SIHFW Rajasthan

Electronic Newsletter

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From the Director's Desk

Dear Readers

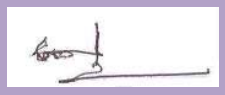
Greetings from SIHFW, Rajasthan!

This year, the state launches RMNCH+A strategy for Healthy Mother and Child. The innovation is a strategic approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH) in India.

The RMNCH+A strategic approach document has been developed to provide an understanding of 'continuum of care' to ensure equal focus on various life stages. Priority interventions for each thematic area have been included in this document to ensure that the linkages between them are contextualized to the same and consecutive life stage. The document also introduces new initiatives.

The document developed by Ministry of Health and Family Welfare, Government of India is to be used constructively at the national, state, district and sub-district levels to improve the condition of women and children and fill in the gaps at various life stages leading to reduced maternal and child mortality and better health for women and children across the country.

Please find the new issue of our e-newsletter with main article based on RMNCH+A strategy.



Director

Inside:

Health Days in June '13

World Environment Day 5 June
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World Blood Donor Day 14 June

RMNCH+ A Strategy

Reproductive and child health strategy is a comprehensive approach linking together a set of initiatives that addresses each stage of life. It is one of the most important steps that the Government of India has taken to fulfill its commitment to improving maternal health and child survival.

In this regard, the RMNCH +A strategy was launched in India in the child survival call to action summit on Feb 8-9th, 2013. The medical health and family welfare department, Rajasthan has also stepped up efforts to launch a Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in Udaipur division. The programme would be launched in entire state but the funding in 10 high focus districts would be 30% more in comparison to other districts. (Source: TOI, 18.5.13)

RMNCH + A Strategy: Services and Interventions

There are two dimensions to healthcare: (1) stages of the life cycle and (2) places where the care is provided. These together constitute the 'Continuum of Care.' This Continuum of Care approach of defining and implementing evidence-based packages of services for different stages of the lifecycle, at various levels in the health system, has been adopted under the national health programme.

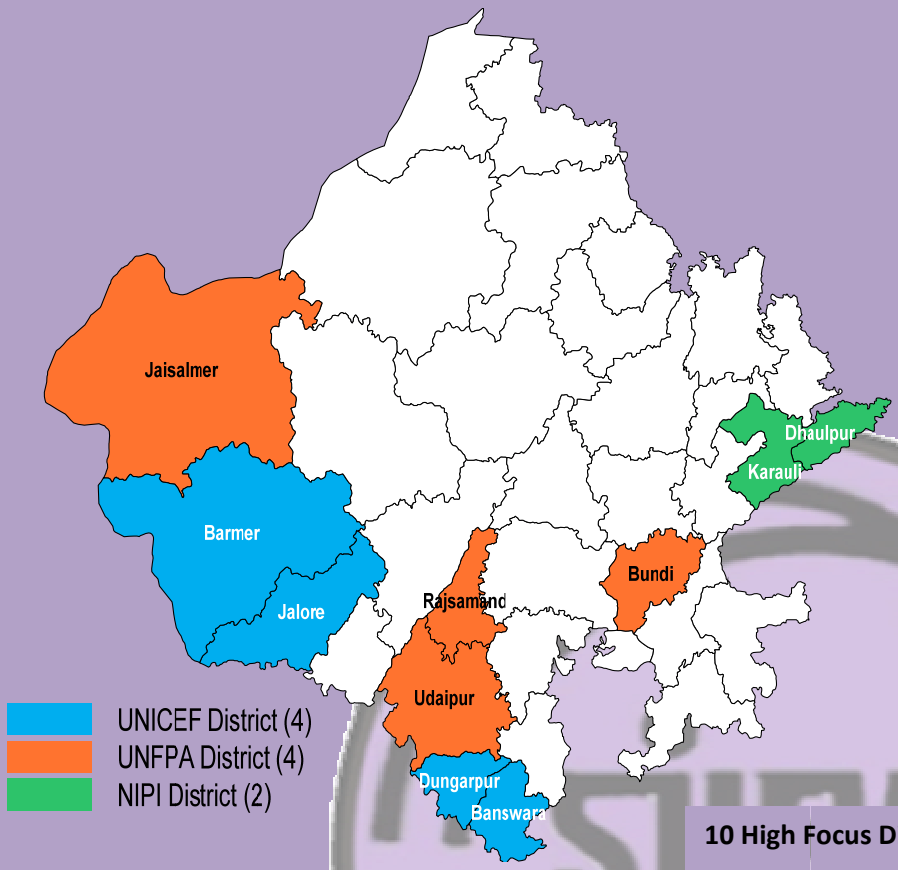
The redifined new strategic approach is called Reproductive, Maternal, Newborn, Child Plus Adolescent Health (RMNCH+A). The 'Plus' in the strategic approach denotes the (1) inclusion of adolescence as a distinct 'life stage' in the overall strategy; (2) linking of maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques (PC&PNDT); and (3) linking of community and facility-based care as well as referrals between various levels of health care system to create a continuous care pathway, and to bring an additive /synergistic effect in terms of overall outcomes and impact.

