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TABLE OF CONTENT

FROM EDITOR'S DESK
World AIDS Day 2024: Advancing Equity, Empowering Communities
Dr. Harshal Pandve , Dr. Smita Chavhan

GUEST EDITORIAL:
Practicing what we preach: Community participation through Information.
Dr Amitav Banerjee

PERSPECTIVE:
Evaluating the Impact of the Family Adoption Program (FAP) Versus Health Camps
Dr. Sarika Patil , Dr Amol Kinge , Dr Vikrant Pagar , Dr Sushant Chavan, Dr Priyanka Akhade , Dr Mohan Doibale

HISTORICAL VIEWS
Transforming Oppression into Empowerment: Exploring the Fight for Women's Rights in Colonial India
Dr. Ujjwal Kadu , Dr. Dhananjay Mankar

PG CORNER:
Broadening Horizons: Journey of a PG student in Community Medicine
Dr. Subhana Siyad

BOOK REVIEW:
Sapiens: A Brief History of Humankind by Yuval Noah Harari
Dr. Abhiraj Suryawanshi

FILM REVIEW:
Kadvi Hawa : Climate Change Depiction through Movie Lens
Dr. Harshal Tukaram Pandve

VIEW POINT:
Health Equity and Access: Addressing Disparities in Healthcare Access and Outcomes.
Dhiya Manoj Thadani, Dr.Nisha Relwani

From the Editor's Desk

World AIDS Day 2024: Advancing Equity, Empowering Communities

Dr. Harshal Pandve [1], Dr. Smita Chavhan [2]
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Each year, December 1st marks World AIDS Day, a global occasion to reflect on the progress made, the challenges that persist, and the renewed commitment required in the fight against HIV/AIDS. In 2024, the theme, " "Take the rights path: My health, my right!"," which is closely aligned with the World Health Day theme of 2024 "My health, my right". With this theme World Health Organization is calling on global leaders and citizens to champion the right to health by addressing the inequalities that hinder progress in ending AIDS.

Over the past four decades, the global community has made significant strides in combating HIV/AIDS. Antiretroviral therapy (ART) has transformed the diagnosis from a death sentence to a manageable chronic condition for millions. Prevention strategies such targeted interventions, harm reduction programs, and mother-to-child transmission interventions have drastically reduced new infections.

However, despite these achievements, inequalities remain a critical barrier to progress. The impact of HIV/AIDS is disproportionately felt in marginalized and vulnerable populations. Factors such as poverty, stigma, discrimination, gender inequality, and limited access to healthcare perpetuate these disparities. For example, young women and adolescent girls in sub-Saharan Africa remain at heightened risk, accounting for a significant proportion of new infections. Similarly, key populations—including men who have sex with men, sex workers, transgender individuals, and people who inject drugs—often face social exclusion and legal barriers that hinder their access to care.

Community empowerment is a cornerstone of the HIV/AIDS response. Grassroots organizations, peer educators, and networks of people living with HIV have played a pivotal role in advocacy, education, and service delivery. Their lived experiences bring invaluable insights into designing programs that are culturally sensitive and accessible. Investing in community-led initiatives strengthens resilience and builds trust—both essential for combating stigma and encouraging uptake of prevention and treatment services. In 2024, we must recognize and amplify the voices of these communities, ensuring that they are integral partners in decision-making processes.

Scientific innovation continues to shape the future of HIV/AIDS prevention and care. Advances such as long-acting injectable ART, vaccine trials, and potential cure research hold immense promise. However, equitable access to these breakthroughs remains a challenge. Ensuring affordability and availability in low- and middle-income countries is critical to translating these innovations into meaningful impact.

In India, the National AIDS Control Organization (NACO) has made commendable efforts in scaling up ART coverage, improving awareness, and reducing stigma. Yet, challenges persist, particularly in reaching underserved populations in rural and tribal areas. Strengthening the integration of HIV services with primary healthcare systems, including Health & Wellness Centres, can enhance accessibility and sustainability.

On this World AIDS Day, let us reaffirm our resolve to end the HIV/AIDS epidemic. It is a call to action for policymakers, healthcare workers, researchers, and communities to unite in advancing equity and empowering those affected. Together, we can overcome the barriers that hinder progress and move closer to a world where HIV/AIDS is no longer a public health threat. As we light candles in memory of those we have lost, let us also ignite the flame of hope for a brighter, healthier future—one where everyone has the opportunity to live with dignity, free from the shadow of HIV/AIDS.

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Guest Editorial

Practicing what we preach: Community participation through Information.

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World history is witness to the fact that the forces "which ruled the seas" wielded immense power. The British Empire at one time was the greatest power in the world. At the core of that power was the Royal British Navy, the strongest naval force which dominated the seas and enabled the Empire to spread its influence and dominion globally. Even today, the oceans are pivotal and drive trade, commercial competition, scientific collaboration and geopolitical supremacy.

The internet of all things has added another sea, the "sea of information." People and even professionals are caught today in the cross currents, high tides and tsunamis in this "sea of information" unleashed in this era of information overload.

Let us hope the periodic IPHA Maharashtra newsletters provide a compass to the readers to navigate this rough infodemic sea empowering them to stand their ground against vested interests trying to sweep them off their feet by sensational news or misguide them by muddying the waters through misinformation. The latter is common in the lagoons of social media.

Public health practice depends on community participation. This is of special relevance to our country with its demographic dividend as well as its digital penetration. India has over 820 million internet users at present, the largest in the world.[1] Around half of the users are in rural areas. Knowledge is power. Misinformation can dilute this power. Separating the wheat from the chaff in the current infodemic is vital to enhance the knowledge power of the people to enable them to participate constructively in healthy debate around public health issues.

In this context it would be desirable to ensure that the contents are written in a manner which is comprehensible to the common person. This will enable them to participate on public health issues in a better and constructive way. It would also be good if few contributions from the lay public and community leaders are also invited in these newsletters. This will give a 360o perspective on publichealth issues which concerns the people.

A compass can only indicate the right direction. It is the sailor who has to decide the destination and take a call. The compass will not save the sailor from predators in the sea like sharks. The newsletters too can guide and will not replace the need for critical thinking on part of the reader. Common sense and critical thinking is the need of the hour as the information space is increasingly being influenced by many stakeholders who may have their own conflicts of interest, the sharks in this information age.

Early on in the recent pandemic an editorial in the British Medical Journal (BMJ),[2] mentioned that during the Covid-19 crises, the science got politicised, corrupted and suppressed. The editorial poignantly stated that when good science is suppressed by the medical-political complex, people die. Easy to read newsletters conveying properly curated information on topical public health issues, reaching the people in simple language, by ensuring transparency and empowerment, can guard against similar situations in the future.

Good public health calls for debate and discussion not limited to public health professionals only, but going beyond and involving the stakeholders. Common sense and critical thinking enriches science instead of passive information. In a vibrant democracy, the people's voice matter. Difficult to digest information is either disinformation or misinformation. Uncomfortable truths too are difficult to swallow particularly by those who can be held accountable. Identifying all these various types of information is an urgent need and newsletters from professional bodies, reaching the people can be the first step in a challenging journey.

