ROLE OF JAN AROGYA SAMITIS IN STRENGTHENING COMPREHENSIVE PRIMARY HEALTHCARE, DISTRICT KHUNTI, JHARKHAND

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Under the Supervision and Guidance of

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TO WHOM SO EVER IT MAY CONCERN

This is to certify that Dr. Ankit Bhonsle worked as an Intern in Knowledge Management Division in National Health Systems Resource Centre, New Delhi from 10th March 2025 to 9th June 2025.

We wish him success in all future endeavours.

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CERTIFICATE

This is to certify that the dissertation titled "**Role of Jan Arogya Samitis in Strengthening Comprehensive Primary Healthcare, District Khunti, Jharkhand**" is a record of the research work undertaken by **Dr Ankit Bhonsle** in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his approach to the research study has been sincere, scientific and analytical.

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled "**Role of Jan Arogya Samitis in Strengthening Comprehensive Primary Healthcare, District Khunti, Jharkhand**" is the Bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature) 

Name of Student: **Dr Ankit Bhonsle**

Date: 17/06/2025

Abstract

Background: Jan Arogya Samiti (JAS) has emerged as a pivotal community-based platform under the Ayushman Bharat initiative, aiming to strengthen comprehensive primary healthcare through participatory governance, social accountability, and community monitoring. Despite its strategic intent, limited qualitative evidence exists on its real-world implementation, especially in tribal and underserved regions like Khunti district, Jharkhand.

Objectives: This study aimed to explore the functioning and impact of JAS in enhancing community participation, social accountability, and service utilization. Specific objectives included examining the formation process, fund utilization, capacity-building efforts, and identifying enablers and barriers to effective implementation.

Methods: A qualitative, exploratory design was adopted. Data was collected over two days from six Ayushman Arogya Mandirs (AAMs), the District Health Office, and the State Health Directorate using purposive sampling. Tools included in-depth interviews (IDIs), key informant interviews (KIIs), focus group discussions (FGDs), direct observation, and document review. Thematic content analysis was used to analyze the data.

Results: JAS formation followed national guidelines, with representation from marginalized groups. However, participation was often passive. While 90% of untied funds were utilized, challenges in digital transactions and limited financial literacy were noted. Community awareness of JAS roles and grievance mechanisms was low, but OPD utilization increased post-JAS implementation. Capacity-building support was limited to one-time orientation sessions, with no ongoing training.

Discussion: The study highlights structural readiness but operational gaps, particularly in capacity-building, participatory decision-making, and community engagement. Where CHOs and community members actively collaborated, JAS contributed significantly to health awareness and outreach.

Conclusion: JAS holds promise in democratizing primary healthcare governance. For sustainability and scale, regular training, increased community ownership, flexible fund guidelines, and institutionalized support are essential.

Keywords:

Jan Arogya Samiti, Rogi Kalyan Samiti, Village Health Sanitation Nutrition Committee, Ayushman Arogya Mandir, Community Health Officer, Untied Funds.

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LIST OF ABBREVIATIONS

S.No	Abbreviation	Full Form
1	AAM	Ayushman Arogya Mandir
2	AB-HWC	Ayushman Bharat - Health & Wellness Centre
3	ANM	Auxiliary Nurse Mid-Wife
4	ASHA	Accredited Social Health Activist
5	AWW	Anganwadi Worker
6	CHC	Community Health Center
7	CHO	Community Health Officer
8	CPHC	Comprehensive Primary Health Center
9	FGD	Focus Group Discussion
10	IDI	In-Depth Interview
11	IEC	Information, Education and Communication
12	JAS	Jan Arogya Samiti
13	MAS	Mahila Arogya Samiti
14	MoHFW	Ministry of Health & Family Welfare

15	MoIC	Medical Officer In-Charge
16	NHM	National Health Mission
17	NRHM	National Rural Health Mission
18	PRI	Panchayati Raj Institutions
19	RKS	Rogi Kalyan Samiti
20	SHC	Sub Health Centre
21	VHSNC	Village Health Sanitation Nutrition Committee

Chapter 1 : Introduction

1.1 Background:

"World Health Organization suggested that the development in health outcomes should be more centered towards the people and should more directly promote people's participation.(1)" "Community participation is one of the core principles of primary healthcare. The World Health Organization suggested that the development should be more people-centered and should more directly promote people's participation.(2) "Decentralization to encourage people's participation is a key strategy for making health care services effective and addressing local problems. This has been highlighted in all significant documents articulating people's right to health such as the Bhore Committee report, Alma Ata declaration, and the NRHM (National Rural Health Mission) documents. A key initiative to achieve decentralization and empowerment of local people to achieve NRHM goal was the introduction of Village Health Sanitation Committee (VHSC) in the year 2007."(3) "The government of India under the National Health Mission (NHM) earlier National Rural Health Mission (NRHM) stated to involve local communities in assessing progress on the health action plans. Public participation in monitoring is mediated through representatives of community-based organizations. One of the key elements in the implementation of the NHM is the Village Health Nutrition and Sanitation Committee (VHNSC). VHNSCs are formed at revenue village level and act as subcommittee of Gram Panchayat. They are particularly envisaged as being central to the "local level community health action" under NHM, which would develop to support the process of decentralized health planning. Thus, VHNSCs are expected to act as leadership platforms for improving awareness and access of community health services, support the healthcare providers, develop village health plans specific to the local needs, and serve as a mechanism to promote community action for health. "(1) "Under Ayushman Bharat, health and wellness centres (AB-HWCs), sub health centres (SHCs) and primary health centres (PHCs) are being transformed to Health and Wellness Centres (AB-HWCs), to provide comprehensive

primary health care (CPHC) services. Such a transformation is expected to enable these AB-HWCs to serve as the first poll of call for a range of primary health care services spanning preventive, promotive, curative, rehabilitative and palliative care to the population in their coverage area AB-HWCs are also expected to play a critical public health role and focus on collective community action for social and environmental determinants of health and support social accountability and community feedback processes. Rogi Kalyan samitis (RKS) were established under national health mission (NHM) in health care facilities at the level of PHC and above. RKS is a registered society to manage the affairs of health facilities in consonance with the principle of decentralization and devolution of administrative and financial powers. At SHC level, ASHA and Village Health Sanitation and Nutrition committees (and subsequently, ASHA and Mahila Arogya Samitis (MAS) in urban areas) Were expected to undertake community action for health, in the form of monitoring health and related public services through undertaking semi-annual Jan Sunwais or community hearings at which staff from AB-HWCs are expected to be present. Under Ayushman Bharat , the SHC level AB-HWC's, are provided Rs 50000 as untied fund, enhancing the amount from Rs 20,000 that is provided to all SHCs. There have been requests from states to form a similar committee at AB-HWC-SHC level. This committee which is being proposed to be formed at the SHC level AB-HWC shall be named as Ayushman Bharat – Jan Arogya Samiti (JAS)." (4) " Rogi Kalyan Samitis (RKS) were established by the Government of India in 2006 under the National Rural Health Mission as community-based bodies aimed at enhancing accountability, community participation, and the quality of healthcare services at public health facilities such as district hospitals, sub-district hospitals, community health centres (CHCs), and primary health centres . In June 2015, the Ministry of Health and Family Welfare issued detailed guidelines formalizing the structure, roles, and responsibilities of RKS to facilitate decentralized decision-making and strengthen community engagement in health service delivery . Currently, approximately 31,763 RKS have been constituted nationwide, playing a vital role in governance and improving service quality in public health facilities (NHM, 2023)."(5)"The Guidelines for JAS "Community Ownership of Health and Wellness Centres Guidelines for Jan Arogya Samiti" have been released by MoHFW, GoI

in December 2020. It lays down the structure, composition and principles for functioning of JAS. This handbook elaborates the functioning of JAS and roles and responsibilities of the JAS members."(6)

1.2 Rationale:

The government, both at the central and state levels, recognizes Jan Arogya Samiti (JAS) as a key mechanism to promote decentralized health governance, community participation, and accountability under Ayushman Bharat. While the central government provides policy direction and financial support, states are tasked with effective implementation at the grassroots level. However, there is limited qualitative evidence on how JAS functions in real settings.

1.3 Aim

To explore the Functioning and Impact of Jan Arogya Samiti in strengthening community participation, social accountability, and health service utilization in Khunti district, Jharkhand.

