

A qualitative examination of interpersonal communication between Community Health Workers (CHW) and pregnant women in Kerala, India

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Abstract

Communication between community health workers and pregnant women plays a significant role in increasing the antenatal and postnatal care they receive. Guided by Social Exchange Theory and the Patient-Provider Communication Model, this study examines how communicative interactions between Accredited Social Health Activists (ASHAs) and pregnant women influence trust, perceived support, and engagement with maternal healthcare services. A qualitative design was adopted, and in-depth interviews were conducted with 18 pregnant women aged 23–29 years from Vayalar Panchayath, Alappuzha district, between June and August 2024, using purposive sampling. Four themes have been identified from the thematic analysis. Women reported that their ASHA workers communicate with them regularly and provide information on maternal healthcare services, including those offered by both central and state governments, pregnancy complications, nutrition and dietary plans, and mental health and well-being. These interactions were perceived as productive and generally positive. However, despite these positive perceptions, there remains a need for more targeted training for public health workers to strengthen their ability to provide effective, comprehensive information exchange, particularly on nuanced and complex aspects of maternal health. Also, the integration of Social Exchange Theory and the Patient Provider Communication Model in the study emphasised the relational and communicative dynamics that shape maternal health engagement.

Keywords: ASHA workers, mental health, pregnancy complications, well-being

1. Introduction

Kerala, a southern state in India, has recently registered a maternal mortality ratio of 19 (per one lakh live births), which is lower than the national average of 97 per 100,000 (Sample Registration System, 2022). With a well-developed stage of demographic change, the state (Kerala) is well known for its highly educated population, with a higher literacy rate of 94% (96.11% for males, 92.07% for females) (IIPS, 2021). The recent National Family Health Survey (NFHS-5), conducted in Kerala from 2019 to 2021, revealed that nearly all mothers (98%) received prenatal care from a medical practitioner for their most recent birth. In line with recommendations, 94% of pregnant women got prenatal care in the first trimester. The percentage of mothers who got four or more prenatal care visits is 79% (IIPS, 2021). According to the WHO's recommendation, women of reproductive age should have undergone at least four prenatal visits (Antenatal Care - UNICEF DATA, 2023). Nearly all (99-100%) Kerala women who had antenatal care for their most recent delivery had all the procedures required to track their pregnancy, including having their weight taken, their blood pressure measured, a urine sample taken,

a blood sample taken, and having their abdomen examined (Sex Ratio & Literacy Rate, 2023). In other states in India, even when they receive antenatal care, women occasionally do not get all the services required to keep track of their pregnancies. This accomplishment is primarily attributed to the accessibility and effective operation of the public healthcare delivery system in Kerala, which provides affordable healthcare to everyone, including the most vulnerable sections of society (Varatharajan, 2004). Different stakeholders are responsible for disseminating this affordable healthcare service to the public. Female frontline health workers (FFHWs) were responsible for managing the community-level health response in India. These FFHWs included Anganwadi Workers (AWWs), Auxiliary Nurse Midwives (ANMs), and Accredited Social Health Activists (ASHAs) (Krishnan, 2022).

The launch of the ASHA program in 2005 by the National Rural Health Mission is a key factor that bridges the gap between the community and the public health system in India (Kohli et al., 2015). ASHA workers facilitate the early registration of pregnant women under the PHCs, provide antenatal, natal, and postnatal care to women, educate women on following proper dietary plans, encourage institutional delivery, and mobilise the community to increase the utilisation of existing health services (Mustafa, 2020). The presence of community health workers, such as ASHA, can facilitate the proper utilisation of high-quality antenatal care (ANC) services (Paul & Pandey, 2020). When it comes to pregnant women, several factors encourage them to access maternal healthcare facilities (Nyamtema et al., 2012). A study on accessing pregnancy-related services in Ghana identified that, compared to women who reported discussing pregnancy-related difficulties with their partner, those who did so with friends or a healthcare provider were more likely to have used an institutional delivery facility and had a trained birth attendant (Dougherty et al., 2018). It has been identified that patients' anxiety is reduced, and their coping skills are improved when providers are emotionally invested in them, which leads to better outcomes (Halpern, 2007). When patients ask questions, assert their preferences, express concerns, communicate understanding, and offer opinions, it demonstrates their involvement in the consultation and decision-making process (Street & Millay, 2001).

