



Notes for Trainers

Induction Training Module for
MAHILA AROGYA SAMITIS (MAS)

2014





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Introduction to the Trainer Notes

Notes for Trainers

The notes for trainers are intended for the use of state and district trainers involved in the training of members of the Mahila Aarogya Samiti (MAS). Before the training, the trainers should get familiarized with the Induction Training Module for MAS.

The trainer notes are divided into seven chapters and include facts and concepts that participants should become familiar with. In order to illustrate the concepts, the chapters include several case studies which enable participants to apply the knowledge gained. At the end of each session, a set of questions are included, which the participants should be encouraged to answer at the conclusion of the session.

The trainers will need to use a mix of participatory and didactic methods. For those sections that deal with facts and details about the MAS, the trainer should introduce the participants to the facts, and then ask them to read the section out aloud in turns. Before embarking on the training, trainers should become familiar with the contents of two accompanying booklets - Induction Module for MAS and the Guidelines for ASHA and Mahila Arogya Samiti in Urban Context. Details regarding training plan are given in the table below.

Training Plan

Sl. No.	Chapters to be covered	Topics to be covered	Days	Time
1	Chapter 1	<ul style="list-style-type: none">❖ Community participation and need for Mahila Arogya Samiti❖ Understanding Health and its various determinants❖ Convergence for Health❖ Understanding Vulnerability	Day 1	5 Hours
2	Chapter 2	<ul style="list-style-type: none">❖ Objectives of MAS❖ Composition of MAS❖ Formation of MAS❖ Responsibilities of key MAS members		1.5 Hours

Sl. No.	Chapters to be covered	Topics to be covered	Days	Time
3	Chapter 3	Major Activities of MAS <ul style="list-style-type: none"> ❖ MAS Monthly Meetings ❖ Monitoring and facilitating access to essential public services and correlating such access to health outcomes. ❖ Community Health planning ❖ Organizing local level community action for health promotion ❖ Community monitoring of health care services ❖ Maintaining Records 	Day 2	5.5 Hours
4	Chapter 4	<ul style="list-style-type: none"> ❖ Untied Fund and Principles of its Utilization ❖ Management and Accounting of Untied Fund 		1 Hour
5	Chapter 5	<ul style="list-style-type: none"> ❖ Structure of Local Self Government 		30 Minutes

Community Participation and Need for Mahila Arogya Samiti

Objectives of the Session

By the end of this session the MAS members will learn about:

- ✓ The importance of community participation
- ✓ The levels of community participation
- ✓ Objectives of NHM and the various institutions set up at different levels under NHM
- ✓ Health and its determinants

1.1 Community Participation

Method: Question- answers, matchstick game and explanation using examples

Material: Board, marker pens and matchsticks

Duration: 30 minutes

Activity

Matchstick Game

1. Invite one of the participants. Give him/her one matchstick and tell him/her to break it. It will break easily. Now tie a bundle of matchsticks together and tell the participant to break it. It will not break easily.
2. Ask the participants what did they understand from this activity? You would get responses such as-“Our strength increases with collective efforts, collective action improves performance, working together helps in overcoming challenges better etc.
3. Summarize the responses, link and use the key messages emerged to build an understanding of the concept of collective action and community participation.

Step 1: Ask the participants their perception about Community Participation.

Step 2: List the answers on the board and proceed to-Ask the participants why is community participation in health important?

Step 3: Explain that Community Participation in health is important because:

- ❖ Communities can play vital role in promotion of healthy behaviours and prevention of diseases.
- ❖ 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.
- ❖ Communities possess several resources-human and financial that can be used to enhance the quality of health care and effectiveness of health care services.
- ❖ The community is most capable of acting on all the social determinants of health.
- ❖ Active community's participation leads to correction of, the mismatch between people's needs and services delivered and leads to increase utilization of health services.

Step 5: Explain to the participants the levels of community participation through the following examples:

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 health services, 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, we find that in most cases, community participation is limited to participating in benefits and activities of the government.

Step 6: Summarize the session by linking to the discussions above and explain that:

MAS are one of the key interventions introduced by National Urban Health Mission (NUHM). They are an important mechanism for the community to participate at all levels, including in implementing, monitoring and planning of health programmes.

Step 7: Ask the participants to read page number 2 and 3 of the Induction Module and explain to them, what is MAS and its key objectives.

1.2 Need and Objectives of Mahila Arogya Samiti

Method: Display the case studies given below on a flip chart and explain using the case studies the objectives of the MAS.

Material: Board, marker pens and flipchart

Duration: 30 minutes

What is Mahila Arogya Samiti (MAS)?

Mahila Arogya Samiti (MAS) is:

- ❖ 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

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 funds.
- 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.

Some case studies highlighting various problems faced in urban areas:

- ❖ In Sitaram Nagar, many children have diarrhea at the same time. There is only one working handpump.
- ❖ In Korgaon, UHND has not been held in the last four months as the ANM has been transferred to another area and no new ANM has been posted.
- ❖ In Khajurikhas, the primary school opens only 2-3 days a week as the teacher does not come everyday. The children are also not getting their mid-day-meal daily.
- ❖ In Baiganagar, the Anganwadi has been closed for most of the month as the AWW, who is from another area, does not come daily.
- ❖ A new alcohol shop has come up in Jahangirpuri area. Men come there from surrounding areas and drink and create chaos on the road. This causes a lot of harassment for the women and girls.
- ❖ Shahdara had four deaths due to dengue this year. Every year people get dengue and many have to be hospitalized.
- ❖ In Lalpur, construction of a mall is going on. Last week, municipal authorities came and stopped the process due to legal issues. Now, labourers have not been paid wages for last three months.

Tell the participants that in all these situations the MAS can play an important role in solving such problems. Therefore MAS is a forum through which:

1. The community can be informed of health programmes and government initiatives.
2. The community can participate in the planning and implementation of the programmes, and take collective action for the attainment of better health status in the village.
3. Convergent action on social determinants and all public services directly or indirectly related to health.
4. The community can voice health needs, experiences and issues with access to health services, for the institutions of local government and public health service providers to take note and respond appropriately.
5. Local community groups can be empowered with the understanding and mechanisms required for them to play their role in governance/monitoring of health and other public services and work for collective action to improve health status.
6. Support and facilitation may be provided to the community health workers like ASHA and other frontline health care providers who have to interface with the community and provide services.

1.3 Understanding National Health Mission and Public Health Facilities under NUHM

Objectives of the Session

By the end of the session the MAS members will learn about:

- ✓ The principles enshrined in our health system
- ✓ National Health Mission and Public Health Facilities under NUHM

Method: Discussion using illustrative charts, card activity

Materials: Chart paper, display board and drawing pins, chart on structure of public healthcare facilities, given on page 4-5 of the Induction Module.

