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Pahal
Partnerships for Affordable Healthcare Access and Longevity
CONNECT TO GROW

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Landscaping of the Urban Poor

Brief Description of the Project and Key Findings from PAHAL Diagnostic Study

Pahal
Partnerships for Affordable Healthcare Access and Longevity

CONNECT TO GROW

PAHAL (Partnership for Affordable Healthcare Access and Longevity), a joint initiative of USAID and IPE Global, aims to provide catalytic support to growth stage scalable social enterprises in developing affordable & quality healthcare solutions for the urban poor.

USAID
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The United States Agency for International Development works to end extreme poverty and promote resilient, democratic societies. USAID partners with the Government of India and the private sector to eliminate preventable child and maternal deaths, create an AIDS and tuberculosis (TB) free generation, and achieve universal health coverage. For more information, please visit www.usaid.gov/india

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Published in July 2018

Contents

Abbreviations 4

Background 5
PAHAL | PAHAL Platform | Strategic Framework

Diagnostic Study 9

Maternal and Child Health (MCH) and Family Planning 11
Challenges | Government Priority | PAHAL Survey

Out of Pocket Expenditure on Health and Health Insurance 14
Challenges | Government Priority | Opportunity | PAHAL Survey

Health Seeking Behaviour 18
Challenges | Government Priority | PAHAL Survey

Water, Sanitation and Hygiene (WASH) 20
Challenges | Government Priority | Opportunity | PAHAL Survey

Tuberculosis 22
Challenges | Government Priority | Opportunity | PAHAL Survey

PAHAL Interventions 24

Fact Sheet 26
PAHAL Diagnostic Study

Abbreviations

AMRUT	Atal Mission for Rejuvenation and Urban Transformation
ANC	Ante Natal Care
ASHA	Accredited Social Health Activist
BOP	Base of Pyramid
CAGR	Compounded Annual Growth Rate
CAPI	Computer Aided Personal Interview
CHE	Catastrophic Health Expenditure
DCA	Development Credit Authority
DSF	Demand-side Financing
EPMCD	Ending Preventable Maternal and Child Deaths among India's Urban Poor
FP	Family Planning
FRU	First Referral Unit
GDP	Gross Domestic Product
IBM	Inclusive Business Models
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
IPD	In-patient Department
MCH	Mother and Child Health
MDR-TB	Multi-drug-resistant tuberculosis
MGHN	Merrygold Health Network
MMR	Maternal Mortality Rate
NCD	Non-Communicable Disease
AB-NHPM	Ayushman Bharat-National Health Protection Mission
NSSO	National Sample Survey Organization
OOPE	Out of Pocket Expenses
OPD	Out-patient Department
PAHAL	Partnerships for Affordable Healthcare Access and Longevity
PNC	Post-Natal Care
RMNCH+A	Reproductive, Maternal, New-born, Child Health and Adolescent
RSBY	Rashtriya Suraksha Bima Yojna
SBM	Swachh Bharat Mission
TB	Tuberculosis
THE	Total Healthcare Expenditure
USAID	The United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Background

India has poor healthcare indicators when benchmarked with WHO set standards and an ever changing demography, lifestyle pattern and disease burden makes it difficult to address the healthcare challenges via the traditional healthcare delivery mechanisms. This compounded with lower public and overall expenditure on healthcare (at 1.15% and 4.8% of the country's GDP) creates a worrisome situation for India's underserved and vulnerable population. Adding to the situation is the low health insurance penetration and high out-of-pocket expenditure which leads to over 39 million people being pushed to poverty every year.

Further, rapid urbanization and unplanned growth of cities in India has led to the creation of a large urban poor population or the Base of Pyramid (BOP) population (spending <$8 a day). They live in squalid conditions and lack access to basic necessities like clean water, education and healthcare. They face a disproportionate burden of ill health and high out of pocket expenditure, creating a severe unmet need for affordable and quality health care.

583 Million
Urban population to grow by 2030

100 Million+
Estimated Urban Poor

>71%
Households Without Insurance

>71%
Hospitals and Clinics in Private Sector

63%
Out of Pocket Expenditure on Health

Background

On the other hand, India's healthcare sector is growing at a CAGR of 23% and will be a $280 billion industry by 2020. India is witnessing rapid urbanization and rising income levels. By 2030, over 40% Indians will be living in urban areas, accounting for 69% of the GDP, implying higher number of underserved urban poor with a capacity to pay, indicating a huge market opportunity.

The private sector, powered by the growth of social enterprises, provides more than 71% of the healthcare services. It is tapping into this opportunity and has been at the fore front of combining innovation in technology and inclusive business models to create scalable social enterprises making quality healthcare accessible and affordable to the population. However, these social enterprises, at an early stage, face challenges including lack of growth capital, access to newer markets, low cost of products and thin margins, etc. making it difficult for them to scale.

There is an evident need for a larger alignment of private and public players for catalyzing these innovations and developing new business models to address the healthcare challenges, which PAHAL intends to provide.

PAHAL

PAHAL (Partnerships for Affordable Healthcare Access and Longevity), a joint initiative of United States Agency for International Development (USAID) and IPE Global, aims to provide catalytic support to growth stage scalable social enterprises in developing affordable & quality healthcare solutions for the urban poor. PAHAL is a collaborative platform which seeks to connect, capacitate and catalyze innovative social enterprises focused on improving health outcomes among urban poor communities.

Reach 10 Million
Urban Poor in India

By 2020 Pahal will

Reduce out of pocket expenditure on healthcare for underserved urban communities by 30% in coverage areas

PAHAL PLATFORM

The project has collaborated with healthcare provider networks consisting of 700+ hospitals, 1,000+ doctors and over 15,000 community workers and owning an exclusive health care delivery model with the objective of reaching out to 10 million urban poor and reducing out of pocket expenditure by 30%.

700+
Health Facilities

3,000+
Doctors

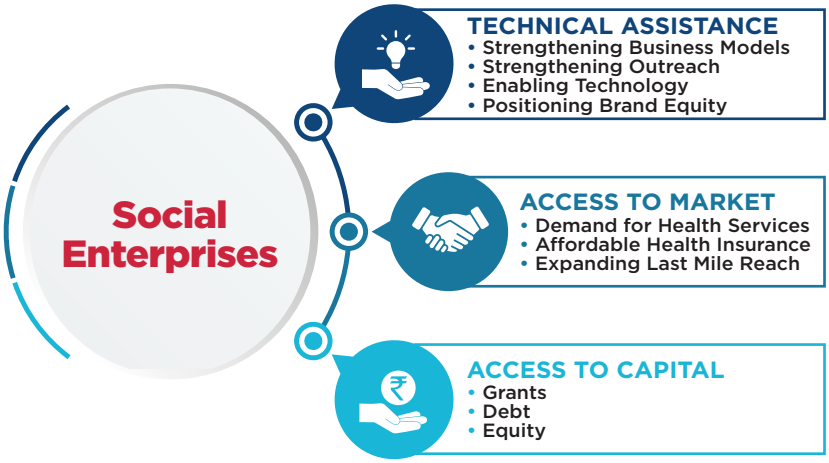
15,000+
Health Workers

10 Million
Urban Beneficiaries

STRATEGIC FRAMEWORK

PAHAL has adopted a **holistic ecosystem approach** to strengthen and scale market based healthcare solutions to improve access to quality healthcare for underserved urban communities. The project focus is to identify innovative business models, and then provide them with Technical Assistance, Market Access and Access to Capital.

SOME OF THE STRATEGIC INTERVENTIONS OF THE PROJECT ARE



Background

PAHAL is uniquely positioned with a balanced team of experts from financial advisory, strategic advisory, investment, public health, Monitoring and Evaluation and policy.

