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CAN EMPOWERING COMMUNITY PLATFORM - MAHILA AROGYA SAMITIS (MAS) UNDER NATIONAL URBAN HEALTH MISSION: STRENGTHEN THE DELIVERY OF PRIMARY HEALTHCARE SERVICES IN URBAN SLUMS?

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Abstract
The Astana Declaration was passed in 2018, forty years after Alma Ata, to provide a new momentum for strengthening Primary Healthcare (PHC) and to speed up the progress towards the Sustainable Development Goals (SDGs). One of the three pillars of PHC endorsed in Astana declaration was community empowerment. The strategies to strengthen community participation in health vary greatly. Unlike the rural areas the challenges are very different in urban areas. The healthcare services do not reach all urban poor settlements, especially the hidden pockets of urban poor and those that are not part of official lists. The weak linkage between slum communities and healthcare providers is a growing barrier to improve the health of the urban poor. The National Urban Health Mission launched in 2013, provides community platform in form of Mahila Arogya Samitis (MAS) to promote community participation in health activities in slum areas. In this article we present the need of empowering the MAS through simple interventions to address the healthcare needs of urban vulnerable population in slum areas.

Keywords: Mahila Arogya Samitis, primary healthcare, urban slums, NUHM.

I. Background
Over the years since it was acknowledged in the National Health Policy (NHP) 2002 that the presence of public health services in urban areas is inadequate and unorganized and there was no specific mention to the special needs of the poor and vulnerable population. There had been very little concerted effort for providing comprehensive primary healthcare to poor and vulnerable sections, up until the launch of National Urban Health Mission (NUHM) in 2013, by Govt of India. During this

policy-launch gap period "Urbanisation" had made significant impact on health such as poorest access to health services, below-average health outcomes, health inequities etc.
The main objective of NUHM is to address primary health care needs of urban poor and vulnerable population and to provide special emphasis on improving the reach of health care services to these groups. The same has been mentioned in NHP, 2017, which prioritizes primary health care needs of the urban poor and vulnerable population, focusing on improved health-seeking behaviour, influenced through capacity building of the community-based organizations & establishment of an appropriate referral mechanism.[1]

It has been nearly a decade since the NUHM was launched, though the mission has been instrumental in channeling much needed resources towards urban health, it is facing certain challenges. The population in urban areas is heterogeneous in nature and challenges are quite different as compared to rural areas. Community empowerment and integrated delivery of quality primary care and public health services are such challenges and are also the pillars of Primary Healthcare endorsed in the Astana Declaration, 2018.[2]

In view of above following questions arises for poor and vulnerable population in urban areas: (1) How to address growing health issues of the vulnerable population living in slums of urban areas? (2) Who can play the lead role in ensuring community awareness and participation in slums of urban areas? The strategies to strengthen community participation in health vary greatly in comparison to urban and rural areas. The healthcare services do not reach all urban poor settlements, especially the hidden pockets of urban poor and those that are not part of official lists. The weak linkage between slum communities and healthcare providers is a growing barrier to improving the health of the urban poor. As a result, slum-dwellers are unable to practice appropriate health behaviours, have limited awareness about location of and services provided in public health facilities or by outreach, lack the confidence to demand and negotiate for services and end up seeking treatment from informal health providers (faith healers/quacks etc).[3]

In order to tackle above mentioned challenges, it is important to understand what are the available resources under NUHM that can be optimally utilized for betterment of community. This article focusses on how we can empower the Mahila Arogya Samitis (MAS), one of the key community platforms under NUHM to promote effective community participation in health activities in slum areas. Currently there are 98,615 MAS groups approved, 83,888 (85 per cent) formed and 72,642(86 per cent) MAS groups trained under NUHM in States/UTs.[4] However, the experience on MAS is not that encouraging. It is essential to understand MAS composition, their process of formation, functioning, roles and responsibilities etc.

Mahila Arogya Samitis (MAS) & its composition: As name suggests it is local women's collective group who are expected to take collective action on issues related to Health, Nutrition, Water Sanitation and its social determinants at Slum / Ward level. A MAS thus is a group of 10-12 local women in an urban slum drawn from neighbourhood cluster/existing community who are active,

possess good communication and leadership skills, hold a sense of social commitment and have desire to contribute to 'well-being of community. Key role in process of MAS formation is played Accredited Social Health Activist (ASHA) / Auxiliary Nursing Midwifery (ANM) with support of non-governmental organization (NGO) / Anganwadi workers (AWW). Each MAS is expected to cover about 50-100 households and has ASHA as Member Secretary and Chairperson as elected MAS member who are responsible for MAS and its activities. The monthly meeting is held to review the work done, plan future activities and decides on how the untied funds are to be spent.
Provision of fund: The financial support is in form of annual untied fund of Rs. 5,000 for each MAS for undertaking different activities in their area. Being an untied fund, it is to be utilized as per

decision of MAS group for nutrition, education, sanitation, environmental protection, emergency transport and public health measures. No other honorarium or incentives provision is there for MAS members.

