

SIHFW Rajasthan

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From the Director's Desk

Dear Readers

Greetings from SIHFW, Rajasthan!



This issue of newsletter focuses on Vaccination. National Vaccination Day is observed on 16 March every year. Vaccination is the process of administering weakened or dead pathogens to a healthy person or animal, with the intent of conferring immunity against a targeted form of a related disease agent.

In common speech, 'vaccination' and 'immunization' generally have the same colloquial meaning. Vaccination efforts have been met with some resistance since its inception.

Widespread acceptance and mass vaccination campaigns are greatly reducing the incidence of many diseases in many areas of the world.

This month, India celebrates first anniversary of being removed from the list of polio-endemic countries.

Every child in the country should still be vaccinated against the crippling illness, as well as other dangerous childhood maladies.

Vaccination is important for a child for a healthy life. We have the potential to bring about a huge change and individual efforts in the health sector will together make a big impact and help save lives of children.

Director

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- Vaccination:
- SIHFW in Action
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Health Days in March '13

International Day for Ear and Hearing 3 March

International Women's Day 8 March

World Consumer Day 15 March

National Vaccination Day 16 March

National Disabled Day 19 March

World Water Day 22 March

World Tuberculosis Day 24 March

Vaccination

Vaccination is the administration of antigenic material to stimulate an individual's immune system to develop adaptive immunity to a pathogen. Vaccines can prevent or ameliorate morbidity from infection. Vaccination is the most effective method of preventing infectious diseases; widespread immunity due to vaccination is largely responsible for the worldwide eradication of smallpox and the restriction of diseases such as polio, measles, and tetanus from much of the world.

Terms of 'vaccination' and 'immunization' have a similar meaning. This distinguishes it from inoculation, which uses un-weakened live pathogens, the process of artificial induction of immunity, in an effort to protect against infectious disease, works by 'priming' the immune system with an 'immunogen'. Stimulating immune responses with an infectious agent is known as immunization. Vaccination includes various ways of administering immunogens. Stimulating immune responses with an infectious agent is known as immunization.

Vaccine

A vaccine is a biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease-causing microorganism, and is often made from weakened or killed forms of the microbe or its toxins. Vaccines may also contain preservatives to prevent contamination with bacteria or fungi.

Vaccines typically contain one or more **adjuvants**, (is a pharmacological or immunological agent that modifies the effect of other agents, such as a drug or vaccine) used to boost the immune response. Tetanus toxoid, for instance, is usually adsorbed onto **alum** the antigen produce a greater action than the simple aqueous tetanus toxoid.

Types of Vaccines

Attenuated vaccines -Live, attenuated vaccines contain a version of the living microbe that has been weakened in the lab so it can't cause disease. Because a live, attenuated vaccine is the closest thing to a natural infection, these vaccines are good "teachers" of the immune system: They elicit strong cellular and antibody responses and often confer lifelong immunity with only one or two doses. Vaccines for measles, mumps, and chickenpox, are made by this method.

Inactivated Vaccines-Scientists produce inactivated vaccines by killing the disease-causing microbe with chemicals, heat, or radiation. Such vaccines are more stable and safer than live vaccines: The dead microbes can't mutate back to their disease-causing state. Inactivated vaccines usually don't require refrigeration, and they can be easily stored and transported in a freeze-dried form, which makes them accessible to people in developing countries.

Subunit Vaccines-Instead of the entire microbe, subunit vaccines includes only the antigens that best stimulate the immune system. In some cases, these vaccines use epitopes—the very specific parts of the antigen that antibodies or T cells recognize and bind to.

Toxoid Vaccines-For bacteria that secrete toxins, or harmful chemicals, a toxoid vaccine might be the answer. These vaccines are used when a bacterial toxin is the main cause of illness.

Vaccination Schedule

A **vaccination schedule** is a series of vaccinations, including the timing of all doses, which may be either recommended or compulsory, depending on the country of residence. Many vaccines require multiple doses for maximum effectiveness, either to produce sufficient initial immune response or to boost response that fades over time. For example, tetanus vaccine boosters are often recommended every 10 years. Vaccine schedule are different in different countries. Vaccination schedule in india are as follows.