Time: 30 minutes

Activity

1. Ask the participants their perception of the 'Health as our Right'. Collect their responses and write on board. Explain that "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. But this is not possible without collective action. 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. 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."
2. Now ask them, have they heard of National Health Mission. Based on the experiences shared and information given at page 3 in the Induction Module of MAS explain the objectives of the National Health Mission.

One of the main objectives of NUHM/NHM is delivery of quality healthcare services to the people living in urban areas with special emphasis on:

Improving the reach of health care services to the most vulnerable and marginalized groups among the urban poor, falling in the category of beggars, street children, construction workers, rickshaw pullers, migrant workers and other such groups.

3. Now proceed to next section on structure of public healthcare facilities. This part is explained by giving a card activity to the participants. Display a set of cards with the following labels on the floor.

a.	District level
b.	District Medical Hospital/Civil Hospital
c.	Ward/Block level
d.	Urban-Community Health Centre
e.	Urban-Primary Health Centre
f.	Sub-Centre
g.	Chief Medical Officer
h.	Medical Officers
i.	Staff Nurse
j.	ANM

4. Ask 3-4 volunteers to come forward. Ask them to review the cards and develop a flow chart which explains the structure of the Public Healthcare Facilities. They need to depict which health facility is available at which level and who are the appointed health care providers at each of these levels.
5. Once they have completed the task ask other participants whether they want to make any changes. If yes, ask them to do so.
6. Once the groups members agree on the final version, display the prepared chart on the healthcare facilities available at various levels. Let the participants compare it.
7. Discuss the various health personnel available at various levels with the health facilities and conclude the session by sharing the information on health care facilities.

1.4 Assessing Quality of Public Health Facilities

Objectives of the Session

By the end of the session the MAS members will learn about:

- ✓ The principles of Quality Health Care as Right of the Community
- ✓ Using checklist for assessing the quality of public healthcare services

Method: Discussion using checklist for assessing quality of health services

Materials: Chart paper, display board, checklist on quality of services given in Annexure 7, page 56 of Induction Module for MAS to be given as handout.

Time: 30 minutes

Activity

1. Ask the participants their opinion regarding 'Quality Health Care'
2. Collect the responses and note on the board.
3. Then discuss the concept of quality of healthcare using the points below-

Quality Health Care Right of the Community

- ❖ A professionally and technically competent and certified person has to take the case history and examine the patient.
- ❖ Appropriate and rational treatment is given.
- ❖ The patient is to be given appropriate/adequate information related to the diagnosis, treatment procedures and drugs prescribed without scaring or causing undue tension.
- ❖ The patient needs to be given time to share concerns. After listening to them, help them to make an informed decision regarding the treatment procedures (risk and safety factors) and choose the most suitable alternative, if there is a choice available.
- ❖ Essential equipment, supplies and technical staff must be available at the facility. Patient/s

must not be told that due to the unavailability of drugs or equipment being out of order s/he cannot get a treatment service.

- ❖ Privacy, comfort, confidentiality and dignity of the patient are to be maintained- have curtains in the examination room, allow the attendant of a patient inside if she/he wishes, and keep registers/files locked.
 - ❖ Behaviour of the providers is courteous, non-discriminatory and reassuring.
 - ❖ Patient must feel motivated enough by the providers and the system to continue and complete the treatment.
4. **Ask them what role MAS can play to ensure the quality of health care services. Let them share their views. Conclude the session by providing the following information:**
- ◆ Creating awareness about the meaning and implications of quality health care among the community members.
 - ◆ Informing them about their entitlements from the health providers and health services.
 - ◆ Mobilizing community members and informal and formal groups to take interest in monitoring access to health care services at the area level, as well as take corrective action through the appropriate authorities.
5. **Trainer now reads the following situations and divide the participants into groups to enact a Role play**

Situation 1: A U-PHC, in an unused condition is situated outside the slum area. It is poorly maintained. The ANM does not stay in the area and does not visit regularly. The role play needs to highlight the following points: The ASHA sends written complaints to the U-PHC and the Chief District/City Health Officer. The ASHA discusses the problem with Mahila Aarogya Samiti members, who discuss the matter with the ANM and use the funds given to her to strengthen the U-PHC. The Mahila Aarogya Samiti members and ASHA offer a place to the ANM to stay at the area level.

Situation 2: The U-CHC doctor and the team are responsible for a school health check-up. But the doctor does not go to the government girls' secondary school, where children come from the poor families. There is no lady doctor in that U-CHC. The U-CHC male doctor, due to his earlier bad experience in another posting, is afraid that he may be falsely implicated for molestation. So he seeks refuge under the plea that he is not obliged to go to the girls' school as he is a male doctor. The role play needs to highlight the following points: The MAS needs to discuss the matter with the principal of the school. They come out with the solution that the ASHA and the lady teacher of the school will remain present during the check-up to ensure that no allegation of exploitation is falsely leveled against the male doctor. This decision is communicated to the doctor and health check-up in the school starts.

Situation 3: There is an illegal slum area where most families are involved in 'Beggary', situated on the outskirts of the town. This area's health day/camp is organized at the main area and this area is neglected. No health camp or Urban Health and Nutrition Day activity is organized here. The people of the area find it difficult to avail services due to the distance. As a result, they mostly depend on a quack who comes on a motorcycle and treat them even on credit. The role play needs to highlight the following points: The MAS will write all the details related to what happened on one particular day. ASHA can take the signatures of all the people present. MAS takes the copies of the letter and posts one copy to the medical

officer, one to the Block Health Officer and one to the Chief Medical Officer. The government authority takes necessary actions.

Note: The detail of what needs to be highlighted in the role plays is given only for your reference. As a facilitator you need to guide the participants to make the situation as realistic as possible, keeping the cultural reality in view.

6. Conclude the session by discussing the checklist on quality of healthcare services from Annexure 7, page 56 of Induction Module.

1.5 Understanding Health and its Determinants

Objectives of the Session

By the end of the session the MAS members will learn about:

- ✓ What constitutes good health and bad health
- ✓ The various determinants of health
- ✓ What is the meaning of Convergence for Health
- ✓ Their role in Convergence

Method: Discussion using illustrative charts

Material: Board, chart paper and marker pens.

Time: 30 minutes

Activity

1. Start the discussion by asking the participants what are the common health problems faced by people in their community.
2. Ask the participants to enumerate the possible factors that are responsible for ill health.
3. Summarize the responses. Explain the concept of health and the difference between good and ill health as per the section below.
4. Ask the participants to read the section in Chapter 2 of the Induction Module describing the factors that contribute to good health, ask for doubts if any, explain all the factors in detail.
5. Now ask the participants and discuss about how each of the following factors are related to Ill Health:
 - ❖ **Malnutrition:** Read page number 8 of the MAS module and explain why nutrition is important and how malnutrition is related to ill-health. Display Intergenerational Cycle of Malnutrition on Board using the diagram given on Pg 8. Also emphasize on 'Healthy Feeding Practices for preventing Malnutrition.'
 - ❖ **Water, Sanitation and Hygiene:** Discuss impact of unsafe drinking water on health from page number 9 of the module. List the important 'Safe Water Handling Practices' and common methods for household water treatment as given in the module. Ask the participants about impact of lack of sanitation on health. Demonstrate the hand washing technique as depicted in the book.

