

**SUMMER TRAINING REPORT
PART- 1
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LIST OF ABBREVIATIONS

1. WHO- World Health Organization
2. COVID 19- Coronavirus disease
3. MOHFW- Ministry of Health and Family Welfare
4. CDC- Centre for Disease Control
5. SARS COV 2- Severe Acute Respiratory Syndrome Coronavirus
6. ICU- Intensive Care Unit
7. BMI- Body Mass Index
8. ICMR- Indian Council for Medical Research

CURRENT STATUS OF COVID-19 IN INDIA AND THE WORLD

INTRODUCTION

An outbreak of 2019 coronavirus disease (COVID-19) was reported in Wuhan City, Hubei Province, China in early December 2019, due to new serious acute respiratory syndrome coronavirus 2 (SARS-CoV-2). As an emergency of international concern, the World Health Organization declared it as a Public Health Emergency on January 30th 2020. Within a short period of time, COVID-19 quickly expanded globally and on 11 March 2020, the WHO declared it to be a pandemic. Fever, weakness and dry cough are the most prominent symptoms of COVID-19. Patients may also have aches and pains, nasal inflammation, runny nose, sore throat or diarrhoea. These symptoms are typically mild and slow to begin. Some may be sick but may not appear unwell and have no signs or symptoms. Many patients (roughly 80%) recover without extra treatment from the infection. About 1 out of six individuals diagnosed with COVID-19 become severely sick and have trouble breathing. Older people are more prone to acquire serious diseases, especially those with existing medical conditions like obesity, heart attacks or diabetes. Medical attention should be sought by people with fever, cough and difficulty breathing. Much of the COVID-19 incubation time ranges vary from 1 and 14 days, typically about 5 days. COVID-19 is an extremely contagious disease and people can catch COVID-19 from others who are infected with the virus. Tiny droplets from the nose or mouth that spread when a person with COVID-19 coughs or exhales can spread the disease from person to person. These droplets land around the human, on objects and surfaces. Others then catch COVID-19 by touching certain objects or surfaces and then rubbing their eyes, nose, or mouth. People may also catch COVID-19 if a person with COVID-19 who coughs out or exhales droplets is breathing droplets in them. That's why staying more than 1 meter (3 feet) away from a sick person is critical.[WHO, 2020][1] Currently, there is no specific medication for the virus and treatment is supportive care. Also, there is no vaccine developed yet to protect one from the virus. Treatment and vaccine for COVID-19 are under development. The countries with maximum number of COVID-19 cases are The United States, Brazil, Russia, India, United Kingdom, Peru, Chile, Spain, Italy and Iran. India is now seen by various nations as a world leader and even the World Health Organization acknowledged that the world is looking to Indian approaches to control the spread of this epidemic. On 24 March 2020, the Prime Minister of India announced a 21-day nationwide lockdown which was further extended several times and a complete ban was imposed on people from stepping out of their homes. Prime Minister Narendra Modi's government was quick to recommend residents avoid or postpone mass gatherings until the virus was contained.

The current study explores various aspects of the COVID-19 outbreak currently occurring in India and the world. The basic research questions (RQ) the analysis addresses are as follows-

1. What is the current status of COVID-19 in India and the World?
2. What is the case load, recovery rate and case-fatality rate of covid-19 in the world, specially in India?
3. What is the distribution of covid 19 according to the continents and Indian states?
4. Which type of population is most affected by covid 19?
5. What steps have been taken by India to contain the pandemic?

Literature Review

For literature review, various papers and articles published in the last six months were studied from google scholar, PubMed, National library of medicine. In the current scenario research industry is targeting the topic of COVID-19 analysis and estimation. There are several amount of papers available which have estimated the effects and explained the characteristics of COVID-19 using different approaches.

Study of the epidemiology of COVID-19, global and India update was carried out by Dr. Tanvzin. The author compared the spread of COVID-19 in China and globally. Cases and deaths in China as on March 4, 2020: Cases-80,422, Deaths- 2984, CFR%- 3.7. The conclusions made in the study were COVID-19 is a respiratory pathogen, easily transmissible from person to person, elderly and co-morbid are at high risk, cases rising outside China including India with limited local transmission, need for case management, Contact tracing and Health system strengthening (isolation wards, medical supplies). [Dr. Tanvzin, 2020] [2]

According to author Dipu Rai, of the 1,801 confirmed cases of novel coronavirus, 43 percent occur in the 20-39 age group, followed by 17 percent in the 40-49 age group, data show. Young Indians are more likely to contract the disease as about 60 percent of patients are under the age of 50 years. According to statistics, 391 confirmed cases, or 22%, are those between the ages of 30 and 39, accompanied by 376 patients (21%) in their 20s, while 17% are in their 40s. Recent research from other countries, such as China and Italy, showed that the most vulnerable group is the elderly. As of April 1, children under 10 years of age were just 3 per cent, or 46 cases. The gender-specific difference is also evident in reported cases, along with age. Statistics show that 73 percent of the 1,801 cases are male, while only 27 percent are female. In female patients, the majority cases are female between the ages of 20 and 29, with approximately 110 cases identified in this category until April 2 [Dipu Rai, 2020] [3].

Clinical features of corona virus were observed using Wei-Jie Guan analysis, Zheng-Yi Ni, et al. The study included 1099 participants, the common symptoms were fever and cough (About 43.8 percent had fever on admission and 88.7 percent of people had fever on hospitalization). Diarrhoea (3.8 per cent) was rare. Average incubation time: 4 days (with a range, from 2 to 7). Main composite outcome (admission at ICU, using the mechanical ventilation and death) in 6.1%, 5.0% in ICU, 2.3% in intrusive mechanical ventilation and 1.4% in death. Close contact with the history of wildlife: 1.9%. 72.3 percent of those not residing in Wuhan had come in contact with the citizens of Wuhan including 31.3 percent which happened to visit the city. [Guan, Zheng- Yi Ni, 2020] [4]

Lancet Journal, March 30 2020, carried out an analysis on the severity of COVID-19 which was a model-based study. As the data was constantly changing and evolving, estimates for COVID-19 case fatality ratios were made, which differ substantially in magnitude. Data was gathered on 24 deaths in the main China and on 165 recoveries outside of China, the mean period from the onset of symptoms until death was calculated to be 17.8 days (16.9–19.2) and 24.7 days (22.9–28.1) to hospital discharge. A case fatality ratio of approximately 3.67 per cent (3.56–3.80) was reported in all lab confirmed and clinically diagnosed cases from the region of mainland China (n=70 117). However, a best estimate of the case-fatality ratio in China of 1.38% (1.23–1.53) was obtained, with considerably larger ratios in elderly age groups (0.32% [0.27–0.38] in those aged less than 60 years versus 6.4% [5.7–7.2] in those aged more than 60 years), up to 13.4% (11.2–15.9) in those aged 80 years and above.

The approximate overall fatality ratio for infection in China was about 0.66 per cent (0.39–1.33), with a rise in age profile. Similarly, percentage of those who were infected and likely to be hospitalized increased with the increase in age to 18.4% (11.0–27.6) in those 80 years of age or older [Lancet, 2020][5].

Methodology

Descriptive secondary research was carried out for the report and data was collected from various secondary sources like articles, journals, official websites of the government and newspapers. Data regarding the total cases, active cases, recovery rate, fatality rate, etc. was taken from official government websites like MOHFW, covid19india.org, and for data of the world, WHO and CDC websites were referred.

The study is based on Systematic review of literature determines the status of COVID-19 in the world and India. Inclusion criteria for this review was to include studies giving information on-

- Total number of cases, active and recovered cases and number of deaths due to covid in the world.
- Case load, infection rate, recovery rate and fatality rate of covid in India and the world.
- Various steps taken by the government and health organizations in India to reduce its spread.

