

**ASSESSMENT OF THE KNOWLEDGE GAPS, ATTITUDINAL BARRIERS, AND
PRACTICE CHALLENGES FACED BY AUXILIARY NURSE MIDWIVES AND
MEDICAL OFFICERS IN IMPLEMENTING URBAN AYUSHMAN AROGYA
MANDIR SERVICES IN JAIPUR DISTRICT, RAJASTHAN**

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The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

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Under the Supervision and Guidance of

Dr. Goutam Sadhu

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CERTIFICATE

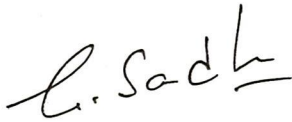
This is to certify that **Dr. Eshvita Bhadoo**, student of MBA, Indian Institute of Health Management Research (IIHMR University, Jaipur) has successfully completed her Dissertation & Internship at National Health Mission, Rajasthan from 10th March, 2025 to 31st May, 2025.

Her performance was found satisfactory. We extend her good wishes for a bright and successful career ahead.


(Dr. Bharti Dixit)
Mission Director, NHM
Joint Secretary
Medical Health & Family Welfare

CERTIFICATE

This remains to certify that dissertation titled **“Assessment of the knowledge gaps, attitudinal barriers, and practice challenges faced by Auxiliary Nurse Midwives and Medical Officers in implementing Urban Ayushman Arogya Mandir services in Jaipur District, Rajasthan”** remains a record of the research work undertaken by Dr. Eshvita Bhadoo in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study possesses been sincere, scientific, and analytical.

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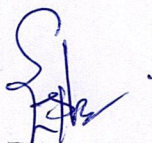
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Date

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **“Assessment of the knowledge gaps, attitudinal barriers, and practice challenges faced by Auxiliary Nurse Midwives and Medical Officers in implementing Urban Ayushman Arogya Mandir services in Jaipur District, Rajasthan”** is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



Dr. Eshvita Bhadoo

Date 20/06/2025.

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Table of Contents

DECLARATION BY STUDENT	Error! Bookmark not defined.
List of Tables	4
List of Figures.....	4
Abbreviations	4
Abstract.....	5
Chapter 1- Introduction	6
Background	6
Chapter 2- Review of literature	9
Research gap.....	12
Research question	12
Chapter 3- Methodology.....	13
Objectives.....	13
Study design.....	13
Study population	13
Setting (Research area).....	13
Data collection method	14
Sampling design	14
Sample size.....	14
Sampling technique.....	14
Development of the tool	14
Description of the tool.....	16
Scoring and interpretation	18
Data analysis.....	19
Chapter 4- Result	20
Chapter 5- Discussion	30
Chapter 6- Conclusion	33
Chapter 7- Recommendations.....	35
References.....	41

List of Tables

S. no.	Title	Page No.
Table 1	Card Tests	09
Table 2	Overview of reviewed papers	10
Table 3.1	Interpretation Criteria for Knowledge score	19
Table 3.2	Interpretation Criteria for Attitude score	19
Table 3.3	Interpretation Criteria for Practice score	20
Table 4.1	Results for the knowledge assessment	26
Table 4.2	Descriptive Statistics of Attitude barriers: A comparison table of MOs and ANMs	22
Table 4.3	Descriptive Statistics of Practices Assessment of MOs and ANMs	25
Table 4.4	Summary of Findings	27

List of Figures

S no.	Title	Page No.
Figure 1	Key steps in KAP development	16

Abbreviations

ANM	Auxiliary Nurse Midwifery
IEC	Information, Education, and Communication
KAP	Knowledge, Attitude and Practice
MO	Medical Officer
U-AAM	Urban Ayushman Arogya Mandir

Abstract

Objectives of the study:

This study aimed to identify and analyze the knowledge gaps, attitudinal barriers, and practice challenges faced by ANMs and MOs in implementing U-AAM services in Jaipur District, Rajasthan. It also sought to compare KAP differences between the two cadres and correlate these with demographic and professional characteristics.

Methods:

A cross-sectional mixed-methods design was employed. The quantitative component involved a structured KAP survey administered to ANMs and MOs working at U-AAM centers in Jaipur. The qualitative component included in-depth interviews with a purposively selected sample to explore deeper insights into implementation challenges. Data was analyzed using descriptive statistical methods, while qualitative responses were coded thematically.

Results:

Findings revealed significant knowledge gaps in key areas such as U-AAM operational guidelines and service protocols. While both ANMs and MOs generally held positive attitudes toward the U-AAM mission, practical challenges—such as staff shortages, high patient load, and inadequate infrastructure—hindered effective implementation. Differences in knowledge and practices were observed between ANMs and MOs, often linked to their training and experience levels.

Conclusion:

This study highlights the critical need for targeted capacity-building interventions, improved infrastructure, and context-specific policy support to enhance the performance of frontline workers in U-AAM centers. Strengthening the knowledge base and addressing attitudinal and practical barriers among ANMs and MOs is essential for the success of Urban Aayushman Arogya Mandir initiatives in India.

Keywords: Urban Ayushman Arogya Mandir, Knowledge-Attitude-Practice (KAP), Auxiliary Nurse Midwives, Medical Officers, Urban Health, Jaipur, India, Primary Healthcare.

Chapter 1- Introduction

Background

The Urban Ayushman Arogya Mandir (U-AAM) programme is a major development in India's urban primary healthcare strategy. The genesis of U-AAM is traced back to the identified differences between rural and urban healthcare access in India. Although the National Rural Health Mission (NRHM) initiated in 2005 greatly enhanced rural healthcare infrastructure, urban slum and underserved populations still encountered difficulties in availing primary healthcare. Despite of having a larger number of health facilities, the urban poor sections experienced major difficulties in accessing economical primary healthcare facilities, with a high level of out-of-pocket spending.

The ground for U-AAM was prepared with the National Urban Health Mission (NUHM), which was sanctioned in 2013, a sub-mission of the National Health Mission. NUHM was established to meet the healthcare demands of the urban and poor urban population through the strengthening of the primary health system. NUHM brought with it Urban Primary Health Centres (UPHCs) to establish comprehensive primary care facilities for providing services to city dwellers.

Ayushman Bharat initiative, started in 2018, was the turning point for India's health policy with twin pillars:

1. Pradhan Mantri Jan Arogya Yojana (PM-JAY): A government health insurance plan for secondary and tertiary care.
2. Health and Wellness Centres (HWCs): Built for Integrated Primary healthcare Services

Between 2018-2021, Urban Health and Wellness Centres (U-HWCs) came up as the urban equivalent of rural HWCs. At initial implementation of U-HWCs in pilot cities, adjustments necessary for the urban environment, such as round-the-clock operation, miniaturized infrastructure, and merging with other urban health infrastructure were observed.

The shift from Urban Health and Wellness Centres to Urban Ayushman Arogya Mandir (U-AAM) commenced in late 2021 and was legalized in 2022 as part of the government initiative to establish a uniform brand image for these canter across the nation.

As per the operational guidelines released by the National Health Authority (2022), the rebranding was intended to establish a unique identity for these canters while ensuring continuity in service delivery and increasing their scope.

Rajasthan introduced U-AAMs in 2022 as part of the urban health policy of the state. The state made the efforts towards the implementation of U-AAMs in urban cities, such as Jaipur, with a focus on localities with high density of vulnerable populations.

The Rajasthan State Health Systems Resource Centre (2022) documented that the state followed a phased strategy, beginning with upgrading existing UPHCs to U-AAMs and then opening new canters on population density and need assessment.

The current guidelines of U-AAM under Department of Medical, Health & Family welfare Services, Government of Rajasthan includes

- **Project Goals**

To improve the health status of underserved and vulnerable population of the state by setting up Urban Ayushman Arogya Mandirs in the marginalized population in the urban areas of Rajasthan.

- **Objectives of the Project**

- i) To provide high-quality IT-enabled primary health care services to the underserved & vulnerable population of the state.
- ii) To create a longitudinal medical history i.e Electronic Health Records of all the beneficiaries.

- **Implementation Strategy**

The implementation strategy will be as follows:

- **Population Coverage:** A U-AAM will be catering to a population of more than 15,000.
- **Location:** U-AAM will be established in the urban underserved, densely populated areas like the slums. Each U-AAM will be linked to a nearby PHC/UPHC.
- **Human Resource:** The U-AAM is to be staffed with a Medical Officer, a Staff Nurse, Pharmacist, Male-MPW, ANM and support staff.

- Services at U-AAM must include
 - 1) OPD consultations by the Medical Officer.
 - 2) Availability of free drugs as per the guidelines provided by the Government of India and 8 free card tests namely

Table 1: Card Tests

Branch	Name of the tests
Clinical Pathological test	Haemoglobin Estimation (Hb)
	Malaria Card Test
	Dengue Rapid Card
Bio Chemistry	Blood Sugar
Microbiology	VDRL Rapid Test
	HIV Card Test
Urine Analysis	Urine Albumin Sugar
	Urine Pregnancy test (UPT)

- 3) RCH services including
 - a) Adolescent Health services
 - b) Maternal health services (Ante Natal Care)
 - c) Immunization services
 - d) Child Health Services
 - e) Family Welfare services
- 4) NCD Screening
- 5) Referral

Chapter 2- Review of literature

Table 2.1 Overview of reviewed paper

S. No.	Author name & Year	Study Location	Sample size (S.S.) and sample technique (S.T.)	Salient Features
1.	Shilpa Karvande, S. S. Gopalakrishnan, Vidula Purohit, B. Subha Sri, Nerges Mistry & Matthews Mathai Year: 2020	Pune District, Maharashtra, India	S.S.-Directed learning: 348 ANMs Self-directed: 125 ANMs S.T.- Program-based inclusion	- Evaluated effectiveness of directed + self-directed learning in skill-building - Significant improvement in maternal/newborn care skills - Better skill improvement in less-experienced ANMs - Kirkpatrick model used for evaluation - Self-directed methods enhanced confidence, experience sharing
2.	Thidar Pyone, Shilpa Karvande, S. S. Gopalakrishnan, Vidula Purohit, Sarah Nelson, S. Balakrishnan, Matthews Mathai, Nerges Mistry. Year 2019	Pune District, Maharashtra, India	S.S.-13 key informants, 41 ANMs (FGDs), 25 community members, 8 observations S.T- Purposive Sampling	- Identified mechanisms (training, supervision, accountability) affecting ANM performance. - Weak regulation and inadequate supervision hindered ANM effectiveness. - Gender norms and hierarchical structures impacted accountability - Realist lens used for analysis
3.	Samiksha Singh, Sanjeev Upadhyaya, Pradeep Deshmukh, Amol Dongre, Neha Dwivedi, Deepak	South India (tribal and non-tribal areas)	S.S.- 114 frontline workers (43 female & 6 male MPHWs, 12 AWWs, 53 ASHAs)	Mixed methods time-motion study Median work hours: ANMs – 7:04 hrs FLHWs in tribal areas spent less time on tasks.

	Dey, Vijay Kumar		S.T.- not specified in the study	• MCH prioritized by ANMs/AWWs; MPHWS focused on seasonal illnesses. • Systemic and personal factors influenced efficiency
4.	Mahesh Chendake, V. R. Mohite, Manisha C Gholap, P. Hiremath, Prakash Naregal. Year: 2015	Satara District, Maharashtra, India	S.S.- 36 ANMs S.T.- Cross-sectional survey	• Assessed knowledge & attitude towards HIV/AIDS 50% had good knowledge; 62.82% average knowledge score 73.66% showed positive attitude • No significant statistical correlation found • Structured questionnaire was used
5.	Bajpai, N., & Wadhwa, M. (2021)	Uttar Pradesh & Tamil Nadu	S.S.- 1000 ANMs across two states S.T.- Multi-stage random sampling	• Found large gaps in clinical knowledge and limited use of training modules among ANMs • Highlighted need for continuous professional development.
6.	Chokshi, M., Patil, B., Khanna, R., & Puri, P. (2016)	Urban health centres across India	S.S.- Policy evaluation S.T.- Document review and key informant interviews	• Highlighted that urban health reforms under NUHM often fail due to lack of community engagement and unclear staff roles.
7.	Chauhan, M., Vora, K. S., & Patel, A. (2022).	Gujarat (Health & Wellness Centres)	S.S.- 48 facilities, 120 service users S.T.- Purposive sampling for facilities; systematic for clients	• Found improved branding led to better visibility but service uptake was hindered by stockouts and inadequate staff availability.

8.	Ray, K., Banerjee, M., & Roy, A. (2020).	Kolkata, West Bengal	S.S.- 150 ANMs S.T.- Stratified random sampling	• Identified poor knowledge of public health programs among ANMs, especially in urban areas. • Training was irregular and often outdated.
9.	Thakur, H., Panigrahi, B., & Singh, S. (2018)	Chandigarh	S.S.- 60 MOs and ANMs S.T.- Convenience sampling	• Identified administrative burden and multiple reporting formats as barriers to efficient service delivery. • Found moderate levels of motivation.

Research gap

Despite the increasing policy focus on strengthening urban primary healthcare by the Urban Ayushman Arogya Mandir (U-AAM) scheme under the Ayushman Bharat initiative, there exists an evident research gap with regard to investigating the ground realities of its implementation at the frontline level. Although certain research works have stressed the need for skill development and capacity building of healthcare providers, especially Auxiliary Nurse Midwives (ANMs), such studies have been mostly focused on rural areas and maternal and child health services with very little insight into the peculiar challenges of healthcare provision in the urban context.

Critically, the literature is deficient with respect to holistic reviews of the Knowledge, Attitude, and Practice (KAP) of frontline healthcare workers—ANMs and Medical Officers (MOs)—towards U-AAM's vast array of preventive methods, promotive efforts, curative care, rehabilitative and palliative services. Additionally, urban-specific issues like plural disease burdens, population mobility, and coordination in service delivery in densely populated urban settings are under-researched.

There is also a strong methodological gap: there are hardly any studies using a mixed-methods approach that ties together quantitative KAP analysis with qualitative findings to get at the whole richness of implementation impediments on the ground. Further, district-level studies in Rajasthan—particularly in the urban areas like Jaipur—are surprisingly limited, even though the program was rolled out statewide.

This research addresses these gaps in a direct way by examining knowledge gaps, attitude barriers, and practice issues of ANMs and MOs in providing U-AAM services in Jaipur District. Through using a mixed-methods design, the research offers context-specific, evidence-based findings required to inform focused training, policy improvement, and health system strengthening in line with the Ayushman Bharat scheme.

Research question

What are the knowledge gaps, attitudinal barriers, and practice challenges faced by Auxiliary Nurse Midwives and Medical Officers in implementing Urban Ayushman Arogya Mandir services in Jaipur District, Rajasthan?

Chapter 3- Methodology

Objectives

Primary Objective

To identify and analyse the knowledge gaps, attitudinal barriers, and practice challenges faced by ANMs and MOs in implementing U-AAM services in Jaipur District.

Secondary Objectives

- I. To assess the current level of knowledge among ANMs and MOs regarding U-AAM protocols, guidelines, and services provided.
- II. To identify attitudinal factors that facilitate or hinder the implementation of U-AAM services.
- III. To document practice patterns, deviations from recommended U-AAM implementation guidelines.
- IV. To develop evidence-based recommendations for improving U-AAM implementation through targeted interventions.

Study design

This study is a cross-sectional mixed-methods study which includes

- Quantitative component: KAP survey questionnaire
- Qualitative component: In-depth interviews and focus group discussions
- Observational component: Based on the observations made by the interviewer

Study population

The study population for this includes the ANMs and MOs currently involved in U-AAM implementation in Jaipur District.

Setting (Research area)

The study was carried out across the Urban Aayushman Arogya Mandir, health facilities in Jaipur, Rajasthan, including:

- ❖ U-AAM- Shekhawati Vikas Parishad, Jaipur
- ❖ U-AAM community building, Murlipura, Jaipur
- ❖ U-AAM Ward number 32, Kanta Chauraha, Jhotwara, Jaipur

- ❖ U-AAM Ward number 19, plot number 59A, Lakshmi Nagar Nangal , Jhotwara, Jaipur
- ❖ U-AAM Ward number 45, community Bhavan, Durga Mata Mandir ke pass, Sushilpura, Jaipur
- ❖ U-AAM Ward number 47, community centre, Madrampura, civil lines, Jaipur
- ❖ U-AAM ward number 33, Bora ka bas, Panchayat samiti ke samne, Jaipur
- ❖ U-AAM, Secretariat, Jaipur

Data collection method

Data was collected using different tools

- Structured KAP questionnaire
- Interview guide for in-depth interviews
- Observations of service delivery processes

Sampling design

Sample size

The study included a total of 8 U-AAM facilities across Jaipur.

Sampling technique

Systematic random sampling based on professional role (ANMs, MOs)

Inclusion criteria

Minimum 3 months' experience in U-AAM services

Exclusion criteria

Other administrative staff directly or not directly involved in service delivery

Development of the tool

The questionnaire was developed after an extensive review of existing literature, national guidelines on cancer screening (such as the NPCDCS guidelines), and discussions with public health experts and practitioners. The goal was to create a practical and contextually relevant tool that could accurately capture both qualitative and quantitative aspects of cancer screening practices at the primary care level.

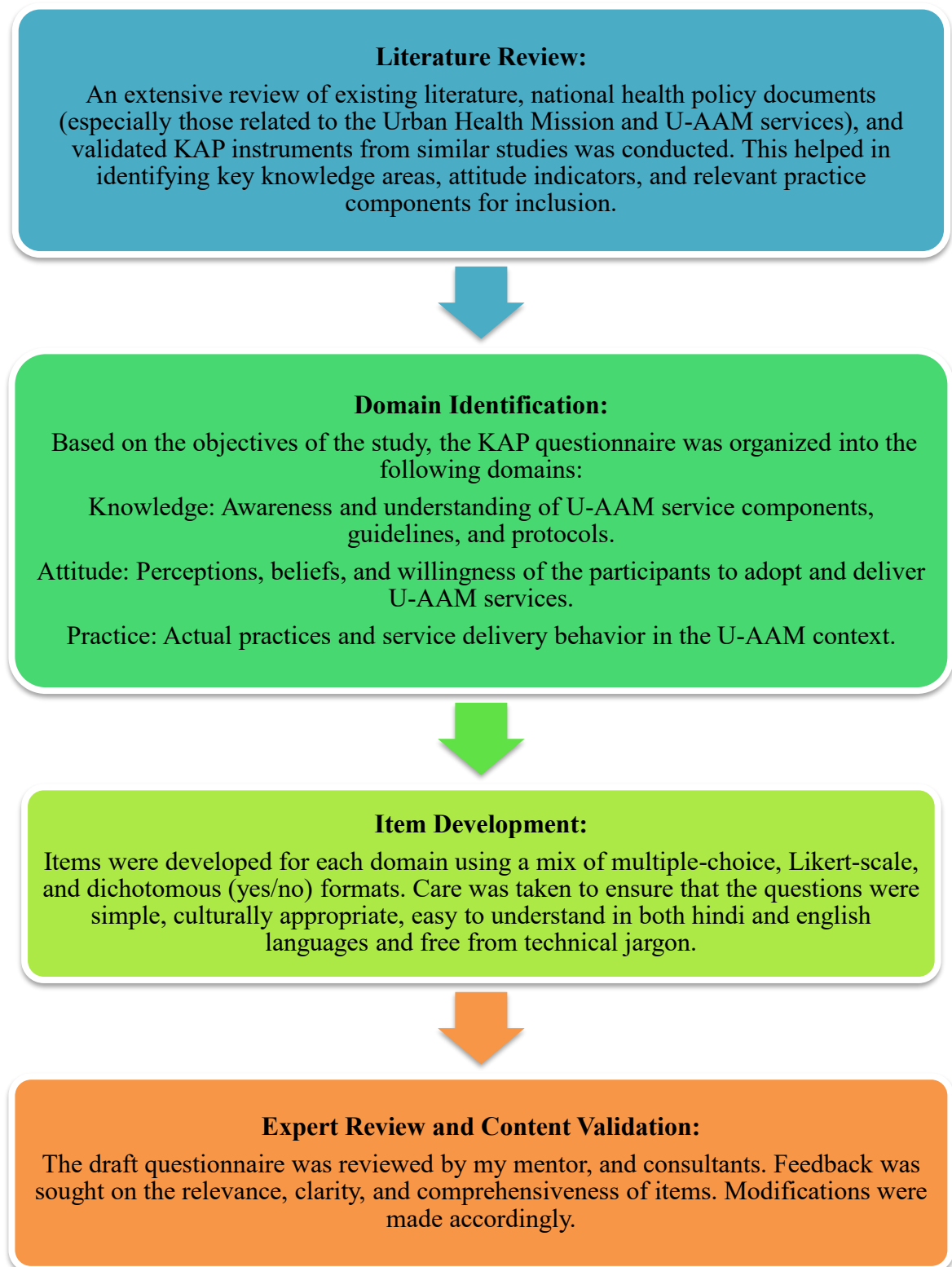


Figure 1 Key steps in KAP tool development

Description of the tool

Primary Data Collection Tool: Structured KAP Questionnaire

The primary quantitative data collection instrument employed in this study was a **structured, self-administered KAP (Knowledge, Attitude, Practice) questionnaire**, developed to assess the **knowledge gaps, attitudinal barriers, and practice challenges** faced by **Auxiliary Nurse Midwives (ANMs) and Medical Officers (MOs)** in implementing **Urban Ayushman Arogya Mandir (U-AAM)** services in Jaipur District.

The questionnaire was designed using **Google Forms** for ease of administration, accessibility, and efficient data collation. It consisted of **close-ended questions**, including multiple-choice and Likert-scale types, and was structured into three primary domains: **Knowledge, Attitude, and Practice**.

Structure and Components of the Questionnaire

The tool was divided into the following key sections:

1. Respondent Profile

This section collected demographic and professional background information to contextualize KAP responses.

- Name (optional)
- Designation (ANM or MO)
- Age and Gender
- Years of Experience
- Facility Type and Urban Ward Location

2. Knowledge Domain

Assessed awareness of U-AAM services, service components, screening protocols, and documentation.

- Awareness of U-AAM services and operational guidelines
- Knowledge of services provided under U-AAM
- Understanding of eligibility criteria, frequency, and target populations
- Familiarity with documentation and reporting procedures

Question Type: Multiple-choice and dichotomous (Yes/No)

3. Attitude Domain

Explored healthcare providers' perceptions and beliefs about the importance, feasibility, and value of implementing U-AAM services.

- Perceived importance of preventive services
- Willingness to implement screening and follow-up
- Views on workload, community engagement, and training needs

Question Type: 5-point Likert Scale (1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree)

4. Practice Domain

Captured the real-world practices and challenges experienced by providers in delivering U-AAM services.

- Frequency of service delivery (screenings, health education, follow-up)
- Availability of infrastructure and logistics
- Participation in U-AAM-related trainings and IEC activities
- Adherence to protocols and referral systems

Question Type: Frequency scale (1 = Never; 2 = Rarely; 3 = Sometimes; 4 = Often; 5 = Always)

5. General Questions regarding the common challenges and available services

It helped to understand better the challenges that might have been missed during the In-depth Interviews.

Question Type: Multiple-choice questions

Scoring and interpretation

The scoring of the data was done keeping in mind certain criteria

1. Knowledge Score

Scoring Method:

Each question = 1 point for a correct answer, 0 for incorrect

Total questions = 12

Final Score = (Number of correct answers ÷ 12) × 100

Table 3.1: Interpretation criteria for knowledge score

Score (%)	Interpretation
≥ 75%	Good Knowledge
50–74%	Moderate Knowledge
< 50%	Poor Knowledge

2. Attitude Score

Scoring Method:

5-point Likert scale (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

Multiple attitude statements scored

Final Score = Mean of all attitude responses

Table 3.2: Interpretation criteria for attitude score

Mean Score	Interpretation
≥ 4.0	Positive Attitude
3.0 – 3.9	Neutral Attitude
< 3.0	Negative Attitude

3. Practice Score

Scoring Method:

5-point Likert scale (1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always)

Each recommended practice scored

Final Score = Mean of all practice-related responses

Table 3.3: Interpretation criteria for practice score

Mean Score	Interpretation
≥ 4.0	Positive Practice
3.0 – 3.9	Moderate Practice
< 3.0	Negative Practice

Data analysis

The data collected through the KAP questionnaire were downloaded from Google Forms in Excel format and analysed using **Microsoft Excel and SPSS (Version XX)**.

Steps in Analysis:

1. **Data Cleaning:** Checked for completeness, removed duplicate or inconsistent entries.
2. **Descriptive Statistics:**
 - Frequency, percentage, mean, and standard deviation were calculated for demographic and KAP responses.
3. **Scoring and Categorization:**
 - Knowledge, attitude, and practice scores were computed as per the criteria described above.

Chapter 4- Result

4.1 Quantitative Result

Based on the google form questionnaire mentioned in ANNEXURE I.

4.1.1 Knowledge Results

The knowledge of Medical Officers (MOs) and Auxiliary Nurse Midwives (ANMs) regarding Urban Ayushman Arogya Mandirs (UAAMs) was assessed through 12 questions. Each question had a correct or incorrect answer. The overall average percentage of correct answers was 60.2%, indicating a moderate level of knowledge.

Table 4.1: Results for the knowledge assessment

SECTION B: KNOWLEDGE ASSESSMENT	Percentage correct
Are you aware of the guidelines provided by the government of Rajasthan, for implementing UAAM?	90.00%
What is the best description of the primary goal of Urban Ayushman Arogya Mandir (UAAM)?	40.00%
What is the suggested population for a UAAM service?	0.00%
National guidelines specify the minimum number of antenatal checkups for pregnant women to be	40.00%
What is TRUE regarding NCD screening in UAAM centres?	70.00%
What is the proper procedure for referral of complicated cases from UAAM?	70.00%
What are the data recording systems used at your UAAM?	90.00%
How many investigations are available at a UAAM centre as per the guidelines?	40.00%
What is the correct procedure for biomedical waste management at UAAM?	100.00%
Which of the following are components of UAAM service delivery?	65%
Objectives of the UAAM program are	31%
Which of the following services are available at a UAAM centre?	86%

Overall Mean Score: 60.2%

The highest correct response rate was 100%, and the lowest was 0%, showing a wide variation in understanding.

Twenty five percent of the questions had more than eighty seven percent correct responses, suggesting strong knowledge in a few areas.

Meanwhile, a quarter of the questions had correct response rates of less than forty percent, indicating significant knowledge gaps, especially related to:

- Population norms for UAAM coverage
- Minimum service provisions
- Detailed roles in NCD screening

4.1.2 Attitude Results

The attitude domain was scored on a 5-point Likert scale with the readings as 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

Table 4.2 Descriptive Statistics of Attitude barriers: A comparison table of MOs and ANMs				
Professional Role		N	Mean	Std. Deviation
Medical Officer	Urban Arogya Mandir is an effective approach to address the healthcare needs of urban population.	5	4.60	.548
	The services provided at UAAM are comprehensive enough to meet the primary healthcare needs of the community.	5	4.20	.837
	The UAAM guidelines and protocols are practical and easy to implement.	5	4.40	.894
	Community participation is essential for the effective functioning of UAAM.	5	4.80	.447
	I feel confident in my ability to provide all services required at UAAM.	5	4.40	.894
	I believe my role in UAAM implementation is clearly defined.	5	4.80	.447
	Training for UAAM is required.	5	3.80	1.304
	The current staffing pattern at UAAM is adequate for effective service delivery.	5	3.40	1.140
	The infrastructure and equipment at UAAM are sufficient for providing quality services.	5	3.40	.894
	The supply of essential medicines and consumables is consistent at our UAAM.	5	3.60	.548
	The workload at UAAM is manageable with the current staff strength.	5	4.00	.707
	Adequate support from supervisors and district officials for implementing UAAM services is received.	5	4.20	.837
	The referral linkages between UAAM and higher facilities function effectively.	5	4.00	.707

	Documentation and reporting requirements at UAAM are reasonable and manageable.	5	4.00	.707
	Community awareness about UAAM services is adequate in our service area.	5	4.00	.000
	Valid N (listwise)	5	4.083	
Auxiliary Nurse Midwifery	Urban Arogya Mandir is an effective approach to address the healthcare needs of urban population.	5	3.20	1.643
	The services provided at UAAM are comprehensive enough to meet the primary healthcare needs of the community.	5	4.00	1.225
	The UAAM guidelines and protocols are practical and easy to implement.	5	3.80	1.643
	Community participation is essential for the effective functioning of UAAM.	5	3.60	1.673
	I feel confident in my ability to provide all services required at UAAM.	5	4.00	1.732
	I believe my role in UAAM implementation is clearly defined.	5	4.00	1.732
	Training for UAAM is required.	5	3.20	2.049
	The current staffing pattern at UAAM is adequate for effective service delivery.	5	3.60	1.673
	The infrastructure and equipment at UAAM are sufficient for providing quality services.	5	3.60	1.517
	The supply of essential medicines and consumables is consistent at our UAAM.	5	3.40	1.817
	The workload at UAAM is manageable with the current staff strength.	5	3.80	1.643
	Adequate support from supervisors and district officials for implementing UAAM services is received.	5	3.00	1.871
	The referral linkages between UAAM and higher facilities function effectively.	5	2.80	1.789

	Documentation and reporting requirements at UAAM are reasonable and manageable.	5	3.80	1.643
	Community awareness about UAAM services is adequate in our service area.	5	3.80	1.643
	Valid N (listwise)	5	3.553	

Table 4.2 clearly states that having an average attitude score of 4.6 on the attitude scale, Medical Officers showed a rather positive attitude toward the implementation of U-AAM services. This means they highly endorse the objectives of the program and feel that the program is competently delivered. In contrast, ANMs recorded a moderate mean score of 3.2, indicating that although they view U-AAM programs favourably on the whole, they have doubts as to the feasibility and clarity of the operational guidelines. Such divergence indicates the need to resolve and attend to concerns unique to ANMs in order to become a better cohesive support for project implementation.

4.1.3 Practice Results

The practice section also used a 5-point scale (1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always) to evaluate adherence to recommended practices. The results were as follows:

Table 4.3 Descriptive Statistics of Practices Assessment of MOs and ANMs

Professional Role		N	Mean	Std. Deviation
Medical Officer	Preventive health education is provided to patients during their visits.	5	4.6	0.548
	All eligible adults visiting UAAM facility are screened for hypertension and diabetes.	5	5	0
	Complete antenatal care services are provided as per guidelines.	5	3.6	0.548
	Immunization for children is done at the facility.	5	4.8	0.447
	Growth monitoring for children under five years is done at the facility.	5	3.4	1.14
	Family planning counselling sessions are available at the facility.	5	2.6	0.548
	Complete and accurate patient records are maintained.	5	5	0
	Outreach activities are conducted in the service area.	5	2.2	1.095
	Follow up reminders are being given to the patients prior to their scheduled re-visits.	5	3.8	1.304
	Community-based groups (MAS, ASHA) for health promotion are coordinated with UAAM.	5	3.6	0.894
	The inventory of medicines and supplies is checked regularly.	5	4.6	0.548
	Monthly review meetings to discuss service delivery are conducted.	5	3.2	0.447
	Feedback from patients about the services provided are regularly taken.	5	4.2	0.837
	Valid N (listwise)	5	3.785	
Auxillary Nurse Midwifery	Preventive health education is provided to patients during their visits.	5	4.6	0.894
	All eligible adults visiting UAAM facility are screened for hypertension and diabetes.	5	4.8	0.447
	Complete antenatal care services are provided as per guidelines.	5	4.6	0.548
	Immunization for children is done at the facility.	5	5	0
	Growth monitoring for children under five years is done at the facility.	5	4.8	0.447
	Family planning counselling sessions are available at the facility.	5	4.4	1.342

	Complete and accurate patient records are maintained.	5	5	0
	Outreach activities are conducted in the service area.	5	3.6	1.949
	Follow up reminders are being given to the patients prior to their scheduled re-visits.	5	4.2	1.789
	Community-based groups (MAS, ASHA) for health promotion are coordinated with UAAM.	5	4.8	0.447
	The inventory of medicines and supplies is checked regularly.	5	5	0
	Monthly review meetings to discuss service delivery are conducted.	5	4.2	1.304
	Feedback from patients about the services provided are regularly taken.	5	4.6	0.894
	Valid N (listwise)	5	4.567	

The above Table clearly reflects that both Medical Officers and Auxiliary Nurse Midwives had high rates of conformity to suggested practices under the Urban Ayushman Arogya Mandir (UAAM) scheme, with a similar average practice score of 4.6. This reflects satisfactory levels of practice among cadres, indicating that the most crucial service delivery elements—patient education, preventive health check-ups, and screening for non-communicable diseases—are being suitably implemented. The consistency in practice scores similarly indicates a common knowledge and implementation of fundamental UAAM mandates, confirming the program's operational reliability at the grassroots level.

4.2 Qualitative Results

Based on the interview question mentioned in ANNEXURE II, in depth interviews with 5 ANMs and 3 MOs were conducted. During the interview three main themes were recognized given below.

1. Capacity and Training needs

The first dominant theme highlights the persistent knowledge and skills gaps in delivering UAAM services. Healthcare providers frequently mentioned their need for additional training — particularly in conducting card tests, NCD service delivery, and proper implementation of health guidelines. Some were unsure about health and wellness activity protocols and how to handle cases when guidelines were unavailable or hard to follow in practice. There were reports that many felt ill-equipped due to a lack of training, which

directly impacted their ability to provide services effectively and to perform health screenings with confidence.

2. Structural and Logistic Barriers

The second key theme underscores a range of structural and logistical bottlenecks that undermine service delivery. ANMs and MOs described poor infrastructure — from unreliable water supply and lack of storage space to insufficient furniture and poor maintenance — as a major barrier to delivering care. Furthermore, scarcity of essential medicines, shortage of human resources, and weak physical facilities were frequently cited as obstacles. Without proper resources, health workers struggle to carry out their responsibilities, adding pressure to their workloads and reducing the overall quality of service delivery.

3. Implementation and Operational Constraints

The third theme focuses on the operational and policy-related issues that affect day-to-day service delivery. Some health workers were unaware of guidelines or were unsure about procedures due to poor communication and oversight. There were reports of heavy workloads, overlapping responsibilities, and competing priorities — for example, ANMs needing to attend meetings or perform administrative tasks instead of health service delivery. Additionally, a lack of community awareness and participation in health and wellness activities was described as a challenge to delivering effective care. Together, these factors reflect a gap not just in resources or training but in the implementation mechanisms required to translate policy into practice.

4.3 Overview of Findings

Table 4.4 Summary Table of the findings

Domain	Medical Officers	ANMs
Knowledge	Good to Moderate	
Attitude	Positive (4.6/5)	Moderate (3.2/5)
Practice	Moderate (3.9/5)	Positive (4.6/5)

The summary findings depicts a complex picture of the dynamics of KAP (Knowledge, Attitude, Practice) among Mos and ANMs in U-AAM services. Medical officers' practice

level was marginally lower at 3.9, indicating potential operational or systemic limitations, although they showed good to moderate understanding and a clearly positive attitude (4.6/5). ANMs, on the other hand, had a moderate attitude (3.2/5) and relatively lower knowledge levels, although they scored exceptionally well on practice (4.6). This suggests that ANMs are carrying out their duties efficiently, notwithstanding any misgivings or lack of conceptual clarity. These results emphasize the significance of focused capacity-building, which includes improving ANMs' knowledge and attitudes as well as removing practice-related obstacles for Medical Officers.

4.3.1 Positive Findings

- 1. Commitment to Service Delivery:**

Despite infrastructural and administrative challenges, both ANMs and MOs demonstrated a strong commitment to patient care and community health. Most expressed pride in their roles, especially in serving underserved populations.

- 2. Comprehensive Care Under One Roof:**

Staff appreciated the U-AAM model's focus on integrating promotive practices, preventive methods, curative care, rehabilitative and palliative services. This comprehensive framework allowed facilities to address a broad spectrum of health issues.

- 3. Standardization and Branding:**

The rebranding from UPHCs to U-AAMs was viewed positively, particularly in how it provided a recognizable identity and instilled a sense of official recognition among community members.

- 4. Community Relationship Building:**

Many ANMs highlighted that, over time, they developed trust-based relationships with community members, particularly through outreach and door-to-door awareness drives.

4.3.2 Challenges Identified

1. Knowledge Gaps:

- Many participants lacked clarity on updated U-AAM protocols, especially regarding the expanded service package.
- There was minimal orientation or refresher training provided post-transition from UPHC to U-AAM.

2. Human Resource Constraints:

- Nearly all facilities reported staff shortages, resulting in role overload and burnout.
- ANMs often managed multiple responsibilities like immunization, antenatal care, and documentation simultaneously.

3. Infrastructure Limitations:

- Lack of separate consultation rooms, waiting areas, and clean toilets was a common concern.
- Diagnostic and emergency equipment was either absent or non-functional in several centers.

4. Drug and Supply Shortages:

- Irregular supply of essential medicines disrupted treatment continuity and eroded patient trust.
- Stockouts of basic items like gloves, syringes, and BP apparatus were reported frequently.

5. Low Community Awareness and Utilization:

- ANMs noted that many residents were unaware of the range of services offered under U-AAM.

- There was a strong preference among urban poor to visit private clinics, driven by perceived quality and accessibility.

6. Administrative Burdens:

- MOs and ANMs cited excessive paperwork and reporting duties, which reduced time available for clinical care.
- Delayed salary payments and contractual job insecurity were frequently demotivating factors.

Chapter 5- Discussion

This study examined the knowledge, attitudes, and practices (KAP) of Auxiliary Nurse Midwives (ANMs) and Medical Officers (MOs) in the context of implementing Urban Ayushman Arogya Mandir (U-AAM) services in Jaipur District. The results reveal that although the vision of comprehensive urban primary health care is widely accepted among healthcare workers, several challenges at the operational level hinder its realization. The findings of this study are discussed below in comparison with similar research in India and comparable low- and middle-income settings.

5.1 Gaps in Knowledge and Training

The study found that both ANMs and MOs faced significant knowledge gaps regarding U-AAM service packages, protocols, and reporting mechanisms. This aligns with findings from Karvande et al. (2020), who reported that lack of formal, consistent training undermines the ability of ANMs in Maharashtra to deliver quality services across thematic areas. Similarly, Pyone et al. (2019) emphasized that absence of structured capacity-building and mentorship hinders effective service delivery, particularly in newly restructured health programs.

Furthermore, Chendake et al. (2015) observed that even on focused domains like HIV/AIDS, ANMs showed suboptimal knowledge due to insufficient refresher trainings and continuing education. The consistency of these observations across various thematic areas and states highlights a system-wide failure to institutionalize training as part of program implementation—an issue clearly reflected in U-AAM rollout in Jaipur.

5.2 Positive Attitudes Amid Systemic Constraints

Despite challenges, a majority of ANMs and MOs in this study expressed strong motivation and positive attitudes towards their work. Many emphasized their sense of responsibility and community service. This finding mirrors the work of Singh et al. (2020), who noted high intrinsic motivation among frontline workers across southern India, despite difficult working conditions.

Branding under the “Ayushman Arogya Mandir” scheme was seen to improve visibility and initial community engagement. A similar sentiment was noted by Kumar et al. (2022), who found that branding and visual identity of Health and Wellness Centres (HWCs) improved public trust and early utilization, although sustained engagement was dependent on the consistency of services and availability of medicines—issues also flagged in the current study.

5.3 Practice Challenges and Service Delivery Gaps

5.3.1 Role Overload and Staffing Shortages

ANMs reported significant role overload, with responsibility for clinical care, outreach, reporting, and health promotion. These findings are in line with Karvande et al. (2020) and Ved et al. (2019), who documented that ANMs often work beyond their capacity without corresponding increases in remuneration or institutional support. In urban settings like Jaipur, this burden is compounded by higher population density and mobility, leading to more demanding service areas.

5.3.2 Infrastructure and Equipment Deficiencies

The observed lack of essential infrastructure—such as consultation rooms, seating for patients, and functioning diagnostic equipment—is not unique to Jaipur. Similar deficits have been reported by NHSRC (2022) in their national audit of Health and Wellness Centres. These limitations erode patient trust and reduce the efficacy of care, often leading patients to prefer private providers.

5.3.3 Supply Chain Disruptions

The study’s finding of inconsistent medicine supply aligns with national evidence on pharmaceutical logistics under NHM. Kumar et al. (2022) noted that frequent stock-outs of basic drugs and consumables remain one of the most reported deterrents to public facility usage. These inefficiencies undermine not only the credibility of U-AAMs but also the broader Ayushman Bharat mission.

5.4 Administrative and Reporting Burdens

Administrative inefficiencies, especially duplication in reporting formats and poor functionality of digital systems, emerged as significant demotivators. This was also noted by Pyone et al. (2019), who reported that frontline health workers spend disproportionate time on documentation, often at the expense of patient care. Ved et al. (2019) emphasized the urgent need for streamlined reporting mechanisms and better-designed Health Management Information Systems (HMIS) to reduce documentation fatigue.

5.5 Community Engagement Deficits

This study found that community awareness of U-AAM services remains low. ANMs reported that IEC efforts were sporadic, generic, and not tailored to urban slum populations. Similar findings have been reported by Chendake et al. (2015) and Ved et al. (2019), who emphasize that IEC activities often lack localization and participatory approaches, making them ineffective in driving behavior change or improving service uptake.

In rapidly urbanizing areas, where the population is heterogeneous and often transient, traditional rural outreach methods are less effective. This calls for innovative engagement strategies such as peer educators, digital outreach, and community mobilizers drawn from urban slums themselves.

5.6 MO vs ANM Perspectives: A Structural Divide

The current study noted a divergence in the roles, expectations, and burdens of MOs versus ANMs. MOs had better awareness of policy objectives but were less involved in field implementation. ANMs, on the other hand, performed multifaceted tasks but lacked adequate support or recognition. This is echoed in the findings of Ved et al. (2019) and Karvande et al. (2020), who advocate for clearer role definitions, equitable workload distribution, and institutional recognition of ANMs' field efforts.

Chapter 6- Conclusion

The Urban Ayushman Arogya Mandir (U-AAM) initiative is a revolutionary one in the health system of India, especially in fulfilling the needs of primary healthcare among urban poor masses. This research, underpinned by a mixed-methods approach, aimed to ascertain and examine the knowledge deficits, attitudinal hurdles, and practice obstacles that Auxiliary Nurse Midwives (ANMs) and Medical Officers (MOs)—two influential pillars of U-AAM service delivery—face in Jaipur District, Rajasthan. The study also sought to develop evidence-based recommendations that would enhance the effectiveness of implementation at the facility level.

The main objective was adequately met via triangulated data obtained from quantitative KAP surveys as well as qualitative in-depth interviews, which facilitated comprehensive insight into frontline provider experiences.

Knowledge gaps identified in the results indicated inconsistent and inadequate knowledge among ANMs and MOs about the range of services, recent U-AAM protocols, and operational procedures. This was primarily due to an absence of formal orientation and refresher training. A large number of participants were not familiar with extended service mandates, including mental health screening, wellness activities, and community engagement procedures, hence constraining the effective utilization of the U-AAM platform.

Identified Attitudinal barriers where MOs generally expressed positive attitudes, prompted by the evident understanding of the programme's purpose and their freedom to practice, most ANMs expressed ambivalent or moderate attitudes, shaped by heavy workload, poor recognition, and poor motivation due to organizational denial. Nonetheless, both groups shared a commonality of entrenched public service ethos and devotion to community health—a positive impact in achieving programme sustainability.

In the practice challenges, the research evidenced a variety of departures from prescribed practices, especially those involving team coordination, regular reporting, and integrated service delivery. Restrictive factors like lack of support staff, high frequency of medicine stockouts, and poor infrastructure extensively hampered health workers' capacities to follow ideal standards of service. Despite these, ANMs tended to have above-average practice

levels, which indicate a pronounced leaning toward patient care even with restrictive situations.

Comparative analysis identified significant variations in KAP scores among ANMs and MOs, with MOs scoring high on knowledge and attitude aspects and ANMs excelling on field practice

In aggregate, the research shows that whereas the vision for U-AAM is robust and popular, the implementation environment is still fragmented and confronted with a number of root challenges. However, the resilience, flexibility, and commitment of ANMs and MOs stand out as an essential strength of the system. They serve not only as service deliverers but also as excellent tipsters of policy blind spots, and need to be purposefully invited into the feedback and planning cycles of health governance.

Through concentrating efforts on knowledge improvement, attitude reinforcement, and operational transformations, the U-AAM programme can move from being a potential model to an effective and functional public health intervention. In this process, it has the potential to meaningfully contribute to universal health coverage and urban health equity in India.

Chapter 7- Recommendations

1. Capacity Building:

- Institutionalize regular orientation and refresher training sessions for U-AAM protocols.
- Include soft skills and community mobilization strategies in training modules.

2. Supportive Supervision

- Implement **mentoring and supervisory visits** to ensure knowledge is reinforced in practice.
- Establish **peer-learning platforms** or communities of practice where challenges and solutions can be shared.

3. Human Resource Strengthening:

- Recruit additional ANMs and support staff to ease workload.
- Provide job security and timely salary disbursement to improve morale.

4. Infrastructure and Supply Chain Improvements:

- Upgrade physical infrastructure, particularly in high-density urban areas.
- Ensure timely and consistent supply of drugs and basic equipment.

5. Community Engagement Strategies:

- Launch IEC (Information, Education, and Communication) campaigns tailored to local urban slum populations.
- Leverage ASHAs, Mahila Arogya Samitis, and local NGOs for community outreach.

6. Administrative Streamlining:

- Digitize documentation and reporting systems to reduce clerical burden.
- Improve coordination between district health authorities and individual U-AAMs for responsive problem-solving.

7. Monitoring and Feedback Loops:

- Conduct periodic monitoring using simple quality checklists.
- Collect and act upon feedback from both providers and beneficiaries to ensure a continuous quality improvement loop.

8. Motivation and Engagement

- Recognize and reward **best-performing ANMs and MOs** based on adherence and innovation in UAAM delivery.
- Create **feedback mechanisms** to capture concerns and suggestions from ANMs, helping improve ownership.

9. Policy and System Interventions

- Integrate **regular monitoring of KAP** into district-level health reviews.
- Use digital tools or micro-learning modules to **reinforce UAAM concepts periodically**.

10. Research and Evaluation

- Conduct **longitudinal studies** to assess the impact of attitude and knowledge on practice quality.
- Evaluate how UAAM services are perceived by the community to **align provider and client expectations**.

ANNEXURE I

This annexure includes the complete questionnaire that was used in the KAP analysis.

SECTION A: DEMOGRAPHY
Professional Role
Age: _____ / years
लिंग / Gender
Total Professional Experience: _____ years
Experience in Urban Health Services: _____ years
Highest Educational Qualification:
Average daily patient visits at your U-AAM centre: _____ रोगी / patients
Nearest UPHC clinic
Current staffing pattern at your centre (select all applicable positions currently filled):
SECTION B: KNOWLEDGE ASSESSMENT
Are you aware of the guidelines provided by the government of Rajasthan, for implementing U-AAM?
What is the best description of the primary goal of Urban Ayushman Arogya Mandir (U-AAM)?
Which of the following are components of U-AAM service delivery? (Select all that apply)
What is the suggested population for a U-AAM service?
Objectives of the U-AAM program are (Select all that apply)
Which of the following services are available at a U-AAM centre? (Select all that apply)
National guidelines specify the minimum number of antenatal checkups for pregnant women to be
What is TRUE regarding NCD screening in U-AAM centres?

What is the proper procedure for referral of complicated cases from U-AAM?
What are the data recording systems used at your U-AAM? (Select all that apply)
How many investigations are available at a U-AAM centre as per the guidelines?
What is the correct procedure for biomedical waste management at U-AAM?
SECTION C: ATTITUDE ASSESSMENT
Urban Arogya Mandir is an effective approach to address the healthcare needs of urban population.
The services provided at U-AAM are comprehensive enough to meet the primary healthcare needs of the community.
The U-AAM guidelines and protocols are practical and easy to implement.
Community participation is essential for the effective functioning of U-AAM.
I feel confident in my ability to provide all services required at U-AAM.
I believe my role in U-AAM implementation is clearly defined.
Training for U-AAM is required.
The current staffing pattern at U-AAM is adequate for effective service delivery.
The infrastructure and equipment at U-AAM are sufficient for providing quality services.
The supply of essential medicines and consumables is consistent at our U-AAM.
The workload at U-AAM is manageable with the current staff strength.
Adequate support from supervisors and district officials for implementing U-AAM services is received.
The referral linkages between U-AAM and higher facilities function effectively.
Documentation and reporting requirements at U-AAM are reasonable and manageable.
Community awareness about U-AAM services is adequate in our service area.
SECTION D: PRACTICE ASSESSMENT

Preventive health education is provided to patients during their visits.
All eligible adults visiting U-AAM facility are screened for hypertension and diabetes.
Complete antenatal care services are provided as per guidelines.
Immunization for children is done at the facility.
Growth monitoring for children under five years is done at the facility.
Family planning counselling sessions are available at the facility.
Complete and accurate patient records are maintained.
Outreach activities are conducted in the service area.
Follow up reminders are being given to the patients prior to their scheduled re-visits.
Community-based groups (MAS, ASHA) for health promotion are coordinated with U-AAM.
The inventory of medicines and supplies is checked regularly.
Monthly review meetings to discuss service delivery are conducted.
Feedback from patients about the services provided are regularly taken.
SECTION E: GENERAL QUESTIONS
What contraceptive products are currently available at your U-AAM centre? (Select all that apply)
Areas in which you feel training is required (Select all that apply)
Which of the following challenges do you face in implementing U-AAM services? (Select all that apply)
How do you address the challenges mentioned above? (Select all that apply)

ANNEXURE II

This annexure contains the structured interview questions that were asked in the in depth interview.

Interview Questions
What specific knowledge or skills do you feel you need more training on to effectively implement UAAM services?
What are the main barriers you face in delivering quality services at UAAM?
What infrastructural challenges are you facing in conducting the daily operations at your UAAM facility?
What innovative practices have you implemented at your centre to improve service delivery?
What recommendations would you suggest to improve the implementation of UAAM services?
What wellness activities are being conducted in your UAAM facilities?
What challenges are you facing in conducting the health and wellness activities at your centre?
How do you handle situations where you are unable to follow UAAM guidelines due to practical constraints?

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