# EVALUATION REPORT OF MAHILA AAROGYA SAMITI, CHHATTISGARH

**State Health Resource Centre, Raipur (Chhattisgarh)**

## Table of contents

**List of abbreviations and acronyms**

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| ASHA | Accredited Social Health Activist |
| AWW | Anganwadi Worker |
| ICDS | Integrated Child Development Services Scheme |
| MAS | Mahila Arogya Samiti |
| MDM | Mid-Day Meal |
| NGO | Non-Governmental Organization |
| NHM | National Health Mission |
| NRHM | National Rural Health Mission |
| NUHM | National Urban Health Mission |
| OOPE | Out-of-pocket expenditure |
| PDS | Public Distribution System |
| PWD | Public Works Department |
| SHG | Self Help Groups |
| THR | Take Home Ration |
| ULB | Urban Local Body |
| WASH | Water, Sanitation and Hygiene |
| WCD | Women and Child Development |

**List of tables and figures**

## Executive summary

Community participation in health is crucial both as a means to improve the health care service delivery and also to increase the involvement of health decision-making. Mahila Aarogya Samiti (MAS) is local women's collective. They are expected to take action on issues related to Health, Food Security, Nutrition, Gender-Based Violence, Water, Sanitation and its social determinants in urban areas on India. The main purpose of MAS includes, demand generation, ensuring optimal utilization of services, establishing referral linkages, increasing community ownership and sustainability. However, whether MAS has been successful in acting on the issues affecting the community, is not known.

An evaluation of the MAS was conducted by State Health Resource Centre (SHRC), Chhattisgarh. The evaluation was informed by the realist framework, and it tried to understand whether MAS has been effective in Chhattisgarh. The action taken by MAS was defined as an effort that was taken by MAS to address the problems faced by the community. These problems were related to health, food-security and nutrition, gender-based violence, water, sanitation and social environment. The action taken by MAS included the act of giving information to people, raising awareness about these issues, intervening in cases of denial of health and welfare services, taking up the issue to elected representatives like Parshads (Ward Councillor), government officials etc. The objective of the evaluation was to estimate the proportion of MAS in the state that is taking action to address community's problems, the facilitators and barriers to their action. A mixed-method approach was adopted to meet the objectives of the evaluation. A state-wide survey was conducted with a sample size (n) = 401 MAS out of the 3600 MAS that have been constituted in the state. 95.3% MAS had taken action on at least one of the problems (health, food security and nutrition, gender-based violence, water, sanitation and social environment) in last 1 year. In last 3 years, 59.1% MAS had taken action on healthcare related problems, 74.1% acted on food-security and nutrition issues, 60.8% took action on gender-based violence, 56.4% on drinking water, 70.8% on sanitation and 64.1% on social environment. 95.3% of MAS had an active bank account while 4.7% did not have a bank account. 54.4% of MAS received their last installment in 2022-23, 28.01% in 2021-2022, and 17.5% in 2020-2021. 45.5% MAS did not receive any funds in 2022-23.

Training and meetings trainings were found to be important facilitators in promoting action taken by MAS. It provides a platform for MAS to learn about the various government programs, and schemes, to discuss the prevailing issues and solutions to it, and consolidate the action they take. Mitanin and their supervisory cadres play a critical role in providing oversight and supportive supervision to MAS. However, inadequate funds were found to be a barrier to the action taken by MAS. The study found that 5,000 rupees were found to be inadequate by both MAS members and program implementers. In addition, no formal linkage with mechanisms with various relevant stakeholders like Municipal Corporations, PWED, food department is a setback, and hinders action by MAS.

Trainings must be conducted with focus on social determinants of health given the study shows that the MAS has a high engagement with issues related to food-security, nutrition, sanitation and gender-based violence etc. The expenditure of untied funds must remain at the discretion of MAS members, and the funds must remain "untied". This will allow MAS to best serve the community as per the needs of community, as evident from the study.

## Background

The World Health Organization (WHO) defines community participation as “a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change”(1). Community participation in healthcare has helped in improving utilization of and acceptance of health services by the citizens. Apart from service delivery, it is also critical in addressing the social determinants of health(2). The Alma Ata declaration postulated that for the attainment of the highest level of health for communities, there is a need for action in social and economic sectors in addition to the health sector(3). It is now widely accepted that there is a need to address the issues around power and control over decisions about health, food security, livelihood, water, and sanitation- to improve health of the population.

Under the National Rural Health Mission, or National Health Mission, Village Health and Sanitation Committees were introduced in rural areas of India in 2005. The committee was formed to involve the community in making decisions about their own health and for taking action on issues related to health and its social determinants at the village level(4). Later in 2012, National Urban Health Mission (NUHM) in 2012, to meet the healthcare needs of the urban poor. The main objective of NUHM was “to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalising and strengthening the existing capacity of healthcare delivery for improving the health status of the urban poor”(4). The program defined community-based interventions as ‘community processes’(5). Two main components of community processes under the NUHM were the community health worker (CHW) program, also known as the Accredited Social and Health Activist (ASHA) program for a population of 1000-2500 and Mahila Arogya Samiti (MAS) or Local Women’s Health Collective program(6).

Mahila Arogya Samiti (MAS) is local women’s collective which was believed that MAS could improve community participation in urban areas, which is often more heterogenous than its rural counterparts ASHAs are responsible for overseeing the work of two to five MAS and she is appointed as the Member Secretary of the MAS(6). However, each MAS is supposed to appoint a Chairperson and a Secretary who cannot be ASHA workers. Each MAS usually has 10-12 members, depending on the size of the slum. Each MAS is allocated 5,000 rupees annually in the form of “untied funds”(6). It is up to the discretion of MAS to use these funds as and when they deem it appropriate, with a goal to improve health, nutrition, education, sanitation, environmental protection, public health measures, emergency transport for patients, etc(4).

