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A REVIEW AND CONSULTATION REPORT ON

JANA SWASTHYA RAKSHAK YOJANA OF MADHYA PRADESH

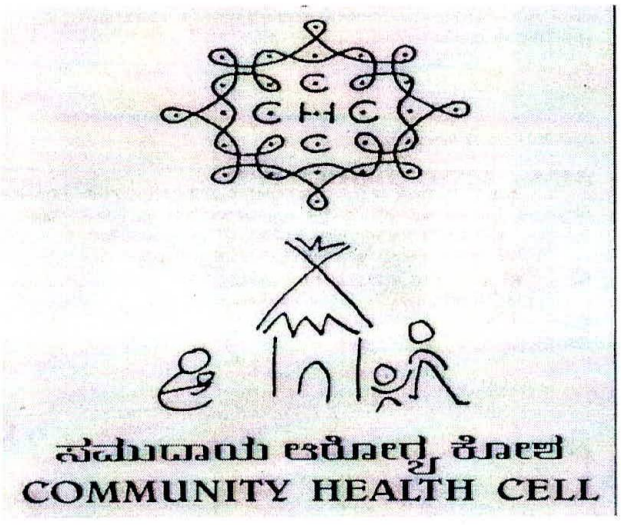
PART 2 THE SUPPLENENT REPORT

JULY –NOVEMBER 2001

COMMUNITY HEALTH CELL TEAM
BANGLORE

SUPPORTED BY DFID, NEW DELHI

Prof Mohammad	Dr Shyam Ashtekar	Dr Shashikant Ahankari
Amulya Nidhi	Dr Dhruv Mankad	Dr Abhay Shukla
& Ravi Narayan		



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POSSIBILITES WITH 'PRIMARY CARE' MODELS

- Dr Shyam Ashtekar

(A) PLANNER'S CONCERNS				
		Usual Possibilities[1] with staff model	Planners can manage[2] with a combined model	What happens with PMP model
Selection	Gender: men or women	Men or women depending upon policy. Women tend to take even small pay jobs.	Mixed-alternate village/both man and women in each village/couple	Men mostly
	Age	late teens/early twenty candidates hunting for Govt. jobs	Post-twenty-five candidates, other health cadres	Generally post 25
	Education	Age strata will decide entries,		Need twenty + for respectable earning
	(caste)	Any	Any is possible..on criteria	Generally upper and middle.
Attitudes of candidates	Work motivation	Declines with tenure, upward mobility if any.	Depends upon candidates/returns/ work satisfaction	Monetary gains are the deciding factors for attitudes.
	Learning	Generally programme-related. Little motivation of their own.	Combining self-interest plus programme interests.	
	Communication	More with administration, less with people/users	Possible to ensure with both administration and users	Only client-bound
Candidate locality		From anywhere	Generally from locality	Usually from outside
Distribution		All, even hamlets, depending upon available funds and pattern	Not so evenly spread—small hamlets can be attached though. Sustainability is prime concern. May not survive less than 2000 without contract payments.	Only big villages, cluster-centers. Can not survive on small population-below 5000 Overcrowding can pose serious problems.
Training	Initial course	Can begin small, stepladder	Qualifying necessary, CME can be done	Initial crash course, little CME later
Monitoring	Social aspects	Poor control	Feasible-	Poor control
	Technical aspects	Theoretically possible	Possible- programme wise	Poor control
Medicine supply		Govt PHC/CHC	Govt for NHPs, from market for other needs.	Market, Medical Reps

[1] Assumes appointment of one primary care worker I each village.

[2] Assumes provision of facility on village showing some preparedness, proper candidates etc

Healing systems		Generally allopathic	Can increase choices with better training and public education	Generally allopathic
Preventives	Overall	Programme-specific	Programme-specific, but expandable	No interest (actually sickness-interest)
	NHPs	NHPs on priority	NHP on contract	Poor compliance for NHPs
Controls		'almost Regimented'	Semi-control	No control
Rational therapeutics		protocol-driven/ narrow	Possible with standard lists and rates.	Poor
Program durability		Yes and No	Can be stable	Generally stable, though with some flux. Increasing competition can destabilize PRMPs
Attrition		Negligible	Can be kept at moderate,	Negligible
System linkages		In built	Need to be designed and administered	Difficult & tenuous always abhorred.
Costs	To the Govt	High	Medium	Low-nil
	to the consumers	Low or nil	Medium to both	Highest
Payment modes		Salaries/honoraria/pensions	Combined: user paid at prescribed rates+ contract payment for NHP/State programmes	User fees
Financial Sources		Taxation/grants to local bodies	User-fees or insurance plus programme grants	Fees or may be insurance at later stage.
Venue for work		Formal center necessary	Former center desired, but interim arrangements possible	Private room in bazaar lanes essential.
Legal status for providers		Easy-with Govt notification	Possible to work out	'Do not care", generally some cover is available.
'Couple'		Not possible	Possible, as payment is on contract for tasks/services	Unlikely, except when both husband and wife are practicing.
(B) PROVIDER CONCERNS				
Basic needs		Mandatory-housing/food/transport/security/	Some costs are less thanks to local residence.	High, ever increasing.
Incentives		Felt as 'always meager'	Always eager	Not valued.
Income		Fixed-effort or no effort	Adjusted to services and tasks	'Rewarding'
Self worth/public image		Unduly low, tormented	Can live respectfully and socially useful career.	Unduly high
Learning		Limited to directives	Can be woven into the programme.	Limited to sales promotion

belonging (sense of)		To Govt system	Both	To professional guild and user community
Professional security/stability		fair, because of unionization	In between, banks somewhat on Govt policy	Ever searching for better position
Upward Mobility		Limited, (a neglected issue in India)	Limited to locality, but skills can be improved.	More equipment, facility upgrading.
(C)COMMUNITY CONCERNS				
Healing: (Medical needs)		Only limited, may not satisfy, may or may not heal	Good healing + satisfaction mandatory for survival	satisfying it must be, (but may or may not heal)
Access		Time bound, programme-linked, not dependable	Ensuring good access is precondition	Time-elastic, but often distant. So access is limited
Economical		may be free, if not doing private practice	Can save access costs and needless medication	High costs, and also hidden costs
Friendly?		Depends upon the person	Professional requirement.	Professional requirement.
Lasting?		transfers, and visiting nature makes it look less like lasting	Can be	Generally
dependable		Not really-because of various factors		Generally dependable and accountable
User control		Poor, works through long politico-administrative links.	Can be fairly controlled.	Poor control on quality of care

JSR EVALUATION I (JULY-DECEMBER 1997) : A FOLLOW UP

Dr Ravi Narayan, CH Cell

THE JSR Scheme : Context

"Another major step towards community-centring of primary health was through initiating the Jan Swastya Rakshak scheme discussed earlier. The much needed gap in rural health care in Madhya Pradesh could only be bridged by unconventional methods like creating a paramedic or barefoot doctor in every village. The scheme has resulted in creating over 20,000 such rural health practitioners who could become effective outreach agents of the government health system. The scheme is premised on community support to these Jan Swastya Rakshaks who will be paid for their services. A mid-course evaluation of the scheme revealed poor ownership of the scheme by the Public Health system which has historically been suspicious of rural health practitioners. Efforts are currently underway to integrate it fully within the system".

"The real challenge in Madhya Pradesh today appears to be to move to a horizontal management of health care delivery as against management of vertical programmes based on national and state level prioritisation. The experience of the two Missions on Health in Madhya Pradesh as well as of the Rogi Kalyan Samiti and Jan Swastya Rakshak point to the need to involve civil society more effectively in the management of health and utilise the opportunities created through decentralised governance of panchayat raj. Issues of public helth being inter-sectoral and requiring societal mobilisation for efficient delivery, the challenge today is for policy reorientation to put the public health system on its head and start planning from below. Problem mapping exercises that can engage community leadership can generate awareness on an unprecedented scale. Networking with other sectoral departments that impinge on health, like water supply, sanitation or rural development could lead to dramatic improvements in health delivery"

Source : The Madhya Pradesh Human Development Report, 1998.

	JSR REVIEW I **(1997 RECOMMENDTIONS**	**FOLLOW UP ASSESSMENT REVIEW II (2001)**
1. Objectives	1. Further clarification of job responsibilities, functions and functional linkages.	1. Revised manual has more clarity on job responsibility and functions but not on functional linkages with the health and PRI system.
	2. JSR should be a resource person under Panchayat supervision.	2. This linkage post–training is still ambiguous
2. Administration	1. For better coordination and streamlining the programme should be located in Health department	1. Has now become part of a new Rajiv Gandhi Mission – SJGYS with greater involvement of Health department in training and district level
	2. There should be a Project Committee to organise scheme with representations of all related sectors.	**2. No JSR Scheme think-tank as yet though the SJGYS – Governing body and executive committee may play that role.**
3. Selection	1. Every effort to select more female candidates.	1. Efforts to select female candidates are ongoing but very inadequate.
	2. Widescale and effective publicity at community level.	2. Some efforts but still very inadequate and not innovative. Must be in campaign mode.
	3. Reduce education limit for females especially in tribal regions to enhance selection.	3. Some reductions done and Anganwadi workers also included. But much more efforts required.
4. Linkages	Develop linkages with all sectors (intra and inter sectoral) at village and other levels.	**No formal linkages developed at any level. Needs further clarity on linkages.**
5. Logistic Support	Adequate and timely availability of	Some delays experienced. Need to

	funds for smooth functioning of scheme	be looked into in ongoing programme.
6. Communication	Use appropriate, effective local media at all levels ❖ Village ❖ Panchayat ❖ Taluk ❖ District ❖ Inter and intra departmental	**No communication strategy evident at any level except regular and detailed Government Orders. Needs clarity and creativity to enhance this dimension for success of programme.**
7. Training	1. Venues should be suitable for problem identification and solving, community experience	1. PHC & CHC comprise 3/4th of venues. District hospital in Bhopal and Government Nursing College in Jabalpur also used
	2. Training should move from content orientation to process orientation and use integrated problem based approaches	2. Training is mostly lectures or manual reading. Some field visits and lots of injection room postings. Audio visual methods or 'problem solving' hardly used.
	3. Training manual to be re-written - various lacunae pointed out	3. Many of the lacunae pointed out have been introduced into rewritten manual. Needs more protocols (Many cheap alternatives with irrational options available)
	4. Regular refresher courses and continuing education through district learning modules.	**4. No. Process of continuing education or even supervisory contact after training.**
	5. Supportive facilities for greater female participation.	5. Some efforts made including anganwadi centres. But not enough.
8. Criteria for certification	Recertification on a periodic basis contingent on defined criterias should be made mandatory.	**No policy for recertification yet in place. Needs urgent attention.**

9. Supervision / Monitoring / Evaluation (SME)	1. Technical supportive supervision linked to health training / primary health centres must be built in even if JSR is under PRI.	1. **No policy for SME yet in place. Role or link to PHCs or training centre inadequately addressed.**
	2. Quantitative and Qualitative indicators to measure process and impact to be collected in collaboration with panchayats and PHCs.	**2. No plan to measure process and impact in place. The concept of 'free standing JSR' has confused issue of accountability of those who train and position them.**
10. Examinations	1. Examination to be handed over to independent professional body – NGO trainer, medical college, etc.	1. Examination conducted by health department once a year and may happen any time.
	2. Examination should assess process (practical skills) and knowledge by judicious mix of short answers, case studies, MCQs, etc.	2. Consists only of a written paper requiring 50% marks to pass. No practical test or problems / case studies cyclostyled papers often unreadable.
	3. Short courses for those who fail exam – first time.	**3. No such process or provision thought off.**
11. Core Project Team	Core project team to train trainers, monitor the JSRs in the field, ascertain feedback from JSR, community and PHC and continuously innovate and improve scheme.	**No core project team as yet. No think tank – so none of the activities suggested are ongoing. Now as part of new Rajiv Gandhi Mission, it may be possible in future.**
12. Peer Support	Core group supported by network of peer group of trainers in northern Hindi belt.	**No core project team – so no peer network operationalised even though there is great potential for this.**

Source : JSR Review I – 1997, JSR Review II, July-November 2001 (Draft).