Coverage targets for key RMNCH+A interventions for 2017

- Increase facilities equipped for perinatal care (designated as 'delivery points') by 100%
- Increase proportion of all births in government and accredited private institutions at annual rate of 5.6 % from the baseline of 61% (SRS 2010)
- Increase proportion of pregnant women receiving antenatal care at annual rate of 6% from the baseline of 53% (CES 2009)
- Increase proportion of mothers and newborns receiving postnatal care at annual rate of 7.5% from the baseline of 45% (CES 2009)
- Increase proportion of deliveries conducted by skilled birth attendants at annual rate of 2% from the baseline of 76% (CES 2009)
- Increase exclusive breast feeding rates at annual rate of 9.6% from the baseline of 36% (CES 2009)
- Reduce prevalence of under-five children who are underweight at annual rate of 5.5% from the baseline of 45% (NFHS 3)
- Increase coverage of three doses of combined diphtheria-tetanus-pertusis (DTP3) (12–23 months) at annual rate of 3.5% from the baseline of 7% (CES 2009)
- Increase ORS use in under-five children with diarrhoea at annual rate of 7.2% from the baseline of 43% (CES 2009)
- Reduce unmet need for family planning methods among eligible couples, married and unmarried, at annual rate of 8.8% from the baseline of 21% (DLHS 3)
- Increase met need for modern family planning methods among eligible couples at annual rate of 4.5% from the baseline of 47% (DLHS 3)
- Reduce anaemia in adolescent girls and boys (15–19 years) at annual rate of 6% from the baseline of 56% and 30%, respectively(NFHS 3)
- Decrease the proportion of total fertility contributed by adolescents (15–19 years) at annual rate of 3.8% per year from the baseline of 16% (NFHS 3)

- Raise child sex ratio in the 0–6 years age group at annual rate of 0.6% per year from the baseline of 914 (Census 2011)

'Reaching the Unreached' in underserved areas in urban slums, tribal areas and vulnerable population including SC, ST, migrants, urban poor and adolescents will be the topmost priority under the RMNCH+A strategic approach. Accordingly 186 high priority districts were selected all over India, of which 10 districts



10 High Focus Districts in Rajasthan

The list of development partners in includes UNFPA – State Lead Partner, UNICEF, NIPI, JHPIEGO, Save the Children, HLFPPT, MSI, and PSI.

In the state consultation meet on RMNCH+A strategy rollout in Rajasthan on May 10, 2013, Smt. Gayatri. A. Rathore (Mission Director, NRHM) stressed on the challenges to be addressed to in the smooth implementation of RMNCH + A in the state. She focused on the Quality of Training, Quality of MCHN services, Use of data at local levels for monitoring and action and Weak Interdepartmental coordination- WCD, PRI.

