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Abbreviations:

CHA: Community Health Assistant

CHC: Community Health Centre

NUHM: National Urban Health Mission

UHC: Urban Health Centre

Integrated or fragmented health care? Experiences from an Action Research Project in an urban poor neighbourhood in Bangalore

Thriveni S Beerenahally, Amruthavalli S, Roopa Devadasan, Upendra Bhojani, Nagarathna, Leelavathi, Josephine S, Munegowda CM, Nargis Tabassum,

Institute of Public Health, Bangalore

1. Tell us a bit about the situation at KG Halli

Fathima, aged 26 years, mother of four children, residing in KG Halli went to a primary care centre (Community Health Centre) run by the State government to access family planning service. She was referred to another primary care centre (Urban Health Centre) run by the municipality (local government), which is the next building separated by a wall. When she approached the urban health centre, she was told by the nurse that the doctor is deputed to another centre, available only the week after.

After a week, Fathima went to see the doctor at urban health centre. After examination, she was diagnosed with anaemia and was referred to maternity centre (Public primary care centre to provide maternal health service) which is at a distance of around four kilometres. Fatima and her husband who accompanied her wondered why they were referred to

another centre. No further information, medicine or referral letter was given to Fatima, nor she and her husband dared to ask the doctor for the reason for referral. In both the centres, Fathima did not receive any information about temporary family planning methods by the doctor or the nurse.

It was difficult for Fatima and her husband who accompanied her on every visit to hop from one hospital to another. Her husband, a daily wage worker, was the only earning member in the family. A visit to the hospital would mean running the risk of losing a day's wage. Fatima's husband decided to take Fathima to a private provider in the interest of his daily work and time, though they had to pay for consultation. But they did not know where to go. On consultation with neighbours, they went to a lady doctor near their house. After a long wait, they met the doctor but they did not get the expected service, because she was trained in alternative medicine (Unani). However she explained them what is the best thing to do considering their financial situation and referred them to Maternity centre, where they can access care for free. After two weeks when her husband had time, Fathima went to the maternity centre, she came back home with lots of iron and folic acid tablets to be taken for two months and go for a follow up check-up. Fathima wanted to go for permanent family planning method after her third child, but she ended up having her fourth child. Fatima was desperate to avoid pregnancy.

KG Halli, a poor neighbourhood is one of the 198 administrative units of Bangalore city, a metropolitan capital of Karnataka, India. KG Halli has a population of more than 44,500 individuals spread over 0.7 square kilometres. The median income of KG Halli residents is INR 73.3 (USD 1.5) per capita per day. The population in KG Halli is a social mix, with people speaking five different languages and representing all major religions of the country.

2. What was the complex issue/situation you were confronted with? What was the situation-background-setting?

The municipal run **Urban health centre (UHC)** includes the residents of ward no 30 in it's population of responsibility. Not much curative care is provided here, with main focus on maternal child health and National TB program. Poorly funded by the local city revenue; understanding of community is poor; staff answer only to superiors. There are 6 link workers who are responsible for the 'outreach activities' of this centre, they are the direct link to the community.

The state run **Community Health Centre (CHC)** is the closest public facility for the residents of ward no 30, but administratively, they are not their population of responsibility. It provides the following services: ... It does not suffer from budgetary constraints, but struggles with staff retention. It now has four specialists (General Physician, Paediatrician, General Surgeon and Gynaecologist) with a functioning labour room and a non-functional operating theatre. Here too, understanding of the community is uneven and staff answer only to superiors.

Both centres provide free service for people with below poverty line card and they charge a nominal fee from others. The referrals from both these centres are usually oral and unrecorded.

These two public centres are physically proximate but they are managed by **two separate departments**, falling under rural and urban government respectively. They are not integrated with work and they report to different authorities. Though the CHC is physically within KG Halli, the area of responsibility is nearly two kilometres beyond the physical presence. This has created confusion, as the CHC expects the UHC to cover the population of KG Halli. In practice, the community residing in KG Halli does not understand that the CHC is for another population. The majority of them utilize the CHC more than the UHC, as it is near, has better infrastructure and better availability of medicines.

