ORIGINAL ARTICLE

Study of functionality of Mahila Arogya Samitis in Strengthening Health Systems under National Urban Health Mission, Indore city, Madhya Pradesh

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ABSTRACT

Introduction: Mahila Arogya Samiti (MAS) is one of the key interventions under National Urban Health Mission aimed at improving the reach and utilization of health services among vulnerable and marginalized population in urban areas. **Objectives:** The study was done to assess the functioning of Mahila Arogya Samiti in Indore city which included the no. of households covered by MAS, there reason behind joining MAS, awareness of role and responsibilities of MAS among its members, awareness and utilization of untied funds. **Material and Methods:** A cross-sectional study was done using a pretested structured Questionnaire to interview health care workers involved in Mahila Arogya Samiti like Accredited Social Health Activist (ASHAs), AWWs, Anganwadi Helpers(AWH), Chairperson and other MAS members maintaining their confidentiality. **Results:** 18(64.3%) ASHA, 15(57.7%) AWW(Anganwadi worker) said that MAS covers greater than 200 households. 91(41.72%) MAS members joined MAS because they were told by ASHA to do so. Majority of Chairperson 17(60.71%) roles and responsibility include ensuring regular monthly meetings of MAS, supporting ASHA in her functions. **Conclusion:** MAS was present and functional in most of the areas covered, there was little proactive participation of all the MAS members.

KEYWORDS

MAS; ASHA; AWW; AWH

INTRODUCTION

Mahila Arogya Samiti (MAS) is one of the key interventions under National Urban Health Mission aimed at improving the reach and utilization of health services among vulnerable and marginalized population in urban areas. MAS is a local women's collective which act as leadership platforms for women and focal community group in each slum area (1). They support the ASHA/ AWW/ Anganwadi helpers to develop health plans specific to the local needs and thus promote community action for all. MAS addresses the issues related to health, nutrition, water, sanitation and social determinants at the slum level. MAS aims to create community level awareness on locally relevant health issues and promote the acceptance of best practices in health by the community. It further emphasizes demand generation at the community level. MAS consist of 10-12 members (minimum 8 and maximum 20 members) including ASHA, Anganwadi worker (AWW), Anganwadi Helper (AWH) and rests of the members are selected from the community. ASHA is the member secretary of MAS while a chairperson is chosen from the members selected

from the community. Each MAS covers 50-100 households. Every ASHA is linked between 2-5 MAS groups. MAS coordinates with the ANM and AWW to arrange a monthly and quarterly meeting with all relevant stakeholders to discuss the community issues and devise a convergence plan. (1). MAS has been functioning in Indore city since past 3 years. Till date, no study has been done to evaluate its functioning, hence this study is an attempt to look into various aspects of functioning of MAS.

Aim of the study was to assess the functionality of Mahila Arogya Samiti in Indore city.

Objectives

1. The study was done to assess the functioning of Mahila Arogya Samiti in Indore city which included the no. of households covered by MAS, there reason behind joining MAS, awareness of role and responsibilities of MAS among its members, awareness and utilization of untied funds, problems faced by MAS members/ bottlenecks as identified by MAS members in implementation of MAS.
2. To suggest appropriate recommendations on the basis of results.

MATERIAL & METHODS

Study subjects- Key Health Staff involved in MAS like Urban ASHAs, Anganwadi worker (AWW), Anganwadi Helper, other members of MAS.

