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Editorial

Mid-day meal Scheme in India

The Mid Day Meal(MDM) scheme is the world's largest school feeding programme reaching out to about 12 crore children in over 12.65 lakh schools in entire country¹. The recent incident on 16th July 2013 where 23 school children died after eating pesticide contaminated midday meal in Chapra, Bihar² has brought to the core the issue of quality and hygiene in midday meals. There are more such cases in the past.

The MDMS started in 1995 as a centrally sponsored scheme, provides cooked mid day meal of 300 calories and 8-12 grams of protein to all children studying in primary and a minimum of 700 calories and 20 grams of protein to upper primary school children. However, it has been a victim of corruption and leakages. But in the southern states, it has done very well; where the committees of the mothers were formed in every village for every school, which monitor everything from procuring of food grains, vegetables, cereals to the cooking and serving to children. But in the northern states like UP, Bihar, parts of Madhya Pradesh etc., the supervision has been an issue. In many states the committees of mothers have remained only on paper. But in Bihar incident, the contamination of vessels is also a big issue. Lack of consciousness as well as attention towards the cooking part could be the reason for poor hygiene and bad quality of food. In many places, schools still don't have proper kitchens, proper storage facilities, adequate supply of utensils and clean drinking water. A study of MDMS running in Kerala, done by Gangadharan (2006)³, in Rajasthan (2007)⁴ and in Delhi by De *et al* (2005)⁵ found similar problems.

In case of the Midday meal scheme, the rot starts from the beginning. Funding is inadequate to supply quality food and most often, funds do not reach schools⁶. According to the data available with the HRD ministry which runs the scheme, many of the states are not able to lift the entire food grains. And from the amount of food grains lifted, not everything is distributed to the schools. PEO (Programme Evaluation Organisation) study found that utilisation of foodgrains averaged 76 per cent in the 48 sample districts it covered. Utilisation was especially low in tribal and backward districts such as Madhepura in Bihar (7%) and Adilabad in Andhra Pradesh (17%)⁷.

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The FCI should ensure standardization of food grain and its delivery⁶. There should be some kind of quality checks on the food grains before they reach the school to check if the food grains supplied by FCI are of adequate nutritional quality or not. Supply of spices and pulses should be in packages. Cooks need to be trained and better paid. The pathetic infrastructure in schools needs to be improved to some basic standard. Funds for the mid-day meal scheme should be increased⁶.

Proper monitoring of scheme at the state level and below should be carried out by making availability of dedicated structure for MDMS at various levels⁷; the role and responsibilities of concerned authorities should be clearly defined. Adopting community-based monitoring could give teachers the responsibility of ensuring that food is cooked as per guidelines. Some states have made provisions for involvement of parents in monitoring and for local women to be involved in cooking. In Uttaranchal, mothers are appointed as *Bhojan Mata* and *Sahayika* in primary schools.

Inter-sectoral partnerships will help to achieve wider health and education benefits. Two states Tamil Nadu and Gujarat have linked MDM to annual de-worming and vitamin supplementation. Following this example, states should leverage funds from other social sector schemes to compliment MDM.

Improving child nutrition is of utmost urgency in most Indian states as 42.5% of the children under 5 are underweight. We can't abandon the scheme because of one or two incidents. This scheme is having a great mission and the success of the scheme is illustrated by tremendous participation of the all stakeholders including Govt., non-government, as well as the NGOs, parents and the children themselves.

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- Dr Muralidhar Tambe & Dr(Air Cmde) Kevin Fernandez



HIMALAYAN TSUNAMI

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In the present 21st century with modern technology, a fast developing nation like India should have averted the colossal loss of lives and property in Uttarakhand. Many questions arise in one's mind. Let us introspect:

Were the hills of Uttarakhand deforested and had unplanned development take place? Did the development encroach upon the course of the sacred rivers that originate in the Himalayas and flow down to the plains? It was known that lakhs of pilgrims flock to the holy shrines of this flood prone region, should the entry of pilgrims in and out of this area, that too in monsoon have been regulated?

