

4th

NEPAL PUBLIC HEALTH FOUNDATION LECTURE ON PUBLIC HEALTH IN THE PAST, PRESENT AND FUTURE



स्थापित १९७६
NPHF

By Dr. Hemang Dixit

June 30, 2013, Kathmandu, Nepal

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4th

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NEPAL PUBLIC HEALTH FOUNDATION

NEPAL PUBLIC HEALTH FOUNDATION LECTURE ON PUBLIC HEALTH IN THE PAST, PRESENT AND FUTURE

Organized by



**Nepal Public Health
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FOREWORD

Annual Public Health Lecture has been a regular activity of Nepal Public Health Foundation (NPHF) performed on 30 June every year since after inaugural lecture by an eminent public health personality, Mr. Kul Chandra Gautam, Advisor to NPHF and former Under Secretary General of the United Nations and Deputy Executive Director, UNICEF. The topic he chose to speak was on 10+2 Agenda for Public Health in Nepal, which was widely acclaimed. It has paved way to the understanding of modern public health in a critical manner.

Organization of the annual public health lecture is a core activity of NPHF inviting eminent personalities with contribution in the field of public health. So far NPHF had the pleasure to organize lecture on 'Understanding Public Health : Conceptual and Philosophical Foundation' by Dr. Mathura Prasad Shrestha, an eminent Public Health Personality and health right activist, former Minister of Health and also advisor to NPHF. It was followed by lecture on Control of Non-Communicable Diseases in Nepal: Scientific, Social and Spiritual Perspectives by Dr. Mrigendra Raj Pandey, eminent cardiologist and first Executive Chairperson of Nepal Health Research Council and a believer in holistic approach to health. These lectures were very rich in content and provided new dimension in thinking of public health.

The lecture by Dr. Hemang Dixit is the fourth in the series dwelling on the Present, Past and Future of Public health in Nepal. A Pediatrician by training and educationist, also a prolific writer, Dr Dixit has traced the history of public health much before 4000 B. C. as revealed from excavations at Mohen-Jo-Daro and Harappa in Indian sub-Continent. In Nepal, an Arogyashala (Ayurvedic Hospital) existed during Lichhavi dynasty long before the sixth century A. D. He pointed out that modern medicine was introduced only during 1740 A. D. and the concept of public health and hygiene was put in practice since. The paper has thrown light on the present state of public health and what he thinks should the future be. I would like to express gratitude to Dr Dixit for the paper, packed with information on the state of public health in Nepal. Nevertheless, the views expressed are personal and not the formal position of NPHF.

In the end, I would like to thank the NPHF staff, in particular Ms. Ashmita Chaulagain and Ms. Shila Bhandari for working hard in its publication.

Dr. Badri Raj Pande
Acting Executive Chair

KEYNOTE ADDRESS

Public health in the past, present & future

Dr. Hemang Dixit

It has been postulated that life originated 600 million years ago and that the continental drift, creating the five continents, occurred some 200 million years ago. Mammals have been estimated to have evolved some 140 million years ago. Hominids i.e. the human type evolved 20 million years ago. However modern man only came on the scene some 200,000 years ago. His migration and colonization of the world occurred during the course of the last 50,000 years. The spoken language developed during the course of the last 10,000 years whilst writing came into being only a few thousand years ago. The phenomenal progress that took place was only over the course of 5000 to 10,000 during the life span of just 200 to 400 generations.

- From Dr. Abdul Kalam's website: www.abdulkalam.com (1)

When we consider the existence of the universe we realize that what we are talking about is an insignificant period of time in the history of the Universe. Besides us humans the range and varieties of lives are immense but because of the callousness of humans many of the flora and fauna have disappeared or have become endangered species. What should be the duty of us humans is that we should leave the earth in the same or in a similar condition that we found it in. This is becoming difficult if not nearly impossible because of various factors that have come into or are coming into our lives. Range of health conditions facing any population varies in the different parts of the world. The definitions of this term have varied from time to time but two which were made in 1988 may be quoted here.

