Original Research Article

An Assessment of Asha Workers Knowledge, Skills and Practices to Improving the Life of Urban Poor Population of the Lucknow District

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Asha Workers, NHRM, CHW, PHC, Health service Delivery etc.

ABSTRACT:
This paper aims to examine how ASHA workers improve the life of urban poor of Lucknow District through their knowledge, skills and practices. This study is confined to the role of ASHA workers for enhancing life indices in three blocks: BakshikaTalab, Kakori and Sarojini Nagar. The findings of this study will help to develop a policy framework for the ASHA community health model. Using significance testing between dependent and independent variables, several factors that impact and enhance the performance of ASHA personnel will be investigated and quantified. Results of the study is shows that the ASHA's work provides valuable contribution in generating awareness in the community towards health, hygiene, improves coverage of communities towards health services. Evidences have suggested that ASHAs can conduct tasks to improve life in the community, with focus on people health. ASHAs are trained to perform activities to implement health programmes at the community, however still do not provide services which have most significant health impact.

1. Introduction

India's overall population is 1.21 billion (according to the 2011 census). After 73 years of independence, India has the world's biggest BPL population, totaling over 260 million people. More than 190 million people live in rural communities. According to the HDR-2019, India ranks 129th out of 189 nations. HDI is estimated using three indicators: mean years of schooling, gross national per capita income, and life expectancy at birth. In all three measures, India ranks poorly. India has a "Life Ambition at Birth" of 68.7 years, a "Mean Years of Schooling" of 6.5 years, and a "GNI Per Capita" income of only USD 2,130. The condition of health in the country quite poor with IMR and MMR rates are quite high i.e. IMR 32 (SRS 2018); MMR 113 (SRS 2016-2018); Stunted (too short for age) 38.4 (NFHS-4 2015-2016); Wasted (too thin for height) 21 (NFHS-4 2015-2016); Underweight (too thin for age) 35.7 (NFHS-4 2015-2016); TFR 2.2 (SRS 2018); CBR 20 (SRS 2018); CDR 6.2 (SRS 2018); Institutional delivery 78.9% (NFHS-4 2015-2016).

The state of Uttar Pradesh has also gained experience with Community Health Worker initiatives, eventually leading to the current stage of a network of Community Health Workers via ASHAs. A key issue for Uttar Pradesh's healthcare systems was to enhance the performance of assigned duties and responsibilities for health care professionals such as ASHAs so that community-level health interventions and services could be performed efficiently and effectively. As volunteers, ASHAs were the most important assets to health systems. The knowledge, abilities, and motivation of ASHAs influenced performance and even the entire primary healthcare delivery system. As a result, it was critical for the health system to plan and offer appropriate working circumstances, such as regular payment of incentives, to guarantee that ASHAs executed their assigned duties and responsibilities adequately, particularly for the HBNC program (GOI, 2015).

India has a large number of ASHAs providing health care at the grassroots level. As CHWs, they were all women who offered preventative, promotional, and curative care services. The HBNC program addresses all three of these issues. ASHAs were required to visit homes during ANC and PNC to offer timely visits and care to the mother and infant. The recently announced comprehensive national health policy for human resources identified ASHAs as a critical human resource for achieving universal health coverage in India. The public sector will need to devise adequate monetary and non-monetary incentive packages to motivate ASHAs to perform optimally. At the same time, expenditures will be required to strengthen the relevance, quantity, and quality of the country's ASHA capacity building activities (GOI, 2015).

ASHAs provided vital prenatal and postnatal care to more than five million births in Uttar Pradesh each year. ASHAs were trained in home-based newborn care in 17 districts where the Government of Uttar Pradesh's Comprehensive Child Survival Programme (CCSP) was expanded in 2007-2008 (NRHM PIP of UP 07-08). The program utilized for the training was the CCSP 40 module, which details critical neonatal care in nine chapters. ASHAs have also received training in other courses. Until March 2017, ASHAs in 55 designated districts in Uttar Pradesh had received training on seven modules recommended by the GOI. ASHAs in the other 20 districts have received training on five modules (GO UP, 2017).

These five sessions included information about neonatal care. As of 2017, training for the eighth module had yet to begin at UP. Periodic performance reviews and needs assessments revealed that the quality and number of ASHA home visits were insufficient, and ASHAs lacked the skills to successfully negotiate behaviour change to enhance infant care practices. Maternal and neonatal disorders accounted for 13.8% of the disease burden in India. (NHP; GOI, 2017)

Asha Workers in Health Service Delivery

Evidence suggests that ASHAs do duties that can enhance community health outcomes, particularly for children. ASHAs are trained to carry out activities to implement health initiatives at the community level, however they do not deliver services that have the greatest health effect.Aside from arranging and delivering health care to individual recipients, ASHAs are also expected to serve as activists or community health mobilisers. This refers to her role in creating rapport in the community, as well as her advocacy for the acknowledgment of health care and community rights, with an emphasis on disadvantaged and marginalised people. ASHAs are encouraged to undertake home visits and provide counselling assistance to mothers with infants under the age of one. ASHAs might help improve child health indices in rural India through mobilizing society.

