ORIGINAL ARTICLE

Qualitative assessment of functioning and associated challenges faced by Mahila Arogya Samiti under National Urban Health Mission in central India

Anjali Parsure, Anuj Mundra, Arul Suresh, Radhika Sharma, Sophiya K, Abhishek Raut
Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sevagram, Maharashtra

CORRESPONDING AUTHOR
Anjali Parsure, Senior resident, Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences Sevagram, 442102, Maharashtra
Email: parsureanjali@gmail.com

CITATION
Parsure A, Mundra A, Suresh A, Sharma R, Sophiya K, Raut A. Qualitative assessment of functioning and associated challenges faced by Mahila Arogya Samiti under National Urban Health Mission in central India. Journal of the Epidemiology Foundation of India. 2026;4(1):97-104.
DOI: https://doi.org/10.56450/JEFI.2026.v4i01.012
ARTICLE CYCLE
Received: 10/12/2025; Accepted: 18/02/2026; Published: 31/03/2026

Abstract
Background: The Mahila Arogya Samiti (MAS) under the National Urban Health Mission (NUHM) addresses the health needs of urban poor populations in India, focusing on community health, sanitation, and women's empowerment. Despite its potential, limited research exists on MAS functioning. This study assesses the functioning, achievements, and challenges faced by MAS in Wardha town, Maharashtra. **Methods:** This qualitative study was conducted in Wardha district, Maharashtra, India**.** This study collected data through Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) with ASHA workers, MAS members, and medical officers. Participants were purposively sampled to gather diverse perspectives. Thematic analysis was performed to identify key themes related to MAS activities and challenges. **Results:** MAS contributes significantly to promoting health awareness, sanitation, and antenatal care. Key activities include cleanliness drives, health campaigns, and community mobilization. Achievements include improved community awareness and better health service access. However, challenges such as irregular funding, lack of incentives for members, limited community support, and insufficient monitoring hinder MAS effectiveness. **Conclusion:** MAS plays a vital role in bridging gap between health services and community needs. Strengthening MAS through sustained funding, capacity building, and improved supervision is crucial. Revitalizing MAS operations and fostering community participation can enhance urban health outcomes.

Keywords
Mahila Arogya Samiti, National Urban Health Mission, Community participation, Qualitative assessment.

Introduction
The National Rural Health Mission (NRHM), launched in 2005, aimed to provide accessible and affordable healthcare to rural populations in India. Building on this model, the NUHM was introduced in 2013 to address the healthcare needs of urban poor and vulnerable populations[1] .The mission emphasizes the

importance of community-based organizations, such as the MAS, in achieving its objectives[2].

MAS is a women-led community-based group formed under NUHM to empower women and improve the health and well-being of urban vulnerable populations, particularly those living in slums. MAS members, typically comprising 8 to 12 women, work to raise awareness about local health issues, hygiene, nutrition, water, sanitation, and social determinants of health. They also engage in neighbourhood health planning, monitor local services, and facilitate access to essential public services. The ultimate goal of MAS is to bridge the gap between the health needs of the community and the delivery of healthcare services[3].

The rapid urbanization in India has led to a significant influx of rural migrants into cities, resulting in overcrowded slums with inadequate housing, water, sanitation, and healthcare facilities. MAS plays a critical role in addressing these challenges by mobilizing communities, promoting health awareness, and facilitating access to healthcare services.

Despite its potential, there is limited research on the functioning and challenges of MAS, particularly in smaller towns like Wardha.

Aims and objectives:

1. To explore the functioning of MAS in Wardha town, Maharashtra, with a focus on its activities, achievements, and the challenges encountered during implementation.
2. To understand the obstacles faced during the formation and ongoing operations of MAS and to identify potential strategies for strengthening its effectiveness.

Material & Methods

Study type and study design: A qualitative research approach was adopted for this study. Data were collected through FGDs and IDIs. Four FGDs were conducted: two with ASHA workers (who also serve as MAS secretaries) and two with other MAS members. Each FGD included 8 to 10 participants and lasted approximately 50 to 60 minutes. Additionally, two IDIs were conducted—one with a Medical Officer from a UPHC and another with an ASHA supervisor. Each IDI lasted 25 to 30 minutes. All FGDs and IDIs were conducted by the principal investigator**,** who has prior experience in conducting community-based qualitative studies.

Study Setting: The study was conducted in Wardha town**,** the district headquarters of Wardha district in Maharashtra. Wardha has two urban Primary Health Centres (PHCs) and a population of approximately 100,000, which is served by 43 ASHA workers. At the time of the study, 19 MAS committees had been constituted in Wardha town.