The major progress made towards the implementation of RMNCH+ A in Rajasthan has been listed below

- State RMNCH+A unit has been formulated
- Meeting of partners conducted and districts distributed amongst partners
  - 4 UNICEF, 4 UNFPA, 2 NIPI
- RMHNC+ A coordinators deployed UNICEF, UNFPA
- Task force constituted at the state level
- Preliminary situation analysis completed.
- Orientation of district officials and detailed evidence based action plan development workshop as part of state launch for C 2 A was held on 23-24 May 2013.

Source: RMNCH+A strategic document

State Consultation on Intensification of Efforts in high priority Districts for Improved Maternal and Child Health

One day State level consultation for intensification of efforts in High Priority Districts for Improved Maternal and Child health was held on 10th May 2013 at Hotel Radisson Blu in Jaipur. The consultation was the first State level consultation after the RMNCH+A strategic framework was initiated by the Ministry of Health and Family Welfare, GoI. The consultation in Rajasthan was jointly organised by the Mohfw,GoI , Dohfw ,GoR, State lead Partner UNFPA ,UNICEF and NIPI.

Senior officials from GoI including Additional Secretary, Ms.Anuradha Gupta, Joint Secretary,Dr. Rakesh Kumar, Deputy Commissioner CH Dr. Ajay Khera , Deputy Commissioner MH Dr.Dinesh Baswal , Deputy Commissioner FP Dr. Sushma Dureja ,Deputy Commissioner Dr.Tejaram and consultant Dr.Deepti Agarwal facilitated the various sessions . From Rajasthan the Honourable Health Minister Shr.A.A.Khan, Principal Health Secretary Mr.Deepak Upreti , Secretary and MD NRHM Ms.Gayatri Rathore ,Director RCH Dr.J.P.Singhal , Director PH Dr. B.R.Meena and Senior State officials participated in the consultation . The District Collectors, Chief Medical Health officers and RCHOs of 10 high priority districts participated in the consultation. From the Development Partners from Delhi, Deputy Representative, UNFPA Mr. Anders Thomsen, Deputy Representative UNICEF Mr. David, Chief of Health Section UNICEF Dr.Genevieve, USAID officials Dr.Karan Sagar and Dr.Rajesh Singh were present in the consultation . From the State representing Development partners were UNFPA State Programme Co-ordinator Mr Sunil Thomas Jacob, UNICEF State Chief Mr.Samuel Mawugnanidze,NIPI Sr.Programme officer Dr.S.P.Yadav apart from other officials from the DPs attended this consultation. Officials from JHPIEGO, HLFPPT, ARTH and Medical Colleges also attended this consultation. Altogether 125 participants attended this day long consultation.

The day long consultation was co-ordinated by UNFPA and anchored by the State Programme Co-ordinator UNFPA. The Principal Health Secretary welcomed the Senior officials from MOHFW and the representatives of the Development partners to the consultation and appreciated the support of GoI and the DPs in partnering with the Government of Rajasthan in achieving the MDGs.

In her address to the delegates, the Additional Secretary and MD NRHM highlighted the following points;

1. Rajasthan as evident from the recent AHS Survey has achieved a good reduction in the MMR and also said that various other surveys have shown that the indicators in Rajasthan are improving.
2. Even in the midst of the positive improvement, there are challenges in the state such as wide inter district variations in terms of MMR, IMR and TFR ; human resource constraints , less functionality of institutions to provide services etc.
3. Quality of Care is an important element for the higher utilisation of the services and priority needs to be given to the same
4. There should be a sharper focus on the reduction on the Maternal and Child Mortality reduction
5. There are differential progress in the indicators in the various districts and so there should be differential programming

6. The high priority districts selected under the RMNCH+A strategy will get 30% additional allocation in the PIP and if this amount is not utilised , then this amount will go back to the NRHM GoI pool and cannot be utilised else where
7. Financial incentives for the human resources in the hard areas in the high priority districts should be encouraged and provided. GoI is ready to bear the costs if the State Government suggests
8. Innovation in service delivery will be encouraged by GoI

