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E-Newsletter

State Institute of Health and Family Welfare (SIHFW), Jaipur, Rajasthan

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From the Desk of Director

Dear Readers,

Greetings from SIHFW, Rajasthan!

*'**It's closer than you think**' is the campaign message for World Hepatitis Day, 28 July, 2012. This issue of the newsletter discusses in brief about the Day, which is organised in recognition of the birthday of Professor Baruch Blumberg, who discovered the hepatitis B virus.*

Hepatitis Day provides us an opportunity for education and greater understanding of viral hepatitis as a global public health problem, and to stimulate the strengthening of preventive and control measures of this disease.

Hepatitis is a silent killer disease. Hepatitis affects everyone, everywhere. Even if treatment is not an option for you, you can do something about your disease. A healthy lifestyle is important. Alcohol, smoking, eating fatty foods, being overweight or extreme dieting (eating no food at all) may worsen your liver disease.

The lead article in this newsletter discusses about another issue of global concern- Population. This issue, we have brought more on your palate.

Director

Health Days in July, 2012

Doctors Day 1st July
World Zoonosis Day 6th July
World Population Day 11th July
World Hepatitis Day 28th July

Population Day

World Population Day is celebrated on July 11, every year. It aims at increasing people's awareness on various population issues such as the importance of family planning, gender equality, poverty, maternal health and reaffirms the human right to plan for a family. The day was established by the Governing Council of the United Nations (UN) Development Programme in 1989 to focus attention on urgency and importance of population issues. It encourages activities, events and information to help make this right a reality throughout the world.

According to UNFPA the world population was 7 billion in 2011, which is expected to increase to 9 billion by 2050. Four out of every five people in the world live in the developing world. By 2050, the developing world will have 88% of the world's population, up from the present 81%.

Some Facts-WORLD

- At least 150 million couples throughout the world want, but do not have, access to reproductive health services
- By 2030, the world's urban population is expected to reach 4.9 billion, while the rural population is expected to decrease by 28 million. (September 2010 Population Reference Bureau)
- The average life expectancy is 61, up from 40 in just 50 years.
- The use of contraception among couples in developing countries has increased from 10% in the early 1960's to 60% today.
- Global population growth has slowed to an annual rate of 1.35%, the lowest in decades.

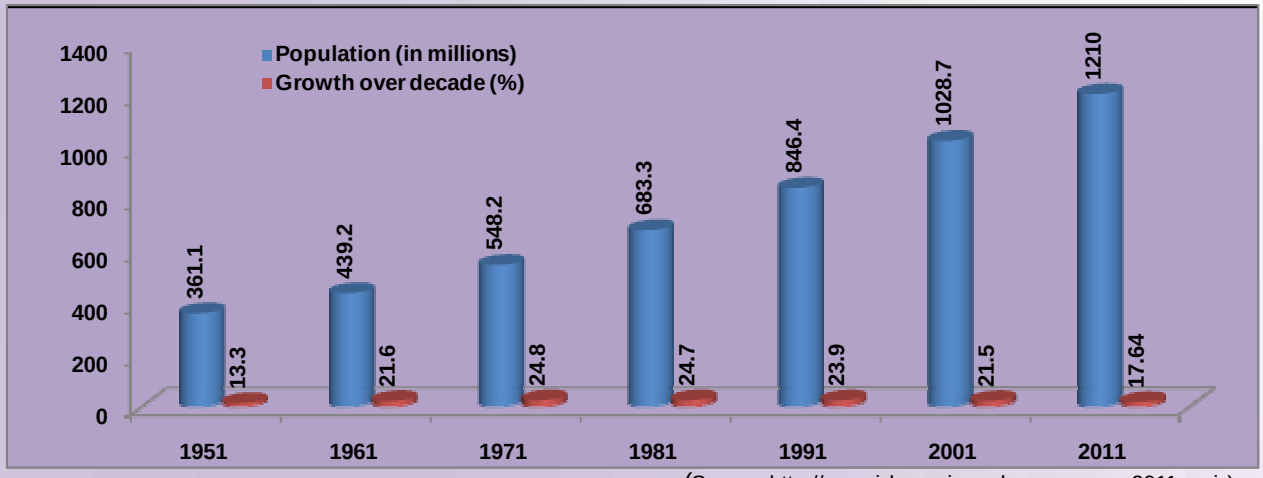
Country	Population%	TFR
China	19.5	1.77
India	17.3	2.76
USA	4.5	2.1
Indonesia	3.5	2.34
Brazil	2.8	2.22
Pakistan	2.5	3.73
50% World Population Lives in 6 Countries		

