

RAPID ASSESSMENT OF AYUSHMAN AROGYA MANDIR IN THE STATES OF MEGHALAYA AND KARNATAKA

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INTRODUCTION

The National Health Policy of 2017 highlighted the requirement of “Health and Wellness Centres” in order to strengthen primary health care, dedicating two thirds of the health budget to primary health care.

In 2018, the Government of India announced the creation of 1,50,000 HWCs, now named Ayushman Arogya Mandir (AAM), as part of its flagship program- Ayushman Bharat.

AAM aim to provide a broad spectrum of CPHC services, including preventive, promotive, curative, rehabilitative, and palliative care.

These centres enhance and broaden existing Reproductive & Child Health (RCH) and Communicable Disease services, incorporating care for Non-Communicable Diseases.

They also provide services for mental health, ENT, eye care, dental health, geriatric and palliative care, trauma care, and health promotion activities like yoga.

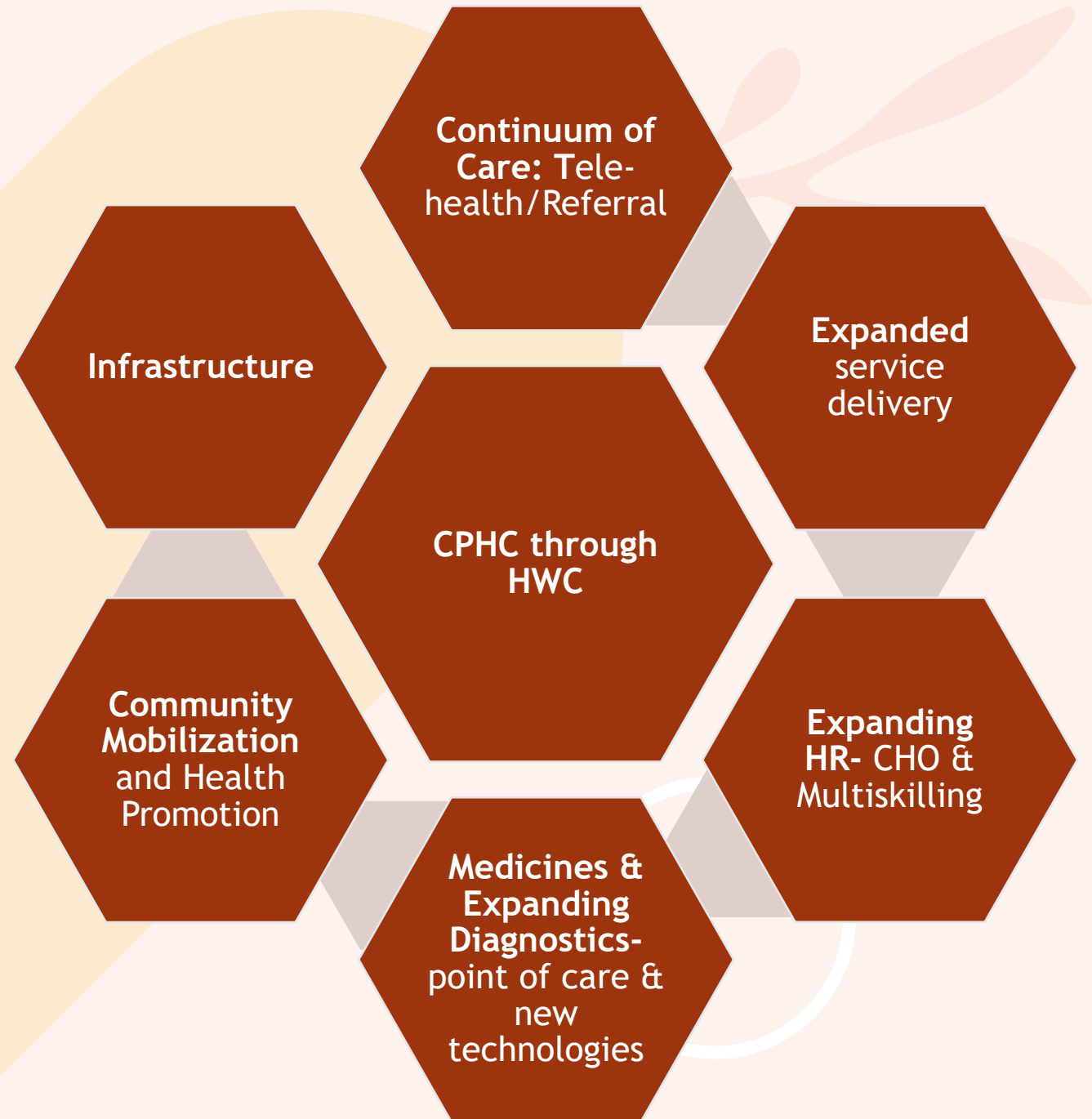
Services made
available at AAM

- Care in Pregnancy and Child-birth
- Neo-natal and Infant Health Care Services
- Childhood and Adolescent Health Care Services
- Family Planning, Contraceptive Services and other Reproductive Health Care Services
- Management of Communicable Diseases
- Out-patient Care for Acute Simple Illnesses and Minor Ailments
- Screening, Prevention, Control and Management of Non-Communicable Diseases and Chronic Communicable Diseases

Services being
added in an
incremental
manner

- Basic Oral Health Care
- Care for Common Ophthalmic and ENT Problem
- Screening and Basic Management of Mental Health Ailments
- Elderly and Palliative Health Care Services
- Emergency Medical Services including Burns and Trauma

KEY COMPONENTS OF THE PROGRAMME



REVIEW OF LITERATURE

S. n o	Title	Author	Year	Findings
1.	India's health and wellness centres: realizing universal health coverage through comprehensive primary health care.	Rajani R Ved, Garima Gupta, et al.	2019	India's health care system is shifting focus towards NCDs, necessitating a re-evaluation of primary health care quality and capacity. The Ayushman Bharat initiative aims to transform public health centres into health and wellness centres, offering free comprehensive primary health care, requiring paradigm shifts in human resources and service delivery.(3)
2.	Health and wellness centers: a paradigm shift in health care system of India?	Hariom K. Solanki, Rama Shankar Rath, et al.	2020	The research paper discusses the changing disease epidemiology in India, focusing on NCDs, mental health issues, accidents, and injuries as emerging health threats. It highlights the weakness of the existing three-tiered public health system in India, leading to non-uniform coverage, overburdened health facilities, and high OOPe for individuals, potentially pushing many into poverty. The proposed HWCs in India are designed to provide comprehensive primary healthcare services under 12 domains, including promotive, preventive, and curative aspects, with a focus on health promotion and disease prevention activities like yoga.(4)
3.	Health & Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward	Chandrakant Lahariya	2020	The AB-HWC initiative focus on team-based service delivery with mid-level healthcare providers like CHOs included in the centers. The paper analyzes the key design aspects of HWCs in relation to primary health care services and operations. The paper also highlights the need for dedicated focus on population-based and public health services within the AB-HWCs to ensure comprehensive primary healthcare delivery.(5)
4.	Health and Wellness Centres as a strategic choice to manage noncommunicable diseases and universal health coverage	Aravind Gandhi P, Ria Nangia, et al.	2022	Study highlights the significance of primary healthcare in managing NCDs and the role of HWCs in expanding NCD services at the community and facility levels. Challenges in NCD management at the primary care level are identified, including lack of awareness, erratic supply of NCD drugs and diagnostics, capacity building for health manpower in NCD management, information flow for continuity of care, and less community participation in NCD screening and management. The study emphasizes the importance of addressing these challenges to progress towards UHC, meet NCD-related targets, and effectively implement the envisioned package in HWCs.(6)

