

Primary Healthcare Delivery at the Grassroots Level: A Study on the Frontline Workers in the Darjeeling District of West Bengal

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Abstract

Primary healthcare delivery at the grassroots level is fundamental to achieving equitable health outcomes, particularly in geographically challenging regions. This study examines the role of frontline health workers, Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), in delivering primary healthcare services in the Darjeeling district of West Bengal. The study explores how decentralised health policies are implemented at the sub-centre level and how frontline workers navigate everyday constraints in service delivery. Employing a mixed-methods approach, quantitative data from frontline workers are combined with qualitative interviews to capture service coverage, coordination practices, workload, incentive structures, and operational challenges. The findings suggest that decentralisation has enhanced community outreach and service accessibility; however, persistent issues, including infrastructure gaps, delayed incentives, role overload, and limited institutional support, continue to affect the effectiveness of service delivery. Frontline workers often rely on adaptive practices to sustain service provision under these constraints. The study contributes to the health systems and primary healthcare literature by providing micro-level evidence from a hilly and under-researched region. It highlights the need for context-sensitive interventions that strengthen frontline support mechanisms to improve primary healthcare outcomes.

Keywords: Primary healthcare; Frontline health workers; ASHAs; Auxiliary Nurse Midwives (ANMs); Decentralised health services; Service delivery; Sub-centres.

Introduction

Primary health care (PHC) comprises essential health services delivered at the community level to ensure accessible and affordable care for individuals and families. It encompasses preventive, promotive, curative, rehabilitative, and palliative services, including the management of chronic conditions and the provision of regular health check-ups. Delivered by a multidisciplinary team of medical practitioners, nurses, pharmacists, and allied health professionals, PHC supports continuity of care and addresses health needs across the life course.

India recognised the significance of PHC early and initiated rural primary health services following the Health Survey and Development Committee Report of 1946, preceding the Declaration of Alma-Ata. The primary objective was to improve population health while

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reducing out-of-pocket expenditure. Over time, initiatives such as the National Family Planning Programme, community health worker schemes, and the National Rural Health Mission launched in 2005 expanded service coverage, particularly for rural populations, women, and children, contributing to improvements in key health indicators, including maternal mortality (Behera et al., 2022).

At the global level, the World Health Organization and the Alma-Ata Declaration framed PHC as the cornerstone of health systems and a means to achieve "Health for All" (Litsios, 2015). Contemporary understandings of PHC extend beyond curative care to include promotive, preventive, rehabilitative, and palliative services, while also addressing the social determinants of health. As a people-centred and cost-effective approach, PHC is widely recognised as essential for achieving Universal Health Coverage and the health-related Sustainable Development Goals. A well-functioning PHC system also plays a central role in delivering integrated health services. As the first point of contact, PHC facilitates continuity of care through effective referral mechanisms, follow-up, and coordination across different levels of the health system. Integrated service delivery reduces fragmentation and improves efficiency in disease prevention, diagnosis, treatment, and rehabilitation. Reflecting this approach, India has consistently positioned PHC at the core of health system reforms. The Ayushman Bharat Comprehensive Primary Health Care Programme, launched in 2018, strengthened peripheral health infrastructure by upgrading sub-centres and primary health centres into Health and Wellness Centres, now known as Ayushman Arogya Mandirs. These centres provide an expanded package of services, including maternal and child health care, noncommunicable disease screening and management, essential medicines, and basic diagnostics (*Primary Health Care - India*, n.d.).

Alongside these reforms, decentralised health governance has emerged as an important strategy for enhancing responsiveness, accountability, and community participation in health service delivery. Decentralisation involves the transfer of administrative authority, decision-making power, and financial responsibility to sub-national and local levels (Rondinelli, 1990; López, 1995). In the health sector, this approach aims to bring planning and implementation closer to communities by strengthening district-level institutions, peripheral facilities, and frontline health workers. In India, initiatives under the National Health Mission have reinforced decentralised service delivery by expanding the roles and responsibilities of community-based and peripheral health personnel, particularly in maternal, child, and preventive health services.

