

DECEMBER 2016

# SEVENTH

**PUBLIC HEALTH FOUNDATION LECTURE ON**

“FROM A RELUCTANT RESEARCHER  
TO PUBLIC HEALTH ADVOCACY:

**MY LIFE AND TIMES”**



**- DR. BUDDHA BASNYAT**



**NPHF**

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7<sup>th</sup> Lecture Series

DECEMBER 2016

# SEVENTH

PUBLIC HEALTH FOUNDATION LECTURE ON

"FROM A RELUCTANT RESEARCHER  
TO PUBLIC HEALTH ADVOCACY"

**MY LIFE AND TIMES"**

NEPAL PUBLIC HEALTH FOUNDATION

Organized by



**Nepal Public Health  
Foundation (NPHF)**  
नेपाल जनस्वास्थ्य प्रतिष्ठान

# FOREWORD

The 7th Nepal Public Health Foundation Lecture " From Reluctant Researcher to Public Health Advocacy: My Life and Times" is delivered by Prof. Buddha Basnyat, an outstanding medical doctor and eminent research scientist. The lecture provides us a glimpse of a deep reflection of his own development and experiences, and share insights profoundly useful for health professionals who are taking their first steps in their journey to the world of Medicine and Public Health.

Dr. Basnyat is a pioneer in mountain medicine, director of the Himalayan Rescue Association (dealing with high-altitude medical problems), director for the Oxford University Clinical Research Unit in Nepal. He is one of the founding members of NPHF and currently leads Global Antibiotic Resistance Partnership Network's Nepal chapter which is hosted here in Nepal by NPHF. He has over 200 scientific publications in peer reviewed journals and coauthored chapters for Harrison's Textbook of Internal Medicine and the Oxford Textbook of Medicine. And the list goes on.

This 7th lecture also reminds us that Nepal Public Health Foundation has already gone through 6 challenging years of its establishment and grown into an organization with impressive national and international linkage. Its vision of ensuring good health as right and responsibility of people, however, demands a continuous effort for concerted action of individuals and institutions. NPHF lectures are one of the major events to foster collective action of professionals around the common agenda of Public Health.

As we had stated before, in these lecture series the speakers are free to express their opinion related to the subject matter of the lecture. We at the same time would like to make it clear that these opinions are not formal position of NPHF. In this way NPHF hopes to provide forum for differing opinion and lively discussion while at the same time ensuring a culture of debate that would lead to consensus for the common agenda of public health.

Executive Board

Nepal Public Health Foundation.

# Welcome Speech by Executive Chair Dr. Mahesh K Maskey

Distinguished Guests, Ladies and Gentlemen

On behalf of Nepal Public Health Foundation I welcome you all to 7th public health lecture series to be delivered by Prof. Dr. Buddha Basnyat. We are delighted and honored to have you all today, and thankful for your gracious presence for the continuity of this fine tradition which already had six lectures annually by eminent public health personalities of Nepal.

Standing before you, my old friends, senior colleagues and young generation of future public health activists, I feel very happy for another reason also. After a rigor of 4 years of diplomatic responsibilities, to rejoin public health community is like coming home, to the place I truly belong. Let me also tell you a secret. I found the job of Ambassador quite easy, perhaps Public Health had well prepared me for the challenge of multi sectoral coordination.

Today I also recall how NPHF came into existence 6 years ago. We had an idea and we believed it was an idea whose time had come, so almost all of the distinguished public health leaders joined hands to form this organization. But we did not have any funding support. So everybody contributed out of their pocket a modest sum. We rented two rooms, bought some furniture with that money. We did not had enough, so some even lent their old phone set for the office purpose. Now public health foundation implements 10s of crores of research and health intervention projects, employs altogether 25 staffs, provided training opportunity for two PhD students and field area for many masters students. And most of it happened in my absence. So I want to take this opportunity to thank the all who made it possible especially the leadership of foundation, Dr. Badri Raj Pande, Dr Sharad Onta, Dr. Tirtha Rana and others.