It is for these unforeseen eventualities like cloud burst and flash floods that National Disaster Management Authority (NDMA) is set up, spending precious and scarce resources. Did this central authority and its state counterpart plan and train their staff and local public in disaster preparedness to prevent loss of life and property, mitigate the effect, rescue and finally rehabilitate the victims?

The meteorological department forecast impending cloud burst and flash floods or was it a standard weather forecast of heavy rains and thundershower? Should the weather forecast not have been area specific and more meaningful?

In the eventuality of the disaster occurring was the media able to give an in depth situation analysis?

Did the local population along with the pilgrims rise up to the occasion in helping fellow humans? Has the rehabilitation process commenced in right earnest for the local population who are without abode, with no means of sustenance, having lost their kith and kin and affected by Post Traumatic Stress Disorder ?

Did the Army and Air Force rise up to the occasion to dare into territories where none traverse, lest they risk their lives? Have we learnt any lessons?

Are the funds collected for the flood victims and their rehabilitation actually reaching the afflicted? How were public health issues in the affected area like drinking water, sanitation, food packet distribution, disposal of the dead, temporary shelter for the homeless attended to promptly and epidemic outbreak prevented?

In conclusion, was it man made disaster super imposed on a natural disaster ?



ROLE OF MEDICAL COLLEGES IN RNTCP

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Continuing success of Revised National Tuberculosis Control Programme (RNTCP) requires involvement of all large providers of care including medical colleges. Medical college professors have an important role in TB control as opinion leaders and trendsetters, in sustaining the programme by teaching and practicing DOTS and most important of all as role models for practicing physicians. Hence, involvement of medical colleges in RNTCP is a high priority.

Medical College Core Committee (MCCC)

Composition: At least 4 members with representatives from department of Medicine, Pulmonary Medicine, Microbiology and Community Medicine. Coordination of TB control activities is done by District TB Officer (DTO).

Functions of MCCC are:

1. Establish Microscopy Centre(MC) cum DOT centre in all medical college hospitals.
2. Organize sensitization/ workshops/ trainings for faculty members/ PGs/ UGs/ Interns/ paramedical staff.
3. Ensure that teaching on TB/RNTCP form part of curriculum for PG students/ Residents/ Interns / UG's.
4. Coordination between various departments so that patients get TB-related services problem under one roof.
5. Coordinate with the district TB programme for participation in the quality assurance network of sputum microscopy, referral network, management of complicated cases of TB, and submission of monthly PHI report.
6. Undertake operational research for RNTCP on the priority areas defined by the State Task Force (STF) for the State. Encourage research on TB by faculty members as well as by students for their thesis, etc.
7. Undertake advocacy for the programme by publishing articles on TB, newsletters, giving radio / TV talks, etc.
8. Hold Monthly meeting to review performance of the MC cum DOT centre in the hospital.
9. Submit a compiled quarterly report of the MC cum DOT centre to the STF

RNTCP sensitization/training in medical colleges

All Medical staff at Medical colleges should be sensitized for one day. The interested faculty members/ those identified by HOD can then be trained for the full 5 days. However the staff in-charge of the DOT centre at Medical College should receive full 12-day training on modules 1-9. For paramedical staff, the training would be DOT provider training using the MPW module for 2 days. The training of Medical officers, Laboratory Technician and DOT providers and other staff as required will be organized by STO.

Management of TB cases presenting to a hospital as outdoor patients: RNTCP diagnostic algorithms are to be strictly adhered to by all attending physicians. Diagnosed TB patients should be referred to the local DOTS centre in the respective hospital / medical college. It may be ensured that patients coming from district where the hospital is situated should be started with DOTS therapy only after verifying the address of the patient and their contact persons. Wherever necessary medical colleges are provided by RNTCP with human resource and logistic support to implement and coordinate the activities of RNTCP in their hospitals. One Medical Officer, one STLS, one LT and one TB health visitor are provided on contractual basis through the district TB Control Society. Drugs, consumables, etc. are provided by the District TB Officer.

Indoor patients: All indoor patients in the medical college hospitals who reside in an RNTCP implementing district are to be treated with RNTCP regimens using prolongation pouches which will be supplied by DTO. The DOTS Centre of the respective Medical College must be informed of the patient's admission at the earliest, to enable transfer of the patient to their respective DOTS Centre on discharge. On discharge, patients may be given a maximum of three doses (1 week drug supply) to cover intervening period prior to their continuation of treatment at their respective DOTS Centre, hence ensuring no interruption in treatment. All indoor patients treated under RNTCP, should be registered under the local TU where the medical College is located.

