many similar countries, New Zealand is facing shortages of doctors (and other heath professionals), and difficulties recruiting and retaining staff. The global market in health means many medical practitioners choose to work in other countries which often pay higher salaries. New Zealand currently trains too few medical students. The incoming government has promised to increase medical student places by 200 over five years, which is a good start but it will still be many years before the increased numbers are able to practise independently. There is an over-reliance on doctors who trained overseas—around 45 percent of doctors working in New Zealand did not train here. The NZMA believes the New Zealand medical workforce needs to be self-sufficient. The ageing population and constant improvements in technology put pressure on health resources. There are also concerns that many in government favour "role substitution," that is, employing nurses and others to do many aspects of doctors' jobs. We are pleased to see that several recent initiatives have been developed to bring about much-needed changes to the health workforce. The NZMA has offered to work with the new Government to address this critical situation.

Primary health care

The NZMA has always supported the objectives of the Primary Health Care Strategy, which aims to improve access to primary health for all New Zealanders. The previous Government increased funding to primary care, in particular it introduced universal patient subsidies which had the effect of lowering patient co-payments for services. However, concerns remain, especially with the Government's attempts to control fee rises. The NZMA has since 1938 supported the right of private sector medical practitioners, including general practitioners, to set and charge fees commensurate with the services they provide. This right has come under increasing and unprecedented pressure in recent years.

Secondary/Tertiary services

In many areas patients face delays and long waiting lists to get access to publicly-funded secondary and tertiary services. This is particularly a problem in relation to first appointments with specialists, and the long waiting times for many elective procedures. Many do not get specialist treatment, but are returned to the care of their GP. This lack of timely access to the care they need causes great distress to many New Zealanders and their families, and the NZMA is keen to see a more transparent approach to managing the wait for necessary care.

Maternity services

New Zealand's maternity services, while of a very high standard internationally, are fast approaching a crisis due to workforce shortages. Since changes to regulations in 1996, most general practitioners have given up intra partum obstetric care and the number of doctors practising obstetrics and gynaecology has decreased. Additionally, many women report difficulties in accessing midwifery services. Pressures also exist on other medical disciplines, including anaesthesia, radiology and paediatrics, which also have implications for the provision of maternity services.

Professional regulation

The NZMA is concerned that professional self-regulation has been substantially undermined due to the profession being unable to elect representatives to the registration body, the Medical Council of New Zealand. The profession accepts the need for professional accountability, but has been pressing successive Ministers of Health to allow a degree of direct representation. We were very pleased, therefore, when at the end of 2008, the new Minister of Health agreed to allow direct elections to the Medical Council.

Public private interface

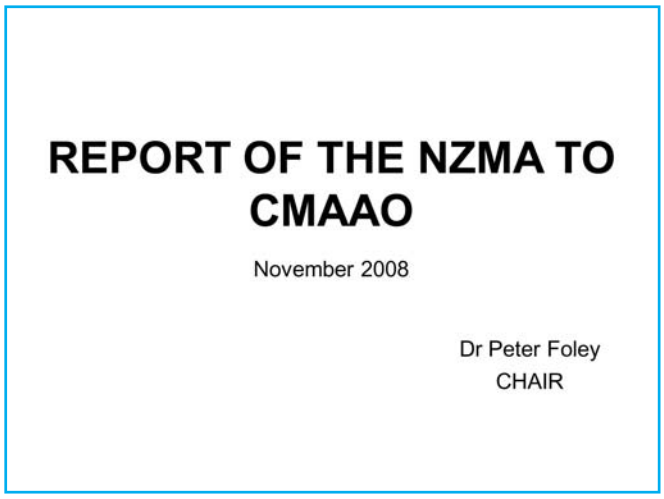
The NZMA has for many years advocated for governments to establish a clearer policy framework around the interface between the public and private sectors. A substantial proportion of health services in New Zealand are delivered by private sector providers, and there is a need for the respective roles of both sectors and their relationship to each other to be more clearly defined.

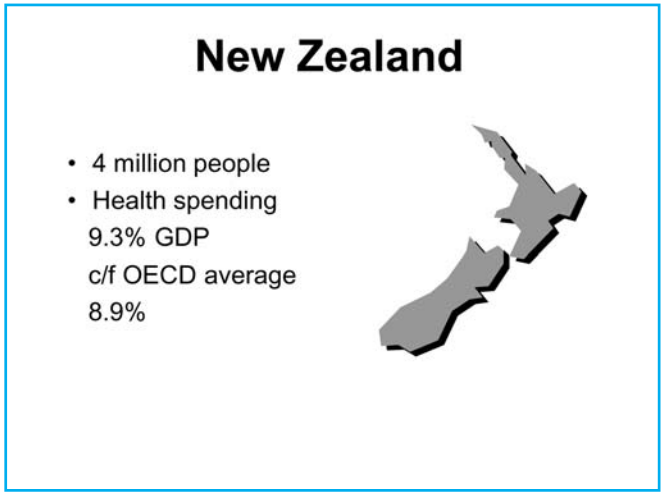
A Snapshot of New Zealand Health

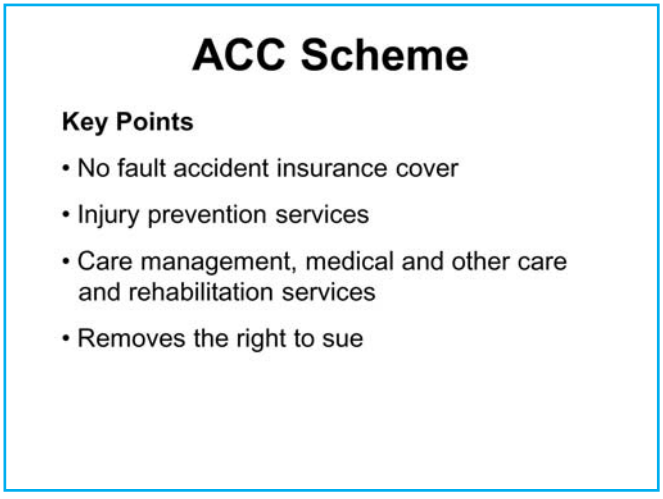
- A newborn girl can expect to live 82.2 years and a newborn boy 78.0 years.

According to *A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey.* (Wellington: Ministry of Health 2008):

- Three out of five adults rated their own health as excellent or very good.
- Nearly all adults (93.3%) had a primary health care provider (a general practice clinic, student health clinic, accident and medical centre or nurse clinic) they went to first when feeling unwell or injured, most of whom (84.7%) had seen a health care worker from this place in the previous 12 months.
- One in twelve adults (8.4%) had used an emergency department at a public hospital in the previous 12 months.
- Two out of three adults (65.7%) had been diagnosed with a chronic health condition. The most common health condition for adults was medicated high blood pressure (13.6%), followed by asthma (11.2%).
- One in five adults (19.9%) was current smokers.
- Half of all adults (50.5%) reported that they were regularly physically active.
- One in three adults (36.1%) was overweight and a further one in four (26.5%) were obese.
- Nine out of ten children (87.8%) were ever breastfed, for an average time of eight and a half months.

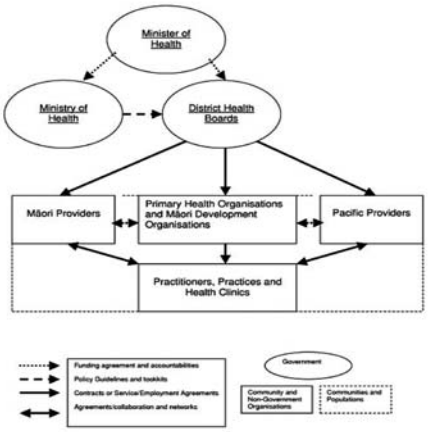






Primary Health Care Strategy

- To improve health and reduce health inequalities in the population for all New Zealanders
- Structure:-



Current Issues for NZMA

- Workforce
  - A workforce crisis
  - Problems of recruitment and retention
  - Need for self sufficiency
  - Role substitution is not “the answer”

Current Issues for NZMA cont

- Primary Health Care
  - Universal patient subsidies
  - Increasing attempts by Government to control fees
- Secondary/Tertiary Care
  - Long waiting lists for elective procedures and first appointment with specialist

Current Issues for NZMA cont

- Maternity Services
  - Workforce shortages
  - Few GPs now involved in maternity
- Profession Regulation
  - Demand for a minority (at least) of members on regulatory body to be directly elected by medical profession

Current Issues for NZMA cont

- Public/Private Interface
  - Need for policy framework around public/private interface
  - Delineation of sector roles

A Snapshot of New Zealand Health

- A newborn girl can expect to live 82.2 years and a newborn boy 78.0 years.
- Three out of five adults rated their own health as excellent or very good.

A Snapshot of New Zealand Health cont

- 93.3% of all adults had a primary health care provider they went to first when feeling unwell or injured, most of whom (84.7%) had seen a health care worker from this place in the previous 12 months.
- One in twelve adults (8.4%) had used an emergency department at a public hospital in the previous 12 months.

A Snapshot of New Zealand Health cont

- Two out of three adults (65.7%) had been diagnosed with a chronic health condition. The most common health condition for adults was medicated high blood pressure (13.6%), followed by asthma (11.2%).
- One in five adults (19.9%) was current smokers.

A Snapshot of New Zealand Health cont

- Half of all adults (50.5%) reported that they were regularly physically active.
- One in three adults (36.1%) was overweight and a further one in four (26.5%) was obese.

A Snapshot of New Zealand Health cont

- Nine out of ten children (87.8%) were ever breastfed, for an average time of eight and a half months.

PHILIPPINE MEDICAL ASSOCIATION

Rey Melchor F. SANTOS*1

The Philippine Medical Association is the umbrella organization of physicians all over the country comprising of about 17 regions, 118 component societies, 8 specialty divisions 63 specialty and subspecialty societies and 38 affiliate societies. The main specialty divisions are: Philippine Society of Anesthesiologists, Philippine College of Physicians, Philippine College of Surgeons, Philippine Pediatric Society, Philippine Academy of Family Physicians, Philippine Obstetrical and Gynecological Society, Philippine Society of Pathologists and Philippine College of Radiology.

The PMA was founded in 1903, and is now 105 years old. All those years, we have been guided by our vision of: "The Association is to have a fellowship of physicians united in the common goal of acquiring the highest levels of medical knowledge and skills through continuing education and research, and to promote the healing ministrations of the physicians in the delivery of health care of patients" and our mission of: "A dynamic, responsive and unified PMA committed to serve its members thru increased benefits, enhanced professional development, and the promotion and defense of the rights and privileges of the medical profession. These efforts, in partnership with other organizations and the government, shall contribute to excellent healthcare delivery to its patients and the community at large. PMA: in a dedicated, selfless and humane service of the medical profession for a healthy Philippines and for the glory of God."

Just recently, we have developed priority programs that would steer the organization to greater heights and make it more relevant to our members, the community and the nation as a whole. Our current theme of *"The Physician, the Community and the Government—All Together for Health"* clearly defines the directions to which the PMA is clearly heading.

Four Key Areas

There are 4 keys areas that we have identified as priority programs of our organization. These are: Membership Development and Benefits, Continuing Professional Education, Socio Civic Concerns and Environmental Advocacies and Political and Legislative Agenda.

Membership Development

Membership Development Benefits is our utmost priority. We believe that our organization exists to protect the rights of physicians and ensure that due benefits are afforded to them. We feel that it is the responsibility of PMA to ensure that physicians practice their profession competently, morally and ethically without regards to the patients status, creed, religion, social standing or the capacity to pay.

Towards this end, we have amended recently our Code of Ethics to make it more relevant to the changing times and at the same time establish standards for self regulation and self discipline within our organization. Currently the PMA Code of Ethics is the one used by the Professional Regulation Commission and any violations of any of the provisions of our Code could be a valid ground for reprimand, suspension or revocation of the physicians' license to practice. Our Code sets the standards of ethical practices in our relationship with each other, with our patient, with the community and with the pharmaceutical industries and attempts to put to a stop the practice of commercialization of the practice of medicine by endorsing health products. We have consistently fought against any legislative attempts to enact the malpractice law and have instead compromised with the patients group to have as an alternate the Patients Rights Bill which aims to protect patients' rights, make them

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aware of their obligations and provide legal avenues for grievances. We have just passed The Cheaper Medicine Bill for 2008 and we were able to successfully remove the controversial provision of mandatory generic prescriptions of physicians since our BFAD, is not yet completely supported logistically to ensure the efficacy and safety of generic formulations relative to the innovative brands.

Mutual Benefits Program

We are trying to expand our mutual aid benefits program for our members. Currently we are giving death, disability and legal aid benefits to them. Soon we will be able to give Annual Physical Examinations to them through the various multi specialty centers that we are trying to set up in each of the 17 regions. We feel that we really need to take care also of the health of our members. How can we keep the nation healthy when the physicians themselves are not? We are working with a marketing company to convert our ID cards into a discount card, which we can use in major establishments all over the country. We have just launched the Senior Physicians Foundation whose main mission is to develop programs that will benefit our senior physicians and help to bring them back to the mainstream of PMA activities. They have contributed a lot to our organization and it is about time to show some gratitude to them.

Continuing Medical Education Activities

Continuing Professional Development is centered on our CME activities which provides avenues for our doctors to update themselves in the current practices in medicine and to help ensure their competency and expertise. The PRC has recently brought back the requirement for CPE as a prerequisite for the renewal of our license to practice. The PMA through its various component societies and specialty societies is the major CME provider for our members. We are also developing our members on how to grow professionally by teaching them non medical topics like financial management, business acumen and investment opportunities to help them prepare more for the future.

PMA Heal the Nation Program

Our Socio-Civic activities are anchored on our PMA Heal the Nation Program—A comprehensive undertaking that is centered on 3 phases namely: Preventive, Therapeutic and Rehabilitation.

Our preventive phase is centered on public health education on the most common causes of morbidities and mortalities in our country. A strong backbone for this is our Health Education Reform Order (HERO) Program, which aims to create preventive health modules for the teachers to teach students particularly in public schools. This is a typical Private Public partnership where members of the PMA will help give health education to children in public schools and at the same time perform annual physical examinations of the students and the teachers. In effect we are trying to take care of our citizens early and properly guide them towards proper health education and wellness.

The therapeutic phase is focused on our medical—surgical missions. We have reprogrammed the missions to make them more consistent and relevant so that the people can get maximum benefits from them. We have started the Adopt-a-Hospital program to provide manpower complement particularly of the specialists, in general hospitals who no longer have the manpower to take care of their patients. We have formulated guidelines for foreign and local missions to make them more proactive, maximize resources and ensure that they are conducted in areas where they are actually needed, without sacrificing patients safety.

The Rehabilitation phase is focused in helping people to be brought back to a productive life. Whether they are victims of CVA, MI, alcoholics, drug addicts or just addicted to smoking, our programs are designed to give them a new lease in life.

Advocacies and Environmental Concerns

Our other advocacies and environmental concerns are ongoing. We are very vocal regarding our advocacies like Anti-smoking Programs, Cancer Prevention Programs, Wellness, the Proper Use of Seat Belt, etc. We have entered into an alliance with various NGO's in our fight against FAKE and counterfeit medicines as well

as assuring the safety of all medicines brought in and manufactured in our country. We are continuing our tree planting activities and other programs to help the environment and address the issue of global warming.

Political and Legislative Agenda

The Political and Legislative Agenda is the 4th key area that we are focusing on. We are in the process of forging an alliance with other allied and paramedical organization who shares with us the common mission of public health. This would allow us to push for more legislations to protect the health of the public and likewise the rights of the patients, physicians and other health workers all over the country.

SINGAPORE MEDICAL ASSOCIATION

Abdul Razakjr Bin OMAR*1

COUNTRY REPORT

PRESENTED BY

Dr Abdul Razakjr Bin Omar
Honorary Secretary
Singapore Medical Association

44TH CMAAO MID-TERM COUNCIL MEETING, 22-24 NOV 2008, MANILA

Membership

- As at 30 September 2008, total membership of the Singapore Medical Association stood at 4,917.
- This represents 63% of all 7,758 registered medical practitioners in Singapore.

48th SMA Council 2008/9

President	Dr WONG Chiang Yin
1st Vice President	Dr CHONG Yeh Woei
2nd Vice President	Dr TOH Choon Lai
Honorary Secretary	Dr Abdul Razakjr Bin OMAR
Honorary Treasurer	Dr LEE Yik Voon
Honorary Asst Secretary	Dr WONG Tien Hua
Honorary Asst Treasurer	Dr Tammy CHAN Teng Mui

Members

A/Prof CHIN Jing Jih	Dr TAN Yia Swam
Dr Raymond CHUA Swee Boon	Dr TOH Han Chong
Dr LEE Pheng Soon	Dr Bertha WOON Yng Yng
Dr TAN Sze Wee	Dr YEO Sow Nam Alex

Conventions & Seminars

Flu Pandemic Workshops

- Jointly organised by Ministry of Health, SMA and College of Family Physicians Singapore.
- First held in 2007. 2 more sessions were held over weekends in February and March 2008.
- Programme included updates, handling suspected cases, PPE and mask-fitting
- GPs were also encouraged to sign up for the Primary Healthcare Response Framework.

*1 Honorary Secretary, Singapore Medical Association, Singapore (sma@sma.org.sg).

Conventions & Seminars

SMA Private Practice Seminar

❖ Held on 15 March 2008.

❖ Theme: "Taking the Plunge – Going into Private Practice".

❖ Talks covered topics like setting up a private practice, managed healthcare schemes, legislative regulations, advertising guidelines and accounting requirements.

Conventions & Seminars

13th SMA House Office Seminar

❖ Held on 26 April 2008.

❖ Talks covered topics like what it means to be a professional, clerking new cases, night calls and medical indemnity.

Conventions & Seminars

SMA Charity Golf Tournament

❖ Held on 7 May 2008.

❖ S$250,000 was raised, of which $150,000 went to the SMA Medical Students' Assistance Fund, $100,000 went to the Nurses Merit Awards.

Conventions & Seminars

SMA Lecture 2008

❖ Held on 10 May 2008.

❖ SMA Lecturer 2008: Professor Zhong Nanshan, President of Chinese Medical Association.

❖ Theme: "Preparing for the Next Epidemic: 5 Years After SARS.... Lessons Learnt".

Conventions & Seminars

39th SMA National Medical Convention

❖ Held on 5 July 2008.

❖ Theme: "Prevention of Sudden Cardiac Death: Perception & Reality".

❖ Programme included concurrent English and Mandarin symposiums for the public, a mass CPR session and medical symposium.

❖ Launch of the Singapore Heart Foundation Mobile CPR, which is an animated package which can be downloaded into handphones, and contains both audio and visual presentations of life-saving instructions.

Conventions & Seminars

12th SMA Annual Ethics Convention

❖ Held on 12 November 2008.

❖ Professional Forum: "Compensation or Incentives for Donors in Organ Transplants: Possibilities and Pitfalls".

❖ Aims:

- To enable the profession to have more in-depth understanding of issues relevant to the topic.
- To raise questions that will help to stimulate further discussion on the topic, and if possible, enable the medical profession in Singapore in coming up with a position that is consistent with their professional values and ethical principles.

Conventions & Seminars

AST Course on Medical Ethics, Professionalism & Health Law

❖ Compulsory requirement for exit certification from specialist training.

❖ Equip trainees with necessary communication skills & working knowledge of clinical ethics & local health statutes.

❖ Help trainees develop more systematic & professional approach to common ethical & medico-legal issues in Singapore.

Publications & Reports

Monthly/Bimonthly Publications

❖ Singapore Medical Journal

❖ SMA News

❖ Sensory *(bimonthly)*

Publications & Reports

Surveys

❖ **Survey of GP Clinic Practice Costs in Singapore**

- To understand current primary care practice costs in the private sector, and to examine how practice costs have changed in the 10-year period from 1996-2006.

- Published in November 2007 issue of SMA News.

❖ **Survey of Specialist Fees in Singapore**

- To provide information, to the profession and public, on prevailing charges of medical services in private sector.

- Published in November 2008 issue of SMA News.

Publications & Reports

Surveys

❖ **Survey on Junior Doctors in Singapore**

- To identify challenges that junior doctors face so that SMA can better lend a voice to this community.

- Survey has been launched in October and is pending collection of results.

❖ **Survey of Abuse of Doctors**

- To have a better understanding of the prevalence of violence against doctors at the workplace and the impact of such violence.

- Pending launch of survey.

Publications & Reports

Advisories

❖ **SMA Advisory on Bill Itemisation**

- Issued following the announcement by the Ministry of Health of the revision of the Private Hospitals and Medical Clinics Guidelines.

- With effect from 1 April 2008, patients should be informed of every item charged for the clinic visit, e.g. consultation, medication, investigation.

- The SMA Advisory provides guidance to practitioners in the implementation of bill itemisation.

International Relations

Membership

❖ World Medical Association

❖ CMAAO

❖ MASEAN

International Relations

Others

❖ MoU dated 11 January 2008 signed with Indonesian Medical Association. Areas of cooperation include

- Advising members to abide by the other country's advertising guidelines when promoting healthcare services overseas.

- Requesting a formal invitation from the other country's national medical association, specialty bodies or hospitals when organising talks or promotional events overseas.

- A joint committee consisting of 3 representatives from each association would also be formed to look into concerns or complaints, and to refer to the relevant authorities where appropriate.

Thank You

SRI LANKA MEDICAL ASSOCIATION

Ruvaiz HANIFFA*1

Introduction

The Sri Lanka Medical Association (SLMA) is the oldest national professional organization of the medical doctors in Asia and Australasia. It brings together medical practitioners of all grades, from all branches of medicine in Sri Lanka.

The SLMA started life as the *"Ceylon Branch of the British Medical Association"* on 17 December 1887 with 65 members on its roll and Dr PD Anthoniz as its first President. However, the moving force behind its inception was Dr WR Kynsey (later Sir William Kynsey), who persuaded 5 doctors to meet on 26 February 1887, at the Colonial Medical Library on Maradana Road, Colombo to form the Association. He had declined to be the first President as he was going abroad on furlough. The change of the name to *"Ceylon Medical Association"* came in 1951 and in 1972 when Sri Lanka became a Republic, the name changed to the *"Sri Lanka Medical Association."*

The SLMA headquarters is at "Wijerama House" named after Dr EM Wijerama, who gifted the house he lived in at McCarthy Road (now Wijerama Mawatha) to the Association in 1964. Although his offer was made in writing in October 1957, resolution of the many issues took 7 years!

The SLMA publishes the *Ceylon Medical Journal (CMJ)*, the first issue of which came out in August 1887, and fittingly the first article in the first issue is authored by Dr WR Kynsey. The name changed to *Journal of the Ceylon Branch of the British Medical Association* in 1904, but changed to its pristine appellation in 1952. It continues to be published as the *CMJ*. At 121 years, it is the oldest surviving English medical journal in Asia and Australasia, and the leading scientific journal in Sri Lanka. The *CMJ* is indexed in *BIOSIS*, *CAB* International, *EMBASE* and the *Index Medicus*. *CMJ*'s editorial policies and quality are of international standard and it is listed by the *International Committee of Medical Journal* editors as conforming to their editorial guidelines.

The historic *Sri Lanka Medical Library*, which is over 164 years old, is also accommodated within Wijerama House. The *Sri Lanka Clinical Trials Registry*, started as recently as 2006, has achieved recognition from the World Health Organization by being selected as a WHO Primary Clinical Trials Registry.

The Annual Scientific Sessions of the SLMA brings together a cross-section of the medical fraternity from both the state and private sector, ranging from senior to junior specialist and generalist, postgraduates, grade medical officers and even medical students. The Sessions gives them the opportunity to present original research papers, exchange views, up date their knowledge through the various plenaries, symposia and workshops and enjoy fellowship. The Sessions serves as the main professional development activity for the profession in general and is a much anticipated academic and social event in the medical calendar of the country for forging useful and lasting links locally and internationally.

Vision

To be the most influential and effective apex medical professional organization in Sri Lanka.

Mission

To lead the medical community to achieve the highest standards of medical professionalism and ethical conduct

To be an advisory body on health policy to the Sri Lankan government and community

General Objectives

1. *Enhance the capacity as an apex professional and scientific organization for all categories of medical doctors as defined in the constitution*

*1 Assistant Secretary, Sri Lanka Medical Association, Sri Lanka (slma@eureka.lk).

of the SLMA.
2. *Play an advocacy role towards comprehensive curative and preventive health services for the people of Sri Lanka.*
3. *Promote professionalism, good medical practice and ethical conduct among doctors.*
4. *Disseminate state-of-the-art knowledge, clinical practice, technology and emerging concepts in medical sciences among medical and allied health professionals.*
5. *Provide opportunities for continuous professional development of doctors and allied health professionals.*
6. *Encourage ethical medical research.*
7. *Educate the public on health-related issues.*
8. *Enhancing closer professional and scientific links between medical doctors and allied health professionals.*

Annual Report of the Sri Lanka Medical Association to be Presented at the 44th CMAAO Midterm Council Meeting — November 2008

I consider it a great privilege and honour to represent Sri Lanka at the 50th Anniversary observance of CMAAO and its 44th Midterm Council Meeting. I am the current Assistant Secretary of the SLMA and bring to this conference the warmest greetings and best wishes from Professor Lalitha Mendis, the current President of the Sri Lanka Medical Association.

The Sri Lanka Medical Association is the apex body of all medical professionals in Sri Lanka. It brings together a cross-section of the medical fraternity from both the state and private sector, ranging from senior to junior specialist and generalist, postgraduates, grade medical officers and even medical students.

Academic activities

The 121st Annual Scientific Sessions were held on 19th–22nd March 2008. The Chief Guest was Prof. Malik Peiris, Professor and Chair, Department of Microbiology, The University of Hong Kong, Honorary Consultant Microbiologist and Head of Division of Clinical Virology, Department of Microbiology, Queen Mary Hospital, Hong Kong, Director, WHO H5 reference laboratory, The University of Hong Kong. The Guest of Honour was Prof. S. Arulkumaran, Professor and Head, Department of Obstetrics and Gynaecology, St. George's Hospital, University of London and President of the Royal College of Obstetricians and Gynaecologist, United Kingdom. There were guest speakers from overseas and Sri Lanka. The Sessions composed of 3 Pre-Congress workshops, 5 Plenary lectures, 3 Guest lectures, 12 Symposia, 2 Interactive sessions and 16 Free paper sessions. From the large number of papers submitted, 65 were selected for oral presentation and 31 were displayed as posters.

The lower key Foundation sessions are due to be held on the 28th and 29th of November 2008.

The educational progamme of the Association also includes Guest Lectures on important and current topic concerning the medical profession in Sri Lanka, Monthly Clinical Meetings targeting post graduate trainees and Quarterly Regional meetings held in the Provinces in Collaboration with Provincial/Regional Clinical Societies. In addition the SLMA awards 6 prestigious annual orations, namely The SLMA Oration, The SC Paul Oration, The EM Wijerama Oration, The Sir Nicholas Attygalle Oration, The Sir Murugesar Sinnathamby Oration and The Sri Marcus Fernando Oration.

The SLMA functions through its expert Committees. I would like to high light some of the noteworthy activities of these Committees for the year 2008.

Communicable Diseases Committee

1. Updating the guidelines on vaccines
   The committee successfully completed updating the 2004 SLMA guidelines on Vaccines. A book containing the guidelines was launched on 7th September 2008.
2. Country Coordinating Mechanism (CCM) of Global Fund for AIDS, Tuberculosis and Malaria
   The SLMA will function as coordinator for HIV sub committee for the development of country proposal for GFATM round 9.

Sri Lankan Clinical Trials Registry

The SLCTR is an internet-based, not-for-profit registry, with free access (www.slctr.lk) to researchers, clinicians, and the public. Thirty clinical trials have been registered as of 1st October 2008, with 17 of them being registered in 2008.

The SLCTR was recognized as a Primary Registry of the WHO International Clinical Registry Platform in March 2008. There are only five other registries that have been granted this recognition to date.

Central Continuous Professional Development Committee

A national CPD programme has been launched for doctors in Sri Lanka. This is a voluntary programme based on scoring of CPD credit points earned under 3 categories—home based activities, participation at meeting and workshops and research and writings. The SLMA has secured budgetary allocation for this purpose from the Sate.

The SLMA is in the process of laying the framework to make this a compulsory programme for all doctors in Sri Lanka.

Ceylon Medical Journal

Three issues of the 2008 *Journal* have been published to date: March, June and September. The December issue is ready for printing. Two-thousands copies are printed of each issue. One-hundred and one articles were sent to the Journal in 2008 of which 89 articles were tabled. Disposal is as follows: full papers 9, research letters 17, case reports 8, picture story 3, correspondence 2, specialist review 2, re-submission 6, rejected 53.

Fees are as follows: past issues Rs. 400 each ($35 internationally), previous articles $10 each.

'*CMJ* indices by author and subject' for 2006 & 2007, 'Style book of the *CMJ*' and 'Accepted abbreviations of the *CMJ*' have also been published.

The *CMJ* can be accessed online through the SLMA website. Full article access is available from 2000 onwards and a Table of Contents from 1987.

The office can be contacted on 00-94-11-269 0212 and at office@cmj.slma.lk

Medical Drugs, Nutraceuticals and Infant Foods

1. Guidelines on "The use of antimicrobial agents"
   Distribution of copies of the guidelines to selected hospitals was commenced during the year.
2. Booklet on "Information on using Western Medicine"
   The Ministry of Health distributed these booklets to the hospitals around the country.
3. Patient information leaflets
   The committee members' commenced writing patient information leaflets on commonly used drugs. The leaflets will be in Sinhala, Tamil and English.

Working Group on Disabilities

The Working group has conducted a consultative meeting with the participation of several stakeholder groups to conceptualize suggestions and recommendations on issues related to disability and improving rehabilitation services. These recommendations have been incorporated into a concept paper, which will be discussed with the Ministry of Health with a view to developing a comprehensive plan for improving care of the persons with disability.

The Working group has been actively promoting awareness on disability related issues. The SLMA Presidential induction address by Professor Lalitha Mendis had disability as its theme. Two joint symposia on disability were held; with the Faculty of Allied Health Sciences, University of Peradeniya, and with the Galle Medical Association.

Ethics Committee

The Committee is reexamining the issue of Advertising by Doctors and Institutions. The draft guidelines issued by the Committee in 2004 are to be discussed more widely within the medical community and the document will be sent to the regulatory body—The Sri Lanka Medical Council—with a request to review the current legislation.

In light of critical comments by the Patients Right's movement with regard to the relationship of the medical profession with the Pharmaceutical industry the Committee took up the issue of Ethical Pharmaceutical Advertising. The SLMA has now entered in to a dialogue with the pharmaceutical industry to come with definitive guidelines acceptable to both parties pertaining to the issue.

Health Management Committee

A Career Guidance Seminar was organized for junior doctors in collaboration with Specialist Colleges and Associations. The Seminar was attended by over 200 junior doctors who were given a comprehensive insight in to current and future cadre positions within the sate health sector for specialist. The process of selection, training and board certification was explained to the participants.

Media Committee

This year too, the high quality medical journalism was encouraged by awarding of prizes for "excellence in health journalism" for articles published in the print media.

Non Communicable Disease Committee

1. Advocacy meetings among stakeholder groups related to prevention of NCDs in Sri Lanka

with the objective of compiling a report on all work, output and outcome carried out by these groups.
2. Reviewed and made specific recommendations for NCD, nutrition and health promotion policies during core-group meetings.
3. Developed an interactive CD for school children including risk factors, preventive measures, and self assessment of BMI.
4. Conducted a health screening centre at the MedEx 2008 medical exhibition organised by the Faculty of Medicine, Colombo. About 3,500 patients were screened for diabetes, hypertension and obesity and health education given during this programme. Final report of this screening was prepared. A leaflet titled, 'Guide to health living' was distributed.
5. A health information poster on promoting healthy lifestyle has been prepared for printing by the Health Education Bureau to be distributed to school children.
6. A seminar on 'Metabolic Syndrome' jointly organized by the SLMA and Sri Lanka Association for Advancement of Science.

Research Promotion Committee

The committee initiated its activities in the direction of promoting a research culture among the members. Committee was able to conduct a research methodology workshop and is in the process of establishing a research fund.

Road Traffic Prevention Committee

The Committee made further representation to the Parliamentary Select Committee on the alarming increase in motor traffic accidents. It is noted that most recommendations made by the Committee had been included in the draft document prepared by the Parliamentary Select Committee which has now been passed in Parliament. A Seminar on Fatigue Related Traffic Accidents was organized.

Committee on Snakebite and Other Animals Envenomation

Out reach programmes were conducted in the Provinces (Ratnapura, Badulla and Monaragala) with a view to educating doctors on the current developments in the management of snakebites which continues to result in isolated deaths. An interactive CD on identification of snakes and management of snakebites, a booklet on management guidelines on snakebites and a poster on identification of venomous snakes were distributed at these programmes. These materials are made available for sale to those interested at the SLMA office.

The committee identified the need to continue the supply of resuscitation equipment to identified centers under its programme of establishing Community Based Resuscitation Centers. Ten centers were established in Puttlam during 2008. A training programme on Ambu Bag and mask resuscitation was conducted in Puttalam in collaboration with local resource person.

On the request of the committee, the Secretary of the Ministry of Health has requested the Snakebite committee to appoint an expert panel to review snakebite deaths. The Ministry of health has also agreed to make deaths due to snakebite notifiable.

A sentinel surveillance system for snakebites has been set up in identified Provincial hospitals.

Tobacco, Alcohol and Substance Abuse Committee

A number of workshops and training programmes targeting the security forces personnel, minor employees of hospitals and medical officers were organized. Following these a behaviour change was reported among all participants with alcohol and tobacco users giving up use completely. They also shared their experience with colleagues and are now involved in community based prevention activities. Ongoing contact with participants is maintained. A prevention program involving schools in the Colombo district was carried out successfully.

Educating the Public

The committee has submitted regular articles to be read on radio programs. Members of the committee also appeared on television on several occasions in discussion regarding tobacco and alcohol use.

Tsunami Disaster Relief

The CMMAO/SLMA Joint Sponsorship Scheme which was made possible by the magnanimous donation of the CMAAO has been functioning smoothly since November 2006.

At present there are 23 children from Galle, Hambanthota, Ambalanthota, Suriyawewa & Tangalle, with ages ranging from 6 to 18 yrs who receive a monthly sum of Rs. 2000/- In the past year it has been possible to streamline the payments through standing orders at the bank instead of posting individual cheques as was done at the inception of the scheme which had the disadvantage of increased work load to our busy office

staff as well as unavoidable delays in payment due to the need of two signatories for the cheques.

Our records indicate that there are at present Three children studying in Grade 1, One each in Grade 2 & 3, Two in Grade 4, One each in Grade 5 & 7, One in Grade 6, Seven in Grade 8, Two in Grade 9, Three in Grade 10 and One in Grade 11.

It was decided to write to each scholarship recipient and request them to furnish a progress report certified by the school principal confirming that they are continuing to attend school, by end of January 2009 in order to continue to be eligible for the scholarship.

Older children who may have already left school or intend to do so were requested to send in details of any Training/Technical/Educational course that they intend to follow certified by the head of the relevant institution in order to continue to be eligible for the scholarship.

Committee on Women's Family Health

A seminar on 'Health implications of leave and other entitlements of working women' for media personnel was organized to commemorate International Women's Day 2008. The seminar was conducted in all three languages and was well attended.

A Symposium on 'Health consequences of Gender Based Violence and the role of the health care professionals' was held as a pre-congress event of the Annual Sessions. The target audience comprised nursing officers from the curative and preventive sectors, junior medical officers, health administrators and general practitioners. An attempt has been made by the Committee to formalize the inputs on Gender Based Violence in to the undergraduate medical curriculum.

A health screening programme for women prisoners was conducted. Three-hundred and seventy women prisoners were screened. Health educational video clips on Breast self-examination, Sexually Transmitted Infections and Family planning were shown. The nutritional and immunization status and medical problems of the 44 infants and pre-school children, living in prison with their mothers were assessed.

TAIWAN MEDICAL ASSOCIATION

Ming-Been LEE*1

Designation of Think Tank and Liaison Office to Tackle the Challenges of NHI

The adoption of global budget payment system by the National Health Insurance in Taiwan suffered from inadequate design of financing and lack of payment policy review, which resulted in financial imbalance and point value depreciation, causing unprecedented challenges to the medical professionals. The Taiwan Medical Association is not only working with our members but also making mid and long term plans to respond to the current situation. First of all, the TMA mobilizes our own experts and invites experts of hospital management, public health, health insurance, financing and medical laws to establish a dedicated team functioning as a think tank; secondly, through creating a professional public image and communication platform with policy makers in the government, TMA hopes to broaden its collaboration with other professions, maintain physicians' autonomous management under the NHI scheme, lay a good foundation for better physician-patient relationship as well as improve quality of service.

To improve operational efficiency, quality of communications between TMA and local branches and information transparency, the TMA emphasizes members' participation at various levels of meetings to harness collective wisdom for achieving timely consensus. TMA also provides assistance to local branches in urgent situations. Every member in any part of Taiwan can rest assured that TMA is ready to render a helping hand whenever needed.

The TMA organizes ad hoc meetings concerning medical profession and members' rights. In this way we build up powerful task forces such as the think tank for medical law and the health informatics analysis work force. We also work with experts from a variety of fields to plan for mid and long term global budget payment negotiation strategy and to study critical issues like medical economics, medical resources allocation, manpower, the NHI global budget, problems with drug pricing practice as well as separation of prescribing and dispensing. TMA makes sure that the mechanism to facilitate communications and negotiations is built upon fair and just ground in the hope to serve and enhance welfare for all the members of TMA.

Since I took office, I realized the importance of dialogue with high government officials. Having built up a regular platform, TMA will be able to strengthen its prestige and participate the process of policy making. With company of the TMA management, I paid official visits to the President, Prime Minister, President of the Legislative Yuan, Health Minister and the General Manager of the National Health Insurance Bureau. On the Physicians' Day, I also wrote an open letter to the President with suggestions on health policies. The President responded promptly by instructing the Health Minister to look into the matter and later the Health Minister replied with another open letter published in our monthly journal.

Resolve Litigation against Physicians and Safeguard Members' Legal Rights

In recent years, the number of medical malpractice disputes increased. Legal actions against physicians involve both civil and criminal liabilities. As a result, physicians in order to avoid costly consequences and criminal punishment are compelled to practice inappropriate defensive medicine. This has increased medical cost, created tension between physician and patient, and influenced the choice of specialty, where medical graduates take less interest in departments with higher risk of litigation. I took it very seriously after I became the President. It is one of my and TMA's greatest challenges to establish a fair system that

*1 President, Taiwan Medical Association, Taipei, ROC (intl@tma.tw).

properly deals with malpractice cases and frees physicians from fear of practicing.