However the distinction of NPHF is its convening power built upon its expertise and wide network. Therefore we have decided to unleash this power with monthly meeting of Health Policy Dialogue, starting as early as possible. It would be a panel discussion of health expert, government representatives, member of parliaments, the external development partners and health related NGOs. We will let you know once we complete our preparation.

Today I also recall my first meeting with Dr Buddha 25 years ago. He had already specialized in internal medicine and Physiology, and I had completed MPH. He also had started to distinguish himself in academia and research and he was involved in public health from that time also making very important contribution in the establishment of Resource center for Primary Health Care. This fast, I am sure, not many people are aware of.

Buddha is a pioneer in Mountain medicine and is a very dedicated health researcher. He is one of the rare individuals who have successfully combined three in one- medicine, public health and research. He is a practicing physician in Kathmandu and is the Director for the Oxford University Clinical Research Unit in Nepal and Medical Director for the Nepal International Clinic (a travel medicine clinic) and the Himalayan Rescue Association (dealing with high-altitude medical problems). He also works at Patan Hospital as a consultant in the internal medicine department and is a professor of medicine and physiology at the Patan Academy of Health Sciences. He is one of the founding members of NPHF and currently leads Global Antibiotic Resistance Partnership Network's Nepal chapter which is hosted here in Nepal by NPHF. Besides his research interests in infectious disease and high-altitude medicine, one of his primary concerns is to encourage young people to go into research.

He is a fellow of the American College of Physicians and the Royal College of Physicians, Edinburgh. He has over 200 scientific publications in peer reviewed journals and coauthored chapters for Harrison's Textbook of Internal Medicine and the Oxford Textbook of Medicine. He also writes a weekly health column for a weekly English paper available online.

I am sure you are quite impressed now and are keen to listen to him. The topic he has chosen is " From Reluctant Researcher to Public Health Advocacy: My Life and Times". I was little surprised when I first came to know about his title. Reluctant Researcher?

I had always found him a dedicated, bubbling with energy, trigger happy researcher who jumps to action when pricked by an interesting research idea. But...hmm... Let us see he may have something up his sleeves. So I invite Prof Dr. Buddha Basnyat to deliver his key note address. Let us give him a big hand.

## KEYNOTE ADDRESS

I started my research career in Calgary, Canada accidentally. I went to Canada in the early 1980s to do a family medicine residency. But in Calgary the powers that be told me to study human physiology in order to teach this subject at the Institute of Medicine (IOM), Maharjgunj. IOM needed a physiology teacher badly. I had dreams of becoming an internist like Dr. Pahari or Dr. ShyamBahadurThapa and studying physiology did not seem the optimal path to get me to be like them. But Calgary told me either I do physiology or pack my bags and go back to Nepal. At this time I had just learnt to ski and drink the local beer and was enjoying the Canadian winter and did not want to return.

So reluctantly I said OK to physiology. I thought a true Gorkhali like me would easily memorize the functions of the kidneys, liver, heart, lungs etc and I would be a good physiology teacher. But my advisers in Calgary had other plans for me. They said I needed to do a thesis-based Masters in physiology and had to begin by generating a hypothesis. Pardon me I said, generate what? A hypothesis. It was a new vocabulary for me. That was not going to be the only new thing for me.

The next two years I was miserable in a lab with Hewlett Packard machines and doing original

research on airflow through the nose and measuring the electromyogram of the alaenasi, and measuring pressure drop and resistance with a pneumotachymeter in the upper nasal passages. The Canadian lab tech from Newfoundland got very tired of me because I had many simple technical questions like how to use a screw driver. He used to run away from me. God knows how I survived the two years and finished my MSc. In addition as I looked upon doing this MSc as a doubtful enterprise, I sneaked off in the evenings to the University of Calgary's medical library and studied for my USMLE exams, just in case. This sneaky studying would turn out to be useful for me later on when I subsequently went to the Phoenix, Arizona and did an internal medicine residency programme at the Good Samaritan Hospital.

