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COLLECTIVE FORUM

MANAGEMENT OF **AYUSHMAN** **AROGYA** **MANDIR**

Challenges and Ways Forward



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Foreword

Strengthening Primary Health Care through Ayushman Arogya Mandirs (IIM Bangalore / AAM study report)



The true test of a health system is not the sophistication of its hospitals but the strength of its foundations — the care available to a citizen on an ordinary day, close to home, before illness becomes a crisis. Primary health care is that foundation. Where it is strong, families are protected, costs are contained, and the higher reaches of the system are reserved for those who truly need them. Where it is weak, no amount of tertiary excellence can compensate. The pursuit of Universal Health Coverage therefore begins, and in large measure is decided, at the level of primary care.

India has made this foundation a national priority. The transformation of the country's primary health facilities into Ayushman Arogya Mandirs represents a commitment to comprehensive, community-based care — care that does not merely treat sickness but promotes health, prevents disease, and accompanies the patient across the full continuum of need. It is one of the most ambitious undertakings in primary health care anywhere in the world. An undertaking of this scale succeeds not on the strength of its design alone, but on the quality of its implementation in every district and every village.

It was to understand that implementation — from the ground — that the Women's Collective Forum supported this study. The choice of the Indian Institute of Management Bangalore as the knowledge partner together with the Indian Institutes of Management at Udaipur, Shillong and Ranchi, and of states as varied as Karnataka, Meghalaya, Mizoram, Jharkhand and Rajasthan as the field of inquiry, was deliberate. India's strength is its diversity, and any account of how its health system performs must be drawn from the lived realities of its different regions — from the hills of the Northeast to the tribal heartlands and the deserts of the west — rather than from a single vantage point.

This report listens to those realities. It records what is working in the Ayushman Arogya Mandirs and, with equal candour, what stands in the way — in workforce, in supplies, in digital systems, in financing and in governance. Its findings are framed not as criticism but as direction: a clear-eyed account of where focused effort will yield the greatest return, and of how the responsibility for that effort is shared across the levels of our health system. That is the spirit in which such studies serve the nation.

For the Women's Collective Forum, this work carries a particular significance. Women are the first point of contact with the health system for their families, and they are among its most dedicated frontline workers — the ASHAs, the ANMs and the community health officers on whom primary care depends. Strengthening the Ayushman Arogya Mandirs is therefore inseparable from advancing the wellbeing and dignity of women. To invest in this foundation is to invest in them.

I extend my appreciation to the Indian Institute of Management Bangalore, Udaipur, Shillong and Ranchi, to the health departments and frontline workers of the participating states who gave generously of their time and experience, and to all who contributed to this study. The responsibility now is to translate these insights into policy design, institutional practice and field implementation, enabling Ayushman Arogya Mandirs to fulfil their promise as the bedrock of India's equitable and enduring path to Universal Health Coverage.

Ms Smriti Z. Irani

Founder & Chairperson

The Alliance for Global Good: Gender Equity & Equality

Advisor – Women's Collective Forum

Foreword

The pursuit of Universal Health Coverage (UHC) in India depends fundamentally on the strength and sustainability of primary health care systems. The transformation of Health and Wellness Centres into Ayushman Arogya Mandirs (AAMs) represents a major effort to reposition Comprehensive Primary Health Care (CPHC) at the centre of India's health system. This study makes a timely contribution by examining not only the policy vision behind these reforms, but also the institutional, managerial, and governance realities shaping their implementation across diverse state contexts.



Drawing on field engagement across Karnataka, Meghalaya, Mizoram, Jharkhand, and Rajasthan, the report provides a grounded understanding of how frontline health systems operate in practice. Through the perspectives of Mission Directors, programme managers, medical officers, Community Health Officers, Auxiliary Nurse-Midwives, Accredited Social Health Activists (ASHAs), and other frontline personnel, the study captures the operational challenges and adaptive strategies that influence delivery of primary care.

Using the World Health Organization's six health system building blocks as an analytical framework, the report demonstrates how infrastructure gaps, workforce shortages, fragmented digital systems, supply chain constraints, financing limitations, and governance practices collectively shape the effectiveness and equity of care. Importantly, the study highlights that policy implementation occurs through negotiated adaptation and context-specific decision-making rather than uniform administrative compliance.

The findings raise important questions regarding allocative efficiency, fiscal sustainability, and the consequences of fragmented programme structures for integrated care delivery. The report underscores that meaningful progress toward UHC requires coordinated reforms across interconnected health system components, supported by adaptive governance, strengthened frontline capacity, integrated systems, and community-centered implementation.

By combining empirical depth with systems-level analysis, this report contributes meaningfully to ongoing efforts to strengthen primary health care as the foundation of equitable and sustainable UHC in India.

Professor Arnab Mukherji

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We also extend our appreciation to the Alliance for Health Policy and Systems Research for their partnership and support throughout the study. Their guidance and collaboration were instrumental in shaping the research approach and ensuring alignment with broader health policy priorities.

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We have made every effort to ensure the accuracy of the information presented in this study. Nevertheless, any errors, omissions, or misinterpretations that may remain are entirely our own and do not reflect on the support, guidance, or contributions of the individuals and institutions acknowledged herein.

Executive Summary

This report analyses the evolution and operationalization of Ayushman Arogya Mandirs (AAMs) as platforms for delivering Comprehensive Primary Health Care (CPHC) in India and advancing Universal Health Coverage (UHC). It situates the study within the shift from selective, programme-driven interventions toward integrated primary care and highlights the importance of governance, leadership, and facility-level management in translating policy intent into practice.

The study is guided by three core questions that assess the current status of HWCs, identify key challenges affecting their functioning, and determine priority areas for strengthening management and performance. To address these, the analysis adopts the World Health Organization health systems framework, using its six building blocks—service delivery, health workforce, health information systems, essential medicines, financing, and leadership and governance—as the analytical lens.

Findings show that HWC/AAM performance depends on interlinked system components rather than isolated programme inputs. Infrastructure gaps limit service provision, workforce shortages weaken management capacity, fragmented digital systems increase administrative burden, medicine availability is shaped by procurement and policy constraints, financing gaps displace costs onto frontline staff, and governance practices often prioritize selective programmes over comprehensive care. Consequently, piecemeal interventions have limited impact, and fragmented strengthening efforts fail to produce sustained improvements in access, quality, and continuity of care.

The analysis of governance and leadership demonstrates that national policies are implemented through negotiated adaptation rather than uniform compliance. State-level flexibility enables cultural and epidemiological alignment of services but is constrained by rigid national norms in areas such as drug lists, staffing patterns, and service mandates. Data systems increasingly inform priority setting and policy design, including by looking at insurance data and Health Management Information Systems (HMIS) data, yet their influence is filtered by programmatic hierarchies and feasibility constraints. Monitoring, supervision, and quality management rely heavily on digital platforms and formal standards, but their effectiveness is uneven due to workforce shortages, connectivity gaps, and limited financial support. Community engagement and intersectoral collaboration enhance accountability and service uptake when rooted in local governance traditions, but remain weakly institutionalized in many settings.

The policy implications emphasize evidence-informed design grounded in frontline experience, context-specific community engagement, ongoing and responsive capacity strengthening to support person-centred comprehensive care, strengthened human resources and infrastructure, integrated supply chains and digital systems, and reinforced referral and follow-up mechanisms to ensure continuity of care. The report concludes that meaningful progress toward CPHC requires coordinated reform across all six building blocks, supported by adaptive governance and leadership, to reposition primary health care as the foundation of equitable and sustainable UHC.



1 Introduction

The quest for Universal Health Coverage (UHC) has been shaped by evolving paradigms in health policy and governance. Since the Alma-Ata Declaration of 1978, global health discourse has grappled with the tension between selective, disease-specific interventions and comprehensive, system-wide approaches to primary health care (PHC). Leadership and governance have emerged as cross-cutting functions that determine whether health systems can move from fragmented programs toward equitable and sustainable coverage.

This chapter situates the study within the historical, political, and institutional contexts of PHC, highlighting how governance, leadership, and facility-level management intersect with strategic health reforms such as Ayushman Bharat in India.

The World Health Report 2000 introduced the concept of government stewardship in health systems, emphasizing vision-setting, regulation, advocacy, and information use (Smith et al., 2012). WHO later expanded this framework into the concept of “leadership and governance,” encompassing policy formulation, oversight, coalition building, system design, and accountability. Among state functions, leadership and governance are regarded as both the most complex and the most critical for effective health system performance.

Leadership and governance are interrelated but distinct processes. Leadership refers to social influence—the capacity of leaders to mobilize followers toward shared objectives—while governance encompasses the rules, values, and institutions that regulate relationships between government, civil society, and the private sector. Effective health system managers are expected not only to exercise formal authority but also to deploy leadership skills that inspire subordinates and drive health outcomes (Kapologwe, Swai, Kesale, & Kengia, 2023).

Governance is commonly conceptualized as a mode of social coordination, operating through hierarchies, markets, and networks. These modalities reflect distinct intellectual traditions—bureaucratic, economic, and sociological—and imply different roles for the state. Hierarchies emphasize centralized control and rules; markets rely on incentives and regulation; networks depend on shared norms, values, and professional exchange (Smith et al., 2012). Ouchi’s framework links these modes to measurability: markets thrive where outputs are quantifiable, hierarchies function where processes are well understood, and networks (“clan control”) are effective under uncertainty. Contemporary health governance typically blends these approaches, with governments “steering” through goal-setting, incentives, and participatory engagement rather than directly “rowing” service provision.

Governance underpins the distribution of power, resources, and accountability within health systems. Effective governance ensures coordination among diverse actors, fostering transparency, collaboration, and legitimacy. Leadership strengthens governance by promoting shared vision and cooperation, while governance structures provide the boundaries, oversight, and legitimacy necessary for leadership action (Kapologwe et al., 2023).

WHO identifies governance as involving three interdependent tasks: priority setting, performance monitoring, and accountability (Smith et al., 2012). Priority setting allocates scarce resources toward health system goals, including improved health outcomes, equity, financial protection, responsiveness, and efficiency. Performance monitoring, increasingly enabled by information technology, promotes transparency and guides clinical and management improvements. Accountability ensures that information drives consequences through political oversight, patient choice, financial incentives, or professional regulation. Comparative research demonstrates that governance quality, rather than financial resources alone, strongly shapes health system performance (Fattore & Tediosi, 2013).

UHC requires attention to both system “hardware” (resources, structures, technologies) and “software” (values, norms, relationships). Governance cultures, categorized along rules (“grid”) and collective influence (“group”), yield four ideal types: hierarchist, individualist, egalitarian, and fatalist (Fattore & Tediosi, 2013). Solidarity-based models—hierarchist and egalitarian—support UHC, whereas fatalist governance undermines collective action. Evidence from low- and middle-income countries highlights that weak political and technical leadership remains a primary barrier to UHC, and that complementarity between political vision and technical execution is essential (Gonani & Muula, 2015; Frenk & Moon, 2013).

At the facility level, governance manifests in operational management, resource allocation, staff supervision, quality improvement, and community engagement. Strong governance at this level links facilities to communities, NGOs, and government structures, thereby reinforcing health system resilience (Kesale & Swai, 2023).

The report is structured into nine chapters that move from context to evidence and policy action. Chapter 1 (Introduction) outlines the study rationale, objectives, and scope. Chapter 2 (From Selective to Comprehensive Primary Health Care: Journey to Universal Health Coverage) reviews the historical and policy evolution of PHC toward UHC. Chapter 3 (Conceptualization and Methodology) explains the analytical framework and research methods. Chapter 4 (Governance and Leadership in Primary Health Care) examines institutional arrangements and leadership processes shaping PHC.

Chapter 5 (Functioning and Management of HWCs/AAMs: Current Status) assesses the operational status and management of HWCs/AAMs, while Chapter 6 (Challenges in delivering CPHC services through HWCs/AAMs) identifies key implementation and management bottlenecks. Chapter 7 (Key Priority Areas for Strengthening the Management of HWCs/AAMs: Ways Forward) proposes priority actions to strengthen facility-level management and leadership. Chapter 8 (Policy Implications: Vision for PHC) translates findings into policy-relevant recommendations. Chapter 9 (Conclusions) synthesizes the main findings and their implications for advancing CPHC and UHC.



2

From Selective to Comprehensive Primary Health Care:

Journey to Universal Health Coverage

This chapter traces the evolution of Primary Health Care (PHC) from selective, disease-specific interventions to a comprehensive, system-wide approach aligned with the goal of Universal Health Coverage (UHC). It reviews how global health policy shifted away from the Alma-Ata vision toward selective PHC due to political and resource constraints, and how the limitations of fragmented programmes led to renewed emphasis on Comprehensive Primary Health Care (CPHC).

Linking these global shifts to the Indian context, the chapter examines how reforms such as Ayushman Bharat reflect this transition while also revealing persistent tensions between vertical programmes and system strengthening. The chapter thus provides the historical and policy context for understanding contemporary efforts to achieve UHC through primary care.

2.1 Governance and Leadership in Primary Health Care:

The role of governments as stewards of health systems has evolved from basic administration to active leadership in shaping vision, regulation, and accountability. The World Health Report 2000 framed governments as responsible for creating conditions for equitable and effective health services (Smith et al., 2012), a role that WHO later expanded into the dual concepts of leadership and governance. Leadership is essential for mobilizing stakeholders toward collective goals, whereas governance provides institutional frameworks that guide interactions across public, private, and civil society actors (Kapoligwe et al., 2023). Together, they form a mutually reinforcing system: governance establishes accountability and legitimacy, while leadership clarifies priorities and motivates action. Contemporary health systems increasingly blend hierarchies, markets, and networks to achieve coordination while maintaining clarity, flexibility, and accountability.

This interdependence between governance and leadership is critical when considering the evolution of primary health care. The Alma-Ata Declaration (1978) articulated a comprehensive vision of PHC, emphasizing equity, community participation, prevention, and holistic care (Cueto, 2004). However, the subsequent rise of selective primary health care (SPHC)—targeted, cost-effective interventions aimed at high-burden diseases—illustrates the tension between measurable short-term gains and long-term system transformation (Walsh & Warren, 1979; Banerji,

1984). While SPHC delivered tangible results, it narrowed the broader potential of PHC to address social determinants of health. Evidence increasingly shows that leadership and governance are central to implementing comprehensive PHC effectively, as they coordinate resources, align stakeholders, and ensure policies translate into sustainable population health outcomes (Baum et al., 2017; Lall et al., 2022).

The analytical link between governance and leadership becomes apparent in their operational functions within PHC. Governance sets structural boundaries and accountability mechanisms, while leadership drives motivation, priority-setting, and patient-centered approaches across all health system components—workforce, service delivery, procurement, and information systems. Weak leadership undermines these processes, creating bottlenecks in policy Management and limiting progress toward UHC, particularly in low-income countries (Frenk & Moon, 2013; Gonani & Muula, 2015). Conversely, strong political leadership provides legitimacy and resource mobilization, while technical leadership ensures evidence-based planning and operational translation of vision into practice. Institutional mechanisms such as constitutional recognition of health rights and routine sector reviews reinforce governance structures and embed accountability into system functioning.

Governance can be analytically understood through three interrelated tasks: priority setting, performance monitoring, and accountability. Priority setting involves allocating resources to maximize health, equity, financial protection, and efficiency, guided by standards, benchmarks, and cost-effectiveness analyses. Performance monitoring leverages digital technologies and routine data systems to track outcomes, guide managerial improvements, and enable citizen engagement. Accountability connects information to consequences through political oversight, professional regulation, financial incentives, and patient choice. The interrelation of these functions highlights that governance is not merely structural but dynamic, requiring continuous leadership to adapt policies, coordinate actors, and respond to population needs.

Finally, governance culture profoundly shapes PHC Management and the feasibility of UHC. Hierarchist models promote collective interests through authority and rules but may constrain professional autonomy; individualist models incentivize efficiency but risk inequities; egalitarian models encourage participation and solidarity, though efficiency may be compromised; and fatalist models, characterized by weak agency, undermine collective action (Fattore & Tediosi, 2013). Analytically, solidarity-based governance—particularly hierarchist and egalitarian orientations—provides the most conducive environment for UHC, demonstrating how culture, governance, and leadership collectively influence the trajectory of primary health care.

2.2 Historical Trajectory: From Alma-Ata to Selective PHC to Comprehensive PHC

The evolution of primary health care (PHC) reflects a complex interplay between ambitious ideals and pragmatic, often donor-driven strategies. In many low-income countries, Essential Health Packages (EHPs) are designed more around donor priorities than local health needs, which can undermine sustainability and long-term system development (Ooms et al., 2014). Multi-year sectoral plans, grounded in evidence and systems thinking, are essential to expand services, strengthen human resources, and develop infrastructure (World Bank, 2017). At the operational level, effective governance ensures that policies translate into functional services, linking communities, NGOs, and government structures (Kesale & Swai, 2023). Institutionalized accountability, rigorous monitoring, and strong research capacity are vital for adaptive learning and sustained reform. Yet, political commitments like the Abuja Declaration often fail to translate into real-world health financing, constrained by donor dependency and weak domestic governance (Lu et al., 2010; Gonani & Muula, 2015).

By the 1970s, the limitations of vertical, disease-specific programs became increasingly evident. Critics argued that narrowly targeted interventions neglected prevention, community engagement, and the broader social determinants of health (Cueto, 2004). In response, the 1978 Alma-Ata Declaration articulated a transformative vision for PHC, positioning it as the cornerstone of “Health for All by 2000.” Alma-Ata emphasized equity, social development, and active community participation, advocating a comprehensive approach that addressed the root causes of ill health rather than focusing solely on diseases.