TMA tries to solve this problem from three aspects. Legally, TMA advocates for legislation. The Health Ministry thus drafted the "Act of Patient Safety and Medical Malpractice," which deals with procedures to handle medical disputes, patient safety reporting, malpractice compensation and so on. The Health Ministry is now working on the draft and seeking advice from different parties. Secondly, the TMA has invited physicians, lawyers, scholars and legal experts to attend seminars on criminal litigation of medical disputes on several occasions. We hope that exchanges and collaboration on this issue will help resolve disputes. Our efforts received positive feedback from all the participants. Thirdly, TMA plans to set up a "Think Tank for Medical Law" consisted of physicians studying law or with attorney qualifications. Missions of the think tank include providing legal advice to members and safeguarding the rights of physicians during practice.

This year we saw several cases where physicians were prosecuted for violating NHI payment rules. One of the physicians even committed suicide. This shows that physicians' lack of understanding criminal procedures or failure to cope with stress could result in tragedy. To address this issue, the TMA compiled relevant documents and published "Guidelines for Physicians Facing Criminal Charges." This manual comes in two parts: things to note during interrogation as defendant or suspect, and things to note as witness. Due to the fact that prosecutors tend to use investigation results provided by health authorities or Bureau of National Health Insurance, TMA introduced "Things to Note When Medical Institutes Receive Interviews or Investigation" and combined the previous documents for the reference of our members so that they know and exercise their legal rights.

TMA as CME Accreditation and Acknowledge Organization, Promoting CME to Improve Health Care Quality

Every physician in Taiwan is entitled to renew their license every six years against 180 CME points, which requires courses on both medical knowledge and medical ethics. The TMA has been authorized by the Health Ministry to continue to act as the sole agency for CME accreditation and acknowledgement of CME points.

To provide multi-faceted access to CME, the TMA not only works with medical institutes to organize training courses, but takes advantage of the Taiwan Medical Journal as a means to provide CME and organizes monthly seminars focusing on current controversial issues. Experts and academics are invited to present and comment so that controversies can be debated and resolved through education, which is the idea we wish to disseminate to all physicians in Taiwan. TMA uses video conference technology to facilitate convenient participation in our monthly CME seminars in Taiwan and offshore islands for those unable to attend physically, attracting record-high participants.

Through CME accreditation, TMA helps the government maintain a quality CME curriculum and provides some 37,000 physicians in Taiwan multi-channel access to different courses and trainings. These efforts are expected to improve the quality of health care and supplement an integrated health care system that Ministry of Health proclaims.

Main Challenges and Opportunity

- Designation of Think Tank and Liaison Office to Tackle the Challenges of ***NHI*** *(National Health Insurance)*
- Resolve litigation against physicians and safeguard members' legal rights
- TMA as *CME Accreditation* and *Acknowledge Organization*, promoting CME to Improve Health Care Quality

2

Designation of Think Tank and Liaison Office to Tackle the Challenges of NHI

The adoption of global budget payment system by the ***NHI*** in Taiwan suffered from:

- *inadequate design of financing*
- *lack of payment policy review*

which resulted in

- *financial imbalance*
- *point value depreciation*
- causing ***unprecedented challenges*** to the medical professionals.

3

The Effort of TMA for members

First Step,

- To invite *experts* of hospital management, public health, health insurance, financing and medical laws.
- To establish a dedicated team functioning as a **think tank.**
- To make mid- and long-term plans to respond to the current situation.

4

Second Step,

- To create a professional public image.
- To build communication platforms with policy makers in the government.
- To broaden the collaboration with other professions.
- To maintain physicians' autonomous management under the NHI scheme.
- To lay a good foundation for better physician-patient relationship as well as improve quality of service.

5

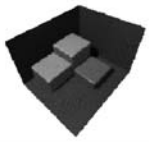
The Duty for Taiwan Medical Association

- To improve operational efficiency and *information transparency*.
- To promote the quality of communications between TMA and local branches.
- To enhance *members' participation* at various levels of meetings to harness collective wisdom for achieving timely consensus.
- To provide assistance to local branches in *urgent situations*.

6

The Responsibility

- To organize **ad hoc meetings** concerning medical profession and members' rights. In this way we build up powerful *task forces*.



7

Such as

- The think tank for medical law.
- The health informatics analysis task force.
- To work with experts from a variety of fields to plan for mid and long term *global budget payment negotiation strategy*.
- To *study critical issues* like medical economics, medical resources allocation, manpower, the NHI global budget, problems with drug pricing practice as well as separation of prescribing and dispensing.

8

The TMA Belief and Achievements

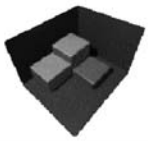
- TMA built up a *regular platform*, in order to strengthen its prestige and participate in the process of *policy making*.
- Paid *official visits* to the President and the ministry with company of the TMA management.
- Presented an open letter to the President with ***suggestions on health policies.***

9

Resolve litigation against physicians and safeguard members' legal rights

The Background

- In recent years, the number of medical *malpractice disputes* increased.
- Legal actions against physicians involve both civil and criminal liabilities.



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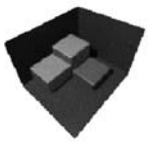
The Impacts

- Physicians in order to avoid costly consequences and criminal punishment are possibly compelled to practice inappropriate defensive medicine.
- This has increased medical cost.
- Created tension between physician and patient.
- Influenced the choice of specialty, where medical graduates take less interest in departments with higher risk of litigation.

11

TMA's Efforts

- To establish a *fair system*
  - To ***properly*** deal with malpractice cases.
  - To ***free*** physicians from fear of practicing.



12

TMA Tries to Solve This Problem from Three Aspects.

❖**Legally,**

TMA advocates for legislation.

"Act of Patient Safety and Medical Malpractice"

The Health Ministry is working on the draft and seeking advice from different parties now.

Which deals with

- procedures to handle medical disputes
- patient safety reporting
- malpractice compensation and so on

13

❖**Practically,**

- TMA has invited physicians, lawyers, scholars and legal experts to attend *seminars* on criminal litigation of medical disputes on several occasions.
- By the exchanges and collaboration on this issue will help resolve disputes.

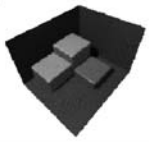
Our efforts received ***positive feedback*** from all the participants.

14

❖**For Internal,**

Set up a "*Think Tank for Medical Law*"

- consisted of physicians studying law or with attorney qualifications.
- To provide *legal advice* to members and safeguarding the rights of physicians during practice.



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❖**An example**

This year we saw several cases where physicians were prosecuted for *violating NHI payment rules*. One of the physicians even committed ***suicide***.

This shows that physicians' *lack of understanding criminal procedures* or failure to *cope with stress* could result in ***tragedy!***

16

❖In order to make our members know and exercise their *legal rights*, TMA compiled relevant documents and published:

- "***Guidelines*** *for Physicians Facing Criminal Charges."*
- *"Things to Note When Medical Institutes Receive Interviews or Investigation"*

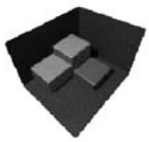
17

CME Accreditation to Improve Health Care Quality

❖**The Background**

Every physician in Taiwan is entitled to renew their license every six years against 180 CME points, which requires courses on:

- *Medical knowledge*
- *Medical ethics.*



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❖The TMA Achievement

This year, The TMA has been authorized by the Health Ministry to continue to act as the *sole agency* for CME accreditation and acknowledgement of CME points.

19

❖Provide *multi-faceted access to CME*

- To work with *medical institutes* to organize training courses.
- To take advantage of the *Taiwan Medical Journal* as a means to provide CME and organizes *monthly seminars* focusing on current controversial issues.
- To invite Experts and academics to present and comment monthly that controversies can be debated and resolved.

20

❖A pioneering work

TMA uses *video conference technology* to facilitate convenient participation in our *monthly CME seminars* in Taiwan and offshore islands for those unable to attend physically, attracting record-high participants.

21

❖Fruitful Achievements

- TMA helps the government maintain a *quality CME curriculum*
- TMA provides nearly 37,000 physicians in Taiwan *multi-channel access* to different courses and trainings.
- To improve the quality of health care and supplement an *integrated health care system* that Ministry of Health proclaims.

22

MEDICAL ASSOCIATION OF THAILAND

Aurchat KANJANAPITAK*1

The Medical Association of Thailand under Royal Patronage of his Majesty the King of Thailand was established by a group of Thai doctors in year 1921 and registered as a public association on October 24, 1921. Now is a public registered association and has been under Royal Patronage of his Majesty the King of Thailand since 1930.

Now the association consists of 18,000 life long members and 3,474 young annual (young doctors or medical students) covering over 60% of the whole amount Thai doctors.

The association is run by 35 council members and a group of senior advisors, presidents of Royal Colleges of various specialty are council members.

The Medical Association of Thailand
Under Royal Patronage of His Majesty the King
Established at October 24, 1921

The present council members are:
President
Dr. Aurchat Kanjanapitak
President Elect
Pol. Major General Dr. Jongjate Aojanepong
Vice-President
Dr. Chatri Banchuin
Secretary General
Assoc. Prof. Dr. Prasert Sarnvivad
Assist. to Secretary General
Naval Lt. Dr. Manopchai Thamkhantho
Treasurer
Prof. Dr. Teerachai Chantarojanasiri
House Master
Group Captain Dr. Paisal Chantarapitak
Publication
Prof. Dr. Amorn Leelarasamee
Welfare Section
Dr. Pinit Hirunyachote
Medical Education
Prof. Dr. Somkiat Wattanasirichaigoon
Ethics
Dr. Sawat Takerngdej
Scientific Section
Prof. Dr. Sriprasit Boonvisut
Special Affair
Prof. Dr. Visuthe Tansirikongkol
Group Captain Dr. Tenehtsak Wudhapitak
International Relation
Dr. Wonchart Subhachaturas
Public Relation
Group Captain Dr. Ittaporn Kanachareon
Registration
Assoc. Prof. Dr. Saranatra Waikakul
Member of Council
Dr. Varaphan Unachak (Rep. From North)
Dr. Kamol Veeraprdist (Rep. From South)
Dr. Kawee Chaisiri (Rep. From East)
President of the Thai Medical Council
President of Royal Colleges of Surgeons
President of Royal Colleges of Physicians
President of Royal Colleges of Anesthesiologists
President of Royal Colleges of Obstetricians & Gynaecologists
President of Royal Colleges of Pediatricians
President of Royal Colleges of Ophthalmologists
President of Royal Colleges of Pathologists
President of Royal Colleges of Radiologists
President of Royal Colleges of Otolaryngologists
President of Royal Colleges of Psychiatrists
President of Royal Colleges Orthopaedic Surgeons
President of Royal Colleges Physiatrists
President of College of Family Physicians
President of Women Medical Association

The Standing Activities of the Association

Continuous medical education and research

- Annual scientific meetings, one in Bangkok in January, and one in province outside Bangkok

*1 President, Medical Association of Thailand, Bangkok, Thailand (wonchats@bma-gap.or.th).

(North, South, North-East and East) in October.
- Providing 6 scholarships under the collaboration of Takeda Science Foundation, 5 scholarships for members who work in the provincial hospital and rural areas, to extend their interest in some special field of medicine in Japan for 3 months and the other is the research fellow scholarship, to study and practice medical research in Japan for one year.
- Research Grant for Thai doctors, who want to do the research project concerning the provincial diseases or problems.
- Lecture tour or special lecture, for continuing medical education.

Medical ethics

- Publication concerning medical ethics, distributed to the members and medical students.
- Special lectures about medical ethics and matters concerned with law and regulation to doctors in private hospital, medical society and medical students.
- Publish Regular topics about medical ethics, in the Journal of Medical Association of Thailand and other medical journals.

Activities for supporting the members

- Publish a monthly Journal of Medical Association of Thailand and distribute to all members and major medical libraries and also distribute to the world as electronic journal.
- Up-date and review the member registration.
- Service and accommodate the members for using medical club house in the office of the association.
- Distribution of the newsletter to all the members every month.
- Set up a project to help and support members who have legal problem from medical practice, and also some emergency medical problem consultation.
- Organize "Post-congress Tour" to visit and observe the healthcare management in neighbour countries, like Myanmar, Laos, Vietnam, Malaysia etc. This year we visit Nepal during 30 November–3 December 2008.

International activities

- Participation in the medical congress meetings and activities in the region as council member of MASEAN, CMAAO.
- Attending the meeting of the other medical associations such as the WMA General Assembly, Annual Meeting of American Medical Association, Australian Medical Association, Singapore Medical Association, Malaysian Medical Association, Philippine Medical Association.

Activities for the public

- Be the leader in the campaign of tobacco smoking cessation program.
- Produce the television program about the health education for the people, five times a week.

National health activities

Organized a special council called "Tri-Medical Parties" consisting of Thai Medical Council, Ministry of Public Health and our Medical Association of Thailand, chaired by the secretary general of the Ministry of Public Health, under signature by the minister of Public Health, by screening the law and regulation concerning health and make suggestion to the cabinet about the actual health problems, consultant to the Parliament, in some issue as sub-committee member.

Current special activities

- Fund raising program: Charity Golf Tournament.
- Culture and traditional activities.
- Walk-Run Rally for Health.

The Function of Thai Medical Association Office

1. Secretariat to all Project
2. Member registration and update, general business
3. Journal production House
4. Meeting activity
5. President and Council Office
6. Library service, linked with the medical library of Siriraj Hospital and Faculty of Medicine
7. Exhibition Hall

The Medical Association of Thailand under Royal Patronage of His Majesty the King

established October 24,1921

President : Dr. Aurchat Kanjanapitak
President Elect : Pol.Major.Gen.Dr.Jongjate Aojanepong
Vice-President : Dr. Chatri Banchuin
Secretary General : Assoc.Prof.Prasert Sarnvivad

and the others in total 35 executive members

The standing activities of the Association

Continuous medical education and research

- Annual scientific meeting.

Annual scientific meeting
October 23-25,2008

Continuous medical education and research

- Providing 6 scholarships to study in Japan under the collaboration of Takada Science Foundation.
- Research Grant for Thai doctors.
- Lecture tour or special lecture, for continuing medical education

The standing activities of the Association

Medical Ethics

- Publications concerning medical ethics.
- Special Lectures about medical ethics and matters concerning law and regulation to doctors and medical students.
- Publish regular topics about medical ethics, in the journal of Medical Association of Thailand and other medical journals.

The standing activities of the Association

Activities for supporting the members

- Publish a monthly journal of Medical Association of Thailand and distribute to all members.

Activities for supporting the members

- Up-date and review the member registration.
- Service and Accommodate the members for using medical club house in the office of the association.

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- Distribution of the newsletter to all the members every month.

Activities for supporting the members

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- Organize "Post-congress Tour" to visit and observe the healthcare management in neighbour countries.

The standing activities of the Association

International activities

- Participation in the Medical Congress meetings and activities in the region as council member of MASEAN, CMAAO.

25th CMAAO Congress and the 43rd CMAAO Council Member

International activities

- Attending the meeting of the other medical association such as the WMA General Assembly, Annual Meeting of American Medical Association etc.

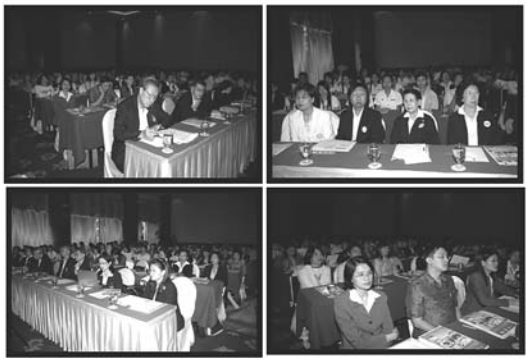
World Medical Assembly Seoul 2008 ,October 15-18,2008

The standing activities of the Association

Activities for the Public

- Be the leader in the campaign of Tobacco Smoking Cessation Programme.

- Tobacco-Smoking Cessation Conference



- Walk-Run Rally on "No Tobacco Day" May 31st Every year.

Activities for the Public

- Produce the television programme about the health education for the people, once a week.

National Health activities

- Organize a special council called "Tri Parties" by screening the law and regulation concerning health and make suggestion to the cabinet about the actual health problems

The standing activities of the Association

Current special activities

- Fund raising programme : Charity Golf Tournament.

- Culture and Traditional activities.

We organized 86th Anniversary Ceremony on 12th. Floor of The Medical Association of Thailand Office

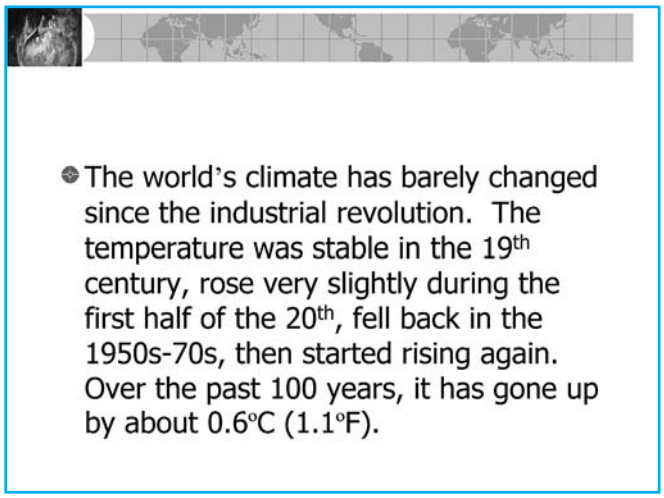
- Culture and Traditional activities.

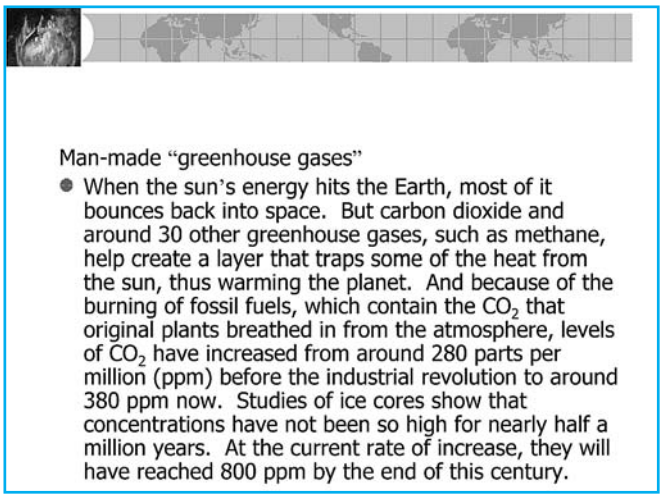
We organized the donation to the Temple at Ayuthaya Province.

[Hong Kong]

The Heat Is On

Alvin Yee Shing CHAN*1





*1 Vice-President, Hong Kong Medical Association, Hong Kong (yvonnel@hkma.org).

The first person to spot the connection between temperature and human activity was a 19th-century scientist called Svante Arrhenlus. He speculated that emissions from industry could double CO_2 levels in 3,000 years, thus warming the planet. Being a Swede, he thought that was just fine.

The mid-20th-century blip turns out to have been the consequence of another by-product of human activity: sulphur and other airborne particles that bounce back sunlight before it can hit the Earth, thus offsetting the greenhouse effect.

The establishment of an Intergovernmental Panel on Climate Change under the auspices of the UN was designed to silence the arguments and give policymakers an agreed line on what the future holds.

The IPCC's latest report, published in 2001, offers a wide range of predicted temperature rises, from 1.4°C to 5.8°C by the end of this century.

Impact on Public Health

Economic forecasts expect climate change to diminish global gross domestic product by around 5% in the coming decades. The bulk of this global decline will hit areas already reeling under HIV and tuberculosis epidemics.

Climate change will also have a direct impact on the usual suspects – malaria, dengue fever, and diarrhoeal illness will increase in incidence – and will likely continue to do the greatest damage to human health globally.

- Dengue is perhaps the most important of the emerging infections that are likely to be affected by climate change.
- The most common arthropod-borne viral infection, and is promoted by unplanned urbanization, movement of goods and people, and warmer, wetter, and more extreme climate conditions – all these trends are on the increase.

Just 100 years ago, dengue was not even considered to be a global health problem, yet it now affects 50-100 million people every year, killing tens of thousands of children. Its incidence has been positively correlated with the natural cyclical El Niño/La Niña weather pattern, which has become much more frequent since the 1970s compared with the previous 100 years.

- Malaria, a massive public-health problem in 90 countries, where it affects more than 2.5 billion people, could also be sensitive to climate change.
- Control measures are already stretched to the limit, a situation that will worsen if the mosquitoes that spread the disease expand their territories.

- Establishment of new diseases that haven't traditionally been able to support their life cycles in northern climates.

If current emissions and land use trends continue unchecked, the next generations will face more injury, disease, and death related to natural disasters and heat waves, higher rates of climate-related infections, and wide-spread malnutrition, as well as more allergic and air pollution-related morbidity and mortality.

The pattern of change will vary regionally depending on latitude, altitude, rainfall and storms, land-use patterns, urbanization, transportation, and energy production. The magnitude of climate change and related increases in allergic disease will be affected by how aggressively greenhouse gas mitigation strategies are pursued, but at best an average warming of 1 to 2°C is certain this century.

The World Health Organization estimates that globally 300 million people currently have asthma, and approximately a quarter of a million people die of asthma annually.

Ambient air pollutants such as nitrogen dioxide (NO_2), ozone, particulate matter (PM), and components of PM including organic carbon and volatile organic compounds (VOCs) have been linked with increased allergic disease and asthma. Studies from around the world have shown hospitalization for asthma increases after increases in levels of airborne PM. Ozone exposure also exacerbates asthma, as shown in increased emergency department visits, hospitalizations, and rescue medication use.

- Individuals exposed to ozone at levels of 0.16 to 0.25 ppm demonstrate an increased level of response to inhaled allergen.
- Ozone exposure may also cause new-onset asthma.
- NO_2, acid vapor, PM <2.5μm, and elemental carbon exposure were significantly correlated to diminished lung function.

Climate change-related increased burden of disease, specifically from allergy and asthma, is anticipated because of changes in the distribution, quantity, and quality of pollens, and changes in the timing and duration (lengthening) of pollen season. Asthma and allergic disease will also likely be worsened because of interaction between heavier pollen loads and increased air pollution; thunderstorms and extreme precipitation events; worsening heat-related ground-level ozone pollution; increased ambient air pollution from natural and anthropogenic sources; and air pollution related to wildfires.

- Climate change has had and will have further impact on a variety of allergenic plants. Increased CO_2 increases plant biomass and pollen production. Increased temperature stimulates earlier flowering and longer pollen seasons for some plants. Increased ambient CO_2 may cause some plant products to become more allergenic.
- There will be increasing amounts of robust allergenic plants and an increasing aeroallergen burden for patients with inhalant allergy.

Table 1. The rationale for the interrelationship between agents of air pollution and pollen allergens in inducing respiratory allergy

Air pollution can interact with pollen grains, leading to an increased release of antigens characterized by modified allergenicity.
Air pollution can interact with allergen-carrying paucimicronic particles derived from plants. The paucimicronic particles, pollen-originated or not, are able to reach peripheral airways with inhaled air, inducing asthma in sensitized subjects.
Air pollution – in particular ozone, PM, and sulfur-dioxide – have been shown to have an inflammatory effect on the airways of susceptible subjects, causing increased permeability, easier penetration of pollen allergens in the mucus membranes, and easier interaction with cells of the immune system.
There is also evidence that predisposed subjects have increased airway reactivity induced by air pollution and increased bronchial responsiveness to inhaled pollen allergens.
Some components of air pollution seem to have an adjuvant immunologic effect on IgE synthesis in some subjects – in particular DEPs, which can interact in atmosphere with pollens or paucimicronic particles.

Inhalation of SO_2 has significant bronchospastic effects with rapid onset of symptoms after exposure. Most individuals with asthma will experience bronchospasm at levels of 0.5 ppm, and sensitive individuals can experience a decrease of FEV, as much as 60% at exposures of 0.25 ppm. Epidemiologic studies have shown decreased lung function in children with increased ambient exposure to SO_2 and to SO_2 mixed with other CAP. Coal is the most abundant worldwide energy source, much of it with high sulfur content, and worldwide coal use under a business-as-usual scenario is projected to increase by 74% over current levels by 2030.

- Increased exposure to PM worsens asthma and is associated with decreased lung function in both children and adults.
- Anthropogenic PM is a complex mixture of components around a carbonaceous core. Components include sulfates, VOCs (such as toluene and xylene), metals (iron, vanadium, nickel, copper, and zinc), polyaromatic hydrocarbons, pollen, and endotoxin.

DEPs cause pronounced airway inflammation. DEP exposure studies have demonstrated increased nonspecific airway reactivity, increased bronchial neutrophil and B-lymphocyte infiltration, and increased nasal production of IgE with enhanced allergen response in sensitive individuals.

Mechanisms by which climate can affect health (I)

1. Extremes of temperature and rainfall, such as heat waves, floods and drought, have direct immediate effects on mortality as well as longer term effects. For example, populations that have experienced flooding may suffer from sustained increases in common mental disorders.
2. Climate change is also likely to affect biodiversity and the ecosystem goods and services that we rely on for human health.
3. Changes in temperature and rainfall may also affect the distribution of disease vectors, e.g. those of malaria and dengue, and the incidence of diarrhoeal diseases

Mechanisms by which climate can affect health (II)

4. Climate can affect levels of air pollutants, for example tropospheric ozone pollution may be higher in some areas of Europe, and lower in others but the relationships are still imperfectly understood.
5. Sea level rise is likely to threaten low lying coastal populations, particularly in countries where economic conditions do not allow construction of sea defences and other counter measures.
6. Flooding, drought and environmental degradation associated with climate change may lead to population displacement and more environmental refugees.

Research on the health impacts of climate change addresses:

1. Current associations between climate and disease
2. The effect of recent changes in climate
3. Evidence base for projecting the future impacts of climate change on health

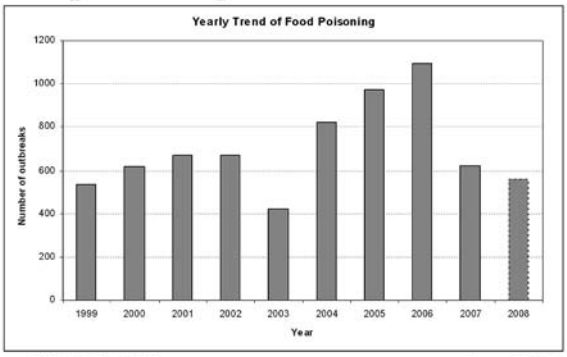
To reduce health risks due to global warming

1. Robust systems for disease surveillance and reporting are crucial
2. Interventions to control emerging and re-emerging infectious diseases
3. Better water and sanitation
4. Strengthened integrated vector management
5. Wider coverage and better delivery of antimalarials would all improve health now
6. General fortification of health infrastructure – especially water systems – is recommended
7. Health professionals must also join forces with other sectors to embrace more long-term efforts to reduce greenhouse gas pollution

- America, the world's biggest CO_2 emitter, turned its back on the Kyoto protocol on global warming
- Will it eventually take steps to control its emissions? And if America does, there is a reasonable prospect that the other big producers of CO_2 will do the same.

Past Trend of Selected Communicable Diseases

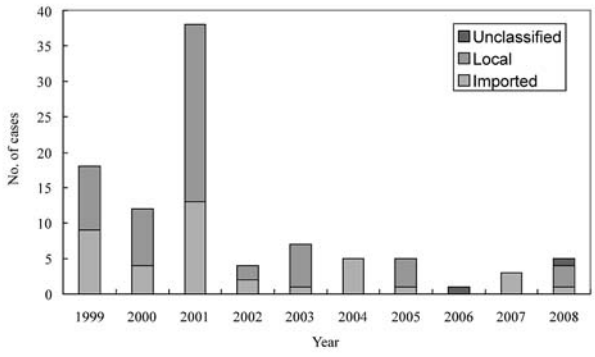
Food poisoning



* Up to October 2008

Source: CHP/DH

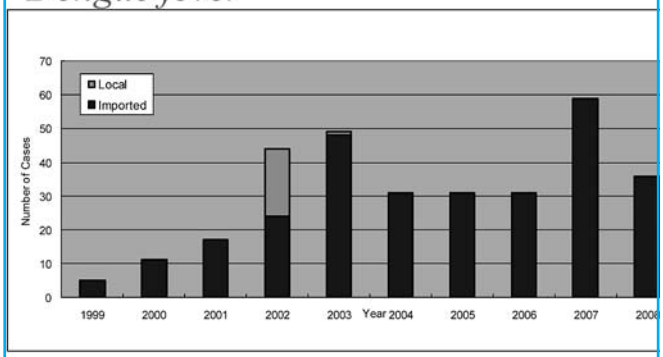
Cholera



* Up to October 2008

Source: CHP/DH

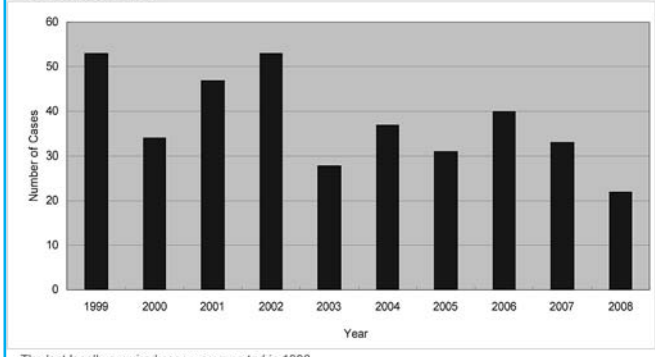
Dengue fever



* Up to October 2008

Source: CHP/DH

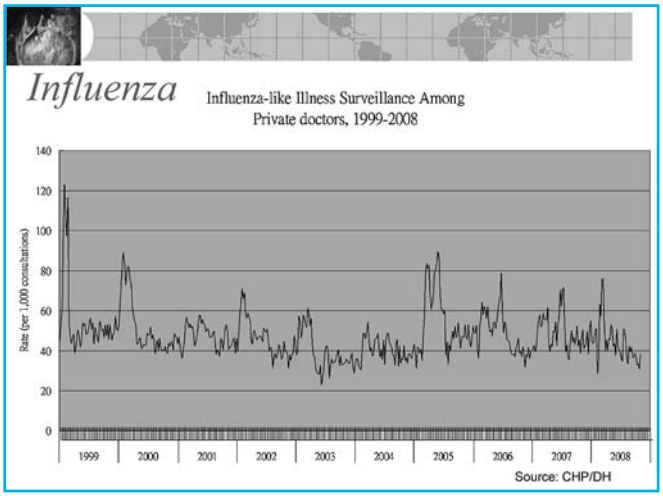
Malaria

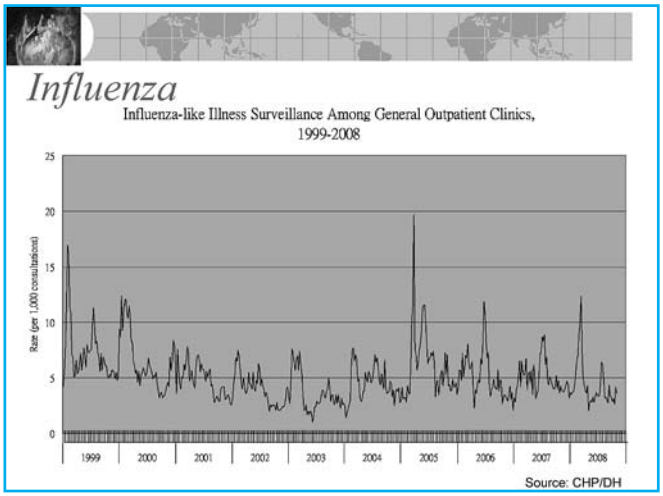


The last locally acquired case was reported in 1998.

* Up to October 2008

Source: CHP/DH





~ Quoted from The Standard Investor Intelligence, The Standard, 18 August, 2006

Bus air-con gives medics the chills

"The buses should not all be air-conditioned. It gives people no choice to open windows and breathe fresh air. We should buy new buses that have the option of being air-conditioned or not, so that in the wintertime, we can just open windows. It will save on energy consumption too," said Dr. Alvin CHAN Yee Shing, Vice-President, HKMA.

- The combination of fridge-like conditions on buses and the choking, hot roadside air is increasing the health risks for Hong Kong commuters, doctors and environmentalists have warned
- While air-conditioned buses burn up more fuel and spew more pollutants at those waiting in the furnace conditions of a bus stop, passengers on the buses also face risks to their health.

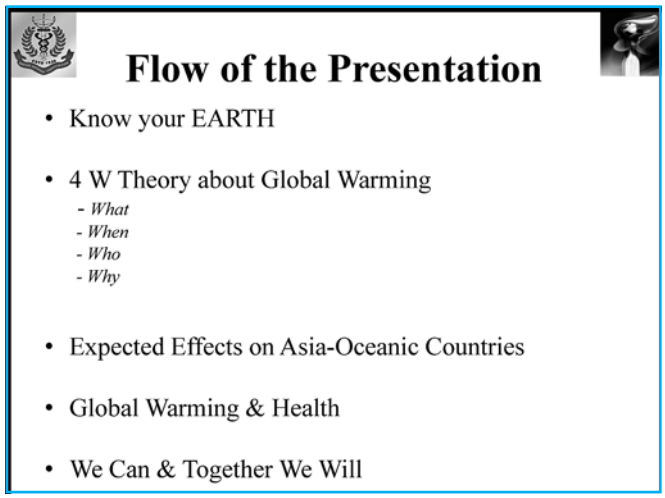
- According to a survey of 5,400 buses conducted between June and this month, 89 percent had temperatures lower than the government recommended 25.5 degrees.
- The cold temperatures indicated buses were burning unnecessary diesel fuel, causing greater emissions of unburned carbon particulates and other pollutants.
- Green Sense researchers also found that exhaust fumes and roadside temperatures increased when temperatures inside the bus were low.

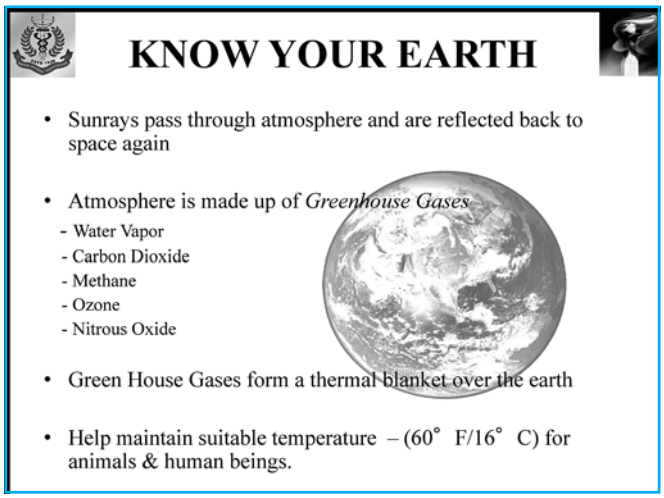
Thank You!!

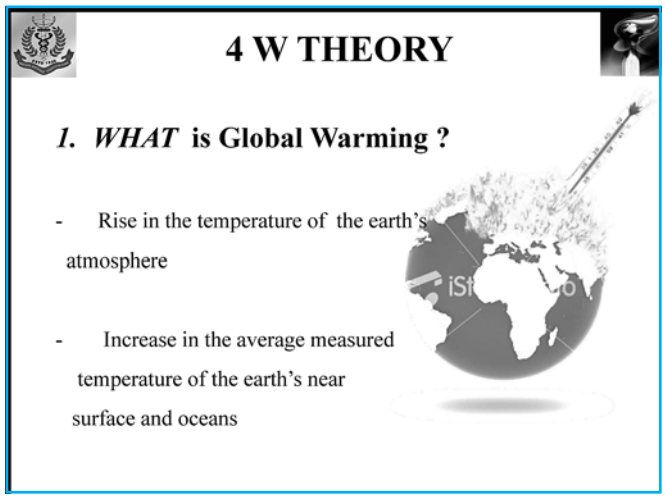
[India]

Global Warming

Ketan DESAI*1







*1 Past President, Indian Medical Association, New Delhi, India (inmedici@ndb.vsni.net.in).

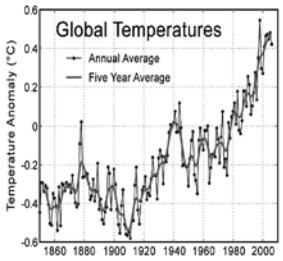
4 W THEORY

2. *When* did Global Warming begin ?

- Mid 20th Century

- Global surface temperature increased 0.74 ± 0.18 ° C (1.33 ± 0.32 ° F) during the 100 years ending in 2005.

- Scientists believe increase by 60° F (16 ° C) by the end of this century



4 W THEORY

3. *Who* is responsible for Global Warming ?

WE

4 W THEORY

4. *Why* are we responsible for Global Warming ?




DEFORESTATION | **BURNING FOSSIL FUEL** | **WATER POLLUTION** | **INDUSTRIAL POLLUTANTS**

4 DEADLY IMPLICATIONS

1. Extreme weather patterns
   - warmer waters leading to Hurricanes, Wildfires

2. Wildlife
   - More eco system shifts and species extinction

3. Glaciers & Sea Levels
   - Melting of glaciers and ice caps
   - Early ice thaw on rivers and lakes.

4. Heat Waves & Draughts
   - Increased desertification and tropical areas
   - Dire effects on agricultural yields

Expected Effects on Asia-Oceanic Countries

- Melting Glaciers in Himalayas
  - •Increase Flooding & Rock Avalanches & Affect on Water Resources
- Coastal Areas in South, East & South-East Asia
  - •Greatest Risk due to increased Flooding from the sea & Mega-Deltas Flooding from the rivers
- Changes in Hydrological Cycle in East, South & South-East Asia
  - •Rise in Endemic morbidity &mortality due to diarrhoea disease
  - •Increase in coastal water temperature would exacerbate the abundance and/or toxicity of cholera
- Reduced precipitation & increased evaporation in Southern & Eastern Australia, New Zealand, Northland & Eastern Regions
  - •Water security problems are projected to intensify by 2030
- Coastal development & population growth in Cairns , Australia & Northland to Bay of Plenty (New Zealand)
  - •Exacerbate risks from sea-level rise
  - •Increase in the severity and frequency of storms and coastal flooding by 2050.

GLOBAL WARMING & HEALTH

SOURCE	IMPACT ON HEALTH
Abnormally High Temperature	Viral Diseases such as West Nile Virus & Malaria as insects thrive in heat
Increased Ozone in the Atmosphere	Damage to lung tissues & Respiratory Problems & Increase risk of Cancer & other Genetic disorders
Increased Melting Leading to Floods	Epidemics along the Coastal Islands
Shift in Vector transmitted Diseases	Newer Diseases in new geographies With no immunity
Spread of Diseases	Increased spending on immunity solutions
GLOBAL WARMING	INCREASED MORBIDITY & INCREASED PRE MORTALITY RATE

CHALLENGES

- **No National Level Solutions**
  - Actions are region centric
- **Many Speakers , No Listeners**

WE CAN & TOGETHER WE WILL

DOCTORS ARE THE PILLARS OF SOCIETY

- Educate Legislators of the consequences
- Mobilize legislations to achieve reduction in Green Emissions (limits on carbon and other emissions)
- Propose solutions to legislators
- Educational workshops in schools ,colleges and other publics
- Reduce and Re-Cycle waste in your neighborhood
- Promote newer methods of water disposal and clean energy

CREATION OF STRONG PUBLIC HEALTH DELIVERY SYSTEMS

WE CAN

&

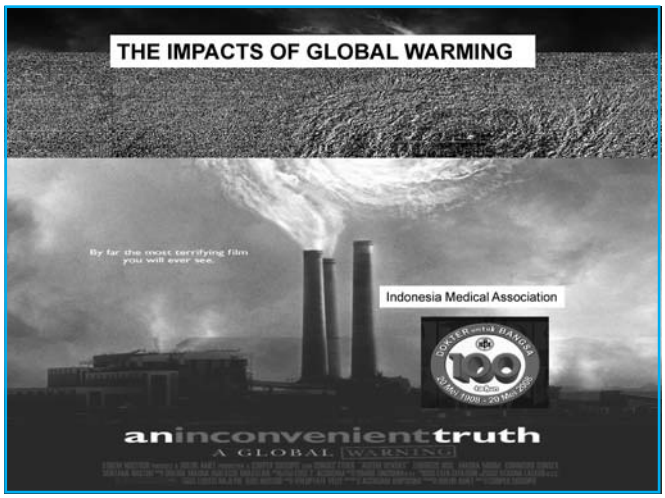
TOGETHER WE WILL

THANK YOU !

