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BLOGOLOGUE

A Compendium of IAPSM Blogs

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Editorial Board Members

Dr. Medha Mathur

Editor-in-Chief

Professor, Department of Community Medicine, Geetanjali Medical College and Hospital, Udaipur, Rajasthan, India
Email: drmedhamathur@geetanjaliuniversity.com, chiefeditorblog@iapsm.org
Contact No: 9983997544

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Editor

Assistant Professor, Department of Community Medicine, GMERS Medical College, Gotri, Vadodara, Gujarat, India
Email: paragchavda@gmail.com, editorblog@iapsm.org
Contact: 9429111940

Dr. Mohit N. Makwana

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Email: mohit.makwana@gcriindia.org, managingeditor@iapsm.org
Contact No.: 9998084054

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Contact no. 9993106699

Dr. Mudita Joshi

Manuscript Editor

Project Coordinator, Aarambh Initiative for Early Childhood Development (UNICEF supported), Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Maharashtra, India
E-Mail: mudita.ecd@gmail.com, manuscripteditor@iapsm.org
Contact No.: 9823832505

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Foreword

It gives me immense pleasure to introduce the IAPSM Blog Compendium, a collection of insightful reflections, analyses, and perspectives on public health. This initiative is a dynamic platform for engaging public health professionals, academicians, and students in thought-provoking discussions shaping our discipline.

The ability to translate knowledge into action is at the heart of public health, and these blogs provide a medium for professionals to share their experiences, innovations, and critical viewpoints. I commend the contributors for their dedication and the editorial team for their efforts in curating this resource.

IAPSM remains committed to fostering knowledge exchange and intellectual growth in public health, and this blog compendium is a testament to that commitment. I encourage all readers to actively engage with these writings, gain new insights, and contribute to the evolving discourse in our field.

Dr. Annarao Kulkarni

President, IAPSM

Foreword

Public health is a continuously evolving field that demands innovative thinking and reflective discussions. The IAPSM Blog Compendium is a significant step in this direction, providing a vibrant space where experiences, challenges, and solutions are articulated in an accessible and engaging manner.

This initiative not only highlights key public health concerns but also encourages young professionals and experts to express their ideas beyond academic journals. It is heartening to see such a platform taking shape, and IAPSM remains committed to supporting intellectual endeavours that strengthen public health dialogue.

I extend my best wishes to the contributors and the editorial team for their dedication to this initiative. May this compendium inspire, inform, and ignite conversations that drive positive change.

Dr. Ashok Bhardwaj

President-Elect, IAPSM

Foreword

The IAPSM Blog Compendium is an encouraging initiative that bridges the gap between technical knowledge and its practical implications in public health. In an era where digital engagement is essential, this platform offers a unique opportunity for professionals, researchers, and students to share their perspectives, voice concerns, and celebrate successes in the field of public health.

IAPSM has always been at the forefront of capacity building and knowledge dissemination. This blog compendium reflects our commitment to fostering meaningful discussions and collaborations that enhance public health outcomes.

I congratulate the contributors and the editorial team of blog compendium for bringing this initiative to fruition and encourage our members to actively participate in this enriching discourse.

Dr. Purushottam Giri

Secretary General, IAPSM

Foreword

The field of public health thrives on continuous dialogue, reflection, and shared experiences. The IAPSM Blog Compendium is a testament to this spirit—bringing together diverse perspectives, critical analyses, and lived experiences from professionals dedicated to strengthening public health in India and beyond.

When we first envisioned this initiative, the goal was to create a space where voices from the field could be heard beyond academic publications. Blogs allow for timely discussions, innovative ideas, and a bridge between evidence and practice. Seeing this vision take shape is heartening, fostering an engaging platform that encourages learning, debate, and collaboration.

I congratulate the contributors and the editorial team for their dedication to making this a reality. May this compendium continue to grow and serve as an inspiring resource for all public health enthusiasts.

Dr. A. M. Kadri

Immediate Past President, IAPSM

Message from Editorial Team

IAPSM Blog & Blogologue: A Growing Platform for Public Health Conversations

The IAPSM Blog was initiated a year ago with a vision—to create a dedicated space for knowledge sharing, discussions, and reflections on public health. Like any new initiative, it faced initial challenges, but with collective effort and enthusiasm, it has grown into a platform valued by many.

To further amplify its reach and impact, we are proud to introduce Blogalogue—a curated collection of insightful blogs, bring together diverse perspectives from our community. This first volume of Blogalogue marks the beginning of a regular series, ensuring that key ideas, experiences, and discussions find a wider audience.

As we move forward, we invite YOU to be a part of this journey—by contributing, engaging, and shaping conversations that matter. Let's continue to make Blogalogue a powerful voice in public health.

Stay engaged, stay inspired, and keep blogging!

Regards,

Dr. Medha Mathur

Editor-In-Chief

IAPSM Blogs & Blogologue

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BY DR PRADEEP KUMAR - 30TH SEPTEMBER 2023

Empathy: A superior alternative to being judgemental

It was Bird Flu outbreak (2005) in Uchchal block of Tapi district (That time it was part of Surat district). Uchchal has been a remote and most backward tribal block of Gujarat, bordering Navapur – another backward block of Nandurbar district of neighboring state of Maharashtra. Situated 100 kilometers from Surat (District HQ), Uchchal offered nothing beyond a guest house with just 2 to 3 rooms, maintained by the Zila Panchayat. To access basic facilities such as a market or hotel or restaurant, or any other minor need, people had to cross the border to go to Navapur (with slightly better bouquet of civic services). Let me add here that this is the same place in India where a railway station has two platforms leading up to two different states.

So, when a human death was reported in Navapur due to suspected bird flu, we on this side of border, were also put on high alert. I was deputed on the site along with the CDHO, RDD and many other health personnel, to assess and manage the outbreak. Considering the distance involved in travelling to and fro and coupled with the instructions from "higher ups", we decided to stay amidst the pitiful conditions.

The usual protocol for Bird Flu management commenced including culling of birds, monitoring of suspected bird flu cases, restricting movement, chemoprophylaxis to health staff and upgradation of health facilities. The decision was to cull all the birds in five big and innumerable backyard hatcheries, that too in the shortest possible time. Professional cullers were brought in. They wore Personal Prophylactic Equipment (PPE) which is a daunting task especially in the hot seasons. The corresponding challenge was to ensure the collection and safe disposal of the used PPEs.

BY DR PRADEEP KUMAR - 30TH SEPTEMBER 2023

It so happened, that on a particular day, a correspondent from a national newspaper came to the 'site', in a two-way hired taxi. On the way, he spotted few children on the streets, playing with a discarded PPE. He took a few photographs, called the "higher ups" in Gandhinagar (State HQ) and demanded for an explanation. Soon, I received a call from Gandhinagar with the caller exhibiting displeasure on the reported incident and asked "to handle it myself".

It was indeed a gaffe and we were clueless about how to explain it all! The correspondent was insistent and questioned, "How can you people be so careless to endanger the lives of the people, that too of children!"

He went on to add that he is in hurry to file this story at the earliest so that he can meet the date line for next day's newspaper. With this last statement I lost my patience and thundered on to him with a stretched monologue which went on something like this:

"Dear friend, do you know that I am a teacher in a medical college and have no business to be here. But along with the others, I am staying here since the entire week, this primitive facility and we are doing our best. In these seven days, I have been to Surat only once to take a bath – which is a luxury statement in current situation, wore fresh clothes, had a hot home-made meal, took a good sound sleep and returned the very next day".

I pointed towards another person sitting next to me and continued, "Do you know who is this middle-aged lean and thin person, looking like a haggard beggar? He is the CDHO –In-charge of all the health activities of this district. Do you see the tee shirt he is wearing? I brought it from my home for him as he chose not to go back to Surat and he has been holding fort since the past seven days".

In between, the RDD joined us. I prodded the journalist further, *"Do you know who this fellow is? He is the RDD – In-charge of 5 to 6 districts of South Gujarat. He is also stationed here for the last 3 days. We all are too exhausted after the hectic and fast paced activities and thanks to your call to Gandhinagar, we were commanded to look into this matter, with immediate effect. At the fall of dusk with the daylight dimming, the RDD immediately went to investigate the matter and has just returned. Our faces have altered beyond recognition because of these harsh working conditions.*

No one from media visited us till date to enquire how are we managing our work here under such conditions? Most of persons file their reports based on the information gathered from Surat or Gandhinagar. Yes, you are the first one to take the pain to travel and visit us. But you too did not bother to seek! You chose to accuse us of negligence and charged us with endangering lives. I know it is a serious matter and promise to do everything to ensure that there are no further lapses.Please remember that hundreds of cullers are using PPE and, they wear it out of compulsion. We collect discarded PPEs and dispose them off safely. Somehow this one must have been left out due to some glitch and reached to the kids in the street. Thank you for drawing attention on this matter. But where is the empathy? Where is the collaboration? You could have then and there barred the children from playing with the PPEs and informed us immediately".