This expansive vision, however, faced immediate challenges. In 1979, the Bellagio Conference, sponsored by the Rockefeller Foundation, introduced SPHC as a cost-effective, disease-focused alternative. SPHC targeted high-impact interventions that could be measured and scaled quickly, epitomized by the GOBI-FFF package—Growth monitoring, Oral rehydration, Breastfeeding, Immunization, Food supplementation, Female literacy, and Family planning (Cueto, 2004). While SPHC achieved tangible improvements in child health, it narrowed Alma-Ata’s broader social and equity-focused goals, privileging technocratic solutions over structural change and community empowerment (Banerji, 1984; Barker & Turshen, 1986). The historical trajectory from Alma-Ata to Selective PHC and back underscores both the challenges of implementing broad social health visions and the enduring importance of aligning global commitments with local realities (WHO & UNICEF, 2018).

Despite the widespread adoption of selective models, the principles of comprehensive PHC remained influential. The WHO’s 2008 PHC strategy and the 2018 Astana Declaration reaffirmed the centrality of comprehensive PHC to UHC and the Sustainable Development Goals (SDGs) (Baum et al., 2017; Lall et al., 2022). Today, comprehensive PHC seeks to balance efficiency with equity, emphasizing prevention, community engagement, and locally responsive care across the life course (Figure 1).

GLOBAL MILESTONES IN THE EVOLUTION OF PRIMARY HEALTH CARE

YEAR / PERIOD	EVENT	KEY CONTRIBUTION
1946	 Bhore Committee (India)	 Proposed comprehensive vision for primary health care (PHC).
1978	 Alma-Ata Declaration	 Declared PHC as the cornerstone of 'Health for All by 2000'.
1979	 Bellagio Conference	 Promoted Selective PHC (SPHC) with GOBI-FFF interventions.
1980s-1990s	 Donor-driven SPHC dominates	 Expansion of vertical, donor-driven programs focusing on specific diseases.
2000	 WHO introduces stewardship	 Framed stewardship as vision-setting, regulation, and advocacy in health systems.
2008	 WHO's recommitment to PHC	 Reaffirmed PHC with emphasis on social determinants of health.
2018	 Astana Declaration	 Reaffirmed comprehensive PHC as central to UHC and SDGs.
2018 onwards	 Ayushman Bharat (India)	 Launched HWCs + PMJAY, shifting toward comprehensive PHC within the UHC framework.

Figure 1: Evolution of Primary Health Care
Source: Compiled by the Study Team

2.3 From Selective to Comprehensive PHC in India

India's journey in PHC has evolved from selective, disease-focused interventions to a more comprehensive, life-course approach. Historical milestones such as the Bhore Committee (1946), the National Health Policy (1983), and programs like the National Rural Health Mission and ASHAs laid the foundation for PHC, improving access to basic services and community engagement. However, challenges such as inequitable access, high out-of-pocket expenditures, and the growing burden of chronic diseases persisted (Lall et al., 2022). Table 1 below briefly highlights the differences between comprehensive and selective primary health care.

Aspect	Comprehensive Primary Health Care (Alma-Ata, 1978)	Selective Primary Health Care (Bellagio, 1979)
Vision	Universal, holistic, "Health for All by 2000"	Targeted, interim, disease-control strategy
Approach	Broad: addresses social, economic, and environmental determinants of health	Narrow: low-cost, specific interventions against major child killers
Scope	Wide range of services: prevention, treatment, equity, community participation	Focused package of interventions (initially broad, then refined)
Core Interventions	Health education, nutrition, safe water, sanitation, maternal & child care, essential drugs, immunization, disease control, community involvement	GOBI: Growth monitoring, Oral rehydration, Breastfeeding, Immunization → later GOBI-FFF (Food supplementation, Female literacy, Family planning)
Strengths	Holistic, addresses root causes, promotes equity	Measurable, cost-effective, donor-friendly, quick results
Weaknesses	Unrealistic targets, difficult to implement, resource-heavy	Narrow, excludes key issues (e.g., respiratory infections), seen as undermining Alma-Ata
Supporters	WHO, advocates of equity and social justice	Donors, UNICEF (under James Grant), and agencies favoring measurable outcomes
Criticism	Too idealistic, vague, and hard to fund	Too narrow, vertical, risks ignoring broader health needs.

Table 1: Differences between Comprehensive and Selective Primary Health Care

Source: Cueto, (2004) (Compiled)

The launch of Ayushman Bharat in 2018 marked a decisive shift toward comprehensive PHC. Its twin pillars—Health and Wellness Centres (HWCs) and Pradhan Mantri Jan Arogya Yojana (PMJAY)—integrate community-based primary care with financial protection for secondary and tertiary services. HWCs expand the scope of care to include communicable and non-communicable diseases, mental health, addiction, rehabilitation, and preventive services, while reinforcing community engagement, surveillance, and local governance. By adopting a life-course and family-centered approach, HWCs reflect a structural investment in comprehensive primary healthcare.

With a target of 150,000 HWCs nationwide, Ayushman Bharat positions primary healthcare as the foundation of India's universal health coverage strategy, moving beyond the limitations of selective interventions and embracing holistic, equitable care (Lall et al., 2022). Global evidence reinforces that strong, comprehensive PHC systems are associated with higher life expectancy and more equitable health outcomes, underscoring the importance of India's ongoing transition.



3

Conceptualization and Methodology

This chapter outlines the conceptual foundations and methodological approach guiding the study. It explains how the key concepts of governance, leadership, and facility-level management are operationalized in relation to CPHC and UHC. The chapter presents the analytical framework for linking system-level policies with frontline service delivery and

management practices.

The chapter also details the research design, study setting, data sources, and analytical methods. By clarifying the assumptions, indicators, and procedures adopted, it establishes the basis for interpreting the empirical findings presented in subsequent chapters and ensures transparency and rigor in the study's analytical approach.

3.1 Conceptualization of AAMs

The Government of India launched the Ayushman Bharat–Health and Wellness Centres (AB-HWCs) in 2018 as a strategic initiative to strengthen the public primary healthcare system. These centres are being developed by transforming existing Sub Centres (SCs) and Primary Health Centres (PHCs) in both rural and urban areas, with the goal of delivering CPHC. The initiative encompasses expanded service scope, a continuum of care, technological integration, financing reforms, community engagement, and health promotion strategies. As of March 2025, 1,78,629 HWCs are operational across the country.

HWCs are designed to provide a comprehensive package of 12 service categories, including preventive, promotive, curative, palliative, and rehabilitative care. These services are universally accessible, free of charge, and located within close reach of communities. A major focus of the initiative is community-level screening and management of Non-Communicable Diseases (NCDs). To support this, a new cadre of Community Health Officers (CHOs) was introduced in 2018 as mid-level healthcare providers (MLHPs).

Despite the programme's wide reach and its commitment to strengthening last-mile healthcare delivery, Management challenges persist (Nabi et al., 2024; Garg et al., 2024). Evidence from various regions sheds light on the functioning of these centres, though most studies have examined select facilities in specific geographies (Magotra et al., 2024). Notably, there remains a limited understanding of the governance and administrative mechanisms at the district and state levels. This highlights the need for deeper inquiry and sustained dialogue to strengthen the strategic management and oversight of the HWC initiative.

HWCs thus represent the transformation of SCs and PHCs into sustainable, inclusive, and integrated primary healthcare institutions. Their effectiveness depends on adopting a holistic, systems-oriented approach that improves service quality while addressing persistent challenges. Such an approach requires systematic tracking of both linear and non-linear progress in their development and functioning.

This study thus aims to explore stakeholder perspectives on the functioning, challenges, and aspirations associated with HWCs, while examining their role in advancing equitable, integrated, and sustainable primary healthcare in India. To gain deeper insights into these dynamics, a series of symposiums was conducted using a qualitative research design. Central to this design was stakeholder engagement through structured Focus Group Discussions (FGDs).

3.1.1. Research Objectives and Questions:

The objective of this study is to critically analyze the evolution and operationalization of Ayushman Arogya Mandirs and Health and Wellness Centres in India by examining their infrastructural and service-delivery capacities, exploring systemic and contextual barriers to their effectiveness, and generating evidence-based insights to inform strategies for strengthening comprehensive primary health care delivery. The study addresses three research questions shown in Figure 2:

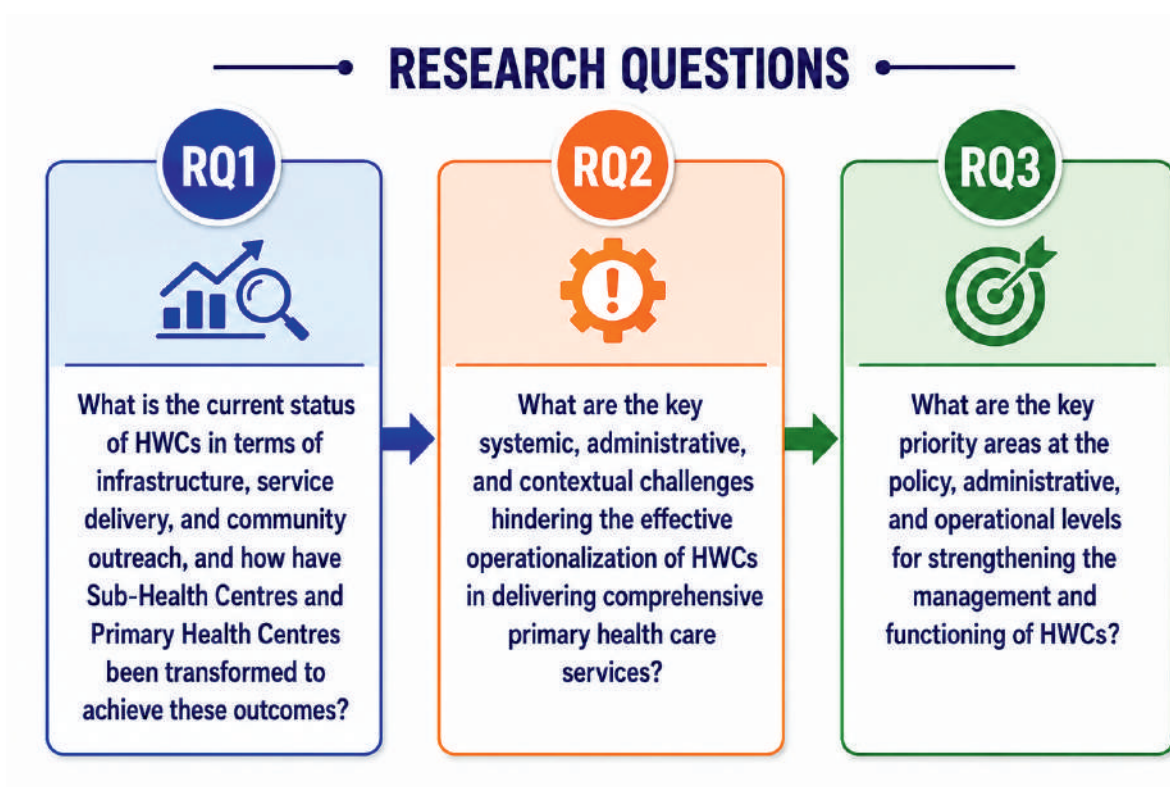


Figure 2: Key Research Questions Addressed in the Study

Source: Compiled by the Study Team

3.1.2. Conceptual Framework

To address these objectives and questions, the study adopts the World Health Organization health systems framework, specifically its six building blocks, as the core analytical lens. The framework conceptualizes health systems as comprising six interdependent components: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance. This approach enables a systematic assessment of both “hardware” elements, such as infrastructure, staffing, and supplies, and “software” elements, such as management practices, accountability, and decision-making processes (WHO, 2010). By using this framework, the study moves beyond a narrow programme evaluation to examine how different system components interact to shape the functioning and performance of HWCs/AAMs (Figure 3).

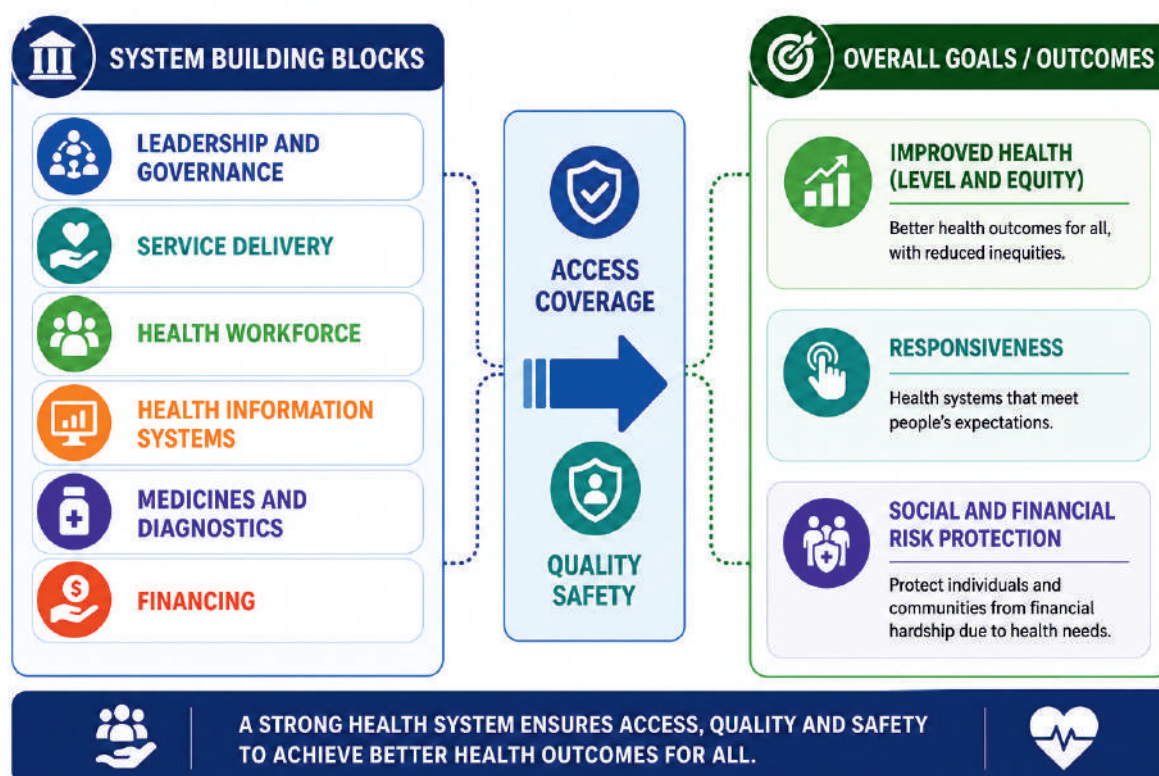


Figure 3: The Six Building Blocks of the Health System

Source: WHO’s building blocks of a health system (WHO, 2010).¹

Methodologically, the framework structures data collection and analysis around each building block, allowing the study to link observed service delivery outcomes to underlying system capacities and constraints. Infrastructure and service delivery indicators address RQ1 by documenting the transformation of Sub-Health Centres and Primary Health Centres into HWCs. Systemic, administrative, and contextual barriers identified across the building blocks inform RQ2. Finally, gaps and strengths revealed through this analysis provide the basis for identifying policy, administrative, and operational priorities under Rq3.

Through this conceptual and methodological approach, the chapter establishes a coherent basis for interpreting the empirical findings presented in subsequent chapters and for situating facility-level realities within broader health system dynamics.

¹Available at <https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf>, accessed on January 30, 2025

3.2 From Selective to Comprehensive PHC in India

3.2.1. Selection of Study Settings

The AAM symposia constituted a structured policy engagement initiative led by IIM Bangalore, and implemented through a series of sequential events hosted at premier management institutes across different regions of the country. The first symposium was convened at IIM Shillong on 22 August 2025, followed by a second at IIM Bangalore on 24 September 2025 in collaboration with IPH Bengaluru, a third at IIM Ranchi on 19 December 2025 in collaboration with Ekjut, and a fourth symposium was conducted by IIM Udaipur on 6th April 2026. IIM Udaipur also conducted a symposium with academicians and experts from social organizations or non-profit institutions on 16th March 2026 (Figure 4).

