Induction module for
MAHILA AROGYA SAMITI (MAS)

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NATIONAL HEALTH MISSION

राष्ट्रीय स्वास्थ्य मिशन

Acknowledgements

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Contents

List of Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BSUP	Basic Services to the Urban Poor
CBO	Community Based Organization
ICDS	Integrated Child Development Services Scheme
IDSP	Integrated Disease Surveillance Programme
IFA	Iron Folic Acid
JnNURM	Jawahar Lal Nehru National Urban Renewal Mission
JSSK	Jananai Shishu Shuraksha Karyakram
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
RAY	Rajiv Awas Yojana
RBSK	Rashtriya Bal Swasthya Karyakaram
RKSK	Rashtriya Kishor Swasthya Karyakram
RSBY	Rashtriya Swasthya Bima Yogana
MAS	Mahila Arogya Samiti
MNCHN	Maternal Newborn Child Health and Nutrition
NGO	Non Governmental Organistion

NHM	National Health Mission
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PHED	Public Health Engineering Department (PHED)
PWD	Public Welfare Department
SNCU	Specialized New-born Care Units
SOE	Statement of Expenditure
SHGs	Self Help Groups
SODIS	Solar Disinfection
TT	Tetanus Toxoid
THR	Take Home Ration
UHND	Urban Health and Nutrition Day
U-CHC	Urban Community Health Centre
U-PHC	Urban Primary Health Centre
UC	Utilization Certificate
WCC	Ward Coordination Committee
WASH	Water, Sanitation and Hygiene
WCD	Women and Child Development
VHSNC	Village Health and Sanitation Committee

CHAPTER 1

Community Participation and Need for Mahila Arogya Samiti (MAS)

1.1 Importance of Community Participation in Health

Community participation in health is important because:

1. Communities can play vital role in promotion of healthy behaviours and prevention of diseases.
2. People have a right and a duty to be involved in the decisions affecting their lives. The experience of participation in improving their health system makes them more confident and empowers them to act on many other areas that affect their lives.
3. Communities possess several resources-human and financial that can be used to enhance the quality of health care and effectiveness of health care services.
4. The community is most capable of acting on all the social determinants of health.
5. Active community's participation leads to correction of, the mismatch between people's needs and services delivered and leads to increased to utilization of health services.

1.2 Levels of Community Participation

There are various levels of community participation in health. Some examples are given below:

1. An ANM reports, "in my slum all mother and children come for the UHND regularly. I have excellent community participation".

   This shows that the community is participating in benefits, as beneficiaries.

2. The Medical Officer in-charge of the U-PHC reports, "we have good participation from the community in my area. We held five health camps and the community not only came for the camps, they also helped in making arrangements for food and water".

   This shows that the community is participating in supporting programme activities for health.

3. In the MAS meeting, the members decided to ensure that the area they live in was free from malaria. They decided to ensure that every family used mosquito nets and that every house was properly sprayed with insecticides.

This shows that the community is participating in implementing national health programmes.

4. In a MAS meeting, the members discussed that the UHND was not being organized regularly and also growth monitoring was not being done at the Anganwadi centre because of non-availability of weighing machines. It was decided that the MAS members will contact the Medical Officer in-charge of the U-PHC to appraise him of the irregularity of UHNDs and also they would write to the concerned CDPO regarding the lack of weighing machines.

This shows that the community is participating in planning and monitoring of health and other essential services.

Amongst all the levels of participation, it is seen that mostly community participation is limited to participating in benefits and activities of the government.

1.3 Need for Mahila Arogya Samiti (MAS)

MAS in one of the key interventions under National Health Mission aimed at promoting community participation in health at all levels, including planning, implementing and monitoring of health programmes. MAS is expected to take collective action on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level. It is envisaged as being central to 'local collective action', which would gradually develop to the process of decentralized health planning.

About Mahila Arogya Samiti (MAS)

Mahila Arogya Samiti (MAS):

- Local women's collective with an elected Chairperson and a Secretary
- Covers approximately 50-100 households in slum and slum like settlements
- Addresses local issues related to Health, Nutrition, Water, Sanitation and social determinants of health at slum level
- Facilitated by the ASHA who acts as the Member Secretary

1.4 Objectives of MAS

The major objectives of MAS are to:

a. Provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.

b. Provide a mechanism for the community to voice health needs, experiences and issues with access to health services.

c. Generate community level awareness on locally relevant health issues and to promote the acceptance of best practices in health by the community.

d. Focus on preventive and promotive health care activities and management of untied fund.

e. 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.

f. 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.

g. Organize or facilitate community level services and referral linkages for health services.

1.5 Basic Principles of our Health System

1.5 a Health is our basic human right

Every human being, whether rich or poor, man or woman, young or old or of any religion or caste, has the right to be healthy and access health services.

1.5 b The government is responsible for making health services available to all

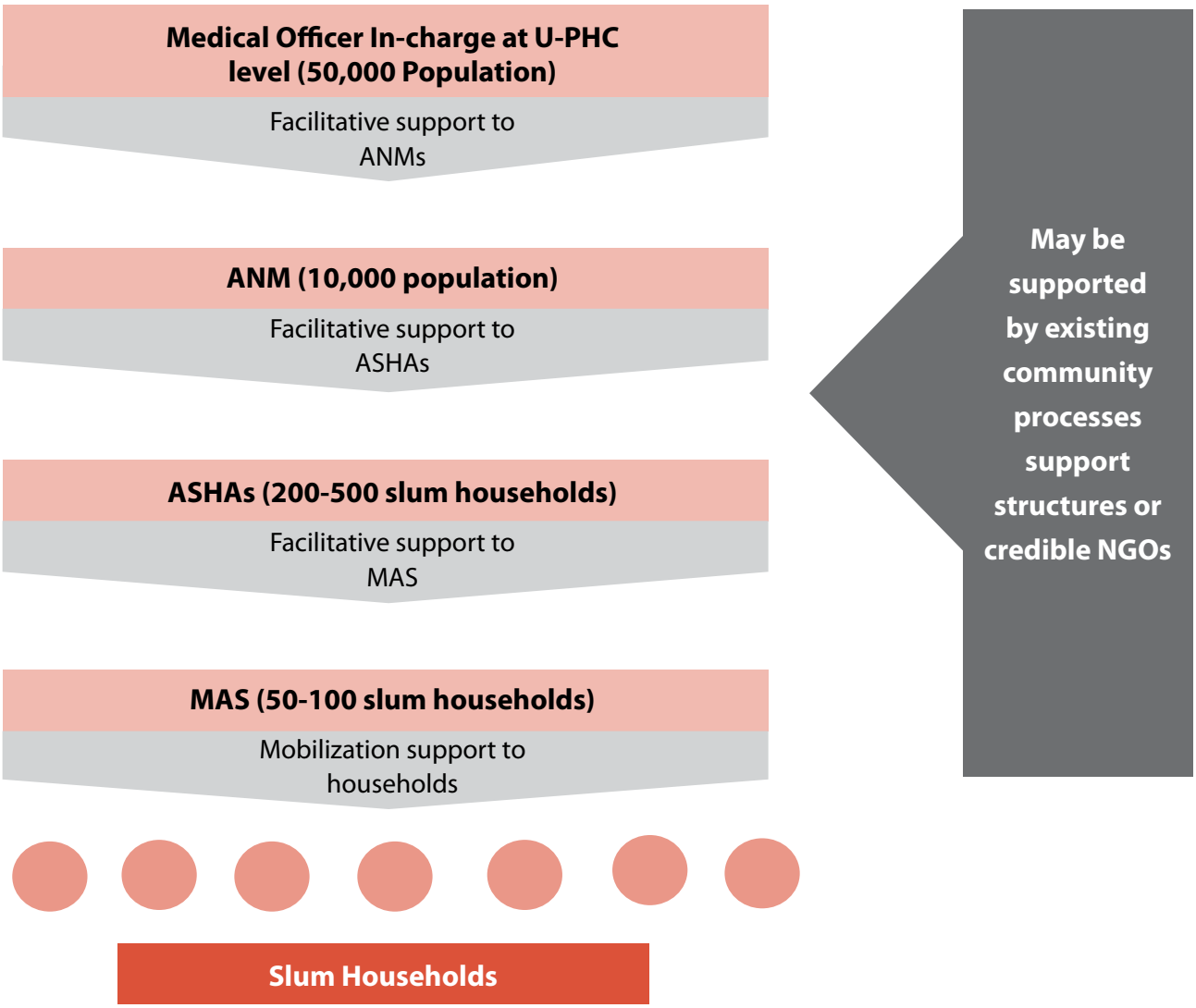
People's collective action is needed for the government to fulfill its mandate of providing food, safe drinking water, employment, leisure and basic health services to all people. But this is not possible without collective action. People need to organize together in order to ensure 'Health for All'. This is the right and duty of every person living in this country.

MAS is a vehicle for such collective action. MAS can work along with the rest of the community to improve the health status of their slum/ coverage area. We need to remember that in order to improve health we have to work on all social, economic and cultural determinants of health.

The National Health Mission

In 2005 the Government of India launched the National Rural Health Mission (NRHM) in order to provide accessible, affordable and quality health care to people living in rural areas of our country. The mission aimed to reduce maternal and child death and provide better access to health services especially for vulnerable section. In 2013, the National Urban Health Mission (NUHM) was launched in order to improve and strengthen primary health care services in urban areas of cities and towns with population greater than 50 thousand. National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) are two distinct sub-missions of the National Health Mission.

The National Health mission aims to ensure universal access to health care through strengthening health systems, institutions and capabilities under National Health Mission. The various institutions which have been set up at different levels for effective health planning have been given in pyramid above. You can see that MAS serve as community level institutions for health planning and action for the marginalized and poor sections.



Public Health Facilities at Various Levels under NUHM

Name of Facility	Population Coverage and features	Providers	Available Services
Outreach Services		One ANM per 10,000 population	**Routine outreach sessions -** Immunization & ANC check up **Special outreach sessions** - Health Camp with doctors, specialists, pharmacist, lab technicians providing screening and check-up services. Social Mobilization and Community level activities

Name of Facility	Population Coverage and features	Providers	Available Services
Urban Primary Health Centre (U-PHC)	50,000-60,000 population located preferably within a slum or near a slum within half a kilometer radius, catering to a slum population of around 25,000-30,000 with provision for evening OPD	One full time Medical Officer In charge One part time Medical Officer 3 Staff Nurses 1 Pharmacist 1 Lab Technician 1 LHV 4-5 ANMs Secretarial staff for account keeping and MIS Support staff	OPD services Basic Diagnostic services Referral services Collection and reporting of vital events and IDSP Counselling Services for Non Communicable Diseases- Screening and Preventive Medication
Urban Community Health Centre (U-CHC)	30-50 bedded facility for every 2.5 lakh population (in non-metro cities with a population of above 5 lakh) and 75-100 bedded facility for metro cities, acts as referral unit for 4-5 UPHCs	5-6 doctors including specialists for different types of health care. Nurses and Paramedical staff as per the need	Apart from all services that an urban PHC is meant to provide as detailed above, each CHC also provides clinical care services in some of the specialist areas and institutional delivery services. Some CHCs are designated and equipped to provide services of Caesarean section.
District Hospital	75 to 500 beds depending on the size and population of the district One per district	Specialists for different types of health care with adequate number of nurses and paramedical staff.	❖ It is a secondary referral facility ❖ Provides all basic speciality services and also certain kinds of highly specialized services. ❖ Has Specialized New-born Care Units (SNCUs) for sick and high risk newborn, blood bank, specialized labs, and provides services for Caesarean section, post- partum care, safe abortion and all kinds of family planning procedures. ❖ Also provides most of the surgical services and has a well-equipped Operation Theatre. ❖ Has provision for dealing with accidents and emergency referrals, rehabilitation, mental illnesses and other forms of communicable and non-communicable diseases.

CHAPTER 2

Various Determinants of Health and their Importance

People usually associate health with illness, doctor, and medicines. Actually good health does not simply mean the absence of disease, but is related to good physical, mental and social wellbeing.