Binocular microscopes and 100% requirement of RNTCP drugs are provided by DTO. All medical colleges are encouraged for establishing certified C&DST Lab. In case of high workload with limited manpower –recommending contractual microbiologist position by STF /STC to CTD for approval with due jurisdiction of workload.

In those places where the State proposes to have MDR TB Centre, the site is established in the Government Medical college hospital under the auspices of department of Pulmonary Medicine or department of Medicine

The medical colleges should stop procurement of anti-TB drugs except for those patients who are critically ill and require in-door and specialized treatment. RNTCP drugs should be used for majority of TB patients

Operational research: All medical colleges are encouraged to promote research (Thesis/Research) by following the OR guidelines provided by the RNTCP.



INVESTIGATION OF REACTION TO IRON & FOLIC ACID TABLETS AT A GIRLS HIGH SCHOOL IN SHIRPUR OF DHULE DISTRICT

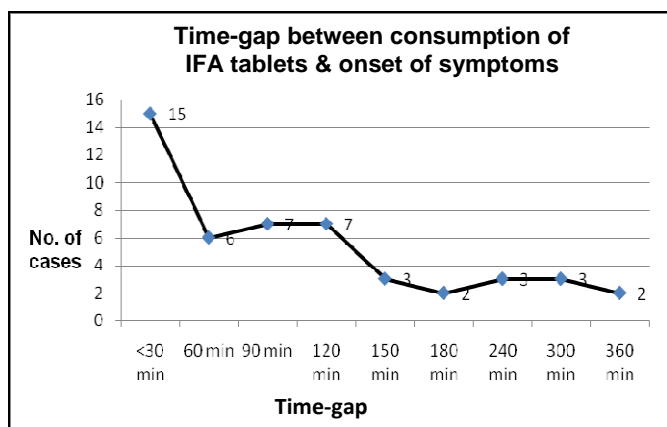
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Background: Ministry Of Health & Family Welfare (MOHFW) has launched the Weekly 100mg elemental Iron and 500ug of Folic Acid Supplementation (WIFS) Programme and biannual deworming Albendazole tablets for school going adolescent girls and boys from class VI to XII std., and for out of school adolescent girls under National Rural Health Mission to combat adolescent anaemia. An episode of suspected side effects to IFA tablets occurred on the afternoon of 30.7.2013 in HR Patel Girls Highschool at Shirpur, Tal:Shirpur, Dist: Dhule. This incidence was investigated by the expert team of SBH Govt. Medical College, Dhule on 31.7.2013 on the order of the Collector, Dhule District.

Methodology: The investigation of this episode included examination of affected children & hospital admitted patients, interview of teachers & school children in the affected school as well as other unaffected schools in Shirpur taluka, laboratory examination of blood, review of office records, Inspection of drug stock and environment at school and regional distribution depots.

Results: The IFA tablets (Batch No. 82350, Mfg. Lic. No. KD322, Mfg. date: 11/12 and Exp. Date: 10/14 manufactured by Healthy Life Pharma Pvt. Ltd., Boisar, Dist Thane-401506) were distributed to 1943 girls; out of which 47(2.41%) developed reactions to it. The common reactions were pain abdomen 46 (97.87%), nausea 21 (44.68%), headache 13 (27.65%) and giddiness 10(21.27%), vomiting, neck rigidity, tingling sensation in palms, etc. The affected girls were admitted to SDH hospital, Shirpur. All the girls recovered completely. It may be noted that no side effects or reactions of any type were observed among girls who had not consumed the said tablets. A total of 73 teachers had also consumed the same IFA tablets with no side effects.



A significant proportion i.e.,15(31.9%) had developed the symptoms between 30 minutes after consumption of IFA tablets. It may also be noted from the cumulative percentage of proportions that majority i.e.,35(74.5%) of the cases had developed within two hours of consumption of IFA tablets. It was mainly the 6th and 7th standard students who were affected. (9.16% & 5.76% respectively). In all, side effects to IFA were noted from 47girls (4.2%).

