

# SIHFW Rajasthan

**Electronic Newsletter**  
**Vol. 2/Issue 4/April 2013**



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## From the Director's Desk

Dear Readers

Greetings from SIHFW, Rajasthan!

World Malaria Day was instituted by the World Health Assembly at its 60th session in May 2007 to recognize the global effort to provide effective control of malaria. It is celebrated on 25 April every year.



During the past decade, global malaria prevention and control efforts have been scaled up. The availability of rapid diagnostic tests has also made it possible to improve and expand diagnostic testing for malaria. However, malaria transmission still occurs around the world, and the malaria burden continues to cripple health systems in many countries.

Sustaining recent gains in various countries require continued political commitment and funding. The present issue of e-newsletter brings light to malaria and the associated health scenario. World Health Day is also being observed this month, on 7 April, with current year's theme of High Blood pressure.

A handwritten signature in black ink, likely of the Director, on a white background.

Director

### Inside:

- Malaria
- SIHFW in Action
- Monitoring and Field visits
- Feedbacks
- Health News

### Health Days in April '13

World Autism Awareness Day : 2 April  
World Health Day : 7 April  
World Haemophilia Day : 17 April  
World Immunization Week : 24-30 April  
World Malaria Day : 25 April  
World Earth Day : 22 April

## Malaria

The history of malaria can be traced back to Romans and Greeks due to their association with agriculture, sowing and harvesting and their inhabitants in swampy areas.

Malaria is potentially life threatening parasite disease caused by parasites known as *Plasmodium vivax* (*P.vivax*), *Plasmodium falciparum* (*P.falciparum*), *Plasmodium malariae* (*P.malariae*) and *Plasmodium ovale* (*P.ovale*). It is transmitted by the infected bite of Anopheles mosquito. Humans take nearly 10-14 days for development of the disease after being bitten by the mosquito.

The magnitude of the disease shows that in India, 95% of the population in the country resides in malaria endemic areas and 85% of the malaria cases reported in the country are confined to areas consisting 20% of the population residing in hilly, tribal, difficult and inaccessible areas.

### Facts about Malaria

- Pregnant Women are particularly at high risk of dying due to malaria- the reason stated high anemia and spontaneous abortion that is responsible for low birth weight babies.
- Half of the world's population is at risk of malaria- people living in poorest of the countries are highly vulnerable
- Every minute a child dies out of malaria, most of which are under five years of age
- Increase in prevention strategies is now contributing to reduction in malarial mortality.

(source: WHO/Malaria Report/2011)

### Disease Spread

- Female *Anopheles* mosquito spreads the infection very fast and discreetly. All of the important vector species bite at night.
- *Anopheles* mosquitoes breed in water and each species has its own breeding preference; for example some prefer shallow collections of fresh water, such as puddles, rice fields, and hoof prints.
- Transmission is more intense in places where the mosquito lifespan is longer (so that the parasite has time to complete its development inside the mosquito) and where it prefers to bite humans rather than other animals.
- Transmission also depends on climatic conditions that may affect the number and survival of mosquitoes, such as rainfall patterns, temperature and humidity. In many places, transmission is seasonal, with the peak during and just after the rainy season.

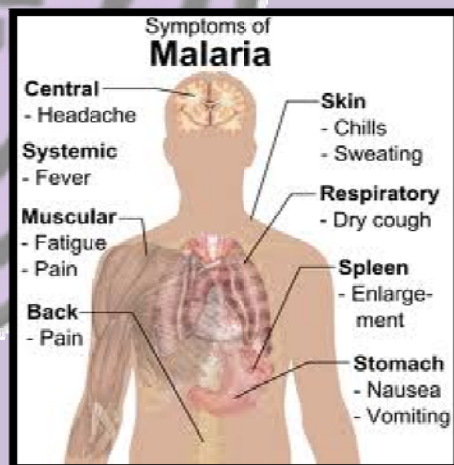


### Symptoms

Malaria is an acute febrile illness. In a non-immune individual, symptoms appear seven days or more (usually 10–15 days) after the infective mosquito bite.

The first symptoms – fever, headache, chills and vomiting – may be mild and difficult to recognize as malaria. If not treated within 24 hours, *P. falciparum* malaria can progress to severe illness often leading to death.

