

# Role of Asha Worker in Improving the Life: The Perception Urban Poor Mother

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## KEYWORDS

Urban Poor Mother, ASHA Worker, PHC, Chws, Child Health Etc.

## ABSTRACT:

ASHA has been identified as one of the key strategy for wider coverage of services, considering her the first port of call for any health related demands, especially women and children. ASHA is a health activist in the community who creates awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She is a promoter of good health practices and provides a minimum package of curative care as appropriate and feasible for that level and makes timely referrals. So, this paper aims to examine the role of ASHA worker in improving the life of urban poor mother. The result of the study is shows that the ASHAs could play an important role in improving child health indicators in rural urban poor parts of India through social mobilization. ASHAs can further contribute in reducing child morbidity and mortality, if supported with trainings, supportive supervision and incentives for motivation.

## 1. Introduction

ASHA workers are inhabitants of the same community aged twenty-five to forty-five years. ASHA personnel should have completed at least the 10th grade. She is chosen by both the village health committee and the local self-government. Each ASHA worker serves around 1000 people. ASHA workers mobilize communities and assist them in accessing government health care services at public health facilities, such as ANC, Immunization, PNC, Nutrition, and the distribution of vital supplies like as ORS, IFA, Zinc pills, Co-trimoxazole tablets, Oral Pills, Condoms, and so on. She advises pregnant mothers on facility delivery and breastfeeding till 6 months of age, CF beyond 6 months of age, age-appropriate vaccination, contraception, and infection prevention (RTI, STI), as well as infant care.

ASHA serves a variety of responsibilities in enhancing community health, including raising awareness about services available at public health institutions. Mobilizing the community for health planning, increasing access to public health services, encouraging good health behaviours, and offering a package of preventive and promotional care with prompt referrals. Child health interventions improved significantly between 2005 and 2015, according to an analysis of Rajasthan's NFHS 3 and NFHS 4 data. All child health indices have improved dramatically, particularly vaccination (from 26.5% to 54.8%), child morbidity, stunting (from 43.7% to 39.1%), and underweight rates (from 39.9% to 36.7%). During NFHS, statistics on ASHAs' expertise and standards in child health were not gathered. As a result, it was critical to gather data from ASHAs, which are one of the most essential foundations of India's public health system and solely provide community-based health services. Furthermore, the

knowledge and behaviours of mother beneficiaries served by ASHA workers were not tested in NFHS 4 to assess the outcome of ASHA workers' social mobilization efforts.

ASHAs are also overworked or lack the planning skills to prioritise and finish house visits; presently, they appear to focus more on pregnancy care and delivery cases. ASHAs feel that improved quality training materials and training methodologies on community and social mobilization are required to attain the desired objectives of community mobilization. ASHAs have insufficient assistance from health systems, AWWs, and Panchayat members to assist them in community mobilization. The quality of ASHA workers' training materials and methodologies for community and social mobilization is inadequate. There is a lack of coordination across Ministries of the Government of India to develop coherent ties between ASHA, AWW, and Panchayat members to assist ASHA in efficiently delivering their neighbourhood mobilization portfolio. The majority of ASHAs were aware of their performance-based reward, but were ignorant of the amount of incentive they would receive for any given activity. Some of the issues that most ASHAs confront include a lack of assistance from government health workers, insufficient training, an uncertain remuneration approach, and little openness in terms of collaboration with ANM and AWW (Gosavi, 2011). Female CHWs do their maternal and CH duties with greater earnestness than their male counterparts. Gender-related dynamics influence task sharing. Social activity helps to deploy a large number of CHWs, but it cannot maintain them. (najafizada, 2014). It was discovered that ASHAs knew more than 80% about ANC and PNC, which was much greater than their knowledge of FP, which was just slightly more than 70%. Their understanding of CH was 65%, whereas knowledge of other health concerns was just 67% (Shet, 2018).