- ❖ **Unhealthy Working and Living Conditions:** Discuss how unhealthy living and working conditions impact our health and lead to physical and mental health problems.
- ❖ **Stress:** Discuss that there are many factors like Breakdown of society or family, unemployment, social insecurity and no relaxation which causes mental stress. Explain how mental stress affects the work productivity adversely and may at times lead to the extreme situations like committing suicide.
- ❖ **Unhealthy Habits like tobacco and alcohol:** Discuss the fact that the burden of unhealthy habits of tobacco and alcoholism is rising day by day, especially in urban areas where people have easy access to these commodities. Explain how it is related to ill-health.
- ❖ **Patriarchy:** Mention that when we compare men 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 many ways. Read the corresponding section from the module.
- ❖ **Lack of access to health services:** Discuss that government is responsible for providing 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 or overburdening of health facility staff may also limit their effectiveness in providing care to the patients. In all these situations, MAS has to come forward and intervene to make sure that every member of their community have equal access to health services and can avail these services in illness without difficulties.
- ❖ **Lack of Health Education:** Explain that complete information on various types of health facilities and their service, health entitlements and schemes help the beneficiaries to make an informed choice and leads to increased utilization of services.

1.6 Convergence for Health

Objectives of this Session

By end of this session, the participants will understand why convergence is necessary for effective health outcomes and how to make efforts for it.

Method: Role Plays and discussion

Material: Chart paper, or board and marker pens.

Time: 1 Hour

Activity

1. Remind the participants of the content covered in Section 2. Ask them to review the non health factors such as: availability of safe drinking water, Anganwadi services for children, education, safe disposal of waste etc. determines the health of the community.
2. Explain that to work for all the factors that affect health, ASHA and MAS will need to meet regularly with officials from various departments. This coordinated action between various departments is called 'Convergence'. Coordination can be done with individuals

on a one to one basis, (for example, agreeing with the Anganwadi Worker at what time they need to start preparing for the monthly Urban Health and Nutrition Day) or through a group meeting (MAS meeting to discuss the next month's plan), or with Municipality worker on removing garbage, water supply or with the medical officer on sending patients to be screened for non-communicable diseases.

3. Display the table given on page 15 of the module and ask participants to read it which lists the major stakeholders with whom MAS can meet and work for the goal of healthy community.
4. Now explain the role of MAS as given on Page 16 of the Induction Module. Explain that MAS members will need to monitor the public services regularly in order to play an active role and advocate with the local authorities for taking necessary actions. (Refer annexure V and Va of the MAS Module). Explain each of its components in detail.

Role Plays

1. Divide participants into four or five groups. Allocate the following cases to each group. Give them ten minutes to prepare and ask them to enact as a role play in ten minutes. After each role play ask the rest of the group to point out the strengths and weakness of each approach and what the outcome was likely to be.

CASE STUDIES: CONVERGENCE FOR HEALTH

Case Study 1: You live in a slum area of Lucknow. Near your area, a large amount of garbage is dumped by the residents of nearby houses. Since the last ten days, there has been no collection by the municipality over this large pile. This has resulted in a foul smell spreading through the colony and flies and mosquitoes breeding just outside your colony. As a MAS what would you do?

Case Study 2: There is a pocket of Jhuggis near the railway line where head-load workers and their families live. Since this colony is not an authorized colony, there is no water supply by the municipality to this area. The municipality tanker of water does not fulfill the need of even half of the families. Therefore, people living in this colony, have to buy private water for their daily sustenance and incur heavy costs. This issue is raised in a Mahila Arogya Samiti meeting. What action MAS members can undertake to resolve this problem?

Case Study 3: You are residing in the slum of Tikri. There is an Anganwadi center in the slum, where about ten to twelve children go daily. You have noticed that there are several children below the age of six years, who are playing on the streets, and do not appear to go to the Anganwadi Centers. You have also found during your visits that there are several days when the Anganwadi Worker sends the children home without food. As MAS member, what would you do?

Divide the group into three. Allot one case to each group. When one group performs the role play, other participants should watch and note down their observations. Give each group 10 minutes to perform. Then ask participants to respond to the way in which the role play was enacted, ensuring that positive feedback is provided before commenting on the gaps.

NOTES FOR MAS TRAINERS:

Explain to participants that the actions in each case would be different in different areas and there are no prescribed, correct answers. The importance of these role plays is that the group understands how MAS should be trained to assess the situation, their skills in explaining the issue to the concerned authorities < how effective they are in allocating responsibilities within the MAS, facilitating written communication if required, and their judgement on who can be called upon for support within and outside their community. The trainer should explain that there are several challenges in urban areas. Sometimes MAS members may be too busy to come together. Sometimes they may face hostility. Government officers may be difficult to reach. ASHA and MAS must organize and ask other community members to join them. Young people are an important resource. While the response of each group would be different i.e. in a well organized city, the MAS could call upon the ULB, in others, self help in the form of collective action may be the only way forward.

1.7 Understanding Vulnerability and Different Vulnerable Groups

Objectives: At the end of the session the MAS will be able to

- ✓ List the different vulnerable groups
- ✓ Know the specific health problems and service needs
- ✓ How to do 'Vulnerability assessment and mapping'

Method: Class room interaction and Group Activity

Material: Black board, Marker pen

Time: 30 minutes

Activities

1. Start the session by telling the participants that increasing numbers of people are coming to urban areas from rural areas in search of employment and better opportunities. But due to the lack of necessary infrastructure like housing, water and sanitation, and basic services like health and education, these people often have no other options but to live in clusters within the towns or cities and on the margins, called *Jhuggis or Slums*.
2. Ask the group to identify what are the geographic locations in which such people live. List these on the board. The list would include localities such as the roadside, under flyovers, railway platforms, bus stops, outside shops without shelter and in unsafe conditions.
3. Ask the group: to list out challenges that these people face in their day to day life. Lead the discussion by highlighting the fact these people struggle for those basic services (like safe drinking water, food, sanitation, health, education, safety and social security) which should be provided to them by the state. Note and list their responses on the board.
4. Explain three types of vulnerabilities i.e. Residential, Occupational and Social Vulnerabilities as given on Page 17 of the Induction Module. Vulnerable populations include the homeless, rag-pickers, street children, rickshaw pullers, construction, brick and lime kiln workers, sex workers and temporary migrants. Categorizing the vulnerable urban groups based on the nature of their vulnerabilities will help the participants to better understand their specific needs so that they can provide the right kind of support.

