ORIGINAL RESEARCH PAPER
Volume - 15 | Issue - 09 | September - 2026 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

WE ARE THE FIRST POINT OF CONTACT : A QUALITATIVE ASSESSMENT OF COMMUNITY HEALTH OFFICERS' PERSPECTIVES ON DELIVERING COMPREHENSIVE PRIMARY HEALTH CARE IN BHARUCH DISTRICT, GUJARAT

Community Medicine

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ABSTRACT

Background: Community Health Officers (CHOs) are a newly created cadre of mid-level health providers who lead Sub Centre-Health and Wellness Centre (SC-HWCs) under Ayushman Bharat, carrying primary responsibility for delivering the expanded comprehensive primary health care (CPHC) service package at the community level. Understanding their first-hand operational experience is essential to identify realistic, field-relevant barriers to CPHC implementation that structured checklists alone cannot capture. **Objectives:** To qualitatively explore the challenges, coping strategies, and perceived solutions reported by CHOs delivering comprehensive primary health care services at SC-HWC in Bharuch district, Gujarat. **Methods:** Semi-structured qualitative interviews were conducted with CHOs at all 22 sampled SC-HWCs in Bharuch district during FY 2024–2025. Interview data were thematically analyzed and organized under administrative/financial, infrastructural, human resource/team dynamics, inter-sectoral/community engagement, and non-communicable disease/newer-service-package domains. **Results:** CHOs consistently reported three to four-month delays in Team-Based and Performance-Based Incentive disbursement, unclear awareness of untied fund allocations, and infrastructural constraints including flooding, absent boundary walls, and lack of separate staff washrooms. Team dynamics challenges included vacant Female Health Worker(FHW) and Multi-Purpose Health Worker(MPHW) posts increasing workload, and unclear role division between CHOs and supervisory cadres for reproductive-child-health versus non-communicable disease responsibilities. Most CHOs were unfamiliar with the formal "Newer 5 Packages" terminology despite delivering component services, reported non-communicable disease drug stock-outs and connectivity barriers affecting data entry. Despite these constraints, CHOs described community engagement solutions including WhatsApp groups, Gram Sabha-linked information-education-communication campaigns, and non-governmental organization-supported wellness activities. **Conclusion:** CHOs in Bharuch district function as resilient frontline problem-solvers navigating substantial financial, infrastructural, and human resource constraints, and their qualitative accounts provide a coherent, systems-level explanation for gaps in non-communicable disease care continuity and community awareness documented elsewhere in this district assessment.

KEYWORDS

Community Health Officer; Qualitative study; Comprehensive primary health care; Health and Wellness Centre; Ayushman Bharat; Gujarat

INTRODUCTION

The Community Health Officer (CHO) cadre was created under Ayushman Bharat as a new category of mid-level health provider, typically a nurse or Ayush graduate who has completed a six-month Certificate Course in Community Health, positioned to lead clinical and public health functions at Sub Centre-Health and Wellness Centre (SC-HWCs).[1] Unlike the traditional Auxiliary Nurse Midwife role, which historically centered on maternal and child health and family planning, CHOs are mandated to manage a substantially wider clinical and administrative scope, including non-communicable disease (NCD) screening and management, communicable disease control, reproductive and child health (RCH) services, adolescent health, geriatric and palliative care, and increasingly, financial and administrative responsibilities tied to Jan Arogya Samiti (JAS) funds and incentive-linked performance schemes.[1,3]

Quantitative facility assessments can document whether services are technically available or functional, but they cannot fully capture why certain services remain incompletely delivered, or how CHOs themselves experience and navigate systemic constraints in their daily work.[4] Qualitative inquiry directly with CHOs therefore provides an essential complementary lens, allowing the human factor behind observed quantitative gaps to be understood in the providers' own terms.[4,5] International evidence on primary care benefit-package implementation consistently identifies financing delays, weak governance support, and workforce strain as recurring, mutually reinforcing barriers, a pattern this study specifically examines within the Indian CHO context.[4]

Semi-structured interviews were conducted with CHOs at all 22 sampled SC-HWCs in Bharuch district, explicitly designed to elicit their first-hand accounts of operational, financial, infrastructural, human resource, and community engagement challenges, alongside self-identified coping strategies and solutions.[2]

This manuscript isolates and presents the CHO-specific findings from this qualitative exercise, distinguishing their frontline, Sub Centre-level perspective from that of Medical Officers at Primary Health Centre-Health and Wellness Centers (PHC-HWCs).