Also, latest articles providing relevant information regarding COVID and its impact were reviewed.

Keywords used for the search included Coronavirus, COVID-19, SARS-COV 2, fatality rate, epidemiology, caseload, lockdown.

Analysis and Discussion

Current status of COVID-19 in India and the World (as of 5th July 2020)

	Confirmed cases	Total Deaths
WORLD	11,125,245	528204
INDIA	673165	19268

Globally, as of 5th July 2020, 11125245 confirmed cases of COVID-19, with 528204 deaths have been reported. About 216 countries, areas, or territories have been affected by COVID-19 globally. [WHO,2020] [6]. According to the statistics of India, a total of 673165 COVID cases have been reported out of which 244814 are active cases, 409082 cases have been cured/discharged from hospitals and total deaths are 19268.[MOHFW,2020] [7]

Case load, Recovery rate and Case fatality rate of COVID in the World and India

The virus Sars-CoV-2 has now invaded Latin America, having rapidly spread in the USA and Europe. Brazil and Peru are among countries with largest caseloads. The coronavirus disease has spread rapidly all over the world after the outbreak was first identified in China last year in December. After China, the virus had a major effect on the US and other European countries. Iran was early affected by coronavirus disease outbreak amongst the countries. The virus reached the world in the month of February and Iran has been putting efforts to combat the epidemic ever since. Italy had been hit hardest by the outbreak of COVID-19 in Europe. See here at the countries with the largest caseload of coronavirus disease, and the current situation over there:

United States- The U.S. is the worst-hit nation where the pandemic has affected more than 2.2 million people and has reported about 1,20,000 deaths and other parts of the country are increasing with infections. The US confirmed the first case of coronavirus disease in Washington D.C. on January 20, 2020. In the US, the infection curve has risen steeply since April, although some state governors say the rate of spread of infection has slowed up. The maximum number of fatalities were found in New York.

Brazil- After United States, Latin America is the number two COVID-19 hotspot in the world. As on 29th June, it had officially reached 50,000 coronavirus deaths. The Covid-19 statistic has now risen to over one million cases in Brazil. Brazil announced the first novel case of COVID-19 on 26 February, 2020. Experts suggest the exact figures are much higher because of a lack of comprehensive research.

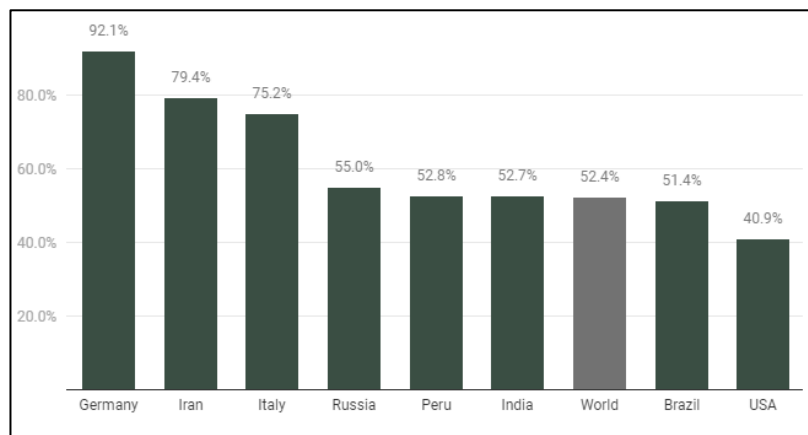
United Kingdom- Britain has one of the highest fatalities of COVID-19, but has seen a steady decrease in the number of cases recently. Since the lockdown in March, UK saw one of the lowest increases in the deaths from 42,632 to about 43,632.

Iran- Iran announced its first cases of coronavirus on 19th February 2020, and has struggled and is still fighting to contain the Middle East's most deadly outbreak since. In Iran, the total number of COVID-19 cases is 2,04,952.

Peru- The SARS-COV 2 has spread quickly in the Latin American region. Peru was one of the hardest hit countries, with nearly 2.5 lakh cases logging on the country. The disease killed nearly 8,000 people in the country Peru has taken some of the earliest and most strict steps in Latin America, but they have failed to track Covid-19's spread [Hindustan Times, 2020][8].

India reported the country's highest single-day rise in COVID case load adding 24,850 new coronavirus cases and 613 deaths on 5 July 2020. India, according to covid19india.org, overtook Russia on Sunday to become the third worst-hit country, with the number of cases at 6,90,396. Russia reported 6,80,283 cases of coronavirus disease. India is now only followed by Brazil and the United States which registered 2,841,124 cases respectively and 1,577,004 cases [The Indian Express, 2020][9].

Recovery rate of COVID-19 –



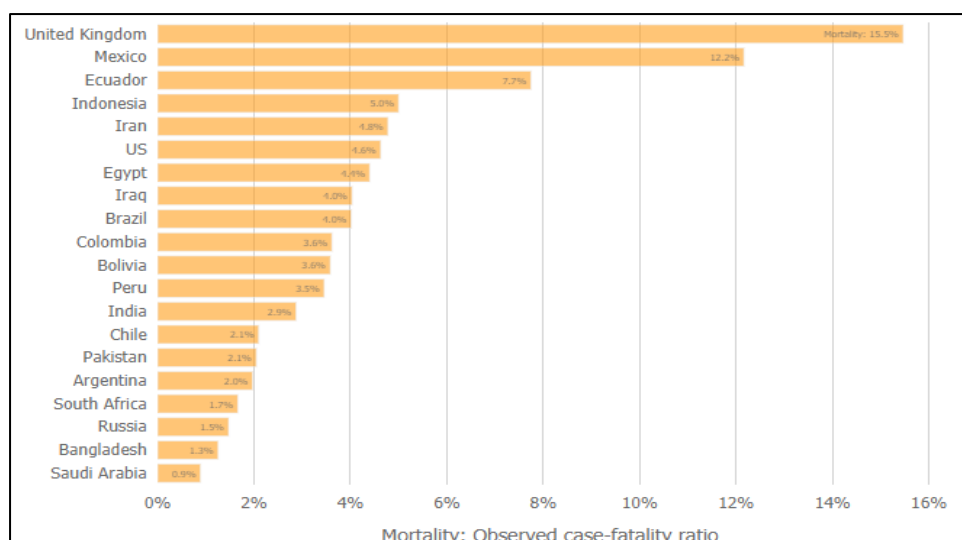
As per global reports, more than 4 million people have now recovered from the virus. Germany has the highest recovery rate among the worst-affected nations, with over 90 per cent of its cases recovered. Iran and Italy followed, were some of the early epicenters when the outbreak started. The recovery rate in the US, with the largest number of cases worldwide, is about 40 per cent. [Dubey, J. 2020][10]

The Union Ministry of Health and Family Welfare said as of July 4 , 2020, there are 1,58,793 recovered cases more than the active cases of COVID-19 in India. As a result , the rate of recovery has risen further to 60.81 per cent. A total of 14,335 COVID-19 patients were cured during the 24 hours between 3 July 2020 and 4 July 2020, bringing the cumulative figure to 3,94,226, as per the Health ministry data.[11]

Case- fatality rate

Fatality or mortality is of considerable significance for calculating COVID-19 's burden worldwide. The case-fatality rates, i.e. , the number of deaths divided by the number of reported cases, differ greatly around the world. Differences in the number of COVID deaths can occur when there is a difference in the number of people tested. Further tests will find further individuals with milder cases and would increase the case-fatality ratio. This also depends on the place's demography as mortality in older populations appears to be higher.