Population of India

India occupies only 2.4% of the world's land area with 1.22 billion people. It is the second most populous country in the world while China is on the top with over 1.35 billion people. India represents almost 17.31% of the world's population, which means one out of six people on this planet live in India. India is projected to be the world's most populous country by 2025, surpassing china. It population reaching 1.6 billion by 2050.

Some Facts-INDIA

- Almost 40% of Indians are younger than 15 years of age
- More than 50% of its population below the age of 25
- The population of children age 0-6 years has fallen by 5 million since 2001
- 51% of India's population is in the reproductive age-group.
- 157 million more people will be added by 2016.
- About 42 % of population increase is contributed by births beyond two children per family
- 188 million couples require contraceptive coverage but only 53% are currently using contraceptives



(Source-http://www.jsk.gov.in and www.census2011.co.in)

Population Growth-India

Every year, India adds more people than any other nation in the world; the individual population of some of its states is equal to the total population of many countries. For example, population of Uttar Pradesh almost equals to the population of Brazil. It, as per 2011 Population Census of India, has 1.21 billion people and the growth rate is 16.16%. The population of the second most populous state Maharashtra, which has a growth rate of 9.42%, is equal to that of Mexico's population. Bihar, with 8.07%, is the third most populous state in India and its population is more than Germany's. (Source-Census of India-2011)

Population in age groups of 0-14 years decreased from 35.4 %(2001) to 24.7 % in 2011.For 15-59 years age group population increased from 57.0 %(2001) to 64.9 %(2011) and 60 + population decreased from 7.5 %(2001) to 5.5 %(2011).

Sex Ratio

India as a patriarchal society leads to a huge gap in between male and female sex ratio. In India it is consider as females per 1000 males which is 940 women per 1000 men in 2011. Kerala is the state which has highest female sex ratio i.e.1084 females per 1000 males followed with Pondicherry (1038), Tamil Nadu (995) and Chhattisgarh (991). Haryana (877), Jammu & Kashmir (883) and Sikkim (889) show lowest sex ratio.

Density of Population

'Density of Population' is defined as the number of persons per square kilometre. It is an important index of population which shows concentration of population in a particular area. As per the Census 2011, the population density of India has gone up to 382 persons per square. West Bengal is at the top with 903 people per square km and Arunachal Pradesh is lowest at 13. (Source-Census of India 2011)

Cause of Population Growth

High growth rate, decline in death rate, decrease in infant mortality, improved medical facilities and public health services are the primary causes of rapid population growth. Rapid transport and communication have facilitated rapid movement of food-grains from surplus areas to deficit areas. People now don't die due to epidemics; drought or famine. Reduction in per capita income and resources; this, in turn, will result in deterioration in quality of life. Illiteracy and lack of awareness as far as the proletariat class is concerned. Family planning programs have only focused on females and haven`t focused efforts on educating males about their responsibility, child marriages & lack of sex education also contributed.

Effects of Population Growth

Rapid growth in population is associated with drought, famine or war or political disturbances. Inadequate fresh water for drinking, depletion of natural resources, increased levels of pollution, high infant and child mortality, scarcity of food, limited land for agricultural operations, unemployment, decrease of savings and capital formation. Increased incidence infectious diseases from crowding, lack of adequate sanitation and scarcity of available medical resources. Starvation, malnutrition or poor diet with ill health and diet-deficiency diseases (e.g. rickets), over-utilization of infrastructure, such as mass transit, highways, and public health systems etc.

Total Fertility Rate

TFR measures average number of children born to a woman during her entire reproductive period. The fertility rate in India has been declining. Bihar reported the highest TFR (3.9) while Kerala and Tamil Nadu, the lowest (1.7) **(**Source-SRS 2011)

Life Expectancy at Birth

Life expectancy at birth is the number of years to be lived by a group of people born in the same year, if mortality at each age remains constant in the future. In India, Life expectancy at birth (total population) is 66.8 years and for male 65.77 years and female 67.95 years in 2011. However, it decreased from 69.89 in 2009 to 66.46 in 2010. Life expectancy at birth is also a measure of overall quality of life in a country and summarizes the mortality at all ages.

