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Our Planet Our Health

As we are hoping to end this COVID-19 pandemic this year, and start paying attention to other issues of concern in health sector including facing the rising burden of Non-Communicable Diseases, on World Health Day 2022, WHO will focus global attention on urgent actions needed to keep humans and the planet healthy and foster a movement to create societies focused on well-being.

World Health Organization estimates that more than 13 million deaths around the world each year are due to avoidable environmental causes. This includes the climate crisis which is the single biggest health threat facing humanity. The climate crisis is also a health crisis. Not to forget, our political, social and commercial decisions are driving the climate and health crisis.

United Nations Climate Change Conference (COP26) in Glasgow, Scotland, spells out the global health community's prescription for climate action based on a growing body of research that establishes the many and inseparable links between climate and health. The WHO COP26 special report includes ten recommendations that highlight urgent need and numerous opportunities for governments to prioritize health and equity in the international climate regime and sustainable development agenda.

1. Commit to a healthy, green and just recovery from COVID-19.
2. Our health is not negotiable.
3. Harness the health benefits of climate action.
4. Build health resilience to climate risks.
5. Create energy systems that protect and improve climate and health.
6. Reimagine urban environments, transport and mobility.
7. Protect and restore nature as the foundation of our health.

8. Promote healthy, sustainable and resilient food systems.
9. Finance a healthier, fairer and greener future to save lives.
10. Listen to the health community and prescribe urgent climate action.

These recommendations are the result of extensive consultations with health professionals, organizations and stakeholders worldwide, and represent a broad consensus statement from the global health community on the priority actions governments need to take to tackle the climate crisis, restore biodiversity, and protect health.

We must set ambitious national climate commitments if we have to sustain a healthy and green recovery from the COVID-19 pandemic.

Padavidhar Sanshodhan Prakalp Anudan - 2022

IPHA Maharashtra State Branch is offering financial support, this year also, to deserving research proposals from under-graduate students from Medical Colleges located in Maharashtra State.

- The project proposal should be submitted through IPHA Maharashtra website on or before 31st May 2022
- The proposals will be scrutinized by panel of experts and five best projects will be awarded funding of Rs. 5,000/- each. The list of accepted proposals will be communicated by end of June 2022
- Student should prepare & complete project under the guidance of IPHA Member Community Medicine faculty.
- Selected student should submit Project Report on or before 31st Dec 2022.
- Please note: Research proposal should be accompanied by –
 1. Institution Ethics Committee (IEC) approval letter
 2. Forwarding letter from Head of Community Medicine Department

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Urban Childhood Malnutrition

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“लोगों को पेट के लिए क्या क्या करते देखा है.....
मैंने भूख को भी भूख से मरते देखा है.....” (Vijit)

These lines very well depict the picture of HUNGER - an age old, universal and critical problem of health of mankind and growing with time like a demon. Being a leading cause of malnutrition, it poses a challenge for the health of community. Malnutrition and hunger have got a very old history. In ancient times which dates about 180 BC and even before that Egyptian upper-class societies were plagued by malnutrition and hunger. Malnutrition is now rampant in children of third world countries. Covid pandemic has aggravated this problem in recent period.

As per global nutrition report 2018, India has 46.6 million stunted children and every third stunted child is an Indian. In the Global Hunger Index (GHI)-2018, India ranks 103rd amongst the 119 qualifying countries and suffers from a serious hunger level. Within the country also there are vast differences in malnutrition rate amongst communities and geographical areas. Earlier malnutrition was thought to be a problem of rural parts and given more attention to tackle this issue. However, childhood malnutrition in urban population is a serious issue and even more complex matter of concern.

Recent studies on childhood malnutrition in urban settings have highlighted the high prevalence of stunting, moderate Acute Malnutrition (MAM) and severe Acute Malnutrition (SAM) in urban areas.

Rapidly increasing urbanization:

According to the 1901 census, India's urban population was 11.4%. As per 2011 census, urban population share was 31.6% and in 2017 it rose to 34%. Maharashtra ranked first with urban population of 50.82 million (51.7%) in census 2011. Urban population is augmenting in the cities which is posing new multidimensional challenges for local administrations.

Childhood malnutrition is a complex issue in urban settings and needs urgent attention. Poor hygiene, poor housing conditions in urban slums, pollution, poverty, poor earning, high disease burden,

food adulteration, overcrowding, proliferation of slums, street children, availability of public health facilities, affordability in private health sector and ignorance, negligence about health are making this issue more complicated in cities. This article specially focuses on under-5 children malnutrition.

Double Burden of Urban Malnutrition:

The coexistence of undernutrition mostly in slums and urban poor and overnutrition (obesity and overweight) due to dietary excess & faulty food habits in affluent population pose the double burden of malnutrition in cities. Childhood malnutrition followed by overweight in later life increases the risk of non-communicable diseases and in women increase the risk of child-birth complications. Undernutrition of children in cities is an issue of great concern because of its medical, social & economic consequences on individuals, families and nation.

As per National Family Health Survey-5 (2019-20) in Maharashtra 34.9% of Urban children under 5 years of age are stunted, 23.0% are suffering from acute malnutrition i.e. wasting (9.5% children having severe wasting), 5.2% are overweight, and 66.3% urban children found anaemic in the age group 6 months to 5 years. Another observation is only 9.2% urban children in 6 to 23 months age group received an adequate diet. These findings are eye opener and express the urgent need to curb urban childhood malnutrition by strengthening existing effective measures & implementing innovations.

Consequences of Malnutrition:

As urban population rose to 50%, the urban child malnutrition is of great concern. About 46% deaths among children under 5 years of age are attributed to malnutrition. The adverse effects of malnutrition are failure of growth, frequent illnesses, reduced capacity to work and potential, reduced productivity in life, poor performance in class, cognitive impairment and risk of infectious diseases. Physical and mental development is hampered in chronic malnutrition. Obesity and overweight in children lead to greater risk of non-communicable diseases in later life. Malnutrition in childhood leads to increase

in child mortality and also enhance disability in later years of life. Malnutrition is a social problem which affects individuals, families and nation. Malnutrition has a great impact on the economy of nation. It largely impedes the potential to reduce poverty and hampers country's socio-economic development. Undernourished women face greater risk of pregnancy related complications. Self-neglect, low confidence, anxiety, apathy and depression are major psychological consequences of malnutrition.

Types of Malnutrition:

Childhood malnutrition includes undernutrition, vitamins and minerals deficiency, over-weight and obesity. Undernutrition comprises wasting (acute malnutrition), stunting (Chronic malnutrition) and under-weight for age.

In wasting there is rapid deterioration in nutritional status over a short period of time. Severity of wasting is divided into Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM).

Stunting is defined as a height that is more than two standard deviations below the WHO child growth standards median. It is associated with delayed motor development, impaired brain function, poor performance in learning, more likely to suffer from chronic diseases, low adult wages and lost productivity.

Children with overweight and obesity have increased risk of mortality, hypertension, diabetes, stroke, heart diseases, osteo-arthritis, breathing problems and sleep apnea, difficulty with physical functioning, depression, anxiety and other mental disorders in later life.

With compromised nutrition children suffer micronutrient and vitamin deficiencies. A lack of iron, folate and Vitamin B12 and Vitamin A lead to anaemia and eye problems. Micronutrient deficiency hampers cognitive development and reduce productivity. Iron deficiency is a most common form of it and major leading cause of anemia.

