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Editorial

Ebola Virus Disease: A Challenge to Health Care Systems

Infectious diseases continue to challenge public health. This is exemplified by the Ebola outbreak which is unfolding rapidly and with unprecedented potential to spread beyond West Africa. Since the detection of Ebola virus in 1976, recorded 13 major epidemics in Africa. The current situation in Guinea, Liberia and Sierra Leone is threatening to turn out into another pandemic. The current Ebola Virus Disease (EVD) was reported in Guinea in December 2013, and since then the virus has been spreading in an unprecedented manner. Already there have been 21,715 cases with 8,635 deaths due to EVD in the world. (21,689 cases & 8,626 deaths in Guinea, Liberia and Sierra Leone only). The outbreaks of Ebola Virus Disease (EVD) in Senegal, Nigeria, Spain, Mali and the United States have ended.

After reviewing the emergency health care systems of the member countries, WHO concluded that Ebola outbreak in West Africa constituted an 'extraordinary event' with public health risks to other States and on 8th August 2014, the WHO declared the Ebola outbreak in West Africa "A Public Health Emergency of International Concern" (PHEIC) under the International Health Regulations (IHR, 2005).

Populations-at-risk include healthcare workers caring for suspected cases and close contacts, such as family members.

Priority intervention should be augmenting surveillance including contact tracing. Countries need to establish laboratory diagnostic capacity; rapid response teams with the capacity to investigate and manage EVD cases and their contacts; and ensure that healthcare workers are aware of and trained in appropriate procedures for universal precautions. Interventions need to be targeted at two levels: i) in health-care settings to ensure isolation of suspected cases, strict adherence to infection control practices, etc.; and ii) in the general population with regard to education of and awareness creation among the community including international travellers and precautions to protect themselves and others.

The evolving EVD outbreak highlights the risk of cases being imported into unaffected countries. With adequate levels of preparation, however, such introductions of the disease can be contained with a rapid and adequate response. The components and tasks for countries preparing their health systems to identify, detect and respond to EVD include: overall coordination, rapid response, public awareness and community engagement, infection prevention and control, case management, safe burials, epidemiological surve-

Toilet For All By 2019, Can India Reach There?

Dr. Purushottam Giri¹, & Dr. Somen Mishra²

¹Professor, Dept. of Community Medicine ²Professor, Dept. Of Ophthalmology, Rural Medical College, Loni, Maharashtra

illiance, contact tracing, laboratory capacity, and capacity building for points of entry. Beyond the focus on priority countries in Africa, significant efforts need to be to strengthen Ebola preparedness. Surveillance and information sharing will have to be increased in the border districts of Guinea-Bissau, Côte d'Ivoire, Mali and Senegal adjacent to the 3 intense-transmission countries.

Assessments in several countries in different parts of the world found that there are still significant gaps and needs related to risk communication, infection prevention and control, laboratory infrastructure, case management and points of entry. There is also a need for standard operating procedures for rapid response teams. Training workshops on risk communication, laboratory testing and biosafety, infection prevention and control, and case management need to be conducted. While urgent steps are being taken to enhance their preparedness and response capacities, the focus must be on containment of outbreak at source, i.e. the four affected West African countries. Coordinated public health actions are essential to stop and reverse the spread of Ebola virus.

Lack of effective antibiotic therapy and vaccine hampers the existing situation. For this reason, there is an absolute necessity to introduce regimes sanitation, quarantine at the suspects and maintain the highest safety measures for emergency responders. Developed procedures require absolute compliance.

The high number of EVD infections in health-care workers (HCWs) continues to be a cause of great concern. A total of 828 health worker infections have been reported in the 3 intense-transmission countries; there have been 499 reported deaths. The incidence of health worker infections has fallen in Liberia and Sierra Leone, but rose in Guinea throughout December. The recent award of Time magazine's traditional '*Person of the Year*' to the Ebola Fighters is testimony to the magnificent work they are doing in the pandemic struck states of West Africa. Justifying the award, Time wrote, '*They risked and persisted, and sacrificed and saved.*' There are many Indian healthcare workers working in Nigeria, Sierra Leone, Guinea and Liberia. India needs to augment its surveillance and response capacities to prevent and control the spread of Ebola to and within its borders.

