EVALUATION OF MOBILE MEDICAL UNITS (MMUS) IN UTTARAKHAND

Investigator(s) : Prof. A.K. Sood, Dr. Gyan Singh, Dr. Renu Shehrawat

Data collection team : Mr. M.P. Meshram, Dr. U.B. Das, Dr. Poonam Khattar, Dr. Hema Gogia, Mr. S.P. Singh, Dr. Joy Kumar, Dr. Gyan Singh, Dr. Manoj Kumar Singh, Prof. A.K. Sood, Mrs. Rita Rani, Dr. Renu Shehrawat & Dr. Yashika Negi

Date of Initiation : January 2013

Date of Completion : 31st March 2013

Objectives

i. To evaluate 17 Mobile Medical Units (MMUs) run under the NRHM. These mobile vans were started around Jan 2009. (There is one NRHM MMU in all 13 districts. Besides Tehri and Chamoli have an additional mobile units run by HLFPPPT and Nainital has 2 more MMUs run by BISR. The evaluation will not cover 13 Mobile units run by state government as per the TORs given by the nodal officer of Uttrakhand Government)

ii. To assess the overall performance and delivery of RCH services through the specified MMUs

iii. To assess the client satisfaction using the services from these specified MMUs.

Study Design (in brief)

The State of Uttarakhand is characterized by mountainous and geographically hostile terrain having sparse and scattered population. Communities living in the remote and disadvantaged areas, especially the BPL population and women are generally unable to
access reliable and cost effective healthcare services. This is mainly due to the secondary costs associated with seeking healthcare services at block/district headquarter towns, such as cost of commuting, wage loss, etc. The Government of Uttarakhand has taken several initiatives to improve access to healthcare services for the disadvantaged communities. One such initiative is to provide healthcare services through the ‘Mobile Health Clinics’ (MHC). The provision of these Mobile Health Clinics has increased the outreach of healthcare services to the hitherto underserved and unserved regions of the State. The concept of healthcare service delivery through Mobile Health Clinics has been implemented in these areas using three distinct MHC models:

Mobile Medical Unit – Arogya Rath-As of now 13 Mobile Medical Units are being managed by MNGOs. These mobile medical units are running in underserved/under-served areas of 13 districts.

Sehat Ki Savari – MMU in Chamoli and Tehri Garhwal -These 2 Mobile Medical Units are being managed by HLFPPT.

Two Diagnostic MMUs in Nainital District-There are in all 2 Vans that are being managed by Birla Institute of Scientific Research, Nainital

NIHFW was requested by the state government to evaluate the 13 Mobile Medical Units functioning under the NRHM in the state with the Terms of References (TORs) to assess the overall performance and delivery of RCH services through the specified MMUs and to assess the client satisfaction using the services from these specified MMUs.

NIHFW teams visited the 13 districts in the state and interviewed the stake holders - staff members of the MMUs (Medical officer, Pharmacist, Lab technician, ANM, X-ray tech, Dark room attendant, Driver); beneficiaries utilizing the services of MMU on the day of visit by the teams (Women who have utilized antenatal service/post natal services, Women who have utilized FP services, Women who have utilized immunization services for children, Users for malaria, TB, leprosy, under various national health programmes etc, Investigation/ diagnostic services, Users of other problems, referred cases etc); Community leaders (Village Pradhan, social worker, school teachers, members of the local Panchayat, local practitioners etc.); Health service providers (medical officers of the nearby PHC, CHC where cases are referred by MMU, ASHA, AWW, ANM etc.); District health officers (Chief Medical Officers, Assistant Medical Officers, District Programme Manager, etc.); Secretary/ designated officers from the NGO running the MMUs; State Programme Manager from the Directorate of Health Services.
Summary of Results & Policy Implications

The overall recommendations based on the observations for the Mobile Medical Units (MMUs) in the State of Uttrakhand are as follows:

1.1. Policy related issues
1.1.1. Budget for MMUs

It was observed that the NGOs are identified based on the basis of bids submitted and the lowest bidder gets the contract of providing the services for MMU. As a result, the budget for running the MMU per year was nearly 20 lakhs. Accordingly, the salary of the staff was much less as compared to the corresponding category in the government staff. This resulted in high turnover rate for the staff and difficulty in getting experienced staff for running of the MMUs. The budget earmarked for maintenance and repair of vehicle and equipment was also inadequate.

1.1.1.1. Accordingly the base budget for providing these services should be rational and increased.

1.1.2. User charges

The user charges collected by the MMU were being deposited in the govt.

