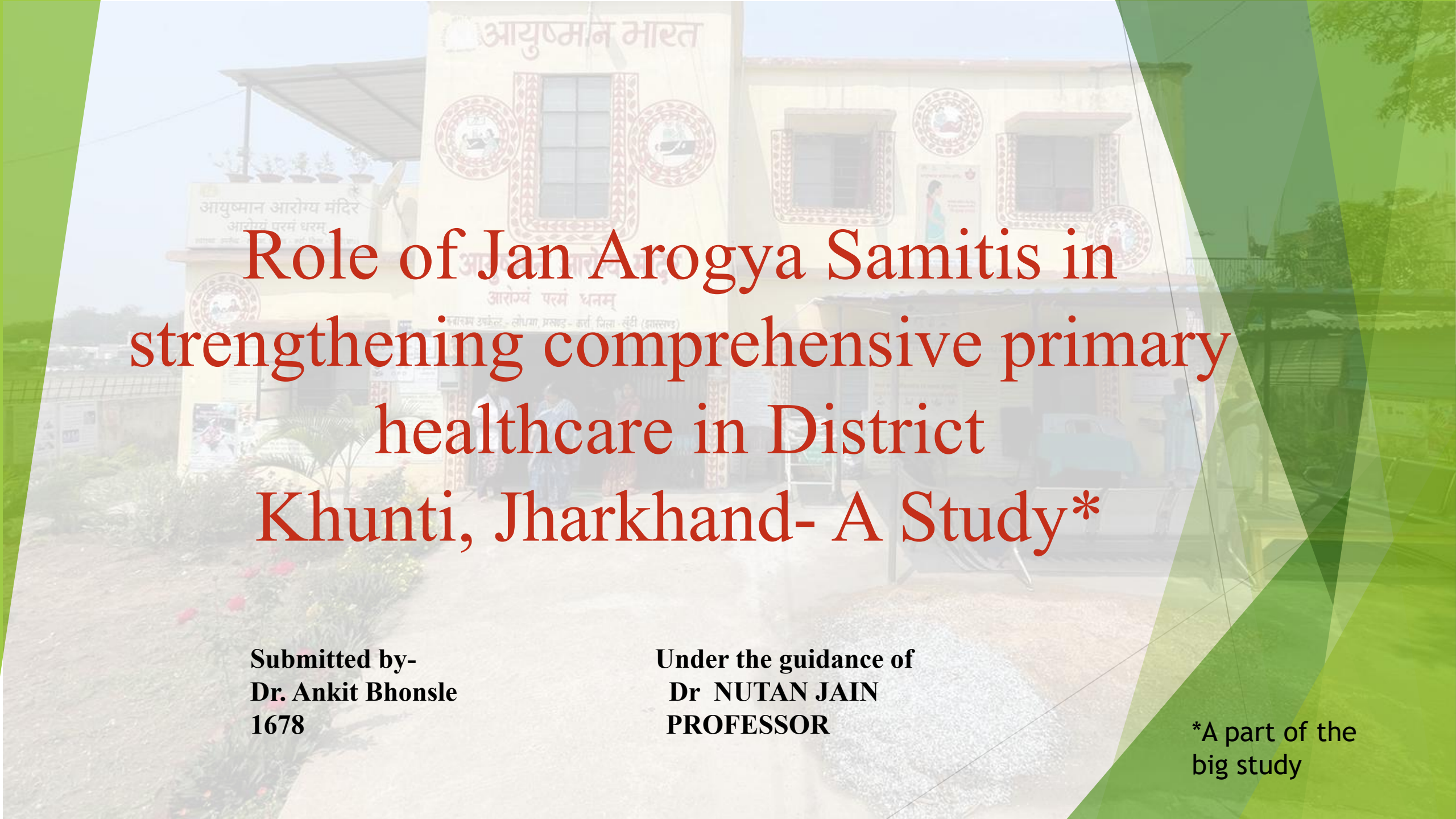

Role of Jan Arogya Samitis in strengthening comprehensive primary healthcare in District Khunti, Jharkhand- A Study*

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*A part of the big study

INTRODUCTION

The World Health Organization emphasizes that health development must be people-centered and driven by community participation, a foundational principle of PHC.