Anyway to pick up the story, I returned from Canada with a MSc and taught physiology at the IOM. I was the "whole and soul" of the department of physiology and felt like a Maharajabut to be honest, I was only 2 classes ahead in knowledge base than my class of brilliant students of IOM as my training in Canada had been solely thesis-based pulmonary physiology. But I did not fear because memorizing came easily to me but it was the analytical part that I now excelled in and clearly performing the alaenasi experiments in Canada had made me scientifically smarter human being. And I could communicate research methodologies to my eager physiology students. I

introduced the multiple choice questions to them and they said, sir laikastonayakuraharuaudo rahecha. Little did they realize that they were actually helping me memorize for my USMLE exams in physiology and biochemistry by teaching them these multiple choice questions.

But honestly I started looking at problems from a different angle than my other clinical colleagues who did not have this thesis- based Calgary exposure. Furthermore because I had to write a MSc thesis, this exercise gave me a taste and flare for scientific writing which has stood me in good stead to this day.

So clearly I was not naturally drawn to research but had honed my skills by having the privilege of this exposure in Canada. And to this day my advice to young doctors who are interested in clinical research is to try and do a thesis- based master programme in a Western setup if possible where you are thrown out of your comfort zone for a few years and you are challenged into thinking with a capital 'T'. Otherwise it is easy to be stuck at memorizing 5 causes of this and 4 causes of that, all rote memory, which is useful but imagine if you can add on the analytical part which our eastern education system lags behind in.

Research is an integral part of public health so I would like to spend a few more minutes on this topic before I talk about public health advocacy, the other portion of my life and times.

We may have been famous scientists during the Vedic“pushpabiman” days as we are fond of mentioning every opportunity we get (not unlike Prime Minister NarendraModi) but at present we lack a basic important quality in doing research,that is careful documentation. One of things I urge medical students and young resident doctors is to write complete notes and get into the habit of doing this. Many young health professionals write down the subjective complaints of the patients and the objective findings like temperature, pulse and blood pressure and physical examination well enough.

But the assessment and plan (SOAP) is very poorly addressed. The assessment and plan of SOAP requires some amount of thinking and we need to commit ourselves even if we are wrong. This is the start of research. Confidence in writing will be built up doing this.

The other simple thing I have urged medical students and young doctors is to write letters to the editor. I tell them, not to hesitate to start with high impact journals like the New England Medical Journal because letters can be published quickly and don't have to go through a lengthy peer review process. I tell them to pick a topic they are familiar with that someone has done a review article about and now make a critical appraisal of the article.I tell them this is the easiest way to get your name in print and it will boost your confidence.

My career in research may have started in Canada but a simple letter to the editor that was accepted for publication helped tremendously. In 2003 there was a review article in the NEJM about typhoid fever and I felt like I should have written that article. So I did the next best thing, I picked up a point in the article and genuinely criticized it and wrote a letter. The editors of the NEJM accepted the letter, but the author of the review article asked me if he could come and visit me at Patan Hospital. One thing led to another and we established the Oxford University Clinical Research Unit in Patan Hospital. This was chance encounter at work here. The author of the review article turned out to be a young dynamic British doctor who is now the head of the Wellcome Trust. The simple letter to the editor (sampadaklaichitthi) which is now archived in the NEJM website made the difference.

Continuing in this theme of documentation and its importance in public health in getting a quick publication is to write simple case reports. The humble case report may not be enough to stack up points for your promotion, but this will push you to put pen to paper and will be good training ground for doing and writing up larger studies. I tell young researchers if you are good at telling stories you should try your hand writing case reports. And don't wait to write the case report later on, do it now when you see that interesting case. The later time will never come. And make sure get them published in peer reviewed journals of which

there are many even in Nepal.

