

# Rotary Club of Secunderabad Sunrise . India

July 2022



*Dist. Gov. : Rtn. Rajasekhar Reddy Talla*  
*President : Rtn. Rajhans Banka*  
*Secretary : Rtn. Ranjay Goel*  
*Editor : Rajesh Pamnani*



**Rotary**  
District 3150

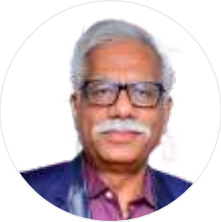




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**Rtn. Sanjay Kabra**



Youth Services  
**Rtn. Praveen Sharma**



Public Image  
**Rtn. Rajesh Pamnani**



Community Service Projects  
**Rtn. Praveen Lunawath**

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Please block your date: 15th August 2022.  
Tree Plantation Drive  
Venue: Various (See message on What's App)  
Time 9.30 am onwards.  
All the Rotarians and Anns are cordially invited.



Cover Page

Supriya Mandal, 14, in class at PACE Universal, a school for girls in Piyali Junction, outside of Kolkata, India, that is funded in part by Rotary clubs and The Rotary Foundation. It was founded by Rotarian Deepa Biswas Willingham both to educate girls and to protect them from slavery, trafficking, and early childhood marriage in a community where these are common dangers for girls. It includes a guarded home where girls who need it can live.



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TOGETHER, WE

# FIGHT HUNGER

Hunger hides in every community. That's why Rotary clubs support programs to provide healthy food and develop sustainable solutions to food insecurity. Fighting hunger to build stronger communities that's what people of action do. **Learn more at [rotary.org/action](https://rotary.org/action).**

Rotary



*PEOPLE OF ACTION*



## EDITOR'S NOTE



*Global problems and solutions concern all of us and are all interlinked.*

How do our food choices affect society?

The food choices we make every day have a big effect on the environment. The good news is that even small changes in what we buy and eat can add up to real environmental benefits, including fewer toxic chemicals, reduced global warming emissions, and preservation of our ocean resources.

We can and must think more deeply about the decisions that we make when shopping, using food to bring about the change needed to guarantee a future for our planet and to help construct a better, cleaner and fairer food system. We can inform ourselves and make choices. Making a choice is the simplest tool, available to all, and also the most powerful. Because when we decide what to put on our table and how, we are also deciding what type of economy to support, what relationships to prioritize, if and how we want to protect natural resources and the environment, if and how we want to defend the rights of workers and indeed our own health. Without forgetting that a food made in an environmentally friendly way, with respect for the dignity of the people who produced it, is also a more delicious and beautiful food.

The consequences of meat culture given the growing concern about the impacts on health, world hunger, animal welfare and the environment of a meat-heavy diet. It comes as no surprise that they also play on the word "revolution," because what we need is a revolutionary change in our eating habits which, not to put too fine a point on it, are currently destroying our planet. We consumers are convinced that we are the last link in the chain and we passively accept whatever the market fobs off on us. The real news is that we are the market and we are the ones who can shape it with our choices.



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## EDITOR'S NOTE

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Choice is our most powerful weapon, let us learn to use it. Only then can we make a contribution to changing the world. There is a need for us not simply to trust the food dogmas imposed by society, but to get to know what we eat, the only way that we can kickstart the revolution. A revolution carried out with love.”

Rtn. Rajesh Pamnani  
Editor (2022-2023).

## Introducing our Editors (2022-2023)



**Ann Seema Jain**

W/o Rtn. Lokesh Jain

Qualification Mcom from Rajasthan university  
& Home maker.

**Ann Mamta Jhawar**

W/o Rtn. Sandeep Jhawar

Qualification B.com Hons in Accountancy from  
Kolkata University, but that was not an end to my  
learning, I aspire to learn something new  
everyday.



**Ann Ritu Gupta**

W/o Rtn. Samir Gupta

BA degree and Masters in Computers, I have  
kept myself engaged professionally in our  
consultancy firm for foreign education -  
providing solutions to students for education  
abroad.