Within this decentralised governance, the sub-centre occupies a pivotal position as the most peripheral institutional unit of the public health system, acting as the first point of contact for communities to access health services such as maternal health and immunisations, and bridging gaps between villages and higher-level facilities. Sub-centres are critical sites where national health policies are translated into everyday practices. Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) are central actors within this space. ASHAs function as community-based mobilisers who facilitate access to health services, promote health-seeking behaviour, and support programme implementation. At the same time, ANMs serve as the principal service providers responsible for maternal and child health care, immunisation, family planning, preventive services, and routine reporting at the sub-centre

level. From a governance perspective, ASHAs and ANMs operate not merely as service providers but as frontline governance actors who interpret policy directives, exercise administrative discretion, and mediate interactions between the villages and local populations. Their everyday decisions shape service prioritisation, programme implementation, and community engagement, particularly in decentralised settings. However, despite their centrality, existing research on decentralised health systems in India has largely focused on institutional reforms, programme effectiveness, or health outcomes, often overlooking the governance practices and administrative experiences of frontline health workers.

There remains a limited empirical understanding of how decentralized health governance is enacted in routine practice at the sub-center level. In particular, the governance roles, coordination mechanisms, accountability structures, and operational challenges faced by ASHAs and ANMs have received insufficient examination. This gap is especially pronounced in rural and geographically challenging regions, where terrain, accessibility, and resource constraints shape governance and service delivery processes. The Darjeeling district of West Bengal presents a critical empirical context for examining these dynamics. Characterized by hilly terrain, dispersed settlements, and infrastructural constraints, the district poses distinct challenges for the delivery of primary health care services. In such settings, the effectiveness of decentralized health governance depends heavily on the capacities, discretion, and everyday practices of frontline health workers operating at the sub-center level.

Against this backdrop, the present study examines decentralised health governance as experienced by ASHAs and ANMs at the sub-centre level in rural areas of the Darjeeling district. The study analyses their roles in primary healthcare delivery, explores their administrative and governance responsibilities, and identifies the challenges they face in delivering maternal and child health services within a decentralised framework. By foregrounding the perspectives of frontline health workers, this study contributes to the literature on decentralised health governance and primary healthcare delivery, offering context-specific insights into the functioning of health systems at the grassroots level.

Methodology

Study Design

This study adopted a mixed-methods research approach to examine the functioning of decentralised primary healthcare delivery and the roles of Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) at the sub-centre level. The mixed-methods design allowed for the integration of quantitative data on service coverage and workload with qualitative insights into governance practices, operational challenges, and coordination mechanisms.

Study Area

The study was conducted in the Darjeeling district of West Bengal, focusing on the Jorebunglow Sukia Pokhri block, which is geographically and administratively relevant for investigating rural healthcare delivery. The block comprises three Primary Health Centres (PHCs), one Block Primary Health Centre (BPHC), and several Sub-Centres (SCs) and Health

and Wellness Centres (HWCs). For this study, the primary focus was on sub-centres, which serve as the first institutional point of contact for the local population and are the operational units where ASHAs and ANMs are most active. Health and Wellness Centres, which were upgraded from sub-centres, were acknowledged but not included, as the study primarily examined the roles of ANMs and ASHAs, excluding Community Health Officers.

Study Population and Sample Size

The study population consisted of frontline healthcare workers, specifically Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs). These cadres were selected because they constitute the operational backbone of decentralised primary healthcare delivery, particularly for maternal and child health services. Purposive sampling was employed to select sub-centres for inclusion in the study. The selection criterion was geographical remoteness, focusing on sub-centres in the block's most remote areas, which typically face greater challenges in healthcare delivery. From each selected sub-centre, ANMs and ASHA were interviewed to ensure representation of both frontline cadres. This approach enabled the study to capture context-specific experiences, workload patterns, and operational challenges.