1. Public Health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society.

Acheson report -1988

2. Public Health is what we, as a society, do collectively to assure the conditions for people to be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered Through effective, organized and sustained efforts led by the public sector.

The Institute of Medicine -1988

This second quote is in the Introduction to the Oxford Textbook of Public Health (2).

PAST

Excavations at Mohen-Jo-Daro in Sind and Harappa in the former India, threw light on the Indus Valley civilization and suggested that the people living there as early as in the fourth millennium BC had a high level of public health facilities.

The Greeks too had in the BC period, their medical practices with Aesculapius' Temple of Healing. The Romans in the first millennium too had Public Health facilities in the form of Baths, Drainage canals etc.

Pompeii, a city founded in BC and near Naples in Italy had baths, a good water supply and a drainage system. It was buried by the volcanic ash in 79 AD.

An unidentified epidemic, Plague struck Athens in 430 BC. Leprosy is mentioned in the Bible. In olden days diseases were said to be a form of punishment from the Gods. This thought was prevalent in Europe especially with regard to Leprosy and Plague

The methods to deal with it were segregation and fumigation.

Because of the impending shortage of water, running water flushes and drainage systems is a thing of the past. The Romans had it, and then the British who as colonial masters could do it and finally the Americans because they had funds and could afford it. Now it is a becoming a thing of the past.

Plague – Black Death (1347-53) caused rampant havoc in Europe. The European population of the 14th Century was then reduced by one third as a result of this. Following this epidemic, plague recurred every two decades for the next three centuries. In 1830 cholera as a disease arrived in Europe and the poor were mainly affected.

Even in what are now developed countries, the conditions of living for the average man or woman in the 18th and 19th Centuries was very unsatisfactory. Health problems were under-nutrition, respiratory diseases as a result of the crowded living or the working conditions in the industries and diarrhoeal diseases because of faecal contamination of drinking water. The story of the Broad Street Pump, the cholera outbreak of 1854 in London, its investigation and solving of the problem by John Snow is well known. It is said that charges were laid by the poor on the rich who they blamed for propagating the disease to kill off the poor. One reason given by the poor was that dead bodies were required for the training of doctors and so this move.

Other major diseases of Public Health importance were:

- Venereal Disease (STD) – French pox. Liaisons with Italian sex workers.

- Smallpox
- Others e.g. Typhus, Typhoid etc.

It is accepted in Judeo-Christian and Islamic nations that there are many commandments or suggestion in all the Holy Scriptures about the acceptable conduct of human beings. Similar thoughts are expressed in our Buddhist and Hindu scriptures (3)

PRESENT

Day of modern medicine may be said to have started from the time of World War II. Though Penicillin was discovered by Fleming in 1928 it was produced and then used extensively during the war years and after that. Older vaccines then in use were for Smallpox, TB and later poliomyelitis.

Changes in thought – Britain introduced the concept of the National Health Service (NHS) at the time of Attlee Labour government when Aneurin Bevan was the Health Minister. This was the first time that such an enterprise on such a scale was being put into practice. The Americans also considered this type of service for themselves but did not start it for they felt that it would be expensive. It has been shown in Britain and Japan in the post war years that good health of the population increases social productivity. If the disease burden is less then productivity increases.

The years from the 1970 may be called age of Liberalism. Stress from that time is being laid on lifestyle, environment and welfare. From 1970 the massive campaigns of immunization took place with the introduction of EPI.

Limited resources – Essential function of Public Health is to effectively plan, manage and administer cost effective health services that is available to all sections of society. It must be noted that in all societies there are health inequalities that limit the capability of members to achieve maximum ability to function.

Most of the communicable diseases of the past are being controlled. When colonial powers were in different parts of the world much research was done and remedies sought. Now WHO supported TDR has taken over that task. The major concerns in the developing and least developed countries are:

- Tuberculosis
- Malaria
- Newly emerging diseases.

