# SIHFW Rajasthan

***Electronic Newsletter***
***Vol. 3/Issue 6/June 2014***

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## From the Director's Desk

*Dear Readers,*

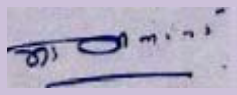
*Greetings from SIHFW!*

*Every year, July 11 is earmarked as World Population Day, by the United Nations. This year the theme for the day is - Investing in Young People.*

*Though world has a high percentage of youth population, but a large number of young people lack resources which they need to lift themselves out of poverty. From health point of view, there is a particular concern about adolescent girls who face discrimination, sexual violence, early marriage and unwanted pregnancies. This results in population increase and declining status of reproductive and maternal health of women.*

*Hence, the lead article of this issue of e-newsletter adds population perspective to maternal health scenario. In my view, by empowering today's youth and making the young women aware about health aspects, we will lay the groundwork for a more sustainable future for generations to come.*

*We would solicit your feedback and suggestions.*



Director

**Inside:**



**Important Days in July 2014**
Doctor's Day July 1
World Population Day July 11
World Hepatitis Day July 28

## Research Study

**World Population Day, July 11, 2014**

In 1989, in its decision 89/46, the Governing Council of the United Nations Development Programme recommended that, in order to focus attention on the urgency and importance of population issues in the context of overall development plans and programmes and the need to find solutions for these issues, July 11 should be observed by the international community as World Population Day.

Today's 1.8 billion young people are shaping social and economic realities, challenging norms and values, and building the foundation of the world's future. Yet a high percentage of young people continue to grapple with poverty, inequality and human rights violations that prevent them from reaching their personal and collective potential.

On 2014 World Population Day, there is a call for investments in support of the largest-ever generation of youth.

**Maternal Health:** ***the population perspective***

Mother, the carrier of generations, goes through a sensitive stage of life cycle-while she's carrying. The pregnancy gives her and her family, new hopes and an opportunity for her to celebrate her womanhood. There's another side of the same coin. Woman faces burden of pregnancy and child birth at a very early age -adolescence, sometimes repeated pregnancies, with negligible or no spacing, which are many a times unwanted. She rarely has decision making in this arena of her life. Much may be attributed to her ignorance. But, a large share of this burden is from outside- decision making of husband, family, culture and traditions.

Community, as a whole need to be made aware about health aspects of early marriage, early pregnancy importance of family planning. Women should be educated to recognize her health concerns. She should be empowered to stand for her health rights. She should have equal decision making for whether to conceive, if yes, then when. The decisions shall support her to continue or discontinue with an un-wanted pregnancy, when and how. Decision making for what methods she can adopt for delaying conception or spacing between two children, and also to decide how many to bear, can ensure her good reproductive health. Women's poor decision making in his aspect specially in the rural and unaware communities, poses gender imbalance and poor sex ratio on population perspective, along with threats to women's reproductive, maternal health and neonatal health as well.

There is another aspect of deteriorating maternal health, that of the population perspective. The correlation is so strong that with every un-wanted or early pregnancy and pregnancy in continuation, the rate of fertility increases coupled with deterioration of maternal health status.

The MMR declined to 264 in 2011-12 from 331 in 2010-11 (-67 points decline). But the decline is abysmal in comparison to decline in CBR. The trends of family planning practices clearly indicate although there was a decline of .30 points in CBR, but there was a rise of .70 points in percentage of female sterilization, while that for males remained without change. Percentage of Copper T/IUDs usage increased with .30 while there was no change in usage of condoms/nirodh percentage (source: AHS 2011-12).

The demographics of India are inclusive of the second most populous country in the world, with over 1.21 billion people (2011 census), more than a sixth of the world's population. Already containing 17.5% of the world's population, India is projected to be the world's most populous country by 2025, surpassing China, its population reaching 1.6 billion by 2050. Indian population reached the billion marks in 2000. Census 2011 recorded +17.7% population growth over preceding census 2001.

Rajasthan is India's largest state by area and covers 10.4% of India's total area. As per census 2011 population of the state contributed 5.67% to the population of the country and ranked 8th amongst 28 states and 7 UTs of the country [3]. Census 2011 recorded +21.3% Decadal population growth of the state over preceding census 2001 which is 3.6% higher than that of Nation's.