- Dr Muralidhar Tambe & Dr(Air Cmde) Kevin Fernandez



With a great fanfare Prime the Government of India has launched this programme on 2nd October 2014. Beyond debate, toilet is one of basic necessity of every household.. On the other hand, about 50% on Indian population (around 600 million) have a habit of open defecation. Open defecation causes many public health problems including many water & insect borne diseases which most Indian are not aware of, resulting in stunted growth & poor intelligent quotient (IQ) in young children.

Problem lies elsewhere. First is Indian mindset. Open defecation is a many century old tradition. Water sealed toilet in a western invention was brought to us by British. One recent survey shows that many rich farmers of rural Uttar Pradesh, Haryana & Punjab prefer open defecation in spite of having household one. Many people enjoy morning breeze & openness of nature in the process than that of a closed room. At the same time, multiple government schemes have given incentives to construct household toilets. Another survey shows that money has gone to the corrupt hand without actually constructing real one. Another practical problem for big part of rural India is that majority of households do not have sufficient amount of water for cleaning, forget about flushing the toilet. Dry toilet is still in practice with shameful act of manual scavenging. So, dry toilet can never be the option to eradicate elsewhere. Then what is the answer to this shameful state of public health?

First to construct a real toilet in every household with incentive or vouchers for cement, iron, pan, pipes etc instead of cash. This will bring down the construction cost and will help those who cannot afford the same. Second is to make sufficient water available for flushing. This is a more difficult problem in many dry part of India. Last, but not the least, is to change the mindset of young people. Major community involvement with commitment involving young men & women is a must. They must be the messengers for the rest making it a social movement. It is a very distant dream for India with all its complexity. Let us join hands for that distant & difficult dream, because every reality starts with a dream.



EBOLA VIRUS DISEASE

Dr Muralidhar Tambe¹

¹Professor & Head, Dept. of PSM, SBH Govt. Medical College, Dhule

What is Ebola virus disease?

Ebola virus disease (formerly known as Ebola haemorrhagic fever) is a severe, often fatal illness, with a death rate of up to 90%. EVD is an infection with a virus of the family Filoviridae, genus Ebolavirus. The first Ebolavirus species was discovered in 1976 in what is now the Democratic Republic of the Congo near the Ebola River. Since then, about 24 outbreaks have appeared sporadically mostly in Central African countries. The current outbreak is in West Africa involving countries of Guinea, Liberia, Sierra Leone and Nigeria. The illness affects humans and nonhuman primates (monkeys, gorillas, and chimpanzees).

Magnitude of the problem: Case Load

Countries with Widespread Transmission			
Country	Total Cases	Laboratory-Confirmed Cases	Total Deaths
Guinea	2871	2539	1876
Liberia	8478	3135	3605
Sierra Leone	10340	7903	3145
Sub-Total	21689	13557	8626
Countries with Limited Transmission/ Previously Affected Countries			
Mali	8	7	6
United Kingdom	1	1	0
Nigeria	20	19	8
Senegal	1	1	0
Spain	1	1	0
United States	4	4	1
GrandTotal	21715	13582	8635

The outbreaks of Ebola Virus Disease (EVD) in Senegal, Nigeria, Spain and the United States have ended. A national EVD outbreak is considered to be over when 42 days (double the 21-day incubation period of the Ebola virus) has elapsed since the last patient in isolation became laboratory negative for EVD.

Ebola Virus: The Ebola virus is an RNA virus of Filoviridae family. There are five identified subspecies of Ebolavirus. The present outbreak in West Africa is by the *Zaire ebolavirus* which has a fatality rate ranging from 60 to 90%.

What is the source of infection?: It is transmitted to humans through close contact with the blood secretions, organs or other body fluids of infected animals like chimpanzees, gorillas, monkeys, fruit bats etc. The virus kills gorillas and chimpanzees and other monkeys in such high percentage – they are not likely

to be its natural host. In Africa, fruit bats are considered to be the natural hosts of the Ebola virus.

How do people become infected with the virus?: Transmission of the infection takes place through close contact with the blood, secretions, organs or other bodily fluids of infected animals, chimpanzee, gorilla, fruit bats, monkeys, etc. and spreads in the human population through human-to-human transmission.