Targets to end malnutrition:

Sustainable Development Goals (SDG) 2 has main focus on end hunger, achieve food security, improve nutrition and promote sustainable agriculture and thus end all forms of malnutrition by 2030. WHO member states have adopted a series of targets to reduce the burden of malnutrition by 2025. These are Neonatal Mortality Rate (NMR) to be reduced to 16, Infant Mortality Rate (IMR) to bring down to 28 by 2019 (not achieved), and under-5 mortality to 23 by 2025. However, the progress to tackle malnutrition is slow.

Need of Multidimensional approach to curb Malnutrition:

In view of multiple underlying factors, it needs a multiprong attack to curb malnutrition. To improve nutritional status and health behavior of young children specially in urban localities, interventions need to begin in preconception period. It is crucial to prevent malnutrition during the first 1000 days of life. This early launch of interventions from pre-pregnancy periods increases nutritional awareness and influences dietary habits. Preventing undernutrition by intervening in first 1000 days is very precious and effective measure to curb malnutrition.

Policy level nutritional interventions through ICDS, popularizing low-cost nutritious foods, preventing micronutrient deficiencies, fortification of foods, improving Public Distribution System, prevention of food adulteration and food security measures are definitely benefiting to end malnutrition. Various national programmes aimed to improve nutritional status have helped to bring down the malnutrition over the years. Promotion of Infant and Young Child Feeding Programme, establishment of child treatment centres, Nutritional rehabilitation centres, Anaemia Mukh Bharat Programme, Vitamin A supplementation, Health and Nutrition days, National deworming day etc. are directly promoting the nutritional status of under-5 children.

The immense importance of these interventions needs to be considered seriously by urban local bodies and strengthening of ICDS services, Antenatal and Postnatal services, availability of subsidized food, conducting routine nutritional screening, addressing street children's issues are crucial measures to tackle malnutrition. NGOs can play important role in this for improving nutritional status of under-5 children in urban localities. Strengthening of network of ASHAs, Anganwadi workers, ANMs is crucial to address and combat malnutrition in urban situation. Lots have been achieved and still it's a long way to end malnutrition with rising urbanization. However combined efforts of all sectors, families, NGOs, social workers, community leaders and frontline worker of ICDS, Health and other departments will succeed and achieve desirable results.

"If we can conquer space, we can conquer Childhood Hunger" (Buzz Aldrin)

Adolescent Health Initiative of Lokmanya Tilak Municipal Medical Collage & Mun. Gen. Hospital, Public Health Department of Municipal Corporation of Mumbai and NGO Sneha

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Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19. It is a unique stage of human development and an important time for laying the foundations of good health.

Adolescents experience rapid physical, cognitive and psychosocial growth. Despite being thought of as a healthy stage of life, there is significant death, illness, injury, from physical, mental and social problems in the adolescent years. Much of this is preventable or treatable.

Sources from WHO on adolescent health says that

- Over 1.5 million adolescents and young adults aged 10–24 years died in 2019. The main causes of death being: Injuries (including road traffic injuries and drowning), violence, self-harm and maternal conditions.
- Half of all mental health disorders in adulthood start by age 14, but most cases are undetected and untreated.
- Early onset of substance use is associated with higher risks of developing dependence and other problems during adult life, and people of younger ages are disproportionately affected by substance use compared with people of older ages.
- Globally, there are 43 births per 1000 to girls aged 15–19 years per year.

Above mentioned data is few among various problems faced by adolescents. In adolescence, health services have an important role to play in addressing a subset of conditions that have a large contribution to adolescent disease burden and are sensitive to timely interventions by health services, such as mental health conditions, sexual and reproductive health needs, malnutrition and communicable diseases. To grow and develop in good health, adolescents need information, including age-appropriate comprehensive sexuality education; opportunities to develop life skills; health services that are acceptable, equitable, appropriate and effective; safe and supportive environments. They also need opportunities to meaningfully participate in the design and delivery of interventions to improve and maintain their health.

Keeping all these is in mind at the Global level WHO produces a range of

policy and programme support tools. At the heart is the Global Accelerated Action for the Health of Adolescents (AA-HA!), which guides national-level policy-makers and programme managers on how to plan, implement, monitor, and evaluate adolescent health programmes.

Adolescent health in India

There are 253 million adolescents in the age group 10-19 years in India. Government of India has recognized the importance of influencing health-seeking behaviour of adolescents. The health situation of this age group is a key determinant of India's overall health, mortality, morbidity and population growth scenario.

In order to ensure holistic development of adolescent population, the Ministry of Health and Family Welfare launched Rashtriya Kishor Swasthya Karyakram (RKSK) on 7th January 2014 to reach out to 253 million adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups.

The programme expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health and substance misuse.

The strength of the program is its health promotion approach. It is a paradigm shift from the existing clinic-based services to promotion and prevention and reaching adolescents in their own environment, such as in schools, families and communities. Key drivers of the program are community-based interventions like, outreach by counselors; facility-based counselling; Social and Behaviour Change Communication; and strengthening of Adolescent Friendly Health Clinics across levels of care.

Recent statistics on adolescent health problems in India

- As per National Mental Health Survey 2015-16, prevalence of mental disorders in age group 13-17 years is 7.3% with an

almost equal distribution between girls and boys.

- Approximately 54 % of girls and 29% of boys in the age group of 15-19 years are anemic in India (National Family Health Survey (NFHS)-4).
- A large proportion of girls are coerced into unwanted sex or marriage, putting them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections, including HIV. AIDS-related deaths have fallen for every other age-group except for adolescents where it has increased. As per NFHS-4, only 19% girls and 28% boys in the age group of 15-19 years have comprehensive knowledge of HIV/AIDS.
- More than one-fourth (26.8%) of the girls got married below the legal age and nearly 8% of them aged between 15-19 years were already mothers or pregnant.
- Only 58% girls between the age group of 15- 24 years use a hygienic method during menstruation.
- More than one-third married females between 15-24 years (37%) have experienced some type of physical, sexual, or emotional violence by their husbands.

Above data indicates need for strengthening RKSK at basic service delivery points. It is duty of each and every health care worker to do his/her contribution for the effective implementation of adolescent health programs.

SNEHA (Society for Nutrition, Education and Health Action), a Mumbai-based non-profit organization addressing four major areas of Public Health, Maternal and New-born Health, Child Health and Nutrition, Sexual and Reproductive Health, and Prevention of Violence against Women and Children along with Department of Community Medicine, Lokmanya Tilak Municipal Medical College has taken an initiative for:

- Strengthening adolescent competency among primary health care workers on aspects of physical health and nutrition, Sexual and Reproductive health, emotional /mental health and gender-based violence related to adolescents.
- Encourage adolescent health seeking participation in the existing health posts by sensitizing front line primary health workers.

In order to attain the above mentioned objectives Medical Officers and Public health nurses from Health Posts and Dispensaries of Municipal Corporation of Greater Mumbai were given training to carry out Adolescent Health Initiative Programme in the urban areas in

collaboration with the Public Health Department of MCGM there by catering to the Adolescent issues by involving all three levels i.e. Primary, Secondary and Tertiary levels of health care delivery system i.e. Health Post and Dispensaries, Peripheral Hospital and Tertiary Hospitals involving Medical Colleges i.e. Seth G S Medical Collage and KEM Hospital, Topiwalla National Medical Collage and B Y L Nair Charitable Hospital, Lokmanya Tilak Municipal Medical Collage and Municipal General Hospital and H B T Medical College and Dr R. N. Cooper Hospital Mumbai in near future.

