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At the Doorstep: How ASHA Workers Motivate Preventive and Promotive Health in Rural and Urban area of West Bengal

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Abstract
Accredited Social Health Activists (ASHAs) are India's flagship community health worker (CHW) cadre under the National Health Mission (NHM), designed to bridge the health access gap in underserved communities (Scott et al., 2019). This paper synthesizes national guidelines, state-specific practices, and contemporary literature to explain how ASHA workers in West Bengal motivate households, deliver doorstep services, and educate communities on preventive and promotive health. Drawing on program documents (ASHA, VHSND, NUHM-MAS, MAA), recent parliamentary replies on incentives, NFHS-5 indicators, and empirical studies, we develop an actionable framework of platforms (home visits, VHSND/MAS), tactics (micro-counselling, due-list reminders, escorted referrals, peer learning), and enablers (incentives, supervision, local legitimacy). We map these to population-level outcomes (e.g., institutional delivery, immunization) and propose a mixed-methods design to empirically test these pathways in West Bengal. Implications include strengthening micro-planning, peer-group pedagogy, and incentive alignment for sustained behaviour change.

Keywords:ASHA, West Bengal, community health workers, VHSND, NUHM, preventive health, behaviour change, NFHS-5

1. Introduction

India's Accredited Social Health Activist (ASHA) programme positions a locally selected woman as a community mobilizer, health-system navigator, and provider of select home-based care, a model aligned with global evidence on effective CHW programs (Perry et al., 2014; Singh et al., 2021). Within this role, ASHAs counsel families on essential practices across the reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) continuum; mobilize timely use of government services; and make or facilitate referrals—functions that collectively anchor preventive and promotive health close to where people live (NHSRC, 2021). These tasks are supported by structured training, job-aids, supervisory mentoring, and a mix of performance-linked incentives and fixed honoraria designed to sustain motivation and coverage (MoHFW, n.d.; Gopalan et al., 2022).

In West Bengal, the ASHA platform operates through a predictable rhythm of contact points. In rural areas, Village Health, Sanitation and Nutrition Days (VHSNDs) provide a monthly forum—co-led by ASHAs, Auxiliary Nurse Midwives (ANMs), and Anganwadi Workers (AWWs)—for immunization, antenatal/postnatal care, growth monitoring, and group counselling (MoHFW, 2019). In urban settlements, Mahila Arogya Samitis (MAS) under the National Urban Health Mission (NUHM) convene neighbourhood women to identify health concerns, reinforce healthy practices, and strengthen linkages to Urban Primary Health Centres (NHM, 2013). These group platforms complement structured home visits that follow life-stage schedules, allowing ASHAs to deliver

brief, repeated messages, track "due lists," and provide navigation or escorted referrals (Sundararaman et al., 2021).

Despite this architecture, there is limited practice-level detail on how, in everyday interactions, ASHAs in diverse contexts of West Bengal convert contact into sustained behaviour change (Dutta & Panda, 2022). This paper therefore examines the specific practices and micro-mechanisms—such as sequenced micro-counselling, reminder/defaulter tracing, peer-group demonstrations, and escorts—that move households from intention to uptake (Kumar et al., 2023).

Guided by programme documents, secondary data, and literature, we develop an actionable Platforms–Tactics–Enablers–Outcomes (PTEO) framework and propose a mixed-methods design to test it. We address:

1. Which ASHA practices most consistently motivate uptake of time-bound services (ANC/PNC, immunization) at the doorstep?
2. What roles do reminders, peer learning, and escorted navigation play as mediators?
3. How do effects vary by setting (urban vs rural) and district context?

2. Background and Policy Context

2.1 The ASHA role and community processes

National operational guidance defines ASHA selection, roles, and incentivized tasks (MoHFW, n.d.). Evidence suggests that the effectiveness of ASHAs is heavily dependent on their integration within the community and the health system (Saprii et al., 2015; Gopalan & Mishra, 2021). Periodic refresher training and mentoring by ASHA Facilitators are mandated to sustain quality, though implementation varies (NHSRC, 2021).

