

SIHFW Rajasthan

Electronic Newsletter

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From the Director's Desk

Dear Readers

Wishing You all a Very Happy New Year!

The year 2012 is gone and we have had enough examples to revisit our efforts to improve the status of public health. The Annual Health Survey for the year 2011-12 was released and gave us evidences of how far we have to go. Status of health indicators for Rajasthan, as per the AHS report, has been shared in this issue.

The year -2013 demands more resolutions and promises to march towards our commitments. The new year also begins with a united call for peace and harmony across the globe, specially for women and children.

The January issue also has an article on World Leprosy Day, observed on 27th of the month. Hope the modified style will be liked, and we will have more feedbacks on the same.



Director

Inside –The New Year Issue

- Leprosy-The war ahead
- Annual Health Survey-Rajasthan
- SIHFW in Action
- Monitoring and Field visits
- Feedbacks
- Health News

Important Days in January'13

World Leprosy Day 27th Jan
World Braille Day 4th Jan
World Laughter Day 10th Jan
National Youth Day-India 12th Jan

Leprosy-The War Ahead

Leprosy is a chronic disease affecting the nerves and the skin - if not treated sufferers can become blind, lose the sensations in their hands and feet; and become prone to a disability through the threat of injury. The awareness day for leprosy is held on the last of January each year. This day was chosen as the closest date to the anniversary of the assassination of Mahatma Gandhi, who was greatly concerned by the plight of those with leprosy.

Leprosy to be consider as the diseases which was originated in Africa and spread very early to India and then china. It was mentioned as a "*Kusht Rog*" in Vedic reference .It is an ancient disease known since 600 BC. Like other chronic, infectious and communicable diseases, Leprosy has also become a major health hazard.

But due to scientific inventions leprosy has been identified a disease that can be eradicated. Hansen of Norway during 873 discovered leprae bacilli, therefore the disease is also known as *Hansen's disease*.



Causes of Leprosy

Leprosy is a chronic infectious disease caused by *Mycobacterium leprae*, an acid-fast, rod-shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes. Symptoms can take as long as 20 years to appear. Leprosy is not highly infectious



Transmission

It is transmitted via droplets, from the nose and mouth, during close and frequent contacts with untreated cases

Leprosy as a public health problem

In 1991 WHO's governing body, the World Health Assembly (WHA) passed a resolution to eliminate leprosy by the year 2000. Elimination of leprosy is defined as a prevalence rate of less than 1 case per 10 000 persons. The target was achieved by the widespread use of MDT.

- Over the past 20 years, more than 14 million leprosy patients have been cured, about 4 million since 2000.
- The prevalence rate of the disease has dropped by 90% – from 21.1 per 10 000 inhabitants to less than 1 per 10 000 inhabitants in 2000
- Decrease in the global disease burden: from 5.2 million in 1985 to 805 000 in 1995 to 753 000 at the end of 1999 to 181 941 cases at the end of 2011.
- Leprosy has been eliminated from 119 countries out of 122 countries where the disease was considered as a public health problem in 1985
- No resistance to antileprosy treatment when used as MDT.



Burden India

Registered prevalence	No. of new cases detected (2011)	No. of new cases of MB leprosy	No. of females among new cases	No. of new cases among children	No. of new cases with grade-2 disabilities	No. of relapses (2011)	Cure rate (%)	
							PB	MB
83187	127 295	63 562	47 111	12 305	3 834	690	690	90.56