In public health perhaps more than in clinical medicine documentation is key so you can compare data, follow cohorts for decades like the Framingham study or the US nurses cohort study, do international studies impacting on health outcomes like air pollution, climate change, and study different internationally-relevant risk factors for heart and lung disease across continents like Salim Yusuf from McMaster University does.

Research in a sense leads me to understand the importance of public health advocacy. Recently from studies done at Patan Hospital we found that fluoroquinolones (even the latest generation) are generally ineffective in the treatment of typhoid fever. Based on our published findings in the Lancet, Ed Ryan, an infectious disease Professor at Harvard, commented that fluoroquinolones should not be used for the treatment of typhoid fever not only in Nepal but all of South Asia because of the ubiquitous H58 typhoid isolate. At our research Unit in Patan we felt a tremendous sense of accomplishment because our team had been the first to show poor clinical outcomes in patients with the H58 isolate.

But because of our lack of public engagement (which is a form of public health), guidelines from our ministry of health initially clearly stated fluoroquinolones (specifically ciprofloxacin) as the drug of choice for typhoid fever. So we spent a lot of

time doing worthwhile research but not enough time talking to our health bureaucrats and policy makers what our findings are. So what good is this? We asked ourselves. Clearly we need to come out of our ivory towers and change this scenario and actively engage with our health authorities and policy makers.

I like the relative new expression “low hanging fruit”, a doable job. Pattatiperakhanahune. In Nepal one of the low hanging fruits where a lot can be done is tuberculosis. Zika virus and Ebola virus will come and go but life threatening tuberculosis will go on forever just like the poem “The Brook” by Alfred Lord Tennyson that we read in high school, “men may come and men may go but I go on forever”. Tuberculosis today is the single most common killer in infectious diseases, but South Asia does not give TB the amount of importance it deserves. If you troll the literature on tuberculosis, most of the studies on TB do not come from this region as they should, given the huge number of cases compared to anywhere in the world. But a vast majority of well done studies on TB come from South Africa. For example, most of the Gene Xpert studies ( GeneXpert being the game changer rapid diagnostic method for TB ) originated from South Africa. This is an area we in South Asia should be leaders. I asked a wise emeritus professor from Oxford why more studies on TB and other common infectious diseases did not come from India give the sheer sample size? He said this was due to a lack

of equipoise or curiosity. He was painting with broad strokes, but he said many elite doctors in India who could make a difference knew it all, that no questions remained. And if you have no questions, you have no research. I don't know if his opinions are true about elite Indian doctors but it gave me pause. I wonder sometimes if he would have the same opinion of us. Here we can be so certain at times “this drugs works for sure” when the evidence may be based on a small sample size of my clinic patients. There is no room for debate. And Houston, as the saying goes, we have a problem!!

Continuing about tuberculosis, I really want to share with you something that has puzzled me over the years and that is active contact tracing. In the US and Europe if someone in an air plane is found to have tuberculosis, then everyone in the plane is conscientiously followed up for months to make sure they didn't get TB from the index passenger and pass it on to others. This job is taken very seriously by the public health department in the West. In our case when someone is diagnosed with pulmonary TB, no system is in place where we check on the family members to make sure they have not been infected. We only take a history to ascertain if any family member is sick with TB. But what if the index patient himself is spreading TB? There is no way we will be able to control the spread of TB in the community until we have this active contact tracing in place. We may not be able to check the work place and other places where

the index patient frequents but at least we could focus on the family members. What is truly amazing is that in South Asia (population 1.7 billion) this active contact tracing is not in place. Lack of treatment or incomplete treatment of infectious diseases like tuberculosis is a public health scourge as this will perpetuate the problem in the community. No wonder although TB rates have been falling in most parts of the world, they have held steady in Nepal. Besides causing tremendous morbidity and possibly death, poor awareness of the spread of TB may also lead to multi drug resistance or the problem with AMR (antimicrobial resistance).