2.1 Important Determinants for Good Health are

- Adequate food (nutrition)
- Safe drinking water, sanitation, and housing
- Clean environment, healthy living conditions and health lifestyle
- Access to better health services
- Education
- Social security measures and proper and equal wages
- Freedom from exploitation and discrimination
- Women's rights
- Protected work environment
- Relaxation, recreation and healthy relationships

2.2 ILL Health is Related to

- Malnutrition
- Unsafe water and lack of sanitation
- Unhealthy living conditions
- Unhealthy habits-alcohol/drug abuse
- Hard labour and difficult work conditions
- Mental tension
- Patriarchy (Unequal power relation between man and woman resulting in gender discrimination)
- Lack of access to health services
- Lack of health education

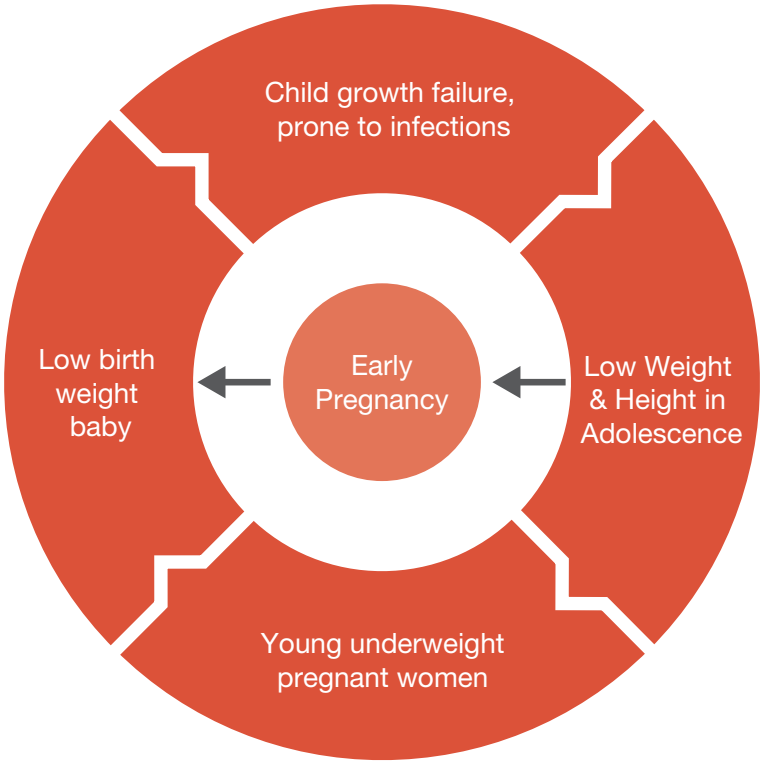
2.3a Nutrition

Nutrition is the intake of food, considered in relation to the body's dietary needs. Intake of an adequate, well balanced diet combined with regular physical activity forms the basis of good health. Malnutrition is one of the major causes of ill health in women and children. Pregnant women, nursing mothers and children are particularly vulnerable to the effects of Malnutrition.

Impact of Malnutrition on Health

- Malnourished people fall ill very easily because they have reduced capacity to keep themselves free from diseases. That's why they fall ill easily and stay ill for a long time.
- Malnutrition also leads to impaired physical and mental development, and reduced productivity.
- Diseases like diarrhea, measles, malaria and pneumonia are often the cause for death of malnourished people.
- Adolescent girls, children under two years of age and pregnant women are more prone to develop malnutrition leading to a vicious cycle.

Intergenerational Cycle of Malnutrition



Healthy feeding practices for children

- Initiate breastfeeding within half an hour of birth
- Exclusive breastfeeding up to six months of age
- Start complementary feeding at the age of six months
- Provide age appropriate quality, quantity and frequency of complementary food
- Continue breastfeeding up to two years of age along with complementary feeding
- Continue feeding during illness

2.3b Water, Sanitation and Hygiene (WASH)

I. Water

Drinking water is basic for human survival but not all the water sources are safe and fit for human consumption. Water sources can be broadly classified as Safe and Unsafe depending upon the water quality. It is important for the MAS members to educate the community on safe water. Water intended for consumption should be both safe and wholesome.

1. Pleasant to the taste (free from color and odour)
2. Usable for domestic purposes
3. Free from pathogenic agents
4. Free from harmful chemical substances

Common Sources of Safe Drinking Water	Common Sources of Unsafe Drinking Water
❖ Piped water	❖ Unprotected dug wells
❖ Public tap or stand post	❖ Unprotected springs, rivers or ponds
❖ Tube well or borehole	❖ Vender-provided water
❖ Hand pumps	❖ Bottled water
❖ Protected dug well	❖ Tanker truck water
❖ Protected spring water	
❖ Rainwater collection/ harvesting	

*Source- WHO guidelines

Impact of Unsafe drinking water on health

- Unsafe drinking water leads to many water-borne diseases like Diarrhea, Cholera, Jaundice (Viral Hepatitis A and E), Dysentry, Amoebiasis, Giardiasis and Typhoid.
- In slum and slum like settlements, the non-availability of safe drinking water facilities for all residents also leads to more diseases.

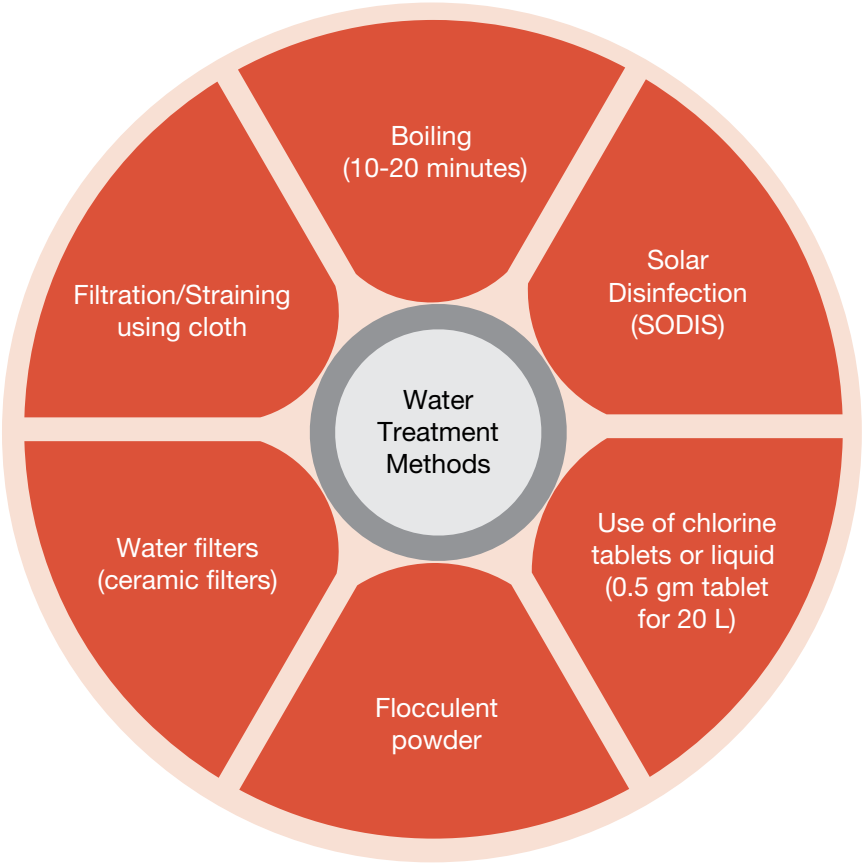
  It is important to note that even though the source of drinking water may be safe, water can get contaminated at various points during collection, transportation, handling and storage. Hence, the following steps need to be practiced while storing and handling water at home:

Safe Water Handling Practices

- Keep the vessel at a raised position
- Keep the vessel covered
- Do not dip hands while taking out water
- Use of ladle or tap-fitted vessel for taking out water
- Do not continually top up the water in storage vessels
- After each use vessels must be thoroughly rinsed

Household Water Treatment Methods

Water treatment at the point of use, for e.gin households or schools, reduces diarrhea by around 30–50 percent. Common water treatment methods may include use of one or more of the following methods:



2.3c Sanitation

Sanitation is a broad term which includes management of human excreta, solid waste, and drainage. In urban areas, especially in slums and slum-like settlements, the status of sanitation is an important concern and a large proportion of urban poor practice open defecation.

Sanitation options in urban areas include:

- **Individual household toilets**
- **Public/community** toilets normally constructed by urban local bodies, local groups or private entities (for example, Sulabh International). The primary purpose of such facilities is to provide sanitation facilities in public places or in areas where the population cannot afford individual household toilets or has space constraints.

Impact of lack of sanitation on health

- Lack of sanitation leads to contamination of drinking water, making it unfit for human consumption and leading to diseases such as Amoebiasis and Teaniasis.
- Lack of proper drainage system in slums leads to water logging. Pools of stagnant water act as breeding sites for mosquitoes leading to a high incidence of vector-borne diseases such as Malaria, Dengue, Filaria, and Encephalitis.

- Unsafe sanitation practices also facilitate transmission of diarrhea and a range of intestinal worm infections such as hookworm and roundworm.

I. Hand Washing

Hand washing is not rinsing hands in plain water. It indicates thoroughly scrubbing hands with a cleaning agent and rinsing them properly with sufficient water. Hand washing is important because of the following reasons:

- It is one of the most important ways of preventing spread of infections and diseases like Diarrhea, Cholera, Jaundice, Typhoid, and Skin diseases.
- It helps to reduce the medical expenses due to diseases.

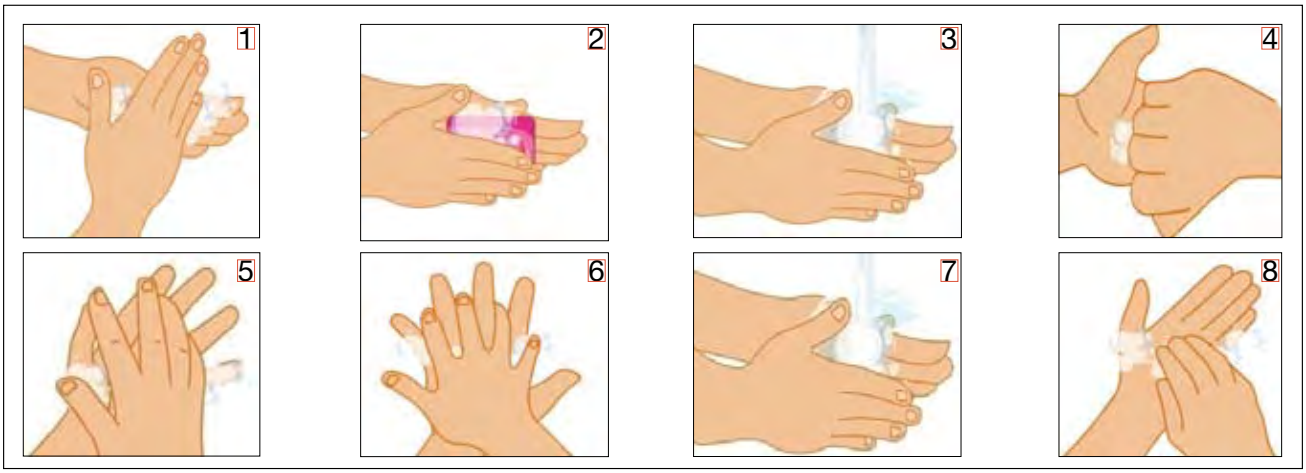
Critical times of Hand Washing

Washing hands after handling faeces	Washing hands before handling food	After handling waste
❖ After defecation ❖ After washing a child ❖ After disposing child's faeces	❖ Before cooking food ❖ Before serving food ❖ Before eating ❖ Before feeding a child	❖ After clearing animal waste ❖ After cleaning the liquid and solid wastes ❖ After any work involving cleaning

Steps for correct Hand wash procedure

- Always wash hands under running water.
- Apply soap.
- Rub hands together for 15 to 30 seconds, paying particular attention to the fingertips, thumbs, and between the fingers.
- Rinse well under running water and dry thoroughly using a clean towel.

Important steps of hand washing are depicted below:



2.3d Work Conditions

Work conditions that adversely affect health include:

- Having to do hard labour e.g. pulling cycle-rickshaws
- Working for long hours
- Conditions of work may increase the possibility of contracting certain diseases. For example: working unprotected in stone quarries leads to severe respiratory problems.
- Unsafe equipment and work tools.

2.3e Living Conditions

All the below mentioned unhealthy living conditions in slums and slum like settlements can lead to health problems like respiratory disorders like Asthma and Bronchitis, TB, skin diseases like scabies, seborrheic dermatits etc.

1. Crowded living spaces
2. Lack of Ventilation
3. Lack of natural lighting
4. Damp rooms
5. Smoke and dust filled environment

2.3f Stress

- Rapid urbanization and industrialization affect mental health by increasing stress, worries, tension and frustration.
- Breakdown of society or family, unemployment, social insecurity and no relaxation are the major causes of mental stress in urban areas.
- People fall ill due to mental stress and often cannot cope with the normal stresses of life.
- Mental stress affects the work productivity adversely and may at times lead to the extreme situations like committing suicide.

