Transforming Primary Health Care in India through Ayushman Arogya Mandirs: A Systematic Synthesis of the Evidence

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Abstract: India's push to strengthen primary health care gained significant momentum in 2018 with the launch of Health and Wellness Centres (HWCs) under the Ayushman Bharat initiative- one of the world's largest efforts to reposition primary care around comprehensive, community-based services characterized by equity, well-being, preventive care innovation and community wellbeing. Envisioned as accessible community-level platforms for preventive, promotive, and basic curative care, HWCs have expanded rapidly, though evidence on their real-world performance has remained scattered.

This systematic review, conducted in line with PRISMA 2020 guidelines, synthesised evidence from eight major databases and key grey-literature sources published between 2018 and 2025. Thirty-eight studies met the inclusion criteria. Collectively, the findings show that HWCs and Ayushman Arogya Mandirs (AAMs) have improved access to essential primary-care services, particularly in underserved settings, with consistent gains in NCD screening, digital health use, and community engagement. At the same time, persistent challenges most notably workforce shortages, infrastructure gaps, uneven implementation across states, and limited awareness of promotive services continue to shape outcomes.

Overall, the evidence indicates that HWCs and AAMs have laid a strong foundation for comprehensive primary health care in India. Sustained investment in people, systems, and community participation will be critical to consolidate these gains and offers lessons of wider relevance for countries pursuing universal health coverage. However, despite this scale and ambition, evidence on their real-world functioning and performance remains evolving, presenting a valuable opportunity for learning and feedback to inform policy refinement, strengthen implementation, and further enhance the role of HWCs and AAMs in advancing equitable primary health care in India.

Keywords: Health and wellness centres, Ayushman arogya mandir, Primary health care, Preventive health, India, Systematic review, PRISMA.

1. INTRODUCTION

India's landmark journey toward universal health care took tangible shape with the rollout of Ayushman Bharat, marked by the inauguration of the first HWC by the Hon'ble Prime Minister Shri Narendra Modi on 14 April 2018 in Bijapur, Chhattisgarh (Government of India, 2018). Shortly thereafter, on 18 April 2018, the first facility formally designated as an "Ayushman Arogya Mandir" (AAM) became operational. In November 2023, the GoI officially renamed all Ayushman Bharat HWCs as Ayushman Arogya Mandirs, reinforcing a renewed national commitment to wellness-oriented primary care and the expansion of preventive and promotive services across the country (MoHFW, 2023).

The vision of AAMs extends beyond hospital-centric care to the creation of a more holistic, equitable, and community-anchored public health system. The initiative emphasizes the delivery of preventive, promotive, curative, rehabilitative, and palliative services, reflecting a decisive shift away from episodic, reactive treatment toward continuous and people-centred wellness care (MoHFW, 2021). At the grassroots level, Arogya Mandirs offer a comprehensive package of free essential services, including population-based screening for non-communicable diseases such as diabetes and hypertension, basic diagnostics, free essential medicines, maternal and child health services, and lifestyle- and wellness-focused promotive care (NHSRC, 2022; GoI, 2018). This expanded scope has played a critical role in improving access to quality primary health care, particularly in rural, remote, and underserved settings.

By reducing financial barriers through the provision of free screenings, diagnostics, medicines, and wellness services, AAMs contribute to lowering out-of-pocket health expenditures while broadening access to timely care (PATH, 2023). As of 2025, more than 150,000 HWCs and AAMs are operational nationwide, making the programme one of the largest community-based primary health care platforms globally (MoHFW, 2025).

The Table **1** below summarizes the key features of HWCs and AAMs that illustrates how these components function in routine service delivery. It outlines the principal feature areas, their operational roles, and their relevance for individuals, communities, and the health system. The "Feature Area" column highlights core components such as digital health, affordable care, last-mile access, preventive services,

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Table- 1: Health and Wellness Centres: Reframing Primary Care through Integrated Wellbeing