**Ann Beena Ramnarayan**

W/o Rtn. Kappana Ramnarayan

Graduation in commerce from SV University.

I worked with a corporate for a while and had to  
give up my career to be a full time mom.



**Ann Kanak Kabra**

W/o Rtn. Sanjay Kabra

Qualified Company Secretary, Sujok therapist,  
certified Angel Practitioner Executive Director  
(finance, HR and legal compliances) in Avishkar  
Industries Private Limited.

**Ann Lopa Mehta**

W/o Rtn. Vikram Mehta

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person by heart. I enjoy my work and make sure  
to do my best each time.





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deserves our best where we  
get up each day knowing that  
we can make a difference."**



**Jennifer Jones**

**RI President 2022-23**

**TOGETHER WE  
IMAGINE ROTARY**

# About the RCSS President



My dear Rotarians and Anns,

“Together, we see a world where people unite and take action to create lasting change across the globe in our communities, and in ourselves.”

What a fantastic Rotary year we have had! As we strive to create a change as a Rotarian, I congratulate IPP Ravi Ladia and his board along with all the members for making their contributions towards our community through various projects. The dialysis centre at Quthbullapur being a jewel in the crown.

What a great feeling to accept the responsibilities of the club as president and I must admit that I am humbled by the love and affection showered by you all. At the same time, new responsibilities bring in new challenges. We have to move forward towards the various goals that we have set for ourselves in achieving them.

More than a century ago, we pioneered a new model of service leadership grounded in person to person connections. Today, those connections are a network that spans the globe-bridging cultural, linguistic, generational and geographic barriers-and shares the vision of a better world. Taking this vision forward, we are fortunate to have added six new members who were inducted during installation, to our Rotary family. We have already completed one month which is generally installation month for all the clubs. The month of August is dedicated to environment. Let us do our bit for protecting our environment by taking up projects for cleaning up of lakes and other water bodies. Let us also plant trees in our neighbourhoods and make the Mother Earth green. As we celebrate ‘Azaadi Ka Amrit Mahotsav’ marking 75 years of independence from British rule, Our district governor Rotarian Raj Shekhar Reddy has advised to go for tree plantation on the 15th August.

Rotary was founded on fellowship, an ideal that remains a major attraction even today. Club members enjoy the companionship with each other and club projects offer additional opportunities to develop enduring friendships.

So friends, let us take pledge to walk that extra mile together and make this Rotary year a very memorable one.

Thank you.

Rtn. Rajhans Banka  
President (2022-23).



**Rtn Lokesh Jain**



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### Why should you be proud of being a Rotarian?

#### Because we are about to eradicate a disease

We are 99.9 percent of the way toward ending polio. As of early June, there were only 16 cases of wild polio virus in the world, and many think this could be the year we see the last naturally occurring case of polio.

As Rotary and our partners work to eradicate the polio virus in Afghanistan and Pakistan, the remaining endemic countries, we also continue immunization campaigns in other high-risk countries to ensure that the disease remains gone for good.

What can you do? Consider using your network to spread the word and make sure polio stays on the global agenda. Provide a link to [endpolio.org](http://endpolio.org) in your email signature. Follow End Polio Now on Facebook and Twitter and share the story of polio eradication with your social networks. "The fact we are grassroots enables us to have a tremendous amount of influence," says International PolioPlus Chair Michael McGovern.

A close-up photograph of a woman with dark hair, wearing an orange sari, administering a vaccine to a young child. The woman is looking down at the child with a gentle expression. The child is lying back, and the woman is holding a small vial and a needle. The background is bright and out of focus, suggesting an outdoor setting.