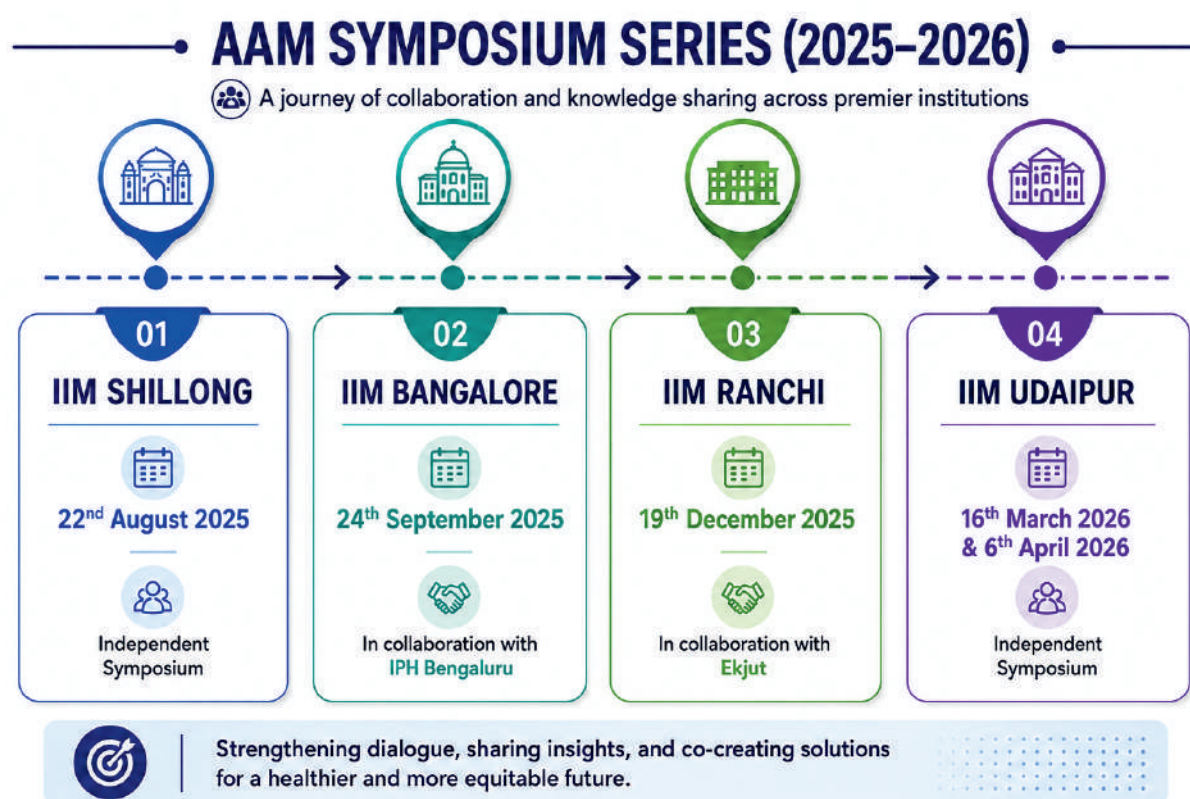


Figure 4: Dates and Venues of the AAM Symposium Series

Source: WHO's building blocks of a health system (WHO, 2010).¹

States were purposively selected across the northeastern, eastern, southern, and western regions of India based on the presence of strong health and management-oriented institutions, supportive state government engagement, and variations in UHC performance. This approach enabled the study to examine the implementation of CPHC within diverse institutional and governance contexts while facilitating collaboration with regional academic and policy partners.

Within each selected state, two districts were subsequently identified using the district-level UHC scores reported by Mukherji et al. (2024): one relatively high-performing and one relatively low-performing. District-level measures were

¹Department of Health and Family Welfare and National Health Mission of Meghalaya, Mizoram, Karnataka, Jharkhand, and Rajasthan

prioritized to account for substantial sub-national variations in health system performance across India (Dandona et al., 2017). This comparative design enabled the study to capture localized differences in health system functioning, governance practices, and service delivery experiences across districts at different stages of UHC progression (Mukherji et al., 2024).

Table 2 below presents selected health indicators from NFHS-5 (2019–21) for Meghalaya, Mizoram, Jharkhand, Karnataka, and Rajasthan, the five states participating in the Symposia on AAMs coordinated through collaborations with IIM Shillong, IIM Ranchi, IIM Bangalore, and IIM Udaipur. The indicators highlight substantial inter-state variation in maternal and child health, nutrition, anaemia, and healthcare utilization, reflecting the diverse epidemiological and health-system contexts within which Ayushman Arogya Mandirs operate.

Indicator	Meghalaya	Mizoram	Jharkhand	Karnataka	Rajasthan
Total Fertility Rate (children per woman)	2.9	1.9	2.3	1.7	2.0
Institutional births (%) out of total births	79.7	95.8	77.9	96.6	94.9
Children 12–23 months fully immunized (%)	63.8	72.5	65.2	89.1	80.4
Children under 5 years stunted (%)	46.5	28.9	39.6	35.4	31.8
Children under 5 years wasted (%)	12.1	28.9	22.4	19.5	16.8
Children under 5 years underweight (%)	26.6	12.7	39.4	32.9	27.6
Women (15–49 years) anaemic (%)	54.8	46.4	65.3	47.8	53.1
Children (6–59 months) anaemic (%)	68.7	49.0	67.5	66.5	71.5
Infant Mortality Rate (per 1,000 live births)	32	25	38	21	30
Under-5 Mortality Rate (per 1,000 live births)	46	31	45	26	38

Table 2: Health Indicators in Meghalaya, Mizoram, Jharkhand, Karnataka, and Rajasthan: Evidence from NFHS-5 (2019–21)

Source: Compiled by the Study Team

The northeastern states of Meghalaya and Mizoram demonstrate contrasting health profiles despite geographical proximity. Mizoram reports comparatively strong performance in institutional births, immunization coverage, and lower fertility, whereas Meghalaya continues to experience high levels of stunting, anaemia, and child mortality. Jharkhand shows persistent nutritional and anaemia burdens, with

high rates of underweight children and maternal anaemia, indicating continuing challenges related to poverty, food insecurity, and access to quality healthcare. Karnataka performs relatively better across most indicators, particularly in institutional deliveries and immunization, suggesting stronger health infrastructure and service delivery systems. Rajasthan occupies an intermediate position, with improvements in maternal and child healthcare utilization but continuing concerns regarding anaemia and child malnutrition.

Collectively, the table illustrates the heterogeneous health needs and service delivery environments across participating states. These differences underscore the importance of context-specific implementation strategies within AAMs, particularly in relation to primary healthcare strengthening, nutrition interventions, maternal and child health services, and community outreach.

3.2.2. Selection of Participants:

At each symposium, two states—one with high UHC attainment and one with low UHC attainment— participated. For each state, in-depth perspectives were gathered from officers assigned to districts representing both high and low UHC scores. Nine stakeholder categories were invited from each state to participate in each IIM symposium. In addition, IIM Udaipur also conducted an FGD with academicians and non-profit institutions.

A total of 13 FGDs were conducted across 4 IIMs. About 93 individuals participated in the study (Table 3).

Sl. No.	Category of Stakeholders	Participants across the four States
1.	Mission Director, National Health Mission/ Project Director- AAM	3
2.	State-level Health Officials (Joint Director, Deputy Director, Nodal Officer, Consultants)	15
3.	District-level Health Officials (Nodal Officer, Consultants, Program Managers)	23
6.	Medical Officers	13
7.	CHOs/ MLHPs	11
8.	ANMs	11
9.	ASHAs/ ASHAs Facilitators	11
10.	Academicians and Experts from social organization or non-profit institutions	6
	Total Participants	93

Table 3: Stakeholders from Five States Participating in the AAM Symposium Series

Source: Compiled by the Study Team

3.2.2. Data Collection Tools

The data collection tools and resource materials for the workshops were developed by the research team at IIM Bangalore and reviewed by experts on the study team. The FGD guides were developed through expert consultations and an in-depth literature review. The key focus areas of the stakeholder FGD guide included is shown in Figure 5 below:

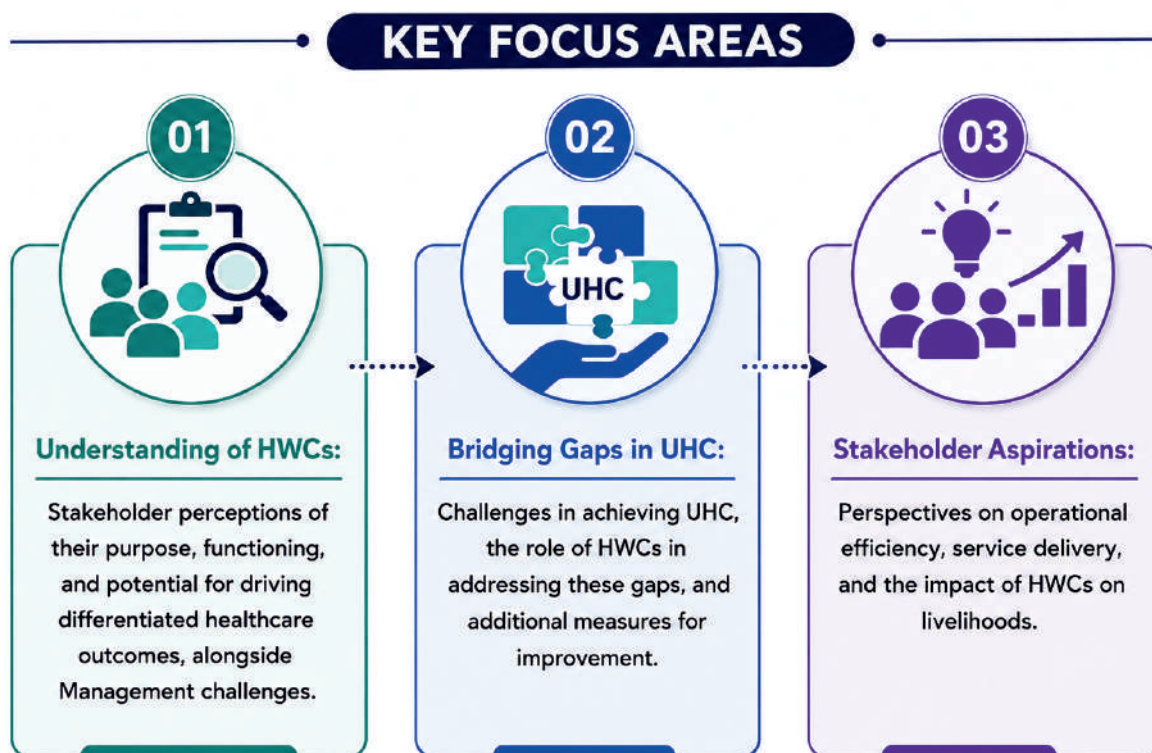


Figure 5: Key Focus Areas of the Stakeholder FGD guide

Source: Compiled by the Study Team

3.2.3. Data Collection & Analysis

A total of 13 FGDs were conducted across four IIMs. The study employed a qualitative approach to capture perspectives from 93 participants at different levels of seniority within and outside the healthcare sector, spanning 5 states and 11 districts where AAM had been implemented. Data collection was conducted through three focused group interactions organized as part of a symposium. The first group engaged stakeholders at the state level, who provided state-specific perspectives on health system functioning. The second group involved district-level stakeholders to capture localized administrative and programmatic insights. The third group concentrated on service delivery, engaging directly with healthcare providers at both facility and community levels.

All discussions were audio-recorded with participants' consent and subsequently transcribed verbatim. The transcripts were then subjected to qualitative thematic analysis using NVivo version 15. A coding framework was developed iteratively, combining both deductive codes drawn from the study objectives and inductive codes that emerged from the data. Transcripts were coded in NVivo and cross-

checked by multiple researchers to ensure reliability and consistency. Recurring themes were identified and synthesized to highlight strengths, gaps, and priorities in the Management of AAM centres and the delivery of comprehensive primary healthcare.

The qualitative process culminated in the preparation of four engagement-specific reports and a consolidated report. Together, these outputs provided an all-India perspective on the functioning of AAM centres and the broader trajectory of comprehensive primary healthcare delivery in the country.



4

Governance and Leadership in Primary Health Care

This chapter examines how governance and leadership shape the functioning of PHC through concrete institutional practices and managerial processes. It focuses on how national policy directions are adapted at the state and local levels and how leadership is exercised through routine systems of planning, monitoring, and quality improvement.

The chapter analyses key governance functions, including state-level flexibility in implementing national guidelines, the use of data for evidence-based policy and priority setting, and mechanisms of monitoring, supervision, and quality management. It further explores the role of community engagement, intersectoral collaboration, and village-level convergence in strengthening accountability and responsiveness. Together, these dimensions illustrate how governance and leadership operate not only as abstract principles but as everyday practices that shape PHC performance and the delivery of comprehensive services.

4.1 State-Level Flexibility with National Guidelines

Across states, implementation of national primary healthcare programmes was shaped by negotiated adaptation rather than uniform compliance. States modified centrally designed guidelines according to local epidemiological patterns, geography, workforce availability, and sociocultural realities.

In Meghalaya, flexibility enabled cultural localization of HWCs/AAMs through Khasi and Garo motifs, translated programme materials, and retention of local nomenclature, strengthening community acceptance and frontline engagement. Jharkhand similarly relied on district-level adaptation through monitoring and infrastructure strengthening to improve trust in AAMs.

In Mizoram, participants highlighted tensions between standardized national mandates and the realities of a sparsely populated hill state. Uniform requirements for sub-centre upgrading and specialist-led outreach were viewed as poorly aligned with terrain, connectivity, and workforce shortages. Participants also criticized nationally standardized drug lists for ignoring local disease epidemiology. One state official explained:

‘IPHS is IPHS [Indian Public Health Standard]; it has been prepared without taking into account Mizoram... Disease epidemiology is different here. We did a long consultation with specialists and pharmacists and devised our own list.’ [State Official, Mizoram]

At the same time, Mizoram attempted to balance contextual adaptation with adherence to national frameworks:

‘We try to make sure that we do not contradict the National Health programs... modules were closely aligned with the national guidelines, with only some additions which are local specific.’ [State Official, Mizoram]

In Karnataka, state governments selectively modified implementation norms, including teleconsultation targets and CHO recruitment criteria, but districts largely remained implementers of centrally designed programmes.

‘Guidelines come from the Government of India and are modified at the state level. Districts mainly execute them.’ [District Level Official, Karnataka]

Rajasthan similarly demonstrated extensive contextual adaptation due to its diverse tribal, desert, rural, and urban settings. Participants repeatedly emphasized that uniform national guidelines were often operationally impractical across heterogeneous regions. A state-level official explained:

‘Health is a state subject... every small community and every place has a local problem... In tribal areas, there are different issues. In hilly areas, they are different. In our desert areas, different issues come up.’ [State Health Official, Rajasthan]

Participants highlighted that Rajasthan selectively modified implementation strategies according to local feasibility and risk considerations. For example, the state did not fully operationalize institutional deliveries at all sub-centres because of staffing and emergency care limitations.

Overall, findings across states indicate that the effectiveness of national primary healthcare reforms depends significantly on state-level flexibility to adapt programme design, workforce arrangements, and service norms to local health system realities and epidemiological contexts.

4.2 Leveraging Data for Evidence-Based Health Policy

Across states, digital health systems are increasingly embedded within disease surveillance, programme monitoring, and health planning. However, their policy value depends not only on the availability of data, but also on interoperability, data quality, and the ability to translate fragmented reporting systems into actionable governance tools.

In Meghalaya, participants described how multiple digital platforms, including the NHM MIS, the state-developed Mother App, and insurance databases under the Meghalaya Health Insurance Scheme (MHIS), have strengthened evidence-based planning by generating both epidemiological and financial insights. Insurance claims data, in particular, was viewed as more reliable for understanding disease burden and household expenditure patterns. A state health official noted that claims databases often capture treatment realities more accurately than routine reporting systems.

Officials explained that triangulating insurance claims, programme databases, and field observations enabled the identification of under-recognized burdens such as dialysis costs and snakebite-related expenditure, thereby informing more targeted policy responses.

In Karnataka, participants emphasized the growing use of epidemiological surveillance and historical trend analysis for anticipatory governance and outbreak preparedness. District officials described how seasonal disease patterns, diagnosis trends, and facility-level surveillance data are routinely analysed to guide geographically targeted interventions, particularly for vector-borne diseases. One district health official explained that prior surveillance data enables authorities to anticipate seasonal outbreaks and allocate resources proactively:

‘We look at data from previous years. We know when malaria and dengue outbreaks occur and when they typically occur. All this data is maintained.’ [District Health Official, Karnataka]

Decision-making was reported to rely on multiple forms of epidemiological evidence, including admissions, case reporting, and surveillance trends across HWCs and PHCs.

In Rajasthan, participants similarly recognized the importance of data-driven governance for identifying localized disease burdens and informing programme priorities. State officials highlighted the need for geographically disaggregated data to identify disease clusters and emerging epidemiological risks. One state official emphasized that localized numerical data is essential for detecting hidden disease pockets and targeting interventions accordingly:

‘To identify this, having number-wise data for some geographical area is necessary... There might be some pockets because of which cancer prevalence is high there.’ [State Health Official, Rajasthan]

Across states, findings indicate that while digital systems increasingly support surveillance and planning, their effectiveness remains constrained by fragmented architectures, inconsistent reporting practices, and limited interoperability. Meghalaya demonstrated stronger integration of epidemiological and financial datasets, whereas Rajasthan highlighted governance challenges arising from parallel reporting systems and uneven data quality.

4.3 Monitoring and Supervision

Across states, governance was experienced primarily through systems of supervision, monitoring, and target-based accountability that shaped programme implementation and frontline performance. Monitoring mechanisms relied heavily on digital reporting platforms, routine review meetings, and hierarchical supervision structures, but their effectiveness varied according to workforce availability, infrastructural capacity, and managerial support.

In Karnataka, governance of AAMs was closely linked to supportive supervision and quality benchmarking under programmes such as NQAS and Kayakalp. District officials described monitoring as highly data-driven, with digital dashboards, weekly reviews, field visits, and performance indicators used to identify implementation gaps. One official explained:

‘Supportive supervision would be looking towards the NQAS achievement or the Kayakalp achievement.’ [District Health Official, Karnataka]

In Jharkhand, participants framed supervision not only as administrative oversight but also as supportive mentoring. Regular monitoring, institutional partnerships, and capacity-building were viewed as important for strengthening implementation and developing model centres.

In Meghalaya, participants described governance and supervisory capacity as significantly constrained by poor connectivity, difficult terrain, and the growing administrative burden of digital reporting systems. Although monitoring increasingly relied on online portals and real-time reporting mechanisms, frontline officials explained that weak network coverage and OTP-based authentication requirements made routine supervision difficult, particularly in remote areas. These technological and infrastructural limitations increased workload pressures and reduced the feasibility of effective field-level oversight. As one district health official explained:

‘Sometimes at night, also keep doing the work. So, this still has deep problems for us because if they ask us to monitor the staff, it is difficult to monitor them, the load is too much’ [District Health Official, Meghalaya].