2.3g Tobacco and Alcoholism

- Tobacco use and alcoholism is a worldwide medical and social problem.
- Almost 30 percent of the Indian population older than age 15 uses some form of tobacco. Men use more smoked tobacco like beedis and cigarrates than smokeless tobacco. Women are more likely to use smokeless (chewed) tobacco.
- Forty percent of the cancers are attributed to use of tobacco.
- Excessive alcohol intake may lead to many medical disorders like diseases of liver, heart and brain, malnutrition, cancers, depression etc.
- It may also be the root cause of many social problems like violence, crime, murder, neglect of families, unemployment etc.

2.3h Patriarchy (Unequal power relation between man and woman resulting in gender discrimination)

When we compare man and women, we find that more women fall ill than men. The core reason for this is patriarchy. It means that our society is dominated by men and accords a lower status to women. This causes ill-health for women in the following ways:

- In the family, women eat last and also get lesser quantities of food to eat
- Women have to bear the burden of work both in the home and outside
- Women have lesser access to health services
- Women are given lesser opportunities for education
- Women are taught to feel ashamed about their bodies
- Women are taught to tolerate everything in silence
- Women are made to give the least importance to their health
- They are subjected to violence, abuse and harassment
- They also face the constant fear that men can leave them or kick them out of the house
- Females are subjected to female feticide, girl infanticide, and dowry death

2.3i Lack of access to health services

- Government Provides healthcare services to all people healthcare services to all people. However, many a time people are not able to access these services. This may be due to many reasons, for example: Health facilities like PHC are non- functional due to lack of availability/ vacant positions of ANMs, doctors, nurses and other staff.
- Overburdening of health facility staff may also limits their effectiveness in providing care to the patients.

- Provision of care is also adversely affected in cases where the staff of health facility lacks initiative or is negligent.
- People are unable to avail adequate health services due to limited availability of diagnostics and medicines in health centres in some places.
- Block and district hospitals sometimes also lack adequate services
- Lack of connectivity, unavailability of transport, geographic barriers limits the reach of the people to avail health services.
- In many places, people have to spend some money from their own pockets even if they go to Government hospitals. The cost of going to private hospitals is even higher. Therefore many poor people are not able to take treatment from proper hospitals.

2.3j Health Education

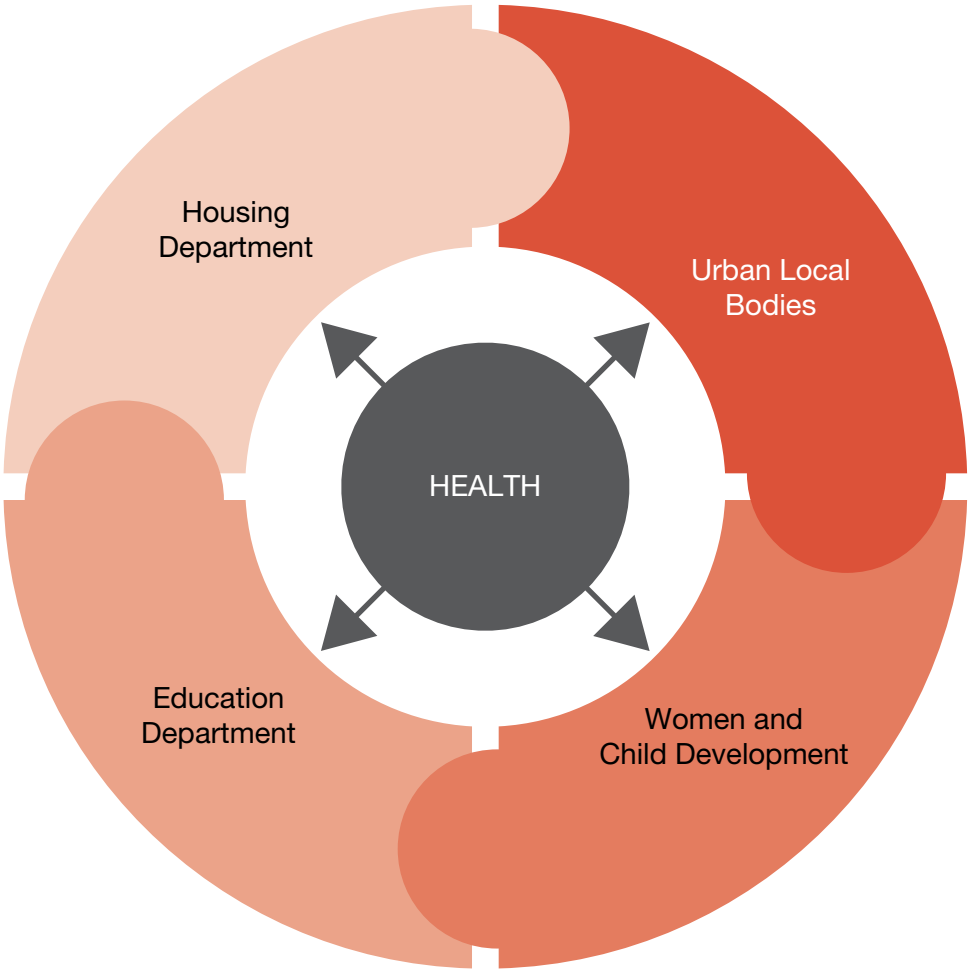
- The urban poor residing in slums and slum like settlements need to be informed about their entitlements to basic services under various govt. programmes and schemes.
- Complete information on various types of health facilities and their service guarantee helps the beneficiaries to make an informed choice and leads to increased utilization of services.
- Most of the times people do not have this information and this prevents them from utilizing the services.
- Lack of participation by the community in health and the lack of relationship between the community and the service provider result in such problems.

2.4 Convergence for Health

Convergence is the process whereby various programme, plans, schemes and departments work in a coordinated way to reach a common goal. As an example to reduce incidence of diarrhea in the community, families need to learn about hand washing and good hygiene. There has to be provision of toilets and safe drinking water in order to prevent diarrhea. When diarrheal episodes happen, the community needs access to immediate treatment at a facility.

In order to address the social determinants, we need to collaborate with the different departments and stakeholders. Various areas of convergence in urban health include prevention of malnutrition, provision of safe drinking water and sanitation, protection from occupational health hazards, and provision of better health education.

MAS members will need to mobilize communities and work as a collective so as that coordinated action between health and other departments like women and child development; water and sanitation, education; Public Works Departments (PWD) etc. takes place. Table below shows department wise management of services and their respective responsible officers.



Sl. NO	Organization/Department	Services	Concerned Persons
1.	Urban Local Body Public health engineering department	Water, Sanitation, Sewage Disposal, Birth and Death Registration, Epidemic control like dengue, malaria etc.	Mayor/Ward Councilor Municipal Commissioner Executive Engineer Executive Health Officer Public Health Officer Sanitary Inspector Sanitary Workers
2.	District Urban Development Authority (DUDA)/ Slum Improvement Board	Housing	Mayor, Municipal Commissioner
3.	Women and Child Development	Integrated Child Development Services ICDS Food and Nutrition	Anganwadi Supervisors Anganwadi Worker
4.	Education Department	Education	School Principal Teacher
5.	Health Department	Health	MO- PHC ANM

Role of MAS in Convergence: MAS is an appropriate body to take collective action on issues related to health, nutrition, water, sanitation and other social determinants at community level. Therefore, MAS members can undertake following activities to perform these functions effectively.

1. Monitor the situation of water, sanitation, food, housing and education services in your area. Details on monitoring of public services will be discussed in detail in the chapter 5 (Annexure- V & Va).
2. Arrange a monthly and quarterly meeting with all relevant stakeholders to discuss the community issues and devise a convergence plan. Coordinate with ANM and anganwadi worker and supervisor to arrange a meeting with the above mentioned stakeholders.
3. Seek support for the use of community structures like municipal community centers for education sessions and promotion of behaviors related to health and health determinants.
4. Utilize the provisions under various government development schemes to advocate with the local authorities for construction of community based health centres, community toilets, water drains, sewerage, drainage and disposal system in the area.

CHAPTER 3

Understanding Vulnerability

3.1 a Understanding the concept of vulnerability and its impact on Health

Urban population is growing rapidly in India. Many rural residents come to cities in search of employment. But due to overcrowding and lack of necessary infrastructure like housing, water and sanitation, employment opportunities and basic services like health and education, these people start living in jhuggi like houses called slums. Some of them also survive on the roads, under flyovers, railway platforms and outside shops without shelter and in unsafe conditions.

Who are the vulnerable groups?

We can categorize the vulnerable urban groups based on the nature of their vulnerability - Residential/ Habitat- based vulnerability, Social vulnerability and Occupational vulnerability as shown below:

RESIDENTIAL

- People living in slum/slum like locations
- Homeless People living on roadsides, under bridges, flyovers, along railway tracks

SOCIAL

- Old Age
- Widow/deserted women
- Women/child headed household
- Differently abled
- Debilitating illnesses- TB, Leprosy etc.

OCCUPATIONAL

- Unorganized/informal
- Seasonal workers/migrants
- Hazardous occupations such as Rag Pickers, Rickshaw pullers, Head loaders, Construction workers, Daily wage labourers

Adverse effects of vulnerability on health

- Poor access to safe water and basic sanitation affects the physical and cognitive development of children, leads to gastrointestinal disorders in adults, and makes it difficult for girls and women to maintain personal and menstrual hygiene.

- Poor housing gives little or no physical protection against the heat, cold, pollution, traffic, accidents, and physical and sexual abuse.
- Children, adolescent girls, women living in such circumstances are particularly at risk for sexual violence, especially when they sleep in the open or in insecure dwellings, collect water, or defecate in the open.
- Densely populated living conditions in slums places them at risk for infectious diseases such as tuberculosis, acute respiratory infections, and various skin disorders.
- Further many urban poor live in city outskirts, low lying areas, near factories and construction sites and are at risk for floods and outdoor air pollutants.

3.1 b Common Health Burdens among the vulnerable Groups are

INFECTIOUS DISEASES	NUTRITIONAL PROBLEMS AND SUBSTANCE ABUSE	CHRONIC DISEASES	MENTAL HEALTH PROBLEMS	INJURIES AND ACCIDENTS
TB, Malaria, Dengue, Chikungunya, Diarrhea, Skin diseases, Typhoid, ARIs	Underweight, Alcoholism	Hypertension, Heart Diseases, Diabetes, Asthma, Cancers	Depression Stigma	Road traffic accidents, Burns, Dog Bites, Occupational diseases, Violence

3.1 c Vulnerability Assessment and Mapping

To work effectively in urban areas, the vulnerable groups and their specific health issues need to be identified through the process of “Vulnerability Assessment and Mapping”. This exercise can be undertaken along with the household survey. The tool to be used for vulnerability assessment and mapping is attached as Annexure IV.

This process of mapping identifies vulnerability with respect to access to piped water supply, sanitation facilities, food security entitlements, type of occupation, legal status of the land and recognition of identity by government. Mapping must carefully identify and bring to visibility the slums which have not been notified and the illegal settlements where people live, and relate it to the services they are provided.

Role of MAS in Vulnerability Assessment and Mapping

- Divide the total target area and allocate around 10-12 households to each MAS member for effective tracking and follow up.
- Identify and map vulnerable households/individuals based on the vulnerability assessment tool, in coordination with ASHA.
- Categorize the households based on the criteria of location, social and occupational vulnerability and make a list. Find their specific health problems/needs.
- Discuss with ASHA and make a weekly/monthly plan to address their specific health needs and burdens.

- Follow up with ASHA in next meeting and visit the identified vulnerable households/individuals/ groups again on intermittent rounds to monitor delivery of care.
- Being a MAS member, use the platform where you meet functionaries of urban local bodies and different departments like Women and Child Development (WCD), Public Health Engineering Department (PHED), Urban Development etc. to advocate and mobilize resources for improving the availability and access to basic services like water, sanitation, secured housing etc.

CHAPTER 4

Objectives, Composition and Process of MAS Formation

4.1 Composition of MAS

MAS should be formed covering 50-100 households and have 10-12 members, depending on the size of the slum/cluster, but the group should not have less than 5 or more than 20 members. Members of the MAS will be drawn from a neighbourhood cluster, by drawing one committee member from each cluster of 10 to 20 houses. Every ASHA would be linked to between two to five such groups. In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and pockets of the slum. So long, in case of small slums of less than 50 families or presence of disparate groups within each slum, the coverage of MAS should be aligned with the coverage area of anganwadi centre and has to cover all pockets of the slum.

