



# IPHA MAHARASHTRA BRANCH

## Newsletter

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IPHA Maharashtra Branch Newsletter

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*IPHA Maharashtra expresses gratitude towards UNICEF Maharashtra Field Office for providing financial assistance for printing & distribution of this Newsletter issue.*

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Volume: 17 Issue: 03

July – September 2025

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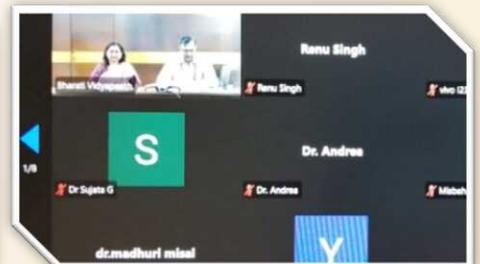
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Dr. Saibal Adhya, Professor & Head & Dr. Varsha Vaidya, Professor, Community Medicine, Bharati Vidyapeeth (DU) Medical College, conducting webinar to roll out the courses by Spoken Tutorial, IIT Mumbai. (August 2025)

*President's Page*

**Online Courses on Maternal & Child Nutrition  
For Medical Students and Health Functionaries  
By Spoken Tutorial, IIT Bombay (Mumbai)**



On 18<sup>th</sup> June 2025, IPHA Maharashtra State Branch signed a Memorandum of Agreement (MoA) with Spoken Tutorial, IIT Bombay (Mumbai) to roll out and introduce their Health & Nutrition courses to Medical Students & Health functionaries in the state.

The Spoken Tutorial Project was established at IIT Bombay with funding from the Ministry of Education (Previously MHRD). Spoken Tutorial under the National Mission on Education through ICT, offers various Health & Nutrition Program tailored to Medical Students and Health Functionaries. This initiative aims to enhance foundational knowledge in key areas such as balanced diets, malnutrition, maternal and child health and disease prevention through high quality self-paced audio visual tutorials. Aligned with the academic needs of medical students and health functionaries the program supports blended cognitive learning and skill development, empowering future healthcare professionals with accessible, multilingual educational resources.

The Health & Nutrition content has been conceptualized and developed by Dr. Rupal Dalal, a renowned pediatrician and public health nutrition expert. Dr. Dalal is a professor at CTARA, IIT Bombay, and has over two decades of experience working on child malnutrition and community health programs across India.

Currently these courses cover following three areas –

1. Third Trimester & Beyond – Covers Breastfeeding skills and Growth Monitoring including anthropometric measurements
2. Complementary Feeding – Including low cost local Recipes
3. Adolescent, Adult and Maternal Nutrition – Including Insulin resistance

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These courses are offered at very nominal fees. Each of these courses have fee of Rs. 236/- (including GST) per participant.

The courses are suitable for self-learning and will improve the clinical perspectives, aligning health functionaries with globally accepted nutritional practices – enhancing both academic learning and patient care outcomes.

**Key Benefits to students:**

- ✚ Each student who registers for these courses will receive login access to download course material, using which they can learn at their own pace, and attempt an online test after course completion.
- ✚ All registered students will receive a Participation Certificate.
- ✚ Those who score 40% or above in the online tests will receive a Completion Certificate with an explicit mention of marks.
- ✚ Students who score below 40% can re-attempt the online test without any extra charges, which ensures that everyone can receive a valid completion certificate.

There is also a provision of institutional annual subscription at Rs. 29,500/- (including GST), which will allow all students of the institute to access these courses free of cost. Colleges & Universities may recommend these courses as **Value Added Courses** to the students to join voluntarily. The technology used on this IIT platform is quite advance and the same course can be accessed in multiple Indian languages including Marathi. This makes the knowledge to reach to ground level and remote interior health functionary.

The roll out event for these courses was conducted through a Webinar on 5<sup>th</sup> August by IPHA & Bharati Vidyapeeth (DU) Medical college with the initiative of Dr. Varsha Vaidya Jt. Secretary IPHA Maharashtra which was attended by several faculties and post graduate students of more than 50 Medical Colleges.

*-Dr. Prasad Waingankar*

## Meeting the Health Needs of India's Urban Population

Editorial

**Dr. Pradip Awate**

Ex- State Surveillance officer, Maharashtra  
National Team Lead, TSU, Metropolitan Surveillance Unit, NCDC Delhi

At our Independence, we were an agrarian country which is dwelling in its villages. Obviously, a Primary Health Care model recommended by Bhore Committee (1946) was suitable enough to build our health infrastructure. But as of today, our demographic landscape has changed a lot, especially after post 1990 era of liberalization & globalization. In last 3-4 decades our urban population has been increasing significantly. In case of Maharashtra, a century back only 15% of our population was urban but now almost every second citizen is residing in urban space. In next decade, we are expecting that near about 600 million of Indian population living in urban areas constituting 40% of its entire population.

This rapidly changing population dynamics of our country & state posed the real challenge of meticulous planning of primary health care (PHC) in urban localities. It is not only planning PHC but keeping pace with urbanization is more daunting task in front of public health planners.

### History of Urban Health Planning

The evolution of urban health planning in India reflects a gradual shift in focus towards addressing the unique needs of urban populations. During the first four five-year plans, urban health took a backseat, with family planning being the primary intervention. The establishment of 126 family planning clinics in the first plan, increasing to 1,800 by the end of the fourth plan (1969-74), marked the initial steps.

Community based approach for the delivery of PHC only discussed in 6th Five-year plan. After Alma Ata declaration of 1978, India's first National Health Policy was rolled out which has reflections of Alma Ata declaration. It speaks about preventive & promotive health for the first time. In 1982, Krishnan committee focused on PHC to urban slums & proposed the model of health posts in urban areas, but the focus is mainly maternal & child health (MCH) services. In 1992, 74<sup>th</sup> constitutional amendment of the

12<sup>th</sup> schedule empowered urban local bodies & defined 18 different public health functions of it including urban planning, water supply, sanitation, birth & death registration etc. 9<sup>th</sup> five-year plan proposed Primary Health Centre within 1-3 kms of urban slums where health indicators are poor while 10<sup>th</sup> five-year plan identified the need to reorganize of existing urban health infrastructure to an all-inclusive approach (Non-communicable Diseases, Communicable diseases, MCH etc.). This has paved the way for National Urban Health Mission (NUHM) which has been proposed during 11<sup>th</sup> five-year plan. Under this scheme all cities above fifty thousand populations are covered including all district & state headquarters & 7 metros. Across the country, 1162 cities are covered under NUHM. Under NUHM, Urban PHCs are planned for every fifty thousand population while Urban CHCs for every 2.5 lakh population in non-metros & 5 lakh population in metros. This scheme provides ASHA for every 1000- 2500 population while ANM for every ten thousand population. Ayushman Bharat Scheme of 2018 tried further to upscaling of urban health infrastructure by establishing Health & Wellness clinics (HWCs) for every 15 to 20 thousand population to provide 12 comprehensive primary health care services. There is provision of rotatory specialty services through at least one UPHC per 2.5 to 3 lakh population. Mahila Arogya Samitis (MAS) & Resident Welfare Associations (RWAs) are also established under NUHM to achieve the objective of community involvement & ownership of health services.

### Critical Review of Urban Health Infrastructure

Looking at the scale of our urbanization, whatever has been done appears to be too small & too late. Though there are policy efforts to address urban health issues they are never adequate & timely. We are at least a decade & a half delayed launching a scheme like NUHM. Our urbanization pattern is too rapid & inadvertent

as compared to our planning with snail's pace. Methodical & comprehensive planning is conspicuous by its' absence. One-size-fits-all approach is also improper as various urban local bodies are at different levels of development & infrastructure availability is also not similar.

