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Health policy must connect innovation with better care for every Indian. This Monsoon Session 2026 issue of the IMPF Newsletter explores six priorities where evidence, public investment and parliamentary leadership can make a lasting difference.

We begin with ABHA-linked electronic health records and the promise of seamless, consent-based care across facilities. ICMR's ambitious research agenda then shows how One Health preparedness, indigenous innovation and clinical trials can turn scientific progress into affordable solutions.

Our focus shifts to patients. Advances in haemophilia treatment offer new possibilities for preventing bleeds and protecting quality of life. On cervical cancer, the imperative is equally clear: translate HPV vaccination, screening and timely treatment into effective last-mile delivery. India's HIV gains demand renewed vigilance, stronger district accountability and wider access to voluntary testing.

We close with a critical question of public spending: how can medical device procurement move beyond the lowest bid to prioritise quality, clinical suitability and long-term value?

Across these contributions runs a common conviction: good policy must reach people, not remain on paper. We thank our distinguished contributors for their insights and commitment. IMPF remains dedicated to helping parliamentarians advance equitable, evidence-led healthcare and measurable outcomes for all, in every constituency, district and community across our diverse country.

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One Citizen, One Health Record: ABHA and the Continuum of Care

Good clinical care rests on good information. Yet a patient's history is often spread across prescriptions, laboratory reports and discharge summaries kept in different places. Electronic health records (EHRs) linked through the Ayushman Bharat Health Account (ABHA) bring this information together, so every clinician, at every level of care, can see the patient's full journey.



India has built a strong foundation for this transition. As of 1 September 2026, the Ayushman Bharat Digital Mission (ABDM) had generated more than 97.8 crore ABHA numbers and linked over 121 crore health records, with over 5.6 lakh health facilities and about 11 lakh healthcare professionals registered on its national registries. Five years after its launch, ABDM ranks among the world's largest digital health ecosystems.

ABHA, a 14-digit health identifier, is the common thread across this ecosystem. Its design is federated and consent-based: records remain with the facility that generates them and are shared only with the citizen's revocable consent. Interoperability standards such as FHIR and SNOMED CT enable systems to read records created by other systems, while citizens can access their own records through the ABHA app and Aarogya Setu 2.0.

A common identifier delivers three distinct gains.

Quality of care: Timely access to prior diagnoses, allergies, medications and investigations enables better-informed clinical decisions, reduces duplicate testing, improves medication safety and lowers out-of-pocket costs.

Holistic care: Patients increasingly live with multiple conditions and engage with several programmes simultaneously, from non-communicable disease management and TB care to maternal health and AYUSH services. A single longitudinal record enables providers to treat the person, not just the presenting condition.

Continuum of care: As patients move between Ayushman Arogya Mandirs, Community Health Centres, district hospitals and medical colleges, or across States for livelihoods, their records move with them. Referrals carry clinical context, and follow-up is assured.

Aggregated and anonymised, these records also provide States with real-time evidence to plan services, supplies, and human resources.

The priority now is to move from enrolment to everyday use. NITI Aayog, in collaboration with the Ministry of Health and Family Welfare, the National Health Authority, States and Union Territories, and experts from clinical practice, public health, the private sector, and industry, is developing a national roadmap to adopt ABHA-linked EHRs across the public and private health ecosystem. Six priorities merit attention for the adoption of EHRs across the country:

1. Institutionalise ABHA-linked EHRs as standard practice across all public facilities, starting with Ayushman Arogya Mandirs and district hospitals.
2. Design clinician-friendly workflows, including Scan and Share registration, concise templates and voice-enabled entry in Indian languages.
3. Expand participation by private clinics, laboratories and pharmacies through affordable software and ABDM incentives.
4. Integrate ABHA-linked records across national health programmes.
5. Ensure inclusion through assisted ABHA creation by ASHAs and frontline workers.
6. Reinforce public trust through transparent, revocable consent under the Digital Personal Data Protection Act, 2023.