At this juncture, I ran out of breath. The journalist left the camp office with minimum verbal exchange thereafter. We were very skeptical about the media coverage and started thinking of a possible reply to the "higher ups". Next day and for that matter, on any other day thereafter, nothing about this appeared in any of the newspapers.

Acknowledgement:
Sincere thanks are due to Ms. Sudeshna my colleague at GSACS for improving the language of this and my earlier blog and making them readable.

Palliative care – The key global mandate for Universal Health coverage

BY DR RENU BEDI - JUNE 22, 2023

Palliative care is an approach that improves the quality of life of patients with life-threatening illnesses, and their families through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical psycho social and spiritual. It is a vital and integral part of all clinical practice, whatever the illness or its stage.

Although the concept of Palliative Care is not new, it has recently become quite popular. Care of the dying has been a constant feature of human society throughout the history. We have ancient traditions in India of looking after and providing special care and attention for the dying. The words hospitality, hotel, hospice, hostel, and hospital are all derived from the same Latin root 'hospes' meaning guest. The earliest institutions who cared for the ill people, primarily pilgrims during their pilgrimage were called hospices and were managed by religious groups. These pilgrims either recovered and continued traveling or died in these set ups. Modern palliative care appreciates the work of Dame Cicely Saunders, a prominent Anglican nurse, from London, who is known for the birth of hospice movement and emphasizing the importance of palliative care in modern medicine. In India, the first hospice was established in Pondicherry in 1876 and named after Count Debassyns De Richemont, the then Senator of India who had made a generous contribution of 10000 French francs to build it.

Palliative care starts as early as possible after the diagnosis of a life limiting illness. At the time of diagnosis, the disease is in an acute stage. For those who have access to medical care, that disease then becomes chronic, while disease modifying therapy is proceeding, changing the disease process into a chronic illness. The focus of care changes over time as the disease progresses.

The patient may be relatively well while therapy is underway. However, a point comes when the disease becomes more advanced and life threatening. In more developed countries, hospice palliative care is available at the end of life to relieve suffering and improve quality of life. Advanced end of life care is instituted until the patient's death, which is followed by the bereavement care.

In India, where hospices are very few, options for high quality end of life care remains limited. However, well run palliative home care services with clear communication and strong family support can go a long way in helping with troublesome symptoms and family concerns. The family support is mandatory as people with life limiting illnesses prefer to die at home where their wishes can be recorded and followed.

Palliative care should be a part of the care given to everyone with life limiting illnesses; it does not replace other forms of care and can be integrated into existing health programmes. Hospital palliative care and community or home based palliative care are models of palliative care. Supportive care helps patients and their families to cope with their disease and treatment from pre- diagnosis, through the process of diagnosis and treatment, to cure, the state of being ill or death and into bereavement. Hospice and hospice care refers to a philosophy of care rather than a specific building or service. It provides palliative or comfort care without concentrating on aggressive diseases reduction. End of Life care is an important part of palliative care and usually refers to the management of patients during their last few days, weeks or months of life from a point at which it becomes clear that the patient is in a progressive state of decline. Rehabilitation in the palliative care settings aims to help patients gain opportunity, control, independence and dignity. It responds quickly to help people adapt to their illness.

To achieve universal health, health for all, is the pivot for the evolving needs of the nation and the world. An estimated 34 million people need palliative care in the country and less than one percent have access to it. The need for palliative care in a developing country like India is huge, where cure of life limiting illness is often impossible, because of late presentation and limited treatment. Universal Health Coverage will be achieved if palliative care is one of the institutional goals for the Indian Medical Graduate.

Palliative care – The key global mandate for Universal Health coverage

BY DR RENU BEDI - JUNE 22, 2023

In the recent guidelines of national medical commission for under graduate medical education regulations 2023 the essential institutional goal for Indian medical graduate is to achieve competency to practice preventive, promotive, curative, palliative and rehabilitative medicine in respect to the commonly encountered health problems. The competency based training program of the Indian medical graduate is to train a learner into a clinician who understands and provides preventive, promotive, curative, palliative, rehabilitative and holistic care with compassion.

The contribution of the Curriculum for Indian Medical Graduate towards Universal Health Coverage is by building competent learners in providing palliative care. The Indian medical graduate is a lifelong learner, leader and member of the health care team and system. He should be able to recognise life limiting illnesses and work effectively on the principles of comprehensive health including palliative and rehabilitative care.

Power of an Administrator or Bureaucrat

BY DR PRADEEP KUMAR - DECEMBER 21, 2023

To those who are uninitiated, Public Health Administration in India includes (1) Political Leadership comprising of elected members of the Parliament/ state assemblies, Ministers etc. (2) Bureaucrats mostly members of the Indian Administrative Services and (3) Technocrats including the medical personnel. While the technocrats are actually the doers, the first two are usually a non-technical cadre to identify the strategies and guide/ monitor actions the. For the success of any multi sectoral intervention, involvement of the bureaucrats is crucial. A mere nod from them or issuance of a simple circular can do wonders. I am sharing one such experience over here.

During NACP Phase III (2007 – 11), I was working as the Additional Project Director (APD) at Gujarat State AIDS Control Society (Gujarat SACS). Incidentally Dr. AM Kadri, National President IAPSM (2023 – 24) was my colleague over there. Thanks to the support from the rung of political leadership and my superiors, working was smooth and satisfying (except that, the governments at the national and state level were headed by political opponents requiring some fine balancing).

The Red Ribbon Express (RRE), a specially designed train with seven bogies was launched by the Govt. of India (flagged off by Mrs. Sonia Gandhi, Chairperson UPA in New Delhi) on 1 Dec 2007. RRE was put on a circular country wide tour of 27000 kilometers with 180 halts. It's the world's largest mass mobilization drive to break the silence surrounding the HIV/AIDS by taking messages on prevention, treatment, care and support to people living with HIV/ AIDS across the country. After covering the entire country, it entered Gujarat at Valsad. After a journey of 1900 kilometers, covering 15 halts in 14 districts in 34 days in Gujarat, it was scheduled to leave the state via Mehsana to proceed towards Rajasthan; and finally, to terminate at Delhi on 1 Dec 2008.

The success of RRE in terms of IEC activities done, people trained, footfalls to RRE etc. was being monitored on daily basis by NACO and Gujarat SACS. Thanks to the efforts of everyone, we set a record of highest footfalls in a single day in Botad town in Bhavnagar (now a separate district). Just for the record, Botad retained this record during RRE 2.0, again in 2009 – 10.

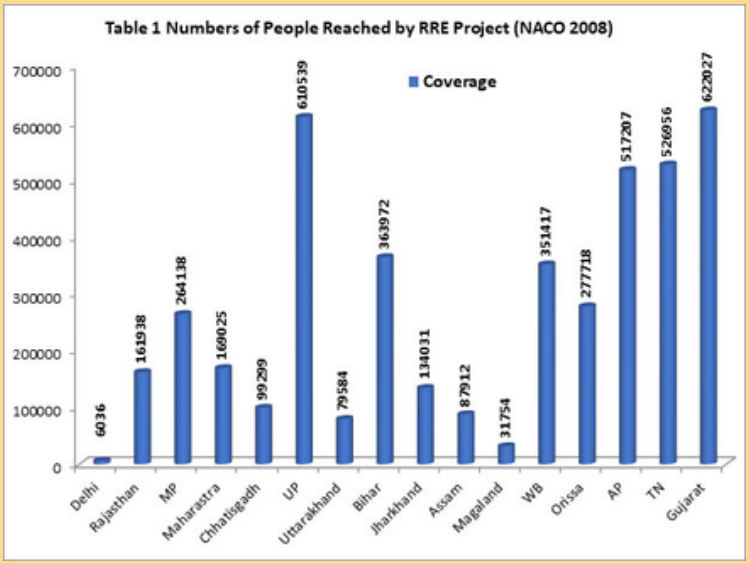
One evening, precisely on 13 Oct 2008, at around 5 pm, Mr. Hardik, Asst. Director IEC entered my office and said that tomorrow (14 Oct 2008), this train is in Mehsana before leaving for Rajasthan. In terms of foot falls we are lagging behind Uttar Pradesh (UP) by just few thousands. It was not unexpected for UP, to create a record, just by its sheer size and population. He further added that if somehow, we can manage an attendance of 4,000 or more to RRE at Mehsana railway station, we will be number one in the country. Next state Rajasthan was not expected to generate any higher and challenging figure because of shorter duration of stay of train and also the functioning of Rajasthan SACS was not ranked very high (by us!).