ASHAs make regular home visits to mothers to help them improve their knowledge and practices, however there is evidence that ASHAs struggle to motivate the community to modify the child care methods that their families have been doing for years. Several community health programs that attempted to produce outcomes have failed in the past owing to unrealistic expectations from ASHAs, which has also unnecessarily undermined the credibility of ASHA workers.ASHAs can help moms improve their child health practices, but their expertise isn't developing fast enough. ASHAs lack the necessary skills and support from health institutions, the community, and Panchayat members to increase mothers' understanding. The quality of training materials and methodologies supplied to ASHA workers on community and social mobilization is likewise inadequate.

ASHAs face a variety of other obstacles, including ill-equipped facilities, a paucity of resources, insufficient incentives, an overload of work, failure to meet objectives, insufficient support from local leaders, and no community reputation.The majority of ASHAs earn relatively little money for their efforts. The amount of incentives offered to ASHAs in relation to the efforts and hard work she does, together with the health care system's limited functioning, are some of the significant issues that restrict ASHAs' roles both in the health care system and in India's rural communities. The Community Health Program in India is constantly evolving, and important exploratory study that offers positive feedback and reforms is required, with a focus on governance structures, inter-ministerial connections, ASHA cohesion, and the ability of the community to provide oversight support. ASHAs confront a variety of challenges when executing their duties, including the absence of regular incentives, a lack of logistical support, and an overburden of responsibility while servicing a high number of residents. The community in rural India envisioned ASHA workers as connection workers or facilitators rather than CHWs or social activists.

2. Litreture Review

According to Jayaswal's (2015) paper "Rural Health System in India: A Review," around 75% of healthcare infrastructure and resources are concentrated in metropolitan regions. Despite several government programs aimed at improving rural healthcare, delays in execution have hampered efficacy. As a result, rural communities continue to bear the burden of numerous infectious diseases, which are exacerbated by filthy circumstances and a lack of knowledge and assistance from the community and government. While rural healthcare facilities address cleanliness through outreach programs, there is still more work to be done to improve overall health. The Primary Health Centre (PHC) has been designated as the core place for patient diagnosis and first referral, but in order to solve present obstacles, primary and tertiary institutions must work together more effectively.

Kishore et al. (2016) did a research titled "ASHA Workers and Adolescent Health: An Explorative Study" to measure their knowledge and understanding of adolescent health concerns. The research included 1650 ASHA personnel from the Sonepat area of Haryana. The results revealed that 1582 (95.9%) ASHAs were aware of the adolescent age group, which ranges from 10 to 19 years. 435 (26.4%) ASHA were aware of anaemia, 368 (22.3%) were aware of vaginal discharge, and 292 (17.7%) were aware of menstruation issues, which are frequent among teenage females. 1297 (78.6%) ASHAs recommended condoms, 58 (3.5%) tubectomy, and 139 (8.4%) oral tablets as contraceptive treatments for teenagers. According to the report, ASHA should be thoroughly taught on adolescent health issues in order to accomplish the objectives of the Reproductive, Maternal, Newborn, Child, and Adolescent Health Programme (RMNCH+A).

Sudhakar et al. (2017) conducted a quasi-experimental research in Khurda district of Odisha to assess the readiness of accredited social health activist workers for tobacco cessation counselling following a brief intervention. The study was conducted to investigate ASHAs' baseline beliefs and practices about tobacco cessation, as well as to assess the effectiveness of an intervention designed to enhance ASHAs' attitudes and practices. A sample of 121 ASHAs was gathered, and the results revealed that when individuals were queried at baseline regarding the ban on smoking in enclosed public areas, more than half were either unclear or disapproved. After the intervention, almost everyone agreed on the reported reality. Furthermore, in the outset, half of the ASHAs were unsure about a total ban on tobacco

product advertising, and 35% were unsure if tobacco product prices needed to be raised significantly. Following involvement, the majority strongly supported this strategy.

Panda et al. (2017) investigated the performance of accredited social health activists (ASHA) in a rural block in Northern India and the factors influencing it. The study's aims were to examine ASHA performance and identify variables influencing it in the Chiri block of Rohtak district in Haryana. Responses were collected from all 110 ASHAs in the Chiri block, and they were given a pretested semi-structured schedule. The findings found that 7% of ASHAs scored poorly, 32% scored averagely, and 61% scored well. Furthermore, ASHAs' replies to their duties and obligations were analyzed. ASHAs with higher household income outperformed those with lower incomes. All of the variables except for on-the-job training were statistically significant. In the performance exam, 77% of excellent scorers reported difficulties at work, compared to 100% of bad scorers, and 94% of good scorers were pleased with their career prospects, compared to 100% of unsatisfied low scorers.

S. Taneja, S. Dalpath, and N. Bhandari et al. (2018) discovered that ASHA played a crucial role in their Haryana study, treating one-third of children with pneumonia and one-quarter of diarrhoea patients. ASHA's assistance lowered the number of households seeking care from private providers for diarrhoea from 81% to 56%, and from 78% to 48% for pneumonia. The ASHA, as campaigners, were regarded as an appropriate and appealing source of therapy close home. Trained, accredited social health activists treated simple children ailments and were accepted by the community in this capacity.

Deshpande et al. (2019) conducted study on ASHAs in tribal Maharashtra, analyzing the challenges and demotivating factors they face while carrying out their roles. The findings found that the key obstacles faced by ASHAs included irregular and low rewards, non-availability of transportation, drug shortages, the attitude of health workers at referral centres, workload and stress, and a lack of training, among others. The research study's result was reached after considering a sample of 49 ASHAs.