Hon'ble Parliamentarians and MLAs play a vital role in this transition. Through DISHA committee reviews, they can monitor the share of OPD visits that generate linked records; through constituency engagement, they can encourage every household to create an ABHA. Building on the success of Aadhaar and UPI, ABHA-linked health records can ensure every Indian receives connected, continuous, and complete care, an essential step towards Universal Health Coverage and Viksit Bharat @2047.

– Prof. (Dr.) M Srinivas,
Member (Health), NITI Aayog, Government of India
and
– Mr. Varun Singh,
Consultant (Health), NITI Aayog

ICMR Shifts Gears for a Healthier India

Made in India, Proven in India

Biomedical research matters when it improves population health. As India advances toward Viksit Bharat 2047, the Indian Council of Medical Research (ICMR) is putting outcomes at the centre of its agenda. Scientific output remains essential, but its true test is adoption in clinical and public health practice. ICMR's 2025–29 roadmap prioritises emerging infections, indigenous medical technologies, digital and AI-based solutions, and solutions to persistent public health challenges.



Preparedness comes first. India's large population, livestock, and wildlife increase the risk of diseases crossing species barriers. COVID-19, Lumpy Skin Disease and avian influenza underline the need for a coordinated response. The National One Health Mission (NOHM), implemented by ICMR, brings together more than 13 ministries and departments across human, animal and environmental health. The mission draws on institutions including MoHFW, the Department of Animal Husbandry and Dairying, AYUSH, DST, DBT, CSIR and ICAR. It seeks to strengthen surveillance where people interact with livestock and wildlife, expand high-containment laboratories, and speed development of vaccines, monoclonal antibodies, antivirals and diagnostics. The goal is simple: detect threats early and respond faster.

Response also requires the capacity to develop and manufacture medical technologies at home. Indian innovators face barriers in regulatory approval, clinical validation and scale-up. Med-Tech Mitra, launched by ICMR and the Central Drugs Standard Control Organisation under NITI Aayog's guidance, addresses these gaps. In under three years, it has engaged over 850 innovators and industry partners, facilitated 10 manufacturing and 74 test licences, initiated eight health technology assessments and begun clinical studies for two therapeutics.

Innovations also need intellectual property protection. The Medical Innovations Patent Mitra initiative provides end-to-end patent support, with ICMR covering the entire cost of Indian filings. It serves medical colleges, research institutions, ICMR institutes and DPIIT-recognised start-ups, including women-led enterprises. In 18 months, it has supported over 1,000 innovators, facilitated 314 patent applications and concluded 81 licensing agreements, transferring 39 technologies to industry.

Strong clinical evidence must follow. The Indian Clinical Trial and Education Network (INTENT) now comprises 88 trial sites. It has initiated 11 clinical trials (five Phase I, four Phase III and two Phase IIa) in therapeutics, vaccines, and cell and gene therapy, alongside eight device pilots and five integrative medicine studies. Biopharma SHAKTI, a 10,000 crore mission announced in the Union Budget 2026–27, will enable ICMR to establish 1,000 accredited trial sites, strengthening India's position in biologics and biosimilars.

Yet even proven interventions matter little unless they reach patients. The National Health Research Priorities (NHRP) programme focuses on

implementation research covering anaemia, child undernutrition, neonatal mortality, tuberculosis, cancer, mental health and antimicrobial resistance. Its projects sit within programmes such as the National Tuberculosis Elimination Programme, Anaemia Mukt Bharat, Tele-MANAS, ICDS and Ayushman Bharat Health and Wellness Centres. Researchers identify delivery gaps and design solutions with state and district health systems and communities. They refine proposed solutions through successive cycles. They test these approaches for coverage, quality, equity and cost, helping successful models scale sustainably.

Together, these initiatives form a continuum: surveillance detects threats, innovation develops responses, patents protect them, trials validate them, and implementation research brings them into health services. Viksit Bharat 2047 will require collaboration among government, Parliament, academia, healthcare institutions and industry. Legislative support for research investment, regulatory efficiency and evidence-informed policy will be critical. Ultimately, publicly funded research must deliver better health outcomes and affordable care for every citizen.

