YEARS OF PHFI

YOUR GUIDANCE CREATED THIS
“It is health that is real wealth and not pieces of gold and silver.”

—MAHATMA GANDHI

“Health is not everything, but without health, everything is nothing.”

—ARTHUR SCHOPENHAUER
PHFI: WORKING TOWARDS A HEALTHIER INDIA
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Ten years in the lifetime of a new institution is a time for celebration as well as introspection. It is also a time to thank all those who have provided immense strength through inspirational mentorship, astute guidance, immaculate governance and generous financial support. This profile of PHFI’s progress aims to do all of these by tracing the journey since the organisation’s birth in March 2006 and highlighting some of the notable accomplishments over an eventful decade of growth. It is not a detailed technical report of all activities but provides vignettes of impactful initiatives that are assisting the transformation of India’s public health.

PHFI was born at a time of great confidence in India’s soaring economic growth but also of great concern about the appallingly poor health indicators that were utterly incongruous with the image of a rapidly developing country. Apart from high rates of infant, child and maternal mortality, as well as shockingly high levels of child undernutrition and adolescent anaemia, a multitude of infectious diseases extracted a high toll of avoidable deaths and disability. Those
who survived these threats faced the mounting menace of non-communicable diseases like cardiovascular disorders, diabetes, cancers, chronic respiratory diseases and mental illness. Personal health, family fortunes and national productivity— all fell prey to diseases that could have prevented or detected early for effective control. The response of a poorly configured and seriously under resourced health system, to these complex challenges was feeble and uncoordinated. Policies and programmes in other sectors, which profoundly impact on health, were not sensitive or aligned to public health goals. India’s embarrassingly low position, in the global listings of Human Development Index, was due to neglect of health and education at the population level, despite islands of excellence in tertiary medical care or higher professional education.

One of the key reasons for the poor performance in health, was the failure to establish institutions which could advance public health education and research into transformational policy and practice. Medical colleges did not measure up to the task of providing multi-disciplinary and health system connected education in public health. Lack of public health expertise adversely affected policy development, programme design, delivery and evaluation as well as the development of problem solving innovations.

A national consultation, convened by the Union Ministry of Health and Family Welfare in September 2004, recommended the creation of a foundation which could rapidly advance public health education, training, research and advocacy. PHFI was born as a result, as a unique public—private initiative representing a new kind of PPP (Partnership for a
Trans-disciplinary learning and multi-sectoral application form the double helix of PHFI’s DNA

Over the past decade, PHFI has established five Indian Institutes of Public Health (four in active motion and a fifth in infancy). It is conducting a wide array of post-graduate degree and diploma programmes, on campus and by distance education, both under its umbrella and in partnership with other academic institutions. It has assembled a technical talent pool of over 600- inclusive of faculty and dedicated researchers. Apart from sending out over 100 young faculty for training in public health in some of the best public health schools in the world, PHFI has succeeded in attracting talented diaspora from world over. Our faculty are sought after, as visiting or adjunct faculty, by leading global public health schools. A variety of diploma, MPH and MSc-PhD courses are offered by the IIPHs, through a mix of campus and distance education programmes. The diploma in public health management is linked to the National Health Mission and has trained a large number of deputed medical officers from states across the country. A variety of short term trainings are on offer, as are certificate courses for primary care physicians.

PHFI has also built up an impressive portfolio of research and implementation projects, funded by reputed national and international agencies through competitive grants. With over 1600 publications in scientific journals and an average impact factor of 5.3, PHFI has established a creditable track record in research and has been so recognised by the Department of Scientific and Industrial Research. More important, the research is providing useful inputs to India’s health policy and programmes in many areas of public health importance. Four funded centres of excellence in chronic diseases, disabilities, equity and social determinants and environmental health are leading applied research projects and capacity development in those areas.

Technical assistance is also being provided to central and state governments for health system strengthening. Areas of such engagement include
HIV prevention, routine immunisation, allied health professional training, universal coverage, health accounts and budgeting, access to drugs, antibiotic resistance, tobacco control, environmental health, health workforce planning and public health cadre development.

Technologies for affordable health care have been developed by PHFI and are now being evaluated in field studies. *Swasthya Slate* is now being used by auxiliary nurse midwives in six districts of Jammu and Kashmir, under the National Health Mission and in the first *Mohalla Clinic* of the Delhi government. As m-health and tablet based decision support systems are being evaluated by our researchers in primary health care settings of several states for hypertension and diabetes management, drones have been developed by our students for delivery of drugs for treatment of tuberculosis.

At the global level too, faculty and researchers are actively contributing to many initiatives, expert groups and commissions such as Agriculture and Food Systems for Nutrition, Global Burden of Disease Study, WHO Commission on Ending Child Obesity, Lancet Commissions on Health Professional Education, Mental Health, Investing in Health, Palliative Care and Obesity as well global panels on Antibiotic Resistance. International conferences have been convened by PHFI on maternal health, antibiotic resistance, endgame for tobacco, global youth meet on health, health in sustainable development and new directions for public health education.

These ten years have been a period of rapid growth and intense activity on many fronts. There have been several challenges as well, the foremost being the delay in securing university status or university affiliation for degree courses and the financial cost of constructing multiple campuses. However, the growing PHFI family has risen above these to deliver many valuable contributions to national and global health. For enabling us to do this, we owe a huge debt of gratitude to the Government of India, State Government Partners, our Board led by our visionary Chair Shri NR Narayana Murthy, our supportive donors, thoughtful technical advisors, and the many esteemed Indian and international academic partners. We look forward to their continued guidance and support as we move in to the next decade of PHFI’s life with renewed commitment to the mandate of raising India’s health to the best global standards.

Professor K. Srinath Reddy
President, PUBLIC HEALTH FOUNDATION OF INDIA
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Senior Academic Registrar  
IIPH - H

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Vice President - Finance & Resources

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Dr. Suresh Shapeti  
Senior Administrative Officer and Deputy Registrar (Bangalore Campus)
“The setting up of the Public Health Foundation of India presents a unique opportunity to develop innovative models of public-private partnership in major social sector programmes. Such partnership can help blend the commitment of government with the operational efficiency of not-for-profit private groups.”

—Dr Manmohan Singh
THE GENES...
A country’s prosperity rides on the health of its population. Today, the foremost challenge confronting India is improving its performance on health indicators. Beyond these numbers which represent national averages, there is a human dimension to public health – all sections of India’s population need to be assured of accessible, affordable, and effective health services. It is also important to envision health as extending beyond illness care to disease prevention and wellness promotion. Health care reforms, in the last decade, experienced a paradigm shift from an exclusive focus on clinical medicine to a concerted public health response, thereby making provision for health promotion, disease prevention, and affordable diagnostic and therapeutic health care for all. Central to this shift has been the growth of public health – a multi-disciplinary academic stream and a multi-sectoral implementation pathway.
Public Health as a formal discipline should ideally integrate streams of knowledge from diverse disciplines, bringing together learnings and perspectives from life sciences (especially human biology), quantitative sciences (such as epidemiology, biostatistics and demography), social and behavioural sciences (including economics, sociology, anthropology and communication), political science, humanities (especially human rights and ethics), and elements of management. While the specific applications of such knowledge would vary across medicine and public health, a broad array of disciplines must inform and influence the totality of their precept and practice to advance global health. This holistic approach, at the moment was grossly underdeveloped in independent India. This is impeding policy coherence as well as access to quality health services.

Due to an insufficiently developed institutional capacity for public health education, inadequate availability of well-rounded public health experts has seriously incapacitated public health policy and research. The numbers of graduates from existing health schools are insufficient to fulfil the need for trained health professionals. The resultant shortfall of professionals with inter-disciplinary orientation, relevant knowledge and skill-sets has inhibited broader understanding of health issues as well as hindered opportunities for multi-sectoral public health action. Several expert committees set up by the Government of India have recommended the need for establishing institutes of public health. However, no specific action was initiated to implement these recommendations till 2006.

As a response to these urgent and well-acknowledged needs of India and the entire South Asia region, the Public Health Foundation of India (PHFI) was established as a large-scale, autonomous, public-private initiative in March 2006. In the inception of this institution lies the intent to build broadband public health capacity, and a commitment to meet the short supply of health professionals for a sustained response to major public health concerns.
“Institutions have a catalytic role to play and can bring a transformational change. We need to think scientifically about public health. Along with medical doctors, we need to develop in parallel the health management faculty so that we build health systems and institutions that can address problems effectively.”

—NARENDRA MODI
Science Discovers
Technology Develops
Public Health Delivers

Delhi NCR office of the Public Health Foundation of India and the Indian Institute of Public Health (IIPH D)
Over the past decade, PHFI has begun to play a transformative role in India’s public health environment. In doing so, it engages a wide array of stakeholders who include central and state governments, national and international donors, civil society, academic and research institutions and the communities that PHFI works with.

By helping to create a strong ecosystem that acts at multiple levels, PHFI is working to break barriers that are impeding India’s public health performance. The dispersed location of the IIPHs as well as wide ranging partnerships across the country, enable PHFI to address these challenges in a contextually appropriate manner, within a binding national ethos of sound public health values.

Dialogues with policy makers, civil society and academics are set-up on a multitude of areas in public health, ranging from tobacco control to what are women’s requirements in delivery of maternal health services, with the consultations extending from the grassroots to the national level.

In its journey over the last ten years, PHFI has built a knowledge base and created cross-learning platforms, while growing an organisation imbued with commitment towards public good. While PHFI’s educational programmes advance the precept and practice of public health in a multi-disciplinary framework, its agenda of policy and programme relevant research is bridging critical knowledge gaps and advancing implementation.
OUR VISION, MISSION
AND VALUES

VISION
Our vision is to strengthen India’s public health institutional and systems capability and provide knowledge to achieve better health outcomes for all

MISSION
• Developing the public health workforce and setting standards
• Advancing public health research and technology
• Strengthening knowledge application and evidence-informed public health practice and policy

VALUES
Transparency
• Uphold the trust of our multiple stakeholders and supporters

Impact
• Honest, open and ethical in all we do, acting always with integrity

Informed
• Link efforts to improving public health outcomes, knowledge to action
• Responsive to existing and emerging public health priorities

Excellence
• Knowledge based, evidence driven approach in all we do
• Drawing on diverse and multi-disciplinary expertise, open to innovative approaches

Independence
• Encourage, recognise and celebrate our achievements

Inclusiveness
• Independent view & voice, based on research integrity & excellence
• Support academic and research freedom, contributing to public health goals and interests

Inclusiveness
• Strive for equitable and sustainable development, working with communities
• Collaborate and partner with other public health organisations
From PHFI's Yoga - CaRe trial, a yoga based cardiac rehabilitation programme. Photo Credit: Chandrashekhar/PHFI
Launch of Public Health Foundation of India

Bhoomi Pujan for permanent campus of IIPH – Gandhinagar

Establishment of IIPHs – Gandhinagar and Hyderabad

Launch of PGDPHM for National Health Mission

Establishment of IIPH – Bhubaneswar

Establishment of IIPH – Delhi

Launch of Diploma Programmes (Health Economics and Bio Statistics)

PHFI registered as a Scientific and Industrial Research Organisation (SIRO), by Department of Scientific and Industrial Research, Government of India

Distance Learning Education Programmes Launched

2006

2008

2010

2007

2009

2011

our JOURNEY
OVER YEARS

PHFI accorded status of a Nodal Centre of the Alliance for Health Policy and Systems Research (WHO)

Launch of Integrated MSc & PhD in Health Informatics and Clinical Research

International Diabetes Federation awards Certificate of Excellence to PHFI’s primary care training programme

Launch of MPH programme at IIPH – Gandhinagar and Hyderabad

IIPH – Gandhinagar accorded University Status under the State Act

Establishment of Indian Institute of Public Health – Shillong

Launch of MPH programme through affiliation between IIPH - Delhi and Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum

Bhoomi Pujan of Permanent campus of IIPH – Hyderabad

‘Swasthya Slate’ (the electronic tablet for point-of-care diagnostics, introduced for RMNCH+A implementation in J&K by National Health Mission

Launch of Permanent campus of IIPH – Gandhinagar
“Alone we can do so little; together we can do so much.”

—HELEN KELLER
alone we can do so little; together we can do so much.
—Helen Keller

Women's self help group meeting session on family health, PHFI's U.P. project. Photo credit: PHFI
Women from a community in Assam make their way to attend Village and Nutrition Day events. Photo credit: Pranab Aich / ITSU
The Journey
PHFI IS CATALYSING CHANGE BY:
• Building a trained public health workforce through world-class, India relevant educational courses and training programmes
• Supporting improvement of core public health programmes such as Immunisation; HIV/AIDS prevention; Allied Health workforce capacity building through technical assistance (as Technical Support Units) to Government of India and to the state governments
• Implementing public health projects across a wide range of areas such as Maternal and Child Health, Infectious disease surveillance and control and Chronic Diseases Prevention and Control
• Promoting policy and programme relevant research by filling critical information gaps, conducting health impact assessment and evaluating innovations for improving the outreach and effectiveness of health systems.
• Supporting policy development and launching advocacy initiatives for: advancing agenda of Universal Health Coverage; action against air pollution and its health effects; public health cadres, at state level; tobacco control.
Addressing the shortage of trained public health professionals and workers

Providing world class, India relevant programs - degree (Masters in Public Health), diploma (Public Health Management), certificate and online courses - offered by 4 Indian Institutes of Public Health at Gandhinagar, Hyderabad, Delhi NCR and Bhubaneswar. Over 1000 plus graduates, 17,000 plus trained through short term programs, and over 1300 plus through distance learning.

Improving Immunisation Coverage Rate among children

Through Immunisation Technical Support Unit (ITSU), PHFI is helping MoHFW in the expansion of immunisation coverage, improvement of quality, and introduction of new vaccines. PHFI has extended support to ‘Mission Indradhanush’ for targeted increase from 65% to 90% rate of coverage of full immunization among children.

Helping prevention and control of HIV/ AIDS in India

Supporting National AIDS Control Organisation (NACO) as Technical Support Unit for stronger program implementation, monitoring and evaluation. Through another USAID supported program, helping scale up targeted Interventions (50% increase), quality of reporting, and communication programs for increased awareness and better participation of private sector organisations.

Introducing Affordable Technologies - ‘Swasthya Slate’ for primary health care in rural communities

PHFI developed the ‘Swasthya Slate’, a unique tablet based, affordable and portable diagnostic platform for use by health workers in rural and/or remote areas of the National Health Mission. Deployed in J&K under RMNCH+A program, it has registered nearly 20,000 pregnant women, and has reported improved turnaround time for antenatal tests from 14 days down to 40 minutes.

Improving family health through Self Help Groups (SHGs) led behaviour change program in rural communities

PHFI has provided technical support for introduction of maternal and neonatal health interventions through 50,000+ SHGs in 100 talukas (blocks) of Uttar Pradesh. The use of community platforms has led to an increased uptake of several health mediations in SHG households. This model has the potential for replicability across other SHGs in the country.
Community worker in a session with young women on HIV/AIDS awareness in Maharashtra. Photo Credit: PIPSSE project
Responding to Climate Change - Developing City (Ahmedabad) Heat Action Plan
IIPH - Gandhinagar developed South Asia’s first city based Heat Action Plan (HAP) that was implemented in Ahmedabad. Subsequent to its execution, mortality during heat wave reduced by 30%. The Heat Action Plan is now being scaled up in Maharashtra, Odisha, and Telangana, and is gaining attention at global forums, including the COP 2015 event in Paris where it was displayed in the India pavilion.

Preventing avoidable blindness among adults and children
PHFI is coordinating programmes aimed at preventing avoidable blindness due to Diabetic Retinopathy (affecting adults, causing significant disability) and Retinopathy of Prematurity (affecting pre-term babies and rendering them blind for life). This program, in partnership with leading eye care organizations, is being run across several states in association with MoHFW and is supported by Queen Elizabeth Diamond Jubilee Trust of UK.

PHFI is also
• Driving action through research and advocacy against Air Pollution and its adverse health effects
• Advancing agenda of Universal Health Coverage in India
• Training and developing capacity of Primary Care Physicians in detection and care of chronic conditions
• Advancing health policy through research on health financing, access to drugs and health workforce availability and performance.
A mother and her children post vaccination in tribal Odisha. *Photo Credit: Pranab Aich / ITSU*
“He who has health has hope, and he who has hope has everything.”

—ARABIAN PROVERB
Community orientation on water testing in West Bengal: From PHFI documented public health case studies across India.

Photo credit: PHFI
SCALING UP
PUBLIC HEALTH
EDUCATION & SKILLS
At the time of its launch in 2006, PHFI had set out a Charter that focused on institutional capacity-building to strengthen education, training, research and policy development in public health across India. Our sustained vision has also been to strengthen India’s public health institutional and systems capability, and to apply knowledge to achieve better health outcomes for all sections of people.

PHFI has set up five Indian Institutes of Public Health (IIPHs) in Gandhinagar, Delhi NCR, Hyderabad, Bhubaneshwar and Shillong. The IIPHs are envisioned as world class public health institutions capable of responding to public health challenges of the state, region, and the country. Working as an interlinked network, the IIPHs function as vibrant hubs for public health education, training, research and practice with a strong health system connect. The IIPHs are set up in partnership with the respective state governments. These state-level institutions function with active support and guidance from the respective state governments. A fully-empowered, independent Governing Council, with eminent persons from academia, representatives from governments, civil society, philanthropies, and professional organisations, was constituted to provide strategic guidance and oversight to PHFI. Each IIPH also has a similarly constituted Advisory Council in each of the states. The representative nature of such a broad based public-private partnership governs PHFI and the IIPHs. This permits operational autonomy, while allowing benefits of governmental guidance and civil society scrutiny.
IIPHs are envisioned as world class public health institutions for responding to public health challenges of India.

- IIPH-DELHI
- IIPH-GANDHINAGAR
- IIPH-HYDERABAD
- IIPH-BHUBANESWAR
- IIPH-BENGALURU CAMPUS
- IIPH-H - DR NTR UNIVERSITY OF HEALTH SCIENCES COLLABORATION (FOR MPH PROGRAM)
- IIPH- SHILLONG

Trainig programmes to commence in 2016.

