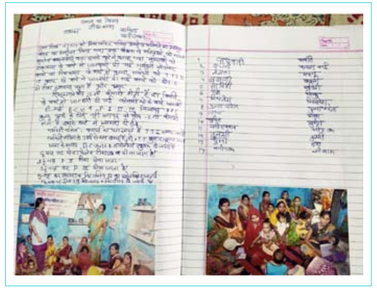
- Mitanins were able to mobilize 80% of expected deliveries to institutions with 76% of them being in government facilities.
- 82% of newborn received designated home visits from Mitanins and 16% referred to health facilities after Mitanin identified signs of sickness.
- 87% of pregnant women received more than three home visits from Mitanin.
- 63% of children under-3 years age received home visits on nutrition and prevention of infections.
- 68400 cases of diarrhea given ORS
- More than 120000 other patients treated by Mitanins using drug-kits.
- 155 TB suspects per 100000 population screened per quarter and referred for sputum examination per quarter resulting in 2140 confirmed cases.
- 2796 Leprosy suspects screened and referred resulting in 611 confirmed cases.
- Mitanins and MAS intervened in 4540 cases to oppose violence against women.
- Water testing using H2S kits by Mitanin.
- Mitanins identified around 3000 homeless population and tried to link them with health services. Assessment of homeless shelters was also carried out.

The MAS worked on Social Determinants of Health like drinking water, sanitation and monitoring the functioning of health and nutrition programmes, and a listing of the most vulnerable households in their areas. Community Monitoring by MAS included cause of death reporting. It helps in analyzing the likely causes due to which child deaths occur in urban slums. The analysis shows that nearly four-fifths of the under-5 deaths are



of newborn amongst whom birth asphyxia is the most common condition followed by low-birth weight. Pneumonia is the main cause in post-neonatal deaths. Other major morbidities in urban slum population where community processes are playing an important role are TB, Leprosy and Sickle cell disease. In Bhilai town, an experiment was done to identify the existing cases of sickle cell disease (SS) and to link them with healthcare services. Mitanins listed 126 Sickle Cell disease (SS) cases and tried to link them with healthcare services. This process will now be expanded to more cities and community demand for expansion of services in all districts is being expressed.

Expansion of Mitanin and ANM network in urban slums improved access to Government health services dramatically. Having a Support structure for CHWs in form of ASHA facilitators and Area coordinators, timely training, provision of drug-kits, emphasis on home visits in CHW role, focus on social determinants of health in role of MAS were key facilitating inputs. Provision of ANMs and linkage with urban-PHCs were also important. NUHM can be valuable for bridging the gap in access to health for urban poor. Community processes and outreach through ANMs are crucial for urban-slums.

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Top Ten Activities to Focus Under NUHM

1. Mapping of urban vulnerable populations and understanding their special needs.
2. Service delivery to urban poor and vulnerable population through proximal U-PHCs and UCHCs.
3. Outreach through Urban Health and Nutrition Days (UHND) and Special Outreach Camps to address special and community specific health needs.
4. Improving ambience, signage, patient amenities, infection prevention protocols should be prioritized at U-PHCs & UCHCs.
5. Defined reporting mechanism under various health programs. Maintenance of requisite records and registers at urban health facilities.
6. Special focus on urban specific health needs such as Non - communicable Diseases - diabetes, hypertension, cardiovascular conditions, substance abuse, mental health etc. in addition to routine RMNCH+A services.
7. Robust and assured referral mechanism with systematic follow up by U-PHC of the referred cases (to FRUs and specialized services for NCDs etc.) - Integration of National Health Programs at the U-PHCs.
8. Convergence with Urban Local Bodies (ULB), with clearly defined roles for the State Health Department and the ULB in NUHM implementation for each city.
9. Financial strengthening under NUHM- Registration and transfer of funds under NUHM through PFMS, formation and registration of RKS etc.
10. Implementation of Public Private Partnerships where public services are weak and innovations to improve service delivery with limited resources.