Source: Weekly epidemiological record, NO. 34, 24 AUGUST 2012-WHO

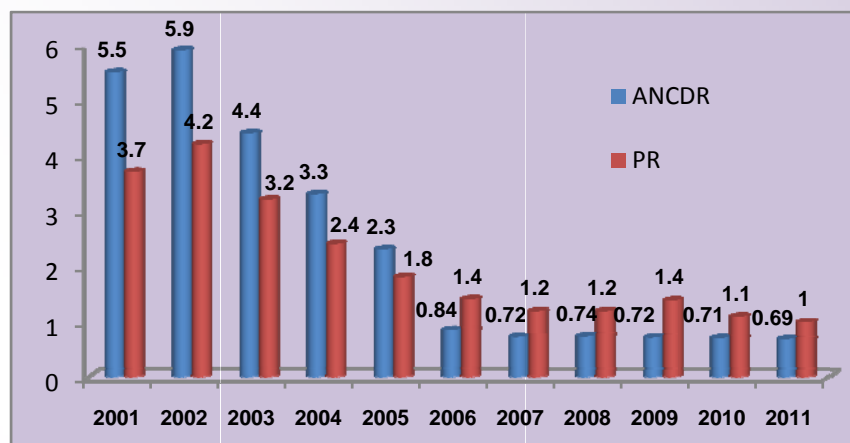
	Total New Cases Detected Dec. 2011	Cases Discharged as cured Dec. 2011	Cases on record under treatment as on Dec. 2011	Cases on record under treatment as on Dec. 2011
Rajasthan	63032	61977	1055	0.15

Source: National Leprosy Eradication Programme, Dte.GHS / MOHFW, GOI

Classification of Disease

- Pauci-Bacillary (PB-State Programme Officer, PB-NLEP-5 skin-patches)
- Multi-Bacillary (MB>5 skin patches)

Trend of Leprosy Prevalence (PR) and Annual New Case Detection Rate (ANCDR) in India



Source: NLEP progress Report-2010-11 (*ANCDR-Annual New Case Detective Rate,* PR-Prevalence rate)

Why Social Stigma?

- A Common belief that leprosy is due to past sins committed by the person.
- There is a belief that leprosy is a hereditary and incurable
- It causes permanent physical disability if full treatment is not taken.
- It is a touchable diseases

There are many misconceptions about disease that causes social aversion and ostracism against leprosy patients leading to the high deformity



State-wise Distribution of country's case load

States	Case Load %
U.P	18.93
Bihar	14
Maharashtra	12.56
West Bangal	10.16
Chattisgarh	5.96
Gujrat	5.76
MP	5.29
Raj	1.37

Source: NLEP progress Report-2010-11



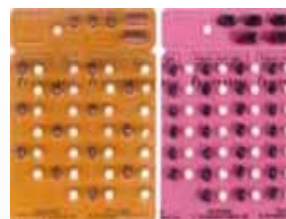
Treatment

Although leprosy was treated differently in the past, the first breakthrough occurred in the 1940s with 1940- Dapsone Therapy
 1960-Rifampicin and Clofazimine
 1981-Dapsone, Rifampicin and Clofazimine **Multidrug therapy (MDT)**

WHO provides free MDT for all patients in the world since 1995.

Advantages of MDT

- Highly effective in curing the disease
- Reduce the period of treatment
- Well accepted by patient
- Easy to apply in the field
- Prevents development of drug resistance
- Interrupts transmission of infection
- Reduce risk of relapse
- Prevents disability
- Improve community attitude



- Single dose of MDT kills 99.9% of leprosy germs.
- Free-of-cost on all working days at all SC, PHC, Govt. Dispensaries and Hospitals

Milestones of Leprosy Eradication

- 1947- Hind Kusht Nivaran Sangh which laid the foundation of organized leprosy work in India.
- 1955- National Leprosy Control Programme and availability of Dapsone monotherapy
- 1970s -Multi Drug Therapy. Dapsone treatment continued.
- 1982 -MDT came into use from 1982,
- 1983 - National Leprosy Eradication Programme (NLEP) launched by Govt. of India with the objective to eliminate leprosy as a public health problem by the year 2000 AD.
- 1993-2000- The 1st phase of World Bank supported NLEP implemented
- 1998-2004:Modified Leprosy Elimination Campaign
- 2001-2004-World Bank supported NLEP II
- 2005 - India achieved elimination National Level



National Leprosy Eradication Programme (NLEP)

NLEP started in 1955 with an objective of early detection of cases and treatment with Dapsone monotherapy and changed into eradication programme in 1983 with the objective of eradicating the disease by the end of 2000.

It is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India and the programme is implemented by the States/UTs. The Programme is also supported by WHO & International Federation of Anti-leprosy Associations (ILEP).