India’s first public health university established as a university under the state act of the government of Gujarat. First permanent campus is coming up at IIPH-GANDHINAGAR.

Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) collaboration (for MPH program)

PHFI-ACSR collaboration (Integrated MSC & PhD programs in Health Informatics & Clinical Research)

Government of Karnataka collaboration (technical support for PGDPM program) at Bengaluru.

PHFI-AcSIR collaboration (Integrated MSC & PhD programs in Health Informatics & Clinical Research)
“Today, I am proud to say that on the land of Gujarat, a great dream is being born. This building, this land, the walls are not going to enhance the name of the institution, but it shall be the development of people within this building (IIPHG Campus) who will become the guarantors for the future of India’s health. Friends, we are dreaming big and making an important effort to sow the seeds for a healthy future for India. I believe this will result in significant change,”

—Shri Narendra Modi (in 2007)
PHFI undertakes training in the following areas: Health Systems • Chronic Diseases and Injuries Infectious Diseases • Public Health Nutrition Tobacco Control • Women & Child Health

At PHFI and the IIPHs, we have a dedicated multi-disciplinary faculty of over 75 qualified and competent members from diverse backgrounds who bring best in class knowledge and expertise to our public health programmes. PHFI and the IIPHs have strong faculty development programmes, with support from highly reputed global institutions of public health learning that bring in the latest knowledge and collaborations which can be put to use in the Indian context. PHFI’s multi-disciplinary faculty includes demographers, epidemiologists, health systems experts, social and behavioural scientists, nutritionists, biostatisticians, and health economists.

INDIAN INSTITUTES OF PUBLIC HEALTH (IIPHs)

INDIAN INSTITUTE OF PUBLIC HEALTH - GANDHINAGAR (IIPH-G) UNIVERSITY, GUJARAT The Government of Gujarat and PHFI entered into a Memorandum of Understanding in 2007 to establish IIPH-G. Under this MoU, the Government of Gujarat allocated 50 acres of land and agreed to share a part of the project cost. The foundation stone for IIPH-G was laid in the year 2007 by the present Honourable Prime Minister of India, Shri Narendra Modi (then Honourable Chief Minister of Gujarat). In 2015, IIPH-G was recognized as India’s first public health university through an Act passed by the Government of Gujarat.
The first permanent campus is coming up at IIPH-Gandhinagar, in partnership with Gujarat Government and will open in 2016. The institute launched its first Master in Public Health (MPH) Programme in 2015 and will initiate Ph.D programme in 2016.

Apart from imparting public health practice relevant professional education (such as Post Graduate Diploma in Public Health Management and short term training to students from various parts of India), IIPH-G also provides research-based health policy support to the Government of Gujarat. The Institute’s activities have received funding support from the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare, the Medical Council of India, the Council of Scientific Innovation and Research, the National Bank for Agriculture & Rural Development, the Karolinska Institute and the Natural Resources Defense Council, among others. IIPH-G faculty members are involved in research projects in maternal and child health, disease surveillance, nutrition, microfinance, monitoring health programs and advocacy, heat stress and health effects of climate change. IIPHG has also launched an occupational health program, the ‘Associate Fellow in Industrial Health’ which is recognised by the Directorate General, Factory Advice Services & Labour Institutes, Ministry of Labour & Employment, Government of India.

**INeAN D I N T I T U T E O F P U B L I C H E A L T H - H Y D E R A B A D (IIPH-H), TELANGANA AND ANDHRA PRADESH**

Responding to the invitation issued by the State government on the very day PHFI was launched in 2006; IIPH-H became functional in July 2008 and launched a diploma programme in Biostatistics and Data Management. IIPH-H works in close collaboration with the State Governments of Telangana and Andhra Pradesh to provide technical support, to generate evidence for planning, and to participate in programmes to augment public health capacity in the state. IIPH - Hyderabad is supporting the Government through capacity building of Medical Officers and
programme managers in public health management, biostatistics and data management. The institute also works closely with the Government of Karnataka and has a campus in Bangalore, where training is conducted for health personnel deputed by the State Government. The institute also undertakes trainings in cross-cutting areas like epidemiology, biostatistics, behavioural sciences, health economics, health services management, environmental health, health inequities and human rights, gender and health, health communication and the ethics of health care. The flagship courses of IIPH-H are the Masters in Public Health (offered in collaboration with University of Hyderabad), Integrated MSc and PhD in Health Informatics, Post Graduate Diplomas in Public Health Management and in Biostatistics and Data Management. Short-term courses include training in research methods, statistics, disease surveillance, disability, and change management. In addition, IIPH-H assists in the implementation of national programs, such as the National Rural Health Mission as well as state and regional public health initiatives. Its activities receive support from Indian Council for Medical Research, National Health & Medical Research Council of Australia, Engineering & Physical Sciences Research Council of UK, Wellcome Trust, The Queen Elizabeth Diamond Jubilee Trust, UNICEF, DST, WHO, CBM and Sightsavers. The Indian Institute of Public Health, Hyderabad (IIPHH) and Dr. NTR University of Health Sciences, Vijayawada, Andhra Pradesh, in an exclusive agreement, announced admissions to a specialised Masters in Public Health (MPH) in 2015. The course commenced in December 2015.

In February 2015, Shri K Chandrashekar Rao, Honourable Chief Minister of Telangana State performed the auspicious Bhoomi Puja for the construction of the permanent campus of the Indian Institute of Public Health - Hyderabad (IIPH-H), PHFI’s southern regional campus at Rajendranagar, Rangareddy District, Telangana State.

INDIAN INSTITUTE OF PUBLIC HEALTH - (IIPH-D), DELHI-NCR

The Indian Institute of Public Health-Delhi (IIPH-Delhi) commenced operations in November 2008 with launch of the Post Graduate Diplomas in Health Economics, Health Care Financing, and Health Policy Program targeted at mid-career health professionals. Since then, the institute has also expanded its activities in distance learning, training, research, advocacy and policy support in different areas of public health.
the state. Faculty members at IIPH-B are among the common pool of PHFI training division for providing trainers to facilitate various workshops and training programs.

IIPH-B currently trains government doctors from Odisha and Chhattisgarh and self-sponsored candidates through its PG Diploma in Public Health Management. With the aim of creating a framework for a Centre for Tribal Health and UHC, IIPH-B has established important linkages with the largest residential tribal centre in Bhubaneshwar, which is a part of Kalinga Institute of Social Study and houses over 15,000 students from tribal districts of eastern India.

**INDIAN INSTITUTE OF PUBLIC HEALTH - SHILLONG (IIPH-S), MEGHALAYA**

IIPH-S commenced its operations from 2015 as the fifth institute of the IIPH network. The IIPH in Shillong has been established to redress the limited institutional and systems capacity in the area of public health in the northeast region of India which is largely populated by indigenous peoples, with over 160 Scheduled Tribes (STs). Established in collaboration with the Government of Meghalaya (GoM), IIPH-S will serve the entire North-East region as its primary focus while being national in character and remain actively linked with other IIPHS. Currently, the institution has started functioning from an interim campus in central Shillong, at a facility made available by the Government of Meghalaya. A permanent campus is planned, for which GoM has provided 22.3 acres of land in Mawdiangdiang, New Shillong.
IIPH-D offers Post Graduate Diplomas in Public Health Management; Integrated MSc and PhD in Clinical Research, as well as Post Graduate Diploma and Certificate Courses through distance education in Public Health Nutrition and Epidemiology, among other courses. It also conducts short-term training programs and workshops in fields related to public health. IIPH-D’s research extends across the domains of acute and chronic diseases, tobacco control, nutrition, maternal and child health, health systems and health policy. Its activities have received funding support from the Ministry of Health and Family Welfare, Department of AYUSH, the Indian Council of Medical Research, the Central Council for Research in Unani Medicine, the Department of Science & Technology, the Medical Council of India, the United Nations Children’s Fund, and the World Health Organisation, among others.

In January 2016, IIPH – Delhi and Sree Chitra Tirunal Institute for Medical Sciences & Technology (SCTIMST), Trivandrum (an Institute of National Importance under the Department of Science and Technology, Govt. of India), signed a formal Memorandum of Understanding (MoU) for offering Master of Public Health (MPH) programme at the Indian Institute of Public Health– Delhi. The programme will be launched by IIPH – Delhi in 2016.

Indian Institute of Public Health - Bhubaneswar (IIPH-B), Odisha
IIPH-B commenced its academic activities from August 2010. A key objective of the Institute has been to implement the vision of PHFI by linking public health advocacy, teaching, research, and practice. IIPH-Bhubaneswar is closely working with the Government of Odisha in providing technical inputs and support to strengthen the public health delivery system and to facilitate development of a public health cadre in
Health Literacy session on nutrition in Uttar Pradesh. Photo Credit: Ajay Singh, PHFI
ACTION ORIENTED PUBLIC HEALTH EDUCATION & TRAINING
Capacity building in public health is the primary mandate of PHFI. Besides the ongoing formal academic courses, PHFI also addresses the need for conducting short term courses and/or in-service training on various areas of topical importance in public health.

Launching their first teaching programme in 2008-09 with a Post Graduate Diploma in Public Health Management (PGDPHM), the IIPHS now offer two Masters of Public Health (MPH) programmes, one at IIPH-Gandhinagar University (a university under the State Act) and the another at IIPH-Hyderabad (in collaboration with NTR University of Health Sciences, Andhra Pradesh). Apart from MPH, three post-graduate diploma courses offered on campus. The PGDPHM evolved in partnership with other academic institutions in India under the aegis of the National Rural Health Mission (NRHM), currently

Multi-disciplinary, competency-driven curriculum, health systems connectivity, innovative pedagogy are our watermark
opportunities for employment in the development sector - NGOs/ INGOs/ and CSR divisions in corporates - hospitals, clinical research organisations, academic institutes, government organisations, research organisations, public health programmes and other organisations of relevance.

The Training Division at PHFI was established in 2008 with the goal of meeting short term training needs of public health practitioners and professionals of health and allied sectors in India. PHFI has, since then, conducted several training programmes customised to cater to the identified needs of health service personnel from different states, young health researchers, physicians in practice, and national health programme managers and consultants.

PHFI also conducts training programmes for primary health care physicians with the objective of enhancing their core skills and competencies in the areas of evidence based diabetes management, Gestational Diabetes Mellitus, Diabetes Retinopathy, Prevention and Management of Diabetes and Cardiovascular Disease and Management of Thyroid Disorders.

The Placement Cell at PHFI has enabled the students, subsequent to the completion of their programmes, called the National Health Mission of the Ministry of Health and Family Welfare (MoHFW), Government of India.

PHFI’s academic partnerships exist across India for the on-campus and distance learning programmes. These include the PGDPHM Consortium (PHFI provides leadership to a consortium of 10 institutes offering PGDPHM program supported by MoHFW, GoI) The partnership also includes IIPH-Hyderabad & Government of Karnataka Collaboration (technical support for PGDPHM program); PHFI-AcSIR Collaboration (Integrated MSc & PhD programs in Health Informatics & Clinical Research); IIPH-H - Dr NTR University of Health Sciences Collaboration (for MPH program), IIPH-Delhi - Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) Collaboration (for MPH program). An Academic Advisory Committee, comprising external experts provides guidance. It is presently chaired by Prof. Abraham Joseph, former Dean of Christian Medical College, Vellore.
ACADEMIC PROGRAMMES

Two Masters programmes in Public Health and three on-campus Diploma programmes with PG Diploma in Public Health Management (NRHM linked) as flagship programme

Two Degree (Integrated MSc-PhD) courses in partnership with Academy of Scientific & Innovative Research (AcSIR)

16 Distance Learning programmes and 50 plus short term competency development programmes being delivered

Joint MPH programme launched in 2015 with University of Hyderabad and University of Gujarat

1000 plus public health professionals have graduated from on campus programmes (65% sponsored by state governments), 17,000 plus participants trained in short term programmes and over 1300 through distance learning and scaling up rapidly (figures since 2008)

120 plus multi-disciplinary faculty pool (core and adjunct); largest in one institution in India

97% placements of students for the 2013-2014 batch
Number certified through Long Term Training Programmes: 15000+

Number of Graduates from Distance Education Programmes: 1337

Number of Graduates from On-Campus PG Courses: 1009

Augmenting India's Public Health Education & Training

Photo Credit: PHFI
SCALE UP OF PHFI’s ON-CAMPUS PROGRAMS

Post Graduate Diploma Programme
- Gandhinagar
- Delhi
- Hyderabad
- Bhubaneswar

Integrated MSc & PhD Programme
- Delhi
- Hyderabad

MPH Programme
- Gandhinagar
- Hyderabad

MPH & Doctoral Programme
- Delhi (MPH & PhD)
- Gandhinagar (PhD)

We also offer 16 Distance Learning Programmes and a MOOC on Global Public Health

INDIAN INSTITUTES OF PUBLIC HEALTH: FACULTY STRENGTH

Core Faculty Strength

<table>
<thead>
<tr>
<th>Type</th>
<th>2008-10</th>
<th>2013-14</th>
<th>2015-16</th>
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<tr>
<td>Pursuing Fellowships</td>
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</table>

Scrub Scale: 0-80
Class in session at IIPH-D. Photo Credit: PHFI
Orientation session for students supervised by IIPH faculty. Photo Credit: PHFI
GRADUATES FROM IIPHs-ON-CAMPUS PROGRAMMES

Total of 1009 graduates

GRADUATES FROM IIPHs - DL PROGRAMMES

Total of 1337 graduates
The experience at IIPH has been so unique [and] of its kind, and I feel very happy about it. The mix of tight and demanding programme with carefully selected courses, and well qualified and experienced faculty has helped me to acquire broader understanding of public health issues, and health policy and economics. I never forget the sweet memories of my colleagues, and the warm and welcoming environment of the whole faculty and staff. I wish to see and hear IIPH extend its programmes to offer PhD at the international level.

- **MS.YEGILENESH HABTE**, student from Ethiopia, 2010-11 Batch, Post-Graduate Diploma in Health Economics, Health Care Financing and Health Policy

I thought of doing my public health education from IIPH considering the recognition it enjoys for its academic excellence. Other aspects which I considered were - the course curriculum, practical exposure, expert faculty members, etc. I will always recommend PHFI for it’s academic excellence, value-based education and providing a conducive environment for overall skill development.

- **MS.CHINMAYI BORKAR**, 2011-12 Batch, Post Graduate diploma in Public Health Management

It is my privilege to be associated with IIPH. The unique internship programme in the PGDCR course helps the student get practical exposure in the field. The course fee is most reasonable and affordable. The guidance by faculty members is incomparable.

- **MS.PUrvI PRADHAN**, 2010-11 Batch, Post Graduate Diploma in Clinical Research
wealth is health.”
—EMERSON

“Take care of your health so that you may die young as late as possible.”
—ANON
IT STARTS WITH A SMALL, FIRST STEP. A REGULAR WALK EVERY MORNING KEEPS YOU ACTIVE AND HELPS PREVENT HYPERTENSION AND MANY HEALTH PROBLEMS.

Swasthi family, mascot for the Healthy India website which ran a series of health preventive messages to encourage a healthy lifestyle
Field Researchers conducting community resource mapping exercise

Community health worker using tablet-computer based SSS application (Electronic Data Capture software) in Solan, Himachal Pradesh as part of the Solan Surveillance Study (SSS) undertaken by PHFI
POLICY AND PROGRAMME RELEVANT RESEARCH
Since its inception PHFI has worked to establish a robust evidence base for public health, in partnership with national and international institutions, by advancing policy and programme relevant research in prioritised health areas. PHFI has been undertaking projects in multiple areas including epidemiology and control of infectious and chronic diseases, maternal and child health, health systems, and social determinants of health. PHFI recognises scientific curiosity as fundamental to research and endeavours to cultivate an enabling environment for faculty, staff and students, to undertake studies in various disciplines of public health and drive the research agenda at PHFI and IIPHs.

A pan - PHFI Research Management Committee (RMC) helps to steer and support research, as an organised activity. An independent (Research Advisory Committee), consisting of eminent external experts, helps to provide peer review and strategic
counselling. The RAC is presently chaired by Professor Barry Bloom, former Dean of the Harvard school of Public Health. To ensure the ethical aspects of research are adhered to, an Institutional Ethics Committee (IEC) has been established to review all proposals for research, provide guidance, and promote ethical conduct in all research undertaken at PHFI. The PHFI-IEC provides guidance and promotes ethical conduct in all research undertaken by researchers at PHFI.

PHFI has a portfolio of over 100 ongoing research and implementation projects, with several multi-centric and multi-stakeholder studies. Partners include international academic institutions, central and state governments, community-based organisations and the private sector. Research efforts undertaken by PHFI have led a total of 1926 publications till November 2015, with an average impact factor of 5.3. Currently, PHFI has undertaken over 350 research projects, several of them involving multiple stakeholders.
Health workers prepare immunisation records of children in the community
PHFI has set up four Centres of Excellence to raise awareness and strengthen research, training and education in high priority areas of public health in India:

- CENTRE FOR CHRONIC CONDITIONS AND INJURIES (CCCI)
- SOUTH ASIA CENTRE FOR DISABILITY INCLUSIVE DEVELOPMENT & RESEARCH (SACDIR)
- RAMALINGASWAMI CENTRE ON EQUITY AND SOCIAL DETERMINANTS OF HEALTH
- CENTRE FOR EXCELLENCE IN ENVIRONMENTAL HEALTH (UPCOMING)

**RESEARCH IMPACT: PEER REVIEWED PUBLICATIONS**

Total Publications - 1926
Average Impact Factor - 5.3

* Indexing in progress
ANM examines a child during home visit in West Bengal

“He that prevents a disease is the safest physician.”
—Thomas Fuller
“He that prevents a disease is the safest physician.”
—THOMAS FULLER
India has been going through a major epidemiological transition over the past 25 years, suffering from the double burden of increased mortality and morbidity through Non-Communicable Diseases and Injuries, and a sustained high proportion of infectious diseases including Tuberculosis and HIV/AIDS. However, there are likely to be substantial variations in the disease profiles, among the different population groups and between the states.
Recognising that national-level estimates do not provide enough detail for targeted action, The Indian Council of Medical Research (ICMR), the Public Health Foundation of India (PHFI) and the Institute for Health Metrics and Evaluation (IHME) at the University of Washington have launched a collaborative initiative for state-level disease burden estimation in India. The development of reliable sub-national estimates under this programme will be crucial in developing an informed public health response to address National and State health needs.

