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Implementation status of Health and Wellness Centers in a community development block of West Bengal: A mixed-method study

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ABSTRACT

Background: Ayushman Bharat is a Flagship Program in India to deliver an expanded range of free health-care services to all. Despite quality health care being a fundamental human right, rural India still grapples with its accessibility. To address this, the Indian Government aims to transform government primary health-care facilities into Health and Wellness Centers (HWCs) for comprehensive health-care delivery. **Aims and Objectives:** This study was done to assess the implementation status of HWCs and to explore the challenges faced by service providers during service delivery in the Bhatar Community Development block of Purba Bardhaman district. **Materials and Methods:** A facility-based, mixed-method study was conducted in Bhatar block, West Bengal from October 22 to February 23. For quantitative component, the implementation status of 12 HWCs was assessed using the national quality assurance standard checklist. For qualitative component, in-depth interview with Community Health Officers (CHOs) was done to explore the constraints. **Results:** Among 12 HWCs, 8 (66.67%) scored satisfactorily (≥70%) in overall score. Service provision, clinical services, infection control, and output were among the 8 areas of concern where all HWCs scored satisfactorily (≥60%) while input scored lowest (mean [SD] - 60.58 [9.53]). Among 12 themes, elderly and palliative health care, emergency medical services, and management of mental health ailments were lowest scoring with no HWC crossing satisfactory score (≥70%). Thematic analysis revealed that inadequate infrastructure, resource constraints, administrative and managerial constraints, lack of motivation and inadequate health promotion, and community participation were major constraints faced. **Conclusion:** Various challenges need to be addressed, including improving infrastructure, enhancing access to medicines and supplies, providing adequate training to CHOs, and increasing community participation.

Key words: Challenges; Community health officer; Implementation status; Health and wellness center; Rural health care

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INTRODUCTION

Primary health-care (PHC) system in India has evolved since independence and Government PHC facilities (GPHCFs) played a significant role in India's achievements in health care.[1] Existing GPHCFs delivered a narrow range of services, mainly focused on maternal and child health, adolescent services, and health programs. Although the primary health-care services provided through PHCs can play a critical role in bringing down the outpatient department care cost as it can address 80% of people's health needs,[2] GPHCFs in India are grossly underutilized and only 11.5% of rural and 3.9% urban people in need of health services used this vast network in 2013–2014 excluding for mother and child health services.[3] All other people either choose higher level of Government facilities (increasing burden) or attend private facility (increasing out-of-pocket expenditure), both situations are bad for well-

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functioning health-care system.[1] National Health Policy (NHP) 2017 proposed to strengthen PHC systems by investing two third or more government health spending on PHC.[1] It endorsed the establishment of Ayushman Bharat Health and Wellness Centers (AB-HWCs) and committed that two thirds of budget should be allocated toward PHC.[4]

Under the first component of Ayushman Bharat, 150,000 Health and Wellness Centers (HWCs) will be created to deliver comprehensive PHC (CPHC) that is universal and free to users, with focus on wellness and delivery of an expanded range of services.[5] Services in AB-HWCs at the Sub-Health Center (SHC) level would be provided by appropriately trained health-care team led by Community Health Officer (CHO) and multipurpose workers and ASHAs.[6,7]

HWCs are not new facilities but are upgraded version of GPHCFs such as health subcenters (SCs), PHCs, and Urban Primary Health Centers (UPHCs). Although there was slowdown in setting up of HWCs due to COVID-19 pandemic, the Government reached the target in March 2021. At present, a total of 1,59,750 HWCs are functional in India[5] (March 31st, 2023). At present, 7289 HWCs are functional in West Bengal[5] (5935 SHCs, 915 PHCs, and 439 UPHCs) and 286 in Purba Bardhaman district.[5]

At this nascent stage of operationalization of HWCs, the current study was done to find the implementation status of HWCs in Bhatar Community Development block of Purba-Bardhhaman district in terms of key parameters such as physical infrastructure, human resource, supplies, health promotion, service delivery, and the various problems faced by service providers.

