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URBAN HEALTH CARE INSTITUTIONS: A CASE OF SWASTHYA SUVIDHA KENDRA (SSK) FROM CHHATTISGARH, INDIA

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Abstract: Urbanisation is among one of the factors which contribute to demographic shifts from rural to urban areas in the last few decades. But, due to non-accessibility and unaffordability of healthcare services in urban areas, there has also been an emerging trend of reverse urbanization. In this context, accessibility, and affordability of health services in urban areas become an important criterion to evaluate healthcare institutions' contribution to the health status of the community. The current paper intended to explore the status and challenges of Swasthya Suvidha Kendra (SSK), a new cadre of infrastructure formed at slum level in cities of Chhattisgarh state under NUHM. These are facing challenges since its inception and the paper recommended how the system could bridge these issues to provide better services to the slum community. **Materials and Methods:** For this, a cross-sectional and explorative research design was selected. The study was carried out in five randomly selected SSK from two cities of the Chhattisgarh state named Raipur and Durg in the year 2013-14. Data were collected through a pre-designed, pre-tested semi-structured schedule, and checklist. For recording the system process part, the observation method was applied. **Results:** The study findings revealed that proper provisioning of infrastructure with an integrated system of public health litracy at the slum level will ensure better accessibility and affordability. However, contact with the community by the grassroots level service provider leads to create rigor in accessibility and affordability for the community. Further, it can also be seen that there are many challenges remain in making the SSK functional in the state and can bridge through convergence and capacity development. **Conclusion:** For delivering quality health services in the urban health center, proper supply chain management along with public health literacy must plan by the government, and the capacity of the frontline workers must be developed to address the need of the urban area with an online monitoring system.

Index Terms **- Urban, Sub-center, accessibility, urban-Poor, Universal-health-coverage**

I. INTRODUCTION

In Census 2011 India's urban population is reached 31.16 percent of the total population, which spread up in the cities. The rate of growth in the urban population has been increased by 37.7 percent in 2011[8]. The United Nation's projections based on decadal growth rate shows that if India continues to grow with the given trend, then, by the end of 2030, about 46 percent of India's population would be living in urban areas. With growing urbanization, the country is also facing a huge challenge of urban health, especially in the context of urban poor[9]. Reanalysis of NFHS III data in the context of urban poor and urban non-poor shows the poor health status of urban poor[10]. According to the National Family Health Survey (NFHS)-Round 3, the data depicts that the under 5 mortality rates in urban poor is higher than the urban average in India. Around 46 percent of the children of the urban poor are reported to be underweight[11]. Not only this, but many other health indicators are also reported to be poor than the rural parts where the system has provisioned health institutions[12]. Hence, Urban Health is an emerging issue in recent decades after getting substantial growth in the urban population as compared to rural India. The poor environment of the locality is one of the reasons which contribute to these poor health indicators[1]. Besides, ineffective outreach, weak referral system, social exclusion, lack of information, and low level of assistance at the health institutions are making the accessibility of the primary health services a challenge to the urban poor. To bridge this gap, in May 2013, the Government of India (GoI) launched the National Urban Health Mission (NUHM), a flagship program under National Health Mission (NHM) that caters to the urban population, especially the urban poor.

It also involves a rigorous process of community involvement through Accredited Social Health Activist (ASHA), link worker, and Mahila Arogya Samiti (MAS), the health voluntary and social organization to create awareness among the residents. At every state, the framework was adopted whereas some of the states go for modification, such as the state of Chhattisgarh, where Swasthya Suvidha Kendra (SSK) was created to cater to the services to the urban poor residing in the slum locality with a population of 5000. The SSK, as the name reflects, created under Mukhya Mantri Shari Swasthya Karyakram in the year 2013, was an urban health center for providing health services to the urban community and acting as a primary contact point for getting quality health care services with free of cost for

the slum communities. These SSK are opened in convergence mode with other departments such as Urban Local Bodies (ULBs), the Department of Health and Family Welfare (DoHFW), and the Department of Women and Child Development (DoWCD).