The bars in the chart below display the number of deaths for the twenty countries currently most affected by COVID-19 globally as per 100 confirmed cases (observed case-fatality ratio). Countries at the top of this list have the number of deaths, not necessarily the most total deaths, in comparison to their COVID-19 cases or population.[John Hopkins Coronavirus Resource Centre, 2020][12]

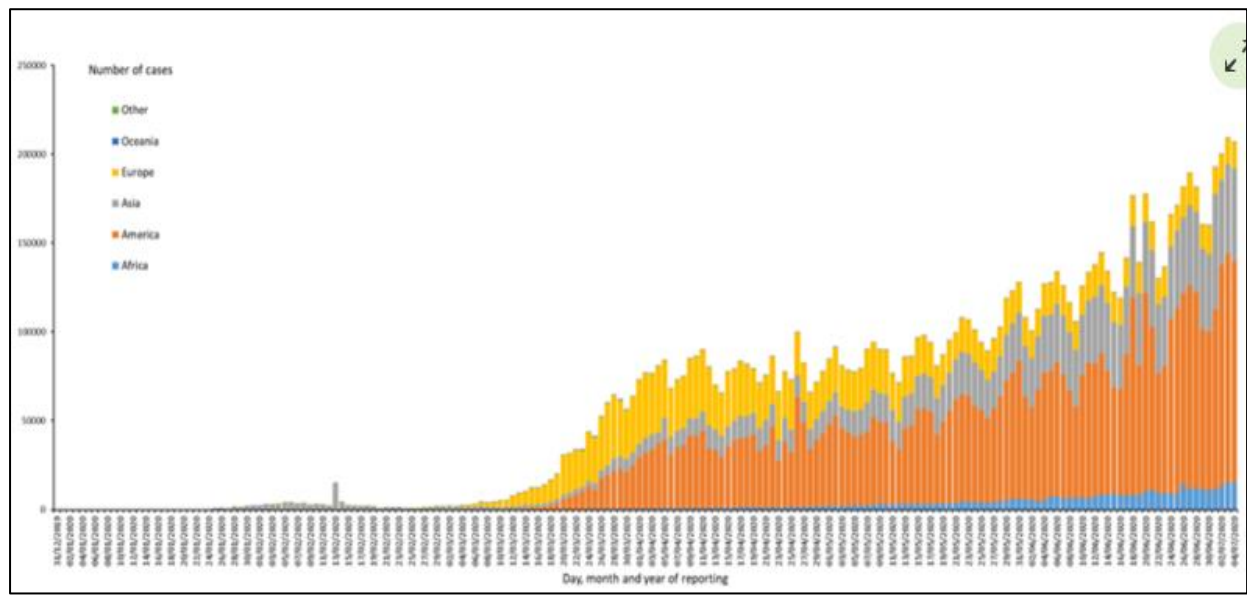


India's fatality rate for COVID-19 on 2 July was 2.95 percent. In Bhutan, Nepal, Maldives, Sri Lanka, Bangladesh, Pakistan, and Afghanistan, on June 26, the case fatality rates in India were 0 percent, 0.21 percent, 0.38 percent, 0.54 percent, 1.26 percent, 2.05 percent, and 2.43 percent, respectively. India's difference with the next worst affected nation, Afghanistan, is close to 50 deaths for every 10,000 patients. In India, Gujarat's fatality rate - the proportion of Covid-19 patients who have died - is the highest at 6.2%. This is more than double the national average of 2.9%. Also, about 3,067 people have died due to the infection in the Delhi, which means that Delhi has a case fatality rate (CFR) of 3%, slightly higher than the national average. [Basu,D.,2020][13]

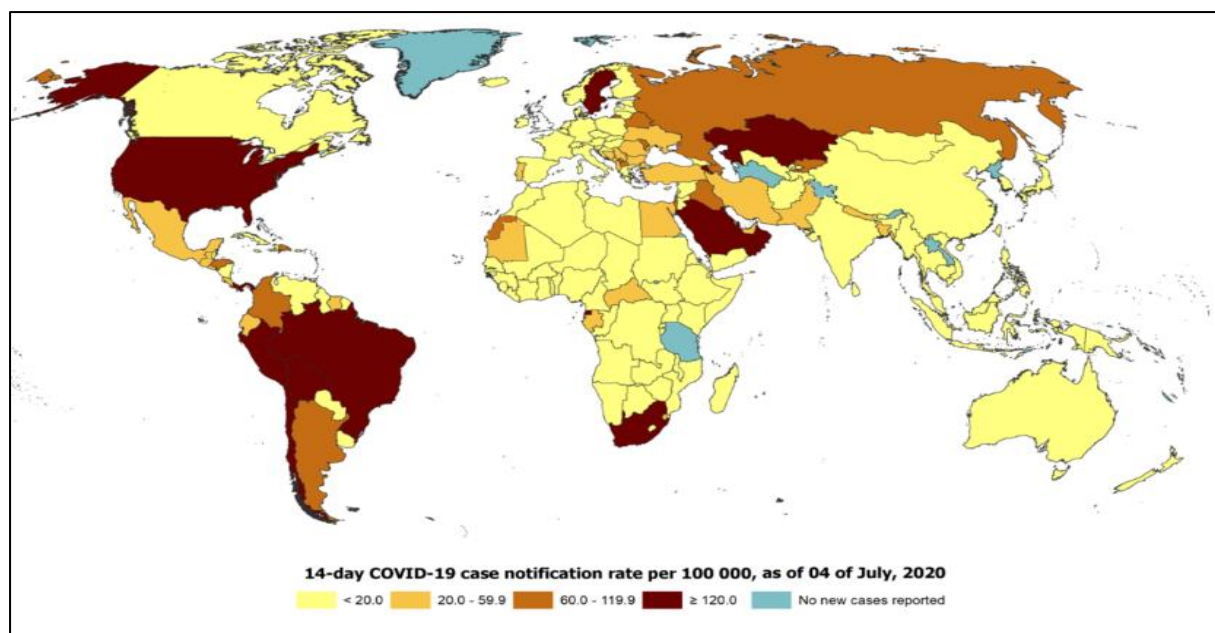
Distribution of COVID-19 according to the continents and Indian states

Every continent except Antarctica have reported COVID-19 cases between 31st December 2020 and 4th July 2020. America has 5704771 cases which are the highest number of cases among all the continents in the worlds. Five countries reporting maximum cases in American continent are The United States, Brazil, Peru, Chile and Mexico. Europe has about 2458791 of COVID cases which is the second highest among all the continents where Russia, United Kingdom, Spain, Italy and Germany are the top 5 countries with greatest number of them. Asia stands with 2430414 cases, with India, Iran, Pakistan, Turkey and Saudi Arabia contributing with majority of the cases. Africa has 448950 cases with highest number of them in South Africa, Egypt, Nigeria, Ghana and Algeria. Ocenia reported about 9866 cases where Australia, New Zealand, Guam, French Polynesia and Northern Mariana islands standing at the top. Also, 696 cases have been reported from an international conveyance in Japan.[14]

Global distribution of COVID-19 (till 4th July 2020)



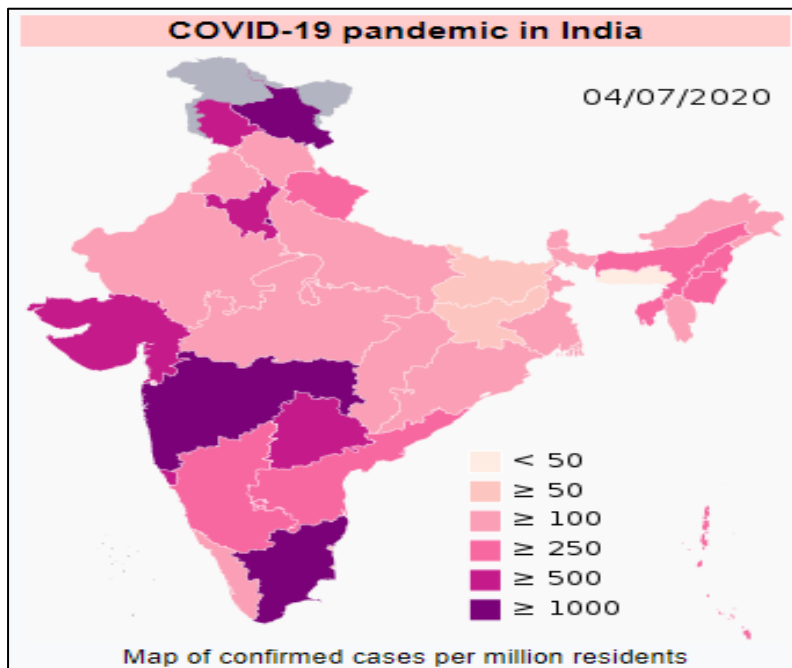
Y-axis shows the day, month and year of reporting COVID-19 cases from 31st December 2019 till 4th July 2020. The X-axis shows the total number of cases during this period. The cases which have been reported are in accordance with the applied case definition and testing strategies in the affected countries.