5. Make three columns on the board and ask participants to first list out the groups in each category, as listed in the boxes on page 17 of the module under “Different vulnerable groups according to the vulnerability criteria”. Then ask participants if this is appropriate to their context, and ask them to suggest additional groups based on their experience to expand the list. The participants can also add these in their copies of the Induction Module on page 17.
6. Now explain to the participants that these challenges have serious implications on their health. (Page 17-18, MAS Module).
7. Ask for a few volunteers from the group and have them read aloud from page number 18 of the Module and enable them to make the link between the conditions in which the urban poor live and particular health problems.
8. Conclude the section by highlighting the fact that the poor and vulnerable in urban areas, are the focus of the programme, and the MAS and ASHA must be specifically concerned about them. The first step is knowing who they are and where they live and this is what has been covered in this section.

1.8 Vulnerability Mapping and Assessment

Objectives: By the end of the session

Participants would be able to identify different vulnerable groups through the use of ‘Vulnerability Assessment Tool’

Method: Class room discussion, group activity or field visit

Material: Black board, Marker pen

Time: 1 hour

Activities

1. Start the discussion by highlighting that in order to identify, reach and work for the most marginalized and vulnerable groups in urban areas, a key skill that MAS and ASHA would require is to understand how to assess “Vulnerability” of the households/individuals in their area.
2. Explain that “Vulnerability Assessment Tool” is designed to help ASHA and MAS in identifying vulnerable households/individuals. [Ask the participants to open Annexure 4 of the Induction Module].
3. You must now explain each section of the tool to the participants- asking them to read out each part aloud one by one and then undertaking an explanation which would be useful in ensuring that they become familiar with it. The tool is divided into five sections. The first three sections contain 17 indicators/variables which assess the extent of residential, social and occupational vulnerability of the household. Section IV helps gather information on the health status and health seeking behavior of the households.
4. After every participant has understood the various indicators, explain how to calculate the scores and categorize the households in the categories listed in the tool:
 - ❖ Each variable is given three scores as 0,1 and 2. Zero being the lowest/worst case.

- ❖ Then, the scores are added
- ❖ Based on the score, the household is categorized into one of three categories i.e.:
 - ◆ 0-15: Most Vulnerable
 - ◆ 16-30: Highly Vulnerable
 - ◆ 31-42: Vulnerable

Explain to participants that this categorization will help them in prioritizing their households and addressing the health needs of the individual/family in a more focused manner.

5. Mention that the last section simply lists the vulnerable groups, so that if the surveyed household/individual belongs to any one of the category, they can tick and mention the category directly for prioritization and follow up action.
6. Now distribute the hand out of the tool to all the participants. If possible, conduct a practical session in which they can go in the field and conduct the vulnerability assessment through the tool.
7. If field activity is not possible, then give a case for role play. Ask for five volunteers. Three participants can play a role of a family consisting of a man, woman and their child. Give a situation like: The man and woman work as construction laborers and reside on a construction site and have a girl child of 2 years. Two participants can play the role of ASHA & MAS Member Ask them to conduct their vulnerability assessment through the tool. Supervise them using checklist given below and give your feedback after completion.
8. Once the discussion on the mapping tool is completed, explain to the participants, that the mapping tool helps them in prioritizing the households based on their vulnerabilities. This is only the first step. The MAS members will need to use skills such as communicating, motivating, counseling, coordinating and mobilizing to ensure that such families get access to the services they need.
9. Conclude the session by asking participants to read aloud pages 18-19 of the Induction Module.

Checklist for assessing the skill for Vulnerability Assessment and Mapping

Sl. No.	Trainer should look for the following	Yes	Partially	No
COMMUNICATION				
1	Members ask questions in clear and simple language			
2	Ensure that the family understands why and what she/he is saying			
3	Listen carefully to assess if family has any queries or doubts			
TOOL ADMINISTRATION				
4	See whether members have understood all the components/indicators of the tool			
5	See whether she/he is asking right questions and in right manner. Their questions should not make them feel disrespected or embarrassed			
6	Assess if she/he is able to appropriately rank the household under each indicator			
7	See whether she/he is able to add and do the cumulative coring correctly			
8	Look for accurate categorization of the household: Vulnerable, highly vulnerable and most vulnerable			
9	Check whether she/he is able to recognize the vulnerability group of the household (under part V of the tool)			
10	Look whether she/he is able to prioritize those houses categorized under highly and most vulnerable			

Questions for practice:

- Q.1. Have you noticed any gaps in your area's sub- centre or U-PHC? List a few.
- Q.2. Do the patients going to your area's PHC encounter any problems? What are the common problems encountered especially by the poorer patients?
- Q.3. When do women wake up in the morning? What all do they do in a typical day till they sleep. How many hours of work does this add up to. How many hours of relaxation do they get? Repeat the same exercise for men and compare.
- Q.4. Is health only related to illness? What is good health?
- Q.5. How does malnutrition affect health of a person?
- Q.6. How does patriarchy affect health of women?
- Q.7. What do we mean by this statement- 'Health is our Right'?
- Q.8. What do we mean by convergence and why it is important?
- Q.9. What problems do people living in urban slums face related to health and other social services?
- Q.10. What are the different components of vulnerability assessment tool? How can we use this tool for reaching and identifying vulnerable groups?

Formation, Composition and Roles of MAS members

Objectives of the Session

By the end of this sessions the MAS members will learn about:

- ✓ Composition of MAS
- ✓ Process of MAS formation
- ✓ Roles and responsibilities of MAS Members

2.1 Formation of Mahila Arogya Samiti

Method: Short lecture with discussion following the steps mentioned below.

Duration: 1 hour, 30 minutes

Step 1: Begin by discussing the level at which MAS will be formed.

- ❖ MAS will 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 neighborhood cluster, by drawing one member from each cluster of 10 to 20 houses.
- ❖ In case of MAS formed in a slum with different social groups, representation should be ensured from all groups and pockets of the slum.

Step 2: Explain the relationship of MAS with ASHA and Anganwadi centre.

- ❖ Every ASHA would be linked to between two to five MAS and will be undertaking the process of MAS formation under the guidance of ASHA facilitator.
- ❖ ASHA will be the Convener and Member secretary of MAS.
- ❖ The coverage of MAS will be aligned with the coverage area of anganwadi centre and has to cover all pockets of slums.

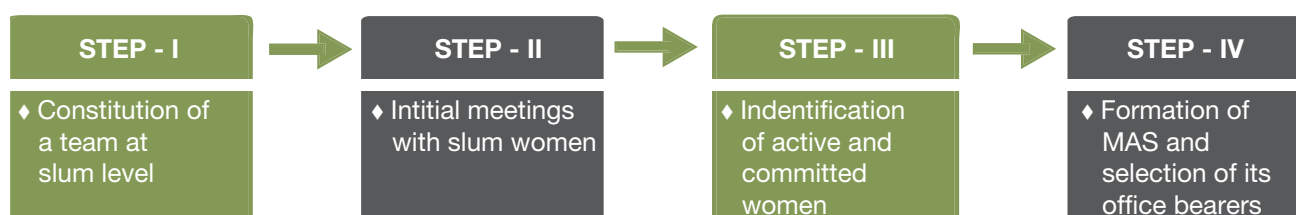
Step 3: Discuss key principles governing the MAS formation.