5.	Health And Wellness Centres: Expanding Access to Comprehensive Primary Health Care in India	Nirupam Bajpai, Manisha Wadhwa	2019	The research paper refers to Operational Guidelines for Comprehensive Primary Health Care through HWCs, emphasizing the importance of providing a package of essential services within a short timeframe to reduce morbidity and mortality burdens. It draws on the Rural Health Statistics Report 2017 to highlight the gaps in rural health facilities, indicating the need for creating new centres to function as HWCs instead of just upgrading existing ones. The paper also mentions the role of ICT in healthcare delivery, showcasing how digitization can enhance the efficiency of service delivery and improve health outcomes.(7)
6.	An Assessment of Implementation of CPHC through Ayushman Bharat Health and Wellness Centres in Karnataka and Goa	Jyoti S. Hallad, H. R. Channakki, et al.	2020	The assessment in Karnataka and Goa underscores the importance of addressing challenges related to human resources, infrastructure, service delivery, and community engagement to strengthen the primary healthcare system through the Ayushman Bharat scheme. Community feedback in both states has been positive, with ASHAs, MPWs, and patients acknowledging the benefits of having MLHPs, essential medicines, and healthcare services available locally, reducing the need for travel to higher-level healthcare facilities. (8)
7.	Assessment of Functioning of Health and Wellness Centers of Western Odisha: A Cross-Sectional Study of this article	Smita K. Panda, Devasish Panda, et al.	2023	Studies indicate sub optimal utilization of public health systems for common illnesses in rural and urban areas, emphasizing the importance of accessible primary care facilities like HWCs. The study highlighted staffing issues at HWCs, with shortages of MOs and staff nurses, impacting services like emergency care, mental health, and oral health, while services like family planning and NCD management were more consistently available. The HWCs establishment under the Ayushman Bharat program is a significant national initiative, with a goal to operationalize many HWCs to enhance primary healthcare services across India.(9)
8.	Assessment of functioning of Health and Wellness Centers in a district of Western Gujarat.	Hetal Rathod, Pradeep Pithadia, et al.	2020	The research paper focuses on assessing the functioning of HWCs in Jamnagar district, Gujarat. The study showed Satisfactory performance of most HWCs, with the presence of CHOs and MPWs in the majority of centers. Prevalence rates of NCDs like hypertension, diabetes mellitus, cancer (oral, breast, cervical) were reported. Identified areas for improvement included the need for staff training in areas like Technology and refresher training. It also highlighted that while most HWCs were functioning well, some services like laughing club, music therapy, and meditation (wellness sessions) were lacking.(10)
9.	Enablers and barriers to work performance: A mixed methods assessment of Ayushman Bharat-Health and Wellness Centres in Punjab state of India	Shankar Prinja, Neha Purohit, et al.	2023	This study shows performance variations among HWCs and the reasons behind these by understanding the perspective of CHOs and ANMs. The research utilizes a mixed methods approach, combining quantitative facility assessments with qualitative in-depth interviews to understand perceptions about service delivery. Findings suggest that infrastructure differences exist between high and low-performing HWCs, with capacity influenced by factors like training, work experience, self-belief, and role clarity. The study emphasizes the importance of improved communication, supportive supervision, incentives, role clarity, and management capacities to enhance work efficiency in HWCs.(11)

10.	Assessment of health and wellness centres in hilly district of Himachal Pradesh	Abhilash Sood, Devender Kumar, et al.	2021	A cross-sectional study was done to evaluate the HWCs in Hamirpur district, Himachal Pradesh. The study utilized a validated checklist provided by the NHM, Himachal Pradesh to assess various domains of the HWCs. The study identified deficiencies in human resources, inadequate skill competencies among newly appointed healthcare workers, and limited tele-consultations despite the availability of telemedicine equipment at the health centres. The results indicated gaps in service delivery and information technology at PHCs. The assessment of sub-centres revealed high gaps in training for health workers and skill competencies.(12)
11.	Health system readiness for roll out of the Ayushman Bharat Health and Wellness Centres - Early experiences from Punjab State	Sehr Brar, Neha Purohit, et al.	2022	The study assessed the health system readiness for establishing HWCs through facility assessment and knowledge evaluation of community health officers (CHOs) and auxiliary nurse midwives (ANMs) in Punjab state. The study underscores the necessity for state and local interventions to strengthen physical infrastructure, ensure a consistent supply of medicines, establish patient referral mechanisms, and enhance community engagement for successful HWC operationalization.(13)
12.	Rapid assessment of NCD services rollout in Health and Wellness Centres in North-Eastern Indian state: A cross- sectional study	Erin Hannah, Neha Dumka, et al.	2023	The research paper focuses on the rollout of NCD services in HWCs in Manipur, India. It acknowledges the unique challenges faced by North-Eastern states in providing routine healthcare services, highlighting the need for tailored approaches to healthcare delivery. Findings revealed increased demand and community awareness for expanded primary healthcare services. Challenges included infrastructural gaps, logistical delays, training deficiencies, funding issues, weak community-level coordination, and disruptions due to the COVID-19 pandemic.(14)
13.	How useful do communities find the health and wellness centres? A qualitative assessment of India's new policy for primary health care	Shriyuta Abhishek, Samir Garg, et al.	2024	The study aims to understand the usefulness of HWC services from the perspective of community through FGDs conducted in various districts of Chhattisgarh, India. Beneficiaries appreciated the proximity of HWCs to their communities, making healthcare services easily accessible. They also highlighted the convenience of having essential medicines, blood pressure measurement apparatus, and point-of-care tests available at HWCs for conditions like hypertension, diabetes, minor injuries, and ante-natal care. (15)
14.	Factors Influencing Utilization of Health and Wellness Centers (HWCs) in Odisha: A Mixed Method Study from Beneficiaries' Perspective	Amitosh Dandena, Paramjot Panda, et al.	2024	The study aimed to evaluate the perception of people in managing hypertension, identify challenges, demographic and clinical factors, barriers associated with healthcare utilization, and assess the knowledge, attitude, awareness, and perception levels among the population towards HWCs and services for hypertension management. Factors including education, proximity to health facility, income status, illness, etc. affect utilization of HWCs Study revealed positive influences on utilization, due to factors of distance proximity to HWCs, free drugs and diagnostics, and barriers to utilization included transportation difficulties, unawareness, and poor perceptions of HWCs.(16)

RESEARCH QUESTION

How are AAM/HWC performing in terms of infrastructure, service delivery, availability of drugs and diagnostics and use of IT systems?



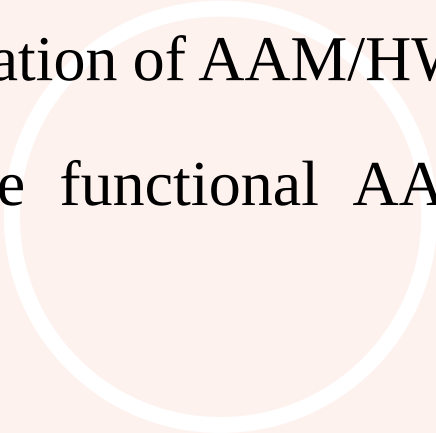


OBJECTIVES



The primary objective of this rapid assessment is to assess the overall performance of Ayushman Arogya Mandir (AAM).

Specific objectives of the assessment are:

- To assess the infrastructure and facilities available at AAM/HWC.
 - To evaluate the quality and accessibility of expanded package of services offered at AAM/HWC.
 - To document best practices and challenges in operationalization of AAM/HWC.
 - To understand the stakeholder's perspective towards the functional AAM for service delivery including wellness component.
- 

Study design: Cross-sectional study with a mixed methodology approach.

Study Setting: Two states, namely Karnataka and Meghalaya are chosen for the study. Primary healthcare settings of two states were assessed in both urban and rural areas including AAM-UPHC, AAM-PHC, and AAM-SHC.

Inclusion criteria

- Facilities that have been converted into AAM/HWC.
- AAM/HWC operational for more than 1year.

Duration of the study: The study was conducted in the span of two months during which field visits were conducted in the month of April,2024.

Sample: A sample of total 24 facilities was taken including 13 SHCs, 6PHCs, 5UPHCs.

Sampling: Purposive sampling was done to select total of twelve health facilities from each state consisting of AAM-SHC, AAM-PHC and AAM-UPHC.