I immediately tried to contact Dr. Amarjit Singh, IAS, our Project Director (PD) to talk with Collector Mehsana another enthusiastic comparatively fresh IAS. I presumed that when done to an IAS by another senior IAS, communication is more effective. Unfortunately, I could not contact my PD that evening as he was busy with a meeting and was not to pick up the mobile. By then it was past 6 pm. So, bidding good bye to the protocols and my assumption, I decided to call Mr. Ajat Bhadoo, IAS, the collector of Mehsana by taking his number from the Commissionerate. I never had a chance to meet him earlier and had only heard his name. The call got connected in 2nd or 3rd attempt. I explained to him everything in detail with my excitement about Gujarat SACS, HIV and the RRE (needless to state, many things were already known to him). He gave me a decent hearing for about 3 – 4 minutes and asked, “Doctor Sahib, what do you want from me?” I said, “Sir, I want a footfall of 4000 or more at the Mehsana railway station tomorrow, so that our state can be number one in the entire country in terms of visitors to RRE”. He just said, “OK, let me see that what can be done” and disconnected the call. Now it was past 6.30 pm, so officially, all offices and institutions in the district were closed. There was no time to draft and share a circular to schools, colleges or other institutions etc.

I do not know what was done, but next day on 14 Oct 2008, we had a total foot fall of 11708 at Mehsana railway station alone making us number 1 in the country (table 1).

End notes

Many a times, a prevailing "technocratic divide" is experienced. But this and many more incidents exemplify the massive reach and impact of bureaucrats and the limitations faced by Technocrats with respect to actual implementation of the program at the grassroots especially when it involves multiple sectors (outside health). Also, to cause mainstream engagement, it's important that we promote a paradigm shift from an "ego-system awareness" to "eco-system awareness" in this world of collaboration and co-creation. If this need is ignored, we will lock ourselves into re-enacting the same old patterns time and again and the results will also be the same (read mediocre). So, during the launch or implementation of any health program, this is a shout out for all my technocrat friends that always take the bureaucrats (also the political leadership) in confidence to reap the maximum gains.



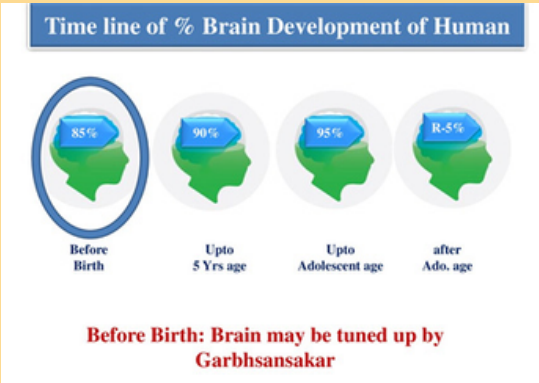
Garbhsanskar: Scientific edit of foetus towards better generation

BY DR. KUSUM GAUR - OCTOBER 30, 2024

Introduction:
Every couple heartily desires to have a very healthy, good-looking, intelligent, cultured, happy and achiever child. For this, usually couple consider that it's all luck, one cannot do anything in it, and if one can do something to develop the desired quality in child that can be done in adolescent period when the child can understand the commands. But there are scientific evidences that 95% of brain develops before adolescent period and that from that 85% of brain develop during mother's womb(1). So educating the foetus will give very fast and very fruitful results as at that time brain is developing at fastest rate so that can be moulded in desired directions. There are many scientific evidences2-7 which reported that child's mental, emotional and spiritual along with physical development begins inside mother's womb and a foetus can hear, understand and respond to mother's activity during pregnancy. Scientists(2-5,6) also reported that baby's senses can be stimulated from outside and thoughts, feelings, and behaviours of surrounded persons especially of mothers also influences foetus. In ancient literature also Acharya Charaka stated that the foetus' mind is connected with the parents' mind, especially with the mother during pregnancy.(5,6) And from ancient ages Garbhoupnishad is available as documentary proof and Garbhini-Paricharya i.e. Garbhsanskar is accepted as one of sixteen sanskars in Indian culture. This Garbhsanskar is educating the foetus in mother's womb in i.e. scientific edit of foetus.(6)

It can be concluded from various studies(1-7) that foetal development is highly adaptive and evolving process which can be given the desired direction by customized Garbhsanskar.
Thus to get desired version of future generation 'Garbhsanskar' should be promoted after having ample evidences. Garbhsanskar also reduces bad pregnancy outcomes thus favouring the mother and child health.(7)

BY DR. KUSUM GAUR - OCTOBER 30, 2024



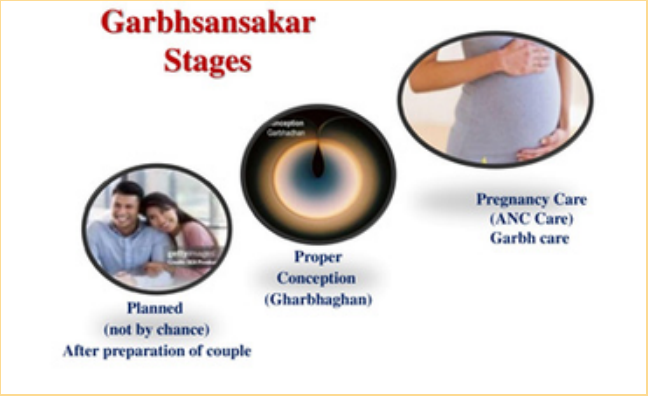
Strategy of Garbhsanskar: There are five fundamental questions regarding strategy of Garbhsanskar, questions and possible answers these questions are as follows:

1. What is the target population for Garbhsanskar ?

Target population of Garbhsanskar is mainly the pregnant women, where the Garbhsanskar care is given throughout pregnancy. But as preparation of couple before conception is also needed to have right conception, thus its target population is not only the pregnant women but all married couples along with whole community should receive respective appropriate Garbhsanskar care.

2. What may be appropriate time for Garbhsanskar?

Appropriate care of Garbhsanskar is beneficial though out life to have life style change but literature reported that atleast before three months of conception it should be started.(6) But it is never late to start with the Garbhsanskar care to pregnant women.



3. What are various tools for conducting Garbhsanskar?
Tools, with which the Garbhsanskar is conducted, may be in the form of IEC materials, modules, audio-visual CDs and YouTube audio-videos to educate target population. To keep a close watch on Garbhsanskar conduction either a checklist or mobile App may be used.

4. What are various methods used for conducting Garbhsanskar?
Methods adopted for conducting Garbhsanskar may be health education camps, counselling, teaching, trainings and personal examination. Personal examination may include physical examinations and investigations.
5. What are various types of care done in Garbhsanskar?

Garbhsanskar care is given of two types:
A. General Garbhsanskar care: This type of care is given for overall development of child to have better physical, mental, social and spiritual health.

1. Garbhsanskar care for physical health: This care include proper & balance nutrition, appropriate physical exercises, proper personal & environmental hygiene, regular ANC checkups, risk factors identifications & their timely corrections and specific protections with TT vaccination, IFA tablets etc.
2. Garbhsanskar care for mental health: This care include proper sleep & yogasana exercises, reading good literature, doing some light mental exercises like solving puzzeles and being in cheerful happy mood (no worries-no stress), which will help in proper development of mental health.
3. Garbhsanskar care for social health: Social health is usually controlled by emotional health. For emotional health care safety and support from spouse, family and community is very important. Thus counselling & IEC of couple and community is needed for that. Every effort should be done to keep pregnant women happy. Another important thing is maternal foetal attachment behaviour should be promoted for better results.
4. Garbhsanskar care for spiritual health: This care include promoting virtuous life. Worshiping, chanting, meditating and listening soothing music also helps in proper spiritual health by which one can cope easily in adversities. All efforts are done to be at peace.

B. Customized Garbhsanskar care: This type of care should be given along with general Garbhsanskar care to them who want an achiever child in a desired dimension, like either genius or devotee or player or musician or singer etc. This type of care is customized and is given to cultivate that desired quality in that particular child.

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Nutrition for Lifelong Health: A Scientific Guide to Preventive Wellness

BY DR ANNARAO KULKARNI - NOVEMBER 6, 2024

Introduction

The field of preventive medicine is increasingly acknowledging the central role of nutrition in maintaining health and averting chronic diseases. A diet rich in essential nutrients not only supports physical and cognitive well-being but also confers resilience against age-related pathologies. This article delves into the scientific foundations of optimal nutrition and its capacity to sustain health across different life stages, enhanced by evidence-based insights.

1. The Fundamental Pillars of a Nutrient-Rich Diet

Whole Foods versus Processed Foods

Scientific literature unequivocally supports the benefits of a diet rooted in whole foods—namely fruits, vegetables, lean proteins, and whole grains. These foods, rich in vitamins, minerals, and phytochemicals, mitigate risks associated with cardiovascular diseases, diabetes, and various cancers. The low glycemic index and high fiber content of whole foods facilitate glucose regulation and improve lipid profiles, as evidenced by longitudinal studies on dietary patterns and chronic disease outcomes.

