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BRIDGING THE GAP: UNDERSTANDING DEMAND-SIDE BARRIERS TO PRIMARY HEALTH CARE ACCESS THROUGH AYUSHMAN BHARAT IN RURAL DISTRICT RAJGARH (MP)

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ABSTRACT

This study examines the demand-side factors influencing access to primary health care through Ayushman Bharat Health and Wellness Centres (HWCs) in rural areas of District Rajgarh, Madhya Pradesh. The Ayushman Bharat initiative aims to enhance healthcare accessibility and affordability for underserved populations. Utilizing a mixed-methods approach, the research involved quantitative surveys of 585 households and qualitative interviews with Jan Arogya Samiti Members. Findings indicate a high level of awareness regarding the Ayushman Bharat scheme; however, knowledge of specific services offered at HWCs remains limited. Accessibility is generally favourable, with most respondents living within 5 km of a centre, yet inconsistent operational hours and staffing issues hinder utilization. Key barriers identified include financial constraints, cultural beliefs favouring traditional medicine, and gender dynamics affecting women's access to care. Recommendations include enhancing awareness campaigns, improving operational efficiency, addressing financial barriers, and providing cultural sensitivity training for healthcare providers. This study underscores the need for targeted interventions to improve healthcare access and outcomes in rural communities.

KEYWORD: HWCs, Healthcare, Rural Communities, Ayushman Bharat

1. INTRODUCTION

The provision of accessible and quality healthcare is a fundamental right and a critical component of public health systems worldwide. In India, where a significant portion of the population resides in rural areas, the challenge of ensuring equitable access to healthcare services is particularly pronounced. The Ayushman Bharat scheme, launched in 2018, represents a transformative approach to addressing these challenges by establishing Health and Wellness Centres (HWCs) aimed at delivering comprehensive primary health care services. This initiative is designed to cater to the needs of the under-privileged and marginalized communities, thereby promoting health equity and improving health outcomes.

The Ayushman Bharat scheme, launched by the Government of India in 2018, aims to provide accessible and affordable healthcare to the underprivileged sections of society. This initiative includes the establishment of Health and Wellness Centres (HWCs) that serve as the cornerstone for delivering comprehensive primary health care services, particularly in rural areas. This study focuses on assessing the demand-side factors influencing access to primary health care through these centres in District Rajgarh, Madhya Pradesh.

District Rajgarh, characterized by its rural landscape and socio-economic challenges, presents a unique context for evaluating healthcare access. The population largely depends on agriculture and informal employment, which often limits their access to essential health services. The Ayushman Bharat initiative seeks to bridge this gap by enhancing the availability and quality of healthcare services through HWCs.

The **"Bridging the Gap**: Understanding Demand-Side Barriers to Primary Health Care Access through Ayushman Bharat in Rural District Rajgarh," aims to delve into these barriers in detail. It seeks to answer critical questions such as: What are the primary reasons individuals do not seek health care? Are there cultural beliefs that influence their decisions? How do economic factors, such as income and employment, impact their access to health services? By addressing these questions, the study aims to provide a comprehensive understanding of the challenges faced by the community.

2. CONTEXT OF HEALTHCARE IN RURAL INDIA

Rural India is characterized by a myriad of socio-economic challenges, including poverty, limited infrastructure, and a shortage of healthcare professionals. According to the National Health Profile of India, rural areas account for approximately 69% of the country's population, yet they face significant disparities in health service availability and quality. The burden of disease in these regions is often exacerbated by factors such as malnutrition, lack of clean water, and inadequate sanitation facilities. Consequently, rural populations frequently rely on informal healthcare providers, which can lead to sub-optimal health outcomes.

The Ayushman Bharat initiative aims to address these disparities by establishing HWCs that serve as the first point of contact for individuals seeking healthcare services. These centres are designed to provide a range of services, including preventive, promotive, and curative care, thereby reducing the need for individuals to travel long distances to access secondary or tertiary care facilities. By decentralizing healthcare delivery, the initiative seeks to empower local communities and enhance their ability to manage their health needs effectively.