A high risk exposure includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or other bodily fluids or secretions (stool, urine, saliva, semen) of EVD patient
- Direct skin contact with, or exposure to blood or body fluids of, an EVD patient without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard bio-safety precautions
- Direct contact with a dead body or soiled clothing, bed linen, or used needles of an Ebola patient without appropriate PPE in a country where an EVD outbreak is occurring *
- In Africa, infection has occurred through the handling of infected chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest.

Close contact is defined as being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (i.e., standard, droplet, and contact precautions. Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact

Household contact with an EVD patient or having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment constitute low risk exposure.

Period of Communicability: As long as the EVD patient is symptomatic, he continues to shed the virus. The ebola virus is recoverable from semen up to 7 weeks after recovery.

Incubation period: 2-21 days after exposure (average is 5-10 days). They are not contagious during the incubation period. If the individual has not developed symptoms, they cannot transmit EVD. **Ebola only spreads when people are sick.** A patient must have symptoms to spread the disease to others.

Who is most at risk?

- Health Care workers: Doctors, nurses, ward boys

- Contacts and family members: in close contact with infected people;
- Mourners: who have direct contact with the bodies of the deceased as part of burial ceremonies.

Signs and Symptoms of Ebola: Typical signs and symptoms include fever (greater than 38.6°C or 101.5°F), severe headache, muscle pain, weakness, sore throat, followed by diarrhoea, vomiting, abdominal (stomach) pain, impaired kidney and liver function & internal and external bleeding.

Case Definitions for EVD:

Suspected (clinical) case: Any person ill or deceased who has or had fever with acute clinical symptoms and signs of hemorrhage, such as bleeding of the gums, nose-bleeds, conjunctival injection, red spots on the body, bloody stools and/or melena or haematemesis with the history of travel to the affected area. Documented prior contact with an EBVD case is not required.

Probable case (with or without bleeding): Any person (living or dead) having had contact with a clinical case of EHF and with a history of acute fever OR Any person (living or dead) with a history of acute fever and three or more of the following Symptoms: headache/ vomiting/nausea/ loss of appetite/ diarrhea/ intense fatigue/ abdominal pain/ general muscular or articular pain/ difficulty in swallowing/ difficulty in breathing/hiccoughs OR Any unexplained death.

Confirmed Case: A probable or suspected case is classified as confirmed when a sample from that person tests positive for EVD in the laboratory.

The distinction between a suspected case and a probable case in practice is relatively unimportant as far as outbreak control is concerned.

Differential Diagnosis for Ebola in India: malaria, typhoid fever, shigellosis, cholera, leptospirosis, plague, rickettsiosis, relapsing fever, meningitis, hepatitis and other viral haemorrhagic fevers.

Laboratory tests for EVD: Enzyme-linked immunosorbent assay (ELISA), Antigen detection tests, Serum neutralization test, Reverse transcriptase polymerase chain reaction (RT-PCR) assay, Electron microscopy, Virus isolation by cell culture. Ebola virus is detected in blood only after the onset of symptoms, usually fever. It may take up to 3 days after symptoms appear for the virus to reach detectable levels.

Packaging & Shipping Clinical Specimens: Blood /Serum is to be transported at 2-8⁰ C within 24 hrs. If delay is anticipated then store Serum at -70⁰C.

Treatment: Early supportive care with rehydration, symptomatic treatment improves survival. There is as yet no licensed treatment proven to neutralise the virus but a range of blood, immunological and drug therapies are under development.

Prevention: Community engagement is key to successfully controlling outbreaks. Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilisation.

While treating, nursing, examination, collection of blood or other body fluids wearing the Personal Protective Devices(PPE) such as head cover, mask or respirator., eye goggles, impermeable gown(If an impermeable gown is not available, then waterproof apron), gloves, puncture and fluid resistant shoes, is a must. While wearing PPE:avoid touching or adjusting PPE; remove gloves if they become torn or damaged; change gloves between patients and perform hand hygiene before putting on new gloves. Use heavy duty/rubber gloves for environmental cleaning and waste management. They should not reuse protective equipment or clothing unless they have been properly disinfected with 1% bleach or phenolic products. Additional barriers (e.g., leg covers, shoe covers) should be used as needed. If reusable heavy-duty gloves are used for cleaning and disinfecting, they should be disinfected and kept in the room or anteroom. Be sure staff are instructed in the proper use of personal protective equipment including safe removal to prevent contaminating themselves or others in the process, and that contaminated equipment is disposed of as regulated medical waste.