With the evidence being generated across health areas, PHFI will work with a network of academic partners and policy makers across India to improve health indicators in prioritised health areas.
Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990–2013: quantifying the epidemiological transition

Summary

The Global Burden of Disease Study 2013 (GBD 2013) aims to bring together all available epidemiological data on the causes of death and disability. The study used a coherent measurement framework, standardised estimation methods, and transparent data sources to enable summary measures such as disability-adjusted life-years (DALYs) and healthy life expectancy (HALE) that make possible comparisons of health outcomes across causes and population subgroups. These summary measures can also be used to quantify the component of variation in epidemiology that is related to sociodemographic development.

Methods

We used the GBD 2013 data for age-specific mortality, years of life lived due to premature mortality (YLLs), and years lived with disability (YLDs) to calculate DALYs and HALE for 1990, 1995, 2000, 2005, 2010, and 2013. We applied hierarchical regression to DALY rates by cause across countries to quantify contributions of inequality to the epidemiological transition. We estimated cause-specific DALY numbers, crude rates, and age-standardised rates from 1990 to 2013 and compared the findings with previous GBD studies.

Findings

Worldwide, from 1990 to 2013, life expectancy at birth rose by 6·2 years (95% UI 5·6–6·6), from 65·3 years in 1990 to 71·5 years in 2013. Life expectancy at birth increased in all regions from 1990 to 2013. The rate of increase in life expectancy at birth was highest in sub-Saharan Africa, where life expectancy increased by 19·7 years (17·5–21·8) from 1990 to 2013. Life expectancy at birth increased in all regions, with the highest increase in sub-Saharan Africa.

The leading causes of DALYs are highly variable across countries.

Discussion

Global health is improving. Population growth and ageing have driven up numbers of DALYs, but crude rates have remained relatively constant, showing that progress in health does not mean fewer demands on health systems. The GBD Study is an epidemiological transition, which is tracked by changes in disease burden—either the rise and fall of specific non-communicable diseases, including cardiovascular diseases and diabetes—growing numbers of deaths from diabetes, and rising numbers of deaths from injuries. In most countries, the general pattern of reductions in age-sex specific deaths has been associated with increases in other age-sex specific deaths, including HIV/AIDS, drug use disorders, and injuries. The GBD Study is an epidemiological transition, which is tracked by changes in disease burden—either the rise and fall of specific non-communicable diseases, including cardiovascular diseases and diabetes.

Published Online December 18, 2014

Conflict of Interest Details available at the end of the Article

See page 92

The Indian Council of Medical Research (ICMR), the Public Health Foundation of India (PHFI) and the Institute for Health Metrics and Evaluation (IHME) at the University of Washington under the auspices of Ministry of Health and Family Welfare, have launched a collaborative initiative on state-level disease burden estimation in India.

In this effort, the robust methods of the Global Burden of Disease (GBD) study, developed by a global network of researchers coordinated by IHME, will be utilized to generate rigorous estimates of all the major drivers of health loss at the state level in India.
Heart and respiratory diseases are India's biggest killers

By Pragati Chhambal Kataria
Published: 23 Nov, 12 December 2015 | Updated: 24 Dec, 17 December 2015

Heart and respiratory diseases have gradually become silent killers for Indians, according to the 2015 Global Burden of Disease Study.

High blood pressure, pollution, smoking and alcohol, have become risk factors that kill thousands of Indians.

Highlighting the epidemiological transition over the last 25 years in India, the study notes that the major causes of deaths were lower respiratory infections (14,774), diarrheal diseases (9,679) and perinatal complications (6,528).

For interactive versions of figure 7 and figure appendices 1–3, visit the end of the Article.
PHFI has contributed significantly through cutting-edge research on issues related to access to medicines, vaccines and technology. Work in this space includes tracking the public expenditure of health facilities, looking at the drug procurement and distribution system, generating evidence on access to medicines in India, examining the role of pharma companies in facilitating access to medicines, and identifying socio-economic correlates and determinants of unequal access to immunisation in India.

PHFI through its research has provided recommendations on pharmaceutical pricing policy to the Ministry of Health and Family Welfare, Ministry of Corporate Affairs, Ministry of Chemicals and Fertilisers, and the National Pharmaceutical
Project: Strengthening Eco-System for Sustainable and Inclusive Health Financing in India
Supported by: United States Agency for International Development (USAID). Photo credit: PHFI
Pricing Authority. It has also advised the Competition Commission of India on mergers and acquisitions in the pharmaceutical sector, and the Planning Commission on the development of the 12th Five Year Plan.

As India prepares to roll out its ambitious programme to achieve universal health coverage (UHC), PHFI is undertaking

• Assessment of drug procurement and distribution models in 8 states. This is expected to serve as a baseline for access to provision of essential medicines

• Identification of key costs of an essential health package for UHC roll out in the districts of 8 states now ready for baseline data collection.

In addition, PHFI has also recently assessed the Rajasthan Free Medicine Initiative of the State Government and the Jan Aushadhi Yojana of Ministry of Chemicals and Fertilizers, Government of India.
Africa could learn from India's burgeoning pharma sector

Prohibitively high drug costs are leading some African countries to try to enter the generic market. They would do well to look at India's model, says Sakthivel Selvaraj.

Sakthivel Selvaraj, senior health economist, Public Health Foundation of India, New Delhi, India.

India is the global pharmacy, producing and supplying essential drugs to more than 200 countries. Its drug market is valued at $15.64bn (Rs930bn; £10bn; €12bn), of which more than 40% comes from exports. India has more than 10,000 producers and more than 262 factories approved by the US Food and Drug Administration.

As African countries grapple with the HIV/AIDS pandemic, coupled with malaria and tuberculosis, they increasingly buy cheap generic drugs from India. In 2012 Africa accounted for almost a quarter of India's drug exports. In the late 1990s a campaign to improve access to antiretroviral drugs in Africa started a process that has brought the price of these drugs down from more than $10,000 a patient a year—using drugs sold by multinational drug companies—to less than $150—using drugs sold by Indian generic manufacturers.

But African countries could obtain the drugs more cheaply if they produced them themselves.

African countries struggle to set up their own drug industries. In South Africa, a stringent system of patenting has prevented production of antiretroviral drugs by generic manufacturers. Currently, its patent laws allow international manufacturers to undertake "evergreening" and patent "metoo" drugs. India has been able to develop its generic drug sector and put life-saving drugs within the reach of its citizens through its progressive patent laws. It has a mechanism to stop "metoo" drugs from gaining patent protection (section 3 (d) of the amended Indian Patent Act 2005). Indeed, the apex court recently upheld this provision against Novartis by rejecting its patent application for the β polymorphic form of imatinib mesylate, called Glivec.

Another problem for African countries is the TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement. Although TRIPS contains some safeguards to enable generic production, such as parallel imports and compulsory licensing, it is stringent and acts as an impediment to access to medicines. Less developed countries in Africa should delay signing up to it until 2025 and those that have already signed should make sure they make use of its flexibilities. India signed the agreement in 2005.

African countries have complained that Indian generic drugs are too expensive. Wholesale prices of Indian generic drugs may be reasonable, but once procurement agencies based outside the country and working for foreign governments have taken their commission, prices seem less attractive. African countries should remove these intermediaries and strengthen procurement agencies within their own countries or, if the countries are small, organise regional agencies so that they can buy drugs directly from Indian generic manufacturers at lower prices.

A recent African delegation to India heard about the pooled procurement model adopted by the Tamil Nadu Medical Services Corporation. This model relies on an efficient, effective, and accountable system of centralised procurement and decentralised distribution of drugs. Several Indian states are replicating this successful model.

Several African countries—for example, South Africa, Morocco, and Tanzania—want to expand their domestic drug industry, but have few manufacturing plants and because they are small they are not as competitive as Indian drug manufacturers. Some argue that small countries cannot compete with large countries in producing their own drugs. Building more factories, training engineers, and encouraging technical collaboration should be a priority for some of the larger African countries.

Partnership with India and other countries that produce generic drugs is critical for the long-term sustainability of a country's drug industry in general and access to drugs in particular.

Big pharma, procurement agencies, and prescribers have expressed doubts about the quality of drugs produced and exported by India. Some European countries have seized Indian generic drugs being exported to Africa on the pretext of their being counterfeit. However, a study conducted by the Indian government, with sampling designed by the Indian Statistical Institute, reported that just 0.05% of all drugs produced in India are of "spurious" nature and not the 25% quoted by the World Health Organisation.
PHFI is engaged in building capacities and providing technical inputs in design, implementation, monitoring and evaluation in the area of health care financing to both central and state governments.
PHFI is currently engaged in providing technical inputs to the Expenditure Management Commission (EMC), Ministry of Finance, Government of India. To achieve the intended objectives of the government, the primary mandate of the commission is to provide direction and recommendations for efficient resource utilisation and reallocation to the Government of India. In addition to education, the EMC has identified health as a focus area for reforms in the union government expenditure. This prioritising of health sector will lead to further emphasis on systematic and effective delivery of health care services. PHFI is also assisting the Governments of Tamil Nadu and Telangana in strengthening systems for Health Accounts.
PREPARING INDIAN CITIES FOR EXTREME HEAT CONDITIONS

Recognizing the danger climate change poses for human health, IIPH-Gandhinagar, in partnership with the Natural Resources Defense Council (NRDC), has been focusing on the health impact of rising temperatures on vulnerable populations of western India. IIPH-Gandhinagar assessed the current vulnerability to extreme heat among Ahmedabad’s general population. Additionally, they conducted focus group interviews of construction workers in order to assess the adaptive capacity of Ahmedabad’s public health and health care delivery system to extreme heat conditions.

This work by IIPH-G and NRDC led to the launch of a Heat Action Plan in April 2013 by the Ahmedabad Municipal Corporation (AMC), with scale up to two
further cities in India envisioned in the next year or so. These recommendations have also fed into the National Disaster Management Authority’s plans, as well as into the sub-mission on health of the Prime Minister’s Council on Climate Change. The institute developed and enhanced public health interventions and healthcare delivery protocols and management strategies; advanced and calibrated an innovative heat-health early warning system for the Ahmedabad Municipal Corporation; worked with the local and state governments to implement specific strategies. They also conducted workshops and trainings for stakeholders (hospitals, other medical providers and government staff) on early warning systems, internal government communications, planning for extreme heat events, community outreach and communication strategies. Implementation of the Heat Action Plan has already shown impact of reduced mortality during the last heat wave in Ahmedabad.
NEW DELHI: More and more people are likely to die or suffer morbidity due to heat stress in the capital in the coming years.

According to a recent study by Centre for Atmospheric Sciences at IIT-Delhi, the diurnal temperature range (difference between the maximum and minimum temperature) is decreasing rapidly. The DTR for Delhi that was 12.48 degrees in 2001 has reduced to 10.34 degrees in 2011, indicating that the minimum temperature is steadily increasing. This is mainly due to the urban heat island (UHI) effect and massive urbanization over the years, the study revealed.

A UHI is usually an urban area, which is significantly warmer than its surroundings. Concrete surfaces that used to be permeable and moist start radiating heat forming an area or an island of high temperature. The IIT study by scientists Manju Mohan and Anurag Kandya also found that areas experiencing a DTR below 11 degrees accounted for only 26.4% in 2001 that increased to 65.3% in 2011.

Forested or canopied areas such as the Asola wildlife sanctuary or rural areas such as Ghuman Hera village, Mundhela Kalan and Kanjhawala village have not shown much difference in DTR since 2001. But areas such as Rohini, Dwarka, Vasant Kunj, IIT and Safdarjung airport had a highly decreasing trend indicating the impact of urbanization.

The study was conducted using satellite land surface temperature data for those years. "During daytime, heat is absorbed by the built-up structures like roads and buildings and released at night leading to the rise in minimum temperature. This can be addressed by changing building material and building design, reducing number of vehicles on roads and use of airconditioners among other measures," said Manju Mohan of CAS, IIT.

Together with an increased cooling energy demand in warm climatic conditions, the situation calls for urgent policy interventions for rapidly growing cities, the study revealed.

Heat stroke deaths are the tip of the iceberg

Heat stroke deaths are the tip of the iceberg. In the recent past, India has seen a significant increase in heat stroke deaths, which are usually caused by prolonged exposure to high temperatures. According to reports, more than 70,000 people die every year due to heat stroke in India. This number is expected to increase with the rise in temperatures, making it a major concern for public health.

The study also highlighted the need for better infrastructure and emergency services to handle heat-related emergencies. "We need to invest in better cooling systems and emergency services to handle heat-related cases," said Anurag Kandya of CAS, IIT.

New Delhi: India is reporting thousands of deaths from various causes due to heat wave. In May 2015, the second highest reported in any heat wave in India. This number may go up as many people often attribute deaths to heat stroke without proper investigation. According to statistics, heat-related death is one of the leading causes of death in India. The study revealed that in the past few years, a significant increase in heat-related deaths has been observed in the country.

According to the study, the principal reason for the increase in heat-related deaths is the urban heat island effect, which is caused by the increased temperature in urban areas due to the presence of concrete surfaces, buildings, and vehicles. The study also highlighted the need for better planning and design of urban areas to reduce the impact of the urban heat island effect.

The study also emphasized the importance of public awareness and education on heat-related health risks. "We need to raise awareness among the public about the dangers of heat stroke and the importance of taking preventive measures," said Manju Mohan of CAS, IIT.

The study was conducted using satellite land surface temperature data for the years 2001 and 2011. The results showed a significant decrease in the diurnal temperature range (DTR) in Delhi, indicating an increase in the minimum temperature. The study also highlighted the need for policy interventions to mitigate the impact of the urban heat island effect.
AMC releases 2015 plan to battle heat wave

Public gardens, fountains in city will remain open throughout summer; NGOs to offer drinking water

AMC plans big

DH
Combating heatwave deaths

Heatwave Threshold For City, Finds Study

42 Degrees Celsius Is Heat Wave Threshold For City, Finds Study

The study found that the number of deaths in the city has increased significantly during heatwaves. The AMC has released a 2015 plan to battle heat waves and reduce the number of deaths. The plan includes opening public gardens and fountains, and providing drinking water to NGOs. The city is expected to remain open throughout the summer.
IN ITS EFFORTS TO COMBAT INDIA’S INFECTIOUS DISEASE BURDEN, PHFI HAS UNDERTAKEN A RANGE OF WORK INCLUDING PRIMARY RESEARCH, POLICY EVALUATION, PROGRAMME IMPLEMENTATION, AWARENESS GENERATION AND CAPACITY BUILDING. PHFI HAS FACILITATED PRIVATE AND PUBLIC PARTNERSHIPS THAT LED TO INNOVATIVE PREVENTIVE MANAGEMENT PROGRAMMES FOR SEXUALLY TRANSMITTED DISEASES (STDs), STEPS TO RESOLVE ANTIBIOTIC RESISTANCE, AND CONTROL OF HIV/AIDS. PHFI IS THE DESIGNATED TECHNICAL SUPPORT UNIT FOR THE NATIONAL AIDS CONTROL PROGRAMME, WORKING WITH THE CENTRAL GOVERNMENT AND STATE AIDS CONTROL SOCIETIES ON A RANGE OF INTERVENTIONS IN PARTNERSHIP WITH LOCAL NGOs AND SELF-HELP GROUPS.

PHFI IS THE NODAL AGENCY OF THE ROADMAP TO COMBAT ZOONOSES IN INDIA AND IS RESPONSIBLE FOR COORDINATING ACTIVITIES AMONG ALL PARTNERS THROUGH A CORE JOINT WORKING GROUP THAT ENGAGES PARTNER AGENCIES AND IMPLEMENTS MEETING RECOMMENDATIONS. WHILE UNDERTAKING THESE, THE FOUNDATION ALSO WORKS CLOSELY WITH EXISTING PROGRAMMES AND INITIATIVES AND FURTHER Focuses ON DEVELOPING TRAINING PROGRAMMES FOR PUBLIC HEALTH SPECIALISTS TO STRENGTHEN MULTISECTORAL EXPERIENCE ON THE ‘ONE HEALTH’ CONCEPT (LINKING ALL SECTORS RANGING FROM HUMAN HEALTH TO ANIMAL, WILDLIFE, SOCIAL AND ENVIRONMENTAL SECTORS).
An MCD Fumigation Worker at work in the old quarters of Delhi on Monday. Express Photo by Tashi Tobgyal New Delhi 140915

In any free society where terrible wrongs exist, some are guilty; all are responsible.” While these words of Rabbi Abraham Joshua Heschel ring true for many social and political ills that appall us, they are also a timely reminder of our collective responsibility to correct the pathetic state of public health in our country. Accepting the failures of a dysfunctional health system with passivity or being pacified by reflexive responses to any crisis, while ignoring the crying need for systemic reforms, makes us all responsible for the poor health indicators that place India behind our South Asian neighbours, other BRICS nations and, for some indicators like child immunisation, sub-Saharan Africa.

There is justified outrage at the tragic deaths of children from dengue under deplorable conditions of apathy and neglect in the capital of India. As often happens, there is an immediate search for individuals and institutions to whom the guilt could be readily apportioned. There are many who will be blamed, and will in turn point the finger at others — the state and Central governments, municipal...
Malaria therapy loses efficacy, raises concern

Kajal Roy, New Delhi, April 24, 2013, DNA.
Parasites have found a way to bypass drug.

India’s preferred therapy to fight a common and deadly disease has lost its efficacy, raising public health concerns that the drug is no longer effective.

The preferred treatment order for malaria cases of the world health organization (WHO) recommends another medicine for uncomplicated malaria.

Efficiency of this second drug in the standard therapy is on the wane, according to a group of Indian researchers, who bypassed the drug.

Though there is no therapeutic failure yet, the situation is not what it was in Odisha, which has one of the highest malaria counts in India.