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Perspective

Evaluating the Impact of the Family Adoption Program (FAP) Versus Health Camps

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Introduction: The Family Adoption Program (FAP), introduced by the National Medical Commission (NMC) in 2021 as part of the Competency-Based Medical Education (CBME) curriculum for MBBS students, aims to provide medical students with hands-on experience in rural and underserved areas of India[1]. This program not only serves as a learning platform but also contributes to India's broader public health goal of "Health for All."

In this newsletter, we will explore the evolution of FAP, its objectives, the expectations placed on Indian Medical Graduates (IMGs), and the perceptions of various stakeholders. We will also highlight its achievements and challenges, while comparing it with the health screening camp model proposed by the NMC, emphasizing the differences in their effectiveness in medical education and healthcare delivery.

Development of the Family Adoption Program: The conceptual foundation of FAP was inspired by successful community engagement models such as the MGIMS Sewagram program[2]. Recognizing the gap between theoretical learning and practical exposure, the NMC included FAP in the undergraduate medical curriculum in 2019. The program aims to provide students with real-world experience in community healthcare while addressing the healthcare needs of underserved populations[3]. As part of the program, students are tasked with adopting five families from rural or underserved areas, ensuring continuous monitoring and healthcare support over the duration of their education[25].

Key Objectives of FAP: One of the core objectives of FAP is to immerse medical students in real-life healthcare situations, giving them a comprehensive understanding of socio-economic, cultural, and health challenges in rural communities[32]. Through FAP, students are exposed to a wide range of healthcare issues, including communicable and non-communicable diseases, maternal and child health, and preventive care[4] . The program also empowers both students and communities by positioning students as primary healthcare consultants, offering health education and connecting families to healthcare services[2]. This experience helps students develop critical communication, empathy, leadership, and public health management skills[6,3]. Furthermore, FAP aligns itself with India's broader goal of achieving "Health for All" by addressing healthcare disparities and promoting health equity in rural regions[3,5].

Expectations from Indian Medical Graduates (IMGs): Medical students participating in FAP are expected to maintain long-term engagement with the families they adopt, ensuring regular visits and follow-ups through telemedicine if necessary[25]. This allows students to monitor chronic conditions, manage acute illnesses, and provide preventive healthcare. Additionally, students are required to collect and analyze detailed socio-demographic and health data from their adopted families, identifying risk factors and social determinants of health to create individualized care plans[2,6]. Beyond clinical tasks, students also serve as health educators, promoting health literacy on topics such as nutrition, hygiene, and disease prevention[4,5]. Building trust with the families is critical for the success of the program, and students must demonstrate empathy and respect for the families' cultural and social contexts[6,3].

Stakeholder Perceptions: FAP has elicited varied responses from students, faculty, and community healthcare workers. Most students reported positive experiences, citing improved empathy, communication skills, and a deeper

understanding of rural healthcare challenges[3,6]. However, some students noted challenges such as infrastructure limitations and language barriers[6,4] . Faculty members across various institutions have recognized FAP's value in enhancing medical education, particularly in terms of fostering critical thinking and problem-solving skills[5]. However, faculty members have also raised concerns about logistical challenges, such as faculty shortages and the difficulty of transporting students to remote rural areas for family visits[3,6]. Community healthcare workers have emphasized the importance of building trust between students and the families they serve. Initially, some families were reluctant to participate due to mistrust of the healthcare system, but over time, continuous engagement led to improved cooperation and health outcomes[5-7]

Achievements of FAP: FAP has succeeded in improving healthcare access for underserved populations, particularly in rural areas[3,5]. By regularly visiting families and providing health education, students have helped bridge the healthcare gap for those who may otherwise lack access due to distance, financial constraints, or lack of awareness. In addition to contributing to public health, students have reported significant improvements in their communication, leadership, and clinical problem-solving skills[3,4] . FAP has also positively impacted health outcomes, with students playing a key role in vaccination drives, health education initiatives, and early disease detection, particularly in the management of chronic conditions such as hypertension and diabetes[2,6].

Challenges and Areas for Improvement: Despite its successes, FAP faces several challenges that hinder its full potential. Logistical constraints such as faculty shortages and transportation difficulties often prevent students from conducting regular family visits[3]. Engaging families and building trust, particularly in areas where there is a history of mistrust toward outsiders, remains a challenge[6,4] . Additionally, ensuring the sustainability of care for adopted families after a batch of students graduates is an ongoing concern. Some institutions have suggested that incoming students take over the responsibility of monitoring families to ensure continuity of care[3,5].

Future Directions: To enhance FAP's impact, several steps could be taken. Strengthening logistical support, such as improving transportation and faculty supervision, would enable better implementation of the program[6,2]. Collaboration with local governments and healthcare organizations can help institutions address these logistical issues. Furthermore, expanding the program to include urban slum populations would provide additional learning opportunities for students while addressing healthcare disparities in marginalized urban communities[3]. Establishing a robust feedback mechanism from students, faculty, and families would allow continuous monitoring and improvement of the program[3,6].

To meet the expectations of the National Medical Commission (NMC) for producing globally competent Indian Medical Graduates (IMGs), the inclusion of practical, community-based programs such as the family adoption program in the MBBS curriculum is vital. By engaging medical students directly with families, they can act as mediators, bridging the gap between primary, secondary, and tertiary levels of healthcare. This role is crucial during referrals to higher centers, where the IMG can ensure a smooth transition by facilitating communication and coordinating care. Furthermore, in the context of national health programs, medical students can play a pivotal role in educating families about available services, thus enhancing program utilization and improving healthcare outcomes.

Beyond theoretical understanding, this hands-on involvement in healthcare delivery allows students to develop practical skills, making them well-rounded, competent professionals. By actively engaging with adopted families, students not only strengthen their own learning but also contribute to reducing out-of-pocket expenses (OOPE) for families and delivering comprehensive health services that address physical, mental, and social well-being. This approach aligns with the goal of training students to provide "health in its truest sense," thereby reinforcing the holistic nature of healthcare delivery.

Comparison of the Impact of the Family Adoption Program (FAP) vs. Health Screening Camps under FAP

The recent guidelines from the National Medical

Commission (NMC)[8] highlight the key differences between health screening camps and the original objectives of the Family Adoption Program (FAP) for training Indian Medical Graduates (IMGs). While both approaches aim to engage students in community healthcare, the camp-based model lacks the depth and continuity required for effective IMG training.

