



IPHA
MAHARASHTRA
BRANCH

Newsletter

(For Private Circulation Only)

Volume 13 Issue 01

April – June 2021

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From President's Desk

It's a matter of great pride to me to write this president's note for the first time, for the present issue of IPHA Maharashtra newsletter, volume XIII 2021. The new executive committee (2021 – 2024) has taken over in the month of April 2021 and all the members have expressed the desire to take up the IPHA Maharashtra chapter activities to a newer height and improve visibility of the association further.

Dr. Dodwad sir, Dr. Doke sir and our immediate past president Dr. Tambe sir have already shown us the correct path to move ahead, and on behalf of the executive committee, I assure to move on the same path by setting further goals to contribute substantially to the activities of the association already existing and initiating new activities in collaboration with all stakeholders of public health in the state, especially with focus on elevating the importance of the subject and developing good image of Medical Students opting for PG studies in this subject, along with extending technical support and capacity building of functionaries working at grass root level as and when necessary.

This is need of an hour on the background of present pandemic of Covid – 19.

Present executive committee is dominated by academicians of the Medical Colleges. Responsibilities on all fronts towards management of Covid 19 pandemic – curative and preventive measures are in toto shouldered by Public Health Department and we are witnessing the presence of all the warriors in the field. The battle will extend for longer time and the fight will continue. It is understood that at this difficult situation, our public health specialist will find it difficult to devote some time for the association work. Of course academicians and public health specialist are like two sides of the same coin and hence they have to be together always.

We all members of Executive Committee feel proud to lead the association built and nourished by public health functionaries and look forward to work in collaboration for bright future to the association and extend helping hand in all endeavors for common goals. Public health encompasses very wide sphere of integrated activities and reveals scope to excel in many directions for common purpose. So let's commit for IPHA philosophy i.e. Involving into People's Health Always.

- Dr. Gajanan D. Velhal

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Epilogue: Second wave of COVID-19 in India

EDITORIAL

Dr. Prakash Doke

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In India in the first wave the peak of 97,859 was recorded on 16th September 2020. On first Feb 2021, a minimum of 8,587 cases were reported. Then gradually the number reached to another peak of 4,14,433 and started declining. It reached to 1,14,537 cases on 5th June 2021. It is a positive indication that the second wave is receding. The country has witnessed more than fourfold rise in cases in second wave. Assuming and wishfully thinking, in coming months it will further decline substantially.

I believe that herd immunity has increased both as a result of the occurrence of numerous cases and as well as due to our vaccination drive. The vaccination in India started on 16th January for health care workers, then to front line workers, senior citizens, and middle aged in that sequence. On the other hand, the infectivity and virulence of mutated strains are uncertain. As per the worldwide experience sharp decline in India is also certain. Almost all the countries have experienced the second wave, in India also it was inevitable. India is the second-highest country in the world and has reported cumulative cases of 2,89,00151 as of 5th June 2021. The USA has reported 3,42,05,248 cases in corresponding period. Rather than the absolute number, cases per million population is refined statistic. In the USA there are 1,02,780 cases per million whereas in India the number is 20,753. This doesn't give us gratitude, as the number of cases is a product of the number of tests performed. In the USA the number of tests per million population is 1,461,353 which means several persons are tested more than once. In India, the number of tested per million is 261,924. But if we apply the law of averages, we are doing better than other countries, the world average is 22,311 cases per million population. We believe that our testing per million is at par with the world average.

The late start of vaccination is blamed for the high second peak. European countries and the USA started vaccination by the first half of December 2020. As of now, the

population covered by vaccination in these countries is certainly high. India doesn't have the clause of permission of vaccine use in an emergency under the drug act. However, for the first two vaccines within few days, approval was given. The time taken for emergency approval is analogous with other countries. For health care workers vaccination started in India on 16th January 2021. When it was started, a large section of our medical fraternity blamed the government for approving vaccine use without waiting for the publication of complete data of phase three trials. Many of my friends decided not to take the vaccine before April because of the doubtful efficacy and safety of the vaccines. The hesitancy percolated in the community. The coverage in the initial weeks was certainly less than desired.

The economy was already paralyzed in 2020 due to the lockdown imposed to minimize the spread of the COVID-19 pandemic. The scientists were doubting the efficacy and safety of the recently manufactured vaccine. In such circumstances to what extent the country can order vaccines is a debatable question. The countries having per capita income more than ten times of India could afford to play blindly. Fortunately, almost all vaccines stood the test of time and now there are no doubts about the efficacy and safety of the vaccines. Most of the health care workers, front-line workers, and senior citizens are vaccinated. The problem propped when the policy of vaccination included persons above 45 years.

If priority is given to the restoring of the economy the first persons to get vaccines may be from 15 to 45 years. On the other hand, priority may be given to reduce the case fatality rate. The case fatality rate is higher in the senior persons. Even the spectrum of severity differs. Most of the young persons had mild to moderate disease. The decision of deciding priority is very delicate. I am sure a lot of hot discussions must have been generated then.

I am uncertain about the means, desire, extent, and effect of prohibiting the enormous crowd at Kisan rallies and agitation in Punjab,

Kumbhmeala in Uttarakhand, Election rallies in West Bengal and Tamil Nadu. Unanimous decision and compliance to it by all political parties in true spirit of letter may have minimized the crowd. But this is post-facto thinking. Its implementation most likely might have resulted in postponing the peak and some reduction in cases.

The third wave or a high peak is unlikely in my opinion. But it will also depend on the vaccination coverage. The neutralizing antibodies titer declines after some months both after vaccination or infection. After revoking lockdown, the behavior of community may

become hysterical disregarding use of proper face mask, keeping physical distance and avoiding crowd. Secondly vaccinated group will have minimum overt cases. Hence, whatever cases occur in future the proportion of affected children may be higher than presently recorded.

Reference:

1. Statistics and Research. Coronavirus (COVID-19) Vaccinations. Available from: <https://ourworldindata.org/covid-vaccinations>
2. Worldometer. COVID-19 Coronavirus Pandemic. Coronavirus Cases. Available from: <https://www.worldometers.info/coronavirus>

***‘Building a fairer, healthier world’:
Role of Public Health professionals***

Major (Dr.) Ashlesha Tawade-Kelkar

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History

World Health Day was envisioned in the World Health assembly in 1948 and the first World Health Day was celebrated on 7th April 1950. Since then, the day is marked every year by activities that are planned well before the actual day and are carried out well beyond it to draw the attention of global community towards the pertinent health related issues. Every year a specific issue is focused upon through a theme adopted by the World Health Organization and publicized through partner organizations, media and community leaderships.

World Health Day 2021

The year 2021 has been unique in many ways. We have not only witnessed but also played our parts as citizens, health care workers and as public health professionals at various levels in once-in-generations public health catastrophe in the form of COVID-19 pandemic.

Inequalities in healthcare and shortcomings in health infrastructure were exposed and role of community health workers was highlighted like never before.

A strong political commitment towards health sector strengthening and health diplomacy at a global level assumed a strategic importance in keeping up with the overall progress of the country and meeting the national and international goals in sustainable development.

At community level, we have seen a public health revolution. People have become aware about the diseases that pose threat to public health, attitudinal changes that are expected of them for prevention and more importantly health seeking behavior is seen in the community which was rarely the case before. Of course, the wisdom comes with a cost and the cost being misinformation, fears, myths and morbidity as well as mortality associated with the disease. Breakthrough efforts have been put in to development of vaccines for COVID-19 and this itself has been one of the greatest achievements in science. On this background, the World Health Day 2021 is a milestone in the history of public health.