Established cities like Mumbai and Pune have some essential health infrastructure on which upscaling envisaged by NUHM is bit easier as compared to emerging cities like Latur, Chandrapur where health infrastructure is far from adequate or totally lacking.

Urban health governance is functioning under the department of Urban development (UDD). Day to day coordination of UDD with state public health department is vital aspect of its' successful implementation. Though 74<sup>th</sup> constitutional amendment empowered urban local bodies to deliver public health services, at many urban local bodies public health department deals only with civil registration of birth & death, sanitation & mosquito control activities. Health care infrastructure is quite rudimentary at many smaller municipal councils. When urban local body doesn't have any regular public health manpower to run the entire juggernaut of health care delivery system, its reliance on the feeble support of contractual manpower makes sustainability of the entire endeavor quite questionable.

Under PM-ABHIM, central government is planning to establish Metropolitan Surveillance Units (MSU) in 20 metro cities to develop proactive disease surveillance systems. Looking at the number of metro cities we have, the pace is too slow. Respective state governments need to take ownership of their own cities & plan comprehensive health care system for each & every city. States' amnesia about their constitutional responsibility (Health is a state subject) is costing our cities too much.

**Need to focus on vulnerable Population**

2017's National Health Policy identified the need to focus on poor & vulnerable populations in cities. It mentioned categorically seven different cohorts in this category viz – homeless, street children, rag pickers, rickshaw pullers, construction workers, sex workers & temporary migrants from listed & unlisted slums. Urban slum

population comprises almost all these vulnerable populations. As per 2011 census which is the only authorized data set, we have, Maharashtra & Andhra Pradesh has more than one third of the slum population of the entire country. The absolute number of slum population in Maharashtra in 2011 was 1.18 cr. It is observed that about 40 percent of the urban population is slum dwelling. It is difficult to get basic facilities like safe water, drainage, sanitation, electricity, pacca house, cooking fuel & public transport for this population which are socio-economical determinants of the health. Though the policy prescription envisaged by NUHM tries to address the social determinants of health, the output we have observed in last decade is far from adequate. Multisectoral convergence is a need of the hour to fulfill this gap. NUHM needs convergence with schemes like urban slum rejuvenation, Smart city initiatives, environmental & climate change related activities to realize its public health objectives.

Cities are often seen as engines of economic growth and centers of innovation and cultural exchange. Ultimately, urbanization is a complex process with far-reaching consequences. Understanding its multifaceted nature, including both the potential benefits and drawbacks, is crucial for sustainable urban development.

**Role of Academic Bodies & Medical Colleges**

We all as a public health fraternity need to understand the challenges & opportunities this urbanization factor is posing in front of our public health system. We need to come forward proactively & review critically various urban health schemes. Our research on various platforms including our various post graduate research activities need to focus on such socially relevant topics. This kind of translational research will help us in bringing positive changes to the field level. This kind of proactive approach will be helpful in bringing essential mid-course corrections which will impact output in a positive manner.

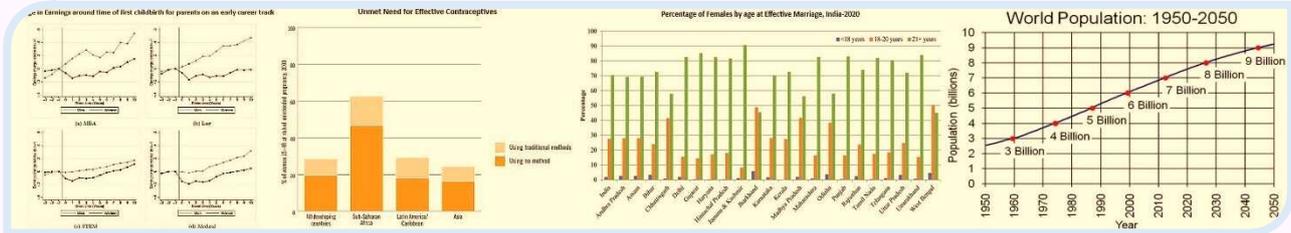
Inputs from academicians, academic bodies, medical colleges will be instrumental to have a flawless blueprint for our urban health rejuvenation which is vital to a community which is becoming more & more urbanized with every passing day.

# Planning to Welfare: India's Demographic Pivot

Laqushvedhi Lekh

Dr. Vipul Kubavat

Ex – Consultant Epidemiologist (MCGM – NHM) & Ex- State IPHS Consultant (NRHM – Maharashtra)



The debate surrounding the relevance of Family Planning (FP) in India is open framed around declining fertility rates. However, this narrow focus misses a crucial point. India's demographic landscape is transforming in complex ways that make a modern, rights-based FP approach more critical than ever. The question is not, if FP is relevant, but how its role must evolve to meet the needs of a changing society. Having engaged with India's FP program for over a sizeable timespan, I see its evolution across the three phases: **Apprehension, Integration, & Opportunity**. We now stand at the threshold of a fourth phase: **Complexity**, where FP must address a web of new social and economic realities.

## New Demographics: Beyond the Nuclear Family

India is no longer is a society defined solely by early, universal marriage and large families. We are witnessing the emergence of realities that demand a broader understanding of sexual and reproductive health (SRH).

✚ **The Imperative of Sex Education:** With earlier puberty and later marriage, adolescence is a prolonged period of vulnerability. A 2022 study found that only 15% of young women and 27% of young men aged 15-24 received any form of sex education before age 18 (NFHS-5, 2021). This knowledge gap has consequences: adolescents account for a significant portion of unintended pregnancies, sexually transmitted infections and unsafe abortions. Comprehensive sex education is not controversial; it is a public health necessity. Without it, FP programs merely react to crises instead of preventing them.

✚ **The 'Unmarried' and the 'Divorce Economy':** A growing number of young, unmarried, and divorced individuals are sexually active but often excluded from traditional FP programs, which historically target married couples. Census data shows a rise in the mean age of marriage for women to 22.1 years (SRS,2020), extending the period of premarital sexual activity. Furthermore, India's divorce rate, while low, has risen by 50-60% in urban areas over the last two decades (BBC, 2016), creating a new cohort of sexually active singles. This creates a significant coverage gap, leaving a large demographic without access to safe contraception.

✚ **The Infertility Economy:** For a significant minority, the problem is not preventing pregnancy but achieving it. The World Health Organization estimates that 1 in 6 people globally are affected by infertility (WHO, 2023). In India, this translates to approximately 27.5 million couples (ICMR, 2021). The Indian assisted reproduction industry is projected to grow to \$3.7 billion by 2030 (Fortune Business Insights, 2023), highlighting a critical, unmet need within the SRH spectrum. A truly comprehensive FP program must integrate infertility services, offering support for those who wish to conceive, thus completing the circle of reproductive choice.

✚ **The Crisis of Elderly Support:** As fertility falls, India is aging rapidly. The share of the population aged 60+ is projected to double from 10% in 2020 to 20% by 2050 (UNPD, 2022). The old-age support ratio (working-age people per elderly person) is expected to fall sharply from 11 in 2010 to just 4 by 2050 (Economic Survey 2018-19),

threatening traditional care systems and public finances.

**The Global Lens: Empowerment in an Era of Fertility Transition**

Globally, we are witnessing a profound demographic shift. Fertility rates are falling not only in developed nations but also across much of the developing world, a complex trend linked to what demographers call the "second demographic transition" theory (Lesthaeghe, 2014) that helps explain these shifts, as societies modernize, values change towards individualism, gender equity, and self-realization, leading to diverse family structures & reproductive journeys. Scholars like Myrskylä, Kohler, and Billari (2009) note that while very high levels of development can potentially moderate fertility decline, the pathway for most countries is characterized by a tension between women's rising aspirations and persistent structural barriers. This is where the role of FP evolves from reducing births to facilitating planned lives.