Whilst diseases such as smallpox, trachoma and poliomyelitis are problems of the past there also exist the Neglected Tropical Diseases (NTD) e.g. Kala-azar, dracunculosis, sleeping sickness, and lymphatic filariasis for which much needs to be done. Western doctors when they first came across kala-azar in 1834 in India had first thought it to be a variant of malaria and though various cures have been tried, it is still a major killer.

Now however the non-communicable disorders are coming to the fore. Heart disease and the increase of type 2 Diabetes in the Indian population have been ascribed to a genetic factor which has become more apparent as the population has a longer lifespan. It has been estimated that as much as 13% of even the rural population in India may be affected by diabetes. Because of the mobility of people the Road Traffic Accidents are an important aspect to be considered.

Because of the stressful life that is on the increase, mental illness has become a major problem all over the world. Added to these types of causes is the violence that seems to be common all over the place. Wife beating or gender abuse though rife in many parts of the world seem more acute in the developing and least developed countries. Their instances and homicide and suicide have become more common occurrences as one pores over the daily papers. The population more vulnerable to these ills are the poor. It is the poor minorities, women, children, elderly, handicapped, illiterate, orphans, immigrants, the displaced and the homeless that fall in this group.

Chronic diseases are coming to the fore because of the increased lifespan.

Together with this, the state has to provide for the care of compromised individuals who are surviving now and need help care in the future.

We are living in a world where because of the marked increase in population the environment has changed all around. We as a community anywhere, produce tons and tons of garbage which is dumped, burned and buried. Some of it may be bio-degradable but the dumping in the rivers or oceans or burning on the ground causes pollution of the environment to a degree that is not only harmful to us but also to animals, birds and fishes in this world. Besides this the greenhouse emissions from our factories or the carbon monoxide fumes from our cars are leading to global warming, the melting of ices, the rising of water levels in the seas and unexpected weather changes leading to floods etc. are occurring. Respiratory illnesses are exacerbated and eye problems increased many fold because of the poor quality of air. The drinking of pure water are luxuries now and the day when water will be a very precious commodity is not far off. As much as 40% of the world's population do not have access to it. The desalination of water of the ocean

is in practice now. We are familiar with the use of masks as people in Beijing and Singapore went about their daily duties were recently shown on television. The start of Cholera epidemic and the alleged (and? now proved) and the attribution of the UN Nepali contingent is also known to us.

The effect of the sound pollution that will perhaps affect many of our teenagers as they get older. The constant impact of rock music on the ear bones of hearing is bound to have its effect.

SITUATION IN NEPAL

An Arogyashala or ayurvedic hospital existed in Nepal during the reign of Amshu Verma (605-620 AD) in the Lichivi period. This is the first reference to health services. It was Ayurvedic medicine that was the major aspect of health services and was being provided by the Vaidyas during the time of the Newar rulers. Over the years health services have been provided by the local traditional healers such as Dhamis, Jhankris and Jharphuks.

The modern type of medicine was introduced into Nepal in 1740 AD when one de Recanti received permission from Raja Ranjit Malla to preach, teach and convert to their religion the people 'without violence and of a free will.' The people in the vicinity of Bhaktapur were possibly being treated by the missionaries. Raja Jaya Prakash of Kathmandu too issued a sanad in 1742 and renewed it in 1754. They probably provided medical services to the poor. Following the conquest of Kathmandu Valley by King Prithvi Narayan Shah the missionaries withdrew from the valley in 1770 and went to the mission home in Bettiah in India. However the involvement of the Christian missionaries really re-started in Nepal in May 1953 when the Friederick and the Fleming couples were given permission to open a hospital at Tansen and clinics in Kathmandu Valley respectively (4).

Dr. Oldfield who was at the British Residency at Lainchaur in 1850 mentions that parts of Kathmandu were dirty and because of the common custom of throwing garbage in the central courtyard, it was likely for one to get various fevers and diseases.

“ There is an utter absence in all the cities of any system of drainage; nearly stagnant gutters on each side of the street, running immediately below the house-fronts, do the duty of sewers, and into them most of the filth and refuse of the adjacent buildings find their way.” (4)

Whilst considering Dr. Oldfield's comment we must remember that conditions in many of the London streets of the 18th and 19th Centuries were similar to those in Nepal.

