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E-Newsletter

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

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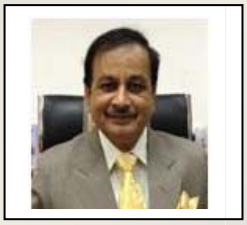
Volume 1/Issue 10 *October 2012*

From the Desk of Director



Dear Readers,

Greetings from SIHFW, Rajasthan!

This year, world observes 20th Anniversary of World Mental Health Day on 10th October. The day raises public awareness about mental health issues and promotes open discussion of mental disorders and emphasizes prevention, promotion and treatment services. This year's theme for the day- "Depression: A Global Crises" brings focus to one of the leading mental disorder affecting about 121 million worldwide.

This issue of our e-newsletter brings a lead article on mental health and gives a message that depression can be reliably diagnosed and treated in primary care. However, as per WHO, fewer than 25% of those affected have access to effective treatment. Our focus should be on promoting mental health throughout the lifespan to ensure a healthy start in life of children and to prevent mental disorders in adulthood and old age.

Director

Health Days in October'12

International Day for the Elderly 1st October
World Mental Health Day 10th October
World Sight Day 13th October
UN International Day for National Disaster Reduction 13th October
World White Cane Day 15th October
World Food Security Day 16th October

Mental Health

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Mental health is an integral and essential component of health. The World Bank report (1993) revealed that the Disability Adjusted Life Year (DALY) loss due to neuropsychiatric disorder is much higher than diarrhea, malaria, worm infestations and tuberculosis if taken individually. According to the estimates DALYs loss due to mental disorders are expected to represent 15% of the global burden of diseases by 2020. While 14% of the global burden of disease is attributed to Mental, neurological, and substance use disorders, most of the people affected - 75% in many low-income countries - do not have access to the treatment they need.

Some facts

- About half of mental disorders begin before the age of 14.
- More than 450 million people suffer from mental disorders. Many more have mental problems.
- Around 20% of the world's children and adolescents are estimated to have mental disorders or problems, with similar types of disorders being reported across cultures.

- Regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources.
- Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people.
- Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.
- On average about 800 000 people commit suicide every year, 86% of them in low- and middle-income countries.
- More than half of the people who kill themselves are aged between 15 and 44.
- The highest suicide rates are found among men in eastern European countries.
- Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. (higher in urban areas and among people with higher levels of education)
- Human rights violations of psychiatric patients are routinely reported in most countries.
- Rates of mental disorder tend to double after emergencies, war and major disasters.
- The financial resources needed to increase mental health services are relatively modest: US$ 2 per person (approx. Rs 100) per year in low-income countries and US$ 3-4 (approx. Rs 400) in lower middle-income countries.

Key Mental Disorders

1. Depression
2. Psychosis and Bipolar Disorders
3. Child and Adolescent Mental disorders
4. Self-harm and suicide
5. Other significant emotional and medical un explained somatic complaints

Depression:

Depression is a common mental disorder characterized by sustained sadness, depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. It is ranked as the leading cause of disability worldwide.

Depression affects more than 350 million people of all ages, in all communities, and is a significant contributor to the global burden of disease. Although there are known effective treatments for depression, access to treatment is a problem in most countries and in some countries fewer than 10% of those who need it receive such treatment.

Psychosis and Bipolar Disorders:

Psycho education should be routinely offered to individuals with psychotic disorder (including schizophrenia) and bipolar disorders and their family members/caregivers.

For individuals with psychotic disorders (including schizophrenia) and bipolar disorder, cognitive-behavioural therapy and family interventions can be considered as an option if adequate trained professionals are available.

Professionals delivering these interventions should have an appropriate level of competence and, wherever possible, be regularly supervised by the relevant specialists. These interventions should be continued as long as needed by the user and his/her family and therefore should be planned and developed in a sustainable way. Individuals and families should be actively involved in the design, implementation and evaluation of these interventions in coordination with health and social professionals.

Child and Adolescent Mental disorders:

Non-specialized health care facilities should encourage and collaborate with school-based life skills education, if feasible, to promote mental health in children and adolescents. For poorly nourished, frequently ill and other groups of at risk children, parenting interventions promoting mother-infant interactions including psychosocial stimulation should be offered to improve child development outcomes. Such programmes should be delivered preferably within ongoing mother and child health programmes.

Besides treatment, additional psychosocial support should be offered to mothers with depression or with any other mental, neurological or substance use condition including home visiting, psycho-education, improving mothers' knowledge on child rearing practices.