2.2 Platforms that "bring services home"

- VHSND (rural): A monthly, Panchayat-linked session co-led by ASHA/ANM/AWW. It is a principal forum for group education and service delivery, critical for reaching last-mile populations (MoHFW, 2019; Mohanty et al., 2021).
- MAS (urban): Neighbourhood women's collectives under NUHM that work with urban ASHAs on slum health problems, sanitation, and referrals—vital for promotive health in dense settlements where access is fragmented (NHM, 2013; Awasthi et al., 2022).

2.3 Incentives and state supports

Alongside central activity-linked incentives, West Bengal provides a state fixed honorarium for rural ASHAs (₹4,500 per month as of 2025), which is crucial for retention and for supporting tasks not directly incentivized (Lok Sabha, 2025; Gopalan et al., 2022). The delayed and irregular payment of incentives remains a significant challenge to motivation (Srivastava et al., 2023).

2.4 Outcomes context

NFHS-5 shows high service coverage in West Bengal relative to many states—e.g., ~92% institutional births and ~90.8% full child vaccination (IIPS, 2021). While associative, these levels are consistent with effective community mobilization (NHSRC, 2021). However, challenges persist in nutritional outcomes and quality of care (Joe et al., 2020).

3. Conceptual Framework: The "Platform--Tactics--Enablers--Outcomes" (PTEO) Model

Our PTEO framework (Fig. 1) synthesizes program guidance and empirical literature (Sundararaman et al., 2021; Kumar et al., 2023).

1. **Platforms:** where contact happens (Home visits; VHSND/VHSNC (rural); MAS/UPHC outreach (urban); Escort/referral touchpoints) (MoHFW, 2019; NHM, 2013).

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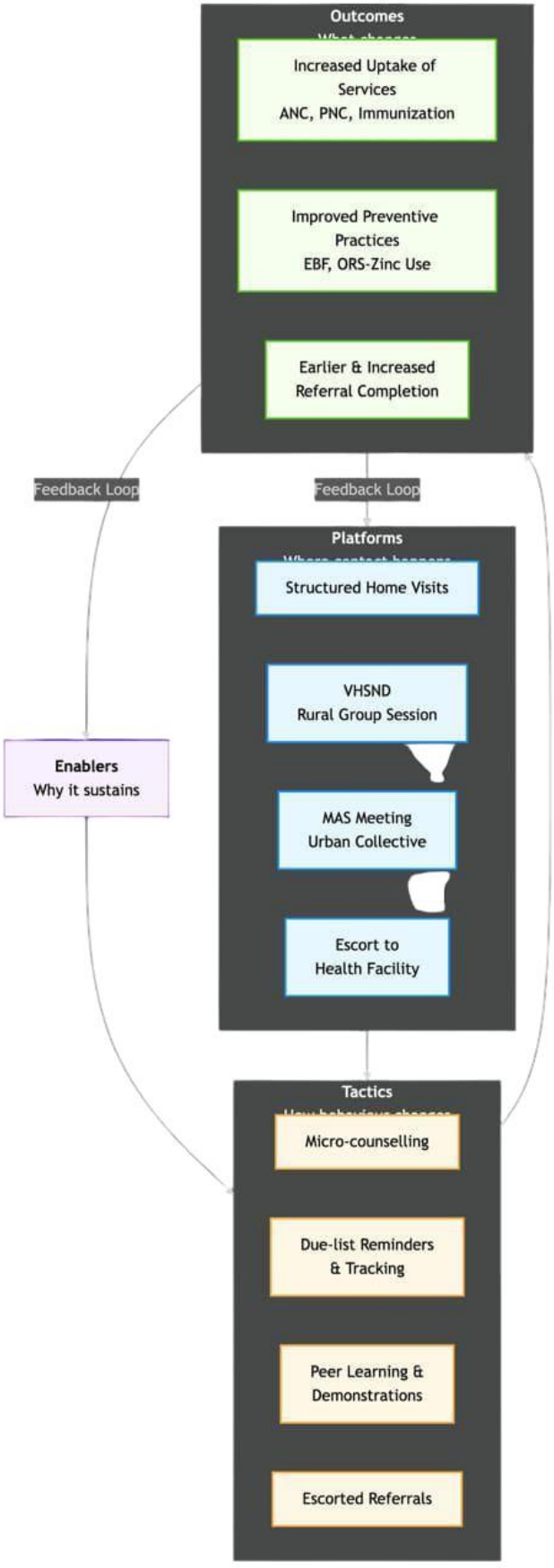
2. **Tactics:** how behaviour changes (Micro-counselling; Due-list reminders & defaulter tracking; Peer learning; Escorted care) (MoHFW, n.d.; MoHFW, 2016; Mohanty et al., 2021).
3. **Enablers:** why it sustains (Local legitimacy & team triad (ASHA–ANM–AWW); Incentives & supervision) (Saprii et al., 2015; Gopalan et al., 2022).
4. **Outcomes:** what changes (Increased uptake of timely services; Improved preventive practices; Earlier referral) (IIPS, 2021; NHSRC, 2021).