3. STATEMENT OF THE STUDY

The study aims to conduct a comprehensive demand-side assessment of access to primary health care through Ayushman Bharat Health and Wellness Centres (HWCs) in rural areas of District Rajgarh, Madhya Pradesh. By evaluating the awareness, perceptions, and barriers faced by the rural population in utilizing these healthcare services, the study seeks to identify critical factors that influence healthcare access and utilization. This assessment is essential for understanding the effectiveness of the Ayushman Bharat initiative in improving health outcomes among underserved communities.

NEED FOR THE STUDY

1. **Addressing Healthcare Disparities**: Rural areas in India, including District Rajgarh, face significant healthcare disparities compared to urban regions. The need for this study arises from the necessity to understand how effectively the Ayushman Bharat scheme is bridging these gaps and whether it is meeting the healthcare needs of the rural population.
2. **Enhancing Service Utilization**: Despite the establishment of HWCs, many individuals in rural areas continue to underutilize available health services. Identifying the barriers to access such as financial constraints, cultural beliefs, and logistical challenges is crucial for developing strategies to enhance service utilization and improve health outcomes.
3. **Community Engagement**: Understanding the perceptions and awareness of the Ayushman Bharat scheme among the community is vital for fostering greater engagement and participation in health programs. This study aims to provide insights that can help tailor communication and outreach efforts to better inform and involve the local population.

4. **Policy Implications**: The findings of this study will have significant implications for policy-makers and healthcare providers. By identifying the demand-side factors influencing access to healthcare, the study can inform the design and implementation of more effective health policies and programs that cater to the specific needs of rural communities.

5. **Contributing to Existing Literature**: While there is a growing body of research on healthcare access in India, there is a need for more localized studies that focus on specific regions and populations. This study will contribute to the existing literature by providing empirical evidence on the demand-side factors affecting healthcare access in District Rajgarh, thereby enriching the understanding of rural health dynamics in India. In this way , this study is essential for identifying barriers to healthcare access, enhancing service utilization, and informing policy decisions that can lead to improved health outcomes for rural populations in India.

4. IMPORTANCE OF DEMAND-SIDE ASSESSMENT

Understanding the demand-side factors influencing healthcare access is crucial for developing effective health policies and interventions. Demand-side assessments focus on the perceptions, preferences, and behaviours of individuals seeking healthcare services. By examining these factors, policy-makers can identify gaps in service delivery and tailor interventions to meet the specific needs of the community. This approach is particularly relevant in the context of the Ayushman Bharat scheme, as it seeks to engage and empower communities to take charge of their health.

OBJECTIVES OF THE STUDY

This study aims to conduct a demand-side assessment of access to primary health care through HWCs in District Rajgarh, Madhya Pradesh. The objectives are multifaceted:

1. To evaluate the awareness and perception of the Ayushman Bharat scheme among the rural population.
2. To assess the accessibility of Health and Wellness Centres in terms of physical distance, availability of services, and operational hours.
3. To identify barriers faced by the community in utilizing primary health care services.
4. To provide recommendations for improving access to health care through HWCs.

REVIEW OF LITERATURE

The demand for accessible and quality healthcare services has been a focal point of research in both national and international contexts. The Ayushman Bharat initiative, particularly its Health and Wellness Centres (HWCs), has emerged as a significant model for addressing healthcare disparities in rural India. This literature review synthesizes key findings from various studies that explore the effectiveness of primary healthcare initiatives, barriers to access, and the role of community engagement in enhancing health outcomes.

NATIONAL CONTEXT

In India, the healthcare landscape is marked by stark disparities between urban and rural populations. According to the National Health Systems Resource Centre (2019), rural areas often face challenges such as inadequate healthcare infrastructure, a shortage of qualified healthcare professionals, and limited access to essential services. The Ayushman Bharat scheme aims to mitigate these issues by establishing HWCs that provide comprehensive primary health care, including preventive and promotive services.

Patel and Chatterji (2015) highlight that while awareness of government health schemes is increasing, the actual utilization of services remains low due to various barriers, including financial constraints and cultural beliefs.