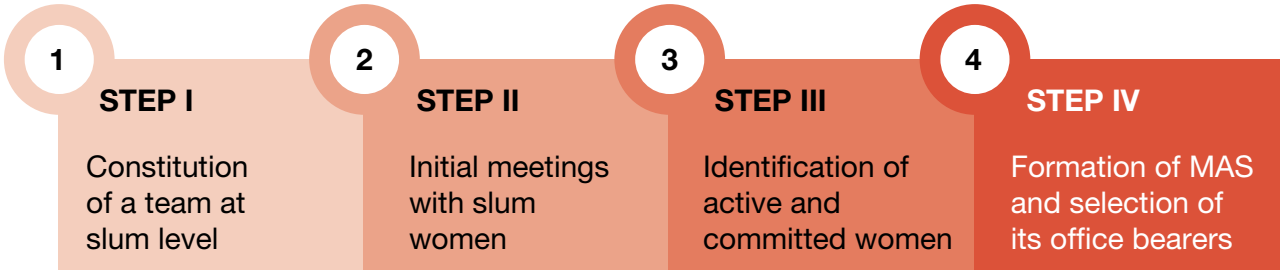
4.2 Key Principles Governing the Composition of MAS Members

The membership in the group would be a natural process, guided by the ASHA and the ASHA facilitator. Some characteristics that can be used for preferential inclusion of members are:

- Women with a desire to contribute to 'well-being of the community' and with a sense of social commitment and leadership skills.
- If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.
- If the slum has a presence or history of collective efforts (as SHGs, Development of Women and Children in Urban Areas (DWCUA) group, Neighbourhood Group under SJSRY, thrift and credit groups), women involved in these efforts should be encouraged to be part of MAS.
- Service users like pregnant and lactating women, mothers of children up to 3 years of age and patients with chronic diseases who are using public services should also find place in the MAS.
- ASHA will be the Member secretary of MAS.

4.3 Process of MAS Formation

The ASHA and the ASHA facilitator/ Community organizer play a key role in the process of MAS formation. Various steps involved in the formation of MAS are depicted below:



Step I: Constitution of a team at the slum level

In order to mobilize the community for formation of Mahila Arogya Samiti, firstly a team has to be constituted at the slum level. The ASHA, ASHA facilitator/Community organizer with support of NGO field functionary (if any), AWW and ANM will constitute a team for selecting the MAS members. Each ASHA will supervise the formation of two-five MAS.

Step II: Initial meetings with slum women

The team (ASHA and others) conducts a series of meetings with women from the slum, parents visiting Anganwadis, service users, participants of various vocational training programs, informal community associations etc. to understand the health conditions and to sensitize the women to work towards improving the health of the men, women and children in the slum. It is generally observed that the initial meetings have a large number of slum women attending mainly due to curiosity or with expectations to get some benefits (monetary).

Step III: Identification of active and committed women

At least a gap of 1-2 weeks is given for the women to reflect, discuss with others and determine their commitment to serve their community. Generally towards the 3rd or 4th meeting, the number of women attending the meetings falls and only interested women come for the meeting.

Active, interested and committed women are identified and over a period of time, are encouraged to work collectively on community issues to form the base of the Mahila Arogya Samiti. It may be borne in mind that each community responds differently and takes its own time to crystallize, and interventions would have to be designed, keeping in alignment with the community. Social acceptance should be ensured by talking to family members.

Step IV: Formation of MAS and selection of its office bearers

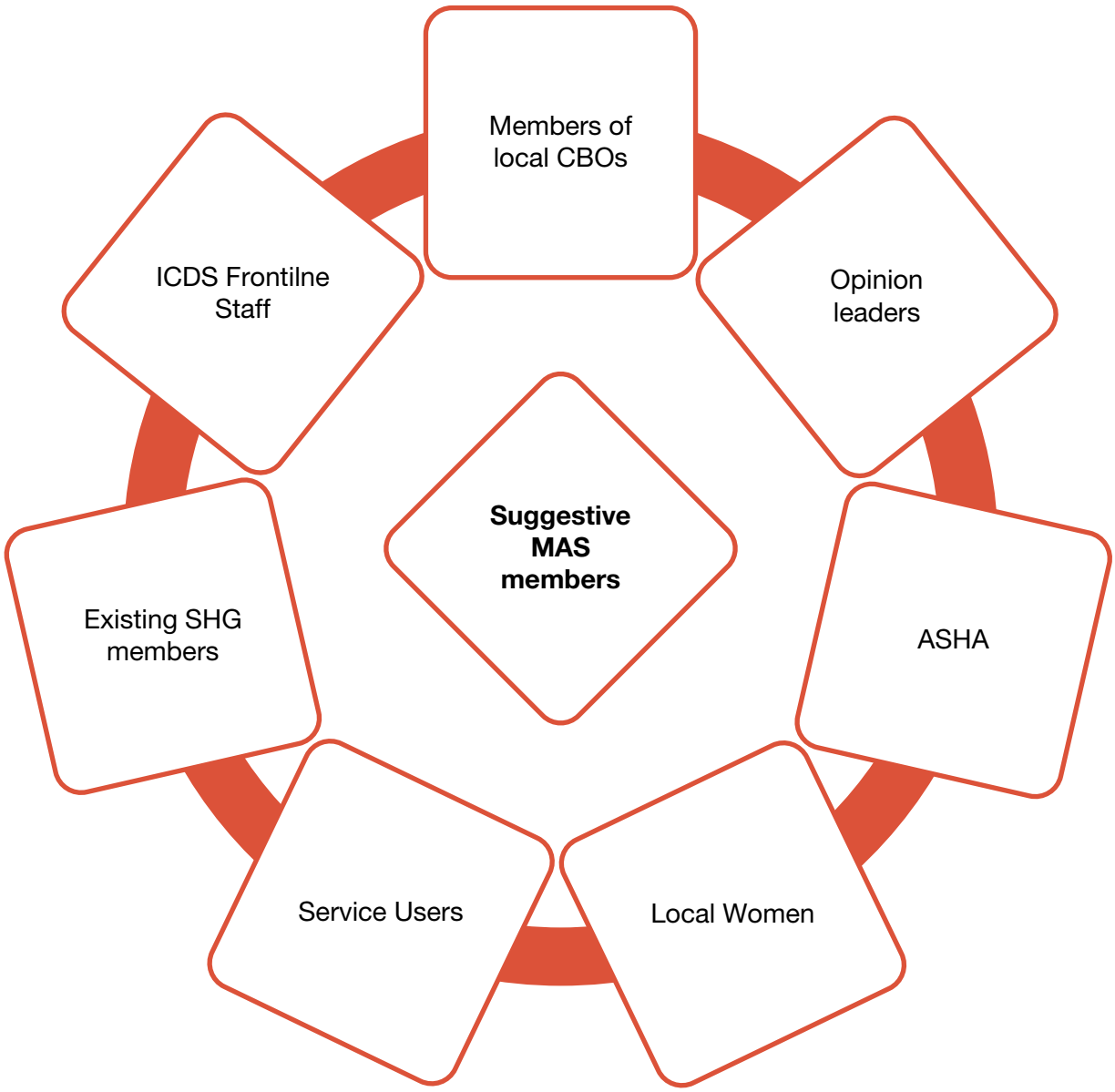
Once the women decide to work as a local collective, a resolution is passed for formalizing the MAS formation. The newly constituted MAS is oriented about its roles and responsibilities and the names and details of MAS members are recorded in the MAS registration sheet. Thereafter, ASHA facilitates the selection of the Chairperson of the MAS unanimously by the group members.

Documentary evidence for MAS formation includes:

- Resolution copy (attached as Annexure I)
- MAS registration sheet (attached as Annexure II)

MAS reconstitution is to be done in case of death of member or any attrition.

4.2.c Probable/ Suggested members of MAS



4.4 Roles and Responsibilities of Office Bearers of MAS

Chairperson: MAS members will unanimously elect the chairperson of the group; who will:

a. Be responsible for ensuring that MAS meetings are held regularly on a monthly basis.

b. Lead the monthly MAS meetings and ensure smooth coordination among members for effective decision making.

c. Develop the community health plan for the slum/ coverage area in consultation with all MAS members.

d. Ensure that the all the records and registers of MAS are adequately maintained.

e. Represent the MAS and voice concerns of the area during interface with service providers and representatives of various government departments.

f. Support the member secretary in her functions.

Member Secretary: ASHA will be the Member Secretary and Convenor of MAS because of the following reasons:

- ASHA can play a very important role in providing a more organized support mechanism and more sustained capacity building of MAS.
- She also has better community ownership and acceptance.
- She has been involved in health related issues over the past few years.
- For successful achievement of her objectives especially health promotion, prevention and community mobilization, the ASHA also requires support from MAS.

As the member secretary of the MAS, she will:

a. Fix the schedule and venue for monthly meetings of the MAS.

b. Ensure that MAS meetings are conducted regularly with participation of all members.

c. Draw attention of the samiti on specific constraints and achievements related to health status of the community and enable appropriate planning.

d. Make arrangements for the Urban Health and Nutrition Days (UHNDs).

e. Ensure utilization of untied fund as per the decisions taken by MAS through regular disbursal of funds jointly with the Chairperson and undertake regular update of the cashbook.

f. Provide information on activity wise fund utilization to the MAS every month and with bills and vouchers / documents on a quarterly basis.

g. Work with the Chairperson for the bi-annual presentation of the activities and expenditures of MAS in the meetings of urban local bodies (ULBs).

h. Work with the Chairperson for preparation of annual statement of expenditure (SOE) and utilization certificates (UCs).

4.5 Opening of Joint Bank Account of MAS

Once the MAS has been formed, it needs to open a joint account in the nearest nationalized bank. In case, some issues occur during opening of new bank account by MAS, the local authorities will facilitate the MAS in opening the bank account. The annual untied fund of the MAS (Rs. 5000/-) shall be credited to this bank account. It is up to the MAS to decide in which bank it wants to open the account. A sample letter for opening the bank account is enclosed as Annexure III.

The joint signatories of the MAS account would be the Chairperson of the MAS and the Member Secretary (ASHA).

All withdrawals from MAS account must be done by a joint signature of both the signatories (if the account is operated by two signatories) are or by two of the three signatories (if the account is operated by three signatories). The withdrawal will only be done through a written approved proposal of the MAS with signatures of its members. The member secretary may be authorized to incur expenditure of up to Rs. 500 for emergencies or undertaking any urgent activities.

CHAPTER 5

Major Activities of MAS

The major activities of MAS can be classified into the categories in the figure. However, it is clear that not all MAS can undertake all activities until such time as they are well trained, well supported and have active and committed members who are willing to undertake all these activities. Thus, MAS will add on activities gradually as they become mature.

Except for management and accounting of untied fund will be detailed in this chapter while management of untied fund will be dealt with in chapter 6.

5.1: Conducting Monthly Meetings

MAS functions through regular monthly meetings. Regular meetings at least once a month are hallmark of a functioning MAS group. Meetings provide an opportunity to the MAS members to identify and discuss the local level issues and plan for local solutions. During the meetings, MAS reviews the situation and develops an action plan for addressing health and related issues.

Meetings also serve as a platform to discuss about the use of untied funds, plan for any upcoming major events or campaigns, share success stories or experiences of other MAS groups and update various records including financial records.

Additionally, ASHA and ASHA facilitator/ Community organizer may also use the MAS meetings for sensitization and capacity building of MAS members on various local issues related to health and health determinants, service entitlements, referral transport mechanisms, existing government schemes for urban poor and grievance redressal mechanisms etc.

How regularly should the MAS meet?

Meetings of MAS should be held at least once every month. It is better if there is a particular day or date for the meeting, for example 10th of every month or third Saturday of every month. This will ensure that the members are aware beforehand of when the meeting is to be held so that they can plan for participating in it.

Who is responsible for organizing the MAS meeting?

The ASHA (Member Secretary) and the Chairperson will be responsible for organizing the meeting. They would, in most circumstances need to inform all the members about the date, place and timing of the meeting, and mobilize them to attend it.

Who should help in facilitating the meeting?

ASHA and the ASHA facilitator/ Community organizer should help in facilitating the meeting.

Where should the MAS meetings be held?

The MAS meetings should be preferably held at a fixed place which is easy to reach and accessible to all members. The possible venues are:

- Anganwadi Centre
- Community Centre

- School
- Office of any Community based organization/ NGO
- House of any of the members

The venue may be changed if required, but any change in venue needs to be discussed in the previous meeting and all group members should be informed in time.

Is it necessary to record the discussion of the meeting?