Reproductive / Maternal health has always been a prime concern of health services of India and Rajasthan since long. Reason behind this of course was the high Maternal Mortality Ratio, high Infant Mortality Rate (Low birth weight/Premature baby being the prime cause, lead by poor reproductive/maternal health before conceiving and during gestation period). And as a result first RCH promramme in India was launched in the year 1997 with the aims to achieve a status in which women will be able to regulate their fertility, women will be able to go through their pregnancy and child birth safely, the outcome of pregnancies will be successful and will lead to survival and well being of the mother and the child. The couples will also be able to have their sexual relation free from fear of pregnancy and of contracting sexually transmitted diseases. Later, in the year 2005 RCH II, Revised RCH programme and then RMNCH+A programme were launched in the year 2013. Since then, reproductive and child health indicators have shown improvement but set objective are still far ahead to achieve. Figure 1 shows the Maternal Mortality Trend in India and figure 2 depicts the MMR trend in Rajasthan State.

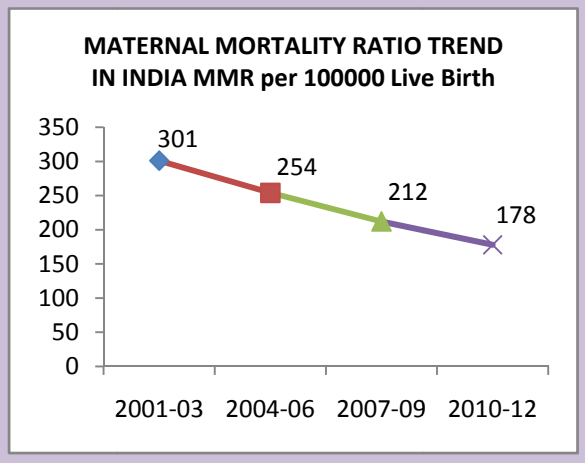



FIGURE 1

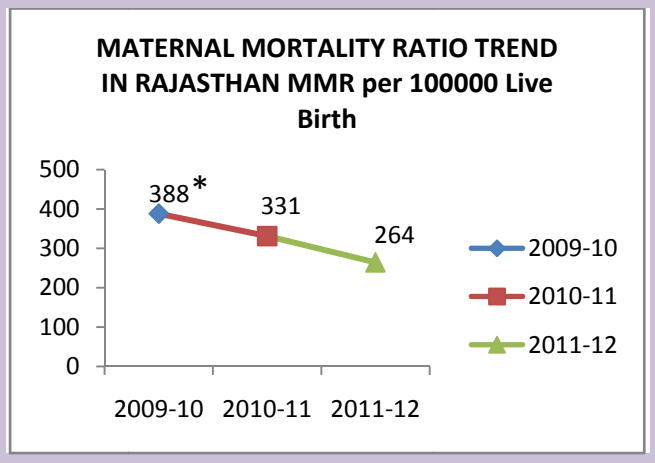



FIGURE 2

National Health Mission/RCH II aims to bring Maternal Mortality Ratio to less than 100 per Lac live birth by the year. Both the graphs shows that irrespective of all the effort we still lag behind in achieving the target.

Population Growth**,** not only exhaust scarce natural resources, increases pressure on availability means of earning, leads to more pollution , deforestation & changes atmospheric composition- global warming etc. but also has a significant adverse effect on maternal health if correlate with other indicators and characteristics such as high TFR (More than 2.1), Imbalance Sex Ratio (Excess of male over females), low mean as at marriage, relation between Age Specific Marital Fertility Rate (ASMFR), Total Marital Fertility Rate, more dependency on female for family planning in both spacing and limiting method, Unmet Need of Contraceptive.

Total Fertility rate**,** is defined as expected average number of children born by a woman during her reproductive age (i.e. 15 – 49 years). Ideally TFR should be 2.1 to balance the sex ratio and for less pressure on female for reproduction. Current TFR of India is 2.4 (estimate SRS 12) whereas current TFR of Rajasthan is 2.9 (estimate SRS 2012), which shows in Rajasthan that every woman in during her reproductive age bears three children on an average.

