Voices of Change: Empowering Urban Communities Through Mahila Arogya Samiti (MAS)

Best Practices From Bengaluru and Mysuru

Context and Background

Mahila Arogya Samitis (MAS) play a vital role in enhancing awareness and access to health care for women in India. They have been established in all urban slum areas to act as community hubs that encourage collective efforts related to health, hygiene, nutrition, and more.

According to the National Health Mission (NHM) guidelines, there should be one representative for every **10-20** households. Typically, a MAS comprises **10-20** local women, including Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs), Self-Help Group (SHG) members, health beneficiaries, and other influential women from the community. The group usually has a leader or chairperson responsible for coordinating activities and meetings. It has been observed that in urban slums, groups have formed, but due to a lack of awareness, restricted access to healthcare services, limited reach and the absence of community-level platforms; this has led to poor health outcomes, particularly affecting women and children.

To address this, KHPT has been aiding in the reactivation and strengthening of these MAS groups to empower them to tackle and resolve health-related issues and determinants, as well as to contribute to public health through active involvement. Here is a detailed scrutiny of the formation, composition, structure, process and functions established under each Urban Primary Health Centre (UPHC) following the Government's guidelines.

Objective of the Intervention

The intervention's objective was to reactivate and strengthen MAS as platforms at the community level to advocate for health, hygiene, and nutrition among vulnerable urban populations in Bengaluru and Mysuru by improving their functionality, participation, and effectiveness through structured orientation, regular meetings, participatory capacity building, and collaboration with public health institutions.

Description of the Practice

3.1. Intervention Design and Process

3.1a. Assessment

KHPT conducted a qualitative study using a human-centric design approach to explore and comprehend the challenges and solutions associated with MAS. The study employed participatory methods, including Focus Group Discussions with ASHAs and a multi-stakeholder consultation workshop.

The study aimed to envision the ideal functioning of MAS

- Assess the knowledge that urban stakeholders such as ASHA and PCHO have regarding MAS
- Identify areas where MAS can enhance health promotion and delivery
- Facilitate convergent action by connecting MAS with JAS and ULBs

Throughout the study and during the consultation workshop with stakeholders, including ASHAs, the challenges hindering effective MAS functioning were identified, and strategies to address these challenges were discussed.

The workshop led to the emergence of several recommendations through the consultative process.

Recommendations to improve the involvement of members	Recommendations for fostering support and sustainability of MAS
❖ Effective MAS could be supported by SHG members, mothers with children under five, individuals who own their own homes, political leaders, women residing in slum settlements, parents attending anganwadis, anganwadi staff, and female counterparts of eligible couples on the list.	❖ Improving MAS's relationship with ASHAs for its long-term sustainability ❖ Including NGOs in the MAS's operation
Recommendations to increase the scope and effectiveness	**Recommendations for recognition of MAS in the community**
❖ To change the broad working framework to a tailored, specialized focus according to the abilities and talents of the MAS members that make it up. A targeted focus minimizes the workload for members and ASHAs while also introducing quantifiability into the actions. ❖ ASHA should use its practical expertise and evidence to support its decision regarding the number of MAS. According to the workshop, one ASHA can operate up to three MAS. ❖ Collectivization is the first stage in gradually expanding the scope of MAS. ◆ Once collectivization is complete, MAS members can expand their involvement. ◆ This includes working with the local health facility, taking part in dispute resolution, keeping an eye on and advocating for improvements in the social determinants of health (SDH), and actively assisting with needs planning. ◆ In addition, members are encouraged to adopt the concept of an "ideal neighborhood" and to develop a sense of proprietorship over their health, family, neighborhood, and community.	❖ During the session, the majority of ASHAs believed that engaging volunteers, conducting awareness campaigns, working with NGOs, presenting success stories, and involving local influencers may all assist in raising knowledge of MAS in the community and changing health-related behaviors. 

3.1b. Interventions for reactivation and strengthening

KHPT initiated the following initiatives to strengthen MAS in considering the findings of the qualitative study mentioned above.

1. Reactivation of MAS
2. Conducting regular MAS meetings
3. Capacity building of MAS members
4. Support for MAS to conduct community health events

Re-activation of MAS

a. Through KHPT, community health workers collaborated with ASHAs to find right members for these committees' restructuring and provided assistance in finding suitable members, such as the head of an NGO or representatives of beneficiaries, local leaders, and other community members.

b. Additionally, they initiated personal visits to the homes of these shortlisted individuals, briefed them on the committee, and asked whether they would be interested in joining MAS.

