



IPHA MAHARASHTRA BRANCH

Newsletter

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Season of Festivals

This quarter ends with the beginning of season of festivals widely celebrated in Maharashtra. After the last two years of sufferings, all physical, mental, and social, from Covid-19 pandemic both by people and health system, the mood is upbeat in the population putting corona agonies behind.

First it is Ganesh Chaturthi, the lord coming home, is prayed for combating 'Vighna' as 'Vighnaharta.' Ganapati is called as God of academics; his large belly symbolizes generosity and acceptance; the large elephant ears symbolize quality of a good listener; a hand with 'Shastra' to fight with enemy of mankind and another raised hand to give assurance that outcome will be 'Shubha' and not to worry the danger. Being a 'Ganadhish' he is a leader of team of 'Gana.' All close to the heart of public health functionary.

Then it is Navaratri and Dasara, the celebration of win over evil. Navaratri, pooja of goddess symbolizing various dimensions of Nari Shakti underlining the equal status of female gender in society.

And here comes, Deepawali the festival of lamps, festival of joy, festival to develop ability to spread light even in the darkness.

Sharing a few lines written aptly by someone, circulating on the social media.

शुभ दिवावली

Dr Prasad Waingankar

ऊन सावल्या येतील जातील
कोब जपावे आतील हिरवे
चला दिवाळी आली आहे
ओजळीत घ्या चार दिवे ॥

पहिला लावा थेट मनातच
तरीच राहील दूसरा तेवत
घरात आणि प्रियजनांच्या
आयुष्यावर प्रकाश बरसत ॥

तिसरा असू दे इथे अंगणी
उजेड आल्या गेल्यानाही
चौथा ठेवा अशा ठिकाणी
जिथे दिवाळी माहित नाही ॥

Padvyuttar Sanshodhan Prakaalp Anudan - 2022

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

Eligibility

1. Applicant should be a post graduate student of Community Medicine OR Master's in Public Health OR Community Nursing OR Community Dentistry
2. Either the Applicant or Guide should be member of Indian Public Health Association.
3. Research study proposed should be community based original research and should be distinctly different from student's dissertation topic.

Guidelines for submission of research proposal

- Topic of research project should contribute to Public Health knowledge base. Student should be the Principal Investigator and Guide should be Co-Investigator.
- **The project proposal should be submitted through IPHA Maharashtra website only, on or before 30th November 2022**
- The projects from only Colleges of Maharashtra will be assessed and FIVE best projects (3 From Community Medicine & 2 From MPH / Community Nursing/ Community Dentistry) will be awarded funding of Rs. 15,000/- each. The funds will be released in 2 instalments i.e., Rs. 10,000/- once the project is approved and Rs. 5000/- immediately after approval of project report submitted within a period of 12 months.
- Student should prepare & complete project under the guidance of Community Medicine / Community Nursing/ Community Dentistry faculty.
- Final submission of Project Report should be before 31st December 2023.
- Please note, research proposal should be accompanied by –
 1. Institution Ethics Committee (IEC) approval letter
 2. Forwarding letter from Head of Department mentioning distinct difference in dissertation topic and topic of study under consideration and validating that the study will be student's original research work.

For Applying Visit: www.iphamaha.org
Email wprasad67@gmail.com for any query

EDITORIAL

ENRICHING PUBLIC HEALTH TEACHING EXPERTISE AMONGST FACULTIES OF COMMUNITY MEDICINE

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Teachers working at medical colleges and for the Medical Education, are like front line workers, hence what is expected at this level matters a lot for students as well as for those going to become teachers in future. Even though teachers are professing the subject of public health for health care services, there are some gaps, lacunas in their expertise to teach public health with relevant live experiences gained through the independent practical work in the field.

Post Graduate students are expected to learn principles and practice of public health in Medical College, from the faculties of Community Medicine. Hence Medical teachers are expected to have public health expertise and skills to fulfil their role as teachers of public health experts. For Clinicians, there are hospital OPDs and wards to gain practical skills, what about Community Medicine teachers – from where, they are going to get practical experiences and skills in public health. We know that public health experts, undergo post graduate training in Community Medicine at the Medical colleges. However, when they work in public sector, usually they get dissociated with the medical colleges or the Departments of Community Medicine. Junior faculties working in Departments of Community Medicine at Medical College level may not be aware about the applications of the subject knowledge in Public Health Sector and similarly those who work in Public sector may not be clear about how their experiences in the field can be incorporated in teaching curriculum to enrich PG teachers and students and enhance the importance of the subject and improve visibility of the subject at Medical college and Medical Profession in general. Lot of deliberations, discussions have taken place in this respect, at macro level i.e., at the level of MOH&FW and medical education policy formulation levels, but there are issues in percolating the actions at ground level, where the real change is required. We must believe in – Think globally and Act locally philosophy.

In medical profession the importance of your work is usually understood on the basis of how much worth you are to the health of the individuals as well as health of the general

public. On these parameters, Community Medicine experts are seen at lower level at medical college and Public Health functionaries are identified as administrators of public health department without understanding their professional responsibility as Community physician.

It is hard to accept that PG students in Community Medicine understand the true importance of the subject, skills and its applicability after obtaining PG degrees. Post graduate students in clinical subjects obtain knowledge and skills to the level of empowerment to manage the practice in the open world. This is limited in case of community medicine. Medical college faculties undergo lot of trainings from public health sector with initiation of any new programme or management practices, but there is hardly any utilization of this knowledge to the public sector. All faculties in Community Medicine and Public Health experts should introspect this paradigm, with due concern to find out strategies to fulfill the gaps on either side. There is scope to initiate or facilitate reforms to enrich our medical faculties in their public health expertise and practice, beneficial to the upcoming PG students and to the public health sector.

Teaching the subject to PG students makes us understand the limitations in building the essential skills amongst the PG students like....

- Will he/she be able to plan and implement intervention program to reduce malnutrition?
- Will he/she be able to evaluate functioning of PHC or SC?
- Will he/she be able to evaluate implementation of any National Health Programme at DH or CHC level?
- Will they be able to undertake Investigation of an epidemic independently?
- Will they be able to plan and implement program for elimination of scabies in 20 villages together?
- Will he/she be able to mobilize community participation for outreach activities?
- How indicators of health are different in two PHCs – one affiliated to medical college and one not affiliated?
- How development of referral linkages in two PHCs differ - one affiliated to medical college and one not affiliated?

The First World Medical Education Conference in London in August 1953 highlighted importance of Preventive and Social Medicine in the training of physicians. The All-India Medical Education Conference organized in 1955 after the World Medical Education Conference recommended major reforms in medical education in the country. It was recommended then that each medical college should have a Preventive and Social Medicine Department with fulltime staff.

National Medical Commission (NMC) guidelines for competency-based PG training programme for MD in Community Medicine and syllabus for MD (Community Medicine) given by MUHS, highlights the importance of public health skills to be acquired by the students. In order to fulfill these NMC & MUHS requirements it is equally important that the teachers who are entrusted the responsibility of teaching these skills, are well versed and competent to impart these skills to the students.

Teachers are expected to perform following roles in line with the expectations by NMC & University

- Teaching & Training – students, HCWs, Research aspirants, NGO functionaries working in public health
- Research – Operational, Action research, field studies, community trials etc.
- Support health services
- Advocacy for community health demands and utilization of health services
- Facilitate good governance practices at beneficiary end
- Empowerment of Community

Medical teachers are clear about their role as teacher and researchers. But what about other roles. If they understand the roles on these domains, question is from where these skills and expertise is going to be generated. Unless and until they have practical experience of working in public health sector, their own empowerment is unlikely.