National Immunization Program Recommended By Government Of India

Age	Vaccine#	Route of Administration	Dose	Disease Protected Against
Birth	BCG	Intradermal	0.1ml	Tuberculosis (severe Form)
	OPV (Dose at birth)	Oral	2 drops	Poliomyelitis
	Hepatitis-B	I/M	0.5ml	Hepatitis-B(Jaundice)
6 weeks	DTP (1st Dose)	IM	0.5ml	Diphtheria, Tetanus, Pertussis (Whooping Cough)
	OPV (1st dose)	Oral	2 drops	Poliomyelitis
	BCG (if not given earlier)	Intradermal	0.1ml	Tuberculosis(severe Form)
	Hepatitis-B	I/M	0.5ml	Hepatitis-B(Jaundice)
10 weeks	DTP (2ndDose)	IM	0.5ml	Diphtheria, Tetanus, Pertussis
	OPV (2nd Dose)	Oral	2 drops	Poliomyelitis
	Hepatitis-B	I/M	0.5ml	Hepatitis-B(Jaundice)
14 weeks	DTP (3rdDose)	IM	0.5ml	Diphtheria, Tetanus, Pertussis
	OPV (3rd Dose)	Oral	2 drops	Poliomyelitis
	Hepatitis-B	I/M	0.5ml	Hepatitis-B(Jaundice)
9 months	Measles	SC	0.5ml	Measles
16-24 months	DTP	IM	0.5ml	Diphtheria, Tetanus, Pertussis
	OPV	Oral	2 drops	Poliomyelitis
5-6 years	DT*	IM	0.5ml	Diphtheria, Tetanus
10 years	TT**	IM	0.5ml	Tetanus
16 years	TT	IM	0.5ml	Tetanus
Pregnancy	TT***	IM	0.5ml	Tetanus

Each vaccination is given as a single injection into the muscle of the anterolateral aspect of the thigh or upper arm. Two injections should never be mixed but can be given at two different sites at the same time at a minimum distance of one inch.

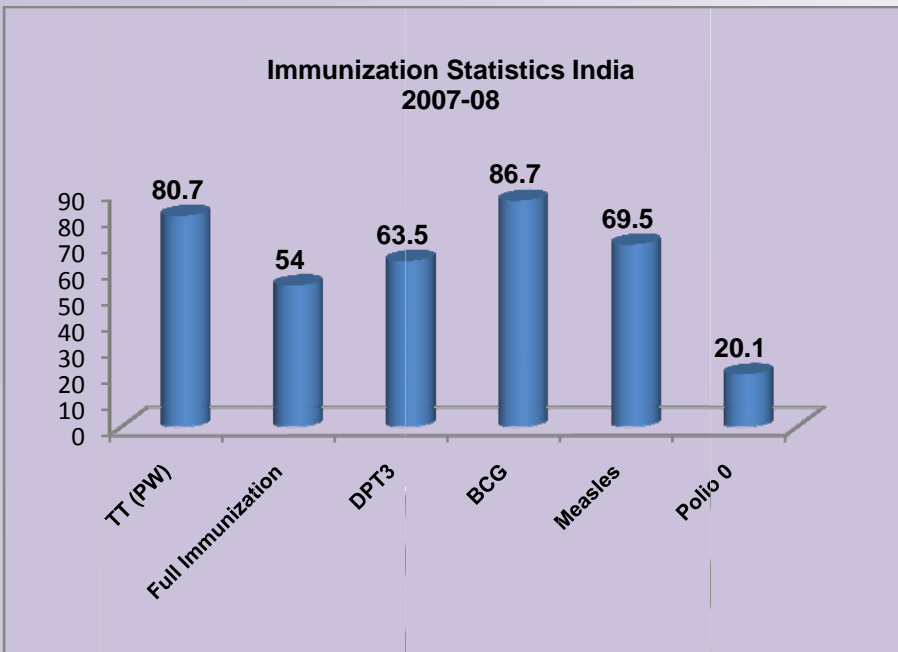
- * A second dose of DT vaccine should be given at an interval of one month if there is no clear history or documented evidence of previous immunization with DTP.
- ** A second dose of TT vaccine should be given at an interval of one month if there is no clear history or documented evidence of previous immunization with DT or TT vaccines.
- *** Tetanus toxoid is given during pregnancy. If there is no prior history of vaccination, 2 doses are administered, the first as early as possible when pregnancy is detected, the second dose one month later. If there is confirmed documentary evidence of proper and complete immunisation during childhood, then a single booster dose is administered in the 2nd trimester.