The majority of ASHA were aware of regular immunizations, escorting pregnant women to the hospital for delivery, and offering ANC and FP advice. Around 99% of ASHAs were aware of reporting births and deaths, assisting ANM during VHND, and raising awareness about basic hygiene and sanitation (Waskel, 2014). On average, each ASHA serves a 1000-person population and visits around 10 families every week. 34% of ASHAs believe nursing should be ceased at 12 months of age, while 25.8% say breastfeeding should be discontinued if there is diarrhoea. 44% of ASHAs agreed that moms can take OCP throughout the breastfeeding period. Most ASHA personnel were aware of their responsibilities in vaccination, ANC and family planning advising, and escorting pregnant women during institutional births. Approximately 20% of ASHAs were aware of the birth and death registration processes, which aided ANM during VHND. ASHAs collect services and may have a role in providing basic health care; nevertheless, they must still convert knowledge into practice and give guidance on government health services to vulnerable women and children.

## **2. Litreture Review**

M. Singh, J. Singh, and Ahmad et al. (2010) found that women's use of ASHA services for early registration, antenatal care (100 iron and folic acid tablets, 2 tetanus toxoid injections, and 3 antenatal visits), and postnatal care was significantly related to their age and religion. Young, educated, and low socioeconomic status women, as well as those linked to Hindu, scheduled caste, other backward class, middle school pass, low class, and birth order one, used ASHA services to the greatest extent for ANC, postnatal check-up, and other ASHA services. Educated women with educated husbands used ASHA services for postnatal check-ups more frequently. Srivastava et al. (2011) assessed ASHA workers' knowledge, attitudes, and practices regarding child health in Palghar Taluk, Thane District, Maharashtra, during a three-month period. 150 ASHA personnel were chosen from the region. Face-to-face interviews with ASHA staff were conducted utilizing questionnaires. According to the

findings, 67.1% of ASHA workers were unaware of the proper preventative measures for vitamin A deficiency, and 29 (19.9%) of ASHAs did not believe that a kid with diarrhea who was unable to drink or breastfeed required referral. Similarly, in the case of acute respiratory tract infection, 35 (23.9%) of ASHAs were unaware that a kid with rapid breathing should be referred to the hospital. 59 ASHAs (50.4%) believed that an infant screaming for more than three hours was not worth recommending to a first referral unit. Prinjal et al. (2012) conducted a study on "Health Care Inequalities in North India: Role of Public Sector in Universalizing Health Care" to identify disparities in self-reported health status, service utilization, and out-of-pocket expenses across Haryana, Punjab, and the Union Territory of Chandigarh. The data shows that morbidity and hospitalization rates were pro-rich in all three regions of investigation, indicating that low-income families underutilized health resources. Nearly 57% and 60% of the poorest income households in Haryana and Punjab, respectively, faced exorbitant out-of-pocket hospitalization costs at the 10% level. However, the incidence of catastrophic costs was extremely low in upper income categories. The public sector also paid large expenditures, and hospitalization had a poor distribution in many states and UTs. Paul et al. (2013) evaluated the role of accredited social health activists (ASHAs) in ICDS-related activities. Data were gathered from 680 respondents via interview schedules, including ASHAs, health and ICDS bureaucrats, beneficiaries, and community leaders. Respondents were chosen using multi-stage stratified random selection from five states. It was discovered that ASHAs in EAG and North Eastern states had a higher level of awareness about pregnancy care than those in other states. They lack knowledge on washing a newborn, caring for low-birth weight newborns, cord care, keeping a baby warm, and other topics. ASHAs were found to be unaware of nutrition and health education (71%), as well as referral services (41%), among the ICDS programs. In their 2014 study, Karol and Pattanaik evaluated the knowledge and motivation of ASHA (Accredited Social Health Activist) workers in Rajasthan, India, in relation to community health workers, reproductive and child health care. The research included 200 ASHA workers, 100 each from Tonk and Jaipur districts. The study evaluated ASHA workers' socioeconomic position, knowledge of many elements of primary health care services, particularly maternal health, and motivational abilities in maternal and child health care, as well as family planning. The results showed that 90.5, 86.7, and 86.62% of ASHA workers are knowledgeable of reproductive, maternal, and child health care, respectively. However, ASHAs had a lower knowledge score in family planning and HIV/AIDS as compared to maternity and child health care (64.16%). It was also discovered that out of the total number of cases, 67.33% enrolled for Antenatal Care, 72.28% were institutional births, 74.97% got Post Natal Care, and 80.78% infants were covered by vaccination programs. 30.49% of eligible couples used various family planning techniques. Singh and Singh (2015) conducted a study on the role of ASHAs in utilizing Maternal and Child Health Services in Ambala district, Haryana. It was shown that nearly one-third of respondents (76.6%) received Iron Folic Acid pills during their initial Antenatal Care appointments. ASHA encouraged 74.7% of respondents to register at a public health facility for delivery. ASHA escorted more than half (52.5%) of the responders throughout their deliveries. ASHA conducted the majority (79.5%) of PostNatal Care visits. In 94.5% of instances, ASHA visited the mother and child at home. The study indicated that ASHAs were a valuable source of information on accessible health facilities and the use of health services in the study area. 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 Sonapat 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. 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. 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 Conflict affected 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. 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. Kalne et al. (2022) conducted a review research titled "Acknowledging the Role of Community Health Workers in Providing Essential Healthcare Services in Rural India-A Review" to better understand how CHWs provide high-quality healthcare to their target demographic. A comprehensive search of key databases, including PubMed, Google, and Google Scholar, was done to investigate CHWs' performance in providing basic healthcare services in low and middle-income nations. Recent research were examined to determine the beneficial social impact of their work. The study's findings show that there is a growing global interest in measuring the effectiveness of community health workers. In terms of incentives, salary, and training costs, CHWs are seen as a less expensive option than other healthcare professionals. The report also said that CHWs are acknowledged as important contributors to promotional, preventative, curative, and rehabilitative healthcare services, notably in enhancing newborn and maternal health, as well as the well-being of children and adolescents. 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. Sufiya Mohsin 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. 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 Study