Comment :

A comparison with the recommendations of the last review show that only some of the recommendations regarding training, selection, logistic support were accepted. Most of the others which had important policy implications and would have greatly improved, structure, framework, operational success sustainability and quality were ignored (see highlighted in table above). Hence the distortions, deviations seen in the present review are not accidental but by default. However, even at this stage, with a new mission emphasis the process can be improved and successfully operationalised.

JSR & MP : A BIMARU INNOVATION

Dr Ravi Narayan

BACKGROUND

"The 'Jan Swasthya Rakshak' scheme launched by the Government of Madhya Pradesh in 1995, is a significant effort aimed at bridging the wide gaps and disparities in health and human development in the state. It is especially significant because since the development of the concept of the disadvantaged BIMARU region in planning circles in India (comprising Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) there has been a growing concern, that these states need some radical and innovative strategies to make health care a reality for the large numbers of marginalised and socially disadvantaged sections of society, who are presently not reached by the existing services.

Madhya Pradesh with the largest land mass amongst Indian states presents a fascinating hue of cultural and geographical diversity. A total of 71,256 villages with varying population are scattered over this region and 76.82% of the State's population is rural-based. The State is divided into five regions, each with its own different characteristics. To provide "Health Care for All by 2000 AD" in such a situation is a daunting task indeed. There continues to exist large unmet felt need for health services. As in rest of India, rural health care is a perpetual problem. Notwithstanding the vast network of Block and Sector PHCs and subcentres, a large percentage of rural population is unable to obtain comprehensive health care. A comparison of rural and urban birth rates (rural and urban) crude death rates (rural and urban) and Infant Mortality rates reveals the extent of health problems and needs lying unfulfilled specially in rural areas. The above figures mask the wide inter-district variation, which also exist.

Where most villages do not have an all season approach road, where many rural area posts still go unfilled because of reluctance of trained manpower to settle down in rural areas and where facilities are more or less non-existent, even an ordinary curable illness undertakes a sinister complexion and often ends in a severe complication or, even death. Very often the cures required are simple and one which a trained and competent health worker can provide in the village itself. For those illnesses that are truly serious, early identification and timely referral by such a village based worker can make all the difference between an early recovery or chronic illness and / or death...." (JSR Review, 1997)

The Village Based Health Workers – A policy challenge

"The idea of village based health workers and the involvement of the community in their selection, support and supervision is not new. There have been governmental and non governmental initiatives in this area and to contextualise the JSR Review undertaken by us, we include a short background overview of these efforts.

Policy initiatives

The Bhore Committee report (1946) which formed the blueprint of post independence - health care service development, had suggested the formation of village health committees and voluntary health workers who needed suitable training. In 1975, the Srivastava report, 30 years later suggested the utilization of part time, semi professional workers from the community who could be trained in the management of common ailments and in basic preventive and promotive services. The fourth Chapter of the report entitled "Health Services and Personnel in the Community" is an excellent concept paper on the significance of community based semi professional health workers.

A few years later the ICSSR/ICMR Health for All study group (1981) reiterated once again the need for Community Health volunteers with 'special skills', ready availability, who see health work not as a 'job' but as a social function.

Finally, the National Health Policy (1982) included a policy statement on 'Health volunteers selected by communities and enjoying their confidence and to whom certain skills, knowledge and use of technology could be transferred'.

CHW - THE INDIAN EXPERIENCE (GOI)

In 1977, the Janata Government launched the Community Health Worker (CHW) scheme, which focussed on CHWs selected by the community, having 6th standard education, and trained informally in the PHCs for 3 months. They were paid a stipend during training and an honoraria

of Rs. 50/- per month after the training, when they began work. Further details and a comparison with JSR scheme is provided elsewhere in the report.

The CHW scheme was a massive operation and was subject to some mid course reviews which identified problems including the lack of adequate preparation; the lack of pilot or feasibility studies; the reduced support of the community; the inability of the community to takeover the scheme; the non-payment of honoraria and the non replenishment of kit boxes; the lack of professional enthusiasm with the challenge of the scheme at all levels; the predominant selection of males as CHW and their subsequent cooption by the system and finally the problem of the whole scheme becoming a subjudice matter due to litigation by CHWs about enhancement of their honorarium, thus becoming non functional!

CHW - the Indian NGO experience

Prior to 1977 and also after it, many Community Health projects in the voluntary / non governmental sector in the country experimented with community based health workers. Some examples are the CHWs of Jamkhed; the village health workers of the Indo Dutch Project; the lay first aiders of VHS-Adyar; the link workers on the tea gardens in South India; the Family care volunteers and Health Aides of RUHSA; the MCH workers of CINI-Calcutta; the Swasthya Mithras of Banaras Hindu University-Varanasi; the Sanyojaks of Banwasi Seva Ashram, Uttar Pradesh; CHW course of St. John's Medical College - Bangalore; the Rehbar-e-sehat scheme of Kashmir government; the CHVs of Sewa Rural and the Community Health Guides of many other projects.

An overview of these CHWs in the voluntary sector show that they were predominantly women; were mostly voluntary or link workers with minimum support; most of them were mature married volunteers; care had been taken by the project to prevent the cooption by village leaders and there was representation of all segments; the participation of the community in identifying the CHWs and their supervision was a goal itself; the training programmes had innovative components and methods and projects had well trained and highly mobile field and supervisory staff; and many projects had women on action/advisory committees or local womens groups supportive of the process.

CHW - The Global experience

At a Global level also, since the late sixties and early seventies, the experiments of training community health workers of various types took place all over the world. Significant initiatives were taken in Mexico, Guatemala, Jamaica, Venezuela, Brazil, Ghana, Nigeria, Sudan, Ethiopia; Kenya; Tanzania, Iran, Afghanistan, China, Bangladesh, Thailand, Malaysia, Indonesia, Philippines and Papua New Guinea. The terminologies were vastly different but the basic framework was similar. These included community / village health workers; the community health aides; barefoot doctors; community health agents; rural health promoters; national health guides; family health educators; aid posts or orderlies; secouristes; hygienist; health auxiliary and health post volunteers. A review of these experiments showed a remarkable diversity in framework and approaches.

Nearly all the countries where these experiments took place were from the developing countries (South). The projects ranged from pilot and local projects to regional and national initiatives. The trainees selected ranged from illiterates, to upto 10 years of schooling.

The duration of training ranged from 5 days to 10 weeks to 6 months and even upto three years for different cadres. The location of training varied from subcentres and local health centres to county and rural hospitals and in some instances there were training centres and national project headquarters. Training methods included lectures, discussions, demonstrations, role playing, field visits, practicals, learning by doing and story telling and dialogue. Finally the evaluation methods ranged from written tests, practicals, oral tests, quiz, field performance reviews, role playing and trainer observations.

The JSR Scheme in context

The concept of the community based health worker has been in vogue, therefore, for many decades with a wide variety of experiments at governmental and nongovernmental level in a wide variety of countries. The Madhya Pradesh Government's initiative - the Jan Swasthya Rakshak scheme - is a significant development against the background of a series of similar initiatives all over the country and the world.

A critical overview of the scheme at this juncture will not only be an important mid course assessment of the initiatives but will also be an opportunity to assess the experience against the

backdrop of a wealth of previous experience so that we do not reinvent the wheel but ensure that the scheme evolves in a way most suited and relevant to the local realities and challenges.

THE CHALLENGE BEFORE US

....The over-emphasis on provision of health services through professional staff under state control has been counter-productive. On the one hand, it is devaluing and destroying the old tradition of part-time semi-professional workers which the community used to train and throw up and which, with certain modifications, will have to continue to provide the foundation for the development of a national programme of health services in our country. On the other hand, the new professional services provided under State control are inadequate in quantity (because of the paucity of resources) and unsatisfactory in quality (because of defective training, organizational weaknesses and failure of rapport between the people and their so-called servants). What we need, therefore, is the creation of large bands of part-time semi-professional workers from among the community itself who would be close to the people, live with them, and in addition to promotive and preventive health services including those related to family planning, will also provide basic medical services needed in day-to-day common illnesses which account for about eighty per cent of all illnesses. It is to supplement them, and not for supplanting them, that we have to create a professional, highly competent, dedicated, readily accessible, and almost ubiquitous referral service to deal with the minority of complicated cases that need specialized treatment.....

-- Srivastava Report, GOI, 1975.

Taking cognizance of the above situation and to improve health care services in rural areas, 18 years and 47 days after the launch of the Community Health Worker Scheme, the Government of Madhya Pradesh on 19 November, 1995 launched the Jan Swasthya Rakshak Scheme under the Integrated Rural Development Programme (IRDP) for unemployed rural youth to provide round the clock curative, preventive and promotive health services in every village of Madhya Pradesh.

Objectives of the Jan Swasthya Rakshak Scheme

1. To improve the health in rural areas, by providing a trained worker who can give first aid care and treat small illnesses scientifically, in the village itself. Efforts are to be made to have both males and females in this scheme.

2. To provide a trained worker in the village who can assist in the implementation of National Health Programmes and health schemes of the Government.

The Scheme has outlined a list of 24 functions for the Jan Swasthya Rakshak (Appendix - 4). These include provision of curative services and first aid care in the village itself, recognition of serious illnesses and epidemics and their immediate notification to health centres so as to provide optimum health care, providing assistance in the implementation of RCH services and other national programmes in the village, collecting health related information and maintaining registers.

TABLE 1 : Analysis of functions of JSR as mentioned in the JSR Manual

Type of Function	Number in Manual	Total	Percentage
1. Preventive	1,2,16,18,20,21,22,24	8	33.33
2. Promotive	3,7,8,9,10,11,16, 23	7	29.16
3. Environment promotion	4	1	4.17
4. Health Education	5,12,15.	3	12.50
5. Health Statistics	6, 19	2	8.33
6. Curative	13, 14, 17	3	12.50
TOTAL		24	100.00

Of the 24 functions envisaged for a JSR, 8 are preventive, 7 promotive and 3 health education related. Only 3 of the 24 functions are curative in nature.

Besides the provision of health services to rural areas, by recommending that only unemployed, educated youth who belonged to families below the poverty line be chosen for training, the scheme hoped to provide an occupation to atleast some of them and thereby a means of livelihood. All financial assistance for training, including stipend, contingency and loans for setting

up the clinic are to come from the IRDP and the health department has to impart the training and provide all necessary technical assistance.