DATA COLLECTION AND ANALYSIS

Data collection

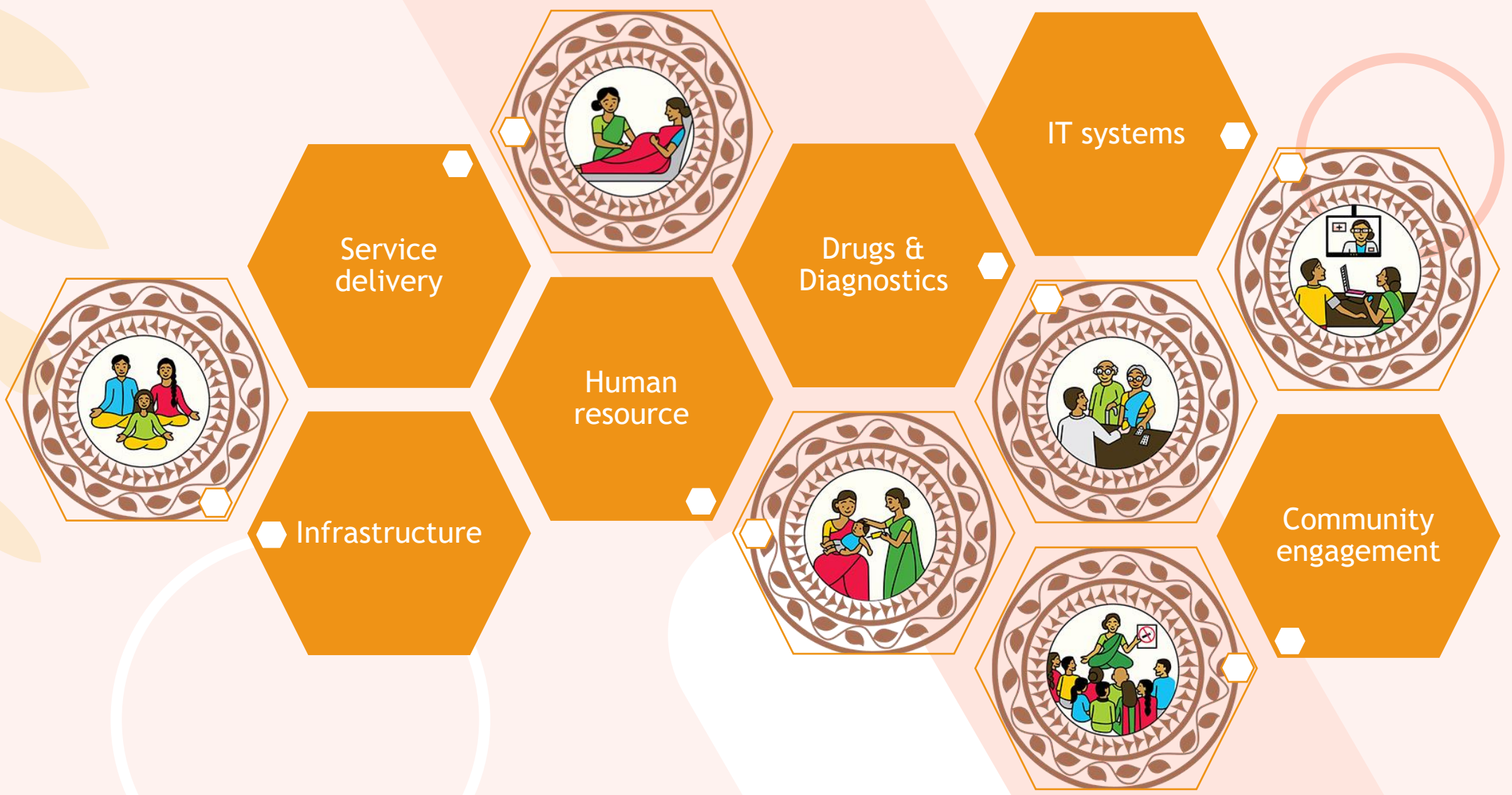
- Both primary and secondary data was collected for the rapid assessment of the AAM.
- A facility-based tool and checklist was used for all the target groups for the primary data collection.
- Interview guide was used to collect qualitative data from stakeholder's interviews of the healthcare staff and beneficiaries.
- Secondary data was taken from the AAM registers, AAM portal, facility reports, AAM assessment reports and available literature.

Data entry and storage

- Data was manually captured and then converted into excel sheets and stored digitally.
- Data was recorded under various key domains in excel spreadsheet for further processing and analysis.

Data analysis

- Quantitative Data: Data collected in this study was compiled, entered, and analyzed using MS-Excel. Descriptive statistics were employed to summarize the data. Measures of central tendency (median) was computed for continuous variables. The results were visualized using appropriate charts.
- Qualitative Data: Data derived from interviews was analyzed using thematic analysis. Themes were refined through an iterative process of reviewing and grouping based on similarity. The final themes were supported by direct quotes from participants, providing contextual insights into the study's findings and understand the stakeholders' perspectives and the overall functioning of the AAM facilities.



RESULTS

INFRASTRUCTURE

Status of Infrastructure	Karnataka	Meghalaya
Status of building ownership (<i>Government Owned/ Rented</i>)	Govt (12)	Govt (11/12), Rented (1/12)
Presence of boundary wall	Y	Y (10/12), Partial (1/12), N (1/12)
External branding undertaken as per guidelines	Y	Partial (branding for HWC is done)
Accessibility provisions for elderly/ people with disabilities (ramps at entry, wheelchairs etc.)	Y (8/12), N (4/12)	Y (7/12), N (5/12)
Continuous electricity supply including power backup of 8 hours	Y (10/12), N (2/12)	Y (12/12) (Solar)
Availability of potable water supply 24X7	Y (12/12)	Y (10/12), N (2/12)
Adequate space for patient examination with privacy	Y (11/12), N (1/12)	Y (10/12), N (2/12)
Adequate waiting space with seating arrangement for 20 users	Y (11/12), N (1/12)	Y (8/12), N (4/12)

INFRASTRUCTURE

Status of Infrastructure	Karnataka	Meghalaya
Adequate dedicated space for laboratory/ diagnostics services	Y (11/12), N (1/12)	Y (9/12), N (3/12)
Adequate dedicated space for pharmacy/ medicine dispensation	Y (10/12), N (2/12)	Y (8/12), N (4/12)
Adequate dedicated space/ room identified for Wellness activities	Y (7/12), N (5/12)	Y (6/12), N (6/12)
Functional toilet facilities- separate for male and female	Y (7/12), N (5/12)	Y (6/12), N (6/12)
Display of citizen charter at the facility	Y (9/12), N (3/12)	Y (10/12), N (2/12)
Display of health promotion / IEC material at the facility	Y (12/12)	Y (9/12), N (3/12)
Deep burial/ sharps pit for BMW Management	None (Managed by external hired agency)	Y (10/12), N (2/12)
Are residential facilities for staff available within premises	Y (3/12), N (9/12)	Y (12/12)

HUMAN RESOURCE & TRAINING

- During the assessment of health facilities in Karnataka and Meghalaya, it was found that all SHCs in both states have CHOs in place, along with Auxiliary Nurse Midwives (ANMs).
- In Karnataka, each SHC has only one ANM, whereas in Meghalaya, most SHCs have an adequate number of ANMs, except for one SHC.
- At the PHC/UPHC level, Medical Officers are present in four out of six facilities visited in Karnataka, while in Meghalaya, one UPHC lacked a Medical Officer among the five facilities assessed.
- Regarding the full complement of human resources at the PHC/UPHC level, Meghalaya has the required staffing (one Medical Officer (MBBS), two Nurses, one Lab Technician, and one Pharmacist) in 80% of the visited facilities, whereas Karnataka meets this criterion in 66.66% of its facilities.
- Training for Expanded Package of Services (EPS) is partially done for MOs, CHOs, ANMs and ASHAs in the visited health facilities with few packages lacking on training.
- Healthcare staff is aware about all the expanded package of services. However, training for Staff nurses at PHC level of facility is absent in many of them related to EPS in both states.

HUMAN RESOURCE	KARNAT AKA	MEGHAL AYA
Percentage of AAM - SHC with dedicated full time CHO	100% (6/6)	100% (7/7)
Percentage of AAM - PHC with dedicated full time MBBS MO as facility in charge	33.33% (1/3)	100% (3/3)
Percentage of AAM - UPHC with dedicated full time MBBS MO as facility in charge	100% (3/3)	50% (1/2)
Percentage of AAM- SHC with two ANM/MPWs	0% (None, all had one ANM/MP W) (0/6)	71.43% (5/7)
Percentage of AAM- PHC/UPHC with full complement* of HR.	66.66% (4/6)	80% (4/5)

SERVICE DELIVERY

Services has changed and revamped for a better turnout which is evident through increase in number of patients in OPD, services increased through expanded packages, continuity of care given through referrals and teleconsultations, changing perception towards AAM, increased awareness and promotion of health seeking behaviour through wellness sessions at AAM.

Stakeholder's perspective about AAM:

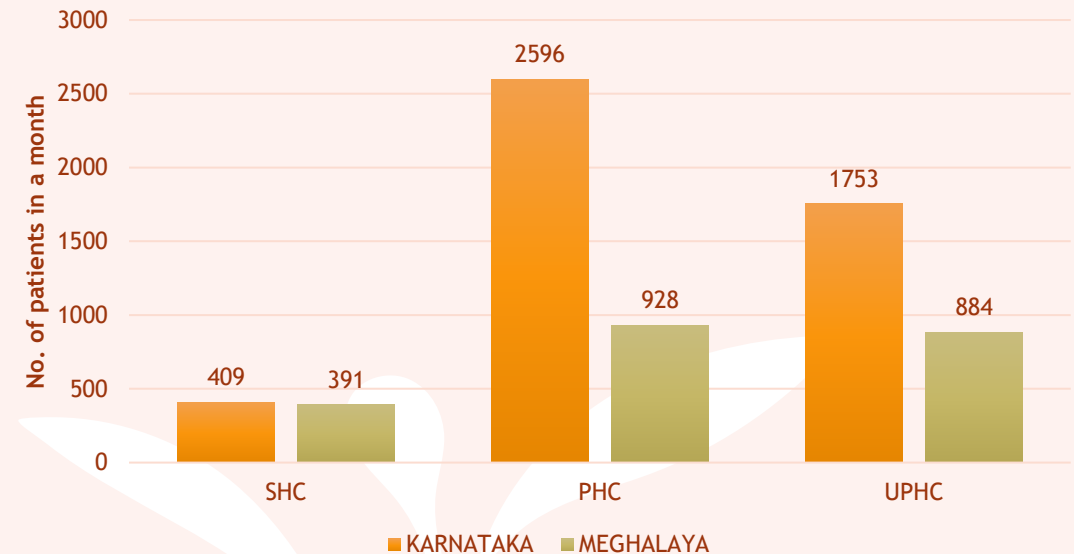
People's perception has changed towards HWCs, previously they used to think that quality services are not provided here, and they preferred private practitioners over us, but now patients have started coming to us. -MO from Meghalaya

Services are within the reach of community, Out of Pocket Expenditure (OOPE) is reduced because of availability of free medicines, quality of treatment has improved, and now comprehensive care can be given to patients. -CHO from Karnataka

Previously we used to think it is a centre for pregnant women, mothers, and children only, but now we know that we can also come here to get treatment and take medicines. -Beneficiary from Meghalaya

There's a notable increase in turnout for OPD services post launch of Comprehensive Primary Health Care services, with approximately 892 patients per month in Meghalaya PHCs/UPHCs and 365 per month in Meghalaya SHCs; 1955 patients per month in Karnataka PHCs/UPHCs and 431 in Karnataka SHCs.