1. To find out the perception among urban poor population at the community level about roles and functions of ASHAs'

### Hypothesis of the Study

H01: There was no significant relationship between availability of drugs and respondents received home visits from ASHAs

H02: There was no significant relationship between respondent's knowledge and respondents received home visits from ASHAs

H03: There was no significant relationship between respondent's practice and respondents received home visits from ASHAs

## 3. Research Methodology

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 urban poor mothers from selected three blocks Bakshi ka Talab, Kakori and Sarojini Nagar of Lucknow districts. The sample size for this study is total 330 urban poor mother in three blocks of Bakshi ka Talab, 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

To solicit the views from users' end regarding utility of ASHAs, urban poor respondents were asked about effectiveness of ASHAs scheme, its usefulness, and improvement in health, a Service provider and as an Activist. The analysis of collected information is as follows:

Table 1: Frequency of Ashas' Home Visit

Frequency of Home Visit	N	%
As per Schedule	147	44.55
As per need	141	42.73
Very less	42	12.73
Total	330	100.00

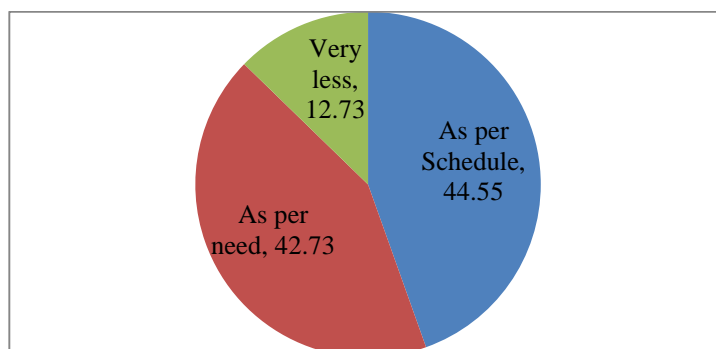


Figure 1: % of Ashas' Home Visit

Table 1 presents the distribution of respondents as per their views on frequency of ASHAs' home visit. This table shows that 44.55% of respondents opined that ASHAs are visiting home as per given schedule, whereas 42.73% of respondents feel that ASHAs are occasionally visiting and 12.73% of respondents feel that ASHAs visiting homes as per need. It is concluded from table that most (87.23%) of respondents opined that ASHAs are visiting home as per schedule (44.55%) or occasionally (42.73%).