Data Collection

Data were collected using semi-structured interviews, focus group discussions (FGDs), and structured survey schedules. Qualitative data were gathered through individual interviews and FGDs with ASHAs and ANMs conducted at village-level sub-centres and HWCs. These interactions explored experiences related to workload, service delivery responsibilities, infrastructure, remuneration, and community engagement. Interviews and FGDs were conducted in the local language and typically lasted between 30 and 60 minutes. Quantitative data were collected through a structured questionnaire administered during field visits to the selected sub-centres. The survey collected information on socio-demographic characteristics, the number of households covered, the frequency of household visits, service-related activities, incentive payments, and access to transportation and infrastructure. Face-to-face administration ensured the completeness and accuracy of responses.

Data Analysis

Quantitative data were analysed using descriptive statistics, including means, frequencies, and population coverage indicators. Qualitative interview data were analysed using thematic analysis, identifying recurrent themes related to roles, coordination, administrative responsibilities, and operational challenges. Integration of the quantitative and qualitative findings allowed for a comprehensive understanding of the functioning of decentralised primary healthcare delivery at the sub-centre level.

Results

Role of ASHAs and ANMs in Decentralised Primary Healthcare Delivery

The findings reveal that Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) perform complementary and interdependent roles within the decentralised primary healthcare system. Together, they constitute the operational backbone of service

delivery at the sub-centre level, particularly for maternal and child health services.

ASHAs primarily serve as community-based health mobilizers and facilitators. Field data indicate that ASHAs conduct regular household visits throughout the week, except on Wednesdays, covering an average of 112 households per ASHA, representing approximately 467 individuals. The frequency and intensity of these visits vary by population size, staffing patterns, and the concentration of vulnerable groups, particularly women of reproductive age, pregnant women, lactating mothers, and young children. During household visits, ASHAs provide preventive and promotive health counseling on family planning, early pregnancy registration, maternal nutrition, personal hygiene, institutional delivery, and child immunization. They also mobilize beneficiaries to attend antenatal care sessions, immunization days, and Village Health and Nutrition Days (VHNDs).

In contrast, ANMs function as the primary clinical service providers and technical supervisors at the sub-centre level. The findings show that ANMs administer vaccinations, provide first aid, treat minor ailments, and deliver essential maternal and child health services. ANMs also play a key role in referral and institutional linkage, particularly for high-risk pregnancies and complications requiring care at Primary Health Centres or district hospitals. The study further finds that coordination between ASHAs and ANMs is central to decentralised healthcare delivery. While ASHAs facilitate outreach, community trust, and service uptake, ANMs provide clinical expertise and formal health system linkage. This coordination contributes to locally responsive service delivery at the sub-centre level.

Functioning of Decentralised Health Governance at the Sub-Centre Level

Insights from field interactions with Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) indicate that the sub-centre serves as the first institutional point of contact between the primary healthcare system and rural communities, serving an approximate population of 3,000. Respondents described the sub-centre as the primary site for the organisation and delivery of maternal and child health services, immunisation activities, and family planning services.

ANMs reported that decisions regarding the scheduling of antenatal care days, immunisation sessions, and Village Health and Nutrition Days are taken mainly at the sub-centre level. ASHAs indicated that their role primarily involves mobilising beneficiaries through household visits, informing women about service schedules, and ensuring community participation in outreach activities. Both ANMs and ASHAs described routine coordination with Anganwadi workers (AWWs), particularly during immunisation sessions and nutrition-related programmes. At the same time, respondents highlighted that administrative oversight remains vertically structured. ANMs stated that they are required to maintain detailed service records and submit regular reports to the Primary Health Centre (PHC) and Block Primary Health Centre (BPHC). These reports include information on antenatal and postnatal care services, immunisation coverage, family planning performance, and the status of medicine stocks. Several interviewees also referred to periodic supervisory visits by block- and district-level health officials, during which registers are reviewed, and service delivery practices are monitored.