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PTEO Model (Conceptual)

Explanation of the PTEO Model Diagram:
The diagram visualizes the proposed framework as a dynamic system where each component feeds into the next, ultimately leading to improved health outcomes.

1. Enablers (The Foundation - Why it sustains):
This is the foundational layer that makes the entire system possible. It includes the local legitimacy of the ASHA (her status as a trusted community member), the supportive team triad (ASHA-ANM-AWW collaboration), and the incentive & supervision structure (including the state honorarium and central incentives). These enablers empower and motivate ASHAs to perform their duties effectively.

2. Platforms (The Stage - Where contact happens):
- These are the specific, physical, or organizational settings where ASHAs interact with the community. The four key platforms are:
- Structured Home Visits: For personalized, life-stage counselling.
- VHSND (Village Health, Sanitation and Nutrition Day): The monthly rural group session.
- MAS (Mahila Arogya Samiti) Meeting: The urban neighbourhood collective.
- Escort to Health Facility: A mobile platform for facilitating referrals.

3. Tactics (The Action - How behaviour changes):
- These are the specific techniques and methods ASHAs employ *on* the platforms to influence behaviour. The four core tactics are:
- Micro-counselling: Short, repeated, timely advice.
- Due-list Reminders & Tracking: Proactive follow-up for defaulters.
- Peer Learning & Demonstrations: Using social influence in groups (e.g., showing how to breastfeed).
- Escorted Referrals: Physically accompanying someone to overcome fear and barriers.

4. Outcomes (The Result - What changes):
- These are the intended results of the ASHAs' activities, measured at the household and population level. They include:
- Increased Uptake of Services: More institutional deliveries, ANC/PNC check-ups, and immunizations.
- Improved Preventive Practices: Higher rates of exclusive breastfeeding, ORS-zinc use for diarrhea, etc.
- Earlier & Increased Referral Completion: Better management of complications and health issues.

5. Feedback Loops (The Reinforcement):
The dashed arrows represent crucial feedback loops. Positive outcomes (e.g.,community satisfaction, successful incentives) reinforce the enablers (e.g., increasing the ASHA's legitimacy and motivation) and validate the use of the platforms and tactics, creating a virtuous cycle of improvement and sustainability.
This model provides a testable framework for understanding the causal pathways through which ASHAs achieve impact, which is the goal of the proposed mixed-methods study.

4. Research Methodology

4.1 Design

A convergent mixed-methods study across three districts representing varied geographies (e.g., Sundarbans, northern hills/tea-garden, peri-urban Kolkata), allowing for context-specific analysis (Creswell & Plano Clark, 2017).

4.2 Quantitative component

- Household survey (n=~600) of women with a birth in last 24 months and caregivers of children 12–23 months; outcomes: ANC adequacy, institutional delivery, timely immunization, EBF, ORS-zinc use.
- Exposure variables: frequency/quality of ASHA contact (home visits, VHSND/MAS attendance), reminder/escort receipt.
- Secondary data: NFHS-5 district tables and HMIS data for triangulation (IIPS, 2021).