It was Dr. Oldfield who vaccinated the children of Jung Bahadur and those of the Royal Household. This is the first reference to preventive medical action.

Khokana Leprosy Asylum was set up in 1857.

Health Services during the times of the Ranas was instituted as a form of charity for the poor. Finance for the same was from the income of the land which had been set aside as guthi. Bir started the first hospital in the country at Kathmandu in 1890 AD. The following year Bir opened another one at Birgunj. He is credited to have started some sort of water supply in the capital by way of the Birdhara and the service to those who were connected, was free.

Health services improved in Chandra Shumsher's time due to the opening of some hospitals. He set up an endowment of Rupees seven lakhs (some authorities claim it was much more) to build a TB sanatorium, which incidentally was opened in 1931, two years after his death.

In 1933 the Dept. of Health Services was established. It was however only after Padma Shumsher became Prime Minister that social reforms were introduced under local self-government in the three municipalities in the valley and at Biratnagar. They were responsible to install water taps, record births and deaths plus to popularize inoculation and vaccination at the times of epidemics. These measures directed towards prevention were under local self-government and this practise was maintained for many years.

The first NGO to start in Nepal was the Paropakar Aushadhalaya which started functioning in 1948. After the ushering of Democracy in Nepal Dr. Siddhimani became the Director General of Health. He was also the first President of Nepal Medical Association. In 1958, a Family Planning Committee was formed under the NMA. It worked towards formation of the Family Planning Association of Nepal later. Many NGO's started functioning in Nepal in the years indicated in brackets. Nepal Anti Tuberculosis Association (1953), Marwari Welfare Association (1953), Nepal Family Planning Association (1958), Nepal Red Cross Society (1963) and the Nepal Netra Jyoti Sangh in 1978. Over the years many more have been started and now the numbers are in thousands.

The goal of public health in Nepal should be like elsewhere to put into place the art and service of preventing disease, prolonging life and promoting the health of all members of society. A big challenge in this was because of the various handicaps or shortcomings of the country. Because it was landlocked, mountainous with a minimal road network and a poverty stricken country, malnutrition was rife. Together with this Iodine Deficiency Disorder (IDD) was common. Though some headway has been made, much remains to be done in the case of nutrition on a national scale. The positive point is that with the remittances from Nepali workers in the Gulf, the degree

of poverty is gradually decreasing and there are some improvements in some parts of the country.

The tendency in the past was to say that the incidence of any disease in Nepal is 1%. Another tendency in the reckoning of any disease was to say that it was imported.

Tobacco and alcohol are two poisons allowed by society. Whilst tobacco consumption in developed countries has decreased, its export into markets in developing countries is encouraged in the same way that opium was traded and encouraged in China during the 19th and 20th Centuries. The use of alcohol like gin in the UK, wine in France or vodka in Russia, having been rampant in the past are now controlled with regulation. Whilst “No smoking” rules are gradually being implemented that of alcohol is a different matter. In Nepal, some action started to stop it from being sold 24 hours a day from any grocer’s shop, which controlled its use to some extent. But over-consumption of alcohol continues with resulting health hazard. Recently the implementation of ‘Ma Pa Se’ in the road (checking riders whether they have taken alcohol) has brought down appreciably the road traffic accidents and deaths there from. Of course the income of some interested parties has come down and they are agitating for some leniency. If anything, the rules for drunken driving should be made stricter.

One way to access what should have or has to be done in the Public Health field would be to look at the legislations that have been enacted or policy decisions that have been made (5). These are: the bringing together of various rules and regulations in vogue in the country by Jung Bahadur during mid-1800, after his visits to England and France. These were divided into five parts, which were in turn sub-divided into various Clauses or Mahals. The health related parts and clauses were as follows:

Part III Clause 15: Pertaining to adoption.

Part IV Clause 9: Pertaining to assault.