OBJECTIVES

1. To qualitatively explore the challenges, coping strategies, and perceived solutions reported by CHOs delivering comprehensive primary health care services at SC-HWC in Bharuch district.

MATERIAL AND METHODS

Study design and setting

This was a qualitative descriptive study using semi-structured interviews, cross-sectional, Comprehensive Primary Health Care (CPHC) baseline assessment carried out in Bharuch district, Gujarat, India, during FY 2024–2025, by the Department of Community Medicine, GMERS Medical College, Gotri, Vadodara, in collaboration with the State Health Systems Resource Centre, Gujarat, for the Health and Family Welfare Department, Government of Gujarat.[1,2]

Study participants and sampling

Participants were Community Health Officers posted at each of the 22 Sub Centre-Health and Wellness Centers sampled for the broader district assessment, representing approximately 10% of SC-HWCs in the district, selected using a probability-proportional-to-size method with representation across all talukas.[2] This included the full complement of CHO leadership across all sampled sites.

Data collection

Data were collected through semi-structured interviews designed to elicit narrative accounts across five broad thematic domains: administrative, operational, and financial challenges (fund availability, timeliness, and adequacy); infrastructure (physical infrastructure and equipment); team dynamics and human resources (inter-team conflicts, role clarity, staff sufficiency); inter-sectoral coordination and community engagement (local civic responsiveness, functionality of Jan Arogya Samiti and Village Health, Sanitation, and Nutrition Committee platforms); and service delivery challenges specific to non-communicable disease and newer service packages (staff competency, drug stock-outs, supervision, referral, and information technology-related data portal usability).

Data analysis

Interview data were analyzed thematically using a structured theme,

sub-theme, and category framework, as pre-specified in the assessment's qualitative analysis matrix, spanning administrative/financial, infrastructure, team dynamics/human resource, inter-sectoral coordination, and service delivery/newer-package domains.

Ethical considerations

Administrative approval was obtained from the Health and Family Welfare Department, Government of Gujarat, and the District Health Authority of Bharuch prior to data collection.

The study was conducted in accordance with the ethical principles for research involving human subjects outlined in the Declaration of Helsinki.[5]

RESULTS

Interviews were conducted with Community Health Officers at all 22 sampled Sub Centre- Health and Wellness Centers in Bharuch district. Findings were organized into five major thematic domains, summarized in Table 1, with illustrative content and corroborating quantitative cross-references presented in Table 2.

Theme 1: Administrative, operational, and financial challenges

CHOs across multiple centers reported delays of three to four months in receiving Team-Based Incentive and Performance-Based Incentive payments, which they directly linked to reduced motivation and delayed service-related interventions. Untied funds meant for minor repairs and maintenance were similarly delayed, and even when disbursed on time, were often described as inadequate relative to incidental facility costs. A recurring finding was that many CHOs were themselves unclear about the exact amount of untied and maintenance grants allocated to their facility, limiting their ability to plan resource use proactively.

Theme 2: Infrastructure and equipment

CHOs described structural deficits directly affecting service delivery, including flooded buildings during monsoon, absence of boundary walls, and long-standing ceiling leaks. Functional constraints included temporary facility setups and inadequate equipment, such as the absence of a dedicated labour table at a facility conducting regular deliveries, and lack of a radiant warmer for newborn care corners. Communication infrastructure gaps were also raised, with poor network coverage disrupting emergency coordination. CHOs also flagged the absence of separate staff washrooms and unmet needs for ramps and rain-shelters as recurring maintenance gaps.

Theme 3: Team dynamics and human resource concerns

CHOs reported that persistent vacancies in key supporting roles increased their own workload and reduced overall team efficiency; like FHW and MPHW, CHOs specifically described misaligned role expectations creating internal friction, particularly regarding division of responsibility between CHOs and supervisory ANM cadres for reproductive-child-health versus non-communicable disease program activities. Safety concerns were raised by CHOs at centers located near highways, citing risks from intoxicated individuals in the absence of round-the-clock security personnel. CHOs also described difficulty adapting to new programmatic and digital reporting methods, compounded by a lack of dedicated administrative or data-entry support.

Theme 4: Inter-sectoral coordination and community engagement

CHOs reported that Jan Arogya Samiti bank accounts were non-functional at several centers, directly limiting their ability to utilize community engagement funds for local health promotion activities. Attendance at Jan Arogya Samiti and Village Health, Sanitation, and Nutrition Committee meetings was reported as poor by multiple CHOs, which they felt weakened local health governance and, by extension, community awareness of available services. Several CHOs also described minimal cooperation from local Sarpanch's and civic leaders as a specific obstacle to organizing community health initiatives.