Yes, the discussion of the meeting should be recorded which would facilitate MAS to make a note of activities conducted during meetings. A discussion register and meeting attendance register should be maintained. (Details are mentioned in chapter 4)

A MAS meeting should be attended by at least 50% of the members for a minimum quorum

Structure of MAS meetings

Sl. No.	Activity	Points to keep in mind
1.	Rendition of motivational song at the start of the meeting	
2.	Sharing success stories and experiences	Please share stories of other MAS groups that have been successful in bringing about some positive change.
3.	Review of last month's action plan	
4.	Filling of public services monitoring tool and register	
5.	Filling of birth and death register	Discuss reasons for preventable child or maternal deaths.
6.	Formulating action plan for the next month	❖ Based on the identified issues; action points would be planned and written ❖ Any applications if required will be written ❖ Copy to be kept with the ASHA
7.	Discussion on any community level events or campaigns to be taken up next	These campaigns may be planned as per seasonal requirement or local level issues. For example before malaria season, MAS may plan to undertake a campaign for clearing of all mosquito breeding sites in their area.
8.	Enumeration of expenses and record writing	Utilization certificate of every month to be handed over to ASHA Facilitator.
9.	Information about next meeting	Date, time and venue of next meeting to be fixed.

Note: Along with the meeting, MAS members can visit the U- PHC, Anganwadi, school etc. also.

The MAS serves as an important platform for facilitating access to services and services providers in the community, in the following ways:

Supporting Organization of Urban Health and Nutrition Day (UHND)	❖ Mobilizing pregnant women and children particularly from marginalized families ❖ Supporting ANM, AWW and ASHA in organizing UHND
Support in organzing Outreach Sessions (both routine and special)	❖ Mobilizing pregnant women and children particularly from marginalized families ❖ Coordination with ASHA and ANM
Supporting community service providers	❖ Allowing community service providers to articulate their problems in MAS meetings ❖ Supporting the ASHA, AWW and ANM to reach the vulnerable and "hard to reach" populations
Facilitating Referral Transport	❖ Generating awareness among community regarding Govt. referral transport and emergency response services like 108 ❖ Organizing local tie-ups with private vehicle owners to transport a patient to the hospital in time of need
Support in Strengthening Anganwadi Centres	❖ Providing important amenities missing in the Anganwadi Centres thereby, improving their functioning
Facilitating Registration of births and deaths	❖ Maintaining records of all births and deaths in the slum cluster
Information on maternal and child deaths	❖ Providing immediate information on any maternal or child death to the ASHA/ ANM/ U-PHC Medical officer ❖ Recording the perceived causes of death
Information on disease outbreaks	❖ Providing immediate information on any disease outbreak to the ASHA/ ANM/ U-PHC Medical officer

5.4: Monitoring and Facilitating Access to Essential Public Services

One of the most important functions of MAS is to facilitate access of all the people in the community or its coverage area to essential public services such as health, water, sanitation nutrition and education. MAS should identify the marginalized and vulnerable groups in their area and ensure that they are not being excluded from receiving various services.

MAS should also undertake regular monitoring of health care and other public services to identify various gaps or problems in service delivery which will be addressed through Community Health planning.

5.4.1 How do we monitor?

MAS will monitor health and other key services by using **Public Services monitoring tool and register** (attached as Anenxure no. V and Va).

The Public Services monitoring tool helps the MAS to ascertain whether key services were available in the previous month and what is the status of some critical indicators for the wellbeing of the community. Based on this tool, the MAS members fill the Public Services Monitoring Register during the monthly MAS meetings.

5.4.2 Which of the essential public services need to be monitored?

Health includes both health care services and health determinants like water, sanitation, hygiene and nutrition. Therefore, monitoring of health of the community does not only include health services like immunization, ANC and health related behaviors like use of mosquito nets, but also includes monitoring of the community's access to other essential public services like nutrition, safe drinking water, toilets, education etc.

5.4.2.a. Monitoring the Anganwadi services

Anganwadi centres are the first community level outposts for health, nutrition, early learning and other women and child related services. Anganwadis can play a major role in prevention and management of malnutrition among children. Therefore, it is important for the MAS to monitor the functioning of the Anganwadi. The MAS has to see whether the services, especially supplementary nutrition have been provided regularly and what were the gaps in the previous months.

5.4.2.b. Education

Improvements in education lead to better health outcomes and it is also the right for all girls and boys to have access to schools. In our slums we find that many children, especially girls, are forced to drop out due to various compulsions. MAS members need to ensure that the right to education of all children in their slum/area is protected.

Regularity of teachers and of mid-day meal are two of the important aspects to monitor in a school. Mid-day-meal has an important contribution to make in ensuring nutrition, social equality and attendance of students. Therefore MAS needs to monitor any school drop outs, teacher absenteeism and whether the menu for mid-day meal is being followed in the school or not.

5.4.2.c. Water, Sanitation and Hygiene

Clean drinking water, safe sanitation facilities and garbage disposal are crucial for community's health. Hand pumps, public stand posts and piped water are some common sources of drinking water supply in the slums. However, most of these hand pumps or stand posts are non- functional and due to poor drainage water collects around them and remains stagnant leading to many waterborne diseases.

MAS needs to monitor the status of clean drinking water, toilets (both individual and community) and cleanliness in the slum/ coverage area so that diseases like diarrhea and malaria may be prevented.

5.4.2.d. Status of Women

One of the most important support functions of MAS is to identify cases of gender based violence in the slum or their coverage area and take appropriate actions. Women can be healthy only if they are able to live their lives without violence and harassment both at home and in the community.

5.4.2.e. Health services and diseases

MAS may monitor the following health services and diseases to identify gaps and plan corrective actions:

1. **Urban Health and Nutrition Day-** UHND is organized once a month at the Anganwadi centre for providing outreach services to the slum population. ANM conducts immunization, antenatal checkups and provides counselling on various health related issues while the AWW distributes the take home ration (THR) and undertakes growth monitoring of children aged 0-5 years. However, gaps exist in the availability of services and regularity of UHNDs and this has to be monitored by the MAS. A detailed checklist to assess key services provided during UHNDs is given in Annexure VI
2. **Outreach sessions (both special and routine)-** MAS would also monitor the organization of outreach sessions by the ANM.
3. **Availability of drugs with the ASHAs-** The ASHAs are provided with drugs essential for treatment of diseases at the community level. The state has to make provisions for regularly refilling the ASHA's drug kit. Unfortunately there are gaps in refilling and this has to be monitored by the MAS.
4. **Deliveries and referral transport-** MAS also needs to monitor the number of home deliveries in the slum/ area. It can also monitor the availability of referral transport. This will help the MAS to prioritize action for promoting institutional deliveries and providing referral transport.
5. **Diseases-** It is important for the MAS to know the number of fever and diarrhea cases occurring in the slum or its coverage area in each month.
6. **Use of mosquito nets-** This is one of the health related behaviours that MAS can monitor.

5.4.3 Who among the MAS members should monitor?

In order to correctly gauge the status of various indicators, these public services need to be monitored throughout the month. The responsibility for monitoring of various indicators has to be divided among all the MAS members so that the burden does not fall on one person. Regarding the status of various indicators related to health services and diseases, like number of deliveries, number of fever cases etc., MAS may also seek information from the ASHA.

Please note:

1. The responsibility for monitoring public services has to be divided among the MAS members.
2. A MAS member responsible for providing a service should not be asked to monitor that particular service. For example, the Anganwadi helper should not be given the responsibility of monitoring the Anganwadi centre.
3. It is better if the beneficiary of a particular service takes the responsibility to monitor that service. For example, MAS members having school going children can monitor schools and so on.

5.5: Organizing Local Collective Action for Health Promotion

MAS serves as an inspiring organization and brings the community together for collective action on health. Some activities in which MAS can involve the community for health promotion are:

- Organizing cleanliness drives during involving MAS members and community volunteers.
- Vector control measures- Identification of mosquito breeding sites and taking appropriate anti-larval measures such as pouring oil on areas of water logging, closing up hollows and depressions where water accumulates and ensuring that septic tanks and overhead tanks are properly closed.
- Undertaking "Sanitation Mapping" for identifying slum pockets/ areas prone to open defecation and improving sanitation status of the slum.
- Undertaking sanitary survey of public drinking water sources for assessing the potential contamination of drinking water.
- Promoting proper disposal of solid and liquid waste.
- Promoting convergent action in partnership with all other urban area initiatives for environmental health, water, sanitation and housing.

5.6: Community Health Planning

Community Health Planning is a continuous process and is to be done in each monthly MAS meeting. It includes discussion and decision by the MAS on:

- Identifying issues related to health care and other basic services in the slum/ area of MAS
- Identifying the underlying causes for these problems
- Deciding the appropriate actions required to address the problem
- Decision on any community level events to be organized in the coming month
- Deciding the responsible persons to lead the action
- Fixing the timeframe for attempting the action

In each monthly MAS meeting, the status of previous month's action plan is reviewed to assess the progress made and also identify areas where support is required from service providers so that these can be brought to the notice of authorities. A fresh action plan is prepared based on the 2-3 issues identified in each MAS meeting. Additionally, the action plan may also incorporate elements regarding upcoming campaigns or community level events.

A plan, in order to get executed, might or might not require funds for example supporting organization of UHNDs does not require any extra funds while on the other hand, activities like organization of community level events may require funds, for which the MAS can utilize their annual untied fund.

5.6.a Major Steps involved in preparation of a Community Health Plan

Step 1: First the MAS has to identify issues related to health care and other basic services in their coverage area or slum

MAS members can identify major gaps or problems in their area with the help of Public Services Monitoring register. The key items monitored by MAS through this register include:

- Functioning of Anganwadi
- No. of malnourished children
- UHND and outreach services (both special and routine) by ANM
- Institutional deliveries
- Availability of referral transport
- Availability of drugs with ASHA
- Use of Mosquito nets
- No. of Fever cases
- No. of Diarrhea cases
- Functioning of Schools including Mid day Meal Scheme
- Cleanliness around public drinking water sources like hand-pumps, stand posts etc.
- Functioning of hand-pumps/ public stand posts
- Cleanliness and functioning of community toilets
- Violence against women

MAS should record and discuss on all the points mentioned above in the public services monitoring register.

In addition, the following should be used in the planning process:

1. Death Registers- These help the MAS members to identify the preventable causes of deaths like diarrhoea, fever, TB, infant deaths and maternal deaths on which planning needs to be done.
2. Understanding the disease burden in the community will help to prioritize actions to be taken. For example, many cases of malaria in a month will indicate the need for rigorous vector control measures.
3. Experiences of MAS members will help to identify and prioritize issues for planning.
4. Focused group discussions with the community will help to identify frequent causes of care seeking in health facilities and challenges being faced.
5. Health Resource Map will also help in planning for outreach service delivery.

Step 2: The underlying causes of the problem/issues have to be identified and discussed

MAS has to identify the underlying causes of the problem. This can be done by discussing with the families or persons most affected by the problem and the related service provider. Through this MAS will come to an understanding of the reasons of the problem. E.g. if the area/ slum has a huge gap in immunization, the cause may be irregular UHND, non-functioning Anganwadi, lack of information regarding dates of UHND or reluctance of families for immunization because of fear of side effects.

Step 3: Deciding the appropriate actions required to address the problem

Once the reasons for a problem are clear, the MAS can make an action plan for addressing it. E.g. if the slum/ area has a gap in immunization due to irregular UHNDs, then MAS may decide to talk to the concerned ANM to resolve the issue. In case there is an issue which requires to be taken up with authorities, then an application stating the problem may be written and a copy of it also handed over to the ASHA for records. For e.g. if the community toilet in a slum is non- functional; then MAS may write to the Sanitary Inspector of the area for getting it repaired.

Step 4: Decision on any community level events to be organized in the coming month

In addition, to addressing the identified problems or issues of the community, community health plan may also include elements of awareness generation on health and health determinants. One of the major objectives of MAS is to promote positive behavior change through organization of various community level events and undertaking collective action.

For facilitating organization of such community level events an annual calendar may be formulated in the beginning of the year with the help of the ASHA. This calendar should be formulated, taking into account the seasonality of diseases, major days like Women's Day, World Health Day, World Water Day etc. and the availability of the community.

An example of the annual calendar is as follows:

Month	Suggested issue/activity
January	Anti-Leprosy Day
February	Awareness Campaign on Measles
March	Women's Day (March 5), World Water Day (March 22)
April	Awareness campaign on Diarrhea
May	Monitoring Diarrhea
June	Awareness campaign on malaria
July	Monitoring malaria/school enrolment drive World Population Day (July 11)
August	Breast Feeding Week (August 1-7)
September	Cleanliness drive
October	Global Hand washing Day (October 15)
November	World Toilet Day (November 19)
December	World AIDS Day

Based on this calendar, MAS may undertake a detailed planning for any upcoming event/ special day during the MAS meeting and incorporate it in the action plan for the next month.