Combating with Population Growth in India

Rapid reduction in the population growth rate can be achieved by meeting all the felt-needs for contraception; and reducing the infant and maternal morbidity and mortality. Persuade people to adopt small family norms, making available family planning methods, financial assistance to the acceptors and motivators of the family planning methods, promoting female education and employment and promotion of delayed marriages. Making reproductive health care accessible is the foundation for stabilizing population.

Stabilization of India's Population/ Demographic Transition

India is certainly at an important stage of demographic transition. It is a transition from a stable population with **high mortality and high fertility** to another stable population with **low mortality and low fertility**.

India had set itself the goal of attaining replacement fertility of 2.1 by 2010 to achieve population stabilization by 2045. However, by the end of 2010, only 14 sates achieved this target; in fact, six states still have significantly higher fertility 3.0 – 4.0.

National Population Policy

The National Population Policy (NPP), 2000 adopted by the Government of India states that 'the long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environment protection.

To address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care

S.No.	Year	TFR-India
1	1990	3.8
2	1995	3.5
3	200	3.2
4	2005	2.9
5	2009	2.6

The "**Jansankhya Sthirata Kosh" (JSK) (National Population Stabilization Fund)** has been registered as an autonomous Society established under the Societies Registration Act of 1860.

Family Welfare Program

India launched a nationwide Family Planning Program in 1952. India is the first country in the world to launch such a program. The program promotes family planning with full community participation, emphasis on two child family and spacing methods along with terminal methods. The services are taken to every doorstep in order to motivate families to accept the small family norm.

Population of Rajasthan

The total population of Rajasthan is 6.86 crore, including male (3,56.20) and female (3,56.01). Besides the largest state in the country it has recorded eighth highest population growth i.e. 21.44% in 2011. The female sex ratio is 926 and child sex ratio is 883 which is below the national average(2011). The total literacy rate is 67.06% including male 80.51% and female 52.66%. Population density stands at 201 persons per sq km in 2011. (Source-Pragti Prativadan 2011-12)

Two Child Norm

Rajasthan introduced the two-child norm in 1992, to regulate family size and promote the 'small family' model. The policy bars people with more than two children from standing for elections or holding any position in PRIs and for jobs in the administration or state government undertaking. Presently, six states including Haryana, Rajasthan, Madhya Pradesh, Andhra Pradesh and Himachal Pradesh have made the two-child norm mandatory for all panchayat members.

Family Planning Schemes-India & Rajasthan

Rajiv Gandhi Population and Health Mission

It was established to achieve TFR of 2.1 by 2016 as per Population Policy 2000. The mission has an objective to improve maternal and child health services, decrease birth rate, IMR and MMR, population stabilization and ensure availability of qualitative health services.

Janmangal Program

It started in 1992 for population stabilization, decreasing IMR and MMR & to promote use and meet the unmet need of spacing methods. Its objective is to make contraceptives available in rural areas & support RCH services.

Jyoti Scheme

This scheme was started with an objective to promote girl child and give privilege to females to become role models for small families. This is applicable for families with no male child & 1-2 female child & has undergone sterilization. These families are also benefitted by health services, education and employment.

Parivar Kalyan Beema Yojana

This scheme is applicable in case of death or any complication due to sterilization operation.

Contraceptive Usage

Low female literacy levels and the lack of widespread availability of birth-control methods is hampering the use of contraception in India. However, the vast majority of married Indians (76% in a 2009 study) reported significant problems in accessing a choice of contraceptive methods. In 2009, 48.3% of married women were estimated to use a contraceptive method, i.e. more than half of all married women did not.

Rewards and Recognition-Rajasthan

Health Department of Rajasthan awards prizes to best performing Panchayati Raj Institute, Government supported NGOs, accredited Private hospitals and Government hospitals (PHC, CHC, Satellite hospitals, District and Sub District hospitals), for achievement of population stabilization targets.