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.

Step 4: Explain the process of formation of MAS as given below by linking it to their responses.

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:



Ask the participants to read the pages 22-23 of the MAS induction module and explain the process.

2.2 Composition of the MAS

2.2a Who all should be included in MAS?

1. **Elected Ward Members:** Those members who are residents of the area are to be preferred. Though more than one elected member of the ward can be included in the MAS, their numbers should be limited to one third of the total number of members, and preference should be given to women members.
2. **ASHAs:** All ASHAs of the area should be on the committee. In small slums, there would be only one ASHA per MAS.
3. **Frontline staff of government health related services:** The ANM of the health department, the Anganwadi Worker of the ICDS, and the school teacher should be included as regular members only if they are resident in that particular area. Otherwise they qualify to be special invitees. Volunteers/ field level workers of other government departments- eg: the hand pump mechanic of Public Health and Engineering Department (PHED) or the field coordinators of the MNREGA programme, should also be considered if they are resident in the area.

4. **Community Based Organizations:** Representatives of existing community based organizations like Self Help Groups, Resident Welfare Committees, Youth Committees, etc.
5. **Pre-Existing Committees:** If there are separate committees on School Education, Water and Sanitation or Nutrition, the first effort should be to integrate these committees with MAS. If that is not possible or till the time it has not been done, key functionaries of each of these bodies should be included as a member in the MAS and chairperson of the MAS should also become a member of these committees.
6. **Service-Users:** Pregnant women, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using public services should also find place.

2.2b How should they be selected?

All selections are undertaken by the community using these above categories and principles as guidelines. The ANM, AWW and ASHA along with the NGO members (if any) are expected to ensure that every section is represented. In particular SC, ST & Minorities should be represented as per their population in the slum/area.

2.2c Who can we call as special invitees?

Other than members a more general category of special invitees can be included. They are welcome to attend and indeed their presence and interaction with the committee is essential. They are generally not residents of the slum/area. This includes Medical Officer of the local U-PHC, Facilitator of the ASHA programme, supervisors in health and ICDS departments, *Nagar Palika or Nagar Nigam* secretary (a representative from urban local bodies), block development officer and elected ward member.

Ideally the medical officer and block development officer should have participated in every MAS meeting at least once or twice a year. ASHA Facilitators who are also facilitators for other community processes including the MAS itself should attend the MAS meetings more regularly.

2.2d Who will be the Chairperson?

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

- ❖ Be responsible for ensuring that MAS meetings are held regularly on a monthly basis.
- ❖ Lead the monthly MAS meetings and ensure smooth coordination among members for effective decision making.
- ❖ Develop the community health plan for the slum/ coverage area in consultation with all MAS members.
- ❖ Ensure that the all the records and registers of MAS are adequately maintained.
- ❖ Represent the MAS and voice concerns of the area during interface with service providers and representatives of various government departments.
- ❖ Support the member secretary in her functions.

2.2e Who will be the Member-Secretary and Convener?

The ASHA will be the Member-Secretary and Convener of MAS.

2.2f Why should ASHA become the Member-Secretary and Convener of MAS?

- ❖ 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 disbursement 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).

2.3 Joint Bank Account

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 of the Induction Module.

2.3a Why should MAS have two joint signatories?

The joint signatories of the MAS account would be the Chairperson of the MAS and the Member Secretary (ASHA). Having two joint signatories reduces the possibility of any wrong doings. It is easy for a single person to indulge in corruption but having two people sign for withdrawal along with written approved proposal by the MAS members ensures that this does not happen. It also ensures more transparency.

Exercise 1:

- ❖ Divide the participants into four to five groups of their respective MAS.
- ❖ Display on a chart paper the table on formation of MAS given below.
- ❖ Revise the steps of formation of MAS and tell the groups to tick the steps which have been completed in their area.
- ❖ Give five minutes to each group to discuss the steps of formation of MAS which were followed in their area. Ask one member of each group to talk about the process of formation of MAS in their slum/area. Other participants are then asked which of the processes fall into the category of good practices and which did not.

Table on Formation of MAS

Steps	Activity	Tick Yes/No
Step 1	Selection of Chairperson and Convener and member secretary ASHA	
Step 2	ASHA, ASHA Facilitator, ANM, Chairperson with the help of Block Community Mobilizer undertake community mobilization.	
Step 3	ASHA, ASHA Facilitator, ANM and Chairperson through a consultative process with the community prepare a list of possible members of MAS, taking care to include leaders of SHGs, Anganwadi, Mother's Committee, Youth group, Water and Sanitation Committee, Ward Committee and people from the marginalized sections, all hamlets etc.	
Step 4	Submit list of MAS members to U-PHC level committee/NGO committee and ASHA Facilitator (or Block Mobilizer)	
Step 5	Resolution for formation of MAS passed by U-PHC committee or NGO committee.	
Step 6	Bank account of MAS opened with Chairperson and Member-Secretary as joint signatories	

Questions for practice:

- Q. 1. What are the key principles that govern the MAS formation?
- Q. 2. What is the importance of community-led formation of MAS?
- Q. 3. Why is it important for the users of services to become members of the MAS?
- Q. 4. Why is it important to have joint signatories instead of a single person?
- Q. 5. Can the joint signatories take out money without approval of the other members of the MAS?

Major Activities of MAS

The activities of MAS can be classified into eight categories. Some activities relate to the essential processes involved in the functioning of MAS and include - Monthly Meetings, Management of Untied Fund, Accounting for the Untied Fund and Record Maintenance. The other set of activities include- Monitoring and Facilitating Access to Essential Public Services, Organizing Local Collective Action for Health Promotion, Facilitating Health Service delivery, Community Health Planning and Community Monitoring of Health Care Facilities.

It must be noted that not all MAS can undertake all activities until such time as they are well trained, well supported and have active and committed members. Thus, MAS will need to take on these activities as they mature.

All these activities will be covered in detail in this chapter.

3.1 MAS Monthly Meetings

Objectives of the Session

By the end of the session the MAS members will learn about:

- ✓ Organizing meetings of MAS- importance of MAS meetings, regularity, venue, and person responsible for organizing meeting
- ✓ Structure of the meeting

Method: Ask the participants about the monthly meetings of their committee, where they are currently being held, which day they are held, how regular they are and what are the common issues discussed.

Activity: Role play: Ask about eight to ten participants to volunteer. Enable them to choose the role of Member secretary, chairperson, ANM and Anganwadi worker etc. amongst themselves. Brief them about each of their roles, explain them the structure and process of MAS meetings as given on page 28-30 of the Induction Module. Ask them to enact the situation of a monthly MAS meeting, while other participants are told to observe carefully.

At the end of the role play ask the other participants to share their observations. Write their responses on a board. Based on the key messages emerged, end the session with a discussion on monthly MAS meeting using the details explained ahead in this section.