OPD FOOTFALL/MONTH



Previously people were unaware about services provided at the health facility, OPD footfall was low, medicines were not available, but now people are happy with the transformation after which more services are present and free medicines are available for patients. -MO from Meghalaya

Services under RMNCAH+N: 3SHCs in Meghalaya are also conducting deliveries whereas none of the SHCs in Karnataka are delivery points. ANC check-ups are done routinely with regular follow up including identification of high-risk pregnancies and referral to higher centres. Immunization is also occurring regularly in both the states. Family planning preferred in Meghalaya are oral contraceptive pills (OCP) and Antara while Antara, chaya and IUCD in addition to condoms and OCPs are preferred choices in Karnataka.

Non-communicable disease services: All AAM centres offer services for non-communicable diseases, specifically hypertension (HTN) and diabetes mellitus (DM), including screening, management, and referrals. Revised CBAC forms are used as a community assessment tool for NCDs, helping frontline workers engage the community for facility-based screening. Medications for chronic conditions like HTN and DM are provided for one month, with regular follow-ups. Both states reported limited screening for breast, cervical, and oral cancers, with a stronger focus on diabetes and HTN than on cancer screening.

Services have improved significantly especially for non-communicable diseases (NCDs), people are more aware about services provided at PHC and are engaged in health seeking behaviour through wellness sessions provided here. -MO from Karnataka

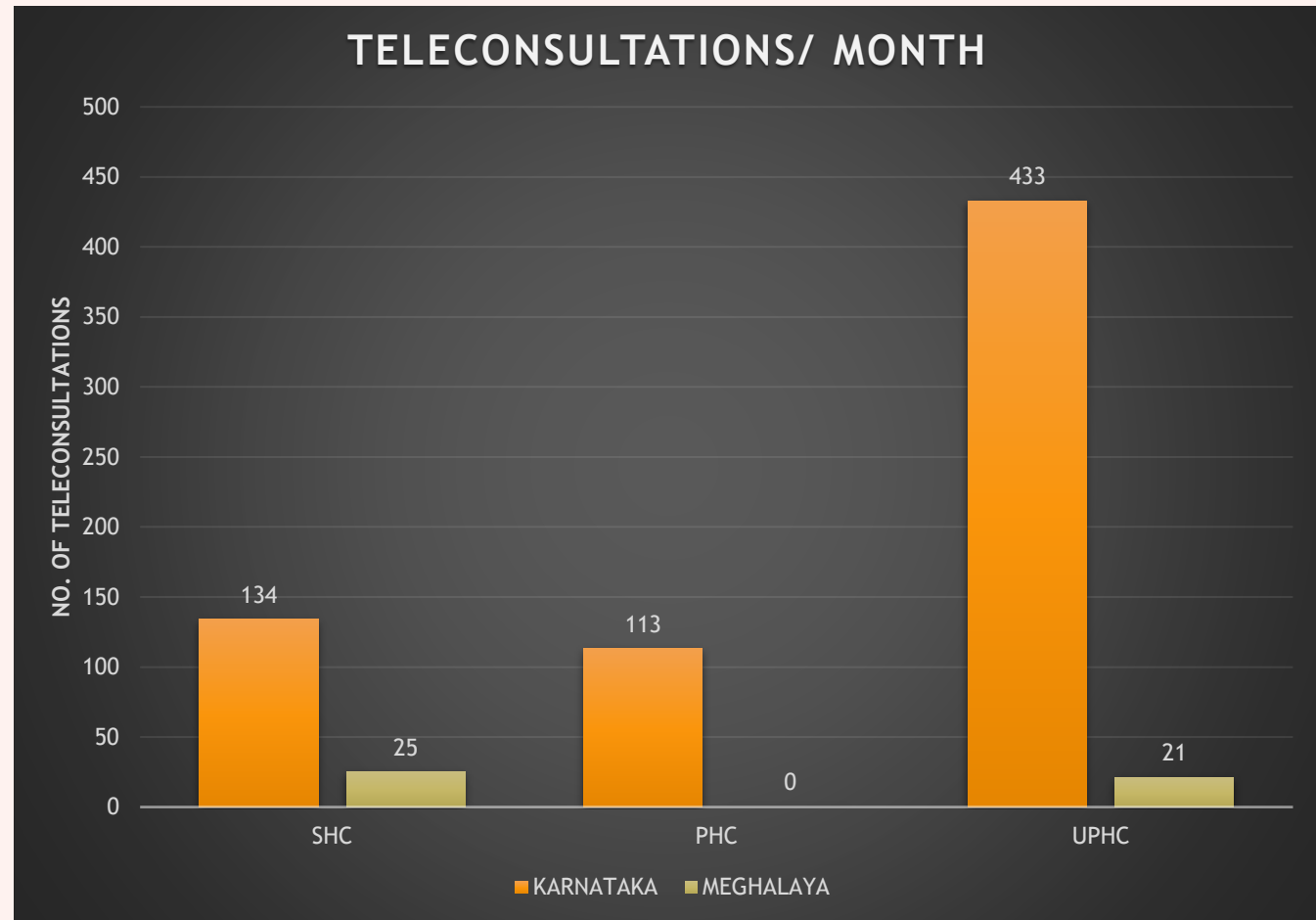
Services under Communicable diseases: The disease control program services including National Tuberculosis Elimination Program is found in the health facilities. The SHC-AAM collect the sputum samples and send them to nearby PHC-AAM for testing. The confirmed cases are being followed up for treatment compliance. Surveillance of infectious diseases at the community level to check and prevent spread of communicable diseases is conducted regularly. Multi-Purpose Workers-Male (MPW-M) is present in few facilities of Karnataka and awareness activities are conducted using IEC material at the community level.

Services under other Expanded packages: The expanded services were partially available at the visited facilities. The provision of expanded services mainly focuses on awareness generation and basic management of Eye/ENT/Oral/Emergency cases, with home-based care for the elderly as case need. Mental health package is not functional, no screening is happening for mental health ailments and lack of availability of drugs in the health facilities. Tele MANAS services have minimal presence and need to be strengthened. Services in Karnataka for other packages are better functioning as compared to Meghalaya as more specialized services are available through specialists' visits and teleconsultations happening routinely.

TELECONSULTATION SERVICES:

Teleconsultation services are available but are primarily limited to consultations with MO at PHC from SHCs, with specialist teleconsultation being negligible in Meghalaya. Teleconsultations are not much used by MO at PHC/UPHC level due to unavailability of specialists at the HUBs. Overall utilization of teleconsultation remains suboptimal because of network connectivity problems, lack of specialist availability, and a general preference for in person consultations.