9. Rational Distribution of the HR to operationalise the health institutions should be undertaken. In Rajasthan many providers are trained in the area of LSAS (Anaesthesia) and SBA and they are not posted in the right institutions.
10. Lack of capacities in Data analysis is a major factor in not able to measure the progress as incomplete data entry is resulting in the wrong monitoring. The State and District level officials should utilise HMIS data for analysis and monitoring and providing feedback to the officials
11. Leadership at the District level by the District Collector and the CMHO is important in achieving the MDGs and the reduction of MMR, IMR and TFR. The institutional mechanisms like DHS , District level meeting , Block level meeting and sector level meeting should be utilised for critical discussions
12. Functionality of the institutions is critical in providing timely and effective health care delivery services. ASMD highlighted that in Rajasthan only very few sub centres are providing delivery services and it needs to be corrected
13. Continuum of Care was emphasized and said that RMNCH+A strategy is addressing the adolescents also as part of the continuum.
14. ASMD emphasized on three elements to improve the health system : Information , Supplies and Services
15. ASMD the DPs and Government should partner together to achieve the MDGs. In Rajasthan UNFPA is the lead partner and the lead partner will co-ordinate with other DPs to harmonise the inputs to strengthen the effective delivery of services. ASMD said each DP has its strengths. UNFPA has its strengths in Family Planning and Adolescents and will utilise the strengths in RMNCH+A strategies. The lead partner in different states should co-ordinate effectively with the State Government in identifying the needs in the high priority districts and then facilitate focused attention of the Government in these districts to address these needs
16. The one concept that ASMD highlighted was “Time to Care Approach” which focuses on the personalised quality care

The Joint Secretary (RCH) provided an insight on the differential indicators among the districts in the State and gave a brief on the basis of the identification of the high priority districts in the State. Joint Secretary also talked about the institutional mechanism at the Country level and the State level to roll out the RMNCH+A strategy.

Secretary and MD NRHM, provided a brief progress on the RMNCH+A interventions in the State and highlighted the progress in the indicators across the continuum of care. MD also shared about the score card which Department has developed on the basis of the HMIS and Survey based data.

Honourable Health Minister in his address highlighted that the status of the Mother and Child health in the State shows the level of socioeconomic progress that has been achieved by the State. Minister shared the various large schemes that the State has rolled out such as Free Generics Drug scheme , Free investigations scheme , Shubhalakshmi Yojana in making a difference in the lives of the community.

Appreciating the NRHM progress in the State, Hon’ Minister thanked the GoI for their support. Minister declared the constitution of a separate division for the High priority districts to look on priority the filling up of the Human resources, the infrastructural requirements and the service delivery challenges.

Deputy Commissioner Child Health talked in detail about how the score card can be developed on the basis of the 16 dashboard indicators. DC also shared about the Rashtriya Bal swasthya Karyakram and the National IFA plus initiative.

In the afternoon session, UNFPA, UNICEF and NIPI affirmed their commitment to RMNCH+A strategy. Deputy Representative UNFPA in his address to the delegates appreciated the commitment and vision of GoI in framing this RMNCH+A strategic framework and affirmed that UNFPA will put all its efforts as a lead partner in the state to harmonise the efforts of the DPs to catalyse the achievement of the MDGs in reducing MMR and IMR. UNFPA also shared the progress so far in terms of the RMNCH+A update against the timeline decided at the National level meeting. UNICEF shared a brief presentation on the skill upgradation as part of the RMNCH+A strategy.

There was an open forum for discussion which was facilitated by the Joint Secretary RCH of GoI and Principal Secretary Health of Rajasthan.

The significance of World Environment Day

World Environment Day (WED) is observed on June 5 every year to promote awareness on the importance of preserving our biodiversity, the need to identify problems related to the environment and ways to take corrective action. It was on this day in the year 1972 that the United Nations Conference on the Human Environment was formed. First celebrated in 1973, World Environment Day, also popularly known as Environment Day, is a means to tackle environmental challenges that include climate change, global warming, disasters and conflicts, harmful substances, environmental governance, ecosystem management and resource efficiency.

