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'No woman should die giving life'

The health of mothers and babies is the foundation of healthy families and communities, helping ensure hopeful futures for us all. A maternal death is defined by WHO as the “death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes”.

This year's World Health Day (7th April 2025) – which marks 5 years from the Sustainable Development Goals deadline — will kick off a year-long campaign titled **Healthy beginnings, hopeful futures**, focussed on maternal and newborn health.

A recent scientific study - multi-strategy systematic review to identify causes of maternal deaths occurring in 2009–20 - published in the Lancet Global Health, is WHO's first global update on the causes of maternal deaths since the SDG were adopted in 2015. [Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis, by Cresswell J A, Alexander M, Chong M Y C, Link H M, Pejchinovska M, Gazeley U, et al March 2025] Haemorrhage – severe heavy bleeding – and hypertensive disorders like preeclampsia are the leading causes of maternal deaths globally, according to this new study. These conditions were responsible for around 80,000 and 50,000 fatalities respectively in 2020, highlighting that many women still lack access to lifesaving treatments and effective care during and after pregnancy and birth.

In addition to outlining the major direct obstetric causes, it shows that other health conditions, including both infectious and chronic diseases like HIV/AIDS, malaria, anaemias, and diabetes, underpin nearly a quarter (23%) of pregnancy and childbirth-

related mortality. These conditions, which often go undetected or untreated until major complications occur, exacerbate risk and complicate pregnancies for millions of women around the world.

To avoid maternal deaths, it is vital to prevent unintended pregnancies providing adequate access to contraception. Most maternal deaths are preventable, as the health-care solutions to prevent or manage complications are well known. All women need access to high quality care in pregnancy, and during and after childbirth. Maternal health and newborn health are closely linked. It is particularly important that all births are attended by skilled health professionals.

Factors that prevent women from receiving or seeking care during pregnancy and childbirth are:

- health system failures that translate to (i) poor quality of care, including disrespect, mistreatment and abuse, (ii); insufficient numbers of and inadequately trained health workers, (iii); shortages of essential medical supplies; and (iv) the poor accountability of health systems;
- social determinants, including income, access to education, race and ethnicity, that put some sub-populations at greater risk;
- harmful gender norms and/or inequalities; and
- external factors contributing to instability and health system fragility, such as climate and humanitarian crises.

To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at both health system and societal levels.

[Source: WHO Website, Lancet]

Dr. Prasad Waingankar

Health is a Right: Facts and Myths

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IPHA Nationwide Essay Contest – World Health Day 2024 – Category A – 1st Prize Essay

Health is not merely the absence of disease but a state of complete physical, mental and social wellbeing. It is a fundamental human right underpinned by international agreements and declarations. The "Right to Health" has been recognized as a set of fundamental human rights for at least the past half-century since the adoption of the Universal Declaration of Human Rights in 1948, which contends in Article 25 that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family". As per WHO- "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions." In the intricate tapestry of human rights, complexities, nuances and misconceptions need exploration. Good Health is also determined by other fundamental human rights such as access to safe drinking water, sanitation, nutritious food, sexual and reproductive information and being free from violence and discrimination. There are different ideas regarding how Health as a right is idealized and how it is considered a privilege by some. There is real-life evidence to support both outlooks. Some people view Health as a right, the government enforcing these rights, or they believe that healthcare is not something everyone deserves. Since there are two viewpoints regarding Health as a Right, for those who take it as a right, it is a tool to attain basic human rights of Health for the marginalized population who struggle to find adequate work or cannot work. It becomes government duty to ensure that these rights become attainable for them, regardless of the lottery of birth.

Moreover, the people who consider it a privilege will express negative rights. For them, one cannot have healthcare as a right because it places a duty or obligation on them to contribute to the care of others. Helping them with healthcare needs should be voluntary. Thus, for those working hard and earning wages that do not cover the cost of healthcare, access to government assistance or charity is an earned privilege. However, from this point of view, those who are not productive members of society do

not deserve access to care nor to collective pools of money paid by those who are productive. Then there are people, though no fault of their own, who are born with physical and mental disorders that bar them from working. Thus, it should not be linked to people's capacity to work. As said- "What impacts one of us impacts all of us- both in positive and negative realms." Therefore, health needs to be a right because if the most vulnerable member of our society is not cared for, it means that we as a collective are not cared for. Therefore, this essay dives into the multifaceted aspects of Health as a right, bringing out the facts, dismissing various misconceptions, describing the implications for individuals, communities, and societies, and discussing the solutions.

Now, speaking about facts, the idea of Health as a human right has garnered colossal attention, international recognition and endorsement. It is written in critical documents such as the Universal Declaration of Human Rights, which states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family." Many countries have incorporated this right into their constitution or legal framework, making it compulsory for the government to ensure equal access to healthcare services, establish healthcare policies and allocate resources equitably. Various public health interventions such as vaccination campaigns, sanitation programs and health education play an essential role in advancing the right to Health by addressing underlying determinants of Health, promoting preventive measures and enhancing access to essential healthcare services. Talking about the concept of "Universal Health Coverage" aims to ensure that all individuals and communities receive the healthcare services they need without undergoing financial constraints, making it a key strategy in advancing the Right to Health for all. With efforts to address disparities in healthcare access, quality, and outcomes among different population groups, people are trying to achieve health equity, where everyone has a fair opportunity to reach their full health potential, thus realizing Health as a right.



Unravelling the myths, one of the most common notions among people is that healthcare is a privilege reserved for those who can afford it, which further perpetuates health inequities, exaggerates disparities in access to health care and diminishes all the efforts to achieve universal health coverage.

Another prevalent myth is that individuals bear sole responsibility for their health outcomes. It is true that personal behaviors and lifestyle choices undoubtedly affect Health. We all make bad choices at some time or another. For example, should smokers have the right to take money for lung cancer treatment? Or do sexually promiscuous people have a right to resources for HIV treatment? Hence, it becomes essential to recognize the broader structural determinants and social factors that shape health disparities, including socioeconomic status, education, employment, and environmental conditions.

On the other hand, providing universal healthcare would be financially unsustainable and economically burdensome. However, evidence from countries with successful healthcare systems demonstrates the economic and social benefits of investing in Health, such as improved productivity, reduced cost, and enhanced social connections. Next is the population viewing healthcare as a commodity, which is spreading the misconception that it can be bought and sold and can only be bought by rich people, making it appear that only those who can afford healthcare deserve access to quality services.

Thus, the commercialization of healthcare weakens the principle that Health is a fundamental human right. Taking into account this thought of considering healthcare as a luxury rather than a right sustains inequities and hinders efforts to ensure universal access to essential services. Access to healthcare should not be determined by one's socioeconomic status but should be guaranteed to all.

After citing all the facts and myths, we can see that there are two sides to the same coin: those who believe that healthcare is a right, whereas others who believe healthcare is a privilege. Thus elucidating its profound implications among individuals, communities and societies, such as upholding the right to Health empowers individuals to actively participate in their Health and well-being actively, fostering an agency of autonomy and

accountability within healthcare, thereby promoting patient-centred care, shared decision making and community engagement. Adoption of Health in various policies requires integrating Health into various sectors such as education, housing, urban planning, food, etc. This holistic approach would address all the underlying determinants of Health, promote health equity and foster sustainable development across all the domains. Health as a right should be recognized so that efforts can be concentrated on removing disparities in access to healthcare, ensuring equitable distribution of resources, improving healthcare infrastructure, implementing policies to remove financial barriers and prioritizing the needs of marginalized and underserved populations.

However, there has been an enormous gap between the idea of Health as a right and the actual condition of healthcare delivery. To fill these gaps, several strategies can be implemented, such as policy reforms and resource allocation, promotion of health literacy and education that will empower individuals to make informed decisions about their Health and well-being, leading to improved outcomes and reduced disparities, community involvement in healthcare decision making which will help in tailoring services to meet specific needs of a diverse population, giving a sense of ownership and accountability in healthcare, raising awareness about the right to Health and advocating for policies that prioritize health equity and intersectoral collaborations, i.e. collaboration between different sectors such as healthcare, education, housing, nutrition, environment, social services etc.

All things considered, the assertion that Health is a right is not merely a lofty idea but a fundamental principle that has been debated and discussed in the realm of public health for more than a century. By dispelling myths and embracing evidence-based approaches, we can move closer to realizing the vision of Health as a universal right that is grounded in principles of equity, justice, and dignity for all individuals. As we navigate through the multifaceted terrain of healthcare provision and policy, let us stay committed to upholding Health as a universal right, ensuring that no individual is left behind, thus honouring the inherent dignity of every human being and paving the way for a healthier, more equitable and sustainable future for the generations to come.

Freedom from Discrimination in Healthcare: Evidence and Pathways

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IPHA Nationwide Essay Contest – World Health Day 2024 – Category B – 1st Prize (Joint) Essay

Mansi, a bright and ambitious medical student, embarked on her journey to become a doctor. Full of passion and determination, she dreamed of making a difference in people's lives through healthcare. However, little did she know that her path would be marred by the shadows of gender-based discrimination ingrained in the Indian healthcare system. During her clinical rotations, Mansi observed subtle yet pervasive instances of discrimination. Male colleagues received more opportunities to assist in surgeries, while female students were often relegated to administrative tasks or less hands-on roles. Despite her academic excellence, Mansi found herself constantly underestimated and overlooked. One day one female patient came to OPD and Mansi really wanted to help her and take care of her. But her senior doctor chose her male counterpart for treatment and support of that female patient. She felt so helpless and decided to file complain to authorities. Do you think that this is the discrimination in health system? Do you have similar experience?