Study Population: The study participants included urban ASHA workers, members of MAS, ASHA supervisors, and 2 medical officers from both the Urban Primary Health Centres (UPHCs). Participants were selected using a purposive sampling strategy to ensure representation from diverse roles and perspectives within the MAS framework.

Study Duration: The study was conducted over a period of three months during the year 2023.

Strategy for Data Collection: The FGDs and IDIs were guided by a structured interview guide with open-ended questions. The FGDs were conducted at two locations: two sessions at a UPHC and two at a local temple. All interviews were conducted in local language arranged at a time and place convenient for the participants to ensure their comfort and availability. Audio recordings were made with the participants' informed consent, and detailed field notes were taken simultaneously. Prompts were used during the discussions to encourage in-depth responses and maintain focus on the topic. At the end of each session, debriefing was conducted for participant validation. The recorded audio data were transcribed for analysis. Data saturation was achieved when no new themes or insights emerged from the data.

Ethical Issue and Informed consent: The study was initiated after obtaining approval from the institutional ethics committee (MGIMS/IEC/COMMED/275/2023). Informed consent was obtained from all participants, and confidentiality was maintained throughout the study. This study complied with all ethical guidelines per the Declaration of Helsinki and Good Clinical Practice (GCP).

Data Analysis: Inductive thematic content analysis was conducted using standard systematic techniques. The transcriptions of each FGD and IDI were meticulously completed by listening to the audio recordings. The data were then coded and organized, with themes identified through a thorough process of reading and re-reading the transcriptions. The interpretation process was reflexive, with the researchers identifying themes after reading the transcripts. The primary coding was carried out by the investigator, with additional support from co-authors for unclear interpretations during the analysis. To enhance the trustworthiness of the findings, the results were reviewed by a faculty member.

RESULTS

The findings of the study are presented under the following major themes that emerged from the thematic analysis.

Formation and Structure of MAS:

The MAS is a community-based initiative comprising 6 to 12 members, including a secretary. Membership is open to individuals who express a willingness to contribute to community welfare. Each MAS is responsible for serving approximately 50 to 60 households. While most ASHAs oversee the functioning of a single MAS, a few manage the activities of 2 to 3 MAS committees. In Wardha town, a total of 19 MAS committees have been established to support community health initiatives.

Functions and structure of MAS:

The study revealed that MAS operates through regular monthly meetings, which serve as a platform for members to identify and deliberate on local issues and collaboratively plan solutions. These meetings also include a review of ongoing challenges, the development of action plans to address health and related concerns, discussions on the utilization of untied funds, and preparations for upcoming events or campaigns.

The activities of MAS predominantly focus on promoting cleanliness and sanitation within their communities. Members reported active involvement in initiatives such as *Swachhata Abhiyan* (Cleanliness Drive), addressing grievances of ward members, and resolving issues related to drainage maintenance, including the timely removal of deceased animals and rectifying overflowing drains. Their collective efforts were instrumental in maintaining overall cleanliness in their respective areas.

MAS also played a significant role in supporting antenatal care (ANC) services by providing assistance to pregnant women throughout their pregnancy. In addition, they extended help to sick individuals by ensuring access to necessary medicines through coordination with ASHAs. Members actively organized health camps and conducted health awareness programs. For instance, specific sessions for adolescent girls focused on menstrual health awareness, accompanied by the distribution of sanitary napkins. MAS members further facilitated access to healthcare by arranging transportation for individuals from remote areas to attend health camps.

To promote behavioral changes within the community, MAS utilized culturally relevant approaches, such as *pathnatya* (street plays) and *nukkad natak* (street theater). During the COVID-19 pandemic, MAS members demonstrated their resilience by distributing masks and sanitizers to families in need, thereby contributing to infection prevention efforts.

Table 1: Themes identified by thematic analysis of the qualitative inquiries

HIGHER ORDER	SECOND ORDER	FIRST ORDER
Formation and Structure of MAS	MAS composition Distribution	ASHA's role, Number of MAS per ASHA, MAS distribution in Wardha district
Functions	MAS activities Responsibilities	Health awareness campaigns, Behavioral changes
Funding	Funding availability, Challenges related to funding and incentives for MAS	Untied funds, Funding constraints, Lack of incentives.