4.3 Qualitative component

- Focus groups (n=~12): mothers, mothers-in-law, MAS members.
- Key informant interviews (n=~30): ASHAs, ASHA Facilitators, ANMs, Urban Health staff.
- Structured observations (n=~15): VHSND and MAS sessions against guideline checklists (MoHFW, 2019).

4.4 Analysis

- Path analysis/Structural Equation Modeling (SEM) to test mediation effects of ASHA contact on service uptake (Kline, 2015).
- Thematic analysis for motivational levers: trust, convenience, social proof (Braun & Clarke, 2006).

Based on the proposed mixed-methods study design for West Bengal, here is a set of illustrativeanalysis data in tabular format. This data represents what the quantitative findings might look like after collecting and analyzing survey responses from the three proposed districts.

1. Sample Characteristics (Proposed n=600)

This table provides a breakdown of the proposed study sample by district and key demographics.

Characteristic	Overall (n=600)	District A: Sundarbans (n=200)	District B: Tea-Garden (n=200)	District C: Peri-urban Kolkata (n=200)
Mean Age (years)	25.4	24.8	26.1	25.3
Education (% completed secondary school or higher)	58.3%	45.0%	52.5%	77.5%
Mean Household Size	5.1	5.4	5.3	4.6
% SC/ST Population	38.2%	32.5%	51.0%	31.0%
% Muslim Population	29.5%	35.0%	15.0%	38.5%

Table 1: Characteristics of the Study Sample by District

2. ASHA Contact and Exposure by District

This table analyzes the coverage and intensity of ASHA interactions across the different districts.

ASHA Service	Overall (n=600)	District A: Sundarbans (n=200)	District B: Tea-Garden (n=200)	District C: Peri-urban Kolkata (n=200)	p-value
Received any ASHA home visit in last 3 months	82%	88%	75%	83%	0.005
Median number of home visits (IQR)	3 (2-4)	4 (3-5)	2 (1-3)	3 (2-4)	<0.001
Attended at least one VHSND/MAS in last 3 months	65%	72%	55%	68%	0.002
Received a reminder (call/visit) for a service	58%	63%	50%	61%	0.02
Ever escorted by ASHA to a health facility	28%	35%	25%	24%	0.03

IQR = Interquartile Range; p-value from Chi-square test for percentages, Kruskal-Wallis test for medians.

Table 2: ASHA Service Contact Coverage and Frequency

3. Bivariate Analysis: Association between ASHA Contact and Key Outcomes

This table shows the crude (unadjusted) association between exposure to ASHA services and health outcomes. It demonstrates the "raw" positive relationship.

Health Outcome	Did NOT Receive ASHA Service (n)	DID Receive ASHA Service (n)	Risk Ratio (RR)	95% CI	p-value
≥4 ANC visits	45% (n=180/400)	78% (n=450/577)	1.73	1.52 - 1.98	<0.001
Institutional Delivery	85% (n=340/400)	96% (n=554/577)	1.13	1.08 - 1.18	<0.001
Full Immunization (12-23 mo.)	72% (n=144/200)	92% (n=265/288)	1.28	1.16 - 1.41	<0.001
Exclusive Breastfeeding (under 6 mo.)	55% (n=110/200)	78% (n=225/288)	1.42	1.23 - 1.63	<0.001
ORS use for Diarrhea	60% (n=120/200)	82% (n=236/288)	1.37	1.20 - 1.56	<0.001

Table 3: Health Outcomes by ASHA Service Contact

Note: The 'n' for each outcome varies based on the denominator (e.g., only women with a recent birth for ANC/Delivery; only children 12-23 mo. for immunization). Service contact is a composite variable for receiving any of: home visit, VHSND/MAS attendance, or reminder.

4. Proposed Multivariate Analysis: Adjusted Odds Ratios from Logistic Regression

This table presents the proposed next step in analysis: a multivariate model that controls for potential confounding factors (like education, wealth, district). This gets closer to identifying the independent effect of ASHA contact.