TOGETHER, WE

# END POLIO

Rotary believes healthy communities are strong communities. That's one reason we've worked tirelessly to help immunize 2.5 billion children against polio. Bringing the world closer to eradicating a deadly disease that's what people of action do. **Learn more at [rotary.org/action](https://rotary.org/action).**

Rotary



*PEOPLE of ACTION*



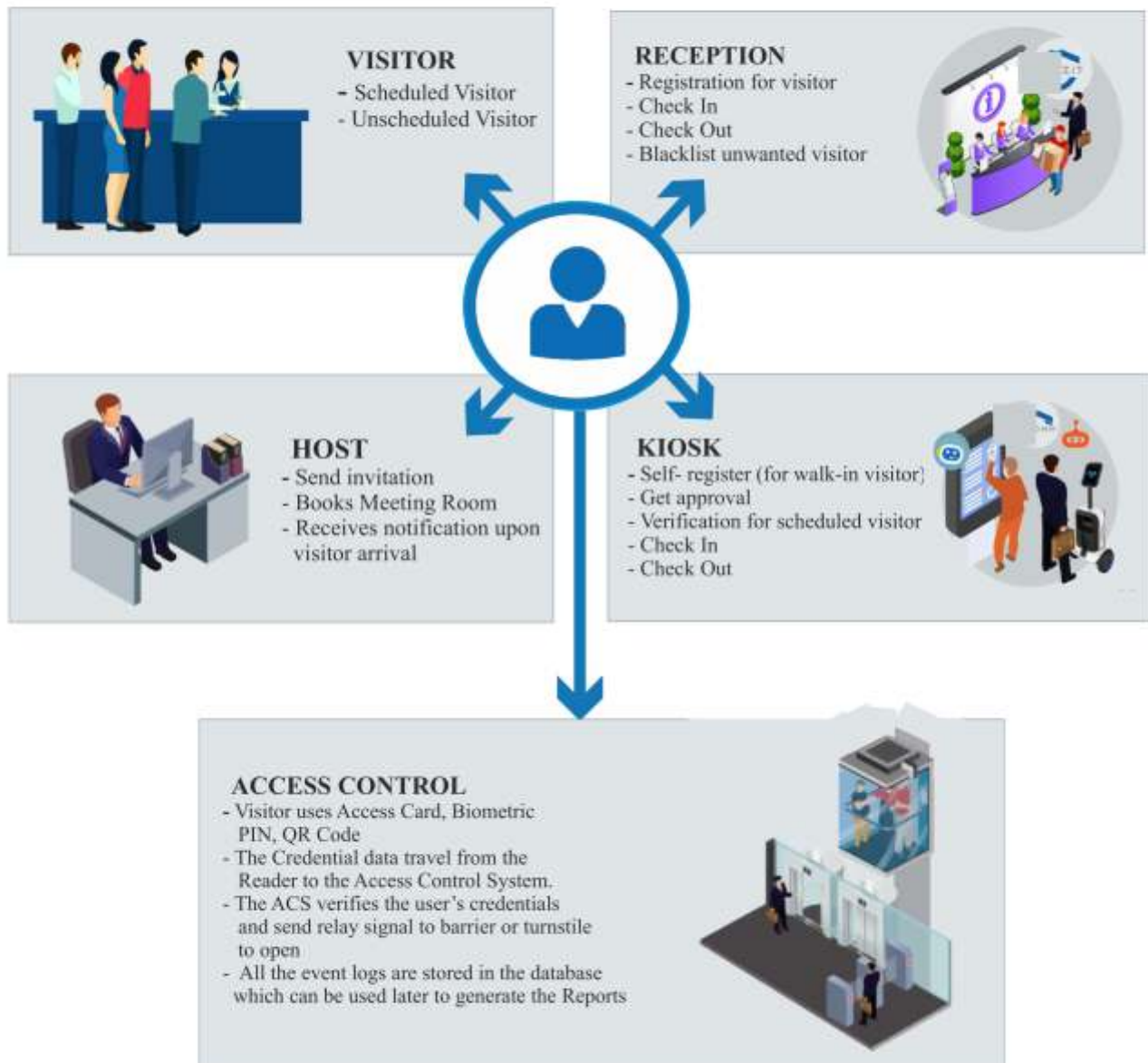
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# VISITOR MANAGEMENT SYSTEM



