SIHFW Rajasthan

Electronic Newsletter

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From the Director's Desk

Dear Readers

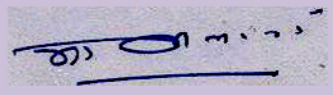
Greetings from SIHFW, Rajasthan!

It has been a long association with SIHFW, now in a different role! I am finding the e-newsletter a medium to communicate with partner agencies, trainees and stake holders.

The International day for the Elderly was on 1st October. For the occasion, we have included a fact sheet in present issue of e-newsletter. Please read more about the training and monitoring related activities being coordinated by our organization, in this issue.

I wish you all a very happy festive season ahead!

We look forward to your feedbacks and suggestions.



Director

Inside:

Health Days in October'13

International Day for the Elderly (UN) 1
Gandhi Jayanti, International Day of Non-Violence 2
World Nature Day 3
World Animal Day 4
World Food Security Day 6
World Wildlife Day 6
World Sight Day 10
World Mental Health Day 10
World Calamity Control Day (UN) 13
World Standard Day 14
World White cane day 15
World Anesthesia Day 16
International Poverty 17
National Solidarity Day 20
United Nations Day 24
International Lead Poisoning Prevention Week of Action 20-26

Welcoming and Farewell

A party was organised at SIHFW on October 9, 2013 to welcome the new Director, SIHFW-Dr M.L. Jain to bid farewell to former director Dr J.P. Singhal.

Welcoming the New Director, SIHFW: Dr M.L Jain

SIHFW Family welcomes our new Director, Dr M.L Jain. Dr. Jain took the position of Director SIHFW on 7 October, 2013.

Dr. Moti Lal Jain is a public health professional having experience of more than 33 years in the area of Public Health, right from grass root level as Medical Officer to state level as Director in the field of Public Health, Hospital Administration, HIV / AIDS and Reproductive and Child Health. He has a progressive track record of successful achievements through building teams, identifying critical gaps through in-depth research and imparting training to various level staff right from ANMs, Medical Officer, Doctors and other district level officers in different field. He has good communication and management skills, which has contributed in achieving various awards by the department where he has worked. He was the key strategic leaders for excelling state of Rajasthan for best performance in country in NRHM in Year 2009-10. During his tenure, he had contributed in highest reduction in Maternal Mortality Ratio and Infant Mortality Rate since last 15 year. He has published many research papers related to maternal health, family planning, epidemiology, child health and disease surveillance.

The team is enthusiastically looking forward to learn more from him for better performance under his leadership and guidance.

Fact Sheet on Ageing

A demographic revolution is underway throughout the world. Today, world-wide, there are around 600 million persons aged 60 years and over; this total will double by 2025 and will reach virtually two billion by 2050 - the vast majority of them in the developing world.

In our fast ageing world, older people will increasingly play a critical role - through volunteer work, transmitting experience and knowledge, helping their families with caring responsibilities and increasing their participation in the paid labour force.

Already now, older persons make major contributions to society. For instance, throughout Africa –and elsewhere - millions of adult AIDS patients are cared for at home by their parents. On their death, orphaned children left behind (currently, 14 million under the age of 15 in African countries alone) are mainly looked after by their grandparents.

It is not only in developing countries that older persons' role in development is critical. In Spain for example, caring for dependent and sick individuals (of all ages) is mostly done by older people (particularly older women); the average number of minutes per day spent in providing such care increases exponentially with the carers' age: 201 minutes if the carer is in the age group 65-74 and 318

minutes if aged 75-84 - compared to only 50 minutes if the carer is in the age group 30-49 (Durán H, Fundación BBVA, 2002).

Such contributions to development can only be ensured if older persons enjoy adequate levels of health, for which appropriate policies need to be in place. In line with the Madrid International Plan of Action, the World Health Organization launched in 2002 a document "Active Ageing - A Policy Framework", outlining its approaches and perspectives for healthy ageing throughout the life course.