It has been long since there were attempts from high echelons of the governmental leadership to bring forth a newfound increase in quality in PHC through HWCs, yet little is brought to knowledge as to how effective this transformation has been and what challenges are faced by practitioners while providing services in rural settings. In this regard, the current study followed a mixed-method approach to have a comprehensive assessment of the operational status, quality of services, and perceptions of the community regarding HWCs. The findings were expected to inform international policymaker, health practitioners, and stakeholders to ensure effective and flawless health-care delivery to all. These information would also play a vital role in optimal implementation of the Ayushman Bharat program.

Aims and objectives

This study aimed to assess the implementation status of Health and Wellness Centres and to explore the challenges faced by service providers during service delivery in the Bhatar Community Development Block of Purba Bardhaman district.

MATERIALS AND METHODS

A parallel mixed-method study design was used, as data for quantitative and qualitative part was collected simultaneously and mixing of data was done at interpretation level. Quantitative part was of cross-sectional descriptive design.

The study was conducted from December 2022 to June 2023 in Bhatar Block of Purba-Bardhaman district, West Bengal, which serves as the rural field practice area for the Department of Community Medicine, Burdwan Medical College (BMC), and comprises one Rural hospital, 6 PHCs, 55 SCs (including 25 HWCs), and 14 Gram Panchayats.[8]

To assess the current situation, this study focused on HWCs operational for over 6 months (as of December 1st, 2022). Out of 16 upgraded HWCs, 4 without CHOs during the study were excluded, resulting in a final sample size of 12.

CHOs posted in these 12 HWCs and working for at least 3 months were interviewed in depth to explore constraints and challenges regarding service delivery till data saturation.

To assess implementation status, National Quality Assurance Standard (NQAS) checklist was used. It consists of eight areas of concerns[9] and, in each segment, there are multiple standards and variables; each point was assessed and marks allocated as 0/1/2 (for non-compliance, partial compliance, full compliance). Each point assessment was done by either staff interview or record review or observation (OB) method as per the direction in checklist. In this process score of all eight individuals, area of concerns was obtained and summed up, and total score was calculated in percentage. Score of 12 themes was also obtained from the checklist. Ethical clearance was obtained from institutional ethics committee (IEC) of BMC (Memo-BMC/IEC/219, Dated: April 20, 2023). Informed consent was obtained from CHOs. Collected data was entered and analyzed in Excel (Version-2018). For qualitative part, inductive thematic analysis was done using Nvivo (release 1.0, QSR International).

RESULTS

Quantitative findings

Overall score of HWCs

Out of 12 HWCs, 8 (66.67%) centers scored ≥70% in overall score and rest 4 (33.33%) scored <70% (≥70% overall score was taken as satisfactory).[10] For better

understanding of the findings of this study, these 12 HWCs were divided under two categories, category I consists of the 8 HWCs that scored ≥70% and rest under category II. Mean overall score for category I HWCs was 79.62 with SD±5.26 and for category II, mean score was 64.75 with SD±2.63.

Area of concern-wise score

All 8 HWCs under category I scored satisfactorily (≥60%) in all 8 areas of concern except for one HWC that scored ≤60% in quality management system. All 4 category II HWCs scored satisfactorily in service provision, clinical services, infection control, and output. None of the category II HWCs scored satisfactorily (≥60%) in inputs and support services. Mean value of input area of concern was lowest in both categories. Higher mean values were found in clinical services, infection control, and output area of concern among both categories (Table 1).

Theme-wise score

Score of all HWCs was satisfactory (i.e., ≥70%) in care in pregnancy and childbirth, neonatal and infant health services, childhood and adolescent health services, family planning, and management of communicable diseases. None of the HWCs scored ≥70% in elderly and palliative health care, emergency medical services, and management of mental health ailments. Higher mean values were found in care in pregnancy and childbirth, neonatal and infant health services, and childhood and adolescent health service themes in both the categories of HWCs. Mean values of emergency medical services and management of mental health ailment were lower in both categories (Table 2).

