SIHFW Rajasthan

Electronic Newsletter
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From the Director's Desk

Dear Readers,

Greetings from SIHFW!

This issue of the e-newsletter brings information on Tobacco consumption, Facts and pattern of consumption. There is information on health risks associated with tobacco use and the lead article also recommends for effective policies to reduce tobacco consumption.

Global, National and State specific facts of Rajasthan have been shared in the lead article on World No Tobacco day, 2014. In the month of May, 2014, SIHFW also conducted a study on COTPA Compliance in three districts-Ajmer, Alwar and Nagaur. Study details have also been added in this e-news, however, findings will follow in the upcoming issue of e-newsletter. Please also find other activity highlights coordinated and implemented by and representations of SIHFW.

We would solicit your feedback and suggestions.

Director

Inside:

- World No Tobacco Day
- Events at SIHFW
- Feedbacks
- Health News

Health and Social Days in June '14
World Environment Day 5
World Day Against Child Labour 12
World Blood Donor Day 14

World No Tobacco day

Every year, on 31 May, WHO and partners mark World No Tobacco Day.
For World No Tobacco Day 2014, WHO and partners call on countries to raise taxes on tobacco.

Reduce tobacco consumption, save lives

Under the WHO Framework Convention on Tobacco Control (WHO FCTC), countries should implement tax and price policies on tobacco products as a way to reduce tobacco consumption. Research shows that higher taxes are especially effective in reducing tobacco use among lower-income groups and in preventing young people from starting to smoke. A tax increase that increases tobacco prices by 10% decreases tobacco consumption by about 4% in high-income countries and by up to 8% in most low- and middle-income countries.

Furthermore, increasing excise taxes on tobacco is considered to be the most cost-effective tobacco control measure. The World Health Report 2010 indicated that a 50% increase in tobacco excise taxes would generate a little more than US$ 1.4 billion in additional funds in 22 low-income countries. If allocated to health, government health spending in these countries could increase by up to 50%.

Goals

The ultimate goal of World No Tobacco Day is to contribute to protecting present and future generations not only from the devastating health consequences due to tobacco, but also from the social, environmental and economic scourges of tobacco use and exposure to tobacco smoke.

Specific goals of the 2014 campaign are that:

- governments increase taxes on tobacco to levels that reduce tobacco consumption;
- individuals and civil society organizations encourage their governments to increase taxes on tobacco to levels that reduce consumption.

Key facts

- Tobacco kills up to half of its users.

  Tobacco kills nearly 6 million people each year. More than five million of those deaths are the result of direct tobacco use while more than 600 000 are the result of non-smokers being exposed to second-hand smoke. Unless urgent action is taken, the annual death toll could rise to more than eight million by 2030.
- Nearly 80% of the world's one billion smokers live in low- and middle-income countries.
- Consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper middle-income countries.
- Only 8% of the world's population live in countries with sufficiently high tobacco taxes.
- Tobacco use is the single most preventable cause of death globally and is currently responsible for 10% of adult deaths worldwide.

Facts about India

Prevalence of Tobacco use

	Among youth		Among Adults			
Smoked tobacco prevalence (%)	Current tobacco use	Current cigarette use	Current tobacco smoking	Daily tobacco smoking	Current cigarette	Daily cigarette smoking
Male	19.0	5.8	24.3	18.3	10.5	6.3
Female	8.3	2.4	2.9	2.4	0.9	0.6
Total	14.6	4.4	14.0	10.7	…	…

Source: WHO Report on the Global Tobacco Epidemic, 2013

	Among Youth	Among Adults
Smokeless tobacco prevalence (%)	Current users of smokeless tobacco	Current users of smokeless tobacco
Male	11.1	32.9
Female	6.0	18.4
Total	9.0	25.9

Source: WHO Report on the Global Tobacco Epidemic, 2013

Smoke Free Environments in India -2012

Public places with smoke-free legislation	
Health care facilities	Yes
Educational facilities except universities	Yes
Universities	Yes
Government facilities	Yes
Indoor offices	Yes
Restaurants	*
Cafes, pubs and bars	*
Public transport	Yes
All other public places	NA
Compliance score #	5
National Law requires fines for smoking	Yes
Fines levied on the establishment	Yes
Fines levied on the smoker	Yes
Dedicated funds for enforcement	No
Citizen complaints and investigations	Yes

* Not categorized because separate, completely enclosed smoking rooms are allowed under very strict conditions

A score of 0-10, where 0 is low compliance (Source: WHO Report on the Global Tobacco Epidemic, 2013)

Leading cause of death, illness and impoverishment

The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing nearly six million people a year. Approximately one person dies every six seconds due to tobacco, accounting for one in 10 adult deaths. Up to half of current users will eventually die of a tobacco-related disease.

Tobacco users who die prematurely deprive their families of income, raise the cost of health care and hinder economic development.