In their study titled 'Challenges Faced by ASHAs during their Field Works: A Cross Sectional Observational Study in Rural Areas of Jaipur, Rajasthan', Meena et al. (2020) explored the challenges faced by ASHAs during their field work. According to the research, 38.5% of ASHAs claimed that their incentives were delayed or insufficient. Following that, 25.1% of ASHAs are overwhelmed with duties from numerous departments. 22.9% of ASHAs reported trouble finding transportation in the field, and an identical percentage of ASHAs reported friction between DWCD and the health department that hampered their job. 2.9% of ASHAs reported non-cooperation by hospital personnel, while 0.7% said that PHC staff did not prioritize cases recommended by ASHA. According to the report, 14.8% of the 20 ASHAs had no challenges.

Gogoi's (2020) research, "ASHA Workers as Human Resources and Problems Faced by them Before and After COVID-19," explored the issues faced by ASHA workers in Assam. According to the survey conducted prior to the COVID-19 pandemic, the biggest difficulties were low pay, social shame, and sexual assault during filed visits. Post-COVID-19 times presented several obstacles for ASHAs, such as a scarcity of masks and sanitizers, embarrassment in the neighbourhood, and inadequate transportation facilities. According to the report, footloose labourers do not receive benefits such as provident funds, gratuities, or pensions, and their pay is low despite their significant workload.

Rajbangshi et al. (2021) conducted a qualitative research titled "Community Health Workers: Challenges and Vulnerabilities of Accredited Social Health Activists Working in Conflictaffected Settings in the State of Assam, India" to address ASHA concerns (04 sample

size). According to the report, ASHAs have problems in accessing health care during and after conflict outbreaks. They had transportation issues and service outages at remote medical clinics. During times of war, their personal safety and security were threatened. ASHAs expressed unfavourable views toward the communities they served as a result of the breakdown of social relationships, trauma from displacement, and the death of family members, particularly wives.

Sinha et al.'s (2021) research, "High Risk Without Recognition: Challenges Faced by Female Front-line Workers," examined ASHAs from Telangana and Bihar. The study focused on how female front-line personnel were overworked and underpaid both before and after the epidemic. Despite being assigned greater jobs, the study found that few ASHAs obtained protective equipment or transportation throughout the epidemic. ASHAs noted that both states had a high workload but low remuneration.

Lee et al. (2022) studied the relationship between institutional delivery and neonatal mortality in India, evaluating the quality of the maternal and newborn health systems and their effectiveness in reducing neonatal mortality. The study used data from the 2015-2016 National Family Health Survey, with a focus on reported prenatal care and immediate postpartum care at the district level, to evaluate health system quality for pregnancy and infant care. Using random effect logistic models, the study investigated the relationship between institutional delivery and neonatal mortality (death within the first 28 days of life) and early neonatal mortality (death within 7 days of live births), stratified by district-level maternal and newborn health system quality quintile. Among the 191,963 births studied, three-quarters occurred in healthcare institutions, with a 2% newborn death rate.

In their study titled "Assessment of Workload of ASHAs: A Multi-stakeholder Perspective Study for Task-sharing and Task-shifting," Manjunath et al. (2022) investigated the workload of ASHAs, the impact of their responsibilities on their quality of life, and the possibility of structured task sharing or shifting with other healthcare workers. According to the research findings, a considerable proportion of ASHAs reported having a high burden, which was linked to reasons such as the size of the population they were in charge of, lengthy working hours, and additional jobs. Limited transportation alternatives, poor help from other healthcare staff, and delayed incentive payment all added to their perceptions of being overworked and underpaid. The research also solicited input from a variety of stakeholders on the work of ASHAs. Overall, the findings highlight the significance of allocating certain jobs among different frontline healthcare staff based on their complexity and each worker's skills. The study indicated that job sharing or shifting can assist reduce the load on ASHAs and improve their efficacy in providing healthcare services.

Sharma et al. (2022) conducted a cross-sectional study titled "A Comparative Study of Knowledge of Accredited Social Health Activist (ASHA) Workers Regarding Child Health Services Working in Rural and Urban Areas of a Block of Haryana" in the Barwala block of Hisar district, Haryana. The study focused on ASHA workers' knowledge levels. Scoring was used to measure knowledge, and statistical tests such as percentages and chi-square ($\chi 2$) were utilized for analysis. According to the data, the majority of ASHA workers had strong understanding of child health services, as demonstrated by their scores. None of the workers displayed inadequate knowledge in this area. Notably, rural ASHA personnel scored higher than their urban colleagues, and the difference was statistically significant. However, both rural and urban ASHA workers demonstrated insufficient awareness of the identification of danger signals during diarrhea, acute respiratory illnesses in children, and danger signs in infants. On the other hand, they displayed adequate understanding in areas such as cord

stump care, breastfeeding practices, regular vaccination, vitamin A supplementation, and home-based postnatal care (HBPNC) visits. The study showed that improving ASHA workers' limited understanding of infant care is critical. Supportive supervision should be applied in their particular job areas to increase their knowledge and performance.

SufiyaMohsin et al's (2023) review study seeks to critically explore the current function of ASHA workers, analyze their problems and triumphs, and present novel ideas for reimagining their position in the Indian healthcare system. This paper emphasizes the potential for ASHA workers to make major contributions to community-based healthcare delivery, health education, and disease prevention by integrating existing knowledge and drawing insights from several sources.

