

Basthi Dawakhana of Hyderabad: The first Urban Local Body led community clinics in India

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ABSTRACT

Basthi Dawakhana initiative was launched by the Greater Hyderabad Municipal Corporation (GHMC) in Telangana state of India, in April 2018. This article documents, reviews, and analyzes the key design aspects of Basthi Dawakhana, delve into why such clinics are important for strengthening primary health care in Indian cities and urban settings, and proposes a few strategies for implementation effectiveness. In the main text of the article, evolution of urban health services, national urban health mission in India, and Mohalla clinics of Delhi has been provided. The implementation challenges and potential solutions for scaling up Basthi Dawakhana have been discussed. The author argues that Basthi Dawakhana initiative is aligned with the 73rd and 74th amendments in the Constitution of India, which transferred the responsibilities for primary care and public health to the Urban Local Bodies (ULBs). The article concludes that Basthi Dawakhana are arguably the first ULB-led community clinics initiative and an opportunities for ULBs in India to lead efforts to strengthen primary healthcare. These Dawakhana along with Mohalla Clinics, can serve platform to reform urban primary healthcare services and advance universal health coverage (UHC) in the country.

Keywords: Ayushman Bharat Program, Basthi Dawakhana, India, Mohalla Clinics, primary health care, universal health coverage

Introduction

The health challenges and provision of primary healthcare in urban areas and potential role of state governments received wider political and public attention with the launch of *Mohalla* Clinics in Delhi in July 2015.^[1] The elected leaders of a number of Indian states had shown interest in opening community clinics on the line of *Mohalla* Clinics, in their home states. Nearly three years later, in April 2018, the Greater Hyderabad Municipal Corporation (GHMC) in Telangana launched *Basthi Dawakhana*, which aims to provide basic primary health care services to under served urban population.

This review article, critically analyses the concept and design of *Basthi Dawakhana* with their potential impact of urban health service delivery. The strengths and limitation have been analyzed with suggestions for the rapid scale up.

Health service in urban India

The traditional ignorance of government provision of primary health care in urban areas is a well recognized. It has resulted in a situation that in India, by March 2017, while there was an elaborate network of Government Primary Health-care facilities (GPHF) with nearly 187,000 government health facilities of health subcenters, primary health centers (PHC), and community health center in rural areas; however, for nearly 400 million Indians living in urban areas (which is nearly half of the rural population), there are around 5,000 to 7,000 GPHF only.¹ This is despite the global evidence that a robust and well-functioning primary health-care (PHC) system has the ability to cater up to 80–90% of all health-care needs of the people and is considered the most efficient way of delivering health services.^[2]

¹There is limited up-to-date data available on number of GPHF in urban India. However, these numbers do not include health facilities of Central Government Health Services, or CGHS and Employee State Insurance or ESI scheme, and railway facilities, which caters to specific target groups and not available for use by general population.

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With this background, it does not come with surprise that the National Sample Survey Organization, based upon 71st round of survey (2013–14), has reported that for outpatient consultations, only 28% rural and 21% urban people go to a public (or government) provider.^[3] Furthermore, even the vast and elaborate network of GPHFs in both rural and urban areas put together, provides less than 10% of total outpatient services excluding mother and child health related services. Clearly, the GPHFs are grossly underutilized, some of which is attributable to poor access and insufficient availability of services and providers. For these reasons, amongst many others, the poor people often delay in seeking health services till their condition worsens. Then, they choose to attend private providers (both formal and informal) and in both cases spending from their own pockets, risking the families falling into poverty. Those with no paying capacity end up visiting secondary and tertiary level health facilities such as district hospitals, medical colleges, and apex institutions i.e. All India Institute of Medical Sciences. None of these situations is good either for beneficiary (who experience long waiting time, indirect cost on transport, and often have to pay multiple visits) or from provider perspective. As in the second scenario, the specialist doctors catering to common conditions lead to poor job satisfaction amongst providers; more serious patients get delayed attention due to overcrowding and from the government perspective, health service delivery becomes expensive.^[4]

The access to GPHF and health outcomes of the urban poor (in India) are often worse than rural settings. The challenges in urban primary health-care services are likely to be compounded in the years ahead as the urban population in India is estimated to increase by 70% between 2011 and 2030, to reach 600 million. In urban India, reforming and strengthening primary health-care services is a felt need in every city, big or small.