Children with severe malaria frequently develop one or more of the following symptoms: severe anaemia, respiratory distress in relation to metabolic acidosis, or cerebral malaria. In adults, multi-organ involvement is also frequent. In malaria endemic areas, persons may develop partial immunity, allowing asymptomatic infections to occur.



For both *P. vivax* and *P. ovale*, clinical relapses may occur weeks to months after the first infection, even if the patient has left the malarious area. These new episodes arise from dormant liver forms known as hypnozoites (absent in *P. falciparum* and *P. malariae*); special treatment – targeted at these liver stages – is required for a complete cure.

### Vectors of Malaria

There are 9 vectors of Malaria which are prominent in different regions of the country. They are as follows:

1. *Anopheles Culicifacies* – Throughout India
2. *Anopheles fluviatilis* – Through out in foot hills
3. *Anopheles minimus* – North Eastern States.
4. *Anopheles philipinensis*- W. Bengal, North Eastern States and Andaman and Nicobar Islands

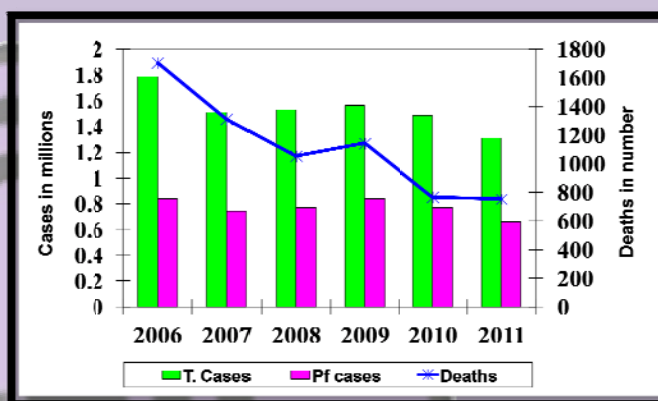
5. *Anopheles Dirus* – Forest Areas of NE States.
6. *Anopheles Stephensi* - Throughout India.
7. *Anopheles Annularis* - Throughout India.
8. *Anopheles Varuna* - Throughout India.
9. *Anopheles Saundicus* – Coastal Areas of West Bengal and Orissa

The prominent vectors in Rajasthan are:

1. *Anopheles Culicifacies* - In rural areas throughout Rajasthan
2. *Anopheles Stephensi* - In urban areas throughout Rajasthan
3. *Anopheles fluviatilis* – In foot hills of Alwar and Banswara

### Scenario (India and Rajasthan)

Malaria is one of the most wide spread especially among the South East Asia network of countries including India. In India, deaths due to malaria decreased from 2006 but again showed an increase in the year 2009. After 2009, a decrease was again reported till the year 2011. (Graph Source: nvbdcp/mohfw/report)



The **table** below shows the number of cases and deaths reported due to malaria in last 10 years (from 2001-2011). Maximum number of malarial deaths was reported in the year 2007. However, by 2011, we could reduce the deaths due to Malaria by nearly half of the number cases as compared to 2007 (753).

In Rajasthan, out of 33 districts, 20 districts are more prone to malaria. These districts are Alwar, Ajmer Barmer, Banswara Bharatpur, Bhilwara, Bikaner, Bundi Churu, Dholpur, Dungarpur, Jaisalmer, Jodhpur, Nagaur, Pratapgarh Rajsamand, Sirohi, Sawai Madhopur, Sri Ganganagar and Udaipur. The table represents the number of cases reported and the trend of deaths from 2009 to 2012 in Rajasthan.

Trend in India				
Year	Cases (in Million)		Deaths	API
	Total	Pf		
2001	2.09	1.01	1005	2.06
2002	1.84	0.9	973	1.8
2003	1.87	0.86	1006	1.82
2004	1.92	0.89	949	1.84
2005	1.82	0.81	963	1.68
2006	1.79	0.84	1707	1.66
2007	1.51	0.74	1311	1.39
2008	1.53	0.77	1055	1.36
2009	1.56	0.84	1144	1.36
2010	1.49	0.77	767	1.3
2011	1.31	0.66	753	1.14

source: nvbdcp/mohfw/report/2011

Trend in Rajasthan			
Year	Cases	Pf	Deaths
2009	32709	1767	18
2010	50945	2331	26
2011	54294	2973	45
2012	45809	1394	22

source: nvbdcp/mohfw/report/2011

### Diagnosis and Treatment

Early diagnosis and treatment of malaria reduces disease and prevents deaths. It also contributes to reducing malaria transmission. The best available treatment, particularly for *P. falciparum* malaria, is **Artemisinin-Based Combination Therapy (ACT)**.