Strategy

- Decentralization of NLEP to States & Districts
- Integration of leprosy services with General Health Care System
- Leprosy Training of GHS functionaries
- Surveillance for early diagnosis & prompt MDT, through routine and special efforts
- Intensified IEC using Local and Mass Media approaches
- Prevention of Disability & Care

Rehabilitation and Care

- Community Based Rehabilitation (CBR)
- Medical Rehabilitation Institutions under ILEP
- NGOs support under NLEP
- Medical colleges/Institutions being facilitated for reconstructive surgery (RCS) with ILEP support.

Challenges faced by the Programme

- Further simplify and shorten the regimen
- Abolish classification for treatment purposes
- Identify areas and communities not yet covered
- Actively change the negative image of leprosy
- Focus more on analysis of detection trends than on prevalence
- Develop an integrated community-based strategy for rehabilitation

Benefits for patients under NLEP Scheme

- An amount of Rs. 5000 is provided as an incentive to each leprosy affected person of a BPL family for undergoing reconstructive surgery in identified institutions to compensate loss of wages during their stay in hospital.
- After completion of the surgery and the release from the hospital the patient will get Rs. 3000.
- On the first follow up visit after one month Rs. 1000 more will be given to the patient and final installment of the incentive will be given at the follow up visit after the third month of operation.

Source: Press Information Bureau-Gol

Leprosy-Human Rights Issue

Human Rights Council had adopted the Resolution "Elimination of discrimination against persons affected by leprosy and their family members", as proposed by the Japanese Government. The Ministry of Health & Family Welfare has communicated to all State, intimating this issue and advised for a suitable action by them

Annual Health Survey- Rajasthan

Annual Health Survey (AHS) of Rajasthan was done during July 2010 to March 2011 with the baseline survey and 4 schedules (house listing, household, woman & mortality). A total of 1841 sample units (1294 rural and 547 urban units) covering a total population of 1790673 were included in the survey. AHS also covered 83 % and 17 % of rural and urban household respectively.

AHS-Rajasthan at a Glance:

Indicator	Rajasthan	District with highest score	Ratio/ Rate	District with lowest score	Ratio/Rate
Sex Ratio at Birth (highest and lowest)	878	Bhilwara	968	Sawai Madhopur	78 2
Sex ratio (all ages)	925	Jalore	1055	Dholpur	822
Effective literacy Rate	70.7	Jaipur	80.4	Jalore	54.0
Married Illiterate women % (15-49 years)	51.8	Jalore	75.5	Ajmer	29.6
Crude Birth Rate (CBR)	24.7	Barmer	32.5	Kota	22
Current married women aged 20-24 years married before legal age (18 years) (%)	57.1	Bhilwara	80. 1	Ganganagar	36.5
Children currently attending schools (age 6-17 years %)	86.2	Jhunjunu	92.6	Sirohi	74
Mothers who availed financial assistance for institutional delivery under JSY (%)	76.5	Nagaur	89.4	Sikar	49.5
Children with birth weight less than 2.5 Kgs	38.7	Jhalawar	63.3	Nagaur	13.7
Mortality: Crude death rate	6.6	Rajsamand	8.7	Chittaurgarh	5.7
Infant Mortality Rate (IMR)	60	Jalore	79	Kota	36
Neonatal Mortality Rate	40	Jalore	58	Kota	25
Mortality Under 5	79	Banswara	99	Kota	45
Households having access to toilet facility (%)	38.7	Hanumangarh	95.3	Barmer	13.9