Community Health Worker / Guide / Volunteer

This scheme is very much in tune with what was recommended in 1974 by the Shrivastava Committee - - "the creation of large groups of part-time semi-professional workers, selected from amongst the community itself, who would be close to the people, live with them, provide preventive and promotive health services including family planning in addition to looking after common ailments". These were to be essentially self-employed people and therefore not a part of Government bureaucracy. The Rural Health Scheme announced by the MHFW, GOI to strengthen health care services in rural areas was an extension of the above concept. Under the scheme, every village or community with a population of 1000, had to select one representative who was willing to serve the community and enjoyed its confidence. The tasks expected of the community health workers were:

* immunisation of the new born and young children;
* distribution of nutritional supplements;
* treatment of malaria and collection of blood samples; and
* elementary curative needs of the community.

The overall philosophy of the scheme was that the health work which was till then looked after largely by Government was for the first time to also rest in the hands of the people. The community health worker belonging to the same community would be accountable to them and they in turn would supervise his / her work.

The community health worker was not envisaged to be a full time health worker and was expected to perform community health work in his/her spare time for about 2-3 hours daily. During the period of training, the trainees were given a stipend of Rs. 200-00 per month for 3 months and a simple medicine kit. Once they commenced work they were given an honorarium of Rs. 50-00 per month and Rs. 600-00 worth of medicines per year.

The responsibility of the Government was limited to training and technical guidance. The philosophy of community involvement and participation in the provision of primary health services, also implied that the community would supplement the resources required for the continuation of this work and would completely takeover the programme at a subsequent period of time.

The scheme which was introduced on 2nd October, 1977 evoked wide public interest. While no one doubted the sincerity of the Government in providing health care to the rural masses, the programme came in for adverse criticism right from the outset. The Government was blamed for inadequate preparation, lack of pilot studies on feasibility especially in the light of heavy investment of public funds required for its implementation and for promoting quackery. In addition, community support remained minimal to nil and the envisaged possibility of the community taking over the programme was an impossible proposition under the circumstances.

Because of the above and various other reasons like non-replishnment of kits, non-payment of honorarium. etc., community health workers scheme which from the beginning had a poor chance to succeed never really took off. Unable to wind it up, due to various matters which are at present subjudice, the Government is now burdened with the recurrent costs for a "non-functional" scheme - the penalty of ill planning, hasty implementation and blind faith.

The present JSR scheme has tried to obviate some of the problems which plagued the old CHW Scheme. The scheme has issued clearcut guidelines on the selection process, training, examination, registration, functions of JSRs and code of conduct.

JSR Scheme versus CHW scheme

The objectives and activities of the JSR Scheme do have many commonalties with the Community Health Worker Scheme of 1977. But, there are some important differences. Important amongst these are :

1. increased duration of training - six months (it was three months in the CHW Scheme);
2. increased stipend from Rs.200-00 to Rs.500-00 per month during the training period with funds coming from TRYSEM (it was Rs.200/- in the CHW scheme and the funds were not from TRYSEM);
3. no monthly honorarium is to be paid to the JSRs. Instead, JSRs who successfully complete the course are to be given a registration certificate which will allow them to 'practise' in the village which nominated them for JSR training. Guidelines which state that they are to provide curative care only for illnesses mentioned in their training manual and for which they have been given training as well as the drugs they can use for treatment of these minor illnesses have been established. To assist in the establishment of their practise, JSRs who

successfully complete their course are eligible to obtain a loan with subsidy from IRDP under TRYSEM;

4. only those who have passed upto 10th standard are eligible for JSR training (CHW scheme permitted those with formal education upto 6th standard and above);
5. whenever qualifications and other criteria are similar, women are to be given preference over men in the selection process.

TABLE 2 : Comparison between CHW and JSR Schemes

Criteria	CHW Scheme	JSR Scheme
Year	1977	1995
Training duration	3 months	6 months
Goal	one CHW/ 1000 population	one JSR / village
Eligibility	upto 6th Standard	upto 10th Standard
Stipend during training	Rs. 200 per month	Rs. 500 per month
Honoraria	Rs. 50 per month	Loan - subsidy
Practice	Informal	Certified
Content of manual (special)	• Mental Health • Minor Ailment by Ayurveda/Yoga/Unani/ Siddha/Homeopathy/ Naturopathy/ Medicinal Plants (See Appendix 5)	• Working with community Anatomy / Physiology • Dengue/Filariasis • STD/Blindness • Patient examination

Though on first impression, these changes appear to be minor, the scheme as now envisaged differs in 2 radical ways from the old CHW scheme. Not providing a monthly honorarium and allowing market forces to determine their income per se could push the priorities of JSRs to paid curative services over preventive and promotive services specially with the spectre of loan repayment looming over their heads. Secondly, under the present format of certification, the Government has no direct supervisory powers over the JSRs as they are not staff of the Health and Family Welfare department and the JSRs theoretically have the liberty to pursue their practise and curative care without having the compulsion of carrying out preventive and promotive services or assisting Government in the implementation of National Health Programmes as envisaged in the scheme.

LIST OF SOME [3]SKILLS JSRS CAN LEARN : LISTING BY ALPHABETICAL ORDER

Dr Shyam Ashtekar

	Diagnostic skills
1	Basic ANC check up-and risk factors in pregnancy
2	Body Mapping
3	BP measurement
4	Breath counting
5	Checking and grading undernutrition with growth charts
6	Checking anemia/pallor
7	Checking creps by auscultation
8	Checking dehydration in adult and babies
9	Checking edema
10	Checking for patch in mouth
11	Checking for signs snake bite : a) drooping b) gum bleed
12	Checking groin Armpit Nodes
13	Checking groin Lymph nodes
14	Checking jaundice in eyes
15	Checking jaundice in urine by froth test
16	Checking liver tenderness
17	Checking neck glands
18	Checking Neck rigidity
19	Checking rhonchi by auscultation
20	Checking skin sensation for leprosy
21	Checking tender nerves at six spots
22	Checking tenderness of frontal/maxillary sinuses
23	Checking testicles for site/swelling/tenderness
24	Checking throat and jugular nodes
25	Checking undernutrition with arm band strip
26	Checking urine retention or no- urine
27	Counting pulse at six sites

[3] List not exhaustive,

28	Detecting fracture
29	Detecting injury/FB/ulcer on cornea
30	Detecting mature/immature cataract
31	Ear care in ASOM
32	Fever diagnosis
33	Headache diagnosis by simple tests
34	Identify carious teeth
35	Identifying snake as poisonous or non- poisonous
36	Light reflex
37	Locating illnesses to matrix of system-cause
38	Mapping GT organs on female pelvic model
39	Measuring temperature
40	P/V bimanual checking
41	P/V inspection
42	Percussing lung fields for solidification/fluid in chest
43	Tying splint for fractured limb
44	Use of basic diagnostic chart/table for Abdominal pain
45	Use of basic diagnostic chart/table for cough
46	Use of basic diagnostic chart/table for LM
	Healing skills
1	Acupressure 50 points
2	Ankle bandage for sprain
3	Basic wound management-cleaning, dressing
4	Clearing airway of newborn
5	Cutting and tying cord
6	Demonstration of condom use
7	Ear care in ASOM
8	First aid in snake bite- immobilization, pressure bandage
9	Hot sponging for urine retention
10	Inducing vomiting with salt water as first aid for poisoning
11	Massaging / primary physiotheray
12	Oil syringe for fecoliths
13	Preparing 10 herbal remedies from local resources
14	Preparing home fluid for rehydration

16	Puncturing and draining a boil with needle
17	Steam inhalation
18	Stopping bleeds by pressure/artery forceps
19	Tepid sponging of fevers
20	Treating minor phimosis with oil massage
21	Treating scorpion bite with burnt alum
22	Vaginal douche
23	Vaginal painting
24	Washing dog bite wounds with soap
	Other skills
1	Correct method of brushing teeth
2	Correct reading technique for IEC
3	Demonstration of soak pit construction
4	Disinfecting of water-at home or well
5	Disinfection of dressings, instruments
6	Explaining copper T on model
7	Explaining correct dosage scheduling
8	Handwash
9	Health education on five topics in school
10	Identify 25 medicinal herbs in the locality
11	Preparing drug labels in Hindi for kit
12	Preparing referral note to Primary Health Care
13	Preparing sanitary pads at home
14	Preparing supplementary feed for malnourished children
15	Record keeping
16	Taking blood film on slide
17	Taking sputum sample, fixing with heat
18	Use of slide show for IEC

LIST OF GENERIC MEDICINES RECOMMENDED FOR PRIMARY CARE WORKERS

List	Category	Generic Name of Medicine	Remarks
F	**Anti Inflammatory, anti-fever, pain killers (Non steroid)**	Aspirin tablets ,also dispersible,	Pain killer, fever-reducing, anti-inflammatory and anti-clotting
S		Ibuprofen tab & syrup	Pain killer, anti inflammatory
		Diclofenac	Do
F		Paracetamol	Relief of fever, pain
F	**Anti-allergic**	Chlorpheniramine tablets	Ffor itch, allergic skin rash etc
F	**Anti Helminthic agents**	Mebendazole/albendazole ,tab/syrup	Broad spectrum medicine for worms
S		Praziquantel tab/syrup	Tapeworms
S		Diethyl-carbamazine tab, syrup	Filariasis
F	**Anti bacterials**	Amoxicillin oral	Broad spectrum
		Erythromycin	URT and LRT infections, pus
F		Furazolidine oral	Bacterial gut infections
S		Phenoxy-methyl-penicillin (oral)	URT bacterial infections, pyodermas
F		Trimethoprim- Sulfa-Oral	Broad Spectrum anti bacterial, LRTI,UTI
S		Doxycycline tab/cap	Some STDs, URTI
F	**Anti-protozoal**	Chloroquine ,oral	As in Malaria Control Programme
S		Primaquine tab	Do
S		Metronidazole tab/pessaries	Do
F		Tinidazole tab	Do
S	**Anti anginal**	Isobarbide	Anti-anginal
S	**Skin medicines-(External)**	Miconazole	Fungal dermatoses
F		Whitfield ointment	Do
F		Gentian violet susp.	anti-infective
S		Neomycin+Bacitracin	Do
F		Providone Iodine	Do
F		Gamma BHC, Benzyl benzoate lotion	Scabies, louse
S	**Eye applications**	Gentamicin & antibacterial drops	Anti-bacterial
F		Tetracycline ointment	Do

F	**Digestive System drugs**	Magnesium/ Aluminium salts	Antacid
		Famotidine	Stops acid secretion
S		Domepridone	Anti emetic
S		Promethazine/meclizine oral	Do
S		Dicyclomine	For colicky pain
		Loperamide	Anti-motility (adults only)
S		Magnesium Sulfate	Cathartic
		Isphagol	Bulk cathartic
S		Anti-Hemorrohidal ointment	Piles
F		Oral rehydration salts	Rehydration
F		Salbutamol oral/ inhalation	do, also as uterine relaxant
S	**Anti-tussives**	Codeine tab/linctus	To suppress dry cough
S	**Vitamins & Minerals**	Vit D	Rickets/Osteomalacia
F		Vit A	Prevent/Treat def blindness
S		Vit B12	specific indications
S		Vit C	Scurvy
S		Calcium oral	calcium supplement
F		Ferrous salt oral (with folic acid)	Anti-anemic
S	**Uterine stimulant**	Methyl Ergometrine tab/inj	After third stage of labour, to minimize bleeding.
S	**Local anaesthetic**	Injection Xylocaine	Only for wound suturing & scorpion bite
S	**Urinary Analgesic**	Fenazo pyridine tab	In dysuric burning pain
F	**Skin Disinfectants**	Chlorhexidine sol	External application
F		Nitrofurantoin ointment/framycetin	Do
S		Hydrogen Peroxide	Do
S	**Emergency medicines**	Adrenaline injection	To be used in shock
S		Steroid injection	Acute Allergic reactions
S		Anti-histamine inj (Diphenhydramine)	Acute Allergic reactions
S		Isobarbide	For anginaal pain
S		Pentazocine in	Pain killer
S		Nifedipine oral	High Blood pressure

COOPERATION ON NATIONAL & STATE HEALTH PROGRAMS[4]

- Dr Shyam Ashtekar

The **JSR** can implement the following components of NHPs

Program	Potential Role of JSR
Malaria control program	Depot holders: Cholorquin and primaquin PBS Control of mosquito breeding spots with help of GP
TB control program	DOT program –detection, therapy
FW program	Condom. OP holders, Health education
Diarrhea diseases control program	Depot holders for ORT , antibiotics
Filariasis control program	Night smear, DEC treatment
Blindness Control Program	Detection of childhood vision defects, cataracts, Vit A depot holder Primary eye care
Child Survival	Neonatal care, feeding advice Promoting immunization, IEC about child nutrition, Treatment of ARI, Care in diarrhea, Malnutrition-prevention and care.