End the Discrimination and Exclusion

Discrimination on the basis of gender, race, cast colour and so on, has always divided the society unjustly and affected the outcome of health programs adversely. Insensitivity to disability, socio-cultural variance leads to fragmentation of society reducing the collective productivity.

The pandemic has shown us that the divide in the society not only impacts the health outcomes negatively but also makes it challenging to overcome a public health crisis efficiently. We as healthcare professionals must neither accept nor promote discrimination through any of our actions.

Health is a Right not Privilege

The current pandemic revealed the concerning health related situations across the world, developed and developing countries alike. Enjoying a state of health and well-being, not just physical but mental and social is a fundamental right of a living being. People in various circumstances suffered in more ways than one. The advancements in medical sciences have surely added the years to life. What remains to be answered is whether these increased years are really improving the quality of life, whether the years are lived in a state of physical, mental and social well-being. Fundamental reforms in lifestyles, work environments need to be acknowledged and implemented. A holistic approach and sustainable solutions to problems are more valued than quick fixes and narrow targeted outlook. These changes as perceived by the society so should be accepted by the leaders.

COVID-19 vaccines, tests and treatment must be available to All

As we saw the rise of the novel corona virus towards the end of 2019 that took the world by a storm through the year 2020 and continued to wreak havoc in most of the countries including India through second wave in the year 2021, we also witnessed governments and international bodies all over the world, building strong, dynamic and fast responses against the effect of the pandemic. India is considered as a strong leader in the south east Asia region. The strategies formulated and implemented by our country for combating the COVID-19 pandemic were not only appreciated but also adopted by many countries globally. As in case of all radical actions, the decisions taken during the pandemic pertaining to the evolving public situation were criticized as well as backed by various schools of thought, yet it was largely appreciated that the approach taken by the country was to protect lives of the countrymen as much as possible. The measures were taken to provide essential services to all strata of the society through various means.

The vaccine production facility available in India has been looked at as the biggest asset for the world today. Testing facilities were ramped up quickly all across the country and mechanisms were established for contact tracing and testing in both urban and rural communities. Despite these efforts, the gaps in healthcare infrastructure were apparent. We, as public health professionals, must strive to identify the root causes of these gaps and

provide solutions, keeping in mind the future of healthcare sector globally. Our research and collective voices must emphasize on making available the treatment modalities, testing facilities and vaccines to all the members in all communities equally.

No one is safe until everyone is safe

The effects of challenges to public health in the past have been felt through time and across generations at times. The communities that did not directly suffer due to a public health crisis also got affected indirectly due to changes in political commitments, economic impact and newer scientific knowledge. COVID-19 has been one of the biggest and worst public health emergencies till date. It is also the first disease against which a vaccine has come into existence in such a short period of time.

Countries and regions that have the capability to develop and produce vaccine sufficient to cover their entire population must not forget that we are only as safe as the most vulnerable amongst us and that the responsibility to provide the vaccine to the regions which lack the facility lies upon them. We are at war with an enemy so enormous in reach that it has reached and caused devastation on all the continents of the earth, including the Antarctica and penetrated all age groups, ethnicities, gender and socio-economic classes. It would not be wise to leave loopholes in pockets of population not covered with the vaccine, drugs and adequate treatment for the disease. Our goal must be to demand and insist on providing the protection against COVID-19 and an environment that is safe and favourable for a healthy living and development to all populations across the globe irrespective of religion, cast, colour, race, ethnicity, age, gender, disability or socio economic class.

It's time to build a healthier and fairer world for everyone everywhere.

Obstacles create an opportunity to reinvent paths to our destination. COVID-19 has provided us with an opportunity to address our existing issues in health with a fresh perspective. We must **'work together'** with affected individuals, communities, generate and utilize **'reliable data'**, **'tackle inequalities'** in all forms at all levels and most importantly, act **'beyond borders'** to overcome the crisis of COVID-19. Today, We, public health professionals are more received and heard than ever. We form a part of the solution. We must stand united for **'One Earth One Health'** 'Let us not accept, what we cannot change. Let's change what we cannot accept and build a fairer, healthier world.'

Report of 22nd Maharashtra State Joint Conference of IAPSM & IPHA 2021 By Organizing Chairperson Dr. Purushottam Giri

The 22nd Maharashtra State Joint Conference of Indian Association of Preventive and Social Medicine (IAPSM) and Indian Public Health Association (IPHA) on the theme “**COVID-19 Pandemic: An Eye Opener for Strengthening of Public Health**” on 03rd and 04th April 2021 with Pre-conference workshop on 02nd April 2021 conducted (Virtual / Online Mode) by the Department of Community Medicine of JIIU's Indian Institute of Medical Science & Research Medical College, Warudi Tq. Badnapur Dist. Jalna

The selection of theme of the conference “COVID-19 Pandemic: An Eye Opener for Strengthening of Public Health” is the need of hour today. This COVID-19 Pandemic is an eye opener in many ways for health and other departments concerned directly or indirectly with it. The corona virus pandemic has made us to host this conference online, which is first of its kind in the history of Maharashtra state chapters of IAPSM & IPHA. In this context this three-day scientific event was worthwhile for the purpose of evoking creative discussion in the relevant areas. Registration for the conference reached new record in history; we had **650** registrations of which **5** were International delegates and more than **150** from rest of India.

Two Pre-conference workshops were arranged on 02nd April 2021 (Friday) and both were followed up with question and answer session.

The First Pre-Conference Workshop was Technology Enabled Health & Demographic Surveillance System (HDSS) with following faculties - Dr. Abhay Nirgude, Dr. Poonam Naik, Dr. Pracheth R, Dr. Navya N., Dr. Pavithra H and Dr. Akshaya K M. The various topics discussed were - what is HDSS and what is its relevance in a medical college setting?, What are the pre-requisites for the development of HDSS?, How to establish technology enabled HDSS?, How does technology enhance utility and ensure data safety?, Non-communicable diseases surveillance and HDSS, Infectious diseases surveillance and HDSS, Role of technology based HDSS in clinical trials and longitudinal studies and How to ensure continuity of care?. The total number of participants those who actively participated were 150.

The Second Pre-Conference Workshop was Systematic Review and Meta-analysis (SRMA) which was conducted by following faculties - Dr. M. Nazli Khatib and Dr. Quazi Syed Zahiruddin.

The following topics discussed were - Overview of Systematic Review, Systematic Literature Search, Screening studies, Data extraction and Risk of Bias (RoB) assessment and grading the quality of evidence through GRADE-Pro GDT. The total numbers of participants were 160.

Prior to the inaugural function, a tribute was given to Dr. Ashok P. Kulkarni with heartfelt condolence for his sad demise. Dr. J. V. Dixit paid his homage to late Dr. Ashok P. Kulkarni. He also brief the audience about life sketch of Dr. Kulkarni.

Conference started with the inaugural function by hands of following dignitaries –

Hon'ble Shri Rajeshji Tope (Health Minister, Maharashtra State)

Hon'ble Maulana Ghulam Mohd. Vastanvi (Chairman, JIIU's Trust)

Hon'ble Maulana Huzaifa Ghulam Vastanvi (Vice Chairman, JIIU's Trust)

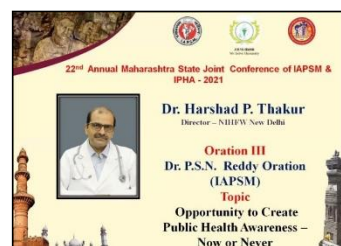
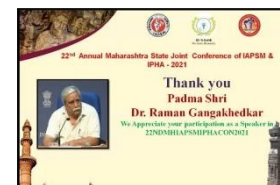


Dr. Azhar Ahmed Siddiqui (Dean, IIMSR Medical College, Badnapur)
 Dr. Ishrath Fatima (Medical Superintendent, Noor Hospital, Badnapur)
 Dr. Sanjay Zodpey (Vice-President – PHFI and Director- IIPH, Delhi)
 Dr. Muralidhar Tambe (President, IPHA Maharashtra Chapter)
 Dr. Swati Mahajan (President, IAPSM Maharashtra Chapter)
 Dr. Purushottam Giri (Organising Chairperson, 22nd mhiapsmiphacon2021)

E-Souvenir of the conference was released by the auspicious hands of dignitaries. e-Souvenir consisting of 140 pages was unique in its kind by adding an exclusive 'Key note address' section and also by presenting a new initiative like 'Archives' first time in the history of conference.