Conducting regular MAS meetings

a. An orientation on the basic concepts of Mahila Arogya Samiti based on the guidelines, including its structure, composition, regulations, and responsibilities, was given during the initial meeting. This was followed by a presentation and interactive debates. The first stage in continuing MAS activities was orienting all of the members of the Mahila Arogya Samiti and reinforcing the significance of each person's involvement and value addition.

b. Monthly meetings focused on planning health promotion activities, analyzing progress, discussing health issues, and addressing any community challenges.

c. All members agreed on the date of the next meeting during this meeting.

Capacity building of MAS members

Additionally, MAS members' capability was built through the monthly meeting platform. Leadership, problem-solving, organizing community activities, and other pertinent topics for MAS were all covered in these capacity-building sessions. These were interactive sessions delivered in capsule mode by Community Facilitators. Community Health Workers (CHWs) facilitated these sessions during monthly meetings; these monthly meetings constituted the schedule below.

a. Recap of the last monthly meeting-10 Mins
b. Capsular sessions-20 Mins
c. Discussion of issues and next steps for resolution-15 mins
d. Finalising the date for next monthly meeting and wind up-10 mins
e. Closing the meeting with refreshment

Support for MAS to conduct community health events (Modifications that worked)

KHPT successfully piloted reconstitution and strengthening of MAS in Bengaluru and Mysuru, which worked well listed as follows

a. Offering support for ASHAs to select appropriate members
b. Scheduling the meetings of MAS as per the preferred date and time of MAS members
c. Effective orientation of all members in the first meeting, which provided a proper perspective to MAS members to function as representatives of the community and their problems, rather than focusing on MAS as a hierarchical structure to enjoy privileges.
d. Keeping the meetings short (not more than an hour), engaging and interesting.
e. Capsular mode of training during the meetings to make meetings more interesting and participatory, simultaneously creating awareness on the discussed topic.
f. Support for MAS members to find steps for the resolution of identified issues.
g. Involving MAS members in the community-level activities that are conducted in the field and acknowledging their efforts.
h. Guiding the MAS members in conducting community-level events
i. Active participation from the MOs of the PHCs in recognising MAS and providing due support to ASHAs

During the process, the point on financial assistance for MAS was deliberately not discussed in any meetings to avoid shifting of focus from community welfare to other issues on money, profit etc.,

Results and Outcomes

Table 1 presents MAS engagement across four UPHCs areas for the period April 2024 to March 2025

UPHCs	No of MAS	Total members	No of meetings conducted	No. of members attended the meeting and capsular training	Avg. Attendance per Meeting
Roopena Agrahara	7	84	71	896	12.62
Singasandra	15	172	143	1657	11.59
Kumbarakoppalu	3	41	34	437	12.85
Vishweshvaranagara	5	81	56	771	13.77

Table 2 presents the UPHC-wise overview of Issues identified and resolved by service type

UPHCs	Public amenities		Public health and Municipal services		Social protection		WASH		Grand Total	
	Identified	Resolved	Identified	Resolved	Identified	Resolved	Identified	Resolved	Identified	Resolved
Roopena Agrahara	0	0	22	20	1	1	10	10	33	31
Singasandra	31	16	39	26	23	22	65	40	158	104
Kumbarakoppalu	0	0	2	1	1	1	2	1	5	3
Vishweshvaranagara	0	0	3	1	0	0	2	2	5	3

Table 3 and 4 presents the proportion of issues identified and percentage of issues resolved by UPHCs.

UPHC	Proportion of issues identified to the total issues			
	Public amenities	Public health and Municipal services	Social protection	WASH
Roopena Agrahara	0	66.7	3	30.3
Singasandra	19.6	24.7	14.6	41.1
Kumbarakoppalu	0	40	20	40
Vishweshvaranagara	0	60	0	40
Total	**15.4**	**32.8**	**12.4**	**39.3**

UPHC	% Issues resolved to the identified				
	Public amenities	Public health and Municipal services	Social protection	WASH	Total
Roopena Agrahara	0	90.9	100	100	93.9
Singasandra	51.6	66.7	95.7	61.5	65.8
Kumbarakoppalu	0	50	100	50	60
Vishweshvaranagara	0	33.3	0	100	60
Total	**51.6**	**72.7**	**96**	**67.1**	**70.1**

Factors Contributing to Success

KHPT explored a few concepts while strengthening MAS to evaluate how feasible they were. The following ideas were effective and produced outcomes:

Consultation Workshop with ASHAs

A consultative workshop was held with ASHAs and other health department stakeholders to discuss and determine a workable model and number of MAS for future interventions. ASHAs were given the opportunity to discuss the issues they were facing and possible solutions by holding meetings in accordance with the guidelines. It also gave them a chance to investigate the assistance required in order to choose suitable representation and reconstruct the MAS.