In today's world, the right to health is a fundamental human right accepted by international community. The principle of freedom from discrimination is fundamental to ensuring equitable access to healthcare for all individuals. Discrimination in healthcare can take various forms, including discrimination against individuals with disabilities, racial or ethnic bias, gender-based disparities, and stigma related to certain health conditions. The principle of freedom from discrimination is a cornerstone of equitable healthcare provision in Bharat. Despite constitutional guarantees of equality and non-discrimination, there are various evidence depict that various forms of discrimination persist within the Indian healthcare system.

Evidence of Discrimination in Healthcare in India

1. Gender-Based Discrimination: Gender-based discrimination in healthcare is observed in Indian health care system. The common areas are access to health care, quality of care, priority in maternal and child care and even at the level of service provider. In male dominating society it is observed that female is not treated at par in health care. Because of this, there is big gap in access to maternal and reproductive health services. Gender biases often lead to inadequate prenatal care, higher rates of maternal mortality, and limited access to family planning services. Additionally, transgender individuals encounter stigma & discrimination when seeking gender-

affirming healthcare services, leading to significant barriers to care.

2. Socioeconomic Disparities: Economic inequalities contribute to disparities in health care access and outcomes in India. Individuals from lower socioeconomic backgrounds often face challenges in accessing quality healthcare due to financial constraints. Private healthcare services, which are often perceived as superior, are inaccessible to many low-income individuals, leading to reliance on overburdened public healthcare facilities.

3. Geographic Disparities: Rural and remote regions in India experience significant disparities in healthcare infrastructure and services compared to urban areas. Limited access to healthcare facilities, shortage of healthcare providers, and inadequate transportation options contribute to poor health outcomes among rural populations.

4. Caste-Based Discrimination: India's caste system continues to influence access to healthcare services, particularly for individuals belonging to Scheduled Castes (SCs) and Scheduled Tribes (STs). Studies have highlighted disparities in health outcomes, including higher maternal mortality rates and lower life expectancy, among SCs and STs compared to higher castes. Discriminatory attitudes among healthcare providers and staff towards lower caste patients can result in substandard care and limited access to healthcare resources.

Thus, there are various level of discriminations observed in health care system in India. In last few years the intensity was observed in lower side but still various sporadic cases surfaced at various time. The government and various agencies took various steps to reduce such discrimination at various level.

The few actions taken are as below-

- **Policy level** – The Constitution of India guarantees the right to equality and prohibits discrimination based on factors like caste, religion, and gender. Additionally, the National Health Policy (2017) has focused on equitable access to healthcare for all citizens without any discrimination.
- **Ayushman Bharat** – PM Jan Arogya Yojana was launched to support marginalized and poor families. Under this scheme health insurance is provided to all poor families up to 5 lakh Indian rupee. They can avail treatment form any hospital even at private hospitals too.

- **Maternal & Child health** – Various schemes are launched or modified to cater full services to all women and children of country without discrimination. Mission Indradhanush is one of such schemes. Under this scheme all children are targeted for full immunization without any discrimination. The mission was successful to achieve the vaccination coverage in nation. Availability of contraception at the doorstep is also one of important service to empower women to partner in family welfare scheme.
- **Recruitment of Accredited Social Health Activist (ASHA)** at village level, is the biggest antidote to remove gender-based discrimination in nation. ASHA is the key volunteer on ground to provide majority of health services to villages and tribal area. They are the trained volunteer to cater mainly mother and child services. They are the female from local village. Not only they are providing services but they are creating awareness about health care rights of women and children in nation. They are the activist not just volunteers.
- **Telemedicine** – This is the new concept which is launched at government hospital with health and wellness centre. Quite large health and wellness centres are equipped with telemedicine instruments. The community health officer at health and wellness centre will take appointment of doctor and doctor will be available on call. Thus telemedicine is bridging the gaps and provide the specialist services for remote villagers and tribal community.

There are few steps taken by the private health care system too. Though it has many limitations but they are welcoming steps. They are like -

- **NABH accreditation and Ethical code practice** – Organizations like the National Accreditation Board for Hospitals & Healthcare Providers (NABH) promote ethical practices and patient-centered care through accreditation programs. These programs can encourage private hospitals to develop policies and training programs to address discrimination.
- **Corporate Social Responsibility (CSR) Programme** – There are many big hospitals and companies have CSR funds to support various community programmes. Under this many hospitals and companies are spending funds to eliminate various discriminations in health care systems. They are creating awareness against diseases and early diagnosis. They do give culturally sensitive training to the health care staff to eliminate various discriminations practices in health care system.

- **Patient advocacy group** – The rise of patient advocacy groups is providing a platform for individuals to report instances of discrimination. These groups can pressure private healthcare providers to address complaints and improve their practices.

With above actions, the system could be able to reduce the various discrimination in health care. But still, we need to work hard and long to eliminate the discrimination.

The way forward with following key steps -

- 1. Policy Reforms:** Enact and enforce anti-discrimination laws and policies that protect the rights of marginalized populations. Not only marginalized but gender-based discrimination elimination is required to focus. The women harassment cell needs to be strengthened in all hospitals & institutions. Strengthen affirmative action measures, such as reservations in medical education and employment for SCs, STs, and Other Backward Classes (OBCs), to increase representation of underprivileged communities in the healthcare workforce.
- 2. Community Empowerment:** Empower marginalized communities to advocate for their healthcare rights and access. Promote community-based healthcare initiatives, such as mobile health clinics and community health workers, to improve access to healthcare services in underserved areas.
- 3. Healthcare Provider Training:** Implement mandatory training programs on cultural sensitivity, gender equity, and ethical healthcare practices for healthcare providers. Foster awareness of unconscious biases and discrimination among healthcare professionals to ensure patient-centered care and equitable treatment for all individuals.
- 4. Investments in Health Infrastructure:** Allocate sufficient resources and investments to strengthen public healthcare infrastructure, particularly in rural and underserved areas. Expand access to essential healthcare services, including primary care, maternal and child health services, and mental health support.
- 5. Research and Data Collection:** Conduct research and collect disaggregated data on healthcare disparities to inform evidence-based interventions and policies. Monitor progress in reducing discrimination and improving health equity through robust data collection and analysis.

There are many other actions that can be targeted to eliminate discrimination. As citizens we all need to support the constitutional right of equality for each citizen. As a health care person, we should not ignore this key issue and we need to be sensitive enough to eliminate this practice. The simple said for elimination of discrimination is **“treat others as you would like to be treated”**.

Freedom from Discrimination in Healthcare: Evidence and Pathways

Dr. Kapil Goel

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IPHA Nationwide Essay Contest – World Health Day 2024 – Category B – 1st Prize (Joint) Essay

Introduction:

Nelson Mandela once said, "Health is a human right, not a privilege!" which encapsulates the belief that access to healthcare should be considered a basic human entitlement rather than a luxury afforded only to a privileged few. In today's society, the pursuit of freedom from discrimination in health is an essential endeavor to ensure that every individual has equitable access to healthcare services and opportunities to attain optimal wellbeing. Discrimination in health, whether based on race, ethnicity, gender, socio-economic status, or other factors, perpetuates disparities that undermine the fundamental principles of fairness and justice within healthcare systems.

This essay seeks to explore the evidence of discrimination in health and delineate pathways towards achieving freedom from such inequities. The evidence of discrimination in health is pervasive and multifaceted, manifesting in various forms across different demographic groups. Studies consistently highlight disparities in access to healthcare services, quality of care, and health outcomes among marginalized communities. These disparities underscore the urgent need for targeted interventions to address systemic inequities within healthcare systems.

Moreover, understanding the pathways perpetuating discrimination in health is crucial for devising effective strategies to dismantle barriers and promote health equity. Structural determinants, institutional biases, interpersonal prejudices, and individual-level factors all contribute to the perpetuation of health disparities. By addressing these root causes and implementing evidence-based interventions, we can pave the way towards a future where every individual has equitable access to high quality healthcare services, regardless of their background or identity.

Through collaborative efforts and a commitment to justice, we can work towards creating a healthcare system that is truly inclusive, responsive, and equitable for all individuals. By understanding the root causes of inequality & implementing targeted interventions, we can pave the way for a healthcare system that is fair, inclusive, and accessible to all.

Evidence of discrimination in health:

The evidence of discrimination in health is clear and compelling, highlighting the pervasive disparities that exist among different demographic groups. Numerous studies have documented inequalities in access to healthcare services, quality of care, and health outcomes based on factors such as race, ethnicity, gender, socio-economic status, and other social determinants of health. Racial and ethnic minorities, for instance, face significant barriers to accessing healthcare services, resulting in disparities in health outcomes such as higher rates of chronic diseases, lower life expectancy, and increased mortality rates. These disparities are exacerbated by factors such as lack of insurance coverage, language barriers, geographic disparities, and systemic racism within healthcare systems.