Theme 5: Non-communicable disease services and newer service packages

CHOs generally reported that monthly Nirmaya non-communicable disease camps were an effective mechanism for early diagnosis and ongoing management of hypertension and diabetes patients. However, most CHOs were not familiar with the specific term "Newer 5 Packages Service Delivery," even though many, on clarification, recognized that they were already delivering component services under different informal labels, an important terminology-versus-practice gap. CHOs identified specific operational constraints including shortages of specialized staff for early cancer diagnosis, recurring stock-outs of core NCD medicines including Metformin, Losartan, and Amlodipine attributable to demand exceeding allocation, and an unmet need for point-of-care diagnostic tools such as glycated hemoglobin testing. Information technology-related barriers were prominent: CHOs described poor internet connectivity and outdated systems hampering NCD software data entry, with one specific complaint that deceased or migrated patients could not be removed from the software, inflating apparent caseloads.

Community Health Officer-reported innovations and coping strategies

Despite these constraints, CHOs described several self-initiated or locally adapted solutions to sustain service delivery. These included using Gram Sabha meetings and local market events as informal information-education-communication platforms, forming WhatsApp groups with community members to enable real-time engagement and follow-up reminders, and collaborating with local non-governmental organizations to organize yoga sessions and other wellness activities. These findings suggest that, even amid documented systemic constraints, Community Health Officers are actively exercising agency to adapt service delivery to local conditions.

Table 1: Thematic framework of Community Health Officer interview findings, Bharuch district (n=22)

Theme	Sub-theme	Illustrative category
Administrative, operational, and financial challenges	Fund availability	Timeliness and adequacy of TBI/PBI and untied funds
Infrastructure	Physical infrastructure and equipment	Flooding, absent boundary walls, ceiling leaks, missing labour table/radiant warmer
Team dynamics and human resources	Inter-team conflicts; job role clarity; HR sufficiency	CHO-ANM role ambiguity; vacant FHW/MPHW posts; workload strain
Inter-sectoral coordination and community engagement	JAS/VHSNC functionality; local civic support	Non-functional JAS accounts; poor meeting attendance; weak Sarpanch support
NCD services and newer service packages	HR competency; drugs/logistics; supervision; referral; IT	Terminology gap; drug stock-outs; software/ connectivity issues

Table 2: Illustrative Community Health Officer-reported challenges and corresponding coping strategies

Domain	Reported challenge	Reported coping strategy / solution
Financial	3-4 month delay in TBI/PBI disbursement; unclear untied fund allocation	Informal follow-up with district office; prioritization of essential repairs
Infra-structure	Monsoon flooding; absent boundary wall; ceiling leakage	Use of untied/local funds for stop-gap repairs where possible
Human resources	Vacant FHW/MPHW posts; role ambiguity with ANM cadre	Informal task-sharing; increased personal workload
Commun ity enga-gement	Non-functional JAS accounts; poor VHSNC attendance	WhatsApp groups; Gram Sabha-linked IEC; NGO-supported wellness sessions
NCD/ne-wer packages	Drug stock-outs; poor connectivity; software usability issues	Nirmaya camps for early NCD diagnosis; manual record-keeping as backup

DISCUSSION

This qualitative assessment demonstrates that CHOs in Bharuch district function within a demanding operational environment shaped by financing delays, infrastructural deficits, human resource strain, and inconsistent community governance support, while simultaneously exercising considerable frontline resourcefulness to sustain service delivery. [2]The consistency of the incentive-payment delay theme across multiple Sub Centre-Health and Wellness Centers is particularly noteworthy, since Community Health Officer remuneration is explicitly tied to performance-based incentive structures under the Comprehensive Primary Health Care model; sustained delays in incentive disbursement risk undermining exactly the motivational mechanism the incentive design was intended to create.[1,2]

The reported lack of clarity among Community Health Officers

regarding untied and maintenance fund allocations is a notable and correctable governance finding, since it suggests that the barrier here may lie as much in communication and financial transparency as in the absolute magnitude of the funds themselves. [2]This represents a low-cost, high-value area for improvement compared with structural fixes such as new buildings or connectivity infrastructure.[2]