1. At state level, three best performing districts (I, II & III)are given a prize of Rs. 30, 20 and 10 lakhs, respectively.
2. Rupees 10, 8 and 6 lakhs are given to best performing three Panchayat Samiti.
3. The government hospital, which performed best received an amount of Rs. 2 lakh.
4. At District level, best performed Panchayat Samiti receives an amount of Rs 4 lakh in each district, best Government hospital in each district gets Rs 1 lakh.
5. Best performed Gram Panchayat in each Panchayat Samiti gets Rs 1 lakh.
6. NGOs and Private hospitals are encouraged for Sterilization and IUD insertion, at the rate of Rs 1300/- and Rs. 1350/- respectively, per case. These institutes performs free of cost sterilization.
7. Private hospitals and NGOs done 1000 or more sterilizations and paid Rs 2 lakh each (14 in number) and the same doing 500 to 999 sterilization and 100 Copper-T insertions are awarded Rs One lakh. (One in each district).

Contraceptives users under Family Planning Program in Rajasthan

S.No	Year	Sterilization			IUD users	Oral Pills users	Condom users
		Male	Female	Total			
1	2007-08	12555	322474	335029	337979	882337	1783439
2	2008-09	12219	344704	356923	353877	925916	1866052
3	2009-10	9314	336586	345900	409560	1050813	1254893
4	2010-11	8200	330374	338574	407122	795327	987507
5	2011-12 (TillDec.2011)	3433	183973	187406	322899	739471	917760

Source-rajswasthya.nic.in,Pragati Prativedan 2011-12

Hepatitis

Hepatitis is an inflammation of the liver, most commonly caused by a viral infection. There are five main hepatitis viruses, referred to as types A, B, C, D and E. These five types are of greatest concern because of the burden of illness and death they cause and the potential for outbreaks and epidemic spread. In particular, types B and C lead to chronic disease in hundreds of millions of people and, together, are the most common cause of liver cirrhosis and cancer.

Hepatitis A and E are typically caused by ingestion of contaminated food or water. Hepatitis B, C and D usually occur as a result of parenteral contact with infected body fluids. Common modes of transmission for these viruses include receipt of contaminated blood or blood products, invasive medical procedures using contaminated equipment and for hepatitis B transmission from mother to baby at birth, from family member to child, and also by sexual contact. Acute infection may occur with limited or no symptoms, or may include symptoms such as jaundice (yellowing of the skin and eyes), dark urine, extreme fatigue, nausea, vomiting and abdominal pain.

Hepatitis is a potentially fatal disease that affects 1 in 12 people worldwide, but there are rarely obvious symptoms.

Hepatitis A: 1.4 million estimated cases of hepatitis A occur annually**.**

Hepatitis B: 2 billion people (estimated) worldwide have been infected with the virus. Approximately 350 million people are living with chronic (lifelong) infections of hepatitis B virus 500,000 – 700,000 people die every year from hepatitis B (WHO)

Hepatitis C: 130 million people at least are chronically infected with hepatitis C virus. In 2000, the WHO estimated that between three and four million people are newly infected every year (WHO)

Viral Hepatitis:

Together hepatitis B and C represent one of the major threats to global health. Hepatitis B and C are both 'silent' viruses, and because many people feel no symptoms, you could be infected for years without knowing it. If left untreated, both the hepatitis B and C viruses can lead to liver scarring (cirrhosis). If you have liver cirrhosis, you have a risk of life-threatening complications such as bleeding, ascites (accumulation of fluid in the abdominal cavity), coma, liver cancer, liver failure and death. In the case of chronic hepatitis B, liver cancer might even appear before you have developed cirrhosis.

In some cases, a diagnosis is made too late and the only option is a liver transplant. If you think you have been at risk, it is important that you get tested as soon as possible and, if diagnosed, consider your treatment options and self-management strategies.
Patients with hepatitis B infection can also be infected with a second virus known as hepatitis delta virus, hepatitis D virus or simply HDV.

The Difference between Hepatitis B and C

- While there is a vaccine that protects against hepatitis B infection, there is no vaccine available for hepatitis C
- Both viruses can be contracted though blood-to-blood contact
- Hepatitis B is more infectious than hepatitis C and can also be spread through saliva, semen and vaginal fluid
- Neither virus is easily spread through everyday contact. You cannot get infected with hepatitis B or C by shaking hands, coughing or sneezing, or by using the same toilet. There are different treatments for the two viruses. While treatment can control chronic hepatitis B, it can often cure hepatitis C
- Try to avoid all alcohol, stop smoking, eat a low fat diet with enough fruit and vegetables, and reduce your weight if necessary.