For patients with HIV infection, refer to vaccination for HIV infected persons.

Rajasthan Statistics & India

	Total	Rural	Urban
Children age 12-23 months who have received BCG %	90.6	89.3	95.1
Children age 12-23 months who have received 3 dose of Polio Vaccine %	78.1	76.4	84.0
Children age 12-23 months who have received 3 dose of DPT Vaccine %	77.0	75.1	83.7
Children age 12-23 months who have received measles Vaccine %	81.8	80.3	87.3
Children age 12-23 months Fully Immunized %	70.8	69.0	77.3

Source-AHS 2010-11



Source-CBHI 2009

Immunization

Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease.

Benefits of Immunization

Immunization is essential to prevent severe diseases like Diphtheria, Polio, Hepatitis B, whooping cough, Tetanus, and meningitis to mention but a few.

- Protecting from diseases, death and disability
- The immune system cannot be weakened by the disease
- The rates of death and complications are much lower than with the disease
- If overall immunization levels are high enough, epidemics can be prevented - protecting the community as well as the individual

Risk of Immunization

- Common to most vaccines are 'local reactions' of redness at the injection site and sometimes swelling as well
- Mild fever

SIHFW in Action**Trainings/workshops organized:**

1.	5-7 Feb, 12-14 Feb, 19-21 Feb 2013(3 batches)	Routine Immunization at SIHFW	49	DM&HS
2.	4-8 Feb, 18-22 Feb 2013 (2 batches)	Training on Malaria for Medical Officers at SIHFW	44	RCH
3.	11-13 Feb 2013	Training on Dengue for Medical Officers at SIHFW	21	DM&HS
4.	15 Feb 2013	State Level ToT for RI Training for Frontline Workers	55	WHO
5.	18 Feb 2013	Training on MIS under National Blindness Control Program	50	NRHM
6.	18 Feb-19 March 2013	Integrated Foundation for Newly recruited Medical Officer	29 (MOs)	NRHM
7.	Feb 19 2013	State Level Workshop on Menstrual Hygiene Program	42	ARSH Component
8.	29 Jan- 5 March 2013	Integrated training of In-service MOs at SP Medical College and Hospital, Bikaner	7	RCH
		Integrated Training with SBA (Plan-4)		
9.	1 Feb – 3 March 2013	Sikar	16	RCH
10.	7 Feb 2013	Udaipur	16	RCH
11.	15 Feb-17 March 2013	Karauli	16	RCH
12.	27 Feb -28 March 2013	Bharatpur	16	RCH
13.	27 Feb -5 April 2013	Pali	16	RCH
		Integrated Training with-out SBA (Plan-4)		
14.	4-18 Feb 2013	Tonk	19	RCH
15.	4-18 Feb 2013	Dausa	30	RCH
16.	8 Feb 2013	Udaipur	25	RCH
17.	28 Feb 2013	Bharatpur	28	RCH
18.	15-16 Feb 2013	RI for Health workers at Jhunjunu	21	RCH
19.	27 Feb – 2 March 2013	FBNC training at JLN Medical College and Hospital, Ajmer	23	RCH