However, there is a paucity of literature on how effectively communication between ASHA workers and beneficiaries enables beneficiaries to access antenatal care services and supports the well-being of pregnant women in Kerala. While some studies focus on the overall impact of ASHA workers on maternal health outcomes, there is a dearth of research specifically linking communication quality to the actual utilisation of antenatal services (Bhattacharyya et al., 2018; Bhushan et al., 2020; Kumari & Shipra, 2020; Karkada et al., 2024). Drawing on Social Exchange Theory (Blau, 1964), this study recognises communication as a relational process shaped by perceived benefits, trust, and reciprocity, wherein pregnant women engage with ASHA workers based on the value they derive from informational, emotional, and instrumental support. Simultaneously, guided by the Patient-Provider Communication framework (Ong et al., 1995), the study acknowledges communication as a multidimensional process involving information exchange, emotional support, mutual understanding, and responsiveness to patient needs. Despite the centrality of ASHA workers as intermediaries between the formal health system and community women, limited research has explored how power relations, communicative competence, and relational trust influence women's engagement with antenatal care services. Moreover, there is a lack of empirical evidence on the specific topics discussed between ASHA workers and pregnant women and how these interactions shape health-seeking behaviour and perceived well-being during pregnancy. Addressing

this gap, the present study examines pregnant women’s perceptions of communication related to antenatal and maternal healthcare services and their overall well-being. By integrating Social Exchange Theory and the Patient–Provider Communication framework, the study seeks to understand how communication processes influence women’s experiences and decision-making during pregnancy. Accordingly, the central research question guiding this study is: How do women characterise their communication with ASHA workers regarding maternal health information during pregnancy?

2. Methodology

2.1. Recruitment and Participants

A non-random, purposive sample of participants was recruited with the assistance of ASHA workers from Vayalar Panchayath in Alappuzha District, Kerala. As women are encouraged to contact the Anganwadi worker or ASHA worker as soon as they learn they are pregnant and to register themselves under various government schemes, the community health workers possess the contact details of women who are currently pregnant. The researcher requested these details and invited the women to participate in the study to share their experiences with ASHA workers. In-depth, semi-structured interviews were conducted from June 2024 to August 2024 with 18 women who are in their first, second, and third trimesters of pregnancy. There were no rewards offered for taking part in the study. Women who participated in the in-depth interview were willing to record their conversation, which lasted between 45 minutes and 55 minutes. The researcher acknowledged the ethical concerns associated with accessing and using participants’ contact details and ensured the study adhered to relevant ethical guidelines. The study strictly adhered to the ethical guidelines outlined in the Declaration of Helsinki and its subsequent updates, ensuring high ethical standards throughout the research. Written informed consent was obtained from all participants, confirming their comprehension of the study and their voluntary decision to participate. The socio-demographic characteristics of the participants, including age, education, employment status, family type, number of pregnancies, and gestational week at the time of the interview, are presented in Table 1.

Table 1. Socio-Demographic Characteristics of Participants

Participant No.	Age	Education	Employment Status	Family type	Number of Pregnancies	Gestation in weeks
1	25	Graduation	Housewife	Nuclear	2	17
2	22	Graduation	Housewife	Joint	1	22
3	26	Post Graduation	Govt Employee	Nuclear	2	23
4	25	Post Graduation	Housewife	Nuclear	2	22
5	26	Post Graduation	Private Job	Joint	1	21
6	23	Graduation	Private Job	Nuclear	1	23
7	25	Post Graduation	Private Job	Nuclear	2	26