There are approximately 170 million people chronically infected with hepatitis C worldwide. In 2000, the WHO estimated that between three and four million people are newly infected every year. (WHO)

World Hepatitis Day

The WHO World Hepatitis Day, 28 July, is marked to increase the awareness and understanding of viral hepatitis and the diseases that it causes. It provides an opportunity to focus on specific actions such as:

- strengthening prevention, screening and control of viral hepatitis and its related diseases;
- increasing hepatitis B vaccine coverage and integration into national immunization programmes; and
- coordinating a global response to hepatitis.

Remember, It's closer than you think!

SIHFW in Action

(1.) Trainings/Workshops:

S. No.	Date	Title	Total Participants	Sponsoring Agency
1.	**2-3 June 2012**	TOT on Capacity Building for Strengthening of RI	9	UNICEF
2.	**4-5 June 2012**	Hands on Training on E - Aushadi of computer operators (District Drug Warehouses) (2 batches)	37	RMSC
3.	**5-7, 19-21, 26-28 June 2012**	Routine Immunization (3 batches)	45	RCH
4.	**7June 2012**	Orientation workshop for SNCU	14	UNICEF
5.	**11-16 June 2012**	Workshop on Early Childhood Education	31	UNICEF
6.	**13-14 June 2012**	Review Meeting for Divisional MCH coordinators	18	UNICEF
7.	**20 June 2012 (continuing)**	IV Professional Development Course	15	NIHFW
8.	**25 June 2012**	RMSC workshop	63	RMSC
9.	**25-30 June 2012**	Workshop on Text Book development	34	Department of School Education and Sanskrit and SIERT

(2) Meetings:

Executive Committee: XXVIII Meeting of the Executive Committee was held on 6th June 2012 at SIHFW. Six members of the EC participated in the meeting.

Governing Board: XIV Meeting of the SIHFW Governing Board was organised on 13th June 2012 at SIHFW. Nine Governing Board members were present at the meet, which was chaired by the Hon' Minister of Health.

(2.) **Monitoring / Field Visits / Studies:**

Appreciative Enquiry:

Five members of SIHFW are involved in this UNICEF supported endeavor. Ms Nirmala Peter conducted AI workshop at SDH Sujangarh of Churu during 11-12 June 2012.

Training at Dalhousie

A team of SIHFW representatives participated in Training Programme on 'Systematic Problem Solving' at Dulhousie, organised by National Productivity Council, Jaipur. The team included Prof. Akhilesh Bhargava, Director-SIHFW, Dr. Mamta Chauhan, Ms. Nishanka, Ms Poonam, Ms. Richa Chabbra and Mr. Ezaz Khan.

Capacity Building

CME session on 'Verbal Autopsy' was taken by Dr. Vishal Singh on 9 June and by Dr. S.S. Yadav on 'Immunization & Cold Chain' on 15 June 2012.

Planned Training/Workshop/Meeting/ Visits

- RI training.
- Integrated training for freshly recruited Medical Officers.
- PDC IV batch participants visit to Panchkula, during 1st to 7th July, accompanied by PDC coordinator Ms. Nirmala Peter and Mr. Hemant Yadav.
- Follow up of PPTCT services, UNICEF on 3rd July 2012
- National Quarterly Workshop on "Convergence for Inclusive Education and Literacy" being organised during 5-6 July 2012, by Department of School Education & Literacy, Ministry of Human Resource Development, Govt. of India.

Other Highlights

Celebrations

Office Party of SIHFW was hosted by a team of six staff members- Dr. Richa Chaturvedy, Mr. Ankur Asudani, Ms. Nirmala Pater, Dr. Shweta Sharma, Ms Lovely Acharya and Mr. Mohit Dhonkariya. The event was held on 15th June at Barbeque Nation, Jaipur.

Birthday Celebration

Birthday of Ms Lovely Acharya was celebrated on 21st June 2012 at SIHFW office.