There are 250 MAS functioning in Indore city of Madhya Pradesh. The information about the number of MAS working in the Indore city was taken from District Community Mobiliser (DCM) Official from CMHO Office located at MTH Compound, Indore. According to NUHM the role of District Community Mobiliser includes selection and proper functioning of ASHAs and monitoring of MAS activities. 10% of total MAS was taken. In each zone 7 MAS were chosen by simple random sampling method. Hence a total of 28 MAS (7 MAS from each zone name Nandanagar, Malharganj, Sanyogitaganj, Hukumchand of urban Indore) were taken in the study as Indore Urban is divided into four zones by Department of Health and Family Welfare. MAS consist of 10-12 members (minimum 8 and maximum 20 members) including ASHA, Anganwadi worker (AWW), Anganwadi Helper and rests of the members including the chairperson are selected from the community (1). In 2 MAS, Anganwadi workers (AWW) were not MAS member therefore total Anganwadi workers taken in the study were 26. In 5 MAS (out of total 28 MAS), Anganwadi Helper (AWH) were not the members of MAS therefore total AWH were 23.So in total 26 AWWs, 28 ASHAs, 23 AWHs,28 Chairperson and a total of 241 MAS members were interviewed. The inclusion criteria for respondents were women 18 years and above and MAS who have completed more than one year of functioning were included in the study. Informed consent was taken from every MAS member selected for the study beforehand; with the agreement of maintaining their confidentiality. Approval from the Institutional Ethics Committee was sought.

Data collection methods: Pretested structured Questionnaire for health care workers: ASHAs, AWWs, Anganwadi Helpers regarding the process of formation of MAS, functioning of MAS, their reason for joining MAS, role and responsibilities of MAS.

Data analysis: Data was entered in excel sheet and analysed using SPSS Software. Categorical data expressed as proportion and percentage and Continuous data as mean and standard deviation.

RESULTS

Majority of MAS members like Anganwadi workers (AWWs) 20(77%), ASHAs 22(78%), Chairpersons 21(75%), Anganwadi helpers 19(83%) and other MAS members (excluding AWW, ASHA, Chairperson, AWW) 111(82%) were in age group of 21-40year. The mean age of AWWs was calculated to be 33.96±7.57, ASHAs 33.35± 6.81, Chairpersons 36.03±8.42, Anganwadi helpers 34.34±6.26 and other MAS members(excluding AWW, ASHA, Chairperson, Anganwadi helper) 33.84±8.43.

Most of AWWs 13(50%), ASHAs 26(92.85%) had higher secondary education, most of the Chairpersons 13(46.42%) and Anganwadi helpers 13(56.52%) had middle school education while other MAS members (excluding AWW, ASHA, Chairperson, AWW) 78(57.35%) were literate. More than half of the MAS members 133(55.18%) belong to Upper lower socio-economic class followed by Lower middle class 97(40.24%) as per modified kuppuswami scale.

18(64.3%) ASHA, 15(57.7%) AWW, 2(8.7%) Anganwadi helpers said that MAS covers greater than 200 households. 47(34.6%) of other MAS members (excluding AWW, ASHA, Chairperson, Anganwadi helper) were not aware of the number of households covered by their MAS. (Table 1)

Table 1 No. of Households covered by MAS according to their members

Serial no.	No. of households covered	MAS Members				
		AWW	ASHA	Chairperson	AWH	Other MAS members(excluding AWW,ASHA,AWW Helper, Chairperson)
1.	<50	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)
2.	50-100	10(38.5%)	8(28.5%)	13(46.4%)	10(43.5%)	11(8.1%)
3.	101-150	1(3.8%)	1(3.6%)	0(0%)	9(39.1%)	25(18.4%)
4.	151-200	0(0%)	1(3.6%)	0(0%)	0(0%)	14(10.3%)
5.	>200	15(57.7%)	18(64.3%)	14(50%)	2(8.7%)	39(28.7%)
6.	Don't know	0(0%)	0(0%)	1(3.6%)	2(8.7%)	47(34.6%)
	Total	26*(100%)	28(100%)	28(100%)	23(100%)	136(100%)

** 2 AWWs were not a part of MAS, therefore total AWWs came out to be 26; **5 AWH were not a part of MAS, therefore total AWH came out to be 23.*

As ASHA is the main person who is responsible for MAS formation thus data of ASHA is not included.