The team dynamics findings, specifically role ambiguity between Community Health Officers and supervisory Auxiliary Nurse Midwife cadres over reproductive-child-health versus non-communicable disease responsibilities, provide an important qualitative explanation for a pattern observed in companion quantitative data from this same district assessment, where non-communicable disease management competency and treatment continuity were comparatively weaker than reproductive-child-health-oriented domains. [2]If Community Health Officers and supervisors are genuinely uncertain about who owns specific non-communicable disease follow-up tasks, this ambiguity could plausibly contribute to observed drop-offs in treatment initiation and follow-up, independent of any individual competency gap.[2]

The terminology gap around the "Newer 5 Packages" framework is a particularly instructive governance and communication finding. [2]It indicates that some apparent implementation gaps identified through structured quantitative tools may partly reflect a disconnect between program branding and field-level practice rather than a true absence of service delivery, since Community Health Officers were often already delivering the relevant services without recognizing the formal programmatic label. [2]This nuance is important for correctly interpreting quantitative service-delivery data collected elsewhere in this assessment.[2]

The information technology-related barriers described by Community Health Officers, particularly around non-communicable disease software connectivity and outdated patient records. This convergence between Community Health Officer-reported qualitative frustration and objectively measured digital infrastructure gaps strengthens confidence that digital readiness is a genuine, high-priority barrier to non-communicable disease data management continuity at Sub Centre-Health and Wellness Centre level.[2]

Finally, the community engagement findings, namely non-functional Jan Arogya Samiti accounts and poor Jan Arogya Samiti/Village Health, Sanitation, and Nutrition Committee meeting attendance, offer a plausible qualitative explanation for the low community awareness of several comprehensive primary health care service categories documented in the parallel community awareness component of this district assessment, since these platforms are the formally mandated channel for local health promotion. [2]At the same time, Community Health Officers' own innovations, including WhatsApp groups, Gram Sabha-linked information-education-communication activities, and non-governmental organization partnerships, suggest that where formal platforms are weak, informal, locally adapted engagement mechanisms are partially compensating, and could be formally recognized and scaled as part of future community engagement strategy.[2]

STRENGTHS AND LIMITATIONS

This study's key strength is that it captures the perspective of the full complement of Community Health Officers across all 22 sampled Sub Centre-Health and Wellness Centres, providing broad frontline coverage directly from the cadre most responsible for community-level comprehensive primary health care delivery. [2]

Limitations include that this manuscript is based on thematically summarized interview data rather than original verbatim transcripts, precluding direct quotation or formal inter-coder reliability reporting. Additionally, findings represent Community Health Officers' own perceptions and self-reports, which may be subject to social desirability or recall bias, and the cross-sectional design cannot establish whether these challenges are improving over time.[2]

CONCLUSION

Community Health Officers in Bharuch district reported substantial and recurring challenges spanning incentive payment delays, unclear fund allocation communication, infrastructural deficits, human resource vacancies, role ambiguity with supervisory cadres, and weak functioning of community engagement platforms. At the same time, Community Health Officers demonstrated considerable frontline adaptability through informal community engagement innovations. These qualitative findings provide a coherent, provider-centered explanation for several quantitatively observed gaps in non-communicable disease care continuity, digital data management, and community awareness documented elsewhere in this district assessment.

Recommendations

- Establish predictable, transparent timelines for Team-Based Incentive/Performance-Based Incentive and untied fund disbursement, with proactive communication to Community Health Officers regarding exact allocated amounts.
- Clarify role division between Community Health Officers and supervisory Auxiliary Nurse Midwife cadres for non-communicable disease versus reproductive-child-health program responsibilities through written, facility-specific task delineation.
- Prioritize digital infrastructure upgrades, including internet connectivity and desktop/laptop availability, at Sub Centre-Health and Wellness Centers with the lowest current connectivity, directly informed by the Community Health Officer-reported information technology frustrations in this study.
- Standardize and clearly communicate "Newer 5 Packages" terminology and expectations to all Community Health Officers, explicitly mapping it to services they may already be delivering under informal labels.
- Formally recognize and scale Community Health Officer-initiated community engagement innovations, such as WhatsApp groups, Gram Sabha-linked information-education-communication activities, and non-governmental organization partnerships, as part of official community engagement strategy, alongside efforts to revitalize Jan Arogya Samiti and Village Health, Sanitation, and Nutrition Committee functionality.
- Address highway-proximity safety concerns at affected Sub Centre-Health and Wellness Centers through basic security provisions.

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