National Urban Health Mission, 2013

The first major acknowledgment of the need for improving urban health service delivery in India was the launch of National Urban Health Mission (NUHM) by the union government of India in May 2013.^[5] The NUHM launch resulted in the National Rural Health Mission being renamed as National Health Mission (NHM). The launch of NUHM itself was delayed by nearly 5 years. The initial framework for implementation of NUHM was drafted in year 2008. This was interpreted by many as low priority given by the government to urban health services.

Even after the launch of NUHM, the financial allocation for the mission has been a small proportion (in range of 2.5–3.5%) of total allocation to the NHM [Table 1].^[5,6] In absolute terms, during the 5 years of implementation, the allocation to NUHM has been less than INR 1,000 Crore with either a stagnant or declining trend (except in year 2014–15).

The low financial allocation to NUHM is compounded by even lower utilization. An analysis by National Institute of Public

Finance and Policy documented that in FY 2015-16 & 2016-17, while utilization under NHM was around 55%; the utilization of allocated funds for NUHM was 38% and 50% respectively, with wide variations amongst the states such as Telangana having fund utilization of less than 10% of allocation [Table 2].^[7]

Health is a state subject

Health is a state subject, as per constitution of India. Clearly, any union government initiative including NUHM could at best work as catalyst and more initiatives and actions are needed from the state governments and ULBs for improving public provision of health services. However, due to variety of reasons – including health being low on the electoral agenda and perception that people do not vote based upon work done by the governments in health sector. Understandably, the state governments in India have not taken enough interest in provision of (urban) health services.

Mohalla Clinics of Delhi, 2015

Urban health received wider political, public & media attention with the launch of *Mohalla* Clinics in Delhi^[8] Soon after, *Mohalla* Clinics became the most well known urban primary healthcare initiative by any state government in India. The elected leaders of a number of Indian states had expressed their interest and intention to set up similar types (with different names) of facilities in their settings. These intentions were not sufficiently followed through and for nearly 3 years, there was no noticeable initiative from any Indian city or state to set up community clinics until April 2018. During this period, by July 2018, there were 185 Mohalla Clinics functioning in Delhi.

Basthi Dawakhana of Hyderabad, 2018

On April 6, 2018, the Greater Hyderabad Municipal Corporation (GHMC) in Telangana state of India launched 17 Basthi Dawakhana² (in English, community dispensaries), with a proposal to set up 200 to 500 such facilities across GHMC area.³ Three of these Dawakhana (in Babu Jagjiwan Ram [BJR] Nagar in Malkajgiri area, in Gaddi Anaram, and in Hashimabad of Hyderabad) were inaugurated by the senior leadership of the state government of Telangana and GHMC.^[9] These facilities were set up after an initial announcement, nearly 11 months ago, in May 2017.^[10] The leaders and officials claimed these facilities to be inspired from and designed on the concept of Mohalla Clinics of Delhi. The stated objectives of these clinics are “to make available to them essential primary health-care services and reducing their out of pocket expenses on treatment.” However, the initial focus seems to be on delivery of “basic clinical outpatient services.”

²The word “Dawakhana” or “dispensary” in India are commonly used for a government health facility with a qualified doctor and other staff. At these facilities, a range of services including consultation, clinical examination, dispensing of medicines, conducting laboratory testing, and a few other services are offered.

³The number of such facilities to be opened in GHMC area has varied in different announcements. Initially 1500, then 1000 were widely quoted. After the opening of such clinics, media reported the state health minister announcing the plan to open 500 such facilities.

Table 1: Budgetary allocation in India (Financial Year) 2013-18

	2013-14 Actual	2014-15 Actual	2015-16 Actual	2016-17 Actual	2017-18 RE	2018-19 BE
Allocation to NUHM	662	1,346	718	491	652	875
Total allocation to NHM (NRHM + NUHM)	18,100	17,628	18,295	20,000	26,110	25,154
Allocation to NUHM as percentage of NHM	3.6%	7.6%	3.9%	2.5%	2.5%	3.5%

(All amount in INR in crore; 1 US\$ = 67 INR)

Table 2: Utilization ratio under NHM in years 2015-16 and 2016-17 (percentage of allocation)

	2015-16			2016-17		
	NUHM	RCH	Overall in NHM	NUHM	RCH	Overall NHM
High focus states (other than northeastern states)	50	71	54	58	66	54
High focus northeastern states	57	73	60	40	68	57
Non-high focus large states	56	67	56	47	69	57
National average	38	70	55	50	67	55