We can say that the local health system at KG Halli is pluralistic. Apart from the two public centres, there are at least **23 private healthcare providers** from various systems of medicine (primarily Unani, Ayurveda, Allopathy and Homeopathy). Private healthcare provision is through several single-doctor clinics, providing only outpatient care and charging fees for service.

Just to summarise:

The situation we are describing is:

- A disintegrated health system
- Poor quality of care - Lack of patient centred care - Poor understanding of the patient's background - Very short consultation time (less than 4 min) with long waiting period – no provision for appointment
- No method to keep a patient's medical record or the referral system, lack of awareness about the importance of the same.
- Poor communication by the providers and power dynamics between the provide and the patient
- Lack of information/awareness about the services in the community

Background setting is:

- Poor urban neighbourhood with pockets of slum
- Disintegrated public health service: 2 centres managed by two different authorities and with different area of responsibility - Lack of motivation in the public health centres with "secure job"!
- Pluralistic health system with majority of non-allopathic private providers cross practicing

3. What did you do to deal with it?

Though in theory there is no dearth of health facilities, accessing quality health care is difficult. The strategy was to work with **three different stakeholders**: community, providers and health authorities, bringing them **in to one platform** to understand ground issues and means to improve access to quality care. We hoped that such a platform would bridge the gap between the providers and the community, or even the health authorities and providers/community.

At the **community level**, the attempt was to understand the health concerns, health seeking behaviour, health care expectations in greater details. We captured this through surveys, discussions and field observations. Four women hailing from K.G.Halli neighbourhood community were trained to be **community health assistants (CHA)**. The main purpose of training CHAs was to act as catalysts of change in the community and the team's role was to facilitate this platform. CHAs were initially aimed to understand community health concerns, but were expected to intervene in several other concerns of the community. Some of these issues were domestic violence, drug abuse, acute poverty, child labour.

We regularly did **motivational visits to UHC** and tried to contact higher authorities to improve facility and establish links with private providers to provide family planning service. But we failed to achieve our objective due to lack of motivation by the staff and lack of financial support from the municipality; focus is very much restricted to preventive care. Even we failed to **establish communication between two public centres**, as there is no interest to integrate and work together. We could achieve some progress with regard to women accessing for temporary family planning methods, working together in the field with UHC link workers. But we failed to bring in any visible changes in the last three years.

It was difficult to **work with private providers** and bring them together. We did one round of introductory visit to all the providers and collected basic information about their specialization and services provide and follow up visit was made to invite them for meeting. We held a few rounds of meetings with these providers. But it became complicated with providers practicing different type of medicine (Unani, Ayurveda, Allopathy and Homeopathy). The majority of the private providers practiced allopathic medicine irrespective of their own discipline of training. There was more cooperation from non-allopathic doctors than allopathic doctors. When we met providers it was clear that non-allopathic providers are looked down by allopathic trained providers because according to them non-allopathic practitioners are providing irrational care. There was interest to provide some selected services by private providers like immunization, temporary family planning methods, Antenatal service by collaborating with UHC. But due to complicated government rules and non-cooperation by UHC staff, we could not arrange or bring them together to think and plan activities together.

To summarize:

Aim was to bring community, providers (public and private) and the health authorities to a **dialogue** to improve quality care.

Work started with initial **mapping** of all the providers and their area of training and specialisation.

1. Working with the community

- i. As the planned entry point through **self-help group** failed, we decided to start **school health program** and meet the parents during parents meeting day. That failed too, as hardly there was any parent's meeting happening, it was mostly one to one meeting by the head of the school and the parent.
- ii. So the decision to **train women from the area** to work as community health assistants (CHAs) to work as a direct link with the community
- iii. Regular **home visits** by the CHAs to create awareness/address health issues-in the family
- iv. Create awareness about the services in the public centre
- v. Home visit by the team doctors as and when required and requested by the CHAs
- vi. Working with the youth
- vii. **School health program** continued as a felt need