A Study by Gupta et al. (2020) emphasizes the importance of community participation in healthcare delivery. Their research indicates that when communities are actively involved in health programs, there is a significant increase in service utilization and improved health outcomes. This finding aligns with the objectives of the Ayushman Bharat initiative, which seeks to empower local populations to take charge of their health.

Moreover, a Study Conducted by Singh et al. (2021) in rural Madhya Pradesh found that despite the establishment of HWCs, many individuals still prefer traditional forms of medicine due to cultural beliefs and mistrust of modern healthcare systems. This highlights the need for culturally sensitive approaches in the implementation of health programs to ensure that they resonate with the local population.

INTERNATIONAL CONTEXT

Globally, the importance of primary healthcare in achieving universal health coverage has been widely recognized. The **World Health Organization (2020)** asserts that primary health care is essential for improving health outcomes, particularly in low- and middle-income countries.

Research by Starfield et al. (2005) indicates that countries with strong primary healthcare systems experience better health outcomes, lower healthcare costs, and reduced health disparities.

In a comparative study of primary healthcare models in various countries, **Kruk et al. (2018)** found that community engagement and the integration of services are critical factors for success. Their findings suggest that health systems that prioritize community involvement and tailor services to meet local needs are more effective in improving access and utilization.

Furthermore, a systematic review by **Haggerty et al. (2007)** highlights the significance of continuity of care in primary healthcare settings. The review emphasizes that when patients have a consistent relationship with healthcare providers, they are more likely to seek care and adhere to treatment recommendations. This underscores the importance of building trust and rapport between healthcare providers and the communities they serve.

The literature indicates that while initiatives like Ayushman Bharat and its HWCs have the potential to improve access to primary healthcare in rural India, several barriers must be addressed. These include financial constraints, cultural beliefs, and the need for community engagement. By learning from both national and international experiences, policy-makers can develop more effective strategies to enhance healthcare delivery and ensure that underserved populations receive the care they need.

5. METHODOLOGY

This study employs a mixed-methods approach, combining quantitative surveys and qualitative interviews. A sample of 585 households was selected from various villages in District Rajgarh. The survey included questions on demographics, awareness of the Ayushman Bharat scheme, frequency of visits to HWCs, and perceived barriers to access. In-depth interviews were conducted with JAS Members to gain insights into the operational challenges faced by HWCs.

STUDY DESIGN

1. Mixed-Methods Approach:

- The use of both quantitative surveys and qualitative interviews enables triangulation of data, providing a richer perspective on the implementation and impact of the Ayushman Bharat scheme. The quantitative data offer measurable insights into community awareness and usage, while qualitative data provide deeper context regarding personal experiences and systemic challenges.

SAMPLING

2. Selection of Sample:

A non-probability sampling approach was adopted to select 585 respondents from 150 villages spread across all seven health blocks of District Rajgarh, Madhya Pradesh. Villages were randomly selected to ensure broad geographical and socio-demographic coverage, given the absence of a complete sampling frame for the district. This approach enabled the study to encompass diverse community contexts ranging from remote hamlets to villages located near functional Sub Health Centre–Health and Wellness Centres (SHC-HWCs).

3. Sample Size Determination:

The sample size for the quantitative component was determined using Slovin's formula, applying a 5% margin of error and incorporating a 10% non-response rate. Based on this calculation, the required total sample size was estimated at 420 households to ensure statistical validity and representativeness. However, during field implementation, responses were successfully collected from 585 households across 150 villages, exceeding the minimum requirement and thereby enhancing the robustness and reliability of the dataset. This expanded sample allowed for a more comprehensive representation of diverse socio-demographic and geographic contexts within District Rajgarh, Madhya Pradesh.

To complement the quantitative findings with deeper contextual understanding, a qualitative component was also integrated into the study design. In-depth interviews were conducted with 20 Jan Arogya Samiti (JAS) members, representing various blocks and facility types, to capture experiential perspectives on community participation, local governance, and service delivery under the Ayushman Bharat Health and Wellness Centres (AB-HWCs) initiative. These interviews were semi-structured and designed to elicit open-ended narratives, enabling participants to articulate their experiences and reflections in their own words. The chosen sample size aligns with Creswell's (1998) guideline recommending 20–30 interviews for achieving thematic saturation in qualitative research, ensuring both analytical depth and data triangulation.