Feature Area	What It Does	Why It Matters
Digital Health (ABHA)	Provides unique Health IDs with electronic health records under Ayushman Bharat Health Account	Ensures continuity of care and seamless data sharing across providers
Affordable Care	Strengthens free and low-cost primary health services	Reduces out-of-pocket healthcare expenses for families
Last-Mile Access	Arogya Mandirs bring services closer to villages and underserved areas	Bridges urban-rural and socio-economic health gaps
Preventive Services	Regular screening for diabetes, hypertension, cancers, etc.	Enables early detection and lowers long-term disease burden
Holistic Wellness	Integrates physical, mental, and social health services	Promotes overall well-being, not just illness treatment
Integrated Health System	Digital infrastructure connects public and private health facilities	Builds a unified, efficient, and scalable public-health system
Community-Centred Care	Healthcare embedded within neighbourhoods and communities	Shifts focus from hospital-based to people-centred care
Health for All	Emphasises equity, access, and universal primary healthcare	Advances inclusive and sustainable healthcare delivery

Source: Author' conceptual synthesis based on the reviewed evidence.

holistic wellness, integrated health systems, community-centred care, and the overarching goal of health for all. The "What It Does" column describes how these features are implemented in practice, while the "Why It Matters" column explains their contribution to early detection, improved access, continuity of care, and better health outcomes. Collectively, Table **1** links services with purpose and impact, offering a concise overview of how HWCs and AAMs reframed primary care through integrated wellbeing centres and why each feature is integral to comprehensive primary care delivery.

In parallel with global recognition of integrated primary care as a foundation for reducing morbidity, improving financial protection, and advancing health equity, India's HWC and AAM model presents a notable example of system-level reform (Starfield *et al*., 2005; World Health Organization & UNICEF, 2018; Lahariya, 2020; Tripathi *et al*., 2024). Anchored in task sharing, digital health innovations, community-level service delivery, and an expanded service package, the model offers important lessons for health system strengthening. However, empirical evidence on its implementation and outcomes remains scattered across academic publications, programmatic documents, and grey literature.

This systematic review brings together the available evidence on the design, implementation, and performance of HWC under the AAM initiative, with a particular focus on preventive and promotive health services. By synthesizing findings on operational performance and stakeholder experiences, the review seeks to inform evidence-based policymaking in India while offering insights relevant to other countries exploring scalable, community-anchored primary health care models.

2. METHODS

2.1. Study Design

A systematic review was conducted in line with the PRISMA 2020 guidelines to systematically identify, screen, and synthesize empirical studies and programmatic reports published between January 2018 and October 2025.

2.2. Eligibility Criteria Guiding Study Selection

Dimension	Inclusion	Exclusion
Population	Communities or health facilities implementing HWCs/AAMs within India	Non-Indian settings
Intervention	Establishment, service delivery, or evaluation of HWCs/AAMs	Non-primary care or tertiary interventions
Outcomes	Coverage, utilization, NCD screening, community acceptance, service quality, digital adoption	Editorials, commentaries
Study type	Quantitative, qualitative, mixed methods, official reports	Duplicates, non-English
Period	2018–2025	Prior to 2018

2.3. Data Sources

To build a robust and inclusive evidence base, a comprehensive search was undertaken across major national and international sources. Key biomedical and public health databases- PubMed, MEDLINE (via Scopus), and Web of Science were searched to capture peer-reviewed literature spanning clinical, health systems, and policy research. To ensure adequate representation of Indian scholarship, IndMED was included, alongside supplementary searches using Google Scholar and the WHO Global Index Medicus to identify recent and regionally published studies.

Recognising the importance of implementation evidence, relevant government documents from the Ministry of Health and Family Welfare and NITI Aayog were reviewed, including policy guidelines, operational frameworks, and monitoring reports related to Ayushman Bharat. Grey literature was systematically incorporated from programme evaluations and reports produced by national agencies and development partners such as WHO, UNICEF, USAID, and the Bill & Melinda Gates Foundation. Publicly available dashboards and performance portals were also consulted to capture recent trends, strengthening the relevance and completeness of the evidence base.

2.4. Search Strategy

A structured search strategy was applied using predefined keywords related to HWCs/AAMs, primary health care, and preventive and promotive services in India. Searches were conducted across selected databases, and retrieved records were screened independently by the author and two voluntary reviewers using Rayyan. Titles and abstracts were assessed first, followed by full-text review of potentially eligible studies, with disagreements resolved through discussion and consensus.