In some countries, children from poor households are frequently employed in tobacco farming to provide family income. These children are especially vulnerable to "green tobacco sickness", which is caused by the nicotine that is absorbed through the skin from the handling of wet tobacco leaves.

Gradual killer

Because there is a lag of several years between when people start using tobacco and when their health suffers, the epidemic of tobacco-related disease and death has just begun.

Tobacco caused 100 million deaths in the 20th century. If current trends continue, it may cause one billion deaths in the 21st century.

Surveillance is key

Good monitoring tracks the extent and character of the tobacco epidemic and indicates how best to tailor policies. Only one in four countries, representing just over a third of the world's population, monitor tobacco use by repeating nationally representative youth and adult surveys at least once every five years.

Second-hand smoke kills

Second-hand smoke is the smoke that fills restaurants, offices or other enclosed spaces when people burn tobacco products such as cigarettes, bidis and water pipes. There are more than 4000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer.

There is no safe level of exposure to second-hand tobacco smoke.

- In adults, second-hand smoke causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung cancer. In infants, it causes sudden death. In pregnant women, it causes low birth weight.
- Almost half of children regularly breathe air polluted by tobacco smoke in public places.
- Over 40% of children have at least one smoking parent.
- In 2004, children accounted for 28% of the deaths attributable to second-hand smoke.

Every person should be able to breathe tobacco-smoke-free air. Smoke-free laws protect the health of non-smokers, are popular, do not harm business and encourage smokers to quit.

Over 1 billion people, or 16% of the world's population, are protected by comprehensive national smoke-free laws.

Tobacco users need help to quit

Studies show that few people understand the specific health risks of tobacco use. For example, a 2009 survey in China revealed that only 38% of smokers knew that smoking causes coronary heart disease and only 27% knew that it causes stroke.

Among smokers who are aware of the dangers of tobacco, most want to quit. Counselling and medication can more than double the chance that a smoker who tries to quit will succeed.

National comprehensive cessation services with full or partial cost-coverage are available to assist tobacco users to quit in only 21 countries, representing 15% of the world's population.

There is no cessation assistance of any kind in one-quarter of low-income countries.

Picture warnings work

Hard-hitting anti-tobacco advertisements and graphic pack warnings – especially those that include pictures – reduce the number of children who begin smoking and increase the number of smokers who quit.

Graphic warnings can persuade smokers to protect the health of non-smokers by smoking less inside the home and avoiding smoking near children. Studies carried out after the implementation of pictorial package warnings in Brazil, Canada, Singapore and Thailand consistently show that pictorial warnings significantly increase people's awareness of the harms of tobacco use.

Just 30 countries, representing 14% of the world's population, meet the best practice for pictorial warnings, which includes the warnings in the local language and cover an average of at least half of the front and back of cigarette packs. Most of these countries are low- or middle-income countries.

Mass media campaigns can also reduce tobacco consumption, by influencing people to protect non-smokers and convincing youths to stop using tobacco.

Over half of the world's population live in the 37 countries that have implemented at least one strong anti-tobacco mass media campaign within the last two years.

Ad bans lower consumption

Bans on tobacco advertising, promotion and sponsorship can reduce tobacco consumption.

- A comprehensive ban on all tobacco advertising, promotion and sponsorship could decrease tobacco consumption by an average of about 7%, with some countries experiencing a decline in consumption of up to 16%.
- Only 24 countries, representing 10% of the world's population, have completely banned all forms of tobacco advertising, promotion and sponsorship.
- Around one country in three has minimal or no restrictions at all on tobacco advertising, promotion and sponsorship.

Taxes discourage tobacco use

Tobacco taxes are the most cost-effective way to reduce tobacco use, especially among young people and poor people. A tax increase that increases tobacco prices by 10% decreases tobacco consumption by about 4% in high-income countries and by up to 8% in low- and middle-income countries.

Even so, high tobacco taxes is a measure that is rarely used. Only 32 countries, less than 8% of the world's population, have tobacco tax rates greater than 75% of the retail price. Tobacco tax revenues are on average 175 times higher than spending on tobacco control, based on available data.

In 2008, WHO introduced a practical, cost-effective way to scale up implementation of provisions of the WHO Framework Convention on the ground: MPOWER. Each MPOWER measure corresponds to at least one provision of the WHO Framework Convention on Tobacco Control.

The six MPOWER measures are:

- Monitor tobacco use and prevention policies
- Protect people from tobacco use
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco.

Measures in India

Indian Tobacco Control Act COTPA 2003

Cigarettes and Other tobacco products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003
COTPA is applicable to all products containing tobacco in any form i.e. cigarettes,cigars,bidis,gutka,pan masala (containing tobacco),Mavva,Khaini,snuff etc.
The Act extends to whole of India
Main Provisions of Tobacco Control Act, 2003

Section 4 : Bans Smoking in all "public places
Section 5 prohibits advertisement, promotion and sponsorship of all tobacco products
Section 6 (a) :Prohibits Sale of tobacco to minors
Section 7: Demands specified health warning labels on all tobacco products
Section 7(5) Every Tobacco package to have nicotine and tar contents along with maximum permissible limits.