The Government of India has increased its surveillance and tracking mechanisms at national and state levels for early detection of cases. International airports have been put on high alert and passengers are being asked about travel to affected countries, with facilities made available for quarantine and isolation of suspected cases. Dr Ram Manohar Lohia Hospital in Delhi has been designated for management of cases arriving in Delhi, while diagnostic facilities are available at NCDC Delhi and National Institute of Virology, Pune. A 24/7 emergency helpline (011-23061468, 23063205, 23061302) is in place.

Vaccine?: There are currently no licensed Ebola vaccines but 2 potential candidates are undergoing evaluation.

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Original Study

OCCUPATIONAL HEALTH HAZARDS OF WOMEN WORKING IN UNORGANISED SECTOR

Vaidya VG, Ray SB, Rajan Beena, Bhathlavande PV, Ubale Smita, Kumbhar Sheetal, Pattar SB, Sawant BS, Mahajan U

Lokmanya Medical Research Centre, Lokmanya Hospital,
Chinchwad, Pune 411039

Almost 400 million people (more than 85 percent of the working populations in India work in unorganized sector and of these at least 120 million are women. This study on Occupational Health Hazards of women working in unorganized sectors primarily from exposure of working environment coupled with the general medical symptom was undertaken by Lokmanya Medical Research Centre 2008-2010 at Pimpri Chinchwad Municipal Corporation. The study highlights on two unorganised sector Brick Kiln and construction site of Pimpri Chinchwad Municipal Corporation concentrating on occupational health hazards of women working in those areas. Gasteck detector pump of model 800 was used to determine gas/ vapours concentration in working place. Health Assessment of 103 working women was examined primarily for exposure. Socio –Demographic questionnaires and Medical questionnaire were used to collect data related to socio demographic and health issues. Databases were developed in CPro and excel and Data analysis was done in SPSS 11.5 In brick kiln & construction industry exposure is mostly of Carbon monoxide & silica dust. Health of the working women (age 18-40) was examined primarily from exposure to working environment coupled with the general medical condition on parameters of ES, WRS & GRS. Minimal safety measures were provided by the organization like protective shoes and goggles only in construction industry.

Out of the 103 women included in the study, 44(43%) were in 18-25yrs followed by 26-30(17%) & 31 to 40 (10%). Most of them (94%) were married. A considerable number 24(23%) of them were using mishri-tobacco.

More than two-third women significantly had more environmental symptoms working in brick kilns than construction industry. Training programmes were conducted to enlighten the workers of the working

environment hazards & required remedial measures with practical demonstration.

The project was supported and catalyzed by RVPSP, Department of Science and Technology, New Delhi.



Media review

Smile Pinki(2008)- A Documentary film

Dr. Harshal Pandve¹, Dr. Kevin Fernandez², VSM

¹Asso Prof & ²Prof & Head, Dept. of Com. Med, Smt. Kashibai
Navale Medical College, Narhe, Pune – 411041

Smile Pinki is a documentary short film directed by Mr.Megan Mylan which narrates the real life story of Pinki Kumari, a small girl who is living with a severe cleft lip in Rampur Dahaba village in Mirzapur, near Varanasi, one of the poorest areas of India. Pinki is not allowed to attend school and ostracized because of her deformity that is cleft lip. Pinki lives a life of quiet desperation as she waits and wonders if she will ever receive the cleft surgery. Her parents could never afford the surgery that she desperately needs. By chance, Pinki's parents meet a social worker one day who is traveling village to village, gathering patients for a hospital that provides free cleft lip surgery to thousands of poor children each year through the "The Smile Train" program.

The film throws light on one of the important health problem of the world that is cleft lip and cleft palate. Many children especially from poor countries suffer tremendous stigma and loose their confidence due to cleft lip which can be easily corrected by plastic surgery. According to Smile Train, more than 4.7 million children in developing countries suffer with unrepaired clefts. Each child could be saved, just like Pinki, with a simple surgery. Over the past 10 years, Smile Train has provided free cleft surgery for hundreds of thousands of children who would otherwise never have received it. The organization is the world's leading cleft charity with thousands of partners and programs in 76 of the world's poorest countries.