### *Chhattisgarh scenario*

The Government of Chhattisgarh launched the National Urban Health Program in 2012. The community processes included two component i) Mitanin program in urban areas; ii) Mahila Aarogya Samiti (MAS). Currently, there a total of 70,000 Mitanins work in the state that work under the supervision of Mitanin Trainers (supervisors)(7). As for MAS, 3775 Mitanins were selected in slums of 19 towns and 3699 MAS were constituted, covering more than two million population in urban slums and vulnerable areas and adjoining households. There is one MAS under each Mitanin in Chhattisgarh (8). Each member of the MAS is unanimously elected by the community, much like the Mitanin. From within the group of ten, two members are then elected as the Chairperson and the Secretary, who are responsible for operating a bank account in the name of MAS. Involvement of the Mitanin Trainers in spending from the untied fund is discouraged and the MAS members are expected to handle their accounts and documentation for their activities. In Chhattisgarh, the appointment of the Chairperson and Secretary is for a period of one year and is extendable if the group agrees, the MAS members can also remove and appoint a new member or the Chairperson and Secretary if a two-thirds majority is in the favor of the decision(8). The Mitanin Trainer is responsible for facilitating the MAS meetings, providing ground-level support for other activities that the MAS might be organizing, and also helping the MAS submit a quarterly spending report to a nearest Primary Health

Centre for the untied funds(9). MAS members attend annual training conducted by SHRC. The training conducted by MAS in Chhattisgarh cover topics related to health and well-being, health program, social determinants of health like food security programs, drinking water, sanitation, and monitoring the functioning of health and nutrition programs. These training are conducted at district levels by Trainers trained by SHRC. MAS members receive travel allowance for the training period(8).

The objectives of the MAS were as follows:

i) Provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
ii) Provide a mechanism for the community to voice health needs, experiences and issues with access to health services.
iii) Generate community level awareness on locally relevant health issues and to promote the acceptance of best practices in health by the community.
iv) Focus on preventive and promotive health care activities and management of untied fund.
v) Support and facilitate the work of community service providers like ASHA and other frontline workers who form a crucial interface between the community and health institutions.
vi) Provide an institutional mechanism for the community to be informed of various health programmes and other government initiatives and to participate in the planning and implementation of these programmes, leading to better health outcomes.
vii) Organize or facilitate community level services and referral linkages for health services.

### *Rationale for evaluation*

Mahila Aarogya Samiti (MAS) is one of the two components of the community processes as defined by the National Urban Health Mission (NUHM). However, unlike the first component of community processes under NUHM (the CHW program)(10). Yet MAS's effectiveness or lack of it thereof has never been empirically tested. One of the reasons why the success or failure of the MAS program is yet to be evaluated is due to the complex, multifaceted nature of community-level programs like MAS. Therefore, an evaluation of MAS was planned. The aim was to understand what kind of action works in addressing the issues affecting the community, who benefits from it, for whom it doesn't work, what circumstances allow for effective action by MAS and what motivates the MAS members to take such action. This would help improve the design and practices related to the program at the state level and inform policy on a national level.

### *Objectives*

The specific objectives of our evaluation study were as follows:

1) To estimate the proportion of MAS that is taking action on issues related to health and social determinants of health.

2) To explore the various forms of action taken by MAS, and understand the facilitators and barriers to their action on health and food security, gender-based violence, drinking water related issues, and sanitation and hygiene.

3) To understand the facilitators and barriers, and motivational factors affecting the work of MAS.

### *Theoretical approach*

A theory driven approach was adopted for the evaluation of MAS given the complex nature of an intervention like MAS. The evaluation drew on the principles of realist evaluation(11). This approach is used to evaluate social and healthcare interventions, with an aim to understand the underlying mechanisms by which and the contexts in which a program intervention works or does not work(12). Realist framework proposes that program works (i.e., have successful outcomes) only where they

introduce appropriate ideas and opportunities (mechanisms) into appropriate contexts (factors that affect the mechanisms). This approach to evaluation has resulted in deeper insights into why a programme/intervention did or did not work and what contextual factors were associated with outcomes(12). Through its focus on understanding why change occurs (or not) and in which conditions, realist evaluation allows decision-makers to draw transferrable lessons about effective implementation strategies, thereby lending greater external validity to the findings(13).

Realist evaluation of MAS involved three broad stages:

i) Identifying the program theory which means developing a theory to explain how was the program expected is work by those developing it. This can be done by reviewing the program documents.

ii) Collecting data from MAS members and implementers (the key stakeholders) to be able to refine the initial program theory *(Objective 2 & 3)*

iii) Using that data to refine the program theory to explain the contexts (real life circumstances in which MAS works), the mechanisms (that factors that enables the work of MAS, the motivation factors and barriers to their work), and outcomes (what has MAS achieved by undertaking action).

## Methods

A mixed method approach was adopted which was informed by the realist framework. An initial program theory was identified by reviewing the program documents. Then, a survey was conducted to assess how active MAS is. The survey was used to estimate the proportion of MAS which is taking action on health, food security and nutrition, drinking water, sanitation etc. (Objective-1). The action taken by MAS included the act of giving information to people, raising awareness about these issues, intervening in cases of denial of health and welfare services, taking up the issue to elected representatives like Parshads (Ward Councillor/elected representative), government officials etc. The qualitative component included focus group discussions to understand the various kind of actions taken by MAS, what enables MAS to work on these issues, what are the barriers they face and what motivates them (Objective-2, 3). We also conducted in-depth interviews with the program implementers. At last, the initial program theory was refined using the data.

### *Sampling, and sample size*

For the quantitative component, we surveyed MAS from across the state. We used the systematic random sampling method. A sampling frame of all the 3600 MAS from 19 cities were randomly selected. A sample size of n=368 was calculated using the formula $\boldsymbol{n = [DEFF*Np(1-p)]/ [(d^2/Z^2_{1-\alpha/2}*(N-1)+p*(1-p)]}$ with an anticipated frequency of 50% at 95% confidence interval, precision of 5% and design effect of 1(14). The actual sample size n=401 covered was adequate for the statistical analyses needed for this study.

For the qualitative component, a purposive stratified sampling method was adopted for the qualitative data collection. The stratifiers included the type of urban local body (municipal corporation or municipality), and slum areas and other low-income areas. We reached out to the MAS working in the slum areas and low-income areas with the help of Mitanins. We conducted 20 focus group discussions conducted with MAS members in Raipur, Baloda Bazar-Bhatapara, and Durg. 2 in-depth interviews with City Program Managers of two different districts. The principle of saturation was followed to determine the sample size of focus group discussions.

### *Data collection*

A survey questionnaire was prepared in Hindi. It included questions related to the domain of healthcare, food security and nutrition, gender-based violence, sanitation, drinking water, and social environment (substance related problems in the locality etc.). The survey questions were posed to one of the MAS members (excluding the Mitanin). Qualitative data collection involved discussions

with the MAS members, and in-depth interviews with the other key stakeholders of the program (CHW supervisors, Medical Officers, Staff Nurses, City Program Managers).