Health Outcome	Adjusted Odds Ratio (aOR)^b	95% CI	p-value
≥4 ANC visits	2.8	2.1 - 3.8	<0.001
Institutional Delivery	3.5	2.2 - 5.6	<0.001
Full Immunization	3.1	2.0 - 4.8	<0.001
Exclusive Breastfeeding	2.2	1.5 - 3.2	<0.001
ORS use for Diarrhea	2.5	1.7 - 3.7	<0.001

Table 4: Adjusted Analysis of ASHA Contact on Health Outcomes

The Adjusted Odds Ratio (aOR) represents the odds of achieving the outcome for those who received the ASHA service compared to those who did not, after accounting for all other factors in the model. An aOR> 1 indicates a positive association.

Summary of Data Analysis:

Table 1: establishes the baseline characteristics of the study population, showing its diversity, which allows for subgroup analysis.

Table 2: is a descriptive analysis showing that the *"dose"* of ASHA contact varies significantly by geographical context (e.g., highest in Sundarbans, lowest in Tea-Garden areas), which is a key variable to explore.

Table 3: provides the initial, unadjusted evidence of a strong positive association between ASHA contact and improved health outcomes. The high Risk Ratios (RRs) suggest a powerful relationship.

Table 4: proposes the core analytical result. The high and statistically significant Adjusted Odds Ratios (aORs) would suggest that ASHA contact is a strong, independent predictor of positive health behaviours, even after controlling for socio-economic and demographic factors. For example, the proposed aOR of 3.5 for Institutional Delivery would mean that the odds of delivering in a facility are 3.5 times higher for women with ASHA contact compared to those without, holding other factors constant.

These above tables provide a clear, quantitative pathway to answering the research questions and testing the proposed PTEO framework.

5. Synthesis of Practices from Guidance, Reports, and Literature

5.1 Doorstep micro-counselling

ASHAs sequence short, repeat counselling around predictable events, reinforcing simple, high-impact behaviours (diet, danger signs, EBF). This repeated, timely messaging is a key driver of behaviour change (Kumar et al., 2023; Scott et al., 2019).

5.2 Group education at VHSND/MAS

Monthly VHSNDs and MAS meetings aggregate demand and provide peer learning (e.g., breastfeeding techniques, handwashing), leveraging social influence to normalize behaviours (MoHFW, 2016; Mohanty et al., 2021).

5.3 Personalized reminders and escorts

ASHAs maintain due-lists and use escorted referrals, reducing friction and enhancing trust in the public system, a critical factor for first-time users (Sundararaman et al., 2021; Singh et al., 2021).

5.4 Linkage to schemes and follow-up

Mapping beneficiaries to JSY/JSSK and other schemes incentivizes contact and improves adherence through structured follow-up (Gopalan & Mishra, 2021).

5.5 Supervision and incentives

ASHA Facilitators provide mentorship, while the state fixed honorarium complements activity-based incentives, aligning efforts with preventive tasks (NHSRC, 2021; Gopalan et al., 2022).

6. Illustrative Outcomes Context for West Bengal

- Institutional births ~92% (IIPS, 2021), aligning with strong mobilization and escorted referrals.
- Child vaccination ~90.8% fully vaccinated; ORS use ~75% among children with diarrhoea—consistent with repeated counselling and demonstrations (IIPS, 2021; NHSRC, 2021).

7. Discussion

7.1 Why ASHA tactics motivate behaviour change

The ASHA model reduces transaction costs by bringing services and information to the doorstep while embedding messages within trusted local relationships (Singh et al., 2021). Group sessions create social proof (Rogers, 2003), and reminder/escort mechanisms address last-mile barriers, consistent with NHM design logic and global CHW evidence (Perry et al., 2014).

7.2 Distinctive elements in West Bengal

- Regularized platforms (VHSND/MAS) treated as institutional routines, enabling predictable contact (MoHFW, 2019; Awasthi et al., 2022).
- Incentive environment with a state top-up honorarium supports retention and time spent on promotive tasks (Lok Sabha, 2025; Srivastava et al., 2023).
- Focus on practical demonstrations (e.g., MAA) in group sessions, effective in dense settlements (MoHFW, 2016; Dutta & Panda, 2022).