Scope and Depth of Training: FAP immerses students in long-term, in-depth interactions with adopted families, offering comprehensive healthcare exposure over three years. This allows for the continuous monitoring of family health, managing chronic conditions, and promoting preventive care. In contrast, health camps are short-term, focusing on basic screenings like blood pressure, blood sugar, and anthropometry. These screenings do not provide the opportunity for long-term follow-up or in-depth learning, which limits the understanding of disease progression and the effectiveness of interventions.[8-9]

Patient Interaction and Communication: FAP emphasizes building trust and rapport with adopted families through continuous engagement. This fosters empathy and communication skills essential for IMGs. In comparison, the brief, data-driven interactions in health camps do not offer students the chance to develop meaningful relationships with patients or understand the cultural and socio-economic factors that influence health outcomes.[3,5,10]

Comprehensive Healthcare vs. Basic Screening: FAP enables students to address a broad range of healthcare needs, including maternal and child health, chronic disease management, and health education. Health camps, however, focus on basic screenings, which do not provide a comprehensive view of patient health. Students miss opportunities to develop critical diagnostic and therapeutic skills, as health camps do not involve detailed patient assessments or long-term care[2,8]

Resource Allocation and Academic Disruption: FAP is integrated into the curriculum over three years, allowing students to balance their academic and fieldwork responsibilities effectively. Health camps, however, require significant logistical coordination and often disrupt regular academic activities. These short-term interventions can divert students from in-depth learning and clinical skill development.[4]

Quality of Training and Skill Development: FAP provides students with the opportunity to apply their clinical knowledge in real-world settings, developing skills in problem-solving, patient management, and navigating primary healthcare systems. Health camps, focusing on routine screenings, do not offer the depth of training required to produce well-rounded healthcare professionals capable of handling complex cases.[10,2]

Challenges in Health Camps: Health camps lack continuity of care, preventing students from understanding the progression of chronic conditions.[3,5] The brief patient interactions limit the development of empathy and cultural competence. Moreover, organizing large-scale camps often strains resources and disrupts academic activities, reducing the overall quality of training.[4,8]

While health camps play a role in community outreach, they do not offer the comprehensive, hands-on training experience that FAP provides. To fully meet IMG training objectives, a greater emphasis on long-term engagement, comprehensive health assessments, and meaningful patient interactions is needed, as demonstrated by the sustained community engagement of the FAP model.

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Padvyuttar Sanshodhan Prakalp Anudan Abstract

Assessment Of Health, Nutritional And Psychological Status In Orphan Children Staying In Orphanages In Panvel Taluka.

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ABSTRACT:

Introduction: Being an orphan is not what anyone chooses but it is a reality of many children around the world. Losing parents at an early age can be traumatic that lead to the various emotional problems such as feelings of loneliness, confusion, insecurity, fear etc. The orphans under institutional care may not undergo such feelings if he or she is provided with a positive environment and proper care. In this study we had checked the physical, psychological and nutritional status in the Panvel orphanages.

Objectives: 1: To assess the health profile of orphans staying in orphanages

2: To assess the nutritional status in orphans staying in orphanages

3: To assess the psychological status of orphans staying in orphanages.

Materials and methods: This was a descriptive cross-sectional study conducted at five orphanages in Panvel taluka of Raigad district. 107 participants were enrolled for the study. Nutritional and health status were assessed through general health check-up, 24-hour recall method, and anthropometry. The psychological status was assessed through Strengths and Difficulties Questionnaire (SDQ). The collected data in excel sheet were analysed using SPSS software.

Results: 107 children participated in the study and the mean age was 9.5years±2.8 years of participants. Among 102 participants aged between 5-19 years based on BMI, 15 (14%) were classified as normal, 12 (11.76%) had thinness and 11 (10.3%) had severe thinness. While 16 (15.68%) were obese, 20 (19.6%) were overweight. The analysis shows a significant association between age group and BMI categories ($\chi^2 = 21.037$, $p = 0.021$). A significant majority 83 (77.6%) reported no chief complaints. The association of gender with the Strengths and Difficulties Questionnaire (SDQ) results indicates that most behavioural and emotional characteristics assessed do not significantly differ between genders, as evidenced by p-values greater than 0.05 for the majority of items.

Conclusion: The orphan children in Panvel taluka who were receiving institutional care had generally good health and few medical problems. The dual burden of malnutrition within the orphan population, where both under nutrition and over nutrition are prevalent issues and moderate level psychological problems related to mental health, conduct, and attention.

Historical Views

Transforming Oppression into Empowerment: Exploring the Fight for Women's Rights in Colonial India

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Out of 542 Members of Parliament, only 78 are women. Additionally, the percentage of women who are neither employed nor in education is significantly higher—48.4% compared to just 9.8% for men, nearly five times as much. India currently ranks 142 among 193 countries when it comes to women representation in Parliament. It is behind most of its neighboring countries Pakistan (137), Nepal (54) and Bangladesh (113). It will raise the question about status of women in India.

A series of recent events, such as the tragic rape and murder of a young woman at R G Kar Medical College and Hospital last week, have once again brought women's rights to the forefront of public attention in India. These incidents highlight the ongoing struggle for women's equality, liberty, and personal security—a matter that has persisted for generations

In this context, it is important to take a closer look at the historical evolution of women rights and issues face by women's, it will provide valuable context for the current challenges surrounding women's rights, shedding light on the long-standing fight for gender equality, legal protections, and societal reform. This understanding is essential to grasp the complexity of the issues women still face today.

Exploitation and Sexualization: The Impact of British Colonial Policies on Indian Women

Western cultural hegemony in India has had a significant impact on the country's culture, society, and self-identity. In the sovereign country Mindset of India still seeks validation from the West which is largely the impact of colonization. Grievous picture of colonization shows how Indian women have been treated during the colonial period.

British concern with women's issues in India combined with the values of equality, human rights, and social justice influenced by European Enlightenment ideas, political objectives, and a push for social reforms. Under Viceroy Lord Ripon, the 1881 Indian census revealed a noticeable gender imbalance, largely caused by the widespread practices of female infanticide and foeticide. However, the census lacked precise data on women's age, occupations, social class, and caste, particularly for rural women. This gap made it challenging to fully grasp the realities of women's lives and the problems they faced in India during that period.

During British colonial rule, Indian women faced severe exploitation and sexualization, especially by the ruling British classes. This was notably evident through a series of Cantonment Acts, including a significant one in 1899, which were designed to regulate prostitution within British military bases. These acts effectively institutionalized the exploitation of women by allowing the British military to control and monitor women, turning them into objects of sexual service for the soldiers. This not only dehumanized women but also contributed to their marginalization.

Moreover, Indian domestic servants, mostly women, were subjected to long hours of labor with little to no wages and without any form of legal protection. These women were often invisible to society and had no recourse to justice, further deepening their vulnerability and exploitation under colonial rule.

As historian Kumari Jayawardena once said, "*Colonialism did not simply reproduce patriarchal systems;* it exacerbated them by adding racial and class exploitation to the gender oppression that women faced." The British regime's legal and social systems reinforced these hierarchies, leaving Indian women doubly oppressed by both their gender and the colonial system.

The Contagious Diseases Acts, enacted by the British government between 1864 and 1869, were aimed at controlling the spread of venereal diseases among soldiers stationed in territories under British control. These laws led to the forced imprisonment, stigmatization, and invasive medical examinations of women suspected of being involved in prostitution. Women were unfairly targeted, often detained without consent, and subjected to medical procedures intended to curb infections in the military, reflecting both gender bias and a disregard for their rights. The

Acts highlighted the use of state power to marginalize and control women, particularly those in vulnerable positions.

These laws developed a legacy that had a psychosocial impact on women's rights, social justice, and the objectification of women's bodies even today This context is essential to understanding the broader impact of colonialism on women's rights, as it institutionalized both gender and racial inequalities that continue to shape socio-political dynamics in post-colonial societies.