### *Data analysis*

Quantitative data was analysed descriptively. Interviews and focus groups were audio-recorded and transcribed verbatim. Qualitative data analysis was done using the CMO configuration as a guide for analysis. Further, thematic analysis was conducted as it allows for classification and organization of data in terms of key themes, concepts and emergent patterns (Ritchie and Spencer,1994). The following themes were included: factors facilitating the action, barriers to the action taken by MAS, and factors affecting the motivation of MAS members.

### *Ethical considerations*

This study has received ethical approval from the Institutional Ethics Committee of the State Health Resource Centre, Chhattisgarh (IEC16/SHRC/2022). All the participants were informed about the purpose and scope of this study. We then obtained written informed consent from the participants.

## Results

An initial program theory was identified by reviewing all the program documents available. It is as follows:

> "Selection of MAS members will be done in a participatory manner by involving the Mitanin and the community. Women who cared about the "well-being of the community", and displayed leadership qualities will be selected for MAS. Each Mitanin will look after 1 MAS. MAS members will be oriented and trained in health and related issues on health and food security, gender-based violence, drinking water related issues, and sanitation and hygiene. These trainings will be informed by a rights-based approach, and emphasized on the role of social determinants of health, and included demonstration of real-life situations, and how to address them. Facilitating processes will also involve monthly meetings and quarterly meetings. Monthly meetings will be conducted by MAS members to discuss the problems that affects the community, what actions have been taken to resolve them and what can be improved. As for supervision, quarterly meetings with supervisors of Mitanin program will also be conducted. Guidelines for action on select issues will be provided. In addition, each MAS will be provided with "untied funds" for 5000 rupees per year to take action of such issues. The utilization of the sum of 5000 rupees is entirely up to the discretion of MAS. Hence, all these factors will make MAS effective in identifying and addressing the problems of the community."

### *Quantitative findings*

A state-wide representative survey was conducted. It included n=401 MAS across 19 cities/Urban Local Bodies. These cities were Raipur, Bilaspur, Birgaon, Durg, Bhilai, Korba, Bhatapara-Baloda Bazar, Ambikapur, Jagdalpur, Dhamtari, Kanker, Jangir-Champa, Kawardha, Charoda, Chirmiri, Mahasamund, Raigarh, Mungeli, and Rajnandgaon.

MAS members were asked about the healthcare service-related problems faced by the community which included issues with pregnancy related care, institutional delivery, immunization, minor ailments related problems, 102/108 ambulance related issues, Janani Suraksha Yojana/Matratuva Vandana Yojana related issues etc. Food security and nutrition related issues related to ratio card, ration shop not opening, higher rates being charged for sugar, unavailability of kerosene oil, non-functional Anganwadi Centres (AWC), Take Home Ration (THR) not being given in AWC, food not being given to children and pregnant women, bad quality of food in mid-day meals (MDM) etc. Gender-based violence, water related issues with respect to quality and availability of drinking water, sanitation related to drainage, cleanliness, street lights, water logging, lack of toilets

in houses etc. Social environment related problem included alcohol and drug problems in the locality, safety of women and children etc.

To understand the activeness of MAS, they were asked whether the monthly meeting was conducted in last 1 year.

**Figure-1 Proportion (%) of MAS that conducted meeting in last 1 month (n=401)**

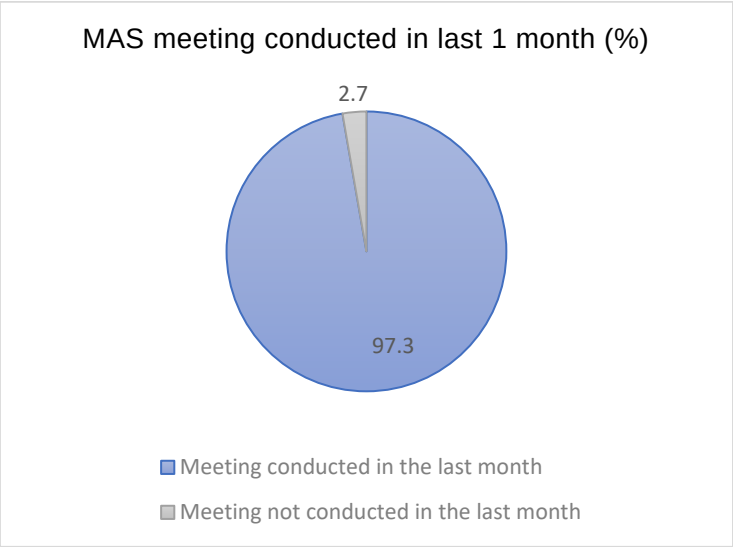



**Table-1 Proportion (%) of MAS that have taken action on different problems in last 3 years (n=401)**

| Types of problems | % |
|---|---|
| Health rights | 59.1 |
| Food security and nutrition | 74.1 |
| Gender-based violence | 60.8 |
| Drinking water | 56.4 |
| Sanitation | 70.8 |
| Social environment | 64.1 |

**Table-2 Proportion (%) of MAS that have taken action to address different problems related to health, food security-nutrition, gender-based violence water and sanitation and social environment in last 3 years (n=401)**

| Action taken | % |
|---|---|
| Action taken against at least 1 type of problem | 95.3 |
| Action taken against at least 2 types of problem | 89.8 |
| Action taken against at least 3 types of problem | 79.8 |
| Action taken against at least 4 types of problems | 62.5 |
| Action taken against at least 5 types of problem | 41.1 |
| Action taken against all 6 types of problem | 16.7 |

**Table-3 Type of action taken to address health related problem in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Information given to the patient | 41.9 |
| Accompanied the patient to the hospital | 23.2 |
| Application submitted to health officials | 18.2 |
| Talk to staff/health workers | 14.7 |
| Bore the expenses of transportation (hospital visit) | 13.2 |
| Informed the local media | 0.0 |

**Table-4 Type of action taken to address food security and nutrition in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Information given to people | 51.6 |
| Talked to the ration shop salesperson to solve a problem | 51.6 |
| Application given to higher officials of food department | 34.9 |
| Monitoring of PDS and MDM | 15.2 |
| Talked to officials of food department | 15.2 |
| Dry ration provided to poor people | 4.2 |

**Table-5 Type of action taken to address problems related to gender-based violence in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Information given to the survivor | 48.6 |
| Talked/counselled/confronted the accused | 45.9 |
| Police/Sakhi Centre | 17.7 |
| Application to WCD | 12.2 |
| Talked to officials from WCD | 6.2 |
| Other | 0.7 |