NUHM: National Urban Health Mission; RCH: Reproductive and child health; NHM: National Health Mission

Basthi Dawakhana are proposed to be located mostly in slums, each catering to 5000–10,000 population. Each clinic would have three rooms – a waiting hall, a consultation cum examination room, and a pharmacy. The staff includes an allopathic (MBBS) doctor, a staff nurse, and one maintenance worker. These facilities function from 10 am to 4 pm with 1-hour lunch break, at most places. The package of services includes consultation with doctor, immunization services, antenatal and postnatal care, sample collection for laboratory investigations, drug dispensing, counseling and contraception services, screening services for anemia, and noncommunicable disease (NCD) such as high blood pressure, blood sugar, cancer, and health promotion activities. Each of these facilities has been provided with stock of 144 essential medicines, a laptop with internet connectivity, a tablet with an App specially designed for Basthi Dawakhana, and a bar code generator for laboratory samples. The facilities are supplied with equipment such as blood pressure apparatus, examination table, etc. The laboratory investigation service has been linked with Telangana free diagnostic scheme. The blood samples are collected by staff nurse at Basthi Dawakhana and sent to next level of facilities, which further send these samples to affiliated network laboratory where tests are conducted. The reports, once available, can be accessed through dedicated online portal, at the original Dawakhana where sample was collected and shared with patients, usually next day. The Dawakhana have a referral linkage with nearby urban primary health center (U-PHC). Each facility is equipped with provision of drinking water facility for patients, a covered waiting area, and patient feedback box, to list a few. The services offered are free of charge to the patients. In the first four months of functioning, the average patient attendance at most of these 17 new facilities was 60-100 patients per day.

The Dawakhana started in April 2018 are mostly functioning at a few rooms of existing community halls, specially modified to accommodate these clinics. These buildings are owned by local administrative bodies. There are plans to identify additional sites to set up Dawakhana through prefabricated cabins. An illustrative example of a Basthi Dawakhana and its functioning is provided in Box 1.

Basthi Dawakhana are being administered through City Health Society comprising officials of department of health and family welfare, Govt. of Telangana as well as the GHMC. The society has been designated to receive funds from both GHMC and the state government. The initial cost of setting up each facility is estimated at INR 500,000 (US\$ 7,150) in addition of INR 200,000 (US\$ 2,850) for renovation. Estimated recurrent cost per annum per facility would be INR 1800,000 (US\$ 25,700). The GHMC has taken responsibility for necessary infrastructure such as buildings, while the health and family welfare department would take care of supplies, medicines, posting of human resources, and other aspects.

Potential 'game-changer' for urban health services in India

The need & design of community clinics has been examined in the past and found to have ingredients for successful delivery of primary health-care services [Box 2].^[5,8] Furthermore, a government health facility with an allopathic doctor is available for every 50,000 or more urban population under NUHM. This provision of facilities and doctors is insufficient by most standards.⁴ Clearly, the community clinics by making provision of a doctor and facility for every 5000–10,000 population ensure increased access to facilities and doctors by 5–10-folds.

Second, the challenges in delivery of health care in most Indian cities are likely to be similar to what is being experienced by Delhi or Hyderabad, at present. Therefore, every Indian city, and their elected local body, should give due attention and consideration to reform and strengthen urban primary health-care system. Establishing community clinics could be a good starting point.

⁴The current approach of one health facility for every 50,000 population is unlikely to work. It is well known that approximately 20–25% of total population above 30 years of age in India is in need of treatment for either hypertension or diabetes. Considering 40% of total population is comprised by this age group, there would be an estimated 4000–5000 people in need of care for NCDs. Therefore, if a facility is for 50,000 people, everyday there would be ~200 patients for NCDs alone. Thus, such provision is far too less and India needs a health facility for a smaller group of population in urban areas.

Box 1: Basthi Dawakhana: Babu Jagjiwan Ram (BJR) Nagar, Malkajgiri, Hyderabad

This facility has three rooms designed by converting/modifying ground floor of two storied community hall. (The first floor of this building is still functioning as community hall.) The facility is in the center of BJR Nagar which is reportedly inhabited mainly by poor people and daily wagers. In this Dawakhana, there is a spacious and covered waiting hall, which is kept clean, well lit with sufficient IEC material in vernacular. The pharmacy is well stocked with medicines & other supplies. The required equipment are available including the list of 31 laboratory diagnostics being offered. There is provision of drinking water for patients and a complaint box. There is enough open space outside the facility. Most of the provisions are per suggested norms of the Basthi Dawakhana including posting of three staff. A continuous flow of patients is noticed across the working hours with maximum patient attendance around 10 am when the clinic opens. This Dawakhana is often visited by politicians and journalists who wish to see and understand the functioning of these facilities.

