Urban Health Programme in Chhattisgarh State: Evolution, Progress and Challenges

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Soon after its formation as a state in the year 2000, Chhattisgarh introduced programmes for strengthening its health system. The Mitanin programme, covering all its rural areas with more than 60,000 Community Health Workers (CHWs), was a key intervention amongst the above. The sustained and near-universal coverage of the programme in rural areas led to demands for its expansion to urban areas. Also, the state had seen impressive decline in IMR in rural areas while it had remained stagnant in urban areas. However without visualising urban health as a complete system, introducing CHWs alone was unlikely to be fruitful. Efficacy of Mitanins in urban localities was doubtful without outreach sessions, ANMs, sub-centres, PHCs and laboratory services. There were atleast three attempts till 2010 to introduce urban programme that failed. In the last of these attempts ANMs were introduced in Rajnandgaon city with NRHM funding, as an innovation. However, this piecemeal attempt was not replicated further as the NRHM funding was found to be unreliable.

In 2011-12, the state seemed to be closer to a consensus for initiating an urban health programme. The impending state elections of

Box 1. Questions, Debates and Final Choices Towards the NUHM Design in Chhattisgarh

1. Do we need more health facilities in urban areas?
One view was that urban areas already had district hospitals or other government health-facilities and if any more facilities are needed, the abundantly available private clinics should be roped in through Public Private Partnerships (PPPs). The other view was that the existing facilities were more suited for secondary healthcare and the new programme should focus on primary health care for the urban poor by introducing sub-centres and PHCs. Provision for secondary care by using private sector was already there through a universal health insurance scheme. The latter view prevailed in the final design, however, mobile clinics were also provided through PPP arrangement though their relevance for urban areas remained debatable. Though the draft National Urban Health Mission (NUHM) (under discussion at that time in 2011) did not have a component on sub-centres, the state decided to have sub-centre like facilities called Swasth Suvidha Kendra (SSK), serviced by urban ANMs, as the constrained spaces in Anganwadis was not sufficient for provision of antenatal care.
2. Is a volunteer CHW feasible in the urban context?
Chhattisgarh had a decade long experience of implementing the Mitanin CHW programme. The common belief was that the sociology is different in urban areas wherein communities lack the cohesiveness to allow ownership of CHW. However, the other view was that CHWs were still very much needed for promotive and preventive health work amongst the urban poor and for linking them to the formal healthcare services. Finally, the latter view prevailed.
3. Should the programme cover only slums or entire population of the cities?
This debate was also going on at the central government level with regards to NUHM design. While the NUHM talked of providing services to the entire urban population with priority to slums, Chhattisgarh decided to have an explicit focus on slums. It however expanded the definition of slums to include non-recognised settlements as well.
4. Are the health challenges very different in urban areas?
One perception was that urban areas have very different health challenges like poorer sanitation, HIV, lack of demand for preventive services with an excessive demand for curative services etc. and therefore the urban programme should focus on these issues. The other opinion was that Chhattisgarh's urban IMR was amongst the worst in the country and therefore the programme should address primary healthcare more comprehensively. The final design was dominated by the latter view.

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Table 1: Comparison of Arrangements for Health Care Provision: NUHM National and Chhattisgarh Norm

Component	NUHM norm	Norm in Chhattisgarh
Urban ASHAs (CHWs)	One ASHA (CHW) per slum, to cover 200-500 HH (average 2000 population or 400HH)	One Mitanin (CHW) per slum upto 200 HH, could cover less than 200HH depending upon geography of slums
Mahila Arogya Samiti (Women's Health Committee)	One per 100 HH, 4 Samitis per ASHA Annual Untied Grant of Rs.5000	One per slum i.e. contiguous with area covered by each Mitanin Annual Untied Grant of Rs.20000
ANM	1 per 10000 population	1 per 5000 slum population
Swasth Suvidha Kendra (sub-centre)	No provision	1 per 5000 slum population
Urban PHC	1 PHC per 50000 population. PHC with one full-time doctor with salary of INR 30000 p.m, one part-time doctor at INR 18000 p.m, 2 staff nurses, no staff for cold chain, accounting or cleaning	1 PHC per 50000 slum population. Full-fledged PHC with two MBBS doctors with salary of INR 45,000 p.m, 6 staff nurses, lab, cold-chain handler, accountant, Sweeper, Ayah
Urban CHC	1 per 100000 population	No provision

2013 and the health minister heading the urban administration department facilitated this too. However, designing the programme still involved making several choices and the main debates were around the issues as detailed in Box 1.