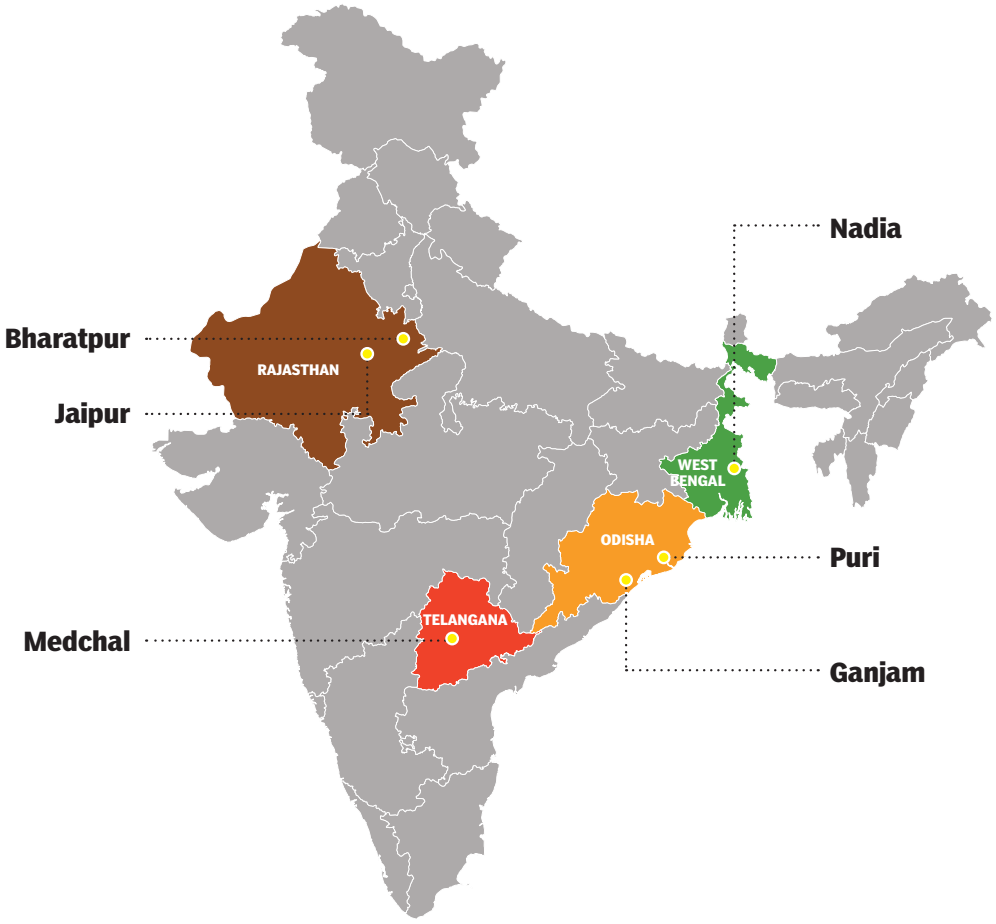
STRATEGIC PARTNERSHIPS

PAHAL has built strategic partnerships with several social enterprises in healthcare delivery, innovation, medical technology, skill building, financing, insurance to develop solutions for improving access and reducing cost of quality healthcare.

Diagnostic Study

PAHAL is implementing cross cutting Monitoring, Learning and Evaluation activities to assess the attribution/contribution of the strategic interventions, and share scientific evidence based insights and learning for knowledge sharing and advocacy with various stakeholders. PAHAL has a team of MLE experts who contribute towards providing regular scientific data by monitoring project indicators from project partners and focus on aligning the strategic interventions to reach the target goal.

A diagnostic study was conducted to understand key areas of health seeking behaviour, access to affordable healthcare and payment capacities of the community before identifying social enterprises with most innovative solutions to provide affordable healthcare services. The study was conducted in selected districts of four project states. The selection of districts was based on RMNCH+A composite index score.



Objective

The objective of the survey was to provide information on relevant health, mortality and morbidity indicators linked to maternal, neo-natal, child health (MNCH), Family Planning (FP) and TB (including awareness, diagnosis, treatment and referral); knowledge, attitude, practice, access, health services utilization pattern, enrolment in health spending support schemes like insurance and out of pocket expenditure (OOPE) on health.

Diagnostic Study

Target Respondents

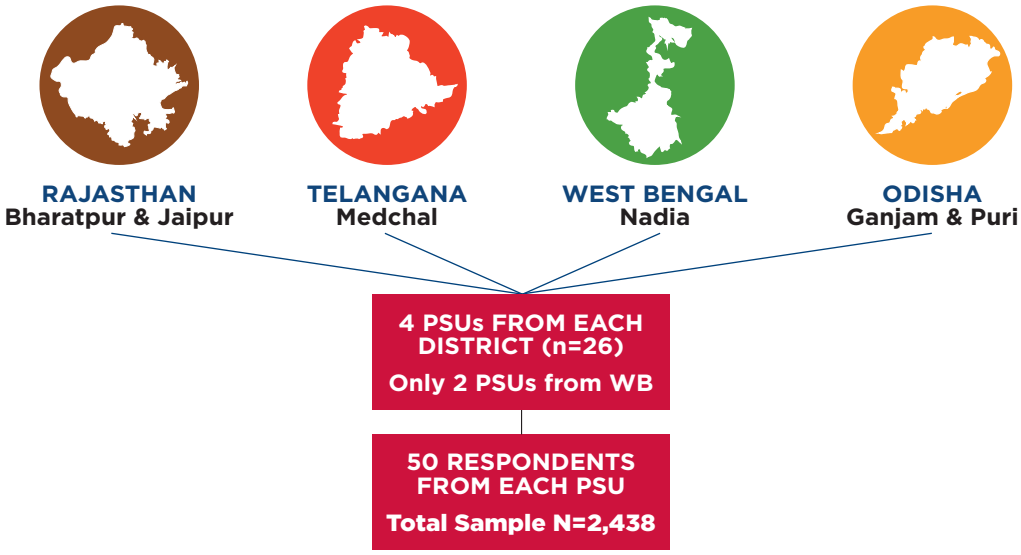
Target respondents for the quantitative data collection were

- Women who were pregnant any time during the last one year
- Mothers of children aged 0-5 years

Methodology

A structured survey schedule was used to collect information from the selected respondents. CAPI (Computer Aided Personal Interview) technique was used to solicit information from the consenting respondents.

SAMPLING



The diagnostic survey focused on key health domains such as:

- Mother and Child Health
- Out of Pocket Expenses on Health Including Insurance Coverage
- Health Seeking Behaviour
- WASH
- Tuberculosis

MCH & Family Planning

CHALLENGES

Maternal and Child health remains a grave challenge for healthcare systems worldwide, which calls for a global reduction in interdependent Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). According to NFHS-4 data more than 12 states and 10 out of the 12 states surveyed have not been able to reduce the IMR even by 2% annually[1].

50% of under 5 children are anaemic

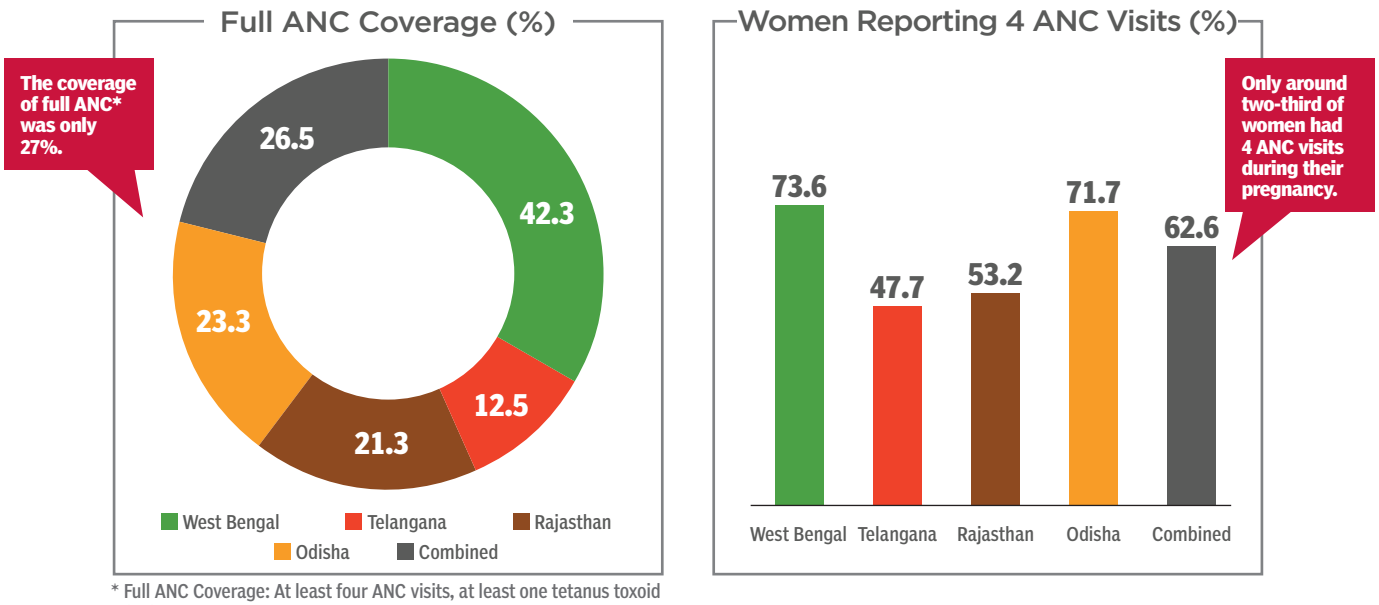
MMR at **246** per 100,000 live births in EAG states

GOVERNMENT PRIORITY

- Announcement to set up 'Mahila Shakti Kendra' at the village level with an allocation of ₹500 crore for 14 lakh ICDS Anganwadi Centres.
- ₹6,000 allocated for each pregnant woman to encourage ownership of a bank account, have institutional delivery and vaccinate their children[2]. (Under the Maternity Benefit Scheme).
- Action plan to:
  - Reduce IMR from 39 in 2014 to 28 by 2019 and MMR from 167 in 2011-13 to 100 by 2018-2020.
  - Increase the number of pregnant women receiving 3 Antenatal Care (ANC) check-ups, institutional deliveries, the number of First Referral Units (FRUs), number of sick newborns admitted to the Facility Based Newborn care units and 'Full Immunisation Coverage'.