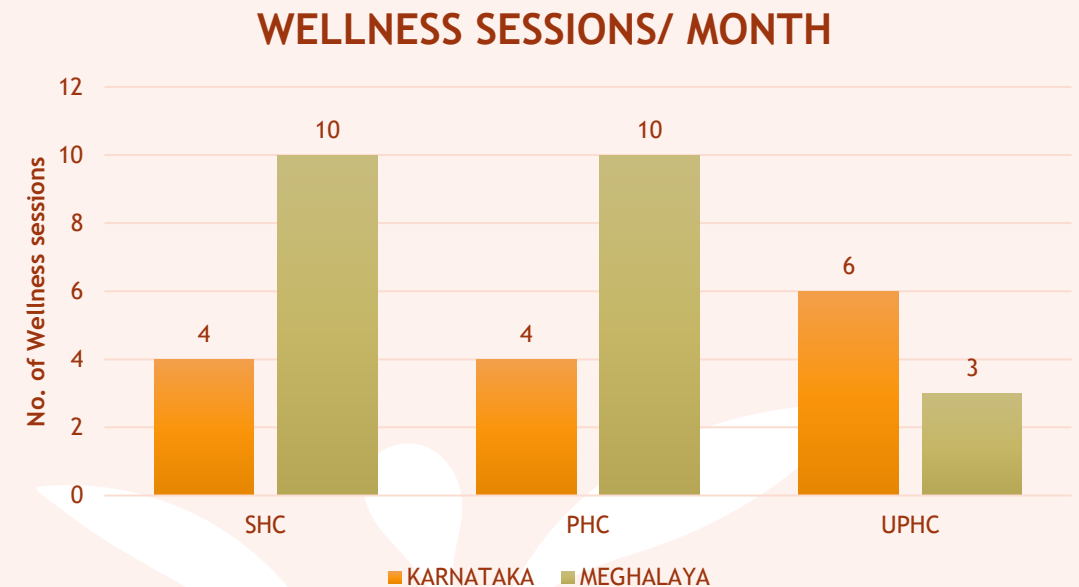
There is always a waiting period of half an hour or more to connect the call due to which patients become reluctant to use these teleconsultations. - CHO from Meghalaya



Teleconsultations are happening effectively in Karnataka as opposed to Meghalaya with much higher number on regular basis. Hubs are manned with specialists that are available and accessible. Online consultations are done to PHC from SHC and to specialists present at Hubs.

- **Continuum of Care:** Referral transport and continuum of care mechanisms are established, with patients mainly opting for upward referral to PHCs, CHCs or DH through physical consultations and teleconsultation, while downward referrals are done partially for limited services like chronic NCD patients, and they are managed by ASHA/ANM/CHO ensuring continuum of care.
- In Meghalaya, referrals are done to PHC/ CHC/ DH depending upon the proximity to the facility and urgency of the case because transportation is a challenge for patients of Meghalaya with ambulance services present in limited facilities.
- In Karnataka, majority cases are handled at the level of facility where the patient has arrived, but for complicated cases patients are appropriately referred to specialists present at the higher facility.

Wellness services: Wellness sessions like Yoga, exercises are being conducted regularly with increasing awareness about wellness component through AAM. Wellness sessions are conducted more in Meghalaya in comparison to wellness sessions in Karnataka. Few equipment like shoulder wheel is installed at all centres but the utilization is minimal.

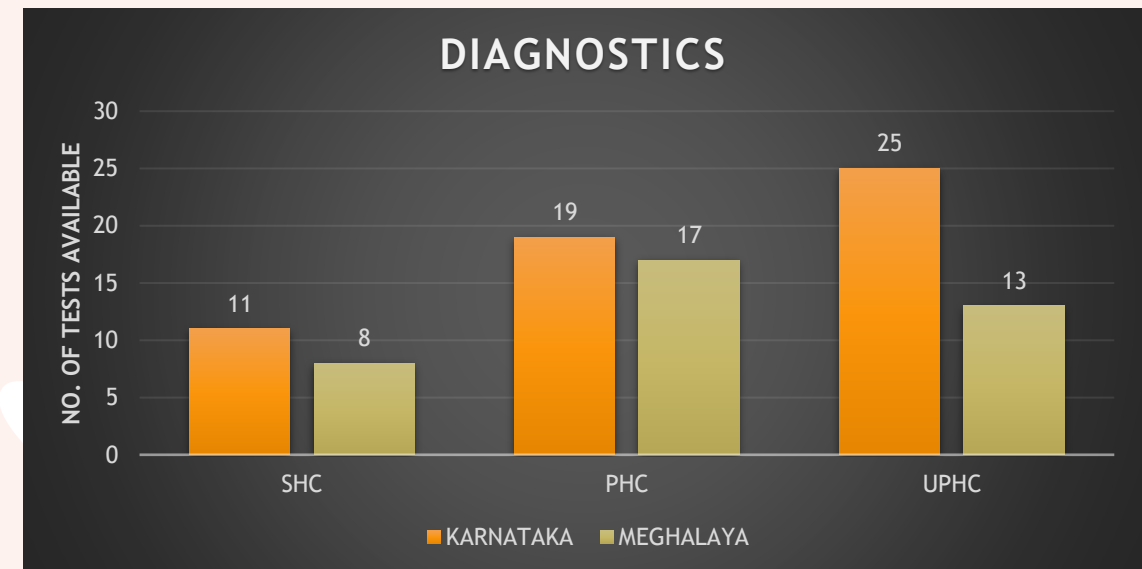
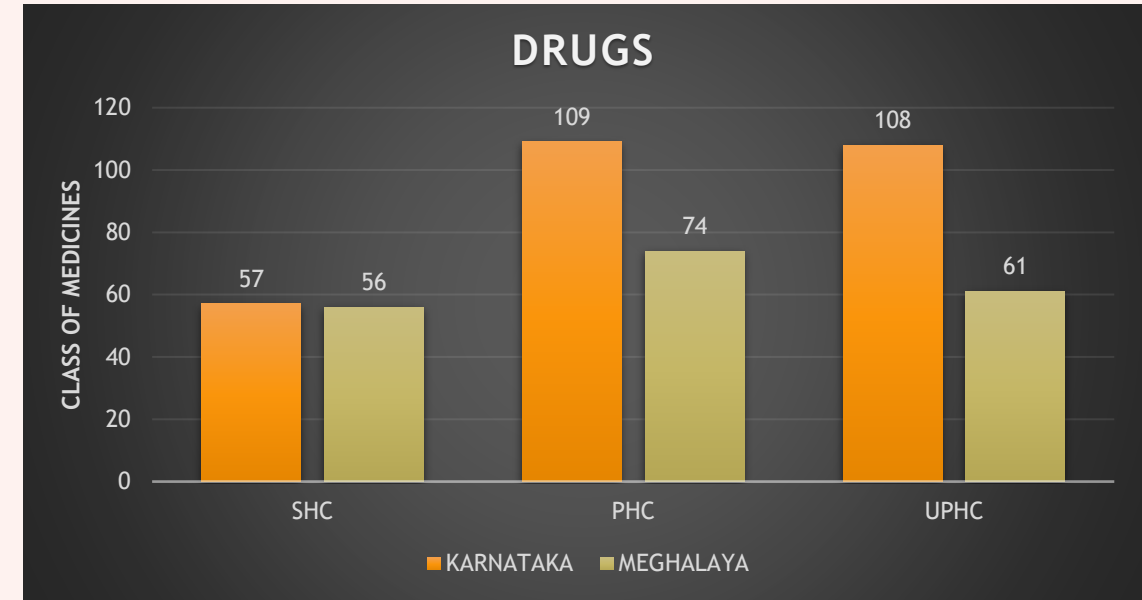


This is my fourth visit in this month, I live 500m away from here. I come here every Saturday morning for yoga session. -Beneficiary from Karnataka

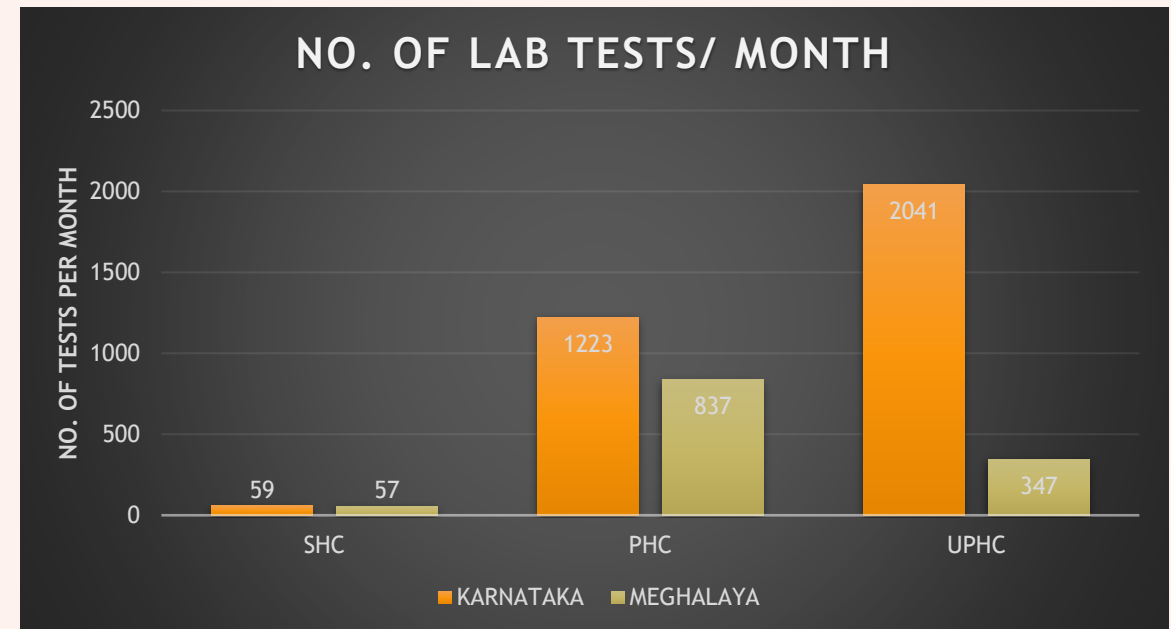
DRUGS & DIAGNOSTICS

- EML of SHC has 106 essential medicines and PHC/UPHC has 172 medicines.
- Only 16.66% of total 12 facilities are found to be having 80% of EML list in both Karnataka and Meghalaya.
- Diagnostic tests available at Sub Health Centres (SHCs) are 14 and 63 at Primary Health Centres (PHCs)/Urban Primary Health Centres (UPHCs).
- Only 25% of total 12 facilities are found to be having 80% diagnostic tests of total list in Karnataka and 16.66% in Meghalaya.