This short documentary is a sincere effort to show various issues related to cleft lip and its repair. The documentary has won the 81st Academy Award for Best Documentary (Short Subject).



Unsafe food is linked to the deaths of an estimated 2 million people annually – including many children. Food containing harmful bacteria, viruses, parasites or chemical substances is responsible for more than 200 diseases, ranging from diarrhoea to cancers.

New threats to food safety are constantly emerging. Changes in food production, distribution and consumption; changes to the environment; new and emerging pathogens; antimicrobial resistance - all pose challenges to national food safety systems. Increases in travel and trade enhance the likelihood that contamination can spread internationally.

This year the theme for World Health Day 2015 will be Food Safety, a theme of high relevance to all people on the planet, and multiple stakeholders, including government, civil society, the private sector, and intergovernmental agencies. As our food supply becomes increasingly globalized, the need to strengthen food safety systems in and between all countries is becoming more and more evident. The WHO is promoting efforts to improve food safety, from farm to plate (and everywhere in between) on World Health Day, 7 April 2015.

Safe food underpins but is distinct from food security. Food safety is an area of public health action to protect consumers from the risks of food poisoning and foodborne diseases, acute or chronic. Unsafe food can lead to a range of health problems: diarrhoeal disease, viral disease (the first Ebola cases were linked to contaminated bush meat); reproductive and developmental problems, cancers. Food safety is thus a prerequisite for food security.

New threats to food safety are constantly emerging. Changes in food production, distribution and consumption (i.e. intensive agriculture, globalization of food trade, mass catering and street food); changes to the environment; new and emerging bacteria and toxins; antimicrobial resistance—all increase the risk that food becomes contaminated. Increases in travel and trade enhance the likelihood that contamination can spread.

WHO helps countries prevent, detect and respond to foodborne disease outbreaks - in line with the Codex Alimentarius, a collection of international food standards, guidelines and codes of practice covering all the main foods and processes. Together with the

UN Food and Agriculture Organization (FAO), WHO alerts countries to food safety emergencies through an international information network.

Key facts:

- Access to sufficient amounts of safe and nutritious food is key to sustaining life and promoting good health.
- Unsafe food-containing harmful bacteria, viruses, parasites or chemical substances -causes more than 200 diseases, ranging from diarrhoea to cancers.
- Foodborne and waterborne diarrhoeal diseases kill an estimated 2 million people annually, including many children.
- Food safety, nutrition and food security are inextricably linked. Unsafe food creates a vicious cycle of disease and malnutrition, particularly affecting infants, young children, the elderly and the sick.
- Foodborne diseases impede socioeconomic development by straining health care systems, and harming national economies, tourism and trade.

Food now crosses multiple national borders from where it is produced to where it is consumed. Good collaboration between governments, producers and consumers helps ensure food safety.

Foodborne illnesses are usually infectious or toxic in nature. They can be caused by bacteria, viruses, parasites or chemical substances entering the body through contaminated food or water.

Foodborne pathogens can cause severe diarrhoea or debilitating infections including meningitis. Chemical contamination can lead to acute poisoning or long-term diseases, such as cancer. Foodborne diseases may lead to long-lasting disability or death. Examples of unsafe food include uncooked foods of animal origin, fruits and vegetables contaminated with faeces, and shellfish containing marine biotoxins.

The main causes of foodborne illness are:

- Bacteria
- Viruses
- Parasites
- Prions

- Chemicals (naturally occurring, and man made)

Five keys to safer food:

Food safety is a shared responsibility. It is important to work all along the food production chain – from farmers and manufacturers to vendors and consumers. For example, WHO's Five keys to safer food offer practical guidance to vendors and consumers for handling and preparing food:

- Key 1: Keep clean
- Key 2: Separate raw and cooked food
- Key 3: Cook food thoroughly
- Key 4: Keep food at safe temperatures
- Key 5: Use safe water and raw materials.

World Health Day 2015 is an opportunity to alert people working in different government sectors, farmers, manufacturers, retailers, health practitioners – as well as consumers – about the importance of food safety, and the part each can play in ensuring that everyone can feel confident that the food on their plate is safe to eat.