PAHAL SURVEY

The key mother and child health findings are:



* Full ANC Coverage: At least four ANC visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup for 100 or more days.

1 Ganotra K. Union Budget 2017: Declining investment, increasing malnutrition – The story of our country's children [Internet]. New Delhi: The Financial Express; 2017.
2 Jaitley A. Budget Speech 2017-18 Internet]. Union Budget; 2017.

MCH & Family Planning

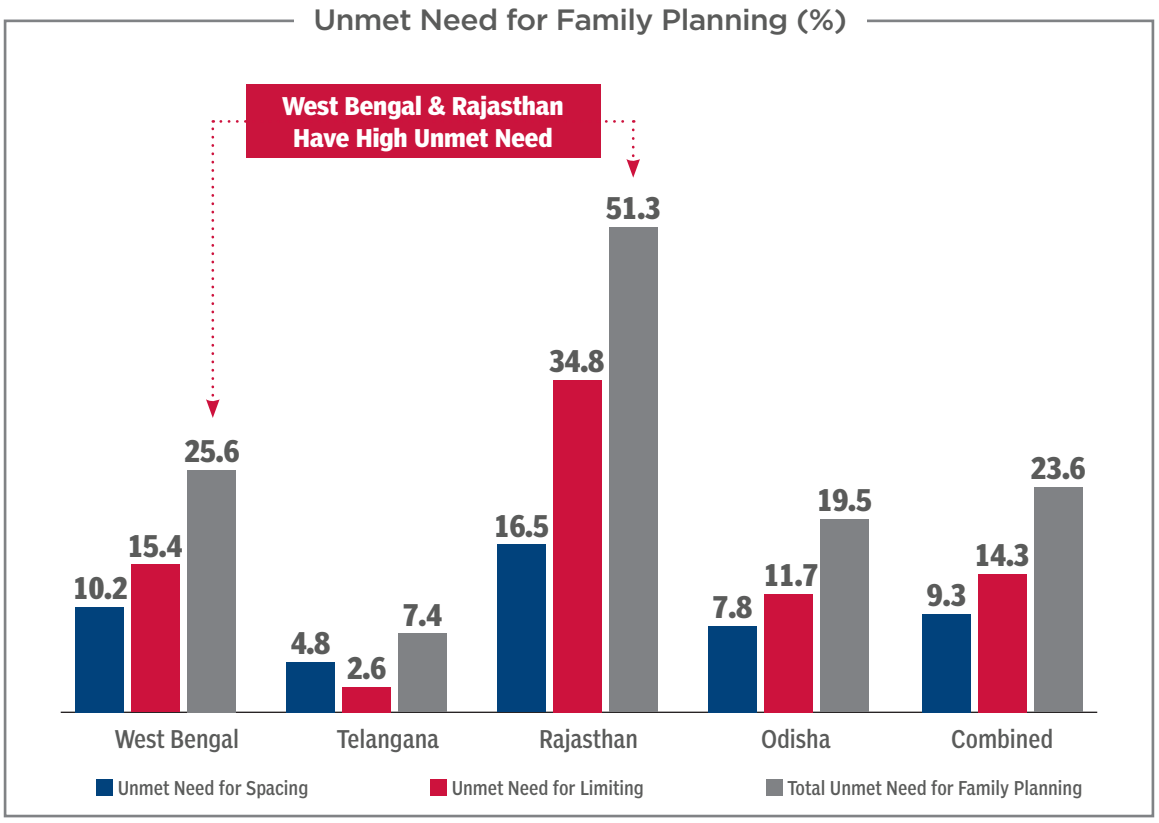
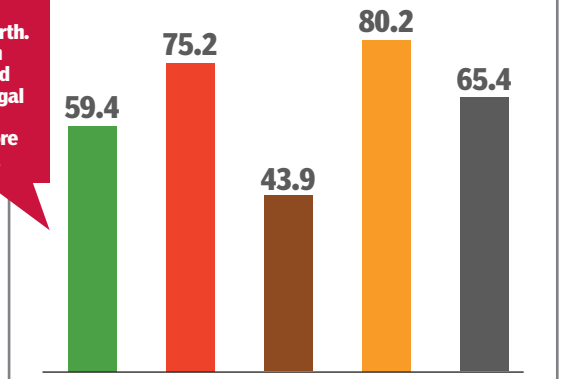


Photo: PCI India/Robin Wyatt

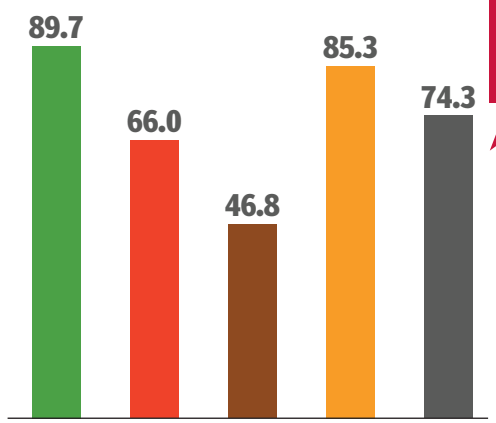
Women Who Breast fed their Child within One Hour of Birth (%)

Only 65% of women breastfed their child within an hour of birth. Rajasthan (44%). and West Bengal (59%) needs more attention.



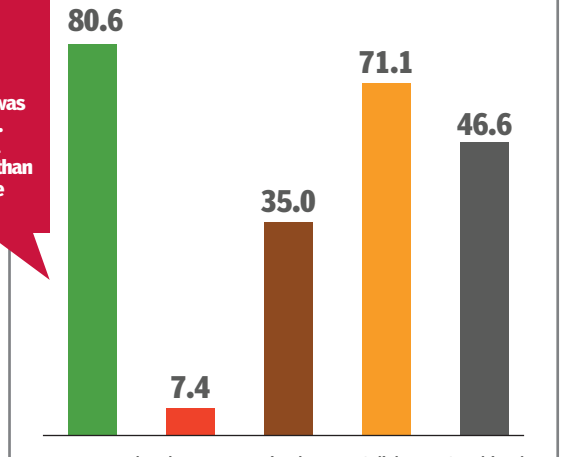
Children aged 12-23 Months who Received Complete Immunization (%)

About ¾ of the children aged 12-23 months received full immunization.



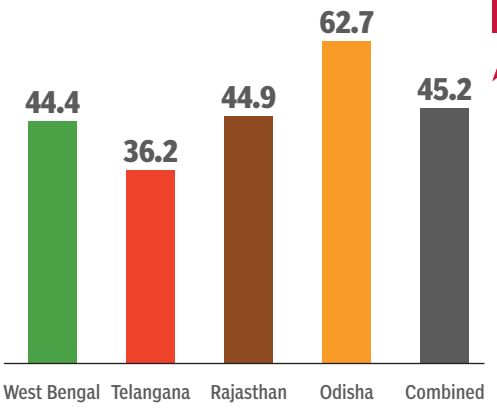
Postnatal care received within 2 days of delivery (%)

Post-natal check up coverage (within 2 days of delivery) was low (47%). Telangana and Rajasthan need more focus.



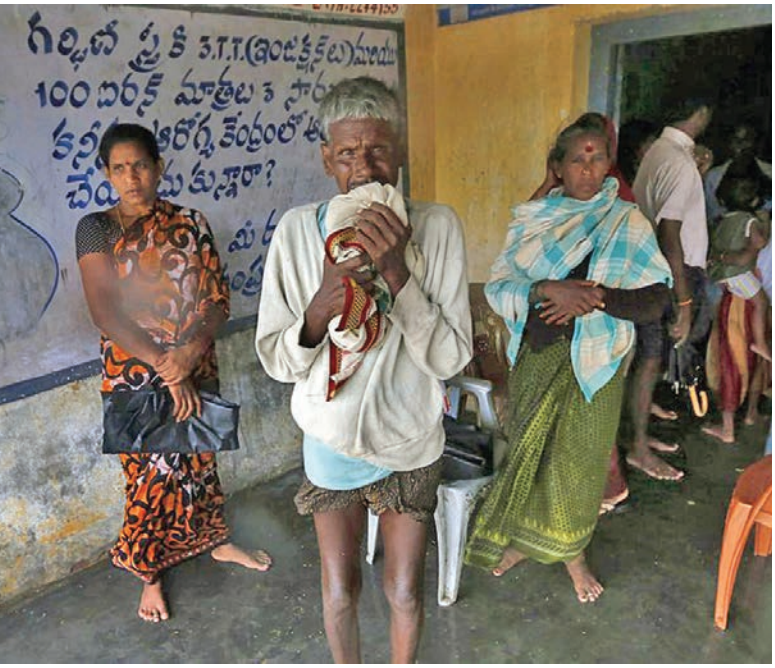
Exclusive Breastfeeding for atleast 6 Months (%)

Penetration of exclusive breastfeeding was very low (45.2%).