On Day 1, we had three Orations, (two of IAPSM and one of IPHA) and one key note address. All the Orations delivered by renowned faculty of Community Medicine and Public Health
 Oration I: Padma Shri Dr. D. N. Pai Memorial Oration (by IAPSM) on topic - Changes in MBBS Curriculum by NMC – Challenges & Opportunities in Community Medicine by Dr. Rajshekhar Wavare Dean, Sri Aurobindo Medical College & PG Institute, Indore.

Oration II: Dr. Banoo Coyaji Memorial Oration (by IPHA) on topic - Learning from COVID-19 Pandemic delivered by Padma Shri Dr. Raman Gangakhedkar, Former Head, Division of Epidemiology & Communicable Diseases, ICMR, Delhi



Oration III: Dr. P.S.N. Reddy Oration (by IAPSM) on topic - Opportunity to Create Public Health Awareness – Now or Never delivered by Dr. Harshad P. Thakur Director- NIHF New Delhi. Key Note address was delivered by Padma Shri Dr. C. S. Pandav, AIIMS Delhi -



Public Private Partnership in Health and Nutrition – A Case Study of IDD in India.

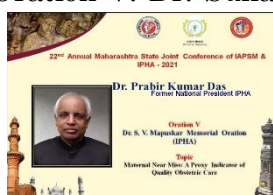
There were two plenary sessions, one was from Alive & Thrive, Delhi on topic - Improving MIYCN – research to policy and implementation, and second was from RNTCP Maharashtra on topic – Policy updates in NTEP TB free certification process.

For scientific session, we received total 90 research papers, of which 54 papers were for oral paper award category and 12 for free paper presentation, and while 24 for the best poster award. There were six award categories for oral paper presentation and two for poster presentation. The day ended with scientific session with presentation of research papers on various topics of public health importance.

On Day 2, Morning session started with scientific session with presentation of the research papers on various topics of public health importance. After scientific paper presentations, there were three orations (two of IAPSM and one of IPHA).

Oration IV: Dr. Mrunalini Pathak Memorial Oration (by IAPSM) on topic - Recent updates in TB Diagnosis & Management under NTEP with special reference to COVID-19 delivered by Dr. Sanjay Suryawanshi, WHO Consultant, NTEP, Bhopal, Govt. of India.

Oration V: Dr. Suhaschandra Mapuskar Memorial Oration (by IPHA) on topic - Maternal Near Miss: A Proxy Indicator of Quality Obstetric Care delivered by Dr. Prabir Kumar Das, Former President, National IPHA, Nagpur



Oration VI: Dr. D. K. Ramadwar Memorial Oration (by IAPSM) on topic - Research Opportunities for Medical Professionals in India delivered by Dr. Sushma S. Thakre Asso. Prof., Community Medicine, IGGMC, Nagpur

Scientific Paper / Poster Winners : 22nd Maharashtra State Joint Conference of IAPSM & IPHA 2021

Name of Prize	Name of Winner	Institute Name	Title of Paper presentation
Dr. Khergaonkar Award – Urban Public Health (by IAPSM)	Dr. Pragati Rathod	Govt. Medical College, Nagpur	Self medication practices in the urban field practice area of a tertiary care hospital from central India: a cross sectional study
Dr. M. V. Kulkarni Prize – Maternal and Child Health (by IAPSM)	Dr. Jyothi Vasudevan	Mahatma Gandhi Medical College & Research Institute, Shree Balaji Vidyapeeth, Pondicherry	Prevalence of reproductive health problems and utilization of RMNCH+A services among adolescent girls in rural area of Kanchipuram district, Tamilnadu
Dr. Bhalerao Prize – School Health (by IAPSM)	Dr. Priya Kulkarni	Symbiosis Women’s Medical College, Pune	Interventions to increase efficacy of ongoing national nutritional anaemia prophylaxis program
Dr. Saroj Jha Prize – Health Education / Gender Issues (by IAPSM)	Dr. Shruti Kardalkar	ESIC Medical College, Gulburga, Karnataka	“HE or SHE”: Still not in the race to accept vasectomy - a qualitative approach
Dr. Sonaji Jogdand Prize – Occupational / Environmental Health (by IAPSM)	Dr. Sangeetha S	Vinayaka Mission’s Kirupananda Variyar Medical College, Salem, Tamilnadu	Perception and knowledge on Artificial Intelligence in health care among doctors of tertiary health care settings in Salem, Tamilnadu
Dr. Sharangdhar Kanhere Prize – Community Based Intervention / Use of Appropriate Technology (by IAPSM)	Dr. Milka Madhale	ARSI University, Ethiopia	A study to develop foot pressure scanner in early identification of pressure points in diabetics
Best Poster Award – I (by IPHA)	Dr. Shiba Sethi	Post Graduate Institute of Medical Sciences, Rohtak, Haryana	Misconceptions about COVID-19 and its effect on vaccine acceptance in urban population of Rohtak: a cross-sectional survey
Best Poster Award – II (by IPHA)	Dr. Mageshwari M	Mahatma Gandhi Medical College & Research Institute, Shree Balaji Vidyapeeth, Pondicherry	Constraints of the palliative care patients during pandemic- a mixed-methods study

The panel discussion conducted on 04th April 2021 with eminent panelist

1. Dr. Sanjay Oak, Head of the Maharashtra State COVID-19 Task Force
2. Dr. Subhash Salunke, Technical Advisor on COVID-19 Task Force, Govt. of Maharashtra
3. Dr. Amitav Banerjee, Prof. HOD, Community Medicine, Dr. D Y Patil Medical College, Pune
4. Dr. Pradip Awate, State Epidemiologist, Public Health Department, Govt. of Maharashtra
5. Dr. Muralidhar Tambe, President IPHA Maharashtra Branch
6. Dr. Swati Mahajan, President IAPSM Maharashtra Chapter

Panel discussion was moderated by Dr. Vijaykumar Jadhav, Treasurer (Maharashtra IAPSM) and Dr. Purushottam Giri, Organising Chairperson, 22nd mhiapsmiphacon2021

Following points were discussed:-

- ❖ *The government, hospitals, medical fraternity and general population was not prepared for such pandemic.*
- ❖ *It had caused lots of human sufferings including financial, social, emotional, and psychological and even many people lost their dear ones.*
- ❖ *Emphasis should be on COVID appropriate behaviour, immunization and preventive health measures.*
- ❖ *Help of existing public health infrastructure and personnel should be taken to combat COVID*
- ❖ *The command to handle the pandemic should be in the hands of public health experts rather than the bureaucrats.*
- ❖ *Various research data was presented and it showed that continuously changing protocols caused lots of confusion and mismanagement.*

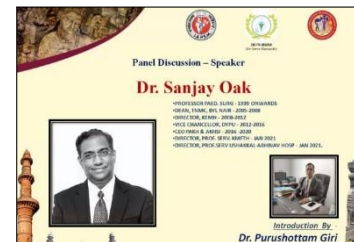
It was concluded that everyone has a role to play and combat this pandemic.

