We have all heard the stories: the mother walking for two days to take her sick child to the nearest health facility, the man losing two days’ pay to seek out medical care for a persisting pain, the millions upon millions of families that forgo care altogether because they don’t have the means to reach a traditional health facility.

Mobile care—the delivery of services by health workers on the move—holds particular promise in extending health care to populations beyond the reach of static facilities. In certain cases, it has been shown to be more effective than static facilities, serving many more people with the same equipment and recovering a larger portion of its operating costs, and more efficient in utilizing staff time. Although much work remains to be done before we truly understand both the potential and pitfalls of mobile medical care, there is no shortage of models that have been developing and evolving the capacity of limited medical human resources to serve disperse and remote populations.

From a basic bicycle carrying health workers and medicine into rural villages to a fully mobile cardiac catheterization lab, CHMI profiles close to 80 mobile care programs. The majority of profiled programs operate in rural geographies and deliver basic primary care (50%), although significant focus is also placed on family planning and reproductive health (13%), HIV/AIDS (13%), general secondary care (12%) and maternal and child health (12%).* Interestingly, mobile care is also becoming a hotbed of eye care innovation; while eye care comprises only about 4% of all programs listed in the CHMI database, 11% of mobile care programs deliver eye care services.
Basic statistics aside, what exactly do we mean when we say mobile care? Is it the health worker that delivers preventative care and basic screening at camps that attract hundreds of people? The team of doctors and nurses that hold regular office hours in a rural schoolhouse? Or is it the highly equipped van that brings traditional medical facilities to remote settings, providing local residents access to more complex treatment? A review of all mobile care programs profiled in the CHMI database reveals three common models:

**Health Camps**

Health camps are typically large-scale initiatives that aim to provide basic health education, preventative care and health screenings to a wide segment of the local population. Because their focus is more preventative than curative, camps are held every few months to a year in different locales and often do not operate on a set schedule. Moreover, as health camps are frequently run by health workers who do not have a wide range of medical expertise, many target just one or two health areas such as voluntary counseling and testing for HIV, basic health screening, or delivery of family planning services. Simple treatment is provided on-site while those who require follow-up care are referred to the nearest medical facility.

The Afya Kenya Foundation, for example, has organized and financed several health camps in the country, with most serving well over 1000 people. Health camps organized by the Islamia Eye Hospital in Bangladesh provide treatment for minor eye diseases. Cataract cases are screened and referred to the hospital for operation at no cost to the patients.

**Mobile Clinics:**

Unlike health camps, mobile clinics are usually smaller affairs and offer the same basic services as a primary health facility. They are often run by a team of doctors or nurses and are thus able to address a wider variety of patient complaints. Furthermore, mobile clinics typically operate on a set schedule and return to each location on a periodic basis, facilitating the provision of longer-term care and the development of closer patient-doctor relationships. Kenya’s Jacaranda Health runs
regular mobile clinics that offer antenatal care and birth preparedness for women in urban slums, while the Fundación Adolfo Kolping in Bolivia uses ambulances to transport doctors and counselors to peri-urban and rural neighborhoods around the city of El Alto, offering low-cost or free medical attention.

Mobile Facilities

Taking mobile medical care one step beyond health camps and mobile clinics are mobile facilities, vehicles that come equipped with some of the same medical equipment present in a static primary care center or hospital, including laboratories and operating theaters. Mobile facilities are often staffed by trained doctors and nurses and are able to deliver higher-level curative care. In the Indian state of Bihar, Arogya Rath is operating mobile medical units that offer the same facilities as a basic hospital, as well as over 30 medications that are issued to patients free of cost. In Peru, Pro Mujer is providing dental and sonogram services out of adapted vehicles. Each vehicle has been converted into two consultation units, one for dentistry with an exam seat and accompanying dental instruments, and the other for gynecological exams. The clinics are operated by a team of specialists and doctors and allow Pro Mujer to provide advanced health services to rural areas.

Central Concepts

Finally, we took a look at what makes mobile care programs truly “mobile”—the variety of vehicles leveraged by programs to deliver services. These are as varied as the geographies in which the programs operate, each one uniquely suited to the local topography. Off road trucks are used to traverse rough terrain (Mailafiya), boats navigate isolated rivers (Projeto Saúde e Alegria, Sailing Doctors), motorcycles pass through rural and unpaved roads (Health by Motorbike, Mama-Toto Mobile Clinic), and camels serve remote desert communities (CHAT).

As mobile care advances, encompassing new technologies and offering more complex procedures, the delivery vehicles are likely to diversify, incorporating repurposed and adapted local transportation to extend the reach of health care beyond brick and mortar.

As we gather more data about the universe of health market innovations, we will continue to track trends and highlight new insights gleaned from analysis of the aggregate. We invite you to do the same by downloading the CHMI Database and sharing your findings with us.

*Percentages do not total 100 as programs may have more than one health focus.

Caveat to these preliminary conclusions: CHMI’s data collection methodology and relationships with partner
organizations in specific countries may result in data collection biases. Furthermore, programs that primarily transport patients (e.g., emergency care) were excluded from this analysis. We acknowledge that many programs provide eye care as part of their general primary, secondary, and tertiary health care services. Finally, CHMI cannot attest to the efficacy or impact of individual models.

*Photo at top: Jacaradna mobile maternity clinic, Kenya