Similar tensions emerged strongly in Rajasthan, where Medical Officers in Charge (MOICs) were expected to simultaneously manage clinical care, supervision, reporting, and medico-legal responsibilities. Participants repeatedly questioned the feasibility of this supervisory structure given the expanding administrative workload. Medical officers further emphasized that governance responsibilities were increasingly administrative rather than clinical.

Across states, findings suggest that while supervision and monitoring are central to contemporary primary healthcare governance, their effectiveness is frequently undermined by workforce shortages, fragmented reporting systems, and administrative overload at the frontline.

Frontline Leadership and Micro-Level Governance

Frontline health workers described their roles as extending beyond the delivery of clinical and preventive services to encompass leadership, coordination, and local-level governance functions. Participants highlighted their responsibilities in mobilizing communities, coordinating human resources, facilitating implementation of public health programmes, and ensuring timely reporting and communication with higher administrative levels. These activities position frontline workers as critical intermediaries between communities, health facilities, and the broader health system.

The discussions revealed that frontline workers play a central role in operationalizing public health interventions at the community level. Participants described leading vaccination mobilization efforts, identifying and reaching children who were not enrolled in schools during National Deworming Day campaigns, conducting house-to-house visits during the Intensive Diarrhoea Control Fortnight (IDCF), distributing oral rehydration salts and deworming medicines, and promoting awareness among families regarding preventive health practices. Such responsibilities demonstrate that the functioning of Ayushman Arogya Mandirs relies not only on formal administrative structures but also on the leadership exercised by frontline workers in coordinating services, engaging communities, and translating programme objectives into locally responsive action. As one participant explained:

‘As frontline health workers, we play a key leadership role in coordinating human resources and facility activities... We take the lead in mobilizing families and ensuring vaccination coverage... ASHAs and ANMs conduct house-to-house visits, distribute ORS packets and deworming medicines, and create awareness among families.’ [Community Health Worker, Meghalaya]

These findings underscore the importance of recognizing and strengthening frontline leadership capacities as a key component of effective governance within comprehensive primary healthcare systems. Frontline workers serve not only as service providers but also as local health system actors who facilitate coordination, accountability, and community engagement, thereby contributing to the effective implementation of AAMs.

4.5 **Priority setting**

Across states, priority setting within primary healthcare systems is increasingly informed by surveillance platforms, HMIS reporting, and routine epidemiological data. However, the translation of evidence into policy remains shaped by longstanding programme hierarchies, operational feasibility, and the continued dominance of RMNCH priorities.

In Mizoram, surveillance data from HMIS, RCH, and IHIP platforms were actively used to identify emerging burdens such as HIV, syphilis, and NCDs, enabling targeted programme responses at AAMs. A district official explained:

‘NCD is one priority... HIV and syphilis are also on the rise... according to that report, the state will take action and make specific plans.’ [District Health Official, Mizoram]

In Meghalaya, participants emphasized the need for decentralized, geographically tailored planning because disease burdens and service constraints varied substantially across districts. State-level actors highlighted that centrally standardized planning often failed to reflect local realities:

‘When it is being done from the state, it’s for everyone... but each district will be different.’ [State Health Official, Meghalaya]

Karnataka similarly relied on surveillance data and seasonal trends for outbreak preparedness, particularly for dengue and malaria. Yet participants acknowledged that programme priorities continued to revolve around maternal and child health, while other priorities shifted according to campaigns and government directives. As one district official noted:

‘The main concept is the mother and the child. That is always the priority.’ [District Health Official, Karnataka]

Rajasthan reflected a similar transition in which RMNCH indicators remained institutionally dominant, even as attention increasingly shifted toward NCDs, geriatric care, and localized disease burdens. State officials highlighted the growing importance of epidemiological transition in shaping future priorities:

‘Currently, the NCD burden is increasing among us, so we have to focus on NCD.’ [State Health Official, Rajasthan]

Overall, findings across states suggest that while surveillance systems and digital reporting increasingly inform health planning, priority setting remains mediated by institutional legacies, political visibility, and implementation feasibility. RMNCH continues to structure routine governance, even as states gradually recalibrate priorities toward NCDs and localized epidemiological risks.

4.6 Intersectoral collaborations

Across states, intersectoral collaboration was formally embedded within primary healthcare governance through coordination committees, village institutions, schools, NGOs, and welfare departments. However, collaboration largely served as a mechanism for coordination and mobilization rather than for redistributing implementation responsibilities, with the operational burden remaining primarily on the health system.

In Meghalaya, convergence was institutionalized at the block level through sector committees comprising ICDS functionaries, self-help groups (SHGs), village councils, and rural development actors. These platforms supported coordination across maternal health, nutrition, early childhood development, and emergency support initiatives. A state official explained: ***'All the office bearers of these different committees were made part of the village health council so that it is more broad-based and convergence can be brought.'*** [State Health Official, Meghalaya]

Participants described convergence as particularly important for linking health with social welfare and education programmes. The Early Childhood Development (ECD) mission was cited as an example where “education, mental health and neurological development” were integrated alongside nutrition and physical health. However, officials also acknowledged uneven participation and resistance in some areas, limiting sustained collaboration. As one district official noted: ***'There is good community participation, but in some particular areas, they are very resistant.'*** [District Official, Meghalaya]

In Mizoram, intersectoral coordination was facilitated through a well-established administrative structure in which the Deputy Commissioner (DC) played a central convening role across multiple programmes related to public health, sanitation, HIV/AIDS, disaster management, and community development. Participants described the DC-led mechanism as providing administrative legitimacy, facilitating coordination across departments, and creating a platform for multisectoral engagement. However, respondents also noted that while strategic oversight and coordination were shared across sectors, responsibility for implementation often remained concentrated within the health department. As one district official observed, ***'Politically and administration wise he is the chairman, but in the real practical world, health department has to take the actions.'*** [District Health Official, Mizoram] This suggests that formal convergence structures may strengthen coordination and accountability but do not necessarily redistribute operational responsibilities across sectors.

At the implementation level, participants described a broader ecosystem of multisectoral collaboration that extended beyond routine coordination between

government departments. Partnerships with the education sector supported school health and nutrition initiatives, including weekly iron supplementation programmes delivered through Health and Wellness Centres and schools. School ambassadors were reported to play an active role in promoting adherence among students and supporting health awareness activities. As one participant explained, ***'Iron supplements are distributed through the HWC once a week... school ambassadors ensure that students take them regularly.'*** [Community Health Worker, Mizoram]

Participants also highlighted collaboration with Anganwadi centres, social workers, and the Forest Department on activities linked to environmental awareness and community wellbeing. These included tree and herbal plantation drives that connected health promotion with broader environmental and climate-related concerns. According to one respondent, ***'Anganwadis, social workers, and the Forest Department... [support] tree and herbal plantation drives.'*** [Community Health Worker, Mizoram] Such initiatives illustrate the potential for Ayushman Arogya Mandirs to serve as platforms for broader community-based action on environmental health and climate-sensitive health promotion.

Collaboration with the Women and Child Development Department, education authorities, and development partners such as UNICEF and WHO was also viewed positively, particularly in relation to immunization campaigns, Poshan initiatives, deworming programmes, and health awareness activities. Participants further reported examples of local convergence supporting infrastructure improvements, including waiting sheds, staff quarters, and sanitation facilities. Taken together, these findings suggest that multisectoral action within Mizoram extends beyond conventional health-sector coordination to encompass school health, nutrition, environmental health, and community development initiatives. The findings highlight the importance of strengthening implementation mechanisms that enable shared responsibility across sectors while leveraging locally embedded partnerships to address the broader determinants of health.

In Karnataka, intersectoral coordination occurred primarily through District Health Society meetings involving Women and Child Welfare, Education, and Panchayat Raj departments. Collaboration was especially important for outreach among marginalized communities and preventive health campaigns. A district official explained: ***'District Health Society meetings are held every three months... Outreach is done for marginalised communities.'*** [District Health Official, Karnataka]

Frontline workers also emphasized the practical value of partnerships with schools, NGOs, and community organizations in supporting camps and awareness activities: ***'NGOs have provided BP machines, glucometers, weighing machines, and medical kits.'*** [CHW, Karnataka]

However, participants suggested that collaboration remained largely campaign-driven and episodic because of weak financing and irregular coordination mechanisms.

In Rajasthan, convergence relied heavily on frontline coordination between ASHAs, ANMs, and CHOs, alongside collaboration with ICDS and NGOs working in tribal health, HIV/AIDS, nutrition, and mining-related illnesses. Participants repeatedly linked effective coordination with improved service delivery and community trust. One

respondent remarked: ***‘The contribution of CHO, ANM, and ASHA is huge. When they work in coordination, things will be much better for the community.’*** [District-level Health Official, Rajasthan]

Across states, these findings suggest that intersectoral collaboration primarily strengthens coordination, outreach, and local problem-solving rather than substantially redistributing implementation responsibilities away from the health sector. The effectiveness of convergence depended heavily on local leadership, frontline relationships, and the ability to sustain coordination beyond campaign-based activities.

4.7 Community Engagement, Local Governance, and Convergence

Across states, community engagement and intersectoral convergence were viewed as essential for strengthening accountability, improving service uptake, and sustaining primary healthcare reforms. However, participation functioned less through standardized institutional models and more through locally embedded governance arrangements, frontline relationships, and informal trust networks. The effectiveness of village-level governance depended not only on formal committees but also on coordination between frontline workers, local leadership structures, and community feedback mechanisms.

In Mizoram, community engagement and accountability were largely mediated through locally trusted institutions and social networks rather than relying exclusively on formal community health committees. Participants described strong collaboration with village councils, churches, youth organisations, school teachers, NGOs, community elders, Anganwadis, community halls, and other locally embedded organizations. These institutions served as important platforms for health promotion, community dialogue, disease surveillance, outreach activities, and public health response. Community organizations were reported to play a particularly important role in mobilizing communities during disease outbreaks, supporting awareness campaigns, and facilitating communication between health services and local populations. As one district official explained, ***‘We have a good relationship with NGOs... they will volunteer to help us, even during any disease outbreak.’*** [District Official, Mizoram]. Participants also described using NGO meetings, community halls, Anganwadi centres, churches, and Community Health Centres as spaces for public dialogue, health awareness activities, and screening programmes. These forums were used to conduct hypertension and diabetes check-ups, disseminate health information, discuss service-related concerns, and encourage community participation in health initiatives. These findings suggest that community accountability within Ayushman Arogya Mandirs may operate through multiple formal and informal mechanisms that are shaped by local institutional contexts. In Mizoram, trusted community organizations and social institutions appear to complement formal health system structures by facilitating participation, strengthening trust, supporting collective action, and enhancing the responsiveness of health services. The findings highlight the importance of recognizing and leveraging locally embedded governance structures when designing community engagement and accountability strategies within comprehensive primary healthcare systems.

In Meghalaya, Village Health Councils (VHCs) functioned as broad-based convergence platforms integrating representatives from women's groups, employment councils, sanitation committees, and local governance institutions. These councils supported maternal health programmes, emergency support, and decentralized planning. A state official noted: **'All the office bearers of these different committees were made part of the village health council so that it is more broad-based and convergence can be brought.'** [State Health Official, Meghalaya]

Participants also described increasing efforts to institutionalize community feedback within governance processes. Consultations conducted under outcome-based budgeting reforms revealed that community priorities often differed from administrative assumptions, with shortages of medicines, diagnostics, and doctors emerging as major concerns.

In Karnataka, formal participatory structures such as VHSNCs and Jan Arogya Samitis (JAS) were intended to institutionalize community voice and accountability at village and facility levels. However, respondents noted that these committees often operated procedurally due to limited training and weak participation. A state official explained: **'We have to strengthen the JAS committee... and sensitize them to give recommendations specifically for that village or that health center.'** [State Health Official, Karnataka]

Intersectoral coordination in Karnataka occurred mainly through District Health Society meetings that brought together Women and Child Welfare, Education, Panchayat Raj institutions, NGOs, and schools, particularly for outreach and preventive health campaigns.

In Rajasthan, community trust and frontline convergence emerged as central to village-level governance. Participants repeatedly emphasized that coordination between ASHAs, ANMs, and CHOs directly influenced service delivery, outreach, and public confidence in government facilities. **'Wherever there is coordination between the ASHA, ANM, and the CHO, the work actually happens better... the community's trust also increases.'** [District Health Official, Rajasthan]. At the same time, respondents described interpersonal tensions and overlapping responsibilities between cadres as barriers to effective collaboration.

Across states, findings suggest that community engagement and convergence are sustained less through formal committee structures alone and more through local leadership, frontline teamwork, trust-based relationships, and the ability to incorporate community feedback into planning and service delivery.



5

Functioning and Management of HWCs/AAMs: Current Status

This chapter provides an empirical overview of the current functioning and management of AAMs as platforms for delivering Comprehensive Primary Health Care (CPHC). It assesses how these facilities translate policy intent into routine service delivery and managerial practice at the frontline.

The chapter examines key system components that shape performance, including service delivery arrangements, human resources for health, infrastructure, financing and budgeting processes, availability of medicines and diagnostics, and the use of health information systems. It also analyses community outreach activities as a critical link between facilities and populations. Together, these dimensions offer a snapshot of the operational status of HWCs/AAMs and provide the basis for identifying gaps and areas for strengthening in subsequent chapters.

5.1 Service Delivery and Access

Across states, AAMs and HWCs have expanded the scope of primary healthcare delivery beyond maternal and child health services toward more comprehensive care models. However, the expansion of service mandates has not always been accompanied by proportional strengthening of workforce, infrastructure, managerial support, and logistics, resulting in uneven implementation across states and regions.

In Meghalaya and Mizoram, HWCs were expected to operationalize all twelve nationally mandated service packages, including NCD management, mental healthcare, palliative care, geriatric services, and adolescent healthcare. Nevertheless, participants reported that implementation remained difficult in remote and hilly areas where transportation barriers, workforce shortages, and infrastructural limitations constrained continuity of care. In Meghalaya, reproductive and child health services continued to dominate service priorities despite the expansion of comprehensive primary healthcare. As one medical officer noted, **‘what we prioritize is mostly immunization number 1, and then number 2 would be MCH.’** [MO, Meghalaya]

In Karnataka, service delivery reflected a transition from outreach-oriented sub-centres toward more institutionalized and facility-based care. Teleconsultation services were increasingly promoted to reduce patient travel costs and wage loss, while participants also emphasized the need to balance programme expansion with service quality. One participant stated that **‘if too many programmes are added, quality goes down. We focus on core services.’** [District Health Official, Karnataka]

In Jharkhand, AAMs expanded their service portfolio to include NCD screening, tuberculosis care, anaemia and sickle cell screening, family planning, telemedicine, and disease surveillance. CHOs were widely perceived as central to improving outpatient attendance, continuity of care, and early disease detection.

Similar transitions were strongly evident in Rajasthan, where participants described improvements in the continuity and visibility of primary healthcare services following the establishment of AAMs and deployment of CHOs. Sub-centres that had previously functioned intermittently increasingly became regular outpatient service points where medicines, consultations, and follow-up care were consistently available. One frontline worker explained that ***‘the patient also becomes aware... he comes on a regular basis for his check-up and follow-up also.’*** [CHW, Rajasthan] Participants further linked improved coordination between CHOs, ANMs, and ASHAs with increasing community trust and healthcare utilization, although some respondents noted that infrastructural improvements did not always correspond to improvements in clinical service availability.

Participants highlighted several context-specific innovations that have improved access to primary healthcare services in remote and challenging geographic settings. In Meghalaya, transportation support mechanisms for pregnant women, infants, ASHAs, and ANMs, along with the provision of transit homes for expectant mothers, were perceived as reducing delays in accessing maternal health services. Similarly, locally supported ambulance services were reported to improve access to referral care in hard-to-reach areas. Such initiatives underscore the importance of adapting service delivery models to local geographical realities and strengthening transport and referral support systems as integral components of comprehensive primary healthcare. Across states, findings suggest that while AAMs have significantly expanded the visibility and scope of primary healthcare services, the effectiveness of comprehensive primary healthcare remains dependent on sustained workforce availability, infrastructural strengthening, and local implementation capacity.

5.2 Human Resources for Health

5.2.1 Shortages of Human Resources and High Vacancy Rates

Across all states, shortages of human resources and high vacancy rates emerged as major structural barriers affecting the delivery of comprehensive primary healthcare. Deficits across cadres—including CHOs, ANMs, doctors, specialists, pharmacists, laboratory technicians, and ASHAs—intensified workloads, weakened continuity of care, and constrained the operationalization of expanded service packages.

In Meghalaya, participants described workforce shortages as one of the most critical bottlenecks within the health system, particularly in remote districts characterized by difficult terrain and high staff turnover. Medical officers reported being required to simultaneously manage clinical care, supervision, reporting, emergencies, and field activities because of inadequate staffing. As one medical officer explained, ***‘I’m the only doctor... I’m the only one compiling reports, looking after fields, OPD, IPD, all the emergencies, and then the NQAS as well.’*** [MO, Meghalaya]

Participants reported managing large catchment populations across multiple villages while simultaneously undertaking clinical, preventive, promotive, and administrative responsibilities. In remote and underserved areas, workforce shortages increased workload pressures, constrained outreach activities, and limited opportunities for follow-up care. Respondents highlighted that staffing norms often did not adequately reflect geographical realities, dispersed populations, and the expanded service package expected under Ayushman Arogya Mandirs. One participant described the situation: ***‘There is a significant shortage of ANMs, with only one ANM posted for eight villages and another for eleven villages, serving nearly 4,000 people each.’*** [CHW, Meghalaya]

These experiences suggest the need for context-sensitive workforce planning, strengthened recruitment and retention strategies, and greater flexibility in staffing models for geographically challenging settings.