2. Working with **public providers** (UHC & CHC)

- i. Regular visit to both centres. **CHC** not so welcoming as their area of responsibility was not the area we were working with.
- ii. Continued to work closely with **UHC**, helping to resolve issues of the UH staff-fixing running water and drinking water issue, helping to get the salary released regularly for the link workers - to build trust and relationship and also as part of the project activity to strengthen the centre
- iii. Encouraged to go for **public private partnership** to improve immunization, antenatal check-up and temporary sterilization coverage. Started on a positive note with the then doctor, but this did not take off as the subsequent doctors did not cooperate
- iv. Effort was to bring both public providers to **dialogue**, but there was a huge resistance from both the side as they are responsibility of authority is different and this was more of a policy decision than at this level. Also lack of motivation to take a step towards this initiative even to discuss from both the end.
- v. Participation of **UHC link workers** to be part of CHAs training, knowing they did not have any formal training to work in the community. CHAs working in collaboration with UHC link workers in the field, to help during national programs
- vi. Attending monthly meeting at UHC to **share data**, which went wrong,

- but at least this brought the team together
- vii. Invitation to participate in the **providers meeting (public and private)**. UHC staff actively participated in all the meetings but CHC though said “no’ but never participated in the meetings
3. Working with private provider’s
 - i. Initial introductory visit to explain about IPH and our future plan for the area
 - ii. Second round of visit to do informal interview to collect basic information about their background and the services provided and clinic set up
 - iii. Created the **list of providers** in the area with address and working hours and shared with all the providers-for them to know each other
 - iv. Many follow up visits made to those providers who showed interest to work with us. Had few rounds of meetings with providers (public and private). Slowly number of providers participated from the first meeting to seventh meeting reduced. There was curiosity among some providers to know what is happening: are we missing out something? How can I improve my practice? Will associating myself will help increase my patient load.... At the end of seventh providers meeting, only 5-6 providers were interested to continue working with us.
 - v. Some agreed to be part of our initiative to introduce patients medical record, but did not go a long way. We had an arrangement with some providers to refer poor patients who would be seen without any consultation charges and receive free medications
 - vi. With selected private providers, we are planning to start intervention for chronic care-with more focused activities
 4. Working with the authorities – was kept as the backburner as the activities in the field and working with providers took longer than we had planned.

4. What were the expected and unexpected results?

We expected before we started that working with the private and public providers will be a huge challenge and we also felt at some point that we were too ambitious with our aim to bring in community, providers and the authorities to dialogue. As expected it was a huge challenge even to access/talk to some of the providers. There were instances providers told us that “we were wasting our time and knowledge we gained as doctors” and many of them offered to utilise their space to run an out patient clinic. Very few private providers appreciated our work and were interested to work with us.

It was known from previous experience that gaining trust and developing relationships in the community would take a long time but that this is possible with a proper approach, through motivated and dedicated community health assistants.

With number of self help groups in the area, the strategy was to enter the community through this group. It did not take long for us to understand these “self help groups” were nothing but “micro financing groups” who came together either to give their contribution or to avail loan. They had no time to listen to us, as most of them were domestic workers who had taken short time off from work to meet the group and put the signature to show their presence.

It was difficult to work with the local elected representative-councillor, who’s husband was the man behind the scene. She is the elected representative for that ward. Also, the team did not make a dedicated effort to meet the local elected member of legislative assembly (MLA), as we were believing that approaching politicians was not worthwhile. But we were proven wrong, when the local MLA contacted us when he heard about our work in his constituency. He has been very accommodative and has interest to work for vulnerable population. Our relation has grown strong and things which were not progressing or had not progressed in the last few years are getting materialised due to his interest and support. This is an example that if the politicians are interested to make a difference, it is possible with little effort.

Working with public providers was not difficult during the initial phase as the doctor in the urban health centre was very cooperative and motivated. She was willing to listen and make changes to improve quality of care. She was replaced by a retired general surgeon as she got transferred to other UHC. Due to shortage of doctors, the govt is taking retired doctors on contract basis and he had no interest even to see the patients. However we could connect and work with him. He was replaced by another retired lady doctor with in few months, who is not at all interested to collaborate with us. She feels we are a threat, as our frequent visit compels her to come to work regularly.