Qualitative findings

The results of the qualitative part have been presented by themes and subthemes as well as hierarchical cluster analysis of themes and subthemes was shown by a sunburst chart. The hierarchical cluster analysis explains how these factors (themes) relate each other and shows the relative importance of the different facets of the challenges as per study subjects' perspectives. "COnsolidated criteria for REporting Qualitative

Table 1: Distribution of mean (SD) of area of concern-wise scores in NQAS checklist among study facilities (n=12)**

AREA of concern	Category I HWC (n=8)		Category II HWC (n=4)		Total (n=12)	
	Score ≥60%*	Mean (SD**)	Score ≥60%*	Mean (SD**)	Score ≥60%*	Mean (SD**)
Service provision	8 (100)	72.87 (5.36)	4 (100)	65.75 (2.62)	12 (100)	70.5 (5.69)
Inputs	8 (100)	66.5 (3.42)	0 (0)	48.75 (5.06)	8 (66.66)	60.58 (9.53)
Patient rights	8 (100)	76.87 (6.47)	3 (75)	58.75 (9.46)	11 (91.66)	70.83 (11.43)
Support services	8 (100)	86.25 (5.94)	0 (0)	48.25 (4.11)	8 (66.66)	73.58 (19.42)
Clinical services	8 (100)	83.25 (5.6)	4 (100)	76 (1.82)	12 (100)	80.83 (5.79)
Quality management system	7 (87.5)	72.37 (13.02)	2 (50)	59.5 (4.93)	9 (75)	68.08 (12.44)
Infection control	8 (100)	79.87 (10.41)	4 (100)	70.25 (3.86)	12 (100)	76.67 (9.77)
Output	8 (100)	88.75 (7.53)	4 (100)	78.75 (6.18)	12 (100)	85.41 (8.41)

**SD: Standard deviation, *≥60% score is the cut-off for satisfactory implementation of areas of concern,[10] NQAS: National quality assurance standards, HWC: Health and wellness centers

Table 2: Distribution of mean (SD) and range of theme-wise scores in NQAS checklist among study facilities (n=12)**

Theme	Category I HWC (n=8)		Category II HWC (n=4)		Total (n=12)	
	*Score ≥70%	Mean (SD**)	*Score ≥70%	Mean (SD**)	*Score ≥70%	Mean (SD**)
Care in pregnancy and childbirth	8 (100)	93.12 (4.45)	4 (100)	93.75 (0.5)	12 (100)	93.33 (3.57)
Neonatal and infant health services	8 (100)	93.13 (4.91)	4 (100)	95.75 (2.75)	12 (100)	94 (4.37)
Childhood and adolescent health services	8 (100)	92 (5.04)	4 (100)	96.25 (2.87)	12 (100)	93.42 (4.77)
Family planning	8 (100)	88.37 (7.27)	4 (100)	83.75 (4.71)	12 (100)	86.83 (6.7)
Management of communicable diseases	8 (100)	88 (7.17)	4 (100)	87.25 (1.7)	12 (100)	87.75 (5.8)
Management of non-communicable diseases	5 (62.5)	74.87 (8.27)	3 (75)	73.75 (6.29)	8 (66.66)	74.5 (7.39)
Care for common ophthalmic and ENT	5 (62.5)	71.12 (4.42)	0 (0)	51.25 (6.65)	5 (41.66)	64.5 (10.97)
Oral health care	8 (100)	83.37 (5.2)	2 (50)	73.25 (11.06)	10 (83.33)	80 (8.69)
Elderly and palliative health care	0 (0)	50.38 (12.34)	0 (0)	36.5 (4.65)	0 (0)	45.75 (12.22)
Emergency medical services	0 (0)	50 (12.96)	0 (0)	29.5 (8.96)	0 (0)	43.17 (15.19)
Management of mental health ailments	0 (0)	43.87 (10.2)	0 (0)	39.5 (12.12)	0 (0)	42.42 (10.53)
Drugs and diagnostics	2 (25)	68.5 (2.26)	0 (0)	46.5 (4.2)	2 (16.66)	61.17 (11.2)

**SD: Standard deviation, *≥70% score is the cut-off mark for satisfactory implementation of themes[10], HWC: Health and wellness centers, NQAS: National quality assurance standards

research (COREQ)"[11] guidelines were followed during reporting.