Macronutrient Essentials

Macronutrients play critical roles in metabolic and physiological health:

Carbohydrates: Integral for cerebral function and primary energy needs, with complex carbohydrates (e.g., whole grains) shown to enhance glycemic control and sustain cognitive performance. But, regular excess intake of carbohydrates particularly refined Carbohydrates is one of the major root cause for Insulin Resistance and Obesity.

Proteins: Essential for cellular repair, immune support, and enzymatic functions, with studies indicating that lean proteins (fish, legumes) contribute positively to metabolic health and longevity.

Fats: Healthy fats, particularly monounsaturated and polyunsaturated fats, promote cardiovascular and neurological health, with omega-3 fatty acids from fatty fish being particularly impactful.

Micronutrient Impact

Micronutrients, though required in trace amounts, are indispensable for numerous biochemical pathways. For example, vitamin D is essential for bone health and immunomodulation, while iron supports erythropoiesis and oxygen transport. A deficit in any critical micronutrient can precipitate substantial health issues, from immune dysfunction to compromised cognitive faculties.

2. Nutritional Considerations Across the Lifespan

Early Childhood

Adequate nutrition in childhood is critical, as it lays the foundation for lifelong health. Effective milk transfer through effective breastfeeding in the first 6 months of life is the first foundational pillar towards lifelong health. Diets rich in proteins, calcium, and vitamins support physical growth and cognitive development, with deficiencies linked to stunted growth and reduced immune response.

Adolescence

The rapid physiological changes of adolescence heighten nutritional demands. Iron, for instance, is essential to offset blood loss during menstruation in females, while calcium supports the peak bone mass accrual vital for future skeletal health.

Adulthood

In adulthood, balanced macronutrient intake and micronutrient sufficiency are crucial for metabolic stability, cellular maintenance, and mental acuity. Diets rich in complex carbohydrates, lean proteins, and healthy fats help prevent the onset of metabolic syndrome and age-related cognitive decline.

Older Age

Nutrition in older adults takes on an even greater significance. Declines in gastrointestinal absorption and appetite necessitate nutrient-dense food choices, particularly for micronutrients like calcium, magnesium, and vitamin B12, which are critical for bone density, cognitive health, and metabolic function.

3. The Role of Antioxidants and Anti-Inflammatory Agents

Antioxidants

Oxidative stress, induced by free radicals, is implicated in numerous age-related diseases, including cancer, cardiovascular diseases, and neurodegenerative conditions. Antioxidants like polyphenols found in berries, nuts, and leafy greens help neutralize free radicals, thereby reducing oxidative damage.

Anti-Inflammatory Nutrients

Chronic inflammation underpins many non-communicable diseases. Nutrients with anti-inflammatory properties—such as omega-3 fatty acids, curcumin from turmeric, and catechins in green tea—have been shown to modulate inflammatory pathways, thus contributing to cardiovascular and cognitive health.

4. Hydration: The Often Overlooked Essential

Water is indispensable for virtually all physiological processes, from cellular function to neural activity. Chronic dehydration can exacerbate joint issues, cognitive deficits, and renal complications. Studies recommend an average daily water intake that aligns with individual factors like age, climate, and activity level.

5. Gut Microbiota: The Nexus of Nutrition and Immunity

The Gut Microbiome and Health

The gut microbiome influences immune function, mental health, and metabolic stability. A balanced gut flora, supported by a diet rich in fiber, probiotics, and prebiotics, is linked to reduced risks of obesity, diabetes, and mood disorders. Dysbiosis, or microbial imbalance, is associated with inflammatory conditions and metabolic diseases.

Probiotics and Prebiotics

Probiotics (found in fermented foods like yogurt and kefir) introduce beneficial bacteria, while prebiotics (in foods like bananas, garlic, and onions) provide sustenance for these microbes. Together, they enhance gut health, aid digestion, and fortify immunity.

6. Practical Approaches to Sustainable Nutritional Habits

Mindful Eating

Mindful eating, or the conscious savoring of food, has been shown to enhance satiety and improve digestion. This practice, linked to better self-regulation in food choices, can help prevent overeating and promote long-term health.

Structured Meal Planning

Consistency is paramount in nutritional success. Studies indicate that meal planning helps individuals sustain a balanced diet, reducing the frequency of fast-food consumption and processed snacks. Preparing nutrient-rich meals in advance fosters dietary adherence, particularly for individuals with demanding schedules.

Conclusion

In the context of preventive medicine, nutrition is a cornerstone of health promotion and disease prevention. A diet emphasizing whole foods, balanced macronutrients, essential micronutrients, and gut health can dramatically improve quality of life and resilience against illness. By adopting these evidence-based nutritional strategies, individuals can cultivate a lifestyle that supports health, vitality, and longevity.

Hippocratic Oath: the dilemma of medical ethics

BY DR PRADEEP KUMAR - NOVEMBER 12, 2024

All medical graduates are familiar with the Hippocratic oath. On joining the medical college, every student reads it. With the new dispensation, it is being replaced by Sushrut Pledge in some places. Out of various versions of the Hippocratic Oath in circulation, few have a component stating, "As a physician, I will respect my teachers and will provide the treatment free of cost to my colleagues and their family members". I remember and apply this part very well as I am a teacher in a non-practicing branch so I hardly have to waive any charges to any other doctor whereas I do not have to pay while visiting the private hospitals/ labs. Of late this complete waiver has been replaced by discounted charges for lab investigations and indoor admissions (provided one is not invoking the benefit of medical insurance). However, to date, I have largely not paid consulting charges to any doctor because mostly I go to those who are well-known to me or have been my students. At times I can read the confusion on the faces of the consultants (whether to charge or not) but before they make up their mind to charge me, I get up and leave the chamber quickly saying "Thanks a lot".

It was some 20 years ago when I was in Surat working as an Associate Professor. I was prescribed a few of the lab investigations. As usual, I went to a reputed lab in Surat owned by a doctor who had been my UG student. As expected, I was not to pay him the charges and manage with "Thank you". For a few of the tests, I am to come early morning with overnight fasting. So, the pathologist introduced me to a lab technician (LT), saying "Sir will come tomorrow morning. Collect the blood sample at that time and also do not collect any charges from him". The LT went away nodding.

Early morning the next day, I went with my wife to the lab to give the blood sample. There was a different technician who was not told not to charge SIR (?). So, he asked me to deposit the charges.

We both exchanged glances but having no choice, I paid the money and gave the blood sample. In my mind, I selfishly invoked medical ethics as it was a bit painful for me to pay for the tests in a lab run by one of my students. I was also hoping that in a couple of days when lab people will reconcile the accounts, the money would probably be refunded. Around 3 pm on the same day, I heard some commotion in front of my office and found the owner of the same lab coming to my chamber holding the reports in one hand and literally pulling the ear of the poor technician (who forgot to tell the other technician not to charge sir) with other hand. He was showering several expletives on this poor fellow (original residents of Surat are infamous for using such words with great ease in any gathering). Anyway, my payment was refunded on the spot with profuse apologies and that technician was also made to apologize. I promptly accepted their apologies and pocketed the money. I was touched by the gesture of the owner of the lab that being such a busy person he decided to come to my office not only to hand over me the reports and return the money but to say sorry as well.

That day I thanked the medical ethics and also felt a genuine pride in my profession of teaching.

Acknowledgement:
I'd like to thank Ms Sudehsna, my ex-colleague at Gujarat State AIDS Control Society (GSACS), for editing the text and making it readable.

Adolescent - Promoting Healthy Sexuality

BY DR MANJU TOPPO - NOVEMBER 14, 2024

Adolescence is a time of major transition physically, emotionally, and socially. It is a time of risk-taking behaviour, particularly sexual risk taking, and experimentation but also vulnerability, which can have far-reaching consequences, such as unintended pregnancy or sexually transmitted infections (STIs) and all forms of sexual violence and coercion.

Those aged 15–24 years continue to be the main group affected by STIs. So Healthy Sexuality is an important part of adolescent development, and primary health care providers play a key role in helping young people develop healthy routines, behaviors, and relationships that they can carry into their adult lives. While most adolescents at this stage of life are thriving, many of them have difficulty navigating this transition, particularly understanding that risky sexual behavior taking can jeopardize their health during these formative years and can contribute to poor health outcomes.

Young people may present to general physicians with systemic symptoms of sexually transmitted infections (STIs), such as arthritis, hepatitis or rash, but may not necessarily volunteer information about sexual activity. It is important for physicians to ask directly about sexual risks and if appropriate test for STIs and pregnancy. Knowing how to take a sexual history and consent a patient for an HIV test are core medical skills that all physicians should be trained to competently perform.

Safeguarding young people is the responsibility of all healthcare professionals who come into contact with them, and young victims of abuse may present with physical symptoms such as abdominal pain or deliberate self-harm.

BY DR MANJU TOPPO - NOVEMBER 14, 2024

Openly addressing the all-too-human questions of sexual development, sexual desire, and the nature of the adolescent's developing sexual identity are critical.