According to Manhardeep Kaur et al. (2023), accredited social health activist (ASHA) workers serve as a "bridge" between rural people and health care providers, playing an important role in accomplishing national health and population policy goals. According to statistics from the National Family Health Survey (NFHS) V (2019 2021), Punjab's rural infant mortality rate (IMR) remains higher (32.4 per 1000 live births) than in urban regions (20.1). The maternal mortality ratio (MMR) is likewise high (129 per lakh), according to sample registration system (SRS) statistics from 2016-2018.

The study, performed by Jain S, Saxena S, Bano T, and Mittal C (2024), included 40 ASHAs from Meerut's urban regions. Interviews were conducted using pretested schedules, and performance assessments were based on established scales. Beneficiaries were also questioned to assess service delivery efficacy. Chi-square and Fisher exact tests were used to evaluate the data and determine the relationship between various parameters and ASHA performance. The findings were divided into performance grades based on the ASHA scores, demonstrating a dispersion of different performance levels. Age, education, training frequency, employment, and timely delivery of incentives all had a substantial impact on ASHA personnel' performance. The study found that younger, better-educated, and frequently trained ASHAs given timely incentives performed better.

Akbar Jan N's (2024) study additionally investigated how organizational virtuousness (OV) and perceived social value moderated the association between precarious employment (PW), EL, and OC. This study included a total sample size of N = 467 ASHA professionals from various healthcare settings. The moderating effects of the Hayes Process Macro were investigated using hierarchical regression analysis. The data indicate that there are significant unfavourable relationships between EL, PW, and OC among ASHA personnel. Nonetheless, OV and perceived social worth (PSW) were identified as important modifiers. More specifically, increased levels of PSW and OV counteracted the negative effects of PW and EL on the OC of ASHA employees.

Objectives of the Research

1. The measure the contribution of ASHA Workers in health service delivery through community mobilization for urban poor population.
2. To Assess ASHA workers for their knowledge on Health, Skills and practices as a community health worker for improving life of urban poor population.

Hypothesis of the Study

H01: There is no association between ASHAs training on Community Mobilization and ASHA Knowledge, Practice & Skills

H02: There is no significant relationship between ASHAs Knowledge and trained on community mobilization, visits & incentive received.

3. Research Methodology

The study will evaluate ASHA workers' knowledge, abilities, and practices in life and health using the following community mobilization principles, as created by the group "Raising Voices" and written by Sara Siebert, Lori Michau, and Evelyn Letiyo. The study will also measure urban poor respondents' knowledge and actions regarding health. The research project will help to demonstrate a scalable strategy for other development areas, such as deploying community-based workers to mobilize communities to seek free government services. The thorough study and philosophical structure will be produced once the literature review is completed. This research study will be cross-sectional descriptive study.A collection of primary data from ASHAs and urban poor mother Secondary data: Include a literature assessment of current investigations on ASHA staff in India and health care workers in different nations.In this study the population were selected the ASHA workers, and urban poor mothers from selected three blocks BakshikaTalab, Kakori and Sarojini Nagar of Lucknow districts.The sample size for this study is total 155 ASHAs in three blocks of BakshikaTalab, Kakori, and Sarojini Nagar of Lucknow District.Following statistical analysis were used:

(a) Bivariate analysis using the Chi-square statistical approach to determine the significance and relationship between both independent and dependent variables.
(b) The significance threshold of the Chi-square test was set at p = 0.05."

Data Analysis and Data Interpretations

Table 1: Intermediary Indicators on Ashas Technical and Support System

Key intermediary	N	%
Trained on Community Mobilization and Inter- personal Skills	136	87.74
ASHAs received Supportive Supervision visits	101	65.16
ASHAs received timely incentives	109	69.87
ASHAs with sufficient Pediatric IFA Stock	138	89.03
ASHAs with sufficient ORS Stock	140	90.32
ASHAs with sufficient Zinc Tablet Stock	70	45.16

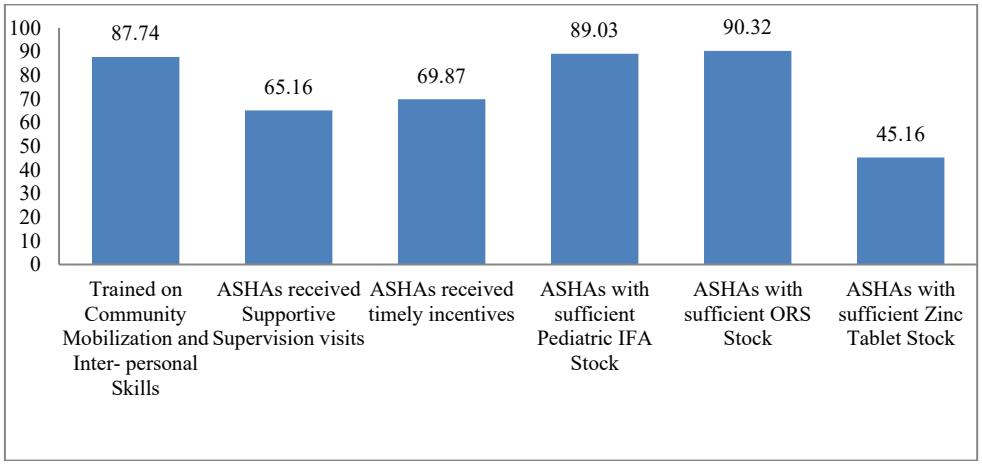

Figure 1: Showing % of Intermediary Indicators onAshas Technical and Support System

Total of 87.74% ASHAs were found to be trained in Community Mobilization and Inter-personalskills. 65.16% ASHAs received supportive supervision visits. 69.87% ASHAs received timely incentives. 89.03%, 90.32% and 45.16% ASHAs have sufficient Pediatric IFA, ORS and Zinc Tablet Stock respectively.