WHO recommends that all cases of suspected malaria should be confirmed using parasite-based diagnostic testing (either microscopy or rapid diagnostic test) before administering the treatment. Results of parasitological confirmation are available in 15 minutes or less. Treatment solely based on symptoms should only be considered when a parasitological diagnosis is not possible.

## Prevention

Vector control is the main way to reduce malaria transmission at the community level. Vector control is an intervention that can reduce malaria transmission from extremely high levels to extremely low levels. For individuals, personal protection against mosquito bites represents the first line of defense for malaria prevention. Two forms of vector control are effective in a wide range of circumstances.

1. Insecticide-treated mosquito nets (ITNs): Long-lasting insecticidal nets (LLINs) are the preferred form of ITNs for public health distribution programmes. WHO recommends coverage for all at-risk persons; and in most of the settings. The most cost effective way to achieve this is through provision of free LLINs, so that everyone sleeps under a LLIN every night.
2. Indoor spraying with residual insecticides: Indoor residual spraying (IRS) with insecticides is a powerful way to rapidly reduce malaria transmission. Its full potential is when at least 80% of houses in targeted areas are sprayed completely. Indoor spraying is effective for 3–6 months, depending on the insecticide used and the type of surface on which it is sprayed. DDT can be effective for 9–12 months in some cases. Longer-lasting forms of existing IRS insecticides, as well as new classes of insecticides for use in IRS programmes, are under development.

## Clinical Prevention

- Antimalarial medicines can be used to prevent malaria.
- For travelers, malaria can be prevented through chemoprophylaxis, which suppresses the blood stage of malaria infections, thereby preventing malaria disease.
- In addition, WHO recommends intermittent preventive treatment with Sulfadoxine-pyrimethamine for pregnant women living in high transmission areas, at each scheduled antenatal visit after the first trimester. Similarly, for infants living in high-transmission areas of Africa, 3 doses of intermittent preventive treatment with sulfadoxine-pyrimethamine is recommended delivered alongside routine vaccinations.

## General Strategy for Prevention and Control of Vector Borne Diseases

Some of the control strategies proposed for the next five-year plan i.e. 12<sup>th</sup> Five Year Plan are:

- Early Diagnosis and Complete Treatment
- Integrated Vector Management (IRS, LLIN, Fish chemical and bio- larvicide, source reduction)
- Supportive Intervention
- Behaviour Change Communication
- Improving Surveillance in high endemic areas
- Strengthening microscopy services at PHCs along with quality assurance both for microscopy and Rapid Diagnostic Test (RDT) and complete treatment of malarial cases and deaths

### World Health Day-7 April 2013

World Health Day is celebrated on 7 April every year on anniversary of the founding of WHO in 1948. Every year a theme is selected that highlights a priority area of public Health concern in the world. The theme for this year is High Blood Pressure.

High Blood Pressure is also known as raised BP or Hypertension-increases the risk of heart attacks, strokes and kidney failure. If left uncontrolled, high blood pressure can also cause blindness, irregularities of the heartbeat and heart failure. Though it affects more than one in three adults worldwide, it remains largely hidden. Many people do not know they have high blood pressure because it does not always cause symptoms. As a result, it leads to more than nine million deaths every year, including about half of all deaths due to heart disease and stroke.