**Table-6 Type of action taken to address problems related to water/drinking water in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Talk to Parshad/Parshad | 49.6 |
| Application to Municipal Corporation/Council/Nagar Nigam | 32.4 |
| Talked to officials directly | 14.0 |
| Repairing of tap/pipeline using funds | 4.2 |
| Informed local media | 1.0 |
| Talk to Parshad/Parshad | 49.6 |
| Application to Municipal Corporation/Council/Nagar Nigam | 32.4 |

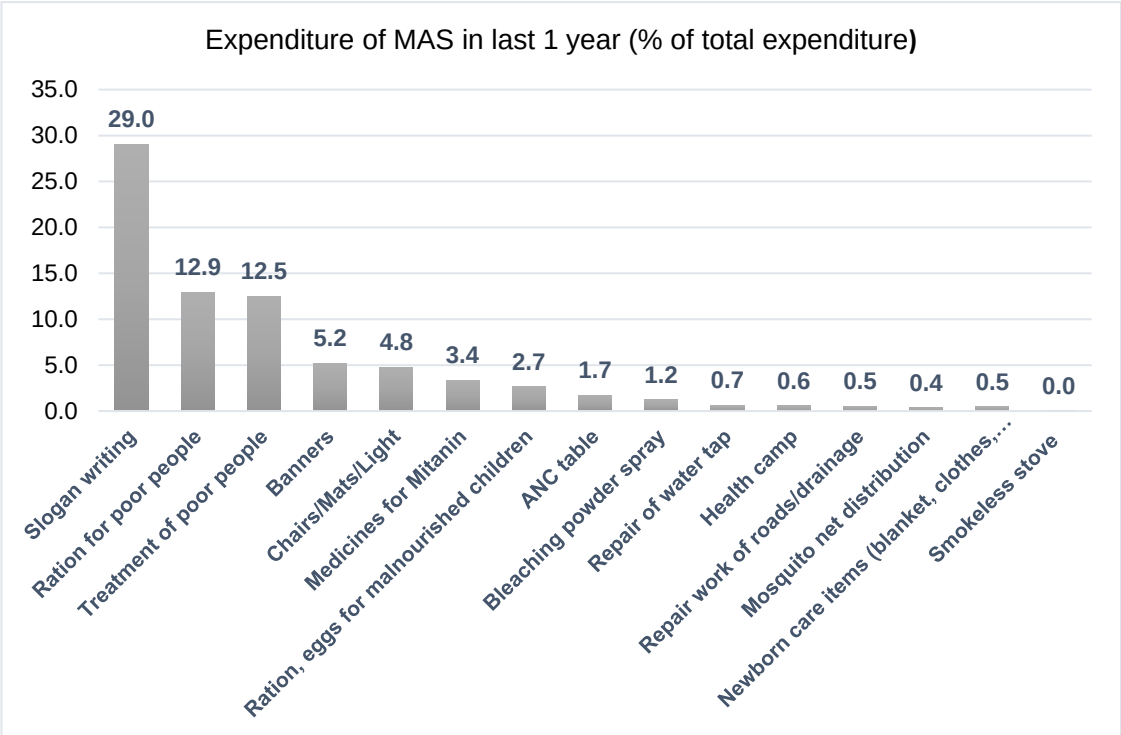
**Table-7 Type of action taken to address problems related to sanitation in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Talk to Parshad/Parshad | 59.6 |
| Application to Municipal Corporation/Council (ULB) | 26.9 |
| Took efforts to promote awareness about sanitation | 21.4 |
| Talk to officials | 16.5 |
| Cleaned it on their own (*shramdan*) | 15.0 |
| Hired someone to clean | 5.0 |
| Road repair work | 2.2 |

**Table-8 Type of action taken to address problems related to social environment in last 1 year (n=401)**

| Type of action taken | % |
|---|---|
| Talk to the person involved in drugs/alcohol related activity | 40.6 |
| Talk to Parshad/Parshad | 36.4 |
| Talk to police | 19.0 |
| Application submitted | 4.7 |
| Increased awareness about alcohol, drugs, tobacco products | 47.4 |
| Call 112 | 13.5 |

**Figure-2 Proportion of expenditure on various kind of work done to address problems related to health, food-security, nutrition, gender-based violence water, sanitation and social environment out of the total expenditure in last 1 year**



*Opening of bank accounts and utilization of untied funds*

95.3% of MAS had an active bank account. Out of all the MAS with an active bank account, 54.4% of MAS received funds in 2022-23, 28.01% received funds in 2021-2022, and 17.5% received funds in 2020-2021. The expenditure pattern of the untied funds shows that MAS has been using the funds on community need based. 24% of the total expenditure is on administrative costs which includes costs of conducting meeting, travelling to the bank etc.

Slogan writing on walls is being done by MAS to raise awareness about the illnesses and how they can be addressed by meeting the Mitanin or going to the nearest health centres, spreading information about government schemes related to food, nutrition etc., gender-based violence etc. See Figure-3.


Figure-3 Slogan writings on wall pertaining to health, air pollution and information about ambulance services

***Qualitative findings***

A majority of the MAS members both in slum areas and low-income areas (non-slum areas) work in the unorganised sector. Some of these work as daily wage workers, domestic workers and as vendors or sellers. Some of them are *Chhattisgarhi* speakers while some women said that *Odia* is their mother tongue. All of these women were married, and in the age group of 22-55 years.

There are 4 major themes that have been identified through our focus group discussions with the MAS members.

**1. Factors facilitating the action taken by MAS**

Under this theme, we will describe the factors that facilitate the action taken by MAS. We asked the MAS members about what allows them to be able to work actively on various fronts like health, food security, gender-based violence, drinking water, etc.

**1.1 Building capacity and inculcation of values through trainings**

MAS trainings include content on various health conditions (communicable, non-communicable disease, maternal and child health, immunization, etc.), government programs, schemes related to food security and nutrition, information on gender-based violence, climate change and its link to health, air pollution, preventing high out-of-pocket expenditure (OOPE) of people, water quality testing, sanitation and detailed information on entitlements, and various public services.

MAS members felt that trainings have played an important role in improving their knowledge. They shared that the trainings have played a role in making them aware of common problems faced by community, given them access to information on public services which common people may not have and sensitized them on taboo topics like gender-related issues, and helped them in acting on these issues.