[4] List can expand depending upon National and State Initiatives

Reproductive health/ Safe Motherhood	Risk detection in pregnancy and childbirth, distribution of iron and calcium, urine tests, Assisting in normal childbirth, Gynac check up, Control of STDs
National Leprosy control program	Detection/screening
National STD control program/	Condom distribution, Detection and treatment according to syndromic approach
National IDD control program	IEC about salt
School health program	Screening for important illnesses Health education-messages
Vital Registration	Keeping track of births and deaths

SUMMARY OF JSR CONSULTATIVE PROCESS AFTER THE FIELD STUDY

	Issues	Mohammad	Dhruv	Shashikant	Shyam	Abhay
A	JSR Scheme- overall impression	Continue, but with prepare the system for it	Continue, work out IEC, Incorporate PHC in the system prepare Clinical protocols	Halt, review, redesign the scheme	Put the scheme in a system framework, redesign Integrate finely with the health system	Scheme in present form is generalising a failed model therefore - Halt all new selection and training for review period Consultation with various agencies working in community health Completely review and redesign the scheme
A	System framework of the scheme	Panchayat framework is enough like GSS	Community regulated model necessary Think of HMOs	RGM itself should evolve an HMO	Can think of a Nigam or HMO Start controlling the quack sector	Collaborative model with community ownership, NGO/ CBO involvement for local supervision and community anchoring processes, Govt. health system to give resources for training, work-linked honorarium, basic medicines and referral support, control of quacks

A	JSR as social-marketing model:		Work on contract with several organization: GP/ CBO - SHG, YG, TU, NGO, PHC etc.		On contract model, with NHP work on contract (see note in appendix) Each model has its own set of requirements, Strengths, limits, weaknesses, BUT a clear choice is necessary	See above for my suggestion of model; may be called 'social partnership model'
A	Pace of the programme		Slow down, review, redesign,	slow down,	Slow down, look for quality & depth of programme, evaluate, look at external factors too	Pace should be decided by community willingness to take up the scheme, not political compulsions In present scenario it means stopping the program for review and subsequently proceeding at a slower pace based on community response
A	JSR cell		Make a think tank from within and outside the Govt health system, a cell on JSR in the dept	Concur	Concur	should include representatives of major voluntary health networks in the state

A	NGO Role	Training, capacity building in JSR	Community awareness Designing/experimenting- a HMO model run by GP, NGO, Pvt Hosp Training participation: curriculum building, designing training and as resource person	training and monitoring	HMO experiments (Try JSR Extended RKS) NGO network on JSR scheme Organizing/networking JRSs House journal-CME	In the first phase there should be mandatory NGO/CBO involvement for local supervision and community anchoring processes. Also role in community awareness building, capacity building for community monitoring
B	Selection of JSRs	Let Gramsabha do it	Develop some technical criteria for selection health dept officer should steer Collector be involved	Combined Gramsabha decision and health staff decision, rather than leave it to GS	Recommend candidates thru GS Entry test	-GS meeting with observer from health dept. / NGO; minimum quorum of villagers required -Certification by GSS and health dept. to ensure non-quack or 'non-resident

B	Women selection	Either take AWW OR the jsrs, do not take both in the same village	Purdah not deterrent problem, start the process to overcome it Involve DPAP or NGO (SHG scheme) in selection process Bonus marks for women candidates Bonus mark for unemployed nurses	Lower educational requirements, ensure learning laearning skills by ET Would prefer an all-women scheme	Select women in all villages, if there is extra post in the same village, take a man on that Lower ed condition to 8th, let entry test decide the rest. Prepare books for entry test. NHP money is essential, village women make poor PMPs	Select women in all villages Lower edn. To 8th / to functional literacy in tribal areas Design special exam material for less educated candidates
B	JSR couple		Feasible, need to develop a protocol on this vis a vis entry test		Who will piggyback-the wife or husband? Women should lead, it will take care of the man-selection. Worth trying at places.	No concrete examples seen
B	Old CHV selection	No scope	Encourage, put bonus marks for them	Entry test with bonus marks (?)	Entry test with bonus marks (?)	Not much scope
B	AWW as JSR	Can select AWW, but then do not take others ithe same village	Encourage, put bonus marks for them	Will work nice	Involve the ICDS dept in the decision, do time-study of AWW and then decide Only 5-10% AWWs are 10th educated (ref Dhar figures) May not work without hon.	May work well in some cases but evaluate the existing workload of AWWs and their willingness to do additional work

B	Age	25-35	for favoring women, marriageable age+10 -- 10 years (28 to 38 years)	35-40 is Ok	For new people to come, put the lower limit at 20 yrs- to 40 to include the older ones Put them to an ET	25 - 40 to favour married women
B	Caste angle	select majority caste if Gramsabha wants it-no insistence for underprivile ged castes	School leaving certificate as SC ST documents Bonus points in ET	SC/ST/OBC should get preference in selection (they can do honest work)	Concur with Dhruv	SC/ST/OBC should get preference in selection
B	Quack-entry in selection	many	5-10% of trainees are current quacks,	5-10% of trainees are current quacks	5-10% of trainees are current quacks, no need to eliminate, but rigorous after-control is necessary	5-10% trainees are quacks, debar them as they sabotage the basic idea

C	Training content	Should be skill-based	Take problem solving approach Redesign manual accordingly, simple problems in first Module like fever, cold, diarrhea, malaria, scabies etc. Complex ones later e.g malnutrition, pneumonia etc.	Enhance clinical training	Redesign the manual Split the course in two Put skills and attitudes also	Redesign manual using other existing material; more practical and clinical content; attitude forming by exposure to NGOs / model JSRs; three level training (literate / 5-8 St. pass / High school ed.)
C	Training venue	CHC with 4 MOs	criteria trainer-availability Availability of clinical experience venue The two venues can be different DTU, CHCs, Nursing schools NGOs as Training Centers, for social. IEC internship Pvt., Public, Trust Hospitals for Clinical Internship	Special institute/staff at DH is preferred for intensive course /select CHC in the district For first course, CHC with special trainer(s) Do it block by block Involve some NGOs	Special training units essential for concerted and committed training, Select model center (can be CHC/NGO) in each district, conecntrate resources	Special trainers from distt. Trg. Centre should coordinate trg.; location part in CHC and part in SC and village setting; exposure to NGO also; involve local health NGOs in trg.

C	Method of training	least didactic	Least didactic Lecture as concept introducing/ info sharing Participatory method for decision making and doing	Educational aids/AV aids	Participatory, AV aids, hands on training	Much more practical and in village setting
C	manual	OK	Rework with changes in venues, trainees, curriculum, content, methods in mind	Not seen thoroughly	See notes on manual	OK for technical content but lacking in attitudinal / social issues; also many small mistakes / gaps
C	BMO's role	Time too little	Variable; some good Entrust organizating training rather than just training (as a principal and as a tutor)	Enroll help of women trainers, DTT	Time constraint Orientation problem Vested interests Methods problem	They have no time or orientation for actual trg.; at the most can helpin organising
C	CME	IEC	House Journal necessary specialty/advance training	House journal	house journal, periodic contact sessions	Regular revision / refresher meetings + journal + village supervisory visits by health staff
C	RFWTC role in training	Only TOT	Involve RFWTC for curriculum setting, methodology and monitoring		Need to involve RFWTCs down to filed level-training and monitoring	Should be more in contact with actual JSR trainings

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C	Exam papers	Not seen	Not seen As afterthought, more problem based questions rather than information based	Too theoretical Increase MCQs	Revamp Include practical tests-internal may be Print papers clean	Very theoretical; need to judge attitudes and test clinical skills
C	Exam process		Pre training Test Formative assessment Evaluative assessment Preferably as points or as grades		Conduct at district/regional town Fixed dates twice a year Skills-test mandatory	Part at dist. And part at Subcentre in working setting
C	Other books	Let them use any book	List recommended books (Can staff sell its own books?) Prepare Problem based learning block-books containing Curriculum, objectives, schedules, topics, basic information, learning material, reference material, exercises		Improve the jsr manual Prepare skills book/CD	Make a JSR library at CHC and stock additional books Stop privatisation of JSR manuals

C	use of Infotech		CDs as a self-learning and self assessing process		CDs-In training interactive diagnosis exercises Records and MIS	Record maintenance and analysis at CHC level
C	Role of other institutions		Involve Open University	Involve Open University (Bhoj?) in distance training/certification	Involve Open University (Bhoj?) in distance training/certification Involve innovative NGOs	Involve health NGOs like MP VHA; PSM depts
D	Drugs used	--	make it EDL based Prepare separate list for each module Encourage home remedies in the first module: herbal+acupressure Add Other systems in basic or advanced or specialist training (Ayurved, Homeopathy, Acupuncture, Yoga) as per the additional time, skill and knowledge required	Appended 40 medicines list	Lists for course I and course II. 20/40 Include other systems (see book H&H)	Three level (as above) - 10 / 20 / 40 drugs

D	Drug Supply		JP should maintain a store Experiment with financial systems incl. social marketing of E D s thru' community groups : co-operative, SHG, Y G s, W G s	Concur with D	Publish approved list for JSRs to begin with Develop LOCOST type stores at JP	Basic drugs (sub centre kit) to be supplied by PHC to JSRs free; Other drugs may be supplied through LOCOST at JP depots
D	Inj /saline	Feel Helpless- how to stop and how to make it viable without that	Revamp the protocols, allow what Injectible are absolutely necessary e.g Inj. TT, or Inj Adrenaline for snake bite, Inj Cyclopam for colic Rates to be negotiated with the GP, user group etc. A campaign to be lead by the JSRs to stop irrational drugs incl inj. Like Inj Lariago and Inj Taxim in OPD/saline in OPD	No-stop	Protocols Allow programme-required inj (gentamycin) & ADR treatment injections Publish rate list start IEC and start action on quacks quietly now	No injectables to be allowed as they are not warranted at this level. Widespread awareness generation through GSS Take strict action against JSR quackery and debar those who persist.
D	Ayurveda		Home remedies as basic I module leading to Ayurved in Basic II module and also as a advanced training		Develop lists for jsrs..about 40-50 medicines Training for preparing some remedies at home	Similar three level list - focus on home remedies or simple herbal remedies rather than marketed preparations