Third, as part of 73rd and 74th amendments in the constitution of India, passed by Parliament in 1993, the delivery of primary care and public health services is one of the 18 responsibilities transferred to ULBs.^[11] However, 25 years since then, with a few exceptions, ULBs in India have not invested enough on health services. The reasons vary – lack of role clarity amongst various agencies delivering health services, poor financial ability of majority of ULBs, higher level of interest in capital expenditure than in social services, and finally, the health not amongst the priorities. By taking leadership in opening Basthi Dawakhana, the GHMC has taken lead in what ULBs (municipal corporations and councils) are mandated and supposed to do. GHMC, arguably, could be termed the first ULB to take lead in setting up the community clinics in India (Delhi's Mohalla Clinics are led by the state government).

Fourth, the NCDs such as diabetes mellitus and hypertension contribute to nearly 2/3 of total disease burden in India. There is evidence that only 10-12% of hypertensive in India are on treatment with their blood pressure fully under control. Managing NCDs require prevention and health promotion, and if the person has diabetes and hypertension than regular interaction with health systems is needed. The NCD management does not need high-end specialist care and can be effectively managed by health providers such as graduate (MBBS) doctors and qualified nurses through regular advice, continued monitoring and medication, etc. It is proposed (and is not happening at present) that to be effective and impactful, all adults affected with common NCDs such as diabetes and hypertension and any other health condition requiring long term care and living in the catchment area, can & should be registered at Dawakhana, for treatment and follow up.

Finally, the experience from Mohalla Clinics of Delhi has shown that the underserved population groups such as women, elderly, and children are more likely to access health services from the community clinics^[8] which in turn contributes to reduce inequities in health services.

Ensuring success of Basthi Dawakhana

Hyderabad city has a large secondary and tertiary care health infrastructure, both in public and private sector. This

Box 2: Community clinics and health service delivery

Increased geographical access to health service: The major challenge in India in accessing health services is long travel and then the waiting time at health facilities (both of which have opportunity cost). The concept of community clinics is all about increasing geographical access to health services and reduce time and cost involved in transport and waiting period. The access to health services in local setting and environment encourage people to attend facilities at the early stage of illness, which would indirectly benefit in reducing cost of the treatment

Increased access to health services by unreachable and marginalized population: The idea of setting up these clinics in underserved locality such as slum clusters, resettlement colonies and where more of the migrant population lives has far-reaching potential. Majority of this population, being new to the urban city atmosphere feel uneasy in attending urban and big health facilities until the health issue, become really serious. They also go to unqualified providers. These clinics introduce such population to mainstream health system and have potential to alter health-seeking behavior

Reduced cost of care through provision of assured free medicines and provision of diagnostics and increasing access to services:

The cost of outpatient department (OPD) consultations, medicines, and diagnostics contribute to nearly 70% of health-care cost by the people. The provision of free medicine for common illnesses at facility level and that of access to diagnostics services make accessing public health facilities attractive and make services affordable for poor people. In addition, easy access reduces the cost of transportation and waiting time (opportunity cost of missing work). The flexible timing of such facilities allows the people do not have to miss on their job or daily earnings

Provision of counseling and referral services. The emerging burden of noncommunicable diseases in all subset of population including poor needs a lot of preventive and promotive services. The hypertensive and diabetic patients are in all sections of society, and need both preventive and promotive services but medicines as well as counseling services. The counseling would be more adhered when people get access to clinical services. An effective referral from these clinics, which is accepted at higher level of facilities, would be a big attraction for people to attend these facilities

Meeting the non-medical needs of the people: The provision of drinking water, clean, spacious, well lit and covered waiting area, and a complaint box could be symbolic but also reflect detailed considerations in identifying common issue gone into designing these clinics