Similar concerns emerged in Mizoram, where shortages among pharmacists and frontline workers significantly constrained service delivery, particularly in geographically remote areas. Participants linked these shortages to limited recruitment and emphasized the importance of Health and Wellness Officers in strengthening primary care service provision. One participant noted that ***‘when there’s a health and Wellness officer, the service improves. Definitely, she’s able to provide more services than a normal ANM.’*** [Participant, Mizoram]

In Karnataka, workforce shortages intersected with growing administrative and reporting responsibilities, compressing clinical, outreach, and managerial functions into fewer staff positions and reducing time available for patient care and community engagement.

Rajasthan reflected many of these broader structural challenges, particularly in tribal and remote rural regions. Participants repeatedly described shortages across CHOs, ANMs, ASHAs, specialists, medical officers, and laboratory personnel, alongside irrational workforce deployment patterns that did not correspond to population needs. Respondents also highlighted concerns regarding low remuneration and contractual employment among frontline workers, which further weakened morale and retention.

Across states, findings suggest that workforce expansion has not kept pace with the growing scope of comprehensive primary healthcare mandates. Chronic vacancies, uneven deployment, difficult working conditions, and contractual employment continue to intensify workloads and weaken continuity of care, particularly in remote and underserved regions. While workforce shortages remained a persistent challenge, participants also highlighted examples of successful capacity-strengthening initiatives. For instance, in Meghalaya, sustained Skilled Birth Attendant (SBA) training was reported to have contributed to substantial improvements in institutional delivery rates in some settings, demonstrating the value of long-term investments in provider competencies. Participants further emphasized the need to review existing deployment arrangements and strengthen context-sensitive workforce planning. In geographically dispersed areas, periodic revision of sub-sector mapping was recommended to ensure that service catchment areas accurately reflect settlement patterns and population distribution.

5.2.2 Training, Capacity Building, and Continuous Learning Systems

Across states, participants described capacity building as a continuous and adaptive process rather than a series of one-time technical training events. The expanding scope of comprehensive primary healthcare under AAMs requires frontline workers to develop competencies beyond traditional service delivery, including digital reporting, chronic disease management, community engagement, and multidisciplinary coordination. Consequently, participants emphasized the importance of ongoing learning opportunities, refresher training, supportive supervision, and mentorship mechanisms that enable health workers to respond to evolving service delivery demands.

In Meghalaya, participants described relatively institutionalized and decentralized approaches to capacity building. Training programmes were reportedly guided by district-specific training calendars, needs assessments, pre- and post-training evaluations, and feedback mechanisms that allowed local priorities to inform training content. Capacity-building efforts also extended beyond technical competencies to include communication skills, community engagement, and behavioural aspects of service delivery. As one participant noted, ***‘Meghalaya has developed a system where they make a training calendar for all districts... based on the needs... and they also take feedback from the district.’*** [District-level Participant, Meghalaya]

Participants in Mizoram highlighted the value of decentralized and small-group training approaches, which were perceived as more effective than large centralized programmes. Smaller training formats enabled greater interaction, facilitated discussion of context-specific challenges, and reduced the logistical burden associated with travel and workforce shortages. However, respondents also reported that financial and resource constraints limited the frequency and scale of training activities. Reflecting on the effectiveness of different training approaches, one participant observed that ***‘when it’s a huge group... most of them don’t listen.’*** [Participant, Mizoram]

In Rajasthan, participants acknowledged that regular technical training programmes were conducted for Community Health Officers and frontline workers. However, they emphasized that formal classroom-based training alone was insufficient for addressing the practical challenges encountered in the field. Respondents highlighted the need for ongoing mentoring, problem-solving support, and digital literacy development, particularly as service delivery increasingly depends on the use of digital platforms and health information systems.

Importantly, capacity building was not limited to formal training programmes. Participants across states described workplace-based mentoring and peer learning as integral components of frontline workforce development. Experienced staff reported routinely supporting colleagues in the management of high-risk pregnancies, family planning counselling, routine immunization, malaria rapid testing, infant fever monitoring, and diagnostic services. Such interactions enabled the transfer of practical knowledge, reinforced clinical competencies, and supported the implementation of expanded service packages within AAMs. As one frontline

worker explained, ***'Mentor staff on monitoring high-risk pregnant women... Guide ASHAs in family planning education... Train and assist staff in routine immunization... Provide guidance on malaria rapid testing, infant fever monitoring, and other diagnostic services.'*** [Community Health Worker, Mizoram]

Taken together, these findings suggest that strengthening workforce capacity within AAMs requires a shift from viewing training as a discrete event towards conceptualizing capacity building as a continuous learning system. Effective approaches combine formal training, decentralized learning opportunities, supportive supervision, workplace-based mentoring, peer-to-peer learning, and technology-oriented support mechanisms. Such integrated capacity-building systems are likely to be more responsive to local needs and better suited to sustaining the delivery of comprehensive primary healthcare services.

5.2.3. Adaptive Workforce Management and Operational Coordination

Frontline teams reported relying heavily on adaptive workforce management practices to maintain service continuity amid persistent human resource constraints. Participants described coordinating responsibilities across ANMs, MPWs, and ASHAs through flexible allocation of roles and responsibilities for outpatient services, immunization activities, maternal and child health programmes, and monitoring of high-risk cases. Operational responsibilities, including data entry, home visits, beneficiary follow-up, and medicine stock management, were distributed among team members to optimize available workforce capacity and ensure uninterrupted service delivery.

These findings suggest that AAMs' functioning is supported not only by formal staffing arrangements but also by frontline teams' ability to engage in dynamic coordination, exhibit role flexibility, and collaborate on problem-solving. Such adaptive practices enhance operational resilience and enable facilities to sustain service delivery despite workforce shortages. However, they also indicate a reliance on informal coordination mechanisms to compensate for structural human resource gaps, raising concerns regarding long-term sustainability and workforce burden.

As one participant described, ***"We collaborate closely with ANMs, MPWs, and ASHAs by assigning responsibilities across outpatient care, immunization, maternal and child health services, and the monitoring of high-risk cases. Team members also share operational tasks such as vaccine data entry, home visits, and medicine stock monitoring to ensure that services continue smoothly."*** [Community Health Worker, Mizoram]

5.2.4 Conflicting Roles and Responsibilities

Across states, the expansion of comprehensive primary healthcare has been accompanied by growing ambiguity regarding supervisory authority, accountability, and task allocation within HWCs and AAMs. Overlapping responsibilities, differences in employment status, and evolving supervisory hierarchies frequently generated tensions across cadres.

In Meghalaya, participants described tensions between newly introduced MLHPs and existing cadres such as ANMs, particularly around authority, qualifications, and contractual employment. State-level sensitization initiatives were reportedly introduced to clarify roles and reduce conflict. One participant noted that **‘there was a bit of a tussle in most of the places.’** [State Health Official, Meghalaya]

Similar concerns emerged in Rajasthan, where participants described conflicts arising from overlapping responsibilities, unequal incentive structures, and increasing administrative demands. Medical officers reported difficulties balancing clinical care with managerial and medico-legal responsibilities, while tensions between ANMs and CHOs further weakened teamwork and coordination.

Across states, findings suggest that unclear role definitions, fragmented incentive structures, and expanding administrative expectations continue to undermine coordination and effective functioning within primary healthcare teams.

Public Health Infrastructure

Across states, the physical and infrastructural environments of HWCs and AAMs emerged as critical determinants of service quality, workforce retention, and community trust. Although substantial investments have been made to upgrade primary healthcare facilities, participants consistently emphasized that infrastructural expansion has often outpaced the availability of essential amenities, staffing support, equipment maintenance, and digital connectivity.

In Meghalaya, difficult terrain and geographically dispersed settlements intensified infrastructural challenges, with several PHCs reportedly serving populations far beyond recommended norms. Participants also described poor facility conditions, transport difficulties, and inadequate staff accommodation, all of which constrained service continuity. One medical officer noted that **‘our PHC... covers around 75 villages, should have been upgraded to a CHC.’** [MO, Meghalaya]

Similar concerns emerged in Mizoram, where infrastructural limitations were strongly shaped by hilly terrain, remoteness, and seasonal inaccessibility. Participants described difficult travel conditions, poor connectivity, and inadequate residential infrastructure that affected workforce retention and access to care. One participant explained that **‘in Lawngtlai district, there are about 190 villages total, out of which 72 villages are not accessible during the rainy season.’** [Participant, Mizoram]

In Karnataka, many HWCs reportedly functioned from rented or inadequate buildings lacking sufficient consultation space, sanitation facilities, privacy, and water supply. Participants linked poor infrastructure with declining staff morale and reduced public confidence in government health services.

Similar infrastructural deficits were strongly evident in Rajasthan, particularly in tribal and remote rural regions where many AAMs continued to lack a reliable water and electricity supply. Participants also highlighted equipment shortages, weak residential infrastructure, and poor staff accommodation as factors contributing to absenteeism and workforce instability.

Across states, findings suggest that infrastructural deficiencies extend beyond physical buildings to include electricity, water supply, transport connectivity, equipment functionality, digital infrastructure, and staff accommodation. These limitations continue to weaken workforce retention, continuity of care, and public trust in primary healthcare institutions.

5.4 Health Financing and Budgeting

Across states, health financing and budgeting arrangements were widely perceived as misaligned with the operational realities of delivering comprehensive primary healthcare. Although programme funding has expanded under the National Health Mission and related schemes, participants consistently emphasized that delayed fund flows, rigid financial structures, and limited local financial autonomy constrained implementation at the facility level.

In Mizoram, participants described allocations for supplies, maintenance, and minor infrastructural works as inadequate and poorly aligned with expanding programme mandates, leaving facilities dependent on centrally allocated funds and limiting local flexibility in addressing operational challenges.

In Meghalaya, comparatively more participatory budgeting processes were reported, where district-level inputs informed Programme Implementation Plans and locally adapted innovations such as drone-supported vaccine delivery. However, participants also highlighted delayed reimbursements and limited untied funds for local problem-solving.

In Karnataka, operational constraints at the sub-centre level reflected inadequate allocations for basic maintenance and routine functioning. Similar concerns were strongly evident in Rajasthan, where participants repeatedly described delays in fund release, procedural complexity, and inadequate decentralization of financial decision-making. Untied funds were identified as particularly important for routine facility functioning, including electricity payments and maintenance activities.

Across states, findings suggest that while financing mechanisms formally support the expansion of comprehensive primary healthcare, delayed fund flows, weak decentralization, and inflexible budgeting structures continue to constrain local implementation capacity and routine facility functioning.

5.5 Medicines and Diagnostics

Across states, the availability of medicines, diagnostics, and functional equipment emerged as a foundational determinant of the effectiveness and credibility of comprehensive primary healthcare services. Participants consistently emphasized that expanding service packages had not always been matched by reliable supply chains, adequate diagnostics, or contextually appropriate procurement systems.

Participants from Meghalaya identified innovative approaches to improving medicine access in remote communities. Medicine delivery initiatives, including doorstep delivery models, were viewed as particularly valuable in overcoming geographic barriers and ensuring continuity of treatment for patients with chronic conditions. At

the same time, concerns were raised regarding limitations in digital logistics systems and inconsistencies in the availability of essential medicines at Health and Wellness Centres.

In Mizoram, medicine and diagnostic availability at the primary care level was described as uneven and poorly aligned with local morbidity patterns, particularly in remote and hard-to-reach areas. Participants also highlighted frequent supply disruptions during the rainy season and the need to expand diagnostic services for emerging health priorities such as cancer.

In Karnataka, state-level therapeutic restrictions reportedly reduced the number of approved medicines and limited the comprehensiveness of care available at AAMs, thereby constraining the scope of primary healthcare services.

Similar concerns emerged in Rajasthan, where participants repeatedly emphasized that continuity of medicine supply and functioning diagnostics were essential for maintaining public trust in government facilities. Weak referral and tracking systems further disrupted continuity of diagnosis and treatment across levels of care.

Across states, findings suggest that medicines and diagnostics remain central to the operational credibility of comprehensive primary healthcare. Supply inconsistencies, weak maintenance systems, and fragmented referral mechanisms continue to undermine continuity of care and public confidence in primary healthcare facilities.

5.6 Digital Systems: Enablers of Continuity and Sources of Administrative Burden

Findings from the operational-level FGDs suggest that digital health systems are experienced simultaneously as critical enablers of service delivery and continuity of care, and as significant sources of administrative burden when fragmented, poorly integrated, or inadequately adapted to frontline realities. Across states, participants acknowledged that digital platforms have strengthened programme monitoring, disease surveillance, beneficiary tracking, commodity management, and reporting functions. Frontline workers reported using eSanjivani and ANMOL for maternal and child health tracking, FPLMTS for family planning commodity management, NIKSHAY for tuberculosis monitoring, IHIP for disease surveillance and reporting, NCD management applications for chronic disease follow-up, UWIN for vaccination tracking, DVDMS for drug and vaccine distribution, and ABHA for digital patient registration and health record management. These platforms were perceived to improve follow-up, reporting efficiency, continuity of care, and the management of medicines and health commodities.

At the same time, participants highlighted that the benefits of digitalization are contingent upon system usability, interoperability, adequate training, connectivity, staffing continuity, and access to digital infrastructure. Rather than functioning as a unified ecosystem, Health Management Information Systems (HMIS) were frequently described as fragmented and programme-specific, requiring health workers to navigate multiple platforms with overlapping reporting requirements. Participants reported limited functionality for correcting or updating records once entered, difficulties arising from duplicate entries across multiple portals, and repeated

retraining requirements following system modifications. Such challenges contributed to frustration among frontline workers and raised concerns regarding data quality and reliability.

In Meghalaya, participants acknowledged that digital systems such as the MOTHER App had strengthened maternal health tracking and service monitoring. However, they also reported that reporting requirements were repetitive, time-consuming, and difficult to manage in areas with poor internet connectivity. One district-level participant explained that ‘sometimes at night also keep doing the work... filling the portal sometimes in a place where there's hardly any network.’ [District-level Health Official, Meghalaya] These experiences illustrate how digital tools can improve programme monitoring while simultaneously extending administrative workloads beyond routine working hours.

Similarly, in Mizoram, participants recognized the value of digital systems for service tracking and programme implementation but described the challenges associated with managing multiple disconnected reporting platforms. The coexistence of several reporting systems was perceived to contribute to duplication of effort and administrative fatigue, particularly in resource-constrained settings. Participants further emphasized that the transition to digital systems requires adequate technical support, training, and infrastructure to ensure that reporting requirements do not compromise time available for service delivery.

The operational-level FGDs indicate that digital platforms are experienced both as enablers and as constraints. Participants reported using eSanjivani and ANMOL for maternal and child health tracking, FPLMTS for family planning commodity management, NIKSHAY for TB monitoring, IHIP for disease surveillance, NCD applications for chronic disease follow-up, UWIN for vaccination tracking, DVDMS for drug and vaccine distribution, and ABHA for digital patient registration and record management. These platforms were widely perceived as improving beneficiary tracking, follow-up, reporting, service continuity, and commodity management. However, their effectiveness depended on usability, interoperability, connectivity, staffing arrangements, and the availability of adequate technical support.

Telemedicine services were generally viewed positively as mechanisms for expanding access to care, particularly in geographically remote and underserved areas. However, experiences from Meghalaya and Mizoram highlighted operational challenges that affected service continuity. Participants reported that telemedicine services often depended on a single doctor, leading to service disruptions during periods of absence. In addition, platform-access arrangements often restricted the use of telemedicine systems to specific personnel, limiting other trained staff's ability to maintain service continuity. These findings suggest that successful telemedicine implementation requires not only digital infrastructure but also role-based access systems, backup staffing arrangements, and clear operational protocols to ensure service continuity during staff absences. As one participant noted, ***‘The HWC has only one doctor, and if the doctor is unavailable, there is no replacement. Telemedicine login credentials are assigned exclusively to the doctor, which limits continuity of services.’*** [Community Health Worker, Meghalaya]

HMIS were often perceived as fragmented rather than integrated, creating substantial administrative burdens for frontline workers and limiting the effective use of data for local planning and continuity of care. Participants reported limited functionality for correcting data-entry errors and difficulties with duplicate entries across multiple portals, which contributed to frustration and concerns about data quality.

Participants highlighted concerns centred on the proliferation of disconnected portals and applications that generated inconsistent datasets and increased reporting burdens. They argued that fragmented digital systems undermine evidence-based planning and governance by producing contradictory statistics across programmes and reducing confidence in data quality. Frontline workers also described practical challenges associated with managing multiple passwords, navigating different reporting platforms, and meeting overlapping data-entry requirements.

In several settings, providers reported relying on personal devices to fulfil digital reporting responsibilities, reflecting persistent gaps in digital infrastructure and equipment availability. Participants also noted that access to certain digital services could be dependent on individual personnel. For example, telemedicine services were reported to be constrained in some facilities because login credentials were restricted to a single physician, limiting service continuity when that individual was unavailable. Such experiences highlight that digital systems can enhance continuity of care only when they are supported by appropriate institutional arrangements, shared access mechanisms, and adequate workforce capacity.

Overall, the findings suggest that digital reforms have made important contributions to surveillance, programme monitoring, beneficiary tracking, and continuity of care under Ayushman Arogya Mandirs. However, the potential of these systems is constrained by fragmented digital architectures, poor interoperability, multiple reporting requirements, connectivity challenges, and inadequate frontline support. Strengthening digital governance will therefore require moving towards integrated, user-centred, and interoperable digital ecosystems that reduce duplication, improve data quality, and enable frontline workers to utilize information more effectively for service delivery and local decision-making.