Sharing factual information with and giving good moral guidance to your teenager is a vitally important part of helping your teen understand herself or himself. We must all be aware of indicators of both child sexual exploitation and HIV infection and not be afraid to ask potentially awkward questions. If we don't we may miss vital opportunities to prevent or minimise harm to young people.

Going the distance for Aaradhana

BY DR. RANJITH VISWANATH - NOVEMBER 6, 2024

Winner of Blog Writing Competition 2024

The story of Aaradhana, the tiny girl in my arms, began on one of our weekly visits to Jawadhi Malai (Jawadhu hills) during my postgraduate training at CMC Vellore. Javadhu Hills— are an extension of the Eastern Ghats reaching through the Vellore and Tiruvannamalai districts of Tamil Nadu—this remote area is a world of its own. Traveling here in the winter months was a hidden blessing; the meadows were painted with blooming wildflowers, bringing the hills to life. After an off-road journey of nearly three hours, our team faced a further six-kilometer trek on foot to reach the village of Jaarthankolai, perched atop the hills with only open fields for company.

Apart from the routine patients, we were warmly welcomed by a timid mother, who was eager for her daughter's routine vaccination at six weeks. Her happiness was so sincere that she asked me to name her daughter, a request that took me by surprise. At that moment, I happened to be listening to songs from Vettayaadu Vilayaadu (a yesteryear movie from Tamil) and "Aaradhana" (meaning admiration) the name of the heroine, sprang to my mind. It seemed to suit this bright-eyed child.

A month later, we returned to the hills. But the Public Health Nurse informed us that Aaradhana's mother hadn't come to the health camp. "Let's go to her," I suggested, though I knew this meant another long walk up the winding paths, a journey few health workers are excited to make. When we reached the village, her house was locked, and a neighbor told us they had gone to the fields. Determined, we continued our walk, though I could sense my nurse's weariness as we trudged along in search of the family.

Going the distance for Aaradhana

BY DR. RANJITH VISWANATH - NOVEMBER 6, 2024

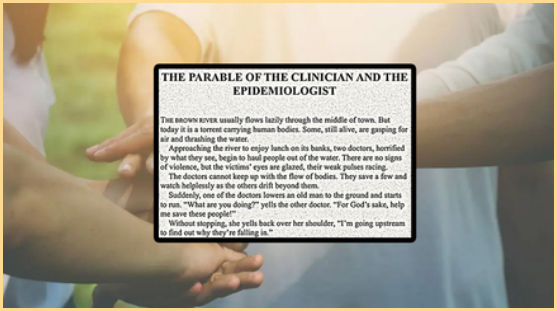
After nearly an hour, we finally found Aaradhana's mother in the fields, but here we faced a new challenge: Aaradhana's grandmother, who was firmly against the vaccine. She recounted how the last dose had given Aaradhana a fever, leaving her inconsolable through the night. While such reactions are common with the pentavalent vaccine, her concerns were understandable. But I noticed that Aaradhana's mother seemed willing, though hesitant. On a whim, I looked at Aaradhana herself and asked, "Do you want the vaccine?" To our surprise, she responded with the kind of smile that melts your heart. Laughing, I turned to the grandmother and said, "Look, even the baby is saying she's ready." At this, the grandmother could only nod in agreement.

After administering the vaccine, I carried Aaradhana back, her mother walking beside me. With a shy smile, she confided, "I named her Aaradhana because you came so far just for her. Not even my husband would do that for us." My heart swelled with warmth, and tears welled within me—I couldn't have asked for a more meaningful reward.

Some may question the effort—miles and hours for a single vaccine. But each step holds meaning. Walking these roads, we deliver more than medicine; we bring hope, building faith in health workers and our work. While traditions and elders may set the rules and many mothers may have no say, sometimes going the distance makes all the difference. It brings strength, shifts perspectives, and redefines the essence of public health.

Advocating for Community Medicine: why does it need to be more popular?

BY DR SUNANDA GUPTA , AUGUST 6, 2024



1st Runner Up of Blog Writing Competition 2024

The hardest question I faced from my MBBS batchmates and juniors when I joined the postgraduate program in Community Medicine was, why I chose this discipline—the black sheep of the healthcare family. While mostly the subject persuaders vehemently deny such charges of hatred, I always wanted to confront the issue. I often fail to explain that this discipline, disliked by majority of medical students, saves life in most unglamourous yet unimaginable ways. Given that this is a lifelong commitment, I will continuously strive to make my point.

In the pursuit of addressing this, we reviewed literature and found several published studies assessing the willingness among medical students to choose Community Medicine for specialization and reasons for not opting it. We chose to conduct a meta-analysis and reported a pooled estimate of 21% (95% CI: 14-27%). (1) The studies included were biased, since most of them were conducted by departments of Community Medicine itself. This points to a graver fact, that the real percentage is even lower. Literature reveals that reasons for dislike included perceived absence of clinical works and intellectual challenge, concerns about job opportunities and financial rewards, stress and challenges of fieldwork, insufficient exposure to practical work, lower self-esteem compared to other specialties, and most disappointing of all, inadequate guidance from seniors.

Before we start, we need to introspect on how confident the brethren itself is. Within the Community Medicine fraternity, there is a strong desire to establish a clinical identity. At the same time, this fraternity is apprehensive about the non-medical public health practitioners.(2) In spite of having the key role of integrating a community-focused perspective into healthcare, with robust epidemiological footing, and having the best scope of practising public health (with MBBS as our core competency, unlike non-medical professionals), while engaging in research, all at once, we fail to have conviction in our prospects.

BY DR SUNANDA GUPTA , AUGUST 6, 2024

The 2018 IAPSM Declaration eloquently outlines the scopes and roles. (3)

As a young enthusiast of the subject, I share its benefits with my juniors. These points are precisely why I chose this discipline. It provides diverse career opportunities, patient interactions, wide scope of research, on job travelling. Since the patient burden at primary health centres is lesser than the tertiary healthcare level (this skewedness, though needs to improve, but certainly will not be so in near future), we can go much beyond medicine and help our patient in a holistic way. We can enjoy work-life balance with fixed number of working hours (mostly true unless in crisis situations). As a specialization with few emerging sub-specializations, there is no need to pass another entrance exam for yet another course. The beauty of the subject lies in its diverse scope, encompassing academia, epidemiological and clinical research, patient care, public health practice, and social medicine. The chance of litigation is also lower than other disciplines. (4)

Few suggestions that I believe, will prove to be helpful:
We need to rebrand our subject, detaching it from the stereotypical notions of latrines and mosquitoes; and the post-pandemic world provides the perfect backdrop.
Passionate mentors should come forward, discuss (specially with medical students).
There should be more collaborative efforts with local health organizations. This will be helpful for facilitating hands-on experiences, for both undergraduate and postgraduate students.
Stalwarts from the field can share their experiences in online or offline mode to students, highlighting the success stories and lessons.
The curriculum should be frequently updated and revised, since ours is a dynamic subject. MBBS students often limit their reading to Park's textbook of Community Medicine. This should be complemented with other reading materials that feature engaging interfaces.
We should be promoting subject-centric activities like national health program evaluation, community-based researches and epidemiological investigations, during internship. Such activities will be requiring strong institutional and medical education regulatory body support.
Students' ambassador programme can be initiated with volunteers.
Digital tools and platforms can be utilized to enhance learning experiences, such as virtual field trips, case studies, interactive modules, projects, workshops, clubs and creative problem-solving.

The societal impacts can be highlighted and demonstrated with examples (at local, national and international levels), to students and interns.
Social media should play vital role in propagating positive narrative, dispelling misconceptions (and not only share Community Medicine jokes).

As someone invested in the field, I eagerly anticipate a day when Community Medicine achieves widespread acclaim. We need fervent individuals who genuinely love the subject and are committed to it, rather than as a feasible choice after entrance examination, for the sake of higher degree. With ardent mentorship, students and interns can inculcate genuine passion for Community Medicine. This not only has the potential to boost the discipline's appeal but also addresses the crucial need for widespread healthcare solutions. Public health crises rank among the most pressing global challenges. Tackling these issues can bring profound benefits to humanity and aid in achieving the Sustainable Development Goals that we all strive for.5 Community Medicine professionals are uniquely suited to address these problems and their passion and commitment are crucial for addressing such global challenges. Hence, the devout individuals are the need of the hour.

THE PARABLE OF THE CLINICIAN AND THE EPIDEMIOLOGIST

THE BROWN RIVER usually flows lazily through the middle of town. But today it is a torrent carrying human bodies. Some, still alive, are gasping for air and thrashing the water.

Approaching the river to enjoy lunch on its banks, two doctors, horrified by what they see, begin to haul people out of the water. There are no signs of violence, but the victims' eyes are glazed, their weak pulses racing.