## BIRTHDAYS & WEDDING ANNIVERSARIES - AUGUST



### BIRTHDAY

01/08 - Rtn. Narender Gauri  
07/08 - Ann. Shilpa Gandhi  
13/08 - Ann. Neha Gupta  
15/08 - Rtn. Lokesh Jain &  
Ann. Seema Jain  
15/08 - Ann. Sonia Notani  
18/08 - Rtn. Vaman Rao  
22/08 - Rtn. Kappana Ram Narayan  
24/08 - Ann. Swathi Munta  
30/08 - Rtn. Vasavi Dhanturi  
30/08 - Rtn. Vinayak Dhumle  
31/08 - Rtn. Tarun Rungta

### ANNIVERSARY

15/08 - Rtn. Dr.L.R.Surender & Ann.LR Surekha  
22/08 - Rtn. Vaman Rao & Ann. Rohini

### PROGRAMME

15/08 - Tree Plantation

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## RCSS 22nd Installation Nite on 16th July 2022



## RCSS Year 2022-23 Board of Director's



## RCSS 22nd Installation Nite on 16th July 2022





RCSS 22nd Installation Nite on 16th July 2022





## RCSS 22nd Installation Nite on 16th July 2022



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## DESIGNATED MONTH



### July – New Leadership Month

- Start of new Rotary officers' year of service.
- Tree Plantation.
- Reduce, Re-Use, Re-Cycle Waste.



**August** - Membership & Extension Month Membership and New Club Development Month, a time to focus on Rotary's continuing need for growth, to seek new members and form new clubs.

- Update your classifications list and circulate amongst members and accordingly fill up the Vacancies.
- Educate members about membership Procedure.
- Induct New Members.
- Invite Retractors to join Rotary.
- Consider inviting Local Personalities to be Inducted as Honorary Members.
- Organise Seminar on Club level & a Public meeting inviting non rotary friends and Rotary Alumni to emphasis Advantages of Joining Rotary.



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# Monkeypox

The virus is spread through close contact with people, animals or material infected with the virus. It enters the body through broken skin, the respiratory tract, the eyes, nose and mouth. Though human-to-human transmission is believed to occur through respiratory droplets as well, that method requires prolonged face-to-face contact because the droplets cannot travel more than a few feet.



## Introduction

Monkeypox is a viral zoonosis (a virus transmitted to humans from animals) with symptoms similar to those seen in the past in smallpox patients, although it is clinically less severe. With the eradication of smallpox in 1980 and subsequent cessation of smallpox vaccination, monkeypox has emerged as the most important orthopoxvirus for public health. Monkeypox primarily occurs in central and west Africa, often in proximity to tropical rainforests, and has been increasingly appearing in urban areas. Animal hosts include a range of rodents and non-human primates.

## The pathogen

Monkeypox virus is an enveloped double-stranded DNA virus that belongs to the Orthopoxvirus genus of the Poxviridae family. There are two distinct genetic clades of the monkeypox virus: the central African (Congo Basin) clade and the west African clade. The Congo Basin clade has historically caused more severe disease and was thought to be more transmissible. The geographical division between the two clades has so far been in Cameroon, the only country where both virus clades have been found.

## Natural host of monkeypox virus

Various animal species have been identified as susceptible to monkeypox virus. This includes rope squirrels, tree squirrels, Gambian pouched rats, dormice, non-human primates and other species. Uncertainty remains on the natural history of monkeypox virus and further studies are needed to identify the exact reservoir(s) and how virus circulation is maintained in nature.

## Outbreaks

Human monkeypox was first identified in humans in 1970 in the Democratic Republic of the Congo in a 9-month-old boy in a region where smallpox had been eliminated in 1968. Since then, most cases have been reported from rural, rainforest regions of the Congo Basin, particularly in the Democratic Republic of the Congo and human cases have increasingly been reported from across central and west Africa.

Since 1970, human cases of monkeypox have been reported in 11 African countries: Benin, Cameroon, the Central African Republic, the Democratic Republic of the Congo, Gabon, Cote d'Ivoire, Liberia, Nigeria, the Republic of the Congo, Sierra Leone and South Sudan. The true burden of monkeypox is not known. For example, in 1996–97, an outbreak was reported in the Democratic Republic of the Congo with a lower case fatality ratio and a higher attack rate than usual. A concurrent outbreak of chickenpox (caused by the varicella virus, which is not an orthopoxvirus) and monkeypox was found, which could explain real or apparent changes in transmission dynamics in this case. Since 2017, Nigeria has experienced a large outbreak, with over 500 suspected cases and over 200 confirmed cases and a case fatality ratio of approximately 3%. Cases continue to be reported until today.