CHOs were interviewed in depth for this study, till there was data saturation on simultaneous analysis. The one-to-one interviews of nine in-depth interviews were audio-taped with proper consent. Handwritten notes were also taken simultaneously. Collected notes and audio records were gone through word by word and then transcribed into verbatim. The transcripts were again read multiple times to gain familiarity and then compared with the handwritten notes. This was done to ensure that the data were captured with those non-verbal responses. The transcripts were then coded inductively. Finally, the coded texts were condensed into different themes and subthemes (Figure 1).

Mixed-method findings

A joint display containing the quantitative and qualitative findings regarding the extent of implementation and the challenges faced by service providers regarding those areas of concern or standards is given for understanding of the current scenario (Table 3).

DISCUSSION

The Alma Ata Declaration,[12] the Astana Declaration,[13] and the Indian NHP of 2017[14] all stressed the need for universal

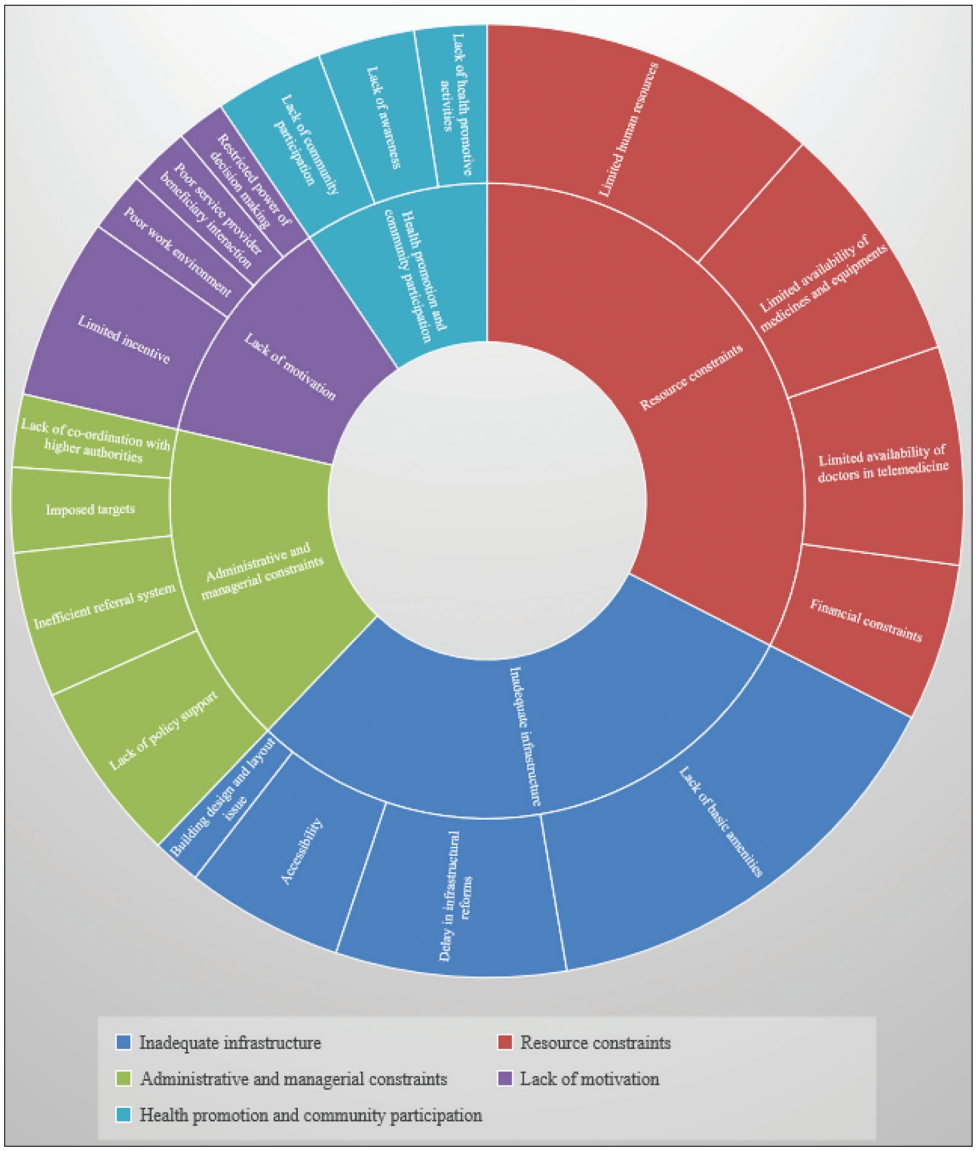

Figure 1: A sunburst chart that depicts relative contribution of the five major themes and various subthemes that emerged from analysis of in-depth interviews. The inner circle of the chart consists of themes and the surrounded outer circle contains the deeper hierarchy level, i.e., subthemes. The angle of each segment is proportional to the representative data weightage. Each theme and the subthemes under it are different color coded