Sex Ratio, generally sex ratio is defined as number of males over per lac females but in India it is calculated as number of female per thousand male. As per census 2011 adult sex ratio for India is 943 whereas for Rajasthan state it is only 928. Situation is rather worst in case of child sex ratio it is 919 per thousand male children in India and in Rajasthan it is only 888. The imbalance sex ratio continuously growing population is self explanatory to understand burden to bear children on each woman in reproductive age. And declining child sex ratio indicates that government efforts to improve maternal health may not succeed if proper measures to control population control are not taken.

Mean age at marriage**,** is the average age for the first marriage. Mean age at marriage for females in Rajasthan is 20.4 years; variation in rural and urban area can clearly be seen as mean age at marriage of female in rural area is 19.8 whereas that of in urban area is 21.9. Marriages are an important social event for population. In India marriages are deemed essential for reproduction purpose and hence Marriage Specific Fertility Rate is significantly higher than without marriage fertility here. In India it is believed that main function of marriage is to produce children. In other way we can say, that early age marriage may result into early pregnancies. And early age pregnancies may lead to poor maternal health as female reproductive organs are not fully developed to bear the child. In Rajasthan low mean age at marriage indicates the prevalence of child marriage (<18 years). And early marriage also longer reproductive period which may lead to more child birth and may potentially influence the *population growth*. Following figure 3 shows Age Specific Marital Fertility Rate (ASFMR) of India and Rajasthan in the as per SRS, 2012.

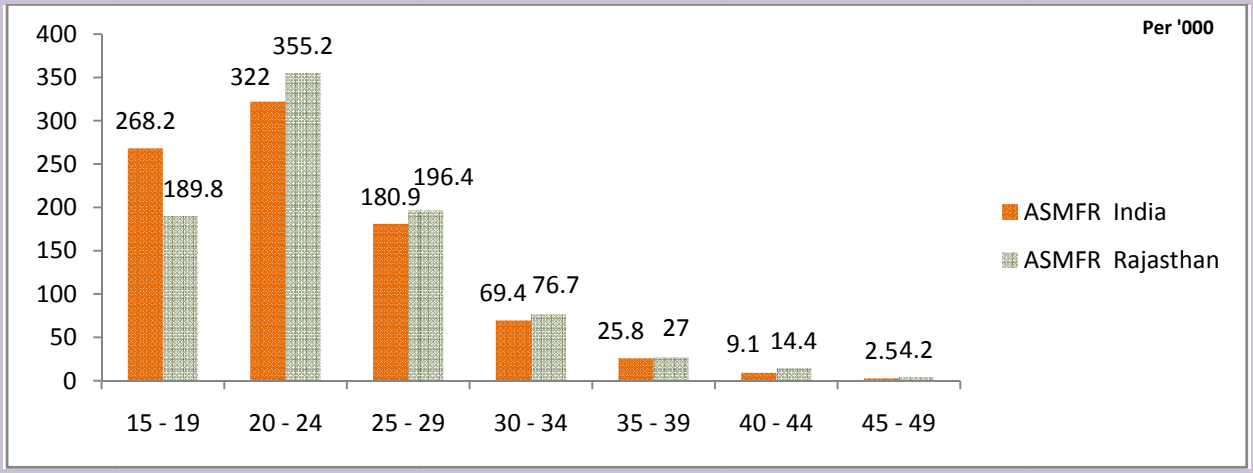



FIGURE 3

The relationship between maternal age and pregnancy outcome has long been recognized. Studies have been shown that the optimal age for childbearing is between 20 and 30 years, with a steadily increasing risk of peri-natal mortality when the woman is over 30 years of age. Considering this mind we can say that all those women who are below 19 & above 30 and active in reproduction clearly are at maternal risk; going by the SRS, 2012 data in India 75 and in Rajasthan State on average 62.42 per thousand married women are at maternal risk.

Further, by using ASMFR we can calculate Total Marital Fertility Rate (TMFR) which indicates the average number of children expected to be born per married woman. TMFR of the country and of Rajasthan state is 4.4 & 4.3 respectively.

