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NEWS AND COMMENTARY OPEN ACCESS

Public health, India and COVID-19

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Public health has numerous definitions, but in its most basic form, it refers to improving the health of a population through planned and coordinated community engagement. These activities include contact tracing, health awareness, vaccine delivery, and other COVID-19-related activities in which health professionals are actively involved [1]. Another perspective is more intellectual and is best described by the term "population health". It is a phrase used to describe a population's health state [2]. The goal of public health, in this case, is to capture and portray a population's health status as determined by current indicators. The term "population health" is rarely used to describe a wide range of endeavours and public health actions that are both dynamic and contextual. Unfortunately, the current focus has been on it, with little attention paid to disease prevention initiatives. The frequency of COVID-19 and mortality caused by it were the main topics of daily and weekly estimations and projections in COVID-19. These forecasts did not point to any concrete actions that could be taken to prevent a pandemic. The debate concerning the COVID-19 lockdown and

It's contribution to containing the pandemic is still raging due to a lack of a clear explanation for how the decline occurred. To be effective, public health must evolve beyond demonstrating the state of 'population health' to providing particular action points (organized community actions) to prevent the disease from occurring [2].

Lack of leadership is another issue that involves the entities in charge of public health Implementation [3]. Technically, public health can be implemented by the private sector, people's representatives, civil society, or the Government. In the past, India's Government was the sole entity responsible for implementing public health activities across the country. During COVID-19, state health departments were in charge of executing public health programs and were at the forefront. This is also true for other disease control efforts, such as tuberculosis, HIV, malaria, and non-communicable diseases.

On the other hand, real public health work is done by field workers at the grass-roots level. Many states have redesignated auxiliary nurses and midwives, credentialed social health advocates, and multipurpose workers as junior health inspectors, public health nurses, and community health volunteers. These front-line warriors carry out actual public health work through their routine community outreach, which was also used during COVID-19. They are the true champions of public health [4].

And to add to this, the administrators are not public health specialists, nor are they affiliated with public health care. It is a matter of research as to how many of these persons taking decisions had previously heard the terms like incubation period, quarantine, contact tracing, etc. The majority of the decisions were made by bureaucrats or clinicians who had no or little public health knowledge. Because of their administrative background, they are considered "experts" in public health policy and planning, which is insulting to public health and harmful to society. States have failed to build

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a robust public health care system by selecting public health professionals at the middle or upper levels of governments' policy planning mechanisms.

The inability to construct and develop institutional systems for maintaining public health through the employment of public health professionals has been systematic [5]. As a result, every public health response has turned into a last-minute crisis management operation. In the case of COVID-19, this was evident. That is when state health departments enlisted the help of a diverse group of volunteers from local governments, political parties, the police force, and others, expecting them to transform public health in a matter of days. The images of 'war rooms', 'jumbo centers', and 'COVID support desks' suggest a reactive attitude during a crisis. Organized community efforts for public health with intersectoral cooperation are also 'boasted' by some.

States argue that this haphazard, short-term approach is a success during a crisis, but there is no rigorous research on how effective these programs prevent future crises. The majority of these efforts arise due to political clout and are legitimized by the health ministries' "public health specialists". These 'experts' are usually senior clinicians from the state health department who work near power centers and have little experience with public health. During COVID-19, some states employed public health advisors and generally followed national standards without considering the local circumstances. This type of anarchy is also observed during specific public health campaigns such as TB control, vaccine campaigns, diabetes, hypertension, cancer prevention, etc. Institutions for public health practice must be established with professional public health cadres (workers, administrators, epidemiologists, policy makers, and others) who have a regular responsibility to sustain public health for a defined population.

Finally, there is the ambiguity that surrounds many public health initiatives. It is commonly understood that any public health effort must consider the social context to be effective. Every disease/ epidemic has underlying socioeconomic reasons that must be addressed in order to prevent it from occurring. This is due to the health approach's social determinants. Every disease has ramifications that have an impact on society's social fabric. Priority should be given to the social causes of disease occurrence rather than the social consequences in public health practice. If the former is avoided, the latter may not even occur. Some people with a 'generic' understanding of public health tends to focus solely on the disease's consequences, perpetuating an implicit assumption that the disease will occur. This ignores the underlying causes of the disease's emergence. The social elements of COVID-19 in India during the two waves revealed the disease's effects on people's lives and livelihoods. Despite this, little was said about how people's lives (the form of habitation, health practices connected to physical distancing and food, and so on) contributed to COVID-19's emergence in the first place. Even for other chronic conditions, including diabetes, hypertension, and cancer, this is true. The emphasis is on screening, treatment, and follow-up, with little effort to identify and interpret the social factors that contribute to its incidence. This approach of focusing on disease results rather than the causes is frequently criticized in public health, with the iconic phrase "mopping the floor while keeping the tap open".

Lastly, coming to the public health associations like IPHA and IAPSM (I also happened to be a member). There is an urgent need for introspection as to what they have done during the COVID19 crisis. What was their role in policy planning from ground level to the top? What were our suggestions to the Government or authorities? No one will understand the importance of public health unless we prove it to be an efficient approach in preventing and controlling health crises in society. Hopefully, we will wake up before it is too late and the discipline gets obsolete.

Conflicts of interest

Author declares no conflicts of interest.

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