STATE	TYPE OF FACILITY	DRUGS	DIAGNOSTICS
KARNATAKA	UPHC	108	25
	PHC	109	19
	SHC	57	11
MEGHALAYA	UPHC	61	13
	PHC	74	17
	SHC	56	8



- In Karnataka, the medication supply chain management at the AAM-PHC and UPHC levels is facilitated through the Karnataka State Medical Supplies Corporation Limited (KSMSCL).
- Both SHCs and PHCs are found to be well adapted to usage of e-Aushadhi portal for indenting and procurement of drugs but two of the visited SHCs are still doing it manually. At PHC level 100% indenting is through e-Aushadhi portal while it is 66.66% at SHC level.
- In Meghalaya, indenting of drugs primarily occurs through offline modes (manually) for SHCs, while in PHC/UPHC, indenting is facilitated through Meghalaya Medical Drugs and Services Limited (MMDSL), in lieu of DVDMS system in Meghalaya.
- While MMDSL is 100% functional at PHC/UPHC level whereas at SHC level none of the facilities are using MMDSL for indenting.
- Inventory management in both the states is done as per significance and usability of drugs following the rule of FEFO (First Expiry First Out). Both states adhere to the principle of FEFO, ensuring that drugs are utilized based on their expiry dates.
- Sample transportation facility is present in 33.33% of SHCs in Karnataka and 28.6% in Meghalaya. At PHC/UPHC level, 66.66% of facilities has this provision in Karnataka while this number is lower in Meghalaya with 20% of facilities having transportation facility.
- The available diagnostics are used more efficiently in the state of Karnataka as compared to Meghalaya primarily because of a higher footfall in the facilities of Karnataka. This is evident from the higher number of tests done monthly in the facilities of Karnataka than in Meghalaya



IT SYSTEMS INTEGRATION

- A fully functional IT system can support the AAM team in planning, recording, monitoring, and management of delivery of all essential services.
- Both Karnataka and Meghalaya have adopted GoI's IT systems, portals, and applications to streamline health-related activities and improve data management including AAM portal, HMIS, NCD portal/app, RCH portal, ANMOL app, IHIP portal, Nikshay portal, e-Sanjeevani, e-Aushadhi, FPLMIS etc.
- This move towards digitalization includes strides taken to improve IT infrastructure, providing essential equipment such as laptop/desktop to MO, tablets to ANM and CHO, and smartphones to frontline workers.
- Both states are also taking initiatives and have developed their own specific portals and apps. In Karnataka, ASHA Soft, designed to capture detailed service information provided by ASHA workers, facilitate online payments to their bank accounts, and generate reports to monitor program progress, a pilot project known as CHO Soft is also underway in selected districts to facilitate Performance Based Incentives (PBI) for CHOs.
- In Meghalaya, state has introduced its own app, the MOTHER App, in lieu of the RCH portal and ANMOL App for tracking pregnant women. Healthcare staff prefers MOTHER App than RCH portal and ANMOL app. Efforts are underway to synchronize data with the RCH portal for consistency.

Stakeholder's perspective:

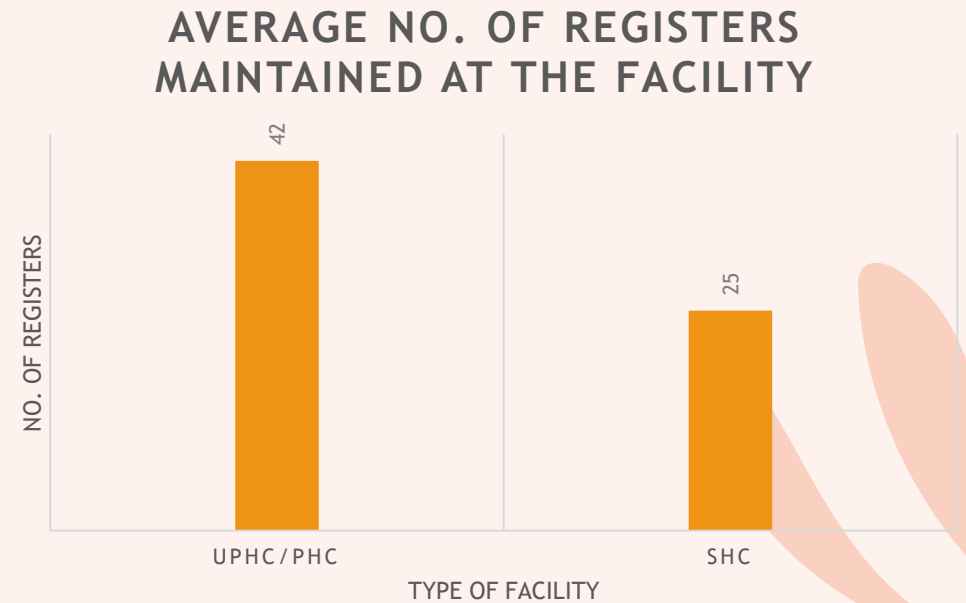
*There are too many portals and apps in addition to registers and paper records due to which data management and record maintenance becomes difficult and staff gets overburdened due to duplication of work. -**MO from Karnataka***

*We do use apps and portals, but we prefer register and paper-based records as it is easier to access them whenever we need it, which is not the case for digital data because of bad network connectivity we are unable to access them timely. -**CHO from Meghalaya***

*We are capable to use all the apps and portals efficiently without facing any problem, but we still have to enter same data on various portals as well as maintain registers too which becomes difficult along with our regular duties. -**ANM from Karnataka***

*It is easier to fill data manually in our registers and keep it with us during household visits, we don't know how to operate apps and portals to fill patients' data. -**ASHA from Meghalaya***

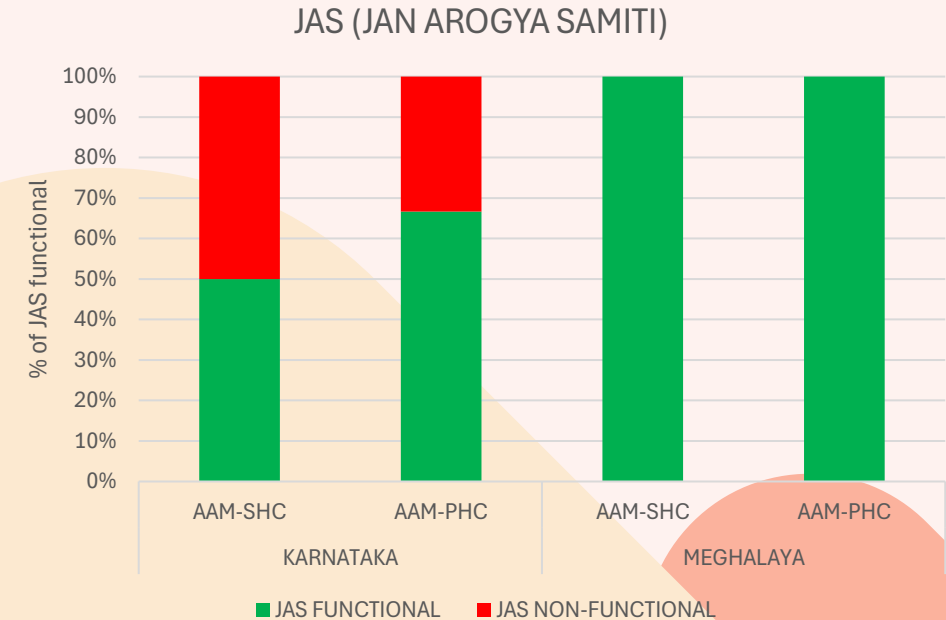
- However, despite the push towards digitalization, many health facilities still rely heavily on maintaining numerous physical registers.
- At the level of PHCs this number is much higher in Meghalaya ranging from 25-177 registers while in Karnataka this range is from 30-60 registers.
- At SHCs level, 20-35 registers are maintained in both the states. These large numbers of registers lead to duplication of data entries across multiple portals and physical registers, increasing the workload and potential for errors.