Crucially, the link between female empowerment and economics is bidirectional. It's not just that economic growth leads to higher contraceptive use. Instead, access to contraception enables women to stay in school, enter the workforce, and build careers, which in turn fuels economic growth. A study by the Guttmacher Institute also found that each dollar invested in contraceptive services saves over \$3 in the maternal and newborn care costs (Guttmacher, 2022).

Evidence from Switzerland's maternity leave policy powerfully illustrates the outcomes for mothers before & after the introduction of paid leave with job protection. A 2019 study in the American Economic Journal: Economic Policy found that such policies led to a 6-7% increase in mothers' employment and a 4% rise in their earnings within five years after childbirth (Butkofer et al., 2019). This demonstrates how supportive policies help women remain attached to the workforce. In India, FP is the foundational policy that provides similar, pre-emptive empowerment in a chain that leads to greater economic security for women and families, validating the need for its continued evolution (Canning & Schultz, 2012).

**India's Three-Phase Evolution and the Path Ahead**

1. **Phase 1: Fear & Stabilization (1952–1994):** Launched as the world's first national program, this phase was driven by the fear of a "population explosion." The primary strategy was promoting female sterilization through incentivized, target-based camps. While successful in lowering the Total Fertility Rate (TFR), this approach sometimes led to coercion and compromised consent.
2. **Phase 2: Integration & Health (1995–2017):** A major turning point was the 1994 International Conference on Population and Development in Cairo. This shifted the global and Indian focus from population control to individual rights and health. In India, FP was woven into broader health missions like the National Health Mission. The emphasis moved from permanent sterilization to reversible methods like condoms and IUDs, with a new priority on quality of care.
3. **Phase 3: Opportunity & Aspiration (2017–Present):** Recent data revealed that the unmet need for contraception was highest among young, aspirational couples who want to delay pregnancy to pursue education and careers. This reflects global trends where fertility decline is driven by the pursuit of opportunity (Bloom et al., 2020). In response, India launched initiatives like Mission Parivar Vikas, introduced new contraceptive choices (like injectables), and reframed its messaging from health to empowerment.

**The next phase must be one of Inclusive Complexity.**

The data from NFHS-5 is clear:

- ✚ **Fertility:** The National Total Fertility Rate (TFR) is now 2.0, below the replacement level of 2.1. States like Sikkim (1.1) and Goa (1.3) have some of the lowest fertility rates in the world (NFHS-5, 2021).
- ✚ **Unmet Need:** Despite progress, the national unmet need for family planning remains at 9.4%, and is as high as 18.4% among adolescents aged 15-19 (NFHS-5, 2021), indicating a critical gap in reaching the youth.

**The way forward requires:**

1. **Expanding the Mandate:** FP must be explicitly linked to robust sex education in schools and SRH services for unmarried individuals
2. **Targeted Priorities:** Focusing on preventing adolescent pregnancies and providing support after childbirth or abortion.
3. **Redefining Quality:** Moving beyond clinical service delivery to ensure informed choice, respectful counselling, and a wide range of methods.
4. **Method mix is changing:** New users are increasingly opting for short-term, user-controlled methods (condoms, pills, injectables) over sterilization, indicating a demand for flexibility & life-cycle planning rather than a one-time, permanent solution.
5. **Broader Partnerships:** Engaging the private sector and pharmacies, which are often more accessible to young people.
6. **Embracing a Full Spectrum of Care:** From contraception to infertility treatment, FP services must cater to all reproductive intentions.
7. **Mainstreaming Gender Equity:** FP programs must actively engage men & boys and address patriarchal norms that limit women's choices.
8. **Preparing for an Aging Society:** FP messaging should connect planned families to long-term financial security & old-age planning.

**Conclusion**

Echoing the recent remarks of UNFPA Executive Director Ms. Diene Keita at the WHA-2025 calling for urgent action; *“Let us place women & girls at the centre of our collective efforts and invest in their rights & choices – the foundation of justice, prosperity & peace.”*

The relevance of family planning in India is no longer just about controlling population growth. It is about navigating the intricate challenges of a modern society: empowering adolescents, supporting diverse family structures, addressing infertility, and mitigating the crises of an aging population. By embracing this broader mandate, family planning can truly become the bedrock of individual well-being and sustainable national

development. Thus, it demonstrates that the paradigm of FP shifts from the historical focus on **planning the family** to a future oriented commitment **to welfare of the family**.

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## Epidemiological study of patients presenting with History of

### Dog bite at a PHC in Palghar, Maharashtra

Original Research

Dr. Smita S. Chavhan<sup>1</sup>, Dr. Angana Chattopadhyay<sup>2</sup>

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#### INTRODUCTION

Rabies is a vaccine-preventable, viral, zoonotic, neglected tropical disease (NTD) causing acute, progressive, and incurable encephalitis. It is caused by a neurotropic RNA virus, family Rhabdoviridae, genus Lyssavirus type1. Rabies is endemic in India, with cases reported year-round across the country except in Lakshadweep and the Andaman and Nicobar Islands. Dogs account for 99% of human rabies cases, with India home to an estimated 6.2 crore stray dogs. Transmission occurs to people and animals via saliva, usually through bites, scratches, or direct contact with mucosa (e.g. eyes, mouth, or open wounds). Once clinical symptoms appear, rabies is 100% fatal. Factors like overpopulation, territorial behaviour, and lack of food contribute to aggressive dog behaviour and rising bite incidents.

In 2023, India recorded over 30 lakh dog bite cases — a 26.5% rise from 2022 — and 286 rabies deaths, with Maharashtra reporting the highest number of cases (435,136, 11.32% increase from 2022). Despite the availability of preventive measures like post-exposure prophylaxis (PEP), including wound washing, anti-rabies vaccination, and immunoglobulin for severe cases, many people still rely on traditional remedies and incorrect practices, leading to delayed or inadequate treatment. Rabies prevention also depends on pre-exposure vaccination for high-risk groups and controlling the infection in animals through mass dog vaccination and sterilization. The National Rabies Control Programme (NRCP), along with initiatives like the National Action Plan for Dog-Mediated Rabies Elimination (NAPRE) by 2030 and the Animal Birth Control (Dogs) Rules, 2023, focuses on reducing human rabies deaths through coordinated efforts. However, gaps in awareness, community practices, and access to care continue to hinder progress, highlighting the need for targeted education and effective

implementation strategies, hence the need for conducting the present study.

#### METHODOLOGY

A cross-sectional study was conducted over 3 months at PHC Kaman, Vasai Taluka, Palghar District, Maharashtra. It included all patients reporting to OPD with confirmed history of dog bite during the study period. Patients with major illnesses that impair communication were excluded from the study. Knowledge of patients concerning fatality of rabies, cause of rabies other than dog bite, transmission of rabies by scratches or licks on open wound/mucous membrane, symptoms of rabies, ARV injections given in abdomen was asked. Their attitude towards necessity of completing full course of ARV, and adoption of dog control measures was elicited. Wound care practices and dietary restrictions being followed were asked. Score was given to each patient based on their KAP, and Median score was calculated (4.34). KAP score <4.34 was taken as unsatisfactory and >4.34 as satisfactory.

#### Results

Totally 221 patients were included in study.