Role & Responsibilities: The MAS serves as an important platform for facilitating access to services and services providers in the community. Their major functions are to support the ANM, AWW and ASHA in organizing Outreach Sessions/ Urban Health and Nutrition Days, Mobilize pregnant women and children particularly from marginalized families, Support community service providers to reach the vulnerable and "hard to reach" populations, generate awareness about Government Referral Transport and emergency response services and facilitate local tie-ups with private vehicle owners to transport a patient to hospital, provide information on maternal and child deaths/ disease outbreaks, facilitate registration of births and deaths etc.[5-7]

In the context of the above and the paucity of literature about the role of community platforms like MAS in health-related activities, below are few studies/ field reports that will help in understanding and implementing MAS effectiveness in the slums.

II. Learnings from States / Union Territories(UT):

Every year Ministry of Health & Family Welfare undertakes the Common Review Mission (CRM) in various States/UT. The objective of the CRM is to understand key drivers and challenges of various National Health Programmes which impacts their implementation and also to observe good practices of programmes. Below is the snapshot of CRM findings for MAS functioning in various States/UTs gives valuable insight and areas for key learnings.
As per 10th Common Review Mission (CRM), 2016, MAS formation was in different stages (formed / in process / struggling to form) in States/UTs. States like Kerala had co-opted the existing Self Help Group (SHG) - Kudumbashree groups as MAS. The ASHA, AWW and mothers from ward/community had constituted MAS in state of Nagaland. The member with higher educational qualifications appointed as the chairperson in state of Sikkim.[8]

Similarly in the 11th CRM 2017, highlights in state of Chhattisgarh, the MAS has been successful in addressing issues like alcoholism and facilitation of land donation for the opening of community-level health facilities. In Karnataka MAS members though were trained but lacked awareness about their roles, how to use untied funds and had limited knowledge on health and sanitation practices.[9] Thus, the report mentions lack of coordination among ANM, ASHA and MAS. The report also highlights strategies such as proactive engagement with NGOs and building capacities of support structures to effectively supervise MAS could be adopted to bridge this gap.

The 12th CRM 2018, mentions about lack of awareness in community about various health-related activities such as nearest public health facility, public health schemes, days of outreach services, free

drugs and diagnostics services etc. in the States of Bihar, Jharkhand and Uttarakhand. This clearly throws light on the underutilized community platforms such as MAS in these States. The report also states about the good practices of MAS observed in State of Andhra Pradesh: where SHG under Mission for Elimination of Poverty in Municipal Areas (MEPMA) units have been co-opted into MAS for effective community process activities. In Chhattisgarh MAS played key role in arranging food for malnourished children, pregnant women, emergency services such as ambulance etc. Such initiatives were undertaken based on locally felt needs and with consent of MAS members in meetings. In Jharkhand MAS members were actively involved in selection of ASHA and engaged in helping ASHA to conduct community activities. Untied funds were mostly used for purchase of identified equipment/items for Anganwadi Centre such as blood pressure apparatus, weighing machine, furniture etc.[10]

The 13th CRM 2019**,** showcases MAS good practices from state of Odisha such as 20% of the best performing MAS are provided with an additional incentive of Rs.3000 under NHM. MAS have been given identity card and empowered to have own letterhead for official communications to Urban Local Body to carry out civic functions.[11]

The Mission for Vision in association with Sightsavers and Kolkata Municipal Corporation in Kolkata conducted crossectional study by involving local MAS who were co-opted to improve demand for eye services in the region. A total of 504 MAS workers were trained. The nine Vision Centers catered to about 40,000 patients, in last two years of which MAS accounted for about a quarter of all referrals. Actively engaging MAS workers has contributed to an increase in the uptake of primary eye health services and ensured the provision of appropriate follow-up services to the patients. No monetary incentives were provided to MAS for their role.[12]

The examples of SHGs which have played key role in delivering health services and have been co-opted as MAS, in States of Andhra Pradesh, Bihar, Tripura, West Bengal etc.[13]A community-based cross-sectional study was conducted in the urban area of Bangalore, Karnataka involving 95 women, who were SHG, to see the extent to which they are involved in health and explore other possible methods to increase their involvement in health activities. Out of 98 women, 95 were interviewed,