[Indonesia]

The Impacts of Global Warming

Fachmi IDRIS*1



OUTLINE OF PRESENTATION

I. Prolog
II. The Impacts of Global Warming (On Health)
III. Facts in Indonesia
IV. How to Deal With It? (What is the role of a NMA?)
V. IMA Role to face GW and CC Issue in Indonesia

(I)

Prolog

Do the Global Warming and Climate Change Related to Doctor Work?

"Whoever wishes to investigate medicine properly, should proceed thus:

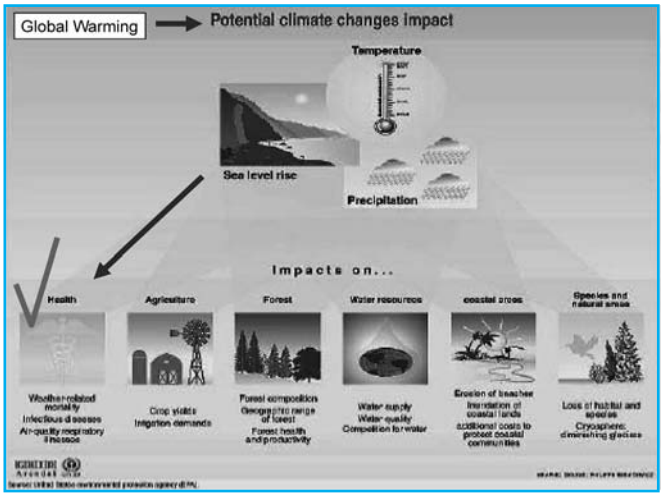
...in the first place to consider the seasons of the year, and what effects each of them produces ...

...Then the winds, the hot and the cold, especially such as are common to all countries, and then such as are peculiar to each locality" **On Airs, Waters and Places....**
Hippocrates (Circa 400 B.C)

*1 President, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).

(II)

The Impacts of Global Warming (On Health)



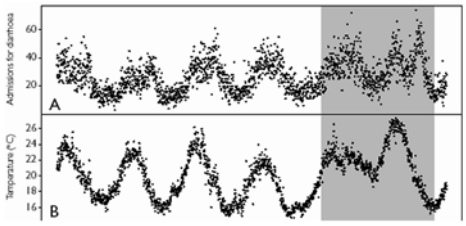
Some expected impacts will be beneficial but most will be adverse. Expectations are mainly for **changes in frequency or severity of familiar health risks**

CLIMATE CHANGE →

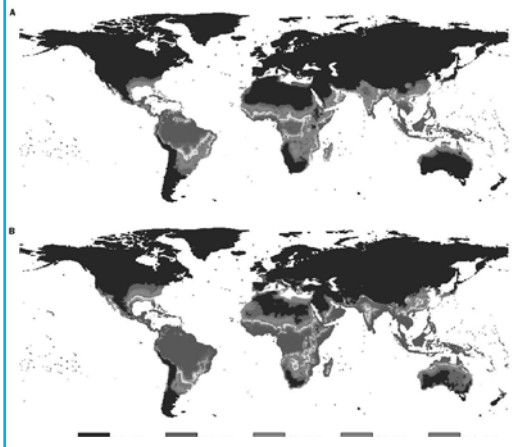
Health effects

- **Temperature-related illness and death**
- **Extreme weather- related health effects**
- **Air pollution-related health effects**
- **Water and food-borne diseases**
- **Vector-borne and rodent- borne diseases**
- **Effects of food and water shortages**
- **Effects of population displacement**

Based on Patz et al, 2000



Incidence of diarrhea disease is related to variations in temperature and precipitation, over both space and time. In Lima, Peru, **diarrhea increased 8% for every 1⁰C temperature increase.** (Checkley et al, Lancet, 2000)



Climate change is expected to increase the proportion of the global population exposed to dengue **from about 35%** (upper figure), **to 50-60%** (lower figure), by 2085. Hales et al, *Lancet* 2002

Disease	Likelihood of change with climate change	Vector	Present distribution	People at risk (millions)
Malaria	+++	mosquito	tropics/subtropics	2020
Schistosomiasis	++	water snail	tropics/subtropics	600
Leishmaniasis	++	phlebotomine sandfly	Asia/southern Europe/Africa/ Americas	350
American trypanosomiasis (Chagas disease)	+	triatomine bug	Central and South America	100
African trypanosomiasis (sleeping sickness)	+	tsetse fly	tropical Africa	55
Lymphatic filariasis	+	mosquito	tropics/subtropics	1100
Dengue	++	mosquito	All tropical countries	2500-3000
Onchocerciasis (river blindness)	+	blackfly	Africa/Latin America	120
Yellow fever	+	mosquito	tropical South America and Africa	-
Dracunculiasis (Guinea worm)	?	crustacean (copepod)	south Asia/Arabian peninsula/ Central-West Africa	100

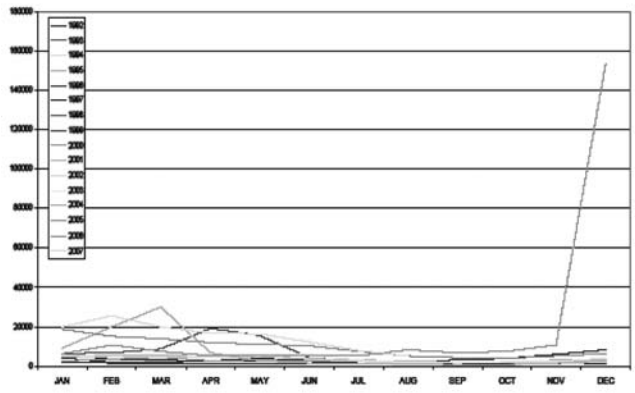
+++ = highly likely, ++ = very likely, + = likely, ? = unknown.
Based on: WHO, 1997; WHO/WMO/UNEP, 1996.

(III)

Facts in Indonesia

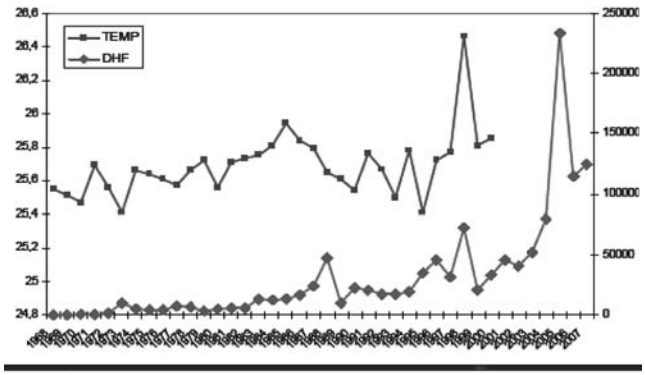
Facts in Indonesia
(Effect of global warming in conjunction to health)

- New Emerging Disease :
  Viral Diseases, SARS, Avian Influenza
- Re Emerging Disease (enhanced) :;
  Malaria, DHF, Japanese Encephalitis, Leptospirosis
- Increased awareness for ;
  - Flood: direct effect → acute ---- physical trauma
    After effect ----- mental disturbances
    Indirect effect → enhancement of hepatitis, food poisoning, diarrhea, diseases contaminated by water borne vectors, leptospirosis, anthrax.
  - Forest fire ; physical trauma, breathing difficulty , respiratory tract diseases, "victims of predators"
  - Draught : bad nutrition, diarrhea, and diseases caused by contaminated food
  - Effect of unstable weather (connected to diseases), filariasis, burned skin, skin malignancy, upper respiratory tract infection, asthma bronchial.



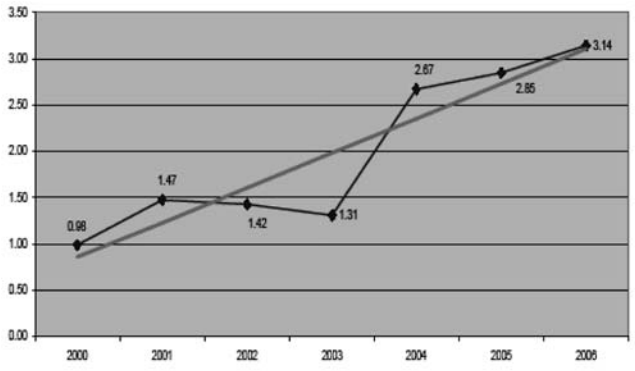
Trend of DHF Cases 1992 Trend of DHF Cases 1992-Sept 2007

Source: Indonesia MOH, 2007



Trend of Temperature and DHF Trend of Temperature and DHF Cases in Indonesia 1968-Sept 2007

Trend of Confirmed Cases of Malaria 2000-2006



(IV)

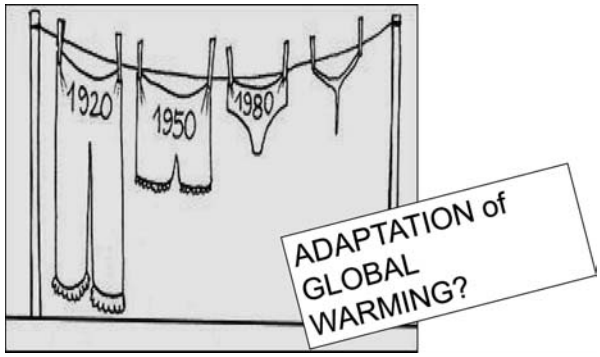
HOW TO DEAL WITH IT ?

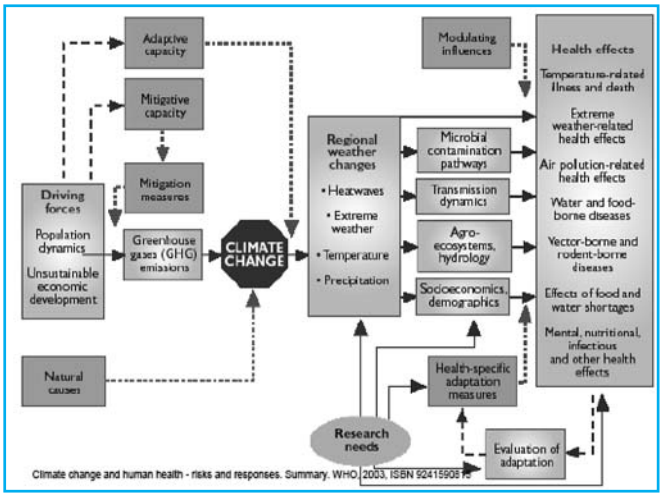
What is the role of a NMA ?
(CMAAO members, particularly archipelago countries are potentially directly affected by climate change/global warming)

THEORITICAL CONCERN

Adaptation :
is the effort to adjust against happenings caused by climate change/global warming

Mitigation :
is an active action to prevent/hinder climate change/global warming and to decrease the effect of climate change/global warming (lowering gas emission of glass house, increasing absorbsion of gas emission, etc)





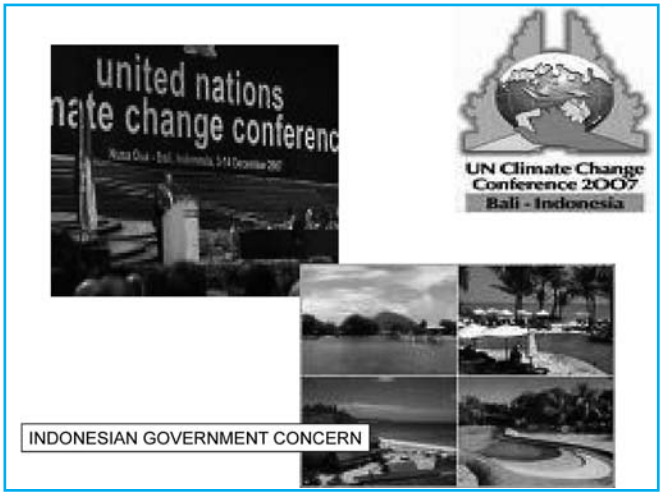
(V)

IMA Role to face GW and CC Issue in Indonesia

INDONESIA MED ASSC (IMA) ACTIVITY

Indo-MA Public Awareness Monthly Discussion and Workshop → Result:

Recommend to establish IMA Taskforce for Global Warming.



IMA Taskforce for Global Warming

Purpose:

Internal
To refresh doctor's competency for global warming in health, and maximize doctor's role in raising public awareness in facing population health problems

External
To advocate in enhancing and (if need) to review health programs for global warming (because negligence will influence human development in Indonesia)

IMA Taskforce for Global Warming

Organization Structure IMA Taskforce for Global Warming in IMA:

Under the coordination of the disaster committee in each IMA branch (districts), IMA region (provinces) and IMA central (national) level.

Main Task and Function:

Task
Responsible for all IMA activities in global warming

Function
Evaluation of every health effect of global warming, socialization, advocating and action

Position in Government Program:
Should be a part of Indonesian government's national action plan for mitigation and adaptation in global warming

IMA Taskforce for Global Warming

Some propose and program:

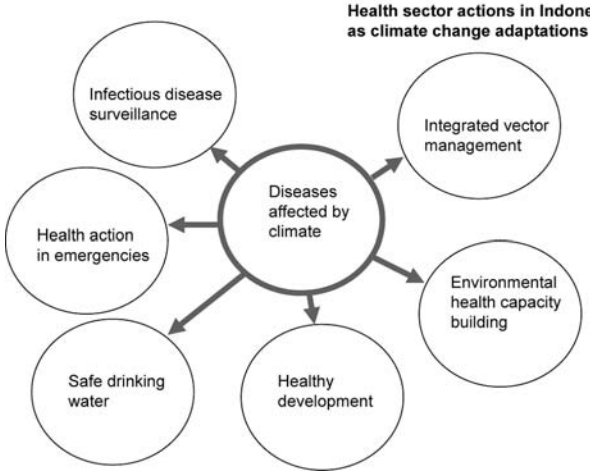
Internal of IMA

- Reactivation of campaigns for health oriented development
- National campaign agains vectors in schools and environment
- Optimalization of award giving or punishment for towns that heeds or neglects the above factors
- Review and follow development of global warming effects in Indonesia and abroad
- To refresh doctor's competency for global warming in health, and maximize doctor's role in raising public awareness in facing population health problems

External

To advocate in enhancing and (if need) to review health programs for global warming (because negligence will influence human development in Indonesia)

Health sector actions in Indonesia as climate change adaptations



[Japan]

Approaches to the Global Warming Problem, which Exerts a Huge Impact on the Survival of Humanity

Satoshi IMAMURA*1

We understand the problem of global warming to be an extremely important issue that has an enormous impact on the future survival of humanity. Dr. Taro Takemi, the 11th President of the Japan Medical Association, regarded "healthcare" as the "Law of existence" and "Bioscience" for humankind. This word "existence" is the ultimate issue for humanity. The problem of global warming today covers issues ranging from familiar healthcare efforts such as the treatment of heat stroke and infectious diseases to global-scale efforts, and is an extremely important issue for healthcare in this new era.

Moreover, Japan has been through two oil shocks, one in 1973 and the other in 1979, experiencing at first hand the importance of the energy issue, and has consequently worked proactively to promote energy conservation and natural energy utilization.

Against this background, the Third Session of the Conference of the Parties (COP3) to the United Nations Framework Convention on Climate Change was held in Kyoto, Japan, in 1997 and the Kyoto Protocol adopted. Under this agreement, Japan was obliged to reduce CO_2 emissions by 6% from the benchmark year (1990) amount between 2008 and 2012.

Accordingly, with Cabinet approval of the Kyoto Protocol Target Achievement Plan given in 2005, the Japan Medical Association and four major hospital organizations formulated and adopted the Voluntary Action Plan for Global Warming in Hospitals in August 2008. With regard to countermeasures to global warming in the healthcare field, it was thought to be important for the health professionals themselves to comprehensively considesr and decide factors related to management, such as the maintenance of balance between improvement of healthcare environments and energy conservation, and so the Voluntary Action Plan was formulated.

Under the Voluntary Action Plan, we aim to improve energy utilization efficiency, reducing the CO_2 emission rate by 1% each year in future for a reduction of 5.9% over the 2006 emission amount by 2012. In order to realize their aims in the future, we are promoting efforts based on six pillars and conducting yearly follow-up on the status of CO_2 emissions and energy conservation efforts at each hospital.

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

The 44th CMAAO Mid-Term Council Meeting
Symposium

"Global Warming, An Alarming Phenomenon: What Shall We Do?"

Satoshi IMAMURA, MD
Executive Board Member
Japan Medical Association

1

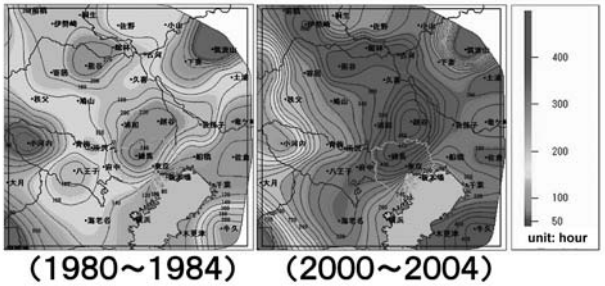
1. Global Warming Threatens the Survival of Humanity

Dr. Taro Takemi
(the 11th President of Japan Medical Association)
"Healthcare is the 'law of existence' and 'bioscience' for humankind."

'Existence' is the ultimate issue for humanity.

2

Escalation of the Heat-island Phenomenon around Tokyo

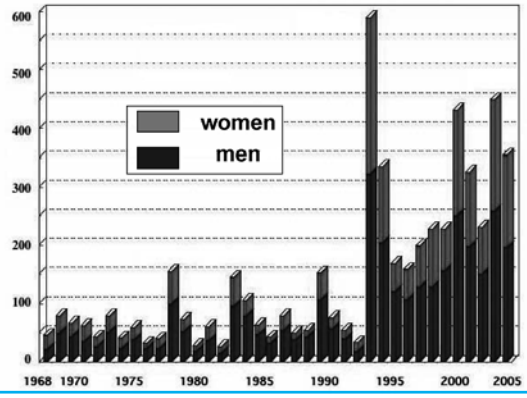


(1980~1984) (2000~2004)

The total number of hours at high temperatures over 30℃ has been increasing.

3

Changes in the Number of the Deaths Due to Heat Stroke



4

Japan has a strong interest in energy conservation and natural energy utilization because…

we have experienced two "oil shocks".

1973 1979

energy conservation | natural energy utilization

5

2. Formulate and Implement a "Voluntary Action Plan for Global Warming in Hospitals "

~~December 1997 (Kyoto)~~
The 3rd Session of the Conference of Parties to the United Nations Framework Convention on Climate Change (COP3)

Adoption of the Kyoto Protocol

Japan is obliged to reduce greenhouse gas emissions by 6% from the benchmark year (1990) amount between 2008 and 2012

6

Formulation and Organizational Adoption of the "Voluntary Action Plan for Global Warming in Hospitals"

The Japanese Government formulated a Kyoto Protocol Target Achievement Plan in 2005

Japan Medical Association

Japan Hospital Association
All Japan Hospital Association
Japanese Association of Psychiatric Hospitals
Association of Medical Care Corporations

2008
"Voluntary Action Plan for Global Warming in Hospitals" was formulated and organizationally adopted.

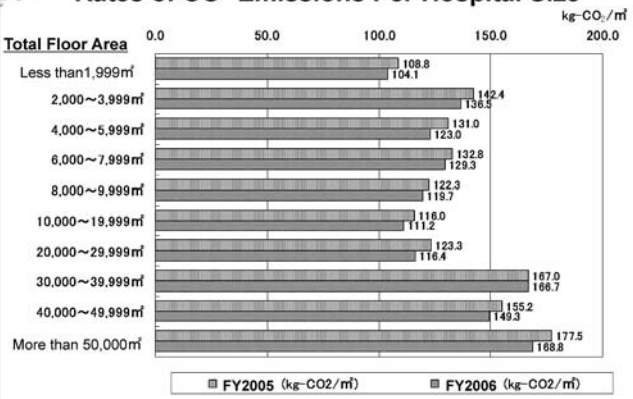
7

Voluntary Action Plan

It is important for health professionals themselves to comprehensively consider and decide factors related to management, such as the maintenance of balance between the improvement of healthcare environments and energy conservation.

8

Rates of CO^2 Emissions Per Hospital Size



9

Numerical Targets Set for the Voluntary Action Plan

Reduce the CO^2 emission rate by 1% each year for a target reduction of 5.9% over the 2006 emission amount by 2012

10

Measures for Achieving Targets

1. Make preparations for promoting global warming countermeasures at hospitals.
2. Make active efforts to implement global warming countermeasures
3. Expand daily actions to conserve energy
4. Take action to reduce the use of dinitrogen monoxide in the practice of medicine
5. Respond to renewal efforts to reduce CO^2
6. Enhance the reliability and effectiveness of the Voluntary Action Plan

11

Issues for the Future

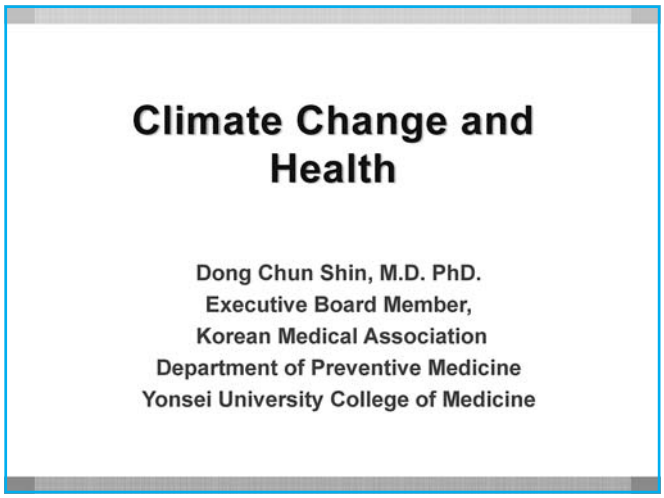
To achieve our goal, we will conduct annual surveys on the status of efforts at each hospital to reduce CO^2 emissions and save energy.

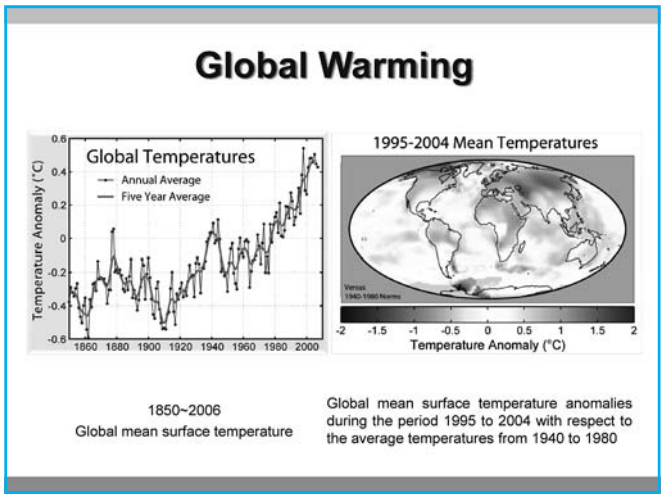
12

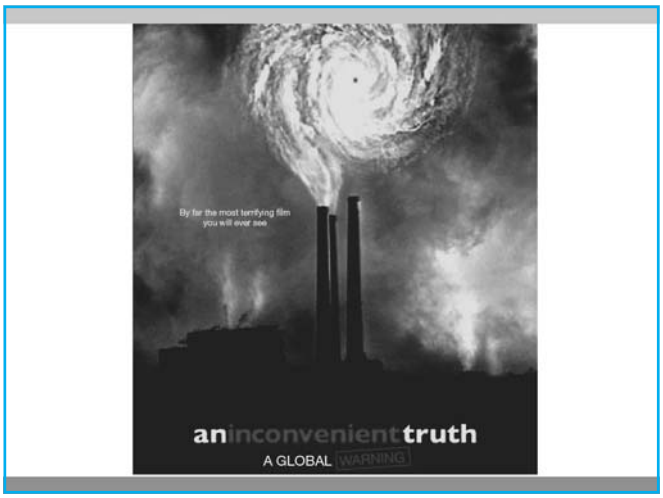
[Korea]

Climate Change and Health

Dong Chun SHIN*1







*1 Executive Board Member, Korean Medical Association, Seroul, Korea (intl@kma.org). Professor, Department of Preventive Medicine, College of Medicine, Yonsei University.

The atmosphere is thin enough that we are capable of changing its composition – CO_2.

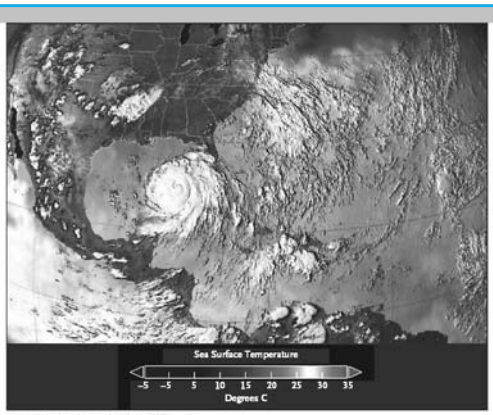
(An inconvenient truth)

The greenhouse gases on Venus are so thick gases that its temperatures are far too hot for humans.

The green house gases surrounding Mars are almost nonexistent, so the temperature is far too cold.

That's why the earth is sometimes referred to as the "Goldilocks Planet".

(An inconvenient truth)



Hurricane Katrina Passing over the Gulf of Mexico
The map shows the three-day average of sea-surface temperatures from August 25, 2005, through August 27, 2005, and Hurricane Katrina growing in strength and breadth as it passes over the unusually warm Gulf of Mexico. Yellow, orange, and red areas are at or above 82° F (27.8° C, the temperature required for hurricanes to strengthen). Since the 1970s, the number of category 4 and 5 hurricanes has increased as sea temperatures have risen.

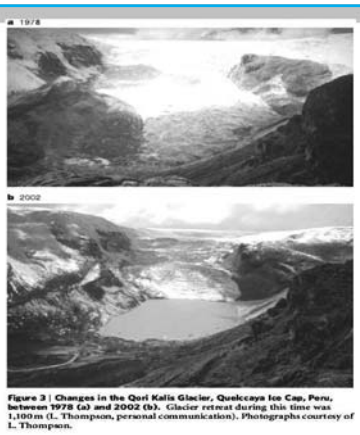
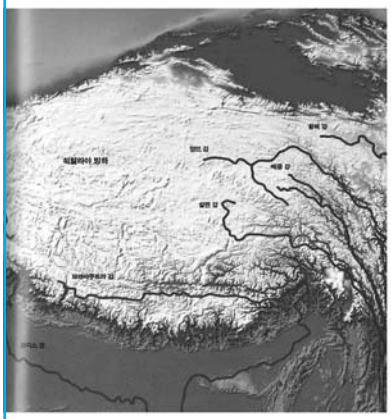


Figure 3 | Changes in the Qori Kalis Glacier, Quelccaya Ice Cap, Peru, between 1978 (a) and 2002 (b). Glacier retreat during this time was 1,100 m (L. Thompson, personal communication). Photographs courtesy of L. Thompson.

Barnett TP, Adam JC, Lettenmaier. Potential impacts of warming climate on water availability in snow-dominated regions. Nature 2005;438:303-309



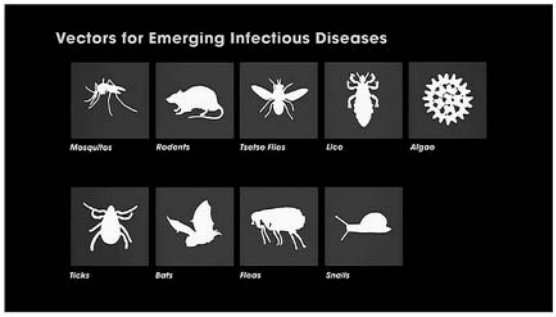
The Himalayan Glaciers on the Tibetan Plateau have been among the most affected by global warming.

(An inconvenient truth)

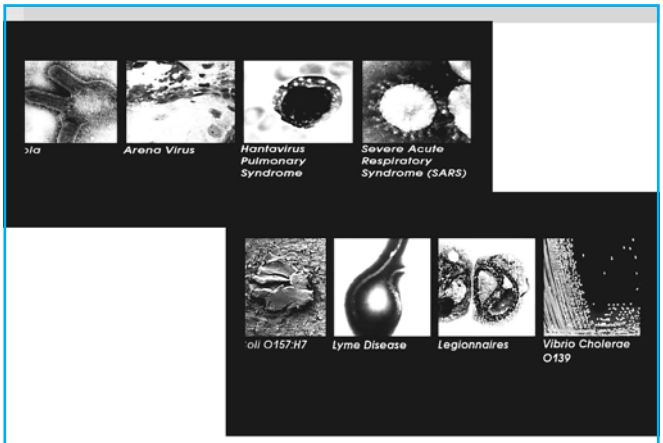
Himalayas contain 100 times as much ice as the Alps and provide more than half of the drinking water for 40% of the world's population through Asian river systems* that all originate on the same plateau.

* Yangtze, Yellow, Mekong, Salween, Brahmaputra, Ganges, Indus Rivers

(An inconvenient truth)



(An inconvenient truth)



(An inconvenient truth)

(An inconvenient truth)

Within the next half-century,

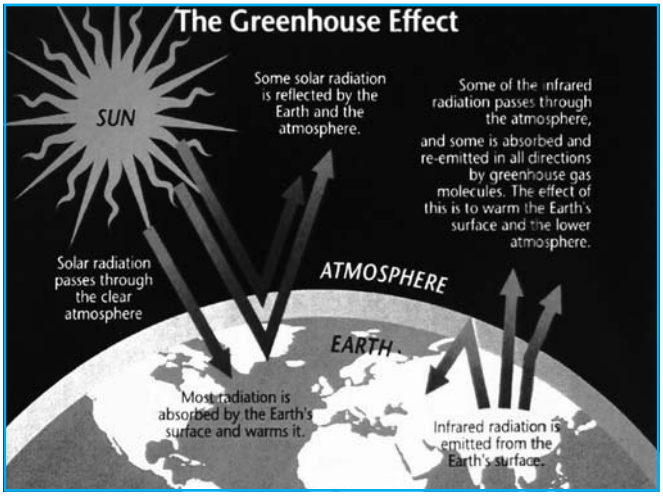
40% of the world's people may well face a very serious drinking water shortage,

unless the world acts boldly and quickly to mitigate global warming.

(An inconvenient truth)

Green House Gas

- Carbon dioxide :
  - 80~85% of CO_2 is generated as a by-product of the combustion of fossil fuels
- Methane (natural gas) :
  - the second most important of the greenhouse gas
  - rice cultivation, cattle and sheep ranching, and by decaying material in landfills
- Nitrous oxide : various agricultural and industrial practices.
- Chlorofluorocarbons (CFCs) : Refrigeration, air conditioning, solvents
- Ozone : created by high concentrations of pollution and daylight UV rays at the earth's surface



Trends in energy use & CO_2

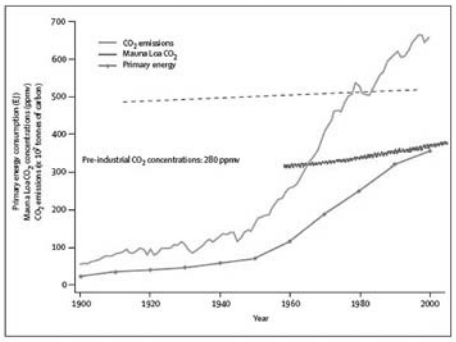
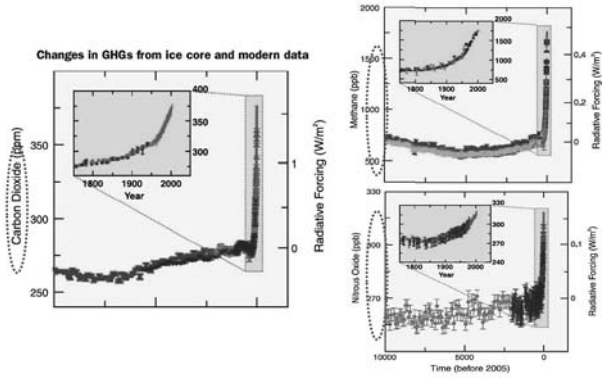


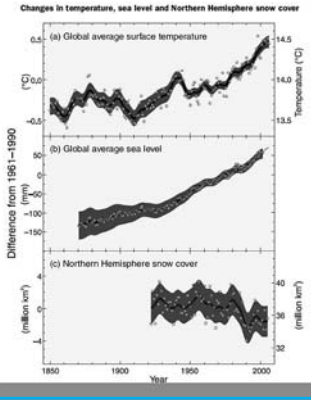
Figure 3: Trends during the 20th century in energy use, carbon dioxide (CO_2) emissions, and atmospheric CO_2 concentrations[43]
Data measured at the Mauna Loa observatory, Hawaii, USA. EJ=exajoules (10^{18} joules).

(Wilkinson P. et al. 2007)

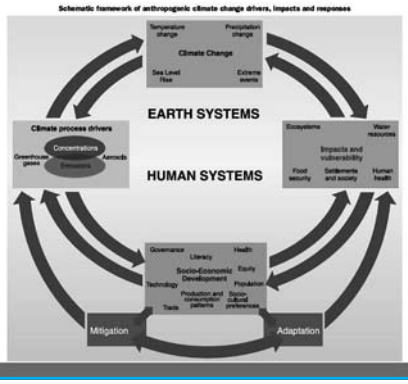
IPCC 4th Report (2 Feb. 2007)



IPCC 4th Report (2 Feb. 2007)



IPCC 4th Report (2 Feb. 2007)

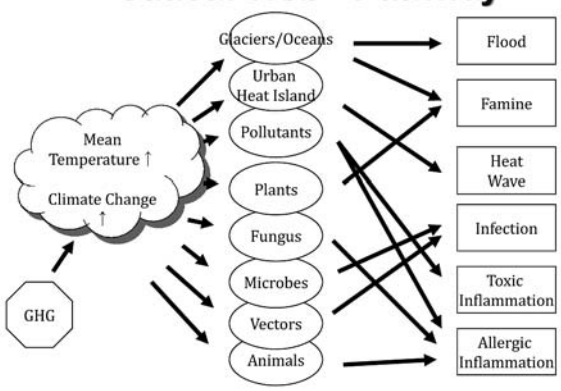


Impact of global warming

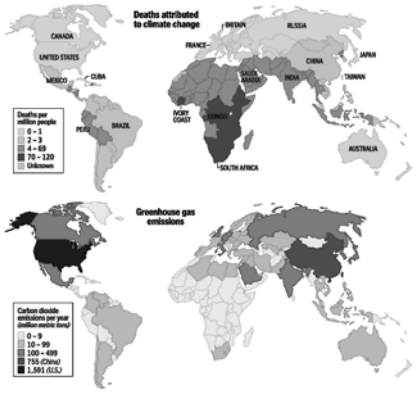
Approximately 20 to 30% of plant and animal species assessed so far are *likely* to be at increased risk of extinction if increases in global average temperature exceed 1.5 to 2.5°C (*medium confidence*).

It is likely that up to 20% of the world population will live in areas where river flood potential could increase by the 2080s.