Some facts:

- 2 billion people will be aged 60 and older by 2050. This represents both challenges and opportunities.
- Around 4-6% of older persons in high-income countries have experienced some form of maltreatment at home.
- 25-30% of people aged 85 or older have some degree of cognitive decline.
- The world population is rapidly ageing. Between 2000 and 2050, the proportion of the world's population over 60 years will double from about 11% to 22%.
- The absolute number of people aged 60 years and over is expected to increase from 605 million to 2 billion over the same period.
- The number of people aged 80 years or older, for example, will have almost quadrupled to 395 million between 2000 and 2050. There is no historical precedent for a majority of middle-aged and older adults having living parents, as is already the case today. More children will know their grandparents and even their great-grandparents, especially their great-grandmothers. On average, women live six to eight years longer than men.
- It took more than 100 years for the share of France's population aged 65 or older to double from 7 to 14%. In contrast, it will take countries like Brazil and China less than 25 years to reach the same growth.
- Chile, China and the Islamic Republic of Iran will have a greater proportion of older people than the United States of America. The number of older people in Africa will grow from 54 million to 213 million.
- Already, even in the poorest countries the biggest killers are heart disease, stroke and chronic lung disease, while the greatest causes of disability are visual impairment, dementia, hearing loss and osteoarthritis.
- Older people in low- and middle-income countries have around three times the number of years lost to premature death from heart disease, stroke, and chronic lung disease. They also have much higher rates of visual impairment and hearing loss. Many of these problems can be easily and cheaply prevented.
- The number of older people who are no longer able to look after themselves in developing countries is forecast to quadruple by 2050. Many of the very old lose their ability to live independently because of limited mobility, frailty or other physical or mental health problems. Many require long-term care, including home-based nursing, community, residential and hospital-based care.
- Good care is important for promoting older people's health, preventing disease and managing chronic illnesses. Most training for health professionals does not include instruction about specific care for older people. However, health workers will increasingly spend more of their time caring for this section of the population. WHO maintains that all health providers should be trained on ageing issues.
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India Scenario:

- India has the second largest aged population the world.
- Currently there are an estimated 100 million elderly in India by 2050 it is said to reach 326 million (projections made by UN in their 1996 revision).
- 55 million elderly sleep on an empty stomach every night.
- 75% of persons of age 60 and above reside in rural areas.
- 1 out 8 elderly feel no one cares they exist.

- 12 million people in India are blind 70 - 80% of these are elderly. 62.6 % are blind due to cataract.
- 30 million are lonely
- 33 % are below the poverty line and majority of them are illiterate.
- 90 % have to continue to work if they have to survive.
- 6.5 million feel no one even knows they exist.
- Only about 11% of India's workforce participates in any sort of guaranteed retirement income.
- Within the next five years, the number of adults aged 65 & over will outnumber children under the age of 5.
- India is said to be the World Capital for heart diseases.
- It is estimated that by year 2015, nearly 7 lakh elderly in India within the age bracket of 60 – 69 will die of coronary Heart Diseases.
- More than two third of the Oldest Old (80+) are financially dependent on others.

(Source: www.helpageindia.org)

Healthy ageing starts with healthy behaviours in earlier stages of life

These include what we eat, how physically active we are and our levels of exposure to health risks such as those caused by smoking, harmful consumption of alcohol, or exposure to toxic substances. But it is never too late to start: for example, the risk of premature death decreases by 50% if someone gives up smoking between 60 and 75 years of age.

Risk factors

Risk factors that may increase the potential for maltreatment of an older person can be identified at individual, relationship, community, and socio-cultural levels.

Individual

Risks at the individual level include dementia of the victim, and mental disorders and alcohol and substance abuse in the abuser. Other individual-level factors which may increase the risk of abuse include gender of victim and a shared living situation. While older men have the same risk of abuse as women, in some cultures where women have inferior social status, elderly women are at higher risk of neglect through abandonment when they are widowed and their property is seized. Women may also be at higher risk of more persistent and severe forms of abuse and injury.