E	Cost of care by JSR		Try innovative methods like FCC insurance work out rates for drug costs+services Co-pay the JSR for state/NHP linked services		Try FCC insurance at places Put price lists in the village Women JSRs can substantially bring down the rates , as they look for supplementary income not a full professional income, and more honest in dealings.	Combination of support from public health system + Panchayat managed FCC insurance; minimal fee at point of service
F	Honorarium for jsrs[1]	let GP/JP decide the level	NHP linked	NHP linked	NHP linked	-Lack of regular support to JSR is a major reason for dropout and lack of accountability of JSRs -There are concretely hardly any marked funds in NHPs for village level activities. -JSR should be supported by public health system through Panchayat with proper monitoring of work (technical by PHC, social by villagers)

[1] All respondents were unanimous on this issue, except the RGM and Principal RFWTC Gwalior

F	Minimum income for surviving JSRs	1000-1500 pm	1500 plus pm[2]	1500 pm upwards, from combined sources-users and NHP honorarium	1500 pm upwards, from combined sources-users and NHP honorarium	JSR work is a part time activity so about 500 pm + some user fees may be adequate
G	Community control	GSS framework	Directed to protect users create administrative tools for GP control	Concur D	Concur D	Orientation of Gram Sabha and vill. Health committee can enable them to do this JSR honorarium should be linked to positive report from Gram Sabha

[2] Here the calculation is

Min wage for skilled labourer @ Rs 100 per day

Time reqd = 2 hours for clinical tasks, no of patients seen - treated or referred = 12

Therefore cost = 100/8*2 = 25 Therefore the JSR can charge Rs 2 to 3 per person as service charge

G	Community IEC		IEC needs to be specified: E.g. Train GSS to Recommend a JSR thru' a mock meeting OR to inform PHC with a copy to CMHO about > 1 case of malaria in a village OR to carry out chlorination of a drinking water source OR to seek and keep account financial resources as a Gram RKS	Ongoing DANIDA work should help	Ongoing DANIDA work should help, Also prepare messages for JSRs and for villagers.	Special material and process for awareness generation is essential
G	Legal issues		legal protection is necessary- based on area practice and drug-use	legal protection is necessary- based on area practice and drug-use	First issue a clear GR on use of remedies look for provisions for certificate courses for jsrs Work for a new FCC act to use all system remedies	Legal cover for self-village based work, use of specified drugs
G	Relicensing		Necessary	Necessary	Necessary every 3 years	Necessary and based on both technical performance and community feedback

H	Linkages with ANM/MPW	-	As colleagues, to mobilize community to uptake NHP linked services of staff Create pathbreaking reporting system later to expand it to all pvt practitioners	NHP-linked support	Mainly NHP linked support, Prepare a simple recording - & reporting system	Can give some NHP related support but should not use JSR as errand boy; no vertical relationship
I	Clinic site	Let GP provide space for jsr clinic	Concur M, GP at least facilitate getting space for the clinic	GP space must be available, but let them work also from home for odd hour services	Some public space is necessary to define the practice and facilitate GP control	Concur Shashikant
I	Boards				Provide standard boards from dept	'Gram Swasthya Kendra' board specifying name of JSR; may be prepared by GP in standard format
I	Clinic records		Work out simple userfriendly relevant record-formats	Avoid paperwork-overkill	Simple, standard, scannable, small, MIS-friendly formats	Very simple, analysable and only relevant records

I	About clinical work jsrs are doing now	-	It has a good range of illnesses covered with treatment or referral incl. asthma, High BP, skin infections, pneumonia in children, migraine, acute abdomen, difficult labor, burning micturition, incising an abcess under local anesthesia It is not systematic: no evidence based diagnosis but based on experience. Treatment based on 'my guru taught us' rather than rationally essential It is filling the gap between the clinical needs and its services To be steered with protocols, CE and supervision	Not satisfactory	Increase both depth and range—thru training /support	Not at all satisfactory; resembles quack practice with just a few differences like use of ORS; lot of overuse of drugs including antibiotics and parenterals

I	Clinic Model		Let HMO setup a clinic model		Develop a standard set, let RKS like bodies build the centers if and when possible. this will give some credence to the JSR as system	
I	System-identity		Let HMO decide : apron with a a colored emblem[3]	Not necessary	Give them Logos/ part of uniform (T shirts/Kameez)	Personal emblems to be avoided; let the JSR remain a part of the village and not a special being; however kit gives a work-related identity
J	Survival rate Working JSRs out of trained	10%	10%	10%	10%	<10%, varies somewhat from area to area
J	What do you feel about it	-	Dismal right now but opportunity hopeful Several potentials : young JSRs; Nascent but widespread model; several players with strong support from CM/RGM	Dismal	Is an opportunity to redesign the scheme	Only a miraculous change of mindset among decision makers or major social movement can transform this scheme

[3] Please see a dummy logo for GP JSRs as JSRLogo1.gif

K	Funding		For experimenting & developing JSR	For experimenting & developing JSR	For experimenting & developing JSR	Adequate funding is required at all levels; present funds for the scheme are grossly inadequate
L	Area size (to make the scheme fee-sustainable)		2000, ideally let it be decided by GS/GP if it can support the jsr differently (like insurance)	2000, ideally let it be decided by GS/GP if it can support the jsr differently (like insurance)	2000, ideally let it be decided by GS/GP if it can support the jsr differently (like insurance)	Making the scheme purely fee-based is neither desirable nor very feasible
L	Village selection		Take villages as they ask & prepare for the scheme, Not somehow roll all in the same batch	Take villages as they ask & prepare for the scheme, Not somehow roll all in the same batch	I Concur with S & D, make it a ongoing scheme, not the fight to finish kind of scheme	Concur with others; let villages take the initiative

L	Links with Other PMP		Standardize internship roles of JSR and the instts Standardize institutional criteria List such facilities Decide a stipend to be paid by the instt for the labor (The stipend offered as student may be contd.) GP. GenPhysician, &Co OR trust hospitals, PHC, CHCs and Civil Hosp, homeopathic, ayurvedic, etc. can be internship instt when these skills are taught		Dangerous area, but need for a pragmatic and systematic approach Need to accredit/list clinics/hospitals where they can officially intern, discourage quack influence (better to make DH facility available)	Present danger of quack-like linkages is very high; primary linkage should be to Govt. centres or charitable centres only
L	Social marketing of preventive services/goo ds		Need to study in greater depth, and in the light of social marketing done by the health dept itself		Possible only if a regular clinic space is available. list articles/services that the community can buy or the JSR can sell (condoms, nailcutters, etc)	Basic preventive services are practically never sold by the public health system and should not be; they are a part of basic social services to be available to all

L	Prevntive programmes		NHP, Health Education incl. School Health Education Health Promotion activities like games, yoga, exercise		NHP/SHP Give them school health programmes on some honorarium	JSRs can do some general and some village-specific activities with Panchayat honorarium
L	Supervision Monitoring & Quality Control		Service supervision/ monitoring: HMO+GSS+NGO+RKS+RFW TC Technical supervision/monitoring: HMO+PHC+NGO+RFWTC Legal supervision/monitoring: PHC+NGO		Set up a special cell, under JSR cell, give contracts to NGOs for technical monitoring with help of SC staff. Prepare feedback system Inform the villager/users about the process, about his/her role	Technical: public health system Social: vill. Health committee / Gr. Sabha Support: NGO / CBO
M	Community concerns		GSS/BlJSS/JJSS + PHC + NGO should review it		Involve NGOs thru JSR cell in studying these aspects, Involve sensitive women officers. Share with providers & users regularly.	

M	Complaint Cell		Rep of NGO/CBO (women) + DHO + MPO (women) + CF Chaired by NGO/CBO and DHO alternatively every three years Should look into matters not controlled by supervisors/ monitoring persons		Put a box in Grampanchayat & Janpad, JSR cell should keep files of press clippings.	

JSR-T RESPONSES TO QUESTIONNAIRES

	Methods used	Frequency	Category
1	Mannual Reading	**53**	theory
2	Practical	30	practical
3	Not yet(training yet to start)	26	Unclassifiable
4	Oral / lectures	**24**	theory
5	NR	33	Unclassifiable
6	PBS (practical)	21	practical
7	Theory (lecture?)	**20**	theory
8	Showing Patients	16	practical
9	Hospital Practical	15	practical
10	Exam	**13**	theory
11	Pictures	12	visual
12	Lab Practical	11	practical
13	Chart	9	visual
14	Dressing	8	practical
15	Post Mortem	8	practical
16	OPD Work	7	practical
17	Illness /Treatment	7	Unclassifiable
18	Discussion	6	participatory
19	Sanitation	6	practical
20	Group	5	participatory
21	Injection	4	practical
22	Medicine room /medicine	4	practical
23	Nothing	4	Unclassifiable
24	Field Work	3	practical
25	Black Board use	3	visual
26	Medical Treatment	3	Unclassifiable
27	ANC	2	practical
28	Experiment (?)	2	practical
29	Leprosy Clinic	2	practical
30	NHPs	2	practical
31	Physical Exam.	2	practical
32	Techniques (?)	2	practical
33	Ward Work	2	practical
34	Anatomy	2	theory
35	JSR Role	2	theory
36	Role	2	theory
37	Diagrams	2	visual
38	Sputum test	1	lab

39	About Tablets	1	practical
40	Body Mapping	1	practical
41	Dispensing	1	practical
42	Environment (?)	1	practical
43	History taking	1	practical
44	Immunisation sessions	1	practical
45	Patient Observation	1	practical
46	Records	1	practical
47	Registration	1	practical
48	Chitthi nikalna	1	practical
49	Explanied about Role	1	theory
50	Physiology	1	theory
51	Written (?)	1	theory
52	Demonstration	1	visual
53	video	1	visual
54	FP (?)	1	Unclassifiable
55	Gastro (?)	1	Unclassifiable
56	Health Science (?)	1	Unclassifiable
57	Malaria	1	Unclassifiable
58	Malnutrition	1	Unclassifiable
59	Many methods	1	Unclassifiable
	Grand total 59 items	**395**	
	Subjects covered in training	**Freq**	
1	Immunisation	60	
2	Malaria	57	
3	Anatomy	45	
4	ANC	27	
5	JSR Role	24	
6	MCH	24	
7	Dressing	23	
8	FW	23	
9	GastroEnteritis	22	
10	Leprosy	21	
11	Not Yet	21	
12	TB	21	
13	PBS	20	
14	Baby Care	18	
15	AIDS	17	
16	Sanitation	17	
17	Illnesses	16	