Family Planning Methods are the methods which are adopted either to maintain space between two pregnancies or to limit the reproduction. The main objective of family planning services are control the family size and population stabilization. As per NFHS 2005-06 data is illustrated in figure 4. As we can see the prevalence of use of contraceptive for both male and female for spacing method is very low both in India and Rajasthan, which again increases the chances of pregnancies/ repeated pregnancies ( unwanted) amongst married woman. This may lead either to repeated deliveries / induced abortion/ miscarriages. In any of the condition non-utilization of available family planning methods have an adverse impact the Maternal Health Indicators and also fail the attempt of the Government for population stabilization.



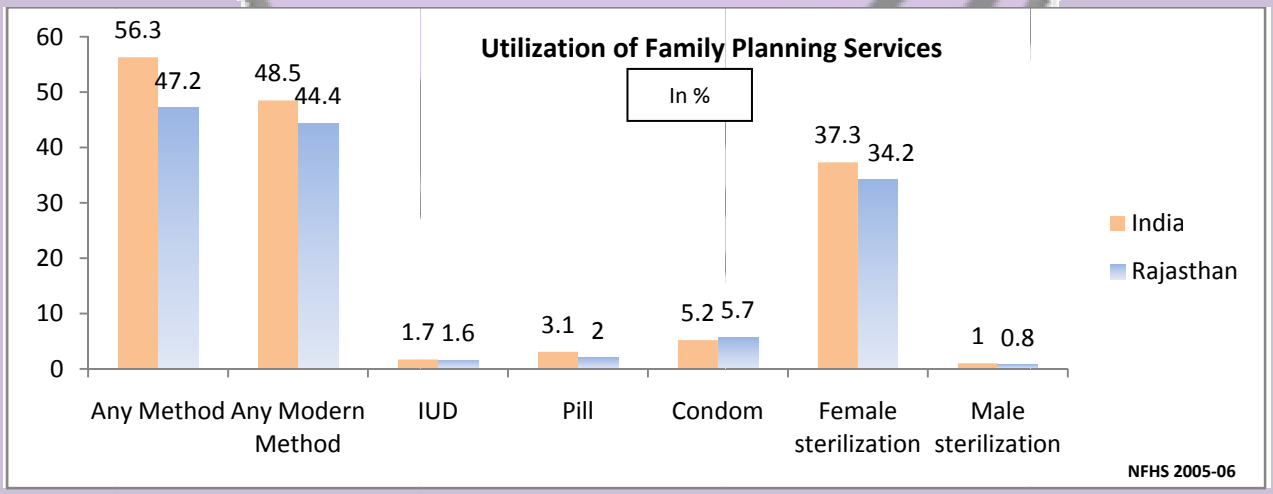
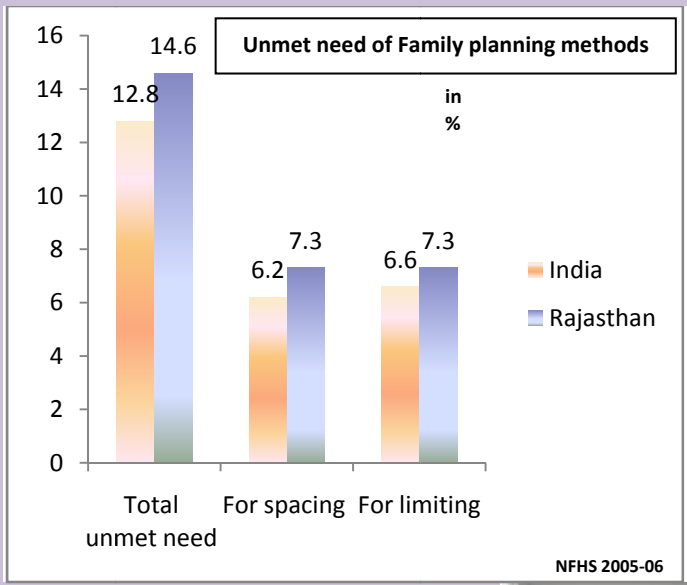



FIGURE 4

On other hand difference between utilization of limiting family planning method (female sterilization – 37.3% & 34.2 %, India & Rajasthan respectively; Male sterilization 1% and .8% India & Rajasthan respectively) explains the dependency on females not only to reproduce but also to control it as well.