Establishment of a feasible MAS model on the ground

One ASHA could conduct three MAS meetings per month, according to the model decided upon by the ASHAs that attended the training. The date was flexible, depending on the community's and MAS members' availability, and was not limited to the first Monday.

Orientation of MAS members after reconstitution

A proper orientation on the MAS structure, function, and role of MAS members, as well as the reciprocal benefits for the community and public health system, were highlighted during the first meeting of the reconstituted MAS. This inspired the members to fulfil their responsibilities for a successful MAS.

Short capacity-building capsules delivered during monthly meetings

During the monthly meetings, capacity-building sessions on leadership, team building, self-esteem, etc, were conducted by community facilitators, along with the discussions on regular issues and resolutions for those issues. Key messages were conveyed using interactive modes, stories, and games in these participatory and dynamic capsule sessions. All Mahila Arogya Samiti members, regardless of literacy level, would be able to participate in these capsule sessions and absorb important lessons through these exercises. Since these meetings were made engaging and participatory with topics that relate to their everyday lives, they are inspired to attend future ones.

Facilitating conversations between facility and community

Having focused and meaningful conversations with PHCs/ Ayushman Aroyga Mandirs (AAM) helped the facilities to understand the issues at the community level and suggest suitable solutions or offer recommendations for resolution in case of escalations, for a speedy redressal.

Community-level events led by MAS', awareness rallies, quick surveys and outreach health and screening camps ease the burden on facilities and add to their efforts to create awareness among vulnerable communities on various health aspects. They also help in reaching the service delivery to the last mile and ensuring accessibility of services for the vulnerable population.

Presently, the CFs play the role of link between the community and facility (MAS members from the community and Medical Officer (MO) and other staff of PHCs/ AAMs). They also provide inputs on referral and linkages as to where they should approach for getting a specific problem addressed.

Challenges Faced and Mitigation Strategies Adopted

Challenges Faced	Mitigation Strategies
Limited Participation and Representation in MAS	Potential MAS members were personally visited and sensitized by CHWs and ASHAs, ensuring appropriate and motivated representation.
Rigid Scheduling of MAS Meetings	MAS meetings were scheduled as per members' convenience rather than adhering to a fixed date like the first Monday.
Lack of Orientation and Role Clarity	All MAS members received a detailed orientation during the first meeting on the structure, function, and responsibilities of MAS.
Low Literacy Levels and Confidence Among Members	Monthly meetings included short, interactive and participatory "capsule" training sessions using games and stories to suit all literacy levels.
Weak Linkages with Health Facilities and Government Stakeholders	Regular conversations between MAS, CHWs, and PHCs (e.g., Namma Clinics) were facilitated to ensure issue resolution and institutional support.
Overemphasis on Financial Support in Previous Models	Financial discussions were deliberately avoided in the initial phase to maintain focus on health outcomes and community ownership.

Lessons learned

What Worked Well	What Could Be Improved
❖ Consultation Workshop with ASHAs: Enabled collective problem-solving and ownership of MAS models. ❖ Flexible MAS Model: Agreement on a manageable number of MAS per ASHA (e.g., 3 MAS/month) helped improve feasibility. ❖ Capsule- Training Approach: Improved participation and learning outcomes irrespective of literacy levels. ❖ Community Events and PHC Collaboration: Led to visible health improvements and built trust among stakeholders. ❖ Supportive Supervision by CFs Strengthened linkages and facilitated practical problem resolution.	❖ Need for Continuous Motivation Mechanisms: Long-term sustainability requires consistent recognition and incentives beyond initial interventions. ❖ Enhanced Visibility of MAS Efforts: Structured media or public recognition could enhance credibility and support. ❖ Conflict Resolution Capacity: ASHAs and MAS leaders need specific training to manage group dynamics and interpersonal issues

Way forward

From now on, our efforts should focus on the following key areas:

- ❖ Building the capacity and capabilities of ASHAs to sustain the MAS and keep it running smoothly
- ❖ Providing ASHAs with training and skills in conflict resolution, management, and bookkeeping
- ❖ Recognizing and acknowledging the valuable contributions of MAS to public health issues

It has been evident that strengthening Mahila Arogya Samitis through participatory approaches, effective reactivation strategies, and innovative practices can significantly improve community health initiatives. By focusing on building the skills and capabilities of MAS members, and fostering strong relationships with the community, these Samitis can continue to play a crucial role in enhancing health outcomes for women and their families.