I would like to spend some time talking about AMR. AMR is a huge problem globally and I am very happy to note that the Global Antibiotic Resistance Partnership (GARP) has been hosted very kindly by the Nepal Public Health Foundation for almost 4 years. As the chair person of GARP, I have one important message I think I want to highlight or flag as we now say.

AMR is a silent epidemic as our past health Minister Mr. Khagraj Adhikari pointed out. It is so silent that most of us including doctors are not aware what is happening in front of our eyes. There are many reasons for this and the remedy is not as simple as saying- just make a law which states that you cannot obtain antibiotics without prescription. What are we to do in the hills and mountains where there may be no doctors to write out prescriptions? It is as someone succinctly put it Access

vs Excess. Access to antibiotics which saves lives is hard in the mountains but in the cities there might be excess use. How do we deal with this?

Importantly many doctors equate AMR with rational use of antibiotics. AMR control is not confined to just rational use of antibiotics or antibiotic stewardship which nevertheless are very important components of AMR. But AMR control goes beyond this because one of the main tenets of AMR control is to try to avoid infections so that antibiotics may not have to be used in the first place. Hence the emphasis on proper hand washing, obtaining vaccinations like typhoid vaccine and even “no open defecation zones” so that infections don’t happen and we don’t need to use antibiotics. This broad remit of AMR control is under appreciated.

But one thing is clear the Western world is going to try to get its act together regarding AMR while we in places like South Asia will find it much more challenging because of the sheer size of humanity in our place and to build up awareness about AMR is not easy. For example we are a country of 30 million people but to the south are Uttar Pradesh and Bihar with over 300 million people, easily more than half of Europe. How do we all work together and build awareness? However AMR is a global problem now and one reason is travel and carrying one resistant isolate from one area of the world to the other. Let me go back to the example of the H58 typhoid

isolate which is ubiquitous, that is found everywhere in South Asia. This resistant bug has now travelled to Africa and probably has reached the shores of Europe and America, thanks to travel. So no one is immune from this. So AMR is a problem that binds us all, rich or poor nation, and we clearly have to unite to deal with this.

## So much about AMR

Please forgive me today but my talk here is a bit of hodge-podge of stories and topics here and there that are close to my heart. And I am doing my best to try to retain your interest which is always difficult when you are delivering a lecture.

Many of you in the audience who do rounds in Nepali hospitals have probably had heart wrenching experiences regarding my next topic.

One of the biggest health problems in Nepal is in dealing with catastrophic illnesses (defined as severe illnesses requiring prolonged hospitalization and recovery leading to poverty) since there is hardly any provision of health insurance. This problem has been exacerbated by more poverty induced by the earthquake.

I relate below the story of a patient in our hospital who had a successful outcome despite a devastating illness. Unfortunately, most patients with such illnesses are not so lucky in

our part of the world. Fifty-year-old Krishna was a busy taxi-driver who started complaining about a feeling of fullness for 3 weeks. A proper history was taken and, on examination, it was obvious he had a massive spleen. Eventually, with a bone marrow biopsy and histological studies, Dr. Gyan Kyastha and his team at Patan Hospital established that he had chronic myeloid leukaemia (CML). That was the easy part. Imatinib, the stunningly effective drug in the treatment of CML, costs about US\$ 30 000 per year, and there is no way Krishna could have afforded this. Fortunately, Novartis, a Swiss drug company working together with the Max Foundation, provides this drug pro bono to poor, eligible patients with CML in Nepal when the patients register with a recognized programme like Dr. Gyan's at Patan Hospital. Krishna was started on this drug, and we observed him make a miraculous recovery; and he went back to driving his taxi.

Unlike many other cancer drugs that kill cells indiscriminately in the human body, imatinib targets specific cells and genes. The target in this case is the Philadelphia chromosome, which characterizes and helps diagnose CML. The activity of this chromosome is detrimental to the body and triggers among other things the growth of a massive spleen as in Krishna's case.