**Table 1: Socio-Demographic Profile**

Variable	Category	Number	Percent
Gender	Male	107	48.42
	Female	114	51.58
Age (yrs.)	18-40	108	48.87
	41 - 60	74	33.48
	> 60	39	17.65
Education	Illiterate	35	15.84
	Primary	68	30.77
	Secondary	79	35.75
	Senior Secondary & above	39	17.65
Socio-economic Status	I	3	01.36
	II	26	11.76
	III	83	37.56
	IV	104	47.06
	V	5	02.26

Majority of patients belonged to age group 18-40 years (48.87%), and were predominantly female (51.58%). 35 (15.84%) patients were illiterate. Socioeconomically, most patients belonged to the lower middle class (47.06%), according to modified BG Prasad scale. A large proportion (41.63%) of patients were employed as farmers or labourers, indicating increased exposure to animals due to outdoor activities.

**Table 2: Occupation-wise Distribution**

Occupation	Number	Percent
Labourer	48	21.72
Farmer	44	19.91
Sweeper	2	0.90
Milkman	1	0.45
Driver	12	5.43
Private Company	28	12.67
Housewife	35	15.84
Clerk	6	2.71
Shopkeeper	8	3.62
Primary school teacher	2	0.90
ASHA Worker	1	0.45
Student	8	3.62
Retired	22	9.95
Unemployed	4	1.80

Majority of bites (67%) were in lower extremity, followed by upper extremity (19%). 70.58% of dog bites were of Category 3, and rest of Category 2. 182 (82.35%) bites were by stray dogs, out of which 143 (64.7%) bites were unprovoked.

**Table 3: Bites by Different Types**

Dog Bites	Pet Dog	Stray Dog
<b>Provoked Bite</b>	28 (12.67)	39 (17.65)
<b>Unprovoked Bite</b>	11 (4.98)	143 (64.70)

On enquiry about the remedies used, it was found that the 85 patients (38.46%) had applied homemade remedies on site(s) of bite, with most commonly Turmeric, Ayurvedic oil, cow dung, chuna, betel leaf, piece of dry iron being used. 68 patients (30.77%) had not washed site(s) of bite. 91 patients (41.18%) had avoided certain food items after dog bite; most commonly avoiding non-vegetarian food, spicy food and brinjal. Also, it was noted that 54 patients (24.43%) reported to PHC after 24 hours.

**Table 4A: Wound Washing Practice after bite**

Wound washing	Number	Percent
Washed in running water for 15 mins	52	23.53
Washed with soap and water	82	37.10
Washed with soap and water & applied Antiseptic	19	08.59
Wound Not Washed	68	30.77

**Table 4B: Home Remedies Practiced after bite**

Home remedies applied after bite	Number
Turmeric	14
Ayurvedic oil	13
Cow dung	11
Chuna	10
Betel leaf	10
Piece of Dry iron	9
Turmeric and Chuna	5
Salt	4
Chilli	3
Soil	2
Lime	2
Alum	1
Datura	1
None	136

**Table 4C: Food Avoidance Practiced after bite**

Avoiding certain foods after bite	Number
Non veg	27
Spicy food	22
Brinjal	17
Milk	12
Multiple	7
Ginger/Garlic	6
None	130

**Table 5: Delayed reporting at PHC**

Reasons for Delay (> 24 Hrs.) in Reporting to PHC	Number
Took treatment from native/traditional healer	14
Took treatment from private practitioner	5
Dog bite is not a serious medical condition	12
Did not know where to go	15
Dog bite on Saturday / Sunday/ Late Night	5
Did not get leave from work	3

A significant difference was found in KAP score among different age groups, socioeconomic groups and among literate and illiterate groups ( $p < 0.001$ ).

**Table 6: KAP score vs Literacy, SES and age**

Variable	Category	KAP score		Total	$\chi^2$ (p) value
		Unsatisfactory	Satisfactory		
Education	Literate	77	109	186	12.8 ( $< 0.001$ )
	Illiterate	26	9	35	
	<b>Total</b>	<b>103</b>	<b>118</b>	<b>221</b>	
Socio-economic status	I	0	3	3	51.2 ( $< 0.001$ )
	II	3	23	26	
	III	24	59	83	
	IV	71	33	104	
	V	5	0	5	
	<b>Total</b>	<b>103</b>	<b>118</b>	<b>221</b>	
Age (Yrs)	18-40	29	79	108	47.2 ( $< 0.001$ )
	41-60	39	35	74	
	> 60	35	4	39	
	<b>Total</b>	<b>103</b>	<b>118</b>	<b>221</b>	

**DISCUSSION**

In the present study, 48.87% of participants belonged to the age group of 18–40 years. Similar findings were reported in studies by Sivagurunathan et al [1], Dutta et al [2], and Kumar et al [3]. Females constituted 51.58% of the study population, which aligns with the findings of Sivagurunathan et al [1]. However, this gender distribution contrasts with that observed by Dutta et al [2] and Wankhede et al [4], where a clear male predominance was noted.

Only 15.84% of participants were illiterate, which is comparable to the findings of Sivagurunathan et al [1] and Dutta et al [2]. A substantial proportion (47.06%) belonged to the lower middle socioeconomic class, consistent with the findings of Dutta et al [2]. In contrast, Kumar et al [3] reported that more than half of the participants were from the upper middle class, and Priya G. S. et al [5] noted that the majority belonged to the upper class. The participants employed as farmers and labourers constituted the largest occupational group (41.63%) in the current

study, a trend also seen in the study by Kumar et al [3]. Lower extremity bites accounted for 67% of cases, and 70.58% of bites were classified as Category 3, both findings consistent with those of Wankhede et al [4]. Furthermore, 82.35% of bites were caused by stray dogs, most of which were unprovoked—similar to the observations of Wankhede et al [4] and Priya G. S. et al [5].

Homemade remedies were applied to bite sites by 38.46% of participants, a significantly higher proportion compared to the findings of Dutta et al [2] and Wankhede et al [4]. Additionally, 30.77% of participants did not wash the bite site, a figure comparable to Wankhede et al. [4], but notably higher than figure reported by Dutta et al [2], Kumar et al [3], and Priya G. S. et al [5]. These variations in wound washing practices may be attributed to differences in cultural beliefs, educational levels, and prevailing myths in different communities.

About 41.18% of participants reported avoiding certain food items post-bite, most commonly non-vegetarian foods. This practice mirrors findings by Sivagurunathan et al [1] and Priya G. S. et al [5]. Delayed presentation to a primary health centre (PHC) after more than 24 hours was observed in 24.43% of cases, which is much higher than that reported by Wankhede et al [4].

A statistically significant difference in KAP scores was observed across different age groups, socioeconomic strata, and between literate and illiterate participants. This contrasts with findings by Kumar et al [3], who reported significant differences only across age and socioeconomic groups, and with findings by Priya G. S. et al [5], who reported no significance across education, SES and age.

**CONCLUSION AND RECOMMENDATIONS**

This study reveals that most dog bite victims were young adults from lower middle-class backgrounds, with a high proportion of bites caused by stray dogs and classified as high-risk (Category 3). Inappropriate first aid practices, such as applying homemade remedies and not washing the wound, were common, often due to cultural beliefs and lack of awareness. A significant delay in seeking medical care was also noted. The KAP scores varied significantly across age, literacy, and socioeconomic groups.

To effectively prevent and manage dog bite incidents, it is essential to launch public awareness campaigns that promote proper first aid and the importance of timely medical care. Training healthcare workers at the primary level enables them to educate communities on prevention strategies and appropriate responses. Incorporating dog bite education into school curricula and community programs helps raise awareness from an early age. Additionally, implementing humane stray dog control measures can significantly reduce the risk of bites. A coordinated, multi-sectoral approach with ongoing monitoring and evaluation of community practices and program effectiveness are crucial to ensure continuous improvement and sustained impact.

**LIMITATIONS**

As the present study includes only those patients who presented to PHC, we have missed those cases who did not report at all. Also, since study period was short, we could not elicit seasonal variation in number of dog bite cases.