From Tradition to Transformation: The Evolving Landscape of Social Reform

India's journey toward women's rights has been shaped by the tireless efforts of notable social reformers. Pioneers like Raja Ram Mohan Roy, Swami Dayananda Saraswati, Rukhmabai Raut, and Iswar Chandra Vidyasagar played key roles in challenging oppressive traditions and advocating for the upliftment of women. Their work laid the foundation for transformative changes, including the abolition of harmful practices like sati, promoting women's education, and advocating for women's autonomy and legal rights. These reformers initiated a shift from rigid societal norms to a more progressive view of gender equality in India.

The decline of Mughal rule and the rise of the East India Company set the stage for the Bengal Renaissance, which spanned from the late 18th to early 20th century. This period fostered a cultural revival in India. Raja Ram Mohan Roy, often referred to as the "father of the Indian Renaissance," played a key role in the abolition of the Sati practice, which forced widows to be burned alive on their husband's funeral pyre. The Bengal Sati Regulation, passed on December 4, 1829, under the first Governor-General of British India, legally banned the practice. However, societal acceptance of the law took decades, and the last recorded case of Sati occurred in 1987, when Roop Kanwar, a Rajput woman, was allegedly forced to immolate herself in Deorala village, Rajasthan.

Swami Dayananda Saraswati, who established the Arya Samaj in 1875, took a traditionalist approach to social reform, advocating for a return to Vedic principles. In addition, prominent women activists such as Begum Roquiah Sakhawat Hossain from Bengal and Rukhmabai Raut also became active in the movement, fighting against practices like sati and child marriage.

But this reform creates questions like thus women reformers depended upon their male allies, a fact that has to be closely examined. Were there possibilities, or space, for women to articulate their struggles openly? One need only consider in this context the Hindu Widows' Remarriage Act of 1856, which was carried through by Ishwar Chandra Vidyasagar, with the help of many women reformers who had no chance of influencing the formative process of legislation,

Some of the reforms took time to accrue like legislation to abolish child marriage, the Child Marriage Restraint Act, commonly known as the Sarda Act, named after the founder Harbilas Sarda, was passed in 1929 and came into force in 1930. The legislation fixed the age of marriage at 18 years for boys and 14 years for girls against the earlier prevailing one of 5 years or below for girls.

Political representation

As India nears 100 years of independence, women remain underrepresented in politics, with their voices often unheard in parliament. Despite comprising nearly half the population, women hold few political positions at the national and state levels. Although local governance includes reserved seats for women, broader political representation remains limited. Issues like gender-based violence, unequal pay, and access to education and healthcare are often sidelined. The Women's Reservation Bill, which proposes reserving 33% of seats for women in parliament, has not yet in action, hindering true gender equality in political decision-making.

While several global suffragette movements were raising their demand for universal adult franchise in the Western countries, Jawaharlal Nehru proposed to engage women in the political process, including in franchisee, at the Indian National Congress (INC) meeting in Lucknow in 1937.

However, the continuous absence of women from Indian politics is traceable to the very roots of the Constituent Assembly of India. Of the 299 members of the Constituent Assembly, there were only 15 women, including Sarojini Naidu, Vijaya Lakshmi Pandit, Rajkumari Amrit Kaur, Hansa Jivraj Mehta, Durgabai Deshmukh, Renuka Ray, Leela Roy. Dakshayani Velayudhan was the first and only Dalit woman and Begum Aizaz Rasul was the only Muslim representative. Later, in the first Lok Sabha, during 1952-1957, only 4.4 percent of the members were women.

At present, only about 14 per cent of the 542 seats in the Lok Sabha are held by women of the 542 Members of Parliament (MPs), only about 78 are women. In the Rajya Sabha, there are just 24 among the total 224 members. Women MPs

continue to grapple with entrenched patriarchalism, party structure and ticket distribution reservations, as well as voter perception.

Female candidates have been judged by strict norms of "winnability" unlike their male counterparts. Very few female candidates are fielded only to meet the quotas.

The 73rd and 74th Constitutional Amendments, introduced in 1993, mandated a 33% reservation for women in Panchayati Raj Institutions, significantly boosting women's representation at the grassroots level. The Women's Reservation Bill, also called the Constitution 108th Amendment Bill, aims to extend this 33% reservation to state legislatures and the Indian Parliament, with seat allocations rotating in each election cycle.

Many reformers have attacked this bill, terming it as mere 'tokenism' toward achieving quotas, rather than actual emancipation of women more so the Dalit and Muslim women.

Discrimination at the Crossroads: Gender, Disability, and Social Exclusion

Despite the Untouchability Offences Act of 1955, Articles 15 and 17 of the Constitution, and the Scheduled Castes and Scheduled Tribes Prevention of Atrocities Act of 1989, caste and class discrimination against Indian women still persists. Scholars like Dr. Savita Ambedkar, Dr. Uma Chakravarti, Dr. Sharmila Rege, and Dr. G. R. G. Krishnamurthy have long examined the complex ways in which caste and class affect gender representation.

A key example is the Devadasi system, where women were formally recognized as religious and social figures tasked with worshiping deities in temples. This practice resulted in the marginalization and sexual exploitation of devadasis by temple priests, patrons, and others, prompting the enactment of the Devadasi Abolition Act in 1988. However, data from the National Commission for Women indicates that there were still 48,358 devadasis in India as of 2011.

In relation to the impact of disability on the socio-cultural identity of women, it can be noted that while the 2011 census estimated that there are around 11.8 million women with a disability living in India who face significant hardship, discrimination, isolation, and marginalization in everyday life.

The National Crime Records Bureau (NCRB) reports that a rape occurs in India every 16 minutes, even after the implementation of the Criminal Law (Amendment) Act, 2013, commonly referred to as the Nirbhaya Act. Additionally, the Protection of Children from Sexual Offences (POCSO) Act, enacted in 2012, aimed to create a comprehensive legal framework to address the rising incidents of sexual abuse against children, including penetration, sexual harassment, and exploitation. Despite these efforts, the stigma surrounding rape continues to persist.

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Padvyuttar Sanshodhan Prakalp Anudan Abstract

ASSESSMENT OF HEALTH-SEEKING BEHAVIOUR & HEALTH PROFILE AMONG TRANSGENDERS IN AURANGABAD CITY: - A Cross-Sectional study

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ABSTRACT

Introduction - Healthcare-seeking behavior (HSB) has been defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy". This study will help us to understand the health-seeking behavior and any problem faced by the transgender in Aurangabad city in accessing the healthcare system. This study aims to assess the health-seeking behavior among transgender individuals.

Material and methods - The Descriptive cross-sectional study was done in Aurangabad city, Maharashtra. The Study Duration was 3 months. The Study population was Transgender population among them participants were Aged 18 years or above and given Consent to participate. No exclusion criteria. The Sampling type was Purposive Sampling. A total of 60 participants were included in the study. The data collection was done through personal interviews. The health profile was assessed using clinical history and examination. For the Data Analysis SPSS 25.0 edition software was used. Data presentation was done using tables and graphs. This Study began after approval from the SAC and institutional ethics committee.