The same model can be utilizing in the rural areas of Maharashtra where the staff members from sub centre, PHC, CHC and District hospitals can be trained and can work for Adolescent health initiative in rural parts of Maharashtra. There by helping to achieve the goals of Adolescent health under Rashtriya Kishore Swasthya Karyakram.

Sensitizing the health care workers who are easily accessible, available and at immediate contact to adolescents can help in properly managing the adolescent health problems and proper referral to secondary and tertiary care centres. This model can be a frontrunner for the country's health system delivery for adolescents.

As have already said in operational framework of RKSK, different organizations including NGOs can take initiatives for making up healthy adolescents. Healthy adolescents are a need of the hour. They constitute about one-fifth of India's population. This represents a huge opportunity that can transform the social and economic fortunes of the country. The large and increasing relative share and absolute numbers of adolescent and youth population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth.

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Need for Palliative Care for the Community

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“How people die remains in the memories of those who live on”

- Cicely Saunders.

In India, 66 % death in the year 2019 were due to non-communicable diseases (1). Most of these non-communicable diseases are chronic in nature like cardiac, renal and pulmonary disorder, stroke, HIV, drug-resistant tuberculosis and cancer. People living with chronic diseases suffer from myriads of problem which include not just physical but also psychological, social, spiritual and financial issues. Patients struggle with symptoms like pain, breathlessness, fatigue, anxiety and depression for which they are not even routinely assessed.

Not just the patients but also their caregivers suffer, impacting their quality of life and well-being. These patients do not require hospital-based care throughout the illness trajectory and are cared for at home by their family members with very limited resource, training and support. Also, health care facility is not easily accessible to most of the patients especially in rural areas.

As their illness progress, curative options get exhausted. Towards the end of life, patients and their family members start feeling abandoned by the health care professionals as they are usually said that “nothing further can be done”.

However adequate symptom management and psychological support from us can help in improving the overall well-being of these patients and sometimes even improve survival. That is why there is increasing demand of Palliative Care at various levels. Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life (2). Palliative care (PC) aims to provide appropriate symptom management, holistic care, improve quality of life and empower caregivers. However only about 14% of people who need palliative care currently receive it. PC is a team work of multidisciplinary team usually consisting of Doctors, Nurses, Allied health professionals, Social worker, Volunteers and Caregivers. Apart from symptom management and discussing goals of care how can PC help patients and the community?

❖ There are studies showing advanced cancer patients receiving Palliative care

had improved survival than those who didn't (3).

- ❖ PC helps in management of depression (4).
- ❖ Patients receiving palliative care were more likely to die with supportive care at home (5).
- ❖ Also, they are less likely to die in intensive care units (6).
- ❖ PC at home helps in reducing the need for emergency department visit (7).
- ❖ PC has played a very big role in recent times in managing symptoms and providing support of patients and families suffering from Covid-19.
- ❖ Community based palliative care is cost benefit for the health care system (8).
- ❖ PC also strives to provide continuum of care during transition from hospital setup to home based care.
- ❖ One might wonder when there are so many benefits of Palliative Care, why are people not aware about it in our country?
- ❖ Awareness about palliative care is very limited not just among patients and caregivers but also the health care professionals and policy makers posing a big barrier to the development of palliative care.
- ❖ Lack of PC training at under graduate level.
- ❖ Talking about death and dying is considered taboo in our culture.
- ❖ Palliative care is usually confused with ‘end of life’ care.
- ❖ Stopping futile treatment is difficult due to lack of adequate guidelines and proper law.
- ❖ There are many misconceptions regarding use of opioid in medical fraternity also. Misconceptions that improving access to opioid analgesia will cause increased substance abuse.
- ❖ Only small number of specialist Palliative care providers in India.

How can we overcome these barriers and improve Palliative Care services?

Let us start by increasing awareness about PC in health care workers and improving outreach of PC services in community. PC services will reach more people when it incorporated at every level of care - primary, secondary and tertiary. Many tertiary care hospitals are incorporating PC services as a part of regular services provided by them. An important step would be to make it a part

of the primary health care system for better outreach. Palliative Care is now a part of the 'Mission Flexipool' under National Health Mission (NHM).

Studies done suggested using community based palliative care model at primary health care level (9). There is high quality evidence for home based palliative care and telecommunication (10). Home based care has been well established form of providing palliative care. Identification of patients who require home based palliative care is the first step. This can be done at the primary health care center or urban health care center the health care workers, nurses, multipurpose workers and volunteers. Providing basic training in palliative care will be useful.

Community based palliative care service should include:

1. Identification and assessment of patients in need of Palliative care
2. Adequate symptom management by multidisciplinary team
3. Discussing goals of care with patients and caregivers
4. Assuring communication within various care providers
5. Timely referral to primary treating team or higher centres whenever required.
6. Provision of 'end of life' care & bereavement

Clearing some myths regarding Palliative Care that may help

Myth 1: Talking about death and dying with patients will lead to loss of will to live?

*** Would we not want to know what is going on with our body especially when it is leading to sufferings? Studies have shown that patients with terminal illness prefer full disclosure of their diagnoses and prognosis. This will help them in future planning. It is actually the caregivers who fear more about disclosing prognosis (11).

Myth 2: Consenting for Do not attempt resuscitation is equal to killing the patient?

*** How many of us would really want cardiopulmonary resuscitation and to be put on ventilator when we know the outcome of our illness? Patients with terminal illness have limited prognosis and the poorer outcome after cardiopulmonary resuscitation. Allowing natural death does not equal to killing (12).

Myth 3: Palliative care involves only end of life care?

*** Palliative care does not involve only end of life care. It can be started as soon as diagnosis of a life limiting illness is made.

Myth 4: Use of opioids in patients can cause addiction?

*** You can safely and effectively manage the majority of cancer patients with pain using opioids. Appropriate screening may be needed in some patients with history of addiction (13).

To conclude, the need for Palliative Care is immense and ever increasing. The services that we build today will not just be beneficial to our patients but will also decide how we will be cared for during our end of life.

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RESPONSE TO COVID-19 PANDEMIC AND ROLE OF COMMUNITY MEDICINE

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Diseases with social impact require comprehensive approach based on social medicine, integrating health, social and economic responses. COVID-19 has proved to be a social disease. It has caused widespread diffusion in the general population along with serious harm on affected patients their families and its impact on the economy and social life of burdened countries.

Though socialization is a risk factor for the spread of the SARS-COV-2, health protection measures such as isolation and lockdown further aggravated the “social” burden of COVID-19. There is evidence that a low socio-economic status (SES) is strongly associated with higher rates of both incidence and mortality attributable to COVID-19[1]. In particular, housing conditions, over-crowding and other aspects that hinder social distancing can greatly influence the risk of COVID-19 transmission.

Furthermore, individuals of lower SES are more likely to rely on public transport to reach their respective workplace, thereby increasing the risk of COVID-19 through inter-personal contact. SES also affects the living environment, the eating habits, the occupational status and the access to health care services, ultimately influencing health.[2]

Most determinants of health are social by nature and the most effective public health interventions to tackle them frequently require a social component in their design and implementation [3].

Given the current scenario caused by the COVID-19 pandemic, interventions to tackle socio-economic disparities should be considered as priorities like the search for effective curative and preventative treatments (e.g. antivirals and vaccines). Indeed, existing inequities worsened during the pandemic and aspects like access to food, education, and psycho-social support must be carefully weighed in a holistic approach.