Table 3: Joint display of quantitative and qualitative findings regarding the extent of implementation and challenges faced by service providers

Area of Concern/standards according to NQAS checklist	Extent of implementation		
	Quantitative findings		Qualitative findings#
	Overall mean (SD**)	Implementation status*	
Inputs			
Adequate and safe infrastructure	67.83 (9.53)	Satisfactory	• Old building • Inadequate space • Lacking boundary wall
Adequate qualified and trained staff	79.91 (7.52)	Satisfactory	• Received initial training • Irregular training on updates • All facilities having one ANM
Drugs and consumables	50.67 (12.12)	Not satisfactory	• Stock out situations • Shortage of parenteral/emergency drugs
Functional equipment and instruments	42.5 (10.55)	Not satisfactory	• Delay in repair/replace
Patient rights			
Information about available services	61.75 (14.59)	Satisfactory	• Diagnosis, treatment plan, and entitlements were informed • Lacks citizen charter and IEC materials
Accessibility of services	58 (9.95)	Not satisfactory	• Not accessible to old, ambulatory, or sight and hearing disable individuals • Conduct outreach sessions
Privacy, confidentiality, and dignity	86.41 (18.22)	Satisfactory	• Separate examination area/room absent
Free delivery of services	95 (6.74)	Satisfactory	• Services provided free of cost • Irregular ambulance service
Support services			
Maintenance and upkeep	75 (18.91)	Satisfactory	• Poor maintenance of infrastructure
Storage, inventory management and dispensing of drugs	82.58 (11)	Satisfactory	• Irregular supply of drugs
Progressive use of digital technology	80.75 (22)	Satisfactory	• Records maintained using IT platforms • Non availability of doctors for tele-consultation
Transparency and accountability	61.33 (30.08)	Satisfactory	• Non-functional Jan Arogya Samiti • Inadequate monitoring and support
Clinical services			
Continuity of care through two-way referral	82.33 (7.86)	Satisfactory	• Inefficient referral system
Emergency care	45.16 (22.17)	Not satisfactory	• Lacks training and equipment
Management of ophthalmic, oral and ENT ailments	69 (12.27)	Satisfactory	• Basic screening done
Screening and basic management of mental health ailments	32.5 (13.56)	Not satisfactory	• Inadequate training and experience
Elderly and palliative care	44.66 (15.42)	Not satisfactory	• Lacks manpower for home based care
Care of new-born, infant, and child	94.58 (5.07)	Satisfactory	• Has established procedure and follows protocols
Family planning services	86.25 (7.25)	Satisfactory	• Some centers lack setup for IUCD insertion and sterilization
Antenatal care	95.66 (4.88)	Satisfactory	• Trained personnel and follows well-established procedure
Intranatal care	0	None	• No provision for admission and delivery
Postnatal care	77.08 (24.9)	Satisfactory	• Inadequate manpower
Infection control			
Personal protection equipment	64 (18.59)	Satisfactory	• Inadequate supply of gloves, mask, and apron
Disinfection and sterilization of equipments	69.58 (21.04)	Satisfactory	• Non-functional sterilizer • Inadequate supply of disinfectant

**SD: Standard deviation, *≥60% score is the cut-off for satisfactory implementation of individual standards,[10] #Qualitative findings shown are overall response and not applicable for all centers, NQAS: National quality assurance standards, IEC: Institutional ethics committee

health coverage (UHC). Under the Government of India's flagship program, Ayushman Bharat, SCs are upgraded to HWCs, which are a strong step toward strengthening CPHC to achieve UHC. The process of converting SCs to HWCs is ongoing and requires cautious implementation across the country. The current study assessed the extent to which HWCs adhere to the National guidelines and to identify the operational challenges faced by service

providers that need to be addressed for the smooth functioning of these centers.