5.7 Community Outreach, Population Engagement, and Locally Responsive Service Planning

Community outreach emerged as a core operational strategy to improve healthcare access, increase preventive service uptake, and maintain continuity of care within Ayushman Arogya Mandirs. Participants described outreach not as a one-way process of information dissemination but as an ongoing mechanism for population engagement, trust-building, service adaptation, and responsiveness to local needs. Across settings, outreach activities enabled frontline workers to identify underserved populations, promote utilization of preventive and curative services, and strengthen relationships between communities and the primary healthcare system.

The findings further suggest that outreach planning is increasingly informed by a combination of routine health information, field-based observations, and community

feedback. Frontline workers reported monitoring disease surveillance data, conducting home visits, and engaging with ASHAs and community members to identify emerging health needs and service gaps. These processes enabled local prioritization of services and facilitated more responsive planning of outreach activities. As one participant explained, 'We rely on a combination of data, observation, and community feedback... monitor daily reports on communicable diseases through IDSP... conduct regular home visits... collect feedback... schedule services such as monthly elderly clinics' [Community Health Worker, Mizoram] This demonstrates that frontline service planning under AAMs is not solely data-driven but is also shaped by continuous engagement with communities and contextual understanding of local health needs.

In Meghalaya, outreach strategies were frequently adapted to local occupational patterns, geographical realities, and community schedules, reflecting the need for flexible service delivery approaches in rural settings. Participants highlighted the importance of village-level engagement and intersectoral collaboration in improving maternal health service utilization and preventive healthcare uptake. However, they also noted that occupational demands could affect participation in health programmes. As one participant observed, 'Male participation is often limited because many community members are engaged in agricultural and field-based work during programme activities.' [Medical Officer, Meghalaya] Such experiences illustrate the importance of aligning outreach strategies with local livelihood patterns to improve service utilization and community participation.

In Mizoram, participants emphasized that outreach activities often required addressing broader social and developmental challenges that shape health-seeking behaviour. Factors such as poverty, educational discontinuation among adolescent girls, and early marriage were identified as important determinants influencing reproductive and maternal health outcomes. Community-based organizations, village councils, and non-governmental organizations were described as critical partners in supporting outreach activities, health promotion, and community mobilization. As one participant noted, 'Teenage pregnancy is more common in rural areas, and early marriage continues to influence health outcomes in some communities.' [District Health Official, Mizoram] These findings highlight the importance of multisectoral engagement in addressing the social determinants that influence healthcare access and utilization.

In Karnataka, outreach efforts focused particularly on marginalized and hard-to-reach populations. Participants described conducting field-based service delivery activities that extended healthcare access beyond facility boundaries through collaboration across departments and programmes. One participant explained, 'Outreach activities are undertaken for marginalized communities, where teams visit settlements and provide services such as immunization, antenatal care, and postnatal care.' [Community Health Worker, Karnataka] This reflects a proactive approach to population health management that seeks to reduce geographical and social barriers to care.

Similarly, in Rajasthan, outreach was described as a foundational component of AAM functioning, supported through coordination among ASHAs, ANMs, and Community Health Officers. Participants linked outreach activities to increased awareness,

improved healthcare utilization, and enhanced trust in public health services, while also acknowledging persistent challenges in reaching migrant and socially marginalized populations.

Overall, the findings indicate that community outreach serves as a critical interface between AAMs and the populations they serve. Its effectiveness depends not only on the availability of frontline workers but also on the capacity of local health systems to integrate routine data, community knowledge, intersectoral partnerships, and culturally responsive engagement strategies into service planning and delivery. Strengthening outreach mechanisms will therefore require sustained investments in community engagement, local decision-making capacity, and multisectoral collaboration to ensure that primary healthcare services remain responsive to diverse population needs.

Frontline workers emerged as critical micro-leaders within AAMs, coordinating service delivery, community mobilization, reporting, and digital health functions across their catchment areas. However, workforce shortages, delayed incentives, supply gaps, limited digital access, and weak administrative support constrained their effectiveness, particularly in low-UHC settings; these systemic challenges are examined further in the next chapter.



6

Challenges in delivering CPHC services through HWCs/AAMs

This chapter analyses the major challenges constraining the delivery of CPHC through AAMs. Rather than focusing only on service expansion, the chapter examines the structural, managerial, and contextual barriers that continue to limit continuity of care, integration of services, and

responsiveness at the primary care level. Across states, challenges were not experienced in isolation but emerged through the interaction of weak infrastructure, workforce shortages, fragmented governance systems, and local socio-cultural realities.

The findings are organized into three broad domains. Systemic challenges relate to financing, policy design, digital architectures, and broader health system linkages. Administrative and managerial challenges concern supervision, workforce management, infrastructure, and operational coordination. Contextual challenges capture the influence of geography, mobility, social norms, health-seeking behaviour, and community trust on service delivery. Together, these dimensions illustrate the persistent gap between the policy vision of comprehensive primary healthcare and the operational realities faced by frontline systems.

6.1 Systemic Challenges

A recurring theme across states was the growing mismatch between the expanding mandate of CPHC and the institutional capacity available to support its implementation. Participants described a situation in which the scope of services delivered through AAMs had expanded substantially, encompassing preventive, promotive, curative, rehabilitative, and digital health functions, while investments in workforce capacity, infrastructure, supply chains, financing mechanisms, and referral systems had not increased proportionately. As a result, frontline providers and facility managers were often required to take on additional responsibilities without the corresponding system-level support.

Human resource constraints emerged as one of the most significant challenges affecting service delivery. Large catchment populations, persistent vacancies, and uneven workforce distribution reduced the capacity of facilities to deliver comprehensive services and maintain continuity of care. Participants from Jharkhand and Rajasthan reported shortages of doctors, ANMs, Community Health Officers, and laboratory personnel, which increased workload pressures on existing staff and constrained outreach, supervision, and follow-up activities. In Rajasthan, Medical Officers In-Charge were expected to simultaneously manage clinical services,

administrative functions, programme implementation, supervision, medico-legal responsibilities, and digital reporting requirements, creating substantial managerial and operational burdens. These findings suggest that the expansion of service packages has not always been accompanied by corresponding investments in workforce planning and organizational capacity.

Digital systems represented another important system-level constraint. Although digital platforms have enhanced surveillance, programme monitoring, and beneficiary tracking, participants frequently described the digital ecosystem as fragmented and administratively demanding. Multiple programme-specific portals operating in parallel generated duplication of effort, inconsistent reporting requirements, and conflicting datasets, limiting the usefulness of information for planning and decision-making. Similar concerns were reported in Rajasthan, Jharkhand, and Karnataka, where extensive reporting obligations diverted time away from clinical care and community engagement. Connectivity challenges further compounded these difficulties in geographically remote and hilly regions such as Meghalaya, Mizoram, and Jharkhand. Poor internet connectivity, OTP-dependent reporting systems, and delays in data synchronization reduced the effectiveness of teleconsultation services, real-time reporting, and digital monitoring mechanisms, highlighting the need for more interoperable and context-appropriate digital solutions.

Supply-chain and logistics challenges also emerged as persistent barriers to effective service delivery. Participants across Rajasthan, Jharkhand, Meghalaya, and Mizoram reported periodic stock-outs, procurement delays, and mismatches between supplied medicines and local disease profiles. In remote and tribal areas, transportation disruptions and difficult terrain further affected the timely delivery of medicines and diagnostic supplies, particularly during monsoon seasons. Respondents noted that expanded screening programmes for hypertension, diabetes, and other chronic conditions had increased case detection but were not always accompanied by reliable systems for ensuring uninterrupted treatment and long-term disease management.

Importantly, medicine and supply shortages were frequently managed through informal coping mechanisms at the frontline. Participants described coordinating repeatedly with higher authorities, scheduling follow-up visits, and waiting for extended periods for replenishment of essential commodities. In urgent situations, health workers reported using personal resources to bridge immediate gaps in service delivery. As one participant explained, ***'When essential medicines or supplies are unavailable, we coordinate with higher authorities and sometimes wait up to 14 days for replenishment. In urgent cases, we spend from our own pocket to ensure that patients receive medicines or essential services without delay.'*** [Community Health Worker, Mizoram] These experiences indicate that supply-chain and financing gaps are often absorbed by frontline providers, creating hidden operational costs that remain largely invisible within formal programme structures.

Continuity of care and referral management represented additional areas of systemic weakness. Participants from Meghalaya and Mizoram reported challenges in maintaining long-term follow-up for patients with hypertension, diabetes, and other chronic conditions. Delayed care-seeking, transport costs, difficult terrain, migration,

and loss to follow-up frequently disrupted treatment pathways. In response, frontline workers often relied on informal communication channels, including mobile messaging platforms, to coordinate referrals and exchange information across levels of care. While these practices demonstrated local adaptability, they also reflected the absence of sufficiently integrated and institutionalized referral systems capable of supporting continuity of care across the primary healthcare network.

Overall, participants acknowledged that initiatives such as Ayushman Arogya Mandirs, NQAS, and Kayakalp have expanded access to screening, preventive services, and primary healthcare delivery. However, these programme achievements often operate within health systems characterized by workforce shortages, fragmented digital architectures, supply-chain vulnerabilities, weak referral mechanisms, and limited managerial capacity. The findings therefore suggest that sustaining and strengthening comprehensive primary healthcare will require coordinated investments across workforce planning, digital interoperability, supply-chain management, referral systems, financing arrangements, and supportive governance structures, rather than relying solely on programme-level expansion.

6.2 Administrative and Managerial Challenges

Administrative and managerial challenges emerged from the growing mismatch between the expanding scope of comprehensive primary healthcare and the institutional capacity available to support implementation. Across states, participants described how the transformation of primary healthcare through Ayushman Arogya Mandirs had increased expectations related to service delivery, reporting, monitoring, quality assurance, and programme management, often without corresponding investments in infrastructure, workforce support, supervisory systems, or governance mechanisms.

Infrastructure deficits remained a persistent constraint on service delivery. Many Ayushman Arogya Mandirs continued to operate from rented premises or ageing buildings with inadequate consultation space, unreliable electricity supply, water shortages, seepage, and limited residential facilities for staff. Participants from Rajasthan and Jharkhand noted that several facilities formally designated as HWCs lacked the physical infrastructure necessary to deliver the full range of comprehensive primary healthcare services. Such gaps constrained service expansion and affected both patient experience and workforce retention.

Supervisory and managerial systems were also under considerable strain. In Karnataka and Rajasthan, monitoring processes relied heavily on digital platforms, periodic review meetings, and hierarchical reporting structures extending from the state level to Medical Officers. While these mechanisms strengthened oversight, participants reported that increasing administrative responsibilities often reduced opportunities for supportive field supervision. Medical Officers were expected to balance clinical responsibilities with programme management, reporting requirements, administrative functions, and quality assurance activities, limiting their ability to provide sustained mentorship and operational support to frontline teams.

The increasing reliance on digital reporting systems further contributed to administrative burden. Participants across states described substantial workloads associated with maintaining multiple portals, responding to repeated data requests, and preparing for programme reviews and certification exercises. In Rajasthan, respondents expressed concern that governance processes had become increasingly documentation-oriented, with quality assurance efforts often emphasizing records, reporting compliance, and inspection preparedness rather than continuous service improvement. Similar concerns emerged in Karnataka, where supervision under initiatives such as NQAS and Kayakalp was frequently perceived as focusing on compliance monitoring and performance scoring.

Human resource management presented another significant challenge. Participants reported that delayed salaries, irregular incentive payments, contractual insecurity, vacancies, and frequent staff transfer negatively affected workforce morale and continuity of care. In Meghalaya and Mizoram, delays in incentive payments to frontline workers were reported as a source of dissatisfaction and reduced motivation. Respondents from remote and difficult-to-reach areas further highlighted challenges including inadequate housing, transportation difficulties, unreliable power supply, and concerns about personal safety, all of which affected staff retention and willingness to serve in underserved locations.

Governance and coordination challenges further constrained implementation. Participants frequently reported that operational issues such as workforce shortages, medicine stock-outs, infrastructure deficiencies, and connectivity problems were routinely communicated through formal reporting mechanisms but did not consistently result in timely corrective action. Experiences from Mizoram highlighted repeated requests for additional staff and improved medicine availability that remained unresolved despite regular reporting. Similar concerns were reported in Meghalaya, where infrastructure and connectivity challenges persisted despite being raised through administrative channels, and in Rajasthan, where respondents described continuing workforce and reporting-related pressures despite repeated escalation. These findings point to a weak feedback-to-action loop within the governance system, whereby frontline concerns are documented and reported but are not systematically tracked, addressed, or resolved. As a result, reporting systems often function more effectively as mechanisms for upward accountability than as tools for problem-solving and adaptive management.

Participants also highlighted varying levels of coordination between health facilities, local governance institutions, and community structures. While Meghalaya and Mizoram demonstrated relatively stronger convergence through village-level committees and community-based institutions, respondents nevertheless reported uneven participation and implementation across regions. In contrast, participants from Jharkhand and Rajasthan described weaker coordination between health staff, Panchayati Raj Institutions, Jan Arogya Samitis, and local leadership structures, limiting opportunities for collaborative planning and local problem-solving.

At the operational level, campaign-driven implementation frequently created tensions between programme priorities and routine service delivery. Large-scale initiatives related to immunization, non-communicable disease screening, surveys, certification exercises, and special health campaigns increased workload pressures

on frontline workers and contributed to reporting fatigue. Participants repeatedly emphasized that programme expectations, service packages, and performance targets had expanded considerably, while managerial support systems, workforce capacity, and supervisory arrangements had not evolved at the same pace.

Overall, the findings suggest that administrative and managerial systems remain heavily dependent on individual commitment, informal problem-solving, and adaptive frontline practices rather than robust institutional support structures. Strengthening the management of Ayushman Arogya Mandirs will therefore require investments not only in infrastructure and human resources but also in supportive supervision, governance responsiveness, coordination mechanisms, and organizational systems that enable frontline concerns to be translated into timely corrective action.

6.3 Contextual Challenges

The effectiveness of Ayushman Arogya Mandirs is shaped not only by health system capacity but also by the broader social, cultural, economic, and geographical contexts within which services are delivered. Across Meghalaya, Mizoram, Karnataka, Jharkhand, and Rajasthan, participants described how geographical barriers, livelihood patterns, social norms, migration, gender dynamics, and varying levels of community trust influenced both healthcare utilization and the ability of frontline workers to deliver comprehensive primary healthcare services. These contextual realities often mediated the extent to which expanded service availability translated into equitable access, continuity of care, and sustained community engagement.

Geographical and infrastructural barriers were particularly prominent in Meghalaya, Mizoram, and Jharkhand, where difficult terrain, poor road connectivity, and seasonal disruptions affected outreach activities, supervision, emergency transportation, and referral access. Participants reported that patients in remote areas frequently incurred substantial travel costs, time burdens, and wage losses when accessing healthcare services, particularly for chronic disease management, specialist consultations, and diagnostic follow-up. These challenges often disrupted continuity of care and reduced utilization of preventive and follow-up services.

Health-seeking behaviour also emerged as an important contextual factor influencing service utilization. Across states, participants observed that many individuals sought care only after symptoms became severe, particularly for chronic conditions such as diabetes and hypertension. The asymptomatic nature of many non-communicable diseases, combined with the costs associated with travel and treatment, frequently contributed to poor treatment adherence and irregular follow-up. These findings highlight the importance of sustained community engagement and long-term patient support mechanisms for chronic disease management.

Sociocultural norms and community beliefs were also important determinants of healthcare utilization. In Meghalaya, participants reported challenges related to limited male participation in health programmes because livelihood activities often took precedence over engagement with preventive services. In Mizoram, respondents highlighted issues such as adolescent pregnancy, early marriage, and the influence of social norms on reproductive health-seeking behaviours, particularly in rural areas.

Across several states, frontline workers noted that resistance to preventive and promotive services, including antenatal care, immunization, family planning, and routine screening, required sustained counselling, trust-building, and repeated community engagement. Adolescent reproductive and sexual health emerged as a particularly sensitive area, where stigma, privacy concerns, and cultural expectations often limited service utilization. These findings underscore the need for adolescent-friendly, confidential, and culturally responsive approaches within AAM service delivery.

Community trust emerged as a critical determinant of healthcare utilization across all states. Participants consistently emphasized that awareness-generation activities alone were insufficient to increase service uptake. Rather, communities were more likely to engage with public health services when facilities were perceived as reliable, responsive, and capable of meeting their needs. Trust was closely linked to the consistent availability of medicines, staff presence, diagnostic services, infrastructure quality, and positive experiences of care. Where service availability was perceived as unreliable, utilization often remained limited despite outreach efforts.

Migration and population mobility presented additional challenges for continuity of care. Participants highlighted difficulties in maintaining follow-up among migrant populations, particularly for maternal health services, immunization, and chronic disease management. Frequent movement between locations often disrupted treatment pathways, complicated beneficiary tracking, and weakened continuity of care. Similar challenges were reported among other mobile and socially marginalized populations, where weak integration into local health systems and communication barriers limited sustained engagement with services.

Gender and social hierarchies also influenced frontline service delivery and community engagement. Participants described situations where social norms affected healthcare decision-making, participation in health programmes, and interactions between providers and community members. Such dynamics often required frontline workers to invest considerable effort in negotiation, relationship-building, and community engagement to sustain programme participation and service utilization.

Overall, the findings demonstrate that contextual realities substantially influence the effectiveness of comprehensive primary healthcare reforms. Strengthening service delivery therefore requires not only investments in infrastructure, workforce capacity, medicines, and digital systems, but also locally responsive approaches that address trust, stigma, accessibility, continuity of care, and the broader social determinants shaping healthcare utilization. The success of Ayushman Arogya Mandirs ultimately depends on their ability to adapt service delivery models to the diverse contexts and population needs they are intended to serve.