Administrative and Governance Responsibilities of Frontline Health Workers

The findings indicated that frontline health workers, particularly Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs), performed substantial administrative and governance functions at the sub-centre level alongside routine service delivery. ANMs emerged as the primary administrative actors, responsible for maintaining programme registers related to antenatal care (ANC), postnatal care (PNC), immunisation, and disease-specific interventions. They also managed medicine stocks at the sub-centre and prepared routine reports for submission to the Block Primary Health Centre (BPHC). ASHAs supported these administrative processes by assisting in beneficiary identification, maintaining household-level information, and facilitating communication between the community and the health system. Their involvement contributed to outreach planning and timely utilisation of services, particularly for maternal and child health programmes.

Both ANMs and ASHAs were actively involved in organising and implementing Village Health and Nutrition Days (VHNDs). While ANMs coordinated service provision, documentation, and adherence to programme guidelines, ASHAs mobilised community participation and assisted during service delivery. These activities required coordination with Anganwadi workers and compliance with directives issued by higher administrative levels. The findings further showed that ANMs exercised operational decision-making authority at the grassroots level, particularly in planning outreach activities, prioritising beneficiaries, and coordinating follow-up care. However, key governance functions such as medicine procurement, supply distribution, and training arrangements remained centralised at the block and district levels. Overall, frontline health workers functioned within a governance structure characterised by decentralised implementation and centralised administrative control.

Challenges Faced by ASHAs and ANMs in Delivering Maternal and Child Health Services

The findings indicate that ASHAs and ANMs working at the sub-centre and Health and Wellness Centre levels encounter multiple challenges in delivering maternal and child health services in the hilly district of Darjeeling. ASHAs reported a high workload due to extensive household coverage across difficult terrain, requiring regular visits for antenatal follow-ups, immunisation tracking, nutrition counselling, and health awareness activities. Several respondents highlighted low community compliance, including resistance to health messages and difficulties in collecting sputum samples. Delayed and inadequate incentives were frequently reported, with some ASHAs using personal funds to purchase registers and basic materials for fieldwork. Both ASHAs and ANMs identified geographical constraints such as poor road connectivity, long distances between villages, and seasonal disruptions during the monsoon. ANMs further reported difficulties in managing multiple villages and maintaining service regularity due to infrastructure limitations and ongoing road construction.

Discussion

This study examined the functioning of decentralised primary healthcare governance at the sub-centre level in rural areas of Darjeeling by analysing the roles and experiences of ASHAs and ANMs. The findings provide insight into how decentralisation is operationalised at the

frontline of service delivery and how governance responsibilities are shared between community-based health workers and formal health staff. While decentralisation appears to have strengthened outreach and service utilisation, particularly for maternal and child health services, the findings also suggest that structural constraints continue to limit the autonomy, effectiveness, and long-term sustainability of primary healthcare delivery at the grassroots level.

Consistent with national evidence on the ASHA programme, this study found that ASHAs perform essential functions in mobilising communities and facilitating access to maternal, neonatal, and child health services. ASHAs in Darjeeling described themselves as critical links between households and the health system, highlighting their role in bridging geographical, social, and institutional gaps in service delivery. This finding aligns with earlier research by Nandan (2010), which demonstrates that ASHAs enhance community engagement and improve health service uptake under the National Rural Health Mission and subsequent health programmes.

Similar patterns have been reported in other parts of India, where ASHAs perceive their role primarily as mobilisation agents and intermediaries between communities and health facilities, often compensating for the limited availability of formal healthcare providers in remote and underserved areas (Guha et al., 2018; Upadhyay et al., 2021). From a decentralisation perspective, this reliance on ASHAs underscores the extent to which frontline governance responsibilities are devolved to community health workers, even as decision-making authority and resource control remain constrained at higher administrative levels.

The findings of this study reveal that ASHAs experience an excessive workload, primarily driven by extensive paperwork, household coverage responsibilities, and continuous availability to community members. This finding is consistent with Guha et al.(2018), who reported that ASHAs found register maintenance highly time-consuming and often had to complete documentation at home, affecting their personal and family life. Such evidence suggests that decentralised primary healthcare has increased frontline responsibilities without adequate administrative support, leading to work–life imbalance among ASHAs. Furthermore, the hilly terrain and poor transport infrastructure in Darjeeling exacerbate these challenges, making routine service activities and emergency referrals especially difficult. Such contextual constraints underscore the limitations of standardised decentralised governance mechanisms in addressing local geographical challenges.