On second day, there were two plenary sessions, one was from Serum Institute, Pune on topic COVISHIELD vaccine safety, immunogenicity and efficacy and second was from Madhavbaug on topic – Evidence based preventive cardiology practice.

Valedictory function was conducted in presence of eminent dignitaries as Dr. Mohan Doibale (Past President, National IAPSM), Dr. Muralidhar Tambe (President, IPHA Maharashtra), Dr. Swati Mahajan (President, IAPSM Maharashtra), Dr. Azhar Ahmed Siddiqui (Dean, IIMSR Medical College, Badnapur), Dr. Purushottam Giri (Professor & Head, Dept. of Community Medicine, & Organising Chairperson, 22nd mhiapsmiphacon2021)

All the Orators honoured by giving honorarium, memento & certificate and also the prize winners from the award categories of oral paper & poster presentation were felicitated by giving cash prize & certificate.

Lastly, Dr. Rajesh Sambutwad (Organising Secretary) gave the vote of thanks and declared that 22nd Maharashtra State Joint Conference of Indian Association of Preventive and Social Medicine (IAPSM) and Indian Public Health Association (IPHA) - 2021 was a grand success.



FAST strategy in prevention of COVID -19 in Hospitals: A Novel Public Health Practice

Dr G D Velhal¹ Dr Rupali Sabale²

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²Assistant Professor, Dept. of Community Medicine, Seth GSMC and KEM Hospital

Abstract: FAST stands for Finding, Actively, Separating, and Treating. The strategy has been implemented for TB prevention in medical setting. But it has never been tested for other diseases. We adopted this strategy for prevention of COVID-19 in the tertiary care hospital, Mumbai in the month of March 2020. Through this, suspected COVID-19 patients were identified through cough surveillance and then they were provided ambulance to refer them to the Infectious Disease Hospital for testing and admission, if required. We conclude that FAST strategy can be implemented to control hospital infection and this strategy can be experimented for other infectious diseases wherein cough is one of the main symptom.

Key-words:

FAST, COVID-19, Hospital Infection Prevention and Control, Public Health Practice

Key Messages: We implemented FAST strategy for prevention and control of COVID-19 infection in our hospital setting. It is said that, many other infectious diseases will emerge or re-emerge in future. Most of the infectious disease has cough as the main symptom. Thus, FAST strategy, which has shown evidence in Tuberculosis, can be experimented for other infectious diseases as well.

Introduction:

FAST strategy is a focused approach to stop tuberculosis spread in healthcare facilities. This strategy has been implemented particularly in HIV and ART clinics to find out suspected cases of tuberculosis from the OPD setting area.^[1] The principle behind implementing it is, detecting the suspected case, and separating him/her from the crowd to prevent spread of infection to other patients and health care staff. In India, as per the TB report – 2019, this strategy has been implemented in 109 health facilities.^[2] FAST strategy for TB control is implemented in the following manner^[3]

F – Finding TB patients: Patients are observed for cough in waiting rooms, registration areas, and admission holding areas.

A – Actively: An assigned staff identifies patients with current cough, fast track them to be screened for other symptoms suggestive of TB.

S – Separating safely - Patients identified through cough surveillance is educated on respiratory hygiene and moved to a well-ventilated area

T - Treatment: Effective TB treatment is started.

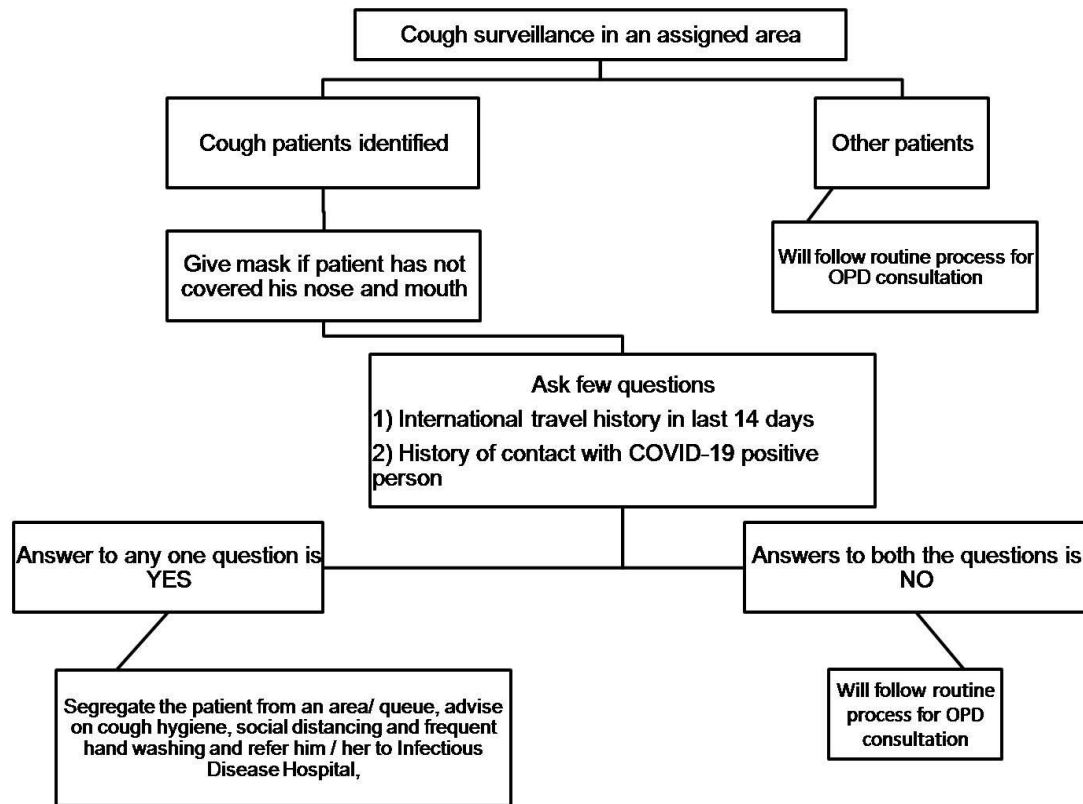
The objective of this paper is to describe FAST strategy that was adopted for prevention of COVID-19 in the tertiary care hospital and to describe socio-demographic characteristics of the patients that were identified through this strategy.

Case Study:

The Department of Community Medicine implemented FAST strategy in the tertiary care hospital, Mumbai, which treats almost 1.8 million out-patients and 85,000 in-patients annually. The hospital renders service, virtually free of cost to mostly to the underprivileged sections of the society.^[4] In Mumbai, first case of COVID-19 was reported on 11th March 2020.^[5] In the same month, our hospital was in the early planning stage of containment measures for COVID-19. Fever clinics had not yet started. General public were not using mask. Use of mask was restricted to those with symptoms of COVID-19. However, it was observed that, in our hospital even those having symptoms, many were not wearing mask. This situation was a concern, since it was leading to mixing of suspected COVID-19 patients with other patients and health care workers.

After analyzing this situation, it was decided to implement FAST strategy to control COVID-19 infection in the hospital. Objectives were to segregate the suspected COVID-19 patient from the congregated patient registration areas, provide them mask, raise awareness in the identified patients regarding cough hygiene, hand washing and social distancing and ensure he / she is referred to Infectious Disease Hospital, if required.

Figure 1 – FAST Algorithm for prevention of COVID-19 in hospital



Managerial activities undertaken were –

- 1) Selection of areas – In FAST, we need to select area which can lead to increase case detection. With this principle, we selected 3 areas viz. - patient registration, casualty and registration area at Cardiovascular and Thoracic (CVTC) building.

Patient registration area was selected, since Out Patient Department (OPD) case paper is issued from this area through different counters depending on the specialty OPD. After the OPD timings, emergency patients or those who need care, avail treatment through casualty area. There is separate building (CVTC building) for patients suffering from cardiac problems with separate registration counter.