Similarly, gender-based discrimination contributes to disparities in healthcare access and outcomes, with women often experiencing challenges in accessing reproductive healthcare services, mental health support, and gender-specific treatments. Socio-economic factors further compound these disparities, as individuals from low-income backgrounds are more likely to experience barriers such as financial constraints, lack of transportation, and limited access to preventive care. Moreover, studies have shown that individuals belonging to marginalized communities, including LGBTQ+ individuals, people with disabilities, and immigrants, also face discrimination within healthcare settings, resulting in disparities in healthcare access and quality of care. Overall, the evidence of discrimination in health underscores the urgent need for action to address systemic inequities within healthcare systems. By recognizing and addressing these disparities, we can pave the way towards achieving freedom from discrimination in health and ensuring equitable access to healthcare services for all individuals, regardless of their background or identity.

Pathways towards discrimination in health:

Understanding the pathways that perpetuate discrimination in health is essential for devising effective strategies to dismantle barriers and promote health equity. These pathways



encompass various systemic, institutional, interpersonal, and individual-level factors that contribute to disparities in access to healthcare services, quality of care, and health outcomes. One pathway involves structural determinants, such as systemic racism, economic inequality, and inadequate healthcare infrastructure, which create barriers to accessing care for marginalized communities. These structural inequities contribute to disparities in health outcomes by limiting access to resources, opportunities, and social determinants of health. Institutional biases within healthcare systems also play a significant role in perpetuating discrimination in health. Discriminatory policies, practices, and norms within healthcare institutions can result in differential treatment and contribute to disparities in care delivery and patient experiences. Lack of cultural competence, language barriers, and unequal distribution of resources further compound these disparities.

Interpersonal biases among healthcare providers, rooted in implicit biases, stereotypes, and lack of cultural competence, can also contribute to discrimination in health. These biases may influence clinical decision making, patient-provider interactions, and access to care, ultimately affecting health outcomes for marginalized populations. At the individual level, factors such as stigma, discrimination, and lack of health literacy can deter marginalized individuals from seeking care, further perpetuating health disparities. Fear of discrimination, mistrust of healthcare providers, and cultural beliefs may also influence health-seeking behaviors and healthcare utilization patterns.

Overall, recognizing and addressing these pathways towards discrimination in health is crucial for promoting health equity and ensuring that all individuals have equitable access to healthcare services. By implementing targeted interventions that address systemic inequities, promote cultural competence, and empower marginalized communities, we can work towards achieving freedom from discrimination in health and creating a healthcare system that is truly inclusive and equitable for all.

Exploring pathways of inequality:

Delving deeper, we uncover the intricate pathways that perpetuate discrimination in health, tracing their origins from systemic injustices to interpersonal biases. Structural determinants, such as systemic racism, economic inequality, and inadequate healthcare

infrastructure, create a landscape riddled with barriers for marginalized populations. Institutional biases within healthcare systems, including discriminatory policies, cultural insensitivity, and unequal distribution of resources, further compound these challenges. Interpersonal biases among healthcare providers, stemming from implicit biases, stereotypes, and lack of cultural competence, can result in differential treatment and contribute to patient mistrust and dissatisfaction.

At the individual level, factors such as stigma, discrimination, and lack of health literacy may deter marginalized individuals from seeking care, perpetuating cycles of inequality and poor health outcomes.

Paving the pathways to health equity:

Despite these formidable challenges, there is hope on the horizon as innovative strategies emerge to dismantle barriers and promote health equity. Policy interventions, rooted in principles of social justice and human rights, hold the power to enact systemic change and address the root causes of discrimination. Legislation aimed at eliminating discriminatory practices, expanding access to care, and strengthening enforcement mechanisms can help level the playing field and ensure equitable healthcare for all.

Moreover, efforts to promote cultural competence and diversity within healthcare systems, through training programs, diversity initiatives, and community partnerships, can foster trust, improve patient-provider relationships, and enhance the quality of care. Interdisciplinary collaborations, community-driven initiatives, and technology-enabled solutions offer additional pathways for innovation, enabling us to harness the power of data, advocacy, and collective action to drive meaningful change.

A call to action:

As we reflect on the evidence and pathways towards freedom from discrimination in health, we are reminded of our collective responsibility to champion equity, justice, and dignity for all individuals. The time has come to rise above complacency and confront the systemic injustices that perpetuate inequality within our healthcare systems. We must leverage our voices, our resources, and our ingenuity to enact bold, transformative change that dismantles barriers and ensures that every person, regardless of race, ethnicity, gender, or socio-economic status, has the opportunity to

live a healthy & fulfilling life. Let us embark on this journey together, united in our commitment to building a future where freedom from discrimination is not just an ideal, but a reality for all.

Conclusion:

Achieving freedom from discrimination in health is imperative for building a healthcare system that is fair, inclusive, and responsive to the needs of all individuals. The evidence of discrimination in health is undeniable, with pervasive disparities existing across various demographic groups based on race, ethnicity, gender, socio-economic status, and other social determinants of health. These disparities underscore the urgent need for action to address systemic inequities within healthcare systems. By understanding the pathways that perpetuate discrimination in health, including structural, institutional, interpersonal, and individual-level factors, we can devise targeted interventions to dismantle barriers and promote health equity. This includes implementing policies to address systemic injustices, promoting cultural competence and diversity within healthcare systems, and empowering marginalized communities to advocate for their rights and participate in decision-making processes related to healthcare.

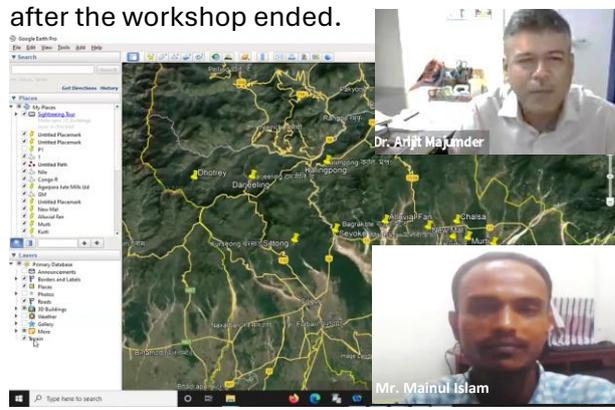
Overall, achieving freedom from discrimination in health requires a collaborative effort from policymakers, healthcare providers, community leaders, and individuals alike. By working together to address the root causes of inequality and promote equitable access to healthcare services, we can pave the way towards a future where every individual has the opportunity to attain optimal health and well-being, regardless of their background or identity. Through collective action and a commitment to justice, we can build a healthcare system that is truly inclusive, responsive, and equitable for all.

Masterclass on Geospatial Analysis for Public Health Professionals

A masterclass organized by IPHA HQ on Geospatial Analysis for Public Health Professionals was held online over five days in February 17th, 19th, 21st, 24th, and 27th, 2025, under the expert facilitation of Dr. Arijit Majumder, Assistant Professor, Department of Geography, Faculty of Science, Jadavpur University, Kolkata, along with his two scholars, Mr. Mainul Islam and Mr. Somen Ghosh.

A total of 86 participants from across the country and various fields of public health enrolled in the workshop. The workshop was successfully coordinated by Dr. Kaushik Mitra, Dr. Rivu Basu, Dr. Arnab Sarkar, Dr. Debduitta Haldar, and Dr. Shibaji Gupta, with technical support from the IPHA office. The facilitators provided comprehensive training on various lessons about QGIS, from basic to advanced, using QGIS software, with a focus on its application in public health. The workshop concluded with an assignment provided by the facilitators.

All class recordings were shared with participants in private mode to facilitate continued support and practice for one month after the workshop ended.



In accordance with the Go Green policy of the Indian Public Health Association (IPHA) and the related decisions by the Annual Central Council and Annual General Body Meetings of the IPHA, print copies of the Indian Journal of Public Health (IJPH) shall henceforth be available only for the institutional subscribers. The full text of all published articles shall be available free of cost on the journal website.

69th Annual National Conference – IPHACON2025

Report By Dr. Mubashir Angolkar
Organizing Secretary

Professor & Head, Department of Public Health JNMC (KAHER)

The 69th Annual Conference of the Indian Public Health Association (IPHA) was successfully held from 21st to 23rd March 2025 at the KLE Convention Centre, Belagavi. Hosted by the Karnataka State Branch of IPHA and the Department of Public Health, JNMC (KAHER). The



event welcomed nearly 700-plus delegates from across India and abroad. The theme, **'Transforming Public Health in India: Innovations, Challenges, Diplomacy, and Future Horizons'** set the tone for an event that was rich in dialogue, learning, and collaboration aimed at building a resilient and inclusive health system.

A Powerful Prelude: Insights from the Pre-Conference Workshops

Preceding the main conference, eleven Pre-Conference Workshops were held on 20th March in collaboration with national and international organizations such as WHO, ICMR, Cochrane, NIHF, and Umeå University.