**Conflict of interest:** None

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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](http://www.iphaonline.org) to fill up the online 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  
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**Inter Medical College Public Health Quiz Competition 2025 for undergraduate medical students under the aegis of Indian Public Health Association, Maharashtra**

**Report by Dr. Yogita Bavaskar**

**State Coordinator – IPHA Quiz 2025**  
**Associate Professor & Head, Community Medicine, Government Medical College, Jalgaon**

IPHA Maharashtra State Branch announced the annual event of Inter Medical College Quiz on 1<sup>st</sup> May 2025, this year. The

IPHA MH executive committee had identified the venue and coordinators for zonal and state rounds in month of April.

**Zonal Round: 3<sup>rd</sup> July 2025**

Zone	Coordinator	Designation
West Maharashtra	Dr. Akhil R Nair	Assistant Professor, D Y Patil Medical College, Pune
Mumbai & Konkan	Dr. Sujata Shirish Pol	Professor (Addl), LTMMC, Sion, Mumbai
Marathwada	Dr. Mohammad Shafee	Professor, JIU'S IIMSR, Badnapur, Jalna
Vidarbha	Dr. Pramita Muntode Gharde	Professor, JNMC, DMIHER, Sawangi, Wardha
North Maharashtra	Dr. Ashok Vankudre	Professor, Dr Vasantrao Pawar Medical College, Nashik

**Final Round: 11<sup>th</sup> July 2025** – Coordinator: Dr. Prashant Solanke, Dean, DUPMC, Jalgaon

The first online meeting for the coordination was conducted by Dr. Deepak Khishmatrao, Secretary IPHA Maharashtra & Dr. Prasad Waingankar, President IPHA, Maharashtra and Dr Yogita Bavaskar State

coordinator IPHA quiz 2025 and all the Zonal coordinators on 18/04/2025. The information about quiz, quiz rounds, etc. was discussed. Second online preparatory review meeting was conducted on 29/06/2025.

**Zonal Round: West Maharashtra**

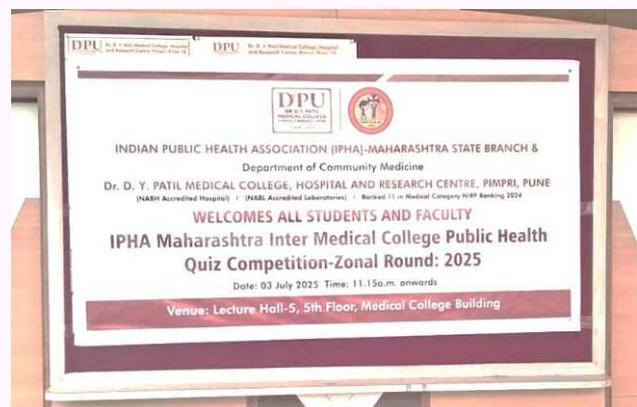
Date: 3<sup>rd</sup> July 2025

Time: 2:00 pm to 4:00 pm

Venue: Dr. D. Y. Patil Medical College, Hospital and Research Centre, Pune

The Department of Community Medicine, conducted the West Maharashtra Zonal round of Quiz Competition 2025 for Undergraduate students (Phase III, Part I) under the aegis of IPHA, Maharashtra. Total 9 medical colleges had participated & 5 entered in zonal round after the elimination round.

1. Dr. Vaishampayan Memorial Govt. Med College, Solapur
2. B. J. Govt. Medical College, Pune



3. Symbiosis Medical College for Women, Pune
4. Armed Forces Medical College, Pune
5. Smt. Kashibai Navale Medical College and General Hospital, Pune



The event was attended by Dr. Muralidhar Tambe, Past President, IPHA Maharashtra & Dr Nandkumar Salunke, Treasurer, IPHA Maharashtra.

- **Winners:** B. J. Govt. Medical College, Pune: Ms. Vaishnavi Kanyalkar & Mr. Shreyash Kulkarni
- **Runner-up:** Symbiosis Medical College for Women, Pune: Ms. Varsha & Ms. Kratee Jadaun



## Zonal Round: Mumbai & Konkan

Date: 3<sup>rd</sup> July 2025

Time: 10:00 am to 12:00 pm

Venue: Lokmanya Tilak Municipal Medical College and Sion Hospital, Mumbai

The Mumbai and Konkan Zonal level quiz competition was successfully conducted by Department of Community Medicine. Only 4 medical colleges participated hence elimination round was not conducted.

Participating Colleges:

1. L.T.M. Medical College, Sion, Mumbai
2. Rajiv Gandhi Medical College, Thane
3. HBT Medical College, Juhu, Mumbai
4. M.G.M. Medical College, Kamothe.



The event was graced by Dr. Prasad Waingankar, President, IPHA Maharashtra. The judges for the event were - Dr. Vijaykumar Singh (Prof. & Head, Community Medicine, Seth G S Medical College and KEM Hospital, Mumbai) & Dr. Vinayak Kulkarni (Addl. Prof. Department of Anatomy, LTMMC, Sion, Mumbai) Total 5 rounds were conducted as per protocol given by IPHA Maharashtra.

**Conduction of quiz:**

- Quiz masters:  
Dr. Sujata Pol, Dr. Nidhi Sastry

- Coordinator: Dr. Tahseen Fatema Sheikh
- Scorekeepers: Dr. Ganesh Kudmate, Dr. Kevin Pashte
- Timekeeper: Dr. Alok Rajoria
- Photos: Ms. Shreeya Patil, Dr. Rachel Teddy



- **Winners:** HBT Medical College and Dr. R N Cooper, Municipal General Hospital, Juhu: Mr. Abdullah Charolia & Mr. Jash Salaskar
- **Runner-up:** L.T.M. Medical College, Sion: Ms. Tanvi Patil & Ms. Dnyaneshwari Patil



**Zonal Round: Marathwada**

Date: 3<sup>rd</sup> July 2025

Time: 2:00 pm to 4:00 pm

Venue: JIIU's Indian Institute of Medical Science & Research, Badnapur, Jalna

The Department of Community Medicine, JIIU's Indian Institute of Medical Science & Research, conducted the Marathwada Zone Inter Medical College Public Health Quiz Competition 2025 for Undergraduate students (Phase III, Part I) under the aegis of the Indian Public Health Association, Maharashtra. An elimination round was not conducted as there were only four entries.

**Participating Colleges:**

1. JIIU's Indian Institute of Medical Science & Research, Warudi, Taluka - Badnapur
2. Govt. Medical College, Nanded
3. Govt. Medical College, Aurangabad
4. MGM Medical College, Aurangabad



The Chief Guest for the event was Dr. Azhar Ahmed Siddiqui, Dean, JIIU's IIMSR, Jalna. The panel of jury included Dr. Purushottam Giri, Professor & Head, Department of Community Medicine and Dr. Hina Kausar, Professor, Department of Community Medicine.

**Conduction of quiz:**

- The Quiz master: Dr. Mohammad Shafee, Professor and Zonal coordinator, IPHA
- Coordinator Dr. Mohammad Ghodke, Dr. Vishal Rathod and Dr Jawwad Hashmi of Community Medicine.
- Scorekeepers: Mr. Abbas Mirza
- Time keeper: Dr. Danish Pathan, Tutor
- Geo-tagged photos: Imran Pathan
- Certificate: Dr. Iqra Shaikh, Dr. Naser Razvi



**Results:**

- Winners: Govt. Medical College, Nanded Ms. Diya Shah & Mr. Prakhar Kumar
- Runner-up: MGM Medical College, Chhatrapati Sambhaji Nagar: Ms. Kiarra Jagtap & Ms. Hanisha Keswani

**Zonal Round: Vidarbha**

Date: 3<sup>rd</sup> July 2025

Time: 2:00 pm to 4:00 pm

Venue: Jawaharlal Nehru Medical College, Sawangi, Wardha

The Department of Community Medicine, Jawaharlal Nehru Medical College, Wardha, conducted the Vidarbha Zone Inter Medical College Public Health Quiz Competition 2025 for Undergraduate students (Phase III, Part I) under the aegis of the Indian Public Health Association, Maharashtra. Total 9 medical

colleges had participated & after elimination round 5 teams were selected for zonal round.