1.4 Objectives

- To review the Government of India and Government of Jharkhand JAS guidelines.
- To study JASs formation, functions, allocation, utilization, and management of untied funds within JAS, and assess the effectiveness of the grievance redressal system.
- To identify the enablers and barriers affecting the effective functioning of Jan Arogya Samiti in Khunti district.

1.5 Research Questions

- Whether the JASs formed and function as per the Government of India JAS guidelines or not in the study district?
- How JASs influence service utilization at Health and Wellness Centers?
- What are the key enablers and barriers to the effective functioning of the Jan Arogya Samiti in Khunti district?

Chapter 2 : Literature Review

S.no	Author	Objectives	Sample size	Sampling technique	Study location	Results
1	Akansha Kalra et al (2024)	To evaluate the functioning of Mahila Arogya Samiti (MAS) in Indore, including household coverage, reasons for joining, role awareness, fund utilization, implementation challenges, and providing recommendations.	28 MAS	Simple random sampling	Indore Madhya Pradesh	A significant proportion of ASHAs (64.3%) and AWWs (57.7%) reported that MAS covers more than 200 households. Nearly 42% of MAS members joined ASHA's recommendation. The majority of MAS Chairpersons (60.71%) were responsible for conducting regular monthly meetings and supporting ASHA in her duties.
2	Dr Shaik Iftikhar Ahmed (2017)	To assess the composition and functioning of VHSNCs,	100 VHNSC	SIMPLE RANDOM	Gurdaspur, Mansa, Mohali	In Punjab, VHSNCs had an average of 12 members, with

		deviations from guidelines, and member awareness about their roles.		SAMPLING	and Firozpur District in Punjab	one-fourth of the chairpersons being illiterate. Only 23% of the committees had prepared a village health plan, and meetings were held only half as frequently as required, with poor attendance. Most of the funds were used for village sanitation, while members lacked awareness about the objectives and components of VHSNC. However, all members agreed that the untied fund was useful and recommended an increase in its amount.

3	Kesavan Sreekantan Nair et al (2015)	To evaluate the structure, functioning, and stakeholder perceptions of patient welfare societies in Uttarakhand.	125 stakeholders(health provider and member of pws),980 patients	Simple random sampling	6 districts of Uttarakhand	The Patient Welfare Society model was widely accepted across health facilities, but meetings occurred infrequently, typically every 5–6 months, with poor attendance from local elected members. In 90% of facilities, planning and fund utilization under NRHM were rushed. Participation was largely limited to health department members, and expenditures were often lumped under vague “other items.” Notably, 32% of inpatients faced

						out-of-pocket costs for diagnostics and medicines, indicating gaps in free service provision.
4	Rupa Sharma et al (2016)	To understand the current pattern of untied fund allocation and utilization at VHSNCs and associated challenges. To assess stakeholders' knowledge about untied fund utilization and their roles	VHSNC's from 3 block, 2 tribal and 1 non-tribal, 120 stakeholders.	Multistage sampling	Udaipur ,Rajasthan	A majority of non-designated community members (73.33%) and nearly half of PRI members (46.67%) lacked awareness about the untied fund flow to VHSNCs, while ASHAs and ANMs showed better understanding. VHSNCs received only 74.66% of the allocated untied funds, of which 81.54% was utilized. About 31% of the expenditure was

						directed towards administrative and mandatory items. No significant difference was observed in fund utilization between Tribal and Non-Tribal blocks.
5	Aradhana Srivastava et al (2016)	To understand the structure and functioning of VHSNCs in decentralized health planning and community action for health, nutrition, and sanitation in rural, underserved areas of India, and to identify factors influencing their functioning.	169 VHSNC's , 10 FGD.	Purposive sampling	West Singhbhum, Jharkhand Kendujhar , Odisha	VHSNCs were equitably formed with over 75% women and members mostly from socially disadvantaged groups, yet less than 1% had any training. Supervision by higher officials was minimal. Their primary focus was on sanitation, health awareness, and support for vulnerable individuals. While 62%

						monitored community health workers, very few monitored sub-centres or drug availability, and almost none tracked malnutrition data. Community health and nutrition workers played key administrative roles. Major challenges included irregular meetings, poor understanding of responsibilities, planning and fund use limitations, and weak health system integration.
6	Bhuputra Panda et al (2016)	To assess local decision-makers' knowledge, perceptions, and	112 stakeholders	Multistage stratified sampling	6 districts in Odisha	The socio-demographic profiles of respondents from

		experiences regarding their abilities, training, roles, and involvement in health unit governance, including governance, infrastructure, HR, finance, and service quality; and to examine perceptual and functional differences between priority and non-priority districts while identifying predictors of RKS members' involvement in local governance.				Priority Districts (PD) and Non-Priority Districts (NPD) were similar, and most were satisfied with their governance roles. However, around 25% found NHM fund allocations to Rogi Kalyan Samitis (RKS) insufficient, and nearly half had requested additional funds, mainly for drug procurement. While 87% expressed satisfaction with their governance roles (PD: 94.3%, NPD: 80.7%), nearly all agreed that local decision-making improved health unit

						performance. Notable PD-NPD differences emerged in training, planning involvement, and interdepartmental participation. Regression analysis revealed that work experience, education, and non-monetary incentives significantly influenced RKS members' involvement in governance.
7	Somya Thakan et al (2023)	To investigate various aspects of untied fund utilization at health centres, including fund availability, adherence to NRHM guidelines, key spending areas,	27 health workers for qualitative data, secondary data from records and registers	Purposive sampling	RHTC Mandawar and its 6 subcenters	Mixed-method study highlighted key barriers and facilitators at sub-centre levels. Health workers were often understaffed, overburdened, and lacked

		decision-making processes and responsible individuals, challenges in fund usage, and to provide recommendations for improved utilization.	(nov2021 - oct2022),			adequate knowledge due to the absence of refresher training. Financial management was treated with extreme caution, reflecting the sensitive and complex nature of handling program funds.
8	Kiran M Narkhede et al (2017)	To assess the utilization pattern of untied funds allocated to RKS at CHC and PHC across Gujarat.	financial report 2013-2014 used, 300 CHC AND 826 PHC Data were collected	NA	Cross sectional descriptive study, Across Gujrat state.	RKS predominantly allocates its funds to meet local facility needs, including outsourcing staff (10%), minor civil works (12%), and drugs, consumables, and logistics (24%). A large amount of funds accounts for contingency expenses, while

						only a small portion is spent on routine operational costs such as printing, linen, and training. This expenditure pattern reflects the existing structural and managerial framework of the system. To maximize the impact of these funds, there is needs to strengthen mechanisms that ensure good fund utilization and greater benefits for the local community through RKS.
9	Manjit Das et al (2016)	To assess the constitution of VHSNCs, the activities they undertake, and fund utilization.	78 VHSNC's	NA	From 3 block of Kamrup district of assam	Over half (55.12%) of VHSNCs had 11 or more members, consistently.

						However, only 16.67% of VHSNCs held 10–12 meetings annually, and the same percentage maintained updated untied fund registers. Common discussion topics in meetings included committee formation and new members (96.15%), ASHA incentives (94.87%), and Anganwadi Center repairs (88.76%). Most VHSNCs (67.93%) utilized over 90% of the funds.
10	E.P. Abdul Azeez et al	To explore the functionality of VHSNCs in	A total of 508 VHSNC's	NA	– 270 from Chhattis garh and	The study results indicate that the majority of VHSNCs exhibit

	(2021)	Chhattisgarh and Madhya pradesh.			229 from Madhya Pradesh.	poor functionality, characterized by inadequate member participation and ineffective implementation of key responsibilities.
11	Reetu Passi et al (2017)	To assess the implementation status of VHSNCs and analyze the challenges related to their implementation in Chandigarh villages.	22 VHSNC's	NA	Chandigarh.	Most VHSNC members, except medical officers, received training and 95.4% had joint bank accounts. Most funds were spent on administrative costs, limiting resources for health and nutrition activities. About 68.9% of villages scored 25–30, indicating a "promising" implementation status of

						VHSNCs, while one village was "low performing" and six were "good performing." Public service monitoring was better in villages governed by Panchayats compared to those under Municipal Councils.
12	Raviraj Uttamrao Kamble et al (2019)	To examine the effect of VHNSC on SDH.	83 VHNSCs under 4 PHCs	purposive sampling	Maharashtra	All VHNSC members were aware that safe drinking water, sanitation, and nutrition are key social determinants of health. However, members from 7.2% of VHNSCs did not recognize the link between literacy and health.