Blood samples from four cases were collected for biochemical tests. One patient had consumed 3 tablets of IFA. Her iron profile like serum iron, total iron binding capacity, percent transferrin were found to be on the higher side of the normal limits. Blood iron profile of the remaining three cases from whom the blood samples were collected showed normal findings. The given drug package, storage, including the doses were satisfactory.

Discussion: Out of the total 1943 persons who consumed IFA tablets, 47 developed symptoms (2.41%). None of the teachers had developed side effects or reactions. It is also worthwhile to note that no symptoms of any kind had developed among girl students who had not consumed these IFA tablets. It was mainly the students from lower standard (5th and 6th standards) who developed side effects to IFA administration. This can be attributed to the fact that these girls will have a lower body weight as compared to the girls from the higher standards i.e, 8th standard onwards.

There was no association observed between mid day meal consumption and the development of symptoms.

Recommendations: The apprehension about the IFA side effects among the students as well as the class teachers has to be addressed through a session of health talk otherwise the students will be reluctant to consume these IFA tablets fearing reactions. Also, arrange a sensitization-training of all the health staff at all levels about the WIFAS programme & to prevent mix up of IFA tablets received under other health programmes such as JSSK and RCH programme. The IFA tablets under WIFAS need to have a prominent picture of an adolescent on its packing thereby preventing such possible mishaps in future. The nodal teachers are to be trained in first-aid to be given to students in case of such an episode.

Conclusion: Looking at the clinical presentation, time gap between IFA tablet consumption and onset of symptoms, the present episode appears to be a case of side effect to IFA tablets.



REFORM IN MEDICAL EDUCATION: DECREASE THE DURATION OF MEDICAL EDUCATION

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Introduction: India is in need of well- trained doctors. But current system of medical education is leading to a generation of half trained doctors that too in a lengthy way¹. The Medical Council of India's (MCI) Vision 2015 draft committee report has proposed sweeping reforms. The report cites three main reasons for India's healthcare woes — shortage of physicians (both generalists and specialists), inequitable distribution of manpower and resources, and deficiencies in the quality of medical education². There is a need to be innovative and urgently evolve strategies to deal with acute shortages of specialists and super-specialists especially for rural health services. In the present system of medical education it takes about 10 years to produce a specialist³. Therefore there is a proposal to decrease the duration of medical education in India to produce a specialist.

Indian medical education system: The Indian medical education sector can be broadly classified into two— the modern system of medicine i.e. Allopathy or Non Indian System of Medicine (NISM) and Indian Systems of Medicine and Homeopathy (ISMH) that includes Ayurveda, Unani, Siddha and Homeopathy. Medical training for doctors in India is provided at the undergraduate, post-graduate and super-specialization levels. The undergraduate degree, referred to as MBBS (Bachelor of Medicine and Bachelor of Surgery), comprises of 4½ years of coursework followed by one year of internship, and provides basic training in clinical medicine and is also the prerequisite for further training (residency) in various specialties. The three main types of "post-graduate" training opportunities include three year residency programs i.e. MD (Doctor of Medicine) or MS (Master of Surgery), one or two year long diploma training programs and three or five years DNB (Diplomate of the National Board) programs offered by the National Board of Examinations, an autonomous organization established by the Government of India. Further, there are super-specialty residency programs in medical and surgical specialties for those who have completed the MD/MS or the DNB⁴.

Following MCI guidelines, medical colleges in India have adopted a pattern of one year of basic sciences (Anatomy, Physiology, Biochemistry), 1 and ½ year of para-clinical sciences (Microbiology, Pharmacology, Pathology And Forensic Medicine) and 2 years devoted entirely to clinical subjects. Last but one year includes ENT, Surgery, Orthopedics, Obstetrics & Gynaecology and

Paediatrics.

Issues related to current duration of Indian medical education system:

Students are also facing a cut-throat competition not only for grabbing seat in medical college for under graduation but also for post graduation which is also a tedious and laborious task requiring lots of day and night hard work. Thus students are always in fear of post graduation entrance examination.

