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NOT FOR CIRCULATION

REVIEW

OF THE

JAN SWASTHYA RAKSHAK SCHEME

OF THE

GOVERNMENT OF MADHYA PRADESH

JULY - SEPTEMBER 1997

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I. INTRODUCTION

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. 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 (35 and 24.3 per 1000 population, crude death rates (12.6 and 7.3 per 1000 population) and Infant Mortality rates (105 and 75 per 1000 live births) reveals the extent of health problems and needs lying unfulfilled specially in rural areas.

TABLE 1 : **District Profile and Regional Disparities in Madhya Pradesh**

State/District	Total Population	Percentage of Rural Population	Rural Female Literacy Rate	Rural			Total (Rural & Urban)	
				SC	ST	SR	CBR (1984-90)	TFR (1984-90)
Madhya Pradesh								
Total	**66,181,170**		**28.85**	**14.55**	**23.27**	**931**	**37.2**	**5.0**
Rural	**50.842.333**	**76.82**	**19.73**	**14.80**	**28.82**	**943**		
Urban	**15,338.837**		**58.92**	**15.72**	**4.87**	**893**		
Districts								
Morena	1,359,632	79.48	14.88	19.87	6.83	826	41.2	6.0
Bhind **	**967,857**	**79.40**	**23.55**	**22.17**	**0.15**	**813**	**39.0**	**5.8**
Gwalior	582,163	41.21	16.46	23.84	5.23	818	35.1	4.7
Datia	307,352	77.55	16.08	27.23	1.95	840	39.5	5.8
Shivpuri	960,907	84.81	9.36	19.87	12.78	848	42.6	6.3
Guna	1,054,741	80.50	10.12	18.80	14.03	875	41.4	5.9
Tikamgarh	781,815	83.10	15.39	23.42	4.60	868	42.1	6.1
Chhatarpur	934,552	80.70	14.12	25.11	4.45	855	42.6	6.6
Panna	598,378	86.98	14.85	20.97	16.39	901	42.2	5.9
Sagar	1,166,357	70.79	26.83	21.47	11.33	884	39.6	5.5
Damoh	735,203	81.86	23.52	20.14	14.76	908	40.1	5.3
Satna	1,176,220	80.27	22.19	18.23	16.05	929	40.7	5.7
Rewa **	**1,318,172**	**84.77**	**22.81**	**15.38**	**13.56**	**946**	**40.9**	**5.8**
Shahdol	1,375,673	78.89	12.85	7.20	54.26	961	39.3	5.3
Sidhi	1,284,586	93.53	11.40	11.52	31.99	934	44.3	6.7

41-94', 7%

CBR - 30 - 45

TFR - (4 - 7)