13	Raviraj Uttamrao Kamble et al (2018)	The objective of The study is to develop a VHNSC Maturity Index (VMI) and pilot it to evaluate VHSNC's.	83 villages under 4 PHC	Purposive sampling	of the Wardha block, Maharashtra	All 83 VHNSCs were constituted according to NHM guidelines. Among them, 57.8% developed an annual Village Health Action Plan, and 86.7% held at least 4 meetings in the past 6 months. Nearly half (48.2%) reported attendance rates of 70% or higher during this period. Almost all VHNSCs (98.8%) assisted in organizing VHND, while 71.1% monitored the implementation of NHP. Additionally, 81.9% fully utilized the untied funds

						received in the previous year.
14	Neha Adsul, Manoj Kar (9) (2013)	This study aimed to analyze operational aspects and challenges of RKS under health systems strengthening	Three RKS, 1RKS at district level and 2 at block levels	NA	Pune, Maharashtra	Rogi Kalyan Samiti (RKS) is gradually working to integrate quality improvement into facility-level health services, but progress is hindered by managerial and structural weaknesses. Despite these challenges, the National Rural Health Mission (NRHM) continues to actively develop strategies to enhance community benefits and encourage stronger local participation through the RKS framework.

15	Anchal Dhiman et al (2020)	To evaluate the extent of awareness among VHSNC members regarding their roles and responsibilities. To assess community members' awareness of the VHSNC and its functions. To examine the disbursement and utilization patterns of untied funds under the VHSNCs.	30 VHSNC's from 30 villages(3 block),	Random sampling	Kanga district of Himachal Pradesh	All committee members knew about the VHSNCs, but only about 67% of the general community were aware. Some committee members were unclear about their specific roles. The most active participants were FHW, AWWs, ASHAs, Mahila Mandal representatives, and female ward panch members. Around 65% of funds were used for cleanliness activities. For nutrition, since Anganwadi Centers (AWCs) already handled most tasks, the committee's role

						remained unclear.
16	Akash Varshney et al (2022)	To assess awareness among village-level functionaries regarding the implementation and functioning of VHSNCs.	69 stakeholders interviewed, (with 3 months of membership)	NA	Doiwala and Raipur blocks of Dehradun district.	92.4% of 69 members had formal education up to high school. About half were aware of the essential documents related to VHSNC. Nearly all members (98.48%) recognized the committee's primary role in village health services; 81.82% identified providing safe drinking water as a function, 72.73% supported access to clean public toilets and sanitation, and some also noted involvement in the Public

						Distribution System.
17	Pramod Kumar Sah et al (2013)	To assess the awareness of VHSNC members about the committee's formation and their responsibilities. To examine the current role of VHSNCs in healthcare delivery at the village level, including the development of Village Health Action Plans. To understand the composition and internal processes of VHSNCs, including meeting conduct, decision-making, resource management, and conflict resolution.	8 VHSNCs Qualitative study using FGDs and interviews.	NA	Wardha, Maharashtra	Awareness of the VHNSC and its functions were highest among ANMs and AWWs. ANMs had the strongest understanding of VHNSC objectives, followed by AWWs, while Panchayat members, ASHAs, and Self-Help Group (SHG) members showed the least awareness. Most committee members were unclear about their roles and reported not receiving formal training before joining. Regarding fund usage, most members lacked

						knowledge about expenditures, with decisions primarily made by the president or secretary, often without broader consultation.
18	Sathish Rajaa et al (2024)	To systematically review articles on the roles, responsibilities, functions, and good practices of VHSNCs in India.	15 Literature Review (>1100 VHNSC's from various states)		Comprehensive data search form different source between 2005 and august 2021.15 studies included	The review shows that most VHSNCs lack clear role definitions, face irregular meetings, and have workforce shortages, with challenges in inclusivity and fund management. Despite this, they actively promote health through village plans, sanitation, and malnutrition referrals. Strengthening support and capacity building

						is essential for their effectiveness in improving rural health outcomes.
19	*Heikrujam Nongyai Nongdrenkhomba et al (2014)*	This paper analyzes the perspectives of Rogi Kalyan Samiti (RKS) members in relation to the evolving community–health system structure aimed at enhancing governance.	64 facilities		NE States including Tripura	Rogi Kalyan Samiti (RKS) was established in 2006–07 to strengthen the health system through local governance, financial management, and service improvement. Funds were mainly used for essential services like furniture and biomedical waste management. Regular meetings, such as those in Tripura (72%), improved facility operations. While RKS enhanced local

						participation in health governance, its effectiveness relies on resources, member capacity, and administrative processes.
20	Annu Antony et al (2023)	To assess the knowledge of male and female health workers and the effectiveness of untied fund utilization at the sub-center level.	24 sub centers (UNDER 1 CHC)	Universal sampling	Tangi Block, Khordha district, Odisha	Seven out of 24 sub-centers did not spend any funds, with a median unspent amount of ₹4,260. About 36.8% experienced delays of up to 9 months in receiving untied funds, which hindered their utilization. Additionally, 37% of health workers misused the funds, and none had full knowledge of proper fund

						usage. Key barriers included communication gaps, workload, lack of cooperation from officials, delays in processing, and irregular Gram Sabha meetings.

Chapter 3: Methodology

3.1 Study Design

This study used a descriptive, exploratory qualitative design to gain an in-depth understanding of the functioning, participation, challenges, and impact of the Jan Arogya Samiti (JAS) interventions in the selected study area. The qualitative approach was chosen to explore perceptions, experiences, and processes from the perspective of multiple stakeholders involved in the implementation of JAS, allowing for rich and contextual insights.

3.2 Study Area

The study was conducted in Khunti district, Jharkhand, a region where the JAS intervention has been actively implemented. The study was conducted over two days, on 16th and 17th April 2025, and Data collection was conducted across six Ayushman Arogya Mandirs (AAMs) where JAS activities were reported to be active. Additionally, data was collected from the Community Health Centre (CHC) in Khunti, the District Health Office (Khunti), and the State Health Directorate in Ranchi to capture perspectives at various administrative and operational levels.

3.3 Sampling

Purposive sampling was utilized to select JAS units and respondents who were actively involved in or knowledgeable about the JAS intervention and its processes. AAM showing consistent participation and timely reporting in JAS registers and meetings were prioritized to ensure rich data on active functioning. Key informants, including Community Health Officers (CHOs), Auxiliary Nurse Midwives (ANMs), Panchayati Raj Institution (PRI) representatives, JAS members, community members, and officials at district and state levels, were purposively selected based on their roles and involvement with JAS.

3.4 Data Collection Methods

Multiple qualitative data collection methods were employed to triangulate findings and obtain comprehensive information:

- **Document Review:**
  Key documents such as JAS registers and Social Audit Registers were reviewed to assess record-keeping, fund utilization, and social accountability practices.

- **Observations:**
  An observation checklist was used to assess the infrastructure, documentation practices, and community engagement activities at the selected AAM.

- **Key Informant Interviews (KIIs):**
  Semi-structured interviews were conducted with CHOs, ANMs, PRI representatives, JAS members, community members, and district and state officials to gather detailed insights on JAS operations, challenges, and perceived impact.

- **In-Depth Interviews (IDIs):**
  Six CHOs and selected state and district officials were interviewed in greater depth using a semi-structured questionnaire, enabling a detailed understanding of administrative processes and implementation challenges.

- **Focused Group Discussions (FGDs):**
  JAS members from three distinct AAMs participated in focus group discussions (FGDs), and one AAM's community members (Munda Tribe) participated in an FGD. The collective experiences, perceptions, and social dynamics influencing JAS functioning were examined in these group discussions.