8	28	Post Graduation	Private Job	Joint	2	22
9	26	Graduation	Private Job	Nuclear	2	25
10	25	Post Graduation	Housewife	Nuclear	1	16
11	23	Graduation	Housewife	Joint	1	18
12	26	Post Graduation	Govt Job	Joint	2	22
13	25	Post Graduation	Private Job	Nuclear	1	25
14	26	Post Graduation	Private Job	Joint	1	21
15	29	Graduation	Private Job	Nuclear	3	23
16	25	Post Graduation	Private Job	Nuclear	2	26
17	29	Post Graduation	Private Job	Joint	2	22
18	26	Graduation	Private Job	Nuclear	2	25

Source: Own research

2.2. Data collection

The semi-structured, in-depth interviews were conducted via telephone conversations. After being informed of the study's goals and receiving their agreement, participants were then asked a series of questions about their interactions with ASHA workers during their pregnancy. To accomplish data saturation and ensure that dense and rich data were gathered, identical questions were asked to all participants (Fusch & Ness, 2015). Participants were contacted based on the inclusion criteria: 1) first, second, or third trimester of pregnancy, 2) registered under Anganwadi or PHC, 3) have a 'Reproductive and Child Health Identification Number' (RCH ID), and 4) contacted by an ASHA worker. After researching relevant previous research materials, the researcher developed an interview methodology aimed at extracting participants' experiences with community health workers. Some of the questions asked were, How would you describe the conversations you had with your ASHA worker? Have you had any discussions on the central and state governments' maternal health programs? What are the ways ASHA contacted you during the pregnancy? Do you talk about your mental health? What discussions have you had regarding the mental health and well-being of mothers during pregnancy? How would you describe the impact of the conversations you had with ASHA workers? Etc. The responses to the questions were recorded and transcribed.

2.3. Data Analysis

The data were analysed using thematic analysis as the primary analytic framework. Thematic analysis was chosen for its flexibility and suitability for identifying patterns of meaning across participants' experiences without the requirement of generating a formal theory (Villegas, 2022).

The qualitative analysis followed a systematic, iterative coding process informed by thematic analysis, grounded theory, and derived coding techniques. Initially, open coding was undertaken by closely reading the interview transcripts line by line to identify discrete meaning units that captured participants' descriptions of their

interactions with ASHA workers. These meaning units reflected the lived experiences of participants related to maternal health services, pregnancy-related concerns, nutrition, emotional support, trust-building, and communication practices. Codes were generated inductively, remaining close to their own language to preserve the authenticity of their narratives.

Subsequently, axial coding was employed to examine relationships among the open codes and to cluster conceptually related meaning units into broader experiential categories. During this phase, codes reflecting similar actions, perceptions, or interactions, such as information sharing, emotional reassurance, guidance on health practices, and the accessibility of ASHA workers, were grouped. The process facilitated a deeper understanding of how different dimensions of communication operated collectively within the maternal health context and helped to organise the data into analytically meaningful categories.

Finally, selective coding was used to integrate and refine these categories into four overarching themes that most comprehensively represented the participants' experiences. The themes, Maternal Health Care Services, Pregnancy Complications, Nutrition and Dietary Plans, and Mental Health and Well-being, were identified through constant comparison and iterative review to ensure internal coherence and conceptual distinctiveness. The final themes reflect patterned meanings across the dataset and directly address the research objective by illustrating how interpersonal communication with ASHA workers influenced pregnant women's health awareness, emotional well-being, and engagement with maternal health services.