*We get to learn about health conditions like Tuberculosis, pregnancy-related conditions, and other health conditions, latest government programs and schemes like our food and nutrition related things through our training. It allows us to learn new thing and see things from a different angle, like about gender and women's rights.* (MAS member, Durg, FGD 4)

*Government should provide services free of cost to the poorest sections and it should be good quality too. Nobody should have to go to the private hospital to get good quality health services.* (while talking about misuse of publicly funded insurance schemes by private hospitals in Chhattisgarh) (MAS member, Raipur, FGD 18)

**2.2 Meetings are a platform to consolidate action and in turn promote action**

As previously reported, a majority of MAS in the state are conducting monthly meetings regularly (97.3%). According to MAS members, monthly meetings and quarterly meeting (cluster-level with other MAS) have been useful in consolidating the work that has been done in the previous, discussing current problems and brainstorming solutions to address those problems. As evident from the quantitative findings, monthly meetings are being regularly held across the state.

*We make it a point to attend the meetings. We gather on 27$^{th}$ of every month. We start by taking attendance, discuss what has been done in the last month, what problem still prevails, and what new problems people are facing related to health, food related benefits, education for school children, etc. Everyone gives their views on how to solve them and we take action then. Apart from this, we all decide how will we raise awareness on health issues etc.* (MAS member, Bhatapara, FGD 4)

*We learn new things in every meeting, and we discuss the work we did the last month in these meetings. When we meet and discuss what we are doing it makes us feel like we are doing something important for the people. We feel like we are doing "jan seva"* (MAS member, Durg, FGD 5)

### 2.3 Guidance and support of Mitanins, Mitanin Trainers and Coordinators

MAS members shared that the support from Mitanins and their supervisory cadre (Mitanin Trainers, Area Coordinators) is one of the key facilitators of their action.

> *We reach out to Mitanin Didi before reaching out to anyone. We take her suggestions for many issues including ration related problems or cleanliness issues in the area, or if there is any problem with the drinking water supply.* (MAS member, Raipur, FGD 1)

> *One time we were getting a bad taste from the water of the public tap. We decided to write an application to the Municipality. But MT Didi suggested that we do the water testing first and make a strong case in front of the municipality. The issue got fixed after a few days and in the meantime, we requested for alternative water supply.* (MAS member, Durg, FGD 4)

> *We look forward to meetings with the senior supervisor (Area Coordinators). She gives us new information, gives us guidance on how to address existing problems in the locality. (MAS Member, Raipur, FGD 19)*

### 2.4 Public hearings (Jan Sammelan) as a platform to raise community's issues

MAS members attend the Jan Sammelans every year along with the Mitanin workers where they get an opportunity to raise problems related to health, food, nutrition, sanitation, drinking water etc. where they speak on behalf of the people of their community, making them the representative of the community in front of elected representatives and community leaders. Members felt it helps them in raising long-pending issues that people face, getting responses from the elected representatives and ensuring that the problems that have been raised are taken by the authorities

> *Mitanin didi guides us with Sammelan and we feel that it gives us a chance to become the "face of our people". Last time we could get hold of our Ward Councilor in front of the MLA and we complaint about the erratic water supply. I was the one who spoke up first but then all members who were there came forward to talk.* (MAS member, Durg, FGD 4)


Figure-4 Members of MAS participating in Jan Sammelans/Jan Samvad program in Raipur

### 2.5 Support of elected representatives and Urban Local Bodies

Many MAS members reported that they escalate multiple issues by reaching out to the Parshad or *Parshad*. As previously reported, 59.6% MAS reported that they reached out to the Parshad for sanitation issues, 49.6% for drinking water issues. In addition, they also write formal complaints to Urban Local Bodies (ULBs) of their respective cities.

*Our Parshad supports us with awareness campaign. He even joined us in one campaign against dengue where we were going house-to-house to tell people to not to store water. He made sure that the places which were dirty and breeding ground of mosquitoes were cleaned.* (MAS member, Durg, FGD 5)

*Last year, we made a written complaint to the Municipal Corporation oregarding the issue of street lights in our locality. It was broken for a while but they took up the problem and solved it.* (MAS member, Raipur, FGD 2)

**2.6 Support of the community in taking action**

The findings from the survey show that MAS is at forefront of addressing people's problems. 23.2% MAS members reported that they accompanied patients to the hospital, while 17.3% members said that they reached out to the police or the Sakhi centres against an accused of gender-based violence. This highlights that MAS members take serious efforts to help the community.

MAS members shared that they have been able to build credibility of their work amongst the community, which is why they receive the support of the community whenever they intervene on issues related to health, food security, and to a lesser extent on issues related to gender-based violence, etc.

*Almost all of the people of our mohalla support us whenever we raise any issue. One time we were being given impure grains (rice) and we questioned the ration salesperson. People came in support of us and backed us. He was forced to provide better quality rice.* (MAS member, Raipur, FGD 18)

One of the program implementers we interviewed shared that MAS has been able to work well in an actively mobile, and heterogenous populations.

*MAS members have taken the ownership of the community and issues that affect them. I have worked in areas like Birgaon where there is a lot of migrant population, but the MAS members still work actively.* (City Program Manager, NHM)

Figure-5 Members of MAS performing street theatre on the topic on superstition and its ill effects on health in Bhatapara. Community members are involved in the play.

**2.6 Relationship with Anganwadi Workers**

MAS members shared that they have been able to forge a cordial relationship with front-line workers like the Anganwadi Workers (AWW) and Anganwadi Helpers, and Mid-Meal Workers which gives them facilitates the oversight of Integrated Child Development Scheme (ICDS) program and Mid-Day Meal program. 1

*We (MAS members) have designated duties to check on the quantity of quality of food being provided in the Anganwadi Centre (AWC). We also check for the quality of mid-day meals provided to school children. They (workers) know us well, and they are cooperative, and take feedback. We also wrote an application to address the issues related to AWC to the food department.* (MAS member, Raipur, FGD 1)

## 2. Barriers to the action taken by MAS

The barriers to the action taken by MAS varied for slum areas and other low-income areas. The barriers faced by slum areas have been listed first followed by the barriers faced by other low-income areas.

### 2.1 Lack of responsiveness of elected representatives like Parshads

Some MAS members did not receive any support or received very little support from elected representatives like Parshads. This slows down the action taken by MAS on issues that require the support of elected representatives.