Map by European Centre for Disease Control and Prevention

The map above shows the geographic distribution of 14-day cumulative number of reported COVID-19 cases per 100 000 population, worldwide, as of 4 July 2020. [European Centre for Disease Prevention and Control, 2020] [14]

Distribution of COVID-19 in Indian states-



The top ten list of highest-caseload of COVID in the country includes the states of Tamil Nadu, Karnataka, Telangana and Andhra Pradesh, and these are currently the only four where COVID-19 cases are rising at a pace greater than the growth rate of coronavirus disease in the entire country.

While Maharashtra continues to add the greatest number of new cases every day, its growth rate remains lower. This is only below the average cumulative growth rate of 3.54 percent for seven days at 3.40 percent. At the other hand, the four southern states add substantial numbers, and also have a rapid growth rate. Between 29 June-5 July 2020, Tamil Nadu registered more than 28,000 new cases. The overall number of State infections exceeded the single lakh mark on 3 July 2020. The fastest growing states, Karnataka and Telangana, have both added more than eight thousand cases each.

On a daily basis Uttar Pradesh contributed large numbers and so did West Bengal. In the third week of June, there was a shoot in the new cases in Delhi. The growth rate in Delhi has slowed but it still reports more than 2,000 new cases of COVID-19 daily. Nevertheless, its growth rate has dropped below three per cent. In the last week between 29th June and 4th July 2020. Delhi registered more than 17,000 new cases of COVID.

Many of the smaller states in India now have remarkable caseloads. Chattisgarh and Uttarakhand have reported more than 3,000 COVID-19 cases, while Jharkhand is reaching upto that mark. In Goa, Tripura, Manipur, Himachal Pradesh and Ladakh, the last two states entering there on 3rd July, the total number of infections has crossed 1,000 too. Puducherry is not so far behind, with 824 cases. In fact Meghalaya is the country's only state with less than 100 reported infections now. Also on 3 July 2020, Sikkim and Andaman and Nicobar Islands crossed this mark.[Indian Express,2020] [15]

Top 10 states in India with maximum caseload as updated on 5th July 2020-

STATE	TOTAL POSITIVE	NEW CASES	TOTAL RECOVERIES	DEATHS
<i>Maharashtra</i>	192,990	6,364	104,687	8,376
<i>Tamil Nadu</i>	102,721	4,329	58,378	1,385
<i>Delhi</i>	94,695	2,520	65,624	2,923
<i>Gujarat</i>	34,686	787	24,941	1,906
<i>Uttar Pradesh</i>	25,797	972	17,597	749
<i>West Bengal</i>	20,488	669	13,571	717
<i>Telangana</i>	20,462	1,892	10,195	283
<i>Karnataka</i>	19,710	1,694	8,805	297
<i>Rajasthan</i>	18,937	390	15,168	440
<i>Andhra Pradesh</i>	16,934	837	7,632	206

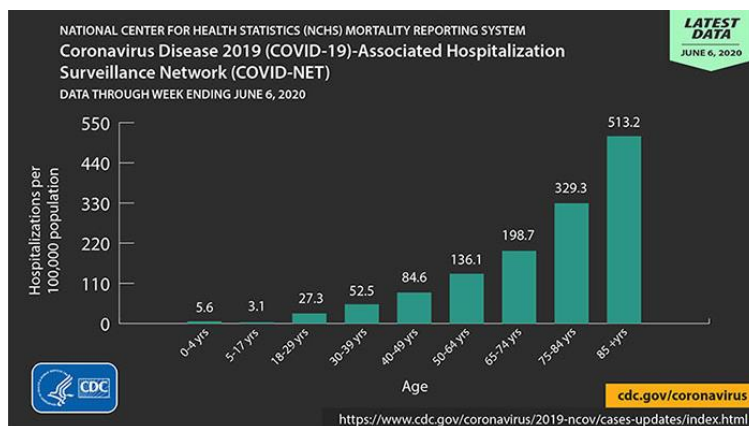
Population most affected by COVID-19

Everybody is at the risk of contracting COVID-19 if they are exposed to the virus. Many people are likely to be more critically sick than others, which means they may need hospitalization, intensive care or a ventilator to help them breathe, or they may even die.

People mainly at increased risk of COVID-19 are

- Older adults
- People with underlying medical conditions

The risk of serious COVID-19 disease rises with age, with highest risk among older adults. For example, people in their 50s have a greater risk of severe illness compared to people in their 40s. Likewise, in their 60s or 70s, people are typically at higher risk of serious illness than in their 50s. For those aged 85 or older, COVID-19 poses the greatest risk of serious illness [CDC,2020] [16].



The risk of COVID-19 hospitalization increases with age rise.

In fact, 8 out of 10 COVID-19 fatalities recorded in the US were among adults with an age of 65 years and above, as per statistics. Individuals of any age with certain underlying problems are even more vulnerable and are at greater risk of contracting COVID-19 and becoming seriously ill. For eg, people with chronic kidney disease, COPD (chronic obstructive pulmonary disease), patients whose immunity has been compromised (weakened immune system) due to organ transpalntation, obesity (30 or higher body mass index [BMI]), Serious heart disorders, such as coronary artery disease, heart failure, or cardiomyopathy, sickle cell anaemia,Diabetes mellitus,etc. Those who are medically complex, have neurological, genetic, metabolic disorders or have congenital heart disease are at greater risk of COVID-19 in children than other normal children [CDC,2020] [17].

On 25 June 2020, the Indian Council for Medical Research (ICMR) announced that the country is definitely not in the community transmission phase of COVID-19, and released the results of the first sero-survey on the pandemic spread that indicated that the urban slum population was most vulnerable to spread, followed by urban settlement. The ICMR calculated that the risk of spreading was 1.09 times higher in urban areas compared to rural areas in India, and 1.89 times higher in urban slums

. The case fatality rate was also stated to be very small at 0.08 per cent. [ICMR,2020] [18]

AGE	DEATH RATE confirmed cases	DEATH RATE all cases
80+ years old	21.9%	14.8%
70-79 years old		8.0%
60-69 years old		3.6%
50-59 years old		1.3%
40-49 years old		0.4%
30-39 years old		0.2%
20-29 years old		0.2%
10-19 years old		0.2%
0-9 years old		no fatalities

The table shows the risk of dying due to COVID-19, for a person in a given age group. In general, relatively few cases are seen among children.