Enforcement Agencies for implementation of tobacco control act

- Any Police Officer, not below the rank of Sub Inspector
- Any Officer of State Food or Drug Administration
- Any Officer, holding the equivalent rank, not below the rank of Sub Inspector of Police. As authorized by Central/State Governments

Punishment For Violations

- A fine up to Rs.200/-for offenses relating to smoking in public places and sale of tobacco products to minors; can be imposed by any officer as authorized by the central/state govt.
- Offences relating to the direct and indirect advertising of tobacco product is punishable with maximum of 2 years of imprisonment or/and with fine upto Rs. 1000. In subsequent offence, imprisonment up to 5 years and with fine upto Rs 5000
- Any person who produces or manufactures cigarettes or other tobacco products which do not contain, either on the package or on their label, the specified warnings and nicotine and tar contents, shall in case of first conviction be punishable with imprisonment for a term which may extend to two years , or with a fine which may extend to 5000 Rs , or with both and for the second and subsequent conviction , with imprisonment for a term which may extend to 5 years and with fine which may extend to 10000 Rs

State Scenario: Rajasthan

Percentage of current tobacco users to States/UTs:
India = 35%
Rajasthan =32%

Percentage of adults age 15 and above by detailed status of tobacco use

Current Tobacco user					Current Non User				
Current tobacco user	Daily user	Occasional user	Occasional user, formerdaily	Occasional user, never daily	Current nonuser	Former daily user	Never daily user	Former occasional user	Never user
32.3	28.4	3.9	1.5	2.4	67.7	2.3	65.3	0.9	64.4

Source: GATS India, 2009-2010

Percentage of males age 15 and above by detailed status of tobacco use

Current Tobacco user					Current Non User				
Current tobacco user	Daily user	Occasional user	Occasional user, former daily	Occasional user, never daily	Current nonuser	Former daily user	Never daily user	Former occasional user	Never user
50.5	44.8	5.7	1.8	4.0	49.5	3.9	45.6	1.2	44.4

Source: GATS India, 2009-2010

Percentage of females age 15 and above by detailed status of tobacco

Current Tobacco user					Current Non User				
Current tobacco user	Daily user	Occasional user	Occasional user, former daily	Occasional user, never daily	Current nonuser	Former daily user	Never daily user	Former occasional user	Never user
12.9	10.9	2.1	1.3	0.8	87.1	0.6	86.5	0.6	85.8

Source: GATS India, 2009-2010

Percent distribution of adults age 15 and above who are current tobacco users by tobacco use pattern

	Type of current tobacco use			
Current tobacco user	Smoked only	Smokeless only	Both smoked and smokeless	Non-user
32.3	13.4	13.5	5.4	67.7

Source: GATS India, 2009-2010

Percent distribution of males age 15 and above who are current tobacco users by tobacco use pattern

	Type of current tobacco use			
Current tobacco user	Smoked only	Smokeless only	Both smoked and smokeless	Non-user
50.5	21.8	19.0	9.7	49.5

Source: GATS India, 2009-2010

Percent distribution of females age 15 and above who are current tobacco users by tobacco use Pattern :

	Type of current tobacco use			
Current tobacco user	Smoked only	Smokeless only	Both smoked and smokeless	Non-user
12.9	4.5	7.6	0.8	87.1

Source: GATS India, 2009-2010

Percent distribution of age at initiation among ever daily tobacco users age 20-34 by age at tobacco use initiation:

	Age at tobacco product initiation				Mean age
	<15	15-17	18-19	20-34	
India	15.7	24.7	19.3	40.3	17.8
Raj	17.0	35.3	21.4	26.3	17.0

Source: GATS India, 2009-2010

GAATS Findings –Rajasthan Fact Sheet

The Global Adult Tobacco Survey (GATS) is the global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators.

GATTS is a nationally representative survey, using a consistent and standard protocol across countries, including India.

This fact sheet represents the state of Rajasthan in India. The estimates were based on 2,046 completed interviews of males and females in Rajasthan with an overall response rate of 95.0%.