OOPE & Health Insurance

Out of Pocket Expenditure on Health and Health Insurance



CHALLENGES

India's out-of-pocket expenditure on health, pegged at ~60% is one of the highest in the world. In 2013-14, the Total Healthcare Expenditure (THE) of India was 4% of the Gross Domestic Product (GDP). Rising prices have left a large number of people unable to access healthcare in India which is aggravated by low insurance coverage. Abysmally low government spending on health, constituting just 1.15% of GDP catering to preventive, promotive and primary care programmes and private healthcare expenditure constituting of 4.25% of GDP catering to curative services along with 30% of Catastrophic Health Expenditure (CHE) – the lowest among the BRICS nations, make the OOPE very high.

90%
of the population has no health insurance

60%
highest Out of Pocket Expenditure (OOPE) in the world

=10

Over the period the private health care expenditure has grown at the rate of 12.84% per annum and for each one percent increase in per capita income the private health care expenditure has increased by 1.47%[3]. Number of private doctors and private clinical facilities are also expanding exponentially.

3 Dr. Saroj Hiremath, "Insurance Sector- Challenges & Opportunities", Insurance Times, May 2013.

Indian health financing scenario raises a number of challenges, which are:

- Increasing health care costs,
- High financial burden on poor, eroding their savings,
- Increasing burden of new diseases and health risks and
- Neglecting preventive and primary care and public health functions due to underfunding

As per the recent NSSO data (April 2018):

80%
not covered by any insurance, dependent on private sector for treatment

Only **12%** urban & **13%** rural people are covered through government health insurance despite 7 years of centre-run RSBY

Around **86%** of the rural population and **82%** of the urban population were not covered under any scheme of health expenditure support

GOVERNMENT PRIORITY

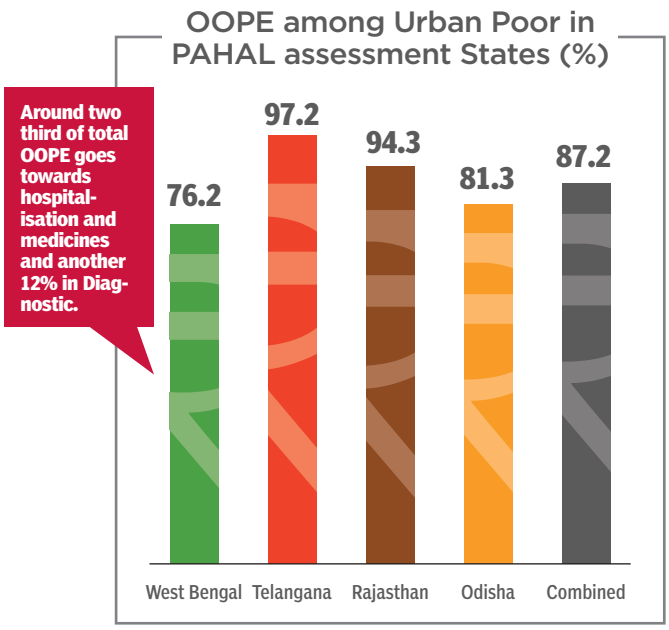
The recent launch of Ayushman Bharat-National Health Protection Mission (AB-NHPM) seeks to provide health insurance to 10 crore poor and vulnerable households under which up to ₹5 lakh insurance cover will be provided to each family per year in secondary and tertiary care institutions and will benefit 50 crore beneficiaries, making it world's largest government-funded healthcare programme to provide quality health cover. These initiatives might reduce OOPE on health significantly in future.

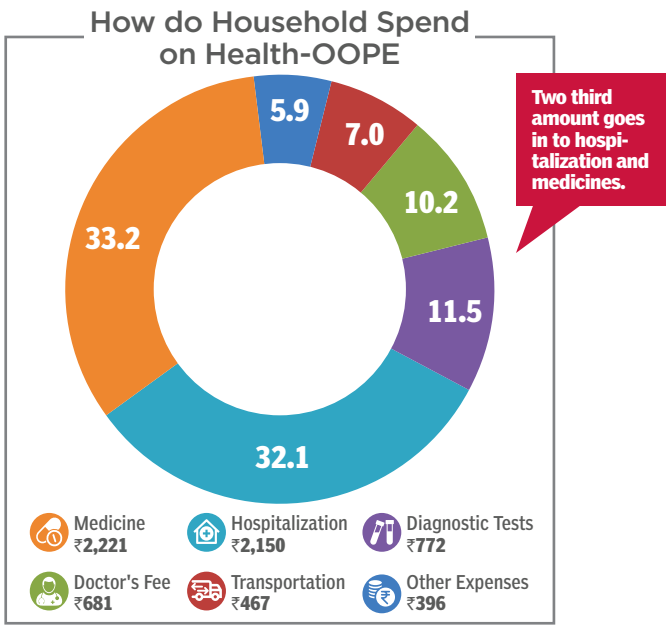
OPPORTUNITY

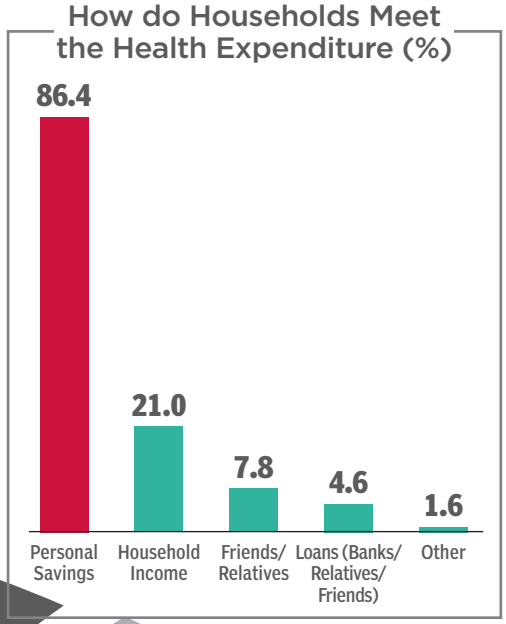
The out-of-pocket expenses leave a big gap between the healthcare financing needs of an individual and what is on offer in current health insurance products, which need to be filled. Given that government has liberalized the insurance industry, health insurance is going to develop rapidly in the future. With the announcement of the Ayushman Bharat Scheme, there is increasing emphasis on finding synergies between the public and private sector and the government is increasingly trying to leverage private sector resources to provide insurance coverage to the underserved.

PAHAL SURVEY

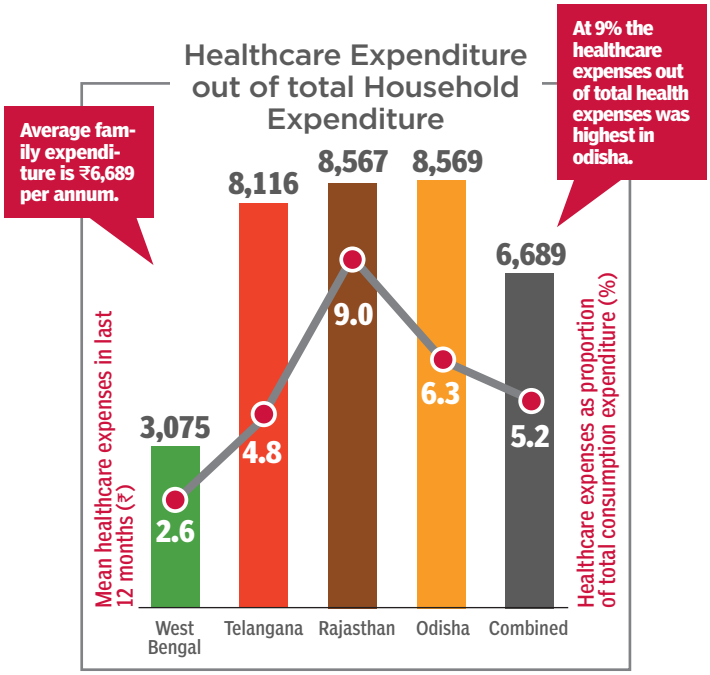
The survey conducted by PAHAL program suggests that the total OOPE on health in the selected states was 87.2% and this is consitent across all the states. This high OOPE can be attributed to low insurance coverage among the urban poor.