– Dr Rajiv Bahl
Secretary to Government of India, Department of Health Research & Director General, Indian Council of Medical Research (ICMR)

Restoring the Balance: A New Frontier in Haemophilia Care

Haemophilia in India: A Continuing Need

India has a significant burden of haemophilia, with an estimated 1,40,000 people living with the condition, among the highest worldwide. Despite treatment advances, patients still face challenges in early diagnosis, access to medicines, and specialised care.

For decades, treatment has focused on replacing missing clotting proteins. While this has transformed care, frequent intravenous infusions and unequal access remain challenges. The focus is now shifting towards preventing bleeds, protecting joints and improving quality of life.

For people with haemophilia, everyday activities such as walking, playing or climbing stairs can pose risks. Minor injuries may cause prolonged bleeding, while repeated joint bleeds can lead to pain, stiffness and permanent damage.

Haemophilia is a rare genetic disorder caused by a deficiency of clotting proteins. Haemophilia A involves factor VIII deficiency, while haemophilia B results from insufficient factor IX. Usually present from birth, the condition can affect mobility, confidence and everyday activities.

A New Approach to Haemophilia Treatment

Imagine the body's clotting system as a car. The accelerator moves it forward, while the brake controls its speed. Similarly, certain proteins promote blood clotting, while others prevent excessive clotting.

In haemophilia, the accelerator is weaker because essential clotting proteins are missing, making bleeding difficult to control.



Scientists are exploring another approach: instead of replacing missing proteins, newer treatments can work by easing the body's natural braking system.

Fitusiran is one such innovation. Using RNA interference (RNAi) technology, it reduces the production of antithrombin (AT), a natural protein that limits clot formation. By lowering AT levels, fitusiran helps improve clot formation and restore the balance between clotting and its natural regulation.

This approach is designed for people with haemophilia A or B, including those with inhibitors, without replacing factor VIII or IX.

Why Antithrombin Monitoring Matters

Just as a car needs controlled braking, the body's clotting system requires careful balance. The aim is not to eliminate the brake but to adjust it sufficiently to control bleeding without promoting excessive clotting.

Because fitusiran reduces antithrombin levels, monitoring AT activity helps healthcare

professionals assess treatment response and guide dosing decisions.

Maintaining AT activity within the range specified in approved prescribing information, alongside regular clinical assessment, is essential for appropriate treatment management.

This represents an important shift: treatment focuses not only on missing clotting proteins but also on managing the body's natural clotting balance.

Innovation Opens New Possibilities

Haemophilia care is entering a new phase. Treatment advances offer new opportunities to prevent bleeding, reduce treatment burden and improve patients' daily lives.

Fitusiran represents a scientific advance through its distinct mechanism of restoring clotting balance. Antithrombin monitoring demonstrates how innovation and personalised treatment management can work together.

For India, progress will depend on greater awareness, early diagnosis, equitable access to specialised care and patient education.

Ultimately, innovation means more than introducing new medicines. It means helping children play confidently, adults live with fewer limitations and families look towards a healthier future.

The goal remains clear: fewer bleeds, healthier joints and a better quality of life for people living with haemophilia.

– Dr. Tulika Seth
Professor of Haematology at AIIMS, New Delhi and a leading voice in haemophilia care and patient Advocacy in India

Cervical Cancer Elimination: From Evidence to Delivery

Cervical cancer is largely preventable, yet it remains the second most prevalent cancer among women in India. The country accounts for roughly one-fifth of global cervical cancer deaths. GLOBOCAN estimates indicate that nearly 124,000 women are diagnosed and more than 77,000 die every year. Screening remains extremely low: fewer than two per cent of eligible women have ever been screened, while more than 65 per cent are diagnosed at Stage II or beyond. Five-year survival is about 51.7 per cent, compared with more than 80 per cent where diagnosis and treatment are timely.