Table 2: Improvement in Health Due to Ashas

Level of Improvement	N	%
Highly improved	131	39.70
Partially improved	142	43.03
Very less improved	57	17.27
Total	330	100.00

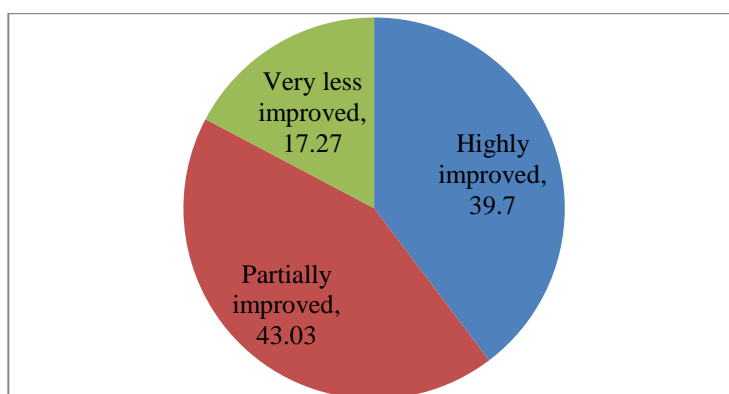


Figure 2: % of Respondent Opinion on Improvement in Health Due to Ashas

Table 2 shows the distribution of respondents as per their views on improvement occurred in health due to ASHAs. This table indicates that 43.03% of respondents opined that health have partially improved due to ASHAs, whereas 39.70% of respondents viewed that health have highly improved and 17.27% of respondents feel that it is very less improved due to ASHA. It is concluded from table that most (82.73%) of respondents viewed that health have highly (39.70%) or partially (43.03%) improved due to ASHAs.

Table 3: Usefulness of Ashas

OPINION	N	%
Fully useful	129	39.09
Partially useful	145	43.94
Very less useful	56	16.97
Total	330	100.00

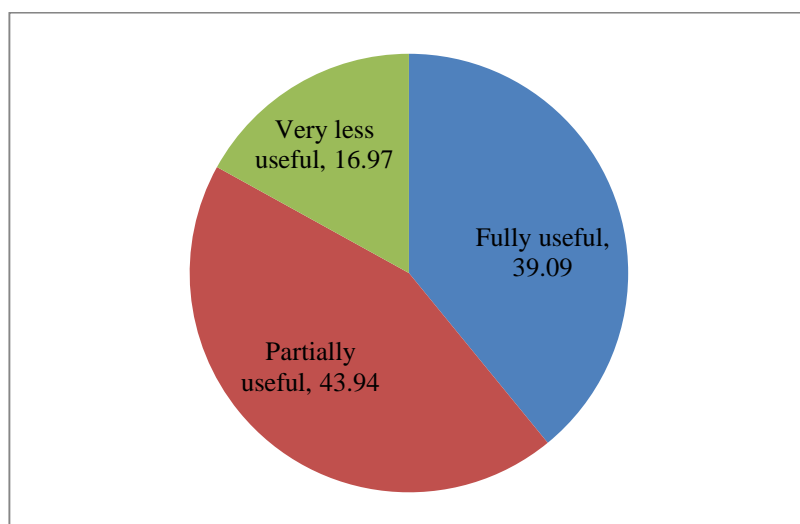


Figure 3: % of Respondent Opinion on Usefulness of Ashas

Table 3 presents the distribution of respondents as per their views on Usefulness of ASHAs. This table shows that 43.94% of respondents opined that ASHAs are partially useful to improve community health services, whereas 39.09% of respondents opined that ASHAs are highly useful and 16.97% of respondents feel that ASHAs are very less useful to improve community health services. It is concluded from table that most (83.03%) of respondents viewed that ASHAs are partially (43.94%) or highly (39.09%) useful to improve community health services.