Monitoring/Field Visits**Monitoring of Integrated Training**

Training	Monitor	District	Date
In service Medical Officers	Ms. Archana Saxena	Bikaner, Nagaur	21-23 Feb
FBNC Training	Ms. Archana Saxena	Ajmer	9-Feb
Integrated Foundation	Ms Richa Chhabra	Jodhpur	4-5 Feb
Integrated Foundation	Mr Hemant Yadav	Bikaner	4-5 Feb
Integrated Training with SBA	Mr Hemant Yadav	Sikar	6-Feb
RCH Work	Mr. Ankur Asudani	Churu	4-7 Feb
Integrated Foundation	Ms. Archana Saxena	Jaipur-Zanana Hospital	4-5 Feb
Integrated Foundation	Mr. Ejaz Khan	Udaipur	4-5 Feb
Health Worker With SBA		Chittorgarh	6-Feb
Integrated Foundation	Dr. Richa Chaturvedy	Udaipur	4-8 Feb
With & without SBA	Ms Nirmala Peter	Bharatpur	4-8 Feb
In service Medical Officers	Ms. Archana Saxena	Jaipur-Gangori Hospital	16-Feb

Co-ordination Visit for Integrated Training

Agenda	Representative	District	Date
Implementation of Integrated Training	Ms Richa Chhabra	Bhilwara	25 Feb -1 March
		Chittorgarh	
		Rajsamand	
	Mr. Anil	Pratapgarh	25 Feb -1 March
		Banswara	
	Mr Hemant/ Ejaz	Alwar	26 Feb -1 March
		Bharatpur	
		Dholpur	
		Karauli	
	Mr. Vikas	Dausa	28 Feb
	Ms. Divya	Ajmer	28 Feb
	Ms. Aditi Sharma	Bundi	28 Feb-1 March
	Ms Bhumika	Kota	
Mr Ravi ji	Jhalawar		
	Baran		

Training On Health Systems Research at National Institute of health and Family Welfare (NIHFW), New Delhi

Dr Mamta Chauhan (Faculty, SIHFW) and Dr Bhumika Talwar of SIHFW were trained in Health Systems Research at NIHFW. It was a 6 day training programme held during 18 to 23 February 2013.



Dr Bhumika Talwar (Fourth from left, standing) and Dr Mamta Chauhan (Fifth from left, standing) at NIHFW.

Research Study on COTPA at Jaipur

According to Global Adult Tobacco Survey (GATS) India Report 2009-10, Rajasthan has 32.3% of Adult current tobacco users (28.4 % Daily Users & 3.9% Occasional users) and Percentage of Male and Female age 15 and above are 50.5% and 12.9% respectively. The use of smokeless tobacco in Rajasthan is 28.7% against 32.9% in India. In order to know the Compliance of COTPA act in a Public Place in Jaipur city the study is being conducted by SIHFW Jaipur along with the Union of South East Asia Office International Union Against Tuberculosis and Lung Disease.

Study are includes three wards of Jaipur city- Moti Dungari, Hawa Mahal East and Mansarover from the total of 7 wards given by Municipal Co-operartion . The sample size is 494 at the estimated compliance of 50 % ,CI 95 % and 5 % marginal error.

The major objective of the study is to assess the current level of compliance to section 4 of COTPA in Jaipur city & assess the preparedness of Jaipur city for declaring it as a smoke free city. Individual surveys have been done at sites such as Hotels, Restaurants and places where food and drink can be purchased (including surrounding open spaces containing refreshment rooms, banquet halls, discotheques, canteens, coffee houses, pubs, bars and airport lounges),Workplaces, Shopping malls, Markets ,Cinema Halls, Educational Institutions and Libraries ,Hospitals ,Auditoriums, open auditoriums, amusement centers, stadiums, Railway stations, bus stops, etc. Data analysis is in progress at SIHFW.