Step 5: Deciding the responsible persons to lead the collective action

The plan has to include names of MAS members who will be responsible for the action. This step is very important because if we do not pin down responsibilities, the tasks may not be done. It is also essential to see that the responsibility is divided equally among the MAS members and one member does not have to bear all the responsibilities.

Step 6: Fixing the timeframe for the action

Along with fixing responsibilities, the other important step is fixing the time frame for the action. This helps the MAS to complete the tasks at hand in time.

Step 7: Reviewing the progress on last month's action plan

In the subsequent meeting of the MAS, the progress made on the actions planned in the last few months is reviewed. You should applaud in case of an action with a successful outcome. You will find that in some cases, the planned action is taken but the outcome is not successful. In such cases, further planning is done to decide on the next action required to solve the issue. There are situations when the action is not even attempted. In such cases, the steps of fixing responsibility and time-frame have to be reviewed/re-decided.

It is good to focus on successes rather than on failures, as it will keep the morale of the group high.

5.6.b Use of Public Services Monitoring Register

The Public Services Monitoring Register will help the MAS to plan and record the whole process of Community Health planning. This register will be filled during the monthly MAS meeting as discussions for the action plan take place.

In the register, MAS will document the local level problems or issues, the possible causes of the problem as discussed in the meeting, the actions to be taken by the MAS, the person responsible for accomplishing the task and the timeline for completing the task. It also has a column for reviewing the action plan in the next month. All the issues and problems discussed and planned for in a MAS meeting will be filled in this register one after the other.

5.6.c Levels of action

An action plan developed by the MAS for its slum/ coverage area will usually involve the following types of actions:

1. **Actions that can be undertaken at the community level** with or without assistance of the community level service providers for e.g. improving quality of Anganwadi services, improving immunization and ANC, making the water sources safe for drinking etc.
2. **Actions that can be undertaken at the family level,** for e.g. families where children suffer from repeated episodes of diarrhea may require use of household water treatment methods like boiling, filters, chlorination etc. for improving the drinking water quality.
3. **Health Education** through interpersonal communication at the family level, supported by mass communication at the community level.
4. **Actions that need to be undertaken at the health systems level,** for e.g. in case of disease outbreaks or in case of irregular outreach sessions being conducted by an ANM despite of several requests, the action plan may include informing the Medical Officer of the U-PHC.
5. **Actions that need to be undertaken at the level of concerned departments or Ward Coordination Committee (WCC) -** Many issues of the slum community would be related to other public services like water, sanitation, nutrition, housing etc. In rural areas, for all such issues the VHSNC can inform and engage the Gram Panchayat for solving their problems.

But in urban areas, the platforms for seeking grievance redressal would be the existing Slum level Committees or the Mohalla Committees or the Ward Coordination Committee (WCC). WCC is headed by the Ward Councillor and includes representatives of all the major departments like Women and Child Development (WCD), Urban Development, Education, Public Health Engineering Department (PHED) etc. MAS members may attend the WCC meetings and present the problems of their slum/ coverage area in the meeting for appropriate solution.

However, in cities where such committees have not been constituted, MAS members may have to seek support from the ASHA/ the ASHA facilitator/ NGOs for directly approaching the concerned department, eg. for issues related to functioning of Anganwadis; MAS members will need to approach the WCD department.

Please remember:

Community health planning is a continuous process and it may not be possible for the MAS to discuss all issues being monitored, in one monthly meeting. So, while developing the action plan, MAS will have to prioritize the issues as per the 'need of the hour' and the severity of the problem.

5.7 Community Monitoring of Health Care Facilities

MAS will play a key role in community based monitoring of public health facilities through the following components:

- **Filling scorecards for health facilities -** MAS members would visit the U- PHCs and interact with service users to understand the key issues related to service delivery and quality of care. This information would be used to fill scorecards for the health facilities.
- **Organizing Jan Samvads-** Various MAS groups of an area would come together to organize Jan Sanwads which act as a forum for dialogue between the community and the authorities and also help in grievance redressal. In the Jan Sanwad, the U-PHCs doing well as per the scorecards will be felicitated and those faring poorly in the scoring would be singled out for appropriate action.
- **Monitoring schemes** such as Rashtriya Swasthya Bima Yojana (RSBY) and private sector partnerships and highlighting their problems.

5.8: Maintenance of Records

Annexure VII contains a checklist to assess quality of services at public health facilities.

The records to be maintained by the MAS can be classified into the following two categories:

Activity Records	Financial Records
Record of Meetings	Cash Book
Public Services Monitoring Tool and Register	Bank Pass Book
Death Register	Statement of Expenditure (SOE)
Birth Register	Utilization Certificate (UC)

5.5.a Activity Records

1. **Record of Meetings:** This includes attendance records and the record of minutes of the monthly MAS meetings (Annexure VIII and VIIIa). Key financial decisions of the MAS for withdrawal and expenditure of untied fund should be recorded in this register with signatures of all the members who have attended the monthly MAS meeting. If there are any changes made by the MAS in its membership or any other critical decisions taken, they should also be written in this register.
2. **Public Services Monitoring Tool and Register:** The Public Services monitoring tool helps the MAS to ascertain the availability and status of essential public services in the previous month. Based on this tool, the MAS members fill the Public Services Monitoring Register during the monthly MAS meetings and develop their action plan. (Annexure V and Va)
3. **Death Register:** Each MAS will maintain a register where deaths and their perceived causes are recorded on a monthly basis. In addition to recording the deaths, the MAS members should also discuss the reasons for the deaths and how the deaths could have been prevented. The MAS should focus on cause of death and good quality reporting of such causes, as this can form the basis for community health planning. All deaths should be followed by the issuance of a death certificate, including for stillbirths. (Annexure IX)
4. **Birth Register:** Along with deaths, registration of births is another activity of the MAS. The focus should be that every newborn is registered, and a birth certificate issued by the appropriate authority reaches the family within the given time standard. (Annexure X)

   The birth register records the name of the mother, sex of the child, date and place of birth and the birth weight. It will help in monitoring institutional deliveries and birth weight of the newborns in the slum/ coverage area of MAS. It can also be potentially useful in improving home visits by ASHAs and for monitoring of neonatal deaths.

5.5.b Financial Records

5. **Cash Book:** Cash book helps the MAS to record details of all expenditures made during a particular month. A very simple format is used for this purpose. (Annexure XI)
6. **Bank Pass Book**
7. **MAS Statement of Expenditure-** Along with the cash book, this record would help the MAS to present an account of its activities and expenditure when asked for. It could be useful in the bi-annual meetings of the urban local bodies and will also be used by the ASHA Facilitator to forward the annual SOE and UCs prepared by MAS through the U-PHC to City/District PMU. The format of SOE is attached as (Annexure XII)
8. **Utilization Certificate** (Annexure XIII)

CHAPTER 6

Untied Fund and Principles of Utilization

Annual Untied Fund

NUHM provides Rs. 5,000 as annual untied fund to MAS for undertaking different activities in their slum or coverage area. The untied fund will be directly deposited in the bank account of the MAS. This amount can be used for conducting fortnightly/monthly meetings of MAS, sanitation and hygiene, meeting emergency health needs etc.

6.1 Purpose of Giving Untied Fund to MAS

The main purpose of the untied fund is not simply to spend it but to use it as a catalyst for community health planning and for executing the plan. It is expected that the MAS should leverage funds from other sources too.

Untied funds:

- Promote decentralization, i.e. allow the slum residents to take decisions about spending on community health.
- Create opportunities for the community to gain capacity for collective decision making around health.
- Provide support to the MAS in executing a plan of action. Any action plan developed by the MAS to address local issues would include some activities for which funds are required. Untied fund helps to undertake those activities requiring funds.
- Community is also encouraged to contribute a revolving fund to the MAS; which may be in terms of money or labour.

6.2 Principles of Utilization of Untied Fund

The MAS can use these funds for any purpose aimed at improving the health of the slum. Being an untied fund, it is to be utilized as per decision of the MAS. Nutrition, education, sanitation, environmental protection, public health measures are key areas where this fund could be utilized.

Decision on the utilization of funds should be taken during the monthly MAS meetings and should be based on the following principles:

- The fund shall be used for activities that benefit the community and not just one or two individuals.

- However in exceptional cases such as that of a destitute women or very poor household, the untied fund could be used for health care needs of the poor household especially for enabling access to care. For example, MAS identified a suspected pneumonia patient who did not have money to go to the U- CHC for treatment. MAS provided funds for her treatment at the U- CHC and one of the members also accompanied her to the U- CHC.
- The fund shall not be used for works or activities for which an allocation of funds is already available through the urban local body or other departments. For example, the fund should not be used in activities like construction of drainage system or roads as these activities are already budgeted in the concerned departments like PHED and PWD.
- In special circumstances the U-PHC or the City/ District PMU could give a direction or a suggestion to all MAS to spend on a particular activity, but even then it should be approved first by the MAS.
- MAS will not be directed to contract with specific service providers for specific activities, regardless of the nature of the activity. For example, if MAS wants to engage someone for providing emergency transport services in the slum, neither health department staff nor anyone else can direct it to give the contract to any particular service provider.
- All payments from the untied fund must be done by the MAS directly to the service provider without involvement of any third party.

Indicative list of activities that may be undertaken with the help of untied fund

- Slum level public health activities like cleanliness drive, insecticide spraying etc.
- Awareness generation in the slum on various govt. schemes for urban poor like JSY, RSBY, JSSK, BSUP, RBSK etc.
- Repair/ installation of community water supply points like public taps, stand posts
- Minor repair of the community toilets to make them functional
- IEC/BCC activities like wall writings, puppet shows, film shows for awareness generation on MNCHN and WASH related issues
- Providing equipments like weighing machine etc. to the Anganwadis
- Helping destitute women or very poor slum households in accessing health care
- Logistic arrangements for Urban Health and Nutrition Days (UHND)
- Paying for emergency transport when 102/108 services are not available.

Please remember:

- The untied funds is provided to the MAS to use for activities which will promote collective good or benefit under privileged marginalized individuals/ families who have no access to other resources. This fund is given to the MAS to use, as they deem proper. MAS has a responsibility towards the community and should utilize the fund with utmost transparency and accountability. The state should not place undue restrictions or give adhoc directions with regard to the use of untied funds.

6.3 Management of the Untied Fund

The management of untied fund is completely in the hands of the MAS. The decisions on utilization of untied funds will be related to the community health planning undertaken by the MAS. The utilization of the funds has to be transparent and should involve a participatory decision making process.

Decisions taken on expenditure should be documented in the minutes of the monthly MAS meetings. It is preferably adopted as a written resolution that is read out and then incorporated into the minutes of the MAS meeting where there was adequate quorum (minimum 50% of the members of the MAS).

The member secretary should be allowed to spend small amounts on necessary and urgent activities, of up to Rs. 500, for which details of activity and bills and vouchers should be submitted in the next MAS meeting and a post facto approval of the samiti taken. This is important for emergency cases.

For example, in one slum, a boy met with an accident while crossing the main road and was badly hurt. He had to be taken to the hospital immediately and his parents were out for work and there was no one to take care of him at home. The ASHA had the emergency fund with her, so she and the Chairperson of the MAS took the boy immediately to the hospital for treatment and paid all the expenses.

6.4 Accounting for the MAS Untied Fund

a. MAS has to present an account of its activities and expenditures in the bi- annual meetings of ULBs/U-PHCs in which the plan and budget of these bodies is discussed.

b. The annual Statement of Expenditure (SOE) and Utilization Certificates (UCs) prepared by MAS, will be forwarded by the ASHA Facilitator to the U-PHC to City/District PMU.

c. All vouchers related to expenditures will be maintained for upto three years, by the MAS and should be made available to ULB, or audit or inspection team appointed by district authorities. After that the SOE should be maintained for 10 years.

d. At the state level, disbursals done by the district/city PMU will be treated as advances, and these advances will be treated as expenditures after the SOE for these advances have been received.

e. City/District Health Society will conduct financial audit of MAS account on a test sample basis annually as a part of auditing district accounts. However, state should progress towards social audit.

f. In case of delayed receipt of untied fund, MAS needs to be given a six month period to spend funds beyond the end of the financial year. When final accounts are presented, unspent funds are to be regarded as unsettled advances. District should top-up MAS funds on the unsettled advances.