The available literature on the evaluation of HWCs mainly consists of opinions, critiques, and editorial pieces, with a notable absence of original research studies. This study, however, provides an actual portrayal of the situation and shares its findings, which should be given precedence in the development of future strategies. 66.7% of the HWCs scored satisfactorily while assessed using NQAS checklist. Inputs and support services were the major lacking areas among the centers that failed to reach a satisfactory score. Similar findings were seen in the qualitative part as inadequate infrastructure and resource constraints were major challenges faced. Poor condition of building, accessibility, and lack of basic amenities were major issues. Under resource constraints, supply of medicines, shortage of manpower, and financial constraints were the challenges faced. A study on PHC system[15] found that, physical infrastructure and human resource were the most challenging constraints faced by service providers. In a similar study done in Punjab[16] observed that only 7 of the 26 HWCs had all human resources as per guidelines and only 9 out of the 15 standalone HWCs had independent building. The study conducted in HWCs that were functional for at least 6 months revealed that there was deployment of CHOs in almost all centers but all centers had only one ANM. The HWCs offered outpatient services and screened for non-communicable diseases, as well as providing the traditional maternal and child health-care services. However, there is a need to continue improving and expanding these services to encompass the other five packages of CPHC, and ensure that the HWCs are equipped to meet the health needs of their local communities. Out of the 12 themes of NQAS checklist, elderly and palliative health care, emergency medical services, and management of mental health ailments were the areas where none of the HWCs scored satisfactorily. Inadequate training and lack of equipment were found to be main reason. Swain et al.[17] reported similar findings, highlighting the importance of not just the quantity but the quality of staff, emphasizing that personnel should be effectively trained and well-oriented to their responsibilities. An OB was made that building a sense of teamwork among the staff was necessary, along with a shift in focus toward the concept of team incentives. Although the HWC program considers the philosophy of teamwork as a strength, conflicts between various staff members pose a threat to the initiative. Another study[18] with similar results suggested that providing regular training, fostering cooperation among staff members, and receiving support from higher authorities could enhance the performance of CHOs and HWCs. A study done in PHC setting in Nepal[19] found the main barriers as shortage of medicine, lack of private space for counseling, workload, and health workers' grievances regarding incentives, similar to the findings of this study.

To ensure a continuum of care, it is necessary to establish a reliable referral system that can connect patients referred to higher facilities. This is particularly important now that the emphasis is on long term rather than fragmented care. Strengthening secondary and tertiary care facilities is crucial for maintaining public trust in the health-care system and ensuring its continued use. Successful primary health-care models have always relied on community engagement, which is why it is important to prioritize it by actively involving community members in HWC activities. This can be achieved by increasing health literacy, promoting feedback on services, and involving the community in decision-making regarding service delivery.

The AB-HWC initiative is regarded as the second most important health system reform, after the National Health Mission. To accomplish the goal of CPHC, issues with funding, human resources, and service delivery pathways must be resolved. To strengthen CPHC, our study has shown important areas for development as well as challenges that must be overcome. During the implementation phase, a methodical and proactive approach to tackling these crucial areas will help to remove technical and organizational inefficiencies and accelerate the conversion of policy into practice. Both supply-side and demand-side interventions are necessary for AB-HWCs to be successful. These interventions include raising infrastructure and consumables spending, developing staff capacity, utilizing information, and communication technologies appropriately, involving the community, offering locally tailored services to meet population needs, and establishing efficient referral networks. These problems must be solved to improve patient satisfaction, service quality, and utilization. This will increase population coverage, lower out-of-pocket costs, free up space in secondary and tertiary care institutions, and eventually lead to universal health coverage.

Limitations of the study

This study, being cross-sectional, provides a snapshot of the conditions at the time of data collection. Since health system is currently undergoing significant changes, continuous monitoring may be needed to fully understand these changes. Due to feasibility constraints, data was collected from only one community development block, which may not represent the situation across the entire country.

CONCLUSION

Although significant progress has been made toward the implementation of HWCs in rural India, there are still

various challenges that need to be addressed, including improving infrastructure, enhancing access to medicines and supplies, providing adequate training to CHOs, and increasing community participation.

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