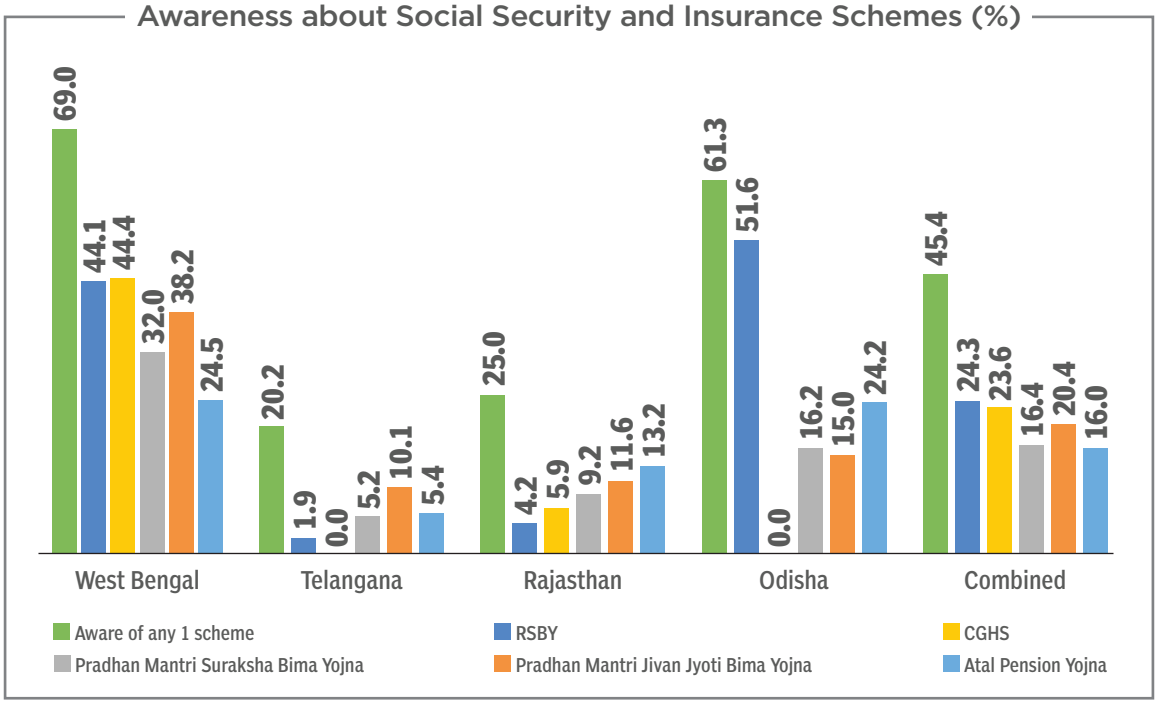


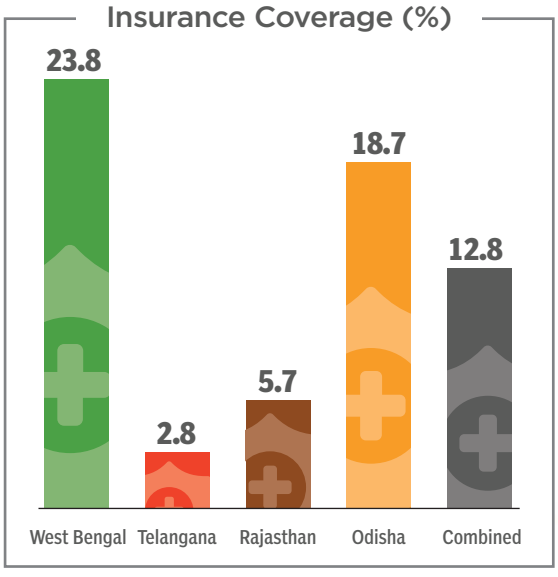


*This is a multiple response data



The survey conducted by PAHAL also showed that the coverage of insurance was only 10% and in majority of the cases the respondents were not aware about the various health schemes. The survey showed that although the awareness level about any health scheme was high in states like Odisha, and Rajasthan but it was largely contributed by their awareness of RSBY schemes, while both these states were not aware of any other health insurance schemes of the Government of India.





The PAHAL survey suggests that overall, the insurance coverage was only 12.8%, with highest coverage was reported from West Bengal 23.8% followed by Odisha with 18.7%. However, in both the states, they were largerly covered through RSBY. Out of the 12.8% that were insured, only 7% of them received benefits during last one year.

Health Seeking Behaviour

CHALLENGES

According to NSS findings, the last two decades have seen an asymmetric distribution of patients across public and private health facilities. Most households prefer private health facilities owing to dissatisfaction with and inaccessibility to government healthcare systems. This is a major cause of concern for those residing in semi-urban and rural areas, where access to basic primary healthcare services remains dismal.