PRE-EXISTING CONDITION	DEATH RATE confirmed cases	DEATH RATE all cases
Cardiovascular disease	13.2%	10.5%
Diabetes	9.2%	7.3%
Chronic respiratory disease	8.0%	6.3%
Hypertension	8.4%	6.0%
Cancer	7.6%	5.6%
no pre-existing conditions		0.9%

The table shows the risk of dying if infected by COVID-19, for a patient with a given pre-existing condition. Here, Death Rate = (number of deaths / number of cases) = probability of dying if infected by the virus (%). [Worldometer,2020][19]

Steps taken by India to contain COVID-19

The Indian government under Prime Minister Mr. Narendra Modi, issued a national lockdown of twenty one days on March 24, 2020 restricting the movement of about 1.3 billion people in India. This was a preventive measure to contain the spread of COVID-19 pandemic In India. The national lockdown was ordered and enacted after a public curfew on March 22, 2020, followed by a set of rules and regulations to be followed in India's regions grossly affected by COVID-19. When the lockdown was imposed, there were about 500 confirmed positive cases of COVID in India. As stated by the researchers, rate of growth of the pandemic had slowed by April 6th 2020 to a rate doubling every six days. By 18th April 2020, the doubling rate of COVID-19 cases was almost every eight days.

Lockdown 1 (25th March-14th april 2020)

March 25th 2020 was the first day of national lockdown in India. Major buisnesses, factories, etc. were stalled. Arrests were made across the states for breaching shutdown protocols such as going out without any emergency, opening up factories or buisnesses and violating quarantine rules at home. The government was continuously in talks with the vendors and e-commerce websites ensuring a smooth distribution of critical products across the country. Several states had declared aid programs for the needy and disabled and a stimulus package had been formulated by the central government.

Minister of Finance Ms. Nirmala Sitharaman announced a stimulus package of about 170,000 crore (US\$ 24 billion) on March 26 to aid those affected by the lockout. The programme, via distribution of free cereals and cooking gas and also direct cash transfers, aimed at providing food security measures for poor households for three months. This also offered health insurance coverage. India's Reserve Bank on March 27 declared a number of steps to alleviate the economic impacts of the lockdown. The government had declared before the declaration of the nationwide lockdown on March 22, that passenger operations would be suspended by the Indian Railways from 31st March 2020.

The freight operations of the Indian rail network were maintained during the lockdown so that essential goods could be transported. On 29th March 2020, Indian Railways declared to launch special parcel trains to transport necessary goods. In addition to this, there was a plan to convert empty coaches of trains into isolation wards for infected patients.

When the end of the initial lockdown period approached, several governments of different states wanted to extend the lockdown until April end . Among the states that pressed for the extension of the lockdown were Odisha, Punjab, Maharashtra , Karnataka, West Bengal and Telangana The growth rate of COVID infections in India had slowed considerably towards the end of the initial period, from a rate of doubling every three days before the lockdown to one of doubling by 18 April every eight days.

Lockdown 2 (15th April-3rd May 2020)

On April 14 2020, PM Mr. Narendra Modi extended the lockdown in the entire nation until May 3, with a conditional relaxation planned for those regions in which the spread had been contained by that time after April 20. Strict protocols were employed to scrutinize how far the spread has been contained in every city or region. The areas that could do so will be released from the lockdown on 20 April. If newcases are found in those regions, lockdowns may be reimposed.

As of April 20, the government announced several relaxations enabling the opening of agricultural enterprises, including aquaculture, plantations, dairy as well as shops selling farm supplies. In addition, it was allowed to restart public works programs with restrictions to maintain social distance. Cargo delivery vehicles, including buses, boats, and aircraft, will fly. Also, it would open banks and government centers that distribute benefits. Small retail outlets were required to open on 25 April, with half of the staff. Regulations for social distancing had to be observed once again.

Guidelines were issued by the Ministry of Home Affairs on 29th April 2020 for states to facilitate travel across the states for the stranded persons. States were requested to appoint nodal authorities and to create protocols and instructions to receive and send certain persons. States were also required to track, quarantine people and periodic health screening.

Lockdown 3 (4th May- 17th May 2020)

On May 1,2020 the lockdown was extended by Government of India for two weeks more with some relaxations. India had been divided into three zones- Red zone having 130 districts, orange zone with 284 districts and green zone with 319 districts. Red zones have high number of cases of COVID-19 and high doubling rates of the infection. Orange zones have relatively less cases and green zones are those which have not reported any cases in the last 21 days. Green zones have been given some relaxations, where buses have been allowed to operate but the capacity has been reduces to 50 %.

Lockdown 4 (18th May-31st May 2020)

The lockdown was further extended for two more weeks beyond 18th May 2020 by the Ministry of Home Affairs and National Disaster Management Authority. Apart from the changes made in Lockdown 3, more of relaxations were given. The states had the authority to further demarcate the red, orange and green zones and the roadmap for implementation was granted to the states. Red zones were divided into two zones- the containment and the buffer zones.

Unlock 1.0 (1st June-30th June)

The MHA released fresh guidelines for the June in which it was stated that the phases of reopening would "have an economic orientation." Lockdown controls would be only imposed in the containment areas, while operations would be allowed in other regions in phases. The first reopening process was named "Unlock 1.0" which made it possible to reopen malls, temples and other hotels, restaurants and religious places from 8th of June 2020. Large gatherings were prohibited but interstate travel was not restricted. However night curfews were effective from nine p.m. to around five a.m. Governments in all the regions and states were permitted to impose effective restrictions on all activities .

Further operations would be allowed in future phases of reopening. Phase II scheduled reopening of all educational institutions in August, after consulting with the state governments. In Phase III, limits on international travel by air, metro operations and recreational facilities (swimming pools, gymnasiums, theaters, amusement parks, hotels, auditoriums) was to be thought upon in August.

Unlock 2.0

Home Affairs Ministry released an order to extend the lockdowns in containment zones until July 31. The order also suggested that all operations beyond containment zones should be permitted in a controlled way.

Guidelines for phased re-opening under Unlock 2-

Following activities will be prohibited outside containment zone-

- Educational institutions , colleges, schools and other training facilities will be closed until 31st July 2020. Schools, universities, and other educational / coaching / training facilities which are to be closed until 31 July. Learning institutions of the central and state governments will be allowed to operate as of July 15, for which the SOP's will be released.
- International air travel by passenger, except as allowed by MHA.
- Metro Rail services
- Cinema halls ,gymnasiums, beaches, amusement parks, movie theaters, hotels, auditoriums, conference rooms, etc.
- The decision to re-open the above activities will be made separately and required SOPs will be given in order to control the COVID-19 spread.
- The movement of individuals in the country, except in emergency situations, will be strictly restricted between 10:00 pm and 5:00 am.

• Limited lockdown for containment areas:

1. Lockdown in containment areas shall continue until July 31.
2. Only necessary activities would be allowed.
3. People would be only allowed to move in case of any emergency like medical emergencies or for the supply of essential goods.
4. States and UT's will identify buffer zones (areas outside containment zones) as well.
5. These zones will be delimited by the respective district authorities as per the guidelines of MoHFW. [covidindia.org,2020] [20]

Conclusion

It can be concluded from the study that as the days are passing, havoc to human life due to this deadly virus is increasing. Globally, several measures and necessary steps are being taken to control the spread of COVID-19 in community. India is under lockdown since 25th March 2020 and now reopening phase has been started. Non-Pharmacological remedies like personal hygiene methods like hand washing, coughing into tissue or elbow, social distancing and avoiding unnecessary touching of eyes, nose, mouth and other body parts from which corona virus can enter the body are being followed. Quarantine method is being followed by people who are in close contact with infected cases. Even though India has adopted several strategies to combat the spread of virus, it is important to work upon improving its testing policy. There is also lack of spread of awareness in some parts of the country especially in rural India.

The need of the situation is that everyone should follow guidelines provided by government and health department and should take necessary precautions in order to eliminate this virus not only from states or countries but from the world. As per the recent scenario we can say that time will address us regarding future of this pandemic, for how long is it going to spread and how it will be tackled.

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**SUMMER TRAINING REPORT
PART- 2 (COURSE REPORT)
BY
UTKARSHA TELANG**

**MBA (Health and Hospital Management)
(MBA HM-24)**



COURSE REPORT

Name of the Course

Understanding and Strengthening Health Systems by John Hopkins University.