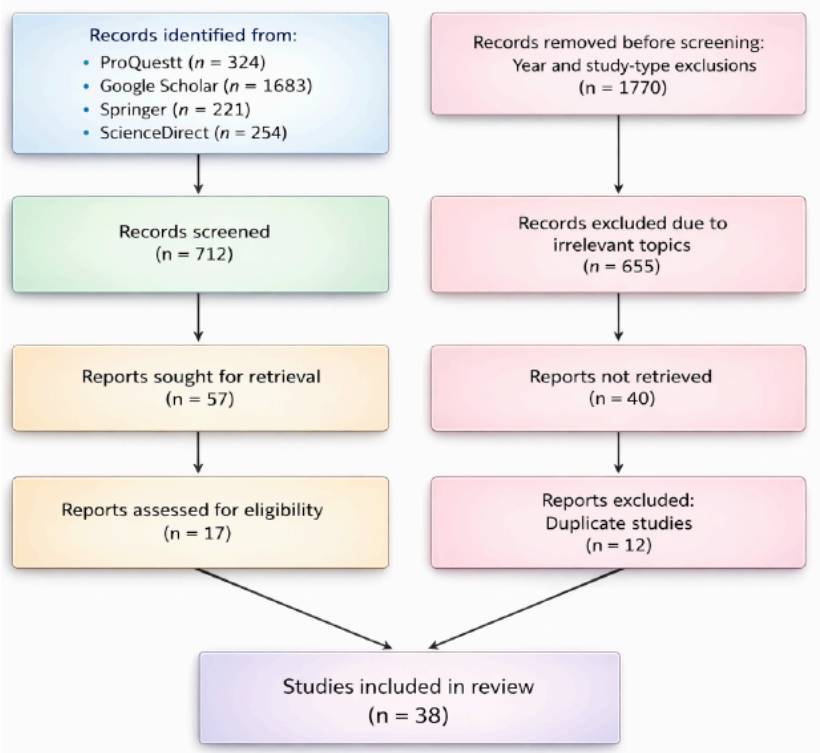
Data were extracted using a standardized matrix capturing study design, setting, methods, intervention components, preventive-promotive outcomes, and reported barriers and facilitators. Study quality was assessed using established appraisal tools appropriate to study design, including RoB 2.0 for quantitative studies, CASP for qualitative research, and MMAT (2018) for mixed-methods studies. Given the heterogeneity in study designs and outcome measures, findings were synthesized narratively and organized across thematic domains reflecting service expansion, preventive and promotive health outcomes, community engagement, and system-level challenges.

3. RESULTS

3.1. PRISMA Flow Diagram of Study Selection

The PRISMA flow diagram of the study selection outlines the core methodological framework of the study, detailing the processes of study identification, screening, and inclusion, as illustrated below.

As shown in the PRISMA Flow Diagram of Study Selection at the initial stage 2482 records were identified through database searches. Subsequently, 1770 records were removed before screening because



of year and study type. Full-text retrieval was sought for 57 reports, of which 40 could not be retrieved. The remaining 17 reports were assessed for eligibility, and 12 were excluded due to duplication. Ultimately, 38 studies met the inclusion criteria and were included in the final synthesis.

3.2. Characteristics of Included Studies

The included studies demonstrated considerable geographic diversity, with the majority conducted in Indian states such as Tamil Nadu, Kerala, Gujarat, Karnataka, and Rajasthan, as well as in several northeastern states, including Assam and Meghalaya. This distribution reflects a broad regional representation across different parts of the country.

In terms of methodological approaches, the body of evidence comprised a range of study designs. Seventeen studies employed quantitative methods, primarily using cross-sectional or quasi-experimental designs. Ten studies adopted qualitative approaches to explore contextual and experiential dimensions, while eight studies utilized mixed-methods designs that integrated both quantitative and qualitative data. Additionally, three studies consisted of evaluations conducted by government agencies or partner organizations, contributing practice-based evidence to the review.