Hence, these 3 areas were selected since we could foresee increase case detection through these areas amongst all other areas in the hospital.

- 2) Appointment of Nodal person– Head and Professor, Dept of Community Medicine was the overall in-charge of the FAST strategy. Assistant Professor was appointed as a nodal person.
- 3) Setting up FAST algorithm – Fig 1 describes the algorithm.
- 4) Sensitization of interns – 3 interns were deployed to work at 3 respective areas. Their duty timing was 7.30 am to 2 pm, 2 pm to 9 pm and 9 pm to 7.30 am. They were sensitized regarding FAST algorithm, cough hygiene and hand washing technique. Interns were provided with necessary protective personal equipments.
- 5) Reporting - Report from each shift intern was collected. Report included number of patients identified and sent to Infectious Disease Hospital with few socio-demographic details of the patients.
- 6) Supervision – Supervision at the areas was done by nodal person. Surprise visits were also done by Dean and Professor of Dept of Community Medicine.

Total 84 suspects of Covid 19, were identified during the period 1st March 2020 to 20th March 2020. After this separate OPD was established and all patients were diverted to this OPD. Mean age of the patients was 37 years (\pm 15 years). Range was between 12 years to 71 years. Age and sex distribution of patients is shown in the Table -1. Proportion of females and males was 41.7% and 58.3% respectively.

Table 1 – Age and Sex distribution of patients

Age of the patient	Sex of the patient		Total
	Female	Male	
12 to 20 years	4 (11.2%)	2 (4.1%)	6 (7.1%)
21 to 30 years	12 (34.3%)	17 (34.7%)	29 (34.5%)
31 to 40 years	5 (14.3%)	13 (26.5%)	18 (21.4%)
41 to 50 years	6 (17.1%)	7 (14.3%)	13 (15.5%)
51 to 60 years	4 (11.4%)	7 (14.3%)	11 (13.1%)
61 years and above	4 (11.4%)	3 (6.1%)	7 (8.3%)
Total	35	49	84

Out of 84 patients identified, all patients except one (was advised home quarantine) were referred to Infectious Disease Hospital as per the protocol then. Around 32.1%, 46.4% and 21.4% of patients were identified during morning, afternoon and night shift duty. Out of 84 patients, 69 of them (82%) did not have international travel history. Amongst 15 patients, countries that visited were USA, Dubai, Israel, Qatar, Ireland, Indonesia, Germany, France, HongKong, Thailand and Belgium. 7 patients had domestic travel history to Nashik, Uttar Pradesh, Karnataka, Pune, Manali and Kerala.

Discussion:

The FAST strategy ensures that patients with presumptive TB are actively evaluated, separated and in case of diagnosis the treatment is timely initiated.^[6] FAST was implemented in Bangladesh for TB infection control. Implementing the FAST strategy at the hospital results in a sharp increase in identification of number of unsuspected TB and DR-TB cases and in effective treatment as compared to routine practice.^[7] We also implemented FAST strategy, with main aim of early identification of suspected COVID-19, segregate him/her from queue and refer him/her to infectious disease hospital. If FAST strategy, would have not been implemented, 84 identified suspected patients would have spread infection to other patients and also to health care workers. As per the protocol, then existed, it was not possible to confirm the diagnosis amongst these 84 suspected patients referred to Infectious diseases hospital.

Since in this strategy, we approach the patient through cough surveillance, and segregate him, the issue of patient getting stigmatized is often discussed especially in TB setting.^[3] This issue, we didn't face in implementing FAST for COVID-19 infection. In fact, we got positive response from the patients. They were contented, with hospital giving them personal care by providing ambulance to reach Infectious Disease Hospital. We observed that interns became a center point of information. Since, they were roaming in their designated areas, non-patients or relatives of patients also started seeking their advice. Through this, we could realize some social issues related to COVID-19. Some were society members and employers insisting the asymptomatic person and workers to get tested respectively. Few patients visited the hospital almost thrice times, just to get verified that they are not suffering from COVID-19. Interns were so pro-active in their work, that they made video to sensitize people on when to report to hospital to get tested for COVID-19. While deciding to implement FAST strategy versus triage, we chose FAST for various reasons. As mentioned earlier, we implemented it in the month of March when first patient was detected on 11th March in Mumbai. So at the start of FAST strategy; fever clinic, isolation wards, SARI (Severe Acute Respiratory Infection) wards were not set up in our hospital. In triage, we approach each and every patient, and ask them symptoms. According to their symptoms they are referred. In the first week of March month, our hospital had usual load of patients with all the OPDs and routine work going on. Thus, it was impractical to ask each and every patient regarding their symptoms to detect suspected COVID-19.

There were 92 confirmed cases by the end of March 2020 in India.^[8] As containment measures in our hospital, fever clinic was established known as CCF (Cough, Cold, Fever) OPD in the casualty area on 21st March 2020. Gradually, many people started wearing mask or covered

their nose and mouth with handkerchief. This faced difficulty in doing cough surveillance. Thus, we could implement FAST strategy only during early phase of COVID-19 pandemic in our hospital. As per our review of literature, we did not find documentary evidences, wherein FAST strategy being implemented in the earlier phase of control of COVID-19 infection in hospitals when use of mask was not compulsory. Thus, this novel case study can be the guiding tool for the hospital administrators, policy makers, hospital infection control teams, researchers to experiment or implement the FAST strategy for other infectious diseases. It is well known that, many other infectious diseases will emerge or reemerge in the future. Moreover, most of it are respiratory tract infections with cough as the main symptom. Thus, FAST strategy, which has shown evidence in Tuberculosis, can be experimented for other respiratory tract infections to control hospital infection.

Conclusion

FAST strategy was adopted to control COVID-19 infection in the medical settings when wearing mask was not compulsory and in the early phase of Pandemic. This is a promising strategy that should be explored for prevention of other infectious diseases in the hospital settings.

Acknowledgement: We acknowledge our Dean and Academic Dean of the college and administrative authorities for providing inputs in FAST algorithm and ambulance for transfer of patients.

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Public Health is our commitment to

P – People making use of all
U – Universal health care components and adopting
B – Best
L – Life style measures
I – Including
C – Care of self and

H – Hygienic practices with due concern to
E – Environmental safety
A – Awareness generation on various health issues
L – choosing good Living conditions
T – Through
H – Holistic Approach

Compliance to timely administration of BCG vaccine at birth – A Cross-sectional study.

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Abstract: According to WHO recommendations, in countries with a high burden of TB like India, a single dose of BCG vaccine should be given to all infants as soon as possible after birth. Timely administration of BCG vaccine is an important preventive measure to develop immunity against TB meningitis and disseminated TB in children. Though national immunization coverage levels of all vaccines under Under Universal Immunisation Programme are sufficiently high, immunization coverage of BCG vaccine is low at birth selectively. **Aim:** 1) To find out age of children at the time of BCG administration. 2) To find out the proportion of children who have received BCG within three days of age. 3) To determine the reasons for noncompliance of BCG vaccination within 3 days of birth. **Settings and Design:** Under five Immunization OPD of a Municipal tertiary care hospital of Mumbai, Cross sectional study. Based on previous year's data, a total of 334 under five children attended immunization OPD per month. By convenient sampling method, 50% of the total i.e. 167 informal interviews were conducted of the mothers of eligible children attending this OPD of a tertiary care hospital. Informed consent was obtained from mothers of eligible candidates. Ethical approval for the study was obtained. Statistical analysis used: Simple proportions, percentages, chi-square test. **Results:** Mean age of administration of BCG vaccine was found to be 26.9 months. Only 59.3% received BCG vaccine within three days of age. Most common reasons for noncompliance to timely administration of BCG vaccine as cited by mothers were illness of child, unaware about timing of BCG vaccination, not informed by hospital staff and unavailability of health services. **Conclusions:** It is essential to focus on factors like long distance residence, time consumed in travelling and unawareness about the nearby health centre services.