The doctors cannot keep up with the flow of bodies. They save a few and watch helplessly as the others drift beyond them.

Suddenly, one of the doctors lowers an old man to the ground and starts to run. "What are you doing?" yells the other doctor. "For God's sake, help me save these people!"

Without stopping, she yells back over her shoulder, "I'm going upstream to find out why they're falling in."

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Beyond the concrete walls

BY DR. ANAMIKA PRASHANT - OCTOBER 31, 2024

2nd Runner Up of Blog Writing Competition 2024

The urban chawl stood looming over us, a blackened structure of weathered concrete, moss, and chipped paint. As a resident, I was leading a group of medical students on their first Family Adoption Program visit. The idea behind it is to bridge the gap between the doctor and the patient while to instill in these young minds the realities of public health as they start their journey in medicine. But as I stepped into the labyrinth of dark, cramped rooms with rodent-infested corridors, a group of young medical students following me, I realized the gap between idealism and reality was wider than I'd imagined.

The heat and humidity were suffocating inside the concrete building. Each room was barely 180 square meters of area, a microcosm of lives lived in close proximity, a tableau of resilience and adversity. We moved from one family to another, taking histories, and conducting basic examinations.

We had divided the families among the students, allotting time slots for each visit. The students were asked to gather at a common place once done, but when the time was up, two girls were missing from the lot. The senior resident asked me to go check up on them. My heart raced as I made my way through the poorly lit corridors until I eventually noticed two pairs of shoes outside an open door that appeared to be misplaced.

Stepping in, I was met with a scene that took me by surprise. The girls were seated on a murky sofa and opposite to them sat an old woman with silver hair on a broken chair. Instead of the expected medical queries, the girls were engaged in animated conversation with her.

They were admiring her hair while paying close attention to her stories, wide smiles plastered on their faces. The small room was filled with a warmth that contradicted its conditions.

BY DR. ANAMIKA PRASHANT - OCTOBER 31, 2024

I realized the true impact of this program at that point. It went beyond just screening diseases or distributing medicines. It was about human connection and acknowledging the life that lies beyond and around a patient's bed. The old woman had found friendship in those young students and maybe, that was the highlight of her day, a break from her boring routine.

As we made our way back to the bus, the students were buzzing with excitement as they exchanged stories about their families, some funny and some not. They spoke of children with big dreams who wanted to become doctors like them and the advice they gave, of elderly couples with unwavering faith and the advice they received, and of mothers who were the pillars of their households, not much different from their own. I watched as a silent observer wondering about how many of these will recollect these moments down the line.

The day had been physically exhausting but definitely, rewarding. It reaffirmed my belief that humans are social animals and nothing is more powerful than human interaction as well as the importance of empathy in the practice of medicine. As the bus made its way through the city, I thought about the lives I had just witnessed and realized that my journey as a public health doctor had just truly begun.

Addressing Vaccine Hesitancy and the Spread of Fake News

BY DR. MOHIT N. MAKWANA - OCTOBER 30, 2024

In today's fast-paced digital world, the dissemination of information—accurate or otherwise—has become almost instantaneous. While this has many benefits, it has also led to the proliferation of misinformation, particularly in the realm of public health. Among the most significant consequences of this phenomenon is vaccine hesitancy, which persists despite strong scientific consensus supporting the safety and efficacy of vaccines.

Misinformation, spread primarily through online platforms, exacerbates this problem. Thus, employing a robust, multifaceted approach to counteract misinformation and promote public confidence in vaccination is imperative.

The Emergence and Impact of Vaccine Hesitancy

Vaccine hesitancy, defined by the World Health Organization as the reluctance or refusal to vaccinate despite the availability of vaccines, has emerged as a growing global concern. The problem has been exacerbated by the pervasive spread of misinformation, particularly through social media. Claims lacking scientific basis, such as those linking vaccines to autism or other severe health complications, continue to circulate and erode public trust in vaccination programs.

In India, which faces significant challenges in immunizing its vast and diverse population, vaccine hesitancy presents a formidable obstacle to achieving comprehensive immunization coverage. The COVID-19 pandemic brought this issue to the forefront, with widespread misinformation about both the virus and the vaccines hindering efforts to control the outbreak.

Addressing Vaccine Hesitancy and the Spread of Fake News

BY DR. MOHIT N. MAKWANA - OCTOBER 30, 2024

The Role of Fake News in Misinformation Spread

The term “fake news” refers to false or misleading information presented as legitimate news. During the COVID-19 pandemic, fake news flourished, with misinformation ranging from unproven remedies to baseless claims about vaccine side effects. This phenomenon has been particularly damaging to public health campaigns aimed at increasing vaccine uptake.

A striking example of fake news related to the COVID-19 vaccines in India was the claim that vaccination could lead to infertility. Despite efforts from health authorities and experts to disprove such assertions, the misinformation persisted, particularly affecting vaccination rates among women of childbearing age. The long-term impact of such rumors extends beyond COVID-19, threatening the success of future immunization efforts as well.

Combating Misinformation: Key Strategies

1. Enhancing Public Health Communication: To effectively counter misinformation, it is essential to improve public health communication strategies. Clear, consistent, and transparent messaging from trusted health authorities is critical. Information must be disseminated in local languages and tailored to the cultural context of specific communities. Additionally, healthcare professionals must be equipped with communication skills that enable them to engage in empathetic, fact-based conversations with individuals hesitant about vaccines.
2. Using Technology to Tackle Misinformation: Social media platforms play a pivotal role in both the spread of and fight against misinformation. Companies must take responsibility for identifying and curbing the distribution of false claims. Algorithms can be employed to flag misleading content, and partnerships with fact-checking organizations can help ensure that accurate information is prioritized. Furthermore, initiatives aimed at increasing digital literacy can empower individuals to critically evaluate the information they encounter online.
3. Mobilizing Community Leaders: In many regions, particularly rural areas, community leaders wield significant influence. Engaging these individuals in public health campaigns can be an effective strategy for countering misinformation and encouraging vaccine acceptance. Religious leaders, cultural influencers, and local authorities can serve as trusted voices, capable of reinforcing the importance of vaccination and dispelling myths.

Conclusion

Vaccine hesitancy, driven in large part by misinformation, poses a significant challenge to global health efforts. Addressing this issue requires a concerted effort from public health authorities, healthcare professionals, tech companies, and communities. Strategies must be multi-dimensional, integrating enhanced communication, technological solutions, community engagement, and regulatory measures. Ultimately, combating misinformation is not merely about correcting facts; it is about rebuilding public trust in science and healthcare.

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The Curious Case of a budding Community Physician

BY DR. NEHA NITIN SHET - OCTOBER 07, 2024

When a 20-something-year-old chooses a branch called 'Community Medicine,' they envision a research scholar whose expertise lies in identifying research gaps and finding ways to fill them with quality evidence.

Sadly, the "Community" in community medicine is most times blindsided. My naivety had failed me to understand how the fairytale of randomly coming up with a research question strips away at lightning speed once you step foot in the community.

It took me some time to grasp the realities of navigating public health through the lens of fieldwork, gradually embracing the essence of a true community physician.

Looking back, perhaps these generational notions were the true barriers which affected our motivation to begin fieldwork in the first place. The prospect of stepping into densely packed urban slums, wading through things generally frowned upon as "unhygienic", to reach dwellings which housed more people than an entire cricket team (including the extras) was not an enticing one. Naturally, the mood was "Not so high, Sir!" to begin with.

Promising (cursing) to ourselves to make this trip as short as humanly possible, we commenced our journey to the moon and hopefully quickly back. Sweating, panting, half-crying, and bumping into everything along the way while uttering countless apologies, we somehow managed to reach our designated households. Despite my initial revulsion towards the community, upon entering the first house, after muttering a quick intro, I began with my survey. This was followed by (unsurprisingly) a series of rookie mistakes.

Completely forgetting that I was wearing a white apron and a stethoscope, I hurriedly began asking questions. Being courteous, without much resistance, the residents obliged and helped me. Feeling eternally grateful for their responsiveness, I went ahead and started enquiring about income, family planning methods and household expenditure.The ease with which I was asking these questions was diagonally opposite to their growing discomfort. Finally, they questioned me about the reasons for asking for such personal details, making me realize that just because I needed to complete my task, it didn't entitle me to pursue it in any manner I wished.

Determined to do better with the next household, I took my time introducing them to the concept of the survey and explaining why I needed certain information from them. However, in my effort to thoroughly justify my purpose, I inadvertently scared them, leading them to believe something was wrong, and I was promptly and unceremoniously shut out of their house.

Reflecting on both experiences, two things stand out to me. First, I had assumed that because I perceived their lifestyle as unhealthy and disease-prone, I decided that they should have the same awareness and should immediately make the necessary changes for a healthier life. In short, I was short-sighted and quick to judge. Second, I completely overlooked the socio-economic and behavioural nuances of health. To me, they had to do everything in their power to stay healthy because that was the aspect of their life I had focused on. This was directly reflected in my lack of effort in communication.