Baseline Study Findings

A Baseline Study was conducted in 11 cities in early 2012 by the State Health Resource Centre. The survey focused on understanding utilization of maternal and child health services by urban slum population. The baseline survey showed that in comparison to rural areas, urban slums were doing better in terms of literacy rates, access to toilets, ARIs amongst children, malaria and child malnutrition. However, the urban slums were worse off in terms of immunisation, breastfeeding, diarrhoea and utilisation of family planning services. More pregnant women from urban slums were having ANC check-ups and institutional deliveries, though mostly in the private sector. One-third urban slum households had National Health Insurance Scheme (RSBY) cards, however, 60% of them incurred high out of pocket expenditure.

NUHM in Chhattisgarh: Variations from the National Design

Overall, the Chhattisgarh urban health initiative has tangible variations from the prescribed NUHM design, as detailed in the table 1.

NUHM: Progress in Chhattisgarh

The urban health programme was piloted in two cities (Bilaspur and Rajnandgaon) in 2011 and was subsequently expanded to 11 cities having population greater than 100000, in 2012. The programme was initially fully funded by the state budget. In early 2014, the programme was merged with NUHM as funds were sanctioned by GoI. The programme now covers 19 cities with a total urban population of 4.12 million, including 1.62 million slum population (as per 2011 census). The key achievements of the programme implemented over last three years are projected in Table 2.

NUHM Achievements in Chhattisgarh: Some Highlights

The Urban Mitanin Initiative: Implemented in similar way as the rural Mitanin Programme, the training modules for urban Mitanin initiative emphasized on social determinants of health, home visits, and community based care and counselling for common health problems. Analysis of activities reported by Mitanins during January to September 2015 showed that:

- They mobilized 80% of expected deliveries to institutions, 76% of them in government facilities

- 82% of newborn received designated home visits from Mitanins and 16% referred to health facilities after Mitanin identified signs of sickness

- 87% of pregnant women received more than three home visits from Mitanin

Table 2: NUHM in Chhattisgarh: Achievements Against Requirements

Component	Requirement as per norms	Status as of Dec 2015
Mitanin (CHW)	3883	3770 selected, trained so far for 25 days. A support structure in place, of 200 ASHA Facilitators and 25 Area Coordinators, supported by the State Health Resource Centre
Mahila Arogya Samiti (Women's Health Committee)	3883	3700 formed, trained so far for 2 days, regularly facilitated by the support structure
Swasthya Suvidha Kendra (sub-centre)	388	249 operational
ANM	388	296 appointed
Urban PHC	36	30 Operational
PHC Medical Officers	72	26 appointed
PHC Staff Nurses	108	59 appointed
PHC lab Technicians	36	26 appointed
Urban CHC	0	Not planned
Mobile units (MMU)	12	12 operationalised

• 63% of children under-3 years age received home visits on nutrition and prevention of infections

• 68400 cases of diarrhea given ORS

• around 120000 other patients provided drugs by Mitanins using drug-kits

• 155 TB suspects per 100000 population screened and referred for sputum examination resulting in 2140 confirmed cases

• 2796 Leprosy suspects screened and referred resulting in 611 confirmed cases.

• Mitanins, with the help of Mahila Arogya Samitis, intervened in 4540 cases of violence against women.

The Mahila Arogya Samitis (MASs): The MASs provided a forum for the women of urban slums to come together and participate in civic action. The MAS has acted as a support group for the Mitanins. The MAS has worked on Social Determinants of Health like drinking water, sanitation, functioning of nutrition programmes and violence against women.

Introduction of ANMs in Urban Slums: This bridged a very important gap with around 1600 immunisation sessions getting organised every month. Mitanins were able to facilitate linkages with government hospitals for ANC, deliveries, TB testing etc. and convince a significant section of slum patients to access Government health facilities.