Source: WHO



**SIHFW in Action****Trainings/workshops organized:****Trainings at SIHFW**

S. No.	Date	Title	Cadre (Total Participants)	Sponsoring Agency
1.	18 February-19 March 2013	Integrated Foundation for Newly Recruited Medical Officer	29 (MOs)	NRHM
2.	4-8 and 11-15 March 2013	Training on Malaria for Medical Officers at SIHFW	46 (MOs)	RCH
3.	8-9 March 2013	CBI-RI Monthly Report	12 (Divisional RI Coordinators and External Monitors)	UNICEF
4.	5-7 Mar, 12-14, 19-21 Mar 2013	Routine Immunization at SIHFW	51 (MOs)	DM&HS
5.	11-13 March 2013	Capacity Building on IEC BCC	38 (District IEC Officials)	DM&HS
6.	18-20 March 2013	Training on Dengue for Medical Officers at SIHFW	28 (MOs)	DM&HS
7.	20 March 2013	PCPNDT Workshop	105 (MN/SDO/Radiologist)	PCPNDT Cell
8.	22 March 2013	Workshop on District Level PCPNDT	66 (Coordinators )	PCPNDT Cell
9.	24 March 2013	Workshop on TB for Ayush Doctors	60 (Ayush MOs)	DM&HS
10.	23 March 2013	Consultation workshop on Maternal Health Security	80 (NGO representatives)	PRAYAS

**Integrated Training for In-Service Medical Officers**

11.	6 March -6 April 2013	Integrated training of In-service MOs at Government Medical College, Kota	10 (MOs)	RCH
12.	12 March -12 April 2013	Integrated training of In-service MOs at RNT Medical College, Udaipur	8 (MOs)	RCH
13.	19-23 March 2013	ToT on FIMNCI at JK Loan Hospital, Jaipur	7 (Pediatricians)	RCH

**Integrated Training with SBA (Plan-4)**

14.	1-30 March 2013	Rajsamand	16 (Health workers)	RCH
15.	1-30 March 2013	Pratapgarh	16 (Health workers)	RCH
16.	1-30 March 2013	Sikar	15 (Health workers)	RCH
17.	4 March - 4 April 2013	Bikaner	16 (Health workers)	RCH
18.	12 March - 17 April 2013	Ajmer	16(Health workers)	RCH

**Integrated Training with-out SBA (Plan-5)**

S. No.	Date	Title	Cadre (Total Participants)	Sponsoring Agency
19.	1-15 March 2013	Tonk	24 (Health workers)	RCH
20.	1-15 March 2013	Jaipur	30 (Health workers)	RCH
21.	2-16 March 2013	Banswara	30 (Health workers)	RCH
22.	5-19 March 2013	Sirohi	30 (Health workers)	RCH
23.	4-18 March 2013	Dausa	30 (Health workers)	RCH
24.	7-21 March 2013	Pali	26 (Health workers)	RCH
25.	11-25 March 2013	Rajsamand	30 (Health workers)	RCH
26.	11-25 March 2013	Nagaur	28 (Health workers)	RCH
27.	15-31 March 2013	Kota	30 (Health workers)	RCH
28.	8-22 March 2013	Ajmer	30 (Health workers)	RCH
29.	11-23 March 2013	Baran	24 (Health workers)	RCH
30.	15-31 March 2013	Chittorgarh	30 (Health workers)	RCH
31.	29 March-29 April 2013	Jaisalmer	30 (Health workers)	RCH

**RI at Districts**

32.	1-2 and 5-6 March 2013	RI for Health workers at Rajsamand	30, 30 (Health workers)	RCH
33.	2-3, 11-12, 24-25 and 29-30 March 2013	Jhunjhunnu	21, 19, 22, 22 (Health workers)	RCH
34.	5-6 March 2013		20 (Health workers)	RCH
35.	7-8 March 2013	Jalore	24 (Health workers)	RCH
36.	8-9 March 2013	Sikar	25 (Health workers)	RCH
37.	15-16 March 2013	Ganganagar	23 (Health workers)	RCH
38.	18-19 and 20-21 March 2013	Hanumangarh	30, 30 (Health workers)	RCH
39.	21-22 March 2013	Dausa	30 (Health workers)	RCH
40.	5-8, 12-15, and 19-22 March 2013	FBNC training at JLN Medical College and Hospital, Ajmer	11, 13, 11 (MOs and Health workers)	RCH
		<b>Training for Blood Storage Unit</b>		
41.	2-6, 07-12, 14-18 and 20-24 March 2013	Training for Blood Storage Unit at Dausa	4 (Lab Technicians)	RCH
42.	11-15, 16-20, 21-25 and March 2013	Training for Blood Storage Unit at Bundi	4, 4, 4 (Lab Technicians)	RCH
43.	20-21 March 2013	Training for Blood Storage Unit at Pali	6 (Lab Technicians)	RCH
44.	29 March-2 April 2013	Training for Blood Storage Unit at Jaisalmer	4 (Lab Technicians)	RCH