When confronted with public health, which is primarily intended to focus on the environment (housing, safe water, and sanitation), social medicine differs by encompassing “the whole of economic, nutritional, occupational, educational, psychological opportunity or experience of the individual or the community” [4].

Basically, social medicine is concerned over the relation between the individual and his environment. People are simultaneously biological and social organisms, and thus human health and disease are affected by social factors as well as by biological factors. Included in the basic idea and concept of social medicine is that the interdisciplinary program between medicine and social science would provide the former with knowledge and skills needed to analyze the social causes of health and illness in the same way as the alliance between medicine and laboratory sciences had provided new insights into the biological, chemical and physical bases of disease [5].

Pandemics have significantly affected economy of each country. Health & political system have been also drastically affected in each part of the country. To fight against pandemic, it demands multidimensional approaches comprising of various measures like surveillance, containment, isolation & quarantine, border restriction as well as various socio-political and community measures. Though the entire health workforce is involved at multiple levels, the role of a community medicine /public health expert is maximum in controlling the spread in the community and managing the situation. The community medicine specialists can contribute to the public health as well as health-care services in combating the pandemic.

The origin of Community Medicine has followed different paths in different parts of the world with a common agreement that community medicine is a linear descendent of public health.

Community medicine in India can be traced back from the year 1946. Bhore report under Health Survey and Development Committee recommended 3 month compulsory training for physicians in Preventive and Social Medicine. [6] Focus then was to impart preventive as well as curative service training to the physicians. Community Medicine departments always focused on public health education at undergraduate and postgraduate level. Family Medicine, modern epidemiology, health management, and health promotion are the major concentrations in Community Medicine

along with social sciences/behavioral sciences, health economics, and environmental, geriatric, mental and occupational health.[7]

Unlike in General medicine, whose primary function is to focus on individual treatment level whereas public health primarily focuses on mass treatment, community prevention and recurrence of a disease. Clinical and public health departments work in coordination when outbreaks occur, understand the epidemiology, slow the spread and investigate the source of infection through contact tracing, thereby help in source reduction and transmission.

During the pandemic community medicine plays a crucial role in minimizing the transmission of infectious diseases.

Moreover, Community medicine physician focusses on the following areas like:

1. *Prepare for field work-Field investigation is conducted before or after conforming increase in cases.*
2. *Establish the existence of an outbreak comparing the previous data.*
3. *Verify the diagnosis-By using Medical and/or Laboratory and /or Epidemiological investigation.*
4. *Define and identify cases.*
5. *Find cases systematically followed by record information-using the epidemiological case sheet.*
6. *Perform descriptive epidemiology-Identification of population at risk and aetiology*
7. *Develop, evaluate & refine hypotheses and carry out additional studies.*
8. *Compare with lab and environmental studies*
9. *Establish control and prevention measures involving in surveillance activity*
10. *Communicate relevant findings with common people as well as authority.*
11. *Communicating with public and educating them-preparing IEC materials and training grass-root level workers to educate the community.*

Contact-Tracing

A) Contact identification

- Preparation of a standard / surveillance case definition for COVID-19.
- Identify potential contacts starting with the case. (Epidemiologist/community physician's visit to the patient's home is mandatory)

B) Contact listing

- All persons considered having significant exposure should be listed as contacts, using the contact form.
- Report any suspicious signs and symptoms such as fever, cold, cough, and difficulty breathing immediately.

C) Contact follow-up

- The epidemiologist / supervisor / contact tracing physician should assemble a competent team involving local supervision and frontline workers (ASHA, AWW, ANM & Supervisors) to track all contacts listed.

The community medicine specialists can impart their expertise at various levels from community level to central level.

1. At Community Level: (Collaboration with Medical officers, Village leaders & Frontline workers)

- Through Rural & Urban Health & Training Centres; faculties, residents, interns & undergraduates can create awareness about hand washing, cough etiquette, social distancing, avoiding gathering, use of mask etc.,
- Preparation of Information, Education & Communication (IEC) materials regarding COVID appropriate behaviour and distribution in their field areas.
- Health promotional activities include installation of low-cost sanitizer dispensing machine.
- Stop spreading infodemic by providing proper knowledge regarding pandemic.
- Supportive supervision of home and institution quarantine.
- Providing Primary health care services in the field area.
- Finding and training self-help group or local NGOs for stitching mask &preparation of sanitizers.

2. At District/ State Level: (Collaboration with district administration, various NGOs, Public health specialists, other specialized departments like pulmonary medicine, General medicine & microbiology)

- Development of district emergency plan and preparedness.
- Be a part of rapid response team and provide valid inputs to the team.
- Active Surveillance, using spot map for case identification, supportive supervision to quarantine centres and ensure COVID appropriate behaviour to be followed
- Contact tracing, defining containment zones & ensuring essential health services to containment zones.
- Establishing a helpline number (toll free) for counselling and avoiding fearfulness among common people

3. At Central Level: (Collaboration with MOHFW, NGOs, NHM, Various research institutes like ICMR)

- Development of guidelines about the disease concerned, prevention, or containment of the pandemic/halting the transmission by studying the epidemiological trend, formulating the mathematical and epidemiological models, using database from IDSP and other field level activities or research), clinical case finding and laboratory confirmation criteria and disease surveillance
- Policies regarding protecting the rights of medical professionals and other health care workers, medical indemnity policies during pandemic situation.
- Policies regarding inventory/logistics management supply chain.

Role of Professional bodies like IAPSM, IPHA & IAE during COVID-19 outbreak:

A combined task force was constituted taking eminent public health experts from different professional bodies of India like Indian Public Health Association and Indian Association of Preventive & Social Medicine in April 2020. Further Indian Association of Epidemiologists (IAE) also joined the task force. This was formed with objective of reviewing and compiling the scientific epidemiological literature pertaining to COVID-19 infection in India at various levels, developing common opinion amongst the experts regarding COVID-19 disease epidemiological trends and developing action, wide dissemination of the common statement and action plan with public health experts, health professional associations and other key stakeholders & with the policy makers at the highest level at centre and state.

First joint statement was submitted to Hon'ble Prime minister, union health minister, NITI AYOOG, secretary (Health & Family Welfare & Department of Health Research) on 11th April 2020. Similarly, the 2nd joint statement was submitted on 25th May 2020 with following recommendations:

- Constitution of panel of interdisciplinary public health experts and social scientists at various levels.
- Sharing of data in public health forum.
- Lift lockdown, replace with cluster restriction or containment.
- Resumption of all routine health services.
- Source reduction measures to be adopted.
- Ensure physical distancing with social bonding.
- Sentinel & Active surveillance.
- Test, trace, track (3T) & isolate cases with marked scaling up.
- Strengthening intensive care capacity.
- Optimal PPE for frontline health care workers.
- Strengthening the public health system/discipline.

The third Joint statement was given to government in 25th August 2020 with a motive to support the Government of India in formulating evidence-based policy for prevention control of COVID-19 pandemic in India and it had certain recommendations regarding:

- No lockdown or shutdown, only cluster restriction.
- Quarantine & isolation policy.
- Pragmatic testing.
- Immediate resumption of comprehensive health-care services
- Protection of high-risk population.
- Continue preventive measures like physical distancing, mask use & hand washing.