Unfortunately, as often happens with drug therapy, resistance to this 'game changer' drug developed in Krishna after 3 years of treatment. Incredibly again, because free

nilotinib, the drug used to treat CML patients who are imatinib-resistant, was also available through the same generous group that supplies imatinib to our hospital programme, Krishna, fortunately, once again recovered with this new drug treatment and went back to driving his taxi.

This is an unusual example of a very expensive drug used to treat a dangerous illness in a poor setting with a successful outcome. Clearly, the availability of these kinds of drugs and a positive outcome of available treatment in many other more common, catastrophic illnesses in the general population in Nepal are few and far between.

In almost all of South Asia where Nepal is only a tiny country many new, effective and modern treatments for chronic diseases (e.g. angioplasty for coronary artery disease, dialysis for renal failure) are widely available. The growth of well-appointed hospitals in this part of the world has witnessed medical tourism that is flourishing in many parts of South Asia. However, the majority of people in this subcontinent will not be able to access dialysis or angioplasty treatments. This brings into sharp focus the question of equity.

For example, in Nepal you have to be financially well-off, or politically well-connected to be able to pay up without incurring a massive debt when your family has to deal with life-threatening diseases such as renal failure, malignancy or coronary

artery disease. Otherwise it is the old story of borrowing money, selling off your land, cattle or jewelry (if you possess them) to pay for the hospital fees. This was true many years ago when I was doing my internship at Shanta Bhanwani hospital and it is still true almost every day in our practice in Nepal.

We encounter families that continue to suffer and be emotionally torn between financial survival and seeking debt to pay the bills for a loved one with a treatable, catastrophic illness. Ideally, the entire population in Nepal should be covered by a universal health insurance package with financing from a combination of public, employer and private sources; and political will is crucial.

It is very heart-warming then that Nepal Public Health Foundation is playing an active role in trying to implement Universal Health Care in Nepal. The large amount of money received by the Nepal government after the earthquake to 'build back better' could be used to implement universal health coverage especially in the earthquake-ravaged districts so that the most affected population who are clearly the most vulnerable are looked after first.

While talking about the earthquake I have one more suggestion that I would like to repeat that was the subject of our comment last year in several issues of the medical journal *Lancet* and *Lancet Global Health*.

No major infectious disease outbreaks (except perhaps scrub

typhus) have been reported one year months since the earthquake in Nepal.

But after an earthquake of this magnitude, there will continue to be an elevated risk of epidemics of infectious diseases already endemic in Nepal, which include cholera, hepatitis E, and typhoid, all vaccine preventable illnesses. Now 3 million people still live in shelters and the hygiene in these places leaves a lot of room for improvement. Now all these three diseases are transmitted fecal orally. My personal viewpoint is that the government of Nepal will be doing the right thing by administering these effective vaccines to these people. Furthermore in the eyes of the world that is watching us we will look innovative if we administer these vaccines which are generally very safe. It is only by the grace of God (OmBhole Baba) that we have not had these disease outbreaks in these camps. But we have to understand that God helps those who help themselves.

Finally I don't want to disappoint. No talk that I have given in the institute of medicine is complete without mentioning altitude sickness. Many recognize me as the altitude doctor and may think with this talk I just gave, I have morphed into a different unrecognizable being. This is not true as altitude sickness and infectious diseases are in plentiful supply here and I have been working on both of these topics for decades.

Altitude sickness is a public health

problem that can be dealt with by proper public engagement. Most of us perceive altitude sickness as a bideshi or western disease. But I want to tell you today that this is very much a swodeshi disease. Did you know that in South Asia, thousands of trekkers and mountaineers ascend to the high Himalaya every year? But guess how many pilgrims ascend to the holy sites in the Himalaya every year-Millions. So it is thousands of tourists but millions of pilgrims. And many of the pilgrims have comorbidities like diabetes. But the pilgrims receive very little attention in terms of prevention and treatment of altitude sickness. In fact they die quietly. One of the missions of the Himalaya Rescue Association and the Mountain Medicine Society is to focus attention on the pilgrims. And also more recently what has come to be known is that the impoverished Nepalis from the plains that go to pick yarsagumba in the high Himalaya also suffer from life threatening forms of altitude sickness and attention needs to focus on these vulnerable populations.