In the year 2013, initiated with two cities at the beginning, the Mukhya Mantri Shahari Swasthya Karyakram (MMSSK), has been spread up in 11 cities in its growing phase and scaled up to the formation of 364 SSK in 19 cities in its later phase. Out of it, 249 were successfully able to get functional by the state government till the end of September 2015. As no provision was proposed under the NUHM framework, the Chhattisgarh government takes a step forefront to provide health services in the theme of "sub-health center" at the slum level. Based on its evolvement with time as an innovation in the health care delivery system, the current paper is aiming to understand the contribution, functionality, and improvement required to improve the health status of slum dwellers.

II. RESEARCH METHODOLOGY

A cross-sectional explorative research design was used in two cities of Chhattisgarh state, which contains the majority number of slums and slum populations of the state in the year 2013-14 (Data from Raipur Municipal Corporation). These urban health centers i.e., SSKs were covering around 23,000 to 30,000 population of the two cities. Among all the functional urban health centers of the cities, sampled SSKs were selected which were located at a far distance from the Urban Primary Health Center (Around a distance of at least 1 kilometer from the UPHCs). Out of 249 Functional SSKs, a total of Five SSKs were selected randomly out of which two belong to Raipur and three from Durg city (See Table 1).

Table 1: Name of the selected SSK in two cities of the Chhattisgarh state, 2013-14

Name of the city	Name of the SSK Selected
Raipur	Babu Jag Jeevan ram ward 40, Zone 4, Raipur
	Ward 37, JLN ward near Phool chowk. Raipur
Durg	Kustha Ashram, Ward 39 Kutchery Road, Durg
	Karidihhi, Kabir Nagar, Ward no 15, Durg
	Ganesh Manch, Shanti Nagar Ward no 17, Durg

A semi-structured schedule was designed and pre-tested before the data collection. The schedule was used for collecting information on the location of the SSK, services given, record keeping, availability of drugs along with management of SSK, community linkages, convergence, monitoring mechanism, provision of IEC and BCC, and fund availability. Besides, the observation method was adopted to compare whether the state-specific guidelines were followed at the SSK level or not. The key in-depth interview was organized with the ANMs of the selected SSK and data were collected during the service delivery hours of SSK.

Inclusion and Exclusion Criteria

As a part of the inclusion, the health facilities which were nearer to the UPHCs were kept out of distance from this study. The second criteria were that it must be posted with a front-like worker and must be having functional on a 24 x 7 hours basis.

Statistical analysis

Descriptive Univariate analysis was conducted to understand the issue more comprehensively. More, the qualitative discussion was also made with the health workers to highlight the challenges faced by the health worker in operationalizing the sub-health centers.

III. RESULTS

"Universal health coverage" contains stimulating, protective, restorative, reassuring, and rehabilitative health services required by an individual. In other words, it aims to provide quality health services equitably and should be protected against any financial risk[2]. Given the above concern, the urban healthcare scenario is a bit different from the rural scenario due to the different lifestyles of the community and habitations. In our country, especially in the big cities, the urban poor population are living in environmentally deprived and shanty locations and are run-down from availing the basic service[3]. In this condition, to fulfill their daily life's needs, they are more involved in income-generating activities and unable to priorities their health, education, and other basic needs for a quality life. Among these issues, the accessibility and affordability of health services are a major concern for the urban poor community. The NUHM framework has made necessary provisions to reduce these gaps by creating infrastructure at the slum level in the case of Chhattisgarh, however, its real contribution would be known only after a few years.