Causal Web - Pathway



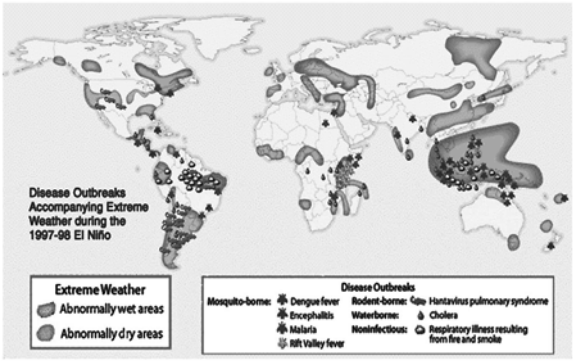
Deaths attributed to climate change



Likely relative impact on health outcomes of the components of climate change

Health outcome	Aspects of climate change			
	Change in mean temperature, etc.	Extreme events	Rate of change of climate variable	Day-night difference
Heat-related deaths and illness		+++		+
Physical and psychological trauma due to disasters		++++		
Vector-borne diseases	+++	++	+	++
Non-vector-borne infectious diseases	+	+		
Food availability and hunger	++	+	++	
Consequences of sea level rise	++	++	+	
Respiratory effects :				
air pollutants	+	++		+
pollens, humidity	++			
Population displacement	++	+	+	

Extreme Weather Events & Disease Clusters



Emerging Infectious Diseases

30 DISEASES "NEW" TO MEDICINE SINCE 1976

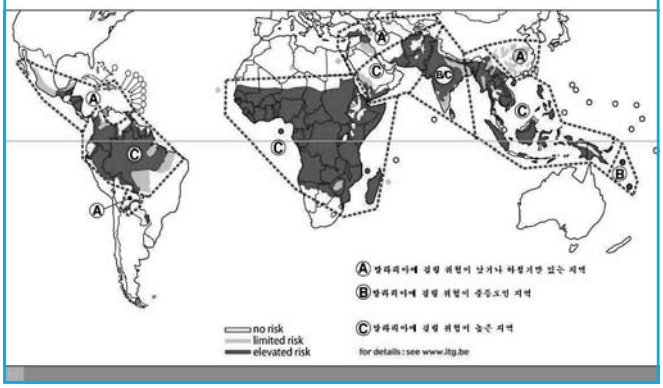
HIV/AIDS Ebola
Legionnaires' E. coli O157:H7
SARS Antibiotic-Resistant Agents

Hantavirus Pulmonary Syndrome
Lyme Disease Nipah Virus
Vibrio cholerae O139 *Arenaviruses*

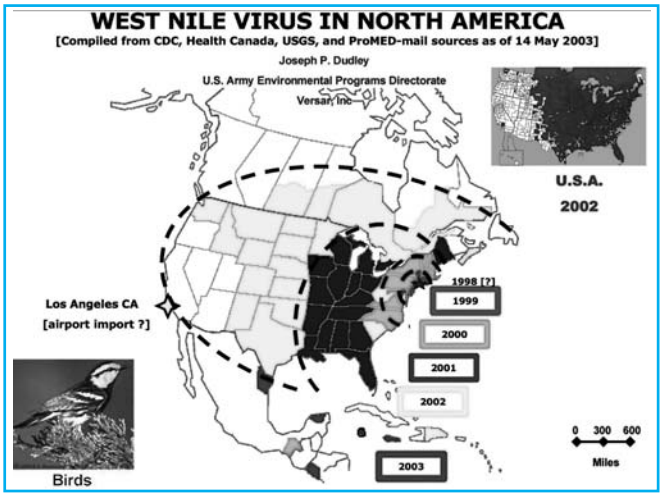
RESURGENT & REDISTRIBUTING
Malaria, Dengue Fever, West Nile Virus, Cholera

VECTORS
Mosquitoes
Ticks
Rodents
Bats
Tsetse Flies
Fleas
Lice
Snails
Algae

Malaria 2006 (source WHO 2004-2005)



The Geographic Distribution of Japanese B Encephalitis Family



Climate and Vectorborne Diseases

Table 1. Selected examples of climatic factors influencing the transmission and distribution of vectorborne diseases

Disease (causative agent)	Vector	Relevant climatic factors	Effects of climatic variability or climate change	References
Parasitic vectorborne diseases				
Malaria (*Plasmodium* vivax, *P. falciparum*)	Mosquitoes	Temperature, rainfall, humidity, El Niño-related effects, sea surface temperatures	Disease distribution; pathogen development in vector; development, reproduction, activity, distribution, and abundance of vectors; transmission patterns and intensity; outbreak occurrence	14–27
Leishmaniasis (*Leishmania* spp.)	Sand flies	Temperature, precipitation, El Niño-related effects	Disease incidence and outbreak occurrence; abundance, behavior, and distribution of vectors	28–37
Chagas disease (*Trypanosoma cruzi*)	Triatomine bugs	Temperature, precipitation, humidity, severe weather event	Vector distribution, increased infestation of houses by vector	38–40
Onchocerciasis (*Onchocerca volvulus*)	Black flies	Temperature	Transmission intensity	41
Arboviral diseases				
Dengue fever (Dengue virus)	Mosquitoes	Temperature, precipitation	Outbreaks, mosquito breeding abundance, transmission intensity (extrinsic incubation period)	42–45
Yellow fever (Yellow fever virus)	Mosquitoes	Temperature, precipitation	Outbreaks, incidence, distribution, abundance, and breeding of mosquitoes, transmission intensity (extrinsic incubation period)	43,44,46
Chikungunya Fever (Chikungunya virus)	Mosquitoes	Temperature, precipitation	Outbreaks; mosquito breeding and abundance, transmission intensity (extrinsic incubation period)	43,44,47
West Nile virus disease (West Nile virus)	Mosquitoes	Temperature, precipitation	Transmission rates, pathogen development in vector, distribution of disease and vector	48–50
Rift Valley Fever (Rift Valley Fever virus)	Mosquitoes	Precipitation, sea surface temperatures	Outbreaks; vector breeding and abundance, transmission intensity (extrinsic incubation period)	43,44,51,52
Ross River virus disease (Ross River virus)	Mosquitoes	Temperature, precipitation, sea surface temperatures	Outbreaks, vector breeding and abundance, transmission intensity (extrinsic incubation period)	53
Tickborne encephalitis (Tickborne Encephalitis virus)	Ticks	Temperature, precipitation, humidity	Vector distribution, phenology of host-seeking by vector	54–62
Bacterial and rickettsial diseases				
Lyme borreliosis (*Borrelia burgdorferi, B. garinii, B. afzelii*, or other related *Borrelia*)	Ticks	Temperature, precipitation, humidity	Frequency of cases, phenology of host-seeking by vector, vector distribution	56–60,63–72
Tularemia (*Francisella tularensis*)	Ticks	Temperature, precipitation	Case frequency and onset	73
Human granulocytic anaplasmosis (*Anaplasma phagocytophilum*)	Ticks	Temperature, precipitation	Vector distribution, phenology of host-seeking by vector	63,65,66,68,69,71,74,75
Human monocytic ehrlichiosis (*Ehrlichia chaffeensis*)	Ticks	Temperature, precipitation	Phenology of host-seeking by vector	68,76,77
Plague (*Yersinia pestis*)	Fleas	Temperature, precipitation, humidity, El Niño-related events	Development and maintenance of pathogen in vector; survival and reproduction of vectors and hosts; occurrences of historical pandemics and regional outbreaks, distribution of disease	78–98

(Gage K.L. et al. 2008)

MAJOR TROPICAL VECTOR-BORNE DISEASES AND THE LIKELIHOOD OF CHANGE WITH CLIMATE CHANGE

Disease	Likelihood of change with climate change	Vector	Present distribution	People at risk (millions)
Malaria	+++	mosquito	tropics/subtropics	2020
Schistosomiasis	++	water snail	tropics/subtropics	600
Leishmaniasis	++	phlebotomine sandfly	Asia/southern Europe/Africa/ Americas	350
American trypanosomiasis (Chagas disease)	+	triatomine bug	Central and South America	100
African trypanosomiasis (sleeping sickness)	+	tsetse fly	tropical Africa	55
Lymphatic filariasis	+	mosquito	tropics/subtropics	1100
Dengue	++	mosquito	All tropical countries	2500-3000
Onchocerciasis (river blindness)	+	blackfly	Africa/Latin America	120
Yellow fever	+	mosquito	tropical South America and Africa	-
Dracunculiasis (Guinea worm)	?	crustacean (copepod)	south Asia/Arabian peninsula/ Central-West Africa	100

+++ = highly likely, ++ = very likely, + = likely, ? = unknown.
Based on: WHO, 1997, WHO/WMO/UNEP, 1996.

Climate Change, Air Quality, and Health

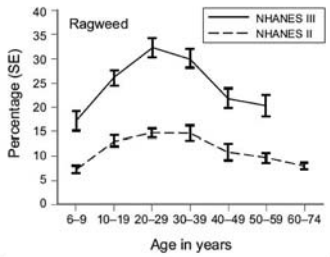


Figure 3. Percentage of the population by age with positive skin test reactivity to ragweed pollen in NHANES II (dashed line) and NHANES III (solid line)[14]
NHANES, National Health and Nutrition Examination Survey
Reprinted with permission from the American Academy of Allergy, Asthma, and Immunology.

NHANES II: 1976-1980, NHANES III:1988-1994 (Kinney P.L. 2008)

Weather Anomalies, Travel & Trauma

STORM OF 2003

WIDER SWINGS IN WEATHER

- **Fog, Ice Storms & Road Travel**
- **Floods & Mudslides**
- **Ice Instability, Heavy Precipitation & Avalanches**
- **Infrastructure Damage, Water & Sanitation Systems**

TRADE, TRAVEL, TRANSPORT, TOURISM

Effect of Global Warming in Korea

- Mean temp. during 100 years: ↑1.5°C
- Sea level during 40 years: ↑ 22cm (Jeju Island)
- Excess death due to extremely hot weather
  - 2,217 during recent 10 years
- Incidence of Malaria
  - 25 in 1994 → 1,973 in 2006

(기후변화 제4차 종합대책)

Excess Death due to Extreme Weather in Korea

- The relation between daily mean temperature during summer in 1994~2003 and the number of death in Seoul, Korea

  - daily mean temp.>28.1°C (a threshold) → the number of death has been rapidly increased

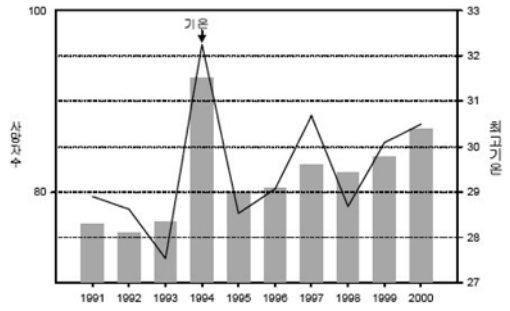
  ↑1°C from 28.1°C → death rate: ↑9.6%

- The predicted number of excess death due to extremely hot weather with global warming in Seoul

  : 300~400 in 2030's, 400~500 in 2040's, 600 in 2050's

(무더위로 인한 초과 사망, 기상청, 2008)

The relation between the highest temp. and the number of death in Korea (1991-2000)



Excess Death due to Extreme Weather in Korea

10년 동안 2131명 '사람 잡은 폭염'

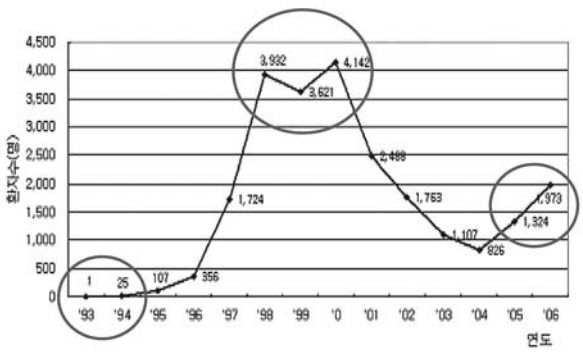
▼ < 표1> 대름철 폭염으로 인한 초과사망자 수와 기상재해 사망자 수 비교 (단위 : 명)

대름철 폭염으로 인한 초과사망자						기상재해로 인한 사망자(실종 포함)
연도	서울	대구	대전	광주	합계	
1994	738	161	134	50	1083	72
1995	40	71	15	18	144	158
1996	66	57	22	22	167	77
1997	130	20	28	14	192	38
1998	0	14	1	11	26	384
1999	129	3	28	8	168	89
2000	61	14	46	9	130	49
2001	52	46	34	15	147	82
2002	29	16	18	7	70	270
2003	0	3	0	1	4	148
합계	1245	405	326	155	2131	1367

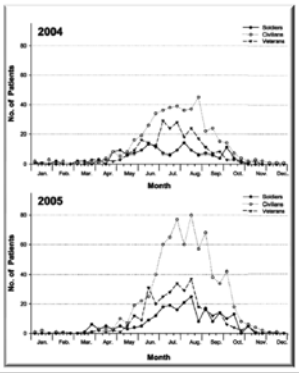
▼ < 표2> 2032~51년 대름철 폭염에 따른 서울의 초과사망자 수 추정 (단위 : 명)

연도	대름철 폭염으로 인한 초과사망자 수
2032	50.6
2033	321.5
2034	147.9
2035	108.3
2046	476.9
2047	303.7
2048	218.6
2049	586.0
2050	491.6
2051	640.1

Incidence of Malaria in Korea



Changing Patters of Malaria in Korea



- Regional increase of vivax malaria in North Korea
- Increased local transmission in South Korea
- Active transmission by vector mosquitoes during the transmission season

(Yeom J.S. et al. 2007)

GHG emissions per unit of GDP

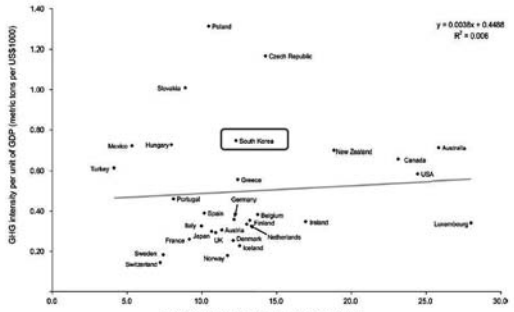


Figure 6. Greenhouse gas intensity (GHG emissions per unit of gross domestic product) for Organization of Economic Co-operation and Development (OECD) countries compared with GHG emissions per capita, 2005. Metric tons of CO_2e (CO_2 equivalent), excluding impacts from land use. (Source: Tables 4 and 5)

(Bloomberg M.R. et al. 2008)

Life Expectancy compared with GHG

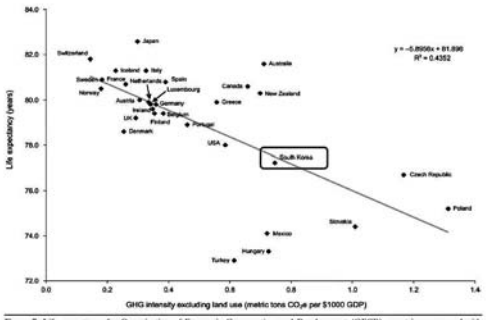


Figure 7. Life expectancy for Organization of Economic Co-operation and Development (OECD) countries compared with greenhouse gas intensity (GHG per unit of gross domestic product) (Source: Tables 4 and 5)
Life expectancy had a negative correlation with GHG intensity with an R^2 of 0.4352; HALE had an R^2 of 0.4148; and adult mortality had a positive correlation of 0.4348.
HALE, healthy life expectancy

(Bloomberg M.R. et al. 2008)

Pro-health policies

I think one of the major problems with mainstream thinking about climate change and health is that **people focus only on the actions** that need to be taken to respond to things like more cases of malaria.

But they really should be thinking in terms of **how this extra stress fits into the entire environmental health agenda.** By considering the issue more broadly we could reduce by 25% the global burden of disease.

(Neira M. 2007)

(Bulletin of the WHO, 2007)

Attitude to Climate Change

MITIGATION

ADAPTATION

(Haines A. 2008)

Nimai Chandra Ghosh

The photo "Sleeping on the river bed" by Nimai Chandra Ghosh won a special mention in the WHO photo and video contest Images of Health and Disability 2007 Special Theme: Health and Environment. A boy sleeps on a dried-up river bed in India. Experts believe that climate change is increasing the frequency and severity of droughts.

[Malaysia]

Global Warming & Its Implications for Health & Society: What can we do?

David K.L. QUEK*1

"An increasing body of observations gives a collective picture of a warming world and other changes in the climate system."

Intergovernmental Panel on Climate Change (IPCC), 2001

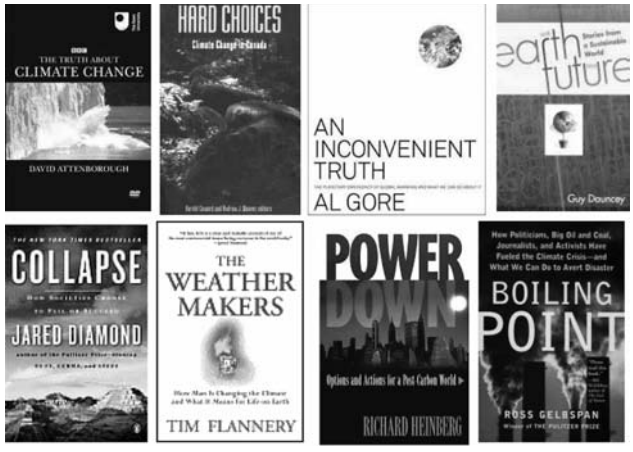
Celebrities are concerned, what about us physicians who should have an even greater responsibility toward society?

Looking after the Future

Jeffrey D. Sachs, Director, Earth Institute of Columbia University

- *"Many of the greatest problems facing the planet will hit hardest in 50 to 100 years. Climate change, which already wreaks havoc through local droughts and heat waves, could well unleash global-scale havoc in a few decades. Higher temperatures and changing rainfall patterns could cut global food production sharply and trigger mass famine in needy parts of the world; conceivably, the great ice sheets of Greenland and Antarctica could partially collapse and raise the sea level by several times, flooding the coasts."*

Scientific American, Nov 2008, pg 20



*1 President-Elect, Malaysian Medical Association, Kuala Lumpur, Malaysia (mma@tm.net.my).

Skeptics Abound…

As climatologist Stephen Schneider notes,

"I'm not 99 percent sure, but I am 90 percent sure [that the climate is changing]. Why do we need 99 percent certainty when nothing else is that certain? If there were only a 5 percent chance the chef slipped some poison in your dessert, would you eat it?"

✓Examples of observed changes in response to 20th century warming include

✓Shrinking glaciers
- ✓ Thawing permafrost
- ✓ Earlier break-up of river and lake ice
- ✓ Lengthening of mid- to high-latitude growing seasons

✓Poleward and altitudinal shifts of plant and animal ranges
- ✓ Declines of some animal and plant populations
- ✓ Earlier tree flowering, insect emergence and egg-laying in birds.

Whatever is the conservative or contrarian view, there is no longer any sensible denial that global warming has come and at an unprecedented rate.
Everyone must play his/her role in helping to kick-start campaigns to help reverse or to slow down this potential worldwide catastrophe
Governments are always pushed by concerns of the expense of activities or programs to limit global warming—it is therefore up to citizens and enlightened activists to help shape public opinion and lobby for some of these concerns.
As physicians, which in almost every society are respected, trusted, we can act as advocates to encourage efforts to alleviate global warming, and help shape decisions and regulations which will be in step with various international efforts e.g. Kyoto protocol, APPCDC (The Asia-Pacific Partnership on Clean Development and Climate)

Help! Retrenched Lehman Brothers Bank employees blockade entrance to headquarters!

GLOBAL WARMING: Early Warning Signs

The impact of global warming in Asia

Click on the numbered icons below for more information.

"In my view, climate change is the most severe problem that we are facing today -- more serious even than the threat of terrorism."

With this warning to an international science meeting in February 2004, David A. King, Chief Scientific Advisor to the British Government, brought the issue of global warming into sharp focus.

NRDC
The Earth's Best Defense

WRI

Sierra Club
Founded 1892

Let's Leave Our Children a Living Planet
WWF
www.worldwildlife.org

e
environmental defense
finding the ways that work

CMAAO?

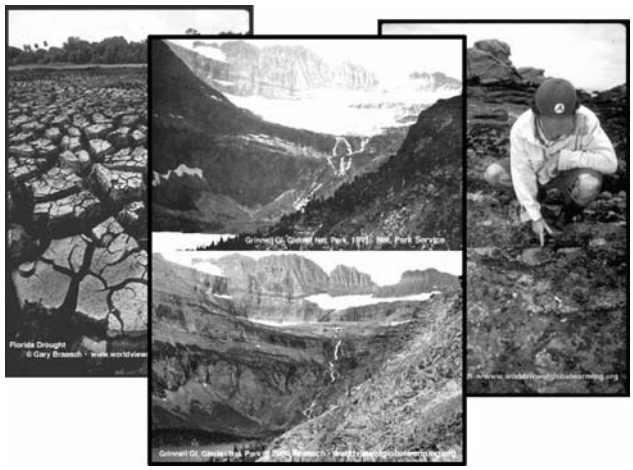
Union of Concerned Scientists

U.S. PIRGonline

Fingerprints of Global Warming

Heat waves and periods of unusually warm weather

The map highlights places that have recently experienced record warmth in regions with a century-long warming trend (1901-1996). Frequent and severe heat waves lead to increases in heat-related illness and death, especially in urban areas and among the elderly, the young, the ill, and the poor.



Ocean warming, sea-level rise and coastal flooding

Warmer temperatures increase melting of mountain glaciers, increase ocean heat content, and cause ocean water to expand. Largely as a result of these effects, global sea level has risen 4 to 10 inches (10-25 cm) over the past 100 years. With additional warming, sea level is projected to rise from half a foot to 3 feet (15-92 cm) more during the next 100 years. On average, 50 to 100 feet (15-30 meters) of beach are lost for every foot (0.3 meters) of sea-level rise. Local land subsidence (sinking) and/or uplift due to geologic forces and coastal development will also affect the rate of coastal land loss.

- ***Glaciers melting***

- Over the past 150 years, the majority of mountain glaciers monitored have been shrinking. Many glaciers at lower latitudes are now disappearing, and scientists predict that, under some plausible warming scenarios, the majority of glaciers will be gone by the year 2100. As glaciers continue to shrink, summer water flows will drop sharply, disrupting an important source of water for irrigation and power in many areas that rely on mountain watersheds.

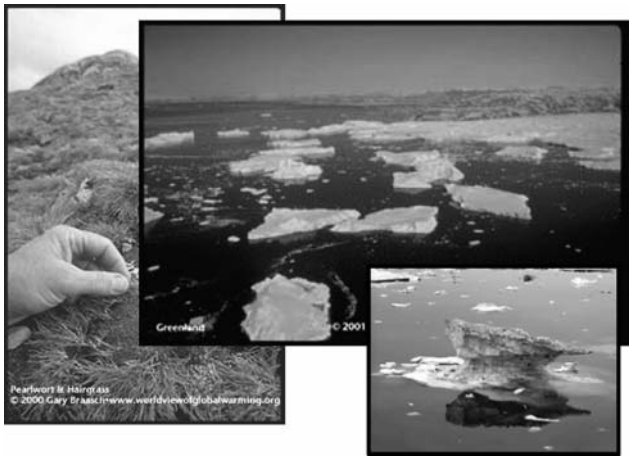
- ***Arctic and Antarctic warming***

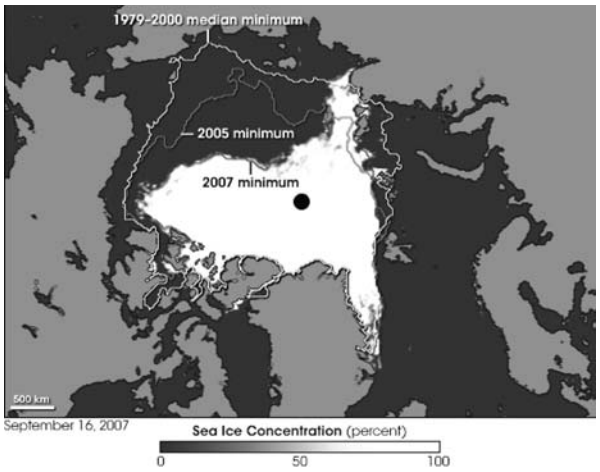
- Parts of Canada, Alaska, Siberia, and the Antarctic have been experiencing warming well above the global average for the past few decades. This trend fits climate model predictions for a world with increasing levels of greenhouse gases. Melting permafrost is forcing the reconstruction of roads, airports, and buildings and is increasing erosion and the frequency of landslides. Reduced sea ice and ice shelves, changes in snowfall, and pest infestations have affected native plants and animals that provide food and resources to many people.

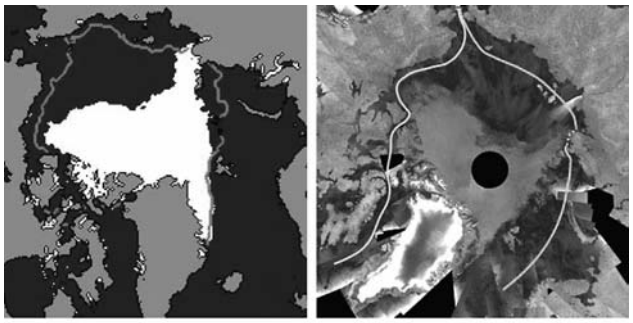
Arctic Ice Disappearing...

✓Scientists have used satellite pictures since 1979 to map the extent of such ice at its minimum, and the picture this year isn't pretty.

✓Covering 1.59 million square miles (4.12 million square kilometers), this summer's sea ice shattered the previous record for the smallest ice cap of 2.05 million square miles (5.31 million square kilometers) in 2005—a further loss of sea ice area equivalent to the states of California and Texas combined.

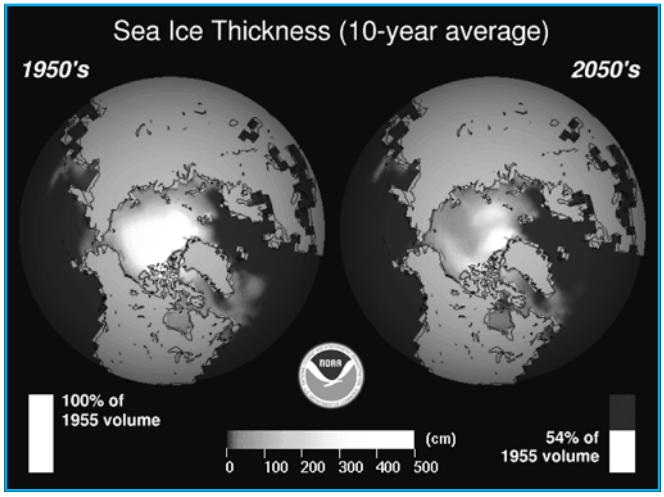




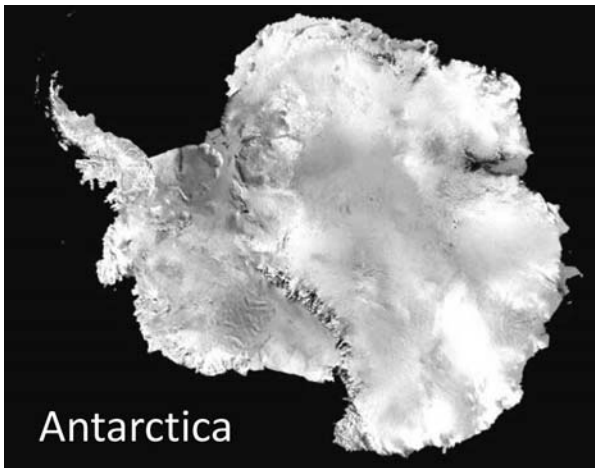


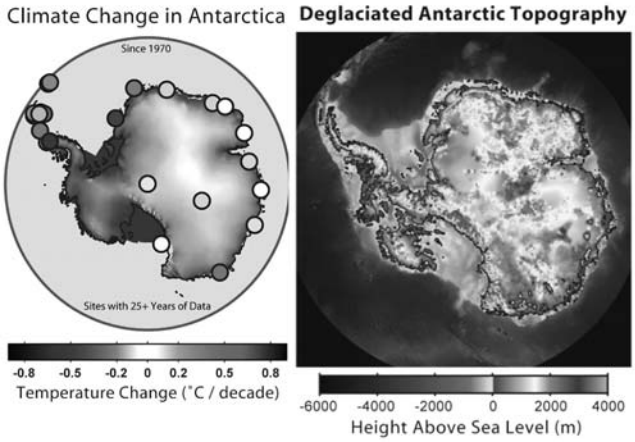
NOT SO COLD FACT: This year's summer ice cover, represented in white, is slightly more than 1 million square miles smaller than the long-term average, represented by the pink line.

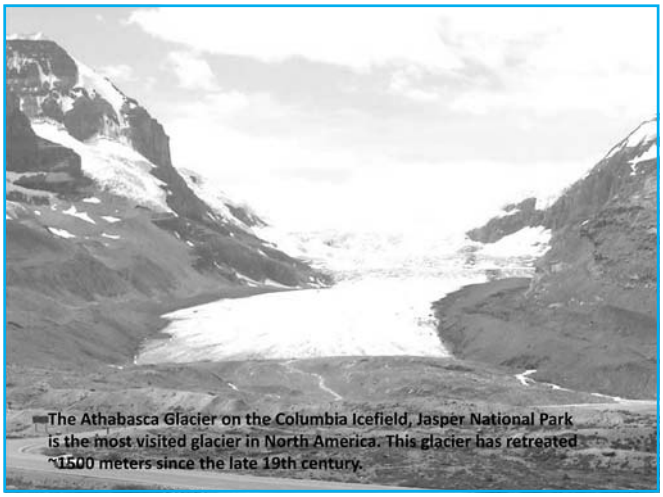
FABLED PASSAGE: A shipping shortcut to Asia from western Europe and eastern North America known as the Northwest Passage opened this summer, represented by the yellow line.



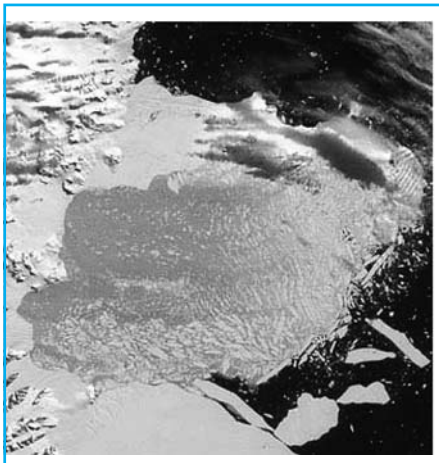
Lewis Glacier, North Cascades, Washington in 1992 after melting away in 1990, there is only scattered snowpatches and no glacier ice left. Author: M.Peltowww.nichols.edu/departments/glacier/






The Athabasca Glacier on the Columbia Icefield, Jasper National Park is the most visited glacier in North America. This glacier has retreated ~1500 meters since the late 19th century.


Surface melt travelling down Athabasca Glacier


GLOBAL WARMING: The Larsen B ice shelf on the Antarctic Peninsula--an area of ice larger than Rhode Island--collapsed as a result of climate change and now such global warming has been detected across Antarctica.

Harbingers of Global Warming

- ***Spreading disease***

- Warmer temperatures allow mosquitoes that transmit diseases such as malaria and dengue fever to extend their ranges and increase both their biting rate and their ability to infect humans. The map highlights locations of mosquito-borne disease outbreaks in previously unexposed highland communities where temperatures have risen during the past century, and other indicators of health impacts.

- ***Earlier spring arrival***

- Spring now arrives earlier in many parts of the world. Evidence of this comes from earlier thaw dates for rivers and lakes; earlier dates for plant blooming and leafing; and earlier animal egg-laying, spawning and migration. An earlier spring may disrupt animal migrations, alter competitive balances among species, and cause other unforeseen problems.

- ***Plant and animal range shifts and population changes***

- Plants and animals generally react to consistently warmer temperatures by moving to higher latitudes and elevations. Recent studies reveal that some species have already started to shift their ranges, consistent with warming trends. Many populations and species may become more vulnerable to declining numbers or extinction if warming occurs faster than they can respond or if human development presents barriers to their migration.

- ***Coral reef bleaching***

- Reefs in 32 countries experienced dramatic bleaching in 1997-98. Bleaching results from the loss of microscopic algae that both color and nourish living corals. Water that is warmer than normal by only 2 to 3F (1.1-1.6C) has been linked to bleaching. Other factors that contribute to coral reef bleaching include nutrient and sediment runoff, pollution, coastal development, dynamiting of reefs, and natural storm damage.

DEAD ZONES
So-called "ocean deserts" or "dead zones" are oxygen-starved (or "hypoxic") areas of the ocean.
They can occur naturally, or be caused by an excess of nitrogen from agricultural fertilizers, sewage effluent and/or emissions from factories, trucks & automobiles....

- ***Downpours, heavy snowfalls, and flooding***

- A warmer climate will bring an increase in precipitation worldwide, especially during winter and in mid- to high latitudes, according to climate model projections. In addition, more precipitation is expected to fall in downpours and heavy snowstorms leading to increased flooding and damages. The area of the U.S. affected by extreme rainfall has increased significantly since 1910. Heavy rainfalls have also increased in Japan, the former Soviet Union, China, and Australia. As climate change increases the risk of flooding, human changes in land use and land cover can also contribute to the growing risk of flooding.

- ***Droughts and fires***

- As the climate heats up, droughts are expected to become more frequent and severe in some locations. Sustained drought makes wildfires more likely, and crops and trees more vulnerable to pest infestations and disease. Generally, local land use and land cover changes can exacerbate the climate change-driven increase in drought risk. For example, in the tropics, "slash-and-burn" land clearing practices can trigger large fires during extended droughts.

Impact of Global Warming in Asia

- **Fingerprints & Harbingers**
- 1. Llasa, Tibet -- Warmest June on record, 1998. Temperatures hovered above 77F for 23 days.
- 59. Garhwal Himalayas, India -- Glacial retreat at record pace. The DokrianiBarnak Glacier retreated 66 ft (20.1 m) in 1998 despite a severe winter. The Gangorti Glacier is retreating 98 ft (30 m) per year. At this rate scientists predict the loss of all central and eastern Himalayan glaciers by 2035.
- 62. Tien Shan Mountains, China -- Glacial ice reduced by one quarter in the past 40 years.
- 90. Southern India - Heat wave, May 2002. In the state of Andhra Pradesh temperatures rose to 120F, resulting in the highest one-week death toll on record. This heat wave came in the context of a long-term warming trend in Asia in general. India, including southern India, has experienced a warming trend at a rate of 1F (0.6C) per century.
- 91. Nepal - High rate of temperature rise. Since the mid-1970s the average air temperature measured at 49 stations has risen by 1.8F (1C), with high elevation sites warming the most. This is twice as fast as the 1F (0.6C) average warming for the mid-latitudinal Northern Hemisphere (24 to 40N) over the same time period, and illustrates the high sensitivity of mountain regions to climate change.
- 93. Taiwan - Average temperature increase. The average temperature for the island has risen 1.8-2.5F (1-1.4C) in the last 100 years. The average temperature for 2000 was the warmest on record.

Impact of Global Warming in Asia

- 94. Afghanistan - 2001 - Warmest winter on record. Arid Central Asia, which includes Afghanistan, experienced a warming of 0.8-3.6F (1-2C) during the 20th century.
- 95. Tibet - Warmest decade in 1,000 years. Ice core records from the Dasuopu Glacier indicate that the last decade and last 50 years have been the warmest in 1,000 years. Meteorological records for the Tibetan Plateau show that annual temperatures increased 0.4F (0.16C) per decade and winter temperatures increased 0.6F (0.32C) per decade from 1955 to 1996.
- 96. Mongolia - Warmest century of the past millennium. A 1,738-year tree-ring record from remote alpine forests in the Tarvagatay Mountains indicates that 20th century temperatures in this region are the warmest of the last millennium. Tree growth during 1980-1999 was the highest of any 20-year period on record, and 8 of the 10 highest growth years occurred since 1950. The 20th century warming has been observed in tree-ring reconstructions of temperature from widespread regions of Eurasia, including sites in the Polar Urals, Yakutia, and the Taymir Peninsula, Russia. The average annual temperature in Mongolia has increased by about 1.3F (0.7C) over the past 50 years.
- 119. ChokoriaSundarbans, Bangladesh - Flooded mangroves. Rising ocean levels have flooded about 18,500 acres (7,500 hectares) of mangrove forest during the past three decades. Global sea-level rise is aggravated by substantial deltaic subsidence in the area with rates as high as 5.5 mm/year.
- 120. China - Rising waters and temperature. The average rate of sea-level rise was 0.09 +/- 0.04 inches (2.3 +/- 0.9 mm) per year over the last 30 years. Global sea-level rise was aggravated locally by subsidence of up to 2 inches (5 cm) per year for some regions due to earthquakes and groundwater withdrawal. Also, ocean temperatures off the China coast have risen in the last 100 years, especially since the 1960s.

Impact of Global Warming in Asia

- 126. Bhutan - Melting glaciers swelling lakes. As Himalayan glaciers melt glacial lakes are swelling and in danger of catastrophic flooding. Average glacial retreat in Bhutan is 100-130 feet (30-40 m) per year. Temperatures in the high Himalayas have risen 1.8F (1C) since the mid 1970s.
- 127. India - Himalayan glaciers retreating. Glaciers in the Himalayas are retreating at an average rate of 50 feet (15 m) per year, consistent with the rapid warming recorded at Himalayan climate stations since the 1970s. Winter stream flow for the Baspa glacier basin has increased 75% since 1966 and local winter temperatures have warmed, suggesting increased glacier melting in winter.
- 130. Mt. Everest - Retreating glacier.TheKhumbu Glacier, popular climbing route to the summit of Mt. Everest, has retreated over 3 miles (5 km) since 1953. The Himalayan region overall has warmed by about 1.8F (1C) since the 1970s.
- 131. Kyrgyzstan - Disappearing glaciers. During 1959-1988, 1,081 glaciers in the Pamir-Altai disappeared. Temperatures in the mountains of Kyrgyztan have increased by 0.9-2.7F (0.5-1.5C) since the 1950s.
- 142. Siberia - Melting permafrost. Large expanses of tundra permafrost are melting. In some regions the rate of thawing of the upper ground is nearly 8 inches (20 cm) per year. Thawing permafrost has already damaged 300 buildings in the cities of Norilsk and Yakutsk. In Yakutsk, the average temperature of the permanently frozen ground has warmed by 2.7 F (1.5C) during the past 30 years.

Impact of Global Warming in Asia

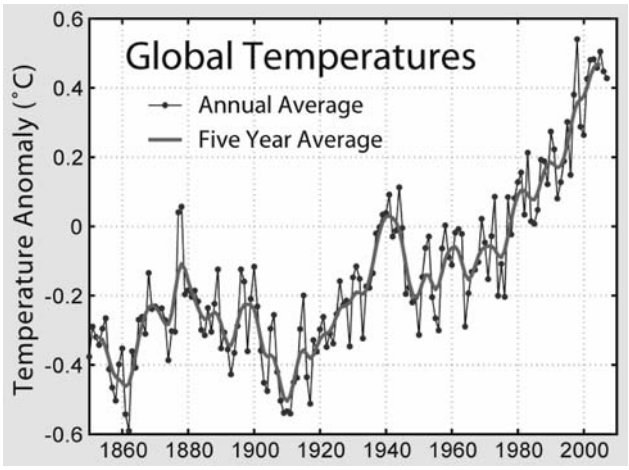
- 18. Indonesia -- Malaria spreads to high elevations. Malaria was detected for the first time as high as 6,900 feet (2103 m) in the highlands of Irian Jaya in 1997.
- 50. Philippines -- Coral reef bleaching.
- 51. Indian Ocean -- Coral reef bleaching (inclues Seychelles; Kenya; Reunion; Mauritius; Somalia; Madagascar; Maldives; Indonesia; Sri Lanka; Gulf of Thailand [Siam]; Andaman Islands; Malaysia; Oman; India; and Cambodia).
- 52. Persian Gulf -- Coral reef bleaching.
- 77. Korea -- Heavy rains and flooding. Severe flooding struck during July and August, 1998, with daily rainfall totals exceeding 10 inches (25.4 cm).
- 87. Indonesia -- Burning rainforest, 1998. Fires burned up to 2 million acres (809,371 hectares) of land, including almost 250,000 acres (101,172 hectares) of primary forest and parts of the already severely reduced habitat of the Kalimantan orangutan.

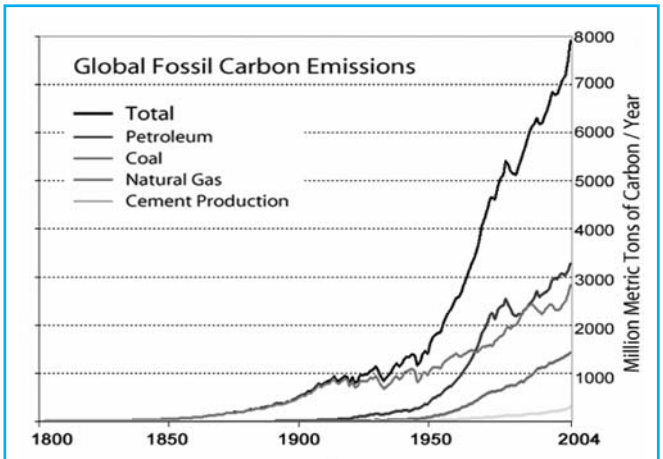
Impact of Global Warming in Asia

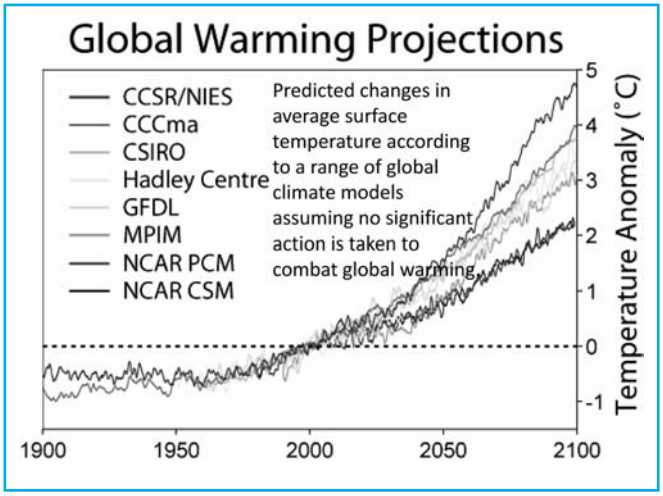
- 88. Khabarovsk, Russia -- Wildfires threaten tiger habitat, 1998. Drought and high winds fueled fires that destroyed 3.7 million acres (1,497,337 hectares) of taiga and threatened two important nature reserves that are habitat for the only remaining Amur tigers.
- 103. Bangladesh - Link between stronger El Nino events and cholera prevalence. Researchers found a robust relationship between progressively stronger El Nino events and cholera prevalence, spanning a 70-year period from 1893-1940 and 1980-2001. There has been a marked intensification of the El Nino/Southern Oscillation phenomenon since the 1980s, which is not fully explained by the known shifts in the Pacific basin temperature regime that began in the mid-1970s. Findings by Rodo et al. are consistent with model projections of El Nino intensification under global warming conditions. The authors make a strong case for the climate-health link by providing evidence for biological sensitivity to climate, meteorological evidence of climate change, and evidence of epidemiological change with global warming. The study likely represents the first piece of evidence that warming trends over the last century are affecting human disease.