Particulars	Total Population	Rural %	Female Literacy Rate Rural	Rural			Total (Rural & Urban)	
				SC	ST	SR	CBR (1984-90)	TFR (1984-90)
Mandsaur	1,195,939	76.90	19.88	17.35	5.69	951	33.5	4.1
Ratlam	662,151	68.13	13.94	15.19	32.72	956	35.2	4.6
Ujjain	836,403	60.47	13.76	30.25	2.60	936	32.1	4.2
Shajapur	850,362	82.30	13.58	24.64	2.68	920	36.6	5.1
Dewas	766,147	74.11	16.20	19.55	18.50	933	37.0	5.0
Jhabua	1,032,325	91.32	6.83	2.79	91.14	983	45.4	7.0
Dhar **	**1,187,702**	**86.86**	**15.64**	**6.85**	**59.45**	**960**	**37.2**	**5.1**
Indore	561,397	30.58	22.53	19.82	12.09	919	29.6	3.6
West Nimar	1,722,871	84.95	17.58	9.76	53.00	956	38.4	5.3
East Nimar	1,037,491	72.47	21.04	12.26	36.09	940	38.5	5.2
Rajgarh	825,926	83.19	9.46	18.70	3.68	927	37.7	5.3
Vidisha **	**775,303**	**79.90**	**19.54**	**21.68**	**5.23**	**872**	**40.1**	**5.6**
Bhopal	270,677	20.03	15.15	21.68	4.26	873	32.5	3.8
Senor	690,025	82.01	15.07	21.73	11.53	901	41.2	6.0
Raisen	738,645	84.28	20.45	17.56	16.37	884	39.1	5.3
Betul	961,551	81.38	26.71	9.58	44.58	981	39.0	5.6
Hoshangabad **	**920,695**	**72.66**	**26.32**	**16.84**	**22.20**	**904**	**38.0**	**5.4**
Jabalpur	1,443,501	54.47	26.06	12.50	28.04	939	34.1	4.2
Narsimhapur	663,708	84.50	36.55	17.10	14.37	915	34.6	4.6
Mandla	1,192,213	92.33	18.57	4.98	64.87	993	36.5	5.0
Chhindwara	1,206,351	76.90	23.58	11.38	42.10	967	37.0	5.3
Seoni	906,024	90.53	27.14	10.81	40.16	980	35.7	5.0
Balghat	1,236,083	90.50	36.27	8.19	23.16	1,009	32.8	4.2
Surguja	1,831,471	87.94	12.50	5.09	59.22	969	38.2	5.3
Bilaspur **	**3,148,763**	**83.00**	**20.92**	**19.12**	**26.33**	**990**	**36.7**	**5.0**
Raigarh	1,559,232	90.53	23.48	11.13	51.16	1,009	32.5	4.3
Rajnandgaon	1,213,184	84.25	22.24	9.64	28.84	1,021	36.2	5.0
Durg	1,551,734	64.73	33.01	13.51	16.05	1,010	33.6	4.2
Raipur	3,136,420	80.26	24.40	15.06	21.58	1,007	34.4	4.6
Bastar	2,109,431	92.87	11.79	5.51	71.17	1,007	35.9	5.0

SC - Scheduled Caste ST - Scheduled Tribe SR - Sex Ratio CBR - Crude Birth Rate
TFR - Total Fertility Rate

* * Districts visited by Study team

Source : Health Monitor 1994 & 1995 (FRHS)

* All the selected districts visited except Hoshangabad had a higher percentage of rural population as compared to the rural population in Madhya Pradesh.

* Dhar and Vidisha districts have a lower rural female literacy when compared to that of the State.

* Bhind and Vidisha have one of the lowest sex ratios. Due to various causes identified in various other studies, this does greatly influence the socio-cultural practices specially gender related in these 2 districts.

* Except Bilaspur, the CBR and TFR were higher in all the other districts visited.

* Bhind and Vidisha have a much higher and Dhar much lower schedule caste population when compared to rural Madhya Pradesh.

* Dhar has 59.45% rural population belonging to schedule tribes. Bhind hardly has any tribal population. Their percentage is low in Vidisha and Rewa.

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.

Taking cognizance of the above situation and to improve health care services in rural areas, the Government of Madhya Pradesh launched the "Jan Swasthya Rakshak" Scheme on 19 November 1995. The scheme envisages that there will be one trained JSR in each and every village of Madhya Pradesh. (Appendix 1)

This 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 provide 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 detailed description of the 1977 CHW scheme is not out of context here. It had many lessons to teach and because of the many similarities of the present JSR scheme to it, it would still be worthwhile to review it - if not for anything else atleast to avoid repeating the mistakes of the past.

It is also necessary to understand that provision of primary health care to the rural population by voluntary health workers is not without scientific foundation. A large number of countries all over the world have and are extensively employing bands of trained voluntary workers for this purpose with great success. Alternative strategies for delivery of health care in different parts of our own country have revealed their potential. It is true that these projects do widely vary on a number of dimensions and taking them to scale would reveal some of their deficiencies. Despite these variations, the projects have proved beyond doubt the potential of non-health workers in the delivery of primary health care to the rural communities as revealed by their popularity and acceptability as well as their fairly impressive results in improving health status and decreasing illnesses.

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.

Details of the present JSR Scheme are given in Appendix 2.

The terms of reference of the present Review were to:

i. document the **profile of the JSRs** in five districts in different regions of Madhya Pradesh;

ii. examine the **process of selection of the** JSRs by the community;

iii. **document the content and methodology of training** in selected PHCs with a view to strengthen this process, keeping in mind the skills required for provision of essential child survival and safe motherhood services at village level; and

iv. **document the system of examination after training** for certification of the JSRs to suggest improvements in the system.