65.2 per cent received economic help through this programme, 26.3 per cent got importance in the family as well as community, 21 per cent had improvement in personal health, 68.4% of individuals self decides to seek medical care for health-related issues.[14] In state of Uttar Pradesh a quasi-experimental study was conducted to assess the effects of health behaviour change interventions through women's SHGs on maternal and newborn health (MNH) behaviours and socio-economic inequalities. The net improvements in correct MNH practices were significant. The improvements over time were higher among the most- marginalised than least-marginalised for antenatal check-ups, consumption of iron folic acid tablets for 100 days, current use of contraception, and timely initiation of breastfeeding.[15]

III. Discussion

Thus, in view of above reports, field experiences, research findings and existing SHG models co-opted as MAS from different States can be used as key learnings for programme implementers in strengthening MAS groups at the slum level.

Though the Mission has laid down the platform of how the MAS will strengthen the community linkages in slums of urban areas in terms of health and social determinants. Still, significant gap in linkages is seen in these areas. In some States the Programme planners visualize MAS only as an instrument to enable target populations to access their programmes, which are largely focused on Maternal & Child Health or Tuberculosis / Malaria. The approach should not be such rather bottom-

up planning is required which is the larger vision of the Mission and is missing as mentioned in CRM report, 2016.[8] It has been observed that community-based platforms such as MAS, are yet to evolve as avenues where the voices of the community in planning and monitoring service delivery, accountability mechanisms and addressing social determinants of health.

As we know the challenges in urban areas is that in settlements of the urban poor, there are fewer organic communities than one may find in rural areas, in such complexity a multipronged approach – a new unified strategy is required for improving health with special emphasis to community processes. Similar unified approaches that need to be supported and coordinated with other non-health sectors such as Water and Sanitation, Housing and Urban development, Environment, Women and

Child Development, NGOs etc

The focus should be on strengthening the delivery of PHC services which will be one point for prevention, promotive and curative services. The Ayushman Bharat-Health and Wellness Centres (AB-HWC) platform can be utilized to strengthen & deliver comprehensive PHC services for vulnerable population. At this point the frontline workers including MAS can play a key role. The HWC provides platform in roping additional technical capacities/NGO partnerships that can enthuse, mentor and hand-hold community platforms such as MAS in urban areas to play a key role in planning, implementing and delivering primary healthcare services.

Above field experiences projects, simply training the MAS members does not solve the purpose. It has been reported that MAS does not get adequate supportive supervision as ASHA and ANM are already overburdened with routine activities. Moreover, there is no provision of ASHA Facilitator in urban as compared to rural areas, who could have continuous handhold both ASHA and MAS.

The States where MAS have been successful in delivering PHC services to the community because of efforts at all levels from building the capacities of these platforms to continuous handholding support. The MAS has been given equal importance with other frontline health workers (ASHA/AWW/ANM), such as Kudumbashree in Thrissur and Kochi, Indira Kranti Padham in Vizianagaram and Visakapatnam, Sampoorna Mahila Samiti, Indore, Mahila Arogya Samiti in Bhubaneswar have been effective in articulating the needs of the communities they represent, as mentioned in Technical Resource Group for NUHM, 2014 and CRM reports, 2016, 2017, 2018 and 2019.[8-11,16] During COVID-19 period, the above MAS groups have played key role in home deliveries of medicines and ration items, organising community kitchen, vaccination etc. The above MAS models were able to sustain as scope for income generation through National Urban Livelihood Mission has been provided, as MAS do not receive any incentives.

If, we empower, the MAS in urban areas, the outcome for the community and health system will be beneficial because women's empowerment enhances caring capacity of the woman for self and family and fosters social support. The empowered women promote better decisions on healthcare, income generation and savings, girls' education, prevent early marriages, contribute to positive gender equation at family and society levels, address social issues domestic violence and alcoholism and provide social support to needy families. Above all empowering MAS will help in improving the health and well-being of vulnerable populations.

IV. Way Forward

As the Mission has mentioned that the main purpose of MAS includes demand generation, ensuring optimal utilization of services under National Health Programmes, establishing referral linkages, increasing community ownership and sustainability and establishing a community-based monitoring system. In order to ensure smooth implementation of Mission objective it is essential to exercise

flexibility and innovative ideas to address the diverse health needs of vulnerable population. Moving forward, we propose following recommendations for empowering MAS to deliver PHC Services in urban slums:

- Provision of Urban Community Facilitator (a mentor, guide, and counselor to the MAS and ASHA who is expected to provide support, supervise, build capacity of the MAS/ASHA and monitor their progress)
- Each MAS member to be provided with Identity Card etc.
- Token of appreciation for good performing MAS group in form additional incentives/awards.
- Involvement of MAS in AB-HWC programme and ward level activities to provide maximum

benefits to community.

