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Context
Four key challenges will prevail post physical HWC footprint expansion given India’s socio-geographic challenges:

1. Limited accessibility: Long travel times (3km ~ 30 mins): Limited availability/high cost of transport; safety issues due to harsh geographies
2. Scarcity of availability/resources: Disproportionate gaps with 11/28 states meeting WHO doctor-to-patient ratio & underserved catchments with closest SC/HWC at >3km distance; unpredictable availability of health staff
3. High OPEX & low facility utilization: ~13 states/UTs with ~40% HWC utilization
4. Demand Hesitancy: Poor care-seeking behavior among rural communities

Activity Description
BCG conceptualized & operationalized a mobile van-based extension of AB-HWCs to take primary health services to the doorstep in under-served areas:

- Unique tripartite partnership model: state govt providing drugs/equipment & engaging FLWs; prvnt partner operationalizing camps & implementation partner (USAID NISHTHA) liaising with govt & prvnt sector.
- Modular village camps: mobile vans carrying HR, equipment, consumables
- 4-5X more conditions covered: provided screening, treatment, diagnosis, drugs & referrals through a hub (Primary Health Centres) & spoke model
- Increased throughput: Each unit covering 50% higher beneficiaries vs NHM MMU guidelines & 2-3X more villages
- Well-trained & commercially incentivized HRH: 1 doctor, 2 nurses, 1 Healthcare asst & 1 Multi-purpose Worker per unit
- Robust data-sharing systems: active follow-ups/ referral tracking by HWCs
- Behaviour change innovations: door-to-door beneficiary mobilization
- Operating model contextualization: radial distance covered, camp frequency & duration contextualized on the area & focus diseases

Activity Impact
A pilot was commissioned with 4 units operationalized across 2 aspirational districts of Jharkhand (Gumla, Ramgarh):

1. Quantitative Impact
   - 40X+ beneficiaries served: 220k+ treatments & 6K+ referrals via 720 camps
   - 30% higher daily throughput vs legacy state MMUs; >2X more tests done during ANCs & NCD screenings vs govt average
   - Access gap reduced from 6% to 2% in <8 weeks in pilot villages

2. Quantitative Impact
   - "Pull" to "Push" based care seeking observed
   - Care continuum approach with robust referral linkages
   - Robust & comprehensive beneficiary records for enhanced governance & longitudinal tracking

Evidence
1. ANC coverage: 8% pregnant women identified v/s monthly targets in pilot villages
2. Daily throughput: 10% increase in last 6 weeks due to mobilization tactics & select operational
3. Quality of care: >2X number of tests conducted per ANC & NCD screenings
4. Cancer Screenings: >15X more eligible population screened for cancer v/s state & India averages

Facilitators
1. Operational excellence: e.g., 1.5x more daily health transactions vs norm; radial distance reduced by 50% vs IPHS norms
2. Demand generation innovations: e.g., improved predictability of services (e.g., camp on every 2nd Tuesday)
3. Well-trained & commercially incentivized staff & operations microplanning for efficiencies & viability—e.g., throughput targets
4. Robust line-listed beneficiary records: unique digital health records & population health/program analytics dashboard
5. Health systems strengthening approach leveraged vs stop-gap—e.g., essential drugs, ASHA led mobilization

Challenges
1. Complex private sector led health system strengthening: need for clear communication of value proposition, attractive incentives
2. Inefficiencies in government onboarding: delayed approvals/ extensive coordination across multiple levels of stakeholders
3. Demand generation required rigorous deliberation & solutioning based on demographics, epidemiology etc.

Lessons Learned
I) Ecosystem-level reflections
   • Govt support & self-sustaining model imperative for success
   • Engage govt. early on for appropriate changes in policy/budgeting
   • Private sector when adequately incentivized is more equipped to deliver better throughput & unit economics
   • CSR can be an effective lever for resource mobilization

II) Operational excellence reflections
   • Improved operational efficiencies via modular vans; low CAPEX programs & catchment level microplanning
   • Repurposing existing govt infra (e.g., schools) can reduce costs
   • Unlocking demand requires creative solutioning—e.g., contextualizing the timings, syncing intervention locations with recurring local events

Patient counselling at the camp
Oral health check-up
PCCs/other equipment & consumables