Duration: 1 hour

3.1a Why is it important to hold Monthly MAS meetings?

Regular meetings are a hallmark of functioning MAS. It is in the meeting that the MAS reviews situation, monitors, identifies a problem and plan for action on health and its various determinants.

The meeting also serves as an important platform for service providers to learn about the gaps from community feedback and for the community to learn about the gaps from provider feedback. For example if toilet construction is not being undertaken, the frontline worker of the government may have her/his understanding of why people do not opt for it; but people may have another set of reasons. In this case the MAS becomes a platform for dialogue and action.

3.1b 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 to participate.

3.1c Who is responsible for organizing the meeting?

The ASHA (Member Secretary) and the Chairperson will be responsible for organizing the meeting. They would, in most circumstances need to remind the members of the meeting, and mobilize them to attend.

3.1d Who should help in facilitating the meeting?

The ASHA and the ASHA facilitator should help to facilitate the meeting.

3.1e Where should the meetings be held?

The meeting can be held in one fixed venue. It may be in a public facility like AWC, Community centre or School which is easy to reach and accessible to all members. The venue may be changed as per need. For example, in order to understand and formulate an action plan for the problems faced by families in the farthest hamlet, in bringing their children for immunization, it may be necessary to hold the meeting in that particular hamlet. Or in order to deal with a case of domestic violence it may be necessary for the MAS to hold their meeting in/near the house of the victim. However, any change in venue needs to be discussed in the previous meeting and all members and Community informed in time.

3.1f Who should attend the meetings?

All MAS members need to attend the meeting along with the special invitees like the Medical Officer, Block or District ward member etc. Other people from the community should also be encouraged to participate in the meeting. It should be doubly ensured that members of marginalized and vulnerable sections of the village participate in the meeting.

3.1g The MAS meeting may be structured in the following manner

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.

Questions for practice:

- Q.1. Why is the monthly meeting of MAS important?
- Q.2. How should the MAS meeting be structured?

3.2 Monitoring and Facilitating Access to Essential Public Services

Objectives of the session

By the end of the session the MAS members will learn about:

- ✓ How to monitor essential public services
- ✓ What are the tools and methods to be used in monitoring
- ✓ What are the things to monitor and why
- ✓ Who is to monitor

Method: Discussion using examples

Duration: One and half hours

As a first step MAS should assess the status of availability of key services in their area. Then, identify the problems and gaps and take action. Regular monitoring of health and other related public services is an important task of the MAS.

3.2a How do we monitor?

MAS will monitor health and other key services by using *Public Services monitoring tool and register* (attached as Annexure V and Va, Induction Module for MAS).

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.

3.2b 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.

3.2c 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.

Indicators to be monitored for assessing Anganwadi services and nutrition status

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?			

3.2d 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.

Indicators to be monitored with regards to education and mid-day meal

Sl. No.	Indicators	Jan	Feb	Mar
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)?			

3.2e 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.

Indicators to be monitored for assessing status of water and sanitation

Sl. No.	Indicators	Jan	Feb	Mar
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?			

3.2f 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.

Indicators to be monitored for assessing status of women

Sl. No.	Indicators	Jan	Feb	Mar
Status of women				
20	Number of cases of violence against women during the last month?			

3.2g 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.

Indicators to be monitored for assessing status of health services and diseases

Sl. No.	Indicators	Jan	Feb	Mar
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?			

Sl. No.	Indicators	Jan	Feb	Mar
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?			

3.2h 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.

3.2i Facilitating Access to Services

Ask the participants to open and read page 30 of the Induction Module for MAS members.

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 organizing 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 tip-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

3.3 Community Health Planning

Objectives of the Session

By the end of the Session the MAS members will learn about:

- ✓ What is community health planning
- ✓ What are the steps of community health planning
- ✓ How to use the public service monitoring tools and other records for this

Method:

- ❖ Start the session by asking participants about their perception of community health plan.
- ❖ Elaborate the concept of community health plan by using the details included in this section and try to link to their responses.
- ❖ Explain each step given ahead to make the participants understand the process of community health planning. At this point also describe the use of public service monitoring tool and register in community health planning.
- ❖ Display on chart paper the possible levels of action and hold discussion as per section 5.6 c on Page 36 of the Module.
- ❖ End the session with the *case study* given on page 35-36 to build clarity on community health monitoring and planning.
- ❖ Use the examples in the end of section 3.3 at page 36 to make them understand how the public service monitoring register will need to be filled.

Give Group Work: Divide the participants into four to five groups of respective MASs. Give each group one or two problems to make community health plan. Distribute the format of Public Services Monitoring register to document their plan. Problems given under questions for practice at page 36 of trainer notes can be used for this purpose.

- ❖ Ask each group to present their work in five to seven minutes. Other participants can provide suggestions.
- ❖ End the session by summarizing the key steps of community health planning.

Duration: 2 hours

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.

Let us now look at the main steps involved in making 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 dengue 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.

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.

Example 1: 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.

Example continued: 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.

Example 2: 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 given in the module.

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.

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 MAS 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 Anganwadi; MAS members will need to approach the WCD department.

Note: *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.*

Please remember: No one purposely wants to remain ill or ridden with problems. Everyone wants to resolve their problems, but often circumstances make it difficult for people to come out of their situation. It is important that we don't start blaming people for their problems and instead identify the reasons and circumstances for the problems. It is only when we act together to change the circumstances that the problem will get resolved.

Let us understand through an example: A MAS identified one 3 year old child in their area who was severely malnourished. She would frequently fall ill and was getting weaker day by day. Few of the members accused the family for not taking good care of their child. The ASHA and other members visited the family to understand the circumstances. They found that the family was very poor and both parents went for work daily to a nearby brick kiln. The child's 10 year old sister took care of her and her 5 year old brother. The family had taken the child to the U-CHC once when she fell very ill. The doctor told them that the child is weak and wrote medicines and expensive tonics. The family only had money to buy the medicines but not the tonics. The ASHA had visited their house earlier and had suggested that they take her to the NRC. However, the NRC was at the district hospital, far from their area and the mother couldn't go there on her own. Staying there for 15 days meant that they could not work for those days and they couldn't afford that. The child was getting extra take home rations from the AWC. However, the ration was saved for days when the parents were not able to go to work and then it was eaten by the whole family. After finding out these details, the members were able to understand the reasons for the situation. They listed them:

1. Abject poverty
2. Lack of adequate work and non-payment of minimum wages for the parents
3. Lack of childcare facilities for working parents
4. NRC difficult to reach without more support
5. Insensitivity of the doctor to the economic condition of the family

This case study will help you to understand the process of community health monitoring and planning:

Case study: MAS improves the Anganwadi centre

Khajuria is a small slum cluster in the Krishna Nagar area of Bhopal. The MAS meeting for the month of June was held on 29.06.2014. There were about 40 people present in the meeting including the ward elected representative (mayor), Anganwadi worker, Sahayika, ASHA, ASHA Facilitator and SHG members and community members. The meeting was facilitated by the ASHA Facilitator.