Teachers' actions, attitudes, enthusiasm, interest and skills in the subject influence the learners directly. Teachers should possess effective public health teaching skills acquired through experiences in public health service. They must see the challenges of community-based teaching and make the learning experience meaningful and appealing. They must engage in research and involve in planning, monitoring and evaluation of public health programmes to be familiar with community-based public health activities. They must be a good role model for students. A good image of the teachers will enhance student's interest in the subject and may probably lead to a career

choice in public health. Medical doctors are leaders of the public health team and need to be trained to have adequate proficiency to meet the demands of health care systems and the health needs of the people.

Stakeholders such as the government, medical councils, medical associations, NGOs and INGOs (International NGOs), national and regional networks can play a critical role in improving teaching of public health in UG/PG medical schools.

	Community Medicine faculties usually
See	through somebody and not directly
Hear	from students/others, but do not listen beneficiary directly
Read	as theory topic but do not develop insights
Speak	but do not advocate at policy/decision making level
Teach	with limited practical experience in the field
Research	but limited direct benefit implications
Write	for academic purpose than for community empowerment
Criticize	without getting involved in work

We all are witnessing Covid 19 pandemic and are involved directly or indirectly in reducing transmission of Covid 19 and reduce its impact on the improving health indicators, socio-economic wellbeing and functioning of general health services. This pandemic also has enlightened us on the scope for preventive services including immunization scope for screening for preventable diseases, issues in utilization of existing health services, level of readiness for handling pandemic/epidemics, scope for sustainable capacity development, Infrastructure limitations in rural/urban areas, Scope for improving functioning of peripheral health institutions, scope for social and behavior change communication and scope for expanding My family – My responsibility campaign for other health issues.

At National level Indian Medical Service (IMS) in line with Indian Administrative Service is recommended on many platforms and is being considered. This arrangement will make human resource available, trained in technical as well as on medical administrative domains. However, strategic reforms may be given considerations in brainstorming workshop to improve utilization of Medical College Community Medicine faculties in management of public health services and public health experts to impart technical and operational skills to Post Graduate students and faculties in Medical College.

Public health departments may be considered as wards/fields for the PGs to gain practical knowledge. Some of the reform strategies which deserve attention on this background could be

1. District's allocation to medical colleges – for collaborative linkages with District Health authorities
2. Establish functional accountability of UHTCs/RHTCs with the Public Health Department
3. Placement of PG students in health services, to be supervised by their guide– up to 6 months with standard programme schedule with short assignments
4. Compulsory deputation of Community Medicine faculties to Public Sector Health Services for a minimum duration of 3 to 5 years – For this purpose, positions in the Public sector Health services may be fixed where there is scope for more technical work than bureaucratic responsibility, like in charge of any National Health Programme at District, circle, regional or state level, Disease surveillance area, Health Management Information system (HMIS), Monitoring functioning of different peripheral level health institutes under district/circle/region or state level, responsibilities of training cells etc.
5. Adopt new approaches to ensure compliance on the part of teachers – extra credentials for academic promotions, case study/case series approach to understand insights into the public health problems, short assignments to be completed with PG students to become more and more familiar with new challenges etc.
6. Compulsory placement of Public Health functionaries (having PG qualifications) in medical college for minimum duration of 3 to 5 years – For this, positions in the medical colleges may be identified either as Assistant Professor or Associate Professor depending upon experience and years of service in public sector. Beside refreshing the self-knowledge, these functionaries may be entrusted the responsibility of classroom teaching to UG and PG students with focus on practical insights and how best the knowledge can be transferred into practices of public health with long run benefits to the general population. Public Health specialist would definitely give justice to these expectations. In medical college, their inputs on behalf of Department of Community Medicine will strengthen the role of hospitals in contributing to public health services

- like – streamlining hospital-based disease surveillance in line with public health norms, improving HMIS at hospital level, training programmes for public health department staff, implementation of National Health Programmes at major hospitals level, advocacy for public health services, etc.
7. Develop data sharing guidelines between medical college, Community Medicine Departments & Public health services to promote health services research.

Attempts on this line are done sometimes. However, these optional arrangements are not substantial to improvise the work culture on either side. We need to think of well-planned strategic reforms in this direction at policy level to make it regular mainstreamed governance practice. Whenever and wherever, this is done, it is proved to be of mutual benefit to the medical college faculties as well as public sector services. Only placement of PGs to Rural Health Training Centres and Urban Health training centres for very limited period of time, without any accountability to the services rendered by them, does not fulfil these expectations.

Covid 19 pandemic has already enlightened all of us the role of Community Medicine in Public Health Services and has created enabling environment to push the agenda further. These suggested reforms, and not the customized arrangements as and when required, will be of mutual benefit for-

1. **Improvement in public health teaching skills amongst the faculties**
2. **Ensuring availability of technical experts in key positions at peripheral levels**
3. **Providing better orientation of Public Health to PG students**
4. **Having better understanding of practical aspects of Community Medicine**
5. **Expansion of Public Health Practice area to the Medical Colleges**
6. **Enhancing research scope in Public Health sector**

To conclude, - Public Health is practice. Practice requires relevant expertise, Expertise develops out of work experience, Work experience is generated by doing the work. Public health teachers should do the work to get experience to develop expertise to become proficient in public health practice. Community medicine faculties are public health teachers hence we all as Community Medicine faculties should adopt reforms, to be a good public health teacher – to uplift the importance of the subject and contribute substantially to fulfil National health goals. Things will look better, provided we change.

Is TB eradication an attainable dream?

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Introduction

Tuberculosis (TB) is a very old disease caused by Mycobacterium tuberculosis. It is a communicable disease which spreads by droplet nuclei inhalation with a high infectivity rate. It is still a threat for public health over worldwide. India is having the high incidence of TB disease and high mortality due to TB disease making India as a TB endemic country. (1) The classic symptoms of active TB disease are chronic cough with sputum, fever, night sweat and weight loss for more than 14 days. In 1993 WHO declared TB as global emergency.

Current scenario

In the Global TB report 2021 by WHO, it has been observed that there is a drop in newly diagnosed TB disease in 2020 compared to 2019 report which is probably the effect of inaccessibility to health care due to Covid19 pandemic situation. (2) Also, a rise in the number of death due to TB has been noted in the same report. In the year 2020 to full-fill the End TB strategy by WHO, India has launched National Tuberculosis Elimination Program (NTEP).

Gap with reality and dream

There is a gap between vision of a TB free world and reality. This is due to several factors. Firstly, there is a lack of awareness among people regarding TB symptoms. Followed by delay in diagnosis of treatment as TB case detection depends upon passive screening in most of the times. After this adherence to treatment may not be there which leads to drug resistant TB causing prolongation of treatment. There are latent TB and TB infections which may turn into active TB within a year. BCG vaccination is available for new-born to protect them from severe forms of TB disease, but it doesn't protect against latent infection and also no adult vaccination is available. Also, there is less involvement of the community and no periodic inspection system is available. Utilization of Rs. 500/- incentives may not be done properly by TB cases. Apart from

this there are defaulters and transferred out cases till now due to lack of awareness and inaccessibility to the health system.