- The dual maintenance of manual and digital records is time consuming and burdensome for healthcare staff. There are inconsistencies between manual and digital entries resulting in inaccurate data.
- Healthcare workers struggle with managing multiple logins and data entries for various portals.
- Network connectivity is a major concern that hinders the data entry, teleconsultations and processing of claims and incentives for healthcare workers.
- Furthermore, Meghalaya has more persistent challenges in adapting digital system pushing them back to manual documentation as their preferred choice of data recording.
- Karnataka is found to be more digitally adaptive upto the level of ASHAs and is openly accepting digital record maintenance using portals and apps and requests elimination of physical documentation in paper format.

COMMUNITY ENGAGEMENT

- ❖ Community platforms play a crucial role in supporting and overseeing the healthcare system, enhancing both service delivery and utilization of public health facilities. These include Village Health Sanitation Nutrition Committees (VHSNCs) at the village level, Jan Arogya Samitis at Ayushman Arogya Mandir, Mahila Arogya Samiti (MAS) in urban areas, and Rogi Kalyan Samiti (RKS) at higher-level health facilities.
- ❖ They raise awareness about health issues and advocate for best practices in health, nutrition, water, sanitation, and other social determinants, encouraging active community involvement.
- ❖ In Meghalaya, JAS is 100% functional at the level of both SHCs and PHCs. Community participation is effectively done using community platforms like JAS, MAS, and VHSNC. VHND sessions are also happening regularly with more than 8 sessions conducted monthly in the health facilities in Meghalaya.
- ❖ In comparison, community platforms are found to be weak in Karnataka where only 50% SHCs and 66.66% PHCs JAS is found to be functional. While VHND sessions are happening regularly in health facilities of Karnataka, but community platforms like VHSNC, JAS and MAS are found to be lacking in many of them. RKS is present in few facilities. Untied fund is received under the Arogya Raksha Kosh (ARK)/RKS fund where JAS and MAS are absent in health facilities.



STRENGTHS & GOOD PRACTICES

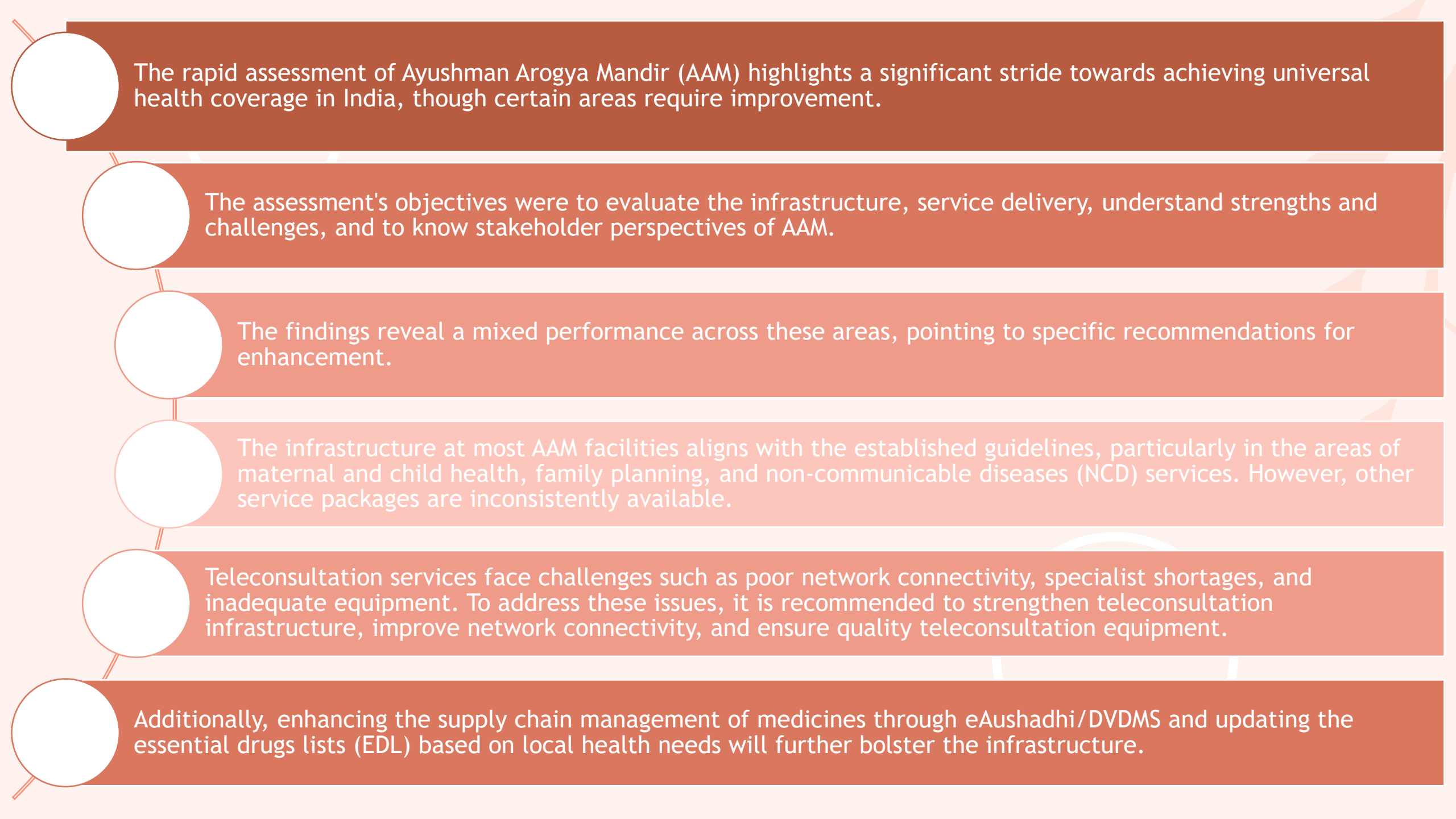
Meghalaya	Karnataka
ASHA First App: The state has successfully implemented the ASHA First App, facilitating Direct Benefit Transfer (DBT) payments to ASHAs. ASHAs can submit their claims directly through smartphones or laptops, ensuring timely payments and efficient financial management	ASHA SOFT: Implemented software system for managing incentive remuneration for ASHAs, streamlining administrative tasks and ensuring timely payments. Additionally, CHO SOFT is also started in some districts on a pilot basis to facilitate Performance Based Incentives (PBI) for CHOs.
BIOWAT: The introduction of the BIOWAT (Biodegradable Waste Treatment) facility at one of the PHC exemplifies innovative liquid waste management practices. This facility employs a four-stage treatment process, significantly enhancing waste management capabilities demonstrating a commitment to sustainable and environmentally friendly healthcare infrastructure.	Ayushmati Clinic: Established specialized care clinics to cater to specific healthcare needs, offering tailored services to patients.
Chief Minister's Safe Motherhood Scheme (CM-SMS): It has 4 components. i. Mobility support for pregnant women and families to access institutional delivery services. ii. Provision of transit homes for temporary accommodation near healthcare facilities. iii. Mobility support for Auxiliary Nurse Midwives (ANMs) to conduct home visits and Village Health and Nutrition Days (VHNDs). iv. Financial incentives for attendants, including Traditional Birth Attendants (TBAs) up to Rupees 1000, to encourage their participation and support for institutional delivery.	Mobile Dental Unit: Implemented mobile dental units to deliver specialized dental care to underserved populations, enhancing access to dental services.
Hospital Management Information System (HMIS): The implementation of the Hospital Management Information System facilitates the digitalization of healthcare records, enhancing data management and accessibility across Primary Health Centers (PHCs) and higher-level health facilities.	NAMMA Clinic are present to provide healthcare services to uncovered populations, addressing disparities in healthcare access
Meghalaya Medical Drugs and Services Limited (MMDSL): The initiative streamlines drug and medical equipment procurement, supply, and maintenance for state health facilities. By ensuring continuous access to essential medical supplies and enhancing service providers' skills in drug management, the initiative contributes to improved healthcare delivery and efficiency.	Regular follow-ups: The AAM team conducted regular follow-ups for high-risk cases such as TB and diabetes using patient monitoring report booklets, emphasizing proactive management and patient care.
	BIN cards: Maintained BIN cards to track drug consumption and monitor shortages of medicines, facilitating effective management of pharmaceutical supplies.