NEW HEALTH PROGRAMMES TO BE IMPLEMENTED IN NEAR FUTURE

National Programme on Prevention and Control of Viral Hepatitis In India under the 12th Five Year Plan (2012–2017):

The State Finance Commission (SFC) has been approved for the 12th Five Year Plan (2012–2017) with an allocated budget of Rupees 30 crores. Activities include training and capacity building of professionals in relevant sectors, finalization of the prevention, control and treatment guidelines for viral hepatitis, development of IEC for providers and the community, as well as the establishment of baseline data for hepatitis to assess the impact of the programme.

The first meeting of the Expert Working Group was conducted at NCDC Delhi to develop treatment guidelines for various types of viral hepatitis, and to develop strategies for IEC and training modules on various types of hepatitis. "Handbook on Safe Injection Practices on Viral Hepatitis" has been published & released.

National Programme on Containment of Anti-Microbial Resistance under the 12th Five Year Plan (2012–2017):

The State Finance Commission (SFC) has been approved for the 12th Five Year Plan (2012–2017) with an allocated budget of Rupees 30 crores. The activities to be undertaken under this programme include i) Surveillance for containment of antimicrobial resistance in various geographical regions. ii) Rationale use of antibiotics. iii) Development and implementation of national infection control guidelines. iv) Training and capacity building of professionals in relevant sectors. v) IEC for dissemination of information about rational use of antibiotics, and vi) Development of a national repository of bacterial strains/cultures.

A meeting of the Expert Working Group was held during February and March 2014 regarding a common unified national treatment guidelines for different infectious diseases that is in the process of finalization. This could serve as a guide to all the hospitals to formulate their own guidelines.

Programme for Prevention and Control of Leptospirosis:

A Programme for Prevention and Control of Leptospirosis under the 12th Five Year Plan (2012–2017) with a total budget allocation of Rupees 3.753 crores is being implemented in 6 endemic states and Union Territories, viz. Gujarat, Maharashtra, Karnataka, Tamil Nadu, Kerala and Andaman & Nicobar Islands. The main objective of the programme is reduction in morbidity and mortality due to leptospirosis.

National Rabies Control Programme:

The MoHFW has approved the National Rabies Control Programme under the 12th Five Year Plan which includes both human and animal health components with a total allocation of Rupees 50 crores. The objective of the programme is to reduce human deaths due to rabies and to cut down transmission in dogs.

The NCDC is the nodal centre to co-ordinate the implementation of human health components while The Animal Welfare Board of India (AWBI), Ministry of Environment and Forests is the nodal centre to coordinate the implementation of the animal health component.



News Report:

News:

**Celebration of World Diabetes Day
(14th November 2014)**

Organized by the Preventive & Social Medicine Department of
Shree Bhusaheb Hire Government Medical College, Dhule



Inauguration of World Diabetes Day Camp at Urban Health Training Center, Sahjeevan Nagar, Dhule



Random Blood Sugar Examination on World Diabetes Day at Urban Health Training Center, Sahjeevan Nagar, Dhule



Health Examination and Blood Pressure Checking on World Diabetes Day at UHT Center, Sahjeevan Nagar, Dhule

**14th World Congress on Public Health
*Healthy People-Healthy Environment***

February 11-15, 2015, Science City, Kolkata, India

The World Federation of Public Health Associations (WFPHA) is an international, nongovernmental, multi-professional and civil society organization bringing together public health professionals interested and active in safeguarding and promoting the public's health through professional exchange, collaboration, and action.

Founded in 1967, it is the only worldwide professional society representing and serving the broad area of public health, as distinct from single disciplines or occupations. WFPHA has more than 100 Members – national and regional public health associations, regional associations of schools of public health and other organizations committed to the goals of public health sustaining Members.

First held in 1975, the World Congress is organized by the WFPHA in collaboration with national public health association members of the Federation. The Congress is a major international event supported by the World Health Organization(WHO) and several UN Agencies including UNICEF.

The 14 World Congress on Public Health will be a unique event with participants from around the world contributing to create transformative beneficial changes in people's health and well-being.

The theme of the Congress '*Healthy People-Healthy Environment*' offers a perfect springboard for discussion on current public health concerns.

Congress Secretariat:

KW Conferences Pvt Ltd
A 56/12, DLF Phase 1,
Gurgaon – 122002, India
Phone: +91 124 463 6700
Fax: +91 124 410 2075
Email: info@14wcph.org



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