World Environment Day has received tremendous support from the public, non-profit organizations and governments around the world. Various awareness campaigns - beach clean-ups, concerts, exhibits, film festivals, community events and much more - are organized to spread the message, which is to improve the quality of life of all living beings on this planet without harming nature. All the activities of World Environment Day are carried out to spread eco-awareness and increase green footprint.

Each year, World Environment Day is hosted in a different city with a different theme for one week that kicks off on June 5. A World Environment Day theme is selected along with an Environment Day slogan, which aims to emphasize the importance of protecting our planet and promote an understanding that they each individually can play a significant and effective role in tackling environmental issues.

World Blood Donor Day

World Blood Donor Day, celebrated on 14 June every year, serves to raise awareness of the need for safe blood and blood products and to thank voluntary unpaid blood donors for their life-saving gifts of blood. With the slogan "Give the gift of life: donate blood", this year's campaign, the 10th anniversary of World Blood Donor Day, will focus on the value of donated blood to the patient, not only in saving life, but also in helping people live longer and more productive lives.

SIHFW in Action

Trainings/workshops organized:

S. No.	Date	Title	Cadre (Total Participants	Sponsoring Agency
	Trainings at SIHFW			
1.	30 April -2 May, 7-9, 14-16, 21-23, 28-30 May 2013 (5 batches)	Routine Immunization at SIHFW	94 (MOs)	DM&HS
2.	6-8, 9-11 May 2013 (2 batches)	National Cold Chain Management Info System (NCCMIS)	52 (Computer Assistant/RCHO/RM)	DM&HS
3.	May 8-9	RCHO Review Meeting	22 (RCHOs/DPM/BCMO)	DM&HS
4.	13-15, 22-24 May 2013 (2 batches)	Workshop on Change Management under EU-SPP-Irrigation Management & Training Institute	80 (AEN/Director/Joint Director)	Irrigation Department
5.	16 May-14 June 2013	Foundation Course for Newly Recruited Medical Officers	29 (MOs)	RCH
6.	18 May 2013	Workshop on Flagship Scheme MNDY, GoR	160 (DDW/CO/Pharmastic)	RMSCL
7.	28-29 May 2013	Training on DevInfo software& PCTS	PD Immunization./Co.ASHA/Data managers	DMHS
8.	29 May 2013	Workshop on Flourosis	PRI/NGO/Media	District Administration-CMHO Jaipur-II
	Trainings at Districts			
9.	7-8 May and 17-18 June 2013 (2 batches)	RI for Health workers at Jhunjunu	36 (Health workers)	RCH
10.	20 May 19 June 2013	Health workers trainings (With SBA-Plan 4) at Jhunjunu	14 (Health workers)	RCH
	From now onwards, all ASHA trainings in the state will be facilitated by SIHFW.			

Monitoring/Field Visits

PDC Visit to Indore

Participants of PDC VII Batch visited RHFWTC, Indore, MP during May 20-25, 2013. This was an important activity under Professional Development Course going on at SIHFW during 25 April to 3 July 2013. A team of 15 members including PDC participants and SIHFW facilitators visited Indore in this visit.

The purpose of the visit was to know the various innovations of other state governments introduced in the health sector and observation of functioning of the same.

The institutions visited included M Y Hospital, Indore, CHC Sanwar, Dewas, Killor Khurd and Sub Centre Tillor.

During the visit, participants were divided in sub groups of 3-4 participant each group for making observations on specific topic assigned to the group. These topics were – Quality Control and Manpower, Physical Infrastructure and Services available at facilities.
After returning from the visit, each group made presentations on the observations and learning of the Exposure Visit, in a session chaired by Dr Sanjaya Saxena, Registrar-SIHFW, and Dr Mamta Chauhan and Dr Vishal Singh, faculties, SIHFW.