Empowering public health actors to make informed decisions on engaging the Private Sector for NCD prevention and control: A practical workshop using applied tools: Organized by WHO, this session addressed lifestyle-based NCD prevention and the role of the private sector. It introduced tools to evaluate corporate involvement, discussed legal and marketing dynamics, and highlighted WHO's influence in shaping global health policy. Medical Officers from the Government of Karnataka were specially deputed to attend this workshop. Dr. Angela De Silva, the Regional Advisor for Nutrition and Health Development at the WHO South East Asia Office in New Delhi, led this workshop.

Systematic Review: Organized by the India Cochrane team, this hands-on workshop trained

52 faculty members, significantly enhancing their capacity to conduct systematic reviews, led by Dr. Anju Sinha (Director ICMR -Cochrane) & her team had an overwhelming response.

Good Clinical Practice (GCP): Conducted in hybrid mode by NIHF in collaboration with KAHER, featuring experts from NIHF, CDSCO, and KAHER, this session was attended by 135 students and offered comprehensive training on ethical and regulatory aspects of clinical research. Dr. Ranjan Ranjan (HOD, Epidemiology, NIHF, New Delhi) himself looked into the smooth working of the workshop, and it was a smashing success.

Scoping Review: Led by Julia Schröders from Umeå University, Sweden, this workshop offered valuable insights into the methodology and application of scoping reviews. Participants explored its relevance to their research, gaining practical understanding and motivation to apply the approach in future studies.

Qualitative Comparative Analysis: The participants learnt to understand the advantages and disadvantages of the QCA methodology, plan a step-by-step QCA study design, and interpret the data coming from a QCA analysis. This workshop was curated by Dr. Miguel San Sebastian, Umeå University, Sweden

Expanding Horizons: Addressing GBV and Amplifying LGBTQIA++Voices: This workshop focused on integrating gender-based violence (GBV) response into routine healthcare through early identification, trauma-informed care, and system-level protocols. It also emphasized the need for LGBTQIA++ inclusive healthcare through SOGIESC sensitization, inclusive practices, and policy reforms to ensure equity and respectful care. This excellent workshop was sponsored and organized by SAATHI.

Health Insurance: Dr. Shruti Prabhu from Narayana Hrudayalaya Ltd, led a highly informative session demystifying complex insurance terminology. Through interactive discussions, participants gained clarity on coverage options, benefits, and the enrollment process.

Precision Perspectives: Mastering RCT Data Analysis Techniques: Led by Dr. Kapil Goel from PGIMER Chandigarh, this workshop provided hands-on training in advanced RCT analysis methods, including Repeated Measures ANOVA



and Generalized Estimating Equations (GEE). It emphasized practical application of the Intention-to-Treat (ITT) approach to improve the reliability of public health research findings.

Spatial and Survey Data Analysis Using GIS and R: This workshop provided hands-on training in using GIS and R for spatial and survey data analysis. Participants learned data-handling techniques and explored real-world public health applications of these tools. Col. Dr. Arun Kumar Yadav (Professor, AFMC Pune) and Dr. Biji Soman (AMCHSS, SCTIMIST, Trivandrum) headed this workshop.

Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS): This skill-based session, led by Dr. Abhijit S. Gogate (ACLS), and Dr. Anupama (BLS) included hands-on training and pre-/post-tests, equipping participants with essential emergency response skills. This session was conducted in the state-of-the-art skill lab at KAHER.

Cultural Competency in Public Health: As part of the Inclusive Bharat Collaborative with the Piramal Foundation, this unique pre-conference session highlighted culture as a vital determinant of health. Participants stressed the need for culturally sensitive training for Indian health professionals and appreciated the use of arts-based methods to deepen engagement and understanding.

**Inauguration Ceremony:
A Grand Commencement**



The Inauguration Ceremony, held on the morning of March 22nd, was an occasion marked by grandeur and distinction. The event was



graced by the Hon'ble Chief Guest, Prof. (Dr.) Nitin Gangane, Vice-Chancellor of KLE Academy of Higher Education and Research. He was joined by the esteemed Special Guest, Dr. Mary Spongberg, Senior Deputy Vice-Chancellor of Southern Cross University, Australia. Also present on the dais were Dr. Sanghmitra Ghosh President IPHA, Dr. Kaushik Mitra Secretary General IPHA, Dr. (Mrs.) N. S. Mahantashetti (Organizing Chairperson), Prof. (Dr.) Mubashir Angolkar (Organizing Secretary), and Dr. H. B. Rajasekhar, President of the IPHA Karnataka State Branch and Director of USM-KLE.

The ceremony featured the conferral of prestigious honors, including the Dr. I.C. Tiwari Lifetime Achievement Award, presented to Dr. M.K. Sudharshan, alongside Fellowships and



accolades recognizing academic excellence. The launch of the E-Souvenir and the 'Nourish' E-book added a commemorative dimension to the event. Notably, the PC Sen Best Paper Award was



conferred upon Dr. Ankit Chandra from AIIMS, New Delhi, in recognition of his outstanding research contribution.

As a tribute to India's cultural heritage, all tokens of appreciation presented to the dignitaries were exquisitely handcrafted in traditional Bidri art. Additionally, the IPHA Headquarters honoured Prof. (Dr.) Mubashir Angolkar, Organizing Secretary, with a distinguished memento crafted in the historic Chola art style, as a symbol of their gratitude. Following the vote of thanks, Prof. (Dr.) Mubashir Angolkar, Organizing Secretary, invited the entire Organizing Committee on the stage, for a picture.



Memorial Orations: Honouring Legacy, Inspiring the Future

The conference featured three eminent Memorial Orations. Dr. Prabhdeep Kaur (Chair & Professor, Isaac Centre for Public Health, IISc,



Bengaluru), delivering the Dr. B. C. Dasgupta Oration on 21st March 2025, emphasized the importance of evidence-based solutions in tackling non-communicable diseases. The session was chaired by Dr. Sanghmitra Ghosh, President, IPHA, and Dr. Pramod Samanta Ray Co-Principal Investigator, KIMS, KIIT University.

Dr. K. N. Rao Oration was delivered by Prof. (Dr.) Priya Abraham (Senior Professor, Department of Clinical Virology, CMC Vellore) on 22nd March 2025, stressing the urgency of HPV vaccination. This session was chaired by Dr.



Kaushik Mitra, Secretary General, IPHA, and Padma Shree Dr. Madan M. Godbole Distinguished Professor KAHER Belagavi.

The Dr. J. E. Park Oration, held on 23rd March 2025, was delivered by Dr. J. Ravi Kumar, (Head of the Department of Community Medicine at Dr. PSIMS&RF), and provided further academic depth, engaging the audience in vital discussions on public health practice. The session was chaired by Dr. Mausumi Basu, Professor & Head



of the Department of Community Medicine, IPGMER/SSKM, Kolkata, and Dr. Surajit Ghosh, President of the West Bengal Branch of IPHA.

Quiz:

The Professor Deoki Nandan Memorial Public Health Quiz drew participation and enthusiasm, with AFMC Pune emerging victorious in the finals.



Scientific Sessions:

Plenary Sessions: Seven Plenary sessions set the stage for impactful dialogue at the conference.

The session **“Strengthening Primary Health Care: Community Engagement, Digital Innovation, and Data-Driven Transformation”**, emphasized the role of community participation, technology integration, and data-driven approaches in enhancing primary health care. Speakers were Dr. J. N. Srivastava (NHSRC), Dr. G. B. Singh (NHSRC), and Air Cmdre (Dr.) Ranjan Kumar Choudhary (NHSRC), with the session chaired by Major General (Dr.) Atul Kotwal (NHSRC) and Dr. Dipika Sur (Former ICMR).



“Vaccinate, Screen, Treat: Pillars of Cervical Cancer Elimination”, highlighted a comprehensive approach to cervical cancer through early vaccination, screening, and treatment, along with implementation challenges and recent advancements. Dr. Rajesh Ranjan (NIHFW), Dr. Imtiaz Ahmed (JNMC), Dr. Anita



Dalal (JNMC), were the speakers. It was chaired by Dr. Muralidhar Tambe (BJ Medical College Pune), Dr. Chandra Metgud (JNMC), and Dr. Hitt Sharma (Serum Institute).

The plenary **“Cancer Registries in the Digital Age”** addressed AI’s role in data management, disparities in cancer data reporting, and registry strengthening. Speakers were Dr. Prashant Mathur (ICMR-NCDIR), Dr. Anita Nath (ICMR-NCDIR), and Dr. Rajaram Swaminathan (Cancer Institute (WIA), Chennai).



Chairs included Prof. (Dr.) Nitin Gangane (Hon’ble Vice-Chancellor, KAHER, Belagavi), Dr. Prakash Doke (Bharati Vidyapeeth Deemed University Medical College Pune), and Prof. (Dr.) Anand Krishnan (AIIMS New Delhi).

On 22nd March, the panel discussion on **“Transforming Public Health Education in India”** focused on curriculum reform, competency-based learning, and academia-practice collaboration. Panellists included Dr.