3.1. Location of the SSK and Services offered

According to the government's guideline published under Mukhya Mantri Shahari Swasthya Karyakram (MMSSK) on SSK, it suggests that the infrastructure for SSK provisioning should be done by the Department of Urban Administration and development (DoUAD) and should be within or nearby the slum locality so that community could be avail the services. It was also prescribed that in case of unavailability of the infrastructure, the SSK could be started at the nearest Anganwadi center or also in Public-Private Partnership (PPP) model. The current findings suggest that all urban sub-health centers i.e., SSK, are located near the slums, and runs in the government buildings given by the DoUAD.

Further, to understand the services offered, the health worker posted at the SSK were interviewed separately. Data analysis depicts that coverage of services such as ante-natal care, postnatal care, immunization, referral services, health education, epidemic management, health education on water and sanitation is comprehensively improved at the community level.

3.2. Drug availability and management

As per the published guideline of the state government, the SSK should be equipped with the generic drug as it is necessary to build faith in the community. The SSK is supposed to provide curative services on communicable and non-communicable diseases, for which 25 types of drugs should be available. However, the data from most of the SSK reported that only a few drugs such as Paracetamol, Diclofenac sodium, Iron Folic Acid, Albendazole, Iron Folic Acid with Zinc, Metronidazole, Cotrimoxazole, Multi-Vitamin, Contraceptive pills, and Oral Rehydration Solution were available during the time of the study. Second, the SSK was not following any

systematic indenting system of receiving the drugs from UPHC or UCHC level. It may be due to the early phase of its conception. It was also found that sometimes the health workers don't keep stock at the SSK which creates a barrier to access public health services from the SSK. The reason cited for not keeping the drugs are the unavailability of proper racks, almirah, and other required things at the SSK infrastructure level.

3.3. Health Management Information system

Record keeping is an important mechanism to gauge the performance based on the operational cost and effectiveness of the program. The Urban Health Program also attempted to keep the record of the services provided at each level. However, it was reported that only one register is provided under the program and the rest of the registers need to be purchased by the health workers posted in the SSK. The study also concludes that health workers are trying to keep a record of the services provided. However, due to lack of registers, the same was not possible. Simultaneously, no feedback system exists which can improve service delivery by health workers.

4.4. Convergence and Community linkages

The NUHM framework highlights the involvement of convergence in the system to sustain the program in terms of providing infrastructure. The urban health sanitation and nutrition day, a key activity of convergence between the department of Health and Family Welfare (DoHFW) and department of women & child development (DoWCD), were observed in every SSK in a month through community participation. The purpose of this convergence is to bring ownership in the community on the different issues of SSK functionality, behaviour change, and cleanliness of the slum ambiance. In the state, the community participation component is being managed by the State health resource center (SHRC), which is a state government's functional body. The study reported that every slum was having MAS and USHA i.e., mitanin, and monthly meetings were also being organized to discuss the health, nutrition, and sanitation issues. The monthly records were also found in the center. However, authenticy of the information require social auditing.

3.5. Concept of Mitanin

Chhattisgarh government has initiated a community approach model to cater to urban health services in its initial round under the name 'Mitanin' which is a synonym for ASHA many years ago. These community-level volunteers are supposed to work with the SSK and its staff and facilitate to generate demand in the local community regarding health services. The present study reported that with respect to the slum area, it is found to be very effective and meetings are organized regularly.

3.6. IEC & BCC, and Fund management

Information, education, and Communication have been key area to address the behavior change communication activities under NUHM. As prescribed by the NUHM framework, the health workers posted at SSK were doing communication at the household level on one to one basis. The result also reports that SSK was well equipped with the IEC material and messages were found to be displayed at the SSK. No doubt, it will help to generate demand at the community level.