3.3. Thematic Findings

Theme 3.3.1: Ayushman Arogya Mandirs as a Wellbeing Innovation

HWCs and AAMs represent a notable innovation in primary health care by explicitly positioning wellbeing rather than service delivery alone at the centre of care. Evidence from this review suggests that HWCs and AAMs contribute to wellbeing equity by reducing disparities across gender, geography, and income, particularly through expanded access to preventive services, free medicines, and community-based outreach in rural and underserved areas. At the same time, the sustainability of these wellbeing gains remains contingent on system-level factors, including workforce capacity and burnout, digital literacy, and stable financing for preventive care. The integration of wellness activities including yoga, lifestyle counselling, and mental health touchpoints further extends primary care beyond treatment, positioning these platforms as holistic and responsive sites of wellbeing.

Theme 3.3.2: Service Expansion and Coverage

Across studies, HWCs and AAMs were linked to clear gains in the availability and reach of essential services. Evidence showed marked expansion of NCD screening particularly for hypertension and diabetes along with stronger maternal and child health follow-up, improved access to basic diagnostics, and increased use of teleconsultations through the e-Sanjeevani platform. Some states also reported the introduction or scale-up of palliative and elderly care services, pointing to a broader primary care mandate. Quantitative findings further indicated substantial improvements, with NCD screening rising by 38-65%, teleconsultation use increasing four- to tenfold, and follow-up adherence improving by 22-34%. Despite these advances, gaps persisted, including limited laboratory capacity, inconsistent availability of essential medicines, and uneven provision of services such as physiotherapy, mental health care, and palliative care, highlighting areas for continued strengthening.

The provision of free essential medicines and diagnostics directly supports financial and mental wellbeing by lowering out-of-pocket expenditure and reducing treatment-related stress, with the greatest benefits accruing to low-income households, thus mitigating economic barriers to primary care. Collectively, these themes demonstrate how HWCs and AAMs address multiple dimensions of wellbeing while targeting structural inequities embedded in India's primary health care system.

The Figure **1** illustrates the progressive expansion of services under HWCs and AAMs and it highlights the pathways through which service breadth and reach contribute to more equitable and sustained wellbeing outcomes at the community level. It illustrates how HWCs and AAMs extend a wide range of preventive, promotive, and basic curative services at the community level, supported by outreach activities and an expanded scope of care. The schematic further depicts the structured referral pathway from sub-centres to primary health centres and onward to secondary and tertiary care facilities, emphasizing continuity of care and integration across different levels of the health system.

Theme 3.3.3: Preventive and Promotive Health Outcomes

Preventive and promotive care emerged as central pillars of the HWCs and AAMs. Across the reviewed studies, community-level health promotion activities-including yoga sessions, wellness camps, and tobacco cessation initiatives were widely implemented, although their scope and documentation varied across settings. Health education sessions delivered through these platforms were consistently linked to improved health-seeking behaviour, particularly among women and older adults, suggesting greater awareness and engagement with preventive services.