- ILI & SARI surveillance.
- Periodic sero-surveillance.
- Opening of educational institutions with certain guidelines.
- Role of vaccine in ongoing pandemic.
- Increase health expenditure to 5% of GDP.
- Formation of public health cadre at national & state levels.

It's the high time all sectors along with community involvement should come forward to fight against this pandemic using appropriate technology. The role of Community Medicine has always been immense during any pandemic. The Community physicians have to play the key role in developing and sustaining the response mechanism. Also, the central and state government should involve the community physicians in various High Level Expert Groups and seek their expertise.

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A Silver Lining amidst the Covid - 19 Pandemic Cloud: Government aided Health Insurance Scheme's response for Private Tertiary Care Hospitals at Maharashtra.

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Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY) is a flagship health insurance scheme of Government of Maharashtra. The scheme provides end to end cashless services for identified diseases through a network of service providers from Government and Private sector.

Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) was launched by Government of India from 23rd September, 2018. AB-PMJAY was launched in the Maharashtra in integration with Mahatma Jyotirao Phule Jan Arogya Yojana and was implemented on mixed Insurance and Assurance Mode.

Beneficiaries under Mahatma Jyotirao Phule Jan Arogya Yojana are Families holding yellow ration card, Antyodaya Anna Yojana ration card (AAJ), Annapurna ration card, orange ration card (annual income up to INR 1 lakh) issued by Civil Supplies Department, Government of Maharashtra and white ration card holder farmer families from 14 agriculturally distressed districts of Maharashtra.

The Covid-19 Pandemic has placed unprecedented financial hardships on most of the health system as well as on the community. Amid a national crisis, Government aided health insurance schemes represent an opportunity to urgently fight the pandemic. Due to rising cases of Covid-19, many private tertiary care hospitals were declared as dedicated Covid centre. Being dedicated Covid Centre; hospitals had to face lot of challenges. Given the rapid spread of Covid 19 across the country and economic effects of lockdown, many people faced devastating effects of the disease and financial hardships. More than one-third of patients were more worried about the financial stress associated with Covid-19 than actually getting the illness itself.

There was an increasing trend of fear surrounding financial downfall in those who have contracted the virus. Under this financial and psychological stress faced during Covid-19 pandemic, state government assured to provide safety net needed for Covid patients.

Here provided an overview of the measures of state government insurance in response to Covid-19 management in private hospitals.

Relaxation and benefits given by MJPJAY scheme for Covid positive patient admitted under private hospitals in Maharashtra:

- Rate cap on the cost of Covid treatments at private hospitals.
- No out-of-pocket expenditure to patients under MJPJAY scheme for Covid-19.
- Due to lockdown, many patients have been unable or unwilling to visit hospital to provide documents for registration under the scheme. In such situation, soft copy of documents was accepted for registration.
- Twenty medical packages were given to hospitals for Covid.
- Strict lockdown hampered the registration process. Extension of preauthorization application for emergency cases from 72 hr for mobilization of document.
- Inclusion of white ration card holder under the scheme.
- Government reserved packages (110) and CGHS packages were provided to Private hospital.
- Higher investigation like HRCT and Covid test were covered in scheme.
- Additionally, post covid Mucormycosis management both surgical and medical was covered under the scheme. Expensive medicines like Inj. Amphotericin B were provided free of cost under the scheme.
- Full Claim amount was given to the hospital for Covid positive deaths.
- State government also decided to provide PPE kit to private hospitals for the protection of doctors and para medical staff from Coronavirus.

All these relaxations and benefits helped the patients in a substantial manner and government aided health insurance scheme acted as a silver lining on the Covid cloud.

Epidemiology Resource Centre under Department of Community Medicine, Seth G S Medical College and KEM Hospital, Mumbai

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Introduction:

Department of Community Medicine, Seth G S Medical College and KEM Hospital, Mumbai has established Epidemiology Resource Centre (ERC) – Research Protocol and Statistics Support Unit which is an extension cell within the department for the benefit of the entire institute including all the faculties and students as well as NGOs and other collaborating partners under various health care related activities, which takes up the responsibility of provision of scientific technical support in the development of research studies, data management, converting data into a relevant information and development of appropriate intelligence out of it, to fulfill the desired expectations of the researchers.

Need for Epidemiology Resource Centre (ERC):

In most Medical colleges there is no formal unit which provides technical support to faculties & students in development of absolute scientific proposals with due consideration to epidemiological and statistical perspectives. Those who are in need of such support, usually contact faculty members of Dept. of Community Medicine, or members of Research Society, Ethics Committee, etc. at individual level. In Community Medicine, technical support in processing the data for analysis and application of statistics is also requested from other institutes like UNICEF, MDACS, MSACS, SNTD Nursing College, Dental College, NGOs etc.

It is observed that demand for scientific research activities for publishing journal articles are increasing among junior faculty members in all departments, to fulfill the requirements for promotion to next level in the hierarchy. Moreover, research activities are increasing even at the level of UG & PG students, sometimes to fulfill the requirements to opt for studies in foreign universities. Many departments are also getting recognized for PhD studies. PhD aspirants also need statistics support to strengthen evidence generated out of PhD studies.

In most of the medical colleges, there are no qualified statistical experts, except only one Assistant Professor / Tutor in Biostatistics in Dept. of Community Medicine.

Present needs of faculties and students are unlikely to be met by this single faculty. Research Methodology workshops are held at the Medical College level, from time to time, however the scope is limited in terms of fulfilling practical demands of the researcher. Handhold teaching/support to fulfill the need of individual research aspirant is not in existence today. There is no mechanism to certify appropriateness of statistical methods to scientific publications, if necessary. Considering these facts, we have established separate Epidemiology Resource Centre for the benefit of the Medical College as a whole. This centre, which is the need of the present time, is one of the activity of academic excellence of its kind at Seth G S Medical College & KEM Hospital, which holds 6th rank amongst top 10 Medical Colleges in the country and the most preferred medical college amongst UG and PG medical students in the country, being reputed as 'excellent in Medical Education'. Establishment of ERC marks an attempt towards strengthening health system in response to current demands.

Vision:

To evolve as one of the centre of excellence to promote scientific research activities at all possible levels, by undertaking the responsibilities of provision of technical support to develop proposals for epidemiological studies as well as analysis of data by using advance statistical methods and capacity development of faculties, UG & PG students, in scientific writing skills by better understanding of different bio-statistical methods.

Mission:

To expand the scope of the centre towards development of separate Department of Research and Bio-statistics, at Seth G S Medical College and KEM Hospital, and adopt leadership role to promote such initiatives at other medical colleges.