GAATS Highlights

Tobacco Use

- Current tobacco use in any form: 32.3% of adults; 50.5% of males and 12.9 % of females
- Current tobacco smoking: 18.8 % of adults; 31.5 %% of males and 5.3% of females
- Current cigarette smoking: 2.8 %% of adults; 4.9 00% of males and 0.6 %% of females
- Current bidi smoking: 16.0% o ff adults; 26.7% of males and 4.6% of females
- Current users of smokeless tobacco: 18.9% of adults; 28..7% of males and 8.5% of females
- Average age at daily initiation in of tobacco use: 17 ee.3 y ears in adults, 17.7 y ears in males, and 11 4.1 y ears in females
- 678% of daily tobacco users consume tobacco within half an hour of waking up

Cessation

- 54.6% of current smokers and 57.4% of users of smokeless tobacco planned too quit or thought about quitting
- 39.7% of smokers and 29.0% of users of smokeless tobacco were advised to quit by a health care provider

Second-hand Smoke

- 74.3% of adults were exposed to second-hand smoke at home
- 40.2% of adults were exposed to second-hand smoke in public places

Media

- Adults who noticed any advertisement or promotion: 36.2% mm for cigarettes, 47.44% for bidis, and 60.7% for smokeless tobacco.
- • Current users of thee following tobacco products who thought bb about quitting because of a warning label: 63.2% for cigarettes, 42.44% for bidis, and 46.8% for smokeless tobacco.

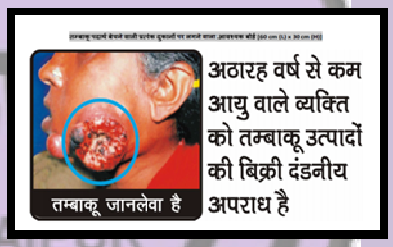
Knowledge, Attitudes & Perceptions

- 92.8% of adults believe smoking causes serious illness.
- 92.3% of adults believe exposure to tobacco smoke causes serious illness in non-smokers.
- 94. 1% of adults believe smokeless tobacco use causes serious illness.

Initiatives in Rajasthan

Rajasthan: Jhunjunu District and Jodhpur City have been declared as Smoke Free in Rajasthan.

Compliance Assessment Survey: State Institute of health and Family Welfare had done a compliance assessment survey on Prohibition of Smoking under COTPA in Jaipur city in the year 2013.



Aims and objectives: The objective of the study was to assess the current level of compliance to section 4 of COTPA in Jaipur city and assess the preparedness of Jaipur city for declaring it as a smoke free city.

Methodology: It was a cross sectional study conducted from 20 February 2013- 20 March 2013 Jaipur city. For compliance monitoring an observation checklist was used which has been developed by the "International Union Against Tuberculosis and Lung Disease". A total of 494 public places were observed at the estimated compliance of 50%, confidence interval of 95% and at 5% margin of error. This survey was conducted using the cluster sampling; hence the 1.3 was taken as design effect. Subsequently, in each clusters, total 164 public places (of all seven categories) surveyed.

Results:

- Out of the 494 public places in Jaipur city , only 199 (40%) places have displayed 'No Smoking' signage', out of which only 49 (25%) are the places which follow the COTPA of having signage at both the entrance and other conspicuous places.
- But 80 (40%) places had these signage at the entrance while 119 (60%) had these displayed at other conspicuous places.
- The places which displayed 'No Smoking Signage' only 11% (56) matched the size of the signage of 20 x 40 inch, 6% (32) followed the text of the signage, 11% had a design similar to COTPA and only 2% gave contact details of the reporting person.
- When we take a look at the evidences of smoking in Jaipur city, we find that at 95 (19%) places people were found actively smoking in the public places while smoking aids – facilitating smoking as ashtrays, match-sticks etc were found at 85 (17%) places and 131 (26.5%) places shows the availability of cigarette butts and beedi stubs.

Conclusion: A majority of the places are not complying to the COTPA presently, and those who are following the norms are not abiding completely to the specifications. It was observed that 'no smoking' signage was available at only 40% of the sites. Of these, signage was available at entrance at 40% places and at other conspicuous places in 60% places. Compliance to COTPA specifications for signage in terms of availability, size, text, design and contact details of reporting person were seen more in

education establishments, Offices & workplaces and Health care facilities as compared to places falling under other categories covered, though nowhere the figures reached a promising place. Active smoking was observed in 19% of the places. Evidences of smoking were below 27%.It needs to be noted that places where display of signage were prominent the number of active smoking or evidences of smoking was less while those places which failed to comply to the norms also showed more evidences of smoking. Thus it was found that only 23% complied with the signage specifications of COTPA and the rest used the signage as per their available information or feasibility. *(Similarly other compliance studies have also been done by enormous agencies/ organizations, which are available on net)*

Establishment of NCD cell in DMHS

Composition of NCD Cell

- State Program Officer
- Program Assistant
- Finance cum Logistics Officer
- Data Entry Operators (2)

Terms of Reference

- State action plan
- Develop district wise NCD mapping,
- Trainings
- Manpower
- Fund flow and SOE/ UCs
- epidemiological profiling
- *Convergence with NRHM*
- Availability of palliative and rehabilitative services
- Monitoring
- Public awareness

Recommendations:

What MOs should do:

- Surveillance
- Screening
- Services
- Statistics

Screening

- To conduct comprehensive examination to diagnose, investigate and manage the cases appropriately.
- To rule out complications or advanced stage.
- To refer complicated cases to higher care facility
- To provide follow up care to the patients
- Health promotion
- Data and record

Health promotion

- Health promotion activities – (i) Educate regarding common risk factors, increased intake of healthy foods (ii) increased physical activity through sports, exercise, etc. (iii) avoidance of tobacco and alcohol and (iv) stress management.
- Risk assessment and management through opportunistic screening
- Motivate and create role models in the community
- Work closely with other sectors/ departments for NCD prevention
- Management of patients suffering from Cancer, Diabetes, CVDs and Stroke referred from different centers
- Establish an effective referral mechanism with the nearest medical colleges
- Supervision of the activities undertaken by paramedical workers
- Assist resource centers/ institution in organizing the training for different cadre of health workers

What staff should do:

- **Nursing staff:**
  - To assist in examination and investigation
  - To teach the patient and family about risk factors of NCDs and promote patients wellbeing
  - To assist in follow up and care
- **Counselor:**
  - To provide counseling on diet and life style management
  - To assist in follow up care and referral

Actions at Hospitals

- **Counseling of identified patients of NCDs:**
  - What is the illness
  - What is the prognosis
  - What complications can arise
  - What drugs to take – proper dosage, importance of regularity of drug intake, possible side effects
  - What other interventions can reduce the severity of illness
    - Habitual physical exercise
    - Balanced diet
    - Meditation
- Proper depiction / display of health education messages / posters
- Educate women on self-examination of breast
- Educate persons coming to the hospital on risk factors for different NCDs (health education corners, documentaries may be shown on TV screens, *etc.*)

- **Screening for early diagnosis of NCDs**
  - Routine measurement of BP of all patients
  - Screening tests In high-risk cases
  - Pap smear examination
  - Routine examination of oral cavity for early signs of cancer
  - Training of different categories of health staff

Research Study

Study on COTPA Compliance

A study on compliance of COTPA Act was done by SIHFW supported by Population Services International during 13 to 21 May, 2013. It was conducted in three districts of Rajasthan-Alwar, Ajmer and Nagaur. This was an observation study which included observing signage compliance at public places, educational institutions, residential places, restaurants, sale outlets and in depth study about smoking and non smoking forms available at various shops.

Compliance study formats were used as observation checklists for various Sections under the COTPA act. Three teams for the three districts including SIHFW supervisors and a team of investigators visited villages, blocks and District HQ (city) of the study area.

The data generated is being analyzed through software and report writing is in progress.

Investigators in process of data collection at a village shop

Little girl carrying tobacco product home for parents…

School wall and display both said…no Tobacco, but it was sold!

Signage displayed, but Incomplete!

Efforts made, Full-proof Compliance!

Trainings, Workshops and Meetings

State level Consultation on SBCC and Formation of Sub-Core Groups

In continuation of the Divisional level Workshops done in month of April, 2014 for compiling District/Block level SBCC plans under RMNCH+A and RI, a half day brainstorming for discussing modalities for updating and developing State specific SBCC strategy for RMNCH+A and RI is being organised at SIHFW on May 2, 2014 at SIHFW. The meeting cum workshop was held under the Chairmanship of Dr. M.L Jain- Director-SIHFW and co-chairmanship of Dr. R.P.Jain – Project Director-Immunization and Maternal Health. The workshop was done with following objectives: To do brainstorming for draft plans and develop a consensus on updation to be done in the existing strategy, To plan for the modalities and tools for finalizing the strategy and rolling out the same and to plan for the actionable points, based on which strategy will be developed further for implementation.

Followed by the Consultation, a meeting was held on May 7, 2014 at SIHFW wherein sub-core groups on each thematic area-key indicators were formed. The groups will be doing think tank exercise on particular thematic area to develop strategy outline. The areas are Reproductive Health, Maternal health, Neonatal and Child Health, Adolescents Health, Routine Immunization, System Strengthening and Community Processes.

Supportive Supervision and Mentoring visits

Team of SIHFW personnel visited facilities of Dungarpur and Banswara districts under Supportive Supervision activity in partnership with Unicef. The visits were done under guidance of Dr. M.L. Jain, Director SIHFW with Resource Persons and experts of Unicef including Dr. Anil Agrawal, Dr Apoorva Chaturvedy, Dr Sanjeev Gupta, Dr Pallavi and Mr Vinod Rathode.

The visits were done during May 21-23, 2014. SIHFW personnel included Dr Vishal Singh, Dr Mamta Chauhan, Dr Richa Chaturvedy, Ms Neha Awasthi and Mr Aseem Malawat. CHC, PHC and Sub centres were visited under this activity.

After the visits, a De-briefing Meeting was done on May 23, 2014 at CMHO Office. Dr.Barwa, Joint Director and Focused District coordinators Mr Ali and mr Kapil were also present at the de-briefing meeting.