Relationship

A shared living situation is a risk factor for elder maltreatment. It is not yet clear whether spouses or adult children of older people are more likely to perpetrate abuse. An abuser's dependency on the older person (often financial) also increases the risk of abuse. In some cases, a long history of poor family relationships may worsen as a result of stress and frustration as the older person becomes more dependent. Finally, as more women enter the workforce and have less spare time, caring for older people becomes a greater burden, increasing the risk of abuse.

Community

Social isolation of caregivers and older persons, and the ensuing lack of social support, is a significant risk factor for elder maltreatment by care-givers. Many elderly people are isolated because of physical or mental infirmities, or through the loss of friends and family members.

Socio-cultural

Socio-cultural factors that may affect the risk of elder maltreatment include:

- depiction of older people as frail, weak and dependent;
- erosion of the bonds between generations of a family;
- systems of inheritance and land rights, affecting the distribution of power and material goods within families;
- migration of young couples, leaving elderly parents alone, in societies where older people were traditionally cared for by their offspring;
- lack of funds to pay for care.

Within institutions, maltreatment is more likely to occur where:

- standards for health care, welfare services and care facilities for elder persons are low
- where staff are poorly trained, remunerated, and overworked

- where the physical environment is deficient
- where policies operate in the interests of the institution rather than the residents.

Prevention

Many strategies have been implemented to prevent elder maltreatment and to take action against it and mitigate its consequences. Interventions that have been implemented – mainly in high-income countries – to prevent maltreatment include:

- public and professional awareness campaigns, screening (of potential victims and abusers)
- caregiver support interventions (e.g. stress management, respite care)
- caregiver training on dementia.

Efforts to respond to and prevent further maltreatment include interventions such as:

- screening potential victims
- mandatory reporting of maltreatment to authorities
- adult protective services
- home visitation by police and social workers
- self-help groups
- safe-houses and emergency shelters
- caregiver support interventions.

Multiple sectors can contribute to reducing elder maltreatment, including:

- the social welfare sector (through the provision of legal, financial, and housing support);
- the education sector (through public education and awareness campaigns);
- the health sector (through the detection and treatment of victims by primary health care workers).

In some countries, the health sector has taken a leading role in raising public concern about elder maltreatment, while in others the social welfare sector has taken the lead.

Events at SIHFW

ASHA programme review

ASHA programme under NRHM in Rajasthan was reviewed under chairmanship of Smt. Gayatri Rathode, MD, NRHM on 17 September, 2013 at SIHFW. Dr. Ravikumar Surpur, Additional MD, NRHM also did a briefing on ASHA programme implementation. Director RCH Dr J.P Singhal also clarified key issues related to ASHA activities.

There was a detailed presentation made by Ms. Priyanka Kapoor, Consultant ASHA, DMHS. In the presentation, progress of all districts was reviewed in terms of targets and achievements. District ASHA coordinators, PHC ASHA supervisors and Block ASHA facilitators, SIHFW Faculties and Research Officers were also present at the review.

Importance on Denominator based monitoring for each activity in NRHM interventions. There were issues of delayed payments being made to ASHAs, but there were possible solutions given to the participants. The review meet included a session on ASHA trainings, wherein it was planned that in case of delay in training implementation, trainings are to be organised at Block level. But quality indicators are to be developed and taken care of during training implementation.

Training coordination

Refresher for ASHA facilitators

First batch of Refresher training for ASHA facilitators was held at HFWTC Jaipur during September 23-27 2013. 32 participants including Block Asha facilitators and PHC Asha Supervisors attended the training. Trainers included RCHO Jaipur, DPM Jaipur, DAC Jaipur and BPM Phagi. Similar trainings are in process in each district to strengthen the facilitators' team for ASHA.

Data Collection for SIHFW Study

SIHFW is conducting a study titled 'developing job aids for the frontline workers to strengthen MNCHN services in Rajasthan', supported by Save the Children. Under the study, data has been collected from Dungarpur and Tonk.