Challenges	Lack of reporting mechanisms	Inadequate monitoring and evaluation, Limited knowledge, COVID-19 related disruptions, Less supportive community,
Areas for Improvement	Need for refocusing, Rejuvenation of MAS	Enhanced community participation, Capacity building of MAS members, Improved monitoring and evaluation, Role clarity and workload management

Funding: Mahila Arogya Samitis receive an annual untied fund of ₹5000, which is entirely managed by the committees themselves. Decisions regarding the utilization of these funds are aligned with the community health planning activities undertaken by the MAS and are made through a participatory decision-making process. Transparency in fund utilization is maintained by documenting expenditure decisions in the minutes of monthly meetings.

The member secretaries are permitted to spend small amounts on urgent and essential activities, with the requirement that details of such expenditures and corresponding bills are submitted for review in subsequent MAS meetings.

Despite this framework, it was observed that only a limited number of committees received funding prior to the COVID-19 pandemic. The funds that were available were primarily used for pandemic-related activities, such as distributing masks and sanitizers. However, the availability of funds has since become irregular, creating financial constraints for the committees and limiting their ability to implement planned activities effectively.

Notably, there are currently no incentives provided to MAS members. However, they felt that incentives would make them feel motivated. This was highlighted by one MAS member, who remarked,

"Amhala pn ASHA tai sarkhe fund milale tr ajun changla kam karu shaku" (If we receive funds like ASHA workers, we could perform even better).

There is currently no provision for providing incentives to ASHA workers for their participation in monthly MAS meetings.

Challenges and Areas for Improvement: The ASHAs play a key role in supervising MAS activities. However, the study found that monitoring, reporting, and evaluation of MAS performance remain limited. Although ASHA provides support, MAS committees face challenges in garnering community support due to limited understanding and awareness. Some community members perceive MAS as profit-oriented, which hampers cooperation for cleanliness and sanitation efforts. The committees also encounter difficulties in working with slum areas, illiterate populations, and individuals with alcohol-related issues. Despite these challenges, MAS members support each other and receive assistance from ASHA to overcome obstacles. Additionally, family members sometimes show resistance, attributing it to perceived lack of personal gain and added household responsibilities.

One of the MAS members said that

"Gharchech Lok sath Det nahit, tar baherchya kadun kay apeksha thevnar?" (Family members do not support us, so what expectations should one have from outsiders?).

Following the COVID-19 pandemic, the attention was predominantly directed towards addressing the crisis and other urgent matters, and due to the overburden on ASHA workers, they were unable to monitor MAS in a timely manner, leading to the lack of functioning of MAS.

A medical officer expressed this concern, stating,

"ASHA could have taken a lead but, asha vr tri kiti goshti thopavycha" (How much work should be imposed on ASHAs?).

DISCUSSION

The study found that MAS in Wardha are structurally established and actively engaged

in sanitation, health awareness, and community support activities, with ASHA workers playing a central coordinating role. However, MAS functioning is limited by irregular funding, absence of incentives, inadequate monitoring, high ASHA workload, and reduced activity following the COVID-19 pandemic. Strengthening financial support, supervision, capacity building, and community participation is essential for revitalizing MAS and improving their effectiveness.

The study provides insights into the formation, functioning, and challenges faced by MAS under the NUHM. The findings reveal the role played by MAS in promoting community health and sanitation initiatives. The NUHM renews and deepens the commitment and recognizes that ASHA and MAS are critical components towards achieving health outcomes[4].

MAS, being a group of 6 to 12 members, including a secretary, is open to anyone willing to contribute to its objectives. The study highlights the diverse activities undertaken by MAS, ranging from cleanliness drives, sanitation efforts, and addressing ward-related issues to providing support to antenatal care (ANC) patients, distributing essential medicines, and facilitating access to ANC services, as mandated by the national guidelines[5].

One of the significant challenges faced by MAS is the irregular availability of funds, which hampers its functioning and effectiveness. The study also brings to light the difficulties MAS encounters in mobilizing the community, particularly among slum dwellers and illiterate populations. Overcoming such challenges requires targeted awareness campaigns and tailored approaches to engage the community effectively. Reaching the National Health Mission's objective requires collaboration among partners.

Evidence from a Gujarat pilot study highlights the importance of sustained capacity-building efforts for MAS committees. In Gujarat, a partnership between NGOs and the Department of Health and Family Welfare supported MAS by providing mentorship and phase-wise training sessions. Over 3,000 MAS members from slums in eight municipal corporations were trained on a range of health topics, including hygiene, sanitation, and maternal health. This ongoing support helped MAS committees strengthen their roles in addressing local health challenges and facilitated their engagement with public health services[6].