18	Mal Nutrition	16	
19	Diarrhoea	13	
20	WaterSafety	11	
21	Child Birth	10	
22	dignosis	10	
23	Physiology	10	
24	Registration	10	
25	ARI	9	
26	NR	9	
27	Skin	9	
28	Anatomy/Bones	8	
29	Chitthi	8	
30	ORS	8	
31	Infections	7	
32	Injection	7	
33	Typhoid	7	
34	NHP	6	
35	Nutrition	6	
36	OPD	6	
37	Anatomy/Muscle	5	
38	Heart	5	
39	Polio	5	
40	Anatomy/Head	4	
41	Dental	4	
42	Maleria	4	
43	Medicines	4	
44	Observing Patients	4	
45	Pulse Polio	4	
46	Tablets	4	
47	Womens Health	4	
48	Anatomy/Blood	3	
49	Anemia	3	
50	Blindness	3	
51	ENT	3	
52	Health	3	
53	Help Staff	3	
54	Obs/gyne	3	
55	Prevention	3	
56	STDS	3	
57	Vomitting & Lm	3	
58	Ayurvedic	2	

59	Coding(?)	2	
60	Cold Cough	2	
61	Eye	2	
62	Gramswasthya samiti	2	
63	Health/Edu	2	
64	High Risk	2	
65	IMR	2	
66	Jaundice	2	
67	Malnourished Women	2	
68	Medical Checkup	2	
69	Pharmacology	2	
70	Primary treatment	2	
71	Village Sanitation	2	
72	Whooping Cough	2	
73	Allopathic	1	
74	Anatomy/Skeleton	1	
75	Antibiotic	1	
76	Breathing	1	
77	Cataract	1	
78	Checkup	1	
79	Child Birth(risk)	1	
80	Cholera	1	
81	Code Of Conduct	1	
82	DPT	1	
83	Fever	1	
84	Fever Inj/Tab	1	
85	Field Work	1	
86	First Aid	1	
87	Health edu	1	
88	Health Pramotion	1	
89	Health/Edu.	1	
90	Homeopathic	1	
91	Illness causes	1	
92	Illness Treatment	1	
93	Leprosy & Naru	1	
94	Lungs	1	
95	Maleria PBS	1	
96	Malnutrition	1	
97	MCH FW	1	
98	Measales	1	
99	Pathology	1	

100	Pharmacoloty	1	
101	Practice of Medicine	1	
102	Responsibilities	1	
103	Safe motherhood	1	
104	Serving People	1	
105	Surgery	1	
106	Symptoms	1	
107	Tounge	1	
108	Village Safety	1	
109	Vital Registration	1	
110	Vitamin A	2	
111	Vitamines	1	
112	Wound Treatment	1	
	Gr total 112 list items	**774**	
	Opinion about training	**Frq**	
1	Good	49	
2	Little use	4	
3	NR	9	
4	OK	17	
5	Very good	122	
6	Very little use	3	
	Gr total	**204**	
	Interim Exam	**Frq**	
1	Not Yet	128	
2	Oral	27	
3	Monthly & Tri monthly	13	
4	NR	12	
5	yes	6	
6	Oral & Written	6	
7	Two tests	4	
8	Monthly	4	
9	About illnesses	2	
10	Tri monthly	1	
11	question Bank	1	
	Total responses	**204**	
	More medicines they want	**Freq**	
1 1	Not Yet necesary	88	
2 2	Injection	78	

3	3	Saline	29	
4	4	Antibiotic	21	
5	5	NA	12	
6	6	Pain killers	11	
7	7	Vomitting remedy	9	
8	8	Dihorrea medicines	9	
9	9	GastroE medicine	8	
10	10	Unreadable	6	
11	11	other+ More Medicines	6	
12	12	All Medicines	6	
13	13	TB Drugs	5	
14	14	Malaria medicine	4	
15		Abd. Pain remedy	4	
16		Tyiphoid medicine	3	
17		Reaction medicine	3	
18		X Ray /Plaster	2	
19		Vitamin	2	
20		Paracetomol	2	
21		No Mannual (so don't know)	2	
22		Like Doctors use	2	
23		Life Saving Medicines	2	
24		Jaundice Medicine	2	
25		Immunisation	2	
26		Cough medicine	2	
27		Cotrimoxazole	2	
28		Clomine Tab	2	
29		Ayurvedic medicines	2	
30		Top Antibiotic	1	
31		Temperature medicine	1	
32		Skin Illnesses medicine	1	
33		Safe Antibiotic	1	
34		PV Bleeding medicine	1	
35		Pulse(?)	1	
36		Plaster	1	
37		NR	1	
38		No Other	1	
39		No More	1	
40		Nimesulide	1	
41		Nil	1	
42		Mebendazole	1	
43		Laxative	1	

7	Metro Entro furran	1	
8	Metro ORS	1	
9	NA	1	
10	Not yet trained	3	
11	NR	32	
12	ORS	12	
13	ORS / Fluids	80	
14	ORS furazolidine	1	
15	ORS Home fluids	1	
16	ORS Medicines	28	
17	ORS Metro	1	
18	ORS Referal	6	
19	ORS SSS	3	
20	ORS SSS Home fluids	7	
21	ORS TAB	1	
22	ORS Home fluids Lomofen	1	
23	ORS Home fluids SSS	1	
24	ORS Norflox Dygine	1	
25	ORS Paracetamol B Plex	1	
26	Pulse (checkig)	1	
27	Referral	2	
28	Reglan Home fluids ORS	1	
29	Saline Metro	1	
30	SSS	1	
31	SSS Home fluids	1	
32	SSS Metro	1	
33	SSS ORS	1	
34	SSS ORS Home fluids	2	
35	Tab ORS	1	
36	Tab SSS	1	
	Total responses	**204**	
	Fever diagnosis	**Freq**	
1	By Symptoms	1	
2	Check Hands	4	
3	Chills	1	
4	Chills Body Ache	1	
5	Chills Fever	1	
6	Chills headache	1	
7	Chills headache PBS	1	
8	Chills PBS	1	

9	Chills Pulse	1	
10	Chills Temperature	1	
11	Fever	1	
12	Fever Sweating	1	
13	Fever BP	1	
14	Fever Chills	1	
15	Fever Chills Symptoms	2	
16	Fever Chills etc	1	
17	Fever chills History	1	
18	Fever Chills PBS	1	
19	Fever headache	1	
20	Fever History	1	
21	Fever History Pulse Temp.	2	
22	Fever History symptoms	1	
23	Fever PBS	1	
24	Fever Pulse	1	
25	Fever Pulse Symptoms	2	
26	Hand Check up	1	
27	headache Bodyache	1	
28	HiistoryTemperature Pulse	2	
29	History	1	
30	History Symptoms	1	
31	History pulse	1	
32	NA	1	
33	Not yet trained	2	
34	NR	7	
35	PBS	1	
36	PBS Chills	1	
37	PBS Pulse	1	
38	PBS Temperature	1	
39	PBS-Eyes lips skin	1	
40	Pulse	2	
41	Pulse Fever Symptoms	2	
42	Pulse PBS	6	
43	Pulse Temperature	8	
44	Pulse Temperature Symptoms	5	
45	Pulse Temperature Symptoms	3	
46	PulseTounge eyes etc.	3	
47	Symptoms	4	
48	Symptoms PBS	4	
49	Temperature	8	

50	Temperature Checkup Saline	5	
51	Temperature chills	5	
52	Temperature History	6	
53	Temperature PBS	7	
54	Temperature Pulse	7	
55	Temperature Pulse Breathing	9	
56	Temperature Pulse Nails	12	
57	Temperature Pulse PBS	21	
58	Unreadable	34	
	Total	**204**	
	Malaria diagnosis	**freq**	
1	Not yet taught	38	
2	PBS	30	
3	Fever Chills PBS	23	
4	NR + NA	19	
5	Fever chills + chiils fever	22	
6	Chills Fever PBS + chills PBS	15	
7	Chills PBS	12	
8	Chills	6	
9	Chills headache	4	
10	Chills Fever AD	3	
11	Symptoms PBS	2	
12	Fever chills symptoms	3	
13	Chills Fever headache	2	
14	Yellow Eyes	1	
15	Temperature PBS	1	
16	Temperature headache	1	
17	Symptoms PBS Pulse	1	
18	Pulse Fever AD	1	
19	PBS Fever	1	
20	Malaria Chills Fever AD	1	
21	History chills PBS	1	
22	Hand Checking	1	
23	Fever Pulse PBS	1	
24	Fever Pain PBS	1	
25	Fever headache chills	2	
26	Fever chills headache PBS	1	
27	Fever Chills referal	1	
28	Fever Chills Pulse	1	

29	Fever chills AD + Chills AD	1	
30	Fever AD PBS	1	
31	Fever AD headache	1	
32	Chills Weakness PBS	1	
33	Chills headache PBS	1	
34	Chills headache fever AD	1	
35	Chills Fever Vomitting	1	
36	Chills Fever headache PBS	1	
	Total	**203**	
	Treatment of malaria	**Freq**	
1	NR	134	
2	Chloro T	37	
3	Malaria T	7	
4	Chloro T Para T	6	
5	Referral	4	
6	Chloro T Inj	3	
7	Not yet trained	2	
8	Tablets	1	
9	PBS	1	
10	Paracetamol T	1	
11	History PBS	1	
12	Cold Sponging	1	
13	Clean Water	1	
14	Choloro T	1	
15	Chlorto T Para T	1	
16	Chloro T Referal	1	
17	Chloro T Prima T	1	
18	Water disposal	1	
	Total	**204**	
	How will you develop the jsr work	**Freq**	
1.	All Services	1	
2.	As a duty	1	
3.	As Good JSR	2	
4.	AS JSR	3	
5.	Clinic (run a clinic)	8	
6.	Clinic Health education	1	

7.	Comprehensive Health	1	
8.	Contacting Families	1	
9.	Field Treatment	1	
10.	FW Health Education	1	
11.	FW Health Promotion	1	
12.	FW and Prevention	1	
13.	Giving Medicines	1	
14.	Good Doctor	1	
15.	Good JSR	2	
16.	Good Work	2	
17.	Health Awareness Sanitation	1	
18.	Health checkup	1	
19.	Health Education	24	
20.	Health Education and Records	1	
21.	Health Education Treatment	3	
22.	Health Education Water Purification	1	
23.	Health Programs	1	
24.	Health Services	3	
25.	Ideal Village(making)	1	
26.	JSR (by being one)	17	
27.	Learn with a good doctor	10	
28.	Learn with a good doctor & Low Cost	3	
29.	Learn with PHC Doctor	1	
30.	Loan and FW	1	
31.	Low Cost Treatment	4	
32.	MCH	4	
33.	Medical Store (will run one)	2	
34.	Medical Treatment	26	
35.	Medical Treatment Health Education	1	
36.	Medical treatment MCH	1	
37.	Medical treatment referal	1	
38.	NA	12	
39.	NHP Information	1	
40.	NR	14	
41.	NY	1	
42.	Public Awareness	1	
43.	Sanitation	5	
44.	Sanitation Health Education	1	
45.	Sanitation Education	2	
46.	Sanitation FW	1	
47.	Serve People	14	

48.	Through GSS	2	
49.	Treatment Referal	1	
50.	Unique (?)	1	
51.	Unreadable	1	
52.	Village care	1	
53.	Water Safety	1	
54.	Win Trust	9	
55.	Womens' Health	1	
	Total	**204**	
	Want an image of	**Freq**	
56.	JSR	63	
57.	Doctor	56	
58.	Good JSR	14	
59.	NR	14	
60.	JSR -doctor	8	
61.	Compounder	6	
62.	Lady Doctor	6	
63.	Serving People	5	
64.	Good Citizen	4	
65.	NA	3	
66.	Serve people	3	
67.	Social worker	3	
68.	Honour (want honour)	2	
69.	Medical Treatement	2	
70.	A Small Doctor	1	
71.	As Good JSr	2	
72.	As Healer	1	
73.	Care for people	1	
74.	Citizen	1	
75.	Clinic	1	
76.	Doctor & Volunteer	1	
77.	Doctor-JSR	1	
78.	Family Doctor	1	
79.	First Contact Care	1	
80.	Godess	1	
81.	Healer	1	
82.	Volunteer	1	
83.	Well Wisher (of village)	1	
	Total	**204**	