Self-harm and suicide:

Suicide is among the top 20 leading causes of death globally for all ages. Every year, almost 1 million people commit suicide; this is approximately 3 000 deaths a day, or 1 death every 40 seconds. A recent WHO study shows that young people are often at risk, and that suicide is the second largest cause of mortality in the 10-24 age group. Suicide accounts for around 6% of all deaths in young males and young females and it becomes prominent as a cause of death in later adolescence and particularly so in young adulthood. (WHO 2009)

Use of social support (from available informal and/or formal community resources) should be facilitated for persons who volunteer thoughts of self-harm or who are identified as having plans of self-harm in the last month or acts of self-harm in the last year. Restricting access to means of self-harm (such as pesticides, firearms, high places) is recommended. For this purpose, collaboration between health and other relevant sectors should be established and the community should be involved actively to find locally feasible ways to implement interventions at the population level.

At the population level, responsible reporting of suicide-avoiding description of the cases and including information about where to seek help is recommended for the reduction of suicidal behaviours. Media shall be assisted and encouraged to follow the responsible reporting.

Mental disorders are one of the most prominent and treatable causes of suicide.

Determinants of mental health

Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. For example, persistent socio-economic pressures are recognized risks to mental health for individuals

and communities. The clearest evidence is associated with indicators of poverty, including low levels of education.

Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations.

There are also specific psychological and personality factors that make people vulnerable to mental disorders. Lastly, there are some biological causes of mental disorders including genetic factors and imbalances in chemicals in the brain.

Strategies and interventions

Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health.

A climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

National mental health policies should not be solely concerned with mental disorders, but should also recognize and address mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector.
Promoting mental health depends largely on intersectoral strategies. Specific ways to promote mental health include:

- early childhood interventions (e.g. home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations);
- support to children (e.g. skills building programmes, child and youth development programmes);
- socio-economic empowerment of women (e.g. improving access to education and microcredit schemes);
- social support for elderly populations (e.g. befriending initiatives, community and day centres for the aged);
- programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters
- mental health promotional activities in schools
- mental health interventions at work
- housing policies (e.g. housing improvement);
- violence prevention programmes (e.g. community policing initiatives); and
- community development programmes (e.g. 'Communities That Care' initiatives).
  (Key Source: WHO)

Mental Health in India:

1.87 lakh people committed suicide in India in 2010 (TOI, Jun 22, 2012). WHO estimates that about 170 000 deaths by suicide occur in India every year, but few epidemiological studies of suicide have been done in the country, which show that the prevalence of major psychiatric disorder is about the same all over the world. The prevalence range from the 18 to 207 per 1000 with the median 65.4 per 1000; and at any given time, about 2 -3% of the population, suffer from seriously, incapacitating mental disorders or epilepsy. Most of these patients live in rural areas remote from any modern mental health facilities. A large number of adult patients (10.4 - 53%) coming to the general OPD are diagnosed mentally ill. (WB Report 1993).

Four of India's southern states — Tamil Nadu, Andhra Pradesh, Karnakata 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). suicide has become the second-leading cause of death among the young in India. (source: The Lancet)

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%.

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. (TOI, Jun 22, 2012)

Unmet Need

The gross disparity between the number of mentally ill persons and the available treatment facilities and trained professionals is reflected in the large 'treatment gap' in the community.

Information about 'psychosis' at the community level from an all-India perspective is available from the World Health Survey (WHS), which is a unique source.

States	Psychosis		Depression	
	Need (% diagnosed)	Coverage (% treated)	Need (%diagnosed)	Coverage (% treated)
Assam	1.0	39.1	3.2	32.3
Karnataka	0.7	85.2	9.2	13.0
Maharastra	2.2	48.7	27.3	9.6
Rajasthan	3.6	36.2	7.3	29.7
Uttar Pradesh	2.7	45.5	7.4	8.2
West Bengal	1.8	66.5	11.7	17.8

Source: The National Medical Journal of India, Vol 24, No2, 2011

Initiatives in India

a. Enactment of Mental Health Act of 1987 for taking care of Human Rights of Mental patients
b. Keeping a vigil over all Mental hospital, by GoI and Human Rights Commission
c. Creation of a Central Mental Health Authority and a State Mental Health Authority in 25 States/UTs
d. Developing guidelines on minimum standards of care by NIMHANS for uniform execution

The Government of India has launched the National Mental Health Program (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it.

Aims: The program aims at prevention and treatment of mental and neurological disorders and their associated disabilities, use of mental health technology to improve general health services and application of mental health principles in improvement of quality of life.