The team of researchers include Dr Vishal Singh, Dr Bhumika Talwar, Ms. Poonam yadav, Mr. Ezaz Khan and team members of Save the Children and Coecoedecon.
Data has been collected from AWCs, ANMs, ASHAs, regarding Sector meetings, Knowledge assessment for MCHN days, proper drug distribution, Immunization schedule, timely referral. The study also includes reviewing functioning of Sub-Centres with a checklist in comparison with the PHS standards. Data from Community members such as Pregnant and Lactating women has also been collected.

Monitoring/Field Visits

S.no	Name	Place	Date (September, 2013)	Activity
1	Dr Richa Chaturvedy	Zenana Hospital, Jaipur	09-13	Comprehensive Abortion Care Training
		HFWTC, Jaipur	26-30	Plan 4-Integrated Training for Health Workers with SBA
2	Dr Monisha Sahai	Tonk	09-13	Plan 4-Integrated Training for Health Workers with SBA
3	Ms Parika Pahava	Udaipur - (RNT Medical College)	12-14	FBNC Training
4	Mr. Aseem	Ajmer	11-13	FBNC Training
		Churu	16-20	Plan 4-Integrated Training for Health Workers with SBA

Training Feedbacks

A Life saved: Success story

Smt Manju, LHV, posted at Shoyasar in Sujangarh block of Churu district, was trained in SBA training under Integrated training plan for Health workers, coordinated by SIHFW.

Early morning of 18th September, 2013 has become a special moment in her life since she assisted the delivery of Smt Manju.

The newborn, a boy, was not breathing and his skin turned blue. The newborn did not cry at the time of birth and was in-active (dull). Everybody had thought that the baby died, but then Smt Manju remembered the key words "*Give it a last try…*", that she had learnt during her SBA training under Integrated Training for health workers being coordinated by SIHFW.

The LHV remembered all the steps of using Ambu-bag, she had learned in the training by trainer Sh Bajrang Harshwal, Nursing Teuter, Churu. She continued to assist the newborn breathing with help of the ambu bag. The baby was immediately referred to Salasar, CHC. On the way, use of ambu bag was continued and there were symptoms of improvement in breathing condition of the baby. Oxygen was available at the centre, bay was given further treatment and baby survived. A life saved.

The trained LHV is thankful for the trainers and training coordinators for providing her a good learning environment where she developed, practiced and improved her skills and result was par excellence. The outcome of training resulted as a success story.

As narrated to Mr Aseem, during monitoring visit to Churu district.

Celebration

Birthday of Mr Anil Sharma was celebrated on September 17, 2013 at SIHFW. While, the special day for Mr Ganjendra Singh was celebrated on October 9, 2013.

Health News

India

Toxic inks from tattoos: risk of cancer

Toxic inks from tattoos can permeate into people's bodies and increase the risk of cancer, experts have warned. British scientists have found evidence that nanoparticles from the tattoo inks can get into major organs of the body. Tattoo ink manufacturers acknowledge that 5 per cent of tattoo studios use inks containing carcinogenic compounds, though they are campaigning to reduce it to zero. Desmond Tobin, director of Bradford University's centre for skin sciences, with Colin Grant, a medical engineer at the university, has shown that collagen, the body's connective tissue, is permanently damaged by the dyes, and that nanoparticles of tattoo pigment are transferred away from the skin and into the body.
Tobin believes that toxins in the dyes may be entering the bloodstream and accumulating in the spleen or the kidneys, both organs responsible for filtering impurities from the blood, 'The Sunday Times' reported.
"It takes a long time for the multiple-step nature of cancer to show its face. I don't think we should wait 20 years to see if there is anything wrong with these ingredients," he said.
A study by Jorgen Serup, professor of dermatology at Copenhagen's university hospital, found cancer-causing chemicals in 13 out of 21 commonly used European tattoo inks.
"Millions of Europeans are now being tattooed with chemical substances of unknown origin," said Serup, who has organised the first international conference on tattoo and ink pigment damage, which is taking place in Copenhagen in November. "Until now, no one has really looked at the risks, and we need to get proper research going in this field," he said.
"People should be given written information about the inks that are used on them. It may be that, like cigarette smoking, they still choose to take the risk, but they need to be informed," he said.
According to the website of the Tattoo Ink Manufacturers of Europe group: "Up to 5 per cent of tattoo studios use inks containing carcinogenic aromatic amines. We want to reduce [the presence of these] to zero." The group is campaigning for regulation and legislation to do this, saying EU member states should force producers of tattoo inks to conduct full risk evaluations on their products and to make the results public.
Source: Indian Express, September 22 2013