Monitoring visit by Registrar

Dr Sanjaya Saxena, Registrar SIHFW visited Jhunjunu for monitoring of ongoing Integrated Training for Health workers –Plan 4 (with SBA) on 30 May, 2013. Dr Saxena interacted with health workers at PHC Pilani, for post-training Follow-up for RI training for health workers, He did a quick knowledge recall assessment and discussed challenges faced by trained participants in converting leaning to practice.

Celebration

Ms Richa Chabbra's birthday was celebrated on 2 May 2013 at SIHFW.

The Forthcoming

1. Integrated Foundation training of Newly Recruited Medical Officers, 17 June to 16 July 2013.
2. Consultation of Seva Mandir, 13-14 June 2013.

Feedback

1. Method of presentation was liked the most in RI training.
2. Dr. S.S Yadav's session was excellent.
3. Accommodation facility and lectures are best.
4. Trainer's way of explaining any problem related to RI training with good examples, was liked the most.
5. Demonstration of waste disposal management was very well done.
6. Faculty at SIHFW is very good, supportive and also understands the basic problems of doctors faced in community.
7. Training was rated excellent by 86% of participants (RI during 14-16 May 2013.)

(Source: feedback forms from participants)

Health News

Global

WHO's Health Assembly

WHO's Health Assembly opened its 66th Session on 20 May 2013 in Geneva with around 3000 participants from around the world. Major health issues to be discussed include:

- preventing and controlling non-communicable diseases such as diabetes, heart disease, cancers and chronic lung disease;
- monitoring of progress countries are making towards the Millennium Development Goals;
- intensifying efforts to eradicate polio;
- protecting more children from vaccine-preventable diseases;
- supporting countries in their efforts to move forward with universal health coverage.

Health in the post-2015 agenda, WHO's budget for 2014-2015, and progress on the Organization's reform are also on the agenda.

In her opening address to the Health Assembly, WHO Director-General Dr Margaret Chan noted that the world is facing challenging times, including financial crisis, job insecurity, armed conflicts and large numbers of people living on the edge, fearing for their lives."In these troubled times, public health looks more and more like a refuge, a safe harbor of hope that allows, and inspires, all countries to work together for the good of humanity," says Dr Chan.

She also acknowledged the important role of the International Health Regulations for detecting and responding to public health emergencies, including those caused by a new disease.

In addition to the delegates from WHO Member States, representatives from many agencies, organizations, foundations and other groups contributing to improving public health will also be in Geneva to engage in dialogues around key topics at WHO's World Health Assembly.

In a recent survey, about the work of WHO, more than 4 out of 5 key public health stakeholders reported that WHO is either indispensable or important for improving people's health. In addition nearly 90% of these global health participants reported that WHO was the most effective organization at influencing global health policy.

The outcomes of the World Health Assembly are particularly significant this year as the Organization enters a new six-year cycle of health programming as defined in the General Programme of Work. The Health Assembly will also take important decisions on how the Organization continues to move forward reforming itself to be positioned to work effectively in the 21st century health landscape.

Source: www.who.int/mediacentre/news/20.5.13

India

Miles to go in maternal mortality rate

The 2015 deadline for the Millennium Development Goals (MDGs) agreed to by world leaders over a decade ago, is fast approaching. According to the UN 2012 report on the 5th MDG 'Improve maternal Health', "Maternal mortality has nearly halved since 1990, but levels are far removed from the 2015 target."

The Millennium Development Goals (MDGs) agreed to by world leaders over a decade ago have achieved important results. Working together, governments, the United Nations, private sector and civil society across the country have succeeded in saving many lives and improving conditions for many more. "There have been important improvements in maternal health and reduction in maternal deaths, but progress is still slow. Reductions in adolescent childbearing and expansion of contraceptive use have continued, but at a slower pace since 2000 than over the decade before, reads the report.

Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 47%.

The maternal mortality ratio in developing countries is 240 per 100,000 births versus 16 per 100,000 in developed countries. There are large disparities between countries, with few nations having extremely high maternal mortality ratios of 1000 or more per 100,000 live births. There are also large disparities within countries, between people with high and low income and between people living in rural and urban areas.