SIHFW in Action
Trainings/workshops organized

S. No.	Date	Title	Cadre (Total Participants)	Sponsoring Agency
1.	5 Dec 12-Feb 12, 2013	Professional Development Course	17 (MO/SMO)	NIHFW
2.	4-6 Dec 12, 11-13 Dec 12 18-20 Dec 12,	Routine Immunization (3 batches)	44 (MO/MOI/c)	RCH
3.	4 Dec 12	Workshop on IEC/BCC	17(Dist. IEC, CO/Health Officer)	NRHM
4.	4-5 Dec 12	Workshop of Follow up of PPTCT in 4 divisions	37 (Counselor)	Unicef
5.	5 Dec 12 -13 Feb 13	Professional Development Course	17 Mo/SMO	NIHFW
6.	7 Dec 12	Orientation Workshop on CBI-RI	33 (PHN/DAC)	Unicef
7.	10-11 Dec 12	ToT for HIV Sentinel Surveillance Round 2012-13	26 (Professor)	RSAC
8.	8 Dec 12	Social Marketing	57, MO-ASO-Dy. CMHO,PD,SMO	NRHM
9.	10Dec 12 -Jan 8 13	Foundation Course for newly recruited MO	32 (MO/MOI/c)	NRHM
10.	17-18 Dec 12	Workshop on Zonal PIP	42 (DPM/DAC)	NRHM
11.	28 Dec 12	Zonal Level Workshop on Measles Catch up	52 (MO/RCHO)	NRHM
12.	10 Oct 12 -13Feb, 13	EmoC at RNT Medical College ,Udaipur	5 MOs	RCH
13.	1-21 Dec 12	Emoc Refresher Training at RNT Medical College ,Udaipur	6	RCH
14.	Dec 10-Jan 9, Jaipur Dec14-Jan13, Kota Dec19-Jan 18 Ajmer	In service Medical Officers	34	RCH
15.	Nov 16-Dec 15 Nov 19-Dec 18 Nov 30-Dec 29 Dec 12-Jan 11,2013 Dec 1-Dec 30 Dec18-Jan17,2013 Dec26- Feb2,2013	Health worker with SBA at Tonk Jaipur Karauli Dausa Barmer Jaipur Karauli	(Health workers) 15 16 16 16 21 16 15	RCH
16.	Nov 26- Dec 10 Dec 3-17 Dec 28-Jan 11 Dec 24-Jan7,2013 Dec 31-15-Jan,2013	Health Worker without SBA at Bharatpur Pali Tonk Churu Jalore	(Health workers) 25 29 17 23 24	RCH
17.	Dec 4-5, Dec 7-8, Dec 11-12 & Dec 14-15	RI for Health Worker at Jaipur (4 batches)	104 (Health workers)	RCH
18.	21-22 Dec	RI for Health Worker at Tonk	17 (Health workers)	RCH
19.	17-18 Dec	RI for Health Worker at Sirohi	24 (Health workers)	RCH
20.	Sept.17-Jan.20,2013	LSAS at six Medical Colleges Jaipur, Jodhpur, Bikaner, Kota, Udaipur and Ajmer	14	RCH

Monitoring/Field Visits			
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Integrated Trainings

SRO –RCH visited Kota on 18-19 Dec for monitoring Integrated training of In-service MOs going on at Kota during 14 December to 13 January 2013. Nine medical officers are being trained on CAC/Minilap/RTI-STI/PPIUCD/IUCD/ F-MNCI/RI/MMA/ARSH/MTC/NSSK in this training.

Training is being conducted at J K Loan Hospital Kota, both Theory and Practical sessions are going on at the same training site. Theory session was scheduled for all the participants in a common seminar room while for hands on participants have posted in Labor Room, Immunization clinic, OPD and FBNC Unit.

SRO also monitored Training of Health workers (with SBA) scheduled from Nov. 16 – Dec. 15 2012 at Tonk for Health workers of the district. Monitoring of the same was done on Dec 04-06, 2012.

15 participants participated in this training which included sessions on SBA, CAC, R.I., IMNCI, NSSK, RTI/STI, IYCF, and IUCD trainings. Training was conducted at ANMTC Tonk and hands on were practiced at District Hospital, Tonk. Theory session was scheduled for all the participants in a common class room while for hands on participants were divided into 3 groups with 5 in each and were posted at Labor Room, FBNC unit etc in a shift pattern.



Data Validation and Monitoring

Two representatives of SIHFW were resource persons for the exercise of data validation and monitoring, at Barmer. The activity was implemented by Unicef, during December 17-20. The activity included a one-day orientation followed by 2 days field visit and team presentations on the last day. The team visited PHCs and Sub centres of Barmer district. Data collected under PCTS system was validated from field with help of formats. (field visit pictures)



Routine Immunization

Two batches of RI for health workers were monitored by an RO during 18-19 Dec at Sirohi. The batches were held on Dec 17-18 and Dec 19-20 at District Training Centre, DH, Sirohi. Trainings were coordinated by Dr. Dinesh Kumar Sharma (RCHO, Sirohi). As per the trainee's opinion, training was relevant to their day to day work and trainers were cooperative and supportive.