Unmet need, the number or percent of women currently married or in union who are fecund and who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method. The total number of women with an unmet need for family planning (FP) consists of two groups of women: (a) those with an unmet need for limiting, and (b) those with an unmet need for spacing.

Total unmet need of India and Rajasthan is 12.8% and 14.6% of total married women. Reason can be unawareness, illiteracy, non-availability or inaccessibility but this also leads to unwanted pregnancies or abortions/miscarriage/child birth, which again lead to poor maternal health and population growth.

FIGURE 5

So by looking at above stated indicators in relation to increasing population, we can say that increasing population has substantially adverse impact on Maternal Health. So, for improving maternal health there is need to improve social indicators such as Mean Age at Marriage, Contracting Fertility Indicators such as ASMFR more during 20-30 age group, controlling TMFR, promoting use of contraception (*by Increasing Awareness, Accessibility, Availability, and breaking the myths attached to contraceptive use)* for both spacing and limiting birth, promoting male responsibility in Contraception use, protecting female fetus and female children to balance Sex Ratio.

Efforts make in improving such indicators finally may help us to achieve other benchmarked Maternal Health Indicators as well the Goal of Population Stabilization.

## Trainings, Workshops and Meetings

### Dissemination Workshop for SBCC Strategy

A Dissemination workshop was organised at SIHFW on June 23, 2014 under chairmanship of Dr. M.L. Jain, Director SIHFW. The workshop was organised to share the documents on Social and Behaviour Change Communication Strategy on RMNCH+A and Routine Immunization developed under partnership between SIHFW and UNICEF.

Presentations were made by freelance consultants for strategy development. Officials from DMHS, subject matter specialists and representatives of development partners participated in the workshop. Participants' feedback and suggestions on strategy documents were collected at the workshop.

In another section of the workshop, IEC material/ Job Aids for AAAs including Posters and Story Books being developed with Save the Children were shared with the experts for suggestions.

**Meeting of the Technical Working Group (TWG)**

The first meeting of the Technical Working Group (TWG) was held on June 3, 2014 at SIHFW, under chairmanship of Shri Neeraj K Pawan, AMD- NHM, Director-IEC, DMHS. The meeting was convened under guidance of Dr M.L. Jain, Director SIHFW. A Technical Working Group has been constituted at SIHFW to strengthen SBCC. the group is expected to focus on institutional strengthening for conceptualizing, planning, implementation and monitoring of health communication at the state, district and block levels. The TWG would encourage use of evidence based approaches to design various capacity building programs for health interventions that reach to the community level and focus on individual and social change. The TWG would look at the strengthening and integration initiatives from viewpoints of quality and sustainability issues in a holistic manner.

**Appreciative Enquiry Training**

Under the UNICEF supported activity based on Thematic approach, two batches of Training of Trainers on Theme 6: Appreciative Inquiry, were organized at SIHFW on June 6-7 and June 20-21, 2014. After discussion on previous mentoring visits and progress made so far, the mentors were oriented on the management tool of appreciative inquiry. The importance of appreciating and highlighting the positive side of every person were highlighted. Participants shared their memorable incidents and discussed them with the help of management tools.

**Hands-on Sessions on BemOC and PPIUCD**

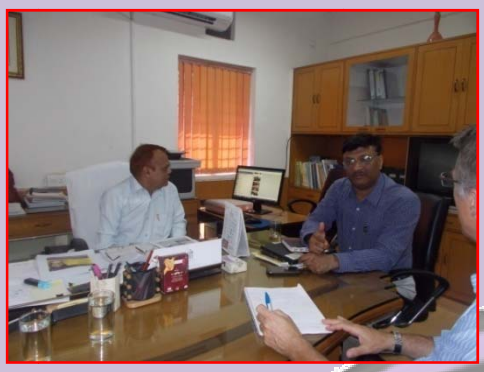
The hands-on sessions on BEmOC and PPIUCD of the third batch (FY 2014-15) of integrated foundation course for the newly recruited Medical Officers of the State were carried out at Jhalawar Medical College, Dr. S.N. Medical College, Jodhpur, S.P. Medical College, Bikaner and RNT Medical College Udaipur during June 23 to July 1, 2014.