- Foster learnings from experiences through Exposure visit and dissemination of lessons for Programme Implementers.
- Convergence with NULM so that MAS may be subsumed for entrepreneurship on the lines of SHGs for side income generation.

V. Conclusion

With the demographic and epidemiological transition happening at a fast pace. The exact health effects and outcomes of this transition process continue to be poorly understood as are the levels of awareness and perceptions around these effects. The MAS are extended arms of urban slum who can contribute towards fulfilling SDG 3, if they are empowered a trust will be built within the community towards the healthcare system.

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VI. References

1. Government of India. National Health Policy 2017. New Delhi: Ministry of Health and Family Welfare, Government of India; 2017. Available from: https://www.nhp.gov.in/nhpfiles/national_health_po licy_2017.pdf.)
2. Basa S, Gupta B. Community clinics - An effective avenue for delivering primary healthcare services to urban vulnerable population under NUHM during COVID era and beyond. Int J Community Med Public Health 2021;8:1003-7.
3. Agarwal S, A. Satyavada A, Patra P, & Kumar R. Strengthening functional community–provider linkages: Lessons from the Indore urban health programme, July 2008, Global Public Health 3(3):308-325.
4. National Management Information System (NMIS), Executive summary,MoHFW(www.nhm.gov.in/NewUpdate-2022-23/NHM-MIS/March-2023/Executive Summary.pdf). [Last accessed on 2022 Jun 05]
5. Ministry of Health and Family Welfare, Government of India. National Urban Health Mission-Framework for implementation; May 2013. Available from : http://www.nhm.gov.in/images/pdf/NUHM/Implementation_Framework_NUHM.pdf. [Last accessed on 2022 Jun 05]
6. Induction Module for Mahila Arogya Samiti, MoHFW, GoI, 2014-15. Available from: https://nhm.gov.in.
7. Guidelines for ASHA and MAS in the urban context, MoHFW, GoI, 2014.Available fromhttps://nhm.gov.in/images/pdf/NUHM/Guidelines_for_Asha_and_MAS_in_Urban_Context.pdf)
8. 10th Common Review Mission Report 2016, NHM, MoHFW, GoI. Available from: https://nhm.gov.in.
9. 11th Common Review Mission Report 2017, NHM, MoHFW, GoI. Available from: https://nhm.gov.in.
10. 12th Common Review Mission Report 2018, NHM, MoHFW, GoI. Available from: https://nhm.gov.in.
11. 13th Common Review Mission Report 2019, NHM, MoHFW,GoI. Available from: ttps://nhm.gov.in.
12. Prem Kumar SG, Bhattacharya Shubhrakanti and Kurian Elizabeth.: Effective engagement of community health workers in primary eye care in India. Community Eye Health 2018,31(102):S13-S14).
13. D.O.letter from JS(UH) in regard to "Probability & Possibility of linkages between MAS constituted under NUHM and self-help groups under the

NULM",September,2016.https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1159&lid=161).
14. Narasimha BC, Anand P, Ravish KS, Navya SS, Ranganath TS. Int J Community Med Public Health. 2016;3(8):2026-28.
15. Hazra A, Atmavilas Y, Hay K, Saggurti N, Verma RK, Ahmad J et al. Effects of health behaviour change intervention through women's self-help groups on maternal and newborn health practices and related inequalities in rural India: A quasi-experimentalstudy.EclinicalMedicine2020;18:100198.Availablefrom:http://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30193-2/fulltext.
16. Technical Resource Group (NUHM) Report, 2014, NHSRC, MoHFW. Available from https://nhsrcindia.org/)
17. Lahariya C. More, better, faster &sustained: Strengthen primary health care to advance universal health coverage. Indian Journal of Medical Research 2019;149:433-36.
18. United Nation SDG 3: Good Health and Wellbeing. Available from http//in.one.un.org/page/sustainable-development-goals/sdg-3-2.
19. Urban Health in Developing Countries. Agarwal S, Srivastava A, Kumar S. Urban health in developing countries. In: Gibbons MC, Bali R, Wickramasinghe N, Eds. Perspectives of Knowledge Management in Urban Health. Springer, 2010:6194.
20. WHO, Urban Health. Available from (http://www.who.int/news-room/factsheets/detail/urban-health) [Last accessed on 2022 Apr 05]