3. Results

A total of 18 pregnant women participated in the study. The mean age of the participants was 25.5. The participants' profile is provided in Table 1. The mean gestation in weeks was 22.16. All participants had completed either their graduation or post-graduation studies at the time of pregnancy. Additionally, the researcher collected information on communication between ASHA workers and pregnant women, which included the frequency of contact by ASHA workers, their mode of communication, and the duration of conversations. Four significant themes have emerged from the analysis of the script (Table 2). They were *1) communication about maternal health care services, 2) communication about pregnancy complications, 3) communication about nutrition and dietary plans, 4) Communication about mental health and well-being.*

Table 2: Analytical Focus based on Selective Coding

Core Theme (Selective Coding)	Axial Categories	Analytical Focus
Maternal Health Care Services	- Access to maternal health information - Health system navigation	Role of ASHA workers in improving awareness, access, and trust in maternal health services
Pregnancy Complications	- Management of pregnancy risks - Supportive communication	ASHA-mediated communication in addressing pregnancy-related concerns and reassurance

Nutrition and Dietary Plans	- Nutritional guidance during pregnancy - Gaps in clinical communication - Resource accessibility	Influence of ASHA workers on dietary practices and compensation for gaps in formal medical counselling
Mental Health and Well-being	- Emotional experiences of pregnancy - Psychosocial support - Relationship and trust building	ASHA workers as key emotional and mental health support figures during pregnancy

Source: Own research

3.1. Communication About Maternal Health Care Services

All expectant mothers were aware of the maternal healthcare services provided by the Central and State governments. Specifically, antenatal care (ANC) during pregnancy is also high. Moreover, this has been achieved through regular updates provided by the ASHA workers.

One participant described:

My ASHA chechi (sister) calls me regularly one day before my antenatal checkup. And also calls me once I visit my gynaecologist. She always asks, How did it go? What suggestions does the doctor give? And when is the next appointment? (Participant 6)

Another participant responded:

It is through ASHA workers that I came to know about different schemes of the Central and State governments, specifically dedicated to pregnant women. My ASHA worker took all my details and uploaded them to the website, so I am eligible for a 5000-rupee incentive for my first delivery through the Pradhan Mantri Matru Vandana Yojana. (Participant 3)

Interviews revealed that women are well aware of the various schemes and programs, which has been achieved through effective communication with their ASHA workers.

Another participant described:

I was hesitant in the beginning to share my details with an ASHA worker, but later I realised it was a blessing for me, as I was regularly updated about my check-ups and scans. Through our conversations, she consistently emphasised the importance of antenatal care and assured me that if any help was needed, she would be readily available to assist me. (Participant 7)

One factor that the respondents felt had increased is their trust in maternal health care services provided by the government. Regular communication with ASHA workers enabled pregnant women to access the utilization of full ANC and vaccinations. Another participant added,

For my antenatal check-ups, my ASHA worker always accompanies me and gives me company throughout the entire visit. (Participant 2)

For those who were undergoing their first pregnancy, their discussions with the ASHA offered the pregnant women extra information on antenatal screening, population risks, specific risks for Down syndrome, the procedure-related risks of amniocentesis, and the possibilities of false positive and false negative results.

3.2. Communication About Pregnancy Complications

Half of the participants indicated that they were comfortable enough to talk about the pregnancy complications that they felt, and the ASHA workers were very supportive and understood their issues with warmth, sympathy, and respect.

One participant who is expecting her third baby said,

My past two labours were a bit complicated, and I had to undergo a C-section. So, from the beginning of my third pregnancy, I was worried about the complications, but the regular interaction with my ASHA worker helped me a lot. Whenever I felt uneasy or uncomfortable, I would call her and inform her of my condition. (Participant 2)

The majority of the participants indicated that ASHA workers were always initiating questions about subjects or issues concerning their pregnancy. During their routine discussions with ASHA workers, pregnant women shared their pregnancy complications such as excessive vomiting, less fetal movement, anaemia, breech presentation, high blood pressure, convulsions, white discharge, and fever.

Another participant reported that,

During my second trimester, I got a severe viral infection, and I was worried about the health of my baby. I was scared to take the antibiotics that were prescribed by a physician. When I called my ASHA worker regarding my concern, she asked me to share the prescription details and cross-check with my gynaecologist, who convinced me it was safe to take during pregnancy. (Participant 12)

Most of the pregnant women stated that during their discussions with ASHA workers, they got information regarding several pregnancy complications that they were unaware of.