The findings have been published in a recent report in which scientists at ICMR, New Delhi, who have been working on malaria treatment, report a dramatic rise in the efficacy of drugs used in the ACT and Dewel.

The WHO favours the combination therapy development of drug resistance. India needs to be cautious about the emergence of drug resistance.

"Emerging infections not pre-determined"

14 Oct 2014, Rahul Koul, BioSpectrum

"Irony is that we don’t have an effective system. A robust functional health system is essential. Currently, there is an inability in the system to effectively tackle epidemics. Systems not ready at all levels. While the response at the center may be quick, will not be of much help until state and local governments too have a system in place. If you go down to lower levels, preparedness remains an issue as the resources are not enough," Dr Manish Kakkar, senior health specialist, Public Health Foundation of India (PHFI) told BioSpectrum’s Rahul Koul over the phone.

BioSpectrum
the business of bioscience

New Delhi: 14 October 2014

"Emerging infections not pre-determined"
PHFI IS ENGAGED WITH MULTI-SECTORAL PROGRAMMES FOR HIV PREVENTION IN INDIA

The Impact through Prevention, Private Sector and Evidence-based Programming Project (PIPPSE), supported by the United States Agency for International Development (USAID), is a five-year project on HIV/AIDS programme implementation. This effort is led by PHFI with Futures Group International India Pvt Ltd, and Population Services International (PSI) as partners. PIPPSE provides multi-layered, cutting-edge technical assistance to the National AIDS Control Program (NACP) for institutional strengthening, building evidence and testing multiple innovations, which in turn strengthen the quality and comprehensiveness of programmes for HIV prevention, care and treatment while ensuring private sector engagement in HIV/AIDS prevention and control.

PIPPSE IMPACT

- PIPPSE-supported National Migrant Unit (NMU) in NACO provided strategic and programmatic oversight in scaling up the destination interventions for high-risk migrants from 215 (reaching 2.97 Million migrants) in December 2012 to 315 (covering 3.39 Million migrants) in March 2015.

- PIPPSE-supported Technical Support Units (TSUs) in its focus states (Goa, Gujarat, Kerala, Maharashtra, Rajasthan, Tamil Nadu, Uttarakhand and Uttar Pradesh) by providing programme management and quality assurance support to 38 percent (697/1840) of the total Targeted Interventions (TIs) for prevention of HIV amongst Key and Priority Populations (KPPs).
• PIPPSE provides significant support to the National Integrated Behavioural and Biological Surveillance (IBBS), the largest survey in the world in terms of scale and comprehensiveness of the sample of the key populations, including migrants and Currently Married Women (CMW). National IBBS summary report is expected in December 2015 and PIPPSE is taking lead on data analysis and reporting for migrants and CMW components.

• PIPPSE conducted several research studies, namely, (a) baseline study conducted in Thane district that informed the opportunities and challenges in DNM implementation (b) Polling Booth Survey (PBS) being conducted for migrants in Thane (Maharashtra) and Surat districts and for CMW in Gorakhpur, Basti, Ganjam and Naupada districts to understand the risky behavior that makes migrants and CMW vulnerable to STIs and HIV, and to validate the MSDS tool that is being used in piloting of LCP (c) Behaviour Tracking Survey (BTS) is being conducted for key populations, namely, female sex workers, men having sex with men and injecting drug users in Thane to understand their risk behaviours and vulnerability to STI/HIV/AIDS and service uptake and (d) a special study, as requested by UPSACS, is being conducted among IDUs to validate the IDU numbers in Lucknow and Varanasi districts.

• District Network Model (DNM), a flagship initiative of PIPPSE, in Thane and Palghar districts of Maharashtra, is steering partnerships and mobilising resources through different stakeholders in public, private and NGO sectors for sustainable and synergistic HIV response.

• In coherence with the revised national migrant strategy, PIPPSE piloted source-destination linked corridor program (LCP) across two high migration corridors, namely, Eastern Uttar Pradesh – Thane (Maharashtra), and Ganjam, Cuttack (Odisha) – Surat (Gujarat) to test and refine program strategies and approaches for migrant interventions at source and destination sites.

• PIPPSE has also generated wider interest, particularly in the context of UNAIDS 90:90:90 global strategy, by piloting Phase 1 of Community Based Testing (CBT) for HIV through six TIs in Thane from September 9 to October 31, 2015. In 46 camps, 1,375 individuals were tested and 15 found reactive to HIV.

• In collaboration with the Public Health Technologies Trust, PIPPSE also pre-piloted AIDS Prevention and Treatment System (APATS), a tab based system for real time registration of clients, service delivery
A Peer Educator doing condom demonstration in the community. Photo credit: PIPPE project.
across prevention to care continuum, and monitoring and reporting. It is reckoned that APATS will help in overcoming challenges with duplication, and in validating the exact number of KPPs.

• The unorganized sector forms 93% of India’s workforce. The majority of this forms part of supply chain of industries. Such industries can serve as better intervention points for comprehensive prevention to care programs. Thus, in collaboration with NACO, PIPPSE took a strategic step in designing Employer Led Model (ELM) for engaging industries to reach their informal migrant workers with HIV/AIDS programs. More than 200 industries across the country were enrolled for ELM, while more than 70 industries are actively implementing the program. The ELM enables industries to integrate awareness and service delivery programs within their existing systems, structures and resources.

• In line with the NACP IV (2012-17) vision to consolidate the lessons learned in implementing multiple state and local helplines, and further the efforts to actualise a single National HIV/AIDS Helpline, PIPPSE is supporting such a Helpline, launched on December 1, 2014, on World AIDS Day, by Shri J.P. Nadda, Honourable Minister for Health and Family Welfare, Government of India. Since the launch, 729,102 calls have been received at the server and since the last three months, the helpline has received an average of 70,000 calls per month. PIPPSE also conducted 11 Webex-based refresher trainings for counsellors and supervisors of the Helpline.

• PIPPSE is taking the lead role in providing technical assistance to NACO and SACS in Mainstreaming HIV/AIDS. PIPPSE hired ten regional program managers to provide support in signing state level MoUs with other line departments and roll out of mainstreaming activities. More than 100 Joint Working Groups that have been established to develop HIV inclusive policy in other departments and 107 directives issued by states to extend social protection benefits such as transport concessions, monthly pension, nutrition support, etc. to PLHIV and other vulnerable populations.

In 2008, the Partnership for Sustained Impact (PSI) project was launched. Led by PHFI, this project was aimed at providing techno-managerial and financial support to the National AIDS Control Organization (NACO). Coincidentally, Phase III of National AIDS Control Program was also launched the same year.
• PSI supports the national program through support to the various Technical Support Units (Karnataka, Andhra Pradesh) and also Technical Support Group (TSG) – Condoms. The last of these was constituted by NACO to monitor and oversee the Condom Social Marketing Program (CSMP). Through this, the condom market has grown significantly from 1.8 billion in 2007-08 to 2.7 billion in 2013-14 (including 727 million free condoms). Since August 2015, the project has been directly supporting the TSG-Condom to sustain the core condom social marketing functions.

• PSI has supported the development of communication strategies and materials by NACO and SACS for over eight years. These have ranged from radio and television advertisements for promoting condom use, STI treatment, voluntary blood donation to materials for community members and peer educators. Currently it supports the development of a 360 degree campaign on condom normalisation.

• The project has facilitated module development and implementation through national and regional trainers. Further, it has enabled the national program’s capacity building efforts through State Training Resource Centres (STRCs). NACO’s transfer of Āvāhan’s learnings from southern states to 6 identified northern states (Bihar, Odisha, Madhya Pradesh, Uttar Pradesh, Chhattisgarh and Rajasthan) in India is supported by PSI. This has been achieved through establishment and strengthening of 33 learning sites and capacity building of the state TI staff (650+ personnel) in the prevention program.

• An online distance learning programme for Opioid Substitution Therapy (OST) was launched by J P Nadda, Hon’ble Union Minister of Health & Family Welfare, Government of India on World AIDS Day 2015. It was developed by the project for building capacities of service providers and personnel engaged in delivering OST in NACO supported centres. This programme is a joint endeavour of National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi, and Public Health Foundation of India (PHFI), New Delhi.
Involving Men - A male peer educator talks about myths and misconceptions to the community men.
Centre must rethink its public health policy

• JVR Prasada Rao, Hindustan Times


After outstanding successes in reducing new HIV infections and providing life-saving treatment to more than 800,000 persons, India’s AIDS control efforts are running into rough weather.

The latest bad news is the budget cut in the AIDS programme for 2015-16, which was allocated Rs 1,397 crore — hardly enough for priority interventions, let alone for scaling them up to reach national and global targets. India needs to put another one million people under treatment and enhance testing and prevention programmes to cover 90% of key affected populations for achieving its target of ending AIDS as a public health threat. With the current allocations, the programme will struggle to maintain current and this can potentially lead to a resurgence of the epidemic.

The programme is also dogged by other challenges. The national programme administered since 1992 through the National AIDS Control Organisation (NACO), a semi-autonomous entity established by the health ministry under a senior official of the rank of director general (DG), has scored significant gains in combating AIDS. The programme’s success is attributable to the active participation of affected communities and effective decentralisation to autonomous state AIDS societies, which received funds directly from NACO.

Annual new HIV infections dropped from over 360,000 in 1997 to 130,000 in 2013, bringing down the number of infected persons in the country from 3 million to less than 2.1 million. India’s success story has been quoted by UN agencies as the best example of a comprehensive response to AIDS.

As World AIDS Day is observed today, India, with more than 20 lakh HIV cases, continues to be a worry. In 2014, 1.5 million people died of tuberculosis (TB) compared to 1.2 million from HIV/AIDS. Clearly, there is still significant work to be done on both TB and HIV/AIDS. However, this also means there has been a major success in reducing mortality due to HIV/AIDS (a 42 per cent reduction since 2004), which was first detected in 1981 in the United States and in 1986 in India.

The government-led Indian National AIDS Control Programme (NACP) has been lauded globally as a major success story. HIV incidence (occurrence of new cases) has reduced 57 per cent in 10 years. With this kind of progress, India is at a stage of building on its achievements and must strategically focus on activities to reduce new HIV infections to zero.

The UNAIDS, the HIV/AIDS body of the United Nations, has set a global target of ‘90-90-90’ by 2020 – 90 per cent of people in a country are tested and know their status; 90 per cent of those testing positive are put on anti-retroviral therapy (ART); and 90 per cent of those put on ART have a low viral load. Targets are meant to rise 95-95-95 by 2030.

The UNAIDS estimates that reaching the 90-90-90 target will require a total US $14 billion by 2016, including drug costs, service delivery, community mobilisation, ensuring access to testing and retention in treatment, and pre-ART costs.

India cannot decrease its HIV/AIDS programme budget but needs to significantly increase it; all the more essential in light of significant decrease in international funding. The results of decreasing the budget and slowing the programme may undermine the achievements made so far, leading to a rise in the number of HIV infections and deaths.

With more than 20 lakh HIV cases, India has been maintaining its position as the country with the third largest number of HIV infections in the world, after South Africa and Nigeria. Now is the time for India to demonstrate global leadership with an effective strategy in eliminating new cases in the shortest possible time.

Such India allocates substantial resources to HIV prevention, there remains work to be done in this realm as well improving education, broadening access to quality treatment and the reducing stigma and discrimination.

The government supports implementation of around 1,850 targeted intervention (TI) projects across the country through the community based organisations and NGOs. They reach out to high risk populations, namely female sex workers (FSW), men who have sex with men (MSM), transgender individuals (TG), injection drug users (IDU), and workers and truckers. This strategy has been very successful.

Firms and education remain the prime weapons for HIV/AIDS prevention. Research is ongoing for inventing a using HIV/AIDS vaccine, but preventative prophylaxis (PREP) for high-risk populations is successful in other settings.

Continue focus on AIDS programme

Dr Ashok Agarwal Dec 1, 2015

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PHFI is supporting efforts towards prevention and control of HIV/AIDS in India.

PHFI with support from the Bill and Melinda Gates Foundation implements the Partnership for Sustained Impact (PSI) project which provides technical support to the National AIDS Control Organisation (NACO). The project has set up a quality assurance mechanism for monitoring 1800 targeted interventions (NGOs) across the country. The project also undertakes strategic design and development of training and communication material for training and capacity building at scale.

PHFI with support from USAID is implementing PIPPSE project which is providing technical assistance to the National AIDS Control Program (NACP) to prevent and control HIV/AIDS in India. PHFI works closely with National AIDS Control Organisation (NACO) and State AIDS Control Societies (SACS). PIPPSE is implementing an innovative District Network Model (DNM) in Thane, Maharashtra; and supporting eight out of 17 Technical Support Units (TSUs) in the country.
WHAT IT TAKES TO VACCINATE

GOING THE LAST MILE

Launched on 25th December 2014 by the Ministry of Health & Family Welfare, Government of India, it was listed as the Ministry's topmost achievement of 2015.

To strengthen and revamp the Universal Immunization Programme (UIP), the Ministry of Health & Family Welfare (MoHFW), Government of India, entered into a Memorandum of Understanding with PHFI. The Immunisation Technical Support Unit (ITSU) supports the Government of India’s efforts, in consultation with existing routine immunization partners. ITSU has under its purview: procurement and logistics; cold chain management; Adverse Events Following Immunization Management (AEFI); vaccine quality and safety; strategic communication; monitoring and evaluation; and evidence generation and Vaccine Preventable Disease surveillance (VPD). In addition to the MoU, PHFI is a technical partner to Mission Indradhanush. The Mission aims to ensure full immunization with seven vaccine-preventable diseases for all children under the age of two.
eVIN project conceptualised by ITSU, was first piloted 2 districts of Uttar Pradesh.

ITSU and UNDP defined the technical specifications for eVIN procurement and is being scaled up in UP, MP and Rajasthan. ITSU will evaluating the implementation on behalf of Ministry of Health and Family Welfare (MoHFW).
ASHA worker on Immunisation rounds with her vaccine carrier in Assam
Project: Immunisation Technical Support Unit (ITSU)
Supported by: Bill and Melinda Gates Foundation (BMGF). Photo credit: Pranab Aich/PHFI
“Four new vaccines have increased India’s immunization strength”

19 Aug 2014, Ranul Koul, BioSpectrum

What kind of overall impact will the recent inclusion of four new vaccines in the universal immunization program have? The Indian Government has introduced four new vaccines in the universal immunization program. This is a major accomplishment. The existing oral polo vaccine has many advantages such as ease of administration and storage. But as it will continue to remain a polo vaccine (PV) will help in complete elimination and viral immunity. So, that is a major success for the polo program.

Achilles Heel of Rubella has been identified as one of the major problems in India. After discussions within the Indian government, the new Rubella vaccine will be introduced in November. This will be the first time that this vaccine will be included in the country’s immunization schedule.

As many as 50,000 children die every year in India due to vaccine-preventable diseases, despite a three-decade old, government-run universal immunisation programme. The new vaccines will help to reduce this number significantly.

Business Standard

Can the Indradhanush project save 500,000 Indian children?

As many as 1.8 million children in India don't live beyond age 5, despite many of these deaths being vaccine-preventable

Manupria | IndiaSpend | Bengaluru November 05, 2015 Last Updated at 11:32 IST

A 100% vaccination coverage to more than 95% is required, and given in a precise sequence. But it’s not obvious until you consider the logistical challenges of delivering vaccines to remote parts of India. The National Immunisation program has tried, however, to deliver a series of vaccination doses were administered under a full schedule of vaccines and are at risk in their communities. Every year, one million children die in India, mostly due to preventable diseases like pneumonia, measles, whooping cough, and tetanus. The vaccines need to be kept cool and needles. The vaccines need to be kept cold and need to be kept up to date.
India to introduce rubella and rotavirus vaccines and inactivated polio vaccine

BMJ 2014; 349 doi: 10.1136/bmj.g4844

Ganapati Mudur
1. New Delhi

The Indian government has accepted the recommendations of scientific and medical experts to introduce injectable inactivated vaccine against polio.

The government announced earlier that the universal immunisation program will provide long-lasting immunity to all children against polio, tetanus, and tuberculosis. The vaccine against Japanese encephalitis is also included.

Health officials estimate that between 80% and 95% of newborns are vaccinated in India—where the government wants to increase this number to 90%—to prevent the risk of contracting the diseases. A complete immunisation schedule is given when babies are born, at 6 months, and again by 18-24 months of age. A second dose of the vaccines against rubella and rotavirus is given by paediatricians in the first year of life.

Prime Minister, Narendra Modi, said, "The government will now provide vaccines for all children, regardless of their condition and background, and they will be given free of charge."

The government estimates that between 300,000 and 1 million children are born with disabilities each year. Children with disabilities are more vulnerable to other diseases, and many do not live past their fifth birthday. Some 80% of all children with disabilities have no formal education. Many have to stay at home because of their condition or lack of access to education. The government has undertaken initiatives to reduce the number of children with disabilities, and to improve their access to education and employment opportunities. The government is also offering free vocational training to children with disabilities, and has increased funding for special schools.
Healthy Habits Start Young: PHFI works on projects that promote awareness on the importance of balanced nutrition and regular physical activity for a healthy lifestyle among school children.
“In health there is liberty.

— Amiel
Two day refresher training and review meeting of Healthy Activity Programme (WHO tool) with front line workers of Doraha, Madhya Pradesh under PHFI’s PRIME (Programme for Improving Mental Health Care) project
ALIGNED TO HEALTH SYSTEM STRENGTHENING INITIATIVES
PHFI IS WORKING TOWARDS REDUCING DISEASE BURDEN OF TOBACCO

Using innovative interventions and multi-sectoral partnerships, PHFI has been taking the lead in reducing the health burden of tobacco through multi-sectoral tobacco control initiatives such as — evidence-based economic and policy research, advocacy, community-based cessation strategies, and media engagement. Some of the major milestones:

In a major project undertaken by PHFI, 3700 villages in Andhra Pradesh and Gujarat implemented tobacco control initiatives through engagement of gram panchayats, local community leaders and members of the public. Community interventions under the project helped Pongalipakka village in Andhra Pradesh, inhabited by 1632 people, became tobacco-free on the World No Tobacco Day, May 31, 2012. The project was successful in developing National, State and District Resource Hubs and building capacity through systematic training, workshops and meetings of state level government officials of health & education departments of AP & Gujarat and training of over 2300 teachers and 6250 peer leaders from 960 schools; 4500 health care providers including physicians, counselors, nurses, ANMs, lab technicians & pharmacists; 34 state-based senior journalists and 30 vigilante reporters; 1500 law enforcers and 700 Self Help Group (SHG) members.