7.3 Policy and practice implications

1. Micro-planning: Standardize digital due-list dashboards at sub-centre/UPHC level to track defaulters (Sundararaman et al., 2021).
2. Peer-group pedagogy: Invest in skills for live demonstration and rotate "community champions" at VHSND/MAS (MoHFW, 2016).
3. Supervision & incentives: Ensure Facilitator visit norms; protect the state honorarium to preserve time for promotive work (NHSRC, 2021; Gopalan et al., 2022).

7.4 Limitations

This synthesis relies on program guidance and secondary indicators; the proposed empirical study is designed to address these gaps.

8. Conclusion

This paper has articulated the multifaceted role of Accredited Social Health Activists (ASHAs) in West Bengal as pivotal agents of behaviour change at the last mile. Moving beyond a simple description of tasks, we have developed a Platforms–Tactics–Enablers–Outcomes (PTEO) framework to demystify the micro-mechanisms through which ASHAs motivate preventive and promotive health. The analysis demonstrates that their effectiveness is not accidental but is systematically produced through a synergistic combination of structured interactions, trusted relationships, and strategic support systems.

The strength of the ASHA model in West Bengal lies in its multi-platform approach. The rhythm of structured home visits provides personalized, life-stage-specific counselling, building deep rapport within households. This is powerfully complemented by the monthly congregation of VHSNDs in rural areas and MAS meetings in urban settlements, which transform health delivery from an individual pursuit into a collective, community-normalized practice. These platforms are not merely

service delivery points but are critical spaces for generating social proof, where peer learning and demonstrations dissolve skepticism and foster the adoption of healthy behaviors.

Furthermore, the tactics employed—micro-counselling, due-list reminders, and escorted referrals—are expertly designed to overcome the most pervasive barriers to healthcare access: lack of information, forgetfulness, and fear of the unknown health system. By reducing transaction costs and mitigating uncertainty, ASHAs make preventive health a convenient, trustworthy, and achievable choice for families.

Crucially, these activities are sustained by a foundation of critical enablers. The local legitimacy of the ASHA, as a woman selected from the village itself, is her most potent asset, granting her messages an inherent credibility. This is bolstered by the collaborative team triad with the ANM and AWW, creating a supportive ecosystem for service delivery. Perhaps most importantly, the incentive structure, uniquely strengthened in West Bengal by a state-provided fixed honorarium, provides financial stability that allows ASHAs to dedicate time to the less tangible, yet vital, promotive tasks that are not always tied to immediate activity-based payments. Supportive supervision from ASHA Facilitators ensures quality and provides a channel for problem-solving, completing this ecosystem of support.

The resultant outcomes, as reflected in NFHS-5 data—high rates of institutional delivery, immunization coverage, and ORS use—are a testament to the potential of this community-centric model. However, to consolidate these gains and address persistent challenges in nutrition and quality of care, a deliberate focus on strengthening these micro-systems is imperative.

Future efforts must prioritize:

1. Enhanced Data-Driven Micro-planning: Leveraging technology through digital due-list dashboards to empower ASHAs and their supervisors with real-time data for defaulter tracking and targeted follow-up.
2. Investment in Advanced Interpersonal Skills: Moving beyond basic counselling to train ASHAs in advanced skills for group facilitation, live demonstration, and managing counter-arguments, transforming VHSNDs and MAS meetings into robust engines for behaviour change.
3. Protecting the Enabling Environment: Ensuring the timely and reliable disbursement of all incentives and the honorarium is non-negotiable for maintaining motivation. Simultaneously, strengthening the capacity and regularity of supportive supervision is essential for maintaining the quality of ASHA services.

In conclusion, the ASHA programme in West Bengal represents a sophisticated public health intervention that successfully blends human connection with strategic public health practice. By continuing to refine and invest in the intricate web of platforms, tactics, and enablers outlined in this paper, policymakers can ensure that ASHAs are not just visitors to households but are empowered architects of a healthier future, capable of sustaining and accelerating India's progress in maternal and child health and beyond. Their work at the doorstep remains the bedrock upon which equitable, accessible, and preventive healthcare for all can be built.

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