As per the MCI curriculum there is one year of compulsory internship to learn the basic clinical knowledge so that after achieving MBBS degree they can be self sufficient to treat the basic morbidities. Only on completion of this internship training, a medical graduate is awarded the MBBS degree and a license to practice medicine anywhere in the country as a general practitioner or Medical Officer. But due to the extremely tenacious entrance examination for post graduation, students do not undergo their internship with sincerity and punctuality. Thus, they lack skills and knowledge required to treat the patients; hence post graduation course becomes essential for them to learn and earn. Has MBBS, once a very prestigious degree been reduced to merely a qualification for PG entrance examination or just a license to practice medicine whether or not a person has necessary skills? Not only in terms of time duration but also in case of financial crisis one cannot head towards medical education because its long duration is making it difficult for people to give financial support to their families. Rather they ask their parents to pay their fees even at an age when they are supposed to earn in contrast to contemporary colleagues in other professional streams like engineering.

Even if many doctors are gaining an educational degree of specialization and super specialization, after such a long duration of study, the doctors are reluctant to serve in villages because they want to get settled in urban areas and there will always be a demand of doctors in rural areas. Patients also prefer specialists rather than MBBS graduates.

They have to spend a considerable amount of money to become what they are and that too by depending on their parents. Marriages and family life also get disturbed. So this may be the cause of their reluctant behaviour to serve in remote areas.

Can we decrease the duration of medical education?

Looking at the problems mentioned above creating speciality doctors in short duration which is the need of the hour. If we look at time distribution of subjects taught in present MBBS curriculum, then there is more than enough time allotted to many subjects. Most of them are not needed when a doctor works at PHC level; some skills are needed only when we work at tertiary level.

After training a student for one year in basic medical sciences, next one year for other para-clinical & clinical and then he/she would be trained for three years in a particular speciality, which is equivalent to current MD/MS duration and for next one and half year he can be posted at district hospital, CHC and PHC for a period of six months each as probationary specialist MBBS medical practitioner. In our view, the ideal duration of *specialised M.B.B.S.* course should be six and half years which is equal to present MBBS, including one and half year of compulsory rural posting (probationary specialist); and only on successful completion of which a student would get his degree. So serving in rural area will then be part of his/her course.

This reformed medical education system can bring a revolution in views and practice of skill based medical education making it easier for students and reducing a gap between doctors and patients. This will also lead to the satisfaction both from student and patient's side.

Newly opened AIIMS like institutes, which are out of MCI jurisdiction, could well be the site to try this new innovation that can indeed solve our age old problem.

To conclude, in our opinion, if such a course will be permitted even for ten years at all India level, we will produce approximately 2 lakh specialist doctors and it will serve all our primary, secondary and tertiary health care levels. Whereas current system will produce only half of the above figure without serving to rural set up by private college student which at present account for more than half of total number of MBBS seats.

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Media Review

THE FINAL INCH - A Documentary film

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Having successfully completed two polio-free years, India is preparing to receive the crucial polio eradication certificate from the World Health Organisation (WHO). The certificate is issued on completion of incident-free three years at the end of 2013. A documentary short film, "*The Final Inch*" directed by Irene Taylor Brodsky follows community health workers across India as they travel to vaccinate children in an effort to eradicate the virus from disenfranchised Muslim communities to rural Ganges River villages to the bustling city of Mumbai, in an effort to dispel misunderstandings and resistance and thus lower the refusal rate.

The film shows the largest non-military army in history going door-to-door, and slum to slum, to reach the last unvaccinated children. The global strategy aimed at hundreds of millions of children becomes intensely personal for the vaccinators working to save them. The film depicts real life people like Munzareen, a UNICEF worker who visits more than 400 homes each month in enclaves in the Indian state of Uttar Pradesh, which has the world's highest concentration of polio infection. Also features a Indian doctor Ashfaq Bhat, a World Health Organization (WHO) personnel in the fight against polio, who risks life and limb to lead teams of volunteers to remote communities in the Bihar state. Film also recalls the devastating polio epidemics in the United States of the 1930s and 1950s through the deeply moving memories of survivors such as Martha Mason.