Challenges Being Faced

The Key challenges were around gaps in provision of safe drinking water, inadequate responses to disease outbreaks, issues in attending the health issues of urban homeless, fund constraints leading to non-fulfillment of certain critical needs.

Disease Outbreaks Resulted by Lack of Access to Safe Drinking Water: Though the Mahila Arogya Samitis have been very active on the issue of safe drinking water, severe gaps in access to safe drinking water persist and have resulted in Hepatitis E outbreaks. For example, an outbreak of Hepatitis E in Raipur town was reported by media in April 2014. Medical College Raipur tested 264 patients and found 114 positive for HEV antibodies. According to the Mitanin program data the outbreak had started earlier in December 2013 when around 30 persons from in an impoverished slum locality showed symptoms of jaundice, with some of them had been confirmed by Bilirubin test. Throughout the season, CHWs reported 2070 cases of Hepatitis including 74 pregnant women and 32 deaths including of eight pregnant women. It was found that there are leakages in drinking water pipelines and ingress of sewage into them. Moreover, some pumping stations are close to sewage. Water testing by Mitanins at 800 points across the city showed that 53% of sources, including big pumping stations, hand-pumps and even the alternative water supply tankers, had contamination. Another outbreak occurred

Table 3: NUHM in Chhattisgarh: Financial Situation

Period	Number of Cities covered in Chhattisgarh	Funds Sanctioned by NUHM to Chhattisgarh	Funds Available per quarter
Jan-March 2014 (3 months)	15	Rs. 14.61 Crores	Rs. 14.61 Crores
2014-15	19	Rs. 26.77 Crores	Rs. 6.66 Crores
2015-16	19	Rs. 20.65 Crores	Rs. 5.16 Crores

from January 2015, though in different areas. A repeat round of water-testing was done by Mitanins in April 2015, which reported worsened contamination. Despite getting recognized as an issue at top levels of government, focus of the civil administration was on curative care and hospitalisation of patients, as well as chlorination of water. The drinking water issue could not gather sustainable media attention too. As a result, the issues in supply of safe drinking water remain unsolved.

Reaching out to the Homeless: The programme has faced challenges in reaching out to the homeless population. Though Mitanins identified around 3000 homeless families, they could cover less than half of them. Attempts to link the homeless with municipal shelter facilities failed and almost none of the 26 shelters in 11 cities were found to be functional. Linking homeless rag-picking communities posed further difficulties because of the discrimination being practiced by health facilities against them. In a shocking case, nurses in a district hospital refused to deliver a pregnant woman belonging to Dewaar caste because of untouchability. The programme came across a large number of migrant men labourers working and living in poor conditions around industrial areas but could not find ways of engaging with this section of urban poor.

The Fund Crunch: There are some differences in funding norms of NUHM compared to the state scheme which has created problems. Broadly speaking, NUHM sanctions lesser number of Health-HR at almost all levels. The salary norm for MO under NUHM proved to be a big hindrance in getting enough MOs for urban PHCs. Moreover, funds sanctioned by NHM for urban health seem to be shrinking year by year. While the sanction was adequate for first three months of implementation in 2013-14, it has been reduced by the central government from 2014-15 onwards. Table 3 presents the comparative financial situation for NUHM in Chhattiagarh.

The community processes component has suffered the worst cuts with no funds being sanctioned for Mitanin-training and support-structure for 2015-16 and the allocation for Mitanin incentives being cut to half. This is despite the fact that the financial utilization of funds allocated for Mitanin and related components has been close to 100%, while other urban programme components have lagged behind. Thus the component showing the best progress has suffered the worst damage in funding.

Conclusion

NUHM can be extremely valuable for bridging the gap in access to health for the urban poor. The Chhattisgarh experience has shown that community processes and outreach through ANMs, combined with strengthening of the formal healthcare institutions are crucial. Despite visible achievements, there is a threat to the Chhattisgarh urban programme due to funds crunch. There is a need for the government to persist with full roll-out of NUHM not only in Chhattisgarh, but across all states.

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