Table 4: Level of Satisfaction from the Performance of Ashas

Satisfaction Level	N	%
Highly satisfied	112	33.94
Partially satisfied	150	45.45
Very less satisfied	68	20.61
Total	330	100.00

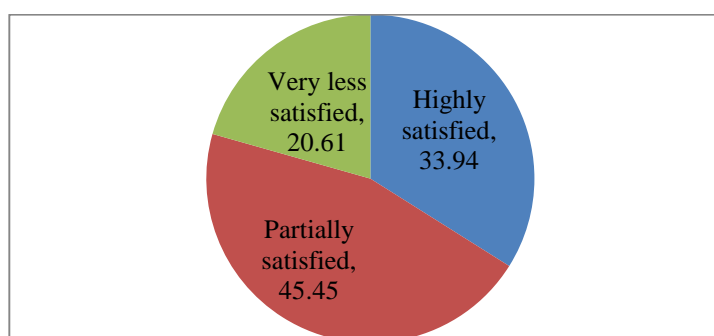


Figure 4: % of Respondent Views on Level of Satisfaction from the Performance of Ashas



Table 4 presents the distribution of respondents as per the their level of satisfaction from the performance of ASHAs. This table shows that 45.45% of respondents are partially satisfied with the performance of ASHAs, whereas 33.94% of respondents are highly satisfied and 20.61% of respondents are very less satisfied with the performance of ASHAs. It is concluded from table that more than three-fourth (79.39%) of respondents are partially (45.45%) or highly (33.94%) satisfied with the performance of ASHAs.

Table 5: Level of Acceptance about Ashas' Suggestions on Sanitation and Health Care

Acceptance Level	N	%
Mostly	69	20.91
Occasionally	172	52.12
Rarely	89	26.97
Total	330	100.00

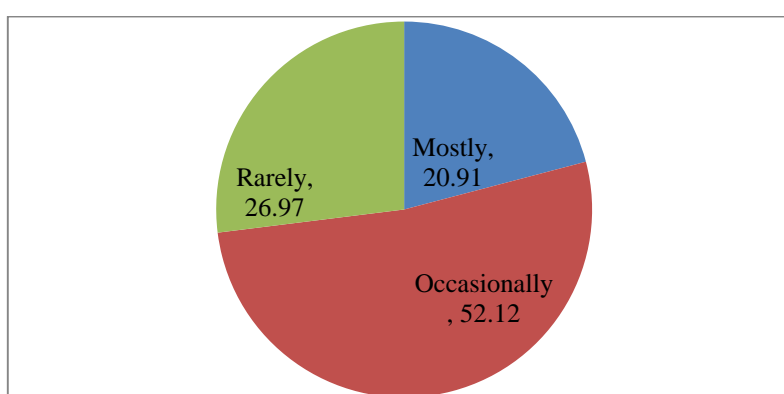


Figure 5: % of Respondent Views on Level of Acceptance about Ashas' Suggestions on Sanitation and Health Care

Table 5 presents the distribution of respondents as per their level of acceptance about ASHAs' Suggestions on Sanitation and health care practices. This table reveals that 52.12% of respondents occasionally accept the suggestions provided by ASHAs on sanitation and health care practices, whereas the 26.97% of respondents rarely accept the suggestions provided by ASHAs on sanitation and health care practices and 20.91% of respondents mostly accept and follow the suggestions given by ASHA on sanitation and health care practices. It is concluded from table that most (79.09%) of the respondents occasionally (52.12%) or rarely (26.97%) accept and follow the suggestions given by ASHA on sanitation and health care practices.

Table 6: Key Variables of Respondent Knowledge and Practices (%)

Variables	Blocks			Total
	Bakshi ka Talab	Kakori	Sarojini Nagar	
Received home visit from ASHA	89.09	82.35	85.71	85.72
Received ORS from ASHA	85.45	82.35	77.55	81.78
Received IFA from ASHA	96.36	100.00	95.92	97.43
ASHA administered IFA	76.36	90.20	57.14	74.57
Diarrhoea episode	27.27	39.22	40.82	35.77

Mothers with correct knowledge of ORS preparation	36.36	54.90	77.55	56.27
Mothers provided and providing Exclusive Breastfeeding to infants	89.09	82.35	55.10	75.51
Mothers provided timely initiation of Complementary Feeding to infants	83.64	82.35	67.35	77.78
Mothers washing their hands with soap and water throughout all the critical times of the day	78.18	78.43	73.47	76.69
Children provided age appropriate vaccines	85.45	82.35	67.35	78.38
Children with age appropriate weights plotted on the MCP card	45.45	33.33	32.65	37.14
Mother knew next date of vaccination	52.73	64.71	48.98	55.47
Mothers knew in which color zone infant weight has been plotted in the MCP card	23.64	9.80	4.08	12.51

### Hypothesis 01

H01: There was no significant relationship between availability of drugs and respondents received home visits from ASHAs

The model below is a linear regression model that attempts to model the relationship between dependent and independent variables by fitting a linear equation to observed data. The independent variables are respondent received home visits from ASHAs. The independent variables are factors that have been hypothesized to have an impact on the dependent variables. In this analysis we are trying to understand and predict dependent variables of availability of drugs with respondent, respondent's knowledge and practice.