32% of hospitalization in urban areas are in public facilities

68% of hospitalization in urban areas are in private facilities

42% of hospitalization in rural areas are in public facilities

58% of hospitalization in rural areas are in private facilities

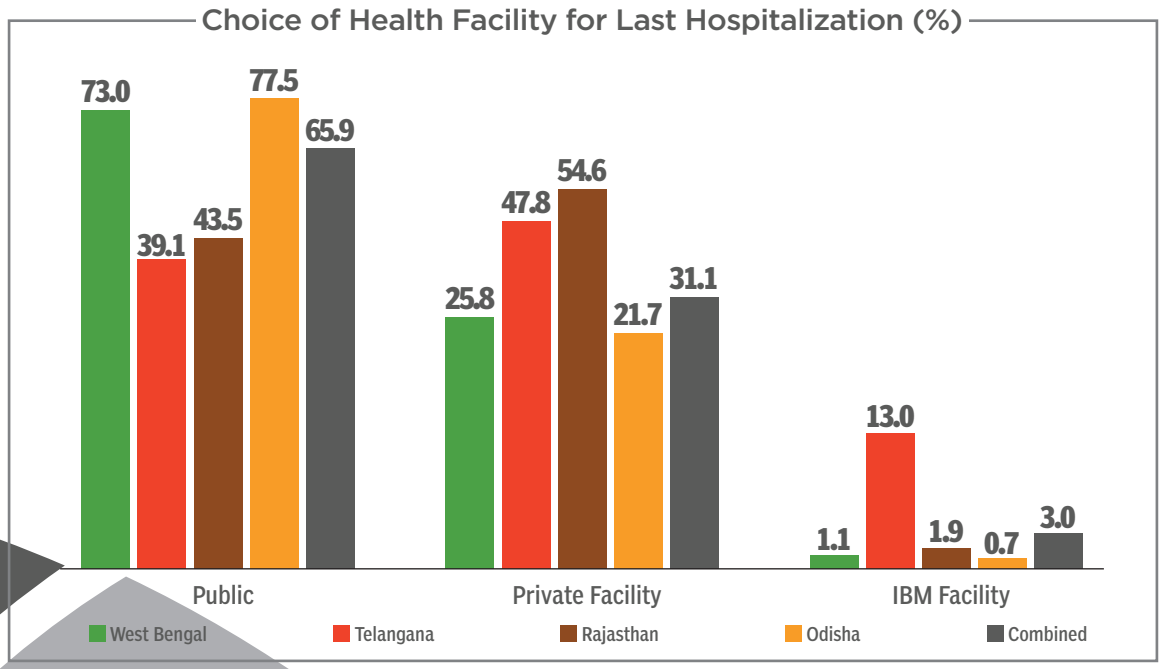
Source: 71st National Sample Survey

GOVERNMENT PRIORITY

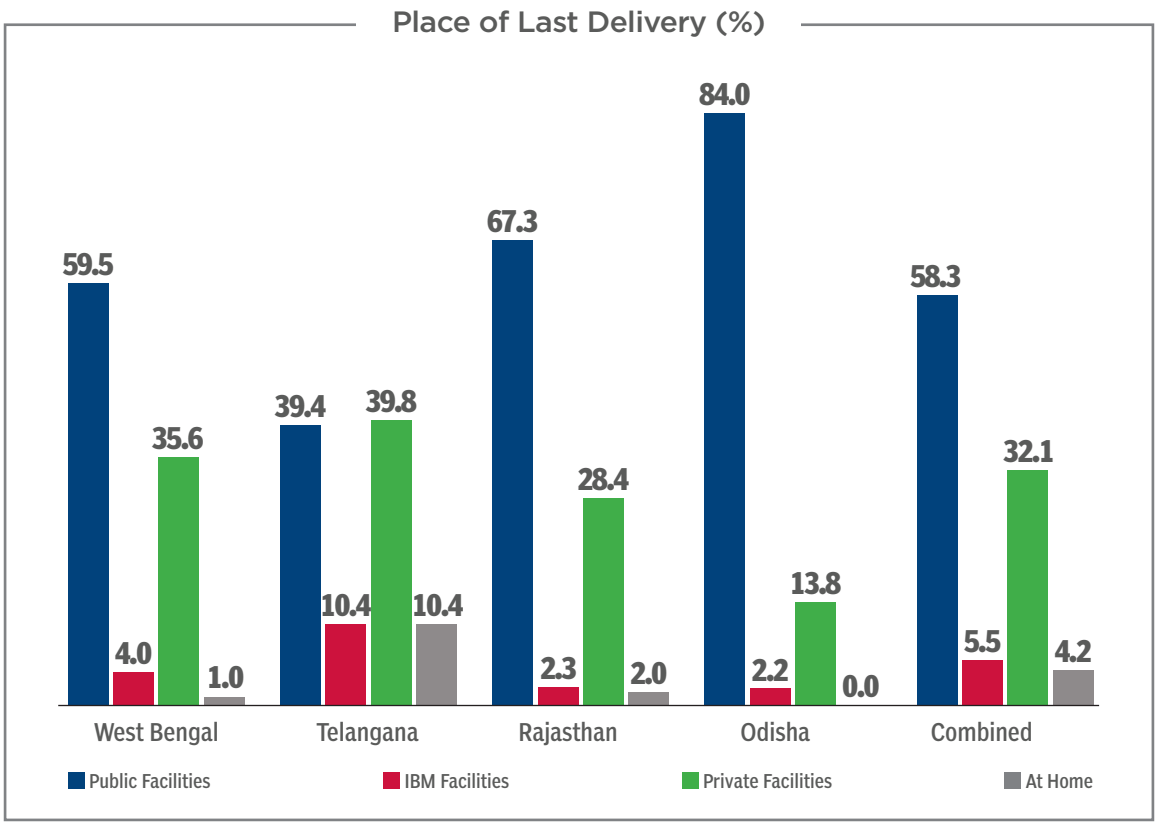
The Niti Aayog has suggested a model that provides for a greater role for private players in India's healthcare sector which has reignited the debate on the merits of involving the private sector in medical care.

PAHAL SURVEY

According to the survey, the overall preference for private healthcare facility was 31%, dominated by Rajasthan (55%) and Telangana (48%).



Most women across all the states, preferred to approach a public facility for their last delivery. The demand for delivery for private health facility was close to two fifth.



WASH Water, Sanitation and Hygiene

CHALLENGES

Urban India is plagued with multiple Water, Sanitation and Hygiene (WASH) challenges which are directly linked to fatal diseases and conditions such as cholera and diarrhoea along with malnutrition, pneumonia, parasites and blinding trachoma. Most of these diseases are caused by the contamination of drinking water, hands, soil and food with human faeces. India tops the global list of countries with the largest urban population without access to sanitation, and an annual urbanization rate of 2.1%[4] further compounds this problem. These challenges are exacerbated by the lack of water availability, outdated technology, poor design* and construction quality of toilets and the behavioural issue of improper public toilet usage.

63 Million
Indians without clean drinking water

140,000
Children die from diarrheal diseases each year

40%
Population practice open defecation

GOVERNMENT PRIORITY

Government of India's flagship scheme – the Swachh Bharat Mission (SBM), along with the Atal Mission for Rejuvenation and Urban Transformation (AMRUT) Programme have taken a big step towards making India open defecation free by 2020. SBM has shown considerable progress by constructing individual household toilets, public and community toilets across rural and urban areas and has also moved a step forward in proper waste collection and management.

OPPORTUNITY

Densely populated cities, combined with rapid urbanization and India's limited urban WASH infrastructure continue to create bottlenecks in the realization of the Indian Government's efforts with the Swachh Bharat Mission and AMRUT Programme.

Moreover, India lacks a comprehensive scheme for safe drinking water. All Indian water bodies within and near population centres are now grossly polluted with organic and hazardous pollutants. The Asian Development Bank has forecast that by 2030, India will have a water deficit of 50%.

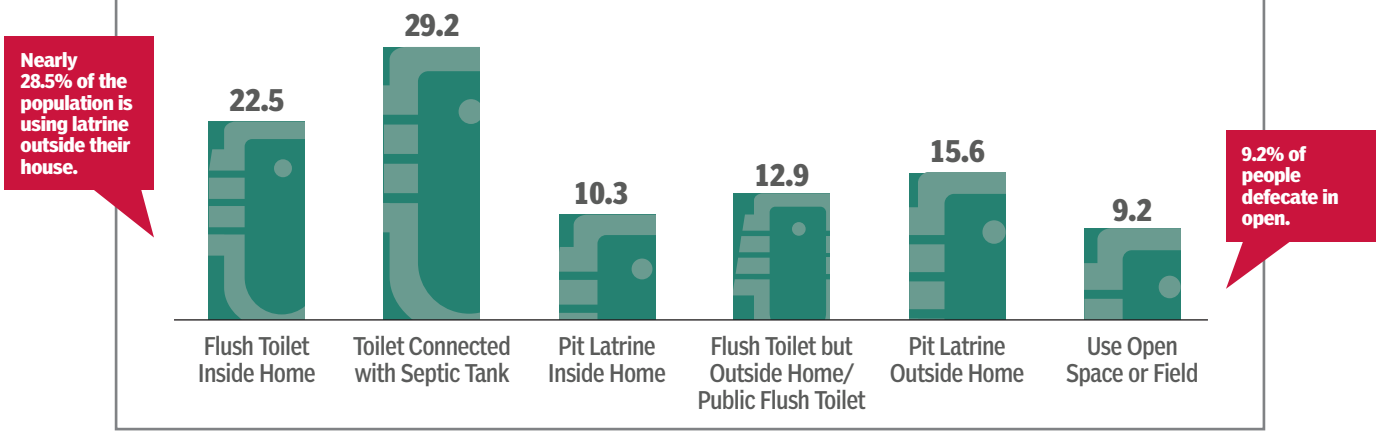
Alliances of individuals, government organizations, the non-profit sector, development experts, investors and businesses together using their diverse perspectives and resources can jointly address these issues, thereby ensuring access to safe drinking water and sanitation for all as envisaged in the Sustainable Development Goals.

4 GOYAL, N., & Tejas, A. (2018, February 28). A Business Accelerator Puts India's Urban WASH Challenges Front and Center. Next Million, 1, 10.

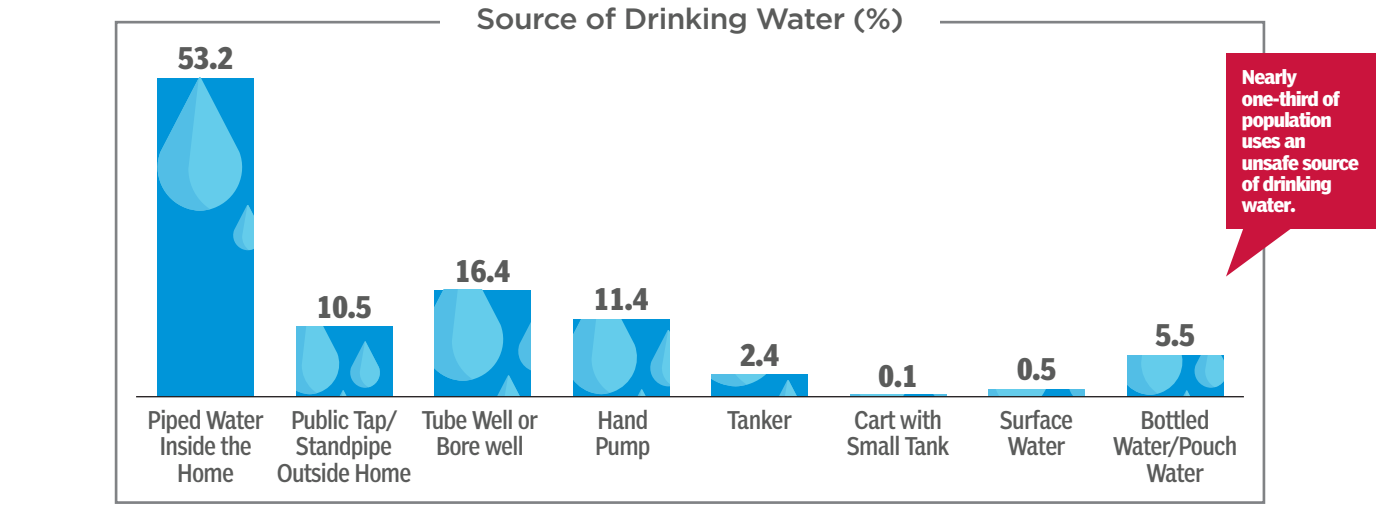
PAHAL SURVEY

The diagnostic survey highlighted some key WASH challenges.