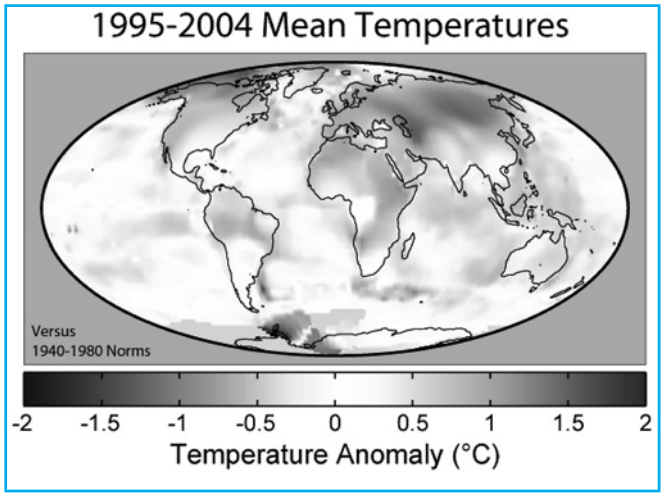
Impact of Global Warming in Asia

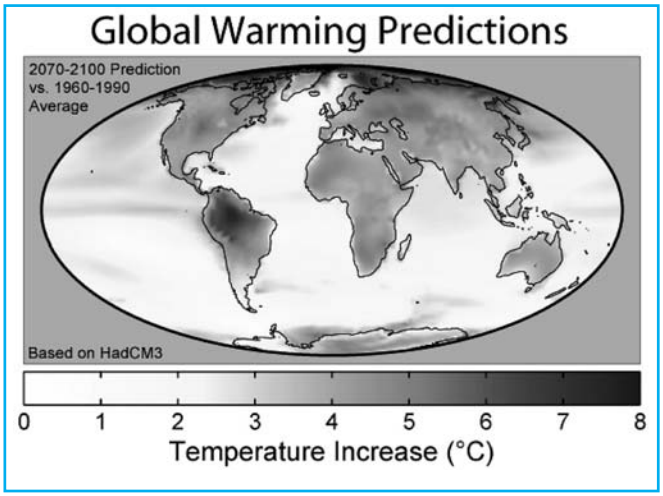
- 105. Lake Baikal, Russia - Shorter freezing period. Winter freezing is about 11 days later and spring ice breakup is about 5 days earlier compared to a century ago. Some regions of Siberia have warmed by as much as 2.5F (1.4C) in just 25 years.
- 147. Iran - Desiccated wetlands, 2001 Ninety percent of wetlands have dried up after 2 years of extreme drought. Much of South West Asia has experienced a prolonged three-year drought that is unusual in its magnitude. Out of 102 years of record, 1999, 2000, and 2001 rank as the fifth, third, and seventh driest on record. 1999-2000 was the driest winter on record.
- 148. Pakistan - Longest drought on record, 1999-2001. The prolonged three-year drought, which covers much of South West Asia, has affected 2.2 million people and 16 million livestock in Pakistan.
- 149. Tajikistan - Lowest rainfall in 75 years, 2001. 2001 marked the third consecutive year of drought, which has destroyed half the wheat crop.
- 150. Korea - Worst drought in 100 years of record, 2001. It coincided with an average annual temperature increase in Asia's temperate region, which includes Korea, by more than 1.8F (1C) over the past century. The warming has been most pronounced since 1970.
- 155. China - Disappearing Lakes, 2001. More than half of the 4,000 lakes in the Qinghai province are disappearing due to drought. The severity of the impact is exacerbated by overpumping of aquifers. Annual average temperature in China has increased during the past century, with pronounced warming since 1980. Most of the warming has been in northern areas, including Qinghai Province, and in the winter.



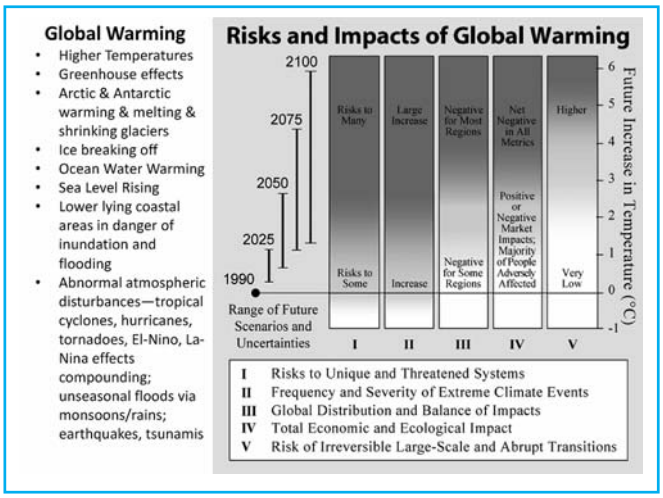


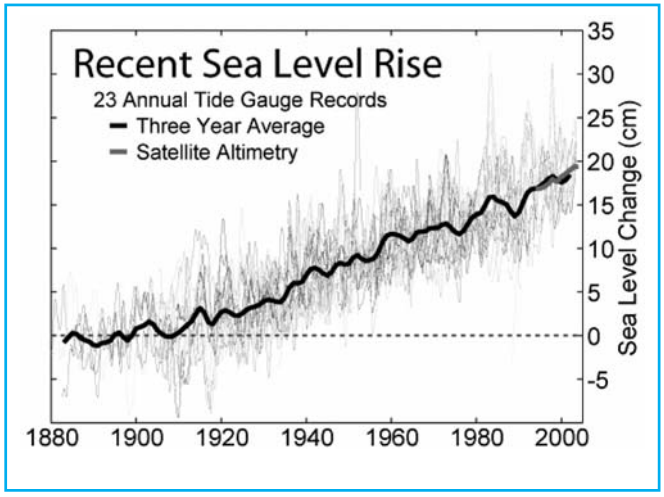


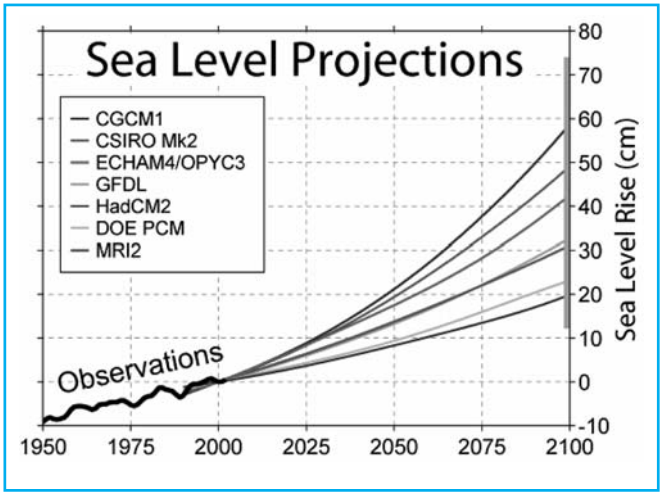

1995-2004 Mean Temperatures
Versus
1940-1980 Norms
-2 -1.5 -1 -0.5 0 0.5 1 1.5 2
Temperature Anomaly (°C)

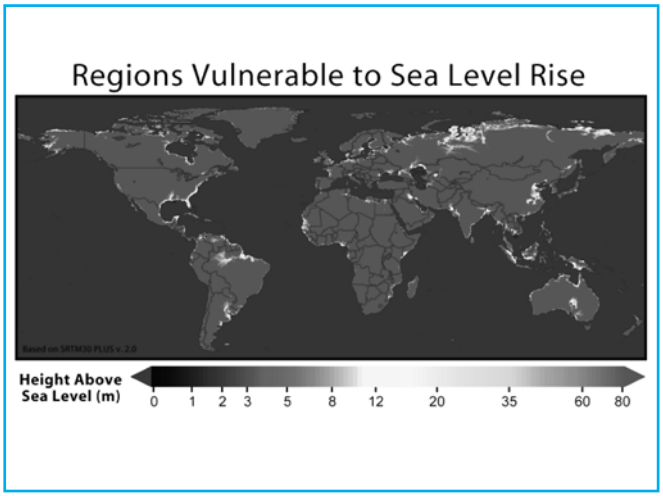

Global Warming Predictions
2070-2100 Prediction
vs. 1960-1990
Average
Based on HadCM3
0 1 2 3 4 5 6 7 8
Temperature Increase (°C)

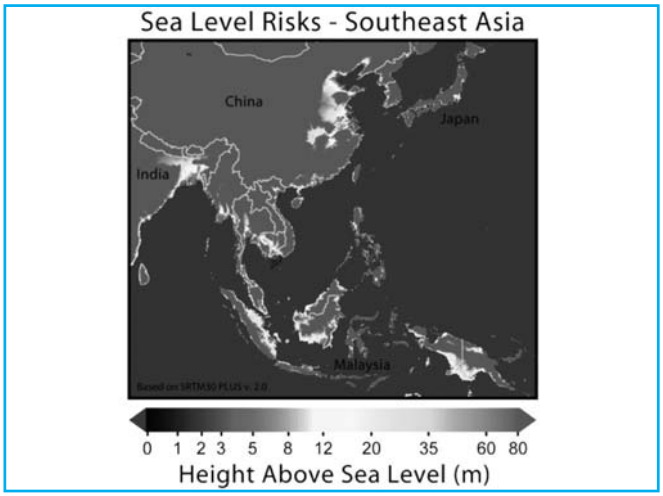

Earth's in Heat

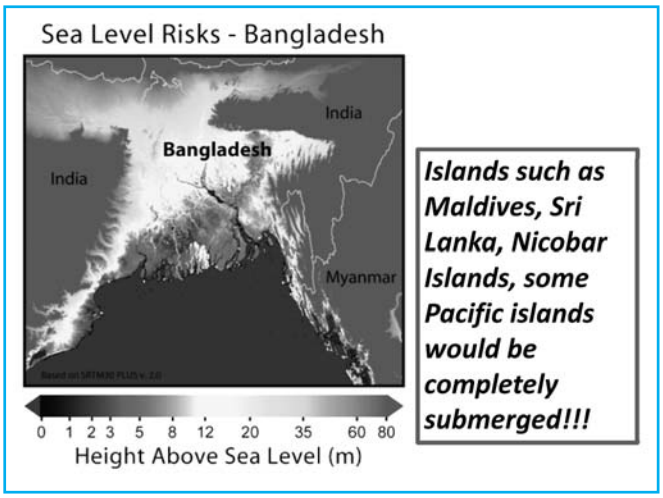

Global Warming
Higher Temperatures
Greenhouse effects
Arctic & Antarctic warming & melting & shrinking glaciers
Ice breaking off
Ocean Water Warming
Sea Level Rising
Lower lying coastal areas in danger of inundation and flooding
Abnormal atmospheric disturbances—tropical cyclones, hurricanes, tornadoes, El-Nino, La-Nina effects compounding; unseasonal floods via monsoons/rains; earthquakes, tsunamis
Risks and Impacts of Global Warming
2100
2075
2050
2025
1990
Risks to Many
Large Increase
Negative for Most Regions
Net Negative in All Metrics
Higher
Risks to Some
Increase
Negative for Some Regions
Positive or Negative Market Impacts; Majority of People Adversely Affected
Very Low
Future Increase in Temperature (°C)
Range of Future Scenarios and Uncertainties
I II III IV V
I Risks to Unique and Threatened Systems
II Frequency and Severity of Extreme Climate Events
III Global Distribution and Balance of Impacts
IV Total Economic and Ecological Impact
V Risk of Irreversible Large-Scale and Abrupt Transitions

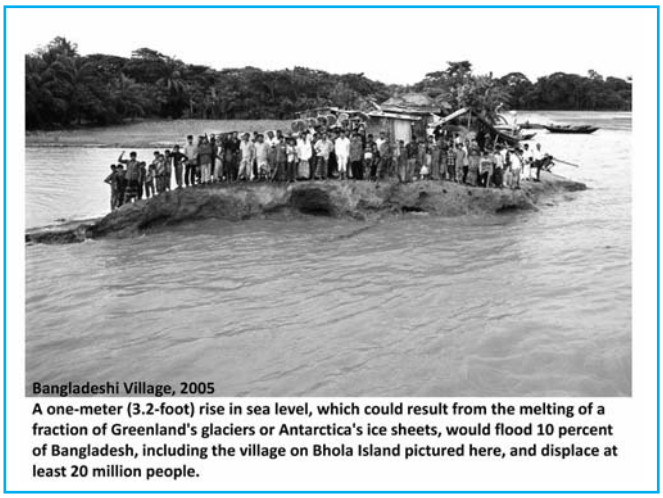

Recent Sea Level Rise
23 Annual Tide Gauge Records
Three Year Average
Satellite Altimetry
Sea Level Change (cm)
1880 1900 1920 1940 1960 1980 2000

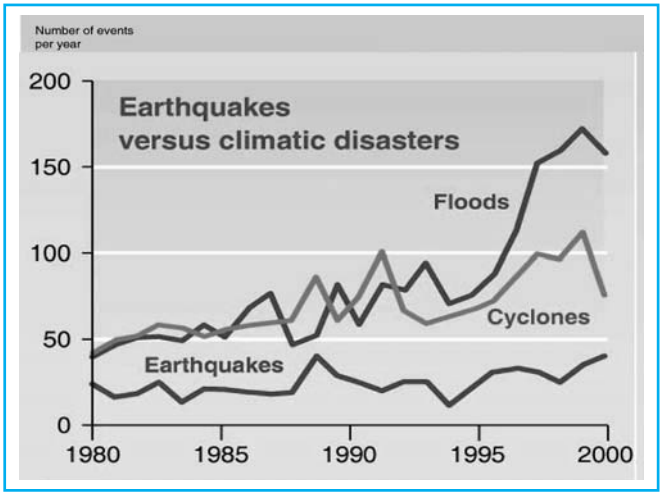

Sea Level Projections
CGCM1
CSIRO Mk2
ECHAM4/OPYC3
GFDL
HadCM2
DOE PCM
MRI2
Observations
Sea Level Rise (cm)
1950 1975 2000 2025 2050 2075 2100


Regions Vulnerable to Sea Level Rise
Height Above Sea Level (m)
0 1 2 3 5 8 12 20 35 60 80

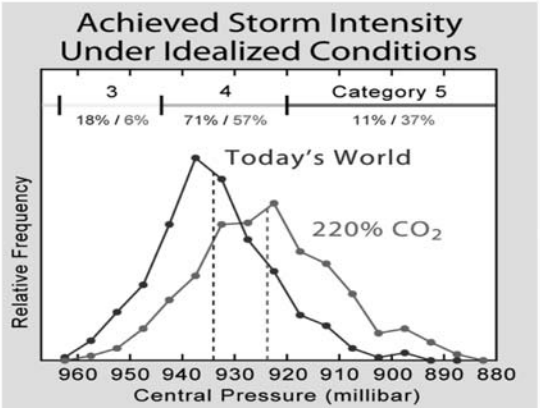

Sea Level Risks - Southeast Asia
China
Japan
India
Malaysia
0 1 2 3 5 8 12 20 35 60 80
Height Above Sea Level (m)


Sea Level Risks - Bangladesh
India
Bangladesh
India
Myanmar
0 1 2 3 5 8 12 20 35 60 80
Height Above Sea Level (m)
Islands such as Maldives, Sri Lanka, Nicobar Islands, some Pacific islands would be completely submerged!!!

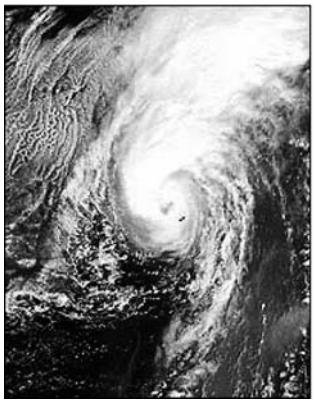

Bangladeshi Village, 2005
A one-meter (3.2-foot) rise in sea level, which could result from the melting of a fraction of Greenland's glaciers or Antarctica's ice sheets, would flood 10 percent of Bangladesh, including the village on Bhola Island pictured here, and displace at least 20 million people.


Number of events per year
200
150
100
50
0
Earthquakes versus climatic disasters
Floods
Cyclones
Earthquakes
1980
1985
1990
1995
2000

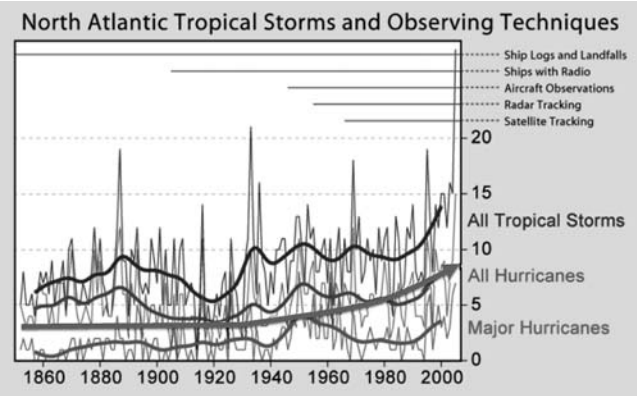
Global warming may be responsible in part for some trends in natural disasters such as extreme weather.

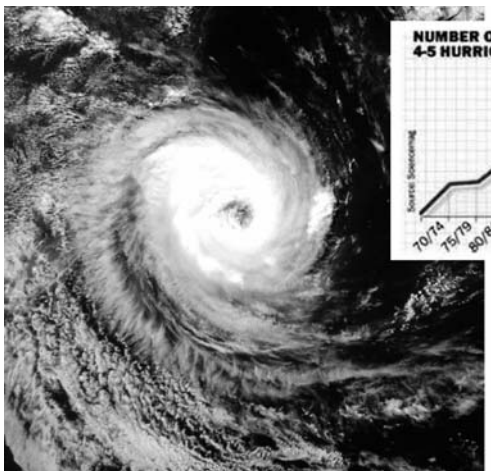


HURRICANE KATRINA



- Hurricane Katrina a few hours before it struck Louisiana, resulting in flooding and catastrophic damage to New Orleans.
- This hurricane resulted in ~$80 billion dollars of damage and killed at least 1,700 people, making it the deadliest hurricane in the United States since 1928 and the most expensive natural disaster in United States history.



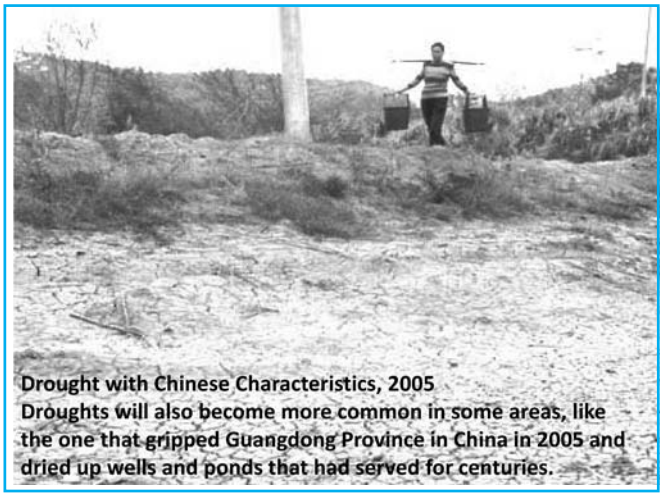


Climate scientist Kerry Emanuel of the Massachusetts Institute of Technology published a prophetic report: **Warming ocean temperatures are making hurricanes more powerful**

- The basic physics is simple enough. A storm gets its potential energy from the ocean, and the warmer the ocean is, the more energy the storm should be able to draw on. In studying the way that tropical storms in turn affect ocean currents, Emanuel developed a measure, or metric, of the power released by a storm over its lifetime.
- As he played with the data he discovered a surprisingly tight match between the surface temperature of the Atlantic Ocean and the intensity of storms that had brewed atop it. "The thing that really struck me is how beautifully this metric is correlated with sea surface temperature," he observes.
- ***What is more, according to his measure, storms in the Atlantic and western North Pacific were 40 to 50 percent more powerful in the last 20 years compared to the previous 20.***

Storms More Powerful, Destructive...

- "Even if we take the extreme of these error estimates, we are left with a significant trend since 1890 and a significant trend in major hurricanes starting anytime before 1920," say atmospheric scientists Greg Holland of the National Center for Atmospheric Research in Boulder, Colo., and Peter Webster of the Georgia Institute of Technology in Atlanta.
- Looking at data from 1855 through 2005, Webster and Holland found that the total number of tropical cyclones per year doubled in that time, from an average of six at the beginning of last century to 14 over the past decade. And the present regime has yet to stabilize: "With increasingly higher sea surface temperatures it is hard to imagine anything lower than 15 storms per year" going forward, the two conclude.
- Globally, areas of warm ocean have nearly tripled in size since the beginning of the 20th century, from roughly 17 million square miles to more than 46 million square miles, Webster and Holland note. "There has been an average of one additional tropical cyclone for each 0.1-degree Celsius increase in sea surface temperature and one hurricane for each 0.2-degree Celsius rise," they write in Philosophical Transactions of the Royal Society.



Drought with Chinese Characteristics, 2005
Droughts will also become more common in some areas, like the one that gripped Guangdong Province in China in 2005 and dried up wells and ponds that had served for centuries.

Penguin Peril, 2000
Islets off of Antarctica's Anvers Island have lost half of their nesting pairs of Adélie penguins (Pygoscelisadeliae) since the 1970s. This rookery that has existed for at least 600 years must move because of rising temperatures and changing ice cover.

Modern Atlantis, 2005
The children of Tuvalu, an island nation in the South Pacific just 16.5 feet (five meters) above sea level at its highest point, wait out an inundating high tide, more common with each passing year, on their "kaupapa," an outdoor sleeping platform.

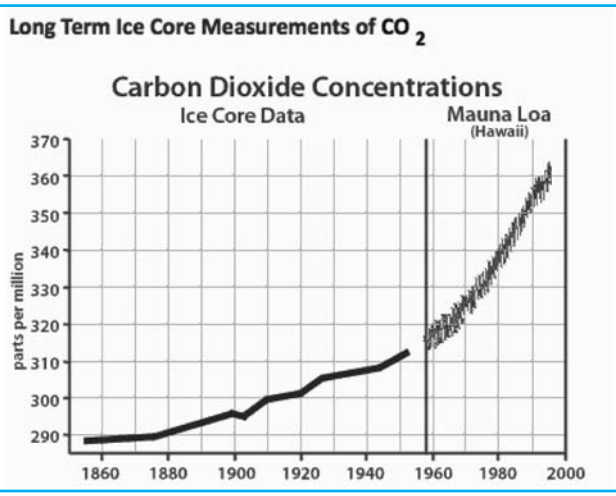
Winds of Change, 2004
Renewable sources of energy, such as the wind farm pictured here in Rockville, Ill., offer hope of alternatives to the fossil fuels, such as coal, that emit the greenhouse gases, which cause climate change when burned.

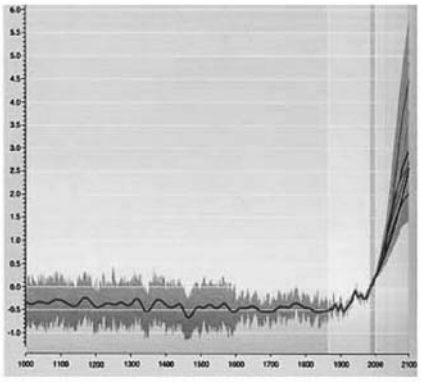
Is there Global Warming?

- Global warming is the increase in the average measured temperature of the Earth's near-surface air and oceans since the mid-20th century, and its projected continuation.
- Global surface temperature increased 0.74 ± 0.18 ° C (1.33 ± 0.32 ° F) during the 100 years ending in 2005.[1][2]
- The Intergovernmental Panel on Climate Change (IPCC) concludes "most of the observed increase in globally averaged temperatures since the mid-twentieth century is very likely due to the observed increase in anthropogenic greenhouse gas concentrations"[3][4] via an enhanced greenhouse effect.
- Climate model projections summarized by the IPCC indicate that average global surface temperature will likely rise a further 1.1 to 6.4 ° C (2.0 to 11.5 ° F) during the twenty-first century.[3]

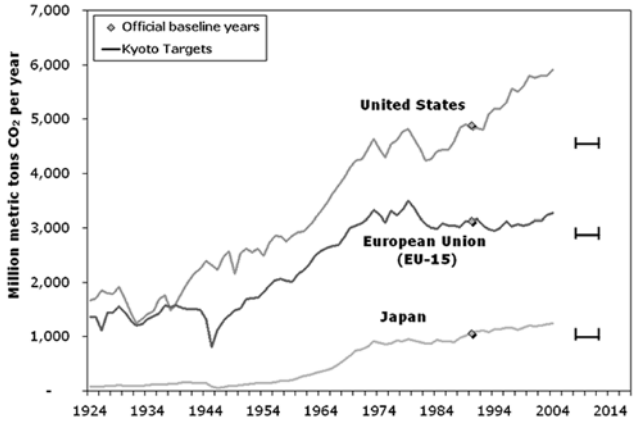
Global Warming Effects:

- Increasing global temperature is expected to:
  - cause sea levels to rise,
  - an increase in the intensity of extreme weather events, and
  - significant changes to the amount and pattern of precipitation, likely leading to an expanse of tropical areas and increased pace of desertification.
- Other expected effects of global warming include:
  - changes in agricultural yields,
  - modifications of trade routes,
  - glacier retreat,
  - mass species extinctions and
  - increases in the ranges of disease vectors.





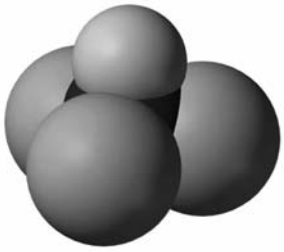
Earth's average temperature from 1000 CE to 2100 CE.

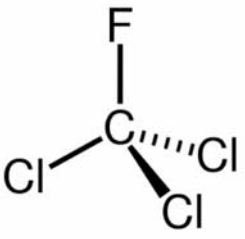


Kyoto Protocol, 1997

- The Kyoto Protocol is a protocol to the international Framework Convention on Climate Change
- It was adopted for use on 11 December 1997 by the 3rd Conference of the Parties, which was meeting in Kyoto, and it entered into force on 16 February 2005.
- As of May 2008, 1,823 parties have ratified the protocol, and a total of 181 countries and 1 regional economic integration organization (the EEC) have ratified the agreement (representing over 61.6% of emissions from Annex I countries).[1]
- Of these, 36 developed C.G. countries (plus the EU as a party in the European Union to a 10% emissions increase for Iceland; but, since the EU's member states each have individual obligations,[2] much larger increases (up to 27%) are allowed for some of the less developed EU countries (see below #Increase in greenhouse gas emission since 1990). [2] Reduction limitations expire in 2013.

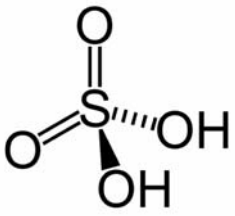
trichlorofluoromethane

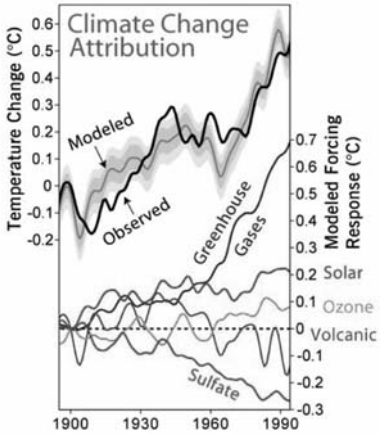




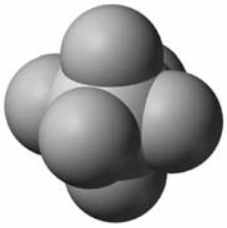
(also known as CFC-11)

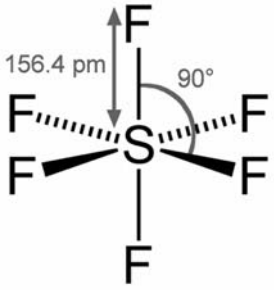
Sulfuric Acid



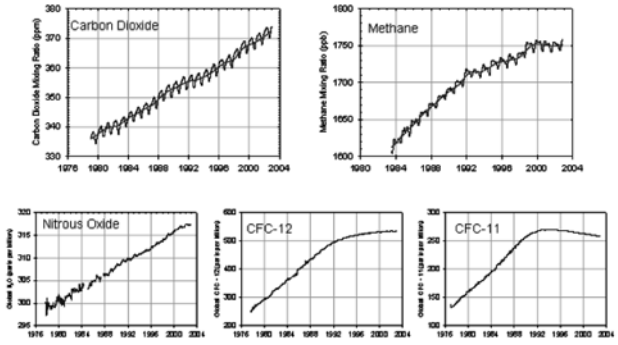


Sulfur hexafluoride is the most potent known greenhouse gas, with a per molecule global warming potential at 100 years of 22,000 times that of carbon dioxide.





Global Trends in Major Greenhouse Gases to 1/2003



Global trends in major long-lived greenhouse gases through the year 2002. These five gases account for about 97% of the direct climate forcing by long-lived greenhouse gas increases since 1750. The remaining 3% is contributed by an assortment of 10 minor halogen gases, mainly HCFC-22, CFC-113 and CCl_4.

Objectives:

- The objective is to achieve "stabilization of greenhouse gas concentrations in the atmosphere at a level that would prevent dangerous anthropogenic interference with the climate system."[3]
- The Intergovernmental Panel on Climate Change (IPCC) has predicted an average global rise in temperature of 1.4° C (2.5° F) to 5.8° C (10.4° F) between 1990 and 2100.[4]
- Proponents also note that Kyoto is a first step[5][6] as requirements to meet the UNFCCC will be modified until the objective is met, as required by UNFCCC Article 4.2(d).[7]

Participation in the Kyoto Protocol: green indicates states parties, yellow indicates states with ratification pending, and red indicates those that signed but declined ratification of the treaty.

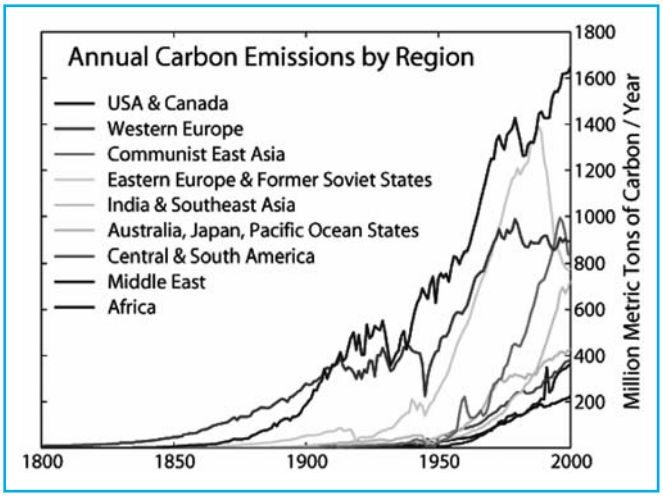
United Nations Environment Programme:

- "The Kyoto Protocol is an agreement under which industrialized countries will reduce their collective emissions of greenhouse gases by 5.2% compared to the year 1990 (but note that, compared to the emissions levels that would be expected by 2010 without the Protocol, this limitation represents a 29% cut).
- The goal is to lower overall emissions of six greenhouse gases - carbon dioxide, methane, nitrous oxide, sulfur hexafluoride, hydrofluorocarbons, and perfluorocarbons - averaged over the period of 2008-2012.
- National limitations range from 8% reductions for the European Union and some others to 7% for the US, 6% for Japan, 0% for Russia, and permitted increases of 8% for Australia and 10% for Iceland.[9]

Common but differentiated responsibility

The United Nations Framework Convention on Climate Change agreed to a set of a "common but differentiated responsibilities." The parties agreed that:

1. the largest share of historical and current global emissions of greenhouse gases has originated in developed countries;
2. per capita emissions in developing countries are still relatively low, and
3. the share of global emissions originating in developing countries will grow to meet their social and development needs.



Country	Change in greenhouse gas Emissions (1990-2004)
US	+15.8%
Russian Federation	-32%
China	+47%
India	+55%

	Temperature change relative to 1900		
	1940	1970	1994
Greenhouse gases	0.10	0.38	0.69
Sulfate emissions	-0.04	-0.19	-0.27
Solar forcing	0.18	0.10	0.21
Volcanic forcing	0.11	-0.04	-0.14
Ozone	-0.06	0.05	0.08
Net	**0.19**	**0.17**	**0.53**
Observed	**0.26**	**0.21**	**0.52**

	Anthropogenic sources	Total global emissions (for 1990, in metric tons)	Atmospheric lifetime (in years)	Direct global warming potential over 100 years
Carbon dioxide	Burning of fossil fuels, cement manufacture, deforestation and other land-use changes	7.1 Gt (in C equiv.)* (1 Gt = 1 gigaton or 1 billion tons)	120	1
Methane	Livestock, wet rice agriculture, solid waste, coal mining, oil & gas production, biomass burning	310 Mt CH4 (1Mt = 1 million tons)	12	21
Nitrous oxide	Nylon production, nitric acid production, biomass burning, cultivated soils, automobiles with three-way catalysts	6.7 Mt (in N equiv.)**	120	270

Sources: Carbon Dioxide Information Analysis Center. 2000. Current Greenhouse Gas Concentrations. (available online at http://cdiac.esd.ornl.gov/pns/current_ghg.html; Sturges, W.T. et al. 2000. A potent greenhouse gas identified in the atmosphere: SF5CF3. Science 289: 611-613.

	Anthropogenic sources	Total global emissions (for 1990, in metric tons)	Atmospheric lifetime (in years)	Direct global warming potential over 100 years
Chlorofluoro-carbons (CFCs)	Chemical products & processes, including refrigeration, industrial solvents, blown-foam insulation	1,672 Mt (for all CFC/HFC/HCFC total in C equiv.)	50->100	3,800 -- 8,100
CFC substitutes (HCFCs and HFCs)	Same usage as CFCs	See above	Varies by orders of magnitude	Varies by orders of magnitude
Sulphur hexafluoride (SF6)	Chemical products and processes	37.7 Mt (in C equiv.)	3,200	23,900
Trifluoro-methyl sulphur pentafluoride (SF5CF3)	Unknown	Minimal, growing fast	~1,000	~18,000

IPCC. 1995. Climate Change 1995: The Science of Climate Change, Radiative Forcing of Climate Change. New York: Cambridge University Press, pp. 65-132; IPCC. 2000. IPCC Special Report: Emission Scenarios, Summary for Policymakers. (available online at http://sres.ciesin.org/.

Post-Kyoto Protocol negotiations on greenhouse gas emissions

- In the non-binding 'Washington Declaration' agreed on 16 February 2007, Heads of governments from Canada, France, Germany, Italy, Japan, Russia, United Kingdom, the United States, Brazil, China, India, Mexico and South Africa agreed in principle on the outline of a successor to the Kyoto Protocol. They envisage a global cap-and-trade system that would apply to both industrialized nations and developing countries, and hoped that this would be in place by 2009.[97][98]
- On 7 June 2007, leaders at the 33rd G8 summit agreed that the G8 nations would 'aim to at least halve global CO2 emissions by 2050'. The details enabling this to be achieved would be negotiated by environment ministers within the United Nations Framework Convention on Climate Change in a process that would also include the major emerging economies.[99]

Post-Kyoto Protocol negotiations

- A round of climate change talks under the auspices of the United Nations Framework Convention on Climate Change (UNFCCC) (Vienna Climate Change Talks 2007) concluded in 31 August 2007 with agreement on key elements for an effective international response to climate change.[100]
- A key feature of the talks was a United Nations report that showed how energy efficiency could yield significant cuts in emissions at low cost.
- The talks are meant to set the stage for a major international meeting to be held in Nusa Dua, Bali, which started on 3 December 2007.[101]
- The 2008 Conference will be held in December 2008 in Poznań, Poland and the 2009 Conference is scheduled to be held in December 2009 in Copenhagen, Denmark.

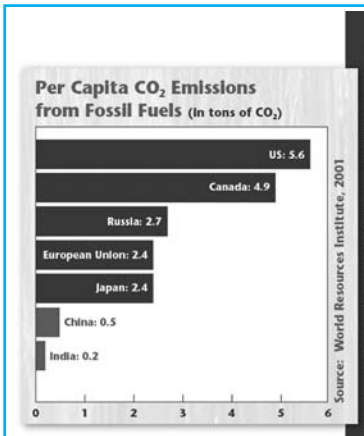
The Asia-Pacific Partnership on Clean Development and Climate, also known as AP6, is an international non-treaty agreement among Australia, Canada, India, Japan, the People's Republic of China, South Korea, and the United States announced July 28, 2005 at an Association of South East Asian Nations (ASEAN) Regional Forum meeting and launched on January 12, 2006 at the Partnership's inaugural Ministerial meeting in Sydney.

COMMON SENSE ON CLIMATE CHANGE

Practical Solutions to Global Warming

Union of Concerned Scientists

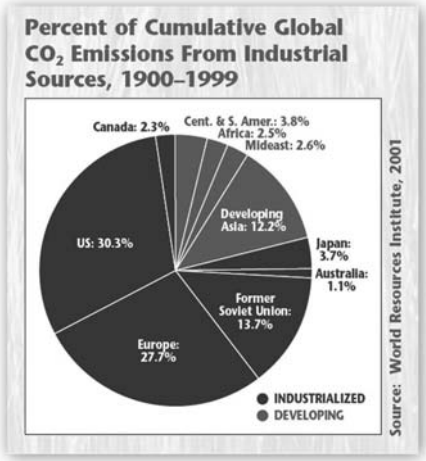
CO_2 remains in the atmosphere for about 100 years.