Seeing the discussion over the activities held in the field, some suggestions were given by Director SIHFW for future course of action for the facilities

Orientation of Training Institutes on RMNCH+A Approach

A half-day workshop was organised on May 5, 2014 at New Delhi. The workshop was organised by the RMNCH+A Coalition Secretariat by Save the Children India. It was organised under the chairmanship of the AS andMD (NHM) Ms Anuradha Gupta.

The objective of the workshop was to orient the key stake holders involved in training and monitoring of RMNCH+A implementation on RMNCH+A strategy of GOI, including 5x5 matrix. Dr M.L. Jain, Director SIHFW and Dr. Mamta Chauhan, Faculty SIHFW participated in the orientation.

National Consultation on CAC: Prioritizing Comprehensive Abortion Care

To discuss the strategies for prioritizing CAC services for women within NHM framework, Ministry of Health and Family Welfare, Government of India in collaboration with IPAS organised a two-day national consultation on May 19-20, 2014 at New Delhi.

The consultation was chaired by Secretary, Health and Family Welfare, Government of India with key representatives from all 35 states and union territories and will also bring together expertise from other stakeholders. Dr M.L. Jain, Director SIHFW participated in this consultation workshop.

Experience Sharing of ASHA Trainers

An experience sharing meeting was organised at SIHFW. Participants trained under ToT of Round One held at Garchiroli, Maharastra participated in the meeting. Each participant made a presentation on learning and experience involved. The trained participants are now eligible to train ASHAs. The meeting was held on May 6, 2014 under chairmanship of Dr. M.L. Jain, Director –SIHFW. Role of trainers in strengthening supervision and monitoring was discussed.

Monitoring/ Visits done by SIHFW personnel

Mr Mohit Dhonkeriya of SIHFW did monitoring of HBNC+ Training of NIPI during May 26-27, 2014 at Bayana, May 29-30, 2014 at Nagar in Bharatpur district.

Celebrations!

Birthday of Ms Richa Chhabra was celebrated on May 2, 2014 at SIHFW

Visitors & Training Feedbacks

1. Training and good behaviour of teachers
2. Interactive sessions and field visits
3. Teaching faculties and their way of communication
4. Healthy conversation between everyone
5. Sessions were two-way communication and did not feel as a lecture only
6. Way of imparting knowledge, friendly hospitability and good services
7. Teaching and demonstration by the trainers with appropriate examples

Source: Training feedbacks

Health News

Global

WHO calls for higher tobacco taxes to save more lives

On World No Tobacco Day (May 31), WHO calls on countries to raise taxes on tobacco to encourage users to stop and prevent other people from becoming addicted to tobacco. Based on 2012 data, WHO estimates that by increasing tobacco taxes by 50%, all countries would reduce the number of smokers by 49 million within the next 3 years and ultimately save 11 million lives.

Today, every 6 seconds someone dies from tobacco use. Tobacco kills up to half of its users. It also incurs considerable costs for families, businesses and governments. Treating tobacco-related diseases like cancer and heart disease is expensive. And as tobacco-related disease and death often strikes people in the prime of their working lives, productivity and incomes fall.

“Raising taxes on tobacco is the most effective way to reduce use and save lives,” says WHO Director-General Dr Margaret Chan. “Determined action on tobacco tax policy hits the industry where it hurts.”

High prices are particularly effective in discouraging young people (who often have more limited incomes than older adults) from taking up smoking. They also encourage existing young smokers to either reduce their use of tobacco or quit altogether.

“Price increases are 2 to 3 times more effective in reducing tobacco use among young people than among older adults,” says Dr Douglas Bettcher, Director of the Department for Prevention of Noncommunicable Diseases at WHO. “Tax policy can be divisive, but this is the tax rise everyone can support. As tobacco taxes go up, death and disease go down.”

WHO calculates that if all countries increased tobacco taxes by 50% per pack, governments would earn an extra US$ 101 billion in global revenue.

“These additional funds could – and should – be used to advance health and other social programmes,” adds Dr Bettcher.

Countries such as France and the Philippines have already seen the benefits of imposing high taxes on tobacco. Between the early 1990s and 2005, France tripled its inflation-adjusted cigarette prices. This was followed by sales falling by more than 50%. A few years later the number of young men dying from lung cancer in France started to go down. In the Philippines, one year after increasing taxes, the Government has collected more than the expected revenue and plans to spend 85% of this on health services.

Tobacco use is the world’s leading preventable cause of death. Tobacco kills nearly 6 million people each year, of which more than 600 000 are non-smokers dying from breathing second-hand smoke. If no action is taken, tobacco will kill more than 8 million people every year by 2030, more than 80% of them among people living in low- and middle-income countries.