5. Which new problems emerged? Which opportunities did you create/use to tackle these new issues?

One of the lessons was, though our entry point was health care and how to improve access to quality health care, we realized **for the community, health did not exist as an isolated domain** and how it was entangled with their everyday lives.

Health bureaucracy theoretically aims at efficiency but in this it crippled health care. Health centres remained fragmented and perceived accountability to their respective authorities.

Administrative difference between CHC and UHC is stronger than expected and it is difficult to integrate their work, as this decision requires approval from higher authority and it involves financial implication for the local and state governments. **Working in collaboration with higher authorities is a must** to bring in any change at primary care level.

In the last three years, it was not possible to merge these public centres to make them work together due to administrative difficulties. However, we are advocating in all the forums/meetings for reallocation of public centres and bringing all the health facilities in the city under one umbrella of administration with the people responsible for the implementation of National Urban Health Mission (which is a flagship program of central govt). This requires strong political will and commitment! Hence decided to work with UHC which is responsible for the area we are working.

One of the strategies we used to work closely with UHC was by **addressing staffs issues**. Like helping to have running water and drinking water facilities, water storage and following it with local govt for the salary of link workers, who otherwise would get their salary once 3-5 months. We also worked in collaboration with UHC during polio program and other national programmes. When we started **training community health assistants (CHAs)**, we invited the link workers from UHC to participate and encouraged them to collect data from CHA's for the monthly reporting. In this way, at least, we could help in understand the gap between their data and the data we had. However, this arrangement created more issues than bringing CHAs and link workers together: the link workers motivation was uncertain with the delayed salary and lack of training and uneven understanding of the community. The huge discrepancy in the data collected between CHAs and link workers put more pressure on the link workers to perform better, without proper support. Also the questions raised about the functioning of link workers openly by CHAs in the meeting distanced the relationship with CHAs. But the team continued to make motivational visit and the distance was slowly reduced. But data sharing did not continue, as it was an informal arrangements we had which the new UHC doctor found to be a threat than an advantage. This experience made us realise that if the doctor is not motivated and interested to bring in change, we could not work together to improve quality of care for the people in the community nor integrate the work between centres.

On and off visits to the field from foreign "white skinned" interns and students created a huge hype about our institute to the extent that "we generate money showing poor faces and public health centres" and the staff at public centres felt that they could ask for any help which we should full fill. Also, in the community, frequent visits by foreigners created negative propaganda about our work -like "they are coming to take away our children or adopt a poor child", and community members questioned our intention of taking them to the field. This was something we did not expect and found it difficult to handle also. However we have adopted different strategy after this experience wherein we will give written letter to the public provider explaining the purpose of visit to India and to the public

centres and take permission before we take them, so that they are clear about our intention and it will be written document for our record. We had to reduce frequent visits from foreign inters/students keeping the larger goal of the project.

6. What are in your opinion the competences or mind sets you need(ed) to deal with this complex issue?

One of the major skills needed to work in this situation was **to have patience** and not to get demotivated. Because all the activities we tried to implement has taken much more time than we expected and that too not necessarily always with positive outcome. Many times it was frustrating and demotivating for the team to take up any new activities, but with strong team support we have been able to hold and motivate each other to keep our work going. Dealing with complexity is dealing with trial and error?

This kind of work also demands regular follow up and to meet government officials who would not give appointment and wherein we have to wait for hours or sometimes whole day and return without meeting, as the official is held up in meeting! This process of accessing the concerned person to get the approval letter signed requires patience and commitment and belief in the work we are doing.

There were also instances where in people have questioned our motivation behind the work, not so in a positive tone. The “eyebrows have gone up asking what is in it for us” to take up so much trouble to follow up on regular basis.

May be continuous persistence and advocacy from our end may help to merge the service or integrate the work when NUHM finally takes off. But changing the mind set of government staff and motivating them to think from the patient’s perspective to provide quality care is long way to go. This can happen when the community is aware of their rights and gets the courage to question the providers, as there is big power dynamics between the providers and patient.

- The need to network people on the ground, not only health staff but also the community, the politicians and the hierarchy?
- Complex problems need home grown solutions, and it is best to try out different approaches, till you find something that works?
- The challenge then becomes: how to learn from what you do?