As doctors, we seldom perceive that without active community engagement in formulating any strategic plan to reduce disease burden, we will be treated as an encroachment upon their lives. Additionally, if health is unalloyed with behavioural and social sciences, then conducting a health survey is like running a fool's errand. When this understanding begins to sink in, one starts to perceive nuances in such activities.

For example, during my hurried survey, I noticed that in five out of the ten households I visited, there were adolescent girls between the ages of 15-18 who had dropped out of school, were helping with household chores, occasionally employed in home-based work, and essentially waiting to be married off.

BY DR. NEHA NITIN SHET - OCTOBER 07, 2024

The issue of gender bias emerges much later in this scenario, as this is often seen as a pragmatic and economic solution to make ends meet for the family.

While these girls are technically educated, do they possess knowledge regarding their health?

Do they know enough to make informed choices regarding their own sexual and reproductive health, let alone the health and nutrition of their prospective families?

Moreover, even if they know, how much of it will be effectively practised considering the cultural norms followed in their current and future families?

How and what can we do to enable them to do so?

It dawned upon me that this list will be never-ending, and there is no objective way of answering them either without systematically approaching it.

Motivation is derived from two pivotal questions: What is the use to me? And to make it sound less self-centred, what is the use to them? However, for a true researcher, motivation is fundamentally driven by curiosity, and in the case of a community physician, that curiosity is fuelled by fieldwork.
I am not saying my perspective has entirely changed, but instead of solely seeking scientific answers, I have become curious about the learning process. And that's what made the difference.

AIDS: A Looming Sinister

BY DR. RITUJA KAUSHAL - AUGUST 10, 2024

Since the epidemic of Acquired Immuno Deficiency Syndrome (AIDS) peaked in 2000, the projected adult HIV prevalence (15–49 years old) has decreased nationally. It was estimated to be 0.54% in 2000, 0.32% in 2010, and 0.22% in 2021. According to India HIV Estimates 2021, the northeast region's states—Mizoram, Nagaland, and Manipur—have the highest adult HIV prevalence, at 2.70 percent; southern states—Andhra Pradesh, Telangana, and Karnataka, at 0.47%, 0.47%, and 1.05%, respectively—have the mentioned rates.

Generally, states with low socioeconomic status, unfavourable health indicators, and inadequate health infrastructure are at risk.

The National AIDS Control Organisation, which has been a part of the Ministry of Health and Family Welfare since 1992, has implemented the National AIDS Control Programme (NACP), which consists of five phases, in an effort to contain and ultimately eradicate the AIDS epidemic in India. It has achieved great success in lowering the annual incidence of new HIV infections by two-thirds and death rate by more than half (54% approx.) in the past two decades. Otherwise about 25 years back, these rates were many times higher than now.

Additionally, from a peak of 0.54% in 2000–2001 to 0.22% in 2020, the nation's prevalence is continuously falling. Despite the low incidence overall, there is a notable geographical variation among the states, with higher averages found in Manipur, Nagaland, and Mizoram.

Andhra Pradesh, Meghalaya, Telangana, Karnataka, Delhi, Maharashtra, Puducherry, Punjab, Goa, and Tamil Nadu are some other states/union territories whose adult HIV prevalence is thought to be greater than the national average.

BY DR. RITUJA KAUSHAL - AUGUST 10, 2024

These notable inter-state differences highlight the necessity of intensifying and broadening preventative initiatives in order to reduce population risk by up to 80% by 2025.

As of right now, the HIV/AIDS epidemic in India has a significant degree of variability, which controls the dynamics of the disease's epidemiological burden and population transmission. High-risk populations including female sex workers (FSWs), men having sex with men (MSM), injectable drug users (IDUs), truck drivers, those with low socioeconomic level (SES), and migrants have been found to have a higher prevalence of HIV/AIDS. As a result, HIV risk is a function of both low awareness and unfavorable social determinants that fuel current high-risk behavior.

For younger generations, some rich parents also provide everything to their children by giving their money..... but by the time they understand the real thing, it is too late.

In recent past, due to excessive liberty in the name of constitutional rights, politics, globalization, over use of gadgets (audiovisual) of communication, mutual unhealthy competition and falling level of sensitivity, the safe structure of the society is continuously deteriorating. This all is pushing community towards high risk behaviors of indulgence.

Rates of HIV have been increasing in Madhya Pradesh (including ANCs & children of Satna district) &in certain North East sectors (IDU population of Tripura schools & colleges) etc in recent past.

In the scarcity of even basic amenities, so many temptations are there for people to get lured. Because of all these, social evils are becoming prevalent and the desire to make easy money, the habit of playing with money, etc. has given rise to playing with freedom.

Nowadays, without performing moral duties, the youth is getting carried away under the guise of human rights. Those who stay away from their parents in the name of education are continuouslydeteriorating the norms & condition of the society. Along with this they also get protection from some anti-social elements. To achieve happiness in life, almost everyone feels it is necessary to become a part of corruption and give up the values of life.

AIDS: A Looming Sinister

BY DR. RITUJA KAUSHAL - AUGUST 10, 2024

Indiscriminate exposure to plethora of content from sources across the web despite of presence of systems for evaluating the content & reporting the suitability for minors etc are leading to the tendencies of experimentation & to imitate for the sake of adventure plus fun. Trigger warnings are often overlooked by high risk individuals. Today's majority of youth, in the grip of degradation of human values along with the abuse of their intellectual rights, justifies the murder of a Value System killed by barbaric cruelty in the absence of conscience. Depriving yourself of available security is a sign of stupidity & nowadays people are doing this stupidity again & again despite of awareness. Ignoring safety rules is proving costly and that is why AIDS and STDs are increasing in certain pockets.

So far we have talked a lot about people's mistakes, let us now talk about the mistakes made by the employees deployed to guard that system. How did the matter keep getting out of hand (in certain geographical locations) despite those people being there?

What were the flaws in surveillance and monitoring services? Why the increasing figures in certain zones were not immediately paid attention to and controlled? Well, we all know that this is a very complex and difficult problem to answer. The deployment of Targeted Intervention (TI) projects is the most effective way to stop the spread of HIV. IDU monitoring, condom promotion, aggressive antenatal care testing, public-private partnerships, telemedicine initiatives, frequent reviews and data quality assessments, and integration with mother and child health programs have all contributed to the drop in HIV prevalence.

To target the elimination of HIV/AIDS authorities need to focus on the hot spots and regions having a higher incidence of HIV in India. When it comes to creating policies and programs that can accomplish the specific aims of SDG 3.3, empirical data is most evident. Every aspect of the epidemiological triad requires the application of micro-level, evidence-based strategies.

With this hope that soon every Homo Sapiens Sapiens will recognize their capabilities and try to improve themselves, I wish well for all the people affected by AIDS.

Covered in Black: Health and Life in Jharkhand's Mining Villages

BY DR. MAMTA GEHLAWAT - SEPTEMBER 21, 2024

In the rural coal mining areas of Jharkhand, India, two colours dominated the scenery: the green of the trees and the black of coal dust. During my stint as a medical officer in the Corporate Social Responsibility (CSR) wing of a Steel company, I had the opportunity to gain profound insights into this unique environment.

The People of Jharkhand's Mining Villages

The local population was a linguistic mosaic, speaking Hindi, Bihari, Oriya, Bengali, and various dialects. This diversity resulted from decades of immigration from all over India, for work in the mines.

The region was strikingly diverse, housing both Particularly Vulnerable Tribal Groups (PVTGs) and various socioeconomic classes. PVTGs engaged in traditional activities like hunting and crafting. The tribes had their own health beliefs and were once highly knowledgeable about medicinal plants. However, displacement from forest habitats may have led to unintended consequences.

While preserving their culture was the intent, they now depend on others for supplies, drifting from their moral norms due to automatic fulfillment of survival needs. They maintain poor hygiene practices, show little interest in modern education, and often marry within their tribes at a young age.

In contrast, people from a few nearby villages have grown wealthy by selling land to mining companies, creating a stark economic disparity between different groups of people in the same area.

The Changing Landscape in the Shadow of Coal

Geographically, the landscape changed frequently due to ongoing mining

activities. This cycle of displacement and reconstruction meant that many residents barely recognized their hometowns after being away for a few years. Coal dust travelled far beyond the mining sites, affecting air quality in nearby towns and cities.

Daily life in these areas was challenging. In many villages, women woke up around 2 AM to gather coal, which the men then transported to the city by bicycle—a gruelling journey—for a meagre income. Health issues were rampant, with coal dust affecting every part of the body.