Prabhdeep Kaur (Isaac Centre for Public Health, IISC Bengaluru), Dr. Tarun Bhatnagar (NIE Chennai), Dr. Prashant Bhatt (Govt. of Karnataka), Dr. Ravi A V (Resolve to Save Lives), Dr. Biju Soman (AMCHSS, SCTIMST Trivandrum),

Prof. (Dr.) Mubashir Angolkar (JNMC), and Dr. Arathi Rao (PSPH Manipal).

The session **“Migraine: Unmasking Migraine from Shadows to Spotlight”** emphasized the public health impact of migraine, advocating for better awareness, diagnosis, and care integration. Speakers were Dr. Naresh Sharma (CDSCO), Dr. Dheeraj Shah (NIHFW), Dr. Pooja Sharma (APAR Health), Dr. Shruti Atul



Prabhu (Narayana One Health), and Dr. Suryaprabha Turaga (NIMS Hyderabad), with moderation conducted by Dr. Bheemsain V. Tekkalaki(JNMC) and chaired by Dr. Dhruvajyoti Debnath (AIIMS Mangalagiri) and Dr. Somnath Naskar (IPGMER, SSKM).

“AI in Healthcare: Innovation, Challenges, Diplomacy and Future Horizons.” featured Mr. Prashant Balraj (Wadhvani AI), Dr. Mohamed Adil (Bangalore Bioinnovation Centre), and Mr. Vijetha Shastry (Bangalore Bioinnovation Centre), discussing AI’s role in diagnostics. This forward-looking session delved into how artificial intelligence is transforming healthcare from tuberculosis detection to modernization of health data and entrepreneurial opportunities. The speakers emphasized the promise of technology balanced by the necessity for ethical governance.

“Silent Resolution in Menstrual Hygiene Management in Karnataka”, by Dr. Veena V. (Aarogya Soudha, Bengaluru) on which explored cultural barriers, policy gaps, and the need for sustained efforts to improve menstrual health, leaving a strong impact on the audience.

Parallel Sessions

“Comprehensive Sexuality Education” featured FOGSI, IAP, IIPH, WHO, and VMMC, focusing on adolescent health. **One Health and Environment and Health** emphasized cross-sector strategies for pandemic prevention. In **Human Behavioural Risks for Road Crashes** in Karnataka, Dr. Gautam Sukumar (NIMHANS) shared key behavioural insights and interventions. **Lifelong Impact of Paediatric HIV** presented ICMR findings, stressing integrated, age-sensitive care. **Influenza Vaccination Among Priority Groups** in India focused on improving vaccine uptake. **Closing the Inequities: A Deep Dive on Tribal Health**

explored community-led solutions in tribal areas. **Advancing Adult Immunization** highlighted the need for wider vaccine coverage in older adults. Dr. Sagar Ghodekar showcased coordinated cardiac care in the **WHO STEMI Project in Goa**.



Sessions on **“Mental Health Survey, and Comprehensive Health Care”** provided policy-focused insights. **One Health Session II** addressed AMR and global collaboration. The panel **Can Professional Midwifery Help Achieve SDG 3?** emphasized midwifery’s role in maternal and newborn health. A panel on the **“Public Health Impact of Venous Thromboembolism”**, featuring Dr. Mahadeva Swamy B.C. (Manipal Hospital-Goa), Dr. V. A. Kothiwale (JNMC), and Dr. Navin M. Mulimani(JNMC) covered clinical trends, public health implications, and prevention strategies. It was moderated by Dr. Parishwanath Patil (JNMC). The scientific sessions concluded with an **“Open House on NCDs”**, moderated by Dr. H. B. Rajasekhar (USM KLE IMP), offering an interactive platform for practitioners and citizens to share perspectives. Community-led solutions and state-level insights enriched the discussion.

Ideas Taking Flight: Free Poster and Oral Presentations

Over three dynamic days, 400+ oral and poster presentations reflected the richness of



India’s public health research. Faculty from premier institutions and passionate postgraduates & undergraduates fostered learning, dialogue, and collaboration. The conference, echoing the theme **“Transforming Public Health in India: Innovations, Challenges, Diplomacy, and Future Horizons,”** embodied the collective drive toward Viksit Bharat 2047 with health at its core.

Evenings of Celebration: Culture, Camaraderie, and Connections

The evenings were marked by spirited celebrations. On 21st March cultural programme featuring student performances added a festive flair, while the Grand Gala Dinner on the 22nd brought together delegates for an evening of camaraderie, live music, and culinary delights.

The conference concluded on a high note with the Valedictory Function, a fitting finale to IPHACON 2025. Awards for the best paper and poster presentations were distributed, recognizing the outstanding contributions of participants from across the country.

The event also reflected the conference's strong commitment to sustainability through several thoughtful "Go Green" initiatives. In a conscious effort to minimize environmental impact, traditional printed materials were

replaced with digital alternatives — e-poster presentations and the substitution of plastic banners with elegant digital displays throughout the venue. Additionally, delegates wore lanyards made from recycled paper, a simple yet powerful gesture toward ecological responsibility. These initiatives not only reduced the conference's carbon footprint but also set a benchmark for sustainable practices in future academic events.

The organizing efforts of KLE Academy of Higher Education and Research (KAHER) received well-deserved praise for the successful execution of IPHACON 2025. The team's vision, meticulous planning, and unwavering commitment to excellence were instrumental in delivering a conference that was not only impactful and academically enriching but also future-forward in its approach.



Cancer Awareness Activities by State Branches of IPHA

IPHA - GUJARAT STATE BRANCH

On January 25, 2025, the Gujarat State Branch of Indian Public Health Association (IPHA), in collaboration with the Gujarat Cancer & Research Institute (GCRI) and Indian Institute of Public Health Gandhinagar, organized a Cervical Cancer Awareness Month at IIPHG. The event witnessed the enthusiastic participation of over 120 attendees, including public health professionals, students, researchers, frontline workers and IPHA-GSB members.

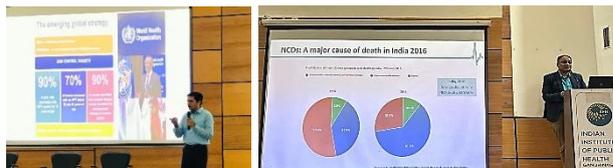
Inaugural Session:

The program commenced with an inaugural address by Dr. Deepak Saxena, Director of IIPHG, who emphasized the significance of cervical cancer awareness and the role of public health initiatives in combating this preventable disease.

Speaker Sessions:

- ❖ Dr. Remi Abdul, Assistant Professor, Department of Gynecological Oncology, GCRI delivered an insightful session on "Awareness on Cervical Cancer," highlighting the global and Indian burden of the disease.
- ❖ Dr. Anand Shah's session focused on the "WHO Cervical Cancer Elimination Strategy." He detailed the global, Indian, and Gujarat-specific burden of cervical cancer, with a special focus on Ahmedabad's urban scenario. He shared insights from his research on cervical cancer and discussed WHO's 2030 elimination strategy, emphasizing the "90-70-90" targets for vaccination, screening, and treatment. Additionally, he highlighted taboos and challenges in rural areas regarding cervical cancer awareness.
- ❖ Dr. Jayesh Solanki, State NCD Nodal Officer, Gujarat oriented the participants on the "NCD Programme" in Gujarat. He elaborated on the state's non-communicable disease burden, the shift from communicable to non-communicable diseases, and the services available through the NCD portal.
- ❖ The event concluded with a vote of thanks delivered by Dr. Tapasvi Puwar, General Secretary, IPHA-GSB acknowledging the efforts of the speakers, participants, and organizers for making the session a success.

Dr Jimeet Soni, Joint Secretary, IPHA-GSB hosted the entire event. Moreover, the event was attended by members of IPHA including Dr Poonam Trivedi, Treasurer, IPHA-GSB. Furthermore, the event was conducted in hybrid mode, allowing members of IPHA-GSB from across the state to participate virtually, in addition to the in-person attendees.



IPHA - MAHARASHTRA BRANCH

 **WORLD CANCER DAY** 
4th February 2025
Cervical Cancer Screening Camp
MGM Medical College, Kamothe, Navi Mumbai
Department of Community Medicine & Pathology
Changu Kana Thakur Arts, Commerce & Science College, New Panvel
18th February 2025 Indian Public Health Association, Maharashtra Initiative

World Cancer Day is observed every year on 4th February to raise worldwide awareness and inspire action for a cancer free world. The Theme for this year is United by Unique. To commemorate this day with the initiative of Maharashtra state branch of IPHA a Cervical Cancer Screening Camp was organized by MGM Medical College, Kamothe & CKT College, New Panvel on 18th February 25. The PAP smear tests of all women were done free of cost by the team of pathologists of medical college and the beneficiaries were counselled about Cervical Cancer screening & early detection by IPHA Member Dr Sunila Sanjeev, both a Public Health Expert & Gynecologist. The students of the CKT college committed to spread the message further in neighboring rural area and create further awareness in society. The event was inaugurated by IPHA Maharashtra state President Dr Prasad Waingankar & NSS Chief Program Officer of CKT College, Dr. S. N. Parkale.

Organizing Team



IPHA – ANDHRA PRADESH BRANCH

On 2nd February 2025 Indian Public Health Association, AP State Branch have participated in Cancer Awareness Day conducted by Mahatma Gandhi Cancer Hospital and Research Centre. In the rally students from various Nursing Colleges, Medical Colleges and Walkers Club International have participated along with members of Indian Public Health Association, Andhra Pradesh State Branch.