In India, WHO vision led to the formation of Village Health Sanitation Nutrition Committe in 2007 under National Rural Health Mission, aiming to empower local communities through decentralized health planning, awareness-building, and the development of village-level health plans.

Under Ayushman Bharat, Sub Health Centers and Primary Health Centers are being upgraded into Ayushamn Bharat-Health & Wellness Centers to deliver Comprehenssive Primary Health Care, covering preventive to palliative care.

To manage health facilities effectively and encourage public involvement, Rogi Kalyan Samiti were established at PHC and above levels. These are registered societies with decision-making powers.

At the SHC level, the government has proposed the formation of Jan Arogya Samiti under Ayushman Bharat to mirror RKS role. JAS guidelines, released in December 2020 by MoHFW, outline the structure, roles, and responsibilities.

Rationale

- Limited qualitative evidence on how JAS functions in real settings.
- Study aims to explore the experiences, practices, and impact of JAS across selected *Ayushman Arogya Mandirs* in Khunti, Jharkhand.

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?

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Study 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.

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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.	28 Mahila Arogya Samiti	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	Anchal Dhiman et al (2020)	To evaluate the extent of awareness among VHSNC members regarding their roles and responsibilities. community members' awareness of the VHSNC and its functions.	30 VHSNCs from 30 villages (3 block)	Random sampling	Kangra 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.
3	Raviraj Uttamrao Kamble et al (2018)	To develop a VHNSC Maturity Index (VMI) and pilot it to evaluate VHSNCs.	83 villages under 4 Primary Health Center	Purposive sampling	Wardha block, Maharashtra	All 83 VHNSCs were constituted according to NHM guidelines. Among them, 58% developed an annual Village Health Action Plan, and 87% held at least 4 meetings in the past 6 months. Additionally, 82% fully utilized the untied funds received in the previous year.

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S.no	Author	Objectives	Sample size	Sampling technique	Study location	Results
4	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.
5	Neha Adsul, Manoj Kar (2013)	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	Progress is hindered by managerial and structural weaknesses. Despite these challenges, the National Rural Health Mission continues to actively develop strategies to enhance community benefits and encourage stronger local participation through the RKS framework.
6	Pramod Kumar Sah et al (2013)	To assess the awareness of VHSNC members about the committee's formation and their responsibilities.	8 VHSNCs; Qualitative study using FGDs and interviews.	NA	Wardha, Maharashtra	Awareness of the VHNSC and its functions was highest among ANMs and AWWs. ANMs had the strongest understanding of VHNSC objectives, followed by AWWs, while Panchayat members, ASHAs, and Self-Help Group members showed the least awareness.

METHODOLOGY

Type of Study: Exploratory in Nature; qualitative

Study Area

Six JASs, CHC in Murhu Block, Khunti district, Jharkhand, where Jan Arogya Samiti interventions have been actively implemented state.

Study Respondents:

- 2 State Officials- State Nodal Officer, State Program Coordinator , State Health Directorate at Namkum, Ranchi
- 2 District Officials- Chief Medical officer, District Program Coordinator , District Health Office
- 1 Block Officials- Block Medical Officer, Murmu Block Office
- 6 Community Health Officers
- JAS members and Community members from Munda tribe

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Sampling and Sample size

- Purposive sampling
- A total of nine facilities/offices were visited.
- The sample included 11 in-depth interviews with CHOs, state and district officials, and a BMO, along with 3 FGDs with JAS members, 1 FGD with the Munda tribal community, and an interaction with a TB survivor. These interactions provided diverse insights across community, facility, and administrative levels.