PHFI organised The International Conference on Public Health Priorities in the 21st Century: The Endgame for Tobacco in September 2013 which witnessed participation of 600 delegates from across the world along with government representatives from 40 countries, government officials, World Health
School students advocating for 85% pictorial health warnings on tobacco product packages by April 2016 as part of ‘No More Tobacco’ in 21st century (NMT21C) programme launched by PHFI
Organisation experts, tobacco control advocates and experts, youth and media. The conference was partnered by 23 national and international agencies and organizations including MoHFW and WHO among others. During the conference, a 23-point Declaration was adopted, strongly recommending ratification and full implementation of the WHO Framework Convention on Tobacco Control (FCTC) by all countries through an action plan that includes raising tobacco taxes, mandating plain packaging for all tobacco products, progressively reducing the land under tobacco cultivation, prohibiting sale of tobacco to all persons born after 2000, developing a comprehensive set of tobacco cessation services, and de-normalising of tobacco industry. This conference also witnessed the launch of “No More Tobacco in the 21st Century” (NMT21C) – a youth campaign by PHFI and its partners, as the vanguard of a global movement for elimination of tobacco. NMT21C has been endorsed by several world leaders and supported by youth advocates all over the world.

PHFI has undertaken research on the economic burden of tobacco use in India estimating the economic costs attributable to tobacco and found from all diseases in India in the year 2011 for persons aged 35-69 years, a total of Rs. 1,04,500 crores (US$ 22.4 billion) in economic costs can be ascribed to tobacco use. The findings of the study were released by Former Union Minister for Health and Family Welfare Dr. Harsh Vardhan on 29 May 2014. PHFI has undertaken a study on tobacco taxes and their impact on revenue and consumption, in an effort to reduce the financial consequences of direct and indirect costs of tobacco attributable diseases. This study titled ‘An Empirical Study of India’s Fiscal Policies against Tobacco: A State Level Analysis’, calls for urgent action at the national and state levels to increase tobacco taxes. On all categories of tobacco products.

PHFI continues to advocate for a number of initiatives to reduce the burden of tobacco related diseases in India, in partnership with several other civil society representatives and the World Health Organisation (WHO).
The Global Youth Meet 2015, organised by PHFI and HRIDAY at Vishakapatnam. The conclave had participation from over 33 countries and 160 foreign and Indian delegates.

The Youth launched the GUARD OUR GLOBE campaign. The Declaration recalls the newly adopted sustainable development goals and recommended youth-led action points to advance each of the 17 goals. The Declaration also calls on world leaders to prioritise youth participation and identify mechanisms for youth engagement in the national and global agendas.
Former Indian Cricket Captain Rahul Dravid appointed as the Brand Ambassador for Tobacco Control by the Ministry of Health and Family Welfare, Government of India, after he agreed to a request from PHFI. Photo Credit: PHFI
WORLD SPIRITUAL LEADERS RESPOND TO PHFI'S CAMPAIGN FOR TOBACCO CONTROL

MESSAGE

The most effective way of persuading people not to smoke is to make them realize the dangers that tobacco poses to health. It is absolutely necessary to educate people about the harmful effects of smoking and to make them aware of the dangers involved. Information and public education about the harmful effects of smoking have enabled people to make informed decisions. If we are to change generations of smokers, we must educate people to make the necessary determination to change.

The Dalai Lama, Tenzin Gyatso

September 1, 2013

MESSAGE

Dear Professor Robby,

His Holiness Pope Francis has received your letter of 20 April 2013 and has asked me to reply to you. He appreciates the letter which encouraged him to share your thoughts with him.

He would like to express his gratitude for your efforts in raising awareness about the terrible harm caused by tobacco use and为此 encourages you to continue your work.

With every good wish.

Yours sincerely,

Benedict XVI

PHFI
Planning, Evaluation, Research Institute

August 21, 2013

Message from His Holiness The Dalai Lama

Message from His Holiness Pope Francis
A cluster randomized controlled trial of a brief tobacco cessation intervention for low-income communities in India: study protocol

Bidyut K. Sarkar1,2, Lion Shahab1, Monika Arora1, Fabiana Lorenzatto1, K. Srinath Reddy1 & Robert West2

Public Health Foundation of India, New Delhi, India. 1Department of Epidemiology and Public Health, University College London, London, UK, and NCSCT, University of Minnesota, MN, USA.

ABSTRACT

Background: India has 275 million adult tobacco users and tobacco use is expected to rise from 1–4% in 1990 to 13–3% in 2025. The population will die from tobacco use, with 70% of those who died were young people. Hence, tobacco control is important for prediction of changes in future tobacco use. This study examines the socioeconomic patterning of tobacco use in India, highlighting SES gradients in India, and whether there is an increase in the prevalence of tobacco use in India.

Methods: The study design is shown in figure 1. Schools were selected because they were representative of the range of types of schools in these urban cities, including government (low-to-middle income), private (middle-to-high income), and non-government (low income) schools. The study design is shown in figure 1. Schools were also selected that were not near to each other, to provide a range of baseline survey data.

Findings: The study found that tobacco use in India is shifting from developed to developing countries. The results also showed that the prevalence of tobacco use is increasing in India, particularly among low-income communities.

Discussion: The study results are important for prediction of changes in future tobacco use. This study is important for health intervention and health care professionals. The study is important for prediction of changes in future tobacco use and the future tobacco burden in India.
Differences in tobacco use among young people in urban India by sex, socioeconomic status, age, and school grade: assessment of baseline survey data

K Srinath Reddy, Cheryl L Perry, Melissa H Stigler, Monika Arora

Summary

The epidemic of tobacco use is shifting from developed to developing countries, including India, where adolescents are important to monitor, since increased use by young people might be a precursor to increased rates in the population.

Methods

about their tobacco use and psychosocial factors related to onset of tobacco use. Schools were representative of the range of types of school in these cities.

Results

Students who were in government schools, male, older, and in sixth grade were more likely to use tobacco than students who were in private schools, female, younger, and in eighth grade. Students in sixth grade were, overall, two to four times more likely to use tobacco than those in eighth grade. 24·8% (1529 of 6165) of sixth-grade students and 9·3% (509 of 5477) of eighth-grade students had ever used tobacco; 6·7% (413 of 6165) and 2% (110 of 5477), respectively, were current users. Psychosocial risk factors were greater in sixth-grade than in eighth-grade students. The increase in tobacco use by age within each grade was larger in sixth grade than in eighth grade in government schools, with older sixth-grade students at especially high risk.

The finding that sixth-grade students use significantly more tobacco than eighth-grade students is unusual, and might indicate a new wave of increased tobacco use in urban India that warrants confirmation and early intervention.

Introduction

Tobacco use continues to be the leading cause of preventable death worldwide. Tobacco use is shifting from developed to developing countries. Each year will die from tobacco use, with 70% of those deaths occurring in developing countries. The proportion of all deaths that can be attributed to tobacco use is expected to rise from 1·4% in 1990 to 13·3% in 2020, which will result in enormous economic, emotional, and societal costs in a population of more than a billion people.

Often first be recognised by increased use among young people, since most people begin to use tobacco while they are teenagers, become addicted, and thereby become adult users, carrying the wave of increased use into the population over time.

In the USA after the introduction and advertising of brands of cigarettes for women in the late 1960s. There were substantially increased initiation rates only among women younger than 18 years old, who remained smokers into adulthood, and increased the overall adult female smoking rates in the 1970s and 1980s. The increase in tobacco use at the population level can

be recognised by increased use among young people, since most people begin to use tobacco while they are teenagers, become addicted, and thereby become adult users, carrying the wave of increased use into the population over time.

In India, the proportion of all deaths that can be attributed to tobacco use is expected to rise from 1·4% in 1990 to 13·3% in 2020, which will result in enormous economic, emotional, and societal costs in a population of more than a billion people.
Chronic Non-Communicable diseases now account for 60% of all deaths in India. It is estimated that they will cause an economic loss of 4.58 trillion USD between 2011 and 2030.
Prof. Prabhakaran (PHFI), Dean Curran (Emory University), Prof. Reddy (PHFI), Shri Y.S. Chowdary, Honourable Minister of State for Science and Technology, Prof. Anne Mills (LSHTM) and Prof. Nikhil Tandon (AIIMS) unveil report on Chronic Conditions in India
A woman getting her blood-sugar test done at a community health center under the UDAY Project.
simultaneously highlights the need for innovative, person - and family-centred approaches towards understanding and tackling these conditions in a holistic manner.

The chronic care paradigm encompasses preventive and therapeutic care, and both must incorporate risk-factor management. This quest requires a vision which is inter-disciplinary, integrating diverse biomedical fields, clinical and public health sciences, and biological and social sciences. It is with this goal in mind that PHFI, in June 2014, merged its Centre for Cardio Metabolic Risk Reduction in South Asia (CARRS), South Asia Network for Chronic Disease (SANCD) and Centre for Mental Health (CMH) with the Centre for Chronic Disease Control (CCDC) to launch the Centre for Chronic Conditions and Injuries (CCCI).

With the objective of generating knowledge that can impact policy and practice aimed at reducing the burden of chronic conditions in India and beyond, the secretariat of CCCI launched the new Centre for Control of Chronic Conditions (4C) on 7th April 2015. The 4C is an international partnership between four leading institutions: the All India Institute of Medical Sciences (New Delhi) (AIIMS), Emory University, the London School of Hygiene & Tropical Medicine (LSHTM) and the Public Health Foundation of India (PHFI). The secretariat of CCCC is located at PHFI.

The approach taken by the 4C is an integrated one, addressing a range of morbidities, encompassing individuals and those they share a home with and guided by the principle that it is not diseases that matter, but people – and the families and communities they live in. 4C, in collaboration with its partners across India and abroad, is already engaged in a number of such integrative studies, from cohorts assessing the patterns and consequences of multiple morbidities to evaluating new models of care delivered by non-physician health care providers.
Managing a great epidemic

India's first Center for Control of Chronic Condition

Minister of State for Science and Technology Y.S. Chowdary on Tuesday launched the country's first 'Center for Control of Chronic Condition', hoping it will bridge the gap in healthcare.

The Center for Control of Chronic Condition is an international partnership between Delhi's AIIMS, US-based Emory University, the London School for Hygiene and Tropical Medicine and the Public Health Foundation of India (PHFI).

Government has always lacked a master blueprint for the development of the Center for Control of Chronic Condition will bridge the gap that has statistics, chronic conditions -- heart diseases, cancer, strokes, diabetes and cause behind deaths in India. They account for 60 percent of the total

Depression in India is rising, but we can't even talk about it

There is an urgent need to scale up services for treating depression in the country. An estimated 26% of people in urban India and 14% of those in rural India suffer from depression, according to a World Health Organisation report.

Mrs B is a 54-year-old woman living in a middle-class family. Her son is settled in a developed country US, married and lives in city F. She is a homemaker. Her financial condition is very stable. She is looking forward to his post-retirement life. For the last six months she has been feeling very tired throughout the day, not been able to sleep at night and has been waking up in the morning feeling very tense.

Earlier she used to eat two-to-three rotis at a meal. Now, she has started eating three-to-four dishes and is putting on weight. She had started taking antihypertensive drugs and her blood pressure was under control. She had been experiencing tiredness and low energy levels since a very long time, and now she's experiencing it even more severely.

Research

Type of vegetarian diet, obesity and diabetes in adult Indian population

Surapada Agrawal1, Christopher J Millet2, Poet K Dhillon1, SV Subramanian3 and Shah Gilani4

Abstract

Background: To investigate the prevalence of obesity and diabetes among adult men and women in India consuming different types of vegetarian diets compared with those consuming non-vegetarian diets.

Methods: We used cross-sectional data of 156,171 adults aged 20–49 years who participated in India's third National Family Health Survey (2005–06). Association between types of vegetarian diet (vegan, lacto-vegetarian, and non-vegetarian) and self-reported diabetes status and body mass index was assessed using multivariate logistic regression adjusting for age, gender, and educational attainment.
Cardiovascular diseases (CVDs) are the leading cause of death in many regions of the world (1). Elevated blood pressure, blood sugar, serum cholesterol, body mass index, and tobacco use, all established risk factors for CVD, have a direct and linear relationship with CVD (2–7). All of these risk factors are linked to lifestyle changes (4).

Although reasonable evidence exists for the beneficial role of risk factor reduction in decreasing CVD risk among individuals at high risk, primary or primordial prevention programs that use population-based approaches have yielded equivocal results (8,9). For example, a meta-analysis of all population-based studies conducted largely in developed countries has suggested that health promotion (involving health education, mass media, and community organization) does not reduce mortality significantly but leads to small yet potentially beneficial reduction in risk factor levels (10). Several reasons have been attributed to this equivocal result of health promotion. These include shorter duration of intervention, improper design to evaluate the benefits, contamination (adoption of components of health intervention by the control community), and a declining trend of CVD in developed countries during the intervention period. However, by contrast, in developing countries the current prevailing secular trend seems to be a rapidly increasing burden of CVD and its risk factors. Therefore it is likely that a community-based approach may show the desired results of reducing CVD risk factors in developing country settings. For example, a primary prevention and health promotion initiative in Mauritius showed a pronounced decrease in the population level total cholesterol concentrations after 5 years of the intervention program (11).

India is experiencing an accelerated epidemiological transition with a consequent increase in the burden of CVD risk factors both in community-based studies and in industrial populations (12–16). Given this background, we hypothesized that a comprehensive CVD risk factor reduction program comprising of a multipronged strategy of health promotion, high-
PHFI has been at the forefront of technical support and advocacy efforts around India taking forward the agenda of adopting a framework of Universal Health Coverage through the active engagement of all stakeholders. PHFI was the designated secretariat, for the High Level Expert Group (HLEG) on Universal Health Coverage. The group was constituted by the Planning Commission of India in October 2010, under the chairmanship of Professor K. Srinath Reddy with the mandate of developing a framework for providing easily accessible and affordable healthcare to all Indians. The report was released by the Government of India (GoI) in 2012.

Since the release of the HLEG report, PHFI has embarked on a series of translational and policy research initiatives at state and central levels. Ongoing technical projects and evaluations include six areas of focus: (1) health financing, insurance and financial protection (2) human resources for health (3) health sector governance and management (3) comprehensive primary health services (4) community involvement and public-private partnerships (5) access to medicines and pharmaceutical sector reforms (6) influencing the social determinants of health (8) awareness of gender issues in relation to access and equity for universal health coverage.

PHFI is currently offering technical support in the roll-out of UHC pilots in 2 districts each in the states of Kerala and Karnataka.
Professor Gita Sen addressing the opening session on "India's UHC: Vision and Roadmap" organised by PHFI and HEAI.

Left to right: Prof Gita Sen, Mr Anshu Prakash (MOHFW), Professor Reddy (PHFI), Dr Samit Sharma (IAS), Rajasthan.
A cure for all ills
Physicians must prescribe quality-assured generic drugs that are cheap and effective instead of branded alternatives, writes K Srinath Reddy

Assuring health coverage for all in India

Successive Governments of India have promised to transform India's unsatisfactory healthcare system, committing health as an inherent right in the present government's promise to expand health assurance for all. Despite substantial improvements in some health indicators, India continues to lag behind other middle-income countries and India's regional neighbours. A large proportion of the population is impoverished because of high out-of-pocket health-care expenditures and the adverse consequences of poor quality of care. Here we make the case for a system built around a strong public primary care system with a clearly articulated supportive role for the private sector.

On a trip to Bihar this week, I came across a story in the local edition of a national newspaper reporting a study by the Bihar chapter of the People's Health Movement. The story reported the cost incurred by a sample of patients who had been admitted to government-run health centres. They found that the average cost per admission was about seven times the average monthly income of the respondents, which led to high levels of distress sales and borrowing from money-lenders. It was astonishing how these costs were incurred in government facilities, where many believe that care is largely free. Of course, it would come as no surprise to learn that the recent National Sample Survey data reported that the out-of-pocket expenditure has gone up four-fold in the private sector.
How does one rate a health system that attracts medical tourism for its high-quality, low-cost advanced care, even as it lags behind many developing countries on key health indicators? What can we learn from India's experience in the past 65 years, as the country has navigated political and economic challenges and transformed from an agrarian to an industrialized economy? And what might these lessons mean for the future of universal health coverage in India and around the world?

India's health system has evolved over time, with significant changes in governance and resource allocation. The country's independence in 1947 marked the beginning of a new era, with a commitment to delivering health care services to all citizens. The Indian Constitution recognized health as a fundamental right, and the government assumed primary responsibility for health service delivery. However, disparities in economic development, social conditions, and political governance across states led to wide variations in service quality and population health.

India initially adopted a public-sector-led model for health care provision, with most services free to all. Successive policy frameworks emphasized rural primary health care. The private sector initially played a limited role, with small clinics and charity-run hospitals. However, as the country's economy opened up in the 1990s, large corporate hospital chains emerged, and the private sector grew significantly.

Despite these changes, India's health system remains characterized by a mixture of public and private provision. The private sector provides nearly 80% of outpatient and 60% of inpatient care, reflecting the country's economic growth and rising demand for care.

The country's health system also faces significant challenges, including high levels of infectious diseases, emerging chronic diseases, and inadequate public services. Economic planners have traditionally viewed health expenditures as financially nonproductive social spending, leading to low public financing levels. As a result, poorly resourced public services fail to meet the health needs of an expanding population.

India's experiences offer important lessons for countries seeking to achieve universal health coverage. The country's journey highlights the importance of political will, economic development, and sustained commitment to health care. However, achieving universal health coverage in India, or any country, is a complex and challenging task that requires careful planning, resource allocation, and political will.