The Chhattisgarh MAS experience provides LMICs with important insights into how governments can enable community participation through the provision of an enabling framework that includes a women-led, participatory MAS constitution, efficient arrangements for capacity building, and suitable accountability relationships[7]. It demonstrated that strengthening MAS requires significant effort and sustained resources. In Chhattisgarh, mechanisms such as inter-MAS interactions to share successes, challenges, and experiences, along with the annual *Jan Samwad Sammelan*, helped MAS committees remain functional by fostering accountability and collective learning[7]. This highlights the importance of mentoring and building connections beyond the local level to keep MAS groups active and effective.

This study also provides broader perspectives on MAS functioning and challenges by showcasing the experiences from Chhattisgarh. It reinforces the importance of community participation, women's empowerment, and capacity building in addressing social determinants of health in urban poor communities.

If funding is not sustainable, MAS can ensure their functioning through community resource mobilization by leveraging local assets, building local partnerships, and encouraging community ownership. Community members with specific skills can volunteer time or expertise to assist with MAS activities. Involving community members in the decision-making process around MAS activities encourages them to see the benefits of their contributions. Partnering with social groups, such as Self Help Groups (SHG), religious institutions like temples, mosques, etc., can also help MAS reach and engage diverse community members, enhancing support for health initiatives[8,9].

Family support is crucial for the success of MAS, but it often faces resistance due to

perceived lack of personal gain and additional household responsibilities. To address this issue, involving family members in MAS activities and demonstrating the positive impact on community health could encourage greater support.

The study points out the importance of regular supervision and monitoring of MAS activities by ASHA and ANM to ensure effective implementation and progress tracking. However, there is a need to strengthen monitoring and evaluation mechanisms to assess the impact of MAS initiatives comprehensively. The study by Basa et al. also highlights the need for greater community understanding and involvement in MAS activities and stated that the MAS are overworked[10].

The COVID-19 pandemic has both revealed the functioning of MAS in times of crisis and highlighted the need for consistent funding and support post-pandemic. ASHA workers receive incentives of 150 rupees for each monthly VHNSC meeting, which could contribute to the effective functioning of VHNSC. This lack of incentive provision may affect the engagement and commitment of ASHA workers in these meetings, highlighting the need to reconsider the incentive structure for better involvement. To enhance the effectiveness of MAS, the study recommends revitalizing MAS operations and providing training to ASHAs for efficient functioning, prioritizing MAS in urban health strategies and high-focus areas. It emphasizes the potential of MAS in empowering communities and improving health outcomes, making it an essential component of urban health initiatives.

This study recommends ensuring sustained funding, offering capacity-building programs, enhancing community engagement through partnerships, and establishing robust monitoring systems to strengthen MAS effectiveness. The qualitative design allowed an in-depth understanding of Mahila Arogya Samiti functioning from multiple stakeholder perspectives. Use of FGDs and IDIs ensured data triangulation, while adherence to COREQ guidelines and achievement of thematic saturation strengthened the rigor and credibility of the findings. However, the study is limited by its focus on one town in Maharashtra and reliance on self-reported data, which may affect generalizability and introduce bias.

Conclusion

In line with the stated objectives, this study found that MAS in Wardha town are formally constituted and engaged in cleanliness drives, antenatal support, health awareness, and pandemic-response activities, with ASHAs serving as the operational fulcrum. However, their functioning is undermined by irregular untied fund disbursement, absence of incentives for both MAS members and ASHAs for MAS-related work, weak monitoring and reporting mechanisms, limited community and family support, and post-COVID-19 attentional drift. Addressing the second objective, the study identifies sustained financial support, structured capacity building, strengthened supervision by ASHAs and ANMs, leveraging of local partnerships (SHGs, religious institutions), and family-inclusive engagement as concrete strategies to revitalise MAS. Strengthening these elements is essential if MAS is to fulfil its mandated role as a bridge between the urban poor and the public health system under NUHM.

Recommendation

To strengthen MAS functioning, sustained and timely disbursement of untied funds is essential, along with the introduction of modest incentives for both MAS members and ASHAs to sustain motivation. Phase-wise capacity building, structured supervision by ASHAs and ANMs, and robust monitoring mechanisms would help track performance and ensure accountability. Where funding is constrained, MAS can draw on local partnerships with SHGs, religious institutions, and community volunteers to mobilize resources and broaden ownership. Engaging family members in MAS activities, fostering inter-MAS learning platforms, and prioritizing MAS in urban health strategies for smaller towns can further revitalize their role as a bridge between the urban poor and the public health system under NUHM.