Raising taxes on tobacco in support of the reduction of tobacco consumption is a core element of the WHO Framework Convention on Tobacco Control (FCTC), an international treaty that entered into force in 2005 and has been endorsed by 178 Parties. Article 6 of the WHO FCTC, Price and Tax Measures to Reduce the Demand for Tobacco, recognizes that “price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons”. Source: WHO/ Media News/ May 27, 2014

E-cigarettes may have unknown health risks

"Despite the apparent optimism surrounding e-cigarettes and their purported therapeutic role in smoking cessation, there just simply is not enough evidence to suggest that consumers should use e-cigarettes for this purpose," explained allergist Andrew Nickels from Mayo Clinic's division of allergy and immunology.

Another cause for concern is that when people use e-cigarettes in public and still smoke regular cigarettes at home, "they continue to expose children and asthma sufferers in the household to dangerous second-hand smoke", researchers warn.

Dual use of both e-cigarettes and regular cigarettes carries the risk of second-hand smoke exposure, causing worsening respiratory effects on children and asthma sufferers.

"It also promotes ongoing nicotine dependence," said Chitra Dinakar, a professor of pediatrics at Children's Mercy Hospitals.

Because e-cigarettes are fairly new, there could be other long-term health complications that are yet to be discovered.

Due to the lack of production oversight, most consumers do not know what is in the e-cigarettes they buy.

"Nicotine delivered by any mechanism represents a drug exposure," said the American College of Allergy, Asthma and Immunology (ACAAI) statement.

Inhaling irritants such as smoke and vapours has an impact on the lungs, whether it is mild or severe.

And irritants can cause asthma attacks in some individuals, said the study published in the journal *Annals of Allergy, Asthma & Immunology*. Source: IANS, May 27, 2014

India

WHO/UNICEF highlight need to further reduce gaps in access to improved drinking water and sanitation

Since 1990, almost 2 billion people globally have gained access to improved sanitation, and 2.3 billion have gained access to drinking-water from improved sources. Some 1.6 billion of these people have piped water connections in their homes or compounds, according to a new WHO/UNICEF report, entitled Progress on drinking water and sanitation: 2014 update, which also highlights a narrowing disparity in access to cleaner water and better sanitation between rural and urban areas.

More than half of the global population lives in cities, and urban areas are still better supplied with improved water and sanitation than rural ones. But the gap is decreasing. In 1990, more than 76% people living in urban areas had access to improved sanitation, as opposed to only 28% in rural ones. By 2012, 80% urban dwellers and 47% rural ones had access to better sanitation.

In 1990, 95% people in urban areas could drink improved water, compared with 62% people in rural ones. By 2012, 96% people living in towns and 82% of those in rural areas had access to improved water.

Despite this progress, sharp geographic, socio-cultural, and economic inequalities in access to improved drinking water and sanitation facilities still persist around the world.

“The vast majority of those without improved sanitation are poorer people living in rural areas. Progress on rural sanitation – where it has occurred – has primarily benefitted richer people, increasing inequalities,” said Dr Maria Neira, WHO Director for Public Health, Environmental and Social Determinants of Health.

“Too many people still lack a basic level of drinking water and sanitation. The challenge now is to take concrete steps to accelerate access to disadvantaged groups. An essential first step is to track better who, when and how people access improved sanitation and drinking water, so we can focus on those who don’t yet have access to these basic facilities,” she added.

In addition to the disparities between urban and rural areas, there are often also striking differences in access within towns and cities. People living in low-income, informal or illegal settlements or on the outskirts of cities or small towns are less likely to have access to an improved water supply or better sanitation.

“When we fail to provide equal access to improved water sources and sanitation we are failing the poorest and the most vulnerable children and their families,” said Sanjay Wijesekera, UNICEF Chief of Water, Sanitation and Hygiene. “If we hope to see children healthier and better educated, there must be more equitable and fairer access to improved water and sanitation.”

Poor sanitation and contaminated water are linked to transmission of diseases such as cholera, diarrhoea, dysentery, hepatitis A, and typhoid. In addition, inadequate or absent water and sanitation services in health care facilities put already vulnerable patients at additional risk of infection and disease.

The report presents estimates for 1990-2012 and is based on data from nationally representative household surveys and censuses for the same period. It reveals that by 2012, 116 countries had met the Millennium Development Goal (MDG) target for drinking water, 77 had met the MDG target for sanitation and 56 countries had met both targets. MDG 7.C aims to halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation.
Source: WHO/Media News, May 8, 2014

Kerala comes together to stub the cigarette

And from what they say, it looks like they mean business. Smokers beware! In 2011 Ernakulam was declared the first smoke free tourist destination in the State. But in 2013, again, a total of 5,324 cases of public smoking were registered under Section 4 of Cigarettes and Other Tobacco Products (COTPA) Products (COTPA) Act. Despite tall claims of being tobacco free in public places, we still have miles to go before Kerala stubs the cigarette.