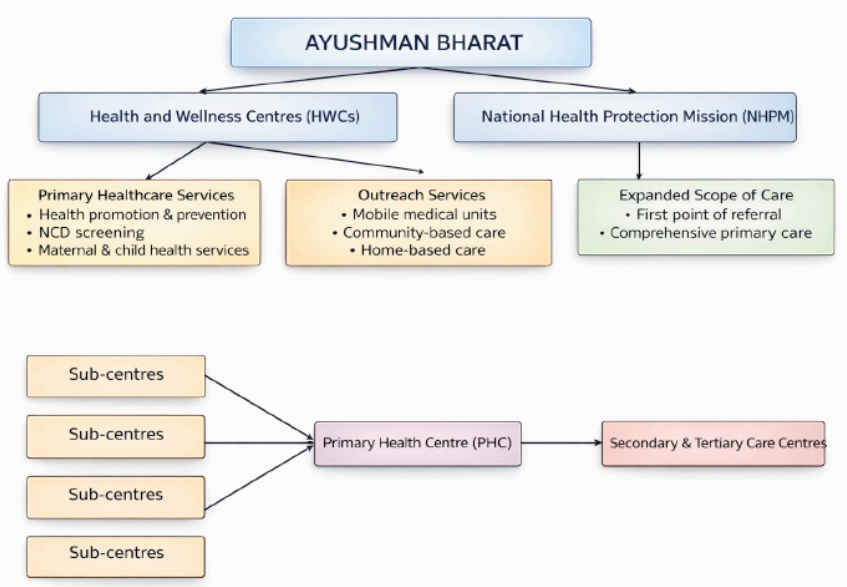


Figure 1: Service Expansion Trajectory: Linking Scale to Wellbeing Impact

Furthermore, systematic screening initiatives led to the identification of a substantial number of previously undiagnosed cases of hypertension and diabetes, enabling earlier clinical intervention and follow-up. Evidence from the reviewed studies indicates that key programmatic components of HWCs and AAMs influence distinct but interconnected dimensions of wellbeing. Non-communicable disease (NCD) screening and early diagnosis primarily strengthen physical wellbeing by enabling early risk identification and timely management, particularly benefiting adults from socio-economically disadvantaged and rural populations who otherwise face delayed diagnosis, thereby reducing inequities in life-course health outcomes. Collectively, these findings highlight the growing role of HWCs and AAMs in shifting primary healthcare toward prevention and early risk detection as described below.

The Figure **2** depicted below highlights the substantial burden of NCD in India, showing that nearly two-thirds of all deaths are attributable to NCDs. Cardiovascular diseases account for the largest share, followed by chronic respiratory conditions and cancers, while diabetes also contributes meaningfully to overall mortality. The diagram provides a comparative, illustrative view of the relative burden of major NCDs, underscoring the widespread impact of these conditions on population health and the importance of early prevention and sustained primary care.

Theme 3.3.4: Community Engagement and Acceptance

Qualitative findings consistently showed stronger community engagement and acceptance of HWCs and AAMs, driven by improved access and trust. Proximity

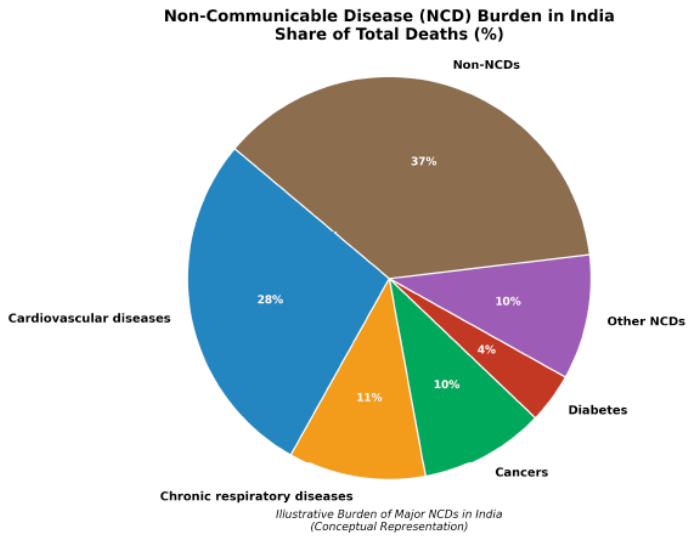


Figure 2: Illustrative Burden of Major NCDs in India – a Conceptual Representation.

to communities, active outreach by ASHAs, and the availability of free, women-friendly services were key facilitators of uptake. Different groups valued different aspects older adults appreciated continuity of care, women emphasized maternal and reproductive services, and adolescents engaged more where wellness and mental health activities were offered.

Community engagement activities, including outreach and health education, contribute to social wellbeing by enhancing trust in public health services and improving care-seeking among women, older adults, and marginalized communities, helping to address long-standing inequities in access and utilisation. Overall, these findings highlight the importance of community-centred design and responsive service delivery in sustaining primary care use. The innovation embedded in HWCs and AAMs lies in their reconfiguration of primary care delivery, notably through task-shifting to Community Health Officers, the use of digital platforms such as ABHA and teleconsultations to support continuity of care, and the shift from facility-centric to community-embedded models of service delivery.