End TB strategy:

Vision	A World Free of TB. Zero death, disease & suffering due to TB			
Goal	End the Global TB epidemic			
Indicators	Milestones		Targets	
	2020	2025	2030	2035
Percentage reduction in the absolute number of TB death	35%	75%	90%	95%
Percentage reduction in the TB incidence rate	20%	50%	80%	90%
Percentage of TB affected households facing catastrophic costs due to TB	0%	0%	0%	0%

Steps to be taken to reduce the gap

Several steps can be taken to reduce the gap between the dream and reality.

1. Awareness regarding the symptoms of TB among the general and high-risk population is needed. High risk population includes- people living with HIV, living in closed unhygienic environment, urban slums, immunocompromised, people with diabetes mellitus, health care workers, miners. Urban slums and closed environment areas need proper cleaning and monitoring for hygiene maintenance. Urban rehabilitation programmes can be developed to build clean housing and environment which will help indirectly to reduce the TB cases.
2. Community engagement: It was suggested to engage TB survivors of a community as they can approach a lot of people of the same community and can keep the patient motivated to continue the treatment. They can also help boost the mental strength of the

family of the patient. (3) Though it is suggested, there is no procedure to monitor these activities. So, there should be intermittent inspection of the community by expert teams. Periodic evaluation of strategies to be done to motivate the community and to increase the engagement of local people. To engage a greater number of TB-survivors, incentive-based counselling sessions and visits can be incorporated in the current scenario. This obviously needs more funding to this programme.

3. Early diagnosis and treatment: Once a person have any of the symptoms of TB for more than 2 weeks duration they should be screened for TB. Early diagnosis and treatment help reduce the spread of infections from an active case. CBNAAT is a rapid diagnostic test so diagnosis is possible earlier than previous. Door to door active screening is the best way to detect the cases. But it doesn't have any proper protocol or evaluation method. So, currently more cases are detected passively when the patient visits hospital. To encourage the active screening monthly target of testing can be set in an area depending upon the burden of cases from that area. Also, a minimum amount of incentive can be allotted to the healthcare worker on detection of cases. Health expert teams needed to pay visits in all centers and communities on a periodic basis and needed to monitor the performance of the centers and community health care workers. There should be standardized evaluation checklist to evaluate the performance and to understand if anywhere implementation of any activity is facing difficulty.
4. Contact tracing: Exposed contacts at risk to be identified by proper contact tracing. Along with household contacts, workplace contacts also need to be evaluated if at risk. But it has been noted that workplace contacts are not disclosed usually due to social stigma. So, the contact tracing team needs to put more effort and they should investigate at the workplaces and social circle of the person.
5. Preventive treatment: For this measure first population at risk (PLHIV adults and children >12months, Infants with HIV with active TB contacts, pulmonary TB cases household contacts) to be identified. Then they can be prophylactically treated with Isoniazid for 6 months. It has been observed that sometimes family members are not aware of prophylaxis of TB contacts.

Counselling and awareness sessions should be conducted regarding this. More study should be conducted on adult prophylaxis in case of TB case contact to bridge the knowledge gap.

6. Cascade of Care approach: Programmatic management of tuberculosis preventive treatment (PMTPT) has been developed under the NTEP but has not given much importance earlier. An integrated and comprehensive 'cascade of care approach' needed to strengthen the PMTPT services across the country. In this process all populations who are at risk to be reached and screened for active TB first. Once TB disease is ruled out, a test for TB infection to be done. 5-10% TB infection converts into TB disease within the first 2 years of exposure. Step by step approach will help finding cases and infections easily and quickly. (4) TST (Tuberculin sensitivity testing) and IGRA (Interferon Gamma Assay) are available to find out TB infections. TST is easy to perform in the field and less costly while IGRA is costly and proper laboratory setup is needed. Also, IGRA testing gives accurate result in adult and doesn't get affected by BCG vaccination. There is a lack of availability of these test setups in peripheries. So, proper setup for these testing and their availability to be made.
7. In case of MDR-TB or failure of DS TB treatment, cases to be given appropriate medicines as per protocol; and contacts need to be evaluated properly and to be started with levofloxacin (R resistance, fluoroquinolone sensitive) or rifampicin (Isoniazid resistance, rifampicin sensitive cases) prophylaxis.
8. Adherence monitor and tracking down the missing out: Monitoring of treatment adherence and any adverse reaction to be done. Regular follow up of the patients to be done properly so that patients should continue their treatment protocol properly. Counsellors need to be more empathetic and should try to put their best efforts to make patients understand the importance of adherence to the treatment. If they find anyone missing their monthly visit, they should immediately start tracking down the patient at the local level. Community officers and Community health care workers should pay visits to the patient and try to find out the causes for which the person stopped visiting the center. They should make the family aware and counsel the person for continuing the

scheduled doses. If the person went to some other place without informing, in that case the person should be tracked down with Nikshay-ID and the nearby center of his/her stay should be informed regarding this, so that the treatment can be continued.

9. Web based recording and reporting system 'Nikshay' has been developed by Government of India. Patients should learn how to utilize this system to get proper education regarding nutrition, cough etiquette and tuberculosis related information.
10. Finding the gap of utilization of incentives: Beneficiaries are getting Rs. 500/- currently under NTEP on each month visits. This money is meant to be for the TB infected person's dietary needs. But there are some pitfalls in this system. The infected person may not be aware of that and some other person whose bank account is linked for the money, is getting the money. Also, 500/- may be utilized by the whole family, the TB infected person may not be getting nutritious food at the end. Also, some tribal and rural areas are far from health facilities and specialist doctors may not be appointed in DOTs centers. So, patients are referred to far away centers. For this patient has to spend on their own. Study needed on the 'out of pocket' expenditure of the TB cases and accessibility of health care to know the current scenario. Also, Rs 500/- may not be sufficient for some urban city slums due to high cost of foods. So, money amount should be revised as per the need of the endemic pockets and money allocation should be done after checking the patients personal bank account.
11. Availability of chest physicians in all DOTs centres is recommended.
12. National policy making and utilization of resources to be taken care of at the government level.
13. Local helping groups and NGOs can collaborate with the public sector to reach the high-risk community to find out cases and mobilize them to the health sector for treatment seeking.
14. Public and private sector should act hand in hand to end TB.
15. Universal health coverage to be ensured.
16. Scope for research to upgrade the knowledge regarding this disease and to find ways to prevent it.

SWOT analysis of End TB strategy

Strengths	Weakness
<ul style="list-style-type: none"> ➤ Inclusion of CBNAAT as diagnostic test. ➤ Local groups and NGOs collaboration. ➤ TB-HIV integration. ➤ Web based initiative. ➤ Programmatic management for tuberculosis preventive treatment. ➤ Community engagement. 	<ul style="list-style-type: none"> ➤ Lack of resources. ➤ Lack of manpower. ➤ High burden of MDR and XDR TB. ➤ Difficulty in tracking down defaulters. ➤ Utilization of Rs. 500/- incentive may not be done in proper way by patients.
Opportunities	Threats
<ul style="list-style-type: none"> ➤ Awareness building. ➤ Step by step approach to find out contacts. ➤ To take initiative for prophylactic measures for TB infection. ➤ Research can be conducted on various aspects. ➤ Public- private partnership. ➤ Scope to increase community engagement. 	<ul style="list-style-type: none"> ➤ Social stigma. ➤ Poor adherence to treatment. ➤ Cultural beliefs.