Several schools and colleges are re-opening on June 2 and the district education department is all set to control the sale of tobacco products in shops next to schools from day one itself. Abdul Azeez, assistant to the district educational officer says, "On May 28, a meeting was held with all the school headmasters. Smoke free labels will be put up in all the school compounds and smoke free zone boards will be erected on the premises."

"Awareness classes will be conducted for the students once school reopens and special care will be taken to find out if cigarettes or any other tobacco products are sold in small stationery shops outside the institutions. Frequent raids will be conducted by the police and training will also be given to student police cadets to create awareness about the ill-effects of smoking."

In Ernakulam, the district administration has joined hands with the police to bring back the smoke-free status of the district. District Collector M G Rajamanickam in April had announced that special teams comprising police, education and health department officials will conduct surprise checks in schools and colleges in the coming academic year to check the sale of tobacco products within 400 metres of the campuses.

Raids are already being conducted and Shadow Police are posted at various parts of the city, especially near educational institutions and hospitals. Commissioner of Police K J James says, "Special drives are being conducted in the entire city . We have been conducting raids and have nabbed several culprits. The fine is charged as per the Control of Tobacco Products Act." Satheesh Bino, District Police Chief, Ernakulam Rural, says, "The past six months have actually seen an increase in the number of cases registered against smokers and illegal sale of tobacco products in the district."

Smoking in any public area, including restaurants, bars, pubs and discotheques, is banned and punishable. "However, one can smoke in the aforementioned institutions, if they have a designated smoking zone, which in turn should not be in the vicinity of a restaurant and any other public gathering space," says Fino Babu, Food & Beverages Manager.

The health department officials meanwhile are also taking efforts to spread awareness in the city. District medical officer Dr Haseena Mohammed says, "On World No Tobacco Day, today, we are conducting special drives in the city. A rally was held in the city along with nursing and other medical students. Recently, a seminar too was conducted at a nursing college to make the students aware about the health hazards of smoking. We are conducting regular programmes to spread awareness and it will continue."

In Trivandrum, authorities say the vicinity of educational institutions have been kept tobacco-free with the help of Student Protection Committees. In early February this year, Trivandrum was named Tobacco Free Educational District as well as a district that's Tobacco Advertisement Free! Citing tobacco as the initiator of many crimes, in addition to being hazardous to health, authorities have called upon the continuous support of students, teachers and society at large to pitch in and curb the menace.

In 2008, Kottayam became the first district to be tobacco free. In 2011, Ernakulam was declared as the first smoke-free tourist destination.

The Kerala Government also came out with an Order in 2011-2012 that bans the sale of pan masala and other addictive products within a radius of 400 meters of educational institutions. This is significant because the central legislation COTPA, 2003 provides a ban of the said products only within 100 yards.

There is still a good clientele for ganja among students in the city, going by the recent seizures by the city police, which had made networks in schools and colleges here. When asked whether there is a rise in the number of students and minors who are customers of such groups, Excise Commissioner Anil Xavier said, "We have not noticed such trends. However, what we see is that people bring ganja from Idukki - which is considered the best - to the capital city and try to sell it here as they get a better price. Through anti-drug clubs formed in about 2100 high schools and higher secondary schools, awareness is been passed on to students about the negative effects of substance abuse." He adds that the awareness campaigns through student cadet corps are also quite impactful. Source: Times News Network, May 31, 2014

Rajasthan

Rajasthan govt seeks 'undertaking of no-smoking' in direct jobs

Applicants should undertake an oath on a paper while applying that they do not smoke cigarette and chew gutka.

Anyone seeking a job through direct recruitment process in Rajasthan government services will now have to submit an undertaking of "non-smoking and non-gutka use" with the application.

State Personnel and Training Department, in an order, circulated to all departments, corporations, agencies, public service commission and district collectors, has asked to get the undertaking in writing from applicants seeking job through direct recruitment, official sources said here today.

Applicants should undertake an oath on a paper while applying that they do not smoke cigarette and chew gutka (betel-nut with tobacco), the order categorically said.

Since the DOPT order was released on the eve of Assembly polls last year (October 2013) and the Code of Conduct was effected immediately last year and now during the Lok Sabha polls too, the order was lying pending for fresh job openings, they said.

Recently last month on April 23, a Co-ordination Committee of five power companies adopted this order effectively and sought "undertakings of non-smoking and non-gutka use" from applicants in its direct job openings in electricity corporations, the state energy and power department sources said. The DOPT order, made in compliance to the state-level committee for tobacco control, had recommended that no person shall be offered a government job, if he or she smokes or chew tobacco.

Hailing the initiative in government services, general secretary of Indian Asthma Care Society Dharamveer Kateva said the move should be welcomed everywhere, and non-alcoholic undertaking should also be added with this oath. Source: Press trust of India, May 23, 2014

We solicit your feedback:

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