*"Naa neta suno, naa koi mantri sunhe hamar para ke"*

*Neither any political leader nor any minister listens to the woes of people of our area.* (Baloda-Bazar Bhatapara, FGD 6)

### 2.2 Irregular disbursal of money with the larger issue of inadequate funding

Many MAS members reported that they often receive money later than stipulated period and that it limits them from taking timely action on issues.

*Sometimes we receive half the amount we are expected to get, sometimes we get nothing and the money gets credited in next year. When the full amount should be sent and the money is supposed to be sent annually then this kind of problems restricts us as we have to spend our own money.* (MAS member, Durg, FGD 4)

*Last year we only received 2000 rupees. What can we possibly do with such little money in today's time when everything is so expensive. Forget about helping others, we ourselves get only 100 rupees for our meeting. We have 10 members; how are we supposed to get tea and snacks for ourselves with such little money.* (MAS member, Baloda-Bazar, FGD 6)

MAS members in both slum areas and other low-income areas (non-slum areas) felt that 5,000 rupees that the MAS receives for their work each year, is far from enough.

*5,000 rupees is nothing in today's times. If we have to help a few people of the community by paying for their transport to the hospital or giving dry grains to a poor family three times a year and then account for our own expenses like travelling to the bank, food expenses for monthly meetings, we are not left with much money.* (MAS member, Durg, FGD 4)

Both in slum areas and other low-income areas (non-slum areas) also felt that allowance given for annual training is insufficient.

*Only 450 rupees were given for 3 days, which is too less. We miss out on one day's work, we should also get some incentive for attending the meetings. We get 500 rupees as daily wages; hence, we lose 2000 rupees for 4 days. So, our family members ask why are you losing money for attending this training?*

(MAS member, Baloda-Bazar Bhatapara, FGD 6)

*We used to give eggs and bananas to one malnourished child who was 2 years old 1 year back. We used to visit his house and ensure he is gaining weight. We want to be able to do this for many children but we get very little money.*

(MAS member, Raipur, FGD 2)

Program implementers also echo their concerns about the inadequacy of the funds that are being current provided to MAS.

> "*I feel 5,000 rupees is way too less. and it needs to be increased to 10,000 rupees*." – City Programme Manager, NHM

### 3.3 Infrastructural barriers

MAS members in slum areas struggled to find a place to conduct meetings every month, whereas those living in low-income areas had better access to community halls and other non-government buildings.

> *There is no place for us to sit for meetings, we sit in Mitanin didi's house but sometimes that's not possible. Sometimes we sit under a big banyan tree, it's difficult to sit outside during summers and rainy days.* (MAS member, Baloda-Bazar Bhatapara, FGD 6)

## 3. Factors affecting the motivation of MAS members

This theme deals with the factors that motivate MAS members to work on the issues of health, food-security, nutrition, gender-based violence etc. without receiving any incentives for their work.

### 4.1 Social recognition and respect

Most MAS members felt that they have gained recognition and respect ever since they have become a part of the program.

> *When we go home and tell our family about things that we learnt, and the action we take, we feel proud of ourselves and they also feel proud of us. Or else why will they send us to do this work, we are not earning from it.* (MAS member, Raipur, FGD 1)

### 4.2 Successful efforts intensify the drive to take action

Every time MAS members made some efforts to address an issue, and they managed to help some people of the community successfully. Their success in addressing the problems of the community motivated them to work further.

> *The ration salesperson was overcharging people by 3 rupees for sugar, the actual price is 17 rupees and he would not give a change for 3 rupees. We started telling people to carry a change, and also confronted him. He said he doesn't have change so he can't help. We told him he is stealing 3 rupees from poor people. We ensure that both people and salesperson continue to carry a change so that people are not overcharged. After this experience, the salesperson listens to us on other issues too. He knows that we are aware of what is going on.*

### 4.3 Altruistic values and solidarity with the community

MAS members are compassionate about the problems that people face. They share a sense of solidarity with people. They see themselves as a part of the community, and they want to be able to help people.

> *I feel very satisfied if I am able to help people in any way. I like to set a good example. When we take out rallies to spread awareness about dengue, or talk about violence against women, or when we take on boys who are misbehaving with women in our area, I feel happy that I am contributing towards the betterment of our community.* (MAS member, Raipur, FGD 15)

### 4.4 Expectations related to employment

One important narrative that came out of our discussions with MAS members working in slum areas was that they had joined this work with a hope that this work will eventually allow them to make some money and support their families.

> *We were always hopeful that we will do some minor work like making disposable plates, or incense sticks and make some money on the side. We do not get paid anything for attending these meetings or for doing the work we do. At least having some small-scale employment opportunities would have helped us in improving our own situation, we too are poor people. We help others but who will help us?* (MAS member, Raipur, FGD 17)

### 4.5 Sisterhood with other MAS members

MAS members share a "sisterly" bond with each other. They like spending time with each other, and they see feel that they are all driven by the same sense of solidarity with the people and conviction in the cause. Their identity of being a woman also unites them.

> *We all want to help people; we believe that we can improve things around here and we have managed to do that. We want to continue to do so. Together we can surely do that.* (MAS member, Raipur, FGD 20)

**Table-9 Refined program theory explaining the mechanism, context, and outcome of the work being done by MAS**

| Mechanism (what works) | Context (in what circumstances) | Outcome |
|---|---|---|
| **Participatory selection** of women who care about the well-being of the community and display leadership skills has allowed selection of women who take keen interest in learning new information which would benefit the community. | These women come from heterogenous social backgrounds. | MAS members proactively reach out to help the community, acting as an interface between the community and the government by helping people avail benefits of government schemes and programs. |
| Trainings and meetings provide MAS members a platform to gain knowledge about government programs, schemes, and etc. They feel **empowered to hold information** that are not easily accessible for common citizens | The value-based content of training is focused at building the overall capacity of the MAS members in government programs and schemes, while meetings allow for continuous upgradation of these information | |
| Trainings and meeting play a key role in **inculcating a rights-based value system**, and understanding of social determinants of health in MAS members. | | |
| **Support and encouragement by Mitanin workers** aid the action taken by MAS. However, Mitanin does not take up a role of a leader despite her strong presence. | MAS is supported by the vertical cascading support structure under the Mitanin program. However, their support is not overpowering. Hence, a leadership within MAS flourished – making MAS capable to take action independently. | MAS members intervene on issues of denial of healthcare, food-security related entitlements, gender-based violence etc. both independently and with the support and guidance of Mitanins and their supervisory structure. |
| MAS members **receive guidance by supervisors** of Mitanin workers (Mitanin Trainers), and Area Coordinators (supervisors of Mitanin Trainers). They help MAS by means of problem-solving, skill building and in helping them in sustaining their | | |