Rajasthan

Govt-run blood banks to go online

All the government-run blood banks in state will now be connected online from Tuesday, which will be observed as the National Voluntary Blood Donation Day. With this, the health department and blood bank officials will be able to check availability blood of any group at any particular blood bank.

A Rajasthan State Aids Control Society (RSACS) official said, "From October 1, the health department officials and government blood bank officials will have access to the online blood checking facility. While in the next phase, the general public will also be able to check the availability of blood online."
Moreover, the RSACS will also connect private blood banks online soon, the official claimed.

It is often seen that the patients' attendants have to run from one blood bank to another to find matching

blood. But in the next phase, everybody would have access to this facility. Also. it would become easy for the attendants to get blood in emergency situations.

In Rajasthan, there are 88 licensed blood banks operating in different parts of the state. Among them, 44 blood banks are run by state government, four are run by Central government and 40 blood banks are operated by private organizations. Apart from connecting the government-run blood banks online, the health department has set a target to increase the percentage of voluntary blood donation upto 90% by the end of the current financial year.

"There are two kinds of blood donation - voluntary and replacement. In 2011-12, nearly 5.24 lakh units of blood was collected, 70% out of which was voluntarily donated. In 2012-13, voluntary donation increased to 79.29% for a total of 5.21 lakh units of blood," he said. Meanwhile, in the current financial year, the voluntary blood donation in the state is 77.52% for a total of 2.15 lakh units of blood.

"The percentage of voluntary blood donation increases after October. The health department has now directed all the collectors to organize blood donation camps in their respective districts along with other activities to increase the percentage of voluntary blood donation," the official said.
Source: TOI, September 30, 2013

Infant death rate falls by three points in Rajasthan

The infant mortality rate (IMR) in the state has fallen for the second consecutive year, as per the recently released Sample Registration Survey (SRS), 2012. The survey conducted by the Registrar General of India recorded that the IMR has fallen by three points from 52 to 49 per 1000 births.

The figures point at the better facilities for newborns at government hospitals in the state. The health department said that the decline in the IMR is due to more facility based newborn care (FNBC) centres and home-based home based newborn care (HBNC) centres. The Janani Shishu Suraksha Yojna has also proved instrumental in bringing down the IMR in the state.

Medical health and family welfare department secretary and national rural health mission (NRHM) mission director, Rajasthan Gayatri Rathore said, "We are taking it as a challenge to reduce IMR in the state. It is a good sign that IMR has decreased. Various kinds of schemes aimed to save infants have helped in decreasing IMR such as the Janani Shishu Suraksha Yojna, in which focus is on infants' health."

The health department's effort in controlling the IMR though has fallen short of the Centre's expectation. The Centre had given the target of 47 per 1000 live births for 2012 but the health department managed to bring down the IMR to 49. In 2013, the department would have to reduce the IMR to 42 deaths per 1000 live births as per the fresh target.

The Centre has asked the department to improve line listing and follow up cases of babies with low birth weight. It has also directed it to increase the percentage of newborns visited by accredited social health activists (ASHAs).

To promote early and exclusive breastfeeding, the department has been asked to counsel pregnant and expectant mothers at all delivery points. Similarly, there has been a reduction of about 4 points in Neonatal mortality of the state, which is a good sign.
Source: TOI September 16, 2013

We solicit your feedback:

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