The film "*The Final Inch*" explores how the final days of any endeavor are always the most challenging and is a profound testament to those working on the front lines of public health in the backwaters of our world. As per the director Irene Taylor Brodsky "*The Final Inch*" reminds us that public health, poverty and politics can converge into a perfect storm of tragic consequence. How else can one explain the fact that children continue to die and become crippled for life by polio more than 50 years after a vaccine for the disease has been discovered? Indeed, the obstacles to eradication are more than just epidemiological. Lack of awareness about the disease and vaccine is just one of many obstacles volunteers face in addition to the sheer number of children in India and their geographical dispersal across an often- inhospitable landscape.

"*The Final Inch*" was nominated at the Oscars (Academy Awards) in the category of best Documentary short film.



EARLY DETECTION OF CANCER IN WOMEN IN URBAN SLUMS OF PCMC AREA: A PUBLIC HEALTH APPROACH

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Cancer is a worldwide Public health concern. Cancer of cervix is the second most common cancer in women next to breast cancer. In order to control the disease, clear understanding of factors contributing to development of cancer is necessary. The present study explains and emphasizes the need for early screening and detection of cancer among women in reproductive age group, as well as increasing awareness on early examination of cancer among the women in the urban slums of PCMC area. During 2002 – 2004 referral system for Cancer Registry was established at Lokmanya Hospital, in PCMC, Pune. The present study also provides a process documentation of the 23 cancer detection camps organized in 2002-2004, in the same areas.

The present study was also conducted to assess the knowledge, attitude & practices of nursing staff towards the early detection of cervical cancer, and to give them training on the Pap Smear Method is one of the objectives of the study.

Methods and Material: This present study documents the process of the activities conducted during 2002-2004, viz-a-vis the Cancer registry, early detection camps and training of the staff on the Pap smear method. The foundation initiated cancer registry in 22 Municipal hospitals. Total ever married women from the reproductive age, residing in urban The preliminary screening forms of the women attending the camp was filled up related to socio-economic and medical history to find out the reproductive health problems of the women in urban slums. The retrospective analysis of 497 women registered in the cancer detection camps was also done using SPSS. Among these 497 women, Pap smear was done for 157 women. Analysis of these 157 was also done separately to assess the risk factors associated with the gynecological and reproductive infections, such as, age, age at marriage, age at first delivery, addiction etc. As per the project a training program was conducted by Lokmanya Medical Foundation for the 32 nurses Staff and ANMs of selected PCMC hospitals to take up Pap- Smear tests. Through these free Cancer detection camps, early cancer detection and creating awareness in the community about the disease was attempted. In these cancer detection camps, lectures & video films on cancer were shown to create awareness in the community.

Out of the total 552 women attending the camps, 55, were unmarried. Hence only ever married women are included in the detailed analysis.

Results and Discussion: Out of the 497 women, Majority were middle aged women, i.e. 21-40 years age group. While 51-60 years group was 12 %. More than 50 percent women were illiterate as they mostly came from different slum locations. The proportion of women with secondary school education was 17.7 while and high school & above was 21.1%.

Majority of the women among 497 were currently married;12.1% were widowed; 4(1%) women were divorced and the proportion of unmarried women was almost 10%. Unskilled and domestic labourers were 56.3 percent while 31% were housewives. Almost 87 percent women are Hindu by religion followed by Muslims and Buddhists. As stated earlier, most of the women are engaged in low end jobs, the proportion of women having low income was high. Almost 29 percent women do not have any source of income. More than 45 percent women monthly earn Rs. 500-1000.

Among the total 497 women attending the camps, Pap smear was advised to 157 women. Among these 157 women, 44.6 percent women were suffering from endocervicitis, and 37 percent from vaginitis, two from cervical erosion while one case each of infiltrating duct carcinoma, were detected. Only fifteen percent cases are found to be normal. Although more than 20 percent of the women did not able to recollect their age at marriage, an association between the risk of early age at marriage and delivery and reproductive tract infections was observed. The fact that 34.1% of these women were married before 18 years of age, clearly shows that still the girls are getting married before the legal age at marriage.

Pap test is a single test to find abnormal cell changes that may arise from cervical cancer or before it develops. Pap test has to be done at least once in every 3 years after a woman begins to have sexual intercourse or later than 21 years.