In addition, we also looked at a few **administrative** and management aspects of the scheme as well as the attitude towards and perception of the scheme by community, panchayat and health department officials. An attempt has also been made to make specific recommendations for strengthening the scheme.

At the outset, we would like to clarify that at the time of Review **not a single JSR had received his registration certificate** - a necessary prerequisite to practise as mentioned in the Government orders on the Scheme. Because of this, the actual, practical Review of the performance of JSRs in the field was not feasible. Only indirect information of their assisting or non-assisting in the implementation of national programmes like immunisation, etc., could be obtained. A study of the effectiveness of the services provided by the JSRs and their benefits to the community will necessarily have to await some reasonably long time after the scheme is able to get off the ground.

II. OBJECTIVES OF JAN SWASTHYA RAKSHAK SCHEME

Exactly 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.

The objectives of the Jan Swasthya Rakshak Scheme are as follows:

1. For improving the health in rural areas, to provide 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 - 3).

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 MCH and RCH and other national programmes in the village, collecting health related information and maintaining registers.

TABLE 2 : Analysis of functions of JSR as mentioned in the 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	
3. Environment promotion	4	1	
4. Health Education	5,12,15.	3	
5. Health Statistics	6, 19	2	
6. Curative	13, 14, 17	3	
TOTAL :		24	

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. From the above, it is quite clear that a JSR will necessarily have to spend a large amount of time on preventive and promotive activities.

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. Thus, 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.

By involving an unemployed, educated youth of the village chosen by the village panchayat, in preventive, promotive and curative health care, it was felt that the overall health status of villagers would show improvement. Assisting in the removal of false cultural beliefs, improving the environment, implementing the MCH and RCH programmes like Immunisation, Family Welfare, Tuberculosis, Malaria, giving Health Education to the villagers on various issues and by provision of curative care, the JSR would help play an instrumental part in improving the overall health status of the villagers. Needless to say, this would then have a positive influence and effect on many other areas of the daily life of a villager.

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

1. increased the 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 scheme;

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.

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 their priorities of JSRs to the 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.

TABLE 3 : Comparison between CHWs and JSRs

Criteria	CHWs	JSRs
Duration of training	3 months	6 months
Stipend	Rs.200-00	Rs.500-00
Honorarium	Rs.50-00 per month	loan - subsidy
Practice	No	Yes
Eligibility	studied upto 6th standard	Passed 10th standard

III. METHODOLOGY

The development of the methodology for this Review Study was influenced to a considerable degree by the purpose and scope of Review and the time-constraint involved in conducting a state-wide study. The various aspects of the methodology can be broadly classified as follows:

1. identification of levels of administrative set-up;
2. identification of functional areas of study;
3. sources of data;
4. development of instruments;
5. sample size and design;
6. methodology for collection of data; and
7. analysis and integration of data.

Identification of levels of administrative set-up

Keeping in view the objectives of the Scheme and the operational details evolved for its implementation, collecting and utilising information from sectors other than health especially at the grass-root level, was considered desirable. Therefore, the levels of administrative set-up from where the information was to be generated were decided as follows:

I. Organised health services set-up

   a) District level concerned with operational details of scheme
   b) Primary health centre complex concerned with training and implementation of scheme at grass-root level.

II. Link between organized health services and community

   Jan Swasthya Rakshak.

III. Beneficiaries or consumers and their representatives

   1) Village level - -
      a) community members
      b) community leaders
      c) village level workers

   2) Block level - -

      a) B.D.Os / C.E.Os
      b) Block Level Presidents

   3) District level -

      a) Zilla Parishad President/members,
      b) CEOs and President of Zilla Panchayat Health Committees.

An effort was made to meet representatives at all the above levels. Though there was no difficulty at the village level, it was not always possible to meet representatives at Block level or District level because of transfers or previous commitments necessitating their absence from headquarters. Also, as some of the Panchayat representatives had left for the Congress convention at Calcutta which was being held at the same time, we were unable to elicit their views in some places which we surveyed.