	Dreams of the trainees	Freq	
84.	JSR	36	
85.	Health For All	27	
86.	Medical Treatment of all	19	
87.	Serve Village	13	
88.	Doctor (to become one)	11	
89.	NR	10	
90.	As Good JSR	8	
91.	Health Education	5	
92.	Good JSR	5	
93.	Better Health Services	5	
94.	Start a clinic	4	
95.	Prevention	4	
96.	Village Development	3	
97.	NA	3	
98.	Healthy Village	3	
99.	Govt. Help	3	
100.	Good Work	3	
101.	Good Treatment & Referal	3	
102.	Win trust	2	
103.	Serve People & family	2	
104.	Progress of self	2	
105.	Healthy People	2	
106.	Health Facility in village	2	
107.	Earn respect	2	
108.	Earn Money	2	
109.	Community Health	2	
110.	Village Sanitation	1	
111.	Study	1	
112.	Right Referal & Good Rx	1	
113.	More Knowledge & Honour	2	
114.	MCH	1	
115.	Low Cost Treatment	1	
116.	Lady Doctor (become one)	1	
117.	Injections to Poor	1	
118.	Improvement of Village	1	
119.	Hospital Term	1	
120.	Honour & Income	1	
121.	Help People	1	
122.	Good Citizen	1	
123.	FW & Healthy People	1	

124.	Free Medicines Supply	1	
125.	For revision (for previous practice)	1	
126.	Facility in Village	1	
127.	Earn as doctor	1	
128.	Doctor(become) & Healthy People	1	
129.	Do my duty	1	
130.	Development	1	
131.	Better Health	1	
	Total	**204**	

JSR-W RESPONSES TO QUESTIONNAIRES

General Info	
Issue	**Results**
Total JSR-w	22
gender	all M
average age	29y
range of age of jsrW	21-46
education	10(1), 12th(14), Gr/PG(7)
working since	0-5 yrs, average 2.7 yrs
distance from work-village	0-1km(16), , ,
	2k(2)
	4k(1)
	9k(1)
	12+(2)
Selection	**Selection by**
	GP/GP&merit(13), ,
	GS/janpad (2)
	Gramsabha(3)
	sarpanch(1),
	other(1)
SCST	10 (non scst-12)
Role&COC	
6tasks listed	
Medical Treatement	12
Water Purification/Bl powder dist	11
PBS/chloro T	9
Help NHPs	8
Sanitation	7
Referal	7
FW+oral pills	7
Immunisation/help in	6

Epidemic Info.	6
registration of VE	6
MCH	5
Help Health Staff	5
Health Education	4
Pulse Polio	3
Epedimic Control	2
5 Safesfor child birth	2
Tablet (giving tablets)	1
Serve People	1
ORS	1
	103
Any Code of Conduct	Yes (11), no/do not know(11)
Describe COC	
(most listed the tasks, not COC)	
Nutrition Edu.	1
NR	7
Medicines	1
Injection	1
Illnesses	1
Home visits-ANC	1
Help in Med. Camp	1
Help People	1
Health Services	1
Fever Dign.	1
Dressing	1
Child Birth	1
ANC-TT/ANC	2
Age of Marriage (awareness)	1
Advice Patients	1
	22
Time given everyday	
Whole day	1
half day	10
Morning evening	1
NR	10
Training issues	
First training venue	
CHC	5

PHC	14
Distric Hosp	1
NR	2
Second training venue	
Ay. Hosp.Bhopal	1
CHC Mazgawa	1
Morn.Even	1
SC Pindra	1
Sub Centre Raygaon	1
Victoriya Hosp.	1
DH Bhopal	1
training batch strength	range 7-75, average 22.5
Received book/manual	All except 2, all found it useful
Training techniques	Fr of mention
Lecture	10
Practical	7
Dressing	6
PBS	5
Pulse Polio	3
OPD+pt observation	3
Injection Room	3
Discussion	2
Syringe Wash	2
Immunisation	2
Registration	1
Compounder room	1
Saline	1
Sub Centre Work	1
Med.Training	1
experiment	1
Illneses(NR)	1
Subjects taught	Fr of mention
Water safety	5
Stitches	1
STDs	1
Sanitation	1

Registration of VE	1
Referal	2
Prevention	1
Polio immunization	3
Physiology	1
PBS	5
pathya ayurveda	1
parcha nikalna	1
ORS	2
Oral pills	1
Observing Patients	1
NR	2
NHP	2
Medicines	6
Medical Treatment	4
malaria	1
Leprosy	1
Lab	3
Immunisation	2
Illnesses	1
Home Remedies	1
Health Education	1
Gastro	1
FW	1
First Aid	2
Dressing	6
Diagnosis	2
Chloro T.	1
Child Illnesses	1
Catract	2
ARI	1
ANC/Child Birth	1
Anatomy	3
5 safes	2
	74
Interim tests	**Interim tests**
	Yes(22)-monthly/writtn/oral/practical
Final test	all respondants said yes-written tests

Results of final test	17 P, 4 await Result (but practicing)
Certificate	3 NR, 3 await, 14 have Cert
Cert obtained at	PHC/CHC/DH/Janpad/ZP/ etc
Other training	7 with a PMP, 1of them vaidya,
	1 other had acupressure training
Workof JSRs	
Time of work	Fr of mention
8 hr	1
12 (8to8)	1
Morning	1
Morning Even.	10
Regular	1
Whenever necessary	2
NR	6
	22
Place of work	
At Home	9
At Home & Clinic	4
At Home & Clinic & Visits	1
At Home Special Room	1
clinic	4
Out doors	2
NR	1
	22

pts seen last month	range 0 to 8--300.(3 NR),
	averge 48 pts per month
women pts last mo	3 to 100, average 14.6, 4 NR
keeping pt register	13 not keeping, 7 keep, 3 NR
main illnesses mentioned	**Fr of mention**
Fever	18
Diarrhoea	16
Vomitting	16
Malaria	13
Boil	11
Cough Cold	11
Abdominal Pain	8

ARI	8
Cold	7
Eye illnesses	7
Injury	6
Itch	5
cough	4
Gastro	4
Measeals	3
Headache	2
Headache& Bodyache	2
Mal nutrition	2
Scodpion Bite	2
Tootache	2
Asthma	1
Burns	1
Chills	1
Constipition/worms	2
Ear Pain	1
Joint pains	1
Leprosy	1
Mahamari	1
Minor Aliments	1
Pain	1
Seet?	1
skin illness	1
STD	1
Typhoid	1
Weakness	1
Total entires	**163**
Medicines/skills	
Listed drugs	**Fr of mention**
Para T	22
Chloro T	19
ORS	10
Cotrimoxazole	9
Avil	8
Dexa	5
Metro T	5
Analgin T.	4
CPM	4

Diclofenac	4
FFA	4
Furadine	4
Perinorm	4
Septran	4
Antibiotic	3
Bleaching Powder	3
Chlorine T	3
Reglan	3
Savlon	3
B Plex	2
Betnesol	2
Gauze	2
Terra cap	2
Amoxicillin	1
Ampoxine	1
Antacid	1
Beta dine	1
Brufen	1
Cipro	1
Combiflam	1
Genta	1
I nj Dexa	1
Inj Diclof	1
Inj Genta	1
Inj Oxy Tetra	1
I nj TT	1
Mebandazole T	1
MVT.	1
Ointment	1
Prima T.	1
Sinarest	1
Spasmolytic	1
Spirit	1
TC?	1
TinctureB	1
NR	1
Listed items 46	**152**
Ay med & home Remedies	
Adrak	2

Adrak+Tulsi	1
Ajvayan	2
Chavanprash	1
Chiryata	1
Cystone	1
Dal Water	3
Garlic	1
Gassex	1
Hadki	1
Hingushtak Churna	1
Kali Mirch	1
Kasamrut	1
Kharwadiya (khadirawati?)	3
LB Churna	1
Lime	1
Live 53	1
Loung	2
Lonug Oil	1
M2 Tone	1
Mustard Oil	1
Neem	1
ORS?Sponzing?	1
Panchasakar Churna	1
Rice Water	3
Shankhapushpi	1
Tapina Goli	1
Trifla	1
Tulsi	1
No/NR	7
listed items 23 incl ORS	**45**
Conditions& injections	
Condition/complaint	Injection used
AB Pain	Ana Forten
Allergy	Avil
ARI	Ampi
ARI	Genta+ decadron
ARI	Taxim +dexona
Boil	Genta+Diclof
Boil	Oxy Tetra
Cold ,Asthama	Dexa

Cold Fever -	Genta
Cold/Boil	Genta
Emergency	NR
Fever	Chloro
Fever	Dexa
Gastro	Reglan
Injury	TT
Itch	Evil
Maleria	Chloro
No.	No inj
NR	NR
On PMP Ad	unnamed
Pain	diclof
Scorpion Bite	CPM +Dexa
Vomitting	MET
SUMMARY	
users 5in(2), 4inj(2), 3inj(1), 2inj(1), I inj(3), 0 inj (7), 5 NR	
2 JSRs use it only for Scorpion bite (CPM Dexa)	
Two say they give it on PMP's advice	
15 commonly used injections	
Ampi	
Ana Forten	
Avil	
Chloro	
Chloro	
CPM +Dexa	
Dexa	
Dexa	
Diclof	
Genta	
Genta	
Genta+ dexa	
Genta+Diclof	
MET/perinorm/reglan	
NR	
Oxy Tetra	
Taxim +dexona	
TT	
unnammed	

Common situations for injections

Abdominal Pain	
Allergy	
ARI	
Asthma	
Cold	
Boil	
Emergency	
Fever	
Injury	
Malaria	
Pain	
PMP advice	
Scorpion Bite	
Vomitting	
15 injectable are listed, Bplex does not find a mention	
Ampi	
Ana Forten	
Avil	
Chloro	
CPM	
Dexa	
diclofenac	
Avil	
Genta	
Decadron	
MET	
Oxy Tetra	
Reglan	
Taxim	
TT	
condition for giving saline	**Freq**
By prescription of other PMP	1
can not drink	1
Dehydration	4
Emergency	1
Ex Dihhorea	1
Ex Vomm.	1
GastroEnteritis	3
Low BP	1

Do not give saline	9
NR	4
Dirrhoea	1
Heat (ayurvedic concept)	1
High fever	1
10/22 jsrs give saline, listed conditions 13,	
want to use medicine not mentioned in manual	
Other medicnes	**fre of mention**
Amox	2
Ampi.	1
Ampoxin	1
Cipro	2
Combiflam	1
Dexona	1
From Store	1
Genta	1
Metro	1
Mikacin	1
Nimesulide	1
No Other	10
NR	5
Pudinhara	1
Soframycine	1
taxim	1
Tetramycin	1
	32
want Info of these meds	Fr
Injection	6
saline	4
NR	7
No Other	2
Aciloc	1
AIDS Medicine	1
All	1
Ampoxi	1
Ampoxin& Other 7	1
Ayurvedic Compounds	1
Elderhit	1
For Abd. Pain	1