Training of RI for health workers was monitored by another RO at Tonk during 21-22 December. This was the last batch of the training, in which 17 participants were present at the training. Target of RI training in the district was completed with this batch. Total number of 661 manpower has been trained in RI against the target of 664.

Monitoring of RI training at Dausa was done by RO during RI, Dec 19-20, 30 participants were trained in this batch. This was the second batch of the RI training held at Dausa

The Forthcoming			
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- Training of Medical officers on Dengue at SIHFW Jan 10-12,2013
- Integrated Foundation for the newly recruited MOs, 07, January 2013
- Training of Health workers (without SBA) during 3-17 January 2013 at Churu, 2-16 January 2013 at Hanumangarh, 1-15 January at Jodhpur, 7 -21 January at Jhunjunu.

Visitors to the Institution			
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Dr Pratima Mitra from NIHFV visited SIHFW in the month of December 2012. Excerpts from her feedback in Visitor's Book:-

"SIHFW has been well designed and well maintained. I am enjoying my stay in this beautiful surroundings. I am glad that I choose to stay here."

Celebration of Birthday

Birthday of Ms Indu was celebrated on 5 December, Mr Mohit on 9 December and Mr Shahid on 17 December 2012.

Feedback			
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- Teaching is excellent, sessions were highly interactive, Teaching involved demonstration, and exercise
- Immunization schedule and cold storage was very well explained, staff cooperation of SIHFW was most liked, way of removing the confusions used by trainers was liked very much.
- Room facility, food and training sessions are most liked.
- Teaching methodology is good at SIHFW.
- Food and breakfast is received at time, no waiting.
- Neatness of rooms is liked most.

Health in News			
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Global

New report signals slowdown in the fight against malaria

During the past decade, a concerted effort by endemic countries, donors and global malaria partners led to strengthened malaria control around the world. The scale-up of malaria prevention and control interventions had the greatest impact in countries with high malaria transmission; 58% of the 1.1 million lives saved during this period were in the ten highest burden countries.

However, after a rapid expansion between 2004 and 2009, global funding for malaria prevention and control levelled off between 2010 and 2012, and progress in the delivery of some life-saving commodities has slowed. According to the *World malaria report 2012*, these developments are signs of a slowdown that could threaten to reverse the remarkable recent gains in the fight against one of the world's leading infectious killers.

For example, the number of long-lasting insecticidal nets (LLINs) delivered to endemic countries in sub-Saharan Africa dropped from a peak of 145 million in 2010 to an estimated 66 million in 2012. This means that many households will be unable to replace existing bed nets when required, exposing more people to the potentially deadly disease.

The expansion of indoor residual spraying programmes also levelled off, with coverage levels in the WHO African Region staying at 11% of the population at risk (77 million people) between 2010 and 2011.

"During the past eight years, scaled-up malaria control helped us avert over a million deaths. We must maintain this momentum and do our utmost to prevent resurgences," says Ellen Johnson Sirleaf, President of Liberia and Chair of the African Leaders Malaria Alliance, who held an official launch event for the report in Monrovia, Liberia.

According to the report, 50 countries around the world are on track to reduce their malaria case incidence rates by 75% by 2015 – in line with World Health Assembly and Roll Back Malaria targets. However, these 50 countries only represent 3%, or 7 million, of the malaria cases that were estimated to have occurred in 2000, the benchmark against which progress is measured.

The malaria burden is concentrated in 14 endemic countries, which account for an estimated 80% of malaria deaths. The Democratic Republic of the Congo and Nigeria are the most affected countries in sub-Saharan Africa, while India is the most affected country in South-East Asia.

The *World malaria report 2012* indicates that international funding for malaria appears to have reached a plateau well below the level required to reach the health-related Millennium Development Goals and other internationally-agreed global malaria targets.

An estimated US\$ 5.1 billion is needed every year between 2011 and 2020 to achieve universal access to malaria interventions in the 99 countries with on-going malaria transmission. While many countries have increased domestic financing for malaria control, the total available global funding remained at 2.3 billion in 2011 – less than half of what is needed.

This means that millions of people living in highly endemic areas continue to lack access to effective malaria prevention, diagnostic testing, and treatment. Efforts to prevent the emergence and spread of parasite resistance to antimalarial medicines and mosquito resistance to insecticides are also constrained by inadequate funding.