Table 1: Date and Facility type for Data Collection with Respondent Details

S.No	Date	Facility/Location	Interviewed
1	16-04-2025	Directorate of Health,Namkum,Ranchi	IDI with State Nodal Officer(CPHC-AAM), State Program Coordinator (CM-Cell)
2	16-04-2025	District Health Office, Khunti	IDI with Chief Medical Officer, District Program Coordinator
3	16-04-2025	AAM-Gutjhora,Sadar Block	IDI with CHO,FGD with JAS members

4	16-04-2025	AAM-Dodhma,Topra Block	IDI with CHO, FGD with JAS members
5	17-04-2025	AAM-Lodhma,Sadar Block	IDI with CHO, FGD with JAS members
6	17-04-2025	AAM-Mahil, Murhu Block	IDI with CHO, FGD with Munda tribe
7	17-04-2025	AAM-Burju, Murhu, Block	IDI with CHO, Interaction with TB survivor
8	17-04-2025	CHC,Murhu,Block	IDI with Block Medical Officer
9	17-04-2025	AAM-Kalamati,Khunti,Block	IDI with CHO

3.5 Ethical Considerations

.All participants gave their informed verbal and written consent prior to data collection after being fully informed about the study's goals, methods, and intended use of the data. Participants were assured of anonymity and confidentiality, including that no publications or reports would reveal their identities. Additionally, they were made aware of their freedom to leave the study at any time without facing any consequences.

3.6 Data Analysis

The qualitative data gathered through interviews, focus group discussions (FGDs), observations, and document reviews were examined utilizing thematic content analysis, a methodology adept at identifying, analyzing, and reporting trends within qualitative data. This technique allows for a comprehensive investigation of themes related to community engagement, governance, challenges, and the effects of the JAS intervention. All audio-recorded interviews and FGDs underwent verbatim transcription. The research team engaged in multiple readings of the transcripts and observation notes to develop a thorough familiarity with the data, ensuring a deep understanding of participants' perspectives. Manual line-by-line coding was performed on the transcripts. Significant segments of text—

comprising phrases, sentences, or paragraphs relevant to the research inquiries—were marked with descriptive codes. Similar and related codes were clustered to create broader categories or themes that reflect common patterns or challenges arising from the data. These themes highlighted crucial areas such as participation strategies, fund management, capacity development, implementation challenges, community accountability, and impacts on service delivery. The themes were reviewed for consistency and coherence. The research team compared coded extracts of data both within and across themes to confirm that each theme was clearly articulated and separate. Each theme was distinctly defined and labeled to effectively communicate its core significance. Sub-themes were also recognized to capture specific aspects within larger themes, offering detailed insights. Themes were interpreted considering the study's goals and the existing literature, contributing to a cohesive understanding of how JAS operates and its results. Direct quotations from participants were included to enrich the narrative and substantiate findings. To enhance the credibility of the analysis, the study implemented strategies such as triangulating data sources (Interviews, FGDs, Observations, and Documents). This thorough analytical method ensured that the findings were credible, reliable, and reflective of the participants' experiences.

Chapter 4 : Results

This study highlights the main results from a qualitative evaluation of the operations and effects of the Jan Arogya Samiti in the Khunti district of Jharkhand. The assessment took place over a span of two days, on April 16th and 17th, 2025, with data gathered from various sources and stakeholders at different levels of the health system to ensure a comprehensive understanding of the JAS initiative. The results are drawn from a review of documents, field observations, key informant interviews, in-depth conversations, and focused group discussions carried out at six chosen Ayushman Arogya Mandirs, the Community Health Centre in Khunti, the District Health Office, and the State Health Directorate located in Ranchi.

The use of purposive sampling enabled the selection of AAMs and respondents who demonstrated consistent engagement with the JAS initiative, ensuring that data reflected active implementation processes. The results are organized thematically and highlight key aspects such as the structure and composition of JAS, community participation, fund utilization and management, capacity building and support, as well as enablers and barriers affecting the overall effectiveness of the initiative. Through the integration of multiple data sources, the study aims to provide an in-depth understanding of the role and functioning of JAS in strengthening community engagement and primary health care delivery in tribal and rural settings.

Table 2: Themes and Sub-Themes for Evaluation of Jan Arogya Samiti (JAS)

Theme	Sub-Themes
4.1 Formation and Structure of JAS	4.1.1 Background and formation of JAS 4.1.2 Composition and Representation of Members 4.1.3 Selection Criteria and Inclusion of Marginalized Groups 4.1.4 Roles and Responsibilities of JAS members
4.2 Governance and Accountability	4.2.1 Frequency and Documentation of Meetings 4.2.2 Transparency in Decision-Making 4.2.3 Grievance Redressal Mechanism 4.2.4 Monitoring and Supervision by Higher Authorities
4.3 Fund Management and Resource Utilization	4.3.1 Disbursement and Utilization of Untied Funds 4.3.2 Financial Planning and Budgeting by JAS
4.4 Community Engagement and Participation	4.4.1 Community Awareness of JAS , Member & Activities 4.4.2 Participation of Community Members in Health Decisions
4.5 Capacity Building and Handholding support	4.5.1 Orientation and Training of JAS Members 4.5.2 Technical Support from Health Department/NGOs
4.6 Impact on Service Delivery and Utilization	4.6.1 Enhanced Utilization of Primary Health Services 4.6.2 Role of JAS in Outreach and Awareness

4.7 Enablers and Challenges	4.7.1 Enablers 4.7.2 Challenges

4.1 Formation and Structure of JAS

4.1.1 Background and formation of JAS

As stated by state nodal officer,CPHC-AAM, the formation of Jan Arogya Samiti (JAS) was guided by the MoHFW's document, *" Guidelines for Jan Arogya Samiti"*, released in December 2020 (MoHFW, GoI, Order No. Z-28015/49/2020/-NHM-1, dated 14.02.2020). These guidelines outline the structure, composition, and operational principles of JAS at Aayushman Arogya Mandir .

JAS was established specifically to support the AAM initiative, with a focused approach to strengthen its local administration and management. The initiative is aimed at enhancing accountability and community participation in the healthcare delivery system. The formation process was supported by two external agencies, which provided both financial and technical assistance, as quoted by state program coordinator, CM Cell.

The establishment of JAS in the selected AAM areas under this study was initiated following a directive from the state government. Community meetings were conducted with the active involvement of health officials. Gram Sabha was formally informed about the program, discussions with community members were documented, and necessary permissions were obtained. All the CHO's said

"We were ordered by the state government to form such a committee in every AAM. After receiving the order, we discussed the entire matter with the Gram Sabha and after discussing with them and taking their permission, we formed Jas."

4.1.2 Composition and Representation of Members

As per the guidelines, each JAS comprises 18–20 members. Special emphasis is given to the inclusion of women, Scheduled Castes (SC), Scheduled Tribes (ST), and recovered TB

patients to ensure equitable and inclusive representation. The Mukhiya (village head) serves as the Chairperson, the Medical Officer in Charge (MOIC) as the Co-Chairperson, and the Community Health Officer (CHO) acts as the Member Secretary.

Table 3: Overview of JAS Formation and Composition at Selected AAM in Khunti District

Block	Name Of the Facility	Jas Formation Date	Chairperson	Number Of Members
Sadar	Aam-Gutjhora	1-0CT-2021	Mukhiya	18
Topra	Aam-Dodhma	APR-2021	Mukhiya	20
Karra	Aam-Lodhma	JUNE-2022	Mukhiya	18
Murhu	Aam-Mahil	JUNE-2022	Mukhiya	20
Murhu	Aam-Burju	28-MAR-2021	Mukhiya	19
Khunti	Aam-Kalamati	22-AUG-2022	Mukhiya	19

The study examined Jan Arogya Samiti (JAS) formation across six Health and Wellness Centres (HWCs) in Khunti district. All committees were chaired by the local *Mukhiya* and formed between March 2021 and August 2022. Membership ranged from 18 to 20 individuals per committee, indicating consistent representation. The timely formation of JAS across blocks like Sadar, Murhu, Karra, Topra, and Khunti suggests active local governance and alignment with guidelines.

JAS meetings are mandated to be held regularly monthly, with a minimum attendance requirement of 50% of members. The CHO is responsible for informing members at least seven days in advance. All meetings must be properly documented, including minutes, attendance, and financial transactions as told by all the respondents CHO's.

JAS members are actively involved in promoting community participation, monitoring health services, managing untied funds, and contributing to the planning of local health

activities. They also play a critical role in conducting meetings, maintaining records, and facilitating communication between the community and the AAM. Many CH0's said

"Because of the JAS members, the work of the Sahiya has become much easier, and community participation has significantly increased compared to earlier."