Table 2: Asha Knowledge on Health Interventions of Urban Poor

HEALTH INTERVATIONS	N	%
ASHAs with Correct Knowledge of CF	136	87.74
ASHAs with Correct Knowledge of ORS preparation	143	92.26
ASHAs with Knowledge of Timely Initiation at correct age of Pediatric IFA syrup	132	85.16
ASHAs with Knowledge on correct Pediatric IFA quantity	136	87.74
ASHAs with Knowledge on correct Pediatric IFA frequency	146	94.19
ASHAs with Correct Knowledge on danger sign detection	95	62.29
ASHAs with Correct Knowledge on SNCU discharge instructions	56	36.13

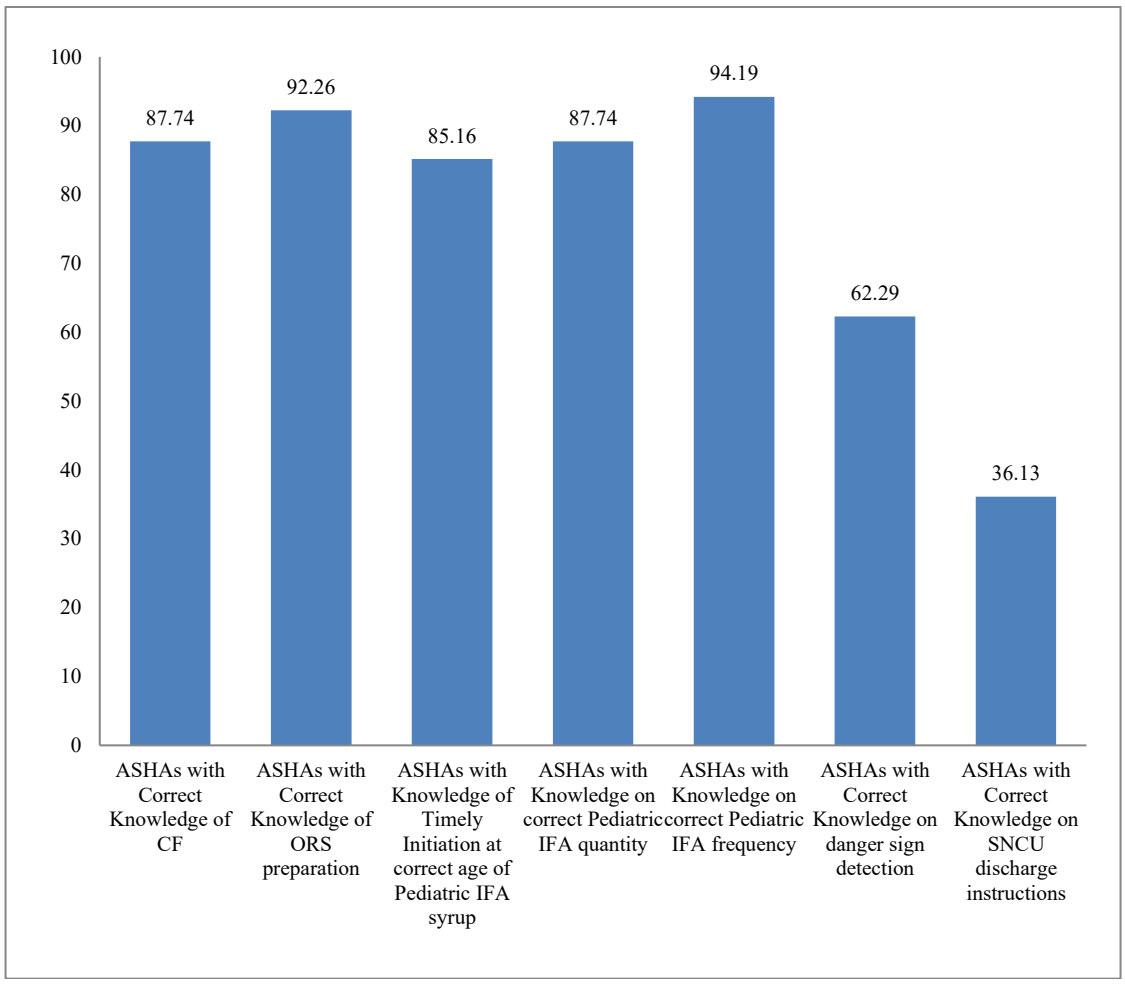

Figure 2: Showing % of Asha Knowledge on Health Interventions of Urban Poor

Most of the ASHAs had knowledge on health interventions of urban poor mother except detectionof danger signs and SNCU discharge instructions. ASHAs with Correct Knowledgeon SNCU discharge instructions was only 36.13%.