6.5 Assessment of the Functioning of MAS

After its formation, MAS needs to be monitored at regular intervals on various parameters to assess its functional status. This can be done with the help of a tool known as the **“MAS monitoring matrix”.**

MAS monitoring matrix helps to assess the status of MAS on the following four parameters:

- Program Capacity
- Coordination and Linkages with the Service Providers
- Financial Capacity
- Institutional Capacity

MAS Monitoring Matrix needs to be filled on a monthly basis by the ASHA/ the ASHA facilitator to assess the progress of the group and is attached as Annexure XIV.

CHAPTER 7

Structure of Local Self Government and Various Government Schemes

7.1 Structure of Local Self Government and its Functions

7.1.1 Structure in Metros and Million plus cities- Mahanagar Palika / Municipal Corporation

(This may vary from state to state)

- It is the top most of urban local government in metropolitan cities, which have a population of more than 10 lakhs.
- It is headed by Municipal Commissioner, who has all the executive powers.
- The other major decision makers are Mayor and Deputy Mayor who are elected for a period of one year by the members of the Corporation.
- Mayor is the titular head of the corporation and presides over the meetings of the corporation.
- Councillors are the members of the Municipal Corporation, elected from each ward.

Functions of Municipal Corporations	
Obligatory/Mandatory	**Discretionary/Non-Mandatory**
❖ Supply of wholesome water ❖ Construction and maintenance of water works ❖ Supply of electricity ❖ Road transport services ❖ Construction, maintenance, naming and numbering of public streets ❖ Lighting, watering and cleaning public streets, etc.	❖ Construction of public parks, gardens, libraries, museums, theatres and stadiums ❖ Planting of trees on road sides and elsewhere ❖ Provision of relief to destitute and disabled persons ❖ Civil reception of VIPs ❖ Registration of marriage ❖ Organization and management of fairs and exhibitions

7.1.2 Structure of Municipal Governance in Smaller Cities and Towns - Nagar Palika/ Municipality/ Municipal Council

- These are set up for an urban area/centre with population of 50,000 to 1 lakh. (This may vary from state to state)
- Members of the Nagar Palika are elected representatives from each ward, for a period of five years.

- The members elect a President among themselves to preside over and conduct the meetings of the Municipality.
- A Chief Officer along with other officers like an Engineer, Sanitary Inspector, Health Officer and Education Officer controls the executive and administrative affairs of the Municipality.

Functions of Nagar Palika
❖ Water supply ❖ Hospitals ❖ Roads ❖ Street lighting ❖ Drainage ❖ Fire brigade ❖ Market places and ❖ Records of births and deaths ❖ Solid waste management

7.1.3 Structure of Municipal Governance in very Small Cities - Nagar Panchayat

- These are for an urban area/centre having a population of more than 30,000 and less than 100,000 inhabitants.
- Nagar panchayats have a Chairperson with ward members.
- Membership consists of a minimum of ten elected ward members and three nominated members.
- Block Development Officer (commonly known as Executive Officer), is the chief of all administration.

Functions of Nagar Panchayat
❖ Provide essential services and facilities to the urban area ❖ Sanitation programme in township ❖ Street lighting and providing roads in every ward and main roads of town ❖ Set up and run schools in urban area ❖ Execute programme for adult literacy and run city libraries ❖ Water supply to every ward of urban area ❖ Drainage system to clear the solid and liquid wastes from town ❖ Build underground drainage system ❖ Records of births and deaths

ANNEXURE

Annexure I: Resolution for MAS Formation

Name of the city :_____

Name of the slum : _____

Date and time of the meeting : _____

Venue of the meeting : _____

The first meeting of the Mahila Arogya Samiti of …… slum in ward number…… of …….. city/town was held under the supervision of Ms./ Smt. …… , working as ASHA. The meeting was attended by ……. members. The objectives, activities, roles and responsibilities, fund management and utilization, record maintenance etc. of MAS were discussed in detail during the meeting. Smt./Ms …… was nominated as Chairperson of the MAS and Smt/Ms. ……. (ASHA of the slum) will act as the Secretary of the MAS. Rs. 5000/- will be sanctioned to MAS under the National Urban Health Mission (NUHM) to implement various health related activities in the slum. To facilitate the same, it was decided to open a joint account in the nearest branch of …… bank.

It was agreed that a copy of this resolution along with a letter of request would be submitted to the Branch Manager, …….. bank for opening of the joint bank account in the name of MAS. The following persons will operate the bank account:

1. Smt./Ms Chairperson

2. Smt./Ms Secretary

It was decided that the functioning of the MAS would be governed by NUHM guidelines and the MAS would meet every month.

Signatures of the MAS members present in the meeting

1. **2.**

Annexure II: MAS Registration Sheet

Name of the MAS _____

Date of formation _____

Total members in the MAS _____

Name of the Slum/ coverage area _____

Total no. of households in MAS coverage area _____

Name of ASHA _____

Name of ASHA facilitator/ Community organizer _____

Sl. No.	Name of MAS member	Age	Address	Designation	Signature	Photo
1.						
2.						
3.						
4.						
5.						

Annexure III: Letter to Bank for Opening of Bank Account

To

The Branch Manager

_____

Sub: Opening of the Bank Account in the name of Mahila Arogya Samiti

Sir,

We would like to inform you that ……..Mahila Arogya Samiti (MAS), …… (Name of the slum) is formed to implement health, nutrition, sanitation related activities in ward no. …… of ……..…. city/town. To facilitate the funds transaction, it was decided in the Mahila Arogya Samiti to open a saving bank account in your bank. The account will be jointly operated by

1. Smt./Ms Chairperson

2. Smt./Ms Secretary

The resolution of the meeting held for MAS formation and opening of bank account in name of MAS is attached herewith for your reference. We request you to open the bank account in the name of ……MAS in your bank. The account opening form duly filled in is also enclosed with this letter. It is therefore requested to immediately open an account in your bank in favor of our Mahila Arogya Samiti.

Yours faithfully,

Chairperson, MAS

Encl: Copy of the resolution of the meeting

Annexure IV: Vulnerability Assessment Tool

Household Information-

- Address/location:
- Respondent Details:
- Date of survey:
- Name of the ASHA/MAS member:

Section I- Residential Vulnerability

1. Slum Status

0 Homeless shelters/roadside/railway tracks

1 Unauthorized Settlement/ Land belonging to local authority/ Leased Land

2 Own land/ authorized quarters/Registered slum

2. Migration status

0 Seasonal/ Recent migration (Less than one year)

1 Living in the area from last few years (1 to 5 years)

2 Living in the area from more than 5 years

3. Location of the household

0 Hazardous location besides dumping ground, polluted water, railway line or airport

1 Slum dwelling with high population density, poor ventilation, limited space

2 Adequate ventilation and space

4. Housing

0 Kutcha house with weak structure, No separate space for cooking, minimal ventilation

1 Fairly pucca but with mud/ tin roof and non-cemented walls/brick walls with plastic or thatch roof; marginally better than earlier category

2 Permanent structure, ventilation present, separate space for cooking

5. Basic Services: Toilet

0 No toilet, defecation in the open by all-men, women and children

1 Use common/community toilet, do not have bath facilities

2 Majority have private/defined space for bathing and toileting

6. Basic Services: Water

0 No piped water supply, use community taps/ tankers etc, irregular supply

1 Use community taps or hand pumps, have regular water supply

2 Have individual water pipe

7. Basic Services: Drainage

0 No drains, clogged drains with open pits

1 Open drains-kutcha or pucca

2 Underground connected drains and paved roads

8. Electricity

0 No electricity connection at all

1 Illegal electricity connection

2 metered individual electricity connection

Section II- Social Vulnerability

9. Type of Family

0 Child Headed household/Women headed household/Single parent family/Single male

1 Nuclear Family with only one earning member with informal employment

2 Joint family with one earning member with regular income or more than one earning member with regular or irregular incomes

10. Social Support Mechanisms

0 Living far from the family, no social support available at all

1 Living alone in the area but people from your community are living nearby

2 Living with family

11. Disability status

0 Member with chronic disability/debilitating illness like TB, AIDS, Cancer, Kidney failure

1 Household member suffering from mild impairment but functional

2 No member with disability

12. Identity Proof

0 Do not have any documents

1 Have at-least one legal documents (BPL Card, Ration card, voter ID, Aadhar Card etc)

2 Have all the necessary documents

13. Episodes of harassment by any groups in power

0 Very often

1 Rarely

2 Not at all

14. Nutrition

0 Children are not enrolled in Anganwadi centre (AWC) and no access to PDS ration

1 Government ration not available but children are enrolled in Anganwadi centre

2 Children enrolled in AWC and access to PDS/Government ration

15. Education: Children and Adults

0 Children in the household do not attend school and adults are illiterate

1 Young children going to school but drop out in other children, adults with minimum/functional literacy

2 All children pursuing elementary education and adults also have minimum elementary condition

Section III- Occupational Vulnerability

16. Employment Pattern

0 Daily wage earner with irregular pattern, daily wages below Rs 150

1 Daily wage earner with regular employment, daily wages upto 150-500

2 Regular employment or irregular employment with daily wages more than Rs 500

17. Occupational Conditions

0 Hazardous working conditions like rag picking, sex trade, mining, recycling waste collectors, construction workers, engaged in bidi making, matchbox making

1 Engaged in unskilled and semi-skilled jobs like street vendors, casual laborers, domestic workers

2 Private or government regular job with monthly wages, shopkeepers

Section IV- Health Related Vulnerability

18. Proximity to the health facility

0 more than 2 kilometers

1 within the range of 2 km

2 Less than 1 km

19. Status of Health and Health Services

0 Reported history of maternal death / child death/death due to TB, Malaria or other infectious diseases in last five years

1 Poor health status of the family/individual eg. Reported cases of diarrhea, TB or any other disease

2 No case of illness at the time of survey

20. ANM visit

0 Never

1 Once in 3 months

2 Monthly

21. Health Seeking

0 Do not take treatment in case of illness

1 Go to local practitioners/quacks/stores

2 Go to government facilities/registered private doctor

HOUSEHOLD SCORE: _____

Cumulative Scoring
0-15= Most vulnerable
16-30= Highly Vulnerable
31-42= Vulnerable

Section V- Categorization

Tick if you find the households/families falling in any of these categories:

- Rag Picker
- Rickshaw puller
- Head loaders
- Construction workers
- Daily wage laborers
- Homeless
- People involved in Begging
- Domestic workers
- Elderly poor
- Widow/deserted women
- Women/child headed household
- Differently Abled
- Debilitating illnesses- HIV/AIDS, TB, Leprosy etc.
- Sex workers
- Street Children
- Trans-genders
- Sanitary workers
- People with mental illness
- People living in institutions like night shelters, homeless recovery shelters, beggars home, leprosy homes
- Any other, Please specify _____

Annexure V: Public Services Monitoring Tool

Sl. No.	Indicators	Jan	Feb	Mar
	Child Nutrition			
1	Did the Anganwadi centre open regularly during the month?			
2	Number of children aged 3 - 6 years in the community?			
3	Number of children aged 3 - 6 years who came regularly to the Anganwadi centre?			
4	Number of 0-3 year children in the coverage area of MAS?			
5	Number of 0-3 year children who are in malnourished or severe malnourished grade?			
6	Was the weight measurement of children done in the Anganwadi centre last month?			
7	Were pulse and vegetables served all days in cooked meal last week in the Anganwadi?			
8	Was Ready to Eat (RTE) food distributed in the Anganwadi during the last month?			
	Complementary Feeding			
9	Number of children aged 6-9 months whose complementary feeding has not started yet?			
	Education			
10	Number of girls and boys in the age group of 6-16 years not attending the school?	G: B:	G: B:	G: B:
11	Did all the teachers come to the school regularly during the last month?			
	Mid Day Meal			
12	Were pulses and vegetables served all days in cooked meal last week in the school (upto 5th standard)?			
	Water			
13	How many hand pumps/ stand posts are non-functional as on today?			
14	Number of hand pumps/ stand posts with stagnant water around them as on today?			
	Sanitation			
15	Number of functional community toilets in the slum/area?			
16	Number of slum households using individual toilets?			
17	Number of slum households not having access to functional toilets?			
	Garbage Disposal			
18	Is there a functional garbage disposal mechanism in place?			
	Drainage			
19	Is there a functional drainage system in place in the slum?			