Activities undertaken at ERC

A. Technical support

1. Review/scrutinize study designs, sampling methods and sample size determinations in a scientific study

- proposals at its formulation stage and provide technical guidance if necessary
2. To develop appropriate data collection tools taking into consideration objectives of the study, level of data collection personnel, proposed plan of analysis and use of statistical software
 3. Support Designing pre-coded data collection tools, if necessary.
 4. Guidance for choosing appropriate statistical software taking into account need of the study.
 5. Guidance and support for installation of statistical software in the individual computer or laptop, if requested.
 6. Plan data entry into Microsoft excel, Microsoft access programmes or in the selected statistical software directly
 7. Guidance and support for using statistical software
 8. Guidance and support for interpreting statistical outputs
 9. Guidance and support for incorporating statistical results into the document
 10. Guidance and support for graphical presentation of quantitative and qualitative data
 11. Expert opinion on appropriateness of statistical methods used by researchers who have written manuscript for journal publication as well as submitting papers for presentation in conferences – International / National / State
 12. Establish & Operationalize Cochrane Collaboration
 13. Get involved in INCLIN supported multi-centric studies

B. Teaching & Training

We plan to train regular batches (each batch of 15 participants) of students and faculties. Proposed workshops are:

1. Hands on training in SPSS – 3 days
2. Cluster Analysis – 3 days

3. Discriminant/Factor Analysis – 3 days
4. Hands on training in Atlas.ti – 3 days
5. Multivariate Analysis – 3 days
6. Meta Analysis – 3 days
7. Sample Size estimation – 3 days
8. Aspects of qualitative research – 3 days
9. Basics of statistics – 5 days

Good Governance Practices:

1. Development of Collaborative network with other institutions to ensure scientific accuracy and seek help to address the problems and issues beyond the capacity of Working Committee of ERC
2. Nondisclosure agreement with the client
3. Conduct as per stipulated operational guidelines
4. Observance of stipulated time frame for accomplishing the work
5. Receipt of user fee/charges
6. Audit of accounts – Internal as well as external
7. Appropriate record maintenance in hard copies
8. Procedure of certification of work done
9. Grievance handling mechanism
10. Feedback mechanism from clients

Future for ERC:

Currently, our ERC is in the infant stage and is in the process of developing as benchmark ERC for all other Medical Colleges in India. National Medical Commission has also proposed to establish research cell with functioning similar to our established ERC. Our ERC model can be replicated in other Medical Colleges. Moreover, there can be collaborative networking with ERCs of other medical college. This will also give new outlook to our Community Medicine specialty as research experts.

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 - iphamahabbranch@rediffmail.com

India's Investment to End TB

Dr Radha Taralekar¹

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World Tuberculosis (TB) Day is celebrated each year on 24th March to generate awareness on Tuberculosis. This year in 2022 the theme of world TB is - 'Invest to End TB. Save Lives.' (1) This message clearly communicates the urgent necessity to invest our resources to scale up the fight against TB and achieve the commitments to end TB globally.

With the current COVID-19 pandemic this is especially critical to drastically bring about a drop in the TB prevalence and to halt the risk factors exposing the TB progress among the vulnerable communities and to ascertain equitable access to prevention and care. TB not only has an impact on the health of an individual but largely affects on people's social and economic dimensions around the world.

World TB Day marks the day in 1882 when Dr Robert Koch proclaimed to have discovered the bacterium that causes TB which further led towards research on diagnosing and curing this disease among mankind. As per the WHO's drive towards achieving Universal Health Coverage, every individual must have equitable access to affordable healthcare, including TB globally. More investment for TB is the need of an hour to save millions more lives, boosting the end of the TB epidemic.

The COVID-19 pandemic has greatly impacted the TB elimination program globally by reversing the multiple years of progress made to End TB and brought in limitations in the provision of essential TB services among the communities. Expected global TB targets were not achieved last year and a major global reduction from 7.1 million in 2019 to 5.8 million in 2020 in the number of people newly diagnosed with TB has been reported (2).

This drop of 18% in reported TB cases in 2020 has taken the fight against TB back to the stage of 2012 with approximately 10 million people who developed TB in 2020 missed reaching the health systems.

Around 16 countries accounted for 93% of this reduction, with India being one of the major countries to be affected (3). The disruption in provisions of Tuberculosis services has been due to lockdown, anxiety in seeking care, social distancing and other isolation strategies.

In India the number of new cases of tuberculosis detected as of April 2020 in public sector saw a drastic fall of 78% with 34,342 cases being diagnosed as compared to 1,56,000 cases in April month of 2019. Considering the adverse vulnerabilities due to undernutrition and limited funding of public welfare programmes in India escalates the susceptibility to tuberculosis and other communicable diseases (4). In this context it is crucial for India to invest its resources and gear up fight against TB.

With this year's world TB Day approaching let's reflect on India's investment plan to End TB. In 2020 the central government of India renamed the RNTCP to the National Tuberculosis Elimination Program (NTEP) for achieving the sustainable development goal of ending TB by 2025, five years ahead of the global targets (5).

Further to mitigate the COVID-19 pandemic, TB and COVID-19 bi-directional screening strategy was introduced by GoI with laboratory service, diagnostic and treatment capacity upgradation for test TB (among COVID 19 patients) and COVID 19 (among TB patients). Active case finding was initiated at community level to identify missing TB cases through involvement of TB champions and local volunteers and NTEP staff. NTEP has also scaled up rapid molecular testing for TB and Drug resistant TB in 2020 to ensure 3147 NAAT machines are available and replace the smear microscopy with upfront molecular testing using NAAT. NTEP initiated the process of establishing 18 new Culture & DST (CDST) laboratories in addition to existing 87 CDST labs. NTEP has developed a National Framework for a Gender-Response Approach to TB for equitable care at community. NTEP is partnering with corporates and other stakeholders to work collaboratively and in 2021 NTEP partnered with Indian industries to launch a TB free Workplace campaign and to involve business leaders in the fight against TB. TB survivors are being engaged and trained through a standard curriculum developed by NTEP. All these newer initiatives under NTEP are investments to End TB in India (6).

With modern healthcare technologies being introduced, World Health Organization (WHO) recommends electronic medication

monitors and video-supported therapy to support TB patients (7).

Similarly, government of India (GoI) introduced virtual communication platforms with integrated telemedicine

Jan Andolan campaign, a part of advocacy communication and social mobilization activity recently introduced with focus on multisectoral collaborative activities is expanding gradually. Investing

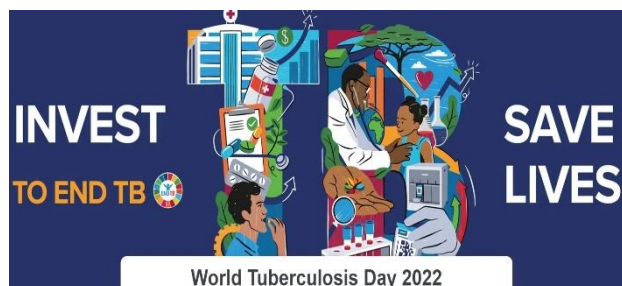
Sub-National Certification of Disease-Free Status Awards			
Award / Status	Monetary award for district (Rs.)	Monetary award for State /UT (Rs.)	Non-Monetary Award
Bronze	200,000	2,500,000	Medal and Felicitations at the National Level
Silver	300,000	5,000,000	Medal and Felicitations at the National Level
Gold	500,000	7,500,000	Medal and Felicitations at the National Level
TB Free District	1,000,000	10,000,000	Certification and Felicitations at the National Level

TARGET: Achievement of reduction in TB incidence as compared to 2015 incident rate (in terms of number of incident TB cases per lakh population)
Bronze – 20 %, Silver – 40 %, Gold – 60%, TB Free District / City > 80 %

Source: TB in India. <https://tbfacts.org/ntep/>

solution named as e-Sanjeevani (8). This tele-medicine platform will reduce the pressure on facility-based health-care systems and this will go a long way in supporting TB patients as well to overcome resource constraints in pandemic situations and through improved provision of accessibility and availability of health care services. GoI also has scaled up Nikshay Aushadhi - a web enabled application for effective utilization and monitoring of universal access to all TB patients (9).