| | | |
|---|---|---|
| motivation to learn more and act on various issues. | | |
| MAS members have been able to demonstrate their credibility to the community by solving their issues. This is why they have gained **community support** on most issues including the ones that requires MAS members to take a stand. | There is 1 MAS under each Mitanin, in every 10 houses. Hence, MAS work is well-defined, and they do not have to cater to a large community. | MAS members have evolved as the representative of the community, as community leaders who are at forefront to address problems affecting the community. |
| **Social recognition** and respect from the community is a major motivational factor for MAS members work and to continue to be a part of the collective. | According to MAS members, the community recognizes MAS members as a group of women who can be reached out to seek information about healthcare, public distribution system, drinking water related issues etc | MAS members have been able to sustained action over the years as they have motivated by factors like social recognition. They have been to establish a positive reinforcement cycle which continues to keep them motivated to work. |
| The **autonomy of MAS** has allowed them to take action based on the community's needs, making their work effective | MAS members decide the problems they work on based on the priorities set by them | |
| A **positive reinforcement cycle** of successful efforts drives MAS to take further action to solve the problems faced by the community. | No monetary incentives are paid to the MAS members for their work. They are only provided with training allowances. | |

## Discussion

-The study found that 95.3% MAS had taken action to address at least one of the problems (health, food security and nutrition, gender-based violence, water, sanitation and social environment) affecting the community in last 3 year. This shows that a majority of MAS is actively working on the issues affecting the community. In last 3 years, 59.1% MAS had taken action on healthcare related problems, 74.1% acted on food-security and nutrition issues, 60.8% took action on gender-based violence, 56.4% on drinking water, 70.8% on sanitation and 64.1% on social environment.

-95.3% of MAS had an active bank account while 4.7% did not have a bank account. 54.4% of MAS received their last installment in 2022-23, 28.01% in 2021-2022, and 17.5% in 2020-2021. 45.5% MAS did not receive any funds in 2022-23. In addition, 5,000 rupees were found to be inadequate by both MAS members and program implementers.

-The expenditure pattern of the untied funds showed that the spendings are community needs based. This has been possible because MAS has been given the autonomy to decide how to spend the funds. The survey showed that 29% of the total expenditure of all the MAS was on slogan writing as a part of Information, Education and Communication (IEC). 12.9% on expenditure was made for purchasing ration for poor people specially those who do not ration through PDS and providing extra food items. 12.5% of expenditure was being made on transportation costs for hospital visit of poor people, 5.2% on banners used for IEC and Jan Sammelans, 4.8% on basic amenities like lights, mats etc. MAS supports the work of Mitanins by contributing in purchase of medicines. 3.4% of expenditure was made for purchase medicines for Mitanins when it is unavailable. MAS identifies malnourished children on their own, and with

Mitanin's help and provide food to them. 2.7% of expenditure was made to provide ration, eggs and bananas to malnourished children. 1.7% of funds were spent on purchase of tables for ANM (for ANC checkup), 1.2% on purchasing bleaching powder which sprayed in drains, containers as a temporary solution to prevent growth of mosquitoes/larvae, 0.7% to repair drinking water taps, 0.6% on organizing health camps, 0.5% repair work of roads in the locality, 0.5% on getting new born care items (blanket, cotton clothes) for poor families, and 0.4% on distribution of mosquito nets. 24% of the total expenditure is on administrative costs which includes costs of conducting meeting, travelling to the bank etc.

-National level training module focuses on health conditions, water and sanitation but the content does not deal with gender-based violence, climate change, environmental pollution etc. Whereas in Chhattisgarh MAS members are being trained in a wide range of topics including health, food security, nutrition, gender-based violence, water, sanitation etc. It was reported that trainings played an important role in promoting the action taken by MAS. It provides a platform for MAS to learn about the various government programs, and schemes, to discuss the prevailing issues and practical solutions to those problems, and meet other MAS members. Training focused on social determinants of health has been particularly helpful in promoting action on water, sanitation, food security and nutrition.

-Quarterly meeting at cluster-level (*sankul baithak*) allow for interaction, and meeting between multiple MAS under ULB. A federation of MAS promotes cross-learning, and increases the motivation of members. It will also allow for better problem solving by MAS members particularly under the guidance of the supervisory cadre (e.g. Mitanin superivisor or trainer and Area Coordinators).

-MAS members support the work done by ANM as evident from the survey findings. However, ANM has not been directly involved in the work done by MAS. It is not quite feasible for ANMs to attend the meetings of MAS or MAS to conduct meetings at SC/PHCs due to the distance, and shortage of time.

-Ward are the primary unit of ULBs and elected representatives at ward level oversee numerous responsibilities. In our study, we found that most Parshads listen to the issues raised by MAS, however, it requires multiple attempts for MAS to get the attention of Parshads. Therefore, there is a missing link due to lack of formal engagement of Parshads. Currently, Parshads attend Jan Sammelans which are annually conducted, which allows them to get sensitized to community's problems. If engaged routinely, they can play a critical role in facilitating, and accelerating the action taken by MAS.

-No formal linkage with mechanisms with various relevant stakeholders like Municipal Corporations, PWED, food department is a setback, and hinders action by MAS.

-MAS members are motivated by the social recognition they receive by virtue of being a MAS member, and this keeps them motivated. MAS members feel that the community sees them as women who has knowledge about government services, and as individuals who solve the problems of the community. MAS member participates in Jan Sammelans as community representatives, and contribute to the welfare of the community of but they do not get much recognition for it. This highlights that the government needs to increase efforts to give recognition to MAS.