The Forthcoming

1. Integrated Training for In-service MOs at Kota from 4 March 2013 and Udaipur from 13 March 2013.
2. Integrated Training for Health workers (with SBA) at Bikaner from 4 March 2013, Rajsamand and Pratapgarh from 1-30 March 2013.
3. Integrated Training for Health workers (without SBA) at Banswara from 2-16 March, Sirohi from 5-17 March, Tonk from 1-15 March, Dausa, Nagaur and Chittorgarh from 4-18 March 2013.
4. RI for Health workers at District level at Jhunjunu from 2-3 March, at Rajsamand 1-2, 5-6 March 2013.
5. RI at SIHFW from 5-7 March 2013.
6. FBNC training at Ajmer from 5-8 March 2013.
7. Workshop on 'Ground Water Scenario of Jaipur Urban Area' organised by Central Ground Water Board, Western Region, Jaipur at SIHFW on 6 March 2013.
8. Training of Malaria for Medical Officers at SIHFW during 4-8 March 2013. Board
9. Training of Blood Storage Unit at Dausa from 2-6 March 2013.

Feedback

1. More than half (56%) of the participants rated overall sessions to be excellent, and almost other half (44%) said it was good. (Training on RI for MOs at SIHFW)
2. An excerpt: ...the way the trainer taught us our small-small mistakes and the way of teaching...is liked most. This training is very useful for monitoring and supervision of RI at session site.
3. More than two third (75%) of participants rated the training as good and 25% aid it to be Excellent. (Training on Malaria for MOs)
4. Environment of SIHFW is excellent (Training on Dengue for MOs)

Health in News

Global

Millions having hearing loss

More than 360 million people in the world have disabling hearing loss, according to new global estimates on prevalence released by the WHO, for International Ear Care Day (3 March).

As the population ages globally, more people than ever before are facing hearing loss. One in three persons over the age of 65 years – a total of 165 million people worldwide – lives with hearing loss. Although hearing loss from ageing can often be helped with hearing devices, there are not enough produced to meet the need.

“Current production of hearing aids meets less than 10% of global need. In developing countries, fewer than one out of 40 people who need a hearing aid have one.” says Dr Shelly Chadha of the WHO's Department of Prevention of Blindness and Deafness. “WHO is exploring technology transfer as a way to promote access to hearing aids in developing countries.”

Another 32 million affected by hearing loss are children under age of 15. Infections of the ear are the leading cause of the disability, especially in low- and middle-income countries. Prevalence of disabling hearing loss is highest in South Asia, Asia Pacific and sub-Saharan Africa, according to the latest WHO review of available studies.

Infectious diseases such as rubella, meningitis, measles, mumps can lead to hearing loss. Most of these diseases can be prevented through vaccination. Other common causes include exposure to excessive noise, injuries to the ear or head, ageing, genetic causes, problems during pregnancy and childbirth (such as cytomegalovirus infection or syphilis) and the use of medications that can damage hearing.

“About half of all cases of hearing loss are easily preventable while many can be treated through early diagnosis and suitable interventions such as surgically implanted hearing devices. Individuals with hearing loss can also benefit from sign language training and social support.”

WHO encourages countries to develop programmes for preventing hearing loss within their primary health care systems including vaccinating children against measles, meningitis, mumps and rubella, screening and treating syphilis in pregnant women, and early assessment and management of hearing loss in babies.

Source: www/who/health news, 27 February 2013

India

Healthcare Spending from International aid for Health

International aid for health may be in billions of dollars, but it is a fraction of what most recipient country governments spend on healthcare for their people. For instance, the \$775 million that India got as development assistance in health (DAH) in 2010, though not a small amount by any measure, was just 1.6% of what the both centre and state governments put together spent on public health.

India received the highest amount as DAH in absolute terms, the fact that it was a fraction of what the government spent is significant considering that government spending on health is itself a mere 32% of the total health expenditure in India, the remaining 68% coming out of people's own pockets. Hence, out of the total expenditure on health in India in 2010, foreign aid was a mere 1.6%. Moreover, in per capita terms, foreign aid for health to India was among the lowest in the world, a mere 63 cents per person annually.

In 2010, while the total global DAH was \$28.2 billion, the government's health expenditure of the countries receiving the DAH was more than 18 times higher at \$521 billion. Thus, international aid was just 5.4% of the total spending on health by governments of recipient countries.

This was revealed in a recent report titled "Financing Global Health 2012: The End of the Golden Age?" brought out by the Institute for Health Metrics and Evaluation, University of Washington. This is IHME's fourth annual report on global health expenditure between 1990 and 2010.