While the plateauing of funding is affecting the scale-up of some interventions, the report documents a major increase in the sales of rapid diagnostics tests (RDTs), from 88 million in 2010 to 155 million in 2011, as well as a substantial improvement in the quality of tests over recent years. Deliveries to countries of artemisinin-based combination therapies, or ACTs, the treatment recommended by the WHO for the treatment of falciparum malaria, also increased substantially, from 181 million in 2010 to 278 million in 2011, largely as a result of increased sales of subsidized ACTs in the private sector.

Tracking progress is a major challenge in malaria control. At present, malaria surveillance systems detect only one-tenth of the estimated global number of cases. In as many as 41 countries around the world, it is not possible to make a reliable assessment of malaria trends due to incompleteness or inconsistency of reporting over time.

Stronger malaria surveillance systems are urgently needed to enable a timely and effective malaria response in endemic regions, to prevent outbreaks and resurgences and to ensure that interventions are delivered to areas where they are most needed. In April 2012, WHO launched new malaria surveillance manuals, as part of its T3: Test. Treat. Track. initiative. Source: WHO Media News, December 17, 2012

A dark cloud over red districts

At a kotha in Garstin Bastion Road, popularly known as GB Road - the biggest red light district in Delhi.. Inquisitive outsiders, especially those asking questions about diseases, are not welcome in this twilight world and queries are often answered with indifference. "Haan pata hai. Kaafi khatarnak bimaari hai. Toh?", asks a sex worker when told about AIDS. But ask them about TB and there are blank stares.

This low awareness about a disease which this community is particularly susceptible to, is quite disturbing, says Rajender Menen, author and journalist who writes about sex trade in India. People from this industry don't die from AIDS now like they used to. Even the local streetwalker uses condoms. The big threat really is TB, especially multi-drug resistant TB (MDR TB) that is tough to cure."

It's not difficult to see why sex workers in India are particularly vulnerable to TB. Most operate in tightly packed spaces that facilitate disease transmission. Then, there is a high level of exposure to a large client base and poor access to healthcare - all of which provides a perfect breeding ground for the silent killer that can remain undiagnosed for years. "Most sex workers may not be allowed to access health services,

even if they have symptoms of TB. So, there may be long delays before the disease is diagnosed. Chances are most would go to quacks or informal providers who may provide incorrect treatment regimens and induce drug resistance," says Madhukar Pai, a TB researcher with McGill University in Canada.

Accurate figures on the number of TB cases in the community, however, are difficult to come by. In Mumbai - a city with close to 30,000 female sex workers - only 222 were referred to the Directly Observed Therapy (DOT) centres run by the government under the Revised National Tuberculosis Control Programme (RNTCP) in the last two years. Minni Khetarpal, special tuberculosis officer at the Brihanmumbai Municipal Corporation admits that the reach of RNTCP is restricted as far as commercial sex workers are concerned. "Brothels are run by former sex workers or gharwalis, who are reluctant to send the young girls to DOT centres every day," she says. Many NGOs working with the community agree that convincing sex workers that they require treatment is a difficult task. "Most of the women are so much into drinking, smoking or tobacco chewing that they are completely unwilling to take medicines," says a counsellor from a Nagpur-based NGO. In addition, their diet is so poor that they catch TB easily due to negligible resistance. "Because of low immunity, they are susceptible to even common cold," says Sanjay Mishra, a member of Jharkhand State Child Rights Protection Commission. "But in the past few years, cases of TB among sex workers are coming up even in far-flung districts. This shows that the problem is getting severe." What makes matters worse is that sex workers have a greater chance of contracting TB if they already have HIV. "For an HIV-positive sex worker, the risk of contracting tuberculosis is twice as high," says Soumya Swaminathan, director of the Chennai-based National Institute for Research in Tuberculosis. Also, the six-month DOT treatment programme has to be diligently followed. Very few sex workers are able to do this and inevitably end up contracting MDR TB which is the result of an incomplete treatment protocol. Jothilakshmi, a 31-year-old sex worker from Chennai says that a few of her friends who contracted TB were told by doctors that they should live in isolation till the six-month course of medication is completed. "All of them ignored the advice because that would have meant no business for six months," she says. "Their condition worsened after a while and one of them died last month." Before more deaths happen, it's time society steps in - much like it has done with a successful AIDS campaign - to save this community from itself.