Observations and Results - The mean age for respondents was 28.32±12.94 years. Among the 60 respondents, education-wise 4 (6.67%) were illiterate and 56 (93.33%) were literate. Among all respondents, the majority 29 (48.3%) would consult the physician if they were experiencing any health problem. Most of them would take self-medication as the first action to be taken. About healthcare giving staff behavior, 29, (48.33%) responded on Average. When the respondents were asked about whether had they encountered discrimination in the hospital majority 34 (56.67%) responded neutral.

Conclusion - This project aims to provide a comprehensive understanding of the health-seeking behavior of transgender individuals in Aurangabad City, ultimately contributing to improved health outcomes and healthcare accessibility.

Keywords - Health-seeking behavior, Transgender, Health-profile.

PG Corner

Broadening Horizons: Journey of a PG student in Community Medicine

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Pursuing a post-graduate degree in Community Medicine, previously known as Preventive Medicine, is a journey that is equally challenging and enlightening. From textbooks to real-world issues, the field equips students in a variety of aspects related to healthcare. Being an interdisciplinary field, Public Health demands a unique approach to learning that combines classroom teaching, fieldwork, research, and social interaction. The relationship between the student and the subject evolves through various phases due to the vastness of the field and the myriad socio-economic and cultural factors in the people across the nation.

Shift in Perspective

For a student who must have spent a significant amount of time analysing the clinical aspect of diseases during MBBS, a major change or shift in perspective would be encountered in the initial months of the post-graduation course. The field of Community Medicine deals with epidemiology, biostatics, health management, administration, outbreak control and public health. As a student delves into the depths of this subject, it pushes their mind to consider not just the clinical aspects of a public health problem, but also the healthcare delivery systems, government policies taking into account the multitude of variables present in the population. The goal is no longer about diagnosing a patient in a hospital setting but about improving the overall health status of the community as a whole.

Field Work

To become public health experts, one has to be thorough with the functioning of the community. The first step towards this is postings in rural and urban health centres, where students get opportunities to conduct health and awareness camps, health surveys; engage with the local people; understand the environmental, social, economic, cultural and political scenario the community confronts. This practical knowledge is pivotal in understanding the real challenges of the Indian healthcare system.

One of the most rewarding aspects of this experience is witnessing the tangible impact of preventive healthcare initiatives. Whether it's through immunization campaigns, sanitation programs, or maternal and child health care services, students see firsthand how basic public health interventions can dramatically improve the health of an entire community. The experience often reveals stark contrasts in healthcare access between urban and rural areas, and students learn to appreciate the complexities involved in healthcare delivery in such diverse settings.

India's vast diversity means that health inequities are prevalent, with a sizable section of the population having inadequate access to healthcare. For a post-graduate student in Community Medicine, these inequities are not abstract concepts but daily realities that they encounter during their training. From rural areas where healthcare facilities are scant, to urban slums where pollution and overcrowding exacerbate health issues, students gain a deep understanding of the social determinants of health.

Interdisciplinary Learning

The vastness of Community Medicine expands well beyond the covers of the theoretical textbooks under the syllabus of NMC. Public health policies, environmental science, social work, nutrition, and economics all play a significant role in shaping healthcare systems. Students have gotten opportunities in this regard through the recently introduced District Residency Program where postings in the Government Public Health Department give them an insight into the various policies and schemes to promote health in the community.

Teaching and Comprehensive learning

The knowledge base of all students pursuing this field must be constantly updated. Teaching activities including group discussions, lectures, seminars, journal club provide a constant push to acquire knowledge regarding the recent updates and advances in the filed of public health. An example of this is the emerging field of

technological applications in medicine. One must be continuously seeking out opportunities to learn and get a hands-on experience on the developing technology in this field.

Learning must not just be confined within the institute, but its imperative that the student find online platforms on a nationwide basis which shares knowledge and experiences of various public health professionals. This helps them to broaden their perspective on the diversity of the problems and needs faced by the local community catered by these professionals.

Research and Medical Literature

Community Medicine is the one subject under medical field which teaches students on the correct research methodologies. Throughout the 3 years of training, students get involved in designing a study maintaining the ethical standards, data collection and analysis, manuscript writing and publishing of research articles. Each research study is an in-depth analysis of a problem faced by a specific section of the community, and it opens doors for various innovative ideas and techniques to improve its health status. It is often encouraged in a student's journey to take up an many projects as possible, more than the mandatory thesis and research study recommended by the NMC. Paper and poster presentations in different conferences provides an opportunity to meet with other students and faculty, which would help in exchange of ideas and perspectives.

Conclusion

Pursuing a postgraduate degree in community medicine in India is an eye-opening experience that integrates field-based learning with rigorous academic study. This journey highlights the importance of a holistic approach to health, one that addresses the underlying causes of health problems rather than just treating them, incorporating preventative, promotive, and curative methods. Through this learning process, students are not only prepared to address public health issues, but they are also motivated by a feeling of duty to enhance the health of entire communities.

Padvyuttar Sanshodhan Prakalp Anudan Abstract

A community based cross sectional study of maternal autonomy and its association with nutritional status of under-5 children residing in area coming under urban health training centre of Tertiary health care centre of Central India

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Background: Maternal autonomy refers to women's control over their lives, including equal voice, access to resources, freedom of mobility and decision-making authority. In India, 36%, 19% and 32% of children were stunted, wasted, and underweight respectively in 2019-21. Financial autonomy and physical mobility are associated with reduced odds of child stunting. Hence, we undertook a study to examine the association between maternal autonomy and nutritional status of under five children.

Objectives:

1. To study maternal autonomy of mothers of under-5 children residing in area coming under urban health training centre of tertiary health care centre of Central India.
2. To study nutritional status of under-5 children of study area.
3. To study association between maternal autonomy and nutritional status of under-5 children of study area.
4. To study some child, maternal and household characteristics affecting nutritional status of under-5 children of study area.

Materials/Methods: A community based cross-sectional study was conducted between September 2023 - February 2024, involving 250 mother-child pairs from the area coming under study institute. The study examined four dimensions of maternal autonomy: household decision-making, freedom of movement, access to economic resources, and attitude towards domestic violence. The relationship between maternal autonomy and the nutritional status of their under-5 children (stunting, wasting and underweight) was assessed using Chi square test.

Results: The study found that the majority of under-5 children were females (52.4%) aged 0-11 months (28.8%), with most mothers aged 25-29 years (27.6%). Also, 24.4% of under-5 children were stunted, 48.4% were wasted, and 38.4% were underweight. Moreover, high maternal autonomy was reported by 148 mothers (59.2%).

Conclusion: The study concluded that prevalence of wasting was significantly greater among children whose mothers had lower levels of autonomy. Factors such as child's age, mother's age, education, occupation, BMI status, gender of head of family, socioeconomic status, family type, religion were found to be associated with under-5 stunting. Along with these factors, gender of child and marital status of mother were also found to be associated with under-5 wasting and underweight.

Key words: stunting, wasting, underweight, nutritional status, under-5, maternal autonomy.

Book Review

Sapiens: A Brief History of Humankind by Yuval Noah Harari

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Understanding our past through the prism of history helps us develop our socio-cultural awareness and the ability to forecast the future based on historical trends and lessons learnt. By analysing and scrutinising historical chronology, we can all learn important lessons, avoid past mistakes, and make better choices that can positively impact our personal and social development. In our public health field, we also study historical discoveries, inventions, patterns, and trends vis-à-vis medicine and civilisation, which helps us envisage the dream of a healthy and better future for humanity and implement the same.