Source: Thrust Areas under NUHM for States

Publications and Training material for Community Processes Interventions under NUHM (Available on NHM Website: http://nhm.gov.in/nhm/nuhm.html)

Ministry of Health & Family Welfare, Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

NHSRC

THRUST AREAS UNDER NUHM FOR STATES
FOCUS: COMMUNITY PROCESSES

OVERVIEW

The National Urban Health Mission approved on 1st May 2013, addresses a hitherto unmet need of providing health care in urban areas. The main objective of NUHM is to "address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of healthcare delivery for improving the health status of the urban poor" (NUHM Framework, 2013).

Community Processes is integral to NUHM, to enable coverage of quality health services for the vulnerable and marginalized. The ASHA and the Mahila Arogya Samiti constitute the substance of the CP interventions under NUHM. This brochure is a follow up to the "Thrust Areas Under NUHM for States", circulated in the Best Practices workshop held at Tirupati between August 29-August 31, 2016. That document highlighted the top ten activities that states are expected to focus on under the NUHM.

The contents of this document pertain to the key focus areas related to Community Processes under the NHM, and also narrates four best practices from the states of Delhi, Odisha, Telangana, and Chhattisgarh, that other states may wish to scale up, with appropriate adaptations to suit their contexts.

Priority Areas for Community Processes for the Next Year

1. Complete the process of ASHA selection based on comprehensive mapping and in accordance with the principle of community representation.
2. Ensure that MAS formation and opening of MAS bank accounts is expedited. Existing self help groups/women groups under other programs such as RAY BSuP, IHDSP etc. can be co-opted and existing NGO platforms can be utilized, if required.
3. Complete the training of ASHA and MAS in the Induction Module with a special focus on household level vulnerability mapping
4. Initiate/Complete the training of ASHA in Module 6 and 7 to provide them with the knowledge and skills to address issues of maternal, new-born and infant health and nutrition, women's reproductive health including gender based violence, and common communicable diseases.
5. States to communicate to and enforce in cities and districts, a zero tolerance policy for ASHA payment delays.
6. Ensure that the management of Community Processes in NUHM is led by the same team that manages the rural component to enable cross learning.
7. Develop and strengthen convergence of MAS with Urban Local Bodies to enable action on social and environmental determinants of health and ensure judicious use of untied funds for health related activities.
8. Leverage programmes such as the National Urban Livelihood Mission, SABLA, Kishore Shakti Sanghatan, National Skill Development Mission and others for deeper community engagement leading to positive health outcomes.
9. Enable use of IEC/BCC material at all community fora to improve awareness and understanding and improve care seeking behaviours.
10. Support ASHAs to enrol in equivalency programmes through the National Institute of Open Schooling (NIOS).

BEST PRACTICES

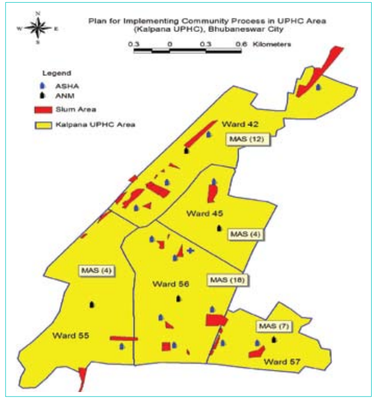
Mahila Arogya Samitis (MAS): Odisha

The state of Odisha has invested in setting up mechanisms for the constitution, capacity building, handholding and monitoring of MAS, to enable high levels of community engagement yielding positive dividends. Early findings indicate that these efforts have led to improved functionality of the MAS across the state. Against the target of 3132, the state has already constituted 2840 MAS. While the state has undertaken innovations in selection and training of MAS, in this narrative we focus on the practice of scoring and grading MAS on a set of indicators. The grading is done by the ASHAs who is trained for this purpose. The grading is undertaken on a quarterly basis. A set of ten indicators each with a weight of ten points has been developed. The MAS is ranked on each of these. Based on a cumulative score of 100, the MAS could be graded in one of three categories:

- Green - 80 and above
- Yellow - 50-79
- Red - Less than 50

List of Ten Indicators for MAS (10 Marks Each)

1. Meetings held regularly each month
2. Universal Coverage for Ante-Natal Care
3. No home delivery conducted in the MAS operational area.
4. All beneficiaries attend Urban Health and Nutrition Day.
5. All children as per due list attend immunisation sessions.
6. Regular cleaning of slum.
7. Additional resources mobilised from other sources.
8. Utilisation of untied fund.
9. Mobilise cases to outreach camp/MHU.
10. No dengue/diarrhoea case found in the MAS area.