One pregnant woman stated,

I have heard that being anaemic during pregnancy is dangerous, but how it will affect my baby's health and my health during pregnancy was clarified by my ASHA worker, who suggested dietary charts and thorough checks on what I eat in a day. (Participant 1)

Most of the first-time mothers admitted that, along with the gynaecologist, ASHA workers also warned them regarding the problems of gestational diabetes. One woman said,

During her (ASHA worker) visits, she always asks about my sugar intake, as I have a family history of diabetes. (Participant 13)

3.3. Communication About Nutrition and Dietary Plans

The majority of the women who were interviewed placed a high value on their own and their children's health. During pregnancy, eating well and understanding nutrition were equally crucial for all. Even though almost all of them are active seekers of health information from multiple sources, such as various online platforms and books, women also sought information from their ASHA workers. As most participants reported that they considered the information shared by ASHA workers relevant, because they believe ASHAs are trained professionals in the field of maternal health, and they usually resonate with pregnant women's personal beliefs.

One woman stated,

During the house visits, ASHA workers used to bring extra iron and folic tablets in case I ran short of them. And her first question to me will always be, 'Have you taken your prenatal vitamins today?'
(Participant 5)

Almost all women reported that they were not satisfied with the information they received from their obstetricians and gynaecologists. The women reported that they had only been given insufficient, sparsely detailed information that was broad.

One participant stated,

My gynaecologist is always busy whenever I visit her, and she never guides me regarding the diet I should follow. However, my ASHA worker regularly updates me on WhatsApp with messages that help me to follow a proper diet suitable for my pregnancy. (Participant 13)

The participants reported that, during their conversations with ASHA workers, more time has been dedicated to topics like what to eat, when to eat, and how much to eat.

My ASHA worker gave me a book called 'Ammayum Kunjum', which consists of all the details, mainly the diet plans and antenatal services. (Participant 8)

3.4. Communication About Mental Health and Well-Being

The participants reported that most of them experienced a roller coaster of emotional changes during their pregnancy, and the conversations with ASHA and other community health workers helped them a lot to maintain their emotional well-being.

One participant stated,

It can be both joyful and difficult to get ready for a baby. During my first pregnancy, we were undergoing a financial crisis, which harmed my mental state. During the house visits of my ASHA worker, I used to share my stress and worry with her, and through her conversation, she made me realise that my feelings would affect the growing baby and that I should always keep a positive attitude towards everything. (Participant 11)

For most of the participants, their ASHA worker is a known person, which made it easy to share their thoughts and worries with them. Another participant stated,

The first question my ASHA worker asked me was, 'How are you?' Starting from there, she talks about how well I am doing. How well is my baby doing? (Participant 4)

As most participants use mobile devices and the internet during their free time, these conversations with ASHA workers, which occur once a week or twice a week, are very helpful to them. They get a chance to discuss their thoughts and issues and consider ASHA as an elder sister. One participant stated,

My ASHA worker acts like an elder sister to me because she always scolds me if I do not take the vitamin tablets or if I do not follow the diet. (Participant 9)

4. Discussion

The study has explored how pregnant women characterise their communication with ASHA workers and has identified key areas discussed in the context of pregnancy. Under the themes developed from the in-depth interviews, the pregnant women reported that effective communication is taking place between them and ASHA workers. This communication aims to provide an opportunity to learn more about maternal healthcare services, nutrition and diets, health complications during pregnancy, and the overall well-being of pregnant women. Also, drawing on Social Exchange Theory (SET) and the Patient-Provider Communication (PPC) framework, the findings demonstrate that communication between ASHA workers and pregnant women extends beyond the mere transmission of information and is deeply embedded in relational, social, and contextual processes. These interactions are shaped by trust, reciprocity, perceived benefits, and relational continuity, all of which influence women's engagement with antenatal care services.