Limitation of the Study

Several limitations should be acknowledged. First, the study was confined to a single town in Maharashtra with only 19 MAS committees, which limits the generalisability of findings to other urban contexts with differing socio-demographic and administrative profiles. Second, data were drawn from self-reported accounts of ASHAs, MAS members, and medical officers, introducing the possibility of social desirability and recall bias. Third, the absence of direct observation of MAS meetings and quantitative verification of fund utilisation records restricts triangulation to verbal accounts. Fourth, community members who were not part of MAS were not interviewed, leaving the recipient perspective on MAS activities unexplored. Finally, the post-pandemic timing may have captured a period of atypical disruption, and findings should be interpreted with this temporal context in mind.

Relevance of the Study

This study adds to the limited body of evidence on MAS functioning in small urban settings of central India, where most published literature has focused on metropolitan or state-level evaluations (e.g., Gujarat, Chhattisgarh). By documenting the post-COVID-19 operational state of MAS in Wardha town, it fills a contextual gap regarding tier-2 urban areas served by overburdened ASHA cadres. The findings extend existing knowledge by demonstrating how irregular untied fund flow, absence of member incentives, and weak supervisory mechanisms interact to constrain a community platform that is otherwise structurally intact. It also offers actionable entry points - community resource mobilisation, SHG and faith-based partnerships, family engagement, and restructured incentives - that are directly transferable to comparable urban poor settings under NUHM.

Authors Contribution

1st 2nd and 3rd author – substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data

4th and 5th – drafting the article or revising it critically for important intellectual content,

6th – final approval of the version to be published

Financial Support and Sponsorship

Nil

Conflict of Interest

There are no conflicts of interest.

Acknowledgement

Nil

Declaration Of Generative Ai And Ai Assisted Technologies In The Writing Process

During the preparation of this work, the author (s) used claude ai tool for grammar correction. After using this tool/service, the author (s) reviewed and edited the content as needed and take (s) full responsibility for the content of the publication).

References

1. Ministry of Health and Family Welfare. Guidelines for ASHA and Mahila Arogya Samiti in the Urban Context [Internet]. New Delhi: Government of India; 2014 [cited 2024 Sep 15]. Available from: https://nhm.gov.in/images/pdf/NUHM/Guidelines_for_Asha_and_MAS_in_Urban_Context.pdf
2. Ministry of Health and Family Welfare. National Health Policy 2017 [Internet]. New Delhi: Government of India; 2017 [cited 2024 Sep 15]. Available from: https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf
3. Ministry of Health and Family Welfare. National Urban Health Mission [Internet]. New Delhi: Government of India; 2013 [cited 2024 Sep 15]. Available from: https://nhm.gov.in/images/pdf/NUHM/Implementation_Framework_NUHM.pdf
4. Lonimath A, Ravish KS, Kumar IS, Ranganath TS. Performance assessment of Accredited Social Health Activists under National Urban Health Mission in Bengaluru. Clin Epidemiol Glob Health. 2023 May 1;21.
5. Ministry of Health and Family Welfare. Introduction Module for Mahila Aarogya Samiti [Internet]. New Delhi: Government of India; 2014 [cited 2024 Sep 15]. Available from: https://nhm.gov.in/images/pdf/NUHM/Training-Module/Mahila_Arogya_Samiti.pdf
6. Department of Health and Family Welfare. Building Capacities of Mahila Arogya Samiti (MAS) in Gujarat: A pilot [Internet]. Government of Gujarat; 2016

[cited 2024 Sep 15]. Available from: https://www.chetnaindia.org/wp-content/uploads/2019/04/mas-report-final-for-print-12-10-16_opt.pdf

7. Garg S, Abhishek S, Dewangan M, Sahu A, Xalxo L, Nanda P, et al. Engaging the urban poor in community action on social determinants of health — lessons from the 'Mahila Arogya Samiti' model in the Indian state of Chhattisgarh. BMC Glob Public Health. 2024 Jan 3;2(1).
8. Spier S. Chapter 6 - Berlin Helps: Resource Mobilization and Social Media Deployment in Berlin's Refugee Aid Movement. In: Spier S, editor. Collective Action 20 [Internet]. Chandos Publishing; 2017. p. 83–105. Available from: https://www.sciencedirect.com/science/article/pii/B9780081005675000062
9. Golhasani A, Hosseinirad A. The Role of Resource Mobilization Theory in Social Movement. Int J Multicult Multireligious Underst. 2016;3(6):1–5.
10. Basa S, Bhattacharya M, Pal V, Tiwari VK. Can empowering community platform - Mahila Arogya Samitis (MAS) under National Urban Health Mission: strengthen the delivery of primary healthcare services in urban slums? J Popul Ther Clin Pharmacol. 2022 Sep 30;29(03):418–24.