Monthly MAS meeting


Cleanliness drive


MAS Meeting


Awareness Rally


Postcard Campaign


Padayatra

The Mandate of MAS Defined as Per State Guidelines are:

- Ensure 100% institutional delivery
- Ensue 100% immunisation of the child
- Family planning awareness to all Eligible Couple
- Construction/use of toilet, ensure open defecation free and slum cleanness
- Full attendance of beneficiary in UHND and immunisation session
- Understand all schemes, programs and entitlement
- Planning and proper utilisation of untied fund
- Co-ordination with front line workers and line departments

The institutionalizing of grading system has facilitated regular monitoring and feedback mechanism for MAS. Preliminary field findings/reports reflect positive impact of intensive inputs provided to MAS, v.i.z - nearly 88% MAS conduct regular meetings and are actively engaged in various slum development activities and about 28% MAS have prepared slum resource map. MAS members have also undertaken community mobilization to raise awareness for Dengue, Diarrhoea, Hepatitis and conducted sanitation drives, in various cities. Positive trends are also seen with regard to immunization coverage during Mission Indradhanush, institutional delivery, UHND attendance and OPD attendance at UPHC. This can be correlated well with the mobilization and facilitation role played by MAS. The state is now considering awards for selected MAS from amongst those that fall in the green category.

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Use of ANMs as ASHA Facilitators: Delhi

Delhi has implemented the ASHA programme since 2008, under the aegis of the National Rural Health Mission, making it the only state with an eight yearlong experience of implementing the ASHA programme in an urban context at scale, before the NUHM was launched. During this period, Delhi has set up several institutional mechanisms to support and manage the ASHA programme. This discussion focuses on the role of the ANM in mentoring and supporting the ASHA. In other states this role is being played by the ASHA Facilitators.

For administrative purposes, state has created "ASHA Units" at the level of Urban Health Centres, and one ASHA unit comprises of two urban health centres. Medical officer in charge of each health centre is responsible for overall management of the ASHA programme in the catchment area of the centre. One of the health centres in a unit is designated as the head quarter for the unit and the MO/IC is designated as the nodal officer. An ASHA unit covers 1,00,000 population which corresponds to about 10 ANMs and 50 ASHAs (1 ASHA per 2000 population). Thus each urban health centre, covering a population of about 50,000 has 25 ASHAs and 5 ANMs. Thus one ANM, responsible for 10,000 population is able to support about five ASHAs in the catchment area of the health centre. Over all state has about 122 ASHA units across all districts and has designated 1038 ANMs to play the role of ASHA facilitator. So far about 943 ANMs have been trained as ASHA facilitators

Most tasks undertaken by the ASHAs at the community level, whether for mobilization or counseling require the ANM to serve the first point of contact for service provision. This make the ANM, a logical mentor for the ASHA, both geographically and functionally. In Delhi, the ANMs provide support to ASHAs and strengthening her linkage with the health system, whether in outreach services or in facility based services. She also serves as a technical resource, in being able to support the ASHA in her tasks, and serves in an administrative capacity in verifying the ASHA's functionality, correlating with the diary records, calculating the monthly incentive and facilitating redressal of ASHA's grievances. The linkage with the ASHA also gives the ANM local recognition and credibility in the community.

This strategy has proved to be effective in providing regular support to ASHAs particularly expanding coverage, since ASHA are able to mobilize beneficiaries to access services provided by the ANM or the urban health center. Payments are also more timely and the existence of state developed software allows better capture of functionality linked to incentives. The current arrangement however, is limited to maternal and child health tasks. As the work of the ANM and the ASHA expand to add more complex tasks such as comprehensive primary health care, including non-communicable diseases, this model of mentoring and support will need to be reinforced by support from the Urban Primary Health center and the use of IT, to keep the ASHA -ANM team intact.