A District Mental health program was launched in one district each of Rajasthan, Assam, AP and TN based on the community based mental health service model developed by NIMHANS (known as "Bellary Model") which integrates Mental Health with Primary Health Care. Subsequently it as extended to 7 more districts in 1997-98, another 5 districts in 1998-99, 6 districts in 1999-2000, and 2 in 2001-02 with the result that 22 districts in 27 States were operating the Mental Health Program at the end of 2002

Mental health in the Eleventh Five-Year Plan (2007–2013)

Shortage of manpower in the field of mental health, namely, psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses is a major constraint in meeting mental health needs and providing optimal mental health services to people. The existing training infrastructure in India produces about 320 psychiatrists, 50 clinical psychologists, 25 psychiatric social workers and 185 psychiatric nurses per year. Due to the shortage of manpower in mental health, the implementation of the DMHP suffered in the previous plan periods.

Besides completion of spill-over activities of the Tenth Plan and implementation of the existing DMHPs, the new areas identified for support consist of the following:

1. Manpower development-establishment of centres of excellence in the field of mental health.
2. A scheme envisaged for the development of manpower in mental health.
3. modernize state-run mental hospitals plans to integrate the NMHP with the National Rural Health Mission (NRHM)

SIHFW in Action

(1)Trainings/Workshops/Meetings:

S. No.		Title	Total Participants	Sponsoring Agency
1.	**3,4,5,6,7,8 and 10 Sept 2012**	ToT on WIFS (7 batches)	187 (NT/RCHO/MO/Officials from Education dept. and WCD)	NRHM
2.	**4-6,11-13, 25-27 Sept 2012**	Routine Immunization (3 batches)	49 (MO and MO I/C)	RCH
3.	**7 Sept 2012**	Review meeting of NIPI Intervention	10 (BMCH/DMCH)	RCH
4.	**10,11,12, and 13 Sept 2012**	State level Training of Data Entry Operators RMSCL (4 batches)	159 (Computer Operators)	RMSCL
5.	**12 Sept to 20 Nov 2012**	V Batch of Professional Development Course	17 (BCMO, SMO, MO)	NIHFW
6.	**12 Sept to 1 October 2012**	Integrated Foundation Course	31 (Newly recruited MOs)	NRHM
7.	**26-29 Sept 2012**	Orientation Training on SNCU	33 (JS Paed./Nursing Staff)	UNICEF
8.	**28-29 Sept 2012**	Workshop on RCH Programme and Social Marketing	28 (DAC)	UNFPA
9.	**28 Sept 2012**	Workshop of RI MTs	39 (MO/Specialists)	RCH
10.	**17 Sept 2012 to 20 Jan 2013**	LSAS Jaipur, Jodhpur, Bikaner, Udaipur, Ajmer & Kota Medical colleges	14	RCH
11.	**17 Sept to 16 Oct ,2012**	Integrated training for in-service Medical officers at Janana Hospital Jaipur	06	RCH

(2.) Monitoring / Visits:

Workshop on PPP in Social Sector: Dr. Akhilesh Bhargava (Director, SIHFW), Dr Vishal Singh, Ms Indu Chaudhary and Ms Richa Chhabra participated at the workshop. It was organised by ASCI during 24-27 September 2012 at Hyderabad.

Dr. Akhilesh Bhargava (centre sitting) and Dr Vishal Singh, Ms Richa Chhabra, Ms Indu (fourth, first and second from left standing)

Session on Team Building:
Dr Mamta Chauhan delivered a session on Team Building to PDC XI Batch participants at IIHMR, on 11Sept 2012. Interactive exercises were conducted by Dr Mamta Chauhan on- Know your team and Impact of communication in team building, during the session.

CAC ToT:
Dr Richa Chaturvedy monitored Comprehensive Abortion Care ToT held at HFWTC, Jaipur. The training was held during 20 to 22 September 2012.

Colloboration with Fortis Escorts Hospital:
Participants of Foundation course visited Fortis Escorts, Jaipur during 26 to 28 September 2012. They got exposure to latest technology and hospital management practices. Fortis-Escorts has committed for exposure visits and educational sessions for health manpower, under its CSR programme. SIHFW place its gratitude on record.

Capacity Building through CME:
Ms Poonam and Dr. Bhumika Talwar took a session on “Monitoring under NRHM”. It was held on 8 September 2012. They shared their learning of training program they participated in, at NIHFW.