Inclusion Criteria:

- CHOs, ANMs, PRI representatives, JAS members, community members, and state/district officials who are actively involved in JAS-related activities.
- AAMs with active JAS units showing regular participation and documentation

***Exclusion Criteria**:*

- Facilities where JAS is not implemented or remained inactive.
- Individuals are not directly associated with the functioning of JAS or unwilling to participate

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Data Collection Methods

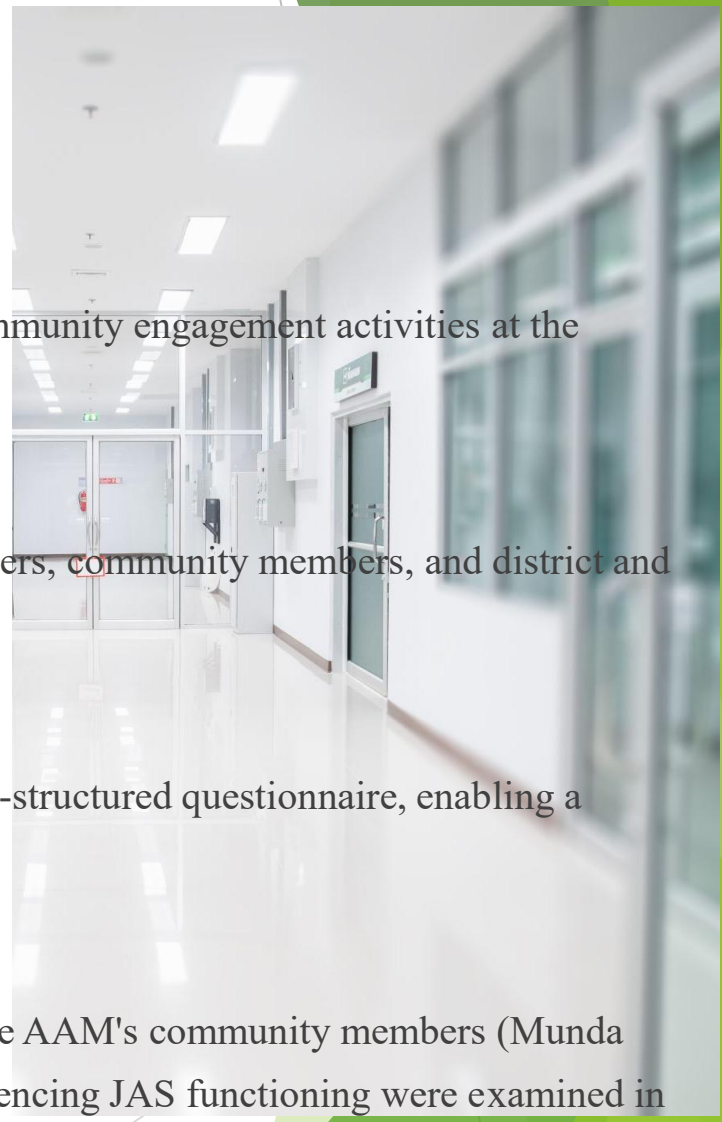
- **Document Review:**
  JAS registers; Social Audit Registers

- **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 a FGD. The collective experiences, perceptions, and social dynamics influencing JAS functioning were examined in these group discussions.



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DATA ANALYSIS

- Thematic content analysis is conducted manually.
- Verbatim transcripts from interviews and FGDs are read repeatedly to develop codes.
- Codes are grouped into themes such as governance, fund utilization, participation, community engagement, and implementation challenges.
- Data triangulation is applied using findings from observations, documents, and interviews.

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ETHICAL CONSIDERATIONS

- Informed written consent obtained from all the participants
- Participants assured of confidentiality and anonymity.
- All data secured and kept password protected; limited access to the team only
- Participants had the right to withdraw at any time without any repercussions.