Monkeypox is a disease of global public health importance as it not only affects countries in west and central Africa, but the rest of the world. In 2003, the first monkeypox outbreak outside of Africa was in the United States of America and was linked to contact with infected pet prairie dogs. These pets had been housed with Gambian pouched rats and dormice that had been imported into the country from Ghana. This outbreak led to over 70 cases of monkeypox in the U.S. Monkeypox has also been reported in travelers from Nigeria to Israel in September 2018, to the United Kingdom in September 2018, December 2019, May 2021 and May 2022, to Singapore in May 2019, and to the United States of America in July and November 2021. In May 2022, multiple cases of monkeypox were identified in several non-endemic countries. Studies are currently underway to further understand the epidemiology, sources of infection, and transmission patterns.

## Transmission

Animal-to-human (zoonotic) transmission can occur from direct contact with the blood, bodily fluids, or cutaneous or mucosal lesions of infected animals. In Africa, evidence of monkeypox virus infection has been found in many animals including rope squirrels, tree squirrels, Gambian pouched rats, dormice, different species of monkeys and others. The natural reservoir of monkeypox has not yet been identified, though rodents are the most likely. Eating inadequately cooked meat and other animal products of infected animals is a possible risk factor. People living in or near forested areas may have indirect or low-level exposure to infected animals.

Human-to-human transmission can result from close contact with respiratory secretions, skin lesions of an infected person or recently contaminated objects. Transmission via droplet respiratory particles usually requires prolonged face-to-face contact, which puts health workers, household members and other close contacts of active cases at greater risk. However, the longest documented chain of transmission in a community has risen in recent years from 6 to 9 successive person-to-person infections. This may reflect declining immunity in all communities due to cessation of smallpox vaccination. Transmission can also occur via the placenta from mother to fetus (which can lead to congenital monkeypox) or during close contact during and after birth. While close physical contact is a well-known risk factor for transmission, it is unclear at this time if monkeypox can be transmitted specifically through sexual transmission routes. Studies are needed to better understand this risk.



## Signs and symptoms

The incubation period (interval from infection to onset of symptoms) of monkeypox is usually from 6 to 13 days but can range from 5 to 21 days.

The infection can be divided into two periods:

- the invasion period (lasts between 0–5 days) characterized by fever, intense headache, lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle aches) and intense asthenia (lack of energy). Lymphadenopathy is a distinctive feature of monkeypox compared to other diseases that may initially appear similar (chickenpox, measles, smallpox)
- the skin eruption usually begins within 1–3 days of appearance of fever. The rash tends to be more concentrated on the face and extremities rather than on the trunk. It affects the face (in 95% of cases), and palms of the hands and soles of the feet (in 75% of cases). Also affected are oral mucous membranes (in 70% of cases), genitalia (30%), and conjunctivae (20%), as well as the cornea. The rash evolves sequentially from macules (lesions with a flat base) to papules (slightly raised firm lesions), vesicles (lesions filled with clear fluid), pustules (lesions filled with yellowish fluid), and crusts which dry up and fall off. The number of lesions varies from a few to several thousand. In severe cases, lesions can coalesce until large sections of skin slough off.

Monkeypox is usually a self-limited disease with the symptoms lasting from 2 to 4 weeks. Severe cases occur more commonly among children and are related to the extent of virus exposure, patient health status and nature of complications. Underlying immune deficiencies may lead to worse outcomes. Although vaccination against smallpox was protective in the past, today persons younger than 40 to 50 years of age (depending on the country) may be more susceptible to monkeypox due to cessation of smallpox vaccination campaigns globally after eradication of the disease. Complications of monkeypox can include secondary infections, bronchopneumonia, sepsis, encephalitis, and infection of the cornea with ensuing loss of vision. The extent to which asymptomatic infection may occur is unknown.

