

# INCREASING ACCESS TO HEALTH SERVICES USING MOBILE HEALTH UNITS

Implementation experiences in Tamil Nadu and Orissa State, India



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This policy brief is based on a research report “Access to health services in under privileged areas: a case study of Mobile Health Units in Tamil Nadu and Orissa”

A full copy of this report is available at: [www.crehs.iitmadras.ac.uk/downloads/publications/Mobile\\_health\\_units.pdf](http://www.crehs.iitmadras.ac.uk/downloads/publications/Mobile_health_units.pdf)

## RESEARCH QUESTION

The research assesses the role of MHUs in providing access to health services for underprivileged populations.

Specifically, it aims to: assess the gains presented by MHUs, in terms of access to care; to identify and analyse factors which hinder or enable the implementation of MHUs; and, to propose policies to improve the overall design and implementation of MHUs.

## METHODS USED

- Secondary data from government and other sources
- In-depth interviews with key stakeholders
- Primary survey data from communities that have used MHUs, collected between November 2006 and January 2007.
- Direct observations on the functioning of MHUs in two States: Tamil Nadu and Orissa.

## INTRODUCTION

Mobile Health Units (MHUs) have been used as early as 1951 in tribal areas of India, with the purpose of improving access to and utilization of health services for people living in underserved and inaccessible areas. In order to access a fixed health facility, these populations have to travel up to 20 kilometres by foot, cart or private vehicle. The long distance and high cost of transport can prohibit access to services, particularly during an emergency.

MHUs vary between states but typically consist of a physician, a pharmacist, an auxiliary nurse midwife, one or two paramedical staff, and a driver. Those Units that do not have a van travel by local buses and, when roads are blocked or inaccessible, walk several kilometres to reach communities.

In India, the implementation and effective functioning of MHUs is the responsibility of Primary Health Centres. Despite their importance for reaching remote populations, the impact of MHUs on health care equity is seldom taken into consideration during the planning stage. As a result, several barriers to their effective implementation and performance remain.

## KEY FINDINGS

- The community surveys found that 80% of the population had used MHUs during the past 3 months and, of this population, 90% travelled less than one kilometre to reach the services.
- Despite satisfaction with the location of MHUs, problems remained with the timing and regularity of visits. In several sites, MHUs reported only once a fortnight or once a month, and, as a result, there was often no effective follow up of patients.
- On average, MHUs covered 40-60 patients over 3 hours, and the amount of time spent with each patient was 3 minutes. This raises questions about the quality of care that they are able to deliver.
- Some MHUs reliance on crowded buses to reach their destination prevented them from being able to carry diagnostic equipment such as blood and urine tests. The limited services that MHUs offer means that they could not always meet the requirements and expectations of populations, for instance, to treat chronic diseases including diabetes, or provide dental care.
- When MHUs did reach very remote communities, there was sometimes no space for private consultations, especially during rainy seasons. Lack of privacy is an important barrier to seeking care, particularly for young girls and women.

## CHALLENGES TO THE EFFECTIVE IMPLEMENTATION OF MOBILE HEALTH UNITS

Several factors have contributed to the poor performance of MHUs. These include:

- Insufficient staff, compounded by a slow process of recruiting health personnel. Harsh working conditions have made it particularly difficult to attract medical professionals to work for MHUs.
- Lack of financial commitment from the government, especially in Tamil Nadu, means that MHUs are underfunded, limiting the services that they are able to offer and preventing essential maintenance of vehicles. This is partly due to frequent changes of policy makers who direct little attention towards MHUs.
- NGOs have not been involved in running MHUs, even though, in some districts, they also provide health services to underserved communities. In Tamil Nadu, this failure to collaborate is due to a lack of clear policy guidelines.
- Insufficient planning has resulted in infrequent field visits by MHUs. When MHUs have not visited communities as scheduled, it has been difficult to gain their confidence and provide high quality care.
- Systems for monitoring MHUs and providing feedback are particularly weak. In some sites there were no records of services delivered and patient numbers.



Patients wait in a queue to get medicine from a mobile health unit in Tamil Nadu

### POLICY RECOMMENDATIONS

The findings suggest that MHUs have reduced geographical barriers to accessing health services for people living in remote and inaccessible areas. However, serious questions remain about the quality of health care that they can provide. The following recommendations may improve the performance of MHUs:

- The state government should set out a budget for MHUs and ensure expenditure for this amount. This is extremely important as it indicates government's commitment to improving access to health care in under-served and inaccessible regions. When planning this budget, the government should work out a definite package of essential services that can be delivered by MHUs.
- The government should consider introducing measures that will attract health professionals to serve in remote areas. These could include financial incentives. Providing a vehicle which is in good condition and a driver may also attract health workers to work in MHUs.
- Operational research should be undertaken with a view to improving the performance of MHUs. This can include studies on the scheduling of vehicles and site visits in order to maximise the coverage of MHUs.
- Sustained efforts should be made to improve the planning capacity of district level officials so that they can carry out careful mapping and scheduling of visits, and develop trusting relationships with the communities that they serve.

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