DAH includes both financial and in-kind contributions for activities aimed at improving health in low- and middle-income countries. This includes financial DAH from bilateral development agencies including the World Bank (IDA and IBRD), Asian Development Bank (ADB), African Development Bank, Inter-American Development Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and the Bill and Melinda Gates Foundation (BMGF).

Countries receiving largest aid- top 20	Country
Foreign aid (in million US dollar 2010)	Foreign aid per capita (in US dollar)
India 775	0.6
Tanzania 722	16
Ethiopia 704	8.2
Nigeria 699	4.4
Kenya 615	15
South Africa 589	11.6
Mozambique 449	19.1
Uganda 432	12.8
Congo, DR 346	5.1
Rwanda 305	29.6
Afghanistan 285	9.8
Zambia 285	21.4
Turkey 268	3.5
Pakistan 261	1.4
Vietnam 252	2.8
Bangladesh 251	1.5
Indonesia 245	1
China 239	0.2
Colombia 222	4.8
Ghana 214	8.7

(Source: Report of Institute for Health Metrics and Evaluation, University of Washington)

For most countries receiving DAH, it constituted less than 10% of total spending by governments. This was true across most of South America, North Africa, and Asia. Governments in East Asia- primarily China - disbursed the most on health, at \$159.6 billion in 2010.

South Asia, which accounts for one-fifth of the world's population, shows the least government expenditure on health, a mere \$22 billion. Barring Sri Lanka and India, in all other South Asian countries, foreign aid for health accounts for over 10% of public health expenditure. Pakistan and Bangladesh received about \$1.5 per capita from global health funds or a total DAH of \$261 million and \$251 million respectively. In China, the DAH per capita is less than 20 cents.

However, in certain countries in Asia and Western and Southern Africa, global health funds given to governments of countries amounted to more than half of total government health expenditure. The report warned against the reliance of these health systems on DAH in light of the decreasing level of DAH for governments from 2008 to 2010.

Over time, global development funds for health have flowed increasingly to NGOs. In 1995, DAH was mainly distributed to governments; NGOs received approximately \$30 million, 2.4% of the total global health funds earmarked to be given to either governments or NGOs. By 2010, DAH for NGOs made up 65.3% of that total, with DAH funding for NGOs over that year amounting to more than \$7.8 billion, which is \$3.7 billion higher than DAH to governments in the same year.

Source: TOI, 25 February 2013

Exercise can improve brain health

Exercise doesn't only strengthen your heart and muscles - it also helps increase brain power, say researchers.

Dozens of studies now show that aerobic exercise can increase the size of critical brain structures and improve cognition in children and older adults, according to University of Illinois psychology professor Art Kramer, a nationally recognized expert on the role of physical fitness on cognition.

"Populations throughout the industrialized world are becoming increasingly sedentary as a result of the changing nature of work and leisure activities. As a result of these societal changes, increases in diseases such as hypertension, diabetes, osteoporosis and some cancers are increasing. Physical activity serves to reduce susceptibility to these diseases," Kramer said.

"Increased physical activity also has direct, and relatively rapid effects on cognition and brain health," he added.

He noted that such results have been reported, over the course of several decades, in animal studies of physical activity.

Studies in humans, many conducted in Kramer's lab, also showed that regular exercise, such as walking three times per week, also increases brain power.

Kramer will present research from his own lab and others that demonstrates that older adults who participate in fitness training and physical activity benefit from significant improvements in their brain structure and function.

Kramer will discuss these brain-changing outcomes at a session of the 2013 meeting of the American Association for the Advancement of Science in Boston on Feb. 16.

Source: TOI: 25 Feb 2013

Rajasthan

Rural public health usage goes up

The general impression is that the public health system is not popular with the public and hence under-utilised. The good news is that there is a significant increase in the utilisation of government facilities in rural areas between 2004 and 2011, which could be the result of enhanced spending and improvement of services through the National Rural Health Mission (NRHM).