Conclusion: There is a high association of risk factors like early marriage and early pregnancy and delivery and reproductive tract infections in the study population.

It proves that there is a great need for educating women regarding sexually transmitted diseases, reproductive tract infections and family planning. Hence early cancer detection program should be conducted more rigorously and it should reach to the doorsteps, especially in the slums.

Maharashtra IPHA Annual Report:2013

This year the Annual Maharashtra IPHA quiz was undertaken as a joint activity with Maharashtra University of Health Sciences, Nashik in memory of Dr Jal Mehta on the eve of World Health Day, 7 April. This activity has been initiated to promote participation of medical students in Public Health and to encourage the budding talent in Maharashtra. The competition was held at two stages namely regional and state level. Regional Quiz competitions were held at five zonal headquarters (Mumbai, Kolhapur, Pune, Aurangabad and Vidharbha). The winning teams from these five zonal rounds competed for the final round.

This year, the final round was hosted by Armed Forces Medical College, Pune on 4th April 2012. The quiz competition was won by contestants -Shivani Handa & Gayathri Warriar from AFMC, Pune. Air Marshal B Keshav Rao, AVSM, Director and Commandant, AFMC graced the occasion as the Chief Guest and gave away the prizes. Dr SS Dodwad, Brig.(Retd) S.K.Ganguli, Dr BSNasir, Dr Muralidhar Tambe & other dignitaries from IPHA, Dr SD Gundre-Director of Students Welfare, MUHS and faculty from various medical colleges were also present.

The Annual Conference of Association for Prevention & Control of Rabies in India was organized at Hotel Hyatt Regency, Pune on 6th and 7th July 2013. Dr SS Dodwad, Dr Muralidhar Tambe and Dr Sanjiv Kamble were in the organizing committee of the conference.

A training workshop on Quality Management in Health Care was conducted as a joint activity with GOM, DD-Thane for the medical officers of Thane, Ratnagiri and Sindhudurg districts with Dr SS Dodwad as the resource person.

The official publication of the association-IPHA Newsletter was published & distributed to all the life members, medical colleges, DHO offices, DDHS offices & other important public health institutes.



Announcements:

- **Official IPHA-MS website:** The official website of IPHA Maharashtra is www.iphamaharashtra.org. Association members are advised to go through the list of life members provided and update their current addresses on this website.

- The Annual Conference of IPHA Maharashtra 2013 is jointly being organized by IAPSM: Maharashtra Chapter and School of Health Sciences, University of Pune during 25th and 26th February, 2014 at YASHADA, Pune on the theme “**Millennium Maternal And Child Health Goals:Post 2015 strategies**”. A Pre-Conference CME on Genetics In Public Health Systems is being conducted on 24th February 2014. Registration fee for students is of 1500/-; and Rs 2000/-for others to be paid by DD drawn in the name of Registrar, University of Pune. Contact pphc2014@gmail.com. Telephone: 20-25691758. Updates at www.unipune.ac.in
- **World Health Day 2014:** Small creatures, Big threat
- **Contact us at :** iphamahabranh@rediffmail.com

Management Lesson ...

One of the most memorable case studies on Japanese management was the case of the empty soapbox, which happened in one of Japan 's biggest cosmetics companies. The company received a complaint that a consumer had bought a soapbox that was empty.

Immediately the authorities isolated the problem to the assembly Line, which transported all the packaged boxes of soap to the delivery department. For some reason, one soapbox went through the assembly line empty.

Management asked its engineers to solve the problem.

Solution # 1 : Post-haste, the engineers worked hard to devise an X-ray machine with high-resolution monitors manned by two people to watch all the soapboxes that passed through the line to make sure they were not empty. No doubt, they worked hard and they worked fast but they spent a whoopee amount to do so.

Solution # 2 : But when a rank-and-file employee in a small company was posed with the same problem, he did not get into complications of X-rays, etc., but instead came out with another solution.

He bought a strong industrial electric fan and pointed it at the assembly line. He switched the fan on, and as each soapbox passed the fan, it simply blew the empty boxes out of the line.

Lesson learnt: Always look for simple solutions; Focus on solutions & not on problems.