Identification of functional areas of Study

The functional areas or dimensions of the Scheme on which the Review was based are given below. These were worked out taking into consideration the status of implementation of the Scheme at the time of conducting the study and in keeping with the objectives and scope of Review.

i. The extent of deviation of the Scheme in its actual implementation to date in different districts;

ii. Attitude and commitment of JSR to his planned work;

iii. Attitude and perception of community members, leaders and primary health staff towards the scheme in general and JSR of their villages in particular;

iv. Adequacy and appropriateness of medicines and drugs supplied to the JSRs;

v. Problems and bottlenecks in the effective selection and training of JSRs;

vi. Administrative and logistics aspects.

The functional areas were decided with a view to cover all the dimensions providing thereby the factual attitudinal assessment of the implementors of the Scheme and potential beneficiaries. These served as guiding principles on the basis of which instruments for data collection were developed.

Sources of data

The study involved collection of primary data from respondents at various levels of the health administrative set up, as well as from the community members and leaders. Data was also collected from secondary sources such as instructions and circulars issued at different points of time and records of district were PHC levels.

The categories of personnel were chosen on the basis of extent of their involvement in the planning or implementation stages of JSR scheme directly or indirectly. The number of respondents in each category and the total number interviewed are as follows:

TABLE 4 : CATEGORY OF RESPONDENTS

Level of administrative set-up	Category of respondents	Total no. of respondents
District	Chief Medical Officer	5
	C.E.O.	2
	Deputy CEO	1
Block	B.D.O.	5
	D.M.O.	10
	M.O. Incharge training of JSR	1
	Block Extension Educator	11
	Male Supervisor	11
	Lady Health Visitor	11
	Jan Swasthya Rakshaks	101
Village	Community members	20 villages
	Community Leaders	20 villages
	Village Health Workers	6

Development of instruments

After having identified the functional areas mentioned earlier, different schedules meant for collection of information from different categories of respondents were developed. In all, 6 such schedules were developed. (Appendix 4a to f). A number of areas were common to some schedules. They were introduced deliberately to obtain information from different respondents on the same dimensions of the scheme for the purpose of cross checking and validation of data.

The schedules contained structured, unstructured and multiple choice items attempting to cover knowledge, attitude and reaction of different levels of respondents.

The District and Block level schedules were in the form of guidelines and were administered in the form of open-ended interviews.

Sample size and design

Because of the diversity of the State, at the outset it was decided to obtain data from as many parts of the State as possible. Keeping in view the quantum of information to be collected at different levels of administrative set-up within the constraints of time and resources, a multi-stage sampling process was resorted to. From each of the five regions of Madhya Pradesh, two districts each were initially selected randomly. From this two, one was then again selected randomly. In these selected districts, two PHCs each were selected more on the basis of practical consideration of time, resources and logistics rather

than on the basis of rigorous statistical requirements. The final list of Districts and PHCs are given below.

TABLE 5 : Districts, Block Primary Health Centres

District	Block PHC	Villages
Vidisha	1. Peepal Kheda	1. Sunpura 2. Busran
	2. Gyaraspur	1. Furtula 2. Mudro Ganeshpur
Bhind	1. Phooph	1. Baralu 2. Deenpura
	2. Ater	1. Hamlet (Ater) 2. Johri Kotwal
Reewa	1. Govind Garh	1. Agdal
	2. Sirmor	2. Bachpao Menhdi
Hoshangabad	Piparia	1. Gadaghat 2. Alipar Kheda
Dhar	1. Nalchha	1. Panela 2. Patliyapur
	2. Sardarpur	1. Badadi 2. Karchi/Ruprel

In each of the PHC unit, effort was made to visit atleast two villages to discuss matters related to the Scheme with community members and leaders. While conducting the field survey, we were informed of RCH training being given to a large group of female "JSRs" under a pilot project being funded by an international agency at Piparia Block PHC. Since the functions and activities of this group were to be very similar to the JSRs in other districts, we decided to review the process of selection and training at Piparia Block PHC also. The relevance of including Piparia was all the more important since at all the other centres there were hardly any female volunteers for JSR training (0 to less than 3).