- Blindness or loss of vision.
- Loss of smell
- Deafness from loss of hearing
- Loss of ability to talk
- Loss of function of breast
- Impotency following sexual injury
- Injury to spine and limbs

Clause 10: Post mortem by hospital doctor and also on abortions.

Clause 12: On Medical Practice

Clause 13:	Assault with intention to rape.
Clause 14:	Rape of women under and over 16 years of age.
Clause 15:	Incest
Clause 16:	Sex with animals
Clause 17:	Relating to marriage- Age at marriage, prohibition of marriage of minors. Medical reasons for divorce.

Then came in subsequent years the following enactments:

IlazGarneko or On Medical Practice in Muluki Ain.

Police Act, 1956.

Jail Act, 1963.

Smallpox Control Act, 1964.

Infectious Diseases Act, 1964.

Food Act, 1966.

Nepal Medical Council Act, 1964.

Some Public Offence & Punishment Act, 1970.

Black Marketing & Other Social Offences Act, 1975.

Drug Abuse Control Act, 1976.

Drug Act, 1978.

Disabled Protection and Welfare Act, 1982.

Nepal Disaster (Rescue) Act, 1982.

Nepal Ayurvedic Council Act, 1988.

Pesticides Act, 1990

Breast Milk Substitutes (Marketing Control) Act, 1990.

Government Prosecution Related Act, 1992.

Nepal Nursing Council Act, 1995.

Health Professional Council Act, 1996

Nepal Health Services Act, 1996

Compensation for Torture Act, 1996.

Iodised Salt Act, 1996.

Consumer Protection Act, 1997.
Human Organ Transplantation Act 1998.
Nepal Pharmacy Council Act, 2000.

Many of these acts have been amended a number of times. That rules and regulations do exist is apparent. What is urgently required is the implementation of all these. Besides these Act there are also a number of Post 1990 policies and guidelines which are:

1. National Health Policy of 1991.
2. Second Long Term Health Plan, 1997-2017.
3. Tenth Five Year Plan 2002-2007
4. Nepal Health Sector Programme-Implementation Plan (2004-2009) i.e. NHSP-IP.
5. Three Year Interim Plan (mid 2007- mid 2010).
6. Strategic Plan for Human Resources for Health, 2003-17.
7. Nepal Health Sector Program –ii (2010-2015).

One notable contribution for the health of the people was done by Late PM Mr. Man Mohan Adhikari in 1996 when he instituted the giving of old age pensions to those elderly persons who were not in services but needed help. There were some criteria laid down for this and though the amount initially was small, it was a start.

It may be noted too that though the Nepal Medical Association has been demanding Health Rights for the people for many years, it became a reality in 2007. 'Basic Health became a fundamental right of the people in the Interim Constitution of 2007 and is slated for inclusion in our new constitution (6).

WHAT REMAINS TO BE DONE FOR THE FUTURE IN NEPAL

It is necessary to formulate, promote and enforce sound health policies to prevent and control disease and remove factors impairing the health of the community.

In this context the Social Services National Co-ordination Council (SSNCC) had been started as long ago as 1977. After the Jana Andolan I it was re-organized in 1994 but has not been functioning 100% due to very frequent changes. There are a large number of NGOs and INGOs currently working in Nepal and a large number are said to be working in accessible areas are said to be duplicating the work.

Some Laws and Regulations may need to be enacted in Nepal but what is more important is that those existing may need to be modified and enforced diligently. The trouble here is that even if laws are enacted it is not put into practice or rather takes a long, long time to be implemented. What is happening in the developed countries is that regarding commitment and implementation at the National or State level, most of the cost is borne by:

- a. Charitable foundations set up by industry.
- b. NGOs & INGOs which usually have been set up for specific purposes. E.g. Doctors Without Borders etc. Here in Nepal Mrigendra Samjana Medical Trust, Heart & Diabetic Associations.
- c. Direct contribution by industry.