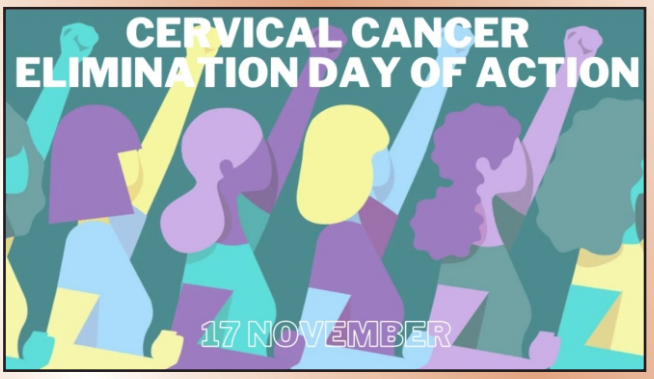
This burden is tragic because cervical cancer develops slowly. Persistent HPV infection can take ten to twenty years to progress to invasive cancer, creating a long window for prevention and early intervention. India already has the essential tools: HPV vaccination, high-performance screening tests and outpatient treatment for pre-cancer. These technologies are increasingly available domestically. The central challenge, then, is not scientific discovery but last-mile delivery.

The Cervical Cancer Elimination Consortium–India (CCEC-I) was convened by the Department of Management Studies, IIT Delhi, in April 2024. It brings together government, private-sector, academic, non-profit and subject-matter experts to support India's cervical cancer elimination agenda through evidence-based interventions. Its work aligns with the World Health Organization's 90–70–90 strategy: 90 per cent of girls fully vaccinated against HPV by age 15, 70 per cent of women screened with a high-performance test by ages 35 and 45, and 90 per cent of women with pre-cancer or cancer receiving appropriate treatment.

CCEC-I translates these goals through its SAVE framework—Screening, Access to treatment, Vaccination and Empowering communities through education—anchored in trust, technology and teamwork.

India's nationwide HPV vaccination programme, launched on 28 February 2026, creates an opportunity. The programme targets around 1.15 crore 14-year-old girls annually, with free vaccination at government facilities through an initial mission-mode campaign followed by routine immunisation. WHO described it as the largest free HPV vaccination campaign in history.

But elimination will falter if vaccination, screening, treatment, and community engagement remain separate verticals. CCEC-I proposes one integrated primary-healthcare pathway, supported



by a district plan, aligned financing and interoperable records. A girl vaccinated at school through the Universal Immunisation Programme and recorded on U-WIN, her mother screened at an Ayushman Arogya Mandir, and her aunt treated for a precancerous lesion at a community health centre should be part of the same continuum of care.

Existing platforms make convergence possible. NP-NCD, RMNCH+A, RKSK/RBSK, PM-JAY, State Programme Implementation Plans and the NCD portal can support screening, referral, treatment, financing and tracking without creating a parallel system.

The last mile remains decisive. Women face inadequate privacy, shortages of trained female providers and consumables, weak referral pathways, travel costs and loss to follow-up. CCEC-I therefore advocates a disciplined pathway from data and gap diagnosis to district demonstration, documentation and scale-up. Treat community mobilisation through teachers, panchayat representatives, self-help groups, and survivors as programme infrastructure.

Design equity from the outset. Women living with HIV, transgender persons, and women in remote, tribal and urban-poor settings require inclusion. Disaggregate every indicator by geography, age, social group, and vulnerability, and report it against the 90–70–90 targets.

India now knows what works. The task is to integrate, measure and deliver it consistently at the last mile. Cervical cancer elimination is no longer a question of knowledge; it is a question of execution.