DATA COLLECTION

4. Quantitative Surveys:

- **Survey Instrument Design:**
- A structured questionnaire was developed, containing closed-ended questions. The questionnaire included several sections:
- **Demographics**: Age, gender, education level, income, etc.
- **Awareness of the Ayushman Bharat Scheme**: Questions aimed at assessing the level of knowledge about the scheme, including benefits and eligibility.
- **Frequency of Visits to HWCs:** Questions regarding how often participants visit HWCs and the reasons for those visits.
- **Perceived Barriers to Access**: Items exploring potential barriers such as transportation, cost, knowledge, and healthcare availability.
- **Data Collection Procedure:**

- Trained enumerators conducted face-to-face surveys with household members, ensuring clarity and understanding of each question. To enhance response rates and facilitate honest reporting, respondents were assured of confidentiality and the voluntary nature of their participation.

5. Qualitative Interviews:
- Participant Selection:
- In-depth interviews were conducted with JAS Members (such as ASHA, School teacher, Village head etc.) selected through purposive sampling, ensuring representatives from diverse perspectives and expertise.
- Interview Guide Development:
- Conducting Interviews:
- Data Analysis

6. Quantitative Data Analysis:
- The quantitative data obtained from the surveys were analysed using statistical software (e.g., SPSS or R). Descriptive statistics (mean, median, frequency) were employed to summarize demographic characteristics and key variables. Inferential statistics (e.g., chi-square tests, t-tests) were utilized to explore relationships between awareness, access to services, and demographic factors.

7. Qualitative Data Analysis:
- The qualitative data from interviews were transcribed verbatim and analysed using thematic analysis. Key themes and patterns related to operational challenges, community perceptions of the Ayushman Bharat scheme, and barriers to access were identified and coded. This qualitative analysis provides depth to the quantitative findings, allowing for a more thorough interpretation of the overall research question.

ETHICAL CONSIDERATIONS

8. Ethical Approval:
- The research protocol was reviewed and approved by an appropriate ethics review board to ensure that ethical standards were maintained throughout the study. Informed consent was obtained from all participants, and measures were taken to ensure confidentiality and the right to withdraw from the study at any time.

FINDINGS

1. **Awareness of Ayushman Bharat:**
The study revealed a striking paradox in community awareness regarding the Ayushman Bharat – Health and Wellness Centres (AB-HWCs). While **93.7% of respondents** reported having heard about AB-HWCs, a more detailed analysis exposed a severe knowledge gap: **96.9% of these "aware" respondents** could identify only one or none of the twelve guaranteed services offered under the Comprehensive Primary Health Care (CPHC) package. Only **2.2% demonstrated high awareness**, correctly naming eight or more services. This discrepancy underscores that awareness is largely **nominal or brand-level**, rather than functional or service-specific. The Accredited Social Health Activist (ASHA) network emerged as the **primary information source for 97.4%** of respondents, indicating both their outreach potential and the limited scope of their health communication. The findings point to a **systemic communication failure**, where promotional visibility has not translated into health literacy or community empowerment.
2. **Accessibility and Affordability of Health and Wellness Centres:**
Rural households in Rajgarh District perceive AB-HWCs as highly affordable and accessible, primarily because services including consultations, basic diagnostics, and essential medicines are provided free of cost and within or near village boundaries. Respondents contrasted this sharply with private providers, where costs average ₹200–₹400 per visit.
The proximity of HWCs also minimizes indirect costs such as transport fares and wage loss, which previously deterred visits to distant PHCs or private clinics. This affordability has reshaped healthcare-seeking behaviour, with families now seeking preventive and routine care earlier and more frequently. As one respondent observed, "Earlier people waited till the illness became worse. Now they come early because they know it will not cost anything." These findings suggest that financial accessibility has become a major driver of utilization, particularly benefiting women, elders, and low-income groups who face mobility constraints

3. **Barriers to Utilization:**
Despite the program's broad reach, several **structural and socio-cultural barriers** continue to limit consistent utilization. The most cited challenges include:

- **Geographical distance and time loss**, especially for residents in peripheral hamlets who forgo daily wages to visit centres.
- **Irregular availability of medicines and diagnostic supplies**, which erodes trust and discourages repeat visits.
- **Competition from nearby private providers**, perceived as quicker and more convenient, especially among male respondents.
- **Cultural perceptions and gendered norms**, which restrict women's mobility and influence care-seeking decisions.