4.1.3 Selection Criteria and Inclusion of Marginalized Groups

Analysis of data from meeting records, recorded interactions with JAS members, and interviews with officials suggests that while the selection process generally followed the prescribed norms, the inclusion of marginalized groups—such as Scheduled Castes, Scheduled Tribes, and women—was consistent. Although these groups were officially represented in the committee, recorded interactions revealed increased engagement in discussions and decision-making. Some members expressed uncertainty about their roles or felt sidelined during meetings. This indicates that while inclusion exists on paper, meaningful participation of marginalized members can be improved further, pointing to the need for more inclusive and empowering engagement strategies.

4.1.4 Roles and Responsibilities of JAS Members

Analysis of recorded member interactions and interviews with both JAS participants and health officials revealed varying levels of clarity regarding roles and responsibilities. While some members articulated their understanding of their roles in planning, oversight, and community mobilization, others showed limited awareness, indicating gaps in orientation and training. Meeting documentation showed uneven participation patterns, further corroborating this variability. This evidence underscores the need for structured capacity-building efforts to ensure that all members clearly understand their roles and can contribute effectively to the functioning of the JAS.

An examination of recorded interactions among members and discussions with both JAS participants and health officials revealed differing degrees of understanding regarding roles and responsibilities. While some members expressed a clear awareness of their roles in planning, oversight, and community mobilization, others displayed a limited understanding,

highlighting deficiencies in orientation and training. Documentation from meetings indicated inconsistent patterns of participation, further supporting this variability. This analysis emphasizes the necessity for organized capacity-building initiatives to ensure all members have a clear grasp of their roles and can effectively contribute to the operation of the JAS.

4.2 Governance and Accountability

4.2.1 Frequency and Documentation of JAS Meetings

Review of the meeting registers and discussions with officials indicated that while documentation of Jan Arogya Samiti (JAS) meetings is maintained whenever meetings take place, the frequency of these meetings has been inconsistent. Regular meetings have only been observed over the past four months. Prior to this period, meetings were held irregularly, suggesting a lack of sustained administrative discipline in earlier phases. The improvement in meeting frequency in recent months reflects a possible shift toward better coordination, though long-term consistency remains an area for improvement.

4.2.2 Transparency in Decision-Making Processes

The functioning of JAS has demonstrated a commendable level of transparency in decision-making. Documentation records confirm the active participation of JAS members in meetings, with decisions and action points being recorded systematically. Interactions with committee members further confirmed their involvement in discussions and planning. This participatory approach not only promotes transparency but also empowers local stakeholders to influence decisions that directly impact health service delivery in their communities**.**

4.2.3 Grievance Addressal System

In all observed AAM, a complaint box was physically present, indicating the provision for a formal grievance redressal mechanism. However, it was said that no written complaints had been submitted by community members. Grievances were primarily communicated verbally and were generally addressed during Jan Arogya Samiti (JAS) meetings or Gram Sabha sessions. While this reflects an informal but functional system of redressal, the lack of written documentation suggests limited community awareness. Most of the CHO’s said

"There is a complaint box, but people prefer to come directly to us and share their concerns. Till now, no one has submitted a written complaint. We try to resolve their issues through the JAS meetings or the Gram Sabha."

4.2.4 Monitoring and supervision

There is an evident gap in the monitoring and supervision of Jan Arogya Samiti (JAS) activities, as highlighted by both higher authorities and the Community Health Officer (CHO). Respondents reported that no formal mechanism has been established to regularly oversee the functioning, meetings, or decision-making processes of JAS. Strengthening monitoring frameworks is essential for enhancing the transparency and performance of JAS at the community level.

4.3 Financial management

4.3.1 Disbursement and Utilization of Untied Funds

The financial management practices of the Jan Arogya Samiti (JAS) reflect a functional yet context-specific adaptation to local challenges. Each JAS receives an untied fund of ₹50,000 annually. Respondents reported that nearly 90% of the entire amount is typically utilized within the financial year, indicating active fund usage. The JAS operates a joint bank account under the names of three members – Mukhiya, CHO and ANM. Withdrawals require signatures from all authorized members, ensuring a level of accountability and transparency.

4.3.2 Financial Planning and Budgeting by JAS

Decisions regarding fund withdrawal and expenditure are collectively made during JAS meetings. Expenditures are only carried out after discussions and consensus among members, showcasing participatory governance.

A small portion of the fund, typically ₹5,000, is retained as petty cash to address urgent or minor expenses. However, members reported operational difficulties, particularly in disbursing payments. Many vendors and community service providers are reluctant to accept cheques, preferring cash transactions. Additionally, some local individuals do not have bank

accounts and do not engage in online financial transactions, creating challenges for digital or cheque-based payments.

A recurrent query raised by JAS members involved the use of untied funds for medicines. Members questioned the rationale behind such expenditure, given the government's provision of free medicines. This reflects the need for better clarity and communication regarding permissible and prioritized use of funds.

These findings suggest that while financial management structures are in place and generally well-implemented, ground-level operational challenges, such as limited banking access and digital exclusion, hinder efficiency. Moreover, the lack of awareness about government fund utilization guidelines indicates a need for enhanced training and information dissemination among JAS members.

4.4 Community Engagement and Participation

4.4.1 Community Awareness of JAS, Members & Activities

The study revealed moderate to low community awareness regarding the existence and role of Jan Arogya Samiti (JAS). While most respondents recognized the *Mukhiya* as the chairperson, many were unaware of other members or specific activities undertaken by JAS. In facilities like AAM-Gutjhora and AAM-Dodhma, awareness was relatively higher due to active communication by ASHAs and ANMs . However, in AAM Mahil, awareness levels were significantly lower, indicating the need for improved IEC (Information, Education, and Communication) strategies.

4.4.2 Participation of Community Members in Health Decisions

Community participation in health-related decision-making processes through JAS remained limited across most facilities. Although meetings were reportedly held, community members—especially women and marginalized groups—were often passive participants. In some blocks like AAM-Burju and AAM-Lodhma , members reported that community concerns regarding maternal health and sanitation were discussed, suggesting good level of

participatory functioning. However, the overall decision-making was still largely driven by the chairperson and health workers, rather than collective community input.

Case studies

In one inspiring story from the field, an elderly women battling advanced TB had lost all hope – refusing both hospital visits and medication, But the unwavering efforts of the JAS members changed her path. Through persistent counselling and timely support ,even tapping into JAS funds when needed, they guided her through treatment. Today, fully recovered, she stands as a proud and active JAS member herself- leading the charge in mobilizing her community with the same compassion that once saved her.

4.5 Capacity Building and Handholding Support

4.5.1 Orientation and Training of JAS Members

Initial training for the Jan Arogya Samiti members was primarily supported by external agencies. Community Health Officers said that a one-day orientation training was conducted to improve members' understanding of their roles and responsibilities. As quoted by the respondents,

"In the beginning, we were given a one-day training session, during which we were provided with information related to the Jan Arogya Samiti (JAS)".

4.5.2 Technical Support from Health Department/NGOs

Additionally, these agencies participated in early JAS meetings to provide on-the-ground guidance and ensure proper functioning during the initial stages. All CHO's said

"For the initial few months, people from an external agency used to attend the meetings and helped with reporting."

However, no additional or refresher training was reported to have been provided by state or district health authorities. This lack of ongoing support suggests gaps in institutional handholding, which could affect the long-term effectiveness and sustainability of JAS

operations. Regular training and mentoring are essential to enable JAS members to perform their functions more competently, especially for the new members.