From a Social Exchange Theory perspective, the interactions between ASHA workers and pregnant women reflect ongoing relational exchanges in which women assess the perceived benefits, such as emotional reassurance (Edmonds et al., 2011), informational clarity (Kj & Angadi, 2015), and access to services, against potential costs, such as time, disclosure of personal concerns, social vulnerability (Singh et al., 2012). The findings indicate that women continued to engage with ASHA workers because these interactions consistently produced valued outcomes, including improved understanding of maternal health, emotional reassurance, and practical support. This reinforces the idea that sustained engagement in health communication is contingent upon the perception of reciprocal benefit and trust within the relationship (Al-Mutawtah et al., 2023). At the same time, the Patient-Provider Communication framework offers insight into how these exchanges are enacted. The study revealed that communication between ASHA workers and pregnant women involved not only information provision but also emotional support, reassurance, and culturally sensitive dialogue. Participants reported being regularly informed about antenatal services, pregnancy-related risks, nutrition, and available government schemes. Such interactions align with core dimensions of effective patient-provider communication, including clarity of information, responsiveness, and relational continuity (Madula et al., 2018).

The study identified what is being communicated and explored the deeper processes shaping these interactions, such as the influence of power dynamics and social hierarchies on communication outcomes. ASHA workers, as trusted community health intermediaries, navigate complex social landscapes where power dynamics and traditional hierarchies influence the nature of communication. Studies have shown that the ability of ASHA workers to foster trust and establish authority is often mediated by their dual role as both insiders within their communities and agents of the formal healthcare system (Bhattacharyya et al., 2018; Chacko & Jose, 2023). This dual positioning allows them to address sensitive topics such as pregnancy complications and mental health issues in culturally appropriate ways, thereby circumventing potential resistance or stigma. For example, the social identity of an ASHA worker, including caste, gender, and socioeconomic status, can either facilitate or hinder her ability to effectively communicate with beneficiaries (Kang et al., 2022).

In the present study, pregnant women were constantly informed of their situation, the necessary procedures, and guidance on care during pregnancy. Through their conversations, ASHA workers emphasised the utilisation of government health programs allocated for pregnant women. This finding is similar to previous research that explored the expectations and understanding of pregnant women regarding maternal healthcare services based on the information provided by healthcare workers and their impact on maternal health outcomes (Raine et al., 2009; Dandeebo & Galaa, 2019; Pervin et al., 2021; Negero et al., 2023). The participants reported they are confident enough to share their health concerns with their ASHA workers and seek guidance from them. Our findings are similar to studies analysing pregnancy-related health information-seeking behaviours and their association with maternal and child health outcomes (Haruna et al., 2019; Kang et al., 2022). Family members and expectant mothers often have limited knowledge about antenatal care and pregnancy complications. Therefore, effective health information provided through community health workers is vital, as it can increase the knowledge of beneficiaries (Raine et al., 2009).

The study also identified that women were provided with booklets and health kits from the PHC to help them understand the quality and quantity of their food intake. Communication about nutrition and dietary plans is deeply influenced by cultural practices, economic constraints, and gender norms, making this observation central to a sociological understanding of health behaviour (Szwajcer et al., 2005; Bookari, Yeatman, & Williamson, 2017; Kazi et al., 2021). ASHA workers often negotiate between medical advice and local dietary traditions, some of which conflict with modern nutritional guidelines (Wennberg et al., 2015). Substantiating the existing evidence, in this study, the pregnant women reported that ASHA workers always find ways to encourage healthy eating without alienating or disrespecting their traditions.

Women identified the ASHA workers as supportive whenever they experienced emotional stress or family issues. The study findings revealed that participants often faced emotional fluctuations during their pregnancy, ranging from joy to stress, influenced by personal and financial challenges. For example, Participant 11 recounted experiencing significant mental distress during her first pregnancy due to a financial crisis. She found solace and guidance in her ASHA worker, who not only offered emotional support during house visits but also emphasised the importance of maintaining a positive attitude for the well-being of the baby. Such narratives signify the integral role of ASHA workers as accessible emotional anchors within the community. This was consistent with past research that has shown pregnant women's feelings of worry can be lessened, and barriers to receiving prenatal treatment in public medical facilities can be removed through friendly, normalising conversations