The role of auxiliary nurse midwives (ANMs) emerged as critical for clinical service delivery and supervision; however, they reported managing multiple programmes simultaneously without commensurate autonomy or resources. This mismatch between responsibilities and authority reflects broader systemic issues in decentralised health systems, where frontline workers implement central policies but have limited control over financial resources, staffing, or planning decisions. These findings align with Purohit & Vasava's (2017) evidence that role overload and resource inadequacy are significant stressors for ANMs, affecting their performance and job satisfaction. Similar patterns have been observed internationally, where frontline health workers face high demands with limited decision-making power, contributing to role stress and reduced effectiveness.

The study also highlights the importance of social context in shaping health worker engagement. Most ASHAs reported receiving family support and noted that community members trusted them, sometimes more than formal providers. Such social capital is recognised in the literature as a valuable asset that enhances the effectiveness of community health programmes, particularly in underserved areas. Nonetheless, social support cannot fully compensate for structural deficits in logistics, training, and organisational support. The findings of this study add to existing studies on decentralised health governance by providing detailed evidence from a hilly and geographically challenging district, a context that remains underrepresented in health systems research. Unlike studies conducted in plains or urban areas, this research highlights how difficult terrain and limited infrastructure interact with local governance arrangements to increase workload for frontline health workers and reduce the health system's ability to respond effectively to community needs.

From a policy perspective, the results suggest that strengthening decentralised primary healthcare requires more than simply assigning additional tasks to frontline workers. Greater decision-making authority should be given to ANMs, particularly in local planning and the use of resources. At the same time, ASHAs need regular refresher training, clear role definitions, reliable logistical support, and timely payment of incentives to sustain their motivation and effectiveness. Adapting decentralisation strategies to local conditions, especially in remote and hard-to-reach areas, is essential for ensuring that primary healthcare services are responsive, efficient, and equitable at the community level.

The study also has certain limitations. First, it was conducted in only one block, which may limit the generalizability of the findings to other regions with different demographic, geographic, or health system contexts. Second, although the block includes PHCs, a BPHC, and Health and Wellness Centres, the research focused exclusively on sub-centers, excluding experiences of ANMs and other staff at higher-level facilities. Third, while ANMs are also posted at PHCs, only those primarily associated with sub-centers were included, which may not fully capture the broader responsibilities or challenges of ANMs across the healthcare system. Despite these limitations, the study offers valuable evidence on the functioning, coordination, and challenges of frontline health workers in decentralized primary healthcare delivery, which can inform future research, policy formulation, and program planning in rural health systems.

Conclusion

This study examined decentralised primary healthcare governance at the sub-centre level by focusing on the roles and experiences of ASHAs and ANMs in rural and hilly areas of the Darjeeling district. The findings show that decentralisation has strengthened community outreach and service utilisation, mainly through the expanded role of ASHAs as community-based health mobilisers and the continued clinical and supervisory role of ANMs. Together, these frontline workers form the backbone of primary healthcare delivery in remote settings. At the same time, the study highlights important limitations in the functioning of decentralised governance. Increasing responsibilities have not been matched with adequate decision-making authority, resources, or institutional support. Heavy workloads, rugged terrain, irregular supervision, and delays in incentive payments, particularly for ASHAs, continue to affect

motivation and service delivery. These challenges are more pronounced in geographically remote and hard-to-reach areas, where standardised programme designs offer limited flexibility. Overall, the study underscores that effective decentralisation requires more than the delegation of tasks. Empowering frontline health workers through greater autonomy, timely incentives, regular training, and context-sensitive planning is essential to strengthening primary healthcare systems and ensuring equitable service delivery in underserved regions

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