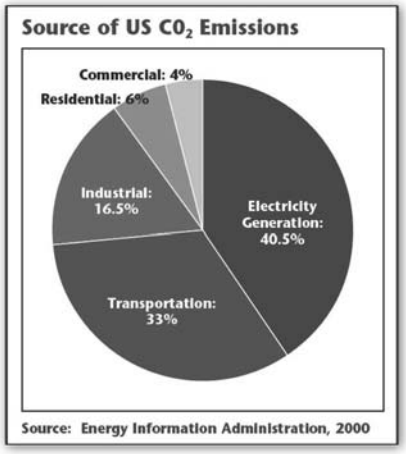


Dumping in Our Oceans

Although a few government agencies and private-sector researchers are exploring the possibility of "fertilizing" our oceans with iron to enhance their natural capacity to absorb carbon, it is unwise to clean up our atmosphere at the expense of our oceans. This approach holds serious risks for marine animals and plants, disrupting the marine web of life.

Another form of marine sequestration, which involves injecting liquid carbon compounds into the deep ocean, is also being explored. Environmental consequences are not yet understood. We must fully evaluate its impacts before any widespread application.





...in the past two decades, energy-efficiency standards kept

53 million tons

of heat-trapping gases out of the air each year.

The Asia-Pacific Partnership on Clean Development and Climate

- Member countries account for around 50% of the world's greenhouse gas emissions, energy consumption, GDP and population.
- Unlike the Kyoto Protocol (currently unratified by the United States), which imposes mandatory limits on greenhouse gas emissions, this agreement allows member countries to set their goals for reducing emissions individually, with *no mandatory enforcement mechanism.*
- This has led to criticism that the Partnership is worthless, by other governments, climate scientists and environmental groups.

APPCDC countries:

- Australia
- China
- Canada
- India
- Japan
- South Korea
- United States

Areas for collaboration

The intent is to:

* develop, deploy and transfer existing and emerging clean technology;
* meet increased energy needs and explore ways to reduce the greenhouse gas without hurting the economies
* build human and institutional capacity to strengthen cooperative efforts; and
* seek ways to engage the private sector.

Asia-Pacific Partnership on Clean Development and Climate, AP7

The Partnership's inaugural Ministerial meeting established eight government and business taskforces [4] on

1. cleaner fossil energy
2. renewable energy and distributed generation
3. power generation and transmission
4. steel
5. aluminum
6. cement
7. coal mining
8. buildings and appliances

Is it too Expensive?

We can't possibly afford it, can we?

- Outgoing US President George W. Bush has argued that addressing global warming could hurt the economy by imposing costly pollution controls on businesses. The International Energy Agency estimated in a June report that the ***world needs to invest $45 trillion to halve greenhouse gas emissions by 2050.***
- But global warming activists say such measures could in fact hasten the end of the economic downturn, for example by weaning major economies from fossil-fuel dependence and developing renewable energy.
- The team of President-elect Barack Obama believes climate change and the economy can be addressed at the same time, according to Alden Meyer, of the Union of Concerned Scientists:
- ***"Clean energy investments and making the economy more efficient — they see that as a key part of the economic revitalisation strategy. The solutions to global warming are the same things as the solutions to the economy."***

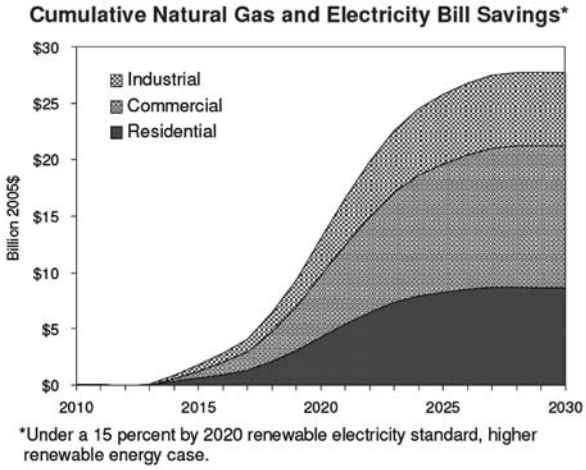
What about local/regional initiatives?

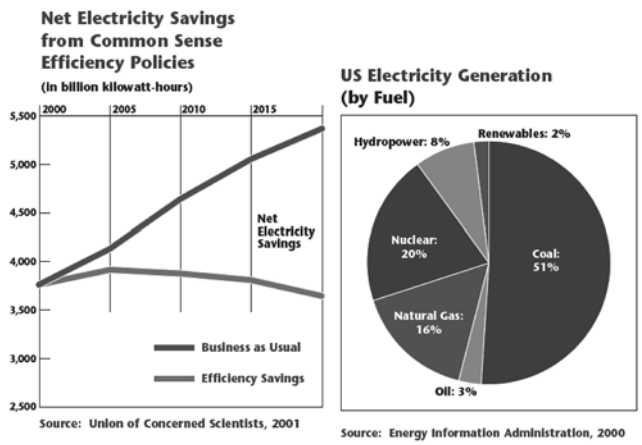
- Most developed nations, around the Asia Pacific and Oceanic islands (except perhaps Japan, S. Korea, Taiwan, Hong Kong, Singapore, NZ and Australia) are still grappling with development & poverty eradication, and now the whopping recession
- It will be difficult for governments to accede to environmentalist concerns especially for short-term objectives which are costly—this is where we need to advocate, lobby and help them focus on the longer term and the future, not for ourselves alone but for our children and our children's children...
- For Malaysia, global warming and climate change figure very little if at all in our development plans, except for pollution controls

Environment	9th Malaysia Development Plan: Mid-term Review—Environmental Commitments
▪ Sulphur content to be reduced in diesel from 3,000 ppm to 500 ppm while petrol from 1,500 ppm to 500 ppm	▪ Improved air quality
▪ Polluted river basins to be upgraded from Class III category to Class II category through the Pollution Prevention and River Water Quality Upgrading Programme	▪ Improved river water quality
▪ A database on Malaysia's biodiversity to be established	▪ Better management of biodiversity
▪ Capability in legal issues regarding biodiversity, biotechnology and biosafety in Malaysia to be enhanced	
▪ Master plans based on integrated and holistic approach to be drawn up as long-term solution for flood incidences especially in the flood-prone areas	▪ Reduced incidences of floods

What about local/regional initiatives?

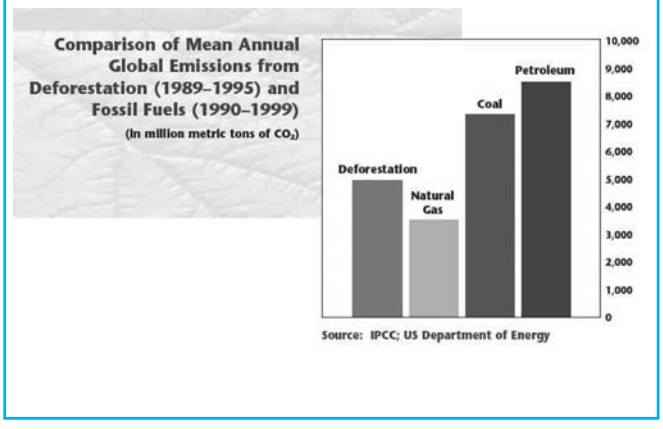
- Sustainable forest conservation is also without far-reaching or committed efforts—most governments think of development (human and physical) which is at the expense of the environment and also of natural forests/jungles/green biodiversity-rich tracts, which have been transformed into one-dimensional plantations (oil palm, rubber, arable rice paddy growing, tobacco even, etc.) Cash and export markets dictate policies, and now with possible bio-fuel interests would compete with efforts to preserve, rather than to transform huge dramatic changes...
- Other energy modes must be encouraged and invested in, e.g. wind, wave, geothermal, even hydro-electric (dilemma of huge dams, river diversions, etc.); low-emission fuel efficient (hydrogen fuel cell technology) transport alternatives, energy saving initiatives e.g. lighting changes, photo-voltaic bulbs, increased use of solar lighting and heating





Forest Conservation and Management

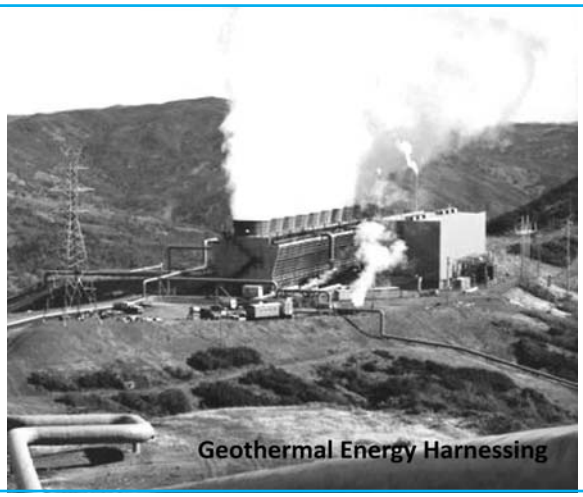
...forests play a critical role in climate change: they store carbon, the main ingredient of CO_2.

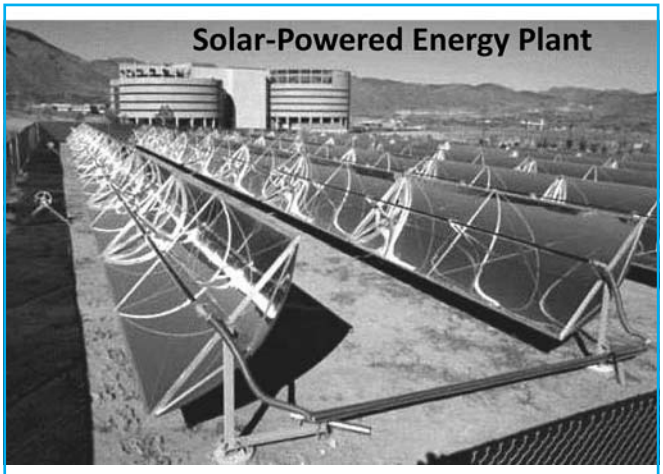


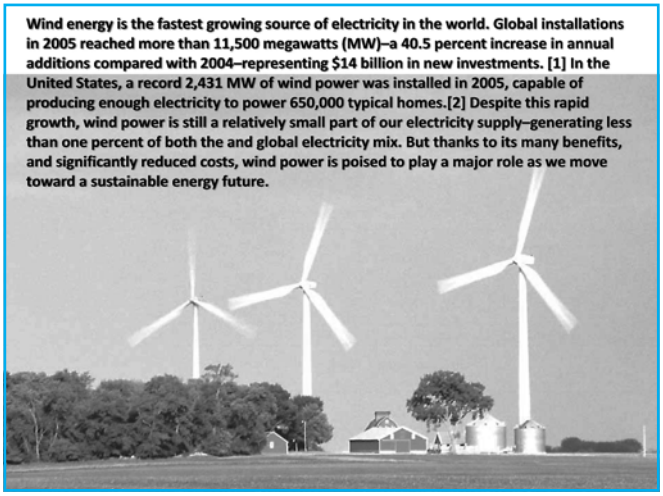
Tree Plantations

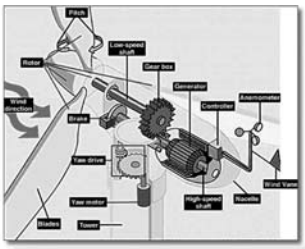
Clearing mature forests and replacing them with fast-growing younger trees is a mistake. To be sure, younger trees draw carbon out of the atmosphere more quickly. But cutting down mature forests releases large quantities of CO_2. And replacing natural forests with tree plantations destroys biodiversity—the web of life which many plants and animals depend on to survive.

The fuel cell ... which runs engines on hydrogen fuel and **emits only water vapor**, is key to moving our transportation system away from the polluting combustion engine.



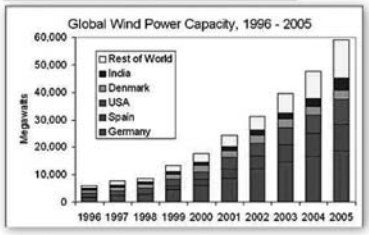


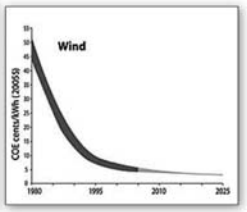


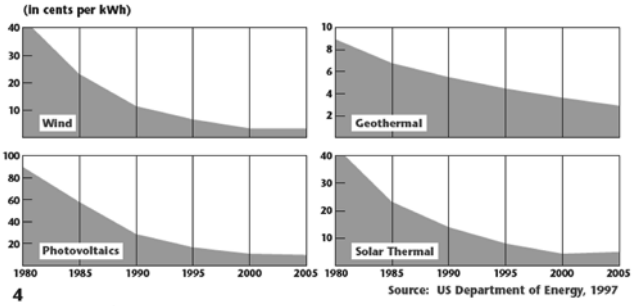


The Market for Wind

The cost of electricity from the wind has dropped from about 25 cents/kWh in 1981 to as low as 4-6 cents/kWh in recent years.



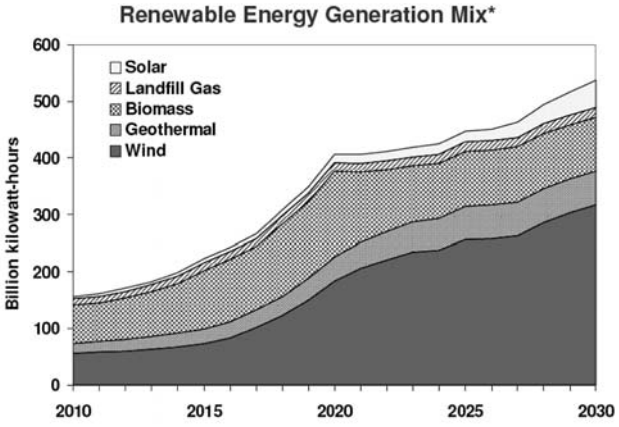




4

The Future of Wind Power

With increasingly competitive prices, growing environmental concerns, and the call to reduce dependence on foreign energy sources, a strong future for wind power seems certain. The World Wind Energy Association projects global wind capacity will double in size to over 120,000 MW by 2010, with much of the growth happening in the United States, India, and China. Turbines are getting larger and more sophisticated, with land-based turbines now commonly in the 1-2 MW range, and offshore turbines in the 3-5 MW range.



*Under a 15 percent by 2020 renewable electricity standard, higher renewable energy case.

Benefits of a 15 Percent by 2020 National Renewable Electricity Standard

Consumer Savings

- $13 billion to $18.1 billion in lower electricity and natural gas bills by 2020 (growing to $27.7 billion to $31.8 billion by 2030)

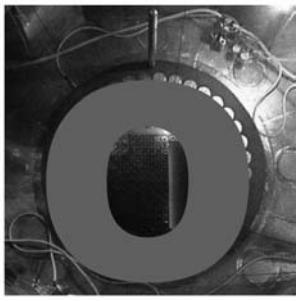
Energy Diversity

- Increase in clean, renewable energy capacity to between 3.6 and 4.5 times over 2005 levels

Global Warming Down Payment

- Reductions in global warming pollution equal to taking between 13.7 and 20.6 million cars off the road

Is Nuclear Power the Answer?



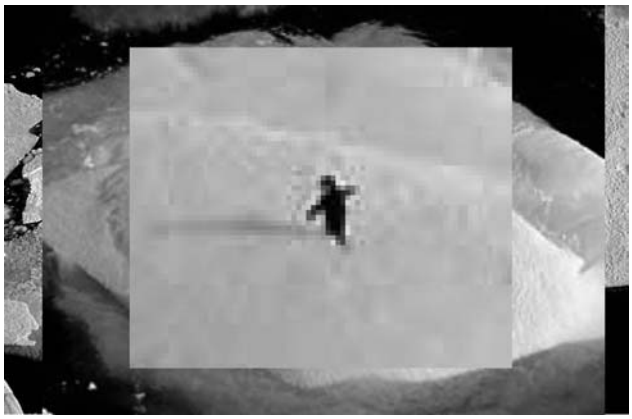
Coal

Some have likened the public relations term "clean coal" to "safe cigarettes." This term is applied to technologies intended to allow coal to burn with little pollution. But government reports show that these coal technologies have yet to prove effective. For example, the coal project at Fort Lonesome, Florida, deemed "the world's most advanced" plant of its kind by the Energy Department in 1996, emits seven times more pollution than a similar-sized natural gas plant. The fact is, coal-burning power plants remain the single biggest source of industrial air pollution. We have better options.

Nuclear power

Nuclear power plants do not emit heat-trapping gases, which might make them an attractive solution to climate change. But the wastes they do produce pose lethal hazards for future generations, and because their safety is often poorly regulated, there is a risk of catastrophic accidents.

Like large power plants that use oil and coal, as well as major pipelines and refineries, these facilities are vulnerable to terrorism and sabotage. Renewable energy facilities—such as windmills and solar panels—contain no radioactive, explosive, or flammable materials. And, since they are also decentralized, they are inherently less attractive targets.



[New Zealand]

A New Zealand Perspective

Peter FOLEY*[1]

Global warming and climate change is treated very seriously in New Zealand. According to the Ministry for the Environment: "If we do not take action to reduce global warming, the world is likely to experience a rise in temperature, increasing sea levels, more frequent extreme weather events and a change in rainfall patterns. These climatic changes will potentially impact on our native ecosystems, industries, infrastructure, health, biosecurity and our economy."

The New Zealand government's focus is on four areas:

- The need to be strategic as a country and think about where we want to be in 30–40 years time.
- Action is required on multiple fronts. This includes preparing for climate variability as well as reducing emissions.
- Climate change is a global issue and New Zealand needs to be influential.
- Industry, general public, businesses, and the international community need to be involved.

The NZMA is concerned about global warming because, if no action is taken, the long-term consequences present a major threat to public health. Climate change is expected to have consequences on economic development, food production, access to water, migration patterns and has the potential to affect transmission patterns of communicable diseases.

While different countries will be affected to different degrees, internationally, projected climate change, combined with poverty, population growth and other forms of environmental change, is expected to place serious stresses on many populations, and could potentially substantially increase the number of displaced people in the Asia Pacific region. Poor urbanised populations are highly vulnerable to adverse environmental and ecological circumstances, including extreme weather events, food shortages consequent to drought, flooding and other catastrophes, and rising sea levels.[1]

The potential health effects of climate change are:

- Thermal stress: deaths, illness. Injury/death from floods, storms, cyclones, bushfires. Effect of these events on food yields.
- Microbial proliferation: Food poisoning—*Salmonella* spp, etc.; unsafe drinking water.
- Changes in vector-pathogen-host relations and in infectious disease geography/seasonality—eg., malaria, dengue, tickborne viral disease, schistosomiasis.
- Impaired crop, livestock and fisheries yields, leading to impaired nutrition, health, survival.
- Loss of livelihoods, displacement, leading to poverty and adverse health; mental health, infectious diseases, malnutrition, physical risks.[2]

The New Zealand government has started a broad range of programmes, largely aimed at reducing greenhouse gas emissions, but also aimed to help New Zealand adapt to the inevitable impacts of climate change. (These may change under the new National-led Government). New Zealand's responses include:

- The Emissions Trading Scheme which places a price on greenhouse gas emissions to encourage New Zealand to reduce and take responsibility for its emissions. All major sectors and all Kyoto greenhouse gases will be covered by the scheme
- The Energy Strategy sets out the government's vision of a reliable and resilient energy system delivering New Zealand sustainable, low-emissions energy services and it describes the actions needed to make this vision a reality.
- The Energy Efficiency and Conservation Strategy is an action plan for energy efficiency and conservation. It aims to: promote sustainability as part of New Zealand's national identity; improve the quality of life for New Zealand families, and; drive economic transformation in business.
- The Sustainable Land Management and Climate Change Plan of Action allows the government to work in partnership the agricultural sector on initiatives that help farmers, growers,

*1 Chair, New Zealand Medical Association, Wellington, New Zealand (nzma@nzma.org.nz).

foresters, and other businesses in the land management sectors develop the skills, knowledge, technology, and management techniques to reduce their emissions and adapt to climate change.
- The Transport Strategy defines the Government's vision of an affordable, integrated, safe, responsive and sustainable transport system by 2010. One of its aims is to ensure environmental sustainability—policies will encourage usage of more energy efficient modes of transport and contribute to reducing greenhouse gas emissions from the transport sector.
- The Waste Strategy sets a new direction for minimizing the country's waste and for improving its recovery and management. It sets out a practical programme of large and small actions for the medium term, as well as some far-reaching, longer-term commitments.
- The adaptation work programme seeks to help New Zealanders prepare for the physical impacts of climate change and enhance our capacity to adapt to these changes.
- A public awareness and education programme aims to raise public awareness about climate change and sustainability, and inform New Zealanders about the actions they can take to reduce greenhouse gas emissions and becoming more sustainable.[3]

A number of New Zealand universities are carrying out important research on global warming and climate change. The New Zealand Climate Change Research Institute is based at Victoria University in Wellington. The University of Canterbury, which is focusing on environmental and climate change over the last 150,000 years in the South West Pacific, Southern Ocean and Antarctica. The University of Otago has an Oceans and Climate Change Research Centre.

As individual medical practitioners, what can we do?

The British Medical Association has done substantial work on this issue. It says there are a number of simple practical measures that healthcare professionals can take in order to reduce their negative impact on the environment. Initiatives include:
- Carry out a carbon audit at work to give a baseline from which targets can be set and progress monitored systematically from month to month and year to year.
- Electricity—increase energy efficiency and reduce costs (such as turning appliances off at the plug when not in use, rather than leaving them on standby; use energy saving light bulbs, and use fewer bulbs; use efficient lighting systems and maximise natural lighting).
- Reduce heating usage (such as turn down unnecessary heating and air-conditioning systems, and ensure refrigerators and freezers are set for optimal energy efficiency; use automatic time-controlled thermostats to ensure optimal usage and reduce costs; make the most of natural ventilation to cool buildings; install insulation to minimise heat loss).
- Increasing water efficiency (convert toilets from single to dual flush systems or install cistern regulators; repair all dripping taps and leaks immediately).
- Reducing the amount of waste produced (such as by communicating by email or telephone wherever possible, including using teleconferencing and videoconferencing whenever possible for meetings; request test results and other information to be sent to you by email [and not printed out]; manage files and patient records on computer to avoid the need for printed documents; ask to be taken off the direct mail lists of pharmaceutical companies and other businesses who regularly post you materials you do not read; when printing, try to reduce paper usage by printing on both sides of the page and only print the pages needed).
- Reduce, reuse and recycle: Rather than disposing of waste in landfill sites there are a number of measures that can be taken (such as do not overstock products/goods which may expire before use; reuse or recycle stationary and equipment where possible; use paper and tissues made from recycled materials; make clearly labelled recycling bins available to both patients and staff; arrange for printer toner cartridges to be collected for refill or recycling).
- Raise staff awareness about initiatives they can take, such as encouraging staff to take public transport or bike to work.[4]

"As well as reducing their own carbon footprint and negative environmental impact, health professionals are in a position to influence others and promote social change. Health professionals have a history of combating major public health concerns and are well placed to play a vital role in combating climate change and the related

adverse effects on health. Health professionals have a responsibility to highlight the public health risks of climate change as well as the numerous health benefits associated with more environmentally friendly economic activities and lifestyles. They can monitor and report health effects of environmental change, empower people to get involved in public debate and promote adaptive responses."[4]

Our health ultimately depends on having a healthy environment to sustain us. Climate change is the biggest environmental and health challenges of our time. Coordinated action from governments, business, the community and individuals internationally is needed to reduce global warming and climate change is essential if we are to protect the health of New Zealanders and the wider global community.

References

1. Climate change health impacts in Australia: Effects of dramatic CO_2 emission reductions. Report for the Australian Conservation Foundation and the Australian Medical Association; 2005.
2. McMichael AJ, Woodruff RE, Hales S. Climate change and human health: present and future risks. The Lancet. 2006;367: 859–869.
3. http://www.mfe.govt.nz/issues/climate/policies-initiatives/policies-strategies.html
4. http://www.bma.org.uk/ap.nsf/Content/climatechange~climatechangerecommendations

"If we do not take action to reduce global warming, the world is likely to experience a rise in temperature, increasing sea levels, more frequent extreme weather events and a change in rainfall patterns. These climatic changes will potentially impact on our native ecosystems, industries, infrastructure, health, biosecurity and our economy."

NZ Ministry for the Environment

The New Zealand government's focus is on four areas:

i. The need to be strategic as a country
ii. Action is required on multiple fronts
iii. Climate change is a global issue and New Zealand needs to be influential
iv. Industry, general public, businesses, and the international community need to be involved

Climate change is expected to have consequences on economic development, food production, access to water, migration patterns and has the potential to affect transmission patterns of communicable diseases.

Could potentially substantially increase the number of displaced people in the Asia Pacific region.

The potential health effects of climate change are:

- Thermal stress: deaths, illness. Injury/death from floods, storms, cyclones, bushfires. Effect of these events on food yields
- Microbial proliferation: Food poisoning – *Salmonella* spp, etc; unsafe drinking water
- Changes in vector-pathogen-host relations and in infectious disease geography/seasonality – eg, malaria, dengue, tickborne viral disease, schistosomiasis

The potential health effects of climate change are:

- Impaired crop, livestock and fisheries yields, leading to impaired nutrition, health, survival
- Loss of livelihoods, displacement, leading to poverty and adverse health; mental health, infectious diseases, malnutrition, physical risks.[2]

[2] McMichael AJ, Woodruff RE & Hales S (2006). Climate change and human health: present and future risks. The Lancet 367: 859-869.

New Zealand's responses include:

- The Energy Strategy
- The Energy Efficiency and Conservation Strategy
- The Sustainable Land Management and Climate Change Plan of Action
- The Transport Strategy
- The Waste Strategy
- The adaptation work programme
- A public awareness and education programme

As individual medical practitioners, what can we do?

- Carry out a carbon audit at work
- Electricity -- increase energy efficiency and reduce costs
- Reduce heating usage
- Increase water efficiency
- Reduce the amount of waste produced
- Reduce, reuse and recycle
- Raise staff awareness about initiatives they can take

- As well as reducing their own carbon footprint and negative environmental impact, health professionals are in a position to influence others and promote social change.
- Health professionals have a responsibility to highlight the public health risks of climate change as well as the numerous health benefits associated with more environmentally friendly economic activities and lifestyles

Our health ultimately depends on having a healthy environment to sustain us. Climate change is the biggest environmental and health challenges of our time. Coordinated action from governments, business, the community and individuals internationally is needed to reduce global warming and climate change is essential if we are to protect the health of New Zealanders and the wider global community

[Philippines]

Presidential Task Force on Climate Change

Datu Zamzamin L. AMPATUAN*[1]

Friends, Colleagues in public service, ladies and gentlemen, Good Morning to all of you.

Allow me to thank our host, Dr. Rey Melchor F. Santos, for the warm reception and for allowing me and the presidential task force on climate change to speak to you today, thus giving special attention to the issue of climate change, which we are all facing today regardless of our geographic location.

As you are all aware, climate change is perhaps the biggest threat to humankind in the twenty-first century. Already, it is affecting our way of life and our collective prospects for survival and sustainable development.

Even a casual observer of World News on television cannot help but notice the occurrence of alarming climate-related events one after the other across our planet. Droughts and extreme water shortage in Spain and Australia. Devastating tornadoes from the American Heartland to Washington, D.C. raging flood waters from London to Iowa to Guangjou to IloIlo. Brush fires in California, Sicily and New South Wales.

Ladies and Gentlemen, we're not just talking about melting icebergs anymore. Climate Change is Real. And we need to bear in mind that its manifestation in unusual weather patterns are not the start of a chain of events and developments that we all need to be prepared for both drought and flood, for instance, signal impending crises in grain and food supply, and we can be sure that severe weather disturbances of any kind would bring a trail of disease in their wake.

On this score, we are gratified to note that the medical profession is exerting proactive efforts to anticipate and adapt to the health impacts of climate change. Much scientific research has already been done on climatic variables and their effects on the incidence of vector-borne diseases like malaria, dengue and typhoid fever. In fact, technical experts at the Philippines' Department of Health confirmed this correlation during the severe El Niño episode which brought severe drought and temperature rise in 1998.

This underscores the reality-long recognized by the international community that climate change is not just an environmental or a predominantly energy-related issue. It is a complex phenomenon that demands a holistic approach and concerted action from all sectors and from all nations.

Compared to industrialized countries, the Philippines does not significantly contribute to greenhouse gas emissions that cause global warming. But, as part of the International Community, we have to do our share in mitigating climate change by pursuing various energy-related actions. By doing so, we can also highlight the urgency of international action on mitigation commitments, particularly in light of the fact that our geographic circumstances make our tropical archipelago highly vulnerable to the effects of climate change.

This gives us the impetus to focus much of our efforts on adaptation responses guided by addressing vulnerabilities of specific sectors, such as agriculture, fisheries, women, children and of course health, and areas like coastal regions and provinces frequently visited by droughts and typhoons. The focus here is on disaster-prone settlements, high-risk population centers and food production areas.

Adaptation strategies must germinate at the local level because a "one size fits all" approach won't work since these measures must be based on specific local conditions, resources and capacities. The task force can merely lend support in terms of spurring initiatives to fill gaps in terms, for example, of vital baseline data, financing, technology and capacity-building, where such interventions might be necessary.

Along this line, we have participated in a series of Regional visits, workshops and climate change schools for local government executives and health workers which are designed to build climate change awareness and understanding at

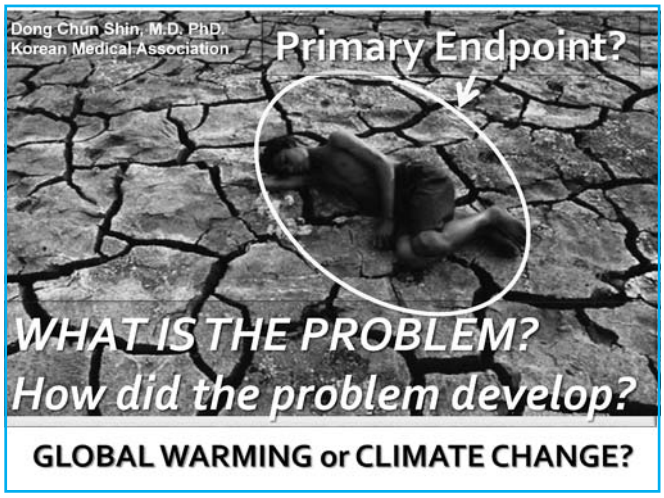
*1 Undersecretary, Department of Energy, Philippines (drjosesabili@yahoo.com.ph).

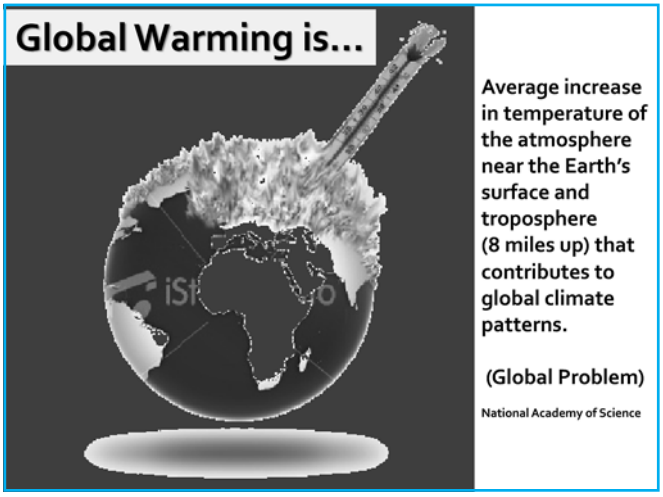
the grassroots, to situate the issue within local concerns and vulnerabilities, and to mobilize communities to act on the problem with a sense of purpose and urgency in the process, we aim to build networks and strengthen relationships with local governments, scientific research institutions and social mobilization champions from the public and private sectors and from civil society.

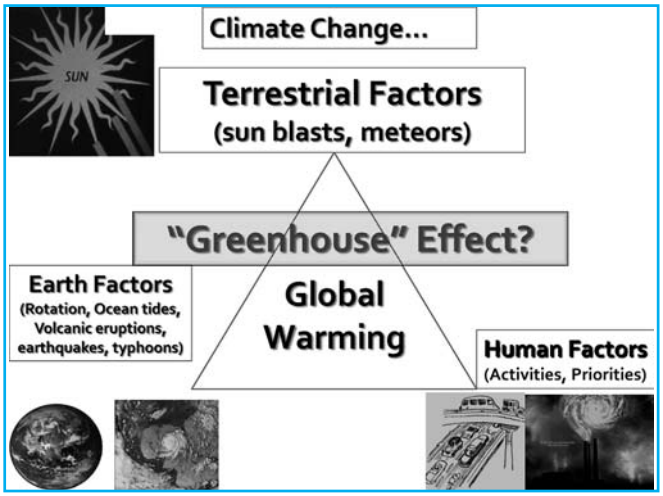
Moving forward, we recognize the importance of strengthening the strategic alliance among various national and local government agencies, and private sector and civil society organizations including professional organizations such as yours since you will be at the forefront of climate change response thus, we will continue to engage all the stakeholders, including the health community, to complement and strengthen our strategies at the local, national even international levels.

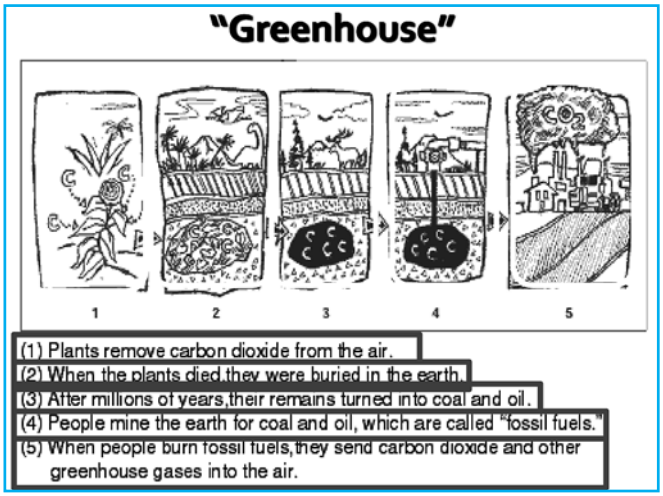
Indeed climate change is an alarming phenomenon but the challenge for all of us here is to act now. Whether it be mitigation or adaptation, whether we come from developed or developing countries, our individual actions however shall they may be, are critical in the earth's overall climate change response for collectively we can all make a difference.

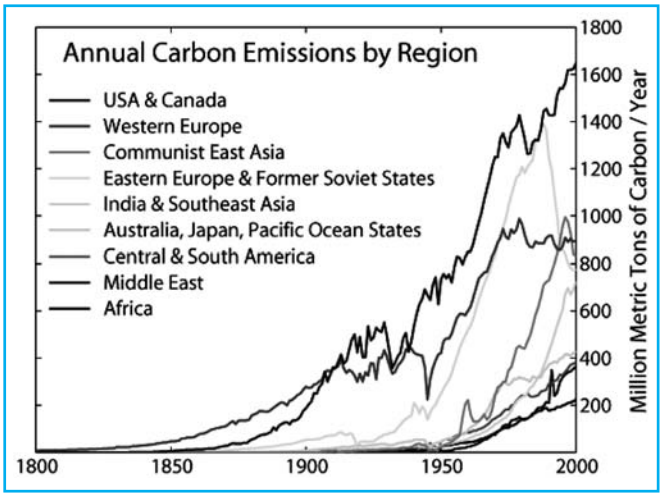
Thank you very much and MABUHAY!

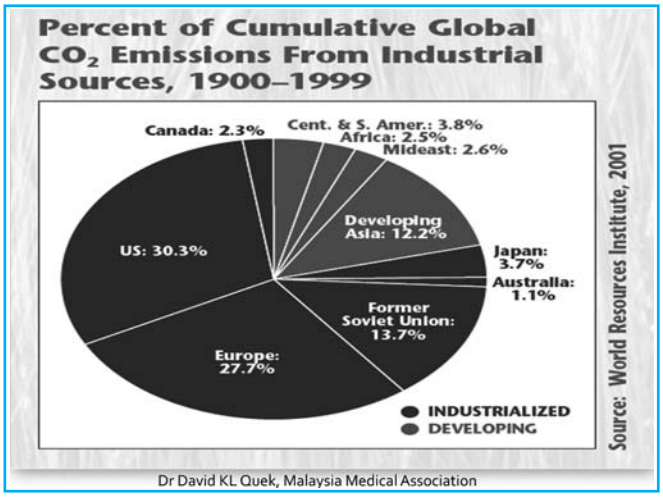


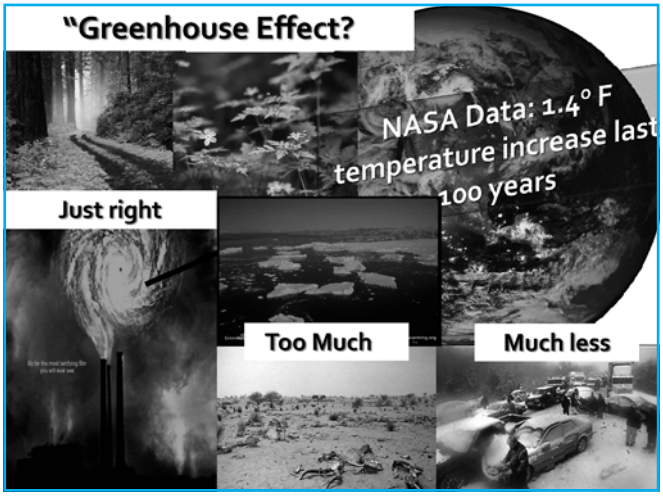


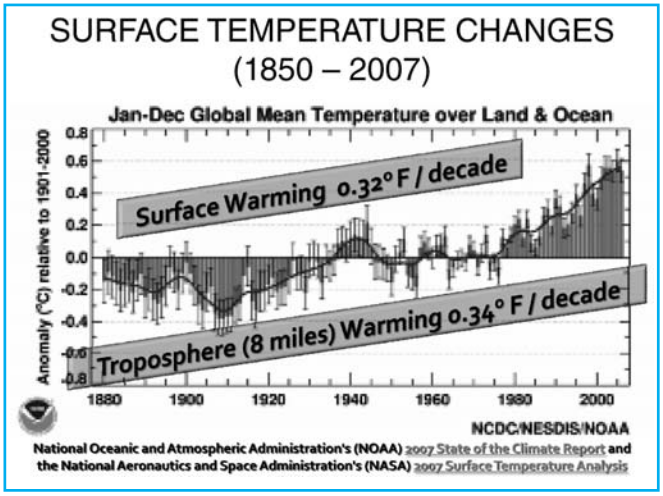

Climate Change...
SUN
Terrestrial Factors
(sun blasts, meteors)
"Greenhouse" Effect?
Global Warming
Earth Factors
(Rotation, Ocean tides, Volcanic eruptions, earthquakes, typhoons)
Human Factors
(Activities, Priorities)

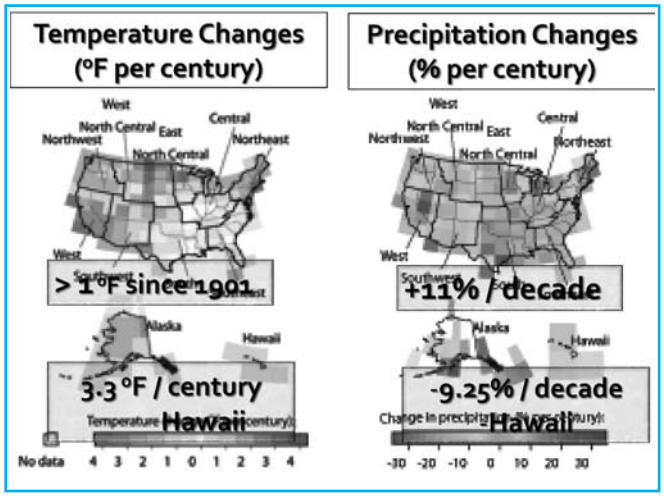

"Greenhouse"
1
2
3
4
5
(1) Plants remove carbon dioxide from the air.
(2) When the plants died,they were buried in the earth.
(3) After millions of years,their remains turned into coal and oil.
(4) People mine the earth for coal and oil, which are called "fossil fuels."
(5) When people burn fossil fuels,they send carbon dioxide and other greenhouse gases into the air.