between patients and healthcare providers (McMahon et al., 2014; Schouten et al., 2021; Mayra et al., 2022). The study revealed that participants had very pleasant interactions with healthcare workers (ASHA), who offered them words of comfort and encouragement. The role of ASHA workers in facilitating these support networks is important, as they could be the only point of contact for many women experiencing emotional distress. Previous research suggests introducing workshops and training sessions to equip health practitioners with extensive knowledge and communication skills, ensuring respectful and dignified care during interactions with pregnant women (Sabetghadam et al., 2022; Mwashia et al., 2023). From a Social Exchange standpoint, emotional reassurance represents a high-value, low-cost form of support that strengthens relational bonds and encourages continued engagement (Ahmad et al., 2023). From a Patient-Provider Communication perspective, emotional responsiveness fosters trust, empathy, and psychological safety, which are key determinants of effective healthcare interactions (Kulińska et al., 2022).

5. Limitations

As with all qualitative research, the findings of this study should be interpreted within the context in which the data were generated. The use of purposive sampling facilitated access to pregnant women who were actively engaged with maternal health services and enabled an in-depth exploration of communication experiences with ASHA workers. While participants were identified with the support of ASHA workers, this approach was adopted primarily to ensure ethical recruitment, trust, and participant safety in a community-based setting. Although this may have influenced the nature of responses, the study sought to mitigate potential bias by encouraging open-ended reflection and by assuring participants of confidentiality and voluntariness during interviews.

The study was conducted within a specific rural panchayath in the Alappuzha district of Kerala, and the participants shared broadly similar socioeconomic and educational backgrounds reflective of this local context. This relative homogeneity enabled a focused examination of interpersonal communication processes within a clearly defined social setting, consistent with the objectives of qualitative inquiry. Rather than aiming for statistical representativeness, the study prioritised depth, contextual understanding, and analytical insight into communication dynamics between ASHA workers and pregnant women.

While the findings may not be directly generalisable to all regions or population groups, they offer transferable insights into community-based maternal health communication that may inform future research and practice in similar settings. Further studies across diverse geographic and socioeconomic contexts and involving other frontline health workers, such as Auxiliary Nurse Midwives and Anganwadi workers could build upon these findings and extend their applicability.

6. Conclusion

To advance public health, the ASHA program in India is a comprehensive initiative that offers an opportunity for state governments, policymakers, and practitioners. There is a need for a better understanding of how effectively

we can utilise the services of ASHA workers, especially in the field of maternal and child health, and how communication as a tool can strengthen the efficiency of these services.

The study explored the communication between pregnant women and ASHA workers to understand their experiences and maternal health outcomes. The study showed that it will be easier to adopt preventive measures, identify risks earlier, reduce problems, and address health inequalities if all pregnant women and their healthcare professionals have more and better-quality interactions during pregnancy. Additionally, for better outcomes, both the patient and the provider must play an active and participatory role. In addition, the findings of the present study can be seen as a preliminary step towards further, more in-depth exploration of the conversations and their potential use by providers for effective and improved maternal and child healthcare interventions.

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Conflict of interest

The authors declare no conflict of interest.

Ethical statement

The study was conducted in accordance with established principles of scientific research and the ethica guidelines of the researcher's institutional affiliation. Participation was voluntary, informed consent was obtained from all participants, and confidentiality was ensured. Given the non-interventional nature of the study, formal approval from an external ethics committee was not required.

Declaration of AI usage

No generative AI tools were used in the preparation of this manuscript.

Data availability

The data supporting the findings of this study are available upon request.

Author contributions

	Amala T. Chacko	Jolly Jose
Conceptualization	X	
Data curation	X	
Formal analysis	X	X
Investigation	X	
Methodology	X	X
Resources	X	
Software		X
Supervision		X
Validation	X	X
Visualization	X	
Writing - original draft	X	
Writing - review & editing		X

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