The sessions were monitored by SIHFW staff including Ms Nishanka Chauhan, Ms Aditi Sharma, Mr Aseem Malawat and Mr Sunil Patel from June 30 to July 1, 2014.

**Team GAVI Visits SIHFW**

A team of experts from Global Alliance for Vaccines and Immunization (GAVI) visited SIHFW on June 17, 2014. The team had a meeting with Dr. M.L. Jain, Director SIHFW and visited on-going training and activities at SIHFW.

There were key discussions on Health indicators, key strategies and activities done by SIHFW in coordination with NRHM and Development partners. The team also documented the discussions in video format.



**ASHA ToT Round Two**


State trainers who successfully completed ToT of Round 1 of ASHA training of Module 6 and 7, were nominated for training of Round 2.
The inter-state training was organised during June 16 to 21, 2014. Training was held at the Rural Development Institute (RDI)

Himalayan Institute Hospital Trust, Dehradun. Participants from SIHFW included Mr Hemant Yadav and Mr Ezaz Khan. Following topics were covered in the training-

1. High Risk assessment and management of LBW/Pre-term baby
2. Asphyxia and its management(Practice using Mucus Extractor
3. Neonatal sepsis, its diagnosis and management
4. Family planning and its methods
5. Safe abortion and role of ASHA
6. RTI/STI and role of ASHA

Participants expressed that practice session of Mucus Extractor and Practice sessions on different topics very helpful to convey the skills to trainees.

**Orientation Workshop for Delivery Points**

Under the RMNCH+A strategy, Government of Rajasthan in collaboration with developmental partners is assigned to support 10 high priority districts in terms of infrastructure, manpower and assess the working of existing system and resources in Rajasthan to reduce high maternal and infant mortality.

One of the priorities under the RMNCH+A framework is Operationalization of Delivery Points.

To achieve this objective, a two day workshop under the Chairmanship of Director- SIHFW was organised for all the identified Delivery Points In- charges (DH/ SDH/ CHCs/ PHCs/SCs) and Labour room In-charges (nursing staff) of the Rajsamand district on June 13-14, 2014. Apart from the technical sessions, the workshop had the privilege of having Mr. Kailash Chandra Verma, District Collector, Rajsamand as a part of the workshop

The MO I/cs and the Nursing staff of the PHCs and CHCs participated on both the days whereas the BCMOs and Nursing staff of the Sub centres participated on the second day of the training.

## Monitoring/ Visits done by SIHFW personnel

### Block Monitoring Visit under Supportive Supervision

In coordination and partnership with UNCEF, team of SIHFW personnel and UNICEF Focus District Coordinator (FDC) did a block monitoring exercise in Jalore and Barmer districts during 25 to 26 June 2014. The visits were done under guidance of Dr. M.L. Jain, Director SIHFW. Health facilities including CHC, PHC and Sub centers were visited. The visit also included interface with the community to validate service delivery records and feedback from the community. Facilities including CHC, PHC and Sub-centres of Block Sindhari and Dhorimanna blocks were visited by Ms Archana and Ms. Neha and Ahore and Raniwada blocks by Dr Vishal and Mr Vikas Bharadwaj of SIHFW.



### HBNC+ Monitoring


HBNC+ monitoring was done in Bharatpur district by SIHFW staff and external monitors in June, 2014.

Mr Hemant Yadav visited Nagar and Deeg blocks during June,5-6and June,9-10, ,2014. Me Mohit Dhonkeriya visited deeg blocks during June,11-12 and June, 27-28, 2014.