## Monitoring/Field Visits

### Monitoring of Integrated Training

Training	Monitor	District	Date
In service Medical Officers	Dr Bhumika	Udaipur	18-19 March 2013
Integrated Foundation			
FBNC Training			
Integrated Foundation	Mr. Anil Sharma	Jodhpur	18-19 March 2013
Integrated Foundation	Mr. Mohit Dhonkeriya	Bikaner	18-19 March 2013
RI at Districts	Ms. Indu	Hanumangarh	19-20 March 2013

### Co-ordination Visit for Integrated Training

Agenda	Representative	District	Date
Implementation of Integrated Training	Mr. Ravi Garg Dr Bhumika Talwar Ms Aditi Sharma	Bundi	28 Feb-1 March 2013
		Kota	
		Baran	
	Ms. Poonam and Ms. Nishanka Chauhan	Sikar,	4-7 March 2013
		Sriganganagar,	
		Churu,	
		Hanumangarh	

## Visitors

### PDC Indore Team

A team of PDC participants from Indore (Madhya Pradesh) visited SIHFW during 18-21 March 2013. The team visited Amer CHC, Jaipuriya Hospital, Disha NGO, Jaipur and HFWTC Ajmer and Bhagwan Mahaveer Viklang Sahayta Samiti.

Dr Mamta Chauhan, Faculty SIHFW made a brief presentations on 'Leadership and Communication skills' and 'Rajasthan at a Glance'.



## Celebration

Birthday of Dr Bhumika Talwar was celebrated on 24 March 2013 at SIHFW.



## The Forthcoming

1. Training for Routine Immunization at SIHFW, 2-4 April 2013
2. PDC VII Batch starting from 25 April 2013.
3. EmOC training starting from 30 March-2 August 2013.

## Feedback

1. Almost all participants (94%) rated the quality of training as Excellent (RI for MOs at SIHFW, 19-21 March 2013).
2. Training was rated 'Good' by majority (74%) of the participants (Training on Dengue for MOs 17-20 March 2013)
3. Detailed information on each and every important aspect of RI was given.
4. Hostel facility was most liked and rooms were clean and good management, with silent environment,
5. 'Room tea arrangement and snacks' was liked the most and overall experience of stay at SIHFW was excellent- By Dr. Srikant Basu, MD Pediatrician, Kalawati Saran, New Delhi

## Health News

### Global

#### Battle Against US Childhood Obesity Sees Success

U.S. groups and companies that have tried to change the country's growing childhood obesity rate are starting to see noteworthy outcomes as more American children exercise and have better access to healthy foods, a new study reports. Exercise has been widely publicised, and has successfully encouraged 3 million children to start becoming more physically active over the last year.

The current report was released by The Partnership for a Healthier America (PHA) in accordance with First Lady Michelle Obama. It is the first progress update on the private sector's solutions to solve childhood obesity throughout the U.S. The findings were released as PHA starts its second "Building a Healthier Future Summit" in Washington D.C., where experts from the private and public sectors united to pinpoint solutions to the childhood obesity epidemic that has become a major public health issue the U.S.

In 2010, President Obama issued a task force to address the nation's growing childhood obesity problem. It came about as a part of Michelle Obama's "Let's Move" campaign, in an effort to combine the work of



the public and private sectors to help children become more active in their everyday lives and adopt a healthier diet.

HA CEO Lawrence A. Soler explains: "Our partner organizations are making changes to their operations and their business practices that help make healthier choices easier for busy parents and families. This report is about holding a mirror up to efforts against those commitments - many of which are multi-year - and giving the public a clear understanding of their progress."

Although the effort has achieved a great deal, some health advocates are saying that even more of an effort is needed, including government input. Currently in the U.S., one in three children is obese and another third are considered overweight. Health professionals are concerned because overweight children have a higher risk of being overweight as adults and may develop heart disease, diabetes, and other health issues.

Health experts have been critical of certain food companies for selling unhealthy products. Manufacturers have always cited consumer choice, but many have started to change their products recently as a growing number of U.S. consumers become more health conscious.