A study of five states has shown that over half of those who sought outpatient treatment (54%) and almost half (48%) of those who sought hospitalised care depended on public facilities.

The bad news is that the total medical expenses for outpatient care and hospitalised care has gone up substantially, by about 70% and 20% respectively, after adjusting for inflation in 2004-11.

The study was conducted by NGO Prayas, along with other similar organisations working on access to healthcare, to assess the out-of-pocket (OOP) expenditure (spending by people from their own resources) in rural areas of five states - Assam, Jharkhand, Rajasthan, Tamil Nadu and Uttarakhand. The data collection design and sampling was done in a manner similar to that of the National Sample Survey Organisation (NSSO) so that the results of this study could be compared with the results of the national survey conducted in 2004.

While the utilisation of public health facilities shows an improvement overall, there are huge variations between states. For instance, the proportion of people using public facilities has fallen sharply in

Jharkhand from 13% to 6% and has shot up in Assam from 27% to 86% and in Uttarakhand from 18% to 66%. Rajasthan and Tamil Nadu show marginal improvement.

Dr T Sundararaman, executive director of the National Health System Resource Centre says the increase in utilisation rates only shows the extent of collapse of the public system earlier. "It was so bad that any increase in investment was bound to show results. However, the current investment is insufficient to overcome the complete collapse which had happened, especially in some of the states, like Rajasthan and Jharkhand," says Dr Sundararaman.

Interestingly, among social groups, it is upper castes or the 'general' population that makes maximum use of the public health system (66%), followed by scheduled tribes, 55%. It seems to be a case of highest usage by those who know how to work the system, mostly the upper castes. The poorest, the STs, are on the other hand forced to take the cheapest option, public health, no matter how well it delivers.

Among SCs and OBCs, less than half of those who availed outpatient treatment used public facilities. For instance, in Jharkhand where just over 6% of those surveyed used public health facilities, the maximum use was by the general population, 17%. Again, in Tamil Nadu, though the majority (70%) preferred to use the private sector, the general category showed the highest use of the public system (46%). However, in Rajasthan, there is least use of the government facilities by the general population, just 39%.

Incidentally, out of the total expense on outpatient care, about a third (32%) is on medicines. In the case of hospitalised care, expenses on medicines constituted 41% of the total. This proportion was the highest in Rajasthan, where medicines constituted 57% of the total expense on outpatient care and lowest in Uttarakhand (22%). In cases of hospitalisation, the cost of medicines accounted for 53% of the bill in Uttaranchal, and 48% in Rajasthan. It was lowest in Tamil Nadu (16%). Tamil Nadu happens to have the most efficient system for procuring medicines in bulk and distributing them free of cost through the public health system.

The study also showed that the poorer you are the lesser the chances of availing hospitalised care. Predictably, the higher the economic class, the larger the proportion of people opting for private hospitalised healthcare. While more than half of the poorest use public facilities for hospitalisation, just over a third in the highest economic class use it. Across all economic classes, barring the highest class (over Rs 2,000 monthly per capita expenditure), a majority of people paid for hospitalisation charges by borrowing money. This only confirms that healthcare expenses are one of the most common reasons for indebtedness.

"The rate of growth of public facilities has not kept pace with people's requirement and so they go to private facilities. There is a lot of unmet need in healthcare and the public health sector is yet to reach a critical stage when it can make a significant difference to the utilisation pattern," explains Dr Sundararaman.

Average of five states — Assam, Jharkhand, Rajasthan, Tamil Nadu and Uttarakhand:	2004 (NSSO)	2011 (study)
%-age of people seeking outpatient treatment	86	89
%-age of people treated in govt facility	26	54
Avg total expenditure for outpatient treatment	Rs 365	Rs 1,063
%-age of people hospitalised for treatment	2	8
%-age of people hospitalised in govt facility	51	48
Avg medical expenditure per hospitalisation	Rs 6,967	Rs 14,704

Average medical expenditure per hospitalization in government facility- Rs 8,703
Average medical expenditure per hospitalization in private facility- Rs 17,715

Source: TOI, 5 Feb 2013

We solicit your feedback:

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