Theme 3.3.5: Systems-Level Challenges

While meaningful progress has been achieved, the evidence also points to persistent system-level challenges affecting the functioning of HWCs and AAMs. Common concerns include shortages of Community Health Officers, rising workloads for ASHAs, gaps in digital connectivity and literacy, and infrastructure constraints that limit counselling and wellness services. Irregular financing flows and supply chain disruptions further affect service continuity. Taken together, these challenges highlight the need to pair service expansion with sustained investments in system strengthening.

From a policy perspective, the findings point to the importance of strengthening workforce policies (including training and incentives for Community Health Officers), financing mechanisms that prioritise prevention, digital inclusion strategies, and community participation models that reinforce trust and accountability. Monitoring frameworks that move beyond service counts to include wellbeing-oriented indicators may further support consolidation efforts. In comparative terms, India's experience with AAMs offers relevant insights for other low- and middle-income countries pursuing Universal Health Coverage and advancing SDG 3 (Good Health and Wellbeing), demonstrating how integrated primary care platforms can simultaneously address access, equity, and broader wellbeing outcomes.

4. DISCUSSION

This systematic review indicates that HWCs and AAMs have played a meaningful role in strengthening India's primary health care system, particularly by bringing preventive and promotive services closer to communities. Beyond expanding service coverage, the evidence suggests that these platforms have begun to reshape how primary care is experienced at the community level, shifting the focus from episodic treatment to more continuous, people-centred engagement.

Within the HWC and AAM framework, wellbeing emerges as a multidimensional construct, extending beyond the absence of illness to encompass physical, mental, and social dimensions of health. Physical wellbeing is supported through activities such as the prevention and early detection of non-communicable diseases, alongside the provision of essential primary care services. Mental wellbeing also features prominently, reflected in efforts to reduce stress, provide counselling, yoga, life style education and introduce other wellness-oriented services that respond to routine psychosocial concerns faced by individuals and families. Importantly, HWCs and AAMs influence social wellbeing by fostering trust between communities and public health institutions, improving access to services, and addressing social and structural barriers that shape health-seeking behaviour. Taken together, these overlapping dimensions underscore the role of HWCs and AAMs as community-anchored spaces that support not only clinical outcomes but also experiences of dignity, inclusion, and sustained wellbeing in everyday life.

Across other domains including service delivery, community engagement, digital enablement, and overall system readiness the reviewed studies point to improvements in access, earlier identification of health risks, and growing public confidence in primary care services. At the same time, the evidence also highlights persistent challenges. Gaps in human resources, infrastructure, digital integration, and supply chain reliability continue to limit the consistency, quality, and long-term sustainability of services in many settings. These findings suggest that future policy priorities must move beyond rapid scale-up toward consolidation, with sustained investments in workforce capacity, standardized infrastructure, digital readiness, and predictable financing. In a health system historically marked by inequities, fragmentation, and constrained public health capacity, integrated primary care platforms such as AAMs remain both timely and essential for advancing equitable and resilient health systems (Das, 2017).

5. LIMITATIONS

This review has some important limitations. Wide variation in study designs, outcomes, and settings limited quantitative synthesis, while the inclusion of grey literature introduced differences in methodological rigor. In addition, uneven implementation of HWCs and AAMs across states restricts the generalizability of the findings. Despite these constraints, triangulation across diverse data sources and methods enhances the overall credibility of the evidence presented. Additionally, this review takes a wellbeing lens, existing studies more frequently document physical health outcomes than mental and social aspects of wellbeing, which are less consistently captured. Patient-reported wellbeing experiences are limited, and variation across states in implementation and reporting may have influenced the assessment of equity.

CONCLUSION

India's transition toward comprehensive primary health care through the establishment of HWCs under the AAM initiative represents a significant policy achievement in strengthening the foundations of the health system. The findings from this systematic review demonstrate tangible gains in service availability, expanded preventive and promotive care, effective use of digital health platforms, and growing community trust and utilization. These improvements reflect sustained governmental commitment to reorient primary care toward a more people-cantered, accessible, and equitable model. The Indian experience offers valuable lessons for other low- and middle-income countries pursuing universal access to preventive and promotive care.

DECLARATIONS

Ethical approval was not required, as this study is based on a review of published literature and involved no primary data collection. The author received no external funding and declare no conflicts of interest. Data supporting the findings are available from the corresponding author upon reasonable request.

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