Highly cost effective intervention: The one-time cost of setting 500–1000 such facilities (approx. 50 to 100 crore or US\$ 7–15 million) would be less than what is needed for setting up a secondary hospital at district level. Similarly, the annual recurrent cost of running nearly 1000 such facilities is also comparative to running cost of one secondary level facility, whereas the number of patients catered by such clinics would be many fold higher

infrastructure has developed through sustained government initiatives as well as catalyzed by government funded health insurance scheme. The heart of the city is punctuated by many sprawling large hospitals, established out of erstwhile five-star hotel buildings. Like many other Indian cities, Hyderabad is in want of more of government primary health-care facilities and Basthi Dawakhana appears to be a promising start. A few specific actions can be considered to improve implementation effectiveness:

1. *Set up an independent advisory group of expert to guide the scale up and implementation:* At present, the initiative is mainly being guided by the government officials and a few elected

leaders. In health sector, while elected leaders often initially get fascinated, before losing interest soon after the building is inaugurated and initiative launched. Similarly, the policy makers and program managers tend to shift their attention to next emerging challenge, once facilities are staffed and supplies dispatched. In reality, what people need is regular uninterrupted access to health services over long period, to meet their health needs in an assured manner. The effective functioning and scale up of such facilities would need sustained attention and expert technical inputs, well beyond 'intuitive interventions' of political leadership. Considering such suggestion and dialogues are not always frank between elected leaders and the government officials, an independent advisory group of health experts should be established. This group should be regularly consulted for guidance and advice for consideration by the policy makers

2. *Make ULB and state engagement "broad-based" and "synergistic"*: A promising part of *Basthi Dawakhana* initiative has been that it was conceptualized by an ULB, the GHMC. Therefore, it was and is an opportunity for the GHMC to strengthen and reform health services. However, this advantage appears to have been lost with both the state government and GHMC distributing responsibilities between themselves in "additive" manner only, whereas both of the stakeholders are providing what they would have provided, in any case. This can become 'synergistic' when both state government and GHMC scale up their investment on human resources (HR) and infrastructure simultaneously.
3. *Sustain political commitment and ensure matching financial resources beyond NUHM funding*: Establishing, for example, 500 Dawakhana would also mean bringing equal numbers of doctors, nurses, and other staff into the system. A political promise without finances is unsustainable. This is not feasible unless state governments and ULBs are willing to invest more than what they do at present. The insufficient financial capacity of ULBs and state governments in India is likely to be key hurdle to the process. This is where committed and determined leadership has to play a role, for what it perceives important initiative. At the cost estimated by GHMC, 500 *Basthi Dawakhana*s would need one-time capital investment of nearly INR 25–30 Crore (US\$ 3.5–4.2 million) and then annual recurrent expenditure of around INR 100 crore (US\$ 15 million). To facilitate the process, a detailed and agreed roadmap and operational plan along with financial resources should be developed and approved. The GHMC and the state government can lead by example by setting a dedicated proportion of their total budget for *Basthi Dawakhana*.
4. *Offer full range of primary health-care services and not curative services only*: These facilities should aim to deliver comprehensive primary health-care services, which require that public and population health, as well as community outreach services are included in the package, at the earliest possible stage. The opportunity with GHMC to set up new facilities, even if named *Dawakhana*, should be utilized to design a full-range public health services, including preventive and promotive health services. Public health, in any case, is responsibility of

ULBs, and therefore, GHMC would be fulfilling its mandate if it expands the public health services as well.

5. *Primary health-care services for all, not for poor and marginalized only*: Even if prioritized for poor and underserved localities, the aim should be to cater all sections of population. Such design would also help in fighting the perception battle of such facilities being considered by some as poor quality services
6. *Reform supplies and procurement of medicines at all government health facilities*: The cost of medicines and diagnostics is a large contributor to total out of pocket expenditure on outpatient services in India. Therefore, the sufficient availability of medicines and diagnostics services need to be assured through establishing systematic mechanisms such as a functioning medical procurement and supply corporation in the state. Evidence points that this can reduce leakage and ensure long-term efficiency in procurement and reduce the cost of medicines and diagnostics as well.
7. *Establish effective accountability and monitoring mechanisms*: The success of *Basthi Dawakhana* would be dependent upon sufficient engagement of community members and elected representatives. There is need for stronger accountability and monitoring system. Appropriate local mechanisms have to be established to facilitate this process. A facility level "management and patient welfare committee," with representation from community members and local elected representatives could be one approach. *Basthi Dawakhana* monitoring committee of four to six community members could be another.