All the AWWs 26(100%), Chairperson 28 (100%), Anganwadi Helper 23(100%) have joined MAS as they were told by ASHA to do so and they wanted to do social welfare. Other MAS members (excluding AWW, Chairperson, Anganwadi helper) 52(38.2%) had joined MAS because they were told by ASHA workers to do so while 15(53.5%) wanted to do social welfare by joining MAS.(Table 2)

According to majority of Chairperson 20(71%), their roles and responsibility include ensuring regular monthly meetings of MAS, supporting ASHA in her functions and education regarding ANC in pregnant women.(Table 3)

Table 2 Reason behind joining MAS according to its members

S.N	Reasons behind Joining MAS	AWW	Chairperson	AWH	Other MAS Member (excluding AWW, Chairperson, Anganwadi helper)
1.	Social welfare cause	11(42.3%)	15(53.5%)	12(52.2%)	46(33.8%)
2.	Their peers had joined	0(0%)	0(0%)	0(0%)	38(27.9%)
3.	Told by ASHAs to join MAS	15(57.7%)	13(46.4%)	11(47.8%)	52(38.2%)
	Total	26 (100%)	28(100%)	23(100%)	136(100%)

Table no.3 Roles and responsibility of Chairperson (chosen from community) of MAS

SN	Role and responsibility of the MAS Chairperson	Chairperson
1.	Ensures regular monthly MAS meetings	8(28.5%)
2.	Awareness about government health plans to nearby residing women	2(7.1%)
3.	Education regarding locally endemic disease to nearby residing women	2(7.1%)
4.	Support ASHA in her functions	7(25%)
5.	Education regarding immunisation in children	2(7.1%)
6.	Education regarding ANC in pregnant women	5(17.8%)
7.	All	2(7.14%)
	Total	**28(100%)**

28(100%) of MAS Secretary and AWW conveyed their roles and responsibilities as providing education regarding immunisation in children, education regarding ANC in pregnant women, creating awareness about local diseases, creating awareness about government health plans and fixing the schedule and venue for MAS meeting.

30% of MAS members(excluding AWW, ASHA, AWH, Chairperson) agreed to all the roles and responsibilities of MAS including education regarding immunisation in children, education regarding ANC in pregnant women, creating awareness about local diseases, creating awareness about government health plans .45% said that the roles and responsibility of MAS members include providing education to ANC women and immunisation in children followed by 25% according to whom they should create awareness about local endemic diseases

All the ASHA workers 28(100%), Chairpersons 28(100%) and majority of AWWs 24(92.3%), Anganwadi helpers 21(91.3%), were aware of untied funds of MAS. Almost all the other MAS members (excluding AWW, ASHA, Chairperson, Anganwadi helper) 129(94.9%) had no awareness regarding untied funds of MAS.

According to all the AWWs 24(100%) and ASHAs 28(100%) untied fund of MAS is utilized for

purchasing equipment at Anganwadi, stationary for ASHA and Anganwadi, emergency transport of poor to health facility while most of the Chairperson 22(78.57%) and Anganwadi helper 18(85.71%) said that the untied fund was mainly used for purchasing equipment at Anganwadi.(Table 4)

Table 4 Awareness of those MAS members who were aware of the untied funds of MAS regarding its heads of utilization

SN	Awareness of MAS members regarding utilisation of untied fund of MAS	AWW	ASHA	Chairperson	Anganwadi helper	Other MAS members(excluding AWW, ASHA, Chairperson, Anganwadi helper
1.	Purchasing Equipment* for Anganwadi	0(0%)	0(0%)	22(78.57%)	18(85.71%)	7(100%)
2.	Purchasing Stationary for ASHA and Anganwadi	0(0%)	0(0%)	6(21.42%)	3(14.28%)	0(0%)
3.	Paying for Transport of poor to health facility in emergency	0(0%)	0(0%)	0(0%)	0(0%)	0(0%)
4.	All of the above	24(100%)	28(100%)	28(100%)	0(0%)	0(0%)
	Total	24(100%)	28(100%)	28(100%)	21(100%)	7(100%)