National Deworming Day observation by IPHA AP Branch

The Indian Public Health Association, Andhra Pradesh Branch, organized a National Deworming Day event at the Anganwadi Center and GVMC Elementary School in Peda Jalari Peta on February 10th. During the event, health staff distributed Albendazole tablets to children.

Health Education was imparted by Dr. M. V. V. Murali Mohan, Central Council Member (South) Indian Public Health Association. It was told that worms can cause long term health issues even if don't show immediate symptoms and drugs given to treat worms are safe even if a child is not infected. The signs and symptoms of worm's infestation were explained. The Children



were educated on hand wash techniques and foods rich in iron. Staff of Anganwadi Center, GVMC elementary school have participated in program.

Youth for Climate Action Workshop by IPHA AP Branch

Youth for Climate Action workshop was organized by Indian Public Health Association, Andhra Pradesh branch on 11th February, 2025.

Dr. M. V. V. Murali Mohan Central Council Member- South of Indian Public Health Association urged the youth to work for environmental protection. He spoke at the Youth for Climate Action workshop organized by Indian Public Health Association, VIEWS a voluntary organization from Odisha and Green Climate team at Sri Bhuvana Vidyaniketan in Maddilapalem.

He urged the youth to work hard to prevent Climate change. He stressed the importance of source segregation of house hold waste into organic, inorganic and hazardous waste. He also stressed to follow the principal of reduce, reuse and recycle.

He stressed to reduce the usage of electricity as it is being produced by burning of coal. He also spoke that planting of trees and reducing emissions from motor vehicles by walking, cycling and reduce the usage of vehicles. If at all it is needed to pool the vehicle.

In the meeting Dr. E.U.B. Reddi Emeritus Professor, Department of Environmental Sciences, Andhra University asked students to plant and grow trees on hills and vacant places. He urged people to be aware and to prevent harmful chemicals, heavy metals and harmful plastic waste from entering into rivers, streams and oceans.

VIEWS NGO representative J Rajeswari said that everyone should work for environmental protection The Principal of the Institute Naveen Kumar said that they are involved in spreading the message of Climate Change. Divya representative of SRU GVMC, Economics warrior J. V. Ratnam, Green volunteers J. Raviteja, I. Krishna Kumari and others spoke.



World Obesity Day 2025 Event by IPHA Gujarat State Branch

Move Better, Work Better: Ergonomic Exercises for a Healthier Workplace

World Obesity Day was observed jointly by the Indian Public Health Association (IPHA) Gujarat State Branch and Parul Institute of Public Health on 4th March 2025. An offline session, "**Move Better, Work Better: Ergonomic Exercises for a Healthier Workspace**", was conducted with 43 active participants, including working professionals and students.

The poster features the Parul University logo, NAAC A++ accreditation, and the Parul Institute of Public Health logo. It includes the following details:

- Event Title:** Move Better, Work Better: Ergonomic Exercises for a Healthier Workplace
- Resource person:** Prof. (Dr.) Bhavana Gadhavi (PT), Dean, Faculty of Physiotherapy, Parul University.
- Date & Time:** March 4, 2025, 10:30 AM TO 12:30 PM
- Faculty Coordinator:** Dr. Pranav Kshetriya, Assistant Professor, Parul Institute of Public Health, IPHA- Gujarat State Branch EC member.
- Convener:** Dr. Parthasarathi Ganguly, Director, Parul Institute of Public Health, President IPHA- Gujarat State Branch.
- Maximum participants:** 40
- Venue:** PRAYAAS Hall of Medical Education Unit, Parul Institute of Medical Sciences & Research, Parul University.
- Registration link:** <https://docs.google.com/forms/d/e/1FAIpQLSdXv7i6TjMeISU3NXyJATcVL-z3HLWkGenge80jN0GAg/viewform?usp=dialog>

The session was conducted by Prof. (Dr.) Bhavana Gadhavi, Dean, Faculty of Physiotherapy, Parul University. The session aimed at educating participants on workplace ergonomics and practical exercises to prevent musculoskeletal disorders (MSDs). The workshop included theoretical discussions as well as hands-on practical demonstrations.



Key topics covered:

- Understanding ergonomics and its importance
- Common musculoskeletal problems due to prolonged sitting
- Ergonomic risk factors and workplace modifications
- Correct postures and workstation adjustments

- Practical demonstration of ergonomic exercises

The session engaged participants in interactive exercises, making it a highly practical and impactful learning experience.

Learning outcomes:

- Understand the concept of ergonomics and its significance in workplace settings.
- Identify common musculoskeletal problems associated with prolonged sitting and improper postures.
- Recognize risk factors contributing to work-related musculoskeletal disorders (MSDs).
- Apply ergonomic principles to their workstation setup.
- Perform simple workplace exercises to relieve muscle strain and improve overall well-being.
- Implement preventive strategies to reduce the risk of MSDs and improve work efficiency.

Key Features of the Event:

- **Interactive Demonstrations:** Hands-on ergonomic exercises tailored for office workers.
- **Expert Insights:** Delivered by Dr. Bhavana Gadhavi, an expert in physiotherapy and ergonomics.
- **Engagement & Participation:** Attendees actively participated in exercises designed for reducing workplace discomfort.
- **Evidence-Based Approach:** The session was based on scientific principles of ergonomics and physiotherapy.
- **Practical Implementation:** Real-life ergonomic adjustments and modifications were demonstrated.

The session provided valuable insights into workplace ergonomics and practical solutions to prevent and manage work-related musculoskeletal issues. The interactive nature of the workshop ensured high participant engagement, making the session both educational and impactful aligning with the broader goals of World Obesity Day—promoting healthier lifestyles and preventing sedentary-related health risks.



Need Assessment for Preventive Oncology Clinic in Tertiary Healthcare Centre

Dr Pankaj Rajan¹, Dr Gajanan Velhal²

¹Assistant Professor, ²Professor & Head, Community Medicine, B K L Walawalkar Rural Medical College, Sawarde, Tal – Chiplun, District – Ratnagiri

During 2022, 9.74 million people worldwide have died due to cancer.[1] Globally, about 1 in 6 deaths is due to cancer. In 2008, the economic impact of premature death and disability from cancer was 1.5% of World's GDP (\$895 billion).[2] More than 70% of all cancer deaths occur in low- & middle-income countries. About 40% of all cancers are preventable.[3]

On the Indian scene, 1.41 million new cancer cases were estimated and 916 827 people have died due to cancer during 2022.[4] India contributes to 7.8% of the global cancer burden and 8.33% of the global cancer deaths.[5]

Figure1: Absolute numbers, Incidence, Both sexes, in 2022 India

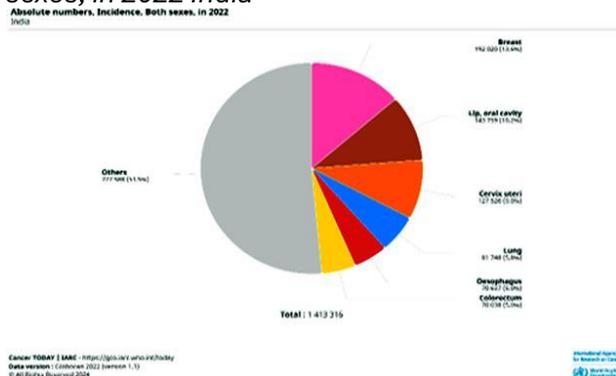
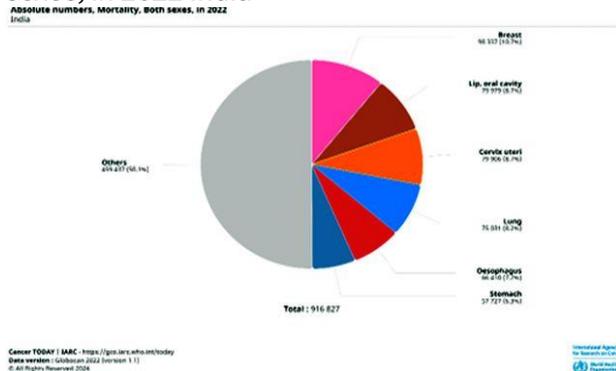


Figure2: Absolute numbers, Mortality, Both sexes, in 2022 India



As per National Cancer Registry Program, the prevalence of cancer is estimated to be around 3.6 million in India. Costs of care for cancer treatment are high, and studies show that almost three quarters of cancer expenditure in India is paid out of pocket. Cancer mortality is reduced when cases are detected and treated early. [6]

The most common cancers are oral cancer, breast cancer, and cervical cancer. Together they account for approximately 34% of all cancers, and hence are a public health priority in India. Each of these three cancers is amenable to early detection and treatment, reducing the burden of cancer related mortality and morbidity. Additionally, cancers of the oral cavity and cervix are amenable to secondary prevention because they can be detected and addressed at precancerous stages through screening using cost effective techniques.[7]

Cancer in India has to be a priority for the government at all levels. There are one million new cancer cases diagnosed every year in India, and this is expected to rise 5-fold by 2025.[8] Early detected cancers are curable and less expensive to treat and the patient goes back into the society to be productive.