**Participating Teams:**

1. Govt. Medical College, Nagpur
2. N.K.P Salve Institute of Medical Sciences, Nagpur
3. Government Medical College, Akola
4. Datta Meghe Medical College, Nagpur
5. Government Medical College, Gondia

**Results:**

- Winners: Government Medical College, Akola: Miss Nandini Kulkarni & Miss Anushka Abhay Dave
- Runner-up: Government Medical College, Gondia: Ms. Khushi Kasat & Miss Rajnandini Singh



**Zonal Round: North Maharashtra**

Date: 3<sup>rd</sup> July 2025

Time: 2:00 pm to 4:00 pm

Venue: Dr. Vasant Rao Pawar Medical College, Hospital & Research Centre, Nashik

The Department of Community Medicine, Dr. Vasant Rao Pawar Medical College, Hospital & Research Centre, Nashik, conducted the Zonal round for North Maharashtra Zone of Inter Medical College Public Health Quiz Competition 2025 for Undergraduate students (Phase III-Part I) under the aegis of Indian Public Health Association-Maharashtra. Total 8 medical colleges had

participated & after elimination round 5 teams were selected for zonal round.

1. Dr. Vitthalrao Vikhe-Patil Foundation's Medical College, Ahilyanagar
2. Government Medical College, Nandurbar
3. SMBT Institute of Medical Sciences and Research Institute, Dhamangaon, Nashik
4. Government Medical College, Jalgaon
5. Dr. Vasant Rao Pawar Medical College, Hospital & Research Centre, Nashik

Dr. Surekha Nemade, HoD Biochemistry, Dr. Prafulla Dhakane, HoD Anatomy and Dr, Balaji Almale HoD Community Medicine were on the panel Jury.



**Conduction of Quiz:**

- Quiz Master: Dr. Akshada Shinde, Assistant Professor, Community Medicine
- Scorekeeper: Dr Yashovardhan Totla, Assistant Professor
- Support Team: Dr Shital Patil, Asso. Prof., Dr Gautam Bhaware, Asso. Prof., Dr Tanuja Brahmankar, Assist. Professor

**Results:**

- **Winners:** Govt. Medical College, Jalgaon: Mr. Aniket Mahadev Hatagale & Ms. Shrawani Valmik Khamkar
- **Runner-up:** Dr. Vasantrao Pawar Medical College, Hospital & Research Centre, Nashik: Ms. Nidhi Trivedi & Mr. Harsh Chintalwar



Jal Minocher Mehta (1927-2001) was a Parsi Indian surgeon, and philanthropist, known for his services for the rehabilitation of people who have leprosy. He was the president of Pune District Leprosy Committee and was involved in organizing self-help groups of the leprosy patients and in creating social awareness about the disease through documentaries. He chaired the Serum Institute of India. He was Instrumental in the development and manufacture of measles vaccine from the seed virus stage and thereby making SILL the only producer of this vaccine in the country. He sat in the Advisory Boards of Pharmabiz, Chronicle Pharmabiz and the Vienna Karl Landsteiner Institute. His efforts towards the Leprosy eradication program included the management of a Leprosy Hospital and a Rehabilitation Centre in Pune. The Government of India awarded him the third highest civilian honor of the Padma Bhushan, in 1982, for his contributions to medical science. **IPHA Maharashtra State Branch awards the Rotating Trophy in the name of Dr. Jal Mehta to the College winning the state final round of the quiz.**

Zone	Colleges participated	Winners of Zonal Round & Participants of State Level Final Round	Runner ups of Zonal Round
West Maharashtra	09	Ms Vaishnavi Kanyalkar Mr Shreyash Kulkarni B J Government Medical College, Pune	Ms Varsha Ms Kratee Jadaun Symbiosis Medical College of Women, Pune
Mumbai and Konkan	04	Mr Abdullah Charolia Mr Jash Salaskar HBT Medical College, Mumbai	Ms Tanvi Patil Ms Dnyaneshwari Patil LTM Medical College, Sion, Mumbai
Marathwada	04	Ms Diya Shah Mr Prakhar Kumar Dr Shankarrao Chavan GMC, Nanded	Ms Kiarra Jagtap Ms Hanisha Keswani, MGM Medical College Ch. Sambhajinagar
Vidarbha	09	Ms Nandini Kulkarni Ms Anushka Dave Govt. Medical College, Akola	Ms Khushi Kasat Ms Rajnandini Singh Govt. Medical College, Gondia
North Maharashtra	08	Mr Aniket Hatagale Ms Shrawani Khamkar Govt. Medical College, Jalgaon	Ms Nidhi Trivedi Mr Harsh Chintalwar Dr Vasantrao Pawar Medical College, Nashik

**State Level Final Round**

**Date: 11th July 2025 @ 2:00PM**

**Venue: Dr. Ulhas Patil Medical College & Hospital, Jalgaon**

The IPHA Quiz 2025 State Final Round was successfully conducted at Dr. Ulhas Patil Medical College & Hospital, Jalgaon on 11<sup>th</sup> July 2025. Winners from all the five zones participated in it. The event was streamed online.

The Chief Guest for the event was the President of Godavari Foundation, former Member of Parliament, **Dr. Ulhas Patil**

The Guests of Honor were:

- ✚ Dr Varsha Patil, Secretary Godavari Foundation.
- ✚ Dr Vaibhav Patil, Member Godavari Foundation
- ✚ Dr. Prashant Solanke, Dean, Dr Ulhas Patil Medical College, Jalgaon
- ✚ Dr. N S Arvikar, Director, Dr Ulhas Patil Medical College
- ✚ Dr Nandkumar Salunke, Treasurer, IPHA Maharashtra State Branch
- ✚ Dr Yogita Bavaskar, State Coordinator IPHA Quiz 2025

**Conduction of quiz:**

- Quiz master: Dr Nilesh Bendale Professor, Community medicine
- Score keepers: Mr. Vijay More, Statistician cum Assistant Professor Community Medicine
- Timekeeper: Dr Girish Ugale, Resident Community medicine
- Judges:  
Dr Dilip Dhekale, Professor and Head, Community Medicine &  
Dr Yashovardhan Kabra, Assist. Professor, Community medicine

**Winners:** Mr. Abdullah Charolia and Mr. Jash Salaskar- HBT Medical College, Mumbai

**Runner-up:** Miss Vaishnavi Kanyalkar and Mr. Shreyansh Kulkarni – B J Government Medical College, Pune





The winning team received a trophy and cash prize while the runner-up team was awarded with cash prize. At each Zonal Round also the winners and runner up received the cash prizes. All participating students received certificates. Travel allowances were also provided to the participants at all zonal rounds and final round as per the guidelines set by IPHA Maharashtra state branch.

The IPHA Maharashtra Quiz 2025 was a very successful event. Students from different medical colleges all over the state participated enthusiastically. The event gave them a chance to showcase their knowledge and compete with others, and they enjoyed it fully.