During the discussion it was found that, the only Anganwadi centre of the area was closed for last two months and during this period THR (Take Home Ration) was not given to any beneficiary. Since the Anganwadi worker was present there, the mayor asked her the reason of keeping the Anganwadi centre closed for two months and not distributing the THR during this period. As per the Anganwadi worker, she was on leave for 2 months, but she had asked the Sahayika to open Anganwadi centre in the meantime and provide related services in her absence. The Sahayika, disagreed with the Anganwadi worker. After a lot of argument, both of them agreed that they had been irresponsible and agreed to provide the THR for two months, to the beneficiaries immediately. It was also found that the Anganwadi worker was not taking the weights either of pregnant women or children. The ASHA explained to the members that it is only by taking weight that the nutritional grade could be identified and additional food and counseling could be given to the malnourished. She also told them that this is one of the main reasons for opening Anganwadi centers across the country. The ULB representatives and other Members were convinced and asked the Anganwadi worker to weigh the pregnant women and children regularly and provide more quantity of THR to those who are malnourished. It was also decided that the AWW and the

ASHA will visit the houses of malnourished children for nutritional counselling. One month was the timeline decided to complete this.

As per the commitment, the Anganwadi worker distributed the THR of pending months to all the beneficiaries in two days. Afterwards, as directed by the MAS, both Anganwadi worker and Sahayika attended the MAS meeting monthly and in each meeting present an update on the services of Anganwadi centre and nutritional status of children.

Let us now take up some more examples of village health planning and see how to record them in the Public Service Monitoring register

Colony: Khureji

Date of MAS Meeting- 3rd November 2014

Gap in service	Name of the area where the gap exist	Possible cause identified by MAS	Possible solution sought by MAS	Person responsible to get the work done	Date By which work will be done	Review (in next meeting)
A TB patient about to default on DOTS	Roop Nagar	The DOTS provider is the U-PHC Medical officer. The U-PHC is 10 kms from the area and the patient has to lose one day's wages each time he goes for DOTS.	ASHA of roop nagar to be made the DOTS provider for the patient	ANM	4th Nov	
Case of violence on woman	Chand Moholla	The husband regularly beats his wife. They have two small children so she is scared even to tell people that he beats her.	To counsel her that she shouldn't be afraid and speak up against violence. To provide support to her in complaining to the police	ASHA	10th Nov	

Questions for practice:

- Q.1. What are the steps to be followed for community health planning?
- Q.2. Identify three current health related problems in your area and plan for resolving them. How can the MAS prioritize issues?

3.4 Organizing Local Collective action for Health Promotion

Method: Ask participants about their perception of the local level community action. List the answers on the board and explain using the text given below.

Health is a product of processes that take place at the level of the family and community. Much can be done at the community level for health promotion. Some activities in which MAS can involve the community for health promotion are:

- a. Organizing an event where volunteers gather and clean the slum/area- especially decaying solid waste (a major breeding site for the kala-azar vector, the sand fly and for the common house-fly) and pools of stagnant water – where mosquitoes breed. The MAS could motivate voluntarism by mobilization and serve as an inspiring organization, or they could pay local youth for the task, or contract labour for this purpose. One advantage with the voluntary approach is that there is community sensitization against poor environmental hygiene practices.
- b. Organizing teams for source reduction work- identify areas of mosquito larva breeding and taking appropriate anti-larval measures- i) pouring oil (usually waste machine oil) on stagnant pools, closing up hollows and depressions where water accumulates, ii) de-grassing the edges of ponds and tanks with a vertical cut iii) ensuring that septic tanks are closed with no cracks and are fitted with a netting on the gas vent and iv) ensuring overhead tanks are well closed and not breeding mosquitoes. Insecticide spraying and introduction of larvivorous fish could also be done on the same day or soon after but such synergize efforts, need inputs from the health department.

3.4 Community Monitoring of Healthcare Facilities

Method: Participatory discussion using the checklist given in Annexure 7 and elaborate, using the details given below.

Duration: 30 minutes

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 Samvads which act as a forum for dialogue between the community and the authorities and also help in grievance redressal. In the Jan Samwad, 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.

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

Questions for practice:

- Q.1. What are the various methods for monitoring health in our colony?
 Q.2. Why is it important for the members to share responsibilities for monitoring?

3.5 Maintaining Records

Method

- ❖ Ask the participants to open page 38 of the Induction module for MAS members.
- ❖ Discuss each type of the records that are to be maintained by the MAS using the details given below.
- ❖ As a next step ask the participants to open annexures given the end of the module and explain in detail the formats given in Annexures 8-13.

Activity

- ❖ Divide the participants in to five or more groups of their respective MAS. To each group give exercise to fill Annexure 8, 9, 10.
- ❖ Ask one participant from each group to present and other participants give suggestions.

Materials: Xeroxed copies of Annexure 8-13.

Duration: 30 minutes

Maintaining records enables MAS to be more organized and function systematically. The records that are to be maintained are as follows:

- a. **Record of meetings with attendance signatures:** This includes MAS monthly meeting attendance records and the record of minutes of the monthly meetings. (Annexure VIII & VIIIa). Key financial decisions adopted for withdrawal and expenditure should be recorded here with signatures of all the members who have attended the meeting. If there are any changes made by MAS in its membership or any other critical decisions taken, they should also be written in this register.
- b. **Cash Book:** To record details of all expenditures: Since it is relatively more difficult for ASHA to learn how to maintain a proper Cash book, a simpler format for recording expenditures is given at (Annexure-XI).
- c. **Bank Pass Book**
- d. **MAS Statement of Expenditure:** Along with the cash book, this record would help the MAS to present an account of its activities and expenditures when asked for. It could be useful in the bi-annual meetings and will also be used by U-PHC to forward annual Statement of Expenditure to the appropriate block level functionaries of NHM. (Annexure XII).

Along with the above records, the MAS should maintain the following:

- a. **Public Services Monitoring Tool and Register (Annexure: 5 and 5a):** Already discussed in section 3.2 above.
- b. **Death Register (Annexure 9):** One specific type of service for MASs to focus on is the registration of births and deaths. 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. All deaths too should be followed by the issuance of a death certificate, including for still births. The MAS should focus on cause of death and good quality reporting of such causes, as this is likely to form the basis for community health planning. Information on any maternal death, child health and any outbreak should be immediately provided to the ANM/U-PHC Medical officer.
- c. **Birth Register (Annexure 10):** 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. The birth register records the name of mother, Sex of child, Date of Birth, Place of Birth and Birth Weight. It will help in monitoring institutional delivery and birth weight. It can also be potentially useful in improving home visits by ASHA for Home Based Newborn Care and for monitoring of neonatal deaths.