CHALLENGES

- Challenge persists to make all the expanded package of services fully functional especially mental health package which is not functioning properly in any of the visited facilities in both states.
- The duplication of data entry across multiple portals compounded operational challenges, exacerbated by the maintenance of multiple registers for the same data across various levels of healthcare delivery.
- With the operationalization of multitude of portals simultaneously, there was a lack of a centralized data entry point (absence of a single interface for data entry) means various portals and apps are not synchronized, further complicating data management processes.
- Network connectivity is a major concern which interrupts the data entry, teleconsultations and processing of claims and incentives for healthcare workers, especially in rural areas.
- Teleconsultation remains suboptimal because of network connectivity problems, lack of specialist availability, and bad quality equipment used for consultations.
- Limited Drugs and Diagnostic Services: drugs and diagnostics present are much lower than advised in the EDL list. The availability of drugs and diagnostic services are limited to more commonly used drugs and point-of-care tests, which may not always meet the comprehensive needs of patients.
- The visited facilities do not have a dedicated covered area for conducting yoga and wellness sessions.
- Deep burial/sharp pits are not available as per Bio Medical Waste (BMW) guidelines in Karnataka. Disposal of BMW is done by collection by BMW team regularly or as per requirement of the health facilities.
- The facilities visited are found to be lacking in quality certification especially in the state of Meghalaya where none of the visited facilities are certified.

CONCLUSION





The rapid assessment of Ayushman Arogya Mandir (AAM) highlights a significant stride towards achieving universal health coverage in India, though certain areas require improvement.

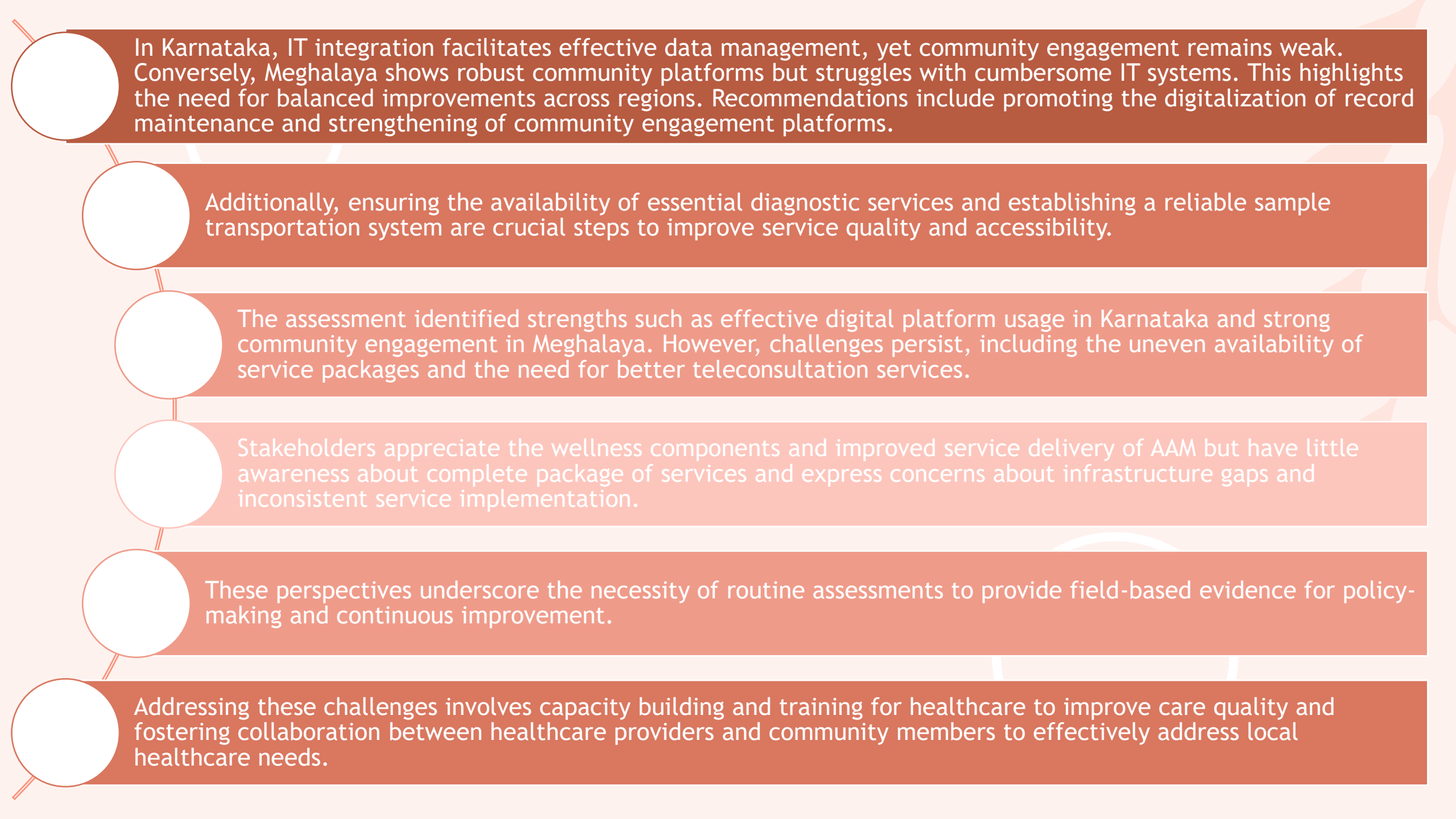
The assessment's objectives were to evaluate the infrastructure, service delivery, understand strengths and challenges, and to know stakeholder perspectives of AAM.

The findings reveal a mixed performance across these areas, pointing to specific recommendations for enhancement.

The infrastructure at most AAM facilities aligns with the established guidelines, particularly in the areas of maternal and child health, family planning, and non-communicable diseases (NCD) services. However, other service packages are inconsistently available.

Teleconsultation services face challenges such as poor network connectivity, specialist shortages, and inadequate equipment. To address these issues, it is recommended to strengthen teleconsultation infrastructure, improve network connectivity, and ensure quality teleconsultation equipment.

Additionally, enhancing the supply chain management of medicines through eAushadhi/DVDMS and updating the essential drugs lists (EDL) based on local health needs will further bolster the infrastructure.



In Karnataka, IT integration facilitates effective data management, yet community engagement remains weak. Conversely, Meghalaya shows robust community platforms but struggles with cumbersome IT systems. This highlights the need for balanced improvements across regions. Recommendations include promoting the digitalization of record maintenance and strengthening of community engagement platforms.

Additionally, ensuring the availability of essential diagnostic services and establishing a reliable sample transportation system are crucial steps to improve service quality and accessibility.

The assessment identified strengths such as effective digital platform usage in Karnataka and strong community engagement in Meghalaya. However, challenges persist, including the uneven availability of service packages and the need for better teleconsultation services.

Stakeholders appreciate the wellness components and improved service delivery of AAM but have little awareness about complete package of services and express concerns about infrastructure gaps and inconsistent service implementation.

These perspectives underscore the necessity of routine assessments to provide field-based evidence for policy-making and continuous improvement.

Addressing these challenges involves capacity building and training for healthcare to improve care quality and fostering collaboration between healthcare providers and community members to effectively address local healthcare needs.

RECOMMENDATIONS

- ✓ **Capacity Building and Training:** Advocate for increased training opportunities focused on an expanded range of healthcare packages, with regular refresher sessions to ensure healthcare workers' proficiency.
- ✓ **Digitalization of Record Maintenance:** Transition to digital platforms for register maintenance at every data entry point, promoting appbased data entry to streamline administrative processes and improve accuracy.
- ✓ **Unified Portal System:** Implement a single data entry point for all portals to simplify administrative processes and enhance efficiency in data management.
- ✓ **Strengthening Teleconsultation Services:** Improve network connectivity, upgrade teleconsultation equipment, and promote specialist teleconsultation services. Strengthen Tele MANAS services with grassroots level awareness campaigns.
- ✓ **Strengthening eAushadhi/DVDMS:** Ensure continuous supply chain management of medicines at the AAM-SHC level.
- ✓ **Revision of Essential Drugs Lists (EDL):** Revise national and state EDLs based on local needs, with demand-based drug indenting tailored to local disease prevalence for efficient inventory management.

RECOMMENDATIONS

- ✓ **Diagnostic Services:** Ensure that minimum essential diagnostic tests are available at all facility levels per IPHS guidelines. Equip healthcare facilities with essential equipment and ensure regular maintenance. Ensure availability of diagnostics as per FDSI, either through strengthening in-house, or adopting PPP.
- ✓ **Sample Transportation System:** Establish a robust system for sample transportation to enhance service delivery.
- ✓ **Enhanced IEC Visibility:** Increase the visibility of Information, Education, and Communication (IEC) materials for expanded services, making them more pictorial for better understanding and avoiding overcrowding of IEC material.
- ✓ **NQAS Certification:** Address gaps for NQAS certification and improve the quality of care provided to patients.
- ✓ **Community Engagement:** Promote community engagement by accelerating the formation of Jan Arogya Samiti (JAS) and Mahila Arogya Samiti (MAS) associated with all the health facilities, fostering collaboration between healthcare providers and community members to address local healthcare needs effectively.

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THANK YOU

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