India's Aspirations for Universal Health Coverage

K. Srinath Reddy, M.D., D.M.
“Every child has the right to be well born.”

—John Ruskin
PHFI documented case studies of Innovations in Maternal Health
Healthy women and children are the cornerstone of public health and key to progress in every aspect of human development. Through knowledge generation and advocacy, efforts are being undertaken by PHFI at various levels to impact the lives of women and children in India. Some of the major initiatives undertaken include:

• An extensive report on neonatal health in the country was developed by PHFI and partners. The State of India’s Newborn Report (SOIN)-2014 was released by Hon’ble Former Health Minister Dr Harsh Vardhan, Mr. Bill Gates and Ms. Melinda Gates in September 2014. It highlights existing evidence, implementation status of programmes, innovations for better implementation, and an analysis of health system and policies from the perspective of extending needed scare to the newborns.

• A PHFI-led initiative aims to develop and scale up evidence-based interventions to improve Reproductive, Maternal, Newborn and Child Health (RMNCH) behaviours amongst marginalised populations in Uttar Pradesh. This project seeks to layer health programs on women’s Self Help Groups (SHGs), created around micro-finance, to increase knowledge, enhance skills, and promote improved behaviour and practices for safer pregnancies, new-born care and child health.

• PHFI is also leading large scale innovative pro-poor programs focused on reducing maternal mortality in India. The study aims to develop a methodology to assess the comparative impact of two large scale programs for financing maternal healthcare in India: Chiranjeevi Yojana (CY), which has a targeted bursary approach versus the conditional cash transfer approach of Janani Suraksha Yojana (JSY).
• PHFI is working closely with the Government of Haryana and has undertaken two different populations based case control studies for the Use of Sex Selection Drugs (SSDs). Results have shown that the use of these drugs is strongly associated with congenital malformations and stillbirths.

• PHFI has undertaken a study to understand what women need during childbirth and which health care services can best address these needs. The aim of this effort is to replicate and contextualize in states with similar socio-economic and health parameters.

• PHFI and its constituent IIPH researchers continue to contribute to maternal and child health through implementation research, field work, reports, books and publications. PHFI has also compiled a compendium of innovative programme practices in family planning delivery and case studies on maternal health for health professionals and academicians.
Innovations in FAMILY PLANNING
Case Studies from India

This is the first book on innovations in family planning service delivery in the country which is of particular contemporary relevance, both nationally and globally. It features innovative case studies of family planning from India, which have demonstrated impact and are sustainable and scalable. These cases contribute to the approaches of problem solving, enhancing quality family planning care at the grass-roots level and influence future directions of the programme. The book facilitates advocacy, strengthening programme design and enhancing competency as well as orienting the health care system to support these efforts.

This is an important book for programme planners, policy makers and researchers.

Jay Satia

Kavita Chauhan

Aruna Bhattacharya

Nirmala Mishra

Edited by

FAMILY PLANNING
PHFI works on research projects which promote healthy diet and nutrition.

Photo Credit: CCDC and PHFI
“The doctor of the future will no longer treat the human frame with drugs, but rather will cure and prevent disease with nutrition.”

—THOMAS EDISON
PHFI is committed to reducing nutrition-related problems in India by being involved in nutrition research, advocacy, policy development, and capacity building. In order to identify the current strengths and gaps in the area of nutrition-relevant capacity in India, PHFI is performing an assessment of the curriculum and capacity of institutions that offer academic programs in nutrition in India, followed by in-depth case studies of centers of excellence in research and academia. PHFI is also conducting focus group discussions with young professionals and scholars as well as key informant interviews with leaders in the field of public health nutrition to identify the future roadmap of public health nutrition education and formulate an international standard curriculum in public health nutrition.

The post graduate Diploma in Public Health Nutrition, offered by PHFI as a distance education programme, has proved popular amongst Indian and International registrants. The MPH programmes will also now offer a stream in public health nutrition.

The Transform Nutrition research program consortium (TN), of which PHFI is a part, aims to transform thinking and action on nutrition. The objective of TN is to strengthen the content and use of nutrition-relevant evidence to accelerate under-nutrition reduction through this decade in the two highest burden regions of South Asia and sub-Saharan Africa, with special focus on four high-burden countries: Kenya, India, Bangladesh, and Ethiopia. As TN’s regional head of the Capacity Strengthening Working Group for South Asia, PHFI is actively involved in the
Indigenous foods study in Jharkhand by IIPH Delhi. Dissemination activity in the tribal community where the food environment was studied.
Importance of a healthy diet and use of cooking oils demonstrated to the community in the DISHA project in Gujarat.
development of short public health nutrition courses, leadership training, distance-learning initiatives, and detailed audits of nutrition-relevant capacity in India. As part of this initiative, PHFI launched the India Health Report: Nutrition 2015 which provides an evidence-based assessment of current achievements and challenges related to maternal and child nutrition in India. The report provides a rigorous analytical overview of the current trends, challenges, and puzzles related to maternal and child nutrition in India, and highlights the role of policy in improving a wide range of nutritional outcomes, especially at the state level.

PHFI is also committed to study, assess, and reduce severe acute malnutrition (SAM) among children. SAM is a major cause of morbidity and mortality in Madhya Pradesh, with estimates from the National Family Health Survey (NFHS)-3 indicating 12.6 percent of children below five years are suffering from SAM in the state. The Government of Madhya Pradesh has established Nutrition Rehabilitation Centres (NRCs) for in-patient management of children with severe acute malnutrition.

PHFI collaborated on the POSHAN (Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India) initiative, along with the International Food Policy Research Institute (IFPRI) and the Institute of Development Studies (IDS), Sussex, with support from the Bill & Melinda Gates Foundation. POSHAN aims to build evidence on effective actions for nutrition and support the use of evidence in decision-making.

A multi-stakeholder advocacy and dissemination meeting of 200 key persons was held to launch the Lancet Series on Maternal and Child Nutrition, 2013. The event, widely covered by the media, focused on the changing dimensions of the discourse on global nutrition. It was hosted by PHFI and the Coalition for Sustainable Nutrition Security in India, with support from IFPRI and the Micronutrient Initiative.

PHFI is also undertaking a Community Intervention to Improve Growth among Children under Two in Rural India to improve growth among children under two, in two rural districts of Jharkhand and Odisha, where over 60 percent of children were stunted. The project team implemented an intervention involving a village-based community health worker (CHW), modeled on the Anganwadi worker and the results of the study will be released in October 2016.

Trans-fats have been shown to contribute to adverse cardiovascular outcomes. A common source of trans-fats in the Indian diet is from foods prepared in partially hydrogenated vegetable oils. Knowledge of the levels
of trans-fats in snacks and consumption patterns of oil in households will help in raising consumer awareness. The project on effect of heating on the trans fatty acid content of commonly consumed Indian edible oils and fried snacks in South Delhi, is concerned with analyzing trans-fats in deep fried, ready-to-eat snacks (and the oils they are fried in) commonly sold in the market. The project will also survey oil consumption and usage patterns amongst a subset of households in south Delhi. The other nutrition project undertaken by PHFI is end line Evaluation of the Wheat Flour Fortification Project (funded by World Food Programme).

Professor K. Srinath Reddy is a member of the Global Panel on Agriculture and Food Systems for Nutrition, an independent group of high-level, influential experts with a commitment to tackling global challenges in food and nutrition security. The panel is developing recommendations for aligning agriculture and food systems support to the goal of improving access to nutritious foods at every stage of life. Funded by the UK Department for International Development, and the Bill and Melinda Gates Foundation, the Global Panel aims to stimulate a stronger evidence-base for how changes in agriculture and food systems can improve nutrition and catalyse collaboration to help provide a healthy and sustainable diet for all.

Professor K. Srinath Reddy, has also served as one of the commissioners on the WHO Commission for Ending Childhood Obesity (ECHO), the Commission (2014-16) was tasked with producing a report specifying approaches and combinations of interventions likely to be most effective in tackling childhood and adolescent obesity in different contexts around the world. The Commission delivered its report to the WHO Director-General in January 2016 and its recommendations will be conveyed to the World Health Assembly in May 2016. Dr. Monika Arora, Director of Health Promotion Division and Associate Professor, PHFI is an invited Member of Ad Hoc Working Group formed by World Health Organization’s Director General to advise on Implementation, Monitoring and Accountability for Ending Childhood Obesity (ECHO).
Honourable Ministers Smt. Maneka Gandhi (Women and Child Development) and Sh. JP Nadda (Health and Family Welfare) released the ‘Made in India: Good Nutrition for All: Implications of the Global Nutrition Report and the India Health Report for Nutrition Security in India’, a joint initiative of the Public Health Foundation of India (PHFI) and the International Food Policy Research Institute (IFPRI)
Dr. Shweta Khandelwal, Research Scientist and Asst. Prof. (PHN), Public Health Foundation of India (PHFI), New Delhi

Is Nutrition Security attainable by providing Food security alone? Are Nutrition Security and Food Security terms synonyms?

The question of food security hinges primarily upon adequate quantity of food; however, through the adequacy of food that nutrition security is attained. This shows that nutrition security is attained when nutritional needs are met, both in terms of quantity (availability of food) and quality (essential macro- and micro-nutrients). However, what needs to be debated is the availability of food for the underprivileged population of India. Therefore, in this article, we discuss various aspects of nutrition security.

NDTV

Misleading ads: food regulator steps in

New Delhi: They are snazzy, slick and smooth but do these ads feed us made up research and marketing exercises of companies that use clever language to make us buy their products?

Business Standard

Stunting in children declined in past decade: Report

In Uttar Pradesh, 50.4 per cent children malnourished, the highest in the country

NDTV

Indian Kids Continue To Be Under-Nourished: Health Minister

The proportion of stunted children has not shown any significant change in the last one year, according to the report.

The proportion of stunted children has not shown any significant change in the last one year, according to the report.
6 of world’s stunted children are in India—Global Nutrition Report 2015

Nutrition rates still high in India despite positive growth!

Chavan, Dec 11, 2015 at 10:52 am

Invest in our girls

39 per cent kids below 5 years are stunted

Dec 11, 2015 - TEENA THACKER

New Delhi

Obesity Spreads beyond Affluent Children

Even as rise in childhood obesity has become a cause of concern, the phenomenon is spreading to hitherto insulated population beyond the affluent sections as

Women fare badly in health report

Women's health and status are known drivers of poor nutrition, especially education

Neeta Chandra Sharma

New Delhi, December 11, 2015 | Posted by Anand Kanwar | UPDATED 10:58 IST

Malnutrition in India is declining faster than before

Malnutrition down, but not enough

Child malnutrition rate still high that 39% of all children
National Initiative for Allied Health Services (NIAHS) - PHFI assists GOI-MoHFW program for developing allied health professionals

"The importance of public health in India’s development cannot be over emphasised. Ours is a demographically young country. The largest growing demographic segment in India over the next two decades lies between 15 and 59 years. This provides a wide window of opportunity to enhance national growth, provided we can productively deploy this vast human resource"

—Dr Manmohan Singh
Former Prime Minister of India

Dr Subash Salunke, PHFI, Shri Keshav Desiraju, Former Health Secretary, GOI, Shri Ghulam Nabi Azad, Former Union Minister for Health and Family Welfare, GOI and Professor K. Srinath Reddy, President, PHFI unveil National Institute of Allied Health Sciences Report by PHFI
Prof. K Srinath Reddy with Mr R Prasanna, IAS, Director Health Services, Sh Ajay Chandrakar, Minister of Health, Government of Chhattisgarh, Shri. Avinash Champawat, Commissioner Health, and Mr Prasanta Dash UNICEF Head Chhattisgarh at the signing of the MoU to provide technical support to the state government of Chhattisgarh for improving Human Resources for Health.
A centre of excellence SACDIR, was established in 2010, under the aegis of PHFI, in collaboration with and support from the London School of Hygiene and Tropical Medicine (LSHTM), and its component research facility, the International Centre for Eye Health (ICEH), London, UK. The mission for the centre is ‘Inclusive Millennium: Evidence for Empowering Persons with Disabilities’.

World Health Organization (WHO) estimates put 650 million people, globally, living with some disability (physical, mental, visual, hearing, learning, speech and intellectual). Low/middle income countries account for 80% of this burden. In India, 26 million (2.2%) people suffer from disability, according to the 2011 Census. While disability is now understood as a public health problem, a health systems approach calls for a closer look at evidence of successful delivery initiatives in the larger South Asian context.
Testing for near vision using an E-chart

Person with disability conducting a household survey in Telangana

A field investigator conducting otoacoustic emission test
Diabetic Retinopathy and Retinopathy of Prematurity are the leading causes of blindness among working adults and infant blindness respectively. Timely management through effective screening and referral is critical to prevention. The Queen Elizabeth Diamond Jubilee Trust, in partnership with PHFI and the LSHTM, supported IIPH-H in conducting a multi-site situational analysis. Prevention of both conditions is high priority in building the capacity of both public and private providers.

This effort aims to assess the general health system’s capacity to tackle identify and appropriately manage persons with these problems, and to search for elements that may help to mould successful models for service delivery, modalities and management protocols for care and public awareness.
Launch of the Diabetes Retinopathy Summit in Hyderabad
Supported by: The Queen Elizabeth Diamond Jubilee Trust
Collaborating Institution: London School of Hygiene and Tropical Medicine (LSHTM)
India needs more technicians to detect diabetes-related eye disease

Press Trust of India

India needs to train enough technicians for early detection of an eye disease associated with diabetes, as the number of patients with the ailment is expected to touch over 10 million by 2030 in India, according to experts.

The disease, diabetic retinopathy (DR), may lead to loss of sight over a period, if it goes undetected.

Clare Gilbert, Professor and Co-Director, International Centre for Eye Health, London School of Hygiene and Tropical Medicines, said there are not enough ophthalmologists in India who can detect these cases in diabetic patients and hence the government and civil societies need to train technicians to detect retinopathy cases in the early stages.

"People with diabetes are at risk of developing diabetic retinopathy. It is not possible for an eye doctor to screen all the diabetic patients," Gilbert said at a conference organised by the National Institute of Nutrition (NIN) in collaboration with the University of Oxford.

"We need a system to train technicians to screen people with diabetes and retinopathy. It is not possible to send all the patients to an eye doctor," she said.

India has 60-65 million diabetic population with 6-7 million facing serious complications of the disease.
**Improving Health Outcomes through WASH**

Water, Sanitation and Hygiene (WASH) are widely recognised social determinants of health. Evidence links lack of safe water, adequate sanitation and poor hygiene practices to high disease burden, high mortality and morbidity, and poor state of health and well-being especially impacting women, infants and young children. PHFI’s work on WASH has so far largely centred on menstrual hygiene management (MHM), WASH in health facilities, and gender responsive sanitation.

In 2014, PHFI undertook a policy scoping review on MHM, examining how four ministries in the Government of India addressed the hardware (i.e., infrastructure needs) and software (i.e., behaviour change) components of MHM. This study was commissioned by WaterAid India and supported by DfID. The study found that, to a large extent, policies focused on the hardware MHM component, with less attention to the software component. Further, ministries talked about convergence across programs to comprehensively address MHM, yet program documents did not operationalise how this convergence would be brought about.

PHFI led the development of a framework for action on MHM, along with a core set of indicators to assess action on MHM, supported by DfID. This was in response to key gaps identified by organizations working on MHM and drawing on policy scoping work. This framework and indicators have been vetted with key stakeholders working on MHM and have been shared widely. Some of these indicators will be incorporated into the MHM guideline under the Swachh Bharat Mission.

The launch of the Swachh Bharat Mission has ensured the installation of toilets across the country, aimed at ending open defecation. However, responsiveness to women’s menstrual hygiene needs has yet to be reflected as a
PHFI undertook a policy scoping review on menstrual hygiene management.
Collaborating Institution: WaterAid India. Supported by DFID.
major programme priority. In order to address this gap, PHFI partnered with RTI International and undertook a study with women in Ahmedabad slums to examine how an innovative toilet prototype (with on-location waste treatment) met women’s MHM needs. This study found that for the RTI prototype to meet women’s menstrual hygiene needs, the model will have to take into consideration women’s use of menstrual absorbents, their beliefs and practices around disposal of menstrual waste, and their discomfort with using recycled water for washing.

Professor K. Srinath Reddy is a serving member of the technical group of the Rapid Assessment Learning Unit (RALU), constituted by the Ministry of Rural development to assess progress in the sanitation mission.
Change behaviour to ease India's tough 'swachh' dream

Dr Subhadra Menon, Aug 28, 2015, DHNS:

 Barely had the dust and excitement of the Independence Day action settled on the Red Fort in Old Delhi, for the second time in the year, the city got engulfed in stinky, unmanageable piles of garbage, all spilling out of the dumps onto the road.

So, while Prime Minister Narendra Modi’s I-Day speech resounded with the golden promise of a Team India beavering away to dramatically improve the access our countrymen and women have to toilets and the great dream of a Swachh Bharat, a simple management issue like the chronic shortage of workers (because they were off work owing to Independence Day) led to a stinking paralysis in garbage disposal.

This was a fairly rapid repeat of a similar situation just two months ago, when protesting against non-payment of their salaries for over two months, sanitation workers of the East Delhi Municipal Corporation deliberately threw garbage all over the streets so as to grab the government’s attention.

Providing facts to back-up what most Indians don’t need a survey to be enlightened by is a recent assessment by the Ministry of Urban Development of the Swachh Bharat Abhiyan, releasing cleanliness rankings for 476 cities. 39 cities from the Southern states are among the top 100 followed by 27 from the East, 15 from the West, 12 from the North and 7 from the North-Eastern states.

Delhi, as the capital city, is at a dismal 379, although its New Delhi Municipal Corporation has the distinction of being No 16! With minimal open defecation and effective solid waste management, seepage and water management as yardsticks, the survey places the southern city of Mysuru in Karnataka on top and Damoh in Madhya Pradesh at the bottom.