Table 3: Overall Composite Scores of Asha Knowledge

Scores	Blocks			Total
	BakshiKaTalab	Kakori	Sarojini Nagar	
1	1	0	0	1
2	1	0	1	2
3	1	3	1	5
4	4	7	3	14
5	2	14	8	24
6	20	15	23	58
7	26	12	13	51
Average	6.07	5.51	5.84	5.81
Total	55	51	49	155

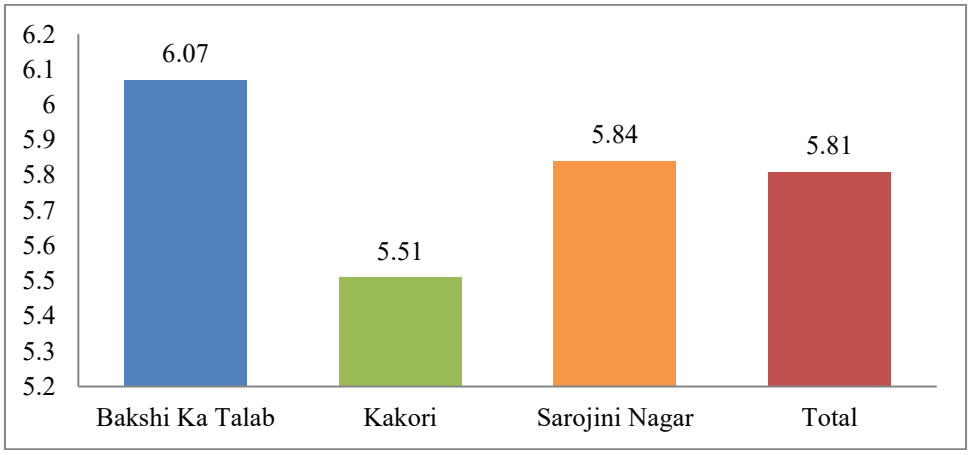

Figure 3: Average Scores of Asha Knowledge

The overall average composite score of ASHA knowledge on health of urban poor in selected 3 blocks was only 5.81 out of 10. The highest score was reported in BakshikaTalab with 6.07.

Table 4: Scores of Asha Skills on Community Mobilization

Scores	Blocks			Total
	BakshiKaTalab	Kakori	Sarojini Nagar	
1	1	0	0	1
2	2	1	0	3
3	2	4	2	8
4	36	32	27	95
5	14	14	20	48
Average	4.09	4.16	4.37	4.21
Total	55	51	49	155

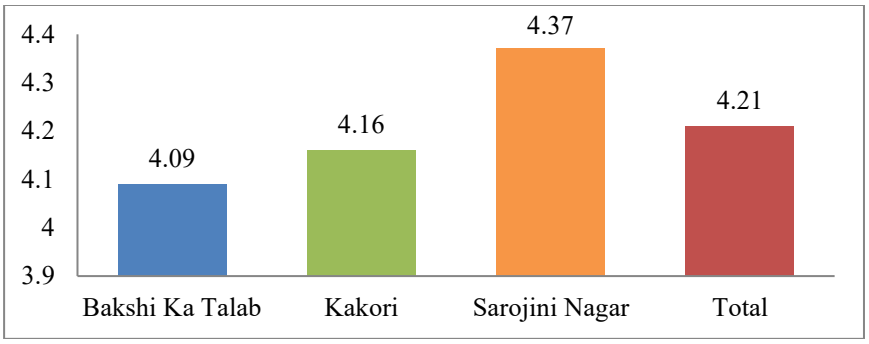

Figure 4: Average Scores of Asha Skills on Community Mobilization

The overall average composite score of ASHA skills on community mobilization outof 5 was 4.21 with highest score reported in Sarojini Nagar Block.

Hypothesis 01

H01: There is no association between ASHAs training on Community Mobilization and ASHA Knowledge, Practice & Skills

Table 5: Association of Ashas Knowledge

Count		ASHAs training		Total
		Not Trained	Trained	
ASHA Knowledge Scores	1	0	1	1
	2	1	0	1
	3	2	2	4
	4	3	12	15
	5	6	17	23
	6	4	54	58
	7	3	50	53
Total		19	136	155

Table 6: Chi-Square Test for Association

	Value	df	A. Sig. (2-sided)
Pearson Chi-Square	48.905[a]	6	0.000
Likelihood Ratio	36.407	6	0.000
Linear-by-Linear Association	30.237	1	0.000
N	155		
a. 6Cells (42.9%)have expected count less than 5. The minimum expected count is 0.12.			

Most of the ASHAs who were trained got a composite score of either 6 or 7 forASHA knowledge. The association between ASHAs training on CommunityMobilization and ASHA Knowledge was highly significant at p <0.001. ASHAs, which were trained, were found to have betterknowledge on urban poor mother health.

Table 7: Association of Ashas Practice

Count		ASHAs training		Total
		Not Trained	Trained	
ASHA Practice Scores	1	0	1	1
	2	0	1	1
	3	3	3	6
	4	8	16	24
	5	3	46	49
	6	4	48	42
	7	1	19	20
	8	0	2	2
Total		19	136	155

Table 8: Chi-Square Test for Association

	Value	df	A. Sig. (2-sided)
Pearson Chi-Square	46.705[a]	7	0.000
Likelihood Ratio	37.466	7	0.000
Linear-by-Linear Association	23.008	1	0.000
N	155		
a. 8Cells (50.0%)have expected count less than 5. The minimum expected count is 0.12.			

Most of the ASHAs who were trained got a composite score of either 5 or 6 forASHA practice. The association between ASHAs training on CommunityMobilization and ASHA Practices was highlysignificant at $p < 0.001$. ASHAs, which were trained, were following better Health practices of urban poor mother.