7

Key Priority Areas for Strengthening the Management of HWCs/AAMs Ways Forward

Across the six building blocks, participants perceived AAMs as strengthening access to primary care and preventive services at the community level. However, persistent challenges in workforce availability, digital

systems, medicine supply, financing, and governance limited their effectiveness. The findings highlight that improvements in service delivery require coordinated strengthening across all six building blocks rather than isolated interventions.

7.1 Policy level

Policy-level recommendations focus on strengthening the structural and regulatory foundations of AAMs (Table 4). These include revisiting transfer policies for CHOs under NHM to ensure stability in remote postings, expanding sanctioned posts to improve the availability of doctors, ANMs, and paramedical staff, and prioritising additional workforce deployment in hard-to-reach areas, including the provision of ANMs and support staff such as cleaners. Policies should mandate that AAMs operate from government buildings that meet IPHS norms and ensure that all centres are equipped to deliver the full range of services under the 12-service package, including any newly introduced programmes. Greater inter-departmental convergence is recommended so that non-health sectors can support AAM activities, while partnerships with academic institutions such as medical colleges or management institutes could help develop model AAMs and introduce innovations. Policy reforms should also promote patient-centric financing to reduce out-of-pocket expenditure for both patients and staff, address security concerns in remote facilities, and institutionalise performance benchmarking through mechanisms such as periodic delta rankings at the state level.

Recommendation	Mechanism	Accountability	Verification
Revisit CHO transfer policy to stabilise remote postings	Defined minimum tenure and hard-area posting norms within NHM service rules	State (NHM)	Turnover and vacancy duration in remote AAMs
Expand sanctioned posts; prioritise deployment in hard-to-reach areas	Sanction revision and equity-weighted deployment in the annual planning cycle	National sanction; State deployment	Share of remote facilities with full sanctioned staffing
Ensure AAMs operate from government buildings meeting IPHS norms	Facility-status mapping against IPHS; phased relocation plan	State; District	Proportion of AAMs in IPHS-compliant government premises
Deliver the full 12-service package, including new programmes	Service-readiness assessment per facility against the package	District	Facilities delivering the complete package
Inter-departmental convergence for non-health support	Standing convergence arrangement at district level	District	Convergence actions recorded against AAM plans
Patient-centric financing to reduce out-of-pocket cost	Review of point-of-care charges and assured free-service items	State	Out-of-pocket expenditure at AAM level
Institutionalise performance benchmarking	Periodic delta rankings at state level	State	Rankings published and reviewed on schedule

Table 4: Policy-level Recommendations

7.2 Administrative level

Administrative-level recommendations emphasise governance, accountability, and capacity building (Table 5). Regular monitoring through monthly field visits by health officials, strengthened grievance redressal mechanisms, and routine audits of infrastructure, power, network connectivity, and staff payments are essential to improve oversight. Administrative systems should ensure proper documentation of all expenditures and strengthen financial management, particularly regarding the use of untied funds and adherence to financial norms. Appraisal and recognition of best-performing staff are recommended to motivate positive work cultures and encourage a change in attitude toward improved service delivery. Training strategies should be systematised through structured induction training at the time of appointment, annual refresher courses, and continuous capacity building in management and community health. Strengthening CHO mentoring programmes and providing regular training not only to facility staff but also to PRI members would improve coordination and local governance. Dedicated nodal persons for each programme can further clarify roles and enhance accountability.

Recommendation	Mechanism	Accountability	Verification
Regular monitoring through field visits	Supportive-supervision schedule and checklist within existing review forums	District	Visits completed against schedule; issues closed
Strengthen grievance redressal	Defined redressal route with response timelines	District; Facility	Grievances resolved within the defined period
Routine audit of infrastructure, power, connectivity and payments	Periodic utility-and-payment audit integrated with supervision	District	Audit coverage; recurrence of flagged gaps
Strengthen financial management of untied funds	Utilisation norms and certificate compliance for JAS untied funds	Facility (JAS); District oversight	Timely fund release; utilisation-certificate compliance
Recognise and appraise best-performing staff	Recognition mechanism linked to benchmarking	State; District	Recognition applied; retention in recognised facilities
Systematise training	Structured induction at appointment, annual refreshers, continuous mentoring	State; District	Staff completing each training cycle
Extend training to PRI members; assign programme nodal persons	Inclusion of PRI in training calendar; named nodal officers	District	PRI members trained; nodal roles assigned

Table 5: Administrative-level Recommendations

7.3 Operational levels of functioning of AAMs

Operational-level recommendations focus on day-to-day functioning at AAMs (Table 6). Infrastructure should be upgraded following systematic gap assessments, with facilities designed to be welcoming and suitable for the local population rather than merely functional. Reliable water and electricity supply, functional toilets, internet connectivity, and IT systems for digital reporting and teleconsultation are critical for routine operations. Operational improvements should ensure that medicines, diagnostics, and equipment are supplied in line with local morbidity data and programme requirements, avoiding mismatches and unwanted drug flows. Logistics systems should guarantee the timely availability of supplies, while regular audits of basic utilities and connectivity can prevent service disruptions. Community-based monitoring through JAS, online location-based patient tracking, and door-to-door surveys can improve outreach and accountability. Sensitising PRI members to AAM services, strengthening security arrangements, and, where possible, providing staff quarters would improve staff retention and continuity of care. Collectively, these operational measures aim to reduce workload pressures, improve service quality, and enhance community trust in AAMs.

Recommendation	Mechanism	Accountability	Verification
Upgrade infrastructure after gap assessment	Functionality baseline per facility, generating an investment map	State; District	Visits completed against schedule; issues closed
Ensure water, power, sanitation, connectivity and IT for reporting and teleconsultation	Utility-and-connectivity provisioning against the baseline	District	Grievances resolved within the defined period
Supply medicines and diagnostics per local morbidity	Indenting aligned to morbidity data, linked to stock visibility	District; Facility	Audit coverage; recurrence of flagged gaps
Guarantee timely supply through logistics	Logistics schedule with stock-level triggers	District	Timely fund release; utilisation-certificate compliance
Community-based monitoring and outreach	JAS review, location-based patient tracking, door-to-door surveys	Facility; Community	Recognition applied; retention in recognised facilities
Strengthen security and staff accommodation	Provisioning plan for remote facilities	State; District	Staff completing each training cycle

Table 6: Operational-level Recommendations



8

Policy Implications: A Strategic Vision for Strengthening Comprehensive Primary Health Care through Ayushman Arogya Mandirs

This study demonstrates that the effectiveness of Ayushman Arogya Mandirs (AAMs) depends not only on expanding the package of services available at the primary-care level but also on

strengthening the broader systems that support service delivery. Findings from Meghalaya, Mizoram, Karnataka, Jharkhand, and Rajasthan indicate that progress toward comprehensive primary health care (CPHC) and Universal Health Coverage (UHC) is shaped by the interaction of workforce capacity, infrastructure, medicines and diagnostics, digital systems, financing arrangements, community engagement, referral networks, and governance mechanisms. Consequently, strengthening AAMs requires a shift from programme-centred implementation toward integrated, people-centred health system development.

The findings highlight the need for policy approaches that recognize contextual diversity while maintaining core standards of quality, equity, and accountability. Across states, participants emphasized that successful implementation depends on the ability of health systems to adapt to local geographical, social, demographic, and institutional realities. The policy implications emerging from this study therefore focus on strengthening system responsiveness, supporting frontline leadership, improving continuity of care, and creating enabling conditions for locally relevant innovation.

1 Evidence-Informed Governance and Adaptive Learning

A consistent finding across states was the importance of designing policies that reflect frontline realities and implementation challenges. Participants emphasized that policies, guidelines, and digital systems are often introduced without sufficient consideration of operational feasibility, resulting in implementation gaps and increased administrative burden. Strengthening AAMs therefore requires institutional mechanisms that systematically incorporate feedback from Community Health Officers, ASHAs, ANMs, Medical Officers, and district managers into programme design and revision.

Policy development should be supported by routine pilot testing, implementation reviews, and structured feedback mechanisms before large-scale roll-out, particularly for digital innovations and reporting platforms. Equally important is the

creation of a continuous learning ecosystem that facilitates cross-state exchange of successful practices and encourages adaptive management based on implementation evidence.

A major governance challenge identified across states was the weak conversion of frontline feedback into corrective action. While workforce shortages, medicine stock-outs, infrastructure deficiencies, digital-system challenges, and operational bottlenecks were routinely reported through administrative channels, participants frequently perceived that these concerns did not result in timely responses. Strengthening governance therefore requires the establishment of a closed-loop frontline support system in which operational issues are formally recorded, acknowledged, assigned to responsible officials, tracked through defined timelines, and reviewed through action-taken reports. Such a system would strengthen accountability, improve managerial responsiveness, and reinforce frontline leadership.

2 Strengthening Person-Centred Comprehensive Care through Workforce Development

The expansion of comprehensive primary health care requires corresponding investments in workforce capability. Findings suggest that capacity strengthening should move beyond programme-specific technical training and instead focus on developing competencies required for person-centred care across the continuum of services delivered through AAMs.

Participants consistently emphasized the value of continuous learning, workplace mentoring, supportive supervision, peer learning, and practical problem-solving support. Effective workforce development should therefore combine structured induction programmes, periodic refresher training, low-dose high-frequency learning approaches, and ongoing mentorship. Training programmes should equip providers not only with clinical competencies but also with skills related to leadership, communication, digital systems, community engagement, chronic disease management, and care coordination.

Addressing workforce shortages and retention challenges remains equally important. Policies should support equitable deployment of health personnel, incentives for service in underserved areas, provision of staff accommodation in remote locations, and strengthened supervisory systems. Timely payment of salaries and incentives must also be recognized as a governance priority. Delays in incentive payments, particularly among frontline workers, directly affect motivation, outreach activities, and continuity of care, undermining the effectiveness of community-based health programmes.

3 Community Engagement and Social Accountability

The findings demonstrate that community engagement is central to the success of comprehensive primary health care. Effective engagement extends beyond health awareness activities and includes community participation in planning, implementation, monitoring, and accountability processes.

Future policy efforts should support structured community engagement frameworks that clearly define the roles of AAMs, frontline workers, local governance institutions, community-based organizations, social workers, educational institutions, and civil society actors. Such frameworks can strengthen health promotion, improve service uptake, facilitate referral compliance, and enhance continuity of care.

Health communication strategies should also become more locally responsive. Participants frequently observed that existing information, education, and communication materials are overly technical, lengthy, and insufficiently adapted to local languages and literacy levels. Future communication approaches should prioritize concise, culturally appropriate, and context-specific messaging delivered through trusted community institutions and local leadership structures.

Financial protection should similarly be integrated into routine community outreach. Frontline workers reported actively linking families with Ayushman Bharat PM-JAY and state-specific health protection schemes while using local communication channels to increase awareness. Embedding financial-protection counselling within routine outreach activities can improve awareness, reduce financial barriers to care, and strengthen continuity of treatment, particularly among vulnerable populations.

4 Strengthening Service Delivery in Diverse Contexts

The experiences of Meghalaya and Mizoram illustrate that expanding access to care often requires innovative service delivery arrangements beyond conventional facility-based models. Transportation support systems, transit homes for expectant mothers, medicine delivery initiatives, community-supported ambulance services, and locally adapted referral mechanisms were all reported to improve healthcare access in geographically challenging environments.

Policy frameworks should therefore encourage flexible implementation approaches that allow states and districts to adapt service delivery models to local needs while preserving the core principles of comprehensive primary health care. Periodic review of catchment areas and sub-sector boundaries should also be undertaken to ensure that service planning reflects changing settlement patterns, population distribution, and healthcare needs.

5 Reliable Medicines, Diagnostics, and Supply Chain Management

The ability of AAMs to deliver comprehensive care depends fundamentally on the uninterrupted availability of medicines, diagnostics, and essential supplies. Although important progress has been made in expanding access, participants reported continuing challenges related to forecasting, procurement, logistics management, and last-mile distribution.

Policy efforts should strengthen integrated supply-chain systems capable of supporting real-time inventory monitoring, forecasting, procurement planning, and distribution management. Particular attention should be given to ensuring uninterrupted access to medicines required for long-term management of non-

communicable diseases and other chronic conditions. Innovative approaches such as medicine delivery schemes should be evaluated and expanded where appropriate to improve continuity of care for remote and vulnerable populations.

6 Building Integrated and User-Centred Digital Health Systems

Digital technologies have become central to service delivery, monitoring, surveillance, and programme management under the AAM initiative. However, findings indicate that fragmented reporting systems, duplicate data entry requirements, limited interoperability, and frequent changes in reporting processes have substantially increased administrative burden.

Future digital reforms should focus on creating an integrated and interoperable digital ecosystem that consolidates programme requirements into a unified reporting platform. Systems should be designed around frontline workflows, function effectively in low-connectivity environments, minimize duplication, and reduce administrative workload.

Telemedicine represents an important opportunity for improving access to specialist care, particularly in remote areas. However, participants highlighted challenges related to staffing continuity and platform access arrangements. Future telemedicine models should incorporate role-based access systems, backup staffing arrangements, and operational protocols that ensure continuity of services during staff absences.

7 Strengthening Referral Systems and Continuity of Care

Comprehensive primary healthcare requires effective continuity of care across different levels of the health system. Participants identified transportation barriers, weak referral coordination, limited emergency infrastructure, and difficulties in patient follow-up as important challenges affecting continuity of care.

Strengthening referral systems should therefore include investments in transport networks, teleconsultation support, communication mechanisms linking different levels of care, referral-tracking systems, and emergency care infrastructure. Particular attention should be paid to strengthening First Referral Units and ensuring access to blood storage facilities and other essential emergency services in underserved regions.

8 Cross-Sectoral Collaboration and Political Commitment

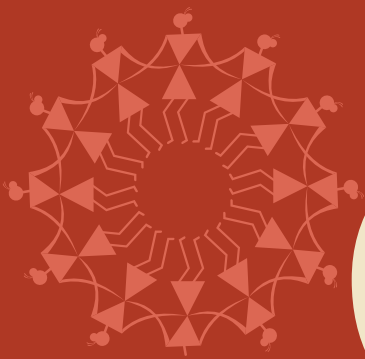
Many of the challenges identified in this study extend beyond the health sector alone. Community nutrition, school health, environmental health, adolescent wellbeing, transportation, social protection, and local governance all influence the effectiveness of comprehensive primary healthcare.

Strengthening AAMs therefore requires sustained collaboration between health departments, local governance institutions, education systems, women and child development programmes, community organizations, and development partners. Positioning primary healthcare as a broader development priority can facilitate resource mobilization, strengthen local ownership, and improve long-term sustainability.

The findings also suggest the need for greater flexibility within national implementation frameworks. Allowing states and districts to adapt implementation strategies to local realities while maintaining core standards of quality and accountability will be essential for ensuring that AAMs remain responsive to diverse contexts and evolving population needs.

Policy implication	Mechanism	Accountability	Verification
1. Evidence-informed design and learning ecosystem	Mandatory frontline consultation and pilot testing before scale-up, especially for digital tools	National; State	Tools piloted before scale-up
2. Community engagement for integration	Locally tailored IEC delivered through gram sabhas and tribal institutions; cross-state IEC exchange	State; District	Engagement activity on priority themes
3. Institutional strengthening	Modular, low-dose high-frequency training; collaborative cross-state workforce programmes	State	Training cycles completed; standards aligned
4. State capacity at the AAM	Equitable distribution and staff housing; collaborative workforce planning	State; District	Remote-facility staffing and accommodation
5. Supply chain and digital integration	Logistics linked to digital stock and procurement data	State; District	Stock-outs; last-mile availability
6. Continuum of care	Joint telemedicine and referral network across levels of care	State; District	Patients retained from screening to follow-up
7. Resource allocation and financing	Predictable, execution-oriented fund flows; prioritisation toward constrained states	National; State	Timeliness of fund release
8. Targeted screening and quality assurance	Technical support and QA for cancer and NCD programmes; cross-state scaling	State	Screening quality; follow-up of detected cases
9. Digital readiness and system adaptation	Single, offline-first reporting platform, phased with training	National; State	Reporting platforms in use per worker
10. Cross-sectoral and political engagement	Joint advocacy for guideline flexibility; PHC positioned within development agendas	National; State	Flexibilities formally granted and exercised

Table 7: Policy Implications Matrix



9

Conclusions

This report examined the governance, management, and operational realities of delivering comprehensive primary healthcare through AAMs across diverse state contexts. The findings demonstrate that progress towards Universal Health Coverage is shaped not by individual programmes operating in isolation, but by the extent to which different components of the health system function cohesively to

support comprehensive, continuous, and people-centred care.

Analysed through the World Health Organization's health system building blocks framework, the findings highlight the interdependence of infrastructure, workforce, service delivery, health information systems, financing, access to medicines, and governance. Deficiencies in one component frequently generated cascading effects across the system. Infrastructure constraints limited service expansion, workforce shortages increased managerial and service-delivery burdens, fragmented digital systems diverted time away from patient care, medicine and diagnostic gaps weakened continuity of treatment, and financing and administrative bottlenecks reduced operational flexibility. These interconnections help explain why isolated programme-level interventions often fail to produce sustained improvements in health system performance.

The findings further demonstrate that governance and leadership operate as cross-cutting determinants that shape the effectiveness of all other system components. Across states, frontline providers, facility managers, and district officials played critical roles in adapting policies to local realities, coordinating service delivery, mobilizing communities, and sustaining continuity of care under resource-constrained conditions. However, participants also identified persistent challenges related to workforce management, fragmented digital ecosystems, weak referral systems, delayed administrative responses, and limited conversion of frontline feedback into corrective action. These findings underscore the importance of strengthening governance not only through accountability and monitoring mechanisms but also through more responsive and adaptive management systems.