The case fatality ratio of monkeypox has historically ranged from 0 to 11 % in the general population and has been higher among young children. In recent times, the case fatality ratio has been around 3–6%.

## Diagnosis

The clinical differential diagnosis that must be considered includes other rash illnesses, such as chickenpox, measles, bacterial skin infections, scabies, syphilis, and medication-associated allergies. Lymphadenopathy during the prodromal stage of illness can be a clinical feature to distinguish monkeypox from chickenpox or smallpox.

If monkeypox is suspected, health workers should collect an appropriate sample and have it transported safely to a laboratory with appropriate capability. Confirmation of monkeypox depends on the type and quality of the specimen and the type of laboratory test. Thus, specimens should be packaged and shipped in accordance with national and international requirements. Polymerase chain reaction (PCR) is the preferred laboratory test given its accuracy and sensitivity. For this, optimal diagnostic samples for monkeypox are from skin lesions – the roof or fluid from vesicles and pustules, and dry crusts. Where feasible, biopsy is an option. Lesion samples must be stored in a dry, sterile tube (no viral transport media) and kept cold. PCR blood tests are usually inconclusive because of the short duration of viremia relative to the timing of specimen collection after symptoms begin and should not be routinely collected from patients.

As orthopoxviruses are serologically cross-reactive, antigen and antibody detection methods do not provide monkeypox-specific confirmation. Serology and antigen detection methods are therefore not recommended for diagnosis or case investigation where resources are limited. Additionally, recent or remote vaccination with a vaccinia-based vaccine (e.g. anyone vaccinated before smallpox eradication, or more recently vaccinated due to higher risk such as orthopoxvirus laboratory personnel) might lead to false positive results.

In order to interpret test results, it is critical that patient information be provided with the specimens including: a) date of onset of fever, b) date of onset of rash, c) date of specimen collection, d) current status of the individual (stage of rash), and e) age.

## **Therapeutics**

Clinical care for monkeypox should be fully optimized to alleviate symptoms, manage complications and prevent long-term sequelae. Patients should be offered fluids and food to maintain adequate nutritional status. Secondary bacterial infections should be treated as indicated. An antiviral agent known as tecovirimat that was developed for smallpox was licensed by the European Medicines Agency (EMA) for monkeypox in 2022 based on data in animal and human studies. It is not yet widely available.

If used for patient care, tecovirimat should ideally be monitored in a clinical research context with prospective data collection.

## **Vaccination**

Vaccination against smallpox was demonstrated through several observational studies to be about 85% effective in preventing monkeypox. Thus, prior smallpox vaccination may result in milder illness. Evidence of prior vaccination against smallpox can usually be found as a scar on the upper arm. At the present time, the original (first-generation) smallpox vaccines are no longer available to the general public. Some laboratory personnel or health workers may have received a more recent smallpox vaccine to protect them in the event of exposure to orthopoxviruses in the workplace. A still newer vaccine based on a modified attenuated vaccinia virus (Ankara strain) was approved for the prevention of monkeypox in 2019. This is a two-dose vaccine for which availability remains limited. Smallpox and monkeypox vaccines are developed in formulations based on the vaccinia virus due to cross-protection afforded for the immune response to orthopoxviruses.

## **Prevention**

Raising awareness of risk factors and educating people about the measures they can take to reduce exposure to the virus is the main prevention strategy for monkeypox. Scientific studies are now underway to assess the feasibility and appropriateness of vaccination for the prevention and control of monkeypox. Some countries have, or are developing, policies to offer vaccine to persons who may be at risk such as laboratory personnel, rapid response teams and health workers.

## **Reducing the risk of human-to-human transmission**

Surveillance and rapid identification of new cases is critical for outbreak containment. During human monkeypox outbreaks, close contact with infected persons is the most significant risk factor for monkeypox virus infection. Health workers and household members are at a greater risk of infection. Health workers caring for patients with suspected or confirmed monkeypox virus infection, or handling specimens from them, should implement standard infection control precautions. If possible, persons previously vaccinated against smallpox should be selected to care for the patient.