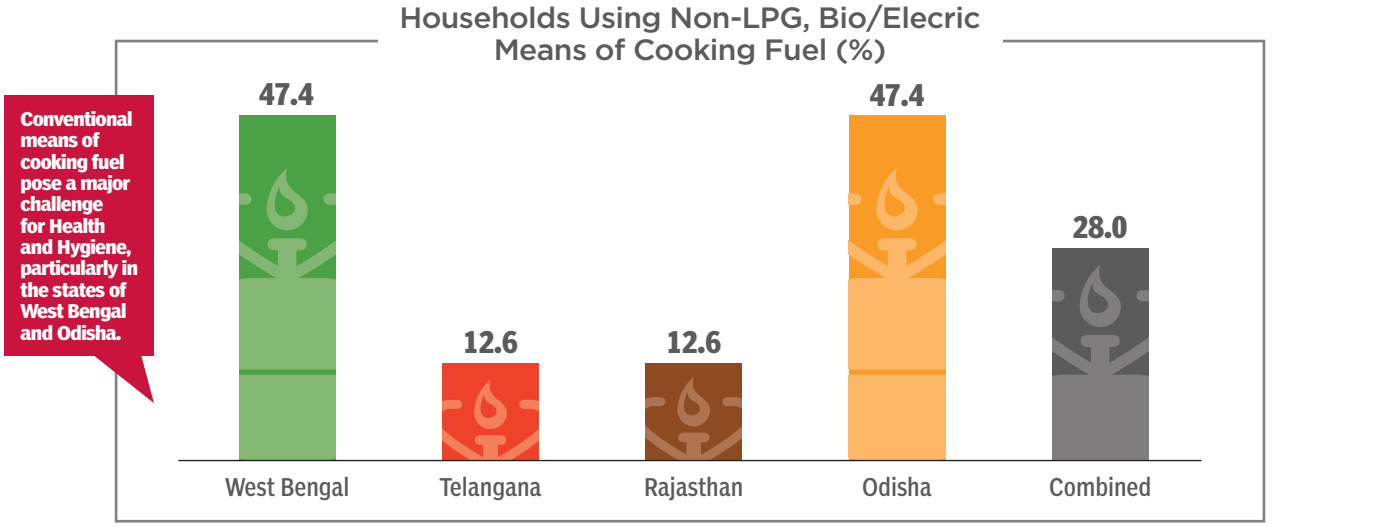
Type of Toilet Facility Used (%)



Source of Drinking Water (%)



Households Using Non-LPG, Bio/Elecric Means of Cooking Fuel (%)



Tuberculosis

CHALLENGES

India has highest burden of both TB and MDR TB based on estimates reported in Global TB Report 2016[5], which is one fourth of the global TB burden.

2.79Million
TB cases reported in India according to WHO

28Lakh
new cases in 2016

1.3Lakh
new cases of MDR-TB

1.1Lakh
HIV and TB co-infection in 2015-37,000 of them[6] died

GOVERNMENT PRIORITY

The Government of India aims to eradicate tuberculosis by 2025 by involving the private sector, NGOs and caregivers to improve early diagnosis, treatment adherence and outcomes for TB patients, and intersectional collaboration between different platforms that promote access to healthcare with regard to tuberculosis.

Photo: World Bank

OPPORTUNITY

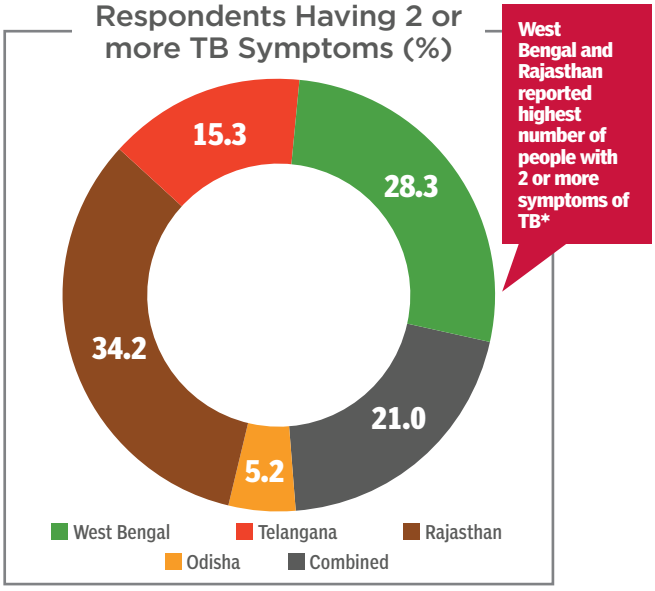
The government, in May 2012, made it compulsory for all private health care providers to notify every TB case diagnosed. This was done with the aim of improving the collection of patient care information. Since then, more than 1,13,961 private health establishments are registered under NIKSHAY till December 2016. Among them, 70,146 are private practitioners/ clinics, 34,105 are hospitals/ clinics/nursing homes and 9,710 are laboratories[7]. More than half of all the TB patients are catered to by the private sector[8].

5 "Global TB Report 2017", WHO, 2017
6 ibid
7 https://tbcindia.gov.in/WriteReadData/TB%20India%202017.pdf
8 https://www.tbfacts.org/tb-statistics-india/

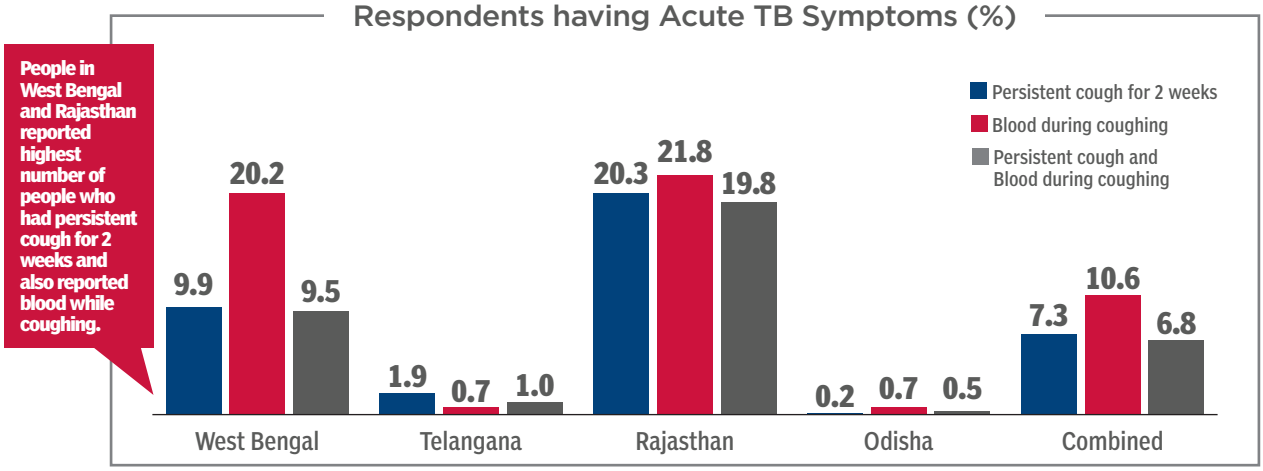
PAHAL SURVEY

According to the PAHAL assessment, TB related symptoms were high in the survey sites, despite the awareness about TB being high.

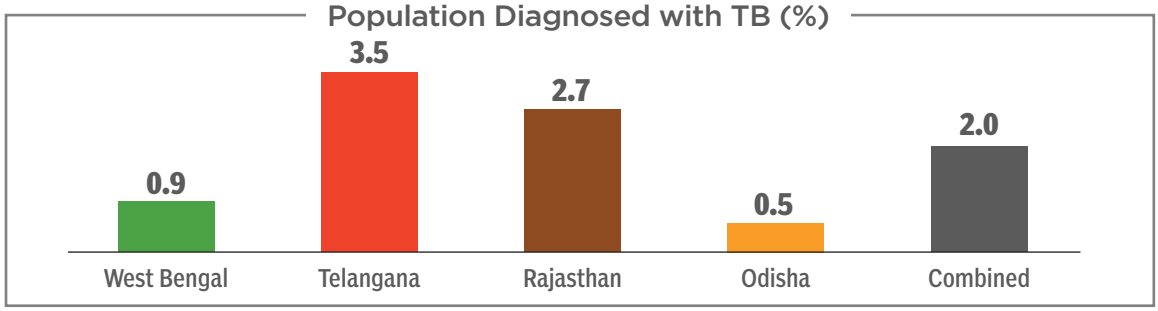
Photo: Medecins Sans Frontieres (MSF)



* Dry Cough, Persistent cough for 2 weeks, Cough with phlegm, Cough with blood, Persistent Fever, Sweating, Restlessness, Loss of appetite, Tiredness/Fatigue, Weight loss, Chest Pain



Despite having high symptomatic prevalence of TB, the diagnosis of TB remains poor, indicating an unfavourable health seeking behaviour



PAHAL Interventions

STRENGTHENING OUTREACH

Outreach is central to the uptake of services for a facility centred health care provider. MerryGold Health Network (MGHN), provides strong community linkages to 700+ urban facilities through its workforce of 15,000 community health workers or Merrytarang Workers. PAHAL works towards supporting MGHN to create an efficient cadre of community health workers that can enable health promotion and disease prevention in communities. The community health workers supports in uptake of primary health care services by triggering behaviour changes by sensitizing the community and creating awareness regarding promotive, preventive and curative healthcare services of MGHN to promote service uptake.