Planned Training/Workshop/Meeting/ Visits

- First visit of PDC V Batch to Panchkula on 1 to 6 October 2012 and second visit to NIHFW, Delhi from 28 October to 1 November 2012.
- Integrated Trainings for Health Workers-With SBA –Jaipur District 1 to 30 October
- Integrated trainings at Jodhpur, Bharatpur, Churu (various plans)
- Integrated EmOC -10 October to 13 February 201213, 2013, at RNT Medical College, Udaipur.
- Integrated Foundation Course of Newly Recruited MOs at Districts-(Jaipur, Ajmer, Jodhpur, Sri Ganganagar) 3 to 11 October 2012
- Integrated Foundation at SIHFW 3 October to 2 November 2012

Other Highlights

Mr Anil's Birthday was celebrated on 17 September 2012. Birthday of Mr Vikas Bharadwaj was celebrated on 26 September 2012.

Blood Donation by SIHFW Staff: Heroes!

Four volunteers of SIHFW staff donated blood at the Swasthya Kalyan Blood Bank on 28 September 2012. The volunteers were Ms Nishanka Chauhan, Mr Vikas Bharadwaj, Mr Ezaj Khan and Mr Hemant Yadav.

The Guest reactions

Principal Secretary Health, Gujarat, Shri P.K. Taneja visited SIHFW on 29 September 2012. He appreciated the remarkable management and functions of SIHFW.

Training Feedbacks:

1. All staff members of SIHFW have a very helping nature-Dr Dinesh Kumar
2. We liked the discipline, management and behaviour of SIHFW staff-Dr Akhilesh Kumar Sharma
3. Quality of residential facilities is very good-Dr Ranjit Singh
4. Overall the facilities and trainings is outstanding-Dr Bhim Chand Meena
5. Trainings are very systematically organised at SIHFW-Dr. Santosh Kumar Sharma
   (Source: Trainees of Integrated Foundation Course-12 September to 1 October 2012)

Health in news

Global

Accelerating progress on child survival

The pace of reducing child deaths has accelerated sharply since 2000, according to new data released today by UNICEF, WHO, the World Bank and the UN Population Division.

An annual report by the UN Inter-agency Group for Child Mortality Estimation (UN-IGME) shows that in 2011, an estimated 6.9 million children died before their fifth birthday, compared to around 12 million in 1990. Rates of child mortality have fallen in all regions of the world in the last two decades – down by at least 50% in eastern Asia, northern Africa, Latin America and the Caribbean, south-eastern Asia and western Asia. And progress is accelerating: between 2000 and 2011, the annual rate of reduction in the global under-five mortality rate jumped to 3.2%, up from 1.8% in 1990-2000. Sub-Saharan Africa, the region with the greatest challenge in child survival, has doubled its rate of reduction, from 1.5% per year in 1990-2010 to 3.1% in 2000-2011.

An estimated 19,000 children died every day in 2011, and 40% in the first month of life, most from preventable causes. The gains in child survival, although significant, are still insufficient to achieve Millennium Development Goal 4 of reducing the global under-five mortality rate by two-thirds between 1990 and 2015.
Sub-Saharan Africa and southern Asia face the greatest challenges in child survival, and currently account for more than 80% of global under-five deaths. Their disparity with other regions is becoming more marked as regions such as eastern Asia and northern Africa have cut child deaths by more than two thirds since 1990. Half of all under-five deaths occurred in five countries: India (24%), Nigeria (11%), Democratic Republic of the Congo (7%), Pakistan (5%) and China (4%). India and Nigeria account for more than a third of all under-five deaths worldwide. Globally, the leading causes of death among children under five are pneumonia (18% of all under-five deaths), preterm birth complications (14%), diarrhoea (11%), complications during birth (9%) and malaria (7%).
Source: http://www.who.int/mediacentre, 13 September 2012

India

Tax-based financing of Universal Health Coverage

The India chief of WHO favoured regulation of private hospitals and tax-based financing of universal health coverage proposed in the 12th Plan.

"The private sector in India is represented by five star hospitals. Their services need to be regulated," WHO's Country Representative Nata Menabde said at a media roundtable organized to discuss World Health Organisation's Country Cooperation Strategy with India over the next five years till 2017. She made it clear that WHO was not a health police but said it was involved in strengthening India's performance as a global leader in health sector.

On the vast unregulated private health delivery sector in India, she said "getting hold of the private health service provisions not regulated for decades is going to be a challenge. Complex strategies are needed to address the issue."