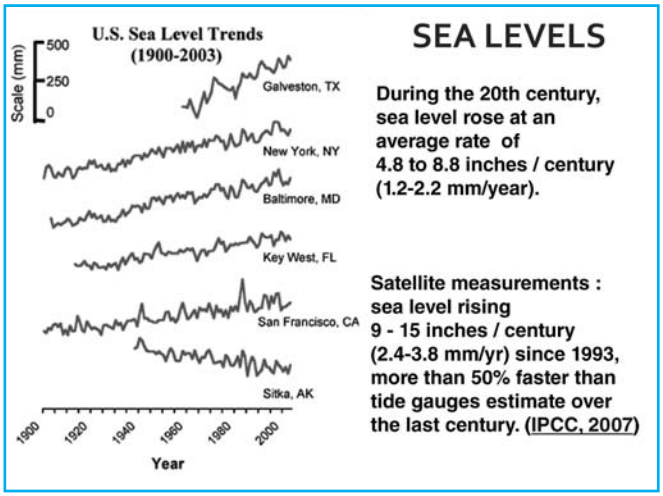

Annual Carbon Emissions by Region
USA & Canada
Western Europe
Communist East Asia
Eastern Europe & Former Soviet States
India & Southeast Asia
Australia, Japan, Pacific Ocean States
Central & South America
Middle East
Africa
Million Metric Tons of Carbon / Year
1800
1600
1400
1200
1000
800
600
400
200
1800
1850
1900
1950
2000


Percent of Cumulative Global CO_2 Emissions From Industrial Sources, 1900–1999
Canada: 2.3%
Cent. & S. Amer.: 3.8%
Africa: 2.5%
Mideast: 2.6%
Developing Asia: 12.2%
US: 30.3%
Japan: 3.7%
Australia: 1.1%
Former Soviet Union: 13.7%
Europe: 27.7%
INDUSTRIALIZED
DEVELOPING
Source: World Resources Institute, 2001
Dr David KL Quek, Malaysia Medical Association

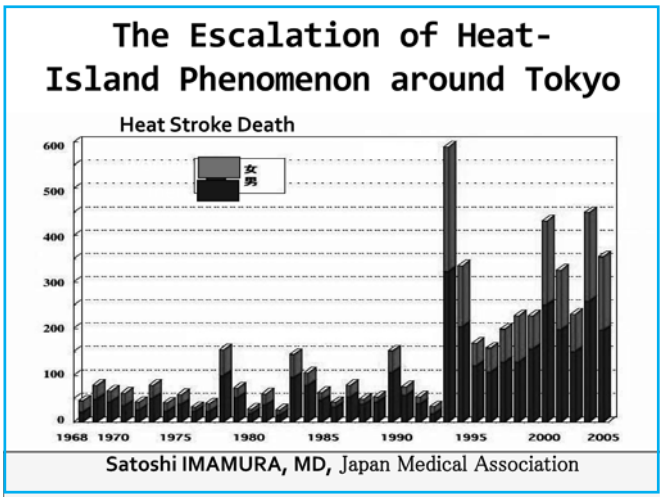

"Greenhouse Effect?
NASA Data: 1.4° F temperature increase last 100 years
Just right
Too Much
Much less

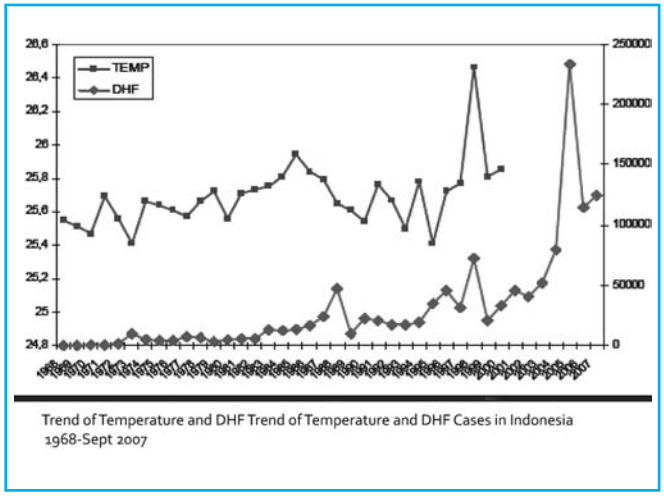

SURFACE TEMPERATURE CHANGES
(1850 – 2007)
Jan-Dec Global Mean Temperature over Land & Ocean
Anomaly (°C) relative to 1901-2000
0.8
0.6
0.4
0.2
0.0
-0.2
-0.4
-0.6
-0.8
Surface Warming 0.32° F / decade
Troposphere (8 miles) Warming 0.34° F / decade
1880
1900
1920
1940
1960
1980
2000
NCDC/NESDIS/NOAA
National Oceanic and Atmospheric Administration's (NOAA) 2007 State of the Climate Report and the National Aeronautics and Space Administration's (NASA) 2007 Surface Temperature Analysis

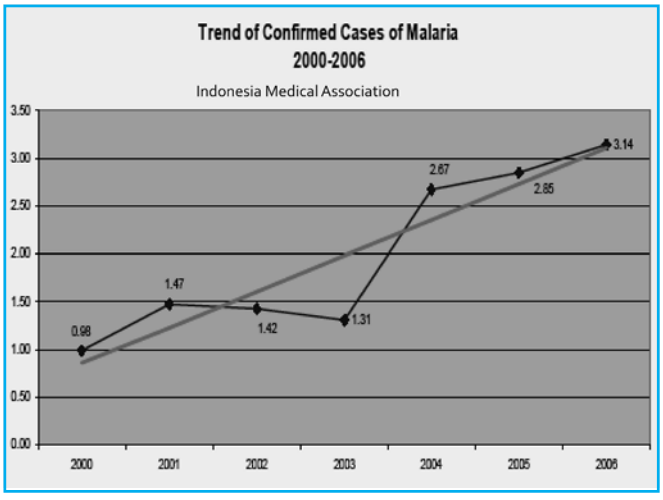

Temperature Changes
(°F per century)
Precipitation Changes
(% per century)
West
North Central
East
Central
Northeast
Northwest
North Central
West
> 1 °F since 1901
+11% / decade
Alaska
Hawaii
3.3 °F / century
-9.25% / decade
Hawaii
Hawaii
No data
4 3 2 1 0 1 2 3 4
-30 -20 -10 0 10 20 30


U.S. Sea Level Trends
(1900-2003)
Scale (mm)
500
250
0
Galveston, TX
New York, NY
Baltimore, MD
Key West, FL
San Francisco, CA
Sitka, AK
1900
1920
1940
1960
1980
2000
Year
SEA LEVELS
During the 20th century, sea level rose at an average rate of 4.8 to 8.8 inches / century (1.2-2.2 mm/year).
Satellite measurements : sea level rising 9 - 15 inches / century (2.4-3.8 mm/yr) since 1993, more than 50% faster than tide gauges estimate over the last century. (IPCC, 2007)

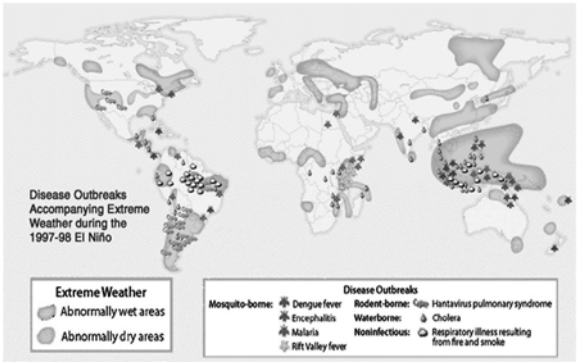

Adverse Outcomes...
Dong Chun Shin, M.D. PhD.,
Korean Medical Association
Nature, 2008


The Escalation of Heat-Island Phenomenon around Tokyo
Heat Stroke Death
女
男
600
500
400
300
200
100
0
1968 1970 1975 1980 1985 1990 1995 2000 2005
Satoshi IMAMURA, MD, Japan Medical Association


TEMP
DHF
26,6
26,4
26,2
26
25,8
25,6
25,4
25,2
25
24,8
250000
200000
150000
100000
50000
0
Trend of Temperature and DHF Trend of Temperature and DHF Cases in Indonesia
1968-Sept 2007

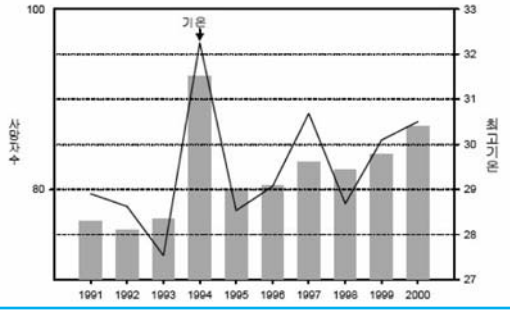

Trend of Confirmed Cases of Malaria
2000-2006
Indonesia Medical Association
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
0.98
1.47
1.42
1.31
2.67
2.85
3.14
2000
2001
2002
2003
2004
2005
2006

Extreme Weather Events & Vector - related Disease Clusters (1997 – 1998 El Nino)



HIGHEST DEATH & TEMPERATURE RELATIONSHIP

- Mean temp. during 100 years: ↑1.5°C
- Sea level during 40 years: ↑ 22cm (Jeju Island)



Advertisements for stop smoking

(Through TV, daily newspapers, etc.)

- Dr. Dong Chun SHIN
- Executive Board Member
- Korean Medical Association

MINISTRY FOR HEALTH, WELFARE AND FAMILY AFFAIRS

KOREAN MEDICAL ASSOCIATION

How to Treat Tobacco Dependence?

- Ask
- Advice
- Assess
- Assist
- Arrangement

- **A** *Ask*
- **B** *Brief advise*
- **C** *Cessation support*

Thailand Medical Association

Respiratory health consequences

Respiratory complaints are the leading cause of out door morbidity in Sri Lanka. – accounts 46.6% (males) & 43.9% (females)

Respiratory symptoms are the 2 leading cause of hospital admissions in Sri Lanka.

???? ENVIRONMENTAL CONTRIBUTION???????

DR RUVAIZ HANIFFA. MSc, MRCGP
Sri Lanka Medical Association

Country & Individual Roles

- The Energy Efficiency and Conservation Strategy
- The Sustainable Land Management and Climate Change
- The Work adoptation, Transport & Waste Strategies
- The public education programs

Dr. Peter Foley, New Zealand Medical Association

For Lay Group:

GLOBAL WARMING IS GLOBAL WARNING

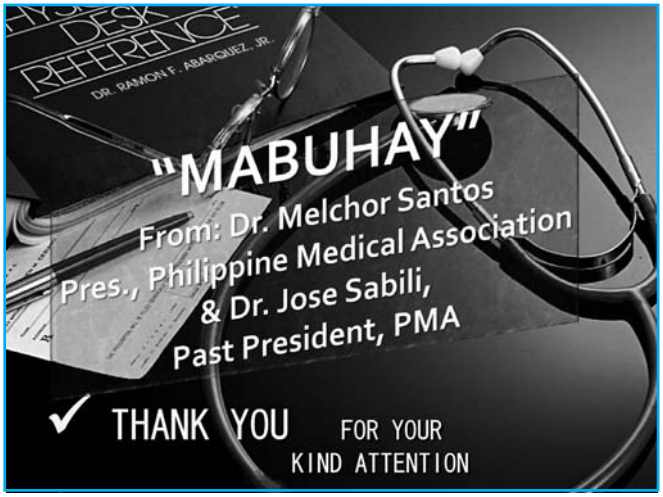
For Medical Group:

GLOBAL WARMING IS HYPOTHESIS GENERATING DUE TO LOW POWER OF EVIDENCE

WE CAN NOT MACRO-MANAGE GLOBAL WARMING

Key message: an ounce of prevention is cost efficient than a pound of cure

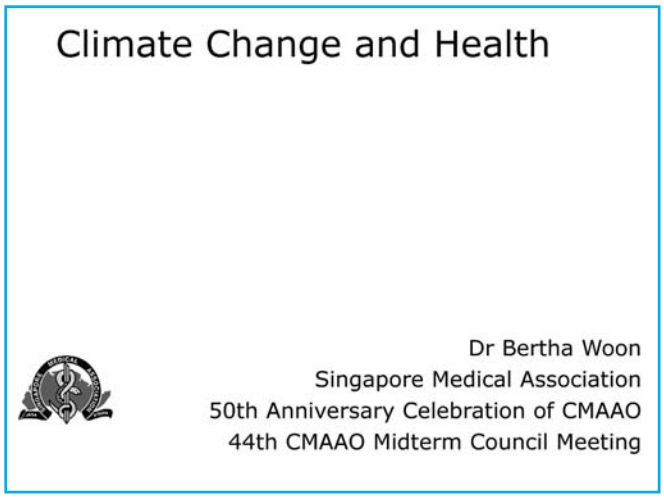
For a Complex Phenomenon, Holistic Concerted Action from ALL NATIONS is Demanded.

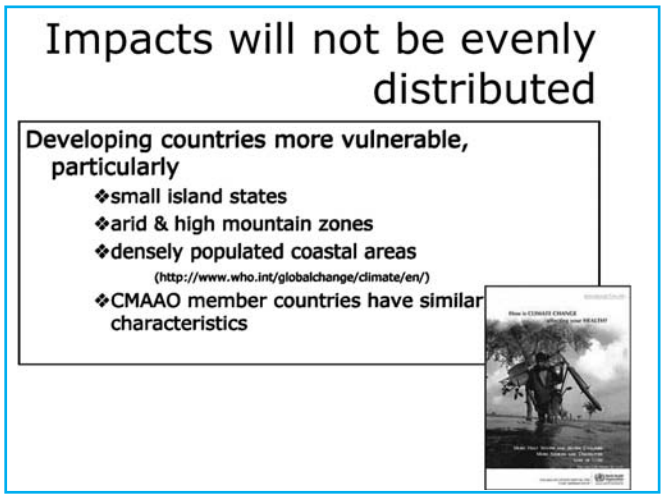


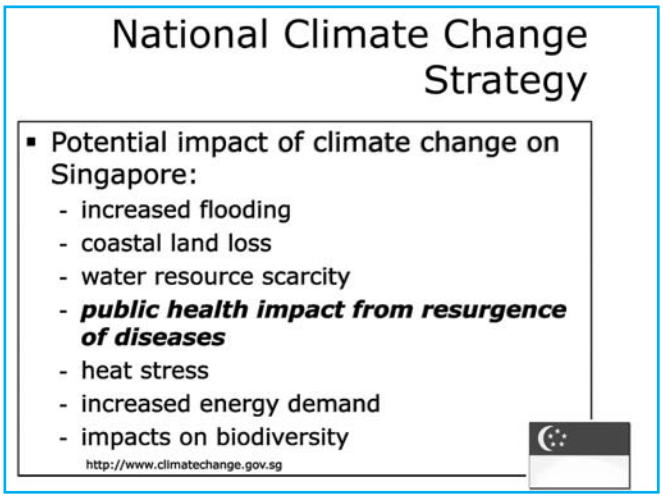
[Singapore]

Climate Change and Health

Bertha Yng Yng WOON*1







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

Public health impact from resurgence of diseases

- Vector-borne diseases, particularly dengue
- Surveillance, control and enforcement system
  - pre-emptive action to suppress mosquito population
  - dengue-related research
  - review of building designs to reduce potential breeding habitats

Aedes Egypti mosquito - Dengue vector

Female Anopheles mosquito

The only vector capable of transmitting malaria

Aedes Albopictus - vector for chikungunya

Effects on vector-borne diseases

- Increased temperatures and altered rainy season patterns affect life cycle of mosquitoes
- Alters patterns of Dengue / Malaria / Chikungunya outbreaks
- Mosquitoes fly to higher latitudes and higher altitudes affecting populations without resistance to above diseases
- In Singapore, our main problem is Dengue
  - 4 strains of Dengue virus and
  - in theory, each person can catch Dengue 4 times in their lifetime...

Effects of climate change

- increased temperatures lead to increased proliferation of germs in food and water
- e.g. outbreaks of Salmonella
- AVA - Agri-Food and Veterinary Authority Singapore is very vigilant about our food supplies
- Food handlers are required to be vaccinated against Typhoid
- Maintain cold-chain in food storage, preparation and distribution

Involvement of medical sector

- No explicit involvement from health ministry or medical association
- However, medical practitioners on the ground are aware of climate change and their effects on health
  - e.g. GPs look out for dengue fever cases during monsoon seasons
  - E.g. army medics are taught how to give first aid to heatstroke victims in National Service

What can doctors do?

- Ideas from WHO
  - Learn about specific climate-related threats and how to assess, and plan strategies
  - Strengthen adaptive capacity e.g. mosquito control
  - Initiate research e.g. Singapore Dengue Consortium
  - Mitigate health implications arising from decisions made by other sectors
  - Lead by example - go green
  - Advocate for health to be at the centre of all climate change policies and plans

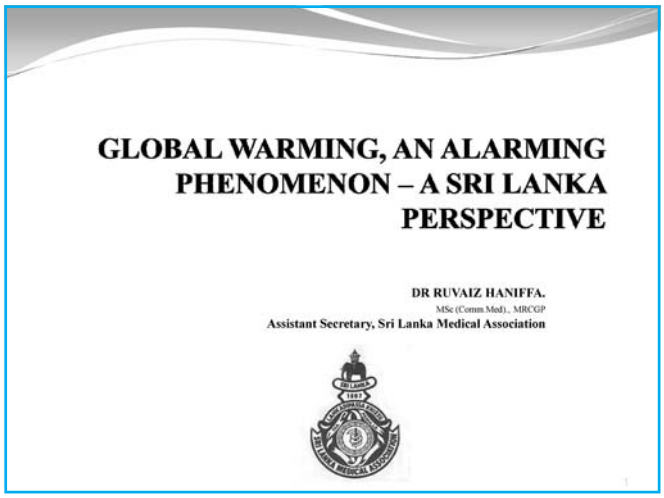
http://www.who.int/entity/world-health-day/toolkit/whd2008_health_prof.pdf

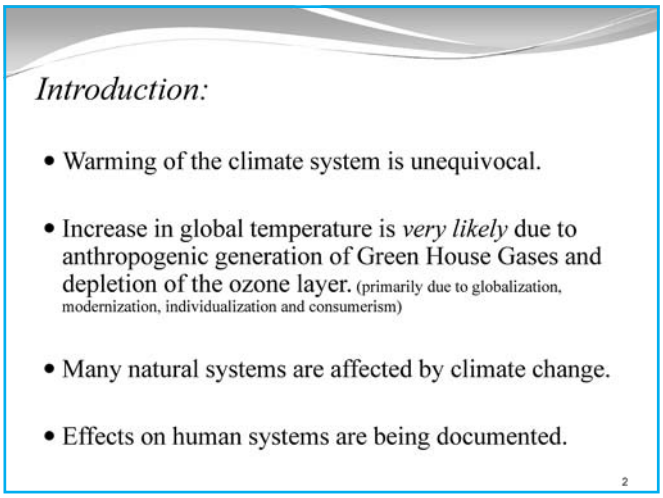
Thank you

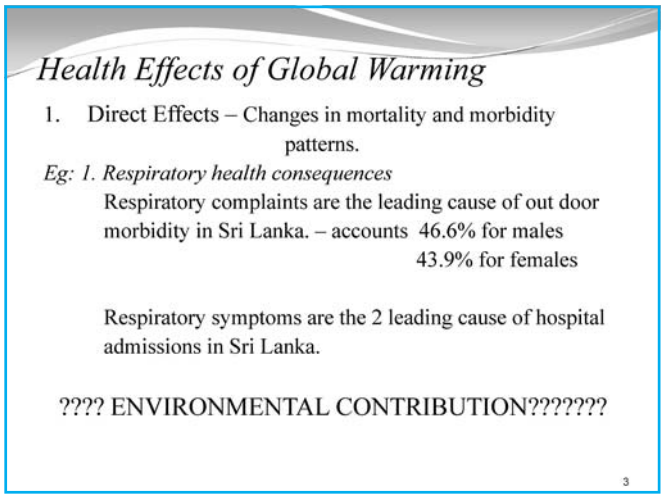
[Sri Lanka]

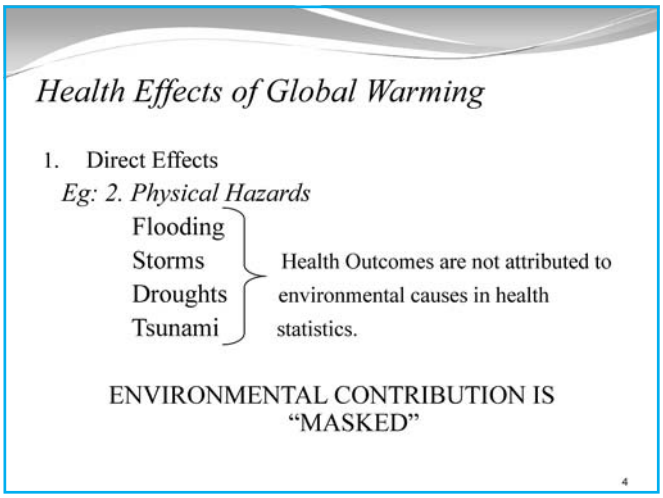
Global Warming, An Alarming Phenomenon—
A Sri Lanka Perspective

Ruvaiz HANIFFA*1









*1 Assistant Secretary, Sri Lanka Medical Association, Sri Lanka (slma@eureka.lk).

Health Effects of Global Warming

2. Indirect Effects

Eg: 1. Alteration of vector borne disease activity

Increased incidence of Dengue Fever, Chikungunya Fever
Cutaneous Leishmaniasis (particularly in eastern Sri Lanka)
Leptospirosis (Incidence more in Urban setting now)

2. Transmission of person to person infections

Diarrhoeal diseases – admission to hospitals over the years has static around 800 cases per 100,000 population. It is the 6th leading cause of hospitalization.

???? Environmental factor which is sustaining this pattern in Sri Lanka

5

Health Effects of Global Warming

Eg: 3. Nutritional health consequences

Poverty, Malnutrition, Micro-nutrient deficiencies
(linked to MDG 1 and 7) – "Improvement in the Environment (MDG 7) will help the process of achieving all MDGs". **UNDP**

4. Psychological health consequences

Effects after "natural disasters"
Population displacements due to "natural disasters'

6

Issues in assessing the contribution of climate change to diseases burden:

1. Our knowledge of etiology of disease is incomplete. ? *Role of environmental impact on disease*
2. The environmental exposure being assessed is often a moving target. *Many of today's diseases are due to yesterdays exposures.*
3. Environmental exposure affects not only occurrence of disease but also its management and outcome.

7

Limitation of health indicators:

- "Traditional" health indicators measures population health "cross-sectionally".
- They are a summation of past activities and consumption patterns.
- These do not provide information on *sustainability* of achieved levels for the future.
- Need for "new" health indicators which will take in to account environmental health effects.

8

The future 1:

- The question to be asked is;

"At what stage might the depletion of the worlds ecological and biophysical capital rebound against the health of the human population"

We as National Medical Associations should device strategies (locally, regionally and globally) to draw attention of colleagues and governments to find an answer to the above question.

9

The future 2:

- The scope of the environmental health agenda should therefore, extend from local communities to whole populations to future generations.
- This strategy brings us in to contact with a group of people we would rather do without – THE POLITICIANS.

Local –
Regional –New Delhi Declaration Sept 08
Global –IPCC/UN/UNDP etc., etc.

10

The future 3:

"The issue of environmental health will be an issue of politics"

Rudolf Virchow

19th century German Pathologist and Public Health advocate.

11

What we can do; adopted from WHO SEARO recommendations

1. Public awareness and education – Community participation
2. Assess vulnerability – Research on impact of global warming on health locally, regionally and globally
3. Disaster preparedness and improving surveillance and early warning systems
4. Shifting to clean energy sources
5. Strengthening of infectious diseases control programmes. Vaccines / Vector control / Diarrhoea control
6. Capacity building in health and non health sectors to address climate change issues

12

Role of SLMA

PRESIDENT'S MESSAGE

SLMA News

AWARENESS OF CROSS CUTTING ISSUES IN PRACTICING DOCTORS.

June 2008 Vol: 1 No: 6 16 Pages Reg-No: ISSN 1800 - 4016

How good or bad is the knowledge and awareness of undergraduates, postgraduates and practicing doctors, about cross cutting issues which influence health?

- **Global warming and its health effects**
- The economy of the country
- Health and social effects of alcoholism
- The problem of substance abuse in Sri Lanka
- Values perceptions and services regarding the disabled and children with special needs.
- Dealing with the problems of malnutrition and under nutrition.
- Food safety
- Patient safety
- Gender issues.
- The problem of violence in the society
- The problems of refugees and internally displaced persons.
- **Poverty and health**
- Mental well being
- Health problems of an ageing population
- **The Millennium Development Goals**
- Ethical and professional practice

The environment and health

13

Summary of Climate Change Impacts and Vulnerable Sectors

Impact Area	Sea level rise	Temperature rise	Droughts	Rainfall	Thunder Activity
Agriculture	Salt water intrusion on low lying agriculture	Depletion of soil moisture, premature desiccation of crops and extinction of Economically important crop types. Affect the yields of all crops, increase of pests and diseases	Reduce the availability of water for irrigation which would lead to a drop in crop production. Dry Zone especially vulnerable.	Decrease yields of many crops with the increased cloud cover and precipitation	
Coastal Zone	Inundation and Coastal erosion. Loss or damage to boat landing sites, fisher folk settlements, shrimp fishing under coastal	Loss of coral reefs, substantial effect on the distribution growth and reproduction of fish stocks.			
Forestry			Fire hazard in forests		
Health		Dehydration & loss of salt leading to Cramps, rash and Heat oedema	Hygiene of the population will be affected due to water scarcity, leading to diseases.	Hygiene of the population will be affected due to pollution of water sources leading to disease.	Loss of life by lightning strikes
Human settlement	People who live in areas that are under threat to the natural hazards are likely to be aggravated by climate changes. They will be vulnerable from all the impacts				

14

Summary of Climate Change Impacts and Vulnerable Sectors Ctd;

Impact Area	Sea level rise	Temperature rise	Droughts	Rainfall	Thunder Activity
Power		Higher rate of water evaporation may reduce the available reserves for hydropower generation		Affects reservoir structure designed for historical rainfall patterns.	Infrastructure damage
Transport		Distortion of road markings, bleeding of bitumen surfaced roads, rail creep due to excessive Temp	Destruction and cracking of road pavements	Inundation of roads, lan and roack slides, eosion of roads & railway tracks	
Water resource	Flood and storm may be triggered by the higher water levels		Depletion of groundwater resource which may cause salinity	Floods, landslides, soil erosion	

Source: Rethinking Vulnerability to Climate Change in Sri Lanka. Akiko Yamane 9th International Conference on Sri Lankan Studies. Matara, Sri Lanka. 2003

15

Proposed countermeasures *Source: Yamne A. 9th ICSL Studies 2003*

Areas	Adaptation Measure
Agriculture	1) Develop tree crop agriculture, 2) Develop drought resistant rice varieties, 3) Change land use patterns in landslide prone areas, 4) Make farmers aware of climate change5) Change irrigation methods
Coastal Zone	1)Monitor sea level rise in critical regions 2) identify most vulnerable areas and prepare management plans, 3) Evaluate engineering interventions to counter salt water intrusion, 4) Promote sustainable use of fishery resources
Forestry	1)Identify critical regions 2) Promote use of alternative timber species 3) Ensure conservation natural forests and ban the clearing of natural forests for commercial purposes
Health	1)Prepare baseline maps of disaster risk areas and develop early warning systems for monitoring of natural disasters 2) Develop early warning systems 3) Develop institutional facilities and provide the financial inputs 4) Upgrade health facilities in vulnerable areas etc.
Human settlement	1)Develop and establish RS/GIS early warning systems 2) Integrate suitable adaptation in urban development 3) Update national disaster management plan 4) Integrate C.C. concerns in national policies 5) Relocate people from vulnerable locations.
Power	N/A
Transport	Improve road/railway infrastructure design standards to incorporate climate change
Water resource	1) Encourage minor storage water reservoirs 2) Investigate feasibility of trans-basin diversion schemes 3) Conserve seasonal water4) Rehabilitate irrigation water tanks networks 5) Promote micro-watershed management 6) Prepare groundwater extraction regulation policy 7) Introduce permit/monitoring systems for ground water extraction and water quality assessment in vulnerable Areas.

16

Conclusion of paper by Akiko Yamane*;

"To date, there have been no significant studies conducted to understanding the issue especially in countries like Sri Lanka that fall under the IPCC category of 'vulnerable small island states'. This research therefore will make a significant contribution to

1) *the ongoing debate on politics of environmental science and viability of global environmental institutions,*
2) *reframing and rethinking the environmental issues in Sri Lanka".*

* *Dept. Geography and Environmental Sciences, Monash University, Melbourne, Australia.*

17

Summary

We as National Medical Associations should device and coordinate strategies (locally, regionally and globally) to draw attention of colleagues and governments to find an answer to climate change.

18

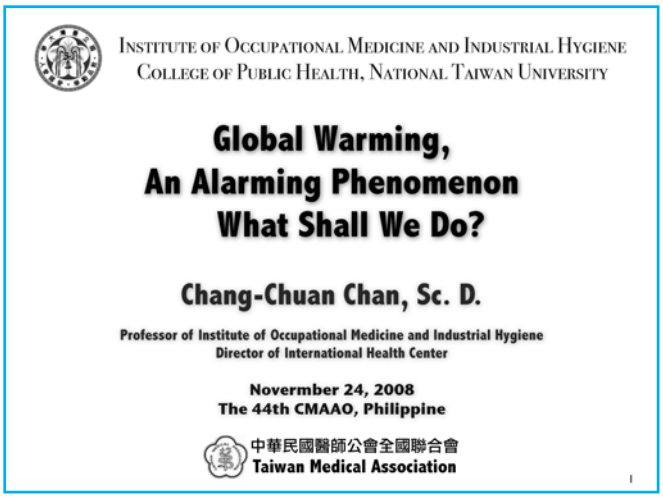
Thank you.

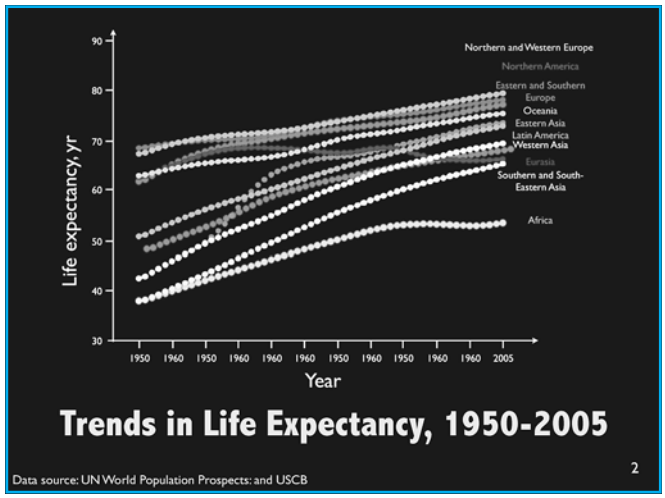
19

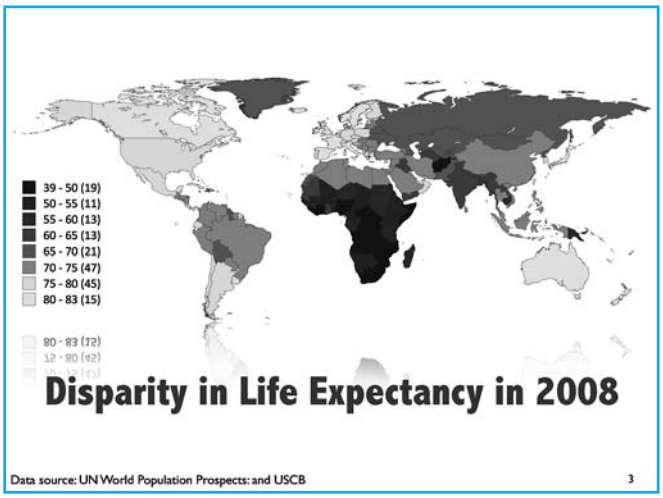
[Taiwan]

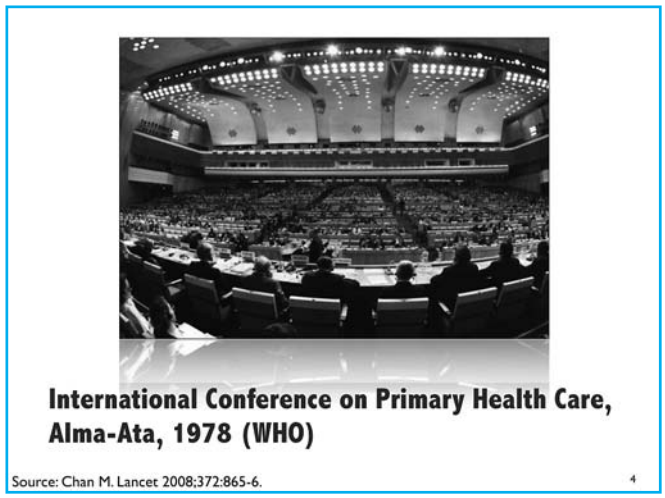
Global Warming, An Alarming Phenomenon, What Shall We Do?

Chang-Chuan CHAN*1

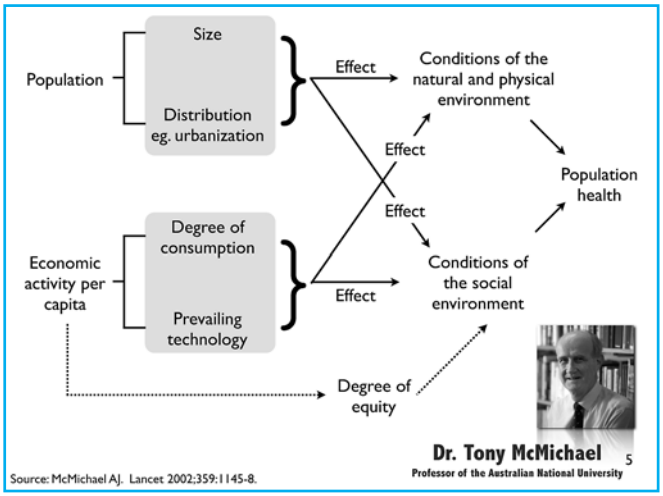


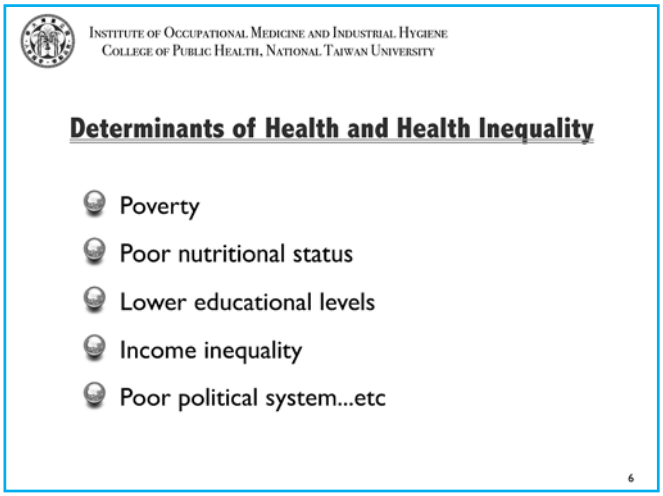


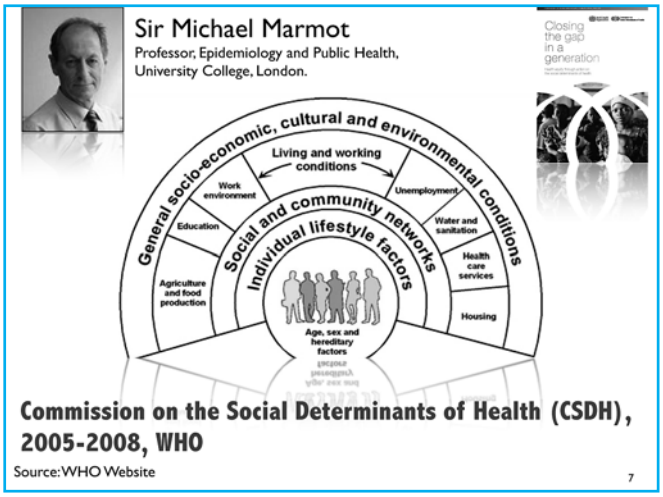


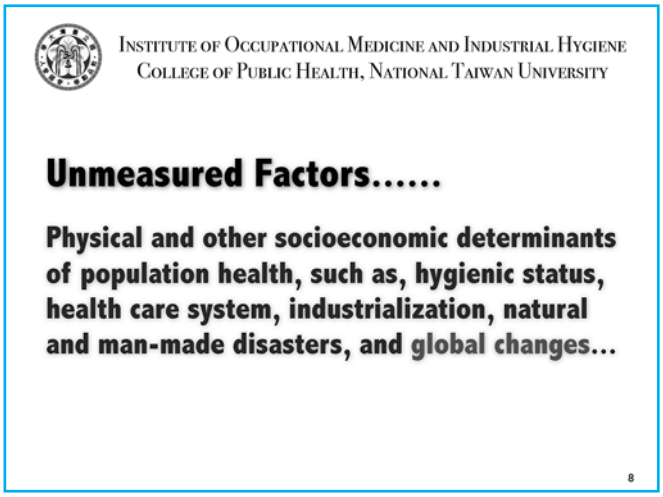


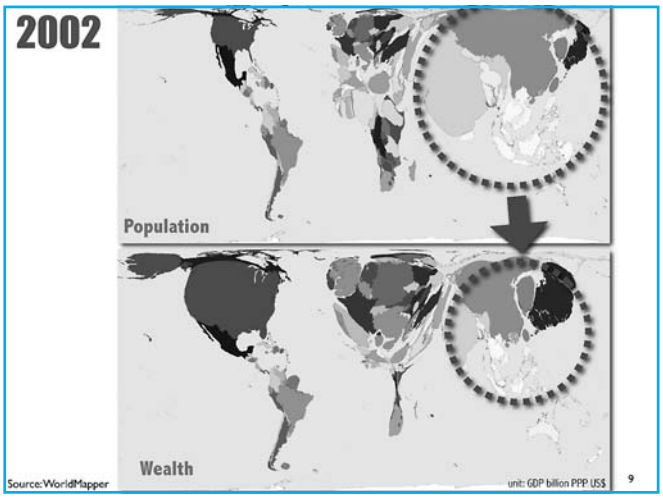
*1 Supervisor, Taiwan Medical Association, Taipei, ROC (intl@tma.tw). Professor, Institute of Occupational Medicine and Industrial Hygiene. Director, International Health Center.