Course Description

The course offers an outline of key components or building blocks of a health care system based on the advice from the WHO. In the course, four major areas of global health systems were clarified, with specific regard to low- and middle-income countries. The first area focuses on knowing organizations in the health sector, the challenges. The second module looks at the six main building blocks or components of the WHO health systems with specific regard to primary health care and the need for community involvement in the design, implementation and assessment of these components of systems. The basic system aspect of human resource development and capacity-building was discussed in the third section. The fourth area includes public policy formulation and stakeholder advocacy. This course is for those learners who are either interested or are training for such a management role in managing health and development programs on the ground in low and middle income countries.

The duration of this course is around 14-16 hours.

Objectives of the course

- Understanding organisations and how they change
- Basic functions and Building blocks of Health systems
- Human resource capacity development for health systems
- Health systems policy development and advocacy approaches

Course Contents

Module 1- Understanding organisations and how they change

- What is an organisation
- Stages in organisational change
- Organisational diagnosis
- Organisational change
- Understanding health systems
- Systems thinking
- Effecting change in a health system

Module 2- Health Systems: Basic Functions and Building Blocks

- Introduction to primary health care
- Health systems building blocks
- Commodities beyond the end of the road
- Community systems strengthening
- Financing
- Human resources for health

Module 3- Human Resource Capacity Development: An Essential Health System Function

- Organisational context for training
- Training in context of program management

- Training policy and functions

Module 4 - Health systems policy development and advocacy approaches

- Policy making
- Advocacy

Learning methodology used in the course

- Video lectures
- Reading materials
- Power point presentations
- Discussion forums
- Case studies

Key Learnings from the course

Week 1-

Key concepts

- Define the term organization especially as it relates to health services.
- Identify environmental and internal indicators of the 'health' of an organization.
- Describe 5 key factors used to diagnosis why organizational problems exist.

Health systems are human organizations. Organizations have membership, structure and purpose. An organization must adjust to the climate in order to stay "Healthy," whether it be funding and policy adjustments or client expectations. Within this section, emphasis has been given on diagnosing organizational health-related factors and suggest approaches to help organizations adapt.

What is an Organisation?

In this lecture we start looking at the ecological model's organizational or institutional level. And we're going to start by defining what an organisation. Ultimately we will be taking our diagnostic skills to the next level in this class, learning how to diagnose the situation in an organization. Organizations are formed to provide social and health services. The ecological model tells us that individuals, although they may desire to seek healthcare, may or may not be able to do so because of the way the service is organized and delivered. To begin with, it's important to define an organization. **An organization is the coordination of different activities by individual contributors to carry out planned transactions with the environment.** Key words are coordination and environment. An organization comprises several individuals, their activities need to be coordinated to achieve an organizational goal. That goal is usually established in response to a need in the broader environment.

There are four concepts on how organisations function:

- ❖ Coordination
- ❖ Systems
- ❖ Environment

❖ Planning

Organisation Diagnosis

Here we look at a Case study of Community Directed Treatment (of Onchocerciasis) with Ivermectin (CDTI) to review the diagnosis with a focus on district and community level for getting the program organised.

Technical factors include; the drug itself, the knowledge and skills to administer the drug, the logistics for getting the drug out to the community, the supply and delivery system. Logistics include also community visits, supervision, acquiring the drug from the state headquarters. Technical factors also involve information system, record-keeping, reporting, management of side effects and drugs for those side effects, and referral.

The Human element, in a case of community-directed treatment, we have district and front-line health staff and their attitudes toward the work, toward community members, toward community participation. We have the relationship between the district staff, and the national staff, and state staff, who they rely on for their own training and drug supplies, their attitudes of superiority and inferiority enter into the picture. We have the relationship between the district staff and community members, especially in this program because communities are expected to provide volunteers for training. All of the human relationship issues are concerned here and the human element of organizational diagnosis, the informal communication, the attitudes, the clicks that form.

It's important, when we're doing our diagnosis of organizations, to recognize that health staff behave in certain ways. What we're concerned about is not health behavior per say but job performance behavior and we can use our various models of individual behavior, social learning, health belief, et cetera, to try to understand why health workers behave the way they do in organizations, why they contribute, why they withhold their services and issues concerning their knowledge or technical factors, the issues concerning their attitudes toward the work and toward other staff are part of the human element. The reinforcing factors oftentimes are part of the human element, the attitude between staff and supervisors, their relationship.

The Environment in CDTI- It concerns not only physical but the cultural and economic environment. In this case community beliefs, perceptions and management of onchocerciasis, community expectations of health department and government programs, overall functioning of the health department in terms of resource allocation to programs like oncho control, geography of village distribution.

The fourth element of organisational diagnosis is the Space-time coordinates- timing of distribution to match epidemiology, timing of inputs (training, drug supply) to match community interests and drug expiration, relating timing of disease with intervention, location of ivermectin- stocked health facilities in relation to district headquarters and villages.

Fifth element is Policy diagnosis in CDTI- using community directed approach to achieve onchocerciasis control, collaboration with non governmental organisations (NGOs), non governmental development organisations (NDGOs), National Onchocerciasis Control Programs established, district level competition for resources among programs directed from above. These also include issues of personal policy, issues of resource policy, organisations have policy about how they get contracts to supply drugs, policies for in-service training opportunities for staff. These management policies also influence people's satisfaction with work.

One significant aid in our organizational diagnosis is designing the organogram. **Organograms** reflect the organisation's official structure. We will then start looking at the unofficial, often unseen, interaction, power structure, communication within organisation. It is necessary to sit down with leaders/ members of the organisation to draw the organogram and

to explain what it means. It is important to involve members of the community in mapping their own communities and to interpret the distribution in the community of various resources, facilities, services, groups. It's crucial for us in the organisation to calm back to reflect about what the organizational map is meant to represent, what it shows everyone about the organization's expected activity, versus what's really going on, then reflect at the difference that will enable us transition from a precontemplative to a contemplative stage to understand their organization.

Effecting a change in Health System

Working and changing a health system requires more than technical expertise, but it also depends on values and ethics. Values and ethics drive behaviour in any human system. It is important to have an ethical perspective to help define the problems and to clarify assumptions and implications that people have.

There are three common sets of ethical perspectives that are important in health-

- 1) **Utilitarianism**- maximise greatest good for the greatest number
Like what is the global burden of a disease and what is the cost effective solution for it, and hence how do you improve health of the public.
- 2) **Liberalism**- individuals having the right to choose for themselves.
- 3) **Communitarianism**- societies raise members with good character to create a good society.

There are three 'Control Knobs' of Public intervention in Health systems-

- **Oversight**- how you regulate and use information to change behaviour of key factors, whether it be the individuals or households to have better behaviour, whether it be health providers to provide good quality care at low cost, etc.
- **Organisation**- who delivers services and manages health systems inputs and how they are delivered.
- **Financing**- how to raise money, pool funds, allocate and pay for health care

There are some strategies to improve implementation in a health system:

Strategy type	Examples
Public oversight	Policy reviews; regulations; contracting; empowering community oversight, supporting consumer organizations
Organizational change: provider based	Quality improvement programs; training; human resource management; logistics systems; decentralization of public services
Organizational change: community based	Community development programs; demand creation
Health financing	Provider payment system change; subsidies; health insurance

Sometimes, Health services implementation may not be successful due to some reasons. Implementation faults are very common, like it is not just good enough to know that we are going to immunize with a vaccine that can be efficacious, implementation problems happen all the time.

Though many different strategies are successful but are not replicable in much detail. Strategies produce many unintended consequences which are not predictable in detail. Also, policy makers define strategies but often have limited influence on how they are implemented.