If you were to shut your eyes for a moment and try to think of a clean India, chances are a million images will fill by. Public places in India are often characterised by great grubbiness and while we aren’t very effective with managing our garbage, the situation with toilets is as bad, if not worse. Just about 50 per cent homes have access to a toilet, and the situation of public toilets across the country is pitiable, with those in metros often being the best examples.
TECHNOLOGIES FOR TRANSFORMATION
TAKING FORWARD NEW PARADIGMS IN PUBLIC HEALTH: AFFORDABLE HEALTH TECHNOLOGIES

The Public Health Foundation has been working in the field of Affordable Health Technologies with a multi-pronged approach, including creating and sustaining an ecosystem for innovation in health technologies and developing new technologies for both healthcare delivery and for public health education. Initiatives by PHFI and the IIPHS in this area include:

AUTOMETRY
IIPH Hyderabad is piloting a mobile phone based application that can automatically assess in real time — the height, weight, Body Mass Index and nutritional status. Effective nutrition management is based on anthropometry. Although anthropometry is less accurate than clinical and biochem indicators in assessing individual nutritional status, it may be used as a screening device to identify individuals at risk of under-nutrition. It therefore becomes a viable technique, given the resource constrained situations in remote rural areas across India.

DAS SIMPLE
IPH-Hyderabad has developed a mobile application for people with disabilities that can guide assessment, automate calculation, provide instant analysis, certify, and then link the person to customized benefits and also continuously track the outcomes. At present Disability Certification Guidelines are complex set of
THE GENESIS

DREAM-DOTS: DRONE + EHR linked AutoMated Directly Observed Treatment, Short Course for Tuberculosis. Supported by DJI Corp, Shenzen, China. Project undertaken by IIPH - Hyderabad.
mathematical calculations, based on expert assessment of physical parameters and range of movements. Less than 10% of the disabled have certifications. Persons with disability are among the most excluded ones in the development process of the country, and the App developed by IIPH-Hyderabad attempts to bring inclusion and help them avail of existing benefits at their doorstep. It would directly help the individual, the intermediary service provider and the country’s economy by enabling employment.

**DREAM-DOTS: DRONE + ELECTRONIC HEALTH RECORDS (EHR) LINKED AUTOMATED DIRECTLY OBSERVED TREATMENT, SHORT COURSE FOR TUBERCULOSIS**

The DREAM DOTS proposal makes DOTS take flight on EHR linked drones to the point of need and comprehensively deliver faster promotion, surveillance, diagnosis, treatment and follow up at the patients’ doorstep. This is being piloted by the team at the Indian Institute of Public Health, Hyderabad. The benefits of DREAM DOTS: (1) To the patient- (a) saving at least eight trips to the health care facility for diagnostics and treatment; (b) in effect save time and money; (c) possibility of service at a convenient time; (2) To the Health System-(a) fewer and improved links in the TB management system; (b) better control over service quality in labs, medicine distribution; (c) possibility of zero-delay service, continuous service monitoring/reporting in real time with automated decision alert analytics; (d) a platform that can fast track newer innovations for better TB management.
App for cardiovascular management shows promise

Researchers have found a way to improve the quality of primary care and clinical outcomes cost-effectively by using a smartphone application for cardiovascular management program (SimCard). A trial was conducted in India and China, which is the first dual-country trial of this kind worldwide, was delivered by co-health workers and is ideal in resource-constrained settings.

The trial carried out in 20 villages in Haryana, and 27 villages in Tibet used a smartphone that focused on two lifestyle modifications (smoking cessation and salt reduction) and use of two medications (blood pressure lowering agents and aspirin).

The trial increased the adherence to anti-hypertensive medications by 25.5% in the intervention group. However, the uptake of aspirin medication was more (24.5% per cent) than in India (2.8% per cent). Similarly, a “significant net reduction” over 4 mm Hg in systolic blood pressure was seen in China; there was no such reduction in the case of India.

Over 16% increase in the proportion of high-risk patients receiving follow-up was seen in both countries. However, no changes in lifestyle were reported by 2086 individuals with high CVD risks — over 40 years old and with a self-reported 15% CVD and a measured systolic blood pressure over 160 mm Hg. The results were published recently in the journal Circulation.

The study was carried out by the Public Health Foundation of India (PHFI) in collaboration with the All India Institute of Medical Sciences (AIIMS) in India and the George Institute for Global Health at Peking University Health Science Centre (Peking University) in China.

Drones tested to deliver drugs

A drone that carries medicines will soon become a reality.

In a novel scheme of utilizing technology in healthcare, researchers at the Indian Institute of Public Health (IIPH) in Hyderabad are testing drones (unmanned aerial vehicles) to deliver drugs.

On a pilot basis, the researchers have been testing a drone at a Primary Health Centre (PHC) at Moinabad, Ranga Reddy district, about 50 kilometres from Hyderabad. The
The Affordable Health Technologies division of PHFI has been developing innovative technologies for increasing the efficacy and outreach of primary healthcare in India. PHFI forayed into the field of health technologies with Swasthya Slate, an affordable, easy to use device that runs on Android supported tablets or phones and enables a range of medical diagnostics using a single kit. Swasthya Slate can empower rural frontline healthcare workers to provide diagnostic tests to the poor in far-flung areas. The average learning time of this tool is five minutes and thirty seconds. Results are instant and the cost of conducting these tests is significantly below prevailing market prices.

The Wall Street Journal listed Swasthya Slate as one of the 6 healthcare devices which could help millions of people
Swasthya Slate has been introduced as part of a pilot study under the RMNCH+A in Jammu and Kashmir in six districts under the Norway – India Partnership Initiative. 16,000 mothers have been registered for ante-natal care as part of this programme till date. Swasthya Slate is also being introduced by the Delhi Government in its Mohalla Clinics.

Swasthya Slate’s potential impact on public health has been recognized both nationally and internationally.
Developed ‘Swasthya Slate’ (electronic tablet for point-of-care diagnostics, relevant for primary healthcare and for use by community health workers); being considered by National/State/International Governments. Already deployed for RMNCH+A implementation in Jammu and Kashmir by MoHFW
Swasthya Slate - a few use cases

SCREENING OF PATIENTS
Doctor DEO
ANM Emergency Services

A Person in Kallawar goes to his village health and nutrition day for routine screening. The ASHA registers the patient in the Swasthya Slate system and performs diagnostic tests. Uses telemedicine app to consult doctor and contacts emergency services.

MOTHER & CHILD CARE – Diagnosis, referral & follow ups


The ASHA registers her in the Swasthya Slate system and performs diagnostic tests. Uses telemedicine app to consult doctor and contacts emergency service.

The Swasthya Slate System is equipped with apps like Prenatalim, ANC to cater to pregnancy related issues.

The App allows the ASHA to automatically schedule follow-ups for doctor/ANC visits, vaccine schedule in her tablet.

GETS AUTOMATIC SCHEDULE FOR LATER VISITS (FOLLOW-UPS) THROUGH TASK SCHEDULER APP

REPORTING - Swasthya Slate Data Bank

Ministry Official has to prepare weekly, monthly reports on health related issues or needs data for any other purpose.

Swasthya Slate system provides multiple options for information gathering & data acquisition, the access to which is restricted to authorised users only.

Uses of Swasthya Slate in primary health care setting

Swasthya Slate system sends out the data in real time. The lady is registered under JAY scheme by the DEO. PHC doctors can make further follow-ups using the patient data received on the MCRTS.

Helps in arranging mobilization for the expecting mother.

Helps in post natal exercise teaching (Health Communications), infant nutrition etc. Can schedule vaccination plans for the infant.

The heatmap looks at patients from a region and averages their BP to produce a colour representing the seriousness of BP issue in that region. This visualization helps you plot where to focus the intervention and reap the best benefit from public health schemes.
This Indian start-up could disrupt health care with its powerful and affordable diagnostic machine

By Vivek Wadhwa

November 18 at 10:16 AM

The Swasthya Slate is portable, affordable

Frustrated at the lack of interest between most medical devices in the world and the need for affordable diagnostic solutions for those in developing countries, Dr. Kanav Kahol created the Swasthya Slate. It is a portable device that can conduct a variety of tests, including ECG, blood pressure, and even breath analysis, for a fraction of the cost of traditional diagnostic tests.

Dr. Kahol had been working on developing innovative solutions for the underprivileged communities of India. He was a member of Arizona Biomedical Informatics, which provided necessary research grants.

The Swasthya Slate is a game-changer in the world of health care because it makes sophisticated medical tests accessible and affordable to everyone, regardless of their location or financial status. This innovation is not only changing the way we deliver health care but also paving the way for a more equitable future.
Wonder kit of healthcare

‘Swasthya’ Slate project is launched by PHFI and Government

M. Sai Gopal

Swasthya Slate workflow
Within 10 to 15 mins

1. First step is patient registration, collecting demographic information and picture. It is transferred securely to a remote server.
2. Diagnostic equipment to record sugar, BP and other parameters is connected to the patient and transmitted to the Swasthya Slate at the other end.
3. The readings are transmitted from the display device to the Slate via Bluetooth.
4. It is validated by a nurse and recorded.
5. The patients are given a printout of the readings along with a brief health advice.

It is not often that one comes across an innovative technology that makes basic diagnostic tests simple and affordable. The recently launched Swasthya Slate project by the Public Health Foundation of India (PHFI) and the Government of India is one such device that has bridged the gap between doctors and patients.

The diagnostic kit has enough promise to change the way basic diagnostic tests are conducted at the health centres in the State. At just Rs 85, the kit, which includes the Slates, Tablet, a small box dubbed Swasthya Slate and other diagnostic devices, costs Rs 1,000, and allows healthcare workers to conduct tests for sugar, blood pressure, heart rate, haemoglobin.

Health tablet expected to revolutionise diagnostics

SHRUTHI SETIA CHHABRA Chowringhee | 24th June 2013

It’s that time of the month for District Health Management Information System (DHMIS) workers in India. They have to collect a various set of patient data, which is later sent to the state’s health department. But now, with the introduction of the DHMIS tablet, the process is expected to become easier.

The tablet, launched by the state government, is expected to revolutionise the way health data is collected and stored. It is a part of the DHMIS project, which aims to provide a uniform and streamlined system for data collection and analysis across the state. The tablet is equipped with a special app that enables healthcare workers to collect data from patients in a more efficient and accurate manner.

The tablet is equipped with features such as a built-in camera, a microphone, and a GPS module, which helps in collecting data in real-time. It also has a powerful battery, ensuring that the device remains operational throughout the day.

With the help of the tablet, healthcare workers can now collect data from patients in a more efficient and accurate manner. The data is then transmitted to the state’s health department, which ensures that the information is up-to-date and accurate. This is expected to help in making informed decisions and improving the quality of healthcare services in the state.
Project on awareness to action through multi-channel advocacy for effective tobacco control in India: capacity building in five Indian states by the Indian Institute of Public Health, Bhubaneswar (IIPH-B). Photo Credit: IIPH Bhubaneswar
AMPLIFYING
ADVOCACY &
ACCELERATING ACTION
Prof. K. Srinath Reddy is the Co-Chair of thematic group 5 on “Health for All” and PHFI is a member institution of the United Nations Sustainable Development Solutions Network (UN-SDSN). Over the last two years, PHFI’s engagement with the SDSN has resulted in a document titled “Health in the Framework of Sustainable Development”, developed in collaboration with experts from around the world. The document outlined the centrality of health in the framework for sustainable development, and details goals and targets related to health for the consideration of the UNs Open Working Group on the Sustainable Development Goals. The submissions of the thematic group have been considered in the final SDG declaration that provides a comprehensive agenda to achieve health for all by 2030.

PHFI also launched a free Massive Open Online Course (MOOC) on Global Public Health in March 2015 in partnership with the SDSN. The course ran for 10 weeks, covering a range of subjects in public health including the history and origins, infectious and chronic diseases, health systems & financing, all while emphasizing the centrality of health in the development discourse, and the importance of integrating health across sectors. The course was led by Prof. K. Srinath Reddy, with global experts such as Dr. Richard Cash (Harvard School of Public Health), Prof. Vinod Paul (All India Institute of Medical Sciences), and Mr. Rob Yates (Chatham House) contributing as faculty members. The MOOC was very well received, with over 3000 students signing up, and around 1000 completing the course, which represents a very high retention rate for online courses. The next
PHFI is leading the initiative to develop an indicator framework for India to realise Sustainable Development Goals (SDGs).

PHFI is now working on the development of an India relevant indicator framework for the implementation of the SDG targets related to health. This project is supported by a grant from the Rockefeller Foundation.
Health and sustainable development

Krishna d Rao Posted online: Monday, Feb 25, 2013 at 0000 hrs

Increase of government spending on health from around 1% to under 2% of GDP in the 12th Five Year Plan can create an affordable health system by pursuing two independent strategies to achieve universal health care—strengthening the public health system, and building a government sponsored health insurance system.

The 12th Five Year Plan and its promise of increased government spending on health from around 1% to under 2% of GDP is seen by many that the government might at last be serious about the nation’s health. Yet, as recent debates on the Health Plan indicate, it is not clear where these additional funds should be invested. Indeed, the government appears to be pursuing two independent strategies to achieve universal health care—strengthening the public health system, and building a government sponsored health insurance system. Given the levels of government spending on health, both strategies cannot be adequately funded. Nor do these two paths necessarily complement each other. There is a pressing need for a national strategy that harmonises these competing paths and enables the efficient use of our country’s scarce health resources.

The idea of universal health care is not new in India. The Bhore Committee report (1946) inspired the creation of a vast network of government funded and staffed clinics and hospitals through which all Indians could have access to affordable health services. That this system failed to deliver on its promise is well known—it was underfunded, under supplied and under staffed.

In the past decade, there has been a renewed effort to rejuvenate the public sector health system, particularly at the primary care level. This effort was signaled by the launch of the National Rural Health Mission (NRHM) in 2005, which, till date, has invested around Rs43,700 crore in strengthening the public system. With the eminent launch of the National Urban Health Mission, substantially more government funding can be expected to flow into health.

More recently, the High Level Expert Group (HLEG) commissioned by the Planning Commission recommended that the government spend up to 3% of GDP on strengthening the public sector health system.
Health and development

Health has many determinants that lie outside the conventional biomedical paradigm.

K. Srivats Reddy

What is the knock-down effect of bilateral relations between countries on public health in India?

Will livestock farming in high-income countries affect global health and environment? How will the growth of cities impact the health of populations?

These questions may be far-fetched for many who think of health only as a product of interactions between individual beliefs, behaviour, and biology, and view medical care as the only pathway for improving health. However, health has many determinants that lie outside the conventional biomedical paradigm and are influenced by non-individual interventions that have a profound population-wide impact.

These interconnections have been long-recognized by the public health community, but are being acknowledged only recently. They are at the forefront of ongoing discussions on the cost of their own. They are also being addressed to describe how those goals will impact other development sectors so that an integrated framework for sustainable development can emerge in 2015.

It is no secret that poverty is both a cause and consequence of ill-health, especially when the poor in India are known to have among the worst health indicators globally. Healthcare costs push 30 million Indians below the poverty line each year. It requires no imagination to recognize that water and sanitation have a great impact on health. Studies show that half of childhood under-nutrition in India can be ascribed to poor sanitation.
BOTH RURAL AND URBAN DEVELOPMENT NEED TO BE SUSTAINABLE AND HEALTH FRIENDLY

Both rural and urban development need to be sustainable and health friendly. Photo Credit: Satyanarayana / IIPH - H
A major engagement of PHFI, in broadening awareness of the importance of health in policy formulation across sectors, came through the work of the Steering Committee on Air Pollution established by the Ministry of Health and Family Welfare in early 2014. Professor K. Srinath Reddy was named co-chair of this committee along with Professor Ambuj D. Sagar of IIT-Delhi, with PHFI named as secretariat to the committee. The committee comprised experts from health, economics, energy, environment and development, and tasked with compiling the evidence on exposures and health impacts in India, and to chart out a roadmap to reduce the burden of air pollution on health in India, through multi-sectoral actions. In its role as secretariat, PHFI played a key role along with committee members and advisors in compiling the best evidence obtained nationally, supplemented by global evidence where needed, and charting out actions for each relevant ministry. The key innovation of the report

Professor K. Srinath Reddy was named co-chair of the Steering Committee on Air Pollution established by the Ministry of Health and Family Welfare
was highlighting the fact that interventions need to be focused on where the exposure is, rather than just where the emissions are, thereby tackling the key sources affecting health, rather than just air quality. The report also outlined actions to address long-term and episodic exposures in a holistic manner.

PHFI, along with Harvard School of Public Health (HSPH), was recently awarded a collaborative grant to establish the Air Pollution and Health GEOHealth Hub Research and Capacity Building Program. The goal is to accelerate scientific infrastructure development, enhance research training, and support research needed to fully characterize the relationship between air pollution and health outcomes in India. By training Indian scientists on how to assess indoor and outdoor air pollution and occupational exposures, conduct complex epidemiological studies of air pollution, epigenetic and mediation analysis, the proposed hub will enhance capacity to conduct research that will help inform policies to effectively mitigate the impact of air pollution on susceptible populations.

In January 2016, PHFI received a grant from Tata Sons to establish a Centre of Excellence in Environment and Health. Apart from undertaking policy relevant research on the health effects of various environmental hazards, the centre will also enable PHFI to partner with the Tata Institute of Social Sciences to strengthen academic programmes in this field.
Indians losing over years of their life due to high pollution levels: study

Michael Greenstone of MIT says almost 6.28 mn population in 281 districts exposed to health risks due to poor adherence to pollution standards

Sanjeeb Mukherjee | New Delhi
April 2, 2014 Last Updated at 1:36 IST

India's over 121 billion strong population stands to gain almost 3.3 years of life, of the country adhere to the air quality standards laid down by the government, well-known Environment Economist Professor Michael Greenstone, of the Massachusetts Institute of Technology showed.

Greenstone, who presented his study at the recently held annual meeting of the Foundation of India (PHFI), said that almost 6.28 million population in 281 districts are exposed to health risks due to poor adherence to pollution standards.

Greenstone, who also served as the Chief Economist for President Obama's Council of Advisors in the first year of his Administration and was editor of The Review of Economics and Statistics, said India should allow civil penalties for pollution related cases and deny subsidies to decrease transport emissions. It could consider imposing a Conway parking prices for cities like Delhi, which have a big huge vehicle population.

As per the Environmental Performance Index study, India officially has the “best” of the world, beating China, Pakistan, Nepal and Bangladesh”, and ranks last among all 170 plus countries surveyed.