Cancer risk depends on a combination of genes, lifestyle and environment.[9]. Prevention ensures reduced physical, emotional, financial burden to the individual. The major hindrances to early diagnosis and treatment were attributed to misinformation, absence of knowledge, low trust in public health services, and inadequate infrastructure, with 80% of health expenditure occurring in the private sector.[10]

If a coordinated effort is to be undertaken all over the country, a three-pronged approach needs to be made:

1. Prevention/ Education
2. Service delivery
3. Research, all in parallel

The old English proverb **“prevention is better than cure”** applies to cancer. Certain cancers are amenable to primary and secondary prevention. This would mean increasing awareness and education programs targeting promotion of healthy lifestyles, reduced tobacco use, investment to change social attitudes and personal habits, improvement of cancer registries, and mass screening for some cancers. The delivery of this has to be prioritized. This should be done through the proper setup of Preventive Oncology Clinic at Tertiary Healthcare Centre.

Preventive Oncology service's focus is to increase the understanding of how lifestyle and risk of cancer are related. It also focusses on

screening of normal individuals for estimating their risk of developing cancer, which in-turn can lead to earlier detection, improved treatment and outcomes. [11]

Preventive Oncology as a Specialty was declared by Dr. Michael Shimkin during 1975, at the University of California, San Diego. It includes any measures taken to prevent development or progression of the malignant process. Because of their causal association with the modifiable risk factors, 50% of the cancers are preventable.[12]

Preventing cancer is better than treating or curing it. Medical oncology clinics focus on secondary and tertiary levels of cancer prevention. The Preventive Oncology Clinic set-up in a tertiary health-care center will provide counselling and screening services to normal individuals and assess his/her risk of developing cancer in the future.

Individuals are at increased risk of cancer because of modifiable and non-modifiable risk factors, which are the targets for preventive strategies. In Preventive Oncology Clinic, history based on the individual's predisposition for cancer stratified by gender, concurrent medical illness, family history, age, lifestyle, and occupation will be elicited. Screening for risk factors such as tobacco use, unhealthy diet (low fruit and vegetable intake), alcohol use, lack of physical activity, sexually transmitted infection, infection by (HBV), radiation exposure, urban (air pollution) or rural (pesticide) existence, occupational exposure and indoor smoke from household use of solid fuels will be done.

Non-modifiable risk factors include genetic factors, which are implicated in 10% of the cancers.

Table1: The screening tools used in Preventive Oncology unit [13]

Organ	Screening tools
Breast	Clinical/Self breast exam, Mammography (after age 40 years), MRI (for high-risk women with mutation in BRCA1/A2 gene)
Colorectal	Faecal occult blood test, Colonoscopy & sigmoidoscopy (average risk individuals in the age group of 50 to 75 years),
Cervix	Visual Inspection with 4-5% Acetic Acid, Liquid Based Cytology test (for women aged 30 to 65 years) HPV test
Oral	Clinical Oral Examination
Prostate	Digital rectal examination, PSA test for men aged 55 to 69 years
Lung	LDCT scan for heavy smokers (30 pack years or more), where 1 pack year is one pack of cigarettes per day for one year, includes individuals 55 to 80 years old, and also those who have quit within past 15 years
Ovarian	Biomarker CA125 test for women with high risk, Transvaginal ultrasound

Services of the OPD should include-

- Screening of asymptomatic and apparently healthy individuals to detect pre-cancerous lesions or early stage of cancer
- Increasing beneficiary awareness regarding early signs and symptoms of common cancers
- Referral services for diagnosis and treatment
- Family history assessment and Genetic counselling
- Smoking/tobacco cessation counselling
- Collaboration with State health units for outreach screening activities
- Research and academic activities

Table2: ACS guidelines for screening- [14]

Disease	Age (for initiation)	Screening tool
Breast cancer	40 years	Mammogram
Colon & rectal cancer, Polyps	45 years to 75 years	Faecal Occult Blood Test (FOBT), Scopes
Cervical Cancer	21 years to 29 years 30 years to 65 years >65 years	PAP test once in 3 yrs Co-testing every 5yrs Test only precancerous lesions for next 20 years
Lung cancer	55 to 74 years	Low-Dose CT scan (LDCT)
Prostate Cancer	50 years	Digital rectal exam, PSA test

Table3: Screening and follow up processes under NHM Operational Framework: Management of Common Cancers [15]

Type of Cancer	Age of beneficiary	Method of Screening	Frequency of screening	If positive
Oral	30-65 years	Oral Visual Examination (OVE)	Once in 5 years	Referred to Surgeon/Dentist/ENT specialist/Medical officer at CHC/DH for confirmation* and biopsy.
Cervical	30-65 years	Visual Inspection with Acetic acid (VIA)	Once in 5 years	Referred to the PHC/CHC/DH for further evaluation and management of pre-cancerous conditions where gynecologist/trained Lady Medical Officer is available.
Breast	30-65 years	Clinical Breast Examination (CBE)	Once in 5 years	Referred to Surgeon at CHC/DH for confirmation using a Breast ultra sound probe followed by biopsy as appropriate.

*The biopsy specimen either to be sent to the nearest Medical College or using the mechanism under the Free Diagnostics Initiative under NHM, to the nearest NABL certified laboratory.

Conclusion:

The Goal of the Preventive Oncology Clinic is to generate cancer awareness and provide services in the areas of cancer epidemiology and prevention, which eventually will make a significant impact on reducing the morbidity and mortality of cancer. This novel initiative in a tertiary health-care center will enable reduction in cancer prevalence as well as empower individuals with knowledge about cancer and risk factors like tobacco, alcohol etc. This in-turn will enable navigation for cancer

screening services and behavioral change modification initiatives for others in their community.

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Addressing Child Malnutrition in Gujarat: Leveraging Artificial Intelligence for Early Detection and Intervention.

Romita Ghosh

CEO | iHeat HealthTech | India

Abstract:

Child malnutrition remains a critical public health challenge in Gujarat, India, despite ongoing economic advancements. This article examines the prevalence of stunting and wasting among children under five and explores the potential of artificial intelligence (AI) in revolutionizing malnutrition detection and intervention. By leveraging AI-driven predictive models and digital tools, healthcare systems can enhance early detection and personalized nutrition planning. The article also highlights the role of MAAP (Malnutrition Assessment and Action Plan), an AI-powered solution designed to improve child growth monitoring.

Introduction:

Child malnutrition in Gujarat manifests primarily as stunting (low height-for-age) and wasting (low weight-for-height), conditions that significantly impact physical and cognitive development. While Gujarat has made notable progress in reducing malnutrition, the prevalence rates remain higher than the national average. Addressing this issue requires innovative approaches that integrate technology and data-driven methodologies to ensure early detection and timely intervention. This article evaluates the role of AI in tackling malnutrition and discusses its application in predictive modeling, anthropometric assessments, and personalized nutrition planning.

Current Status of Malnutrition in Gujarat:

Recent data reflects a decline in stunting rates among children under five, from 53.6% in October 2022 to 40.8% in October 2024. While this 12.8 percentage point reduction is significant, Gujarat's stunting prevalence remains higher than the national average of 35.5%, indicating a persistent public health challenge.

Wasting, an indicator of acute malnutrition, was recorded at 9.2% in June 2024. Although this figure represents a decrease from previous years, it underscores the need for continued efforts to enhance nutritional interventions and child health monitoring.

The Role of Artificial Intelligence in Malnutrition Detection:

Artificial intelligence has transformed the healthcare landscape by offering advanced

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solutions for disease detection and management. AI-based tools can automate malnutrition screening processes, improving efficiency, accuracy, and scalability. The key applications of AI in malnutrition assessment include:

1. **Anthropometric Measurements:** AI-driven image processing techniques can accurately assess height, weight, and mid-upper arm circumference (MUAC), reducing human error and improving efficiency.
2. **Predictive Modeling:** AI algorithms analyze large datasets to identify malnutrition risk factors, allowing for early intervention and targeted nutritional strategies.
3. **Personalized Nutrition Planning:** AI systems process individual health data to generate customized dietary recommendations, promoting optimal growth and development.

The Importance of Data in AI Applications:

The effectiveness of AI models in malnutrition assessment depends on the quality, diversity, and volume of available data. Key factors include:

- ❖ **Data Quality:** AI models require accurate, comprehensive, and consistent data to improve prediction reliability.
- ❖ **Data Diversity:** Incorporating information from diverse demographic & socioeconomic backgrounds enhances model's applicability
- ❖ **Data Volume:** Large datasets enable AI to detect patterns and refine predictive accuracy.

Leveraging Historical Data for Predictive Insights:

Historical health and nutrition data provide essential insights for training AI models to predict malnutrition trends and identify high-risk populations. By analyzing past data, AI can:

- ❖ **Identify Risk Factors:** Determine environmental, socioeconomic, and health-related contributors to malnutrition.
- ❖ **Monitor Intervention Outcomes:** Evaluate the effectiveness of nutritional programs over time.
- ❖ **Forecast Trends:** Predict potential malnutrition outbreaks, enabling proactive interventions.