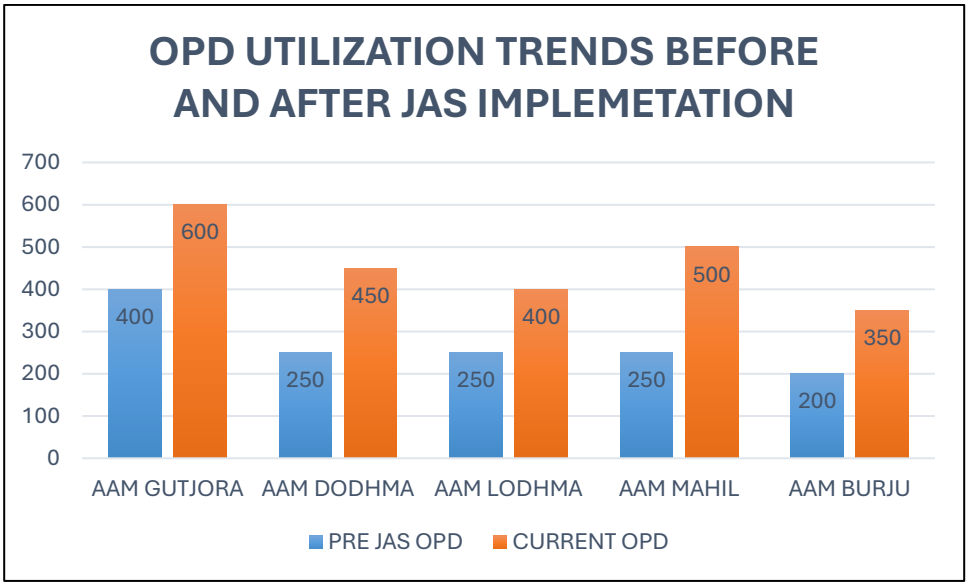
4.6 Impact on Service Delivery and Utilization

4.6.1 Enhanced Utilization of Health Services

After the implementation of the JAS, a notable increase in service utilization was recorded. Patient footfall has grown significantly, with OPD attendance rising by approximately 1.5 to 2 times compared to Pre-JAS era. This growth reflects increased community awareness about available healthcare services and their active engagement in utilizing them.

Beneficiaries have shown gratitude for the ease offered by AAM, highlighting that the combination of services has allowed them to save time and decreased the necessity of going to several facilities. Additionally, this reliable and readily available care has helped foster trust within the local community, with numerous individuals expressing interest in having more services offered at the AAM.

Graph 1 : OPD utilization trends before and after JAS implementation



4.6.2 Role of JAS in Outreach and Awareness

The study found that Jan Arogya Samiti (JAS) played a supportive role in health awareness and community outreach activities. In most of the cases observed, JAS members helped mobilize the community and supported frontline workers. However, consistent outreach was hindered by irregular meetings.

4.7 Enablers and Challenges

4.7.1 Enablers

The study identified several key enablers that supported the effective formation and functioning of Jan Arogya Samitis (JAS) across the selected Health and Wellness Centres in Khunti district. A primary factor was the consistent leadership of the *Mukhiya* as chairperson in all committees, which provided strong local governance and helped mobilize community involvement.

Support from frontline health workers like ASHAs and ANMs played a vital role in enhancing awareness about the roles of JAS and connecting the committees with existing community health programs. Moreover, the accessibility and use of untied funds encouraged members to engage actively in the planning and execution of local health projects. Collectively, these elements greatly influenced the operational effectiveness and community involvement of JAS in the area.

4.7.2 Challenges

The establishment and operation of JAS have encountered numerous obstacles since it was created, particularly concerning community dynamics and involvement. During the early stages, disputes emerged regarding the selection of members. Some individuals from the community voiced their unhappiness, questioning their exclusion from JAS membership. This suggests initial deficiencies in community awareness and clarity about the criteria and process for selecting members. Moreover, a perceived lack of personal benefit was identified

as an impediment to participation. Several people explicitly indicated that joining JAS did not provide any financial rewards, prompting them to reconsider the value of participating in the committee. This indicates a need for improved communication regarding the purpose of JAS and the importance of community involvement that does not involve financial incentives. Insufficient internet connectivity in the region limits the ability to hold meetings online. Furthermore, many members live far from the AAM and juggle various personal and work commitments, which restricts their capacity to attend meetings consistently. Additionally, challenges related to the disbursement of funds were reported. The reliance on cheques for payments often creates difficulties, especially for minor or urgent expenditures. Both community members and vendors showed reluctance to accept cheques for small transactions, resulting in delays and complications in using funds. In summary, these challenges reveal systemic, infrastructural, and perception-related obstacles that hinder the efficient operation and involvement of JAS. Tackling these issues through enhanced orientation, improved communication, and better infrastructural support may increase the committee's effectiveness and long-term viability.

Chapter 5 : Discussion and Limitations

5.1 Discussion

This study examined the functioning of JAS in the context of decentralized health governance, focusing on its formation, governance, financial management, capacity building, and community engagement in rural Jharkhand. The discussion contextualizes findings by comparing them with similar structures such as RKS and VHNSC across India, as documented in the provided references.

5.1.1 Formation and Representation

The formation process of JAS, involving local representatives and Panchayat members, is in accordance with guidelines laid out by the National Health Mission (MoHFW, 2020; NHSRC, 2020).(4) Similar to the Rogi Kalyan Samitis discussed by Adsul and Kar (2013)(7) and Kiran et al. (2017) (8), JAS aims to incorporate local governance structures to ensure community ownership.

However, this study noted, consistent with findings by Kamble et al. (2018)(9) and Dhiman et al. (2020) (3) in VHNSCs, that while formal representation exists for women and marginalized groups, their active and meaningful participation remains limited. The presence of Scheduled Tribes in JAS was mandated, yet their involvement was often nominal, echoing observations by Sah et al. (2013)(10) where social hierarchies restricted true inclusiveness.

These findings highlight that formal inclusion of marginalized groups, although a critical first step, requires continuous empowerment efforts through training and sensitization to enhance their decision-making role (Kamble et al., 2019)(1).

5.1.2 Governance and Accountability

JAS committees improved in holding regular meetings over time, reflecting a pattern similar to RKS documented by Nongyai Nongdrenkhomba et al (2014) and Nair et al. (2015), (11) (12) where committee functionality improved with experience and local support. The maintenance of meeting minutes and records, although not always consistent, is an important step towards transparency, mirroring challenges seen in RKS in Maharashtra and Gujarat (Adsul & Kar, 2013; Kiran et al., 2017).(7,8)

However, formal grievance redressal systems remained largely undeveloped in JAS, a shortcoming also reported in VHNSCs by Kamble et al. (2019) and Sah et al. (2013).(1,10) The lack of institutionalized complaint mechanisms undermines accountability and can weaken community trust in the committees.

5.1.3 Financial Management of Untied Funds

The use of joint bank accounts with multiple signatories for untied funds aligns with recommended financial governance practices in NHM guidelines (MoHFW, 2014; NHSRC, 2023).(4) This measure is designed to ensure accountability and prevent misuse, as emphasized in the RKS studies by Adsul and Kar (2013).(7)

Nevertheless, practical challenges such as difficulties with digital transactions, as reported in this study, were also documented by Kalra et al. (2024) and Kamble et al. (2018).(9,13)These barriers limit the smooth utilization of funds and sometimes force reliance on cash, which can compromise transparency.

Confusion about permissible expenditures, particularly around procurement of medicines, reflects a knowledge gap in committee members' financial training, a concern also noted by Dhiman et al. (2020) (3) in Himachal Pradesh. This points to the need for clearer guidelines and continuous financial literacy efforts.

5.1.4 Capacity Building and Member Training

Initial orientation sessions for JAS members were found beneficial but insufficient for long-term empowerment. This observation is consistent with evaluations of VHNSCs by Kamble et al. (2019) and Sah et al. (2013),(1,10) which stress that periodic refresher training is critical for sustaining committee effectiveness.

The lack of ongoing capacity-building activities, including mentoring and peer learning, limits the ability of JAS members to address emerging challenges effectively. This mirror concerns raised by Adsul and Kar (2013)(7) about the need for regular training in RKS functioning to strengthen governance capacities.

5.1.5 Community Awareness and Service Utilization

An increase in utilization of Aayushman Arogya Mandir (AAM) services following the establishment of JAS reflects the positive impact of community involvement in health governance, similar to findings from Nair et al. (2015)(12) on patient welfare societies and Kalra et al. (2024)(13) on Mahila Arogya Samitis.

However, awareness of JAS roles among the general community was limited, and decision-making was often dominated by local elites or health staff, a pattern also reported in VHNSCs by Kamble et al. (2018) and Sah et al. (2013).(9,10) This restricts broad-based community ownership and limits the potential for JAS to serve as a true platform for participatory governance.