**Weighing machine, BP instrument*

Problems faced by majority of MAS members 21(80.76%) AWW, 26(92.85%) ASHAs, 8(28.57%) Chairpersons, 18(78.26%) Anganwadi helpers and 18(13.23%) other MAS members (excluding AWW, ASHA, Chairperson, Anganwadi helper) include lack of proper space for MAS members, all the MAS members do not attend meetings regularly as they were busy, no monetary benefit therefore lack of interest in attending meetings and lack of regular training of MAS members.

DISCUSSION

In this study, majority of MAS members were in age group of 21-40year. The education status varied from Graduation in AWW, higher secondary in ASHA to middle school and being literate among MAS members. In a pilot study conducted by Chetna NGO in Gujarat (2) most of the MAS members were in the age group above 35 years. The above variability is explained by guidelines for MAS in urban context, NUHM, Government of India (1) according to which there is no specific age group included in the criteria for selection of MAS members.

In the present study it was found that many MAS members 88(36.51%) said that MAS covers greater than 200 households. NUHM guidelines states that the number of households covered by each MAS should be approximately 50-100 which may vary according to the ground realities of each slum area. The possible explanation can be as the number of MAS is less in comparison to urban slum population of Indore (3); therefore the number of households covered by each MAS are greater than expected.

More than one third of the MAS members 91(37.75%) joined MAS because they were told by ASHA to do so. This finding is dissimilar to the findings of Pilot study done in Gujarat (2) where majority MAS members 511(46%) joined MAS for a social cause followed by joining MAS as told by ASHA and friends 381(33%). Proactive participation may help to become a MAS member by choice and not by force. Complete knowledge of all the roles and responsibilities is one of the most important factor for effective functioning of a Programme. Despite this in our study Chairpersons were aware of only some activities like ensuring regular monthly meetings of MAS 8(28%), providing health education to ANC women 5(17.8%), creating awareness about government plans 2(25%), and supporting ASHA 7(25%)in her functions. They were not aware of various other responsibilities like developing the community health plan for the slum/ coverage area in consultation with all MAS members, ensuring all the records and registers of MAS are adequately maintained as mentioned in NUHM (4).

ASHAs knowledge regarding their role and responsibility as MAS secretary was limited to creating awareness about various Government Health plans, education about immunisation in children, awareness about local diseases and fixing the schedule and venue for MAS meeting 28(100%). Making arrangements for the Urban Health and Nutrition Days (UHNDs) and ensuring utilization of untied funds were amongst the other responsibilities of Secretary as mentioned in NUHM guidelines which the ASHAs were not aware of (4). Proper training should be given to all the MAS members so that they become aware of all their roles and responsibilities. Rajesh kumar Rai in his study mentioned that MAS is responsible for health and hygiene, behaviour change promotion, and

facilitating the community to utilize the healthcare services in their coverage area (5).108(44.81%) of total MAS members were aware about untied funds. The members who knew about untied funds were mostly ASHAs and Chairperson. Almost all the MAS members selected from community except the chairperson

129(94.9%) had almost no awareness regarding untied funds of MAS. The findings of our study are almost similar to the findings of pilot study of Gujarat where only 444(39.96%) MAS members knew about untied fund (2). Therefore the information regarding untied funds was not made completely available to MAS members. According to them it was utilized for purchasing equipment's and stationary for Anganwadi and for emergency transport of poor to the health facility. As mentioned in NUHM guidelines (4), the untied funds can be utilized for public health activities like cleanliness drive, insecticide spraying, repair or installation of community water supply points, repair of toilets, IEC/BCC activities and logistic arrangements for Urban Health and Nutrition Days (UHND). The various problems faced by MAS members include lack of proper space for meetings; lack of 100% attendance of MAS members during meetings, all the MAS members did not show interest due to lack of monetary benefits, no regular training of MAS members and some of the MAS have not received untied funds since their formation. Limited access to training and inadequate training methods leads to lack of competency so it is recommended that stress should be given on providing adequate training and ample infrastructure to MAS and urban health activities. Even Satish Kumar et. al in their study have concluded that the state governments need to give a high priority to plan and set up primary healthcare infrastructure in urban areas (5).