BRAND ENHANCEMENT & MARKETING

PAHAL is working towards brand enhancement of the Merrygold Health Network and provide support for increased awareness and demand-generation through its branding, communication and advocacy team. The aim is to establish MGHN as a network that provides quality healthcare services at affordable prices.

TECHNOLOGY SUPPORT

Technology is an integral part of the expansion strategy and enhances operational effectiveness & customer experience. PAHAL provides technical support to improve data management and reporting, and designing a structured solution which impacts the overall governance of the network.

DEMAND SIDE FINANCING

PAHAL focuses on the potential of Demand- side Financing (DSF) schemes with community participation to reduce out of pocket expenditure. Towards the same a health insurance product has been designed and demonstrated to reduce OOPE and enhance access to quality health care & improve health seeking behaviour amongst the urban poor.

STRENGTHENING BUSINESS MODEL

PAHAL is providing strategic guidance & business advisory in restructuring the MGHN business to create a sustainable and scalable model, which will enable it to attract necessary resources including commercial capital (equity and debt) to fulfil its expansion goals while continuing its existing sources of funding from donors, CSR and government.

ACCESS TO CREDIT

At the franchisee level, PAHAL is working towards creating a structured credit product, backed by a loan guarantee- such as the USAID/DCA Loan Guarantee, with a value proposition which is compelling for any bank/NBFC in terms of scale and opportunity to make financial returns. This in turn will improve access to credit for MGHN franchisees and utilization of the DCA guarantee.

CAPITAL ADVISORY & SUPPORT IN FUND MOBILIZATION

PAHAL is well networked with social impact investors, private equity funds, financial institutions (banks/NBFCs), corporates and donors. PAHAL is assisting in identification of suitable investors and support in raising capital from investors. PAHAL will undertake an assessment to understand the capital needs, for debt, equity and grant of the social enterprises. PAHAL is also complementing existing CSR fund raise efforts of MGHN.

Factsheet PAHAL Diagnostic Study

Indicators	West Bengal (%)	Telangana (%)	Rajasthan (%)	Odisha (%)	Overall (%)
Socio-Demographic Profile					
Average Household size (Mean ± SD)	4.76±1.69	4.10±1.19	5.76 ±2.42	5.16 ±1.80	4.77±1.80
Ethnicity					
Scheduled Caste	36.0	36.2	24.5	17.5	31.1
Scheduled Tribes	4.1	14.1	15.6	10.5	10.4
OBC	10.6	24.5	36.9	31.2	23.1
Others	49.3	25.2	23	40.9	35.4
Proportion of Household having Pucca house	42.9	74.3	91.3	69.1	66.0
Proportion of BPL households	43.8	49.2	19.8	64.8	45.1
Health Expenditure and Insurance Coverage					
OOPE among urban poor in Pahal Assessment states (%)	76.2	97.2	94.3	81.3	87.2
Proportion of expenses on health in the last 1 month (%)	2.6	6.3	4.8	9.0	5.2
Insurance coverage (%)	23.8	2.8	5.7	18.7	12.8
Community Mobilization					
Proportion of Household participating in community related functions, meetings and other events	9.4	9.3	1.2	2.5	6.8
Proportion of women who are member of any Self-Help Group or Youth club or Mahila Mandal	15.0	8.4	0.7	14.5	10.3
Morbidity Pattern					
Percentage of people fallen sick in last 15 days	16.9	5.7	21.4	19.2	14.9
Proportion of people who fell sick during last 15 days and did not take any treatment	13.2	19.0	4.6	3.8	9.2
Percentage of People Seeking Treatment (OPD) from:					
Public Sector Facilities	45.2	27.4	29.8	45.6	38.7
Private Sector Facilities	38.9	51.0	60.0	47.2	48.8
IBM Health Facility	0.0	21.0	2.2	0.0	2.9
Percentage of People Seeking Treatment (IPD) from:					
Public Sector Facilities	73.0	39.1	43.5	77.5	65.9
Private Sector Facilities	25.8	47.8	54.6	21.7	31.1
IBM Health Facility	1.1	13.0	1.9	0.7	3.0
Sources to Meet Healthcare Expenses for Households					
Personal income	81.8	84.7	98.3	87.3	86.4
Household income excluding personal income	36.0	20.3	0.5	13.5	21.0
Savings Loans (Banks/Relatives/Friends)	9.9	3.2	0.7	0.7	4.6
Contribution from friends/relatives	6.4	7.6	5.4	13.7	7.8
Selling assets/property	0.5	0.5	0.0	0.5	0.4
Insurance coverage	1.2	0.2	0.5	0.5	0.7
Reimbursement from employer	0.1	0.2	0.0	0.2	0.2
Others	0.2	0.0	1.2	0.2	0.3

Indicators	West Bengal (%)	Telangana (%)	Rajasthan (%)	Odisha (%)	Overall (%)
Maternal and Child Health					
Proportion of women registered for ANC during last pregnancy	99.7	86.8	92.8	99.2	94.1
Proportion of women registered in their first three months of pregnancy	92.8	57.4	62.9	84.6	74.3
Proportion of women had at least 4 ANC check-ups during last pregnancy	73.6	47.7	53.2	71.7	62.6
Proportion of women who had complete ANC done during last visit	42.3	12.5	21.3	23.3	26.5
Proportion of women had institutional delivery	99.0	89.6	98.0	100.0	95.8
Proportion of women breast feed their child with in an hour of birth	59.4	75.2	43.9	80.2	65.4
Exclusive Breastfeeding for atleast 6 months (%)	44.4	36.2	44.9	62.7	45.2
Proportion of children aged 12-23 months who received complete immunization	89.7	66.0	46.8	85.3	74.3
Childhood Morbidity					
Proportion of children who had diarrhea during the last 2 weeks preceding the survey	5.7	0.2	3.7	7.1	3.6
Proportion of Children received ORS Packet Solution for Diarrhea Treatment	61.1	100.0	34.8	68.4	59.0
Proportion of Children who had cough in the last 2 weeks	17.5	1.4	24.2	21.7	13.8
Family Planning Methods					
Proportion of Women currently using any FP Methods to avoid pregnancy	37.5	39.1	55.0	51.1	43.2
Unmet need for spacing	10.2	4.8	16.5	7.8	9.3
Unmet need for Limiting	15.4	2.6	34.8	11.7	14.3
Tuberculosis					
Proportion of respondents aware of TB as a disease	87.9	16.3	91.1	32.7	54.9
Respondents who reported 2 acute symptoms of TB-Persistent cough for 2 weeks and Blood while coughing	23.3	2.3	30.4	1.0	13.7
Respondents who reported 2 or more symptoms of TB*	28.3	15.3	34.2	5.2	21.0
Respondents who had 2 acute symptoms of TB -Persistent cough for 2 weeks and reported blood while coughing	9.5	1.0	19.8	0.5	6.8
Respondents who reported Persistent cough for 2 weeks	9.9	1.9	20.3	0.2	7.3
Respondents who reported blood during coughing	20.2	0.7	21.8	0.7	10.6
Proportion of population diagnosed with TB	0.9	3.5	2.7	0.5	2.0
Water, Sanitation and Hygiene (WASH)					
Open Defecation	2.6	3.0	4.2	40.1	9.2
Piped water inside the home	12.1	84.6	80.4	42.4	53.2
Proportion of household using conventional means of cooking fuel**	47.4	12.6	12.6	47.4	28.0

* TB Symptoms: Dry Cough, Persistent cough for 2 weeks, Cough with phlegm, Cough with blood, Persistent Fever, Sweating, Restlessness, Loss of appetite, Tiredness/ Fatigue, Weight loss, Chest Pain, **Conventional means of cooking fuel includes, Wood, Charcoal, Coal, Kerosene, Straw/ shrubs/grass, agricultural crop waste, dung cake

Pahal
Partnerships for Affordable Healthcare Access and Longevity

Urban Health (USAID) Project

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Disclaimer: This publication is made possible by the support of the American People through the United States Agency for International Development (USAID), under the terms of Cooperative Agreement No. AID-386-A-15-00014. The contents of this report are the sole responsibility of IPE Global and do not necessarily reflect the views of USAID or the United States Government.