Soler concluded: "We know the private sector alone cannot solve this crisis - it will take work from everyone, including communities, schools, non-profits, governments, families and more. PHA commends our partners for the remarkable goals they have set to help make it easier for kids and families to make the healthy choice."

Source: [www.NIHFW/Health News/Medical News Today](http://www.NIHFW/Health News/Medical News Today), 9.3.13

### **Exercise Prevents Children from Getting Stressed**

New research published in The Endocrine Society's Journal of Clinical Endocrinology & Metabolism (JCEM) reveals that exercise could be key to helping children cope with stress.

The study identified that sedentary children exposed to stressful events produced more of the hormone called cortisol, which is linked to stress, than kids who were very active. The cardiovascular benefits of exercise in children is already very well established, but it also has a significant impact on their mental health too. One study found that regular exercise can help children do better in math.

The study is the first of its kind to link physical activity in children with stress hormone responses. According to the lead author of the study, Silia Martikinen, of the University of Helsinki: "The findings suggest physical activity plays a role in mental health by buffering children from the effects of daily stressors, such as public speaking,"

A total of 252 eight year old children participated in the study. The researchers monitored their physical activity by making them wear accelerometer devices and measured cortisol levels by taking saliva samples. The children were given tasks involving mathematics and story-telling.

They separated the children into groups (active, intermediate, or sedentary) based on the amount of physical activity they did. The active group exercised for longer and more rigorously than the children in the others, the researchers found that their cortisol levels didn't increase as much during the tasks.

In contrast, the cortisol levels went up significantly among those in the sedentary group. Martikainen said: "Clearly, there is a link between mental and physical well-being, but the nature of the connection is not well understood. These results suggest exercise promotes mental health by regulating the stress hormone response to stressors."

Source: [www.NIHFW/Health News/Medical News Today](http://www.NIHFW/Health News/Medical News Today), 9.3.13

## **India**

### **Digital Database for TB**

India has set up a digital database of 1.4 million people being treated free for tuberculosis, under the Rs 710 crore revised National TB Control Programme (RNTCP), to ensure better treatment and compliance.

'Nikshay enables near-real time reporting of TB cases and ensures tracking and case management, specially in inaccessible areas and places where patients have high mobility' said Anshu Prakash, Joint Secretary, Union Ministry of Health and Family Welfare.

In India, TB kills two persons every three minutes-more than AIDS, sexually-transmitted diseases, malaria, leprosy and tropical diseases combined.

India has 66,000 cases of MDR TB and 22 of extreme drug-resistant TB. To ensure early diagnosis and treatment, the government will provide 200 districts with DNA-based MDR and XDR testing equipment in 2013-14. Currently, sputum samples of suspected MDR cases are transferred to a few dozen DNA testing centers, so results take four to five days. By the end of the 12<sup>th</sup> Five-Year Plan (2012-17), all districts will have DNA-based testing facilities.

Diagnosis and treatment are already provided free to all under RNTCP, which ensures patients will take the drug under supervision on alternate days.

TB was made a notifiable disease in May 2012, since then it has been mandatory for all private clinics to report all cases to the government and follow treatment protocols.

Source: Hindustan Times, 25. 03.2013

### **India to introduce new TB drug**

With multi-drug resistant (MDR) and extensively drug resistant tuberculosis (XDR TB) threatening the country, the government is set to introduce a new TB drug, Bedaquiline, on an experimental basis. The drug will be introduced in areas which have so far reported a large number of MDR TB and XDR TB cases.

The government is in the process of identifying these areas. The drug would be administered to patients found to be resistant to two vital primary drugs in the DOTS Plus regimen. As per records, nearly two million Indians develop TB each year. Mumbai is emerging as ground zero for MDR TB. Approved by the US regulator in January this year, Bedaquiline is used for treatment of MDR TB as part of combination therapy in adults. According to the Lancet, results from randomised trials on the efficacy of Bedaquiline showed significant reduction in the infection period. Approval of the drug was also based on studies that showed it "killed" bacteria quicker than the existing drug regimen.

Discovered by scientists at Janssen, the pharmaceuticals unit of Johnson & Johnson, the FDA approval for a new TB drug comes after more than 50 years. The Indian Council of Medical Research and Central TB Division of DGHS recently convened an expert group for the introduction of Bendaquiline. "It is proposed to introduce the drug in India under controlled conditions at 4-5 DOTS Plus sites to assess its impact on MDR and XDR TB," Union health minister Ghulam Nabi Azad said.