Key-words: BCG vaccine, vaccination, Immunization, at birth, timely, administration of vaccine

Introduction:

BCG vaccine is a live attenuated vaccine obtained from culturing *M. bovis* isolated from cattle. (1) According to WHO recommendations, in countries with a high burden of TB, a single dose of BCG vaccine should be given to all infants as soon as possible after birth. (1) According to National Immunisation Schedule of Govt. of India, BCG vaccine must be administered at birth or as early as possible till one year of age. The recommended dose is 0.1ml (0.05ml until one month of age) intradermally at left upper arm. (5) Immunization of a newborn with BCG vaccine enhances the efficacy of the vaccine by avoiding the interference with atypical mycobacterium which can infect the child during the post neonatal period. (6) Most infant deaths occur during the neonatal period, particularly in the first week of life. (7) It has been shown that BCG vaccination can reduce neonatal mortality by 48% in children with low birth weight when administered at birth. (8) When their mortality risk is highest, any delay in timely administration of BCG vaccine may have major consequences due to loss of benefits from BCG vaccination. Immunization coverage of BCG vaccine is low at birth. In a tertiary care set up, once children are delivered, mothers are usually kept in post-natal care (PNC) wards and discharged. Average time of discharge is three days after the delivery. When the PNC mother is discharged from ward without taking BCG vaccination, there is likelihood of missing the BCG vaccine due to its unavailability at general practitioner level. Various studies have been reported about determinants of overall immunization coverage but very few studies have been done on determinants of noncompliance of timely administration of BCG vaccine.

Hence we mainly aim to study compliance to timely administration of BCG vaccine at birth in mothers of under five children reporting at immunization OPD. Objectives were to find out the proportion of children who received timely BCG vaccination and to determine the reasons for noncompliance to the same.

Study settings: The study area is a Municipal tertiary care hospital in Mumbai. The 2193 bedded Municipal hospital providing immunization services through immunization in labour room, PNC wards and under five Immunization OPD on daily basis(6). Monthly, on an average, 334 children below the age of five years report at the immunization OPD of study area.

Study design and population: This was a cross-sectional observational study. Convenient sampling was done. After taking 50% of this total number of children below five years of age who had reported at immunization OPD in a month, sample size was taken as 167. Study subjects were under-five children accompanied by their mothers/ caretakers reporting at immunization OPD.

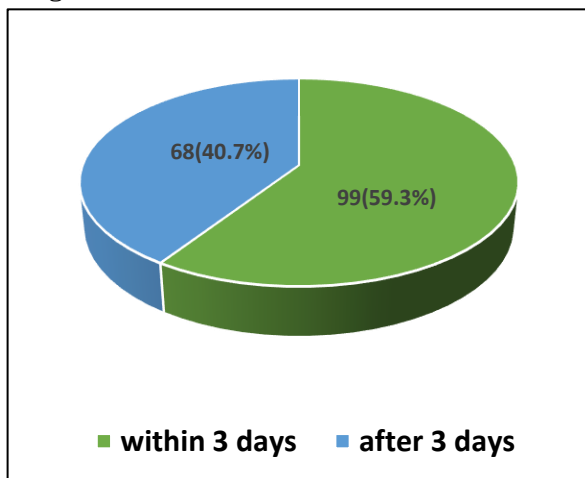
Study tool: A semi-structured interview schedule had been designed comprising of four parts which included socioeconomic details of the mother, relevant obstetric history of mother, information of child, birth history, BCG immunization status, questions related to reasons for noncompliance. This interview schedule was validated by experts in the concerned subjects according to the objectives of the study.

Study procedure: Approval for the study was obtained from the Institutional Ethics Committee. Study subjects were selected after obtaining informed consent for those who met inclusion criteria. Data collection was started with the child and his mother/ caretaker who had reported at immunization OPD and had fulfilled inclusion criteria and was willing to participate was selected in the study. Then consecutive eligible children and their mothers/ caretakers were included in the study till the sample size was completed. The investigator filled interview schedules while conducting face to face interview of the mothers/ caretakers. Privacy was maintained during interview.

Statistical analysis: Timely vaccination of BCG was defined as administration of BCG vaccine within first three days of life. All responses were tabulated by the investigator using Microsoft Excel 2016 version. Data were analysed by using SPSS software version 21. Data were summarized using proportions, percentages. Association between socio-demographic and various other factors with outcome were assessed by Chi-square test.

Results: Total 167 children and their mothers participated in the study. The mean age of mothers was 28 years, with range of 20-43 years. 62.9% mothers were below the age of 30 years. Mean age of children at time of administration of BCG vaccine was found to be 26.9 months, with range of 0-190 days. The mean age of children was 6.4 months, with range of 0.5-62 months. Almost 86.8% children were in the age group of 0-12 months (below 1 year). Study findings revealed that coverage of BCG vaccine was 100%. Out of this coverage, BCG vaccine was timely [within 3 days of life] administered in 59.3% children and delayed [after 3 days of life] in 40.7% children (Diagram 1).

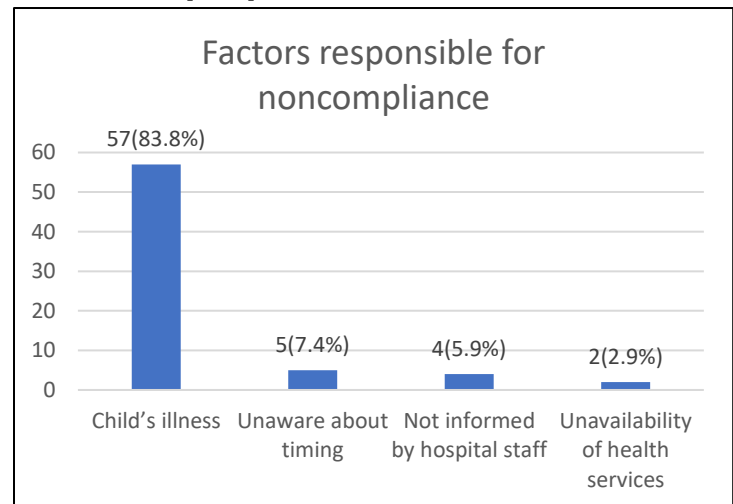
Diagram 1: BCG vaccine administration in the study area [N=167]



From the various socio-demographic factors, gender of child, type of delivery, gestational age at the time of delivery, distance of residence from the study area, mode of transportation used to reach study area, time required to reach study area, immunization status of the siblings,

The main reason for noncompliance to timely BCG vaccination as perceived by the mothers was given as child's illness (83.8%) followed by being unaware about the timing of vaccination (7.4%).

Diagram 2: Factors responsible for noncompliance to timely administration [N=68]



information about the nearby health service unit were found to be positively associated with delayed BCG administration.

Table 1: Association of socio-demographic factors with BCG administration:

Discussion:

This study was conducted during the period of February 2018 to April 2018. Findings of the study showed BCG vaccination coverage to be 100%, which is little higher to NFHS-4 data (91.9% for India and 90% for Maharashtra) (7).

The results were supported by report of DHLS-4, which showed BCG immunization coverage of Maharashtra 95.6%(8). A study conducted by Vashishtha showed BCG coverage 86.9%[9]. Similar results i.e. 83.3% BCG coverage were found in the study by A.M. Kadri et al. [10]. Another study conducted by Jatti and Bandichhode on evaluation of primary immunization coverage showed BCG coverage of 97.5%[11].