Samples taken from people and animals with suspected monkeypox virus infection should be handled by trained staff working in suitably equipped laboratories. Patient specimens must be safely prepared for transport with triple packaging in accordance with WHO guidance for transport of infectious substances.

The identification in May 2022 of clusters of monkeypox cases in several non-endemic countries with no direct travel links to an endemic area is atypical. Further investigations are underway to determine the likely source of infection and limit further onward spread. As the source of this outbreak is being investigated, it is important to look at all possible modes of transmission in order to safeguard public health.

### **Reducing the risk of zoonotic transmission**

Over time, most human infections have resulted from a primary, animal-to-human transmission. Unprotected contact with wild animals, especially those that are sick or dead, including their meat, blood and other parts must be avoided. Additionally, all foods containing animal meat or parts must be thoroughly cooked before eating.

### **Preventing monkeypox through restrictions on animal trade**

Some countries have put in place regulations restricting importation of rodents and non-human primates. Captive animals that are potentially infected with monkeypox should be isolated from other animals and placed into immediate quarantine. Any animals that might have come into contact with an infected animal should be quarantined, handled with standard precautions and observed for monkeypox symptoms for 30 days.

### **How monkeypox relates to smallpox**

The clinical presentation of monkeypox resembles that of smallpox, a related orthopoxvirus infection which has been eradicated. Smallpox was more easily transmitted and more often fatal as about 30% of patients died. The last case of naturally acquired smallpox occurred in 1977, and in 1980 smallpox was declared to have been eradicated worldwide after a global campaign of vaccination and containment. It has been 40 or more years since all countries ceased routine smallpox vaccination with vaccinia-based vaccines. As vaccination also protected against monkeypox in west and central Africa, unvaccinated populations are now also more susceptible to monkeypox virus infection.

Whereas smallpox no longer occurs naturally, the global health sector remains vigilant in the event it could reappear through natural mechanisms, laboratory accident or deliberate release. To ensure global preparedness in the event of reemergence of smallpox, newer vaccines, diagnostics and antiviral agents are being developed. These may also now prove useful for prevention and control of monkeypox.

### **WHO response**

WHO supports Member States with surveillance, preparedness and outbreak response activities for monkeypox in affected countries.



## Recovering from monkeypox at home

If you think you might have monkeypox, self-isolate and contact a health worker immediately. If they advise that you isolate at home, keep in touch with them and seek immediate advice if your rash becomes more painful, shows signs of being infected (such as fever, redness or pus), if your fever, nausea or vomiting get worse, if you are unable to eat or drink, have difficulty breathing or if you feel dizzy or confused.

### How to take care of yourself if recovering at home:



Keep hydrated, eat well and get enough sleep. Use medication for pain and fever if needed.



#### Take care of your rash:



Don't scratch



Clean your hands before and after touching lesions.



Keep your rash dry and uncovered



Keep rash clean with sterilised water/antiseptic



Rinse lesions in your mouth with salt water



Take warm baths with baking soda/Epsom salt



Use paracetamol to manage the discomfort of lesions, if needed

#### Take care of your mental health:



Do things you find relaxing/enjoyable



Stay connected



Exercise if you feel well enough and can do so while isolating



Ask for support if needed

### How to protect others if you are isolating at home:

**Avoid contact with anyone** until all of your lesions have scabbed over, fallen off and a fresh layer of skin has formed. Ask friends or family to deliver supplies.

#### If you live with other people:



Isolate in a separate room



Use a separate bathroom, or clean and disinfect (with household disinfectant) after each use



Clean hands frequently using soap and water or an alcohol-based hand sanitizer



Clean and disinfect frequently touched surfaces and objects with soap and water and household disinfectant



Avoid sweeping and vacuuming



Use separate dishes, cups, bedding, towels and electronics such as phones



Do your own laundry. Put everything in a plastic bag before carrying it to the washing machine. Use soap and water > 60 degrees.