Twenty-two countries bear 80 per cent of the burden of TB worldwide. According to WHO, there are around nine million new cases of TB detected and close to two million people die of it each year. In India, TB is rated as a major public health problem and the country accounts for one-fifth of global TB cases.

Source: The Asian Age: 9.3.2013

### **Over 56 Percent Young Indian Girls, 30 Percent Indian Boys Anemic**

Anemia is prevalent among Indian youth and over 56 percent of adolescent girls and 30 percent of the boys in India are anemic, the Indian parliament was told Tuesday.

More than 39 percent adolescent girls in the age group of 15-19 years are mildly anemic while 15 percent and 2 percent suffer from moderate and severe anemia respectively. Health Minister Gulab Nabi Azad told Rajya Sabha.

Anemia is a long standing problem in India and the country has high prevalence of anemia amongst adolescents.

As per reports of the national Family Health Survey (2005-06), adolescent girls in particular are more vulnerable to anemia due to the rapid growth of the body and loss of blood during menstruation.

Azad said to contain the spread of anemia, the ministry of health and family welfare has launched a weekly iron and folic acid supplementation.

The programme is estimated to cover approximately 13 crore beneficiaries and will meet the challenge of anemia amongst adolescent girls and boys in the age group of 10-19 years.

As of now the programme has been rolled out in 18 states and remaining states and Union territories are at different stages of preparedness for implementing the programme.

The programme is being implemented in both rural and urban areas and covers school going adolescent girls and boys in 6<sup>th</sup> to 12<sup>th</sup> class enrolled in government or government aided schools and anganwadi centres.

Source: IANS, 13 March 2013

## **Rajasthan**

### **Anti-tobacco campaign held**

The state's health department and tobacco control cell have organised a 20-day campaign in the city to help school children understand the ill effects of consuming tobacco and its derivatives. More than 40 schools have been covered under this campaign held as part of the National Tobacco Control Programme.

As part of the campaign, volunteers of a theatre group, Ras Rang Manch Sanstha, went to the schools and conducted training sessions for students from classes seven to 12. They answered questions and delved into reasons and behavioural influences that lead to tobacco addiction in students. Besides, they discussed remedies. The campaign also focused on making students aware of the anti-tobacco laws existing in the country.

Source: 14 March H.T

*We solicit your feedback:*

State Institute of Health & Family Welfare  
Jhalana Institutional Area, South of Doordarshan  
Kendra Jaipur (Raj)  
Phone-2706496, 2701938, Fax- 2706534  
E-mail:-sihfwraj@gmail.com; Website:  
www.sihfwrajasthan.com

## **New Scheme**

### **Motivation for Giving Birth to Girl Child**

With objective of reducing Female Feticide and bringing improvement in Sex ratio of the Rajasthan, Mukhyamantri (CM) Shublakshmi Scheme was launched in State on 1<sup>st</sup> April 2013. The scheme has a provision of payment of Rs 7300 (in installments) for a span of five years after the birth of a girl child. Hon' Minister, Shri A. A Khan distributed cheques of Rs 2,100/- to women who delivered bay girls at Mahilla Chikitsalaya at Sanganeri Gate, Jaipur.

The Medical, health and Family Welfare department has given its officers the responsibility to ensure that the new scheme is successfully implemented and eligible women get its benefit without any difficulty. There will be a nodal officer of director rank at the state level and at the district level, the RCHO (Reproductive and Child Health Officer) will be the nodal officers for the scheme. The In-charge at the CHC and PHC will be nodal officer at sector level. The scheme's benefit will be given to the beneficiary at sub-centre level by auxiliary nurse midwife (ANM). After completing one year (after the first installment of Rs 2,100/- at time of birth) the women will get another benefit of Rs 2,100/- after successful completion of routine immunization programmes of the state government. The last benefit under the scheme of Rs 3,100/- will be given after completion of five years of child's life. Under Janani Suraksha Yojana, women are paid Rs 1,400/- (Rural) and Rs 1,000/- (Urban). After the launch of the new scheme, women will now receive Rs 8,700/- in rural areas and Rs 8,300/- in urban areas.

This scheme will also encourage parents to follow routine immunization programmes.