Table 9: Association of Ashas Practice

Count		ASHAs training		Total
		Not Trained	Trained	
ASHA Skills Scores	1	0	1	1
	2	1	1	2
	3	5	23	28
	4	11	91	102
	5	2	20	22
Total		19	136	155

Table 10: Chi-Square Test for Association

	Value	df	A. Sig. (2-sided)
Pearson Chi-Square	40.395[a]	4	0.000
Likelihood Ratio	29.814	4	0.014
Linear-by-Linear Association	9.388	1	0.003
N	155		
a. 5Cells (56.3%)have expected count less than 5. The minimum expected count is 0.12.			

Most of the ASHAs who were trained got a composite score of either 5 or 6 for ASHApractice. The association between ASHAs training on Community Mobilization and

ASHA Skills was highly significant at $p < 0.001$. ASHAs,which were trained, had better skills on Health of urban poor mother.

Table 11: Ashas Health Practices for Urabn Poor Mother

HEALTH PRACTICES OF URBAN POOR	N	%
ASHAs providing regular and structured home visits to mothers	130	83.87
ASHAs providing counseling on health	136	87.74
ASHAs providing counseling on ORS use during Diarrhea episodes	143	92.26
ASHAs providing counseling on Pediatric IFA supplementation	132	85.16
ASHAs providing counseling on danger Signs detection	95	61.29
ASHAs Referring sick infants to health facilities	16	10.32

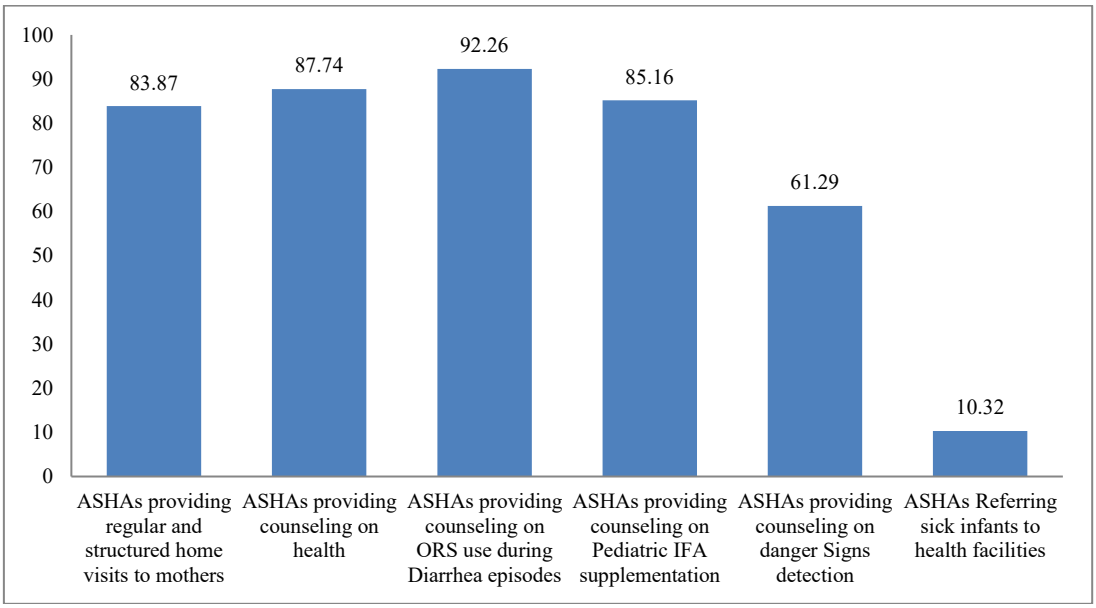

Figure 5: % of Ashas Health Practices for Urabn Poor Mother

Almost all the ASHAs were correctly practicing the health interventions of urban poor mother,except referring infants to health facilities in their area. Overall, only 10.32% ASHAswere referring sick infants to health facilities in their areas.

Table 12: Composite Scores of Asha Practices

Scores	Blocks			Total
	BakshiKaTalab	Kakori	Sarojini Nagar	
1	1	0	0	1
2	1	0	1	2
3	2	4	2	8
4	5	12	6	23
5	14	15	20	49
6	21	17	14	52
7	10	3	5	18
8	1	0	1	2
Average	5.51	5.06	5.29	5.29
Total	55	51	49	155

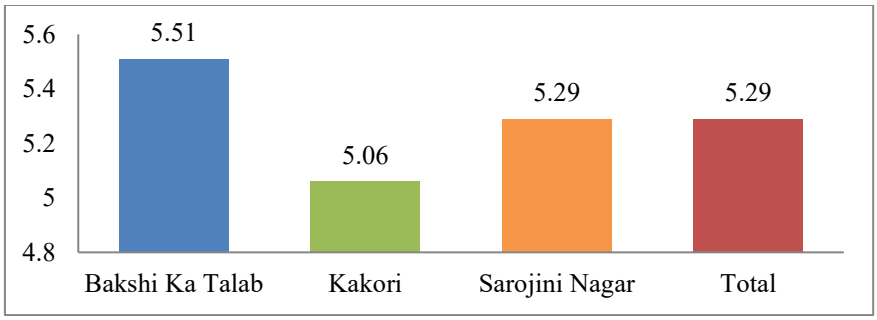

Figure 6: Average Scores of Asha Practices

The average overall Composite Scores of ASHA Practices in selected area was 5.29 out of 10.