Conclusion

There is a gap in reality and dream and it is difficult to achieve; but this dream is attainable with smaller steps. With emphasis on proper service delivery, accessibility to health care, adherence to treatment, finding of TB infections and prophylaxis and utilization of resources can make the dream of a TB free world or TB eradication attainable.

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Assessing Indian Public Health Standards for A Rural Hospital in Maharashtra: A Case Study

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Introduction:

National Rural Health Mission advocates upgrading public health infrastructure in rural areas to measurable standards of quality as a key strategic intervention. (1) Healthcare services in India is provided at three levels – primary, secondary and tertiary. Secondary level of healthcare includes community health centers (CHC) which are the first referral units, sub-district and district hospitals. CHC is a 30 bedded hospital which provides specialty services in Medicine, Obstetrics and Gynecology Surgery, Pediatrics, Dental and AYUSH. (2) One CHC is established for every 100000 population. (3) There are 5649 CHCs functional in India, consisting of 5183 rural and 466 urban CHCs according to Rural Health Statistics Bulletin 2019-2020 of Ministry of Health and Family Welfare, Govt. of India. (4)

Indian Public Health Standards are being set up for CHCs in order to ensure quality of services and to provide the yardstick to measure services being provided there. Objectives of IPHS for CHCs are – to provide optimal expert care to the community, to achieve and maintain an acceptable standard of quality of care and to ensure that services at CHC are commensurate with universal best practices and are responsive and sensitive to the client needs/ expectations.

Under IPHS guidelines, services are divided as ‘essential services’ and ‘desirable services’. Promotive, preventive, curative, referral services and all the national health programs forms essential services. IPHS are in operation since 2006 under National Rural Health Mission (NRHM). As per the changing protocols of national health programs and launch of new programs, revised guidelines of IPHS have come up in 2012. (5)

The P.R.I.D.E India (Planning Rural-Urban Development through Education) is a non-governmental organization with the core foundation based on a holistic approach to bring about a sustainable change in the marginalized communities living in rural & urban poverty. PRIDE India has set up a 30 bedded SPARSH

(Sastur Project of Action Research Services Through Hospital), a public private partnership initiative rural Hospital in Sastur village of Osmanabad district of Maharashtra in the wake of 1993 earthquake that hit 83 villages taking thousands of lives. (6)

Little efforts have been made in India to assess the Indian Public Health Standards (IPHS) at rural hospital level (7-9). An effort has been made to assess IPHS at rural hospital level in the present study. The objective of this study is to study services available, availability of infrastructure facility, manpower and diagnostic services available at SPARSH rural hospital and compare these with the Indian Public Health Standards (IPHS) for rural hospital.

Methodology:

The Present study was conducted at SPARSH rural hospital after taking permission of the project manager over a period of one month from 1st January 2020 to 30th January 2020 by direct observation with essential secondary data and interviews of key functionaries in the hospital. Indian Public Health Standards (IPHS) (2) updated in 2012 are taken into account to assess the situation.

Results & Discussion:

Specialist services:

According to the IPHS revised draft (2012), a rural hospital should have specialist services available in Medicine, Surgery, OBGY, Pediatrics, NHPs, Emergency services, Laboratory and Blood storage. It was found that all specialist services were available as per IPHS recommendations at SPARSH rural hospital.

Infrastructure facility:

According to the IPHS from revised draft (2012), a rural hospital should have 14 OPD rooms (4 for General doctors, 2 for AYUSH Doctors and 8 for Specialist Doctors), waiting room for patients, two Operation theatre, one labor room,

laboratory, X-ray room, blood storage, pharmacy, water supply, electricity and transport facilities. It was found that SPARSH rural hospital has 8 OPD rooms, waiting room for patients, one Operation theatre, one labour room, laboratory, X-ray room, blood storage, pharmacy, water supply, electricity and transport facilities as per IPHS recommendations. It was found that gaps in infrastructure facilities

were present. Due to a smaller number of OPD rooms, two doctors were consulting in same room.

Manpower:

As per IPHS recommendations, total essential and desirable manpower at rural hospital should be 46 and 53 respectively but manpower available at SPARSH hospital was 34 and 36 respectively.

Table 1: Availability of Manpower at SPARSH Rural hospital

Personnel	Essential	Desirable	Available at SPARSH Hospital	Remarks / Existing gap
Block Public Health Unit				
Block Medical Officer / Medical Superintendent	1		1	No
Public Health Specialist	1		0	1
Public Health Nurse (PHN)	1	+1	0	1
Speciality Services Officers				
General Surgeon	1		2	No
Physician	1		2	No
Obstetrics & Gynaecologist	1		2	No
Paediatrician	1		1	No
Anaesthetist	1		1	No
General Duty Officers				
Dental Surgeon	1		0	1
General Duty Medical Officer (MBBS)	2		1	1
Medical Officer – AYUSH	1		1	No
Nurses and Paramedical Staff				
Staff Nurse	10		10	No
Pharmacist	1	+1	2	No
Pharmacist – AYUSH	1		0	1
Lab Technician	2		2	No
Radiographer	1		1	No
Dietician		1	0	0
Ophthalmic Assistant	1		0	1
Dental Assistant	1		0	1
Cold Chain & Vaccine Logistic Assistant	1		0	1
OT Technician	1		1	No
Multi Rehabilitation Worker	1	+1	0	1
Counsellor	1		1	-
Administrative Staff				
Registration Clerk	2		1	1
Statistical Assistant / DEO	2		1	1
Account Assistant	1		1	-
Administrative Assistant	1		1	-
Group D Staff				
Dresser	1		0	1
Ward Boys	5		5	-
Driver	1	3	2	-
Total	46	53	39	12

Table 1 depicts comparison between availability of Manpower at SPARSH Rural hospital and IPHS recommendations. Out of 46 essential manpower, 12 unavailable manpower at SPARSH rural hospital was- One public health specialist, one public health nurse (PHN), one dental surgeon, one general duty medical officer (MBBS), one pharmacist – AYUSH, one ophthalmic assistant, one dental assistant, one cold chain & vaccine logistic assistant, one multi rehabilitation worker, one registration clerk, one statistical assistant/ DEO and one dresser. Rest all manpower was available as per IPHS recommendations. Two desirable manpower available at SPARSH rural hospital was one pharmacist and one driver.

Diagnostic Services:

Table 2 depicts comparison between availability of diagnostic services at SPARSH Rural hospital and IPHS recommendations. Out of 35 essential and 36 desirable diagnostic services, 32 essential and 33 desirable diagnostic services were available at SPARSH rural hospital.

Table 2: Diagnostic Services available at SPARSH Rural hospital

Speciality	Diagnostic tests available at SPARSH hospital	Remarks / Existing gap
Clinical Pathology	a) Haematology b) Urine Analysis c) Stool Analysis	Available Available Available
Pathology	a) Sputum cytology	Available
Microbiology	Smear for AFB, KLB, Gram stain for Throat swab, sputum etc	Available
Serology	VDRL, Pregnancy test, Widal test	Available
Biochemistry	Blood sugar, Liver function tests, Kidney function tests, Blood lipid profile	Available
Cardiac Investigations	ECG (Desirable)	Available
Ophthalmology	a) Refraction by using Snellen's chart b) Retinoscopy c) Ophthalmoscopy	Available Not Available Not Available
Radiology	X ray for chest, Skull, Spine, Abdomen Bones Dental X ray Ultrasonography (Desirable)	Available Not Available Available

Conclusion

SPARSH rural hospital complies with most of the guidelines of IPHS 2012. However few gaps which are identified with reference to IPHS guideline are fulfilled through support from NHM.

Acknowledgement

We acknowledge Dr. Gajanan. D. Velhal, Ex.- Professor and Head of the Department of Community Medicine Department of Seth GSMC & KEMH and staff of SPARSH rural hospital for providing the support and encouragement.

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World Population Day

Dr Ravikiran P K¹, Dr Rahul Chopade¹, Dr Avinash Borkar¹, Dr Namita Deshmukh¹

¹Associate Professor, B. K. L. Walawalkar Rural Medical College, Dervan, Ratnagiri

Every day we add 227,000 more people to the planet — and the UN predicts human population will surpass 11 billion by the end of the century. Global population growth and the destructive consumption habits of high-wealth countries put pressure on biodiversity and human communities, exacerbating food and water shortages, reducing resilience in the face of climate change, and making it harder for vulnerable groups to rise out of intergenerational poverty.¹

In 1989, the Governing Council of United Nations Development Programme recommended that 11th July be observed by the international community as World Population Day, a day to focus attention on the urgency and importance of population issues.

WHY POPULATION DAY?

World Population Day, which seeks to focus attention on the urgency and importance of population issues, was established by then-Governing Council of United Nations Development Programme in 1989, an outgrowth of the interest generated by the Day of Five Billion, which was observed on 11 July 1987.

By resolution 45/216 of December 1990, United Nations General Assembly decided to continue observing World Population Day to enhance awareness of population issues, including their relations to the environment and development.

The day was first marked on 11th July 1990 in more than 90 countries. Since then, number of UNFPA country offices and other organizations and institutions commemorate World Population Day, in partnership with governments and civil society.

WORLD POPULATION DAY 2022 THEME

“A world of 8 billion: Towards a resilient future for all – Harnessing opportunities and ensuring rights and choices for all”.

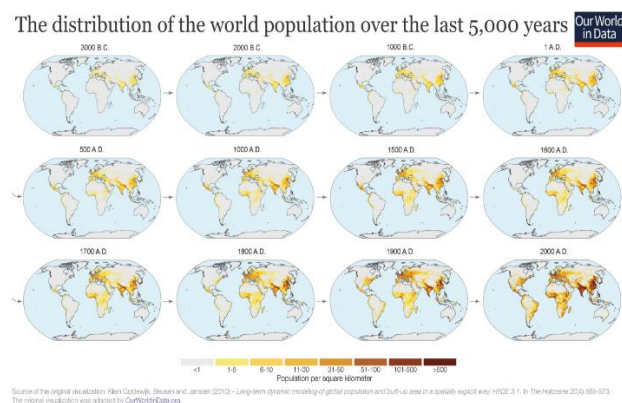
As the theme suggests, there are 8 billion people living today but not all of them have equal rights and opportunities. Based on gender, ethnicity, class, religion, sexual orientation, disability and origin, among other factors, too many are still exposed to discrimination, harassment and violence. In an ideal world, 8 billion people

means 8 billion opportunities for healthier societies empowered by rights and choices.

Population trends of World and India

It took almost thousands of years for the world population to grow to 1 billion. Two hundred years ago the world population was just over one billion. Since then, the number of people on the planet grew more than 7-fold to around 8 billion today. Global population reached the 7 billion mark in 2011, stands at almost 7.9 billion in 2021, and it's expected to grow to around 8.5 billion in 2030, 9.7 billion in 2050, and 10.9 billion in 2100. In recent past there has been enormous changes in fertility rates from 4.5 in early 1970s, to below 2.5 children per woman by 2015.² Between 2000 and 2020, global population grew at an average annual rate of 1.2% while 48 countries grew at least twice as fast: 33 in Africa & 12 in Asia.

India -According to a recent analysis by the Lancet, India's population to peak around 1.6 billion in 2048 from 1.38 billion in 2017. It will be followed by a 32% decline to around 1.09 billion in 2100.³ India in 2100 will be the world's most populous country. Total fertility rate has fallen from 6 in 1880 to 2.1 in 2019.⁴



Why is the population still increasing with decline in fertility rate?

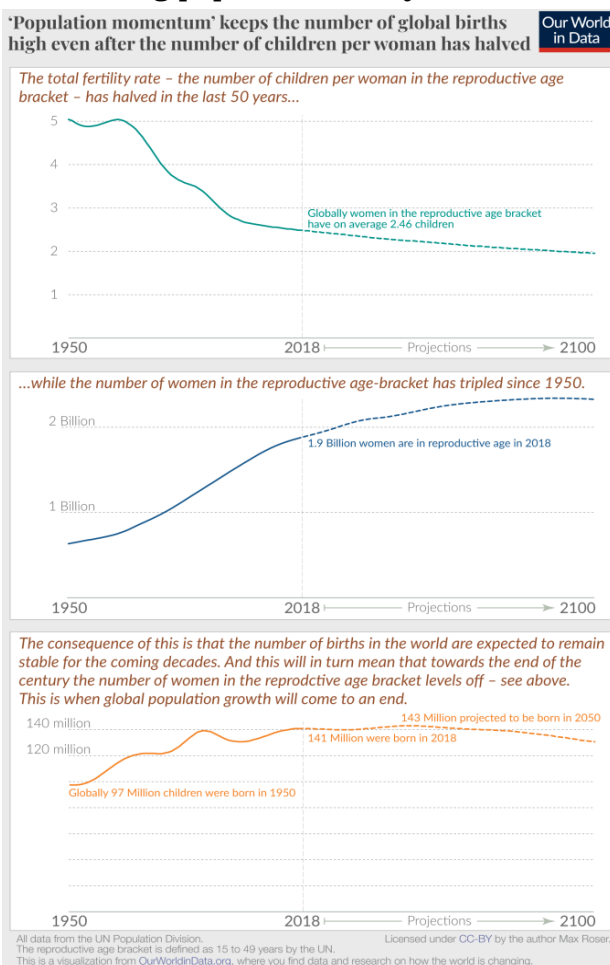
REPLACEMENT FERTILITY RATE

The total fertility rate at which a population replaces itself from one generation to the next. If no children died (developed countries) before they grew up to have children themselves the replacement fertility rate would be 2. Because some children die, the global replacement fertility

rate is currently 2.3 and therefore only slightly lower than the actual global fertility rate (2.46)

POPULATION MOMENTUM

For a given population, total population momentum is the size of the hypothetical stationary population achieved by projecting today's starting population with replacement fertility (If there were few women in the reproductive age bracket the number of births will be low even when the fertility rate is high. At times when an increasing share of women enter the reproductive age bracket the population can keep growing even if the fertility rate is falling), zero net migration, and today's constant death rates, divided by the size of the starting population today.



Impact of Rapid Population Growth

Increasing population can have effect on social, economic and political aspects

1. Air and water pollution: As the population increases forests are cleared. Two most common reasons for deforestation are to provide houses for increased population and use of wood as a fuel in the industries. Trees help in reducing the air pollution and thereby reducing global warming. With increase

in population calls for increasing numbers of factories. These factories lead to various kinds of pollution, including water pollution. Countries like India, which is agrarian country, the water pollution also comes from pesticides used for agriculture.

2. Deforestation: with increase in population leads to environmental damage. Scarcity of land due to rapidly increasing population pushes large number of people to ecologically sensitive areas such as hillsides and tropical forests. It leads to over grazing and cutting of forests for cultivation leading to severe environmental damage. Continuing deforestation, therefore, has brought us face to face with a major ecological and socio-economic crisis.
3. Extinction of species: About more than 1.1 billion people occupy those areas that conservationists consider the richest in non-human species and are mostly threatened by human activities. Such areas occupy around 12 percent of the planet's land surface, but these hold nearly 20 percent of its human population. The population growth rate is at the rate of 1.8 annually, compared to the world's population of 1.3 percent. Many species are of immense value to humans as sources of food, medicines, fuel and building materials
4. Land/soil degradation: On the global basis, the soil degradation is caused primarily by overgrazing (35%), agricultural activities (28%), deforestation (30%), over exploitation of land to produce fuel wood (7%), and industrialization (4%).
5. Global warming and climate change: one of the greatest threats There is a worldwide consensus among climate scientists that global average temperature has raised about 1F (0.4C - 0.8C) in the past 140 years.
6. Unemployment
7. Standard of living: Rapid population growth is to be blamed low standard of living. Even the necessities of life are not available adequately since resource distribution becomes major issue.
8. Social problems: population explosion causes migration of people from rural areas to urban areas, resulting in creation of slum areas. People live in the most unhygienic condition. Among the educated youths unemployment and poverty lead to frustration and resentment further leading to robbery, prostitution and crimes. Overcrowding, traffic congestion, frequent accidents and pollution in large cities are the immediate result of overpopulation.

9. Illiteracy—mainly in families with uncontrolled population. Those Families having a greater number of children are not in a state to provide better education and some time to take care of younger brothers and sisters the elder has to sacrifice their education.
10. Increased bonded labor
11. Urbanization: higher levels of urbanization and accelerating migration. 2007 was the first year where in large number people lived in urban areas than in rural areas, and by 2050 about 66 per cent of the world population will be living in cities.
12. Water and food Scarcity

Measures to control Population in India⁵

1. Contraceptives- should be made affordable and available. Stigma related to it must be uprooted. Awareness should be created of contraceptive measures and their importance among the population.
2. Standard of women- should be elevated in terms of education. If educated, made aware of the importance of their health and are not seen as objects to bear and rear children, population growth would surely decrease.
3. Legal marriage age- Legal age of marriage for men is 21, and for women, 18. Younger age of marriage devoid people of knowledge regarding family planning and sensitization towards the issue of population.
4. Literacy- Illiteracy plays a vital role in a population explosion. Literate people prefer to have small families, are aware of contraceptive methods and realize the consequences of a large family.
5. Spreading awareness- The benefits of family planning should be propagated through mass media. The population is also a cause for illiteracy, illnesses, and malnutrition and its adverse effects need to be preached to the general populace to develop their reasoning and understanding.

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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.**

Email – sec@iphamaha.org

Mobile – 9324714313

Web: www.iphamaha.org

Report of 66th Annual National Conference of Indian Public Health Association

(23rd - 25th September 2022 with Preconference workshops - 22nd September)

By Organizing Chairperson Dr. (Mrs.) Jayashree Gothankar

The conference was organized by department of Community Medicine, Bharati Vidyapeeth DTU Medical College Pune, department of Community Medicine BJGMC Pune & Maharashtra branch of IPHA. It was held on 23rd to 25th September 2022 and preconference workshops on 22nd September 2022 at Bharati Vidyapeeth DTU Medical College Pune. The website (iphacon2022pune.com) was created and hosted in the month of May 2022.

Maharashtra Medical Council granted five credit points for the conference and two credit points for each of the five preconference workshops. Dr. Rajan Sancheti was appointed as MMC observer and Dr. Sachin Mumbre as a special MMC observer.

There were five full day preconference workshops. Viz. Basics of health and demographic surveillance, Regression Analysis, Time Series Analysis, Qualitative research with focus on Analysis, Artificial Intelligence, and deep machine learning in health. A total of 180 participants registered for these five workshops. There was one convener per workshop and a total of 14 facilitators. The workshops were conducted in the Bharati Hospital building of Bharati Vidyapeeth (DTU)MC Dhankawadi campus, Pune.



Oral and Paper presentations:

A total of 564 abstracts were received. All the members of scientific committee reviewed abstracts as per the prescribed guidelines. On day one of the conference a total of 22 oral sessions with 265 presentations were conducted and on day two, 11 oral and 15 poster presentation sessions were conducted in which a total of

132 and 165 presentations were done, respectively. A total of 123 judges for oral presentations and 25 for poster presentations were invited. A winner from each of oral and poster presentation session were selected based on the predefined criteria finalized by the scientific committee. Thus 48 winners were announced, and names were displayed during the conference.

Scientific sessions:

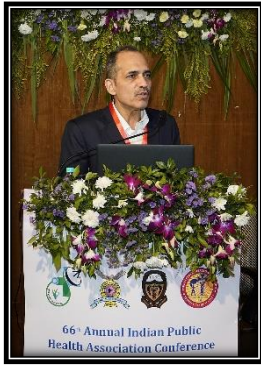
First day of the conference started with the oral presentations for Dr. P.C. Sen memorial best paper award on 'Rural health practice' and Dr. S. D. Gaur memorial best paper award on 'Environmental health practice'. Dr. Arup Chakraborty and Dr. Ramanandi Ananya Jyotirmay received the awards respectively.

A plenary by UNICEF on 'Preconception care and early childhood development'. The importance of preconception care and the details of the preconception care project in Nasik district and a session on early childhood development was discussed. Next session of Dr. B. C. Dasgupta memorial oration was delivered by Dr. Harshad Thakur. The topic of oration was 'Post COVID 19 pandemic public health issues and challenges'. Dr. Sanghamitra Ghosh and Dr. Girish Dhumale chaired the session.



Inauguration ceremony was graced by chief guest Prof. Dr. Tanaji Sawant, Hon'ble Minister of Public Health and Family welfare, Government of Maharashtra. Dr. Ramaswamy N. IAS Commissioner Health services and Mission Director NHM, Maharashtra, Dr. Vishwajit Kadam, Hon'ble secretary of Bharati Vidyapeeth University, and Dr. Shashank

Dalvi Hon'ble Vice Chancellor MGM institute of Health Sciences, Navi Mumbai were the guest of honour.



A keynote address on 'Health equity through digital technology' was delivered by Maj. Gen. Retd. (Prof.) Dr. Atul Kotwal Executive Director NHSRC.

Post-lunch sessions were a panel discussion on 'Approaches to error free publishing in Medical journal' by

Editorial team of Indian Journal of Public Health was conducted. The session was moderated by Dr. Rajib Dasgupta and Dr. Sanjay Chaturvedi, Dr. Pritam Roy and Maj. Gen. (Prof.) Dr. Atul Kotwal. The authors perspective and editor's perspective were discussed in the session.



There was a special session on 'Alternate dimensions in public health-I'. Various topics on building a digital health ecosystem, public health approaches for health ageing, epidemiology of congenital disorders, maternal and neonatal survivorship were presented. The session was chaired by Dr. Sachin Palve and Dr. Parvinder Chawla.