IV. DISCUSSION

The utilization of health care services pattern and its barrier has been studied in the urban community by various academicians in the past, due to rapid urbanization. However, the current study from 5 slum localities with a new slum-based health institution is providing some information that provides a glimpse that how the emerging needs of the health of urban poor are being addressed. More specifically, the urban health theme is research into the effect of health distribution and disease in relation to urbanization in earlier times[5]. As compared to the rest of the states in India, Chhattisgarh state has implemented a new cadre of health infrastructure at the slum level, which is beyond the scope of NUHM. Hence, the paper attempts to understand its accessibility and functionality through the service provider's perspective within the NUHM framework. The baseline report published by the State Health Resource Center (SHRC) of Chhattisgarh that urban slums are doing better in terms of access to toilets, literacy rates, malaria prevalence, and child malnutrition[2]. Besides, as a part to improve the service at the community and to generate demand, community needs assessment was also conducted by the health worker in association with Urban Accredited Social Health Activist (USHA) and MAS members in these centers. However, the deliveries at private institutions are still a concern for the urban health program. As reflected from the location of SSK, the health worker must stay in the locality but is not staying due to a lack of accommodation facility in the SSK. Second, irrespective of the requirement of drugs, services, and other pathological tests, the urban poor community is depending more on the private sector as the study findings say that limited numbers of drugs were available. This disparity is required to explore more in the future if a center is required to perform better. The report published by SHRC on urban health says that the state government-funded program has not taken up the NUHM while funding has been increased as compared to its initial days. However, the SSK and the worker were not able to reach the homeless population of the cities through MAS and link workers. Second, the SSK could not be able to reach the industrial migrant labour working with the industry in catchment areas of the two cities [3]. The study also emphasized that for the proper functioning of the SSK, proper system should be incorporate and human resources need to be oriented towards indenting and procurement procedure. Currently, it was lacking in the system as the staff does not have any idea about this system. Similarly, the performance was also captured in the health management information system of the Government of India, but the health workers were not able to keep an updated register as per the study reported.

The data revealed from January to September 2015 from the state government that health indicators have been reported whereas the gaps pertaining to water sanitation and hygiene still exist. This needs to be explored further to understand the role of it in reducing mortality. Funding may be a reason for this, as evidence from secondary data analysis shows that funds available per quarter have been declined consecutively from 2013 to 2015 by the Ministry of Health and family welfare[3]. Lastly, provisioning infrastructure and posting of skilled human resources at the slum level or any place is not the only solution to attract the end-users. A proper campaign through information education and communication and quality service by the service providers can help the community to access the available services more frequently. However, it is too early to expect any outcome of this. Second, the preference of the slum community on accessibility also needs to be explored as mentioned by many researchers.

V. CONCLUSION

As the urban population is increasing in Indian cities, the system needs more attention to provide urban basic infrastructure services such as health, education, water sanitation, and hygiene, and employment. In many big cities, due to lack of space, the migrated urban population is forced to reside in the outskirts area in very vulnerable conditions. Due to less income and distance from the center of the cities, they are not been able to access the health facilities to get primary and curative health care services. In this scenario, it is very much necessary to develop infrastructure at the slum level where urban poor are residing in vulnerable conditions. A study carried out in July 2017 states that in the slums of Durg city, for acute communicable disease around 43.3 percent do not go anywhere whereas 56.7 percent preferred to go to a private facility for seeking treatment[4]. It clearly shows that the accessibility of the centers is not so eye-catching and needs concern form the government in a period where fund crisis is going on for urban health. Although, the current study has proved that the Urban Sub Health Center or so-called SSK is an effective strategy to address the health care services of the urban community with a special focus on the urban poor. But the current infrastructure and lack of fund is a barrier to improving the accessibility and availability of its services. Second, the new cadre of the service provider needs to be oriented and monitored regularly for bringing effective results. And third, convergence and sharing of the budget from every concerned department would help to bridge the existing gaps and making the system more effective.

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Nil

VII. SOURCE OF FUNDING

Self

VIII. ETHICAL CLEARANCE

Informed consent was taken from each of the respondents pertaining to their voluntary participation, the right to withdraw from the interview at any point in time during the interview, confidentiality, and privacy of collected information.

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