The risk of maternal mortality is highest for adolescent girls under 15 years old but according to the report, fewer teens are having children in most regions, but progress has slowed. "Complications in pregnancy and childbirth are the leading cause of death among adolescent girls in most developing countries. Maternal health and newborn health are closely linked. More than three million newborn babies die every year, and an additional 2.6 million babies are stillborn," reads the report.

Women in developing countries have on average many more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death - the probability that a 15 year old woman will eventually die from a maternal cause - is 1 in 3800 in developed countries, versus 1 in 150 in developing countries.

"Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for 80% of all maternal deaths are, severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure pregnancy (pre-eclampsia and eclampsia) and unsafe abortion," said former supdt. Zanana Hospital, Dr. Shashi Gupta.

Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth.

99% of all maternal deaths occur in developing countries.

Maternal mortality is higher in women living in rural areas and among poorer communities.

Young adolescents face a higher risk of complications and death as a result of pregnancy than older women.

Skilled care before, during and after childbirth can save the lives of women and newborn babies.

Between 1990 and 2010, maternal mortality worldwide dropped by almost 50%

Source: TOI, 07.05.13

Rajasthan

New programme on health and family welfare department's anvil

The medical health and family welfare department has stepped up efforts to launch a new programme- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in Udaipur division.

The senior health department officials reached Udaipur and held a meeting with the department officials in districts of Udaipur division. Banswara, Chittorgarh, Dungarpur, Rajsamand, Pratapgarh, and Udaipur were discussed in the meeting.

An official said that the department has started its preparations for RMNCH+A, which will be launched in the entire state.

A meeting of all chief medical health officers and block chief medical officers was held to provide all the necessary information on the new programme. The medical directorate officers also visited rural areas in the tribal region of Udaipur division.

"The programme would be launched in entire state but the funding in 10 high focus districts would be 30% more in comparison to other districts," the official said.

The health department is preparing a complete project to make use of the RMNCH+A fully to improve health indicators.
Source: TOI, 18.5.13

Rajasthan Records Highest decline in MMR

The Annual Health Survey (AHS), which was conducted on nine states, shows that Rajasthan has recorded the highest decline in maternal mortality rate (MMR). The survey was released in May.

The survey states that the MMR in Rajasthan declined by 67 points, which is highest among the nine states surveyed. This is a positive sign as state's MMR is usually above the national average.

The report says that the state has shown significant improvement in controlling maternal deaths from financial year 2010-11 to 2011-12. This can be attributed to the state government's flagship schemes implemented in the past two years which proved life saving for the pregnant women.

The medical health and family welfare department also made its contribution, but is yet to achieve the target set by the ministry of health. The department has been directed to reduce the MMR to 150 deaths per 100,000 live births till 2015-17.

The other states included in the survey are Bihar, Jharkhand, Odisha, Rajasthan, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Uttarakhand and Assam.

In Rajasthan, the survey was conducted on 4.46 lakh female population and 1.29 lakh live births in all districts of the state.

In 2011-2012, the MMR in the state reduced to 264 per 100,000 live births. It was 331 per 100,000 live births in 2010-11.

The survey report states that the proportion of maternal deaths declined in the two consecutive years. In 2011-2012, out of 2,264 female deaths, which was taken as a sample, 341 were maternal deaths. While 1,923 females died from non-maternal reasons.

While in 2010-11, out of 2,028 female deaths, there were 430 maternal deaths while 1,598 were non-maternal deaths.

Meanwhile, Uttarakhand recorded the lowest MMR with 162 maternal deaths per 100,000 live births. Assam recorded highest MMR with 347 maternal deaths per 100,000 live births, the survey said.

Source: TOI, 07.05.13

Udaipur division: significant decline in MMR

The districts in Udaipur division have reported a significant decline in the maternal mortality ratio (MMR). Most of these divisions are tribal areas and were placed in the high-focused districts by the medical, health and family welfare department.