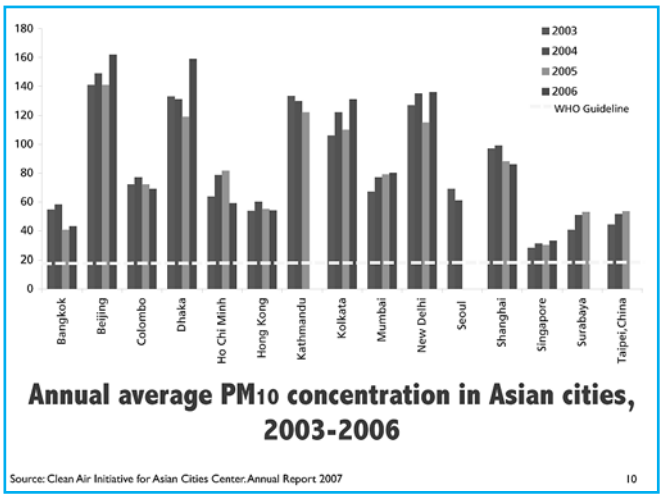

Population
Size
Distribution
eg. urbanization
Economic
activity per
capita
Degree of
consumption
Prevailing
technology
Effect
Effect
Effect
Effect
Conditions of the
natural and physical
environment
Conditions of
the social
environment
Population
health
Degree of
equity
Dr. Tony McMichael
Professor of the Australian National University
5
Source: McMichael AJ. Lancet 2002;359:1145-8.


Institute of Occupational Medicine and Industrial Hygiene
College of Public Health, National Taiwan University
Determinants of Health and Health Inequality
Poverty
Poor nutritional status
Lower educational levels
Income inequality
Poor political system...etc
6

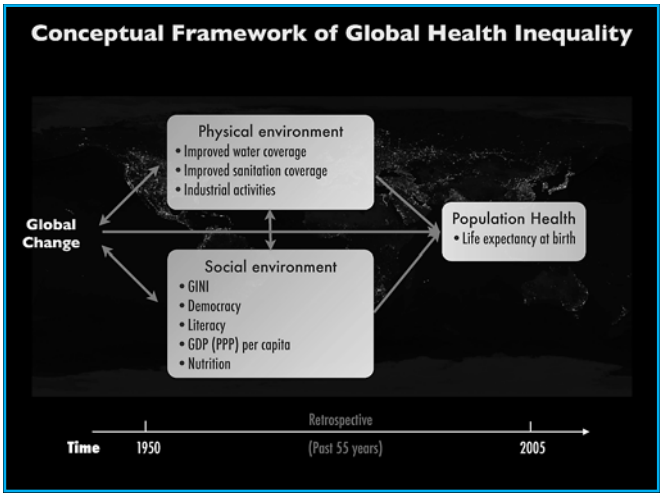

Sir Michael Marmot
Professor, Epidemiology and Public Health,
University College, London.
Closing the gap in a generation
General socio-economic, cultural and environmental conditions
Living and working conditions
Work environment
Unemployment
Social and community networks
Individual lifestyle factors
Education
Water and sanitation
Health care services
Agriculture and food production
Housing
Age, sex and hereditary factors
Commission on the Social Determinants of Health (CSDH), 2005-2008, WHO
Source:WHO Website
7

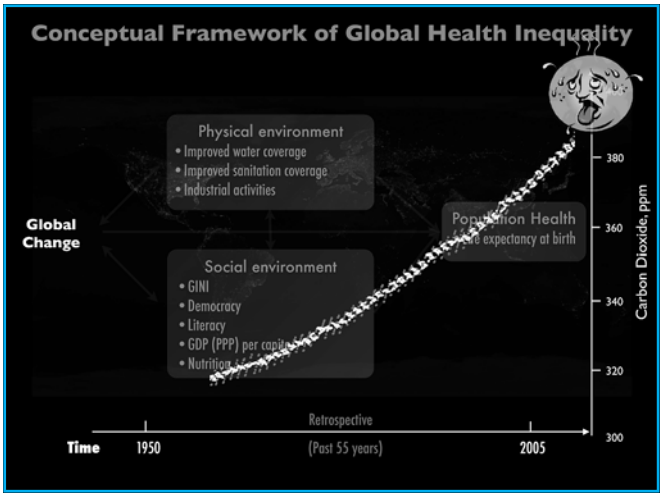

Institute of Occupational Medicine and Industrial Hygiene
College of Public Health, National Taiwan University
Unmeasured Factors.....
Physical and other socioeconomic determinants of population health, such as, hygienic status, health care system, industrialization, natural and man-made disasters, and global changes...
8

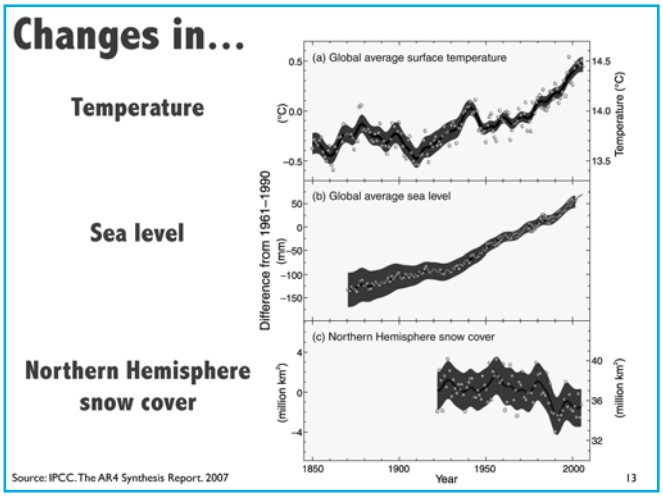

2002
Population
Wealth
unit: GDP billion PPP US$
Source:WorldMapper
9

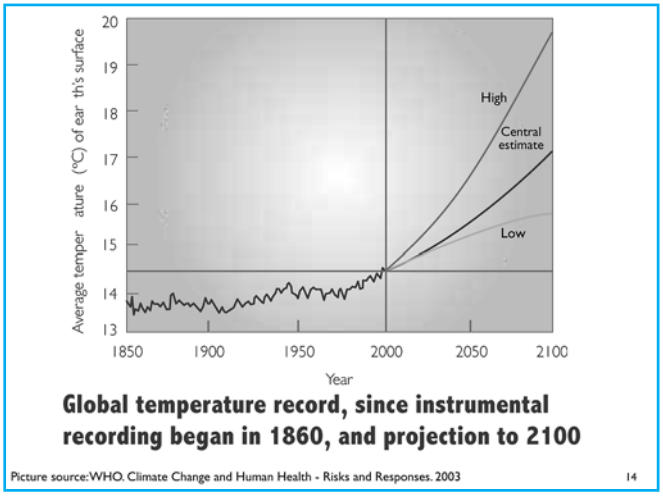

180
160
140
120
100
80
60
40
20
0
2003
2004
2005
2006
WHO Guideline
Bangkok
Beijing
Colombo
Dhaka
Ho Chi Minh
Hong Kong
Kathmandu
Kolkata
Mumbai
New Delhi
Seoul
Shanghai
Singapore
Surabaya
Taipei,China
Annual average PM10 concentration in Asian cities, 2003-2006
Source: Clean Air Initiative for Asian Cities Center.Annual Report 2007
10

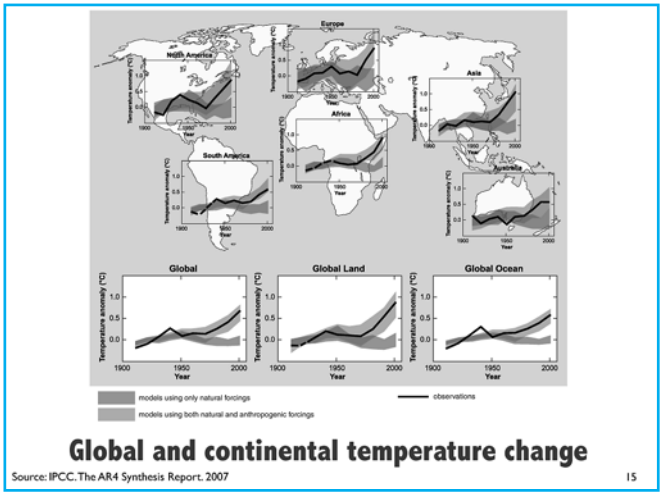

The challenge of sustainable development in Asia
Facing up to the challenges ahead
'Ecosystems don't follow the rules of private property'
60%
New certification standards ensure sustainable palm oil
Source: International Herald Tribune. June 16, 2008
11

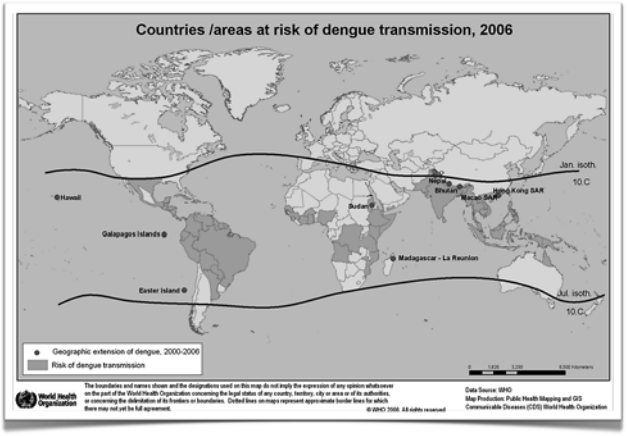

Conceptual Framework of Global Health Inequality
Physical environment
• Improved water coverage
• Improved sanitation coverage
• Industrial activities
Global Change
Population Health
• Life expectancy at birth
Social environment
• GINI
• Democracy
• Literacy
• GDP (PPP) per capita
• Nutrition
Retrospective
Time
1950
(Past 55 years)
2005


Conceptual Framework of Global Health Inequality
Physical environment
• Improved water coverage
• Improved sanitation coverage
• Industrial activities
Global Change
Social environment
• GINI
• Democracy
• Literacy
• GDP (PPP) per capita
• Nutrition
Carbon Dioxide, ppm
380
360
340
320
300
Retrospective
Time
1950
(Past 55 years)
2005

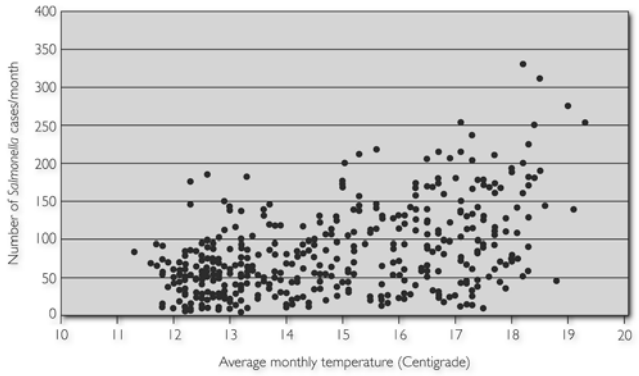

Changes in...
Temperature
Sea level
Northern Hemisphere snow cover
(a) Global average surface temperature
(b) Global average sea level
(c) Northern Hemisphere snow cover
Difference from 1961–1990
Temperature (°C)
(million km²)
Year
Source: IPCC. The AR4 Synthesis Report. 2007
13


Average temperature (°C) of earth's surface
High
Central estimate
Low
Year
Global temperature record, since instrumental recording began in 1860, and projection to 2100
Picture source: WHO. Climate Change and Human Health - Risks and Responses. 2003
14


Europe
North America
Asia
Africa
South America
Australasia
Global
Global Land
Global Ocean
Temperature anomaly (°C)
Year
models using only natural forcings
models using both natural and anthropogenic forcings
observations
Global and continental temperature change
Source: IPCC. The AR4 Synthesis Report. 2007
15



Source: WHO. Impact of Dengue 16



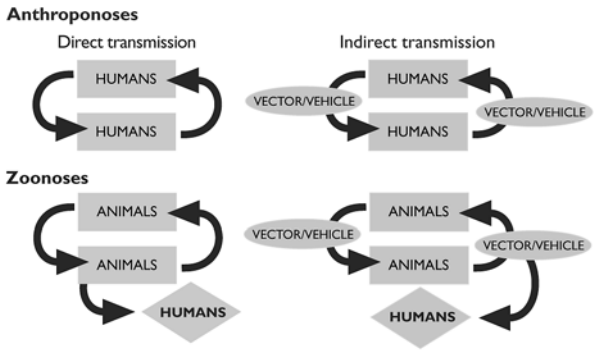
Relationship between mean temperature and monthly reports of Salmonella cases in New Zealand 1965-2000

Source: WHO. Climate Change and Human Health - Risks and Responses. 2003 17

Numbers of extreme climatic/weather events, people killed and affected, by region of the world, in the 1980s and 1990s

	1980s			1990s		
	Events	Killed (thousands)	Affected (millions)	Events	Killed (thousands)	Affected (millions)
Africa	243	417	137.8	247	10	104.3
Eastern Europe	66	2	0.1	150	5	12.4
Eastern Mediterranean	94	162	17.8	139	14	36.1
Latin America and Caribbean	265	12	54.1	298	59	30.7
South East Asia	242	54	850.5	286	458	427.4
Western Pacific	375	36	273.1	381	48	1,199.8
Developed	563	10	2.8	577	6	40.8
Total	1,848	692	1,336	2,078	601	1,851

Picture source: WHO. Climate Change and Human Health - Risks and Responses. 2003 18



Four main types of transmission cycle for infectious diseases

Source: WHO. Climate Change and Human Health - Risks and Responses. 2003 19

Examples of how diverse environmental changes affect the occurrence of various infectious diseases in humans

Environmental changes	Example diseases	Pathway of effect
Dams, canals, irrigation	Schistosomiasis	▲ Snail host habitat, human contact
	Malaria	▲ Breeding sites for mosquitoes
	Helminthiasies	▲ Larval contact due to moist soil
	River blindness	▼ Blackfly breeding, ▼disease
Agricultural intensification	Malaria	Crop insecticides and ▲ vector resistance
	Venezuelan haemorraghic fever	▲ rodent abundance, contact
Urbanization, urban crowding	Cholera	▼ sanitation, hygiene; ▲ water contamination
	Dengue	Water-collecting trash, ▲ *Aedes aegypti* mosquito breeding sites
	Cutaneous leishmaniasis	▲ proximity, sandfly vectors
Deforestation and new habitation	Malaria	▲ Breeding sites and vectors, immigration of susceptible people
	Oropouche	▲ contact, breeding of vectors
	Visceral leishmaniasis	▲ contact with sandfly vectors
Reforestation	Lyme disease	▲ tick hosts, outdoor exposure
Ocean warming	Red tide	▲ Toxic algal blooms
Elevated precipitation	Rift valley fever	▲ Pools for mosquito breeding
	Hantavirus pulmonary syndrome	▲ Rodent food, habitat, abundance

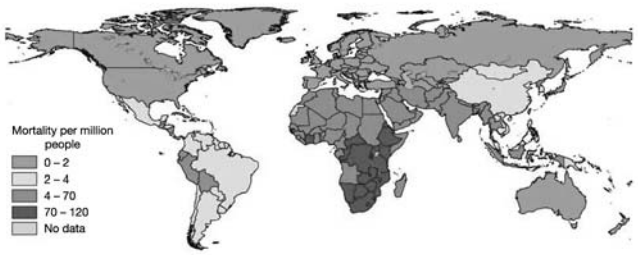
▲ increase
▼ reduction

Source: WHO. Climate Change and Human Health - Risks and Responses. 2003 20

Impacts of climate change on some major health outcomes

Type of outcome	Outcome
Food and water-borne disease	Diarrhoea episodes
Vector-borne disease	Malaria cases
Natural disasters*	Fatal unintentional injuries
Risk of malnutrition	Non-availability of recommended daily calorie intake

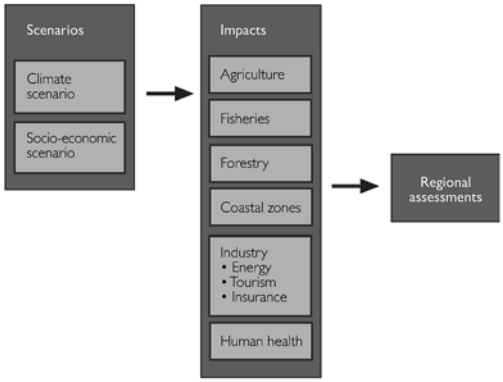
Source: WHO. Climate Change and Human Health - Risks and Responses. 2003 21



Estimated mortality attributable to climate change by the year 2000

Picture source: Patz et al. Nature 2005; 438: 310-7. Data source: McMichael et al. In Ch 20 of the WHO Comparative Quantification of Health Risks 2004

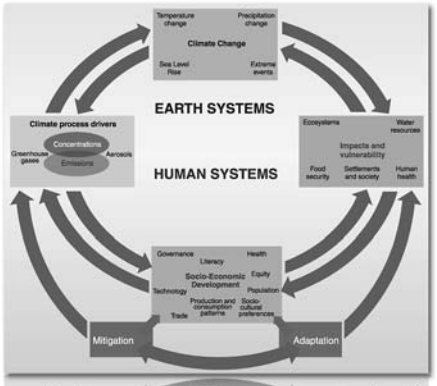
22



Steps in climate change impact and adaptation assessment

Source: WHO. Climate Change and Human Health - Risks and Responses. 2003

23

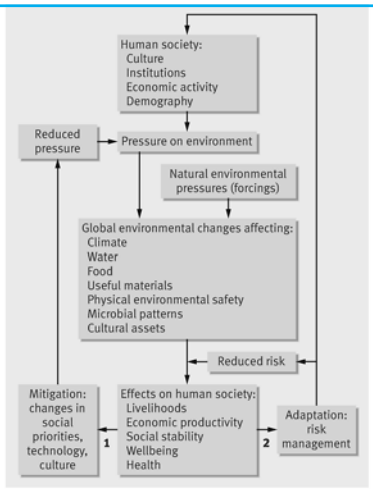


Schematic framework of anthropogenic climate change drivers, impacts and responses

Source: IPCC. The AR4 Synthesis Report. 2007

24

Relations between human induced global environmental changes affect health and social policy responses



Source: McMichael et al. BMJ 2008;336;191-4

25

How health professionals can promote adaptive strategies?

- Public education, especially through healthcare settings such as doctors' waiting rooms and hospital clinics
- Preventive programs—e.g., vaccines, mosquito control, food hygiene and inspection, nutritional supplementation
- Health care (especially mental health and primary care) for communities affected by environmental adversity
- Surveillance of disease (especially infectious disease) and key risk factors
- Forecasting future health risks from projected climate change
- Forecasting future health risks and gains from mitigation and adaptation strategies
- Health sector workforce training and in-career development

Source: McMichael et al. BMJ 2008;336;191-4

26

Strategies that extend beyond health sector...

- Early warning systems for impending extreme weather (e.g., heat waves, storms)
- Neighborhood support schemes to protect the most vulnerable people
- Climate-proofed housing design, urban planning, water

Source: McMichael et al. BMJ 2008;336;191-4

27

Are international medical conferences an outdated luxury the planet can't afford?

YES!
Unnecessary luxury
Environmental impact
--> Can alternatives work?

NO!
Importance of real contact
--> Compromise?

Source: BMJ 28 June 2008;336:1445-1512 28

Source: iVAS website 29

謝謝

Maraming salamat po

बहुत बहुत ...

Terima Kasih

ขอบคุณคะ

Thank you for your attention

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Chang-Chuan Chan

cchan@ntu.edu.tw

林若婷
Ro-Ting Lin

roting@ntu.edu.tw

どうも有難う御座います

감사합니다

धन्यवाद

நன்றி

Cám ơn

dhonnobad

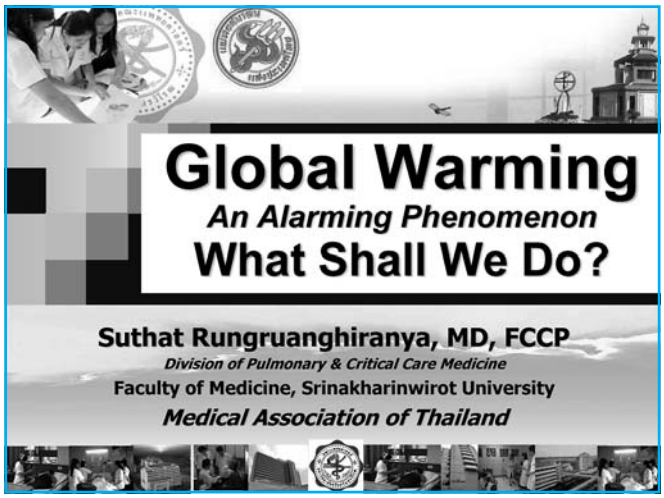
sourm-or-kun

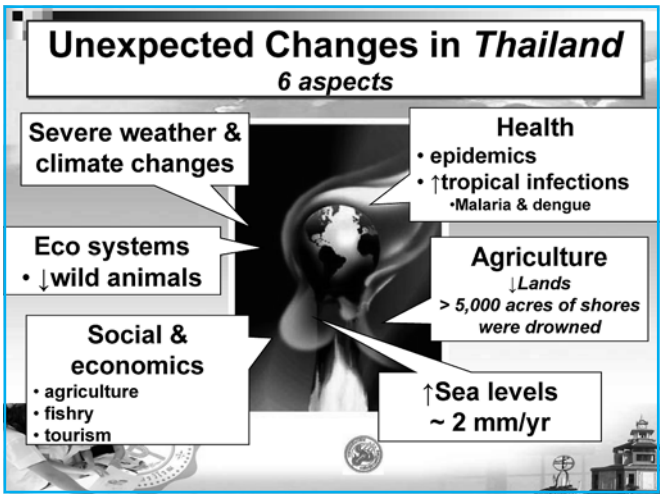
30

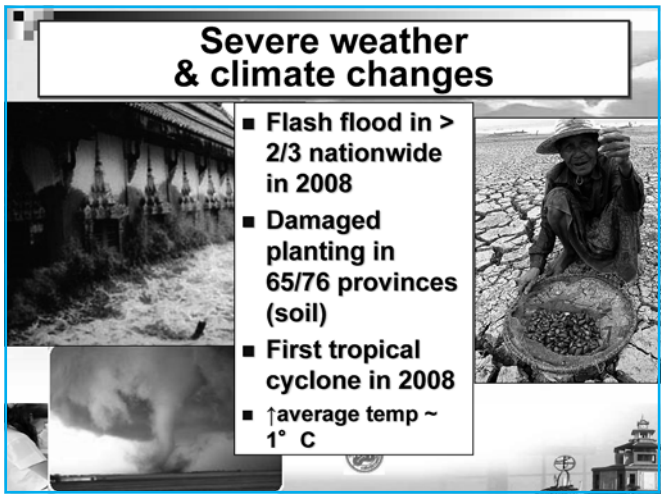
[Thailand]

Global Warming, An Alarming Phenomenon, What Shall We Do?

Suthat RUNGRUANGHIRANYA*1







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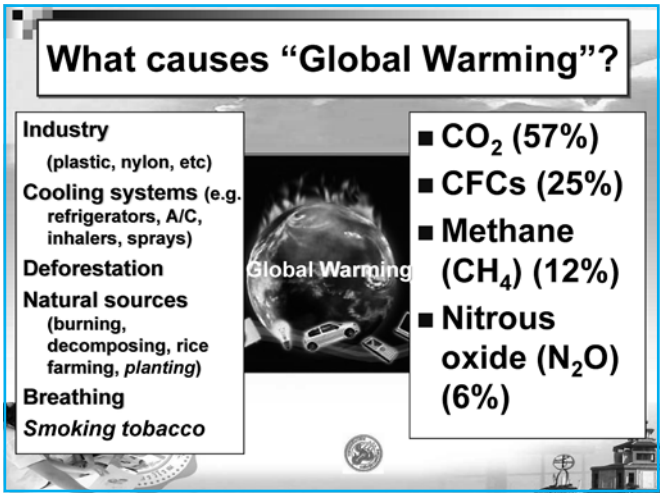
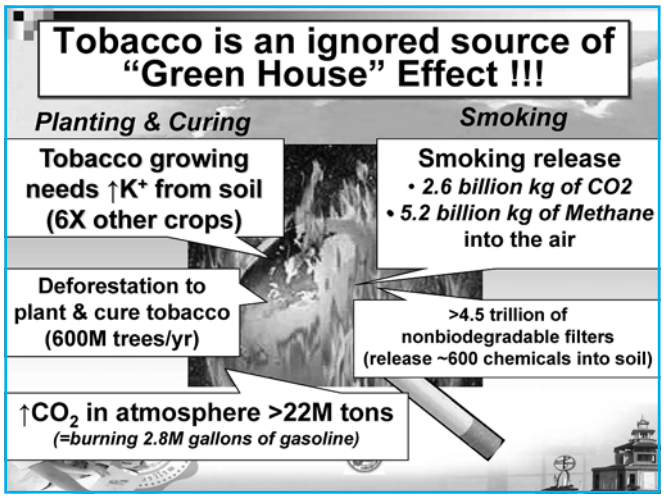
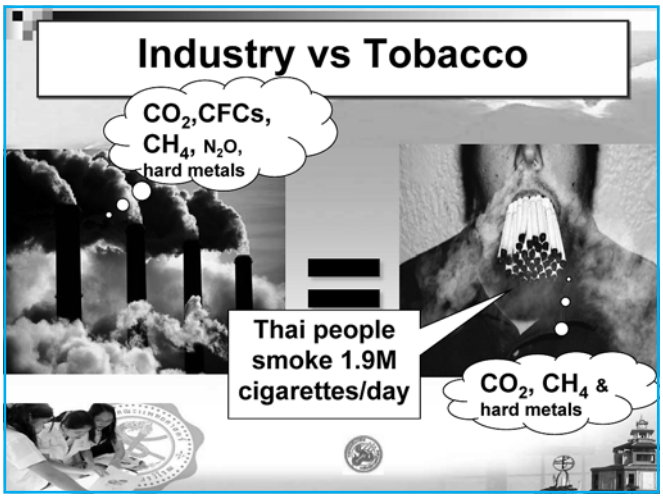
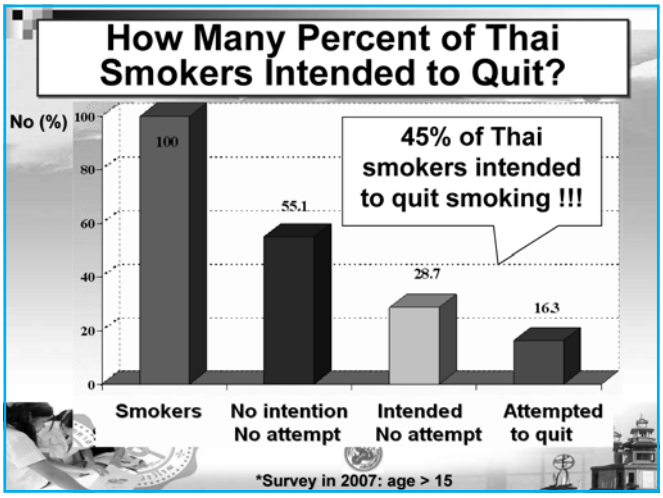
What Shall We Do?
ISSUE 8
Let's get naked at work!!!


What causes "Global Warming"?
Industry
(plastic, nylon, etc)
Cooling systems (e.g. refrigerators, A/C, inhalers, sprays)
Deforestation
Natural sources (burning, decomposing, rice farming, planting)
Breathing
Smoking tobacco
Global Warming
■ CO2 (57%)
■ CFCs (25%)
■ Methane (CH4) (12%)
■ Nitrous oxide (N2O) (6%)

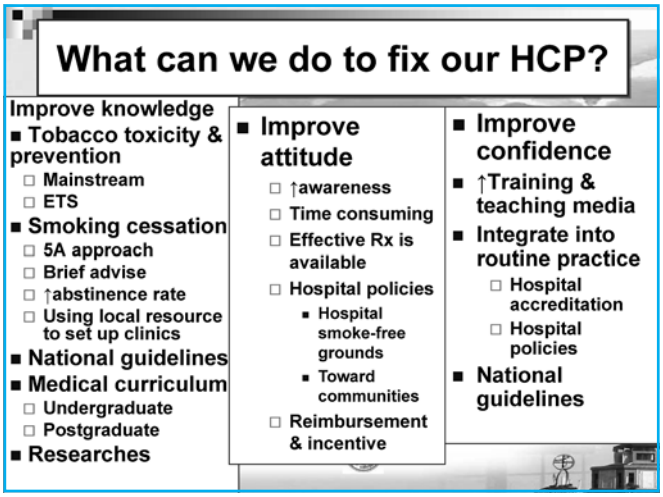

Tobacco is an ignored source of "Green House" Effect !!!
Planting & Curing
Smoking
Tobacco growing needs ↑K+ from soil (6X other crops)
Smoking release
• 2.6 billion kg of CO2
• 5.2 billion kg of Methane
into the air
Deforestation to plant & cure tobacco (600M trees/yr)
>4.5 trillion of nonbiodegradable filters (release ~600 chemicals into soil)
↑CO2 in atmosphere >22M tons
(=burning 2.8M gallons of gasoline)

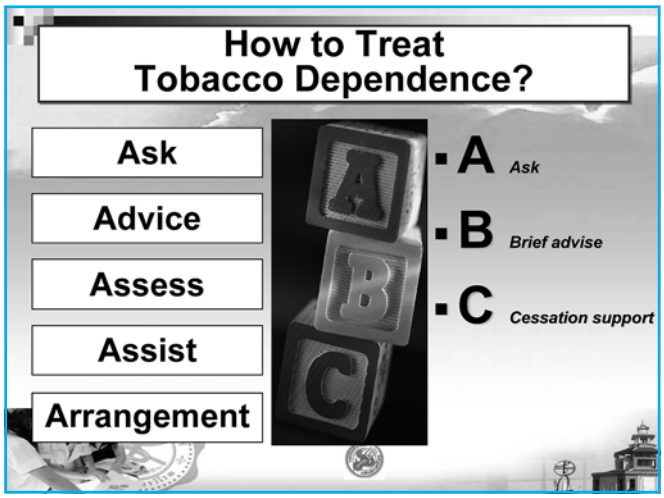

Industry vs Tobacco
CO2,CFCs, CH4, N2O, hard metals
Thai people smoke 1.9M cigarettes/day
CO2, CH4 & hard metals

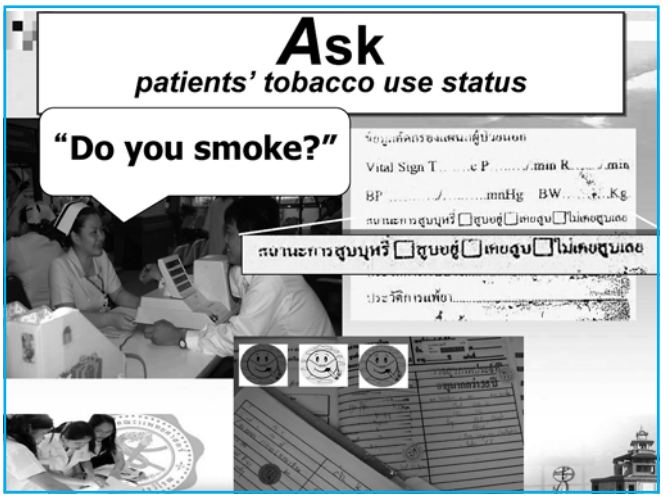

Help Your Pts Quit = Cooling Down Our Earth

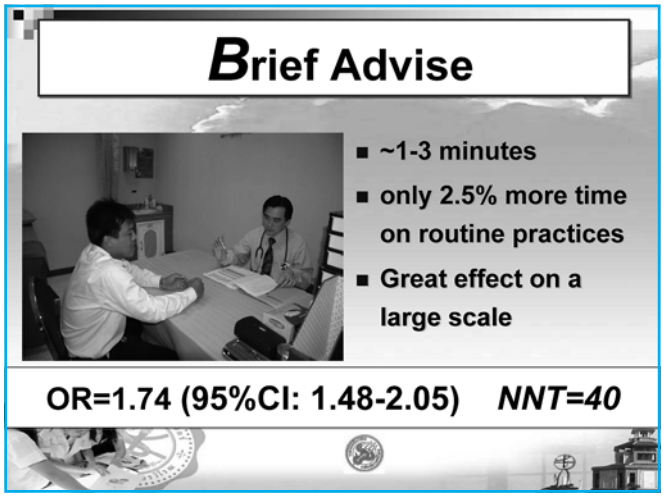

How Many Percent of Thai Smokers Intended to Quit?
No (%)
100
80
60
40
20
0
100
55.1
28.7
16.3
45% of Thai smokers intended to quit smoking !!!
Smokers
No intention No attempt
Intended No attempt
Attempted to quit
*Survey in 2007: age > 15

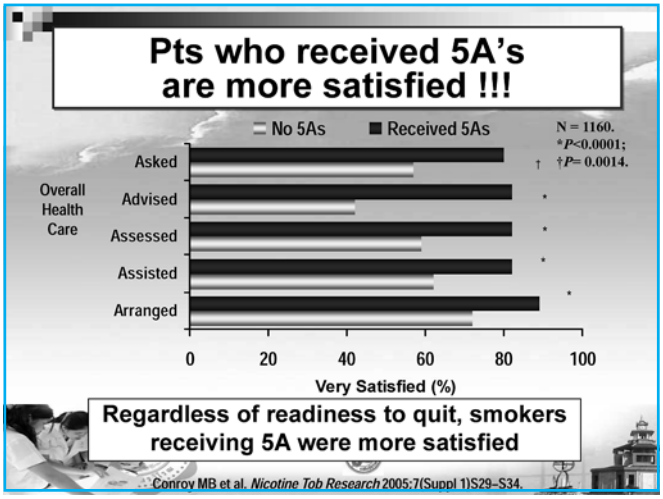

Thai Health Professional Alliance Against Tobacco (THPAAT)
Thai Traditional Medicine
Physician
Medical Technician
Chinese Traditional Med.
Dentist
Nurse
Physical Therapist
Primary Public Heath
Pharmacist
Public Health
Clinical psychologist
Medical Illustration
Radiological technologist


What can we do to fix our HCP?
Improve knowledge
Tobacco toxicity & prevention
Mainstream
ETS
Smoking cessation
5A approach
Brief advise
↑abstinence rate
Using local resource to set up clinics
National guidelines
Medical curriculum
Undergraduate
Postgraduate
Researches
Improve attitude
↑awareness
Time consuming
Effective Rx is available
Hospital policies
Hospital smoke-free grounds
Toward communities
Reimbursement & incentive
Improve confidence
↑Training & teaching media
Integrate into routine practice
Hospital accreditation
Hospital policies
National guidelines


How to Treat Tobacco Dependence?
Ask
Advice
Assess
Assist
Arrangement
A Ask
B Brief advise
C Cessation support


Ask
patients' tobacco use status
"Do you smoke?"


Brief Advise
~1-3 minutes
only 2.5% more time on routine practices
Great effect on a large scale
OR=1.74 (95%CI: 1.48-2.05) NNT=40


Pts who received 5A's are more satisfied !!!
No 5As
Received 5As
N = 1160.
*P<0.0001;
†P= 0.0014.
Overall Health Care
Asked
Advised
Assessed
Assisted
Arranged
0
20
40
60
80
100
Very Satisfied (%)
Regardless of readiness to quit, smokers receiving 5A were more satisfied
Conroy MB et al. Nicotine Tob Research 2005;7(Suppl 1)S29–S34.

Best Results with Combined Pharmacotherapy & Behavioral Support*

	Behavioral Therapy	Brief Advice	No Therapy
Medication	30%	20%	10%
No medication OR Placebo	15%	10%	5%

*Hughes JR. *CA Cancer J Clin.* 2000;50:143-151.

Arrange

- Follow up
- 1st visit = 1-2 weeks
- Next: 1 month, 2 months, 3 months, 6 months, 12 months.

Take Home Messages

- Global warming is no longer far away from us.
- Tobacco is an overlooked cause of global warming.
- We may help relieve it by treating tobacco dependence on our pts.
- 5A's or ABC is a standard way to treat tobacco dependence

Thank you

From the Editor's Desk

Consecutive visit to Manila

I had two occasions to make official visits to Manila, the Philippines, last autumn. The first was the 59th Session of the WHO Regional Committee for the Western Pacific, which was held September 21–26, 2008. Several subjects were discussed, including the strengthening of health systems and primary care, protection of human health from the effects of climate change, avian and pandemic influenza, and Asia-Pacific strategies for emerging diseases. I attended this meeting as a representative of the WMA, and I observed that there are many issues closely linked to global health issues within the Asia-Pacific region at present.

My second visit to Manila was for the 44th Midterm Council Meeting of the Confederation of Medical Associations of Asia and Oceania (CMAAO), which was hosted by the Philippine Medical Association (PMA) on November 22–24, 2008. This meeting was held in conjunction with the CMAAO 50th anniversary celebration at the EDSA Shangri-La Hotel. Details of the council meeting discussion appear in the main part of this issue, and will also be posted on the official CMAAO website at www.cmaao.org. Prof. Keizo Takemi, son of Dr. Taro Takemi, who served 25 years as JMA president and worked to promote the organization and establishment of CMAAO, delivered the Takemi Memorial Oration commemorating his father Taro at the council meeting. It was a special moment, with Dr. Alberto G. Romualdez, Jr., the son of one of the founders of CMAAO from the Philippines, also attending the meeting and making warm comments after the lecture.

The main topic for the CMAAO symposium was global warming, a highly topical issue for national medical associations not only in our region, but around the globe. Finally, there was a lively discussion regarding the promotion of the future activities of CMAAO over the coming 50 years. The celebrations were a milestone to be remembered. I would like to thank all the participants and especially PMA President Dr. Santos, Immediate-past President Dr. Sabili, and all the members of the PMA for their tremendous efforts and kind hospitality.

Sign board at the entrance of the CMAAO meeting room

This is a quick digression regarding the CMAAO symposium. Prof. Keizo Takemi, a speaker at the symposium, attended the meeting in Manila after a long two-day journey from Africa. During this flight, as often happens to frequent flyers such as him, his baggage was lost. That was why he had to make his speech in a casual jacket and pants, as you can see from the picture in this issue.

Masami ISHII, Executive Board Member, Japan Medical Association (jmaintl@po.med.or.jp), Secretary General, Confederation of Medical Associations in Asia and Oceania (CMAAO), Council Member, World Medical Association.

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Vol. 51 No. 4 (July–August 2008)

Vol. 51 No. 6 (November–December 2008)

50th Anniversary Special Edition for CMAAO