Dissertation Synopsis

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by

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SYNOPSIS

1. TITLE: Role of Jan Arogya Samitis in strengthening comprehensive primary healthcare District Khunti , Jharkhand.

2. INTRODUCTION: 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)

4.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. This study aims to explore the experiences, practices, and impact of JAS across selected Ayushman Arogya Mandirs in Khunti, Jharkhand.

5. RESEARCH QUESTION:

- 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?

6. 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

7. HYPOTHESIS: NA

8. MATERIAL AND METHODS

STUDY DESIGN:

This study will employ an exploratory qualitative design to gain an in-depth understanding of the functioning, participation, challenges, and impact of the Jan Arogya Samiti (JAS) interventions. The qualitative approach will be appropriate for capturing stakeholder perceptions, lived experiences, and operational processes from multiple administrative levels involved in JAS implementation.

SETTING:

The study will be conducted in Khunti district, Jharkhand, where Jan Arogya Samiti interventions have been actively implemented. Data will be collected from six Ayushman Arogya Mandirs (AAMs), the Community Health Centre (CHC) in Murhu Block, the District Health Office in Khunti, and the State Health Directorate at Namkum, Ranchi.

STUDY POPULATION:

- **Inclusion Criteria:**
    - Community Health Officers (CHOs), Auxiliary Nurse Midwives (ANMs), Panchayati Raj Institution (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.
- **Study Tools:**
    - Semi-structured interview schedules for Key Informant Interviews (KIIs) and In-Depth Interviews (IDIs).

- Focus Group Discussion (FGD) guides for JAS members and community members.
- Observation checklist for infrastructure and engagement assessment.
- Review of JAS Registers and Social Audit Documents for fund utilization and
- Participation records.

DURATION OF STUDY:

The fieldwork will be conducted over two days, from 16th to 17th April 2025. The overall study duration, including planning, data collection, transcription, and analysis, spanned March 2025 to May 2025.

SAMPLE SIZE:

A total of nine facilities/offices were visited. The qualitative sample included:

- 6 CHOs (IDIs)
- 2 state-level officials (IDIs)
- 2 district-level officials (IDIs)
- 3 FGDs with JAS members (Gutjhora, Dodhma, Lodhma)
- 1 FGD with Munda tribal community (Mahil AAM)
- 1 Interaction with a TB survivor
- 1 BMO (IDI)

SAMPLING TECHNIQUE:

Purposive sampling will be used to select facilities and participants based on their active involvement in JAS. Facilities with functioning JAS units and adequate documentation were prioritized.

DATA COLLECTION PROCEDURE:

Data will be collected through:

- In-depth Interviews (IDIs) with state, district, and block-level health officials and CHOs.
- Key Informant Interviews (KIIs) with ANMs, PRI members, and JAS stakeholders.
- Focused Group Discussions (FGDs) with JAS members and tribal community representatives.
- Observation of AAM facilities using a structured checklist.
- Document review of JAS registers and social audit records to verify activities, fund use, and community participation.

All interviews and FGDs will be audio-recorded (with consent), transcribed verbatim, and analyzed manually.

OPERATIONAL DEFINITIONS:

- **Functioning of JAS:** Active conduct of meetings, maintenance of records, fund utilization, and engagement in health-related activities.
- **Community Participation:** Involvement of community members in planning, monitoring, and executing health activities at the AAM level.
- **Impact:** Perceived and documented changes in service delivery, community awareness, and accountability attributed to JAS functioning.

8. DATA ANALYSIS PLAN:

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

9. ETHICAL CONSIDERATIONS:

- Informed verbal and written consent will be obtained from all participants after explaining the study objectives.
- Participants will be assured of confidentiality and anonymity.
- All Data will be secured and anonymized for privacy protection.
- Participants had the right to withdraw at any time without any repercussions.

10. IMPLICATIONS OF RESEARCH:

The proposed study will generate valuable insights into the functioning and community-level outcomes of Jan Arogya Samiti in Jharkhand. Findings are expected to inform future policymaking, enhance training modules, and guide improvements in implementation frameworks. The research will also suggest strategies to foster better engagement with tribal populations and contribute to more inclusive and accountable primary healthcare service delivery through the Ayushman Arogya Mandirs.

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