The preliminary round on PG quiz was conducted by 'the national IPHA PG quiz coordinators.

A plenary session by NHSRC titled 'Technology in health: a way forward towards Universal Health Coverage'. The session was chaired by Maj. Gen. Prof. Dr. Atul Kotwal and Brig. Dr. S K Kaushik. Various topics on digitization of health action plan, building safe health system, technology enabled comprehensive primary health care, human resources for advances in digital health and digital innovation for accessible and affordable health care were discussed.

A session was conducted by NCEAR-A on 'Sustainable and accelerated control

of Anaemia- Anaemia Mukht Bharat'. Topics like 'Milk fortification to address nutritional anemias and 'Linking national centres with state centres of excellence for anaemia research' were discussed. The session was chaired by Padmashri Prof. Dr. C. S. Pandav and Dr. Sanjay Rai. A panel discussion on 'SWOT analysis of AMB and the way forward' was done with Dr. Kapil Yadav as the moderator for the session.

The last session of the day one was 'Accelerating effort towards elimination of Neglected Tropical Diseases: role of medical institutions.' 'Global and regional overview of NTDs' and a 'Brief overview of VL and LF' was given by Dr. Dhruv Pandey and Dr. Naresh Kumar Gill. This session was followed by a panel discussion on 'How medical colleges/public health institutions and the national elimination programme can complement each other'. The session was supported by NCVBDC, PATH, BMGF-Country office and WHO country office.

A cultural programme and gala dinner was arranged in the evening. The organizers as well as some delegates presented their extra-curricular talents during the cultural event as it was enjoyed by all.

Day two started with a plenary on 'Vaccine updates' supported by Serum Institute India (SII) Pune. There were presentations on 'Spike protein COVID19 new vaccines', 'Post marketing surveillance of human rabies monoclonal antibody' and



'Oral polio vaccine or inactivated polio vaccine which one is best for polio eradication'. The session was chaired by Dr. Prakash Doke and Dr. Pankaj Bharadwaj.

Dr. K. N. Rao memorial oration was delivered by Dr. Archana Patil, current Executive Director, SHRC, Maharashtra and former DHS, Maharashtra state on 'Maternal mortality perspective: Maharashtra's success story.' She highlighted on the status of Maharashtra about Maternal mortality and discussed



various process and impact indicators for measurement of the maternal mortality. The session was chaired by Dr. Rajib Dasgupta and Dr. Jayashree Gothankar.

A session on 'COVID 19 vaccination programme' was conducted by Immunization Technical Support Unit (ITSU) it was presented by Dr. Pradeep Halder. The session was followed by the panel discussion on 'Vaccine hesitancy in India' moderated by Dr. Sanjay Kapoor.



PATH supported Panel discussion on 'RMNCH+A nutrition digital interventions' was moderated by Dr. Sudhir Maknikar. Panel Discussion

covered the topics namely 'Using digital intervention to maintain the food chain especially rice fortification,' 'Supply chain challenges about contraceptives' etc.

MINErVA network supported session on 'Strengthening death certification in medical colleges' was chaired by Dr. Anand Krishnan and Col. Dr Swati Bajaj. Topics like assessment of MCCD in tertiary medical colleges, interventions to improve the quality of medical certification of cause of death, and framework for audit of MCCD at health facility were presented. There was a panel discussion on 'Strengthening teaching of MCCD in medical curriculum and medical certification in hospital', it was moderated by Dr. Anand Krishnan.

A panel discussion on 'Lessons learned from COVID 19 pandemic and the way forward' was moderated by Dr. Harshal Pandve. Dr. Priya Abrahm, Dr. Shivkumar Iyer, Dr. Muralidhar Tambe, Dr. Lalit kumar Sankhe, Dr. Pradip Awate and Dr Shashikala Sangale were the panelists.

A session on 'Continuum of care for non-communicable diseases' was presented by Dr. Prashant Mathur followed by a panel discussion with following panelists Dr. Sandeep Rai, Dr. Prakash Doke, Dr. Tejpal Singh Chavan, Dr. Nupur Lalvani and Dr. Prashant Mathur.

A second session on alternate dimensions in public health -II was conducted as a parallel session in post lunch time. It was chaired by Dr. Gajanan Velhal and Dr. Abhay Saraf. Dr. Yogesh Gurav presented on 'Role of health technology in public health', Dr. Nilanjana Ghosh presented on topic 'Mental health

abuse in patients. 'Best practices in integrated MJPJAY and PMJAY and their impact,' 'The danger of texting and what teenagers need to know' were presented by Dr. Bahubali Nagaonkar and Dr. Manju Lata Sharma, respectively. Dr. Ashoo Gandhi presented on topic 'Standard treatment workflow: an approach towards universal health coverage.'



Final round of National IPHA PG Quiz was conducted as the last session of day two of the conference. First as well as second position was won by AFMC, Pune.



A banquet was arranged at Marigold banquet & conventions. Arrangement for transportation was done from the conference venue to the Marigold and back.

Day three started with a plenary on 'Application of GIS in public health' by Mr. Ronak Sutaria. He elaborated on the need of open-source software- community GIS, levels of governance where software can improve life, Health GIS, GIS role was discussed. The session was chaired by Dr. Muhammad Salim Khan and Dr. Yogesh Sabde.



A plenary session on 'What does it take to protect nations from contemporary public health threats?' by NCDC -CDC. The session started with a plenary on 'Emerging and re-emerging public health threats: The global perspective' by Tran Minh Nhu Nguyen followed by a session on 'Work force development under the global health security agenda,' by Dr. Kristin Vander Ende. There was a panel discussion which was moderated by these two speakers and the trainers of Field Epidemiology Training Programme (FETP) programme from different parts of the country were panelists. They shared their experiences about their role as trained field epidemiologists.

Dr. J. E. Park memorial oration was delivered by Dr. Samiran Panda on topic 'Looking back to move forward: A travel rule underlined by the current pandemic'. The session was chaired by Dr. Amitav Banerjee and Dr. Sanjay Rai. Dr Panda highlighted



on the Pandemic response, modelling capacity, impact of vaccination on a 'combined variant' scenario and Journey towards 'ENDEMIC-19'.

The last session of the conference was supported by National TB Elimination programme (NTEP). It was chaired by Dr. R. C. Goyal and Dr. Purushottam Giri. 'Updates in NTEP' and 'Role of medical colleges', 'Private sector engagement in NTEP and DRTB were various topics and the last talk in this session was delivered by Dr. Himanshu Pophale on COPD as a public health problem.



A total of 80 guest speakers of various academic partners and/or medical colleges shared their knowledge in the conference. Around 33 experts were chairperson for these sessions. The organizers express their gratitude to various academic partners of the conference.



The valedictory function was graced with Tran Minh Nhu Nguyen, Team leader WHO India as the chief guest and Dr. Nitin Ambadekar, DHS, Maharashtra, Pune as the guest of honour. Other dignitaries on the dais were Dr. Gajanan Velhal, and Dr Prasad Waingankar, President and Secretary Maharashtra branch of IPHA respectively.



The glimpses of conference were shared during the valedictory function. The conference ended with National Anthem.



IPHA Maharashtra Inter Medical College Public Health Quiz Competition: 2022

Report by IPHA Maharashtra Branch Quiz Coordinator Dr. P. L. Gattani¹

¹Professor and Head,
Department of Community Medicine, Dr. S. C. GMC, Nanded

This year the first announcement of IPHA Maharashtra Inter Medical College Public Health Quiz competition was made in the month of May.