The Guest reactions

- Liked most the interaction with Dr S.S. Yadav, Registrar SIHFW, during training program- Dr Prabhakar Vyas, RI, training in June 2012 and technique of training by Dr. Yadav-Dr. Narrotam Singh, RI
- Cleanliness and Quality of training- Dr. Girraj Prasad Sharma, RI, June 2012
- Excellent management and teaching methodology- Dr Prem Singh, RI.
- Teaching methodologies and management was liked by almost all trainees.

Health in news

Global

Rio+20 declares health key to sustainable development

The UN Conference on Sustainable Development (Rio+20) has adopted a series of measures that have the potential to contribute to a more equitable, cleaner, greener, and more prosperous world – and recognizes the important linkages between health and development.

Health linked to sustainable development

"The Future We Want" conference outcome document, agreed upon by member states attending the 20-22 June conference, highlights the fact that better health is a "precondition for, an outcome of, and an indicator of all three dimensions of sustainable development".
"This focus on the links between health and sustainable development is critical," said Dr Margaret Chan, Director-General of the World Health Organization. "Healthy people are better able to learn, be productive and contribute to their communities. At the same time, a healthy environment is a prerequisite for good health."
The outcome document also emphasizes the importance of universal health coverage to enhancing health, social cohesion and sustainable human and economic development. And it acknowledges that the global burden and threat of non-communicable diseases (NCDs) constitutes one of the major sustainable development challenges of the 21st century.

Health-related development issues

Health-related development issues covered in detail in the outcome document include:

- access to better energy services including sustainable cooking and heating solutions, which can significantly reduce childhood pneumonia and adult cardiopulmonary disease deaths from indoor air pollution;
- greater focus on urban planning measures including more sustainable, energy-efficient housing and transport – which can significantly reduce many NCD risks, e.g. cardiopulmonary diseases from air pollution, health risks from physical inactivity and traffic injury;
- better sanitation in cities and villages to protect against the spread of communicable diseases;
- sustainable food systems that combat hunger and contribute to better health and nutrition;
- more sustainable water usage, meeting basic needs for safe drinking-water, and stewardship of water supplies to grow food;
- assurance that all jobs and workplaces meet minimum safety and health standards to reduce cancer, chronic lung diseases, injuries and early deaths.

Universal health coverage

Rio+20 also underlined the vital need for universal health coverage (including policies to prevent, protect and promote public health). Currently, 150 million people worldwide suffer severe financial hardship each year because they fall ill and cannot afford to pay for the services or medicines they need to recover. Universal health coverage can therefore fight poverty and build more resilient and prosperous communities.

Protecting and promoting human health

An outcome of the 1992 Rio Conference (The 1992 UN Conference on Environment and Development) was Agenda 21, a comprehensive plan for global and local action. Chapter Six of this document focused on 'Protecting and Promoting Human Health'.
Over the past 20 years, WHO has worked in the five areas outlined in that chapter:

- meeting primary health care needs particularly in rural areas;
- control of communicable diseases;
- protecting vulnerable groups;

- meeting the urban health challenge; and
- reducing environmental health risks, which are often exacerbated by unsustainable development.

The Organization will continue this work and scale up efforts to help countries aiming to achieve universal health coverage and prevent and treat non communicable diseases.

Source: www.who.int/mediacentre/news

India

Delhi hospitals to get latest technology to check donated blood

The Delhi government is going to introduce Nucleic Acid Amplification Test (NAT) to check the safety of donated blood, state health secretary Anshu Prakash said on 14th June. He said that new technology will reduce the window period to identify life-threatening infections, for example hepatitis B and C and HIV. He added the linking of various blood bank in the city through computers, a project that has been stalled for over five years is also being taken up and will be completed soon.

"We plan to start this facility at two centres-LNJP Hospital and GTB Hospital. The modalities for implementation of the new system are being worked out," said Dr Bharat Singh, Director, State Blood Transfusion Council. He said that while an Elisa test-technology available at present-costs only Rs 100, NAT will cost Rs 900 per donor. Donated blood undergoes five tests: malaria, syphilis, HIV, hepatitis B & C.

AIMS, RML Hospital (both under the Centre), some private hospitals and blood banks run by NGOs already have NAT facility.