Homeopathy	1
Many	1
Netobion	1
Ranitine	1
Spasmolytic	1
Tablets	1
Taxim	1
tricort	1
	35
Skills emploed by jsrs	Fr
History taking	8
Pulse	8
BP	5
Stetho	5
Check up	4
Thermameter	4
PBS	3
Weight	3
Temperature	2
Toung Check up	2
Blood check	1
Eye & Nails	1
NR	2
Palpation	1
torch	1
vacc,currete	1
	51
(the idea of skill is not very clear, so confusing answers)	
want to learn more skills	
Injection	3
Stiches	3
All Illnesses	2
Dignoses	2
High Treatment	2
More Training	2
Saline	2
Accupressure	1
ARI	1
Ayurvedic	1
Better training	1

Doctor/Compounder skills	1
High Bp	1
Homeo	1
I & D abscess	1
Lab	1
Like Doctor	1
Medical Treatment	1
Medicines	1
NR	1
NR	1
Reki	1
Special Training	1
Sujog & Magnet	1
toothache (treatment)	1
Total	**34**
many options, so total (34) exceeds 22 w jsrs	
Clinical practices	
Treatment for Diarrhoea	Fr of mention
ORS	8
HF	3
ORS ,ParaT.Metro T	2
ORS HF	2
ORS HF Metro	2
ORS Metro	2
Anti D Tab.+ORS	1
ORS Furadine	1
SSS/ORS+Antibiotic	1
Total	**22**
Fever Dig	Fr
Fever chills	5
Chills Fever Symptoms PBS	1
Eye,toung,Pulse checkup	1
History Symptoms	1
History Temperature	1
Malaria?	1
NR	2
Pain Chills etc	1
PBS	1
Pulse PBS	1

Pulse temperature	1
Symptoms	1
Temperature/thermometer	2
Temperture,Eye weight,PBS	1
Touch	1
blanket-wrapped & Thermameter	1
Total	**22**
malaria diagnosis	
PBS	13
Fever chills PBS	3
Fever Chills Symptoms PBS	3
Fever Chills	1
Fever Sweating PBS	1
Fever chills	1
T	**22**
malaria action	
Chloro T.	7
Chloro T. Para T	2
Antibiotic + Para T.	1
Chloro T.	1
Chloro T.	1
Chloro T	1
Chloro T.	1
Chloro T	1
NR/not taught yet	7
Total	**22**
	2-30 range. Average 9.47, 5 NR
	PHC is the major backup for referral

Govt centers for referral	
PHC	11
NR	6
CHC	4
NR	1
	22
Ref-causes last month	**Fr**
Fever/high fever	10
Diahrroea	7
Malaria	4

Injury	4
Gastro	4
Vomitting	3
Fracture	3
Child Birth	3
ARI	3
Anemia	3
Snake Bite	2
Measeals	2
Cancer	2
ARI	2
Urine ret.	1
Unconscious	1
TB	1
Swollen Feet	1
skin illnesses	1
Poisioning	1
PBS (no slides)	1
Malnutrition	1
Immunisation	1
High BP	1
Headache	1
For saline?	1
For injection	1
Family welfare	1
Eye Problems	1
Ex Vomitting	1
cough cold	1
Cold Fever	1
Chronic fever	1
Bone Illnesses	1
Blood Spit	1
Appendicitis	1
Acute abdomen	1
Abdominal pain	1
Ref causes 39	**76**
39 causes, 76 incidents of referral tp PHC/CHC	
Income/financial	
Average fees earned	
No fees/don't pay	8

5 RS	5
NR	4
2 RS	1
7 Rs	1
10 Rs	1
15 Rs	1
NR	1
5 Rs	**22**
Range of fees earned	**Freq**
No fees	5
NR	3
5 to 10	3
5 to 20	2
2 to 5	2
2 to 10	2
5 to 5	1
10 to 40	1
10 to 15	1
1 to 5	1
1 to 2	1
	22
monthly income	**Fr**
0	7
500	4
100	2
200	2
800	2
NR	2
300	1
1200	1
1500	1
	22
Monthly income , including non earners is 360,	
Av income excluding Non earners is 553Rs	
Income-satisfaction	
No	15
NR	3
Yes	3
Unhappy	1

Total	**22**
Any Other work?	
NR	6
No	5
farming	4
half day	3
NR	2
Yes	1
Farming & Bazar	1
	22
TRYSEM loan	
No loan	21
yes-got it	1
Lnkages/support	
Links with health personnel	**Fr**
MPW/ANM	7
MPW	3
ANM/MPW?LHV	2
None	2
ANM	1
Govt. Doctor	1
MPW ANM Dai	1
MPW/ANM/AWW	1
MPW/AWW	1
NR	1
PHC	1
PHC staff & PMP	1
	22
Contact with staff last month	
NR	9
No	8
MPW	2
Immunisation	2
Helped Staff	1
	22
Actual Support from Village Staff	Fr
NR	5

No	5
Sub Center Staff	2
PHC	2
MPW/ANM	2
MPW/ANM/ Dai	1
Compounder	1
ANM/MPW/LHV	1
ANM & CHC Staff	1
ANM	1
All	1
	22
PHC/CHC Meeting attended by /called for JSR	**Fr**
No Meeting	5
NR	5
4 meetings	4
Yes	3
2 meetings	2
Monthly once	2
5 meetings so far	1
	22
Subject in Meeting	**Fr**
No subject	7
NR	5
Malaria Pneumonia, bleeching powder	3
FW	2
Dihorrea/ARI/Blindness/Meseals	1
JS Abhiyan + Child Nutrition	1
Malaria & Gastro	1
Nutrition,Dihorrea,MCH	1
Seasonal illnesses	1
	22
TA/DA for Meeting	
NR	10
No	12
	22
Material Supplied at Meeting	Fr of mention
NR	11

No	8
Poster	2
NHP forms	1
	22
Suggestions for meetigs	
NR	11
Other Doctors should also attend	3
Hon. Rs.2000/-pm.	1
None	1
OK	1
Solve Our Problems	1
TA DA & medical Supply	1
TA DA Hon.	1
Teachabout Medical Treatment	1
Want Meeting	1
	22
Referral to PMP ?	**Fr**
No	12
NR	6
Yes	3
Nil	1
	22
No ref to PMPs?	**Fr**
No ref	12
NR	6
Yes	3
Nil	1
	22
PMP resp?	**Fr**
NR	17
Yes (good)	2
Help ful	2
PMP Feels I am a threat.	1
	22
Monitoring?	
There is no monitoring	7
NR	6

NR	3
Good (?)	1
Desired but none	1
BY PHC Compounder	1
BY BMO &BEE	1
Yes, by PHC staff	1
SC Staff	1
Total	**22**
PHC-help?	
NR	7
No Cooperation	3
NR	2
Yes-treatment Edu.	1
Yes-ORS,Op, Chloro T-supply	1
Yes-OP ORS, Bleeching Powder-supply	1
Yes Many ways	1
Medicines (they support)	1
In Emergency (they support)	1
In difficulties (they support)	1
Guidence (they give)	1
Govt. Doctor & Ward Boy helpful	1
Desired	1
	22
Suggestions for PHC support	FR
NR	17
Contact will Help	2
Many ways for help	1
Patient treatment, Observation (training)	1
Want Help	1
	22
Village/GSS	
Any GSS? (members)	Fr
Yes (7)	6
NR	4
Yes(12)	3
Yes (8)	2
Yes (6)	1
Yes (15)	1

Yes	1
No Co op.	1
No	1
No	1
Don't Know	1
	22
GSS met & date	Fr
NR	10
No	4
twice	2
Last month	2
No Meetings	1
Last Yr. 5 times	1
Last Year	1
Yes-20 july	1
	22
Opinion-about GSS	
NR	8
We should Help & Inform GSS	2
Special Discussion?	2
GSS Checks reg./ has good opinion	1
GP is still developing GSS	1
GSS cooperates	1
GSS praises our work	1
Health Edu	1
Helpful	1
I am Health Secretary	1
I Learn from GSS	1
Like JSR	1
Not existing-Want GSS	1
	22
GP/GS Discussion	
Yes (some discussion)	7
No discussion	4
NR	3
responsibility of JSR	3
Discussed about My work	1
Good Work-Honour me	1

Health for All	1
OK Work	1
worried about?	1
	22
IssuesJSR raised in GP?	
NR	5
About Health	3
Sanitation & Water Safety	3
Health	2
Demand SC in village	1
About Medicine Cost	1
Hon & Loan	1
Maleria + Gastro	1
Medical Treatment	1
No issue	1
Payment	1
Sanitation FW	1
Yes-FW & Age of Marriage	1
	22
Your efforts for Communtiy health?	
NR	7
GSS meeting	2
Health/Edu.	2
Sanitation	2
Demand SC in village	1
Give me a chance in Med. Camp	1
Hand Pump Improvement	1
Help MPW	1
No effort	1
I will work with regularity	1
Sanitation, Health Edu.	1
Water Purification	1
Water Safety & ORS	1
	22
Do all strata use JSR services?	
Yes	12
Yes but limited	3

NR	2
Few	1
No	1
No - No Medicines	1
No-Many PMPs in village	1
Only Poor	1
	22
Suggestions	
Is Current income enough?	
Not enough	13
NR	3
No-Hon. is necessary	1
No . must be improved	1
No Benefit	1
No Income	1
OK	1
yes-enough	1
	22
Suggestions for income	
NR	7
Hon	5
Hon.1000	3
Better training & Equipment	1
Hon Or Loan	1
Hon.500/-	1
Monthly Payment	1
Salary	1
Salary & Medicine	1
Salary & Permission to practice	1
	22
Problems (From 4 options)	
No Money/capital	5
No Kit	4
Lack of Medicines	7
No problem	3
No Equipment	3
No Permission for Inj/Saline	2
No Stationery	2
NR	2

Medicine shortage	2
Blind Faith of people	1
Can not buy Medicine	1
Can not Prevent	1
Dignostic Difficulties	1
Inadequate Training	1
No Fees	1
No Hon	1
No Income	1
No Injection	1
No Injection - No Patient	1
No Medicines from PHC	1
No Money-No Medicine	1
No releif from PHC Mediciens	1
Panchayat doesn't support	1
People don't inform	1
People don't Trust	1
People uncooperative	1
PHC Doesn't support	1
PMP threatens	1
Time	1
Udhari	1
	51
Suggestions of jsrs(4 slots)	
NR	6
More Training	6
Medicine Supply/tablet	5
Village Swasthya bhavan/clinic room	4
Hon 1000/-	3
Medical Kit	3
Equipment	2
Hon.	2
Permission for Inj./Saline	2
PHC Meeting	2
1 Yr. Training	1
500 Hon.	1
call me in Med. Camp	1
Clinic room & Equipments	1
Drainage	1
Hand Pump Improvement	1

Hon 500/-	1
Hon.& Higher Training	1
inform sarpanch	1
Inform.people	1
Injection	1
Kit Box	1
Latrines	1
Link with DH	1
Loan	1
Medicine+equip	1
Officers should inform people	1
Panchayat Help	1
PHC Help	1
Public Notice	1
Some Payment	1
Stationery	1
Sulabh Shauchalaya	1
	58