But there are also some factors responsible for successful implementation-

- ◆ Identifying and minimizing systemic constraints.
- ◆ Stakeholder involvement and consultation
- ◆ Mobilization of adequate resources.
- ◆ The initial and continuous adaptation of the strategy to the local context is associated with more complete strategy implementation and adaptation is easier in small scale intervention.
- ◆ Strategies to strengthen disease specific programs that are effective in one area can be successfully scaled up nationally.
- ◆ Multiple component strategies are more effective than single strategies but risk of failure is greater.

What are the uses of Health systems models in effecting change-

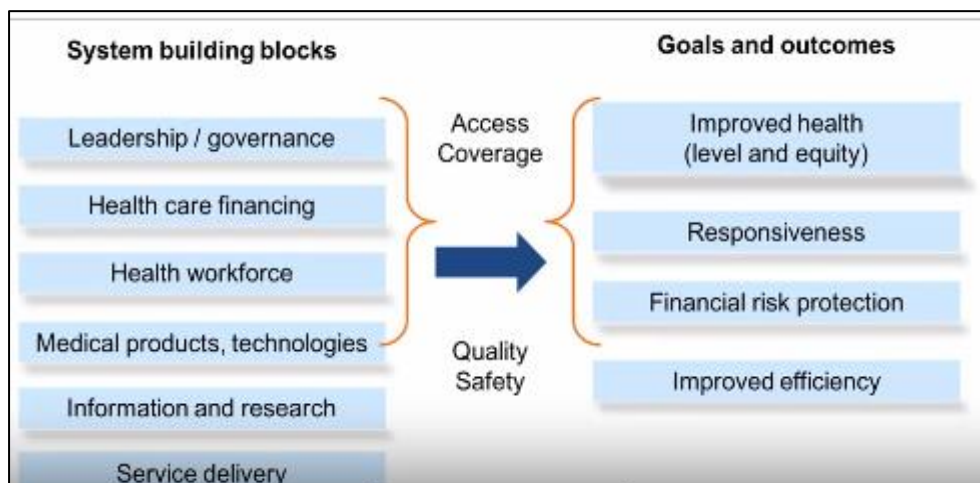
- Identifying policy choices and selecting options
- Describing a system (For e.g., at national level)
- How to strengthen or reform a health system
- Understand causation of changes in a health system
- Plan, monitor, evaluate strategies for implementation and scaling up
- Develop theories about health issues

Week 2-

Key concepts

- List the six main components or building blocks of a health systems
- Identify some of the major funding sources for health systems in low and middle income countries

Following are the 6 different **health systems building blocks**-



The six different health system building blocks given by WHO are : **Leadership and governance, Healthcare financing, Health workforce, Medical products and technologies,**

all of the consumables, **Information and Research**, people include monitoring and evaluation, and of course **service delivery**. All of these elements work in harmony to make sure people receive the care they need. If these building blocks are in place, if they are improved, then people will have greater access to these facilities and assured quality.

Community Health Systems

Things like financing, health workforce, commodities, all of these aspects of the health system must be geared towards serving the community, to serving the clients, to serving people. So, we must understand also that the community is organized as a system. And so, we want to achieve a partnership or a close working relationship between the community and the health system for maximum and most effective coverage of our health services.

There are different systems in the community that build together to create a well functioning community- Social, geographical, political, economic and a cultural system.

The WHO framework of the building blocks of Health systems is linked to the different systems of the community.

Comparison of Health System and Community System Elements

- | | |
|--|---|
| <ul style="list-style-type: none"> ▶ WHO health system framework <ul style="list-style-type: none"> ▶ Leadership/governance ▶ Health care financing ▶ Health workforce ▶ Medical products and technology ▶ Information and research ▶ Service delivery | <ul style="list-style-type: none"> ▶ Community systems <ul style="list-style-type: none"> ▶ Political system ▶ Economic system ▶ Social system ▶ Cultural system ▶ Geographic system |
|--|---|

These community system elements relate to health and work in partnership with the health systems. The political system involves power, governance and leadership. Community leadership and Health systems leadership need to work together.

The community economic system determines the resources people have that are available to them to spend on disease prevention, on promoting their health, people's occupations, how they make a living, how those resources are distributed, the fact that some people in the community have more resources than others. These are just a few of the concerns we have.

And again, if we think about this aspect of service delivery, and if there are any charges involved in funding the health system, we have to consider what the community can afford.

We also have our political, economic, and social structures which play a crucial role into proper functioning of the community health systems.

Health Financing

Health financing is important to achieve universal health coverage. This module examines healthcare at all levels-

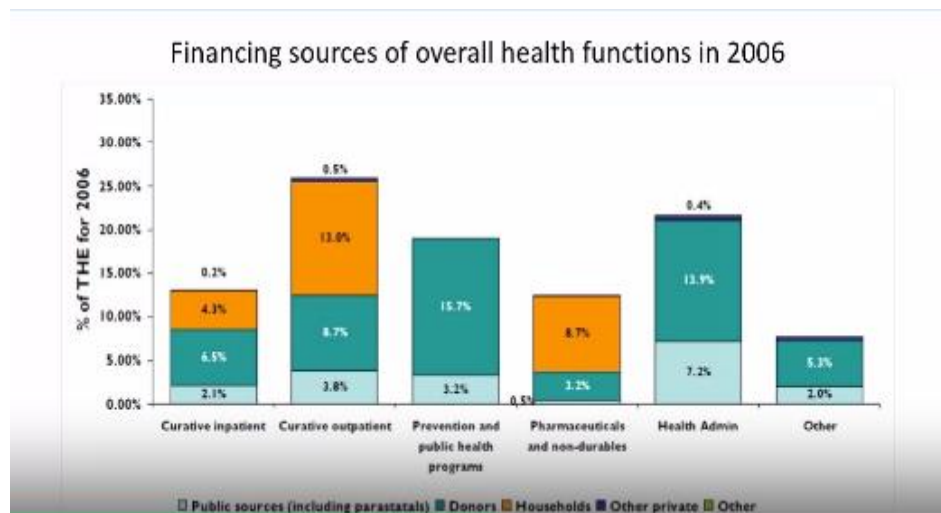
- Whether it is the individual seeking preventive or curative services or an international agency maintaining its technical assistance capacity, finances are required to make all levels of global health function
- Major players in the global health financing- from the national and global level.
- And much of the financial requirements specially with donors, countries and households is needed for the purchase of basic commodities like medicines, contraceptives and supplies and equipments like medical devices, reagents, etc.

There is one way to see from where the money is coming and where it is going, which is the **National Health Accounts (NHA)**. The NHA framework is one way of organising, tabulating and presenting health sector information expenditure from a country perspective.

NHA presents health expenditure information on-

- ✚ Who pays?
- ✚ How much is paid and for what?
- ✚ As opposed to just separate who from what.

This is the National Health Account of a country A. There are sources of finance and different functions.



Various issues can be seen on the X- axis such as curative inpatient services, outpatient services, preventive services, etc. and this is mainly related to Malaria program. And we can see the sources, where the donors form the most common source which is a matter of concern for this particular country as there is a dependency on the donors to make the main systems of the health system work. The orange part of the bar depicts what the citizens, consumers, community members pay out of the pocket for these health systems functions. It is important to analyse that if this Malaria program becomes successful in the future, we cannot entirely depend upon the donors but we need to find out ways that could boost the public sector, to know if the industries and businesses could contribute more so that there is lesser burden on the community members.

Financial sources-There are a number of major financial sources for health financing like the World Bank, UNICEF, GAVI, The Global Fund to fight AIDS, TB and Malaria.

Week 3-

Key concepts

- Explain the role of human resource development in organizational management
- Identify different approaches to human resource capacity development
- Describe the process of getting health commodities from source to users at the community level
- Outline the aspects of community systems strengthening to improve health programs

Here much emphasis is given on health workforce issues and how they can be addressed. It starts with an overview of human resources for health, with a focus on particularly low and middle income countries.