Questions for practice:

Q.1. Write resolutions for withdrawal of money and expenditure on the following items:

- ❖ Rs. 1000 given to an aged person for treatment of pneumonia
- ❖ Rs. 200 for wall writing
- ❖ Rs. 1500 for buying a weighing machine
- ❖ Rs. 25 to buy a register

Untied Fund and Principles of Utilization

Objectives of the Session

By the end of this session the MAS members will learn about:

- ✓ What is the untied fund and why its given
- ✓ What are the principles for utilization of untied fund

Method

- ❖ Ask the participants whether they have some idea about the annual Untied Fund given to each MAS.
- ❖ Ask what in their opinion should the untied fund be used for? Explain the activities and principles of utilization by using the details given ahead.
- ❖ Discuss the three examples given at the end of section. Ask them to identify the problem in those examples and reinforce the principles of untied fund utilization.

Duration: 1 hour

4.1 Purpose of giving untied fund to MAS

NUHM provides Rs. 5,000 as annual untied fund to MAS for undertaking different activities in their slum or coverage area. 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.

4.2 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 given in the module:

- ❖ 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.

Let us look at a few examples where, ignoring the principles of Untied fund, MASs have been ordered to spend their money in a particular way:

Example 1: In Sultanpuri, the BMO ordered all the MASs to deposit Rs. 3000 per MAS for audit expenses.

Example 2: In one state, the State Malaria officer took out an order for all MASs to pay the labour charges for DDT spraying in their colonies.

Example 3: In another state, the letter transferring the untied fund to the MAS lists down the following eleven items for all the MASs to mandatorily spend their funds on:

Sl. No.	Item/Activity
1.	BP Machine for the ANM
2.	ANC table
3.	Weighing machine Child
4.	Weighing machine Adult
5.	Wall writing on Yaws
6.	Wall writing on Polio
7.	Sari for ASHA
8.	Refreshments
9.	Four Plastic Chairs
10.	One table
11.	Stationery

What is problematic in these examples?

The problematic thing in these examples is that through such orders, the UNTIED FUND is being made into a TIED FUND. This goes completely against the spirit of an Untied Fund.

Please remember: The untied fund, as the name suggests, does not and should not come with any guidelines for expenditure. This fund is given to the MAS to use, as they deem proper. Providing the untied fund is a significant step towards decentralized planning and execution of programmes. The MAS has a responsibility towards the community and to utilise the fund with utmost transparency and accountability.

4.3 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.

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.

4.4 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.

Structure of Local Self Government

Objectives of the Session

By the end of the session participants will:

- ✓ Understand the structure and function of local self government in urban areas
- ✓ Importance of effective mechanisms for convergence of urban primary health care services with other government run schemes responsible for health determinants

Method: Participatory Discussion

Material: Blackboard, markers

Duration: 30 minute

Activity

1. Ask the participants to say what they know about the structure and function of urban local bodies in their area.
2. Explain the concept of local self government, structure and its functions by using the details given below.
3. Discuss the three typologies of urban local bodies given at the end of section.

5.1 What is Local Self Government? What are its Functions?

- ❖ Urban local government institutions/municipalities are constituted for the maintenance and planned development of urban areas.
- ❖ Their objective is to ensure that suitable levels of infrastructure and services are available to the citizens. The creation, maintenance and provision of services in urban areas come under the purview of the urban local bodies.
- ❖ The 73rd and 74th Constitution Amendment Acts in Schedule 12 of the Constitution of India provide the powers and functions of such bodies.
- ❖ These Local Bodies play a critical role in the delivery of social, economic and infrastructure services like public health, sanitation, primary education, water supply, and maintenance of road networks.

- ❖ The common set of non-medical public health functions of these bodies are:
 - ◆ Epidemic control
 - ◆ Disease Surveillance
 - ◆ Treatment and disposal of sewage
 - ◆ Solid Waste Management
 - ◆ Drinking water supply
 - ◆ Birth and Death Registration
 - ◆ Food Safety
 - ◆ Implementation of social welfare schemes

5.2 Key Provisions for Local Self Government in Constitution of India

- ❖ Constitution of Municipalities (namely, Municipal Corporation, Municipal Council, and Nagar Panchayat) in every Indian State.
- ❖ Constitution of Wards Committees within the territorial area of a municipality, to ensure people's participation in civic affairs at the grass-roots level.
- ❖ Regular and fair conduct of municipal Elections by statutorily constituted State Election Commissions.
- ❖ Adequate representation of weaker sections (i.e., Scheduled Caste, Scheduled Tribe, Backward Class) of the society and women in municipal governments through reservation of seats.
- ❖ Specification by law, through the State Legislatures, of the powers (including financial) and functional responsibilities to be entrusted to municipalities and wards committees.

5.3 Structure of Urban Local Bodies

Different types of municipalities exist in the different States of India. This is due to the varied character of urban areas.

a. **Metros and Million plus cities- Mahanagar Palika/Municipal Corporation**

- ❖ It is the top most of urban local government in metropolitan cities, with a population of over 10 lakhs.
- ❖ Mayor and Deputy Mayor are elected head of the corporation, elected directly by voters or by elected Councillors.
- ❖ Municipal Commissioner is appointed by state government as its executive officers.
- ❖ Councillors are the members of the Municipal Corporation, elected directly by voters from each ward.

b. Smaller Cities and Towns - Nagar Palika/Municipality/Municipal Council

- ❖ This is urban local body for the medium sized cities.
- ❖ Members of the Nagar Palika are elected representatives from each ward, for a period of five years.
- ❖ A Chief Executive Officer along with other officers like an Engineer, Sanitary Inspector, Health Officer and Education Officer performs the executive and administrative functions of the Municipality.

c. Very Small Cities - Nagar Panchayat

- ❖ These are for an urban area/centre having generally population of more than 30,000 which is in transition from a rural to an urban area.
- ❖ Nagar panchayats have a Chairperson with ward members.
- ❖ Membership consists of a minimum of ten elected ward members and three nominated members.
- ❖ Chief Executive Officer is the chief of all administration.

Questions for practice:

- Q.1 List the key important functions of a Nagar Palika, Nagar Nigam or Mahanagar Palika. How it is related to health?
- Q.2 What is the structure of urban local body in a metro city?
- Q.3 List few social schemes run by the urban local bodies for welfare of poor or vulnerable?

Annexures

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 Managerbank 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 thatMahila 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

Smt./Ms

Chairperson

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 ofMAS 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-kutchra 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 5 th 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?			

Sl. No.	Indicators	Jan	Feb	Mar
Drainage				
19	Is there a functional drainage system in place in the slum?			
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?		
6	Did AWW give take home rations to pregnant women?		
7	Did AWW give take home rations to lactating mothers?		

Sl. No.	Parameters	Assessment (Yes/No/Partial/NA-Not Applicable)	Remarks
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? | Yes/No |

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)

Sl. 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					
a) Total amount in hand/ cash					
b) 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 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		June 2014	July 2014	August 2014
A.	Program Capacity of MAS (If activities are undertaken, please mark it 'Yes' for the month)			
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 years 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