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Mission for Elimination of Poverty in Municipal Areas (MEPMA) – Convergent Efforts for Strengthening Mahila Arogya Samiti (MAS): Telangana

Mission for Elimination of Poverty in Municipal areas (MEPMA), the poverty elimination programme implemented by Government of Telangana, aims at improving people's lives through multi-sectoral interventions, with community participation as its central strategy. The programme's vision aims at reducing poverty and vulnerability of the urban poor, with a focus on enabling people 'to build strong institutions for assertion of their rights and entitlements and attaining quality life in a sustainable manner'. MEPMA was registered in 2007 as a society under Department of Municipal Administration & Urban Development, and envisages convergence with National Urban Livelihood Mission (NULM), National Urban Health Mission (NUHM) and other relevant programmes.

MEPMA's convergent approach focusses on effecting a process of change at four levels, a) engaging community groups and seeking feedback - ensuring active people's participation b) empowering communities to choose the service basket and mechanisms-ensuring provision of comprehensive, and high quality primary healthcare services c) introducing community health risk fund for mitigating catastrophies - ensuring reduced OOPs, risk sharing and reduced catastrophic health expenses d) Improving Governance - by forming a small team of health department & government, with a representation from communities and other departments, and empowering it to monitor, sanction and reward.

When NUHM was launched, 10-15 members of existing slum level federations (SLFs) under MEPMA were grouped to form MAS in a particular area. The SLF president and ASHA were made the joint signatories of the account. 3020 MAS are presently involved in supporting outreach health services, with MEPMA facilitation. MEPMA has mobilised 1.41 Lakh urban women into Self Help Groups (with a corpus and savings of Rs. 659 Crores), 4579 Slum Level Federations (SLF) and 104 Town Level Federations (TLFs), who are now involved in supporting the MASs under NUHM. Strengthening MASs and building their capacities is the key strategic focus of MEPMA's interface with health interventions.

The MEPMA programme focuses on following approaches for strengthening of MAS - MAS trainings (Outreach and Prevention), Strengthening of MAS monthly meeting records, Strengthening 14 records of MAS, Awards and recognition, Continuous monitoring by NUHM &other departments involved, Supervision and social audit. MAS members were trained to maintain 14 registers on various health aspects. The town level federations (TLFs) and ULBs played a role of monitoring MAS meetings.

The programme has documented clearly identifiable health services impacts (based on third party evaluation), achieved through strengthening of MASs, in terms of; a) increase in regularity of MAS meetings (urban health centers with 100% MAS meetings rose from 48% in 2015-16 to 76% in 2016-17), b) better mobilization for Urban Health Nutrition Day (with average participation going up from 18 in 2015-16 to 42 in 2016-17), c) improvement in delivery of complete ANC services by UPHCs, and d) increased % of UPHCs achieving complete immunization. Toilet coverage also went up in the programme area from 15% to 36%.

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Leveraging Community Processes in NUHM to Improve Access to Health for Urban Slum Population: Chhattisgarh

Slums constitute 32% of the 6 million urban population in Chhattisgarh. Primary healthcare facilities and outreach services were non-existent until 2012. The State Government of Chhattisgarh launched Urban Health Program in 2012 with a focus on urban slum population. It was subsumed under the National Urban Health Mission (NUHM) from January 2014.Community Health Workers (CHWs) known as Mitanins were selected through community consensus. Community Health Committees known as Mahila Arogya Samitis (MAS) were organised. Primary healthcare facilities were set-up. State Health Resource Center, an autonomous technical body supported the roll-out. 3775 Mitanin (ASHA) were selected in slums of 19 towns and 3699 MAS were constituted, covering more than 2 million population in urban slums and vulnerable areas and adjoining households. Mitanins received 25 days of training over 3 years. ANMs were appointed for urban slums and urban PHCs were started.

Analysis of activities reported by Mitanins during 2015 showed that: