

Knowledge of Accredited Social Health Activists on SDGs, Maternal Health, Child Health, Reproductive Health in selected District of Andhra Pradesh

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DOI: <https://doi.org/10.52403/gijash.20260113>

ABSTRACT

Background: Accredited Social Health Activists (ASHAs) play a crucial role in achieving the Sustainable Development Goals (SDGs) related to maternal, child, and reproductive health at the community level. Their knowledge and awareness are essential for improving maternal and child health outcomes, especially in rural and urban communities.

Objective: To assess the knowledge of ASHAs regarding Sustainable Development Goals (SDGs), maternal health, child health, and reproductive health in rural and urban areas of Chittoor District, Andhra Pradesh.

Methods: A non-experimental descriptive research design with a survey approach was adopted for the study. The study was conducted among ASHAs working in rural and urban areas of Chittoor District, Andhra Pradesh. Using simple random sampling, a total of 362 ASHAs (309 rural and 53 urban) were selected. Data were collected using a structured questionnaire consisting of multiple-choice questions related to SDGs, maternal health, child health, and reproductive health. Each correct response was given a score of one and incorrect responses were scored zero. The knowledge scores were categorized as low, medium, and high. Data were analyzed using descriptive statistics (frequency and percentage) and inferential statistics (Chi-square test) using SPSS version 16.

Results: The findings revealed that 53% of ASHAs were aware of the Sustainable Development Goals, while only 31.5% were aware of the target to reduce maternal mortality. Knowledge regarding neonatal and under-five mortality reduction targets was reported by 27.6% and 18% of ASHAs respectively. Majority of the respondents demonstrated good knowledge in areas of child health and reproductive health such as kangaroo mother care (78.5%), high-risk signs in children (80.1%), and legal aspects of abortion (80.7%). Overall, 46.1% of ASHAs had a moderate level of knowledge, 27.3% had low knowledge, and 26.5% had high knowledge. A statistically significant difference was observed in the level of knowledge between rural and urban ASHAs ($\chi^2 = 14.74, p = 0.001$).

Conclusion: The study indicates that although ASHAs possess moderate knowledge regarding maternal, child, and reproductive health, their awareness of Sustainable Development Goals and specific health targets is limited. Continuous training and capacity-building programs are essential to enhance their knowledge and enable them to effectively contribute to achieving SDGs related to maternal and child health.

Keywords: ASHA workers, Sustainable Development Goals, maternal health, child health, reproductive health, community health workers.

INTRODUCTION

The most important factor that affects both economic development and human well-being is health. Internationally, the definition of health is found in the preamble of the 1946 Constitution of the World Health Organization (WHO), which states that it is not only the absence of illness or disorder but also a state of total physical, mental, and social well-being. The significance extent says that every human being, no matter which race, belief, political party, economic standing, or social conditions, has the fundamental right to the highest possible quality of health. Women are the main core of the family's general health, and good indication of health of communities and families depends on the well-being of women. Women in India face lot of health difficulties, which has effects on economy and productivity. Investment in women's health is a sign of a country's progress in terms of politics, society, and the economy. According to the 2011 Census, women make up 48.5% of the population. Nearly half of India's population, are 943 females for every 1000 males. Reproductive and non-reproductive health are integral part of women's health. Maternal, intrapartum, and postpartum health are in reproductive health.

Sustainable development is defined as growth which meets requirements and having ability of future generations to meet their demands. Co-ordination of three major factors—prosperity, social integration, and environmental management—is essential for sustainable development. Integration of the economy, environment, and social inclusion is required for the well-being of individuals and communities. In order to create an inclusive, sustainable, and resilient future for people and the world, sustained development requires concerted efforts. The SDGs' third target was promotion and guarantee healthy lifestyles for people. SDG 3.1.1 estimates that by 2030, the rate of maternal deaths should be lesser than 70 per 100,000 live births. The global maternal

mortality rate decreased by 38% between 2000 and 2017.

It is death of new-borns and children under the age of five by the year 2030, with nations aims to less neonatal mortality at least 12 per 1,000 live births and under five mortalities to least 25 per 1000 births.

The SDGs and Reproductive Health

By 2030 following things are to be achieved, combining family planning, information, and education, comprehensive approach to sexual and reproductive health-care facilities, and including reproductive health into governmental actions and programmes if health care unit provided to all.

The Sustainable Development Goals for maternal and child is main objective and community health workers are required for this. Every village should have qualified female community health activist, also known as an ASHA associated with National Rural Health Mission, as they will receive training so she can perform her duties and take care of the health care system locally.

ASHA is an essential part of community operations. Her responsibilities as a co-ordinator and provider of care at the community level

Objective

Examine ASHAs knowledge on the SDGs, maternal, child, and reproductive health in rural and urban areas of the Chittoor district of AP, to accomplish the SDG goals related to women's health.

METHODOLOGY

Non experimental descriptive research design and Survey approach was adapted to carry out the study. Chittoor district was chosen to carry out the study as the setting was feasible for the researcher to carry out the study.

A sample framework of the ASHAs list was obtained from the AP state Nodal officer. According to the ASHA Data Base Register, there were 2907 ASHAs working in the

Chittoor District's rural areas and 205 ASHAs working in the district's urban areas. The sample size is calculated using the formula of 10% of the population. simple random technique was used to select the samples from urban and rural areas. The sample size was 309 ASHAs from rural areas and 53 ASHAs from urban areas.

Questionnaire was developed to assess the knowledge. It consists of multiple-choice questions on various aspects of women's health that are about SDG goals, pregnancy care, care during delivery, postnatal care, knowledge of child health, and reproductive health. Correct response scored as one, and incorrect response given score as zero. Awareness score categorized into low, medium, high scores.

After obtaining permission from the Project Officer, District Training Team (PO DTT) Chittoor District, permission was taken from medical officers of Primary Health Centres and Urban Health Centres, the researcher started collecting data from ASHAs using

structured Interview schedules. Data collection process is arduous and time-consuming process. Meeting the respondents at the appointed time in the leisure hours at their work places, demanded a lot of prior planning. Collecting data consumed one complete year, starting from Jan 2021 and ending on December 2021. The data was manually edited, coded and then entered into sheet of 16th version of SPSS.

RESULTS AND DISCUSSION

Most of the respondents 154 (42.5%) are in the age group of 25-35 years. Married, 151 (41.7%) studied up to secondary education, 164 (45.3%) belonged to the BC category. All the women in the sample were in their productive years. These women have conceded to working as ASHAs despite having domestic responsibilities as married women. They belong to poor Socio-economic Strata.

Table-1 Knowledge of ASHAs on Sustainable Development Goals

S. No.	Variable	Rural F (%)	Urban F (%)	Total F (%)
Awareness on Sustainable Development Goals				
1	Aware of SDG goals	161(52.1)	31(58.5)	192(53)
2	Awareness of target to reduce MMR	91(29.4)	23 (43.4)	114(31.5)
3	Target to decrease neonatal mortality	86 (27.8)	14(26.4)	100(27.6)
4	Target to decrease under five years of age mortality	50(16.2)	15(28.3)	65(18)

India has committed to Sustainable Development Goals and Universal Health Coverage by 2030. As per the table one, half of the sample of 192(53%) are aware of SDG goals. 161(52.1%) in rural areas, 31(58.5%) in urban areas are aware of SDGs. One third of the sample 114(31.5%) knew about the target to reduce MMR by 2030. Awareness is high 23(43.4%) among ASHAs working in urban areas than 91(29.4%) ASHAs in rural areas regarding the goal of reaching a decreasing Maternal

Mortality Ratio. About 100 (27.6%) only knew the goal of reducing Neonatal Mortality. Knowledge about goal to reduce neonatal mortality is less in both 86(27.8%), 14(26.4%) rural and urban areas consecutively. Only 65(18%) are aware of the target to decrease under-five mortality. Awareness was higher in urban areas 15(28.3%) than in rural areas 50 (16.2%) about the goal to reduce under five mortalities.

Table 2. Knowledge of ASHAs on Prepregnancy care

S. No.	Variable	Rural F (%)	Urban F (%)	Total F (%)
Awareness on pre-pregnancy care				
1	Weeks of gestation that pregnant should go 4 th visit	150(48.5)	12(22.6)	162(44.8)
2	Interval between 1 st and 2 nd dose of TT	206(66.7)	33(62.3)	239(66)

3	The age during which women face health issues during pregnancy	182(58.9)	23(43.4)	205(56.6)
4	Advice given to pregnant women who is suffering with burning micturition	237(76.7)	35(66.0)	272(75.1)

Pregnancy is a natural event in the lives of women of reproductive age. However, during pregnancy and childbirth, some problems may arise that can threaten the life of the mother, baby, or both. It is possible to identify women with some problems quite early if they have a routine antenatal check-up. This will enable them to access specialist care. During pregnancy, it is important to monitor the progress and growth of the baby, detect complications at the earliest and treat them accordingly.

The knowledge of ASHAs on the nature of the activities and responsibilities is the prerequisite for effective service delivery only 162 (44.8%) responded correctly to the question of when a pregnant woman should go for fourth check-up. Comprehension is

high in rural areas 150 (48.5%) more than in cities, 12 (22.6%) about the time of the fourth visit of pregnant women. 239(66%) correctly identified the interval between two doses of TT injection. Knowledge about the interval between two doses of injection is better in rural areas 206 (66.7%) than in urban areas 33(62.3%). More than half of the sample 205(56.6%) have the insight that as the age of a woman increases, so does the risk of complications. Three-fourths of subjects 272 (75.1%) were aware of advice given to women suffering from burning micturition. Rural areas have higher awareness of the advice given to pregnant women suffering from burning micturition 237 (76.7%) than urban areas. 35(66%)

Table-3 Awareness about Care during delivery

S. No.	Variable	Rural F (%)	Urban F (%)	Total F (%)
Awareness about care during delivery				
1	Identification of true labor	128(41.4)	30(56.60)	158(43.6)
2	Time taken to deliver placenta	82(26.5)	38(71.7)	120(33.1)

All the ASHAs should have the knowledge about identification of true labour pains so that they can take the pregnant women to the hospital facility in the appropriate time. Table -3 outlines that 158 respondents (43.6%) were answered correctly about identification of true labour pains. The knowledge of identifying true labour pains

is higher in cities 30(56%) than in rural areas, 128 (41.4%). The time required to deliver the placenta is known by 120 (33.1%) subjects. Nearly 38(71.7%) of sample in urban areas has correct knowledge about the time taken to deliver the placenta than ASHAs in rural areas 82 (26.5%)

Table-4 Knowledge of ASHAs on postnatal care

S. No	Variable	Rural F (%)	Urban F (%)	Total F (%)
Awareness on post-delivery care				
1	No. of home visits is women deliveries at home	117(37.90)	16(30.2)	133(36.7)
2	When to take mother to hospital if the mother is bleeding	235(76.1)	33(62.3)	268(74.)
3	Advice given to postnatal mother if temperature is 102°F	144(46.6)	8(15.1)	152(42)

The post-natal period is the period of six weeks immediately after delivery, which is important both for the mother and the newborn. During this time, the changes that occurred in the woman's organs/systems during pregnancy return to normal. 133

(36.7%) of subjects were aware of the number of visits that she must make if she delivers at home. Table -4 shows 117 (37.9%), 16 (30.2%) are aware of the number of postnatal visits to be made by their on others. Less knowledge about this

might be because, most of the ASHAs are accompanying the women for institutional deliveries and also the government is promoting institutional deliveries. Maximum number of ASHAs 268 (74%) told correctly when she has to take postnatal women when she is bleeding. Three-quarters of the 235 (76.1%) in rural areas

and 33 (62.3%) in urban areas knew when to take a bleeding postnatal mother. If the postnatal mother has a temperature of more than 102 degrees F, 152 (42%) are aware of the advice or action to be taken. Knowledge is insufficient in both rural and urban areas about the action taken by her if the postnatal mother's temperature is 102 degrees F.

Table-5 Knowledge about child health

S. No	Variable	Rural F (%)	Urban F (%)	Total F (%)
Knowledge about child health				
1	Main reason for mortality under five	181(58.6)	27(50.90)	208(57.5)
2	The age group at which death rate is high in children	195(63.1)	33(62.3)	228(63)
3	Observation of new born if delivered at home	225(72.8)	45(84.9)	270(74.6)
4	Kangaroos care means	235(76.1)	49(92.5)	284(78.5)
5	High risk indication in children	244(79)	46(86.80)	290(80.1)
6	No. of doses of rota virus vaccine to be given	237(76.7)	42(79.2)	279(77.1)
7	Measles booster dose is given during the months of	214(69.3)	36(67.90)	250(69.1)
8	Amount of ORS solution to be given after passage of each stool in child with less than 2 years of age	177(57.3)	15(28.3)	192(53)
9	Abnormal RR in 1-2 years children	216(69.9)	21(39.6)	237(65.3)

Table 5 shows more than half of the sample 208(57.5%) were aware of the main reason for under-five mortality. Half of the ASHAs in rural and urban areas, 181 (58.6%), and 27 (50.9%), are aware of the causes of under-five mortality. 228(63%) are aware of the age group at which infants die. 195(63.1%), 33 (62.3%) in rural and urban areas are aware of the age group in which mortality is high.

Highest number of ASHAs 270(74.6%) knew what to observe in the baby when a mother delivers at home. 225(72.8%) in rural areas, 45 (84.9%) of ASHAs in urban areas have an understanding about parameters that have to be noted in the new born when the mother delivers at home. Majority 284 (78.5%) are aware of kangaroo care. Kangaroo care knowledge is higher in urban areas 49 (92.5%) than in rural areas 235(76.1%). This might be due to the fact that ASHAs might be regularly observing practises of kangaroo care in referral hospitals. Greater number 290 (80.1%) are knowledgeable about high-risk indications in children. Majority 46 (86.80%) in urban areas, while 244(79%) in

rural areas has the knowledge to identify high-risk conditions in infants.

More than three fourths of the sample 279(77.1%) knew about the number of doses of rotavirus vaccine to be given .237 (76.7%) and 42(79.2%) knew about the number of rotavirus vaccines to be given to children in rural and urban areas consecutively.

Most of the respondents 250 (69.1%) knew when the measles booster dose had to be given. 214(69.3%) in rural areas and 36 (67.9%) in urban areas, also knew when the booster dose of measles has to be given.

Nearly more than half of the sample 192 (53%) are aware of how much ORS solution has to be given after the passage of each stool in children less than two years. Half of the 177 subjects (57.3%) in rural areas and nearly one-quarter of the samples 15 (28.3%) in urban areas were aware of the amount of oral re-hydration solution to be given to the child who is less than two years after passing each stool.237 (65.3%) are able to recognise abnormal respiratory rates in children. In the one to two-year age group of children, 216 (69.9%) rural ASHAs have

more knowledge about abnormal respiratory patterns than in urban areas. 21(39.6%).

Table-6 Knowledge about Reproductive health

S. No	Variable	Rural F (%)	Urban F (%)	Total F (%)
Knowledge about Reproductive Health				
1	Copper T safe in- years	176(57)	8 (15.1)	184(50.8)
2	Abortion legal in –weeks	251(81.2)	41(77.4)	292(80.7)
3	Symptoms of genital tract infections	271(87.7)	42(79.2)	313(86.5)
4	Carcinoma cervixis identified by-test	263(85.1)	45(84.9)	308(85.1)
5	Mammography is done to detect - cancer	218(70.6)	35(66)	253(69.9)

Use of contraception gives better option for individuals to determine the number and spacing of their children. Use of contraception prevents pregnancy-related health risks for women, especially for adolescent girls, and when births are separated by less than two years, the infant mortality rate is 45% higher than it is when births are 2-3 years apart and 60% higher than it is when births are four or more years apart (Family Planning Can Reduce High Infant Mortality Levels. Guttmacher Institute.

https://www.guttmacher.org/sites/default/files/report_pdf/ib_2-02.pdf). It offers a range of potential non-health benefits that encompass expanded education opportunities and empowerment for women, and sustainable population growth and economic development for countries. Table six reveals that half of the subjects 184, (50.8%) are aware of how long copper-T can be used as a contraceptive. More than half of the ASHAs 176 (57%) in rural areas are aware of duration of usage of copper-T than in urban areas, 8(15.1%).

Unsafe abortion is a preventable cause of maternal mortality. Despite abortion being legal, the high estimated prevalence of unsafe abortion demonstrates a major public health problem in India. Thousands of deaths are reported from unsafe abortions due to a lack of trained abortion providers. Lack of knowledge about the legality of abortion and the availability of safe services are also causes of death. This is compounded by the social stigma, especially when unmarried women are conceived. Abortion is a common health intervention. It is safe when carried out using a method

recommended by WHO, appropriate to the pregnancy duration, and by someone with the necessary skills. Six out of 10 of all unintended pregnancies end in an induced abortion. 45% of all abortions are unsafe, of which 97% take place in developing countries (Abortion

[https://www.who.int/news-room/fact-sheets/detail/abortion.](https://www.who.int/news-room/fact-sheets/detail/abortion))

Majority 292 (80.7%) are aware of ceiling of gestational weeks of pregnancy for abortion, while 251 (81.2%) and 41 (77.4%) subjects in rural and urban areas are aware of the legally permissible criteria for abortion.

Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) are major public health problems worldwide. These infections effect the quality of life and cause serious morbidity and mortality. STIs and RTIs have a direct impact on reproductive and child health through infertility, cancers, and pregnancy complications, and they have an indirect impact through their role in facilitating the sexual transmission of human immunodeficiency virus (Patel, N. J., and V. S. Mazumdar 2019).

Maximum number of ASHAs .313 (86.5%) were aware of the symptoms of genital tract infections, with 271 (87.7%) in rural areas and 42 (79.2%) in urban areas being aware of the signs and symptoms.

Cervical cancer is the second leading cause of cancer deaths among women in India. India accounts for 25% of all global deaths from cervical cancer. The reason for this difference is the lack of effective screening and access to services. (<https://www.georgeinstitute.org/cervical-cancer-in-india->

challenges-and opportunities). Most of the ASHAs 263 (85.1%) are aware that pap smear tests are used to screen for cervical cancer. Nearly equal proportion of samples from rural and urban areas. Most of the ASHAs 263 (85.1%) and 45 (84.9%) were aware of PAP smear test that is used for early cervical cancer diagnosis.

At global level breast cancer is the most common malignancy among women 253(69.9%) were aware that mammography was done for screening and early detection of breast cancer. Greater number of sample 218 (70.6%) in rural areas and 35 (66%) in urban areas have considerable knowledge that mammography was done to screen breast cancer.

Table -7 Level of Knowledge on SDGs, Maternal, child and Reproductive Health in Rural and Urban ASHAs

Chi-square Value	p-value	Level of Knowledge			Total
		Low	Medium	High	
**14.74	0.001				
Place	Rural	83	133	93	309
		26.9%	43.0%	30.1%	100.0%
	Urban	16	34	3	53
		30.2%	64.2%	5.7%	100.0%
Total		99	167	96	362
		27.3%	46.1%	26.5%	100.0%

* Significant at 5% level, ** Significant at 1% level

Table 7 indicates most of the ASHAs 167(46.1%) possess average understanding of maternal, child, and reproductive health. One-fifth of the sample, 99 (27.3%), has a low level of awareness, while 96 (26.5%) of respondents have high knowledge. A significant difference exists in awareness between rural and urban ASHAs at a 1% level (Chi-square value: 14.74, p-value 0.001) on maternal, child health, and reproductive health.

Declaration by Authors

Ethical Approval: Approved

Acknowledgement: None

Source of Funding: None

Conflict of Interest: The authors declare no conflict of interest.

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How to cite this article: S. Swarna. Knowledge of accredited social health activists on SDGs, maternal health, child health, reproductive health in selected district of Andhra Pradesh. Full title of article is written here. *Galore International Journal of Applied Sciences & Humanities*. 2026; 10(1): 88-95. DOI: <https://doi.org/10.52403/gijash.20260113>