– Dr. Sharmila Sarkar
Member of Parliament (Lok Sabha)
Dr. Raj Shankar Ghosh
Environmental Health, Public Health Foundation of India (PHFI)

India's Next Step Against HIV

India has made remarkable progress against HIV. These gains reflect decades of investment, mobilisation, and work by clinicians, counsellors, and civil society. Between 2010 and 2024, new infections fell by 49%, from 1.25 lakh to 64,500, while AIDS-related deaths declined by 81% to 32,200. National HIV prevalence stands at 0.20%, against a global rate of 0.7%. More than 38,000 testing centres, access to lifelong antiretroviral treatment and the HIV/AIDS (Prevention and Control) Act, 2017, underpin this achievement. Indian generics also supply about 70% of the world's antiretroviral medicines.

Yet success is not victory. An estimated 25 lakh Indians live with HIV, and only 85% know their status, against the global target of 95%. Injecting drug use and sexual transmission continue to fuel infections, particularly in the Northeast. Stigma discourages testing, while funding pressures threaten hard-won gains. With the National AIDS Control Programme's fifth phase ending in 2026, India faces a defining policy moment.

The National AIDS Control Organisation's Mobilisation for AIDS Suraksha (MAS), launched in 2026, offers a practical way forward. It makes districts accountable for the three global 95 targets: diagnosis, treatment and viral suppression. Districts progress from Sangharshsheel to Saksham and Surakshit as they achieve these milestones. Surakshit Plus recognises districts that also eliminate mother-to-child transmission of HIV, syphilis and hepatitis B. These categories should



become public dashboards, not merely labels in administrative reviews.

In 219 priority districts, local teams review gaps and coordinate action through Suraksha Sankalp Karyashalas. Maharashtra's reported progress, from one Saksham district at the campaign's outset to six Surakshit and 23 Saksham districts, shows what focused leadership can achieve. The national ambition is to bring the epidemic under control by World AIDS Day 2027.

But district accountability needs visible political ownership. India should designate 27 June as National HIV Testing Day: a yearly invitation to seek free, voluntary and confidential testing, with immediate linkage to treatment where needed. The Indian Medical Parliamentarians' Forum could champion a national resolution, while NACO

establishes common protocols and mobilises health facilities and community organisations. Mobile testing teams and peer educators could reach campuses, workplaces, transport hubs and underserved communities.

Members of Parliament can turn this proposal into local action. Each MP should publicly take a voluntary HIV test, while keeping results private; know and publish their district's MAS grade; bring district collectors, ART centres and community networks together to improve weak outcomes; seek district-wise first-95 data through parliamentary questions and committees; and safeguard funding for the next AIDS control programme while insisting on enforcement of the 2017 Act and stronger public awareness campaigns.

The Prime Minister could give the first observance national visibility by voluntarily taking a test alongside the Health Minister and MPs representing every state. Ministers, legislators and youth organisations could then lead awareness and testing drives across constituencies. Participation must always rest on informed consent, with privacy protected. The Day should also reconnect people who have discontinued treatment with accessible, respectful and non-judgemental care. The message should be simple: testing is routine healthcare, not a cause for shame.

India already has affordable medicines, public-health infrastructure and legal safeguards. It needs sustained leadership, stronger retention in care, and a determined effort to reach those still undiagnosed. A National HIV Testing Day would transform a public-health priority into a shared civic commitment. Treatment saves lives, but the journey begins with a test.

– Dr. V. Sam Prasad, MBBS, MPP
Country Program Director
AHF India Cares, New Delhi

Beyond the Lowest Bid: Smarter Medical Device Procurement for India

Every medical device a hospital buys, from a syringe to a robotic surgical system, shapes patient outcomes for years. In India, where public health spending is under pressure and the device market relies heavily on imports, how we procure matters as much as what we procure. An effective approach weighs cost against quality, local manufacturing against clinical need, and stability against innovation.

While resource constraints call for competitive pricing, the L1 principle may be restrictive if applied across medical devices. For complex devices, this can be counterintuitive to value. A cheaper ventilator with high downtime, costly consumables or weak after-sales support can cost a district hospital far more over its lifetime than a better-built alternative.

A balanced approach considers total cost of ownership: purchase price, maintenance, consumables, training, uptime, and lifespan. Quality and cost-based selection, which scores technical merit alongside price, is increasingly recognised for high-value equipment, and procurement bodies should apply it more widely.