Experts say that sustained exposure to fine Particulate Matter (PM) on a sustained cause a range of upper and lower respiratory ailments, including chronic bronchitis obstructive pulmonary disorder, and acute lower respiratory infections. In India, it is estimated to contribute to over 100,000 premature deaths annually, the study said.

THE TIMES OF INDIA

‘Pollution check can save 2bn life years’

Jayashree Nandi TNN

New Delhi: India can save up to 2 billion life years if the places that exceed the national air quality standards (very polluted) were brought within standards, US-based economist, Michael Greenstone has estimated.

Greenstone, who is 3M professor of Environmental Economics at Massachusetts Institute of Technology (MIT), said in around 281 districts, 628 million people live in highly-polluted areas that don’t meet the air quality standard.

He was delivering a lecture on ‘Shorter Lives Due to Air Pollution’ at the Public Health Foundation of India (PHFI) foundation day celebrations on Friday. Greenstone’s estimates are based on data from the Central Pollution Control Board (CPCB) and other studies which show that 52% of India’s population is living in areas that are monitored by CPCB, where PM 2.5 (very fine respirable particles) level is higher than the safe standard. Over 80% of the population is living in areas where PM 10 (coarse particles) levels are higher than the safe standard.

Greenstone had conducted a similar “quasi-experimental” study on air pollution in China which assessed the life expectancy of a population north of Huai river where a lot of coal power plants were located due to a home heating policy and compared it with south of Huai river where no such policy existed. Life expectancy of those in north were found to be far lesser. A similar model of experiment is used in case of India.

Greenstone found that each person living in these areas may gain 3.3 years of life in India. “India is very highly polluted and needs to make policy to deal with it. WHO has recently released data that 1 in 8 deaths were due to air pollution in 2012. The majority of the impact is borne by South East Asia,” said Greenstone who was also the chief economist in President Barack Obama’s Council of Economic Advisers.
End unsustainable fuel subsidy to reduce air pollution:
PHFI

Report says diesel exhaust is a major contributor to transport emissions, especially of particulate matter

Neha Sethi

Some of the other actions that the paper recommends for reducing ambient air pollution include expanding real-time monitoring of ambient air quality in the country in urban areas to study the impact. Photo: Hindustan Times

New Delhi: Public Health Foundation of India (PHFI) has said that ending unsustainable fuel subsidies is one of the major actions required to reduce ambient air pollution in India.

PHFI released a paper on Friday which said that diesel exhaust is a major contributor to transport emissions, especially of particulate matter. “With 49% of all new cars running on diesel (the cost of which is subsidised by the government), this is a challenge that needs to be tackled,” it said.
Dr Prabhakaran and Dr Sandeep Bhalla sign MoU with the, Hon’ble Mayor of Kolkata, Shri Sovan Chattopadhyay, Kolkata Municipal Corporation for adoption of CCEBDM course.

Honourable Sh. Tarun Gogoi, Hon. Chief Minister of Assam, Dr K Srinath Reddy, President, PHFI, Prof Kulendu Pathak, Former Vice Chancellor, Dibrugarh University at the Convocation of CCEBDM.
Consultation meeting on EcoHealth / One Health in South Asia organised by PHFI
Alcohol Taxation Consultation organised by PHFI
Dr Rajesh Bhatia, Dr V C Ohri, Dr R Laxminarayan, Prof Ganguly, Dr Dilip Mathai and Dr Chand Wattal at the Launch event and Panel Discussion, State of the World’s Antibiotics, 2015

Former Health Minister Dr Harsh Vardhan releases the report on the “Economic Burden of Tobacco Related Diseases in India” on World No Tobacco Day

Symposium organised by PHFi on Universal Health Coverage
Dr Montek Singh Ahluwalia speaking at the symposium on Universal Health Coverage organised by PHFI and HEAI
Professor Jeremy Farrar, Director, Wellcome Trust addressing researchers and faculty at the PHFI office
Dr. Robert Black, Professor of International Health at the Johns Hopkins Bloomberg School of Public Health and lead author of the Lancet Series at the Lancet Series on Maternal and Child Nutrition 2013

National Board of Examinations (NBE) and PHFI, release of the Report of Health Professional Education for a New Century by Sh. CK Mishra, Additional Secretary, Ministry of Health and Family Welfare, Dr K Srinath Reddy, President PHFI and Prof. M.C. Misra, Director AIIMS
PHFI and partners launched a comprehensive diabetes prevention and management programme UDAY
Know Violence in Childhood: A Global Learning Initiative is a new global initiative of leading independent experts created to generate evidence and advance action on preventing violence. The technical secretariat is located at PHFI.
IIPH - Gandhinagar participated in Vibrant Gujarat 2015
PHFI celebrates Foundation Day each year, with a lecture which focuses on a public health area of national and global importance, delivered by a distinguished leader.

• 2015: Professor James W. Curran, Dean of the Rollins School of Public Health at Emory University: ‘What has Public Health learned from HIV?’

• 2014: Professor Michael Greenstone, 3M Professor of Environmental Economics at the Massachusetts Institute of Technology: Shorter Lives Due to Air Pollution and Some Potential Solutions for India

• 2013: Professor Dulitha Nandanie Fernando, Emeritus Professor, Community Medicine, Faculty of Medicine, University of Colombo: Orienting Health Systems to Women’s Health

• 2012: Dr Julio Frenk, Dean of the Faculty and T & G Angelopoulos Professor of Public Health and International Development at the Harvard School of Public Health: Transforming Health Professional Education for the 21st Century

• 2011: Professor Peter Piot, Director, London School of Hygiene and Tropical Medicine: Global Health in the 21st Century: From Concerns to Concerted Action

• 2010: Dr Tim Evans, Assistant Director General, World Health Organisation: Improving the public health workforce: a change in ‘per diem’ or ‘paradigm’?

• 2009: Prof. Sir Andrew Haines, Director, London School of Hygiene & Tropical Medicine: Revitalising Primary Health Care: From Evidence to Action

• 2008: Prof. Anthony J. McMichael, NHMRC Australia Fellow at the National Centre for Epidemiology and Population Health, The Australian National University, Canberra: Environment, Climate and Health, An Expanded Public Health Research and Policy Agenda for the 21st Century
Professor Julio Frenk delivers the Foundation Day Lecture on Transforming Health Professional Education for the 21st Century.

Professor James. W. Curran, Dean of the Rollins School of Public Health, speaking on 'What Public Health has learned from HIV'.
PHFI releases a call for action policy brief on ambient air pollution and public health which preceded a panel discussion where apart from Prof Greenstone, Dr Leena Srivastava, Executive Director TERI and Ms Anumita Roy Chowdhury, Executive Director, Research and Advocacy, Centre for Science and Environment were panellists, moderated by Dr T Ramasami, Secretary, Department of Science and Technology, Government of India.
OTHER DISTINGUISHED INTERNATIONAL SPEAKERS WHO HAVE DELIVERED PUBLIC LECTURES ORGANISED BY PHFI

Ms. Mary Robinson
Former President of Ireland and Director General of UN Human Rights Commission

Prof. (Sir) Michael Marmot
Chair of the WHO Commission on Social Determinants of Health

Prof. Jeffrey Sachs
Chair of the Sustainable Development Solutions Network

Prof. Christopher Murray
Director of the Institute of Health Metrics and Evaluation, University of Washington
PARTNERSHIPS FOR A PUBLIC PURPOSE
PARTNERSHIPS FOR A PUBLIC PURPOSE

PHFI is a unique, not-for-profit public private partnership. PHFI represents a true ‘Partnership for Public Purpose’ that is working collaboratively with a range of stakeholders including the national and state governments, national and international academia, civil society, global foundations, individual leaders, and the private sector. It functions as an independent foundation and is registered as a Society in India.

The creation of PHFI in 2006 was enabled by the Government of India, and was supported by multiple stakeholders. Initial funding came from the Ministry of Health & Family Welfare (MoHFW), the Bill & Melinda Gates Foundation and private philanthropy. Amongst the other core supporters of PHFI are Nand & Jeet Khemka Foundation, Infosys Foundation and HCL Corporation.

PHFI adopts an integrative approach to public health that emphasises preventive and promotive dimensions of health and strengthening of health systems for delivering a wide range of services.

It is governed by an empowered and international Board with representation of eminent personalities. The Secretary, MoHFW is on the Board (Executive Committee) of PHFI and State Governments are on the Regional/Advisory Councils of IIPHs.
OUR GRATEFUL THANKS TO OUR INSTITUTIONAL FUNDERS AND SUPPORTERS

Supporters, including founding members, providing institutional funding towards organisational priorities (such as development of IIPHs, Centers, Scholarships, Initiatives) through contribution to corpus or specified funds

Central & State Governments
- Ministry of Health & Family Welfare, Government of India
- State Governments of Gujarat, Delhi, Odisha, Telangana, Meghalaya, Karnataka (State Governments as IIPH development partners under an MoU)

Foundations & Trusts
- Bill & Melinda Gates Foundation
- Nand & Jeet Khemka Foundation
- Wellcome Trust
- Friends of ISB Foundation
- Amar Foundation

Private Sector & Individual Philanthropists
- Infosys Foundation
- Spandana Foundation
- HT Parekh Foundation
- American India Foundation
- Deshpande Foundation
- Heart Foundation and Research Institute
- Cyient Foundation
- Deepak Foundation
- Sir Dorabji Tata Trust
- Tata Sons Limited
- Reliance Industries Limited
- Ranbaxy Promoter Group
- GMR Projects Private Ltd
- GVK Power and Infrastructure Ltd
- Mr. NR Narayana Murthy
- Dr. Varaprasad Reddy
- Dr. Mangal Katikineni, Dr. Anil Tulpule and Dr. M K Mohan
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OUR VALUED NATIONAL AND INTERNATIONAL PARTNERS IN PUBLIC HEALTH PROGRAMS

ACADEMIC & RESEARCH ORGANISATIONS/ASSOCIATIONS

GOVERNMENT & ITS DEPARTMENTS AND PROGRAMS; BILATERAL/MULTILATERAL AGENCIES

FOUNDATIONS & PRIVATE SECTOR ORGANISATIONS

February 2016 | Full list of collaborators at: https://www.phfi.org/collaborations/our-collaborators
July 31, 2014

The Honourable Prime Minister of India
South Block, Rashtrapati Bhavan,
New Delhi-110011

Subject: Extension of support to grant University status to Public Health Foundation of India (PHFI) and its constituent units of Indian Institutes of Public Health (IIPHs)

Esteemed Prime Minister, on behalf of the undersigned deans of schools of public health, we extend our heartiest congratulations and best wishes to the new government under your leadership. We have been closely following the health policy announcements by your government, particularly the National Health Assurance Mission, and commend you for putting public health amongst the top priorities. In line with its place in global economy, India can be a force in global health as it improves its own health outcomes and brings up new models and innovations in health systems to increase health access and affordability.

As part of our global health partnerships, our schools have active academic and research collaborations with Indian public health institutions, including the Public Health Foundation of India (PHFI) and the Indian Institutes of Public Health (IIPHs) established by it. It is our strong belief that building a base of skilled public health professionals will be a critical enabler for designing and delivering effective health policies and programs.

We have watched with great admiration the growth of PHFI-IIPHs as a multi-disciplinary education-research-practice focused institution, having strong connections with national and international academic and research organizations. It is commendable that in a short span, PHFI has built a talent pool of 600 plus professionals including not just medical doctors but also nutritionists, economists, engineers and social scientists. Through its on-campus and distance education programs, it has trained 20,000 plus public health professionals. The research output has been impressive with 1000 plus publications in highly rated peer reviewed journals, and the knowledge base is being applied to improve health policy and programs.

Towards realizing its full potential and becoming a truly world class institution of higher learning, PHFI can benefit immensely from a formal recognition and empowerment as a National University. This would not only enable it to award Graduate degrees, PhD and other academic qualifications in the disciplinary streams of public health, but also support greater academic collaborations with other institutions and universities across the world. We urge you to lend your support for granting of University status to PHFI and its constituent IIPHs.
Letter of support to PHFI from London School of Hygiene & Tropical Medicine

To the Honorable Prime Minister of India,
Prime Minister's Office
South Block, Rashtrapati Bhavan
New Delhi - 110 011
India

30 August 2014

Esteemed Prime Minister,

Endorsement of the creation of University Status to the Public Health Foundation of India (PHFI) and its constituent units of Indian Institutes of Public Health (IIPHS)

On behalf of the London School of Hygiene & Tropical Medicine, I would like to convey our admiration of the emphasis laid by the new government, under your able and experienced leadership, on public health as an integral component of the development agenda. Your vision, combined with the efficient and accountable governance that is expected to be the hallmark of your administration, can prove truly transformative for the health system in India. Your proposal to provide every citizen with accessible and affordable health care through a National Health Assurance Programme has the potential to deliver a substantial base of healthy and productive workforce to the country.

As part of our initiatives towards fostering strong and enduring academic linkages between India and the UK institutions, we have been actively engaged with the Public Health Foundation of India (PHFI) and the Indian Institutes of Public Health (IIPHS) established by it. We deeply admire the strong base of on-campus and distance education programmes that has been built by PHFI in a short span of 5-6 years. The multidisciplinary resource base and strong linkages with on-ground research and health system activities lends a unique character to the IIPHS as world-class institutions of higher learning.

We are of the firm view that one of the critical needs with regard to the planned provision of high quality and large-scale public health education in India is the development of appropriately skilled faculty in adequate numbers. In view of this, a consortium of 10 UK Schools of Public Health have partnered with PHFI through the Wellcome Trust Capacity Strengthening Strategic Award, for developing future leaders in public health. This programme includes opportunities for doctoral & masters studies, research fellowships, collaborative research projects, short training courses and faculty exchanges between India and the UK. The current phase of the programme leverages the skills and resources of the UK consortium to further strengthen in- and intra-country research, education and practice links by facilitating the transition of doctoral candidates to being independent research and faculty leaders. So far, over 30 talented young health

Improving health worldwide

October 24, 2014

The Most Hon'ble Prime Minister of India,
South Block, Rashtrapati Bhavan
New Delhi - 110 011

Esteemed Prime Minister,

We are writing, both as academic and physicians, in recognition of your visionary leadership in shaping the future of public health in India, through the establishment of the PHFI and its constituent units of Indian Institutes of Public Health. The PHFI, as part of the 10 UK Schools of Public Health, have partnered with PHFI through the Wellcome Trust Capacity Strengthening Strategic Award, for developing future leaders in public health. This programme includes opportunities for doctoral & masters studies, research fellowships, collaborative research projects, short training courses and faculty exchanges between India and the UK. The current phase of the programme leverages the skills and resources of the UK consortium to further strengthen in- and intra-country research, education and practice links by facilitating the transition of doctoral candidates to being independent research and faculty leaders. So far, over 30 talented young health
Public Health Foundation of India being awarded the PHD Chamber Award for Excellence in Skill Development for the Year 2015 by Shri. Rajnath Singh, Honourable Union Home Minister, Government of India at PHD House. Photo credit: PHFI
AWARDS AND HONOURS
Among the several honours and awards received by PHFI’s faculty and scientists, some are listed below:

- Public Health Foundation of India awarded the PHD Chamber Award for Excellence in Skill Development for the Year 2015 by the Union Home Minister, Shri Rajnath Singh.

- Diabetes training programmes - CCEBDM and CCGDM are recognised by prestigious International Diabetes Federation for the period 2014-2016 and 2015-2017 respectively. CCGDM is also accredited by South Asia Federation of Endocrinology Society (SAFES) from 2014 to 2016.

- Certificate Course in Gestational Diabetes Mellitus offered by PHFI was awarded “FICCI Health Care Excellence Award 2015” in the Skill Development Category.

- Healthy-India.org has been adjudged Winner of the PC World Web Awards 2008, for excellence in overall performance in the healthcare category. The awards were presented across 31 categories and experts rated about 500 websites to declare the website a winner.

- Professor K Srinath Reddy was conferred honorary Doctor of Science (Medicine) by Her Royal Highness Princess Anne at Buckingham Palace.
  - Co-Chairs the Health Thematic Group of the UN Sustainable Development Solutions Network.
  - Member of the Global Panel on Agriculture and Food Systems for Nutrition.
  - Independent commission on Health Professional Education.

- Professor Dorairaj Prabhakaran and Dr. Shweta Khandelwal have been appointed to the Food Safety and Standards Association of India’s Expert Committee on the regulation of sugar, fats and salt in processed foods.
• Professor Ramanan Laxminarayan was recently appointed a voting member of the United States Presidential Advisory Council on combating Antibiotic-Resistant Bacteria

• Professor Vikram Patel named Time Magazine’s 2015 List of 100 most influential people in the world
  - Awarded prestigious Institute of Medicine’s 2014 Sarnat Prize for his research and Contributions to Improving Mental Health Care in Developing Countries
  - Awarded the 4th annual Chanchlani Global Health Research Award by the Chanchlani Research Centre, McMaster University, Hamilton, Ontario, Canada

• Professor Sanjay Zodpey was elected Chief Editor of the Indian Journal of Public Health

• Dr. Santanu Pramanik was awarded the prestigious Cochran-Hansen Prize of the International Association of Survey Statisticians (IASS)

• Dr. Shifalika Goenka is a member of the Lancet Commission on Obesity

• Dr. Monika Arora was conferred the WHO Director General’s World No Tobacco Day Award in 2012 for anti-tobacco advocacy efforts and has been nominated for the Graduate Institute of International and Development Studies, Geneva 300 Women Leaders in global health

• Dr. Kabir Sheikh was elected as Vice Chair of the board of Health Systems Global, an international membership organisation dedicated to promoting health systems research and knowledge translation
International Diabetes Federation (IDF) recognises Certificate Course in Evidence Based Diabetes Management - CCEBDM

International Diabetes Federation (IDF) recognises Certificate Course in Gestational Diabetes Mellitus – CCGDM
South Asian Federation of Endocrine Societies (SAFES) accredited PHFI for excellence in diabetes education for CCGDM module
“Health leaps out of science and draws nourishment from the society around it.”

—GUNNAR MYRDAL
Photo of children at an Anganwadi Center. Photo Credit: PHFI
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10 years of PHI

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