Table 13: Summary of Descriptive Statistics

Dependent Variables	Mean	Std. Error	SD	Variance
ASHAs Knowledge	5.81	0.066	1.145	1.311
ASHAs Practice	5.29	0.065	1.126	1.265
ASHAs Skills	3.01	0.032	0.553	0.305

Table 14: Correlation between Dependent Variables and Independent Variable

	Pearson Correlation	Trained on Community Mobilization	Home visits By ASHA	Received Supportive Supervision	Received timely Incentives	Composite Score of Knowledge	Composite Score of Practice	Composite Score of Skills
Trained on Community Mob.	Correlation Coefficient	1.000	0.056	0.055	0.231**	0.275**	0.265**	0.136*
	Sig.(2-tailed)		0.317	0.347	0.000	0.000	0.000	0.015
Home visits by ASHA	Correlation Coefficient	0.056	1.000	-0.016	0.208**	-0.023	0.298**	-0.045
	Sig.(2-tailed)	0.318		0.761	0.000	0.696	0.000	0.438
Received Supportive Supervision	Correlation Coefficient	0.055	-0.016	1.000	-0.006	-0.113*	-0.105	-0.027
	Sig.(2-tailed)	0.347	0.761		0.905	0.048	0.067	0.618
Received timely Incentives	Correlation Coefficient	0.231**	0.208**	-0.006	1.000	0.317**	0.455**	0.024
	Sig.(2-tailed)	0.000	0.000	0.905		0.000	0.000	0.693
Composite Score of Knowledge	Correlation Coefficient	0.275**	-0.023	-0.113*	0.317**	1.000	0.386**	0.177**
	Sig.(2-tailed)	0.000	0.696	0.048	0.000		0.000	0.003
Composite Score of Practice	Correlation Coefficient	0.265**	0.298**	-0.105	0.455**	0.386**	1.000	-0.077
	Sig.(2-tailed)	0.000	0.000	0.067	0.000	.000		0.174
Composite Score of Skills	Correlation Coefficient	0.136*	-0.045	-0.027	0.024	0.177**	-0.077	1.000
	Sig.(2-tailed)	0.015	0.438	0.618	0.693	0.003	0.174	.

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

ASHAs trained on Community Mobilization hashighly significant positive correlation (significant at the 0.01 level) with ASHAsknowledge and Practices. Moreover, it also has significant positive correlation(significant at the 0.05 level) with ASHA skills.

Hypothesis 02:

H02: There is no significant relationship between ASHAs Knowledge and trained on community mobilization, visits & incentive received.

The model below is a linear regression model that attempts to model the relationshipbetween dependent and independent variables by fitting a linear equation to observeddata. The independent variables are trained on community mobilization, supportive supervision visits received from ASHAsupervisors and Incentive received by ASHAs. The independent variables are factors that have been hypothesized to have an impact on the dependent variables. In thisanalysis we are trying to understand and predict dependent variables of ASHAknowledge, Skills and Practices.

Dependent variable: ASHA Knowledge

Independent Variables:

- ASHAs trained on Community Mobilization
- Supportive Supervision Visits received by ASHAs
- Timely Incentives Received by ASHAs

Table 15: Regression Analysis

Model Summary				
Model	R	R Square	Adjusted R Square	Std.Error of the Estimate
1	0.422[a]	0.178	0.168	1.044

a. Predictors:(Constant),
I. Trained on Community Mobilization
II. Supportive Supervision Visits received
III. Incentive ReceivedbyASHAs

Table 16: Anova Results

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	71.42	3	23.81	21.86	0.000[b]
	Residual	331.92	151	1.07		
	Total	403.33	154			

b. Predictors:(Constant)

Table 17: Coefficients

Independent Variables	Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.
	B	Std.Error			
Constant	4.77	0.194		24.83	0.000
Trained on Community Mobilization	0.88	0.185	0.257	4.82	**0.000**
Supportive Supervision Visits received	-0.25	0.125	-0.104	-1.97	**0.047**
Incentive Received by ASHAs	0.67	0.134	0.265	4.97	**0.000**

There is a significant relationship between ASHA knowledge (dependent variable)and the ASHAs trained on Community Mobilization, Supportive Supervision Visits received by ASHAs, and Timely Incentives Received by ASHAs (independent variables).

4. Conclusion

ASHA's work provides valuable contribution in generating awareness in the community towards health, hygiene, improves coverage of communities towards health services. Evidences have suggested that ASHAs can conduct tasks to improve health outcomes in the community, with focus on child health. ASHAs are trained to perform activities to implement health programmes at the community, however still do not provide services which have most significant health impact. In order to get effective contribution from ASHAs, they have to be appropriately selected, trained and continuously supported. CHW programmes require substantial support in terms of planning, training, supervision, management and logistics. CHW programmes neither a substitute for fragile public health system nor an economical substitute for providing easy access to health care for deprived, marginalized and urban populations. Several programmes have failed to achieve results due to impractical expectations from community health programmes, which has unreasonably destabilized the credibility of ASHA concept.The analysis of the primary data collected from ASHA interviews revealed, ASHAs are conducting home visits to respondents with infants less than one-year-old; they found to have adequate ORS, Paediatric IFA syrup and they were distributing and counselling respondents for its correct use; and ASHAs had appropriate knowledge on Complementary Feeding and detection of danger signs in infants that require referral to health facilities.

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