In addition to the broader issues, there were a few local level operational challenges at many *Basthi Dawakhana* in July 2018, which need to be dealt through design modifications [Box 3].

Laying foundation to reform urban health services in Telangana

The political commitment, has potential to reform urban health services in India.^[8,12] Setting up community clinics, with any name, should not be seen in isolation and has to be the first step in reforming the primary health-care service delivery. Following should be considered by GHMC and Telangana state.

- *Reform and strengthen urban health system*: Hyderabad city has advantage of a strong and robust secondary and tertiary care system. Therefore, *Basthi Dawakhana* should be utilized for harmonization of services at existing facilities run by different agencies, supplemented by effective and well-functioning referral linkages. The next level of referral could be to a secondary level facility and not to an U-PHC. The existing U-PHCs are staffed with a graduate (MBBS) doctor (same as one at *Basthi Dawakhana*) and may not fully serve the referral needs of patients. The possibility of having a mechanism of back-referral from district hospitals and medical colleges to community clinics should also be explored. For example, patients diagnosed with diabetes and hypertension should be facilitated to get registered at community clinics and for follow up consultations and medications.

Box 3: Local level operational issues in Basthi Dawakhana

Three indicative operational issues, which needs to be addressed in process to for successful scale up of Basthi Dawakhana:

1. Branding: At facility level, a few Dawakhanas have been named as “Health and wellness centers” or HWCs. This has been done to meet the funding requirement under NUHM and Ayushman Bharat Program in India. However, the branding of “Basthi Dawakhana” could prove a useful tool for political visibility and attention, as well as accountability and long-term sustainability perspective.

2. Data recording and reporting: The facilities have been provided with a laptop, a tablet, provision of internet connection and a dedicated App (application) for Basthi Dawakhana. However, the data recording and reporting at most of these facilities is manual and mostly aggregate reporting. Limited or no analysis of patient data was being conducted till July 2018. The opportunity to improve recording and reporting in health system is completely being missed & need to be harnessed.

3. Skewed doctor to nurse ratio and over-burdened staff nurses: The nursing staff posted at these facilities have been assigned multiple responsibilities including drug dispensing, record keeping, sample collection, and data entry amongst others. Their workload need to be rationalized and possibly more nursing staff need to be posted.

- *Opportunity for innovations in health care:* One, though the interim need for human resources at these facilities, could be fulfilled by posting of the staff already available at secondary and tertiary level facilities. As the staff at tertiary care facilities is often not fully exposed to the trials and tribulations of the common people at primary level care. Such postings could be immensely useful opportunity to expose them to this work environment. Second, considering that these clinics are only outpatient services, the flexible timing and evening shift for clinics should also be considered to optimally utilize the resources. The current timing of the clinics, 10 am to 4 pm may not be suitable for the target beneficiaries (of working and poor people). The authorities may explore variable timings such as morning 7 am to 1 pm shift and the afternoon and evening shift of 2 pm to 8 pm, for ensuring better patient attendance. Third, globally, the recommended doctor-to-nurse ratio is 1:3 or even higher. Many of the primary care services to be delivered at Basthi Dawakhana, especially health promotion and services for NCDs, can be effectively delivered by nurses. It is the opportunity to explore the system by posting more nurses per facility per doctor, implement Task Shifting, and document the experience
- *Ambitious yet achievable target for Basthi Dawakhana:* It was the scale of plan - 1000 Mohalla Clinics that attracted the attention of the people and politicians. Therefore, setting a target of 50 or 100 Basthi Dawakhanas in GHMC area would be “business as usual” and may not serve the purpose fully. Considering that each Basthi Dawakhana is planned for 5000–10,000 populations, which is one-fifth to one-tenth of population covered by each U-PHC. As the GHMC has 145 approved U-PHC, the approximate numbers of Basthi Dawakhana in GHMC area would range anywhere from 600 to 1000, excluding those areas which are well served or being covered by other government health facilities. In this

context, prior to selecting locations and arriving on required numbers, a detailed mapping of health facilities (run by any agency) and gap analysis (required and available) in health services in the city should be done. The required numbers of health facilities can be based upon also factoring-in the future health needs, at least for next 3–5 years, alongside a plan to revamp existing facilities. There is limited value in administration trying to do only what it is capable; it should challenge itself to fulfill the needs of the people and the future health needs.