The study also highlights the importance of context-sensitive implementation. While states differed in their institutional arrangements, geographical conditions, community structures, and health system capacities, several common themes emerged. Effective community engagement relied on locally trusted institutions and relationships; capacity building extended beyond formal training to include continuous mentoring and workplace learning; and successful service delivery depended on the ability of frontline teams to adapt programmes to local social, cultural, and geographic realities. These findings suggest that national policy frameworks require sufficient flexibility to accommodate diverse implementation contexts while maintaining core standards of quality and accountability.

Overall, the evidence indicates that strengthening primary healthcare requires a shift from programme-centred approaches towards integrated health system strengthening. Investments in infrastructure, human resources, medicines and diagnostics, digital systems, financing, and community engagement must be accompanied by governance arrangements that promote coordination, responsiveness, learning, and continuity of care. Reorienting health systems towards people-centred care, rather than narrowly programme-driven implementation, will be essential for enabling AAMs to function as effective platforms for comprehensive primary healthcare and as a foundation for equitable, resilient, and sustainable UHC in India.

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Appendices

A. Thematic Analysis of Stakeholder Perspectives on Ayushman Arogya Mandirs Across Participating States

1. Health System Governance and Leadership

Theme	Analytical Inference
Centralised governance and limited decentralisation	Excessive centralisation limits district-level flexibility and weakens contextual planning for geographically and epidemiologically diverse regions.
Weak district autonomy in implementation	District officials perceive themselves as implementers rather than decision-makers, reflecting constrained local governance authority.
Continued dominance of RMNCH priorities	Maternal and child health continues to dominate review mechanisms, often overshadowing emerging priorities such as NCDs and mental health.
Epidemiology-driven district prioritisation	District planning increasingly relies on surveillance and epidemiological evidence for programme prioritisation.
Importance of field-based monitoring	Field visits are viewed as critical for understanding implementation realities that are often hidden in online reviews and reports.
Geographical mismatch in national norms	National guidelines are often perceived as poorly adapted to local geographical and demographic contexts in Northeast India.
Weak monitoring due to workforce overload	Administrative burden and digital reporting requirements undermine effective supervision and programme monitoring.
Demand for decentralised district planning	Stakeholders strongly support district-specific planning approaches responsive to local health needs and resource constraints.

2. Human Resources and Workforce Challenges

Theme	Analytical Inference
Shortage of CHOs	Inadequate CHO deployment directly affects service continuity and utilisation at sub-centres.
Workforce absenteeism and commuting barriers	Lack of residential infrastructure contributes to absenteeism and reduced service delivery time.
Role conflict between ANMs and CHOs	Incentive disparities and unclear hierarchies create interpersonal tensions that undermine teamwork.
Contractual insecurity among CHOs	Contractual employment reduces professional recognition and morale among CHOs.
Scarcity of specialists	Specialist shortages increase delays in diagnostics and referral processes.
Burden on ASHAs	ASHAs experience heavy workloads, low remuneration, and emotional exhaustion.
Need for technical and digital support	Digital health systems increase technical demands on frontline workers without adequate support mechanisms.
Supportive supervision as strengthening mechanism	Effective supervision is viewed as central to improving accountability and service quality.

3. Financing and Resource Constraints

Theme	Analytical Inference
Delayed or absent untied funds	Delays in fund disbursement undermine routine functioning of AAM facilities.
Limited decentralisation of finances	Highly centralised financial procedures reduce local responsiveness and operational efficiency.

Out-of-pocket expenditure by staff	Health workers frequently compensate for systemic funding gaps through personal expenditure.
Inadequate funding for outreach	Community outreach activities remain underfunded despite expectations for extensive public engagement.
Constraints on intersectoral committees	Financial shortages weaken community-level governance and multisectoral collaboration mechanisms.
Demand for outcome-based financing	Emerging governance reforms seek to improve accountability through direct facility financing and outcome-based budgeting.
Budget insufficiency for mandated activities	Nationally mandated activities are difficult to operationalise due to inadequate budget allocations.

4. Medicines, Diagnostics, and Service Availability

Theme	Analytical Inference
Inconsistent medicine supply	Weak last-mile supply chain systems affect medicine availability at AAM facilities.
Centralised procurement challenges	State-controlled procurement systems may create delays and supply bottlenecks at facility level.
Local adaptation of drug lists	States seek flexibility to tailor essential drug lists according to epidemiological and contextual realities.
Geographic barriers to medicine access	Terrain and climatic conditions significantly affect continuity of medicine supply in Northeast India.
Expanded service delivery through AAMs	Upgradation to AAMs has expanded the scope and continuity of primary healthcare services.
Teleconsultation limitations	Teleconsultation remains constrained by low community trust and preference for face-to-face interaction.
Lack of comprehensive diagnostics	Stakeholders emphasise the need for expanded diagnostic capacity within comprehensive primary healthcare.

5. Community Engagement and Trust Building

Theme	Analytical Inference
Importance of intersectoral collaboration	Community-level partnerships are critical for outreach, mobilisation, and health promotion activities.
Trust building through service delivery	Community trust in public health systems strengthens through visible and successful service outcomes.
Low male participation	Gendered livelihood patterns affect participation in community health programmes.
Community resistance and cultural beliefs	Cultural beliefs and hesitancy continue to challenge maternal and preventive healthcare uptake.
Importance of regular community interaction	Continuous engagement between frontline providers and communities is considered essential for effective care delivery.
Role of NGOs and community groups	Civil society organisations play an important supportive role in emergency response and awareness campaigns.
Community feedback for policy making	Participatory governance and feedback systems are emerging as important strategies for responsive health planning.
Weak functioning of JAS due to limited funds	Community governance structures are highly dependent on financial support for sustained engagement.

6. Health Information Systems and Digital Challenges

Theme	Analytical Inference
Fragmented health information systems	Multiple parallel reporting platforms contribute to inefficiency and data fatigue among health workers.
Duplication of work	Lack of interoperability results in repetitive data entry and inefficient workforce utilisation.

Frequent changes in portals	Constant software transitions disrupt continuity and increase digital adaptation burdens.
Delayed integration of data systems	Stakeholders express frustration over long-standing failure to achieve integrated digital health systems.
Data quality concerns	Weak verification mechanisms reduce reliability of routine health management information systems.
Insurance data as alternative evidence source	Insurance claims databases are increasingly viewed as valuable sources for evidence-based policymaking.
Digital burden on frontline workers	Digitisation has increased administrative workloads for already overburdened health staff.

7. Quality of Care and Health System Strengthening

Theme	Analytical Inference
NQAS as a quality improvement mechanism	NQAS implementation is seen as driving improvements in facility quality and accountability.
Cleanliness without clinical expansion	Quality initiatives risk prioritising infrastructure aesthetics over comprehensive clinical care delivery.
Need for strengthened diagnostics and continuity of care	Sustaining long-term management of chronic diseases remains a major challenge within primary healthcare systems.
Importance of quality supervision	Quality assurance has become institutionalised within district-level monitoring frameworks.
NCDs emerging as major priority	Health systems are increasingly shifting focus toward chronic disease prevention and management.
Gap between policy mandates and feasibility	National quality mandates may not align with workforce realities in resource-constrained settings.

8. Socio-Cultural and Geographical Determinants of Healthcare Access

Theme	Analytical Inference
Difficult terrain and access barriers	Geographic isolation remains a structural barrier to healthcare access in hilly and remote regions.
Migrant populations and communication barriers	Language barriers and migration complicate healthcare outreach and trust-building efforts.
Poverty and early marriage	Social determinants such as poverty and gender inequality continue to shape maternal and adolescent health outcomes.
Community distrust of digital schemes	Low digital literacy and mistrust affect uptake of digital health initiatives such as ABHA and Ayushman Bharat registration.
Educational differences affecting health communication	Variations in literacy and education significantly influence health awareness and programme uptake.
Occupational and livelihood constraints	Healthcare participation is shaped by community livelihood patterns, requiring flexible programme scheduling.

Concluding Analytical Observations

The tables above reveal several cross-cutting findings across the participating states:

1. **AAMs have improved access and visibility of primary healthcare services**, particularly for NCD screening, continuity of OPD services, and community-level outreach.
2. **Human resource shortages, contractual insecurity, and role conflicts** remain major barriers to effective implementation.
3. **Centralised governance and financing systems limit district-level flexibility**, particularly in geographically diverse regions such as Meghalaya and Mizoram.
4. **Fragmented digital health systems and excessive reporting burdens** significantly affect frontline health worker efficiency.
5. **Community trust and intersectoral collaboration are central to successful implementation**, especially in culturally diverse and hard-to-reach populations.

6. **National guidelines often fail to account for local realities**, leading to implementation gaps in remote and resource-constrained settings.
7. **Quality improvement initiatives such as NQAS have strengthened accountability**, but concerns remain regarding sustainability, financing, and emphasis on clinical service delivery.
8. **Socio-cultural and geographical determinants continue to shape healthcare access**, underscoring the importance of context-sensitive policy and implementation strategies.

B. Photographs from the AAM Symposium Conducted across the four IIMs





Figure 1. IIM Shillong



Figure 2. AAM Symposium IIM Bangalore



Figure 3. IIM Ranchi



Figure 4: IIM Udaipur



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About IIM Bangalore:

IIM Bangalore, a premier management institute which is renowned the world over for the quality of its Post Graduate and Doctoral programmes, continues its legacy of being ranked among the top MBA institutes, in global and national rankings, reflecting the Institute's commitment to delivering versatile, high-quality management education across various formats. IIMB is internationally accredited by the EFMD Quality Improvement System (EQUIS) since 2010. In December 2021, the Institute was re-accredited by EQUIS for a further period of five years. Housed in a renowned award-winning campus, IIMB is India's top research-focused business school with over 100 full-time faculty members, who have studied and taught at some of the best universities in India and abroad. Their research regularly appears in leading publications and academic journals around the world. They bring vast industry, consulting, policymaking and academic experience into the classroom, making for a unique and stimulating learning environment.

IIMB has been constantly reinventing itself to stay relevant and ahead in terms of academics and research, which is reflected in the launch of new academic programmes and Centres of Excellence. The Institute has recently introduced undergraduate programmes to its academic portfolio. At IIMB, there is a deep focus on entrepreneurship and its innovation centre NSRCEL has given a great fillip to that. IIMB's digital learning initiative IIMBx provides flexible, accessible and high-quality learning opportunities, empowering students, professionals and managers to advance their knowledge as well as careers. The Institute continues to be a preferred destination for recruiters looking for top talent, as the school provides industry-ready graduates. IIMB is a change-oriented institution committed to advancing and supporting important national initiatives.

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About The Women's Collective Forum (WCF)

The Women's Collective Forum (WCF) is built on one conviction: India's hardest public health challenges are not solved in silos, but when government, industry, science, philanthropy and communities are brought to the same table and held to the same outcomes. WCF convenes that table — and turns the conversation into measurable change. Our work runs on two tracks: building credible platforms where the whole system can align, and backing evidence-based innovations that save lives at scale.

Advancing Public Health: An Evidence Initiative

In its first phase, WCF aligned with 18 of India's premier research and management institutions — across the IITs, IIMs, AIIMS, ISB and ICMR network — to examine a defined public health challenge and chart India's path forward. The themes span the elimination of tuberculosis, malaria, kala-azar, lymphatic filariasis and other neglected tropical diseases; maternal, child and adolescent health; family planning and women's health innovation; and the systems that carry care to people — immunisation, technology for universal health coverage, Ayushman Aarogya Mandirs, and equitable, affordable access. Together they form an evidence base that turns ambition into geography-specific strategy.

Advancing Public Health Outcomes Forum

Our flagship platform convenes policymakers, scientists, industry and civil society in a single, results-oriented conversation. The inaugural Forum in New Delhi was addressed by Union Health Minister Shri J.P. Nadda and Dr Rajiv Bahl on the theme of Disease Control and Immunisation — designed not to celebrate progress, but to interrogate how it is sustained and scaled.

Engaging Policymakers and Industry

WCF carries its research directly to those who can act on it. A closed-door interaction with Members of Parliament and senior industry leaders, hosted with CII, drew on four white papers on family planning, maternal health, child and adolescent health, and women's health innovation — closing with a commitment to use geography-specific data for constituency-level solutions. These papers were formally launched at the 6th CII Public Health Summit 2025, graced by Ms. Smriti Irani, Founder and Chairperson of the Alliance for Global Good: Gender Equity & Equality and Advisor to WCF, alongside Dr. Randeep Guleria (Medanta), Hari Menon (Gates Foundation) and Dr. V.K. Paul (NITI Aayog).

Innovation in Maternal Health: The PPH Drape Protocol

Postpartum haemorrhage remains a leading cause of preventable maternal death — yet early detection can change the outcome entirely. WCF is leading the development of a standardised PPH drape protocol with ICMR and key clinical partners: a first-of-its-kind, South-led innovation grounded in the maternal-care realities of India and Africa, combining cost-effective design, clinical validation and systemic integration. Clinical training is already underway, including at the Army Hospital, to bring the protocol into mainstream care.

Future Forward: Shaping Global Futures with Indian Solutions

Co-convened with CII and joined by Mr. Bill Gates, Future Forward spotlights India's frugal, scalable innovations on the global stage — across agriculture, fintech, gender equity and public health. In a dedicated dialogue, WCF and ICMR presented a portfolio of low-cost, high-impact Indian health technologies, showcased for their investment potential and adaptability across the Global South — positioning India not as a laboratory of innovation alone, but as a global partner in rethinking how development is delivered and funded.

Our Approach

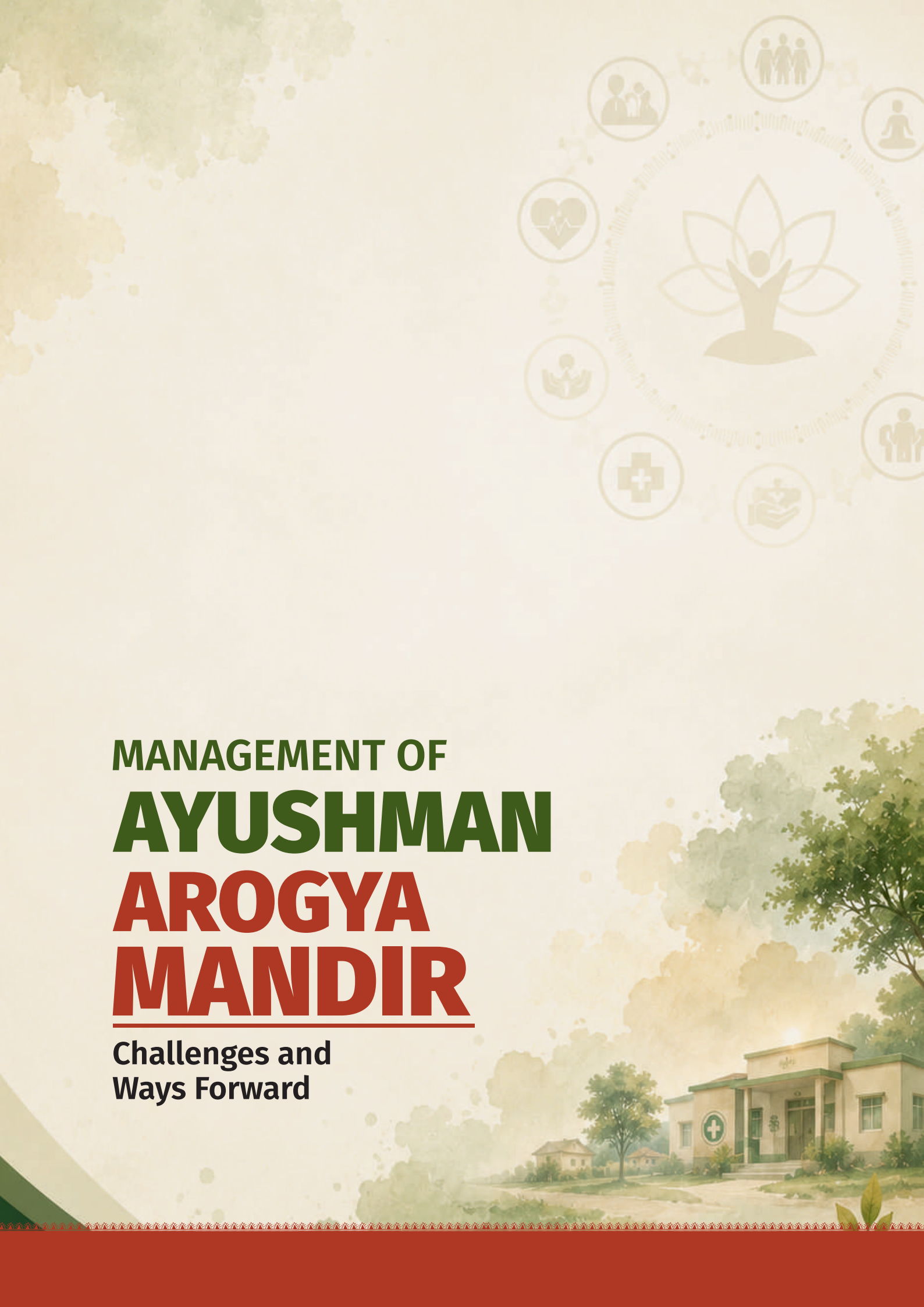
WCF convenes the whole system, anchors decisions in evidence, and measures success by outcomes rather than activity — placing women and children at the centre of India's public health story not as beneficiaries, but as the measure of whether the system is working.



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MANAGEMENT OF **AYUSHMAN** **AROGYA** **MANDIR**

Challenges and
Ways Forward