These barriers reveal a persistent mismatch between policy intentions and lived realities, emphasizing the need for reliable supply chains, gender-sensitive outreach, and decentralized scheduling to enhance regular use

4. **Quality of Services and Trust:**
Trust in AB-HWCs was found to be rooted more in interpersonal and experiential factors than in formal publicity. Respondents consistently associated positive experiences with respectful staff behaviour, cleanliness, consistent service delivery, and availability of medicines. Conversely, any service disruption or unavailability of diagnostic supplies quickly diminished community trust.
Clean and organized facilities were viewed as symbols of credibility, while continuity of care,particularly for chronic conditions such as hypertension and diabetes,fostered sustained engagement. These findings indicate that relational quality and reliability are central to the perceived quality of care, reinforcing the importance of staff empathy, consistent service delivery, and dependable logistics systems

DISCUSSION
The establishment of Ayushman Bharat Health and Wellness Centres (AB-HWCs) marks a pivotal shift in India's public health strategy, aiming to build a robust foundation of comprehensive primary care accessible to all. However, this study's findings from the rural district of Rajgarh, Madhya Pradesh, illuminate a complex reality where the promise of accessible primary care intersects with a persistent network of informational, structural, and socio-cultural barriers. The central argument emerging from this research is that while AB-HWCs have successfully established a physical and financial presence, their full potential is unrealized due to a profound gap between nominal awareness and functional knowledge, and between physical accessibility and consistent utilization. For the rural residents of Rajgarh, the journey to an HWC is not a simple, linear path from illness to care. It is a negotiation within a paradoxical ecosystem. The journey begins within a landscape of widespread but superficial awareness. While an overwhelming 93.7% of residents have heard of the HWCs, this brand recognition belies a critical information void. A staggering 96.9% of these "aware" individuals could not name more than one of the twelve essential services the centres are mandated to provide. This transforms the HWC from a well-understood resource into a vaguely familiar entity, its specific purpose and offerings shrouded in uncertainty. The primary source of information, the local ASHA worker, while trusted, appears to disseminate the brand more than the details, creating a community that knows of the HWC but not what it is for. Should a resident decide to visit, they encounter the scheme's greatest success: affordability and proximity. With services and medicines provided free of charge, the HWCs stand in stark contrast to private providers, where a single visit can cost between ₹200 and ₹400. This removal of direct financial barriers has reshaped health-seeking behavior, encouraging earlier and more frequent consultations, particularly for women and the elderly. The physical closeness of the centres minimizes the indirect costs of transportation and lost daily wages that have long plagued rural healthcare access. However, this success is fragile and frequently undermined by a third set of barriers related to operational reliability and socio-cultural norms. The benefits of proximity are negated if the centre has irregular hours or if essential medicines and diagnostic supplies are unavailable. Such inconsistencies erode the very trust that affordability helps to build, pushing residents back towards private providers who are perceived as more reliable, albeit more expensive. Furthermore, every decision to seek care is filtered through a dense mesh of social and cultural norms. Deep-seated gender inequalities often restrict a woman's mobility and autonomy, making her access to the local HWC contingent on household dynamics, not just on her health needs. This analysis, therefore, frames these barriers not as a simple checklist of problems but as a mutually reinforcing system. The lack of functional knowledge prevents residents from demanding the full suite of services; inconsistent service delivery undermines trust in the accessible and affordable care that is offered; and socio-cultural norms dictate who is ultimately able to overcome these hurdles to seek care.