Success Story

Transforming Health and Sanitation: A Success Story of a Mahila Arogya Samiti (MAS) in Bengaluru

Virat Nagar, located in the southern part of Bengaluru near Bommanahalli, Lake City, and Roopena Agrahara, is home to a vibrant women's collective, the Mahila Arogya Samiti (MAS). There are two MAS groups, comprising of 17 dedicated women from each MAS selected based on a population of 2,500. These groups have taken the initiative to address pressing community health, nutrition, and sanitation challenges. Through training and support from the Urban Primary Health Centre (UPHC) and KHPT, these women have become empowered to take collective action on issues related to drainage, mosquito infestation and garbage management, and have organised health screening camps for persons with hypertension and diabetes.

One of the key problems identified by these two MAS in their area was the lack of proper drainage, which led to stagnant water and created breeding grounds for mosquitoes. Members said this increased the risk of diseases such as dengue and malaria. Additionally, improper garbage segregation, particularly between dry and wet waste, contributed to unsanitary conditions and environmental degradation. The MAS also identified the need for better drinking water storage facilities for the community when visiting the local Namma Clinic. They also noticed that elderly individuals could not come to the Namma Clinic for the non-communicable disease (NCD) testing organised in their area, and Ayushman Bharat Health Account (ABHA) card registration.

The MAS conducted monthly meetings at the Ayushman Arogya Mandir, and members coordinated through WhatsApp and phone calls. They organized door-to-door awareness drives, met with officials from the city corporation- Bruhat Bengaluru Mahanagara Palike (BBMP), and liaised with healthcare professionals to push for solutions to identified issues. In collaboration with the UPHC and KHPT staff, they engaged the community and local authorities to clean up the area, resolve drainage issues and mosquito problems, build a health camp for aged persons and promote proper waste management. These initiatives were undertaken for six months (March-August 2024).

Despite facing initial scepticism from their neighbours, who often teased them for "doing time pass", saying "they do not have work to do until children return from school", and "do not have small children to look after", the MAS members remained determined in their work. As time passed, the community started to acknowledge and appreciate

the hard work and dedication of the group. Many community members began seeking out the group to seek assistance in addressing their own health and sanitation issues. This transformation confirmed the MAS members' hard work and strengthened their resolve to continue advocating for the community's well-being.

One MAS member reflected on her personal growth, saying, *"Before, I didn't know how to approach people and government officials, for helping my neighbour with a mosquito issue. Now, I can easily approach the BBMP." This empowerment represents the core success of the MAS, transforming women into community leaders capable of driving change for better health and living conditions in Virat Nagar.*

One of the beneficiaries stated, "In our Muslim community, women typically do not have the freedom to leave their homes. However, my family has been very supportive. Thanks to MAS, my family and my disabled son have been able to access a range of services such as ABHA card registration, healthcare facilities, and health education, which have been incredibly beneficial to us."

The MAS members have thoughtfully developed a comprehensive plan for future activities, focusing on a variety of initiatives aimed at strengthening community engagement, promoting their professional development, and creating a lasting impact. These include resource mapping and gathering information on key individuals who can assist in resolving community issues.

Voices from the Ground

Many residents in our area were unaware of the Anganwadi centre due to its location in a rented building with limited outreach. During a Mahila Arogya Samiti (MAS) meeting, we decided to raise awareness about its services. We conducted a door-to-door campaign, which helped more families learn about the centre, leading to increased enrolment of children and a rise in the use of services like nutrition, early childhood education, and health check-ups. We also organized a successful Ayushman Bharat Card registration camp at the centre.

-Mamatha

Anganwadi Teacher,
Virat Nagar, Bengaluru.

With KHPT's support, our MAS group took several initiatives like enrolling three children in school, conducting immunization awareness drives, and leading door-to-door campaigns. We helped those in need of health services and collaborated with BBMP for area cleaning. This experience boosted my confidence in engaging with officials and participating in UPHC meetings.

-Bhagyalakshmi

President of MAS, NGR Layout,
Roopena Agrahara, Bengaluru

KHPT
IT Park, 5th Floor,
1-4, Rajajinagar Industrial Area,
Behind KSSIDC Admin office, Rajajinagar,
Bengaluru, Karnataka - 560 044

Ph: + 91 80 4040 0200
Fax: + 91 80 4040 0300
Email: khptblr@khpt.org
Website: www.khpt.org

Scan Here