- *Expand beyond GHMC to other ULBs and urban areas in the state:* The initiative, as already been considered useful by state government of Telangana should be expanded to all ULBs and urban areas of state. The officials in GHMC and the state government can guide and facilitate the district level officials in rapid scale up and effective implementation.

Lessons for other states and ULBs in India

The early experience from scale up of Mohalla Clinics in Delhi and now, Basthi Dawakhana in Hyderabad has a few generic lessons, for Indian cities/ULBs, planning to set up similar type of facilities or aiming to reforms in urban health-care services.

- *High-level political commitment, leadership, and stakeholder engagement:* The process of setting up clinics is likely to face a number of hurdles and oppositions, which might be political or administrative. Irrespective of the origin, these would need interventions from high level of political leadership. Therefore, while one of the bodies of elected representatives (the state government or municipal corporation, as the case may be) can take lead, there has to be a mechanism for coordination and engagement with other stakeholders, from the very beginning. The drafting of 3–5-year roadmap cum plan to reform health-care system with investment plan, approved by highest levels, can ensure sustainability and continuity and has potential to survive any possible change of leadership or government
- *Detailed budgeting and sufficient financial allocation:* A detailed budgetary analysis should be followed by a public commitment of resources. Engagement of possible highest level of leadership, that is, chief minister of state or the mayor of a municipal corporation, is desirable. Alongside, minister of health need to have a functioning coordination with the ministers of finance and/or that of urban development. It might be helpful if a line item in the respective budgets of ULBs and state health departments is included for these initiatives
- *Interventions to strengthen mechanisms for health data collection and analysis:* The initiative would require a good data support and analysis at the early stage to respond to queries, criticisms, and also for planning and redesigning the services and taking appropriate corrective measures. The existing data collection and reporting systems are amongst the weakest link in health systems. Setting up the clinics can be utilized as an opportunity to establish new mechanisms for robust data collection and analysis. An initial step should be conducting a

a detailed scoping study, situation analysis and documentation of challenges in data collection and reporting, specific to each setting. The newly established data system could then be used for strengthening overall health information system, in next 2–5 years. The use of information and communication technology tools and emerging technology for patient identification records, data collection, and monitoring could very well fit into the process

- *Provision of free medicines and laboratory services:* The community clinics, where patients will have access to a qualified doctor, would be only partial success and not enough from the perspective of people, unless these clinics have assured and uninterrupted provision of free medicines and diagnostic services. The cost of these components also needs to be factored, from the budgetary perspective, from the very beginning. The opening of new facilities should be used to further scale up and strengthen free medicines and diagnostics services, if already in place.
- *Assured availability of providers and services:* The community clinics should be designed to showcase the best of health services which can be offered through the government health facilities. These clinics could be useful entry point for new patients and bringing back the faith of the people in public health system. However, this would require ensuring that if a doctor is on leave, his replacement comes to the facility on time; if there is increased workload, additional HR is posted; if there is a complaint against the facility, appropriate corrective measures are taken in timely manner and that the referral sent from this facility is either given preferential treatment or assured care at the next level of facility.
- *Making referral system functional:* The success of community clinics would be a lot dependent upon the functioning of referral system. The patient experience, specially of those who would be requiring referral, and their retention in the system would be dependent upon how they are treated during the referral process. This would need better coordination and linkage between next level of health facilities, specially those of specialized Centre.
- *Active community engagement and participation:* The success would be a lot dependent upon level of community engagement and participation. The patients, community members, and elected representatives need to be engaged in selection of sites for these facilities, monitoring of functioning, regular feedback and social audit, to list a few.

Conclusion

Basthi Dawakhana are arguably the first Urban Local Body (ULB)-led community clinics in India, with potential to increase the role and contribution of ULBs in delivery of primary health care and public health services. Once scaled up to a sufficient level and sustained over period of time, the ULBs in other parts of India can consider this to be a model to emulate. More specifically, Basthi Dawakhana have potential platform for better engagement of ULBs in overall delivery of urban health services

in Indian states. The recent Community Clinics initiatives such as Mohalla Clinics and Basthi Dawakhana in Indian states appears complementary to ongoing initiatives under National Urban Health Mission as well as to Health & Wellness centres (HWCs) under Ayushman Bharat Program (ABP) to advance universal health coverage (UHC) in the country.

Disclaimer

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Conflicts of interest

The author has provided technical advice to the officials of Greater Hyderabad Municipal Corporation (GHMC) since inception stage of Basthi Dawakhana.

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