(..... Continued from Page 19)

inspections) are labour- and time-intensive, often missing inaccessible rooftops, construction pits, and large water-holding structures. Small uncrewed aerial systems (“drones”) can generate high-resolution maps quickly, potentially improving coverage in dense and informal settlements. **Objectives:** To compare yield, timeliness, cost, and operational feasibility of traditional surveys versus drone-based surveys for detecting vector breeding sites in high-risk wards of Aurangabad. **Methodology:** High-risk wards were first prioritized using IHIP case data from the previous 12 months (hotspot mapping). In each selected area, teams conducted house-to-house inspections per NVBDCP guidelines and UAV RGB flights with analysis, followed by targeted ground-truthing. **Result:** Drones rapidly flagged inaccessible habitats (rooftop tanks, construction pits, overhead reservoirs) and improved coverage/safety; traditional surveys were superior for small indoor containers. A hybrid workflow (drone pre-mapping → focused verification) yielded the best overall detection and operational efficiency. Key constraints were permissions, line-of-sight, and privacy of community. **Conclusion:** Drones should complement, not replace—routine surveillance to accelerate hotspot identification and optimize resources at ward scale.

\* Guide: Dr. Shobha Salve, Prof. & HoD, Community Medicine, MGM Medical College, Chhatrapati Sambhajanagar



## 18th World Congress On Public Health

Join the World Federation of Public Health Associations (WFPHA) and Public Health Association of South Africa (PHASA) in Cape Town, South Africa, on September 6-9, 2026, as we unite public health professionals to shape a healthier, more equitable future for all.

## Research Study Abstracts of Winners of IPHA Maharashtra State Branch Scheme: Padvyuttar (PG) Sanshodhan Prakalp Anudan for MPH / MD Community Medicine Post Graduate Students in Maharashtra

**2024: Dr. Tanvi Joanne Pinto\***

**Seth G. S. Medical College & KEM Hospital, Mumbai**

An Interventional study to determine the impact of a campus-based intervention on the food choices of students of a medical college

**Background:** India has observed an epidemiological transition in disease burden and deaths, with a steady increase in non-communicable diseases. Risk factors for NCDs have been classified by WHO into modifiable and non-modifiable risk factors. The most important of them are unhealthy eating, lack of physical activity, and use of tobacco and alcohol, which are all modifiable factors. College life is a transitional period during which young adults acquire new behaviours. Many college students reside in hostels or on campus, making the food available in college canteens a key factor influencing their dietary choices. This study was undertaken to assess the alignment between students' food preferences and the availability of suitable options in college canteens along with the impact of a colour coded menu on their food preferences in the canteen. **Methods:** An interventional study was conducted in three phases. The first phase included conducting a baseline survey to assess the dietary preferences and the factors influencing the same of the students of the medical college. After a month, the colour-coded menu was introduced in the canteens and made available to the students on their college WhatsApp groups. After another month a follow-up survey was conducted on the students to assess the change in their behaviour after introduction of the colour-coded menu. **Results:** A total of 520 students participated in the study. Maximum participants were aged 21-25 years (48.2%). In the follow up survey, a total of 103 (19.8%) students responded to the form circulated. Regarding food purchase habits, the most commonly ordered food items were Indian breakfast items like *idli* and *dosa* (76.9%), tea and coffee (66.2%), and fried snacks (57.7%), and healthy options like fresh fruits/salads (6.1%) and boiled eggs (0.4%) were least preferred. Post the intervention, a decrease in the students opting for fried Indian breakfast items was noted (65.3%) and increase in consumption of sprouts was noted (52.4%). The factors that determined food selection were taste (65.2%), convenience (62.5%), and price (60.3%). The 13.9% of participants consistently considered nutritional value before purchasing food. The students were receptive of the colour coded menu that was circulated and found it useful in making their food preferences. Based on the suggestions of the study participants, healthier food items were introduced in the canteen wherever feasible. **Conclusion:** Introduction of healthy items prepared keeping taste in mind appears to be a way to encourage students to eat healthy foods. The introduction of the colour-coded menu and its acceptance by the students highlights the opportunity to create nutritional awareness amongst students and in turn improve their dietary preferences.

\* Guide: Dr. Yuvraj Chavan, Professor (Addl.), Community Medicine, Seth G. S. Medical College & KEM Hospital, Mumbai.

**2024: Dr. Shivcharan Kendre\***

**MGM Medical College, Chhatrapati Sambhajinagar**

Compare the difference between traditional surveys and drone surveys for identification of vector breeding places at the high-risk areas in Aurangabad city, Maharashtra.

**Background:** Rapid identification of mosquito breeding habitats is critical for dengue and malaria control in Indian cities. Traditional larval surveys (house-to-house and peridomestic...

(Continued to Page 18.....)

## Hooked Young: Tobacco’s Trap for the Next Generation

Dr. Emilia Dsouza<sup>1</sup> Dr. Smita Chavhan<sup>2</sup> Dr. Roshni Miranda<sup>3</sup> Dr. Kirti Supe<sup>3</sup>



<sup>1</sup>Senior Resident, <sup>2</sup>Professor (Additional), <sup>3</sup>Assistant Professor,  
Department of Community Medicine  
HBT Medical College & Dr. R N Cooper Hospital, Mumbai

*“A cigarette is a pinch of tobacco rolled in paper with fire at one end and a fool at the other.” - George Bernard Shaw*

It was in the year 1988, that the 31<sup>st</sup> of May was designated as World No Tobacco Day by the World Health Organization. Ever since, annually, this day is observed as World No Tobacco Day with different themes released every year targeting various aspects of tobacco control. This year 2025, “Unmasking the Appeal: Exposing Industry tactics on tobacco & nicotine products.” was the chosen theme. It highlights the deceptive marketing strategies and practices adopted by the Tobacco Industry to attract the youth to buy their products. Today decades of research works have proved the devastating effects of tobacco on human health. Despite the crystal clear evidence stating the hazards of tobacco use, the tobacco industry has turned a blind eye towards it. The industry however has gained the audacity to mislead the youth and to get them addicted to tobacco. The gimmicks by the industry include targeted marketing, misleading claims, industry interference in policy making, social media advertisements, gaming platforms ads etc. They spend millions of dollars on advertisements and surrogate marketing. The Global Youth Tobacco Survey (GYTS) – 2019 has stated that 8.5% of students in the age group of 13 – 15 years consume tobacco either in the smoked form or the smokeless one. Arunachal Pradesh and Mizoram have the highest prevalence with a whopping, 58% students consuming tobacco.

The environmental costs of tobacco production and consumption have not been extensively studied; however, a growing body of evidence demonstrates that the tobacco industry is having a significant effect on the planet’s natural resources and vulnerable ecosystems. Tobacco also puts gigantic financial burdens on countries along with lost productivity due to ill health and premature deaths. As tobacco consumption rates and tobacco-related illnesses increase in

developing countries, so do tobacco related health care costs.

The National Medical Council (NMC) issued a public notice advising all medical institutions to observe World No Tobacco Day 2025. Complying with the NMC notification,



World No Tobacco Day was celebrated jointly by the Department of Community Medicine and the ENT Department at HBT Medical College and Dr. R. N. Cooper Hospital, Mumbai. A street play was performed by the Interns at various common areas of the



hospital to attract large crowds and create awareness among the masses. Also, an all day long free screening of the oral cavity was carried out by the ENT department at their OPD. Patients were screened for possible precancerous lesions and were advised accordingly. At the exit entrance of the OPD free samples of nicotine replacement tablets and dermal patches were being distributed to all those willing to quit tobacco. Multiple IEC sessions at various locations of the hospital were conducted regarding the ill effects of tobacco on health and how early quitting can help save life from a catastrophe triggered by tobacco abuse.

What World Health Day 2025 Theme tells us.....