The most common reasons for delayed BCG vaccination as perceived by mothers were child’s illness (83.8%), unaware about timing (7.4%), not informed by hospital staff(5.9%) and unavailability of health services (2.9%).

A study conducted by B. Sharma et al showed that most common reasons for noncompliance to immunization were given by respondents as child’s illness (56.4%), unawareness (16.4%), lack of time (10%), away from home (7.2%), no one to accompany(6.4%)(12). A study conducted by Kar et al. showed that the major causes for incomplete immunization were illness of child(30.8%), unawareness (23.1%), and migration to native place (23.1%) (13).

There was significant association between BCG vaccine administration and gender of child, delivery place, gestational age at the time of delivery, distance of home from health service unit, mode of transportation used to reach, time required to travel, immunization status of the sibling and information about nearby health service unit.

A study conducted by B.Sharma et al found significant association between child immunization and delivery place (12).

Variable	BCG administration		p value
	Timely	Delayed	
Gender			
Male(n=80)	41	39	0.043 (<0.05)
Female(n=87)	58	29	
Mother’s age			
20-29years(n=105)	64	41	0.567
30-45(n=62)	35	27	
Mother’s occupation			
Homemaker(n=138)	85	53	0.185
Working(n=29)	14	15	
Type of family			
Nuclear(n=82)	45	37	0.322
Extended(n=46)	27	19	
Joint(n=39)	27	12	
Socioeconomic status			
Upper(n=6)	3	3	0.505
Upper middle(n=35)	24	11	
Lower middle(n=58)	32	26	
Upper lower(n=66)	38	28	
Lower(n=2)	2	0	
Birth order			
1st (n=99)	58	41	0.188
2nd(n=52)	33	19	
3rd(n=13)	8	5	
4th(n=3)	0	3	
Type of delivery			
Normal(n=108)	71	37	0.022 (<0.05)
Cesarean section(n=59)	28	31	
Birth place			
Govt. institution(n=151)	91	60	0.223
Pvt. Institution(n=14)	8	6	
Home(n=2)	0	2	
Gestation			
Preterm(n=41)	4	37	<0.0005 (<0.05)
Term(n= 126)	95	31	
Distance(km)			
<15(n=108)	81	27	<0.00001 (<0.05)
15-30(n=19)	4	15	
>30(n=40)	14	26	
Mode of transport			
Local train(n=70)	32	38	<0.0005 (<0.05)
Bus(n=19)	8	11	
Taxi(n=63)	53	10	
Other(n=15)	6	9	
Time(minutes)			
<30(n=63)	52	11	<0.00001 (<0.05)
30-60(n=62)	28	34	
>60(n=42)	19	23	
Immunization in Siblings			
Yes(n=41)	31	10	0.014 (<0.05)
No(n=126)	68	58	
Information of nearby Health service unit			
Yes(n=122)	66	56	0.025 (<0.05)
No(n=45)	33	12	

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Covid 19 Pandemic - Concerns related to Public Health

1. Gaps in natural history of the disease
2. Difficulties in making diagnostic test services available up to PHC level – technology and cost
3. Efficacy of various drugs in the management of the disease
4. Development of protective herd immunity and it's parameters – serial sero surveys
5. Influence of Covid 19 on non covid illnesses
6. Influence of Covid 19 on demand for hospital services for non covid illnesses
7. Vaccines for all age groups and for different vulnerabilities
8. Issues related to vaccine efficacy
9. Post covid complications – short and long term, including Mucor mycosis
10. Lockdown or cluster containment – what works better
11. Out of pocket expenses for Covid 19 victims
12. Cost concerns – average costs for Home isolation, institutional isolation, home and institutional quarantine, In patient treatment cost on O₂ bed, ICU bed etc.
13. Biomedical waste management issues in Covid 19 pandemic
14. Issues of children who have lost parents during the pandemic

Public Health specialists and academicians should undertake research studies with major focus on above mentioned aspects.

Re-emerging threat of fungal infections superimposing the second wave of COVID-19 pandemic.

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Background:

India is still reeling under the second wave of Covid-19 pandemic. Worsening the situation is a slew of opportunistic fungal infections affecting actively infected as well as recovered post-covid-19 patients. Monikered as the 'black fungus', Mucormycosis is most prevalent among the lot. It is an angio-invasive fungal infection leading to necrosis and death of tissue, resulting in high levels of mortality and morbidity. Initially believed to affect only severe cases of Covid-19 or immunocompromised patients, currently, it is affecting young patients with no known comorbidities and patients with undiagnosed Covid-19 as well. Candida auris, invasive candidiasis, and Aspergillosis have joined the battery of fungal infections that have made an appearance in the trails left by the Covid-19 virus. [1] Candidemia or bloodstream infections caused by candida, known as the 'white fungus' has been making the headlines along with the much more difficult to diagnose and rare pulmonary aspergillosis also known as the 'yellow fungus'. The rarity of pulmonary aspergillosis is attributed to its non-specific symptoms and the requirement of the specimen from deep in the lungs for diagnosis. Histoplasmosis and cryptococcosis have also been associated with covid-19, prolonging the hospitalization of affected patients. [2]

Public Health Impact of Opportunistic fungal infections:

Many Indian states like Rajasthan, Telangana, Odisha, Tamil Nadu, Gujarat, Karnataka, Punjab, Haryana, Bihar have already declared mucormycosis as an epidemic. The state of Maharashtra and Gujarat have been the worst hit, reporting over 2000 cases each by the end of May 2021 with 120 deaths in Maharashtra, and more than 250 deaths in Gujarat. [3] Plagued with an unprecedented shortage of antifungal medications the health system has resorted to arranging antifungals while ignoring its epidemiology and prevention in the first place. CAM (Covid-19 Associated Mucormycosis) has been first reported during the first wave. However, the incidence is much more in the second wave and has gained public attention with more than 14,872 cases as of May 28, 2021. [4]

Other opportunistic fungal infections have followed suit recently. It is several months since the initial cases of mucormycosis but, has been made notifiable only recently since 19th May 2021. [5] A rising trend of mucormycosis cases has been reported in India from 2005 – 2010 onwards, owing mainly to the increasing prevalence of Diabetes and other factors such as immunocompromised conditions, hematological malignancies, allogeneic stem cell transplantation, and increased diagnostic capability. [6] This is unlike other developed nations where it is seen more in hematological malignancies and allogeneic stem cell transplantation. It is also transmitted through wound infections especially after natural disasters due to contamination of the wound. For CAM, a combination of factors like the unmasking of diabetes in Covid-19, indiscriminate use of steroids in its management, use of impure water in steam inhalers, unclean oxygen cylinders, prolonged ventilator dependency, industrial oxygen support, and repeated use of old masks swarming with pathogens have been hypothesized. Unhygienic conditions caused by the reuse of basic equipment owing to the shortage faced as a result of a steep rise in cases have also been implicated. However, development of mucormycosis in patients with unknown swab results and no history of hospitalization have also been reported. [7] Unlike mucormycosis, invasive candidiasis has been reported in hospitalized patients. Aspergillosis occurs as a co-infection more commonly in severe cases of Covid-19 and presents with unspecific symptoms making diagnosis difficult.