5.2 Limitations

This study is exploratory in nature and done to examine the topic qualitatively within this specific context. As such, the findings are based on a small, purposively selected sample, which may limit the generalizability of the results. While the insights generated provide valuable initial insights, they may not be representative of the wider population. Further research with larger and more diverse samples is recommended to validate and expand upon these findings.

Chapter 6 : Conclusions and Recommendations

6.1 Recommendations

Based on the challenges and insights emerging from the qualitative study on the functioning of JAS, the following recommendations are proposed to enhance its effectiveness, inclusivity, and sustainability:

1. There should be greater flexibility in the utilization of untied funds to allow JAS to respond to context-specific needs. Clear guidelines with adaptable provisions can empower committees to address local health priorities more efficiently.
2. The current petty cash limit of ₹5,000 may be inadequate for addressing minor but urgent expenses. A review and possible enhancement of this limit can facilitate smoother day-to-day operations, especially in areas where cheque payments are not feasible.
3. Inclusion of traditional or informal community leaders, specific to each village context, should be considered. Increasing the number of JAS members to represent a broader cross-section of the community can foster better trust, participation, and accountability.
4. Regular training sessions and induction programs should be institutionalized for new JAS members to build their understanding of roles, responsibilities, fund management, and health system linkages. This can improve participation quality and decision-making.
5. A dedicated M&E committee should be formed to ensure regular assessment of progress and performance. Development of user-friendly tools, checklists, and scorecards can support systematic evaluation and accountability.
6. To gain a comprehensive understanding of the functioning, challenges, and outcomes of JAS across regions, a large-scale research study is recommended. This would inform evidence-based policy refinements and scale-up strategies.

6.2 Conclusion

The analysis of these community-based health committees, including JAS, underlines their importance as instruments of decentralized governance and community engagement in health. However, structural weaknesses, lack of role clarity, inconsistent participation, and inadequate training continue to hinder their potential. For JAS to effectively contribute to primary health system strengthening, especially in tribal and underserved regions like Khunti, Jharkhand, there is a pressing need to institutionalize regular training, ensure participatory planning, promote financial transparency, and strengthen monitoring mechanisms.

Chapter 7 : References and Appendices

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7.2Appendices

7.2.1 CHECKLIST (Q/As)

Problem Identification

1. How was this community engagement identified as a priority?
2. What led to an understanding of community engagement being low? What is the role of external and internal factors/stakeholders.
3. What indicators suggested that there was low community engagement?
4. What were the reasons for low community engagement?
5. What initiatives have been undertaken to strengthen the community engagement- in policy and programs, on the ground by the health system (National and state policies, Programs and guidelines)?
6. How did this low community engagement impact health service delivery, its access and utilization of services.
7. How did external stakeholders engage with this process?
8. At what levels of public dialogue or health systems engagement with community did the concerns regarding community engagement were identified?

Program Design

1. How was the strengthening of community engagement framework designed and what were its key elements (objectives, strategies and stakeholder, activities and action plan, output/outcome)
2. Were metrics for regular reporting of participation included?
3. Was monitoring and feedback mechanism built to track improvements?
4. Were training and orientation programs conducted to improve community mobilisation.
5. How were the partnerships formed to implement and support the intervention?

6. Were new IEC activities developed as a part of the program design?
7. How were these objectives met?
8. How was the intervention aligned with national guidelines? (AB-AAM, JAS)
9. What were the indicators/ means of verifications and reporting mechanisms for improvement in community engagement?

Program outputs and outcomes.

1. What were the program outputs and outcomes that were - seen on the ground and how were they reported and documented?
2. In what ways community participation improved/strengthened?
3. Was an improved awareness and trust reflected through patient feedback forms?
4. Did this initiative lead to the reporting of more grievances or suggestions from the community?
5. Were Jan Samwads and Arogya Sabhas more inclusive and better attended?
6. In what ways attendance registers or meeting photos also reflected improved engagement? And were these used as a proof/means of verification? What were the other sources/means of verification used?

Financial aspects; Initial Investment and present and long-term costs

1. What resources (physical, human and financial) were invested for the intervention?
2. What were the sources and mechanisms? (both external and internal)
3. How were these sources utilised?
4. How were the initial investments in the intervention made? (physical, human and financial)
5. How are the resources required for the intervention being managed presently?
6. What are the long-term plans to sustain the intervention?

Present Status, mechanisms, processes continued and pathways for future.

1. What is the program's plan to sustain and institutionalize community participation?
2. How has the program impacted or engaged with public platforms like Arogya sabhas?
3. Can the mobilization templates (e.g., invitation format, IEC materials) be adapted elsewhere?
4. How adaptable is this model to urban PHCs or high-migration zones?
5. Present status of program- activities, mechanisms, partnerships.

Key Learnings from the programs and its scalability at District, State and national level

1. What worked best in improving community engagement – personal outreach, IEC, peer mobilization, or leadership training?
2. Are there any barriers or challenges? do they still remain?
3. What role did collaboration (if any) play in improved outcomes?
4. Were there any unintended positive outcomes?
5. Are there specific dos and don'ts identified by the team that can guide future efforts?
6. What are the overall learnings for effectiveness of this program and its scalability at district, state and national Level?

7.2.2 Informed Consent form

Participant Information Sheet (PIS)

Division: Knowledge Management Division, NHSRC

Name of Participant:

Title: ***Strengthening comprehensive primary health care through community monitoring and social accountability exercise by JAS***

1. You are invited to take part in this research study. The information in this document is meant to help you decide whether or not to take part. Please feel free to ask if you have any queries or concerns.

2. Who will be the participants in this study?

The present study is being conducted in Jharkhand and involves all key stakeholders of the Jan Arogya Samitis as key respondents.

3. What procedures will be followed during this study?

The purpose of the study is to understand the current status of Comprehensive Primary Health Care through Community monitoring and Social Accountability Exercise by JAS and well as to help make existing initiative more effective and replicable. This research study involves in-depth interviews, and you will be asked questions related to the initiative. Each interview will take approximately 30-40 minutes of your time. With your permission, I will audiotape and take notes during the interview.

The purpose of recording is to accurately record the information you provide and will be used for transcription purposes only. The audio recording will be done only after taking your consent. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request or if you don't wish to continue, you can stop the interview at any

time. In the entire process, the name of the participant will not be revealed, also the identity will be kept anonymous even after completion of the study.

4. What are the risks and discomforts to you?

This does not involve any risk. Your information collected for this study is completely confidential and no individual participant will ever be identified with his/her research information.

5. What benefits are expected from this research?

There is no direct individual benefit to you other than research and benefit to society. The study will be beneficial in strengthening comprehensive primary health care.

6. Are the data/records of the participant kept confidentially?

No person outside of this study will have access to your data. We ensure that there are no personal identifiers in your data form so that it cannot be latter linked to you. We will store the information in locked places under the charge of Principal Investigators.

7. What is compensation and/or treatment(s) available to the Participant in the event of research related harm?

There is no cost associated with joining this study. Neither will you be at risk of any physical or social harm in joining this study. Hence there is no compensation provided as part of joining this study.

8. Whom to contact for research-related queries and what are the rights of participants in the event of harm?

If you think that you have not been adequately informed about this study or have further queries or you think that you have not been treated well or have been hurt as a result of joining this study, you can contact Dr. Neha Dumka (Lead Consultant), Knowledge Management Division, NHSRC.

9. Are the participants paid to take part in this study?

The participant will not be paid for their participation in the study.

10. The research is voluntary: Participant can withdraw from the study at any time and that refusal to participate will not involve any penalty or loss of benefits to which the Participant is otherwise entitled.

Contact person:-_____Knowledge Management Division, NHSRC.

Informed Consent Document

CONSENT FORM

I_____S/o or D/o_____

R/o_____give my full consent to participate in the study titled ***"Strengthening comprehensive primary health care through community monitoring and social accountability exercise by JAS".***

The details of the study have been provided to me in writing and explained to me in the language I understand. I confirm that I have understood the above study and had the opportunity to ask questions. I understand that my participation in the study is voluntary and that I am free to withdraw at any time, without giving any reason.

I agree not to restrict the use of any data or results that arise from this study, provided such use is only for scientific purposes with no personal identifiers.

I have been given a Participant information sheet giving details of the study. I fully agree to participate in the above study.