Senior health officials said that with the current testing methods it is difficult to identify the viruses during the 'window period'. "In this phase, the virus is multiplying in the body but the donor may unknowingly donate infected blood", she said. The official added that the union government had made blood screening mandatory in 2000 given the high prevalence of hepatitis and HIV in India. However, existing standard of care (ELISA serology testing) in India continues to allow a 'window period' between viral infection continues to allow a 'window period' between viral infection and viral detection.

Source: The Times of India, 15 June 2012

Suicide may soon be leading cause of death in India

Four of India's southern states — Tamil Nadu, Andhra Pradesh, Karnataka and Kerala — that together constitute 22% of the country's population recorded 42% of suicide deaths in men and 40% of self-inflicted fatalities in women in 2010. Maharashtra and West Bengal together accounted for an additional 15% of suicide deaths.

Delhi recorded the lowest suicide rate in the country. In absolute numbers, the most suicide deaths in individuals, aged 15 years or older, were in AP (28,000), Tamil Nadu (24,000) and Maharashtra (19,000).

The first national study of deaths in India, published in the British Medical journal The Lancet, says that suicide has become the second-leading cause of death among the young in India.

Of the total deaths by suicide in individuals aged 15 years or older, about 40% suicide deaths in men and about 56% in women occurred in individuals aged 15-29 years. Suicide deaths occurred at younger ages in women (average age 25 years) than in men (average age 34 years). Educated persons were at greater risk of completing a suicide.

The risk of completing a suicide was 43% higher in men, who finished secondary or higher education, in comparison to those who had not completed primary education. Among women, the risk increased to 90%.

Lead author of the study Professor Vikram Patel of the London School of Hygiene and Tropical Medicine told TOI that the 1.87 lakh people committed suicide in India in 2010.

About half of suicide deaths (49% among men, and 44% among women) were due to poisoning, mainly ingesting of pesticides. Hanging was the second most common cause for men and women, while burns accounted for about one-sixth of suicides by women.

Professor Patel felt that with the decline in maternal death rates, suicide could soon become the leading cause of death among young women in India.

The study says the National Crime Records Bureau underestimates suicide deaths in men by at least 25% and women (36%).

He told TOI, "Overall, more Indian men commit suicide than women, but the male to female ratio for suicides is smaller in India than in many Western countries, in particular among youth. Studies have suggested that social factors such as violence and depression are key determinants of suicide in women."

Prof Patel pointing out to lack of national strategy for suicide prevention in India, said, "Suicides can be prevented through interventions like banning the most toxic pesticides and teaching rural communities on safe storage of pesticides. India should also start mental health promotion for young people through schools and colleges and introduce crisis counseling services and services for treatment of depression and alcohol addiction."He added that although much of the current concern about suicides has focused on agricultural workers, over three in four suicide deaths in India occur in other occupational groups (including those who are unemployed and homemakers).

"Compared to most other countries, suicide rates are especially high in young adults and, in particular, young women for whom suicide rates in India are four to six times higher than in developed countries. The suicide rates vary 10-fold between states with the highest rates in the southern states of India," he added.

Suicide deaths among men were almost 11-times higher in Maharashtra as compared to Delhi. When it came to women, it was four times higher in Maharashtra than Delhi.

The study says the age standardized suicide death rate per 100,000 people at all ages was 18.6 for boys and men and 12.7 for girls and women.

The suicide death rate in men aged 15 years or older varied little across age groups in comparison with that of women, which peaked in 15-29 years and decreased thereafter. At ages 15-29 years, suicide was the second leading cause of death in both sexes.

Most suicide deaths occurred in rural areas — the age standardized death rates were about two times higher in rural than in urban areas.

In the absence of other causes of death, men aged 15 years or older have a lifetime risk of suicide of 2% or higher in AP, Karnataka, Kerala, and Tamil Nadu.

"The large variations we observed between states clearly point to the role of as yet poorly understood social factors in influencing the risk of suicide in India. We recorded a reduced risk of suicide versus other causes of death in women who were widowed, divorced or separated, compared with married women and men," Prof Patel said.

The study says, suicide claims twice as many lives in India as HIV-AIDS and almost as many as maternal deaths in young women. Suicide kills nearly as many Indian men aged 15-29 as transportation accidents. Studies have shown that the most common contributors to suicide are a combination of social problems, such as interpersonal and family problems and financial difficulties, and pre-existing mental illness.