This unexpected rise in cases has led to a shortage of antifungals like Amphotericin B, Liposomal Amphotericin B, Isavuconazole, Posaconazole, voriconazole, etc, further adding to the misery of the ailing patients. These antifungals are quite expensive too. Surgical debridement may be required in advanced cases. After making it a notifiable disease central government is now allocating Amphotericin B to the districts based on the number of prevalent cases. [5] Declaration of mucormycosis as an epidemic in worst-affected states has led the state governments to cap treatment costs and take control of the allocation of hospital beds too. In Maharashtra, treatment

for mucormycosis is now included in its flagship health scheme- Mahatma Jyotiba Phule Jan Aarogya Yojana. [8]

Irrespective of the type of fungus, or the color of its monikers, opportunistic fungal infections have surely impacted the ability of the healthcare system to fight the virus. It can no longer be treated as just a clinical condition. An urgent and detailed epidemiological investigation into the widely hypothesized factors needs to be followed up while increasing the capacity for its early diagnosis and timely treatment. Strict regulation of over-the-counter steroid abuse, adherence to sterile principles of management, allocation of sufficient effective antifungals, and strict glycaemic control in diabetics is vital to the management of opportunistic fungal infections.

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Research Study Abstracts of Winners of IPHA Maharashtra Branch Scheme Padvidhar Sanshodhan Prkalp Anudan for M.B.,B.S. Students from Medical Colleges of Maharashtra

2018: Anshi Jain*, K. J. Somaiyya Medical College, Mumbai
Psychosocial aspects of persons living with type-2 Diabetes mellitus in urban slum area

Introduction: Diabetes is one of the major chronic diseases prevalent in the world. Diabetes often has a negative effect on a person resulting in persistent distress. There is not enough evidence of how diabetes affects psycho-social aspects of an individual. Therefore, the purpose of the study is to assess the psychosocial problems prevailing amongst the diabetics under different domains (emotional, physician related, regimen related and interpersonal distress). **Methodology:** A Cross-sectional Descriptive Study was conducted amongst 62 diabetic individuals with onset of diabetes at least a year back; belonging to a low socio-economic group. The participants were recruited for the study from the registered patients at Urban Health Training center of K.J. Somaiya Medical College in the city of Mumbai from Jan to Mar 2019. Variables used in the study were Age, Sex, Religion, Educational Status, Income, Working conditions/Occupation, Marital Status. After obtaining the consent, questions were asked in Hindi and responses recorded on structured tool.

Results: The 90% of the diabetic individuals did not feel cheerful and happy at times. These individuals were mainly above 75 years(37.5%), not living with spouse (23.8%), employed (19.5%) , with a comorbidity (18.9%) and living with Diabetes for a duration of 5-10 years (33.3%). A little over one third (38.7%) of the participants felt depressed when they thought about diabetes whereas some (29.03%) even felt scared. The 43.55% of participants were worried about developing complications of Diabetes Mellitus like Retinopathy, Nephropathy and Neuropathy. 29.03% of the participants felt angry about living with Diabetes and 48.39% felt stressed due to Diabetes. About one-third of the patients felt that there were too many medicines to be taken everyday and were not able to do things as advised by the physician and also felt there were too many medicines to be taken. All study participants were satisfied with care being provided by their physician. Friends and family were not perceived as being supportive sometimes in their diabetes management effort by 22.6% of the individuals. The 79.8% of patients felt that God could cure their diabetes whereas 79.03% felt that trusting in God has helped them to manage Diabetes better. **Conclusion:** Diabetes isn't as big a disease as its outcomes are. Diabetes weakens various aspects of our physiology of the body such as cardiovascular, renal, ocular system but most important aspect is that it can break our inner-selves. Diabetes can only overtake us only if we allow it to.

* **Guide: Dr. Padmavathi Dyavarishetty, Professor and Head, Dept of Community Medicine**

Padvidhar Sanshodhan Prakalp Anudan - 2021

In order to promote interest for research among undergraduate medical students, there is a need to encourage research aptitude among undergraduate medical students to undertake small research projects. The students aspire recognition and may need some financial support to pursue these small research projects. As a response to this need, Indian Public Health Association, Maharashtra Branch is offering last few years financial support to deserving research proposals from under-graduate students from Medical Colleges located in Maharashtra State. This will not only provide an opportunity to students to familiarize themselves with research methodology & techniques but will also serve as an incentive for them to take up research as a career in the future.

Guidelines for submission of research proposal

- Topic should be related to Public Health /Community Medicine
- The project proposal should be submitted to IPHA Maharashtra Branch office by email on iphamahabbranch@rediffmail.com . The proposal should reach on or before 30th November 2021
- The proposal will be scrutinized by panel of experts.
- The acceptance of proposal will be communicated by end of December 2021 to the concerned student by email.
- The projects from all Medical Colleges will be assessed and five best projects will be awarded funding of Rs. 5,000/- each.
- Student should prepare & complete project under the guidance of Community Medicine faculty.
- The funds will be released in 2 instalments i.e. Rs. 2,500/- once the project is approved and Rs.2,500/- at the end of final submission of one hard copy of the project report.
- Final submission of Project Report should be before 31st December 2022.

Format of Application

1. Title page with Name and details of the student and guide bearing signatures
2. Research Proposal
 - a) Title
 - b) Introduction
 - c) Objectives
 - d) Material and Methods
 - e) Plan of Data Analysis
 - f) References
 - g) Annexure: Study tools, details of budget requirements, etc.
3. Enclose Institution Ethics Committee approval letter
4. Enclose Covering letter from Head of Community Medicine Department

All documents to be submitted in single e-mail as typed or good quality scanned documents.



IPHA Maharashtra Branch Executive Committee (2021-24)



PRESIDENT: Dr. Gajanan Velhal

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Assistant Professor, Community Medicine, B. J. Government Medical College, Pune **E-mail: dr.nandusalunke1285@gmail.com**



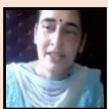
EXECUTIVE COMMITTEE MEMBER: Dr. Prakash Gattani

Professor & Head, Community Medicine, Dr. S. C. Government Medical College, Nanded **E-mail: pragat2015.pg@gmail.com**



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EXECUTIVE COMMITTEE MEMBER: Dr. Sarika Patil

Associate Professor, Community Medicine, Shri Bhausaheb Hire Government Medical College, Dhule **E-mail: drdurgapjp@gmail.com**



EXECUTIVE COMMITTEE MEMBER: Major (Dr.) Ashlesha Tawade-Kelkar

Assistant Professor, Community Medicine, MGM Medical College, Navi Mumbai **E-mail: ashlesha.t@gmail.com**

ANNOUNCEMENTS

1st Virtual Conference of IPHA

With immense pleasure we wish to inform you that the 65th Annual National Conference of the Indian Public Health Association (IPHACON 2021) is being organized by Department of PSM, JISPH and IPHA Pondicherry State Branch from 24th to 26th September 2021.

For Registration, please visit:

<https://iphacon2021.com/>



Dr. Gautam Roy
ORGANIZING CHAIRPERSON
President of Pondicherry State branch

Dr. Sitanshu Sekhar Kar
ORGANIZING SECRETARY
Secretary of Pondicherry State branch

APPEAL

The Indian Public Health Association (IPHA) existing since 1956 is a professional registered body (Society Act No. S/2809 of 1957 – 58) committed to promotion and advancement of public health and allied sciences in India, protection and promotion of health of the people of the country, and promotion of co-operation and fellowship among the members of the association. IPHA has local branches in almost all states of the country.

Any professional graduate, MBBS or any equivalent degree recognized by any Indian university in Indian System of Medicine / Dentistry (BDS) / Engineering (BE) / Nursing (B Sc Nursing) / Veterinary (BV Sc & AH) are eligible to be ordinary & life member of the association after paying the necessary subscription.

We, the executive committee members of IPHA – Maharashtra Branch sincerely appeal the eligible qualified individuals to become the life members of the organization and enhance our strength and visibility. Kindly visit National IPHA website, www.iphaonline.org to download the application form and for further official procedures of payment of membership fee.

If you need any help in this regard please feel free to contact Secretary, IPHA – Maharashtra Branch on phone (022 - 2743 79 96 / 97) or on email - iphamahabranh@rediffmail.com