Diving deep into our past and enquiring about the nitty-gritty of our evolution as a human race is imperative. A question about ourselves being humans follows us throughout our existence. The thought process that pushes human knowledge forward is fuelled by curiosity. In the quest to know our past, Israeli historian Yuval Noah Harari brings insights from science and the humanities together to answer the curiosity of what it means to be human with his book "Sapiens: A Brief History of Humankind", and this is my selected choice of book for the book review section of this issue of IPHA Maharashtra Newsletter.

It was first published in Hebrew in Israel in 2011 based on a series of lectures Harari taught at The Hebrew University of Jerusalem and in English in 2014. This book navigates us through our entire human history, from early years as a primitive human beings to today's ultra modern age where humans command and reign all over the planet. It focuses on cardinal processes that shaped humankind and the world around it, such as the advent of agriculture, the rise of the nation-state, etc., by taking a multi-disciplinary approach.

According to the book, human history has been shaped by three significant revolutions and humankind's unification. There was the Cognitive Revolution, which happened more than 70,000 years ago. The cognitive revolution facilitated humans to maintain free will while creating standard systems, such as money, that required only belief to be realised. When the Cognitive Revolution occurred, sapiens could imagine and describe things that did not exist in the real world. This phase was followed by the Agricultural Revolution approximately 10,000 years ago. This period saw how hunter-gatherers developed themselves into the first major agricultural civilisation. This was the era of technological advancements and increased crop productivity. The sapiens developed and implemented significant inventions that catapulted a major change in agricultural production, improving our living standards.

While discussing the Unification of Humankind, Harari argues that over its history, the trend for Homo sapiens has increasingly been towards political and economic interdependence. For centuries, most humans have lived in empires, and capitalist globalisation has effectively produced one, a global empire. Harari explains that money, empires, and universal religions are the principal drivers of this process. Finally, 500 years ago, the Scientific Revolution brought forward the period when humans transitioned to a scientific and factual approach towards life. These revolutions prove that humans could form ideas that no other life form could, such as politics, religion and capitalism.

In contemporary times, 'Sapiens' represents the only remaining human species. A very long time ago, 100,000 years ago to be more precise, at least six human species inhabited the Earth. Today there is just one – us, the Homo Sapiens. According to the book, Homo Sapiens rules the world because it is the only animal that can believe in things that exist purely in its imagination, such as gods, states, money and human rights. Most humans assume that we are always the ones in charge. Naturally, we feel entitled to everything, given our superior knowledge and intelligence compared to animals. However, Yuval Noah Harari and his book remind us that there was nothing special about us long before we built the pyramids, wrote symphonies or walked on the moon. It is important to note that other species also have big brains and specific intellectual capabilities. However, the Homo Sapiens were successful due to their ability to cooperate on a large scale. Humans have learnt how to organise as nations,

companies and religions.

Apart from science and intellectual capabilities, capitalism is another force with which humans identify. The author also discusses the notorious relationship between money and happiness. Harari presents well-documented research that shows a person's happiness has little to do with material circumstances. However, there is a catch: Money can undoubtedly make a difference in a person's happiness, but only when it lifts us out of poverty.

Towards the end of the book, the author starts asking pertinent questions relevant to our species' destiny. One of the main questions is: What is the next chapter for sapiens, for us humans? This question is difficult to answer because no one can foresee the future, but a particular trajectory for humans can be anticipated, considering our journey so far. Humans are destined for great things and nothing less. Our complexities make us unique, and we should be proud of that. Indeed, there are things that we can improve upon, but life is a beautiful process.

Lastly, I think a point may be considered a limitation on the book's side. Harari has presented the ideas and concepts regarding the evolution and development of human beings over the millennia that were already discussed, researched extensively and presented and documented very well in detail in the past by many legends. Still, ultimately, the overall presentation and discourse in the book seem very educational and exciting.

Conclusion :

It is a delightful reading experience through Harari's virtual time machine. It is a well-designed narrative of humanity's creation and evolution. It explores how biology and history have defined us and enhanced our understanding of being human. This book provides a beautiful framework and perspective for guiding and interpreting what we do and how we act as humans.

As public health specialists, we must read this book and go through the author's discourse to deepen our knowledge, widen our vision, and see our past to better humanity's future, considering our counterparts on the planet. This book will help us to set the philosophical agenda to look towards ONE HEALTH. As we all know, One Health is an integrated approach that aims to sustainably balance and optimise the health of people, animals and ecosystems. As this book suggests, We must study the interdependence of all factors influencing human lives in the past and future. We, being SAPIENS, must be aware of ourselves, our planet and our cohabitants and be vigilant and operational towards bringing harmony and health for all of the stakeholders on this beautiful planet Earth proclaiming the divine idea VASUDHAIV KUTUMBAKAM!

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Padavidhar Sanshodhan Prakalp Anudan Abstract:

Prevalence of Cyber Bullying and its impact on self-esteem among undergraduate medical students: A mixed method research

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Background: Use of internet has increased exponentially worldwide with prevalence of cyberbullying. Cyberbullying has been linked with self-esteem indicating low self-esteem among individuals involved in cyberbullying. Victims have a feeling of being worried, sleep disturbances, and being irritated with others. They may also have a feeling to end their lives, especially immediately after the episode has occurred.

Objectives: To find the prevalence of cyberbullying and its impact on self-esteem among undergraduate medical students.

Methodology: A mixed method approach with quantitative and qualitative was conducted in 453 undergraduate medical students of a rural medical college in Konkan region of Maharashtra from Aug 2023 to Feb 2024. Information was collected on a semi-structured, self-administered proforma containing socio-demographic details and questionnaire related to internet use. Focus group discussion (FGD) was conducted on 56 students selected based on a higher prevalence of cyberbullying and its impact on self-esteem.

Results: The mean age of participants was 20 ± 0.96 year. The female students were 45.47% and 54.52% were males. Out of all, 15.23% were victims of cyberbullying and 8.60% of students were found to be engaged in cyberbullying others (cyberbullying perpetration). About 59.42% of males and 40.57% of females were victims of cyberbullying. However, 92.30% students were males and 7.69 % were females who cyberbullied others. Self-esteem was found low in 29.80% of students. The self-esteem was low among one third of cyberbullied individuals.

Conclusion: Cyberbullying has become a growing concern as mobile phone usage proliferates in the contemporary age. As a result, ongoing surveillance of the potential adverse impacts of electronic media on the health and welfare among medical students is essential. This study concluded that students who experienced cyberbullying both as victims and perpetrators exhibited diminished self-esteem. Hence, corrective actions are required to address and prevent the incidence of cyberbullying among medical students.

Keywords: cyberbullying, self-esteem, victimization, cyberbullies, prevalence, students.