Coal dust affected not only mining workers but also nearby villages up to tens of kilometres. Hints of black could be seen even in bordering towns. An outsider could clearly notice the sharp smell of coal in the air. When it rained, the rain was tinged with black. When the wind blew, it made houses even blacker. Offices avoided using fans as they spread more dust, preferring air conditioners for ventilation. Mine blastings created tremors and noise pollution. Due to the heat produced in mining, a large area felt heated like an oven with fire inside. Railway tracks bisected towns, with coal trains halting traffic every few minutes and adding to the noise pollution.

Availability of clean water was one of the biggest problems in mining areas as all water sources get contaminated sooner or later due to mining. Most of the villages depended on tanker water supply by different agencies and drank bottled water only.

Health Impacts of Coal Mining

Generally, in medical books, we read only about lung-related diseases in coal mining areas.

The health problems of people here were endless. People used to have a battery of health issues mostly related to the effect of coal dust on different parts and systems of the body like Otitis media, allergic rhinitis, bacterial skin infections (children), COPD, asthama, tuberculosis, malnutrition and chronic energy deficiency, STDs and genital infections, eczema and dermatoses.

Social Challenges in Mining Communities

The Particularly Vulnerable Tribal Groups (PVTGs) received monthly benefits from government schemes and non-governmental organizations,

providing essential supplies that alleviate their basic survival concerns. However, this support often lead many tribal members to veer away from traditional ways of life, resulting in increased instances of smoking, alcohol consumption, and even teenage gambling addiction. Issues such as teenage pregnancies, unwanted pregnancies, unmarried pregnancies and unsafe abortion were also common.

The mining areas faced a complex web of interrelated social and health issues. Prostitution and domestic abuse were prevalent, compounded by limited education and job opportunities, especially for young girls. A concerning trend was the sudden discontinuation of schooling by teenage girls, who eloped to marry, perpetuating a cycle of incomplete education and early pregnancy. These social challenges exacerbated health problems, fostering environments where addiction, gambling, and violence thrive. Moreover, there was a critical lack of basic health knowledge among residents, evidenced by the failure to seek timely medical attention for conditions like fractures, open wounds, and antenatal care. This interconnected web of issues creates a challenging environment requiring comprehensive interventions addressing both social and health domains.
Despite the various Government health programs, CSR activities and NGO work; the lack of proper health facilities and health workers remained a dire issue in the mining areas. The shortage of medical staff in these areas was stark due to the lack of incentives, isolation from urban amenities, and challenging working conditions.

Strategies for Improvement

A few strategies for improving health and social issues in mining communities will be:

- Healthcare: Mobile clinics, health education, provider training on coal-related illnesses
- Environment: Dust suppression, air/water quality monitoring, community reforestation
- Safety: Mining protocols, regular health screenings, comprehensive training
- Community: Alternative livelihoods, infrastructure improvement, local engagement
- Welfare: Psychosocial support, miner social security, gender equality initiatives
- Policy: Health-focused mining policies, responsible practices, community legal support

Conclusion: A Call for Action

Improving medical facilities and accessibility in Jharkhand's mining communities is imperative. Government bodies and healthcare organizations must prioritize the health and well-being of these vulnerable populations. Sustainable development should aim to benefit everyone, ensuring that progress does not come at the cost of community health and livelihoods.

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Is the problem with the person?

BY DR. CHAYANIKA BISWAS - NOVEMBER 06, 2024

'What are the main problems that you experience in this community?'
We were conducting a panel meeting with some people from a poor, difficult and generally disreputable slum. This included a school principal, NGO members, UPHC doctors, a women's self-help group leader and a rickshaw-driver.
'Addiction.'
'Addiction.'
'Addiction.'

If there was one thing that our diverse group agreed upon, it was that addiction was the biggest problem in their community.
'Children as small as 11-year-olds are found with tobacco. They're sent to buy addictive substances for elders, and then they also experiment and get addicted.'

One by one, all echoed the same. The womens' self-help group leader narrated stories of the domestic violence faced by women from drunk husbands. She also talked about the financial hardships faced by households where all money was spent on addiction.
'It's the worst thing ever invented. It ruins life, it ruins savings,' said the rickshaw-driver. 'It doesn't even truly reduce stress.'

Evidently most of their major health problems were either caused or exacerbated by the problem of addiction.

Medicine was one of my favourite subjects in undergrad. The first clinical case that we were taught, and given repeatedly (as it was the commonest cause for admission) was ascites. Patients with Alcoholic Liver Disease, with the abdomen swollen like a balloon, caput medusae veins prominent.

BY DR. CHAYANIKA BISWAS - NOVEMBER 06, 2024

Conversations with these patients were... bewildering. These were alcohol addicts, who came repeatedly to the hospital for ascitic taps. And even when their health had declined so much, they continued to drink. We judged them to be weak losers.

Then came internship.
While we'd been confined to academics earlier, now we ground day and night in the hospital. It was incredibly stressful compared to before and physically demanding.
That's when most started smoking. If there were any free evenings, we'd go out with seniors and party in pubs. It also seemed a symbol of freedom and rebellion against childhood rules.

Everyone said – it's just a beer, it won't do anything! We all have it – do you see any of us having problems?
But the truth was, some did start having problems. Some became chainsmokers, some spent all their stipend on drinks. Some puked and were absent the next day after an episode of binge-drinking. It was essential to deal with the stress, they said. But the problem was in the person, we believed. They were weak.

I think those words have harmed more people than any others. Not only does it discourage those who are addicted from seeking help, but it's also one of the biggest lies told.

The truth is, no one, including our patients, starts an addiction with the intention to become an addict with ALD, lung cancer or runamok. It is vital to realise this. It's always 'just the occasional stress-buster'. Still, some people of a class of hundred will end up addicted, and there's no way to tell beforehand who those are going to be.

The problem is with the substance, not the person.
Maybe this realisation came after a belief-changing webinar. Or was it the unexpected suicide of someone close to me, whose life has been ruined by alcohol? But that's another story.

The point is, more evils have been caused by addictive substances than anything else. From the rapid spread of HIV among I.D.U.s to the crimes and suicides committed under the influence of alcohol to the sinking of

families into debt following a tobacco-related cancer or even simply the expenditure on addictions that the family can't really afford, the consequences of substance use are myriad. WHO estimates that 3 million deaths every year are attributable to alcohol. Addictions cause distress for both patients and their loved ones. Every doctor has an anecdote of lives ruined by addiction. The saddest I remember is of an 11-year orphan. He'd lived with his grandfather who struggled to make ends meet. To 'alleviate stress', his grandfather used tobacco. As he did not have the time to take care of his 3-year grandson, he introduced him to tobacco as well, to keep him quiet. When they arrived at the Palliative OPD, both had advanced oral cancer.

The ill-effects of alcohol, tobacco and cannabis are undeniable and well-documented.

It's high time for us to recognise and assert that the problem lies with the substance. It is also essential to recognise these patients as part of our own community and be genuinely empathetic. Addiction can be a chronic and relapsing disease, requiring empathy and support. While the best thing is to never start, once started, it's never too late to quit. For quitting successfully, it's best to seek help as early as possible but most delay that as they're afraid of being judged even by healthcare providers. Stigma remains a barrier.

Addictive substances like wine, hookahs and bhang are an integral part of many cultures. However substance use disorders don't discriminate and can affect anybody from any culture. For healthcare providers, it's important to acknowledge this and take an approach of 'cultural humility'. DSM-5-TR suggests that healthcare providers be mindful of cultural factors while counseling for substance use disorders. We need to be mindful of our own possible biases but guide patients to quit using evidence. This is a tall order and requires training and practice. All mental health disorders are stigmatised, but some are stigmatised much more. Substance use disorders are probably the most stigmatised. They're also among the commonest mental health disorders.

How much could we achieve as a society, not just in improving the lives of so many people, but also in terms of decreasing crime rates and making society a more peaceful place to live in, once we all started acknowledging that the problem is with the substance, and not with the person!

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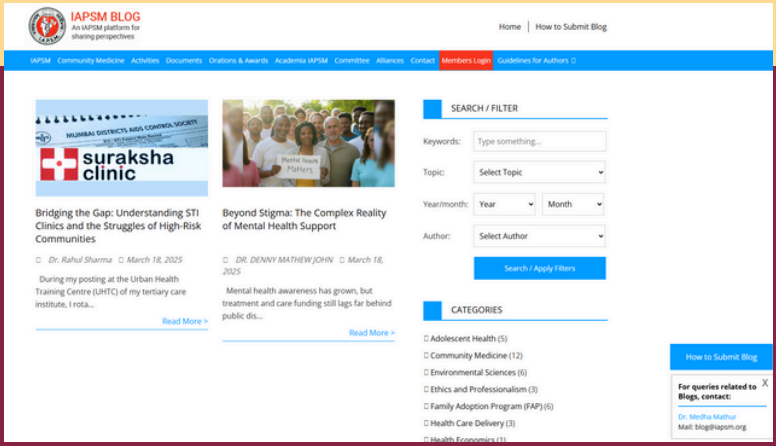

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