1.1.2.1. It would be appropriate if user charges collected by MMU are used for miscellaneous expenses to ensure immediate facilities in the local sites.

1.1.3. MOU with NGOs

At present the MOU was done for one year and the renewal of MoU was a time consuming process. As a result there was discontinuity in the services rendered by MMUs.

The present MOU does not give details of the targets for various services from MMU (except for minimal number of cases per day as 30 and at least once a month visit to the villages etc.) especially for FP, RCH, National Health programmes, Immunization, IEC, Counseling etc. Although these activities are expected to be carried out through the MMUs, but in the absence of targets, the actual performance of most of the MMUs was negligible.

1.1.3.1. It is therefore suggested that MOUs should be signed for 3-5 years with the identified NGO to ensure continuity of services and this will also reduce the increase turnover of the MMU states.

1.1.3.2. In the MOUs there should be clearly defined scope for the services of MMUs. The targets for various services especially in the areas of FP, immunization, RCH, National Health Programmes for Malaria, TB, IEC, lab
investigations etc. should be given and accordingly the monitoring formats need to be modified.

1.1.3.3. It would be appropriate to develop essential drugs list for MMUs considering the local disease pattern.

1.1.3.4. Similarly the list of investigations through MMUs may also be increased as in the remote areas these facilities were considered very important by the stake holders.

1.1.4. Selection of villages

It was observed that in some districts selection of villages was being done under pressures from local leaders and the sites for the MMU were also being changed due to the same.

1.1.4.1. The selection of villages should be done on the objectives of parameters. The state government has already defined villages as remote/difficult, considering the height, distance from National highway, link road, electricity and water availability, senior secondary school and type of uses.

1.1.4.2. The other parameters suggested by various stake holders were location of subcentres in the villages, availability of ANM in the sub centre, proportion of BPL/SC/ST/OBC population in the village.

1.1.5. Frequency of visit

The present frequency of visit of the MMUs to the villages was once a month, as mentioned in the MOUs. The patients coming to MMUs were being given medicines for 3-4 days and this was considered to be inadequate by the patients and the local leaders. It was expressed by various stakeholders that once a month visit to these villages were not effective.

1.1.5.1. It is therefore suggested that the frequency of visit to the identified villages should be increased to at least once a week/fortnight. For this, the number of villages selected for one MMU may be reduced to ensure effective delivery of services for these facilities.

1.1.6. Information to the communities about the services and route plan for MMU:

The present mechanism of sharing the information with the local health institutions and communities was not adequate as a result the reach of the services from MMU was restricted and some of the services of MMUs were underutilized.

1.1.6.1. The detailed information on the services available at MMUs, date of visits etc should be shared with the local medical officers of PHC, CHC and also the ASHA, AWW, ANM of the local villages so that the information is
communicated to all the potential users for the optimal use of the facilities.

1.1.7. Location of MMUs

It was observed that location of MMUs was in the accommodation provided by village Pradhans, AWWs, primary schools, Panchayat Ghasr etc. These places lacked in proper privacy, sitting and examination facilities for patients specially women.

1.1.7.1. It is therefore, suggested that basic minimal physical infrastructure such as furniture, water and light facilities etc. should be provided at the location of MMUs in the village. The local leaders and communities should be asked to provide these facilities on the day of visit of MMUs

1.2. Performance of MMUs

The total number of cases seen per day in the previous months in most of the MMUs which were functional was as per the expected norm of 30 per day. (In ___ districts the MMUs were not operational as these were sent by the NGOs for repair work) However, the % of cases Below Poverty Line (BPL) coming to the MMUs was less than the expectation. The reason mentioned was that the community members were not having the BPL cards (which were last made in the state in 2002-2003).

The major types of cases coming to the MMUs comprised of Bronchitis, URIs, Arthritis, diarrhoea PID, viral fever & anaemia etc.

The number of cases referred and the feedback and follow up of referred cases was not adequate at MMUs as these were visiting the village site once a month. This aspect also affected the effectiveness and reach of the MMUs.

In some MMUs the X-ray machines were functional but the number of X-rays done per month showed that these facilities were grossly underutilised. In the functional MMUs, Hemoglobin, blood sugar, blood grouping, HIV and Urine tests were being done. The Lab. Technicians were also well trained. However, the utilization of these facilities was also less.

The availability of medicines in functional MMUs was satisfactory, in fact in some MMUs the types of medicine available were same as those recommended for a CHC/sub district hospitals. There was no clear cut guidelines from the government and NGOs were selecting the drugs as per their own.