Challenges in AI-Driven Malnutrition Detection:

Despite its potential, AI implementation faces several challenges:

- ❖ **Data Privacy Concerns:** Ensuring the confidentiality of health data is crucial for ethical AI deployment.
- ❖ **Infrastructure Limitations:** Resource constraints may hinder AI adoption in low-income and rural settings.

- ❖ **Ethical Considerations:** AI systems must be designed to minimize biases and ensure equitable access to healthcare services.

MAAP: AI-Powered Innovation for Malnutrition Prevention in India:

MAAP (Malnutrition Assessment and Action Plan) is an AI-driven solution designed by **RevolutionAlze**, an AI startup, to revolutionize malnutrition screening in India. By integrating smartphone-based AI technology, MAAP enables caregivers and healthcare workers to measure children's height accurately from a single photograph, eliminating the need for traditional height measurement tools.

Future Prospects: Eradicating Malnutrition Through AI-Driven Screening:

Malnutrition is preventable through early detection and timely intervention. MAAP aims to make real-time anthropometric screening accessible to all children, ensuring that no child remains undiagnosed due to technological or logistical barriers. By integrating AI-driven insights into public health strategies, India can achieve a significant reduction in stunting and wasting rates by 2030, aligning with the Sustainable Development Goals (SDGs) and the Government of India's mission to eradicate malnutrition.

Conclusion:

The application of artificial intelligence in malnutrition detection offers a transformative approach to addressing child health challenges in Gujarat. By utilizing AI-driven predictive analytics and digital health solutions, early detection and intervention strategies can be significantly enhanced. While challenges such as data privacy and infrastructure limitations must be addressed, AI holds immense potential to revolutionize child malnutrition management, ensuring healthier futures for millions of children.

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Healthcare Systems in India in the Twenty-First Century - A Situational Analysis -

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With its staggering population of over 1.4 billion people, India boasts one of the world's largest healthcare systems [1]. The Indian healthcare system is a blend of public and private providers, with the public sector being the primary source of healthcare services. Despite post-independence developments, India's healthcare system faces numerous challenges. A World Health Organization report 2000 ranked India's healthcare system at a lowly 112 out of 190 countries [2]. In 2019, another WHO report on universal health coverage placed India at 117 out of 188 countries. This analysis will delve into India's healthcare system and future challenges using a SWOC (Strengths, Weaknesses, Opportunities, and Challenges) framework.

Public Healthcare System in India

The public healthcare system in India is overseen by the Ministry of Health and Family Welfare at the national level, with state health departments managing healthcare at the state level. The system comprises health and wellness centres, primary healthcare centres, community health centres, sub-divisional hospitals, district hospitals, and tertiary care hospitals. Health and wellness centres, primary healthcare centres, and community health centres are the backbone of primary healthcare in rural areas, while district and tertiary care hospitals provide specialized care for complex medical conditions [3].

Private Healthcare System in India

In contrast, the private healthcare system in India, particularly in urban and suburban areas, surpasses the public sector in scale. It offers a broad spectrum of healthcare services, from primary to specialized and tertiary care. Private hospitals and clinics predominantly cater to society's middle and upper echelons. However, private healthcare in India is characterized by high costs, with private facilities charging considerably more than their public counterparts [3]. Nevertheless, they offer high-quality care and access to advanced medical technology. The private healthcare landscape is fragmented, consisting of numerous small and medium-sized hospitals and clinics.

Strengths

Abundant Healthcare Professionals:

India boasts one of the world's largest pools of healthcare professionals, including doctors

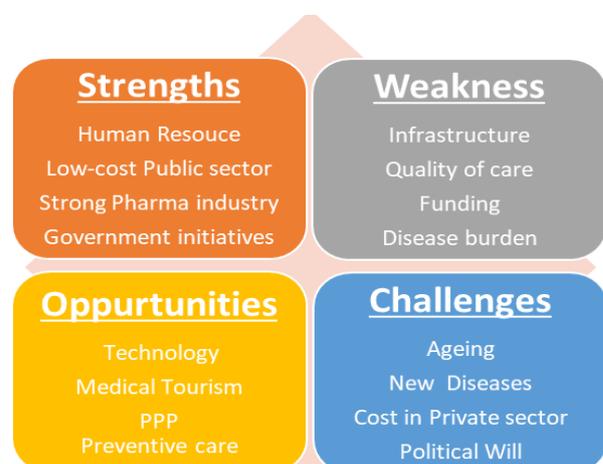
(MBBS and traditional AYUSH), nurses, paramedics, and support staff. The country has over 1.2 million registered doctors, with ongoing efforts to address the doctor-to-patient ratio imbalance [2,4].

Affordable Public Healthcare: Healthcare services in India, especially in the public sector, are comparatively affordable, making them accessible to a significant portion of the population, especially those unable to afford expensive treatments. This affordability has also driven medical tourism in recent years [2,3].

Robust Pharmaceutical Industry: India is a global leader in the pharmaceutical sector, producing a substantial share of the world's generic drugs. Government initiatives promoting affordable healthcare and expanded medication access have catalyzed the industry's growth. Notably, during the COVID-19 pandemic, Indian companies like Serum Institute and Bharat Biotech played vital roles in vaccine production and distribution [2].

Government Initiatives: The Indian government has launched various initiatives to enhance healthcare services, such as the Ayushman Bharat scheme, to provide healthcare coverage to more than 500 million underprivileged citizens. The government continually introduces new programs and schemes to address prevalent health issues, aligning with global health initiatives [2].

Figure1. The SWOC Analysis of Healthcare Systems in India



Weaknesses

Inadequate Infrastructure: The healthcare infrastructure in India, especially in rural areas, is insufficient. A shortage of hospitals, clinics, and medical equipment creates barriers to accessing healthcare services [3,5].

Poor Quality of Care: Healthcare services in India suffer from suboptimal quality, with many healthcare professionals lacking adequate training and experience. This often results in misdiagnoses and inappropriate treatments. Additionally, a scarcity of human resources in many hospitals, particularly rural ones, further compromises care quality [4].

Insufficient Funding: According to the National Health Policy report, India allocates 1.2% of its GDP to healthcare. This figure is significantly lower than that of other developing and underdeveloped nations. The dearth of funding impedes infrastructure development and healthcare service enhancement [3,4].

High Disease Burden: India grapples with a dual disease burden, featuring a high incidence of infectious diseases expected in developing nations and a surge in non-communicable diseases due to adopting unhealthy modern lifestyles. This exerts substantial pressure on the healthcare system, hindering its ability to provide adequate services [2].

Opportunities

Technology Integration: Leveraging technology, such as telemedicine, can substantially improve healthcare delivery in India. Telemedicine was successfully employed during the COVID-19 pandemic to extend healthcare services to remote areas, showcasing its potential for addressing rural healthcare disparities. Electronic medical records can also enhance care quality. Initiatives like Startup India and Make in India can further bolster the healthcare tech sector [2,5].

Medical Tourism Potential: India has the potential to become a hub for medical tourism, attracting patients from across the globe. The country boasts world-class hospitals, exceptional medical expertise, and state-of-the-art healthcare facilities that can draw international patients [3].

Public-Private Partnerships: Underutilized public-private partnerships can enhance India's healthcare infrastructure and services. Private sector involvement can provide the necessary funding, expertise, and monitoring while the government sets the regulatory framework [4].

Emphasis on Preventive Healthcare: Shifting focus from curative care to preventive healthcare can reduce India's disease burden. Achieving this requires educational and awareness campaigns, robust vaccination programs, and early disease screening and detection [4].

Challenges

Ageing Population: India faces the challenge of an ageing population, with more than 100 million individuals aged over 60. The breakdown of the traditional joint family system, combined with the erosion of social support structures, poses potential loneliness and other psychosocial ailments among the elderly, straining the healthcare system. Older individuals generally require more healthcare services, and the system may struggle to meet the increased demand [2].

Emergence of New Diseases: The appearance of new diseases like COVID-19 can strain India's healthcare system. The system may not be adequately prepared to handle unexpected outbreaks. Healthcare professionals and medical equipment shortages can exacerbate the challenge [2,4,5].

Escalating Healthcare Costs: Healthcare costs in India, particularly corporate hospitals, are rising. This can make accessing healthcare services challenging, potentially leading to deteriorating overall health and catastrophic healthcare expenses [3].

Lack of Political Will and Coordination: A significant threat to healthcare reform in India is the absence of political will to drive change. The government may not allocate sufficient funds or implement necessary reforms due to a lack of understanding of the long-term benefits of healthcare improvements. Politicians often seek immediate and visible effects, hindering healthcare system progress. Additionally, variations across different states & inconsistent strategies hinder coordinated efforts [4].

In conclusion, while India's healthcare sector faces numerous challenges, several sub-sectors within the industry have demonstrated impressive performance in recent years. The pharmaceuticals, medical devices, diagnostics, telemedicine, and health insurance industries have all thrived due to the government's push for affordable and universal healthcare, growing healthcare demand, and significant investments from domestic and foreign players. These sub-sectors are poised to continue growing and contribute to the overall advancement of India's healthcare industry [2,3,4,5].

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