The WHO batted strongly for the adoption of the Clinical Establishment Registration Act passed by Parliament in 2010 but not adopted by the states so far. Only four of the states and UTs have ratified the law which seeks to regulate the high rates charged by private hospitals for different services they offer. Menabde said "over-diagnosis" in private hospitals was a problem and so was "misuse of technology". The WHO India representative asked the government to raise the public financing of health as a percentage of GDP.

"We have supported tax-based financing... The decision is in the hands of the government," she said.
Source: The Economic Times, 13 Sept 2012

Bihar uses internet to make anganwadis work

Integrated Child Development Services (ICDS) is a scheme meant to wipe out hunger, malnutrition and ensure basic education for young children. Under the primary social welfare scheme, many states have anganwadis offering a range of services to pregnant women, young mothers and children in the under-six age group.

In the last few years Bihar was facing many challenges in running its anganwadi centres. Less than half the centres in the state opened daily; and of the children enrolled in them, less than half showed up.

"Only 46 percent anganwadi centres open daily and the presence of children at the centres that open is low. On an average, 24 of 46 children come to a centre," said Social Welfare Minister Parveen Amanullah, citing two surveys, one of which was conducted under the aegis of Britain's Department for International Development. "In view of the poor functioning of the anganwadi centres, the government had decided to initiate several measures to improve them," added the minister. The minister expressed confidence that the functioning of the centres could be substantially improved in just a year's time.

The first step of the government was taking punitive action against officials found lacking in the discharge of their duties. 1,593 anganwadi sevikas (workers, mostly women) were relieved of their charge; three Child Development Project Officers (CDPOs) were dismissed, 35 suspended and 20 others face punishment. Departmental proceedings have also been initiated against some women supervisors and clerks.

In a bid to keep a closer watch on the anganwadi centres, the Social Welfare Department has decided to introduce web-based reporting of their functioning. "By making monthly reports of the centres available online, Bihar has become the first state in the country to implement web-based reporting of the functioning of anganwadis," said Mr. Rajit Punhani, Secretary, Department of Social Welfare.

Mr. Punhani was sanguine that the web-based reporting would also help check corruption. "Details of anganwadi centres, including distribution of take-home ration and presence of children, will be made available online," he said. The department has also introduced the e-dak software that will facilitate instant communication with CDPOs. Punhani said that the web facility already covers 60,603 of the state's 80,000 anganwadi centres.

About 6.5 million children, 2.3 million adolescents and 1.3 million pregnant or lactating women are covered by different programmes offered under ICDS in the state.

Source: http://www.igovernment.in, 24 Sept 2012

Rajasthan

Janani Ambulance Service

Chief Minister, Shri Gehlot, launched Janani Express Service-a referral transport service for pregnant women under the Janani Shishu Suraksha Yojna on October 2, by signaling ambulances at the Jaipuria hospital campus at Jaipur. The beneficiaries of this service will be pregnant women and Newborn (till 30 days)

Health minister Shri A A Khan said, "At least 400 ambulances are being deployed under the Janani Express service in the state with an aim to provide free of cost referral transport facilities to pregnant women for safe deliveries and infants. This will be particularly helpful for women living in remote and distant places in the state."

These ambulances will be deployed between two primary health centers and in remote places which are out of reach even for the 108 services.

The department will also install global positioning system in the ambulances to keep a track on their movement. Also, control rooms at district level have been set up in all the 33 districts.
Source: TOI, 27 September and 3 October 2012

After medicines, free tests

A national conference was held on 'Universal Access to Essential Medicines in India' on 2 October 2012 on the occasion of first anniversary of the CMs free medicine scheme (for free-generic medicine), which was launched on Gandhi Jayanti, last year. The event was organised by Rajasthan Medical Services Corporation.

To mark a year of the scheme, State Health Minister Shri A A Khan announced that the number of free medicines is now being increased from 400 to 600. He added "90% of the diseases are now covered under free medicines and patient admitted in our hospitals don't have to spend even negligible amounts on medicines." On this day, a manual on Standard Treatment was also launched for 9000 doctors of the state. On this occasion, the CM also inaugurated the computerized Drug Distribution centres by clicking the mouse.

Shri Gehlot said that a 52% rise in outdoor patients authenticates the success of the scheme. He added that Seven crore people turned up in government hospitals since the launch of this scheme. The government is now trying to conduct free tests for all in hospitals. Various pathological tests are being considered for this test plan. This will be implemented after a pilot survey.

Source: HT and RP, 3 October 2012

We solicit your feedback:

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