A deeper examination of the evidence from Rajgarh reveals the stubborn and multifaceted nature of the demand-side barriers that persist despite the establishment of local HWCs. These constraints are not superficial implementation glitches but are structurally embedded in the informational and socio-cultural fabric of the community. The foundational challenge confronting the AB-HWC initiative in Rajgarh is a profound paradox of

awareness. While promotional efforts have achieved near-universal name recognition (93.7%), they have failed to cultivate a functional understanding of the services offered. This gap between "brand awareness" and "service literacy" is the single most significant informational barrier identified. The finding that 96.9% of respondents could identify one or none of the twelve guaranteed services under the Comprehensive Primary Health Care (CPHC) package is a stark indictment of the current communication strategy. This deficit has critical consequences. When community members are unaware that the HWC provides care for chronic conditions, maternal and child health, or basic diagnostics, they cannot demand these services, nor can they make informed choices about where to seek care. This leads to underutilization of the centre's full potential and continued reliance on private providers for services that are, in theory, available for free.

The AB-HWC model's core strengths lie in its affordability and accessibility, which have tangibly altered healthcare-seeking patterns in Rajgarh. By providing consultations, diagnostics, and medicines free of cost, HWCs have eliminated the direct financial barriers that previously deterred or delayed care. As one respondent noted, “Earlier people waited till the illness became worse. Now they come early because they know it will not cost anything.” The proximity of HWCs has also been transformative, drastically reducing the indirect costs associated with seeking care. However, these powerful advantages are consistently undermined by structural inconsistencies. The most frequently cited barrier is the irregular availability of medicines and diagnostic supplies. When a resident visits the HWC only to be told that the required medication is out of stock or that a basic test cannot be performed, it creates a powerful negative experience. This unreliability erodes trust far more quickly than outreach campaigns can build it. This makes the supply chain the Achilles' heel of the HWC model; without a consistent and dependable flow of essential supplies, the benefits of affordability and proximity are severely compromised. The decision to utilize an HWC is also profoundly mediated by a combination of structural factors and deep-seated social norms. One of the key structural barriers is the competition from private providers. Especially among male respondents, private clinics were often perceived as quicker and more convenient. More deeply embedded are the cultural perceptions and gendered norms that govern health-seeking decisions. A woman's ability to visit the local HWC, even if it is just a short walk away, is often not her decision alone. It can be constrained by household responsibilities and the need for permission from a male family member. These socio-cultural filters represent a formidable "last mile" barrier, ensuring that even perfectly functioning HWCs may remain inaccessible to the most vulnerable women in the community.

The demand-side barriers to primary healthcare access identified in Rajgarh are not an isolated local phenomenon. They are a microcosm of the systemic challenges confronting the nationwide rollout of AB-HWCs. The "awareness paradox" observed in Rajgarh,high brand recognition coupled with low functional literacy,is a recurring theme across India. National surveys and regional studies have consistently found that while communities are aware of the existence of government health facilities, their knowledge of the specific package of services they are entitled to remains extremely limited. Similarly, the critical role of a reliable supply chain for medicines and diagnostics is a cornerstone of the Indian Public Health Standards (IPHS), yet its inconsistent implementation, as seen in Rajgarh, is one of the most frequently cited reasons for the underutilization of public health facilities nationwide. The erosion of trust due to stock-outs is a well-documented factor that drives patients, even the poor, to the private sector. This study's findings also contribute to the national debate on the importance of the "software" of healthcare,interpersonal quality, staff attitudes, and facility cleanliness,in building trust. The Rajgarh respondents' emphasis on respectful staff behavior and clean facilities as symbols of credibility aligns with national research indicating that patient experience is a primary driver of provider choice.