Source: TOI, 16 Dec 2012

Scary images on cigarette packs

Gory images of cancerous tumours, rotting teeth and diseased throats on cigarette packets will become mandatory from December 1. According to the revised Packaging and Labelling Rule 2007, which was notified by the health ministry to the tobacco industry on Tuesday, "the pictorial depiction of skull and crossbones as health warning has been removed and the pictorial representation of a dead body has been replaced". Nearly 50% of fresh packets will now have to carry warnings in local languages. According to an earlier directive of the Shimla High Court, the pictorial warnings were to be in place by October. But the health ministry asked for a twomonth extension as it had moved a bill in Parliament in August to amend Section 7(1) of the Cigarettes and Other Tobacco Products Act, which calls for compulsory skull and crossbones warning on cigarette packets. But political pressure made the Cabinet pass a legislation making the skull and crossbones sign optional. The new notification says, "All tobacco product packs including cigarettes, gutka and bidi produced/manufactured after December 1, 2007 will have to bear/depict specified pictorial health warnings." Health secretary Naresh Dayal said that some sections had problems with two of the warnings — the image of a dead body and the skull and crossbones sign. "We therefore replaced the image of a dead body. But because the skull and crossbones warning is specified in the anti-tobacco Act, we moved a bill in Parliament to amend it." Anybody who produces or manufactures cigarettes or tobacco products without the specified warning will face imprisonment upto two years or be fined Rs 5,000 or both. If the offence is committed for the second time, imprisonment will be extended to five years with a fine of Rs 10,000.

Source: TOI, 1 December 2012

Rajasthan

Free Basic Medical Tests

The Rajasthan government will launch the facility of free basic medical tests for patients here from April 7 next year, Chief Minister Ashok Gehlot announced Thursday. Addressing a press conference on completion of the Congress government's four years under his leadership, Gehlot said the free medicine scheme launched in October 2011 has benefited millions of people across the state. 'Distributing free medicines paved the way for a revolutionary change in the healthcare field in the state and it became one of the flagship programmes of our government. We want to take our priority of common men's welfare a step further by launching the free basic medical test scheme from April 7 next year,' he said.

In the first phase, the scheme will be launched at the government hospitals and other medical faculties in district headquarters. 'Government hospitals in each district and those associated with medical colleges would provide the facility for all the basic medical tests completely free of cost,' Gehlot said. He added that the scheme will be extended to community health centres and primary health centres in small towns and villages in the second phase.

The free medicine scheme launched by Gehlot on Mahatma Gandhi's birth anniversary Oct 2, 2011, had seen a footfall of 70 million people at the distribution centres within a year. Senior medical and health department officers said that two lakh (200,000) people take advantage of this scheme every day. The patients are being given free essential medicines at 15,355 medicine distribution centres and in all the government hospitals.

Source: IANS December 13, 2012

New drugs in the offing for free distribution over counters

The Rajasthan Medical Services Corporation (RMSC) has sought suggestions from senior doctors of Sawai Man Singh (SMS) hospital to prepare a list of more advanced new drugs for distributing them to patients under chief minister free medicine scheme.

At present, more than 480 essential medicines and surgical items are being distributed free to patients but now the state government is increasing it to 600 after successfully implementing the scheme in the state.

The government officials said that the patients coming to the government hospitals have increased by more than 50% after the launch of free medicine scheme on October 2. Now, more than 2.33 lakh patients are coming to hospitals daily. So, far more than 7 crore patients have benefited from the free medicines scheme, as per the medical, health and family welfare figures.

A committee of senior doctors would prepare a list of more than 100 medicines. The list of medicines would be presented in the high power state level technical advisory committee, which would be held next week under RMSC. The key persons in the committee would be RMSC managing director Dr Samit Sharma, Rajasthan University of Health Science vice-chancellor, medical health and family welfare department directors and principals of government medical colleges. Earlier, chief minister Ashok Gehlot had announced that the number of free medicines available at drug distribution centres (DDC) would be increased to 600 soon. The medical health and family welfare department has now stepped up efforts to release the list of new medicines soon.

Source: TOI, 16 December 2012

We solicit your feedback:

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