Some of the MMUs provided antenatal care, injection tetanus toxoid, BCG, Measles, OPV & DPT Immunizations, contraceptive services mainly condoms and oral pills,
counselling for breast feeding, family planning & RTI was also being provided. But the number of these activities was much very poor and there were no documentation to identify the users. The involvement of MMUs in National Health Programme for TB, Leprosy, Malaria, etc. was also poor.

IEC activities were grossly inadequate in almost all the MMUs. There were no posters, flop charts, booklets or IEC Kits in the MMU.

1.2.1. The MMUs should be given targets for the lab investigations, immunization, FP and for the National Health Programmes, this could may result in better performance in these areas.

1.2.2. The involvement of MMUs in National Health Programme for TB, Leprosy, Malaria, etc. need to be strengthened. The staff of MMU be provided short term training on providing basic services under their National Health Programmes in local CHC’s/PHC’s. Moreover training of Lab. technician of MMU in examination of slides for malaria and tuberculosis could ensure more involvement in National Health programme.

1.2.3. The services of MMUs will improve once better linkages are established with ASHA & local health functionaries.

1.2.4. X-ray facilities in the MMU were under utilized. Considering the types of cases being examined at OPD, this facility may not be of much relevance. There was difficulty in regular maintenance of X-ray equipment as the company which supplied had closed down. The state may reconsider this matter in view of the above. Or else for better utilization of X-ray facilities, better linkages with local PHC’s be developed, who could also use these facilities.

1.2.5. The IEC material be procured for the district. A panel for display of IEC material be added to MMU.

1.3. Client satisfaction

Although majority of the users of the services were satisfied with behaviour of MMU staff, availability of drugs & investigation facilities in the MMUs, which were functional.

5.3.1 The clients suggested more frequent visits of MMUs in their village atleast once in week.

5.3.2. The time spent by the MMU in the village was desired to be increase (Current time spent by MMU in the village ranged from 4-6 hours).

5.3.3. The drugs given to them were for 3-4 days and there was not considered sufficient for the treatment of their medical problem.

Some of these issues need to be taken care at the policy level as mentioned above.
1.4. **Involvement of Local Communities**

The current level of involvement local communities, ASHAs, AWWs, health staff and Panchayat members was poor as a result there was sub-optimal use of the facilities and services of MMUs.

1.4.1. It is therefore suggested that some incentives to ASHA (Rs.150-200) during the day of visit of MMUs would be useful.

1.4.2. The AWWs could be involved through local CDPO/PO of the ICDS as a scheme.

1.4.3. Panchayat members may be involved through the Tehasildars/BDOs/District Magistrate to ensure that minimum facilities on the day of visit of MMUs are provided.

1.5. **Linkages with Health Services**

The current linkages with health functionaries and local health institutions were observed to be poor. For better and effective linkages, the following suggestions are made:

1.5.1. The medical officers, NMS/Health workers should be informed about the date & time of visit of MMUs and they should actively participate in MCH, family planning, immunization and other activities related to RCH, Malaria, Tuberculosis, Leprosy programmes etc.

1.5.2. The MMUs staff should be sensitized on the activities under RCH, family planning, national health programmes by health functionaries in the form of short term trainings.

1.5.3. The IEC materials should be made available to MMU staff through districts/local CHCs, PHCs. The MMUs should also have a display panel which could be put at the location for display of posters and other IEC materials.

1.5.4. The representative from MMUs should regularly attend the meetings at districts, PHCs and CHCs for better coordination and linkages with health services.

1.5.5. Considering the better lab. facilities of MMUs, local health workers can utilize these facilities for the benefit of patients.

1.6. **Supervision and Monitoring Mechanisms**

Although there were mechanism defined for supervision and monitoring of the MMUs services at district and state levels but in practice these were not being followed in most of the areas. There is need to strengthen these mechanisms to carry out supportive supervision of the MMU and the following suggestions are:
1.6.1. Certifying format currently used by the MMU is signed by Village Pradhan need to be modified giving much more details of the services provided on the day of visit to the village and suggestions to improve the services next time in the villages.

1.6.2. The monthly monitoring format currently used need to have some more columns to include items details related to types of cases seen, types of cases referred, services given under RCH, National Health Programmes etc.

1.6.3. The monthly monitoring report should be discussed in the meeting being held at district/CHC/PHC and regular feedback to improve the performance should be given to the MMUs.

1.6.4. The health functionaries from CHC/PHC/District should also periodically visit the sites of MMU services.

1.6.5. There is need to have regular interactions for problem solving between the representatives of NGOs running these MMUs and the State Programme Manager and District Programme Managers.