Future endeavors

Newer problems and newer diseases:

1. HIV & AIDS in the past. Also outbreaks of Ebola etc.
2. SARS
3. H5N1 Influenza virus
4. Staphylococci resistant to all drugs

Disparities widening between the rich and the poor.

Must ensure that we have effective ways to change behaviour and get the population at large to lead healthy lifestyles.

When Thomas Malthus in 1798 published 'An Essay on Principle of Population' his contention was that the world's population would not have enough to eat in future years. Darwin came out with his theory of Survival of the fittest. There were suggestions that the sea, if properly exploited would provide enough food in the future. The letting out of sewage of coast towns may not have been a problem in the past, but it is so now. The worry confronting societies with coastlines is that the dumping of human wastes into the sea may endanger the marine life in that environment.

The years after the World War II saw the introduction of mechanized farming which brought about the Green Revolution and the ability to feed many hungry mouths. New discoveries and innovations have now changed many aspects of our lives. The wide spread use of tissue culture and genetic engineering now has to a certain extent shown the way to feed the rising population of the world. One has only to remember the Bengal famine of the twentieth century to realize that this would have occurred again and again had it not been for tissue cultures, improved seeds by genetic engineering, modern harvesting and storing techniques. There are pros and cons in the use of hybrid Genetically Mutated seeds. Monsanto GM maize seeds were a disaster in Nepal. With all these modern day techniques there are still many mouths to feed. It is because of the intricacies of world trade, limited production and destroying the excess to prevent the drop of food prices. Letting land lie fallow may be a rational decision but the dumping of grains, milk, eggs or the slaughter of meat producing animals to maintain prices cannot be condoned when much of the population in the developing and least developed countries are going hungry.

The current world population of 6.5 billion is expected to grow to 9 billion by 2050. The percentage of elderly will go up – 30% of the population in the developed countries and China will be over 65 years. Special facilities will have to be made to cater to their needs. There are expected to be an increase in Mega Cities with populations of over 20 million in each. The degradation of the environment will be more. A great deal of urbanization will occur in Nepal. One last word however is that because of the falling fertility rates, smaller families, immunization, a new factor known as 'demographic transition has come into play and so the anticipated population of 9 billion will probably only be reached towards the end of the 21 Century.

Acknowledgements

Following this lecture there was a discussion in which the under-mentioned doctors commented on various aspects that had been left out or not stressed in the presentation. The comments were from: Dr. Mrigendra Raj Pandey, Dr. Gauri Shanker Lal Das, Prof. Dr. Sharad Onta, Dr. Tirtha Rana, Prof. Dr. Rajendra Wagle, Dr. Moin Shah, Dr. Kedar Baral and Dr. Nillamber

Jha and Dr. Badri Raj Pande. I have tried to include these comments in this final format of the oration. If I have left out any thoughts expressed I beg forgiveness for the same.

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Gallery



Nepal Public Health Foundation

Concept

Nepal confronts with triple burden of diseases, malnutrition, and a weak health system as the major threat to nation's health as well as a formidable barrier to meeting Millennium Development Goal. While communicable diseases are still an important cause of preventable deaths, the chronic non-communicable diseases have emerged as major killers. Injuries and disasters, along with emerging and reemerging diseases associated with the change in environment, constitute the third category in the burden of diseases.

In spite of economic backwardness, difficult terrain and decade of violent conflict, there has been remarkable improvement in health indicators such as Infant Mortality Rate, Maternal Mortality Ratio and Total Fertility Rate. The right of Nepali people for basic health care is enshrined in the interim constitution of 2007. However, the nutritional status has not changed much, and there is much to be desired for achieving health for all, calling for a need to integrating health action with equitable and sustainable development efforts, strengthen health system through revitalization of Primary Health Care and ensure good nutritional status through multi-sectoral collaboration.

To meet such challenge, a concerted public health response is needed which gives as much emphasis on multi-sectoral cost effective intervention for health promotion and disease prevention as to affordable diagnostic and therapeutic health care. It requires both capacity for "research for health", healthy public policy development and analysis, pilot interventions and evaluation, in developing models of prevention and control strategies, health care management, health care financing and health system organizations. It highlights the role of systematic review and system thinking as important tool to strengthen health systems. Such response demand effective and efficient networking with public health professionals and institutions both within the nation and on regional and global level, so as to ensure policy and interventions that are evidence based, context specific and result oriented.