According to the Annual Health Survey 2011-12 which was released in the first week of May by the Centre, Udaipur division reported a fall of 79 points in MMR. The MMR in districts in Udaipur division including Rajsamand, Udaipur, Dungarpur, Banswara and Chittorgarh has reduced to 285 per 1,00,000 live births. This was 364 per 1,00,000 live births in 2010-11.

Dungarpur chief medical health officer Kantilal Mochi said, "We are identifying high-risk pregnant women in our district. The high-risk pregnant women are those who are less than 4 feet tall, less than 18 years or more than 33 years. Also, the high-risk pregnant women include those who have already delivered four times."
Besides, the districts in Jaipur division, including Jhunjhunu, Alwar, Dausa, Jaipur and Sikar, reported highest decline in MMR in the state. The MMR was 319 in 2010-11, which reduced to 238 in 2011-12.

Similarly, the districts in Bikaner division reported a decline of 80 points, Kota reported a fall of 82 points but Bharatpur division reported lowest decline of 41 points in MMR.

Annual health survey 2011-12

Division MMR (per 1,00,000 live births)

Bikaner 264 (331)

Jaipur 238 (319)

Bharatpur 251 (292)

Ajmer 293 (338)

Jodhpur 262 (322)

Kota 261 (343)

Udaipur 285 (364)

(Figures of annual health survey 2010-11 given in bracket)

Source: TOI, 07.05.13

Anti-malaria activities well in advance

Nearly 70% of malaria cases are reported in the tribal and desert areas. To curb malaria deaths in state, the medical health and family welfare department has stepped up anti-malaria activities well in advance before the rainy season sets in.

According to the Draft Annual Action Plan 2013-14, A Stephensi, A Culicifacies and Aedes Aegypti are the vectors responsible for causing malaria and dengue.

Health department director (health) Dr BR Meena said, "We have started our anti-malaria activities in tribal areas. Our additional director is camping in Udaipur division and preparing to deal with malaria cases. Also, officials including joint directors and microbiologists are inspecting other districts to ensure there is reduction in cases of malaria and other vector-borne diseases this year. Vector-borne diseases spread during the rainy season, so we have started the preparations well in advance."

"In 2012, the health department successfully decreased the cases of malaria and related deaths," he said.

Since the tribal areas with hilly terrain are not easily accessible, therefore, prevention of diseases becomes challenging. Also, diseases spread quickly in these areas due to low literacy and socio-economic status coupled with cultural taboos and ethnic problems, report says.

"These tribal areas contribute 20-40% of the disease burden. During the last decade, western districts such as Jaisalmer and Barmer reported highest Annual Parasite Incidence (API) and the area was serious cause of concern especially between 2001 to 2003. Breeding of vectors in the household drinking water reservoirs was responsible for persistent endemic in these areas along with the migration and seepages in the India Gandhi Canal as other risk factors in some areas," the report says.

Additional director (rural health) Dr PC Dhindhoria, said, "We are making it sure that chloroquine drug is available at each and every heath centre in Udaipur division for treatment of malaria cases. Also, we have started anti-malaria activities in Udaipur."

Moreover, as Jaisalmer is the largest district of India with lowest population density of about 11 per sq km, the far-flung areas with low population density are the major hindrance in implementation of public health programme in western Rajasthan, the health department claimed.

Source: TOI, 20.5.13

MoU singed for 108 Service

The health department has signed a memorandum of understanding (MoU) with GVK-EMRI (Emergency Management and Research Institute on 23 April 2013 to run 108 ambulance emergency services in the state.

The health department will pay Rs 1.12 lakh to GVK-EMRI per ambulance per month for its operation in the state. There are 464 ambulances, which would be run by GVK-EMRI. However, the state government has plans to add more ambulances to its fleet, as Chief Minister Shri Ashok Gehlot announced in his budget speech 2013-14.

The MoU is for two years and the company would take over the 108 ambulance services from next month. Till then the health department would continue operating it in the state.

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We solicit your feedback:

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