Special attention to the problems of adequate health workers planning, deployment and operation is given. Also, the value of pre-service or basic education and training in service management, continuing professional development, and effective regulation of national standards for particular areas of health service such as disease prevention, maternal and child safety, and HIV treatment have been examined. The question of work change is also discussed with commitment to ensuring that district and community level human resources are available

to provide critical services. This module ends by discussing the role of training and continuing education in allowing health service organizations to sustain sufficient and reliable front-line healthcare.

Education is a part of continuing education, all health professionals need continuing education. The policies change, the procedures change, the needs of the community change. And health workers need to be aware of those changes on a daily basis, if possible, and find ways to update their needs and skills. But one way to do it is preparation, formal preparation. Some of the main aspects of handling human resources or personal management within an enterprise is the problem of continuing education. And finally, personnel management itself is part of the overall management of the organization which considers how the organization uses resources to achieve its objectives.

Personnel management elements provide all processes within an organization that are intended to hire and retain a high level of human resources. Also, an organization can not accomplish its goals without staff, and other health-related programs without well-trained community members are involved. This workforce requires not only the resources and the expertise to achieve the goals, but also the organization's programs. Yet it must also have the drive to do its work. Two areas of personnel management we are concerned with are their working conditions and work performance.

Firstly, **conditions of service** involve many things. The basic salary scale, remuneration, the location of the time and work, specifications about how one gets promotions when one's due for promotion. How transfers are handled, how separation from duty is managed. All these things are set out in organizational policies. Performance appraisal, discipline are part of deciding out how that happens as part of condition of service. Another crucial component is benefits or incentives, such as health care, insurance, retirement plans, pension plans, entitlements, continuing education for yourself, possibly tuition allowances for your children. Of course, the actual health and safety of the work site is part of the service condition, which should be guaranteed to employees. And finally, duty requirements can include items such as hazard compensation benefits, holidays, and other forms of special activities. A second important aspect is **job efficiency or the job performance**. So personnel policy should describe work requirements, job skills, who may apply. Personnel policy should also define working relationships who oversees whom, who reports to whom. And again, job performance requires identification of those tasks that would improve performance including continuing education and the supervisory process of evaluations and feedback.

The five different components of an organizational diagnosis include-

- 1) **Environment**
- 2) **Human element**
- 3) **Policy issues**
- 4) **Technical proctors**
- 5) **Training**

Training in context of program management

Training will resolve a range of issues related to the environment of the organisation. Training will allow workers to be more receptive to customer group demands and needs. Be attentive to advances that emerge professionally through science, through research, so the organisation can respond to them in time. Thus workers should use the latest techniques.

Training will address enhanced interpersonal interactions and communication skills in the human dimension.

There are some issues which cannot be resolved by training and which require supervisors or counselors to address those issues. Following are the issues that cannot be addressed by training-

Environment	Changes in regulation, resource flow
Human element	Ethnic rivalries, personality clashes
Technical	Appropriateness of equipment
Space- Time	Location and scheduling of work
Policy	Complaints arising from personal policy

Training Policy and Functions

An organisation needs training and continuing education departments but unfortunately these are less common in the organisation. The idea for improving skills is a satisfier or a motivator to the employees working in the organisation. That is why, it is important for the organisation to recognize it and institutionalise the training and continuing education units. This not only benefits the employees, but also ensures that the organisation works efficiently and is up to date. Training and continuing education unit would assess the training needs, organise training opportunities and seek outside training experiences suitable for the employees.

For example: To train a Community health committee on mobilization for immunization, they need to be trained for specific skills such as mapping the community, identifying where people live, identifying community leaders and convincing them of the importance of immunization, explaining the parents about the benefits of immunization, and for all these, training is imperative.

To institutionalize training, following components are necessary-

- ❖ Position of the training manager and the establishment of a training department must be legitimized in the form of an organizational policy.
- ❖ Training must be an entitlement
- ❖ Setting a resource centre

Functions of a training unit-

- Determining and recognizing organization's training needs.
- To implement staff development and training according to overall plans.
- Designing plans for the organisation by training specialists
- Planning and evaluating future training
- Providing individual training if necessary

Continuing Education

Different processes and components of continuing education have been described under this. Continuing education is a process of combating continuing ignorance. It is a life long process which helps us in remembering basic learnings, knowing the job realities that were never taught in school and learn about new technologies and changes.

There are people who are at a risk of continuing ignorance. **For example:** Health workers in an isolated setting with few supervisory visits, lack of reading materials, less opportunity to attend meetings, seminars, etc.

Continuing education strategies that can be adapted to any work setting :

- Staff meetings within the workplace
- Meeting with professional colleagues at seminars, workshops, conferences
- On-site supervision and coaching
- Self-study with books, distance- education
- Formal in service training courses
- Clinics developing good programs such as TB control and management

Week 4

Organizations and systems of health and development are formed and funded through policy decisions. There are policies and procedures within organisations that decide what actually functions and how in the organisation. This module looks at stakeholders and helps understand advocacy strategies to influence healthy policy change.

Key concepts learned from this module are:

- Describe the health policy making process
- Identify stakeholders in health policy development and their roles and positions on health issues.
- Explain the role and forms advocacy as a policy development and change tool

There is need for effective and up to date health policies as part of health systems leadership, governance, and accountability. We look at how policies are formulated, and analyze the presence, and roles of different stakeholders in the policy making process. Advocacy must also be the subject of the policy process. Advocacy of strategies helps community members and consumers of health services make their needs and preferences known to policy makers. The module concludes with a case study on policy analysis and advocacy strategy for planning, and strengthening community participation.

Policy Making

The final section takes a look at the ecological model's policy level. This discusses how policy reform is required by improving the environment in individuals, families and communities to promote health. **Policies** are explicit and implied declarations of objectives and goals, as well as the means by which they are intended to achieve the goals.

Policies are expressed through many procedures. Most noticeable are the legislative mechanisms involving governments, as well as informal political processes like backroom negotiation and lobbying. Policies reflect priorities as an organization or government just couldn't do everything it wishes. Policies may also be applied at federal, state, and lower levels, down to the district or county level, where different laws are passed. To us in public health is necessary to know how public decisions are made as organizations set their decisions.

STAKEHOLDERS

All these kinds of policy decisions have an impact on the community and individuals. So it is important to understand the behavior of policymakers and people who are directly or indirectly

trying to influence policy in the background. And this is where we enter the phase of **stakeholder analysis**.

For example-

The stakeholders in HIV/AIDS include various people and groups like activist groups, government health departments at local, state, federal level, international donor agencies that are providing funds and programs, community-based support groups, religious groups, and many others, including pharmacy manufacturers that make anti-retroviral drugs, condom manufacturers, professional and trade groups, from the point of view of professional groups, such as health workers and their concerns personally in terms of exposure and their concerns professionally to prevent the disease in the community, other kinds of trade groups and work groups, such as dockworkers and transporters who may be at risk. Media also has a stake in such a major health issue.

The stakeholder analysis tries to, first, identify along six different variables, how much investment concern interest a particular stakeholder has in the issue. The six different elements are- involvement, interest, power, position, impact, and strategy.

ADVOCACY

Advocacy is an activity that seeks to change policies, attitudes, and programmes. Advocacy pleads, defends, suggests an argument in front of others. In other countries, the word advocate is often used for lawyer. And here again we can see the role of a change agent in public health, helping mobilize, helping organize, particularly in the sense of changing the form of social action, changing the type of community action to help the group have a voice, speaking on the community's behalf. Advocacy is speaking out, attracting the attention of a group to an critical problem and leading decision-makers towards a solution. Advocacy involves engaging in coalitions with other individuals and other organizations, to make a difference. Advocacy is about putting an issue or question on the agenda. Priorities can't be set unless there is a issue that people know. Advocacy has approaches to give solutions