Film Review

Kadvi Hawa (2017)
Climate Change Depiction through Movie Lens

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Film: Kadvi Hawa (2017)

Language: Hindi with English Subtitles

Director: Nila Madhab Panda

Cast: Sanjay Mishra, Ranvir Shorey and Tillotama Shome

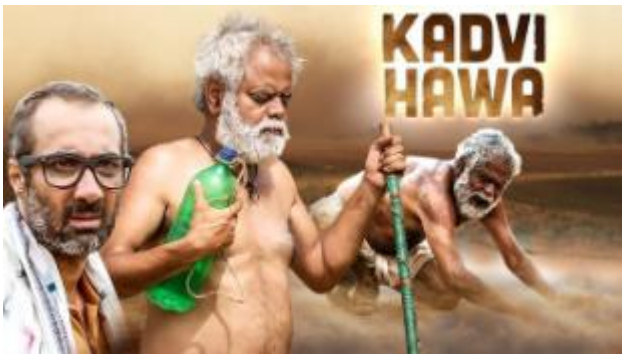
Run-time: 1h 39m

Kadvi Hawa (2017) is a poignant and stirring film directed by Nila Madhab Panda, which dives into the lives of those living on the fringes of society, whose existence is directly affected by the relentless forces of climate change. The film's title, meaning "Bitter Wind," hints at the harsh realities faced by the rural population dealing with erratic weather patterns, drought, and the subsequent economic and social ramifications.

The film is set in the drought-prone regions of Bundelkhand region, India, and follows two central characters: Hedu (played by Sanjay Mishra), an aging blind farmer haunted by memories of a time when his village was lush and fertile, and Gunu (Ranvir Shorey), a debt collector from Odisha, whose family has suffered due to rising sea levels. Gunu, known as the "death messenger" in Hedu's village, pressures villagers into repaying their debts—a challenging task in a drought-stricken land. Despite the seeming opposition in their roles, Hedu and Gunu form an unlikely bond as they face their shared struggles and fears, both related to the devastating effects of climate change.

Sanjay Mishra delivers a heart-wrenching performance as Hedu. His portrayal captures the pain, guilt, and helplessness of a man who can feel the suffering of his land and people, even without sight. Ranvir Shorey, as Gunu, balances the roughness required of a debt collector with a layer of vulnerability, especially as he is haunted by his personal loss. The performances are subtle yet powerful, carrying the emotional weight of the film.

Visually, Kadvi Hawa makes remarkable use of the barren landscapes of Rajasthan, portraying nature



as both a victim and a silent judge of humanity's actions. Panda's direction and screenplay avoid preachiness, instead presenting the grim effects of climate change as an inescapable reality, letting the audience draw their own conclusions. Cinematographer Ramanuj Dutta captures the dry, cracked lands and the weathered faces of the villagers, allowing the imagery to tell much of the story's anguish.

One of the film's major strengths is its screenplay, which remains rooted in reality and never loses its subtlety. Kadvi Hawa doesn't offer any easy solutions or quick resolutions to the problems it presents, reflecting the real-world complexity of environmental issues. The film, though slow-paced, carries a haunting intensity that stays with the viewer, prompting a reflection on our own role in the looming environmental crisis.

In conclusion, Kadvi Hawa is a compelling piece of cinema that serves as both a critique of humanity's negligence towards nature and a tribute to those who suffer its consequences. It's a must-watch for anyone interested in socially conscious cinema, as well as for those who wish to understand the human aspect of climate change, which often gets buried beneath statistics and headlines. Through its deeply personal storytelling, Kadvi Hawa reminds us of the urgent need to address climate change before more lives are swept away in its bitter wind.

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View Point

Health Equity and Access: Addressing Disparities in Healthcare Access and Outcomes.

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Ensuring that every individual, regardless of their background, has the opportunity to achieve their highest level of health is a fundamental goal. Unfortunately, disparities in healthcare access and outcomes persist, impacting millions of people across the globe. Let's explore these disparities and discuss ways to bridge the gap for a healthier, more equitable future.

Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.[1]

Healthy People 2020 defined a health disparity as *"... a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion".*[2]

Health disparities, which are sometimes referred to as health inequities, have garnered an increasing amount of attention from physicians and health policy experts, as well as a renewed focus from federal health agencies. As a complex and multi-factorial construct, differential access to medical care, treatment modalities, and disparate outcomes among various racial and ethnic groups has been validated in numerous studies. The antecedents of such differences involve such "drivers" as cost and access to the healthcare system, primary care physicians, and preventive health services. In addition, the subtle role of bias in creating and/or exacerbating health disparities is well documented in the literature.[3]

Health outcomes are defined as those events occurring as a result of an intervention and are measures of quality of care. A health outcome refers to both physical and psychological well-being and takes into account the length of life as well as the quality of life. Measuring outcomes helps make decisions about how to best care for patients. Measuring, reporting, and comparing outcomes are important steps in achieving better health outcomes. Improving health outcomes can improve the performance and accountability of health care teams by uniting the interests and activities of stakeholders around a common goal.[4]

This article highlights the dimensions and extent of health inequities and emphasizes the challenges facing physicians and others in addressing them

Key Areas of Concern:

1. **Racial and Ethnic Disparities**
   - Minority groups often experience higher rates of chronic diseases, such as diabetes and hypertension, and face barriers to receiving timely and appropriate care.
   - Systemic racism and implicit bias within healthcare systems contribute to unequal treatment and poorer health outcomes for these populations.
2. **Socioeconomic Disparities**
   - Low-income individuals are more likely to be uninsured or underinsured, limiting their access to necessary medical services.
   - Economic instability can lead to delayed care, medication non-adherence, and higher rates of preventable illnesses.
3. **Geographic Disparities**
   - Rural areas often lack sufficient healthcare facilities and providers, forcing residents to travel long distances for care.
   - Urban areas, while having more resources, can still exhibit disparities in certain neighbourhoods due to socio-economic

factors.

4. Gender and Disability Disparities

- Women and people with disabilities may face unique challenges in accessing healthcare, including biases and inadequate provider training on specific health needs.
- Sexual and reproductive health services are often less accessible to these groups.

Statistics:

1. Healthcare Access Disparities:

Urban vs. Rural Access: The National Health Profile 2020 indicates that while nearly 70% of India's population lives in rural areas, only about 20% of healthcare facilities are located there. This uneven distribution highlights significant access issues.[5]

2. Public vs. Private Sector

Healthcare Financing: According to the ICMR, about 75% of healthcare expenses are borne out-of-pocket by patients, with a predominant share of services being provided by the private sector.[6]

3. Socioeconomic Factors:

Income Inequality: The National Family Health Survey (NFHS-5) 2019-21 reports that stunting affects 38.6% of children from the poorest quintile, while only 14.3% are affected in the richest quintile.[7]

Education Level: NFHS-5 data shows that anaemia prevalence among women with no schooling is 60.2%, compared to 49.2% among women with 12 or more years of schooling.[8]

4. Health Insurance Coverage:

Insurance Penetration: As per NFHS-5, approximately 37% of households have health insurance, indicating significant coverage gaps across different states and demographic groups.[9]

5. Maternal and Child Health:

Maternal Mortality Ratio (MMR): The Sample Registration System (SRS) 2018 reports an MMR of 113 per 100,000 live births. The MMR is notably higher in states like Uttar Pradesh and Bihar compared to states like Kerala and Tamil Nadu.[10]

6. Regional Disparities:

State Variations: According to the National Health Profile 2020, life expectancy varies significantly across states, with Kerala having a life expectancy of around 77 years compared to Uttar Pradesh's 66 years.[11]

Potential solutions:

Health care leaders and medical professionals can advance health equity by working to improve access to care and reduce uninsured rates. Additionally, care facilities can implement community outreach efforts and chronic disease management programs to advance health knowledge in affected populations. Below are other possible solutions.