Results

- Seven thematic areas
- 1. Formation & Structure of JAS
  - Jan Arogya Samitis (JAS) were formed across all selected AAMs in Khunti between March 2021 and August 2022 following state orders.
  - Each JAS comprised 18–20 members, with mandatory inclusion of women, SC/ST, and recovered TB patients.
  - All committees were chaired by the village Mukhiya, ensuring local governance leadership.
  - Member roles included planning, fund management, community mobilization, and service monitoring, though clarity on roles varied.

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2. Governance & Accountability of JAS

- Regular monthly meetings were mandated, but actual meeting frequency was inconsistent until recently.
- Meeting documentation was maintained, with improved compliance noted in the past four months.
- Decision-making showed transparency, with minutes and financial records maintained.
- Grievances were mostly communicated verbally; no written complaints were found despite provision of complaint boxes.
- *"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." (CHO's said)*
- No formal system exists for monitoring or supervising JAS activities at higher levels.

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3. Fund Management

- ₹50,000 annual untied funds were generally well-utilized, with 90% fund usage reported.
- Financial decisions were made collectively, though cheque-based disbursements caused delays.

4. Community Engagement and Participation

- Community awareness about JAS varied across facilities, with better awareness where ASHAs/ANMs were active.
- Community participation in meetings was limited, especially among marginalized groups.
- Case stories showed positive community transformation and successful patient mobilization.
- *"Because of the JAS members, the work of the Sahiya has become much easier, and community participation has significantly increased compared to earlier." (CHO's said)*

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- 5. Capacity Building
- Initial orientation training was provided by external agencies, but no refresher training was conducted.
- 6. Service Delivery and its Utilization
- JAS contributed to 1.5 to 2 times increase in OPD footfall post-implementation
- 7. Enablers & Challenges
- Key enablers included leadership by Mukhiya, active ASHA/ANM support, and access to untied funds.
- Challenges included unclear member selection processes, lack of incentives, poor digital access, and logistical barriers to participation.

Discussion

- Despite formal inclusion (ST ,SC,), participation was nominal. Similar to VHNSC findings by Kamble et al. (2018), Sah et al. (2013
- Meeting and its documentation is inconsistent. Reflected in RKS/VHNSC studies by Adsul & Kar (2013), Kamble et al. (2019)
- Fund usage is affected by poor digital access and unclear spending rules. Also noted by Kalra et al. (2024), Dhiman et al. (2020)
- One-time orientation insufficient; no refresher or peer learning. Consistent with findings by Sah et al. (2013), Adsul & Kar (2013)
- Public unaware of JAS roles; decision-making led by health staff/PRI. Similar trends in studies by Kamble et al. (2018), Nair et al. (2015)
- Improved Utilization of AAM Services Post-JAS Formation, Indicates potential impact of community-led governance. Similar to findings by Nair et al. (2015), Kalra et al. (2024)

Conclusion

- The study assessed the structure, functioning, allocation, utilization, and management of untied funds of Jan Arogya Samiti (JAS) at selected Aayushman Arogya Mandirs (AAMs) in Khunti, Jharkhand, aligned with national and state guidelines.
- Initial orientation was provided, but ongoing capacity-building and role clarity remain limited.
- Overall, strengthening training, enhancing community participation, and improving financial and grievance systems are essential for sustaining and scaling the impact of JAS in local health governance.

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Recommendations

- Strengthen capacity building by continuing efforts (CHOs, JAS Members)
- Enhance community awareness of JAS functioning (CHOs, JAS Members)
- Grievance redressal – promote active use of complaint box(es) to inform the grievances anonymously.
- Simplify fund disbursement mechanisms (alternative) especially for remote areas where internet connectivity is low, inadequate of digital literacy.
- Promote Inclusive Participation of traditional (e.g. Munda) leaders to promote better participation and effective implementation.
- Institutionalize monitoring and supervision by BLOs using standard format; and establish feedback mechanisms.

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EMERGENCY TOLLFREE NUMBER
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VITAL DRUG
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आयुष्मान आरोग्य मादर
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Thank you