Signature of the participant: _____ Date: _____

I consent to this interview being audio recorded for transcription purposes

……..(Signature)

I do not consent to this interview being audio recorded for transcription purposes

…… (signature)

Signature of the Interviewer_____Date: _____

प्रतिभागी सूचना पत्र

विभाग: ज्ञान प्रबंधन विभाग, NHSRC

प्रतिभागी का नाम:

शीर्षक: ***Strengthening comprehensive primary health care through community monitoring and social accountability exercise by JAS***

1. आपको इस शोध अध्ययन में भाग लेने के लिए आमंत्रित किया जाता है।

   इस दस्तावेज़ में दी गई जानकारी आपको यह निर्णय लेने में मदद करने के लिए है कि आपको भाग लेना चाहिए या नहीं। यदि आपके पास कोई प्रश्न या चिंता है, तो कृपया पूछने में संकोच न करें।

2. इस अध्ययन में कौन प्रतिभागी होंगे?

   वर्तमान अध्ययन झारखंड में किया जा रहा है और इसमें जन आरोग्य समितियों के सभी प्रमुख हितधारक प्रमुख उत्तरदाताओं के रूप में शामिल हैं।

3. इस अध्ययन के दौरान कौन सी प्रक्रियाएँ अपनाई जाएँगी?

   अध्ययन का उद्देश्य सामुदायिक निगरानी और सामाजिक जवाबदेही अभ्यास द्वारा जेएएस के माध्यम से समग्र प्राथमिक स्वास्थ्य देखभाल की वर्तमान स्थिति को समझना और मौजूदा पहलों को अधिक प्रभावी और पुनरुत्पादक बनाना है। यह शोध अध्ययन गहन साक्षात्कारों में शामिल है और आपको पहल से संबंधित प्रश्न पूछे जाएंगे। प्रत्येक साक्षात्कार में आपके समय का लगभग 30-40 मिनट लगेगा। आपकी अनुमति से, मैं साक्षात्कार के दौरान ऑडियोटेप और नोट्स लूंगा।रिकॉर्डिंग का उद्देश्य आपके द्वारा प्रदान की गई जानकारी को सही ढंग से रिकॉर्ड करना है, और इसे केवल लिप्यांतरण उद्देश्यों के लिए उपयोग किया जाएगा। ऑडियो रिकॉर्डिंग केवल आपकी सहमति लेने के बाद की जाएगी। यदि आप ऑडियोटेप में नहीं जाना चाहते हैं, तो मैं इसके बजाय नोट्स लूंगा। यदि आप ऑडियोटेप में जाने के लिए सहमत हैं लेकिन साक्षात्कार के दौरान किसी भी समय असुविधाजनक महसूस करते हैं, तो मैं आपके अनुरोध पर रिकॉर्डर बंद कर सकता हूँ या यदि आप जारी रखने की इच्छा नहीं रखते हैं, तो आप कभी भी साक्षात्कार को रोक सकते हैं। पूरी प्रक्रिया में, प्रतिभागी का नाम प्रकट नहीं किया जाएगा, और अध्ययन की समाप्ति के बाद भी पहचान को गुप्त रखा जाएगा।

4. आपके लिए जोखिम और असुविधाएँ क्या हैं?

   इसमें कोई जोखिम नहीं है। इस अध्ययन के लिए आपकी जानकारी पूरी तरह से गोपनीय है और किसी भी व्यक्तिगत भागीदार की पहचान उनके अनुसंधान की जानकारी से नहीं की जाएगी।

5. इस अनुसंधान से कौन-कौन सी लाभ अपेक्षित हैं?

आपकी कोई व्यक्तिगत सीधा लाभ नहीं है केवल अनुसंधान और समाज का लाभ है। यह अध्ययन समग्र प्राथमिक स्वास्थ्य देखभाल को मजबूत करने में लाभकारी होगा।

6. क्या प्रतिभागी के डेटा/रिकॉर्ड को गोपनीय रखा जाता है?

   इस अध्ययन के बाहर किसी भी व्यक्ति को आपके डेटा तक पहुँच नहीं होगी। हम सुनिश्चित करते हैं कि आपके डेटा फॉर्म में कोई व्यक्तिगत पहचान करने वाली जानकारी नहीं है ताकि इसे बाद में आपसे जोड़ा न जा सके। हम जानकारी को मुख्य शोधकर्ताओं की देखरेख में बंद स्थानों में संग्रहीत करेंगे।

7. यदि अनुसंधान संबंधी नुकसान होता है तो प्रतिभागियों के लिए मुआवजा और/या उपचार क्या उपलब्ध हैं?

   इस अध्ययन में शामिल होने के लिए कोई लागत नहीं है। इस अध्ययन में शामिल होने पर आपको किसी भी शारीरिक या सामाजिक नुकसान का जोखिम नहीं होगा। इसलिए इस अध्ययन में शामिल होने के भाग के रूप में कोई मुआवजा प्रदान नहीं किया गया है।

8. अनुसंधान-संबंधी प्रश्नों के लिए किससे संपर्क करना है और हानि की स्थिति में प्रतिभागियों के अधिकार क्या हैं?

   दि आपको लगता है कि आपको इस अध्ययन के बारे में उचित रूप से सूचित नहीं किया गया है या आपके पास और प्रश्न हैं या आपको लगता है कि आपको ठीक से नहींTreat किया गया है या इस अध्ययन में शामिल होने के परिणामस्वरूप आपको चोट पहुंची है, तो आप डॉ. नेहा डुमका (लीड कंसल्टेंट), ज्ञान प्रबंधन विभाग, NHSRC से संपर्क कर सकते हैं।

9. क्या प्रतिभागियों को इस अध्ययन में भाग लेने के लिए भुगतान किया जाता है?

   प्रतिभागी को अध्ययन में भागीदारी के लिए भुगतान नहीं किया जाएगा।

10. 10. अनुसंधान स्वैच्छिक है: प्रतिभागी किसी भी समय अध्ययन से वापस ले सकता है और भाग न लेने के लिए कोई दंड या लाभ की हानि नहीं होगी जिसके लिए प्रतिभागी अन्यथा हकदार है।

    संपर्क व्यक्ति:

    _____, ज्ञान

    प्रबंधन विभाग, NHSRC.

    अनुमति पत्र

    मैं _____ पुत्र/पुत्री _____

    निवासी _____ इस अध्ययन में भाग लेने के लिए अपनी पूरी सहमति देता/देती हूँ जिसका शीर्षक है "समुदाय निगरानी और सामाजिक जवाबदेही अभ्यास द्वारा समग्र प्राथमिक स्वास्थ्य देखभाल को सुदृढ़ करना"। इस अध्ययन का विवरण मुझे लिखित रूप में उपलब्ध कराया गया है और समझाई भाषा में समझाया गया है। मैं पुष्टि करता/करती हूँ कि मैंने उपरोक्त अध्ययन को समझा है और मुझे प्रश्न पूछने का अवसर मिला है। मैं समझता/समझती हूँ कि अध्ययन में मेरी भागीदारी स्वैच्छिक है और मैं बिना किसी कारण बताए किसी भी समय वापस लेने के लिए स्वतंत्र हूँ। मैं सहमत हूँ कि मैं इस अध्ययन से उत्पन्न किसी भी डेटा या परिणाम का उपयोग सीमित नहीं करूंगा/करूंगी, बशर्ते ऐसा उपयोग केवल वैज्ञानिक उद्देश्य के लिए किया जाए जिसमें कोई व्यक्तिगत पहचानकर्ता न हो। मुझे अध्ययन का विवरण देने वाली प्रतिभागी सूचना पत्रिका दी गई है। मैं उपरोक्त अध्ययन में भाग

लेने के लिए पूरी तरह से सहमत हूँ। प्रतिभागी का हस्ताक्षर: _____ दिनांक: _____

मैं इस साक्षात्कार के ऑडियो रिकॉर्डिंग के लिए सहमति देता हूँ ताकि उसे लिप्यंतरण के लिए इस्तेमाल किया जा सके……..(हस्ताक्षर)

मैं इस साक्षात्कार के ऑडियो रिकॉर्डिंग के लिए सहमति नहीं देता हूँ ताकि उसे लिप्यंतरण के लिए इस्तेमाल किया जा सके…… (हस्ताक्षर)

साक्षात्कारकर्ता का हस्ताक्षर_____ तारीख: _____

SR. No.	Name of the participant	signature
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