Raising Awareness Among Health Care Providers

Raising awareness through education can help address health equity. Improving resource coordination can also help populations most harmed by health disparities. For example, health care organizations can help reduce ethnic health disparities by offering cultural competency training to health care providers.

Increasing Health Literacy in Affected Communities

Health care organizations can play a pivotal role in increasing the health literacy of affected groups by expanding educational programming. For optimal impact, health care organizations should identify the highest-risk groups and accordingly target educational and support programs.

Advancing Health Equity

Social, racial and economic inequities cause many examples of health disparities. Health care providers can engage with policymakers, urging action to help communities impacted by these factors. For example, they can use health disparity data and evidence-based clinical knowledge to recommend expanding health coverage to individuals with limited health care access.

Providing More Resources

Racial and ethnic groups are less likely to have proper access to health resources and are typically underrepresented in the health care workforce. Similarly, rural and low-income communities typically have fewer health care professionals per capita than urban and high-income areas.[12]

Partnering with Organizations

Health care facilities can collaborate with agencies, organizations, coalitions, boards and councils working on initiatives to address the root causes of health disparities. For example, working with the Anganwadi workers, Asha workers, etc.

Tracking Results

Monitoring and documenting a program's

effectiveness and health impact enables health care organizations to determine what's working and find improvement opportunities to improve health outcomes for all.

Innovative Programs already making a Difference

Community Health Workers (CHWs)

- CHWs are trusted community members who connect individuals with healthcare services and provide education on managing chronic conditions. Their culturally sensitive approach has been shown to improve health outcomes in marginalized communities.

Telehealth Expansion

- Telehealth services have grown significantly, especially during the COVID-19 pandemic, providing remote access to care for those in rural and underserved areas. Continuing to expand telehealth can help bridge the gap in healthcare access.

Policy Initiatives

- Recent policies aimed at expanding Medicaid, funding for community health centres, and enforcing non-discrimination in healthcare have been steps toward greater health equity. Advocacy for these and similar policies is essential for continued progress.

Conclusion:

Overall, while India has made notable strides in improving healthcare access and equity, significant challenges persist. Addressing these issues requires a multifaceted approach, including targeted investments in rural healthcare infrastructure, policies aimed at reducing socioeconomic disparities, and efforts to improve health insurance coverage and financial protection. Ensuring equitable access to healthcare for all, regardless of geographic, economic, or social factors, is crucial for advancing public health and achieving sustainable development goals in India.

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Padvyuttar Sanshodhan Prakalp Anudan Abstract

Perception and attitude towards human milk banking among urban women of Central India : a mixed - method study.

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Background : Modern human milk banking is in its infancy in India. Despite establishment of over 90 milk banks in the country, they remain under utilized due to several reasons including the risk of infection to the child, fear of loss of affection for the child, loss of nutrients, easy availability of formula milk and several socio-cultural factors.

Objectives: The aim is to determine perceptions and attitudes of urban women from central India towards human milk banking and to understand the barriers and facilitators for acceptance of human milk banking.

Materials/Methods: A cross sectional mixed method study was conducted among 190 women who delivered a live baby within last 5 years for quantitative data and for qualitative part of this study women who are knowledgeable about breastfeeding and infant feeding practices like ASHA, trained dais, in Central India were considered. Qualitative study data was collected with in-depth interviews (IDIs) performed using a semi-structured interview form with open ended questions. A predesigned, pretested questionnaire was used to collect the quantitative data of the study. Quantitative data was evaluated using the SPSS 24.0 statistics program.

Results: Among 190 lactating mothers, 50 was aware of milk banking. In FGDs, women generally stated that they would donate their milk to an HMB but would not take milk from the HMB for their children. Majority of the mothers 80% (152) have been willing to donate the milk and 20% (38) of mothers refused donating human milk due to reasons like Concerned about not being able to provide enough breast milk for their own infant, cultural practices and traditions discourage this. 60%(114) of mothers believed that donor milk contains more nutrients than formula feed.

Conclusions: The findings indicate support for milk banking as a potential 'temporary' solution and reveal that milk banking is a tool that is currently being underutilized. It is imperative that stakeholders address the challenges identified by the current study to improve infant feeding and health.

Important Health Related Days, weeks, events in the month of October, November and December

Sr.No.	Day/Week/Event	Date	Theme for 2024
1	International Day for Elderly	1st October	"Ageing with Dignity"
2	National Anti-Drug addiction Day.	2nd October	"The evidence is clear: invest in Prevention"
3	World Mental Health Day	10th October	"Mental Health bat Work"
4	World Food Day	16th October	"Right to Food for a better Life and a Better Future"
5	International day against Poverty	17th October	"Ending Social and institutional Maltreatment"
6	World Polio Day	24th October	"A Global Mission to Reach Every Child"
7	Universal Children Day	31st October	"For Every Child, Every Right,"
8	Lung Cancer Awareness Month	1-30 Nov.	"Stronger Together: United for Lung Cancer Awareness".
9	World Immunization Day	10th Nov.	"Vaccines for All"
10	World Diabetes Day	14th Nov.	"Breaking Barriers, Bridging Gaps,"
11	World New Born Care Week	15- 21 Nov.	"Optimising Antimicrobial Use to Prevent Antimicrobial Resistance(AMR) in Newborns"
12	International Day for Elimination of Violence against Women.	25th Nov.	"Every 10mins, a woman is killed."
13	World AIDS Day	1st December	"Take the Rights Path: My Health, My Right!"
14	National Pollution Prevention Day	2nd December	"Clean Air, Green Earth: A Step Towards Sustainable Living."
15	World Disability Day	3rd December	"Transformative Solutions for inclusive development: the role of innovation in fuelling an accessible and equitable World"
16	World Patient Safety Day	9 December	"Improving diagnosis for patient safety"

APPEAL

The Indian Public Health Association (IPHA) existing since 1956 is a professional registered body (Society Act No. S/2809 of 1957 – 58) committed to promotion and advancement of public health and allied sciences in India, protection and promotion of health of the people of the country, and promotion of co-operation and fellowship among the members of the association. IPHA has local branches in almost all states of the country. Any professional graduate, MBBS or any equivalent degree recognized by any Indian university in Indian System of Medicine / Dentistry (BDS) / Engineering (BE) / Nursing (B Sc Nursing) / Veterinary (BV Sc & AH) are eligible to be ordinary & life member of the association after paying the necessary subscription. We, the executive committee members of IPHA – Maharashtra Branch sincerely appeal the eligible qualified individuals to become the life members of the organization and enhance our strength and visibility. Kindly visit National IPHA website, www.iphaonline.org to download the application form and for further official procedures of payment of membership fee. If you need any help in this regard please feel free to contact Secretary, IPHA – Maharashtra Branch on phone (022 - 2743 79 96 / 97) or on email - iphamaha@gmail.com

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