To launch such response a critical mass of public health experts and activists have to come together in an apex body that has full autonomy exercised by its governing board and general body. Such an organization should be able to work together with government and non-government organizations, private sector and community based organizations, health sciences and research institutions, and most importantly, people's health movements. It would be the principle vehicle of civil society to ensure public health advocacy and community based action that would empower the people at community level and above.

Nepal Public Health Foundation is conceived to become such organization.

Vision Ensuring health as the right and responsibility of the Nepali people

Mission Concerted public health action, research and policy dialogue for health development, particularly of the socio-economically marginalized population.

Goal Ensure Civil Society's pro-active intervention in public health

Objectives

The Objectives of Nepal Public Health Foundation are to:

Engage public health stakeholders for systematic review and analysis of existing and emerging health scenario to generate policy recommendations for public health action; especially in the context of the changing physical and social environment, the increasing health gap between the rich and the poor, and the impact of other sectors on health.

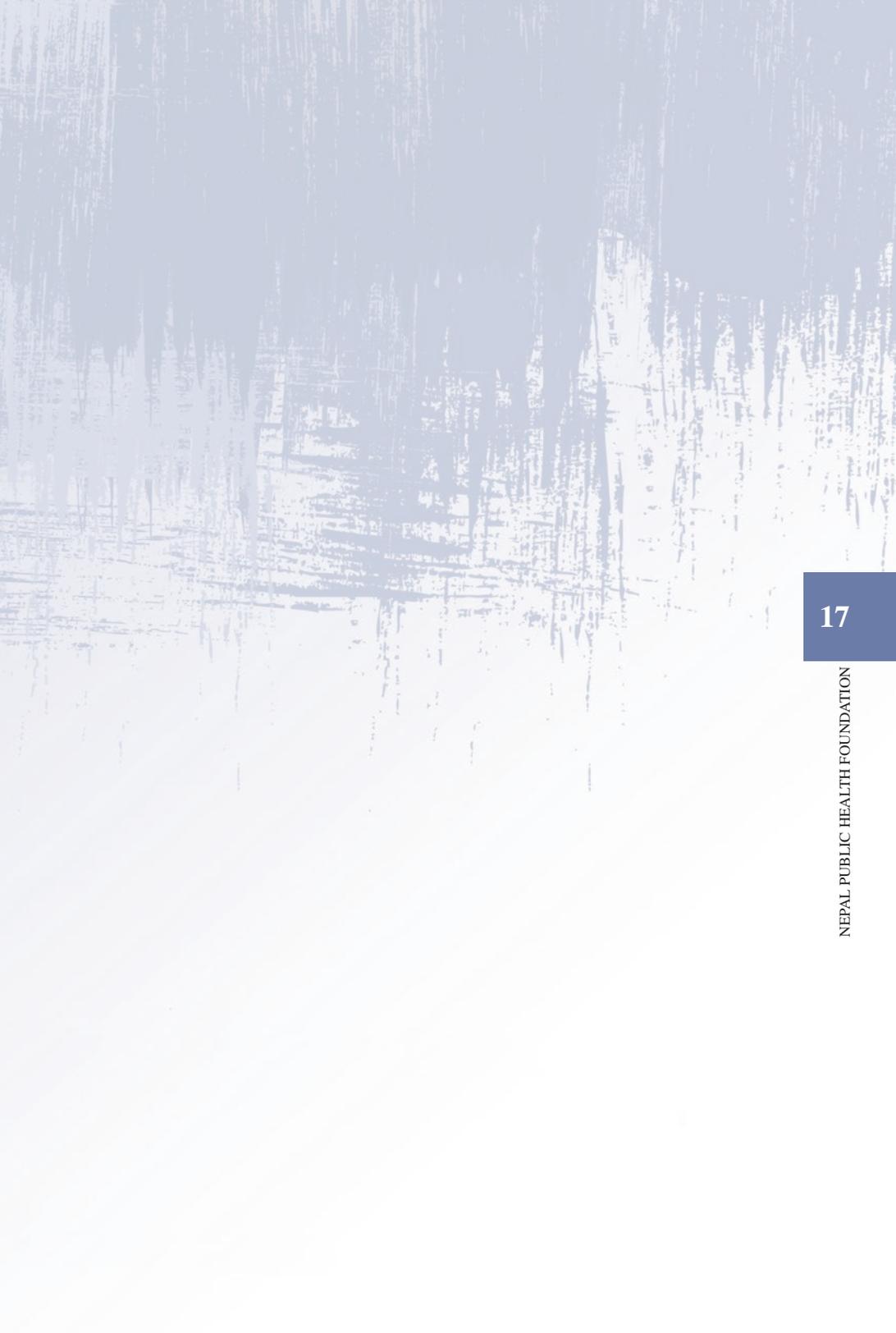
Prioritize public health action and research areas, facilitate pilot interventions in collaboration with national and international partnerships with special emphasis to building communities capacity for health care.