The insights from Rajgarh demand a shift in policy and implementation focus from simply establishing HWC infrastructure to ensuring these centres are functionally literate, operationally reliable, and socially accessible to all community members. The current communication strategy must evolve. The focus must shift from promoting the "Ayushman Bharat" brand to educating the community on the specific, tangible benefits available at their local HWC. A key recommendation is to develop and deploy targeted IEC materials that clearly list and explain each of the 12 guaranteed services. Trust is the currency of a public health system, and in Rajgarh, it is built on reliability. The single most important step to increase utilization is to ensure that HWCs are consistently staffed and stocked. This requires implementing a robust, technology-enabled supply chain management system to prevent stock-outs and ensuring operational hours are standardized and strictly adhered to. Recognizing that access is governed by social norms, outreach must actively work to overcome gender-based barriers. It is recommended to design specific community engagement programs that involve not just women, but also men and community leaders, to discuss the importance of women's health and their right to seek care. Finally, the community's perception of quality is shaped by their experience at the facility. Investing in the "software" of care is as important as investing in the "hardware" of infrastructure. This includes regular training for all HWC staff in

soft skills, including empathetic communication, and treating cleanliness as a clinical priority, as it is a powerful visual cue of quality and credibility for the community.

This study provides a granular, qualitative exploration of the demand-side barriers to primary healthcare access in a specific rural district. While its findings offer rich, context-specific insights, it is important to acknowledge its limitations, which in turn point towards a forward-looking agenda for future research. The study's cross-sectional design provides a snapshot at a single point in time, and its single-district focus means the findings may not be directly generalizable to all regions of India. Furthermore, the study is focused on the demand side,the perceptions and behaviors of the community. A comprehensive understanding requires an equally rigorous supply-side investigation into the challenges faced by HWC staff and administrators. These limitations highlight critical areas for future inquiry. There is a clear need for longitudinal studies to track HWC utilization and community health outcomes over several years. Comparative multi-state research is essential to understand how the effectiveness of the HWC model is mediated by different levels of health system maturity. Finally, future research must include supply-side analyses that explore the perspectives of Community Health Officers (CHOs), ANMs, and ASHAs to design interventions that are not only demanded by the community but are also deliverable by the frontline workforce.

RECOMMENDATIONS

The insights from Rajgarh demand a shift in policy and implementation focus from simply establishing HWC infrastructure to ensuring these centres are functionally literate, operationally reliable, and socially accessible to all community members. The current communication strategy must evolve. The focus must shift from promoting the "Ayushman Bharat" brand to educating the community on the specific, tangible benefits available at their local HWC. A key recommendation is to develop and deploy targeted IEC materials that clearly list and explain each of the 12 guaranteed services. Trust is the currency of a public health system, and in Rajgarh, it is built on reliability. The single most important step to increase utilization is to ensure that HWCs are consistently staffed and stocked. This requires implementing a robust, technology-enabled supply chain management system to prevent stock-outs and ensuring operational hours are standardized and strictly adhered to. Recognizing that access is governed by social norms, outreach must actively work to overcome gender-based barriers. It is recommended to design specific community engagement programs that involve not just women, but also men and community leaders, to discuss the importance of women's health and their right to seek care. Finally, the community's perception of quality is shaped by their experience at the facility. Investing in the "software" of care is as important as investing in the "hardware" of infrastructure. This includes regular training for all HWC staff in soft skills, including empathetic communication, and treating cleanliness as a clinical priority, as it is a powerful visual cue of quality and credibility for the community.

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CONCLUSION

The study concludes that while Ayushman Bharat Health and Wellness Centres (AB-HWCs) represent a transformative step toward equitable primary healthcare in rural India, their full potential remains constrained by gaps in community awareness, operational reliability, and social accessibility. The findings affirm that creating healthcare infrastructure alone is insufficient; what truly determines success is whether these centres are understood, trusted, and consistently utilized by the communities they serve.

Bridging this gap requires a shift from visibility to comprehension, from construction to consistent functionality, and from service provision to relationship-building. Strengthening supply chains, ensuring regular operations, and enhancing staff responsiveness are essential for sustaining trust. Equally vital is fostering community ownership

through culturally sensitive communication and inclusive engagement that empowers women and marginalized groups to seek care freely.

The study underscores that universal health coverage is not achieved through policy declarations alone it is realized in every village where people feel confident that public healthcare will respond to their needs with reliability, dignity, and compassion. Ayushman Bharat has laid the foundation; the challenge ahead lies in deepening its human connection, ensuring that each Health and Wellness Centre becomes not just a facility, but a trusted space for care, continuity, and community wellbeing.

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