India must also balance procurement with its Atmanirbhar ambitions. While the Government has taken pioneering steps to encourage local device manufacturing through product-linked incentives and medical device parks, making indigenous technologies the blanket preference may at times sideline clinical suitability. Where a domestic device meets the required standards, preferring it makes sense. Where it does not yet exist, or the performance gap is clinically meaningful, patients should not pay the price for policy rigidity. The aim is to build domestic capability while keeping access to the best available technology, with local-content requirements that rise gradually as industry matures.

What does this procurement approach require?

First and most critically, it requires improving the ease of doing business and addressing regulatory barriers for imported and locally manufactured devices. While considerable work has been done and regulators are more approachable, we still need to address long-standing pain points. For example,



Quality Control Orders are a barrier that needs to be addressed immediately to allow smoother entry of parts into the country for Make in India units. These regulatory hurdles can delay procurement and impact patients. Uptime also becomes a challenge in such cases, reducing the value the technology delivers.

Balanced procurement also needs skilled people. Biomedical engineers, clinicians and procurement officers should work together from needs assessment through to decommissioning. Platforms like GeM improve transparency, but they work best when paired with strong technical evaluation and vendor performance tracking. Tenders issued across states should start with unbiased evaluations of clinical needs. Clinicians should have a voice throughout the procurement life cycle to ensure installed technology suits their needs and the on-the-ground realities of the health centre where it is installed.

Buyers also need data to compare value. A rigorous Health Technology Assessment (HTA) ecosystem provides the clinical, economic, and organisational evidence required to shift procurement from a unit-cost focus to whole-life value and patient outcomes.

Many medical equipment items are also donated, including by Public Sector Undertakings (PSUs). While priority areas may change regularly, these donations go a long way in equipping hospitals and providing a much-needed financial bridge. A donation framework that ensures equipment is appropriate and sustainable will keep equipment from lying idle and ensure it is used to capacity to serve patients.

A balanced future is essential. Procurement is not just an administrative function; it is a powerful lever for health outcomes and fiscal responsibility. India's challenge is to strike a fine balance among access, quality, patient outcomes, and cost-effectiveness.

– Nikita Hira
Senior Principal, BORBHAG Consulting

IMPF National Policy Summit in Vapi Calls for Wider MedTech Access in India



The Indian Medical Parliamentarians' Forum (IMPF) convened the National Policy Summit on MedTech Access at Meril Academy, Vapi, under the theme "Swasth Bharat Se Saksham Bharat: Reimagining MedTech Access in India." The summit brought together parliamentarians, senior government officials, clinicians, healthcare institutions, and industry representatives to discuss strengthening India's MedTech ecosystem and expanding access to advanced, affordable healthcare technologies.

The summit examined two key areas: building a sustainable and globally competitive MedTech ecosystem and improving patient access through innovation.

Discussions focused on indigenous research and development, regulatory quality, clinical evidence, domestic manufacturing, Health Technology Assessment, financing, reimbursement, workforce capacity and wider adoption of medical technologies across the healthcare system.

IMPF Chairperson, Dr Anil Bonde, MP, Dr Shivaji B Kalge, MP, Dr Jashvantsinh Parmar, MP, Dr. Sharmila Sarkar, MP, and Senior representatives from the Department of Pharmaceuticals, Department of Health Research, ICMR, Ministry of Health and Family Welfare, National Health Authority, NHSRC, DGHS, Senior officials of Meril and leading healthcare institutions participated in the deliberations.

As part of the summit, participating government officials and IMPF Members of Parliament also visited Meril's manufacturing facilities and interacted with senior members of the Meril leadership team. The visit provided first-hand exposure to indigenous R&D, advanced manufacturing capabilities, quality systems and the broader innovation-to-adoption ecosystem.

The summit emphasised that innovation must be backed by credible evidence, appropriate financing, clinical skills and institutional readiness to ensure that quality medical technologies reach patients, including those in underserved and rural areas.

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