As India has set the target of reducing the incidence of new TB cases by 80% to End TB by 2025 and for achieving the same GoI has announced that it will incentivize and reward States/Districts for achieving the targets through the Sub-National Certification of Disease-Free Status. The 67 districts of India along with some states like, Kerala, Lakshadweep & Puducherry have already claimed TB Free Status in 2021(10). NTEP is scaling up all its recent initiatives introduced in 2018 onwards like Nikshay Poshan Yojana,



universal drug sensitivity testing, screening for HIV among TB patients, improving treatment success rate, scaling up drug resistant TB patients on shorter regime, contact tracing & chemoprophylaxis, active case findings activities pan India.

in TB not only saves lives but prevent economic crisis and GoI is committed to fight against TB.

With all these NTEP initiatives as an investment for saving lives, India is setting the stage for achieving the End TB goals by 2025.

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World Cancer Day 2022: 'Close the Care Gap'

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'Cure Some Times; Treat Often; Comfort Always' - Hippocrates

Advancements in Medical sciences have been focused on all aspects of cancer. The very aim behind every effort is to ease the living, improve the quality of life of those patients who are suffering from this disease. As we now know that as many as 40% cancer related deaths are preventable and maximum of these occur in Lower Middle-Income Countries, according to the World Health Organization.

WORLD CANCER DAY was envisaged 22 years ago at the first world summit against cancer in Paris, when the "Charter of Paris against Cancer" was signed. Ten articles focus on different aspects of cancer prevention, treatment, and care in this global petition. [3] February 4th was officially declared as world cancer day by the article X of the charter, "so that each year, the Charter of Paris will be in the hearts and minds of people around the world." [4]

Thus, World Cancer Day has been observed to reiterate the continued focus and commitment of political and other influential communities as well as to stand in solidarity with the Cancer survivors and families all over the world. This year's theme is - Close the Care Gap.

The Disparities in cancer care globally, across countries, regions, races, communities and gender have been exposed yet again during the recent pandemic, COVID-19. The health care delivery systems were disrupted with challenges that were never faced before, furthermore exacerbating the inequalities.

Closing the Care Gap: 3-year campaign

Conducting a multi-year campaign allows more exposure, engagement of community and provides opportunities to create global awareness and impact. Year - 2022, is about "Realizing the problem".

The Year - 2023 aims at - "Uniting our voices and taking action" in order to establish a strong community with a sound knowledge of the issues and challenges at hand. We seek to bring government and leaders' attention to this cause in 2024 with the campaign, "Together, we challenge those in power". [2]

World Cancer Day Themes in past

2019 – 2021	'I Am and I Will.'
2016 – 2018	'We can. I can.'
2015	Not Beyond Us
2014	Debunk the Myths
2013	Cancer Myths - Get the Facts
2012	Together let's do something
2010 – 2011	Cancer can be prevented
2009	I love my healthy active childhood
2008	I love my smoke-free childhood

The problem:

Cancer prevention and cancer awareness is of paramount importance. The dire need for which can be explained succinctly by the following facts - An estimated 2.25 million people live with the disease in India. Every year over 1.16 million new cancer patients are registered. Risk of dying from cancer before the age of 75 years is 7.34% in males and 6.28% in females. Risk of developing cancer before the age of 75 years in Male: 9.81% and in Female: 9.42%. The total deaths due to cancer in 2018 in India were 7,84,821 (Men: 4,13,519, Women: 3,71,302) [1]

In the South East Asia region, among cancer deaths, lung cancer accounted for 10.6% deaths, breast cancer 9.4%, cervical cancer 8%, liver 6.6% and lip, oral cavity cancer 6.4% deaths. (7)

In India cancers of oral cavity and lungs account for over 25% of cancer deaths in males and cancer of breast and oral cavity account for 25% cancers in females. The top five cancers in men and women account for 47.2% of all cancers.

All these cancers can be prevented, screened for and/or detected early and treated at an early stage. This could significantly reduce the death rate from these cancers. [1]

Figure 1: The steps in Screening Pathway

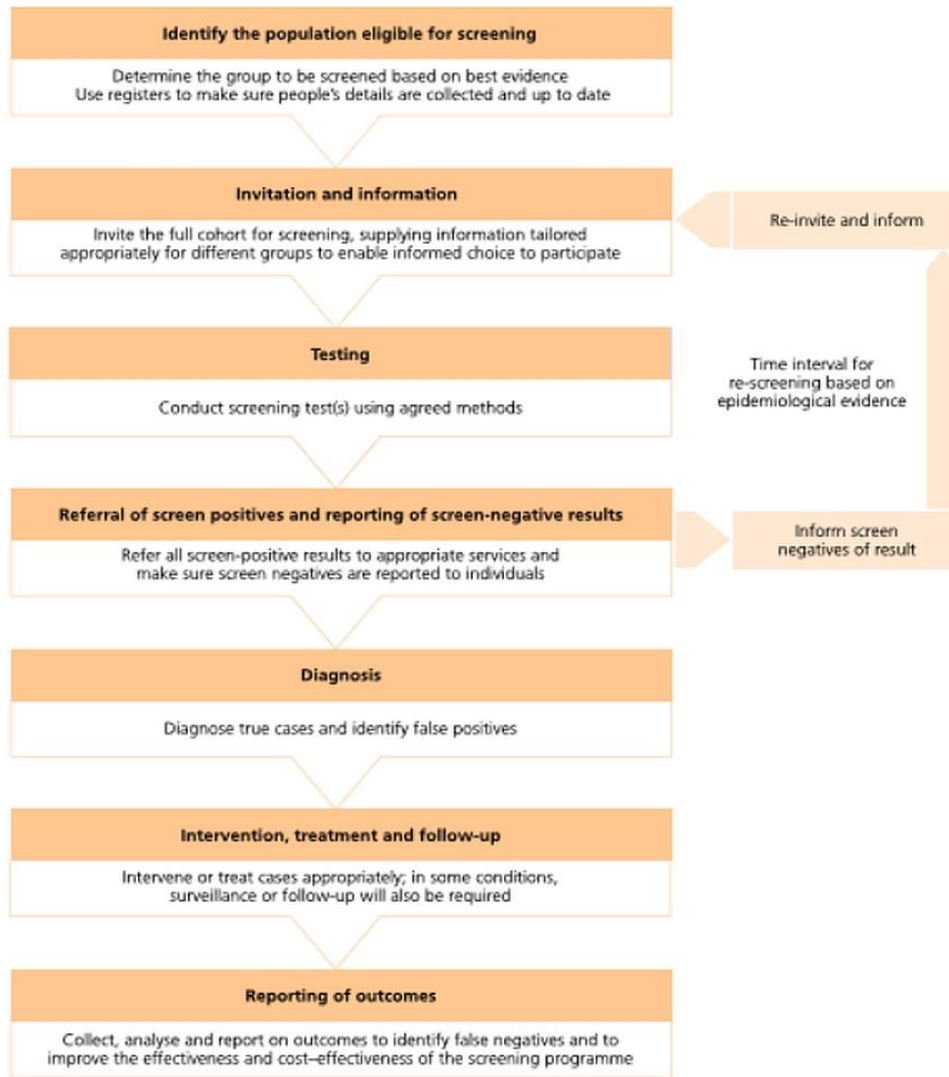
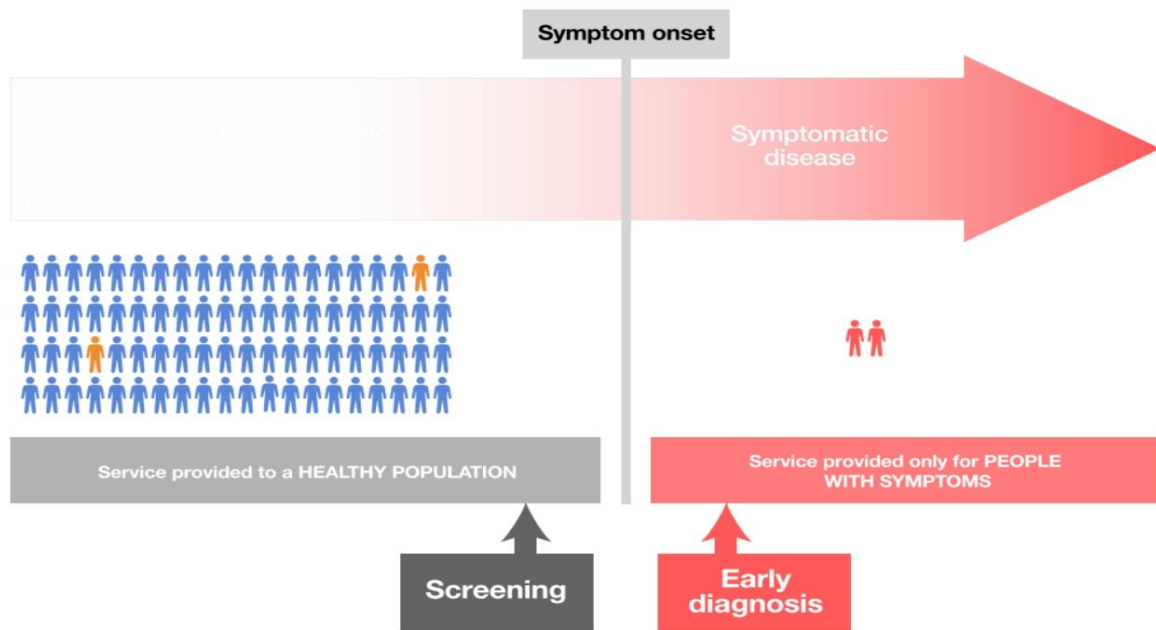