Conclusion

MAS was present and functional in most of the areas covered in the present study in Indore urban slum. Most MAS had almost all the committee members. The number of households covered by some MAS was substantially greater than that mentioned in NUHM guidelines. There was little proactive participation of all the MAS members as they joined MAS because they were told by ASHAs to do so. As MAS members are local community women and with their becoming part of MAS their awareness about health related activities and government health plans has increased significantly but they were partially aware of all their roles and responsibilities. ASHAs and Chairperson knew about the untied funds and their utilization but other members didn't know much about it as mainly it is being handled by ASHAs and Chairperson

Recommendation

Increase in the number of MAS- Most of the MAS are covering substantially more number of households than mentioned in the guidelines therefore the number of MAS should be increased so that in the existing MAS, members are not overburdened.

Effective monitoring mechanism- Proper monitoring is required for effective functioning of MAS. It will ensure regular attendance of meetings, all MAS are aware of various functions of MAS.

Formation of Self Help Groups- MAS should be encouraged to form Self Help Groups (SHGs) which promotes small, regular savings among their members. SHGs use the saving amount for giving loan to the members so that they can help each other to solve their problems. Although the amount is small but savings are regular and continuous habit thus it is a step towards self-dependence. SHGs take loan from the bank and give it to its members.

Incentivisation- The provision of incentives/certificates/reward (acknowledging the role of MAS in urban health) will encourage its members to actively participate in meetings which will lead to increase in the number of members attending the meetings.

Continuous supply of Untied Funds- Uninterrupted supply of untied funds to MAS will ensure its proper utilization.

Limitation of the Study

All the MAS functioning in Indore city could not be covered due to time constraint. Ideally the impact of MAS can only be assessed if the awareness status is measured before and after the formation of MAS. Since no data was available before the formation of MAS hence no pre-post formation of MAS comparison could not be done. Accessing MAS members was tough as they were busy. No comprehensive study or any international study could be found related to MAS therefore as a beginner it was quiet challenging for me to conduct the study. Although the concept of MAS is formed to implement uniformly everywhere, every MAS is proceeding on its own formed convenient procedures. Therefore analysis of observation was also challenging. The responses of MAS members were not as per the guideline checklist of MAS concept. Mostly they responded in their own verbatim as per their own perception making my analysis more challenging.

Relevance of the Study

MAS was present and functional in most of the areas covered in the present study in Indore urban slum. Thus functionality of MAS is an excellent example of Community Participation in Primary Health Care.

Authors Contribution

AK: (acquisition, analysis and interpretation of data, drafting the article and revising it critically for important intellectual content, final approval of the version to be published). **DR:** (analysis, interpretation of data, drafting the article and revising it critically for important intellectual content, final approval of the version to be published). **SS:** (interpretation of data, drafting the article and revising it critically for important intellectual content, final approval of the version to be published). **SD:** (drafting the article and revising it critically for important intellectual content, final approval of the version to be published)**. PM:** (drafting the article and revising it critically for important intellectual content, final approval of the version to be published. **GS:** (drafting the article and revising it critically for important intellectual content, final approval of the version to be published. **AS:** (drafting the article and revising it critically for important intellectual content, final approval of the version to be published.

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Conflict of Interest

There are no conflicts of interest.

Declaration of Generative AI and AI Assisted Technologies in the Writing Process

The authors haven't used any generative AI/AI assisted technologies in the writing process.

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