**Recommendations**

*State-level*

- Trainings must be conducted with focus on social determinants of health given the study shows that the MAS has a high engagement with issues related to food-security, nutrition, sanitation and gender-based violence etc.
- The study shows that an annual sum of 5,000 rupees is inadequate for the community needs focused work that is being done by MAS. Therefore, untied funds amount must be increased to 10,000 rupees.
- The expenditure of untied funds must remain at the discretion of MAS members, and the funds must remain "untied". This will allow MAS to best serve the community as per the needs of community, as evident from the study.
- A formal convergence mechanism, a space should be created for MAS members to share the concerns of the community with the key local ward-level stakeholders like ration salesperson, AWW, SHGs etc., as well as representatives of ULBs, PHED, PWED, food department. Parshads should be made responsible for coordinating with these stakeholders for action and inter-sectoral coordination. This kind of space is a must for community representatives like MAS.
- MAS should be involved in overseeing the work of Urban Primary Health Centres (UPHC) particularly at a cluster level. They can collectively identify issues with the functioning of UPHC including absenteeism of doctors or nurses, non-availability of medicines, issues with the infrastructure, service delivery like Ante Natal Care given by ANM/staff nurse etc. and register these issues to health workers, elected representatives like Parshad, and ULBs.
- To promote the community participation in urban areas, members of the community like elderly people, adolescents and youth can be encouraged to get involved in the work done by MAS, specially in activities related to generating awareness on topics related to health, food, nutrition, and particularly with respect to gender-based violence, climate change and its effect on health, air pollution. For example, participating in carrying out rallies, house to house visit for raining awareness about vector-borne diseases, street theatre on gender-based violence, climate change etc.
- MAS members must be recognized and celebrate the way Mitanin Diwas is organized on 23rd November every year. A day of relevance to the state, or the day NUHM was rolled out can be fixed to recognize and pay respect to MAS members. In addition, Jan Sammelans must visibly include the name of MAS, in banners and posters.
- MAS members are motivated by a sense of autonomy. They get to choose what issues they want to prioritize, and how to address they want to address issues with no interference of higher officials. This has allowed MAS members of Chhattisgarh to become community leaders, hence, their autonomy must be protected.

*National-level*

- In Chhattisgarh, Mitanin Trainer (equivalent to Urban-ASHA Facilitators) played a key role in facilitating the action of MAS. Supervisory cadres like ASHA facilitators need to be strengthened; they can play a key role in imparting training, supervision and support to MAS.
- The study found that trainings are essential to promote action by MAS, hence they must be conducted annually on a regular basis. Trainings content should focus on topics related to social determinants on health like food-security and nutrition, water and sanitation, gender-

based violence, the issue of OOPE among poor patients etc. The study shows that MAS has been able to make a difference on these issues. Currently, there is not enough emphasis on these topics in the training module of MAS.

- 1 ASHA worker for 1 MAS will allow for optimal oversight and supervision of MAS as against the current national standards of 2-5 MAS under 1 ASHA worker.
- MAS must be given recognition for their work by acknowledgement of their work in public platforms.
- The study showed the benefits of mutual network created by means of cluster-level meetings. A federation of MAS must be constituted to facilitate formation of a mutual support network. Cluster level meetings comprise of 5-10 MAS, and can take place on a quarterly basis.
- A convergence
- The study found that a sum of 5,000 rupees in the form of united funds for 12 months is insufficient in fulfilling the needs of the community and solving their problems, and must be increased.
- Untied funds must remain in exclusive discretion of MAS members, with complete flexibility to the MAS as the study found it is best utilized when MAS has the autonomy to decide what to spend on.
- The autonomy of MAS in terms of type of action they engage in, must be respected. They should not be handed with additional responsibilities as no monetary incentives are being provided. For example, the push to involve MAS in National Deworming Day, or supplementary immunization activities for Polio etc. should be contained. The motivation of MAS member can take a hit if they are burdened with the work that the health department deems appropriate for them.
- The work done by MAS must be recognized, valued and celebrated on public platform or in the form of an event. MAS members are motivated by the social recognition they get by virtue of being a MAS member mainly when the MAS is working actively on various issues, and such an approach will keep their motivation high.

## References


1. Community participation in local health and sustainable development: approaches and techniques [Internet]. [cited 2023 Mar 24]. Available from: https://apps.who.int/iris/handle/10665/107341
2. Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Reports [Internet]. 2014 [cited 2023 Apr 26];129(Suppl 2):19. Available from: /pmc/articles/PMC3863696/
3. World Health Organization [Internet]. 1978 [cited 2023 Mar 24]. Declaration of Alma-Ata. Available from: https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata
4. Ministry of Health and Family Welfare. Framework for Implementation of National Rural Health Mission (NRHM) [Internet]. 2014 [cited 2023 Jul 7]. Available from: https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf .
5. National Health Mission. Community Processes under National Urban Health Mission [Internet]. 2012 [cited 2023 Mar 24]. Available from: https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1226&lid=597
6. National Health Mission. Guidelines for ASHA and Mahila Arogya Samiti in the Urban Context [Internet]. 2014 [cited 2023 Jul 7]. Available from: https://nhm.gov.in/images/pdf/NUHM/Guidelines_for_Asha_and_MAS_in_Urban_Context.pdf
7. State Health Resource Center. Mitanin Program: Conceptual Issues and Operational Guidelines. 2003.
8. National Health Mission. Consitution of Mahila Aarogya Samiti [Internet]. 2012 [cited 2023 Jul 7]. Available from: https://shsrc.org/wp-content/uploads/2023/03/MAHILA_AAROGYA_SAMITI_FORMATION_MAS_GUIDELINE.pdf
9. Directorate of Health Services Chhattisgarh. Untied Funds for Mahila Aarogya Samiti [Internet]. 2013. Available from: https://shsrc.org/wp-content/uploads/2023/03/MAHILA_AAROGYA_SAMITI_UNTIED_FUND_GUIDELINE.pdf
10. Tata Institute of Social Sciences. Evaluation of Mitanin Porgramme in Chhattisgarh [Internet]. 2015 [cited 2023 Feb 25]. Available from: https://shsrc.org/wp-content/uploads/2021/08/Evaluation-of-Mitanin-Programme-in-Chhattisgarh-2015.pdf
11. Pawson R, Tilley N. Realistic evaluation [Internet]. 1997 [cited 2023 Jul 7]. Available from: https://psycnet.apa.org/record/1997-36931-000
12. Pawson R, Tilley N. An Introduction to Scientific Realist Evaluation. Evaluation for the 21st Century: A Handbook. 2014 Jan 17;405–18.
13. Marchal B, Dedzo M, Kegels G. A realist evaluation of the management of a well- performing regional hospital in Ghana. BMC Health Serv Res [Internet]. 2010 Jan 25 [cited 2023 Jul 7];10(1):1–14. Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-24
14. Dean AG SK. OpenEpi: Open Source Epidemiologic Statistics for Public Health, Version 3.01 [Internet]. 2023 [cited 2023 Jul 7]. Available from: https://www.openepi.com/Menu/OE_Menu.htm