A very large proportion of suicides in India can be attributed to the manner in which families and society at large deal with all forms of mental illness. Where something as common as depression is rarely

recognized and when recognized is even more rarely treated because there is a stigma attached to ailments of the mind, there clearly is a problem. What can be easily treated with some medication and counselling more often than not goes untreated till it develops a more serious form. Both government and civil society need to act to change this. Above all awareness must be built that the mind is as liable to be affected as other bodily organs and there is nothing to be ashamed of in acknowledging this.

Source: The Times of India, 22 June 2012

Rajasthan

Anaemia among girls still a challenge for Rajasthan

Over 80% girls in Bikaner are suffering from anaemia. This disturbing figure was revealed by a survey conducted by NGO Ajit Foundation.

"There is an emergency situation in Rajasthan vis-a-vis anaemia and the BPL families are suffering the most," said Aditi Mehta, principal secretary, social justice and empowerment. Addressing a workshop on 'Addressing anaemia' in the city, she said calorific difference was the major reason for the problem and called for effective monitoring of the anaemia control programme.

The survey's findings state that 83.4% adolescent girls were found to be anaemic in the district with 2.98% suffering from severe, 22.2% moderate, and 58.21% mild anaemia.

Though various national and state level programmes to fight against anaemia have been launched over the last decade, a large percentage of the population is still anaemic.

Economist and member of the Prime Minister's Economic Advisory Council Prof VS Vyas said, coordination is a must between various government departments including education, medical health and family welfare and women and child development to tackle the issue effectively. Shri Vyas, who is also deputy chairman of the Rajasthan State Planning Board, said the board is ready to play an active role in evolving policies on the issue. He also suggested roping in voluntary groups and non-government organizations to address it.

The experts at the workshops claimed that anaemia is prevalent among adolescents and women in the rural areas in Rajasthan.

UNICEF state chief (Rajasthan) Samueul Mawungadize said anaemia is affected by public perceptions, behaviour and social reactions. "Despite the presence of adequate resources, plans of action and the government's positive attitude, anaemia is still a challenge. There is need for enhanced policy interventions in the matter," he said.
The experts debated on the issues like if anaemia is common among vegetarians, is it region specific, economic specific, age specific or gender specific. They also talked about the impact of various programmes run by the state and the centre.

Neurologist Dr Ashok Panagariya said the quality of iron supplied to the target groups through iron and folic acid (IFA) tablets was not good and these tablets did not ensure retention of iron in the body.

UNFPA state head Sunil Thomas Jacob said anaemia should be discussed as a subject matter at the Gram Sabha level and public awareness on the issue should be generated at a wide scale.

Source: The Times of India, 19 June 2012

Climate change to increase vector borne diseases in Rajasthan

Climate change is expected to adversely impact human health in the state by increasing the risk of exposure to vector, water- and food-borne diseases. It can also aggravate malnutrition and increase mortality and morbidity associated with changes in intensity and frequency of extreme events.

Potential impacts of climate change can thus be expected to become an additional stressor for Rajasthan's health sector. While the state in the last few years has shown progress in terms of health status and outcomes, much still remains to be done.

"High infant mortality rate (IMR), maternal mortality ratio (MMR), malnutrition among children and women, high incidence of childhood diseases, declining sex ratio of girls, low female literacy in comparison to national average, inadequacy in drinking water supply and sanitation, poor health and poor socio-economic status of women along with social discrimination, are all already a cause of concern for population health in the state," the Rajasthan State Action Plan on Climate Change (RAPCC) on Climate Change report by the Rajasthan State Pollution Control Board stated. The report has been prepared with the help of a multi-disciplinary team of experts from TERI with support from GIZ

"VBDs are probably the most sensitive to changes in climate parameters. Malaria is a major health problem in Rajasthan especially in the north western desert part of the state. Dengue and Chickungunya (and more recently Swine Flu) are the other major VBDs in the state," the report said.
"Operational integration in policy and programme between various vertical programmes within the health sector, and between health and other related sectors such as drinking water, sanitation, and nutrition has also been limited, resulting in a lack of holistic approaches to health," it added.

Source: The Times of India, 18 June 2012

We solicit your feedback:

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