Mr Vikas Bharadwaj visited Roopbas block for monitoring during June 23-24,2014. Monitoring details of external monitors follows:

| District | Block | Dates | Name |
|---|---|---|---|
| Bharatpur | Bayana | June,2-3,2014 | Ms. Arti Shrivastava |
| | Nagar | June,9-10,2014 | Ms. Arti Shrivastava |
| | Nadbai | June,11-12,2014 | Mr. Pankaj Bhatnagar |
| | Bayana | June,13-14,2014 | Ms. Arti Shrivastava |
| | Bhusawar | June,21-22,2014 | Mr. Pankaj Bhatnagar |
| | Roopbas | June,26-27,2014 | Mr. Pankaj Bhatnagar |

**UNICEF Review Activity**

Development Partner UNICEF organized a quarterly review of supported activities for SIHFW. This was held during June 13-14, 2014 at Udaipur under the chairmanship of Samuel Mawunganidze, Chief, UNICEF Rajasthan. UNICEF specialists and consultants were also present at the review meeting.

Dr. M.L. Jain, Director along with SIHFW team including Dr Vishal Singh, Dr Mamta Chauhan, Ms Poonam Yadav participated at the event. Presentation on programmes and progress were made by Dr Vishal Singh and Dr. Mamta Chauhan.

**Training Monitoring at Districts**

ASHA and SBA Trainings were monitored by Ms Archana and Ms Neha at Barmer during June 25-26, 2014. During this period, Training of Supportive supervision supported by UNICEF was also observed.

## Visitors & Training Feedbacks

**Success Story: PDC**

A participant of Ninth batch of PDC training (December 18, 2013 to February 25, 2014) shared post-training success story.

Experts from letter received:

*…..I didn't know that I could do a success camp on Maternal Health….when I did the training I had no idea to do something special which increased my confidence level. Some theoretical and practical learning was done during PDC course, hence it was planned to organise a health checking-camp for pregnant women, at each panchayat of my sector. All planning and resource pooling was planned by me, and I received support and contribution from administration and staff. After doing first camp at Sub-centre Ramganj Balaji, a mobile unit was developed. At DHS meeting, a presentation of the activity was done, which was appreciated. I am thankful to Dr. M.L. Jain, Director SIHFW and his team of Faculties and Training Coordinators at SIHFW, for coordinating the training in a manner which helped me plan the activity and implement it, making the training a successful experience…*

Dr Vinod Sharma,
MO/IC PHC Matunda,
Bundi

**Feedbacks during trainings**

1. Way of teaching was very practical and it included very basics.
2. The method of teaching and discussing was liked the most.
3. The information given by trainers is very useful.
4. Detailed explanation was given on every topic in simple language.
5. The training will definitely help me to execute and implement my knowledge more effectively and practically.

Source: Training feedbacks

## Health News

### Global

**Vit D deficiency could lead to hypertension**

The findings suggest that vitamin D supplementation could be effective in combating some cases of hypertension.

Study leader Professor Elina Hypponen from the University of South Australia, said in view of the costs and side effects associated with antihypertensive drugs, the potential to prevent or reduce blood pressure and therefore the risk of hypertension with vitamin D is very high.

The Mendelian randomisation study used genetic data from the D-CarDia collaboration, involving over 146 500 individuals of European ancestry from across Europe and North America.

Researchers used two common genetic variants that affect circulating 25-hydroxyvitamin D or 25(OH)D concentrations (which are generally used to determine a person's vitamin D status), to measure the causal effect between vitamin D status and blood pressure and hypertension risk.

They found that for each 10 per cent increase in 25(OH)D concentration there was a drop in diastolic blood pressure (-0.29 mm Hg) and systolic blood pressure (-0.37 mm Hg), and an 8.1 per cent decrease in the odds of developing hypertension.

According to Professor Hypponen, "Mendelian randomisation helps to determine cause and effect because by using genetic data we can better avoid confounding, reverse causation, and bias. However, because we cannot exclude the possibility that our findings were caused by chance, they need to be replicated in an independent, similarly powered study. Further studies using randomised controlled trials are also needed to confirm causality and the potential clinical benefits of vitamin D supplementation."

Source: June 26, 2014, TOI

### India

**Health Minister to speed up plans to give essential generic drugs for free**

The health ministry is trying to speed up the free generic drug programme which will ultimately aim to provide 348 drugs under the National List of Essential Medicines for free to 1.6 lakh sub-centres, 23,000 primary health centres, 5,000 community health centres and 640 district hospitals. The ministry in consultation with state governments is working out all logistical details with respect to procurement and distribution of free generic medicines in all government run health institutions across the country.