Table 7: Regression Analysis

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.121 <sup>a</sup>	0.015	0.011	1.121
a. Predictors:(Constant)				

Table 8: Anova Results

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	3.984	1	3.984	3.175	0.075 <sup>b</sup>
	Residual	274.624	328	1.255		
	Total	278.605	329			
a. Dependent Variable: Availability of drugs						
b. Predictors:(Constant), home visits from ASHAs						

Table 9: Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std.Error	Beta		

1	(Constant)	2.386	0.202		11.868	0.000
	Respondents received home visits from ASHAs	0.386	0.216	0.121	1.783	0.075

There was no significant relationship between Availability of drugs (dependent variable) and independent variable of respondents received home visits from ASHA.

## HYPOTHESIS 02

H02: There was no significant relationship between respondent's knowledge and respondents received home visits from ASHAs

Table 10: Regression Analysis

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.035 <sup>a</sup>	0.002	-0.004	0.765
b. Predictors:(Constant)				

Table 11: Anova Results

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	0.153	1	0.153	0.258	0.612 <sup>b</sup>
	Residual	128.535	328	0.586		
	Total	128.687	329			
c. Dependent Variable: Respondent's knowledge						
d. Predictors:(Constant), home visits from ASHAs						

Table 12: Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.162	0.137		8.441	0.000
	Respondents received home visits from ASHAs	0.075	0.147	0.035	0.508	0.612

There was no significant relationship between respondent's knowledge (dependent variable) and independent variable of respondents received home visits from ASHA.

## HYPOTHESIS 03

H03: There was no significant relationship between respondent's practice and respondents received home visits from ASHAs

Table 13: Regression Analysis

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.202 <sup>a</sup>	0.041	0.035	1.732
c. Predictors:(Constant)				

Table 14: Anova Results

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	27.646	1	27.646	9.226	0.004 <sup>b</sup>
	Residual	656.164	328	2.995		
	Total	683.811	329			
e. Dependent Variable: Respondent's practice						
f. Predictors:(Constant), home visits from ASHAs						

Table 15: Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std.Error	Beta		
1	(Constant)	4.872	0.312		15.667	0.000
	Respondents received home visits from ASHAs	1.018	0.336	0.202	3.037	<b>0.004</b>

There is a significant relationship between respondents practice (dependent variable) and independent variable of respondent received home visits from ASHA.

#### 4. Conclusion

It is clearly evident that, there is growing awareness and need in the health sector for the increased value of contribution provided by community health programmes involving CHW for generating awareness on public health service. However, community health programmes have some limitations such as social determinants, cultural practices followed by the families in the rural areas, ability of CHWs to mobilize community and generating awareness regarding public health services and getting the ownership from the community for scalability. It is essential to understand and discourse the prospect of CHW programmes which is one of the key challenge in institutionalizing community participation in public health service delivery. ASHAs are incentivized for conducting home visits for providing counselling support to mothers with infants up to one years of age. ASHAs could play an important role in improving child health indicators in rural urban poor parts of India through social mobilization.

ASHAs can further contribute in reducing child morbidity and mortality, if supported with trainings, supportive supervision and incentives for motivation. It is clearly evident that, there is growing awareness and need in the health sector in India for the increased value of contribution provided by ASHAs for generating awareness on public health services. Significant improvement in health indicators in urban parts of three blocks of Lucknow districts Bakshi ka Talab, Kakori and Sarojini Nagar between 2019 and 2023 can be directly associated with the contribution and attribution by ASHA workers. Independent assessments have also suggested, increased contribution of ASHA workers in improving urban poor health outcomes in blocks where ASHAs are provided additional training on Child Health interventions and improving social mobilizations skills.

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