Zonal level rounds were conducted in all 5 zones at Mumbai, Pune, Dhule, Nanded and Nagpur on 28th June 2022.

Zone	Zonal Coordinator	Zonal Nodal Institute
Mumbai (Konkan)	Dr. Yuvaraj Chavan	Seth G. S. Medical College, Mumbai
Pune (Western MH)	Dr. Muralidhar Tambe	B. J. Government Medical College, Pune
Dhule (Northern MH)	Dr. Sarika Patil	Shri Bhausaheb Hire GMC, Dhule
Nanded (Marathwada)	Dr. Prakash Gattani	Dr. S. C. GMC, Nanded
Nagpur (Vidarbha)	Dr. Uday Narlawar	Government Medical College, Nagpur

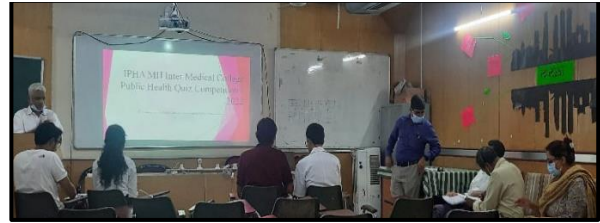
Zone wise names of colleges participated in zonal rounds were as follows

Zone	Institutes Participated
Mumbai (Konkan)	Seth G. S. Medical College, Mumbai MGM Medical College, Navi Mumbai
Pune (Western MH)	B. J. Government Medical College, Pune Bharati Vidyapeeth DU MC, Pune MIMER, Talegaon, Pune PIMSR, Islampur AFMC Pune
Dhule (Northern MH)	Shri Bhausaheb Hire GMC, Dhule Dr. VVPF MC, Ahmednagar Dr. BVP Rural MC, Loni Dr. UPMC, Jalgaon Dr. VPMC, Nashik GMC, Jalgaon
Nanded (Marathwada)	MGM MC Aurangabad Dr. S. C. GMC, Nanded VDGMC, Latur
Nagpur (Vidarbha)	Government Medical College, Nagpur NKP Salve MC, Nagpur MGIMS, Sewagram GMC, Chandrapur IG GMC, Nagpur GMC, Akola

All five zonal coordinators prepared one set of questions each for all rounds and these sets were randomly distributed among five zones by state quiz coordinator, Dr. P. L. Gattani, Prof & Head, Dept. of Community Medicine, Dr. SCGMC, Nanded

Zonal Rounds – 28th June

Mumbai (Konkan)



Pune (Western Maharashtra)



Dhule (Northern Maharashtra)



Nanded (Marathwada)



Nagpur (Vidarbha)



Following were the zonal winner teams:

Zone	Winners / Eligible for Final Round
Mumbai (Konkan)	Seth G. S. Medical College, Mumbai <ul style="list-style-type: none"> • Amey Ambike • Debayan Banerjee
Pune (Western MH)	B. J. Government Medical College, Pune <ul style="list-style-type: none"> • Rahul Raman • Ishan Tungar
Dhule (Northern MH)	Dr. BVP Rural Medical College, Loni <ul style="list-style-type: none"> • Saurabh Nagar • Sanya Takkar
Nanded (Marathwada)	Dr. S. C. GMC, Nanded <ul style="list-style-type: none"> • Kasturi Brhame • Deandra Vaz
Nagpur (Vidarbha)	Government Medical College, Nagpur <ul style="list-style-type: none"> • Aman Sansare • Aditya Dokwal

Participation certificates and TA/DA was given to all the teams by IPHA Maharashtra. Also, winner team and runner up team of each zone was awarded with cash prize of Rs. 1000/- and Rs. 500/- respectively. All the zonal coordinators and Heads of the Dept. Community Medicine of all the participatory teams supported wholeheartedly for this activity.

FINAL ROUND of QUIZ 2022

Five winner teams from the five zones as mentioned above participated in the final round of IPHA Maharashtra inter-college Quiz Competition.

It Was held by Department of Community Medicine, MGM Medical College, Navi Mumbai on 11th July 2022 (Monday) in MGM Institute of Health Sciences Auditorium.



The competition started with welcome speech by event coordinator (Major) Dr. Ashlesha Tawde and IPHA Maharashtra Branch Secretary Dr. Prasad Waingankar. Further the felicitation of guests was conducted with the flower bouquet followed by Lamp lighting Ceremony.

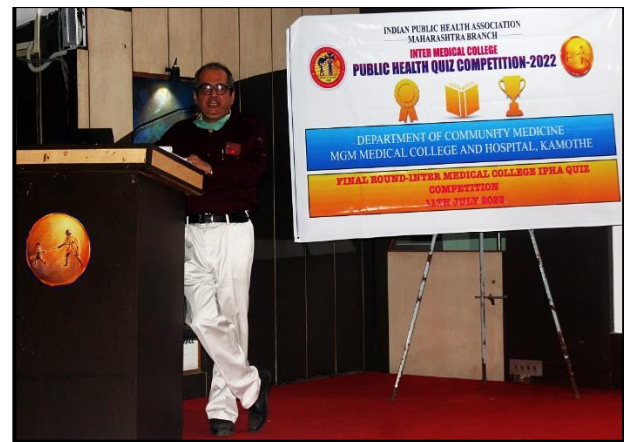
Dr. Gajanan Velhal, President, IPHA Maharashtra Branch and Dr. Nandkumar Salunke, Treasurer, IPHA Maharashtra Branch were present for the event.



Dr. G. S. Narshetty (Dean), MGM Medical College, Navi Mumbai was the chief guest for the event and Dr. Manasee Thakur, Director, MGM School of Biomedical Science was guest of honour.



The judging panel consisted of experts from Department of Community Medicine, MGM MC. Professor Dr. Mrunal Pimparkar and Professor Dr. Pradeep Sawardekar. Dr. Saili Jadhav was Quiz Master and Ms. Bhargavi Bora was scorer.



Dr. Prasad had structured the quiz which consisted of five rounds. Direct question round, Visual round, Multiple Choice Question round, Rapid fire round and Buzzer round. After each successful round the scores were declared and there was close competition among the teams till the end. The audience also participated in the quiz as some questions were passed to them. Dedicated questions for the audience were also received very well.

The participants shared their experience of the quiz competition from elimination rounds uphill the final rounds. Judges appreciated all the participating teams for their performance as well as the sportsman's spirit displayed.

IPHA MH Quiz'22 Result:

- **First Prize & Rolling Trophy**
 - Rahul Raman & Ishan Tungar.
 - B J Govt. Medical College, Pune.
- **Second Prize**
 - Debayan Banerjee & Amey Ambike.
 - Seth G S Medical College, Mumbai



Breast Feeding Week Activity by IPHA MH
In Rural Area – Primary Health Centre, Nere
 Capability Strengthening of Anganwadi and ASHA to enable them to guide pregnant and lactating mothers about Breast Feeding and Supplementary Nutrition proficiently using lecture demonstration and skits, in August'22.
Focal Point: Dr. Ashlesha Tawade, EC Member
 Resource Faculties: Dr. Priyanka Parekh & Dept. of Nutrition, School of Biomedical Science, MGM Shilpi Malhotra, Lactation Professional, Mumbai



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