The Planning Commission had earlier estimated that the free generic drug programme would cost Rs 28,560 crore during the 12th plan period (2012-2017). While the Centre would bear 75% of the cost, the states are supposed to contribute 25%. The National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) are to be used as vehicles for implementation of the free generic drug distribution programme.

Original comments on the scheme in 2012 said that the new programme was likely to benefit India's strong generic pharmaceutical industry, but will be a huge concern for multinational pharmaceuticals seeking to sell their medicines in the country. However, the research-driven pharma industry often highlights the importance of an effective generic market in providing low-cost access to out-of-patent medicines. Health budget holders can then afford more truly innovative medicines which have to be priced higher to recover some of the R&D costs

A question that the new government needs to urgently address is how it is going to tackle the poor health infrastructure across India, without which free drugs will not make much difference. Most government hospitals in India are overcrowded, understaffed and lack medicines and supplies. There are significant shortages in the number of doctors, nurses, paramedics and hospital beds and these pose a great challenge for speedy implementation of universal healthcare in the country.

Source: June 23, 2014, Health Issues.com

**Rajasthan**

**Hearing impaired in Jodhpur benefit from cochlear implants**

Jodhpur became the second town after Jaipur to have expensive Cochlear Implantation - surgical installation of an electronic device - in the hearing impaired. Mathura Das Mathur Hospital of Jodhpur has conducted five such successful surgeries in the past three days. The ENT department of the hospital and Dr S N Medical College had been striving hard for this surgery to start in Jodhpur for the past three years.

Head of the ENT department of the hospital, Dr Bharti Solanki said, "We had moved the proposal for the surgery here three years back along with the SMS Hospital, which has already been doing the surgery." Project approval and arrangement of all the required infrastructure and surgical procurement took the hospital a little longer than SMS Hospital.

Mining department aided them with Rs 40 lakh for the entire infrastructure required for the implantation and the state government arranged to provide free implantation for the patients entitled under different government schemes and categories like BPL etc. Costing Rs 5 lakh to start with, the implantation in these five cases has been carried out by Dr Rajesh Vishvakarma from Gujarat Government Civil Hospital, as a mentor surgeon. "Since Dr Vishvakarma was an expert in this cochlear implantation, he would keep coming until we attain the expertise required to perform the surgery on our own," said Dr Solanki.
Elaborating the technique, Dr Vishvakarma said the devise, which has two parts, internal and external, is very costly and has to be imported to India. "The internal implantation devise has a warranty of 10 years whereas the external device had a warranty of three years," he said.

He added that this implantation is suitably for children as young as one year as well as older people with hearing disability. "But for the children with congenital disability, the sooner the implantation is done the better it is for the kid to help him/her speak properly through a long rehabilitation program of speech therapy," he said. Source: June 1, 2014, TOI

**SMS hospital gets new neurosurgery ward**

Giving a much-needed relief to patients, the Sawai Man Singh (SMS) hospital finally opened a 60-bedded neurosurgery ward. Out of 60 beds, there are 20 beds which have facilities of semi ICU. The hospital administration claimed that the patients would avail better facilities in the hospital.

The SMS hospital had drawn flak when patients in the neurosurgery ward found it difficult to get a bed. Neurosurgery is the unit where critical patients in large numbers get admitted. Since the old neurosurgery ward always remain completely occupied due to its limited bed availability, the patients had to lie on the floor. SMS hospital Additional Superintendent Dr Ajit Singh said, "The patients who were lying on the floor in the old neurosurgery wards have been shifted to the new neurosurgery ward."

Earlier, the patients lying on floor had to wait for days for availability of bed and patients' attendants had to seek recommendation from influential people to get the bed. The doctors also faced difficulties to provide treatment to patients in such condition when the recommendations for beds kept pouring in.

The hospital officials said that there are around 105 beds in the old ward. To open the new ward, the hospital administration had appointed two nodal officers. The officials said that earlier there were many problems like arranging space in the ward, financial constraints, shortage of nursing staff and beds but they overcoming all problems and the new ward was opened. Source: June 1, 2014, TOI

*We solicit your feedback:*

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