Strengthen health system through systems thinking for effectively responding to the problems of public health.

Support/establish existing or new community based public health training institutions.

Ensure continued public health education (CPHE) by disseminating latest advancements in public health knowledge and research. Publish books, monographs, educational materials and self-learning manuals.

Provide research fund for deserving researchers and public health institutions, with priority given to community-based institutions.





Dr Hemang Dixit is a Nepali born at Kathmandu in 1937. Following schooling at Sherwood College, Naini Tal and Bishop Cotton School, Shimla in India, he went to the UK to do his A-Levels. Starting his medical education at Charing Cross Hospital Medical School of London University in 1956 he completed the same in 1961 doing both the MBBS (U. Lond) and LRCP, MRCS of the Conjoint Board After his year of internship at the Charing X Hospital on the Strand, he went on to do his DTM & H from London School of Hygiene & Tropical Medicine and the DCH from the Conjoint Board, London Returning back home to Nepal in 1965 he started work at the Bir Hospital at Kathmandu. Subsequently in 1970, he

was posted to the newly established Kanti Children's Hospital. In 1975, after about 11 years he left government service. He was awarded the Coronation Medal in 1973 and later the Suprabal Gorkha Dakhin Bahu in Dec. 1993. In Feb. 1994 he was awarded a Gold Medal for "Development of Paediatrics in APSSEAR Countries" at the Paediatric Conference held in New Delhi.

Joining the Institute of Medicine (IoM) of Tribhuvan University as Reader in Child Health in 1977, he subsequently became Dean of the IoM for almost four years. After his term as Dean, he later became in 1985 the Professor in Child Health and worked again on deputation at the Kanti Children's Hospital. At the same time he worked as Director of the Health Learning Materials Centre of IoM for the production of teaching/learning materials. From February 2001, after retiring from IoM, he worked as Principal of Kathmandu Medical College. He survived an assassination attempt in May 2006. He was awarded the 'Qualified Teacher' award by the Dr. Balaram Joshi Gyan Bigyan Rastriya Purashkar Pratistan in October 2009. Dr. Dixit handed over his Principal ship of Kathmandu Medical College on 8th June 2013. He still works at KMC as Head of Medical Education Department and Co-ordinator of PBL.

He has been President of both the Nepal Paediatric Society (1986/87) and the Nepal Medical Association (1990/91). He has been in the Nepal Medical Council for almost 25 years, of which eight ending 1996, were as Vice Chairman.

His served for two years as Chief Editor of the Journal of the Nepal Medical Association, starting in 1965/66 He has also been Chief Editor of the Journal of the Institute of Medicine from 1983 to 1992. Besides being an occasional contributor to various newspapers of Kathmandu, he has written one children's story book and five other novels under the pseudonym of Mani Dixit More information about him can be found in his website: www.hdixit.org.np