Sl. No.	Indicators	Jan	Feb	Mar
	Status of women			
20	Number of cases of violence against women during the last month?			
	Health Services			
21	Did the ANM come last month for the immunization/ UHND?			
22	Did the ANM organize outreach session in the last month?			
23	Whether all children of the slum/ area are being vaccinated in appropriate age?			
24	Whether the BP measurement of pregnant women was done in the UHND?			
25	Did the ANM provide medicines to the patients free of cost?			
26	Does the ASHA have more than 10 Chloroquine tablets?			
27	Did the ANM distribute ORS Packets?			
28	Did the ANM distribute IFA tablets?			
29	Does the ASHA have more than 10 Cotrimaxazole tablets with her?			
30	Whether the referral transport facility was available to take the serious patients, delivery cases, sick newborn cases, etc to health facilities?			
31	Number of home deliveries in the last month?			
32	Number of families not using mosquito nets?			
	Diseases			
33	Number of diarrhoea cases during the last month?			
34	Number of fever cases during the last month?			

The above table is an indicative list. Exact details of each row can change according to the state, district or city. MAS too can add on aspects which it wants to monitor. Based on above table- the following notes are kept- which is a monthly action plan

Annexure Va: Public Services Monitoring Register

Sl. No.	Gap Identified in table above	Date on which identified	Action to be taken	Person Responsible	Timeline for action	What happened next

Annexure VI: Checklist for Urban Health and Nutrition Day (UHND)

Name of the Slum: _____

Ward Number: _____ Ward Name: _____

Name of City: _____

Sl. No.	Parameters	Assessment (Yes/ No/Partial/NA-Not Applicable)	Remarks
Presence of Health Workers during UHND			
1	Was ANM present during UHND?		
2	Was ASHA present during UHND?		
3	Was AWW present during UHND?		
Service Delivery During UHND by ANMs			
1	Was ANM doing ANC check- up of pregnant women?		
2	What components of ANC were being provided?		
i	Tetanus toxoid injections		
ii	Blood pressure measurement		
iii	Weighing of pregnant women		
iv	Blood test for anemia using Haemoglobinometer		
v	Examination of abdomen		
vi	Counseling of appropriate diet and rest		
vii	Inquiring about any danger signs like – swelling in whole body, blurring of vision and severe headache or fever with chills etc.		
viii	Counseling for institutional delivery		
3	Was ANM providing vaccination to children?		
4	Did she also provide medicine or referral in case of any sickness of any child below 2 years of age ?		
Services Provided by AWW During UHND			
1	Was AWW weighing all the children of 0-6 years of age?		
2	Was AWW weighing the children correctly?		
3	Did AWW record the weight on the growth monitoring card correctly?		
4	Did AWW give take home rations to children 6 months – 6 years of age?		
5	Did AWW give take home rations to adolescent girls?		

Sl. No.	Parameters	Assessment (Yes/ No/Partial/NA-Not Applicable)	Remarks
6	Did AWW give take home rations to pregnant women?		
7	Did AWW give take home rations to lactating mothers?		
Quality of Services Delivered During UHND			
1	Weighing machine of ANM was in order		
2	Weighing machine of AWW was in order		
3	Thermometer was working accurately		
4	BP apparatus was working accurately		
5	Supplementary food was available		
6	Quality of supplementary food was good		
Roles played by Frontline Worker/ASHA			
1	Did ASHA make a list of potential beneficiaries who need either ANM or AWW services?		
2	Was ASHA able to motivate most (>75%) of the beneficiaries to attend the UHND?		
3	Did she inform the beneficiaries at least a day before about the date of UHND?		
4	Did she help ANM or AWW in organizing the UHND?		
General Questions			
1	What was the venue of the UHND?		
i	Anganwadi centre		
ii	School		
iii	Community hall/ centre		
iv	Some other – open venue		
2	Was UHND held on a fixed date every month?		

Annexure VII: Checklist for Assessing Quality of Services at Health Facilities

OBSERVATION CHECKLIST FOR URBAN PHC

General Information

Name of the U-PHC: _____

Total population covered by the U-PHC: _____

Name of the City/ Area: _____

Availability of Infrastructure

- Is there a designated government building available for the U- PHC? Yes/No
- Is it functioning from a rental building? Yes/No
- Is the building in working condition? Yes/No
- Is water supply readily available in this U-PHC? Yes/No
- Is electricity supply readily available in this U-PHC? Yes/No
- Is there a telephone line available and in working condition? Yes/No

Availability of Staff

- Is a Medical Officer available/appointed at the U-PHC? Yes/No
- Is a Staff Nurse available at the U-PHC? Yes/No
- Is a lab technician available at the U-PHC? Yes/No
- Is ANM available at the U-PHC? Yes/No
- Is support staff/attendant available? Yes/No

General Services

Availability of Medicines

- Are the basic medicines available in the U-PHC? Yes/No
- Is Anti-rabies vaccine available in the U-PHC? Yes/No
- Are drugs for tuberculosis available in the U-PHC? Yes/No

Availability of Curative Services

- Is primary management of wounds done at this U-PHC? Yes/No
- Is primary management of fracture done at this U-PHC? Yes/No
- Is primary management of burns done at the U-PHC?
  Health Sanitation and Nutrition Committee Yes/No59r

Reproductive and Maternal Care and Abortion Services

Availability of Reproductive and Maternal Health Services

- Are ante-natal clinics regularly organised by this U-PHC? Yes/No
- Is facility for normal delivery available in the U-PHC? Yes/No
- Are internal examination and treatment for gynaecological conditions and disorders like leucorrhoea and menstrual disturbance available at the U-PHC? Yes/No
- Is treatment for anaemia given to both pregnant as well as non- pregnant women? Yes/No

Child Care and Immunization Services

- Are low birth-weight babies treated at this U-PHC? Yes/No
- Are there fixed immunization days? Yes/No/No information
- Are BCG and measles vaccine given at this U-PHC? Yes/No
- Is treatment for children with pneumonia available at this U-PHC? Yes/No
- Is treatment of children suffering from diarrhoea with severe dehydration done at this U-PHC? Yes/No

Laboratory and Epidemic Management Services

- Is laboratory service available at the U-PHC? Is blood examination for anemia done at this U-PHC? Yes/No
- Is detection of malaria parasite by blood smear examination done at this U-PHC? Yes/No
- Is sputum examination to diagnose TB conducted at this U-PHC? Yes/No
- Is urine examination of pregnant women done at this U-PHC? Yes/No

Annexure VIII: MAS Monthly Meeting Attendance Record

Mahila Arogya Samiti, Slum .....

Ward Number ..... City .....

Meeting Date: ..... Meeting Time: .....

Meeting Chaired by.....

Serial No.	Name*	Slum/Cluster	Signature

*Mention details of special invitee if any.

Annexure VIIIa: - MAS Monthly Meeting Minutes Record

Agenda Item	Key discussions**	Decisions Taken	Name of individuals assigned responsibilities	Financial allocations, if any with stated details

**Specify issues in objection or support of the Agenda item.

Sign of Member Secretary: **Sign of Chairperson:**

Annexure IX: Death Register

Name of Slum: _____

Ward Number: _____ Name of City: _____

Sl. No.	Name of Deceased Individual	Age and Sex	Name of Father/ Spouse	Name of Slum	Date of Death	Place of Death	Cause of Death

MAS should use this information to facilitate death registration for issuance of death certificate by appropriate authority. All deaths should be recorded, including still births if any. This list is used for discussion in MAS meetings on how to prevent such deaths in future as record of causes of death is important and will form the basis for community health planning.

Annexure X: Birth Register

Name of Slum: _____

Ward Number: _____ Name of City: _____

Sl. No.	Name of Infant	Sex of Infant	Name of Mother and Father	Name of Slum	Date of Birth	Time of Birth	Place of Birth	Birth Weight (kg)

MAS can use this information:

- To facilitate birth registration for issuance of birth certificate by appropriate authority
- In monitoring institutional deliveries, birth weight
- In improving home visits by ASHAs and for monitoring of neonatal deaths

Annexure XI: Cash Book for MAS

The cash book of the MAS is to be maintained for recording income and expenditure of the MAS. It is maintained by the MAS Member Secretary cum Convener (ASHA) with the help of AWW/ANM/ Chairperson of MAS.

One part (PART 1) of the cash book comprises income of the MAS (untied fund, donation, other source) and other part (PART 2) of the cash book comprises expenditure.

PART 1- Income Details-(To be maintained on left side of the cash book)

Sl. No.	Opening Balance	MAS Untied Fund Received – Contribution/ Donation/Untied fund from government				Details of funds received by MAS- Donation or Untied (Cheque no./ draft no./ Cash)			Date of receiving funds			Source of donation/ income			Signature of Member Secretary
		Contribution (a)	Donations (if any) (b)	Untied fund from government (c)	Total (d=a+ b+c)	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	

PART 2- Expenditure Details-(To be maintained on right side of the cash book)

S. No.	Amount of Fund Spent by MAS	Details of Funds Spent by the MAS- (Voucher No. Bill No.)	Date of the expenditure	Activity on which funds were spent	Signature of Member Secretary

Annexure XII: MAS Statement of Expenditure (SOE)

Sl. No	Period of Activity (Date/Month)	Name of Activity	Purpose (including details on beneficiaries and location of activity)	Details of expenditure (rates of items, break-up of expenses)	Total expenditure on activity
Total expenditure (All Activities)					
Total amount received					
Total unspent amount					
Total amount in hand/ cash					
Total amount in bank					

Annexure XIII: Format of Utilization Certificate (UC)

Name of the MAS: _____

Name of Slum: _____

Ward Number: _____ Name of City: _____

Utilization Certificate for the Year: **Dated:**

Sanction Letter No. and Date	Opening Balance As on	Funds received in Current Year Total (d= a+b+c)	Interest Earned	Grand Total (Funds received and interest earned)	Expenditure in Current Year	Balance (If any)
1	**2**	**3**	**4**	**5**	**6**	**7 = (5-6)**
(Please give here details of Sanction Letters) 1. 2. 3.						

Further certified that I have satisfied myself that the conditions, on which the grants – in – aid was sanctioned, have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

1.

2.

3.

Sign of Member Secretary: **Sign of Chairperson:**

Annexure XIV: MAS Monitoring Matrix

Name of the MAS : _____

Name of the slum : _____

Date and Year of Formation of MAS: _____

Total Number of Members : _____

Name of the office bearers of MAS: _____

Name of the ASHA/ ASHA facilitator: _____

Indicators				
A.	**Program Capacity of MAS** (If activities are undertaken, please mark it 'Yes' for the month)	**June 2014**	**July 2014**	**August 2014**
1	MAS members have received training			
2	MAS members are active (at least 50 %) in community awareness and mobilization as per responsibilities fixed			
3	MAS Members conduct health information sessions in the community at least once every month			
4	MAS Members participate in organization of awareness generation campaigns in the community at least once every month			
5	Members of MAS collect and update information regarding pregnant and lactating women, infants, children up to 5 yrs and eligible couples in the Health Resource Map			
6	Members of MAS regularly conduct home visits and provide relevant counseling			
7	Members of MAS provide prior information to pregnant women and mother of the children about date, day, venue and timing of immunization sessions/UHND			
8	Records and registers are updated after meetings			
9	Members identify and track left out/ drop outs after immunization sessions/ UHND			
10	All members keep information about their allocated households			
B.	**Coordination and Linkages of MAS members with Service Providers** (If following activities are undertaken, please mark it ' Yes ' for the month)	**June 2014**	**July 2014**	**August 2014**
1	MAS members have monthly meetings with ANM and AWW for making action plan and carrying out health related activities			
2	Members support the service providers through community mobilization in organizing immunization sessions/ UHNDs in the slum or coverage area			
3	Members regularly coordinate with the service providers to ensure reach of services to the vulnerable and marginalized population			

C.	**Financial Capacity of MAS** (If activities are undertaken, please mark it 'Yes' for the month)	**June 2014**	**July 2014**	**August 2014**
1	MAS holds a bank account in their name			
2	Decisions for utilization of untied fund are taken in MAS meetings in presence of at least 50% of MAS members			
3	MAS follows all the guidelines regarding the utilization and accounting of untied fund			
4	MAS maintains all financial records			
5	A monthly financial statement of the untied fund is prepared and shared with all members			
D.	**Institutional Capacity of MAS** (If following activities are undertaken, please mark it ' Yes ' for the month)	**June 2014**	**July 2014**	**August 2014**
1	Name of MAS has been documented			
2	Members have nominated Chairperson of the MAS			
3	MAS conducts regular meetings at least once a month			
4	Meeting registers maintained with all of the following components – agenda, attendance of members, record of proceedings, decisions taken			
5	MAS prepares action plan to address health and other related service gaps on a monthly basis			
6	MAS reviews the work plan of the previous month			

NATIONAL HEALTH MISSION
Ministry of Health and Family Welfare
Government of India
Nirman Bhawan, New Delhi