Figure 2: Comparison of Cancer Screening and other Early Diagnosis Strategies



Source of Figures 1 & 2 & Table 1: A short guide to cancer screening. Increase effectiveness, maximize benefits and minimize harm. Copenhagen: WHO Regional Office for Europe; 2022.

Table 1: Comparison of Cancer Screening and other Early Diagnosis Strategies

Issue	Cancer screening	Cancer early diagnosis
Number of people to be tested	Screening programmes test large numbers of asymptomatic people.	Early diagnosis programmes focus only on people with symptoms, which is a much smaller number (approximately one person examined compared to thousands of people screened).
Resource requirements	Screening programmes require a lot of staff, equipment and resources. These need to be available at the start of the programme.	Early diagnosis programmes use fewer resources and can be started while investment is made in appropriate technology and capacity to diagnose and treat cancer.
Implementation	Screening programmes can lead to improved clinical pathways and increase diagnostic and treatment capacity. However, to be effective they require upfront investment and are not suited to incremental implementation over a long period of time.	Early diagnosis programmes can support incremental improvement in delivering clinical services. Individual projects on topics such as community engagement, improving health literacy, training professionals to recognize signs and symptoms of cancer, increasing diagnostic capacity and strengthening referral mechanisms can lead to better outcomes.
Complexity	Cancer screening is a complex public health strategy that requires significant additional resources, infrastructure and coordination.	Early diagnosis programmes are fewer complex to deliver and require fewer resources and central coordination.

..... Continued on Page 20

Winners: Padavidhar & Padvyuttar Sanshodhan Prkalp Anudan - 2021

SN	Name of Under Graduate Student	Name of Guide	Institute
1	PARAS WAGHMARE	DR. UJWALA UKEY	GOVERNMENT MEDICAL COLLEGE, NAGPUR
2	SWATHI PILLAI	DR. PADMAVATHI DYAVARISHETTY	K. J. SOMAIYA MEDICAL COLLEGE, MUMBAI
3	ISHITA LANJEWAR	DR. RUPALI SABALE	SETH G. S. MEDICAL COLLEGE, MUMBAI
4	VISHAKHA JAYRAM	DR. SHITAL PATIL	DR. D. Y. PATIL MEDICAL COLLEGE, PUNE
5	ANUSHA SHOLAPURKAR	DR. MANASI PADHYEGURJAR	SMBT INSTITUTE OF MEDICAL SCIENCES, NASHIK

SN	Name of Post Graduate Student	Name of Guide	Institute
1	DR. DEVYANI WANJARI	DR. ABHISHEK RAUT	MGIMS, SEVAGRAM
2	DR. MINAL HATNAPURE	DR. MALANGORI PARANDE	B. J. GOVT. MEDICAL COLLEGE, PUNE
3	DR. DAMINI MAHANUBHAV	DR. NANDKUMAR SALUNKE	B. J. GOVT. MEDICAL COLLEGE, PUNE
4	DR. PRACHI GHORPADE	DR. ASHLESHA TAWADE	MGM MEDICAL COLLEGE, NAVI MUMBAI
5	DR. RACHHANAA PAWASKAR	DR. RUPALI SABALE	SETH G. S. MEDICAL COLLEGE, MUMBAI

Congratulations to the students on selection of research proposals under the scheme for year 2021

Key issues:

According to union for international cancer control the key issues in cancer are –

- 1) Equity and in access to cancer care
- 2) Prevention and risk reduction
- 3) Awareness, understanding, myths and misinformation
- 4) Government action and accountability
- 5) Beyond physical: mental and emotional impact
- 6) Saving lives and saves money
- 7) Reducing the skills gap
- 8) Working together as one

Cancer and Covid-19 Pandemic:

The covid 19 pandemic affected the cancer screening, treatment as well as care profoundly. It caused distress among health professionals and a burn out due to being overworked. [5] At the same time, cancer organizations around the world struggled to reach out to cancer patients with essential services. The resources were diverted towards COVID-19 in certain resource constrained set ups. Thus, the vulnerable populations were affected disproportionately.

Prevention of Cancer:

Cancer causing infections such as human papillomavirus (HPV) and hepatitis, are responsible for approximately 30% of cancer cases in low- and lower-middle-income countries. (6) Apart from it, Cancers are being caused by factors that are largely lifestyle dependent. Promotion of healthy lifestyle therefore is a must. Also, many cancers show better outcome if detected and treated early.

Strategies advocated by WHO include –

- *National cancer centers: key to comprehensive approach.*
- *Facilitating decisions on screening*
- *Reinvigorated efforts to increase access to radiotherapy*
- *Scale-up critical given the impact of the pandemic (8)*

Prominent advancements regarding Cancer care -

- *Central cancer research portal such as India Against Cancer of ICMR and NICPR*
- *Ambitious forward-looking project of National Cancer Grid that networks major cancer centers across India for uniformity in standard of care and training. (10)*
- *Integration with National Digital Health program,*
- *Adopting the international guidelines and facilitating research regarding newer Screening techniques for cervical cancer and advanced training facilities for the same i.e., Self-testing kit for Cervical Cancer Screening (11)*
- *Creating specialized workforce through courses specifically designed pertinent to program needs e.g., KEVAT (9)*

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Views expressed by the Authors in this Newsletter are their own and not official view / stand of IPHA