Open windows

#### If you can't avoid being in the same room as someone else:



Cover rash with clothing/bandages



Avoid touching each other



Wear well-fitting medical masks



Open windows



Clean hands often

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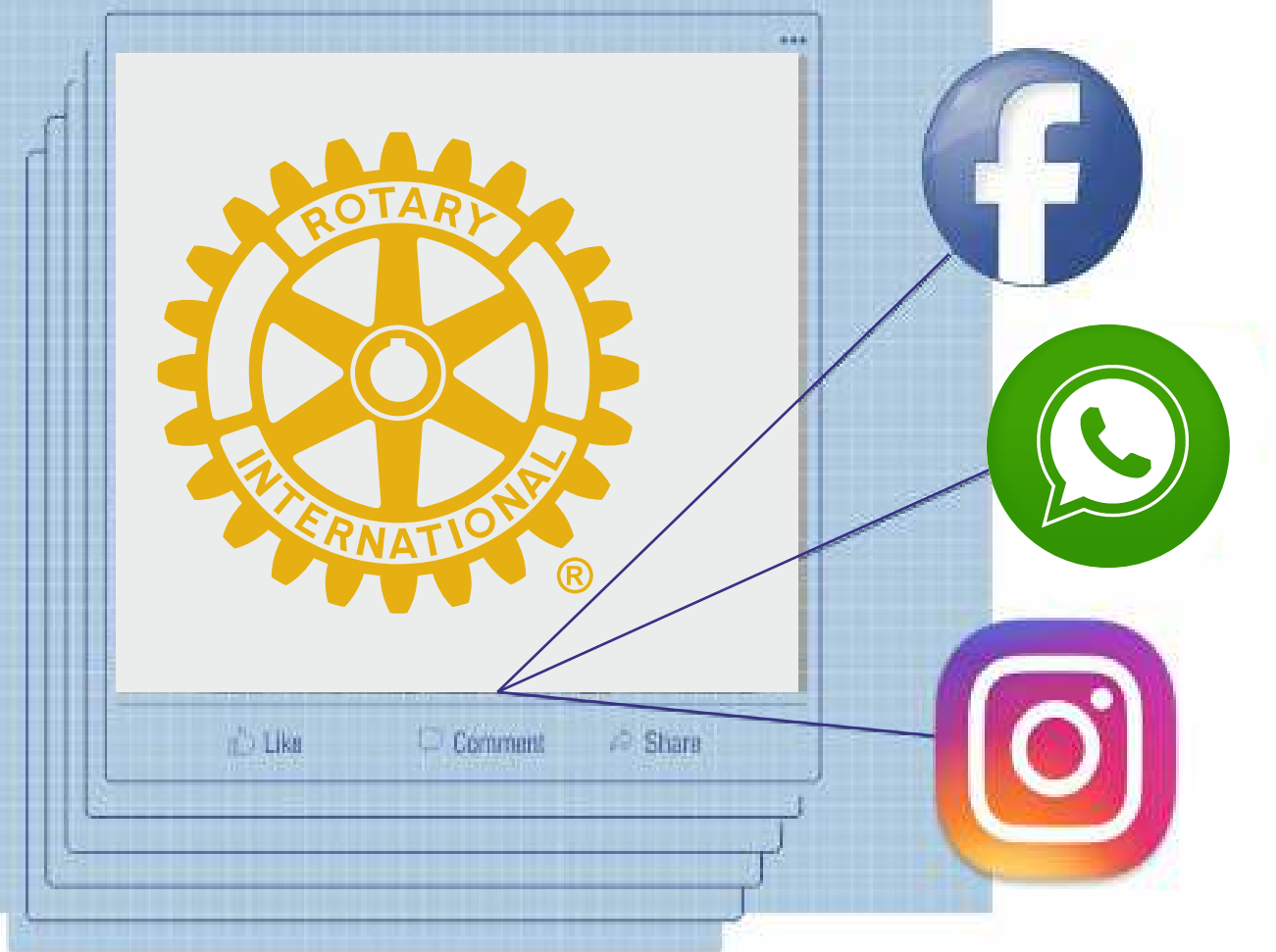
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