**We can end preventable maternal and newborn deaths**

WHO is calling for a worldwide reinvigoration of efforts to ensure access to high quality care for women and babies, especially in the poorest countries, humanitarian emergencies and fragile settings where most maternal and newborn deaths occur.

**Beyond survival, critical investment is needed to improve women’s longer-term health and well-being**

Women everywhere need access to health providers who listen to their concerns and meet their needs – including in the months after pregnancy when millions lack critical support, despite enduring lasting health consequences after birth.

**Better maternal health means improving the rights of women and girls**

Better maternal health means improving the rights of women and girls so that they can plan their lives and protect their health. Their agency and empowerment are fundamental for tackling both maternal and newborn deaths and achieving health for all.

**High-impact investments**

- ✦ **Antenatal checks:** High quality antenatal services – including at least eight checks with a skilled health worker and early ultrasound – are essential for all women to support healthy pregnancies, reduce risks and detect possible complications. Up to 15% of pregnant women have been estimated to develop a potentially life-threatening complication during pregnancy or birth.
- ✦ **Lifesaving care during and after birth:** At least 70% of all maternal deaths are due to direct obstetric causes like haemorrhage and pre-eclampsia; most of these fatalities occur during labour and birth, along with more than 40% of stillbirths, or shortly after delivery. Access to quality care from skilled providers during and after childbirth is critical, including vital emergency services if dangerous complications occur.
- ✦ **Address indirect causes:** Infectious diseases and pre-existing health conditions like anaemias, HIV/AIDS, malaria, and diabetes underpin nearly a quarter of maternal mortality. It is vital to improve care, prevention, and early detection of these health conditions that complicate pregnancies and increase risks for millions around the world.
- ✦ **Immediate newborn care:** Newborn deaths account for nearly 50% of deaths among children under the age of 5 globally, resulting in 2.4 million lives lost each year. All babies need essential care at birth and in their first month of life, including breastfeeding support, so they are protected from infections, can breathe normally, and are warm and well-nourished.
- ✦ **Special attention to vulnerable babies:** Complications relating to prematurity and low birth weight are the leading cause of death in newborns and children under five. Since small and sick babies require round-the-clock in-patient care, significant investment is needed in special newborn care units, quick referrals, and vital family support.
- ✦ **Focus on midwives:** Midwifery care models, where midwives provide ongoing support to pregnant women and babies after birth, have been shown to improve survival while reducing preterm births and unnecessary medical interventions. Investing in these models, and ensuring sufficient well-trained midwives, is a cost-effective strategy to improve maternal and newborn health.
- ✦ **Access to family planning:** Approximately 218 million women of reproductive age in low- and middle-income countries have an unmet need for modern contraception. Addressing this need can significantly reduce unintended pregnancies and related risks.
- ✦ **Solutions for low-income contexts:** Research is needed to identify cost-effective solutions that tackle the leading causes of maternal and newborn deaths, particularly targeting healthcare settings in poorer countries and fragile contexts.

**Beyond survival**

- ✦ **Compassionate and respectful care:** Services must not only be safe and effective, they must also ensure women, newborns and caregivers are treated with dignity, empathy and respect. This includes compassionate care for those affected by stillbirth and miscarriage – requiring dedicated trainings for health workers and bereavement counselling for those in need.
- ✦ **Postnatal support:** Around a third of women suffer long-term health complications after childbirth, which can increase risks during future pregnancies, while up to 20% of new mothers have been estimated to experience postpartum depression or anxiety. An integrated approach to postnatal care connects physical health, mental health, and social support services in this critical period and beyond.
- ✦ **Family-friendly policies:** Family-friendly policies and laws are critical to ensure women have the right support to take care of their health and their babies, including paid maternity leave (at least 18 weeks, ideally 6 months or more), legal protections, and workplace support for breastfeeding.
- ✦ **Empowering girls and woman:** Girls’ access to education is associated with reduced likelihood of maternal death. Ensuring girls can stay in school and take decisions about their health and bodies is critical for improving their health.



# IPHACON2026

## 70<sup>th</sup> Annual National Conference of Indian Public Health Association



### Theme

Equity, Resilience, and Integration:  
Reimagining Public Health for a  
Sustainable Future

**Conference:** 13,14,15 March 2026

**Pre-conference:** 12 March 2026

### Venue

Katuri Medical College and Hospital,  
Guntur

### Hosted by:

AP State Branch of IPHA  
and  
Department of Community Medicine  
Katuri Medical College,  
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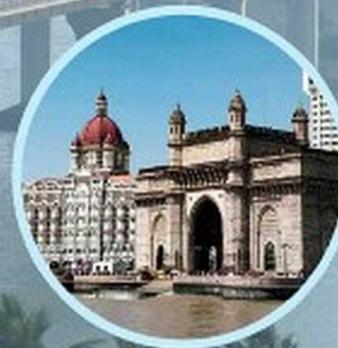
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FRI & SAT

JOINT ORGANIZING SECRETARY  
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PROFESSOR (ADDL)  
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**A Moving Portrayal of Mental Health, Inclusion, and the Healing Power of Compassion**

**Dr. Harshal Pandve**

Professor & Head, Community Medicine, PCMC's PGI & YCM H, Pimpri, Pune

**Film:** Sitaare Zameen Par (2025)

**Film Language:** Hindi (with English subtitles)

**Cast:** Amir Khan, Aroush Datta, Gopi Krishnan Varma, Vedant Sharma, Rishi Shahani, Naman Misra, Rishabh Jain, Ashish Pendse, Samvit Desai, Simran Mangeshkar, Aayush Bhansali

**Director:** R. S. Prasanna

**Running time:** 2 Hrs. 35 Minutes

**Film Review**

There are films that entertain, and then there are those rare ones that illuminate — forcing us to reflect, question, and empathize. Sitaare Zameen Par belongs to the latter category. The film Sitaare Zameen Par shows characters with several neuro-developmental conditions and disabilities, including autism spectrum disorder (ASD), Down Syndrome, Fragile X Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), and Dyslexia. More than just a cinematic experience, this film is a powerful conversation starter about mental health, disability inclusion, and the psychosocial fabric of modern India.



The film follows Gulshan, a hot-headed professional basketball coach played by Aamir Khan, whose arrogance and insensitivity land him in legal trouble. As punishment, he is ordered by the court to undertake community service — specifically, to coach a basketball team made up of individuals with intellectual and developmental disabilities. What begins as a humiliating obligation slowly transforms into a journey of self-discovery. Gulshan's interactions with the team, 10 young men and women with diverse cognitive challenges, form the heart of the story. Each character brings a unique shade of humanity, humor, vulnerability, and strength. As Gulshan learns to communicate beyond words, beyond conventions, and beyond prejudice, we too are invited to shed our assumptions about ability, intelligence, and worth.

From a clinical lens, the film avoids over-medicalizing disability. Instead of defining its characters by DSM labels or IQ scores, it portrays them as whole individuals, whose challenges are as real as their dreams, frustrations, talents, and joys. This approach aligns with modern person-centered models in psychology and psychiatry, which emphasize identity and lived experience over pathology. Importantly, Sitaare Zameen Par explores the secondary mental health challenges often experienced by people with disabilities: social rejection, internalized shame, isolation, and low self-worth. These are not just the byproducts of a diagnosis. They are outcomes of a system and culture that often fail to accommodate or respect neurodiversity. The film aims to highlight the diverse strengths and challenges of these individuals and promote a more inclusive understanding of neurodivergence and reflects how we treat those who move differently, think differently, and express themselves outside the "norm." It asks us to reconsider not only how we define intelligence and success, but how we define human dignity. To conclude with beyond its emotional impact, Sitaare Zameen Par holds significance for health policymakers, educators, and mental health professionals.



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