I want to conclude by thanking Dr Mahesh Maskey from the Nepal Public Health Foundation for giving me this opportunity to make this presentation. Now that I have bored you all with my hodge-podge talk, I would like to end on a darsanik or philosophical note especially directed towards my younger colleagues.

In Nepal it is possible to feel really alive. I am not talking about escaping the earthquake. Here in Nepal if you

## 7<sup>th</sup> Lecture Series

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can find a way to financially sustain yourself, there are so many areas (unavailable to the Western doctor or researcher) that a microbiologist, a clinician or any health care profession or public health worker can find to help people or society at large in a very meaningful way. Pursuing this path has the potential to be very fulfilling whereby we stop doing things to achieve purposes of outer value i.e. name, fame, and glory. It is possible then to concentrate on the inner value, that is associated with the rapture (the ananda part) of being alive. We no longer need to look far for the meaning of life. It will come with the rapture, the ananda.

So, as my father used to say as he made his way every day at the crack of dawn to Shree Swayambhu Nath, Ananda la, Pasha? Jai Gorakh Kali.



# 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.

### Focus areas of NPHF

- Health policy and Systems Research
- Human Resource Development
- Communicable disease control
- Non-communicable disease control
- Nutritional Research
- Maternal and Child Health
- Disaster Prevention and Management
- Co-ordination, Advocacy and communication
- Social Determinants for Health
- Health Economics
- Health Technology Research
- Epidemiology, Biostatistics and Demography

## 7<sup>th</sup> Lecture Series

# Glimpse of Seventh Lecture Series



Top Row from Left; Dr. Sameer Mani Dixit; Dr. xeChhatra Amatya; Dr. Bharat Pradhan; Dr. Shrikrishna Giri; Dr. Sharad Onta

Bottom Row; Dr. Badri Raj Pande, Dr. Buddha Basnyat, Dr. Mohin Shah; Dr. Mahesh K Maskey; Dr. B.D Chataut; Dr. Tirtha Rana

## Biographical Sketch of Dr. Buddha Basnyat



Dr. Buddha Basnyat is a medical doctor practicing medicine in Kathmandu, Nepal. His research interests are infectious disease and high altitude medicine both of which are in ample supply in Nepal. He has published widely in both these fields in well-known medical journals and written chapters with co- authors in the latest standard medical textbooks( for example, Harrison's textbook of internal medicine Oxford textbook of medicine and Manson's Tropical Diseases). He is

the Director for the Oxford University Clinical Research Unit\Nepal and is also the Medical Director for the Nepal International Clinic (a travel medicine clinic) and The Himalayan Rescue Association (dealing with high altitude medical problems). In all these institutions one of his primary interest is to encourage young people to do research. He also works at Patan Hospital as a consultant in the internal medicine department and is a Professor of Medicine and Physiology at the Patan Academy of Health Sciences. He is a Fellow of the American College of Physicians and also a Fellow of the Royal College of Physicians (Edinburgh). He is also the Principal Investigator, Nuffield Department of Medicine, University of Oxford. He has over 200 scientific publications in peer reviewed journals. Recently he has been appointed as the Honorary Consul for Canada in Nepal.

*Link to Google Scholar page for Buddha Basnyat to check for article citations:*

**<http://scholar.google.com/citations?user=jyidWzAPe6gC&hl=en>**

*Our website*

**<http://www.tropicalmedicine.ox.ac.uk/nepal>**

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# SEVENTH

PUBLIC HEALTH FOUNDATION LECTURE ON

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