Methodology for collection of data

For the purpose of collection of data, a team of two members visited the various institutions and administered the various questionnaires to different categories of respondents and held open-ended interviews as appropriate with the different levels of personnel mentioned earlier. Discussions were held with community members and leaders of identified villages based on guidelines mentioned earlier. Discussions were also held with JSRs after they submitted their filled up questionnaires to elicit their views in a group situation.

unstructured interview, focused grp discussion

Analysis and interpretation of data

All data collected was analysed either manually or with the help of the Computer and appropriate interpretations were made from the analysed data.

IV. SELECTION OF JSR

Clear guidelines (Appendix 2) have been issued for the selection of JSRs. The Government was supposed to give information of the Scheme via newspapers, radio and television and by putting up notices at the Gram Panchayat Office and other prominent places. However, during our survey, in none of the villages visited by us was the above carried out and the only information that Gram Panchayat received was a letter asking that one of the villagers who fits the criteria be nominated for JSR training to the Janpad Panchayat. Also, no efforts were made to make use of locally available communication means or other field based organisations for this activity.

The JSR nominee from 40% of the villages that we visited, was chosen by a few leaders of the village (or the Sarpanch himself). In 3 places, there was a Gram Sabha meeting called where the most appropriate name was suggested. Often nominations were arbitrary and depended upon extraneous factors. As mentioned later, of the 101 JSRs who participated in the Review process, 82.2% were selected by the Gram Panchayat and 13.8% by the Janpad Panchayat.

Some areas adopted novel methods to select JSRs. Thus to obtain the most ideal person, in Pipariya PHC region, health camps were arranged in the villages of the district where adequate information was then given to the village leaders and villagers of the Scheme and the need to select the most appropriate candidate. This greatly helped in selecting the right candidates. As mentioned earlier, it was not that all selections were arbitrary. In some villages, the Gram Sabha did meet and chose the most appropriate candidate. But very often, only 10-15% of the members attend the Gram Sabha and this becomes a stumbling block to free and fair selection - since by being absent most villagers are then unaware of the Scheme or its objectives and by fault the appropriate person does not apply. At the same time, we did come across 3 cases where the Sarpanch himself decided who should be sent for training and did not inform the villagers.

The inappropriate selection of the JSR trainees has many ramifications. The duties of a JSR calls for a certain degree of commitment. The trainers clearly mentioned that during the training period they did observe that some JSRs were not interested in the training (they were coming as "timepass", "for the stipend" or because it might lead to a permanent government job later). This is bound to affect the performance of the JSRs and will also be detrimental to the welfare of the village. The whole objective of the Scheme would then be defeated if the villagers are not going to benefit from the Scheme.

Selection of JSR trainees therefore needs to be given further thought. One of the suggestions given by one group of trainers was to make it criteria based and since the health department staff visit every house in the village, their help be taken in identification of right nominees from whom Panchayat can select the most appropriate candidate based on a set of defined criteria. However, we feel selection has to be in the hands of the people - Gram Sabha and they may take the help of teachers, anganwadi workers or other government functionaries who are familiar with the residents of the village. The success of the JSR Scheme to a large extent will depend on the competence and commitment of the JSR and appropriate selection of candidates is most essential.

V. ASSESSMENT OF TRAINING

A. *PERCEPTION OF TRAINERS*

With a view to ascertain the opinion of various category of trainers on the scheme in general and the training process and supervis' ו specifically, open-ended interviews based on set guide-lines were held in every Block PHC visited. Ideally, we would have liked to interview each trainer individually but because of time constraints, the whole team of trainers were interviewed together in a group initially and later the trainers were asked to give their individual opinions if it differed from the group opinion. The responses from all members were then collated and analysed.

Objectives

TABLE 6 : The trainers mentioned the following objectives of the JSR Scheme:

Objectives	Percentage
1. Provision of health care for minor illnesses	81
2. Helping the health team in National Health Programmes	72
3. Assisting in immunization and motivating for FP	72
4. Chlorinating wells	27
5. Improving health of the villagers	18
6. Production of village based cadre of health workers	9
7. Provision of jobs for unemployed educated youth	9

The above does indicate that the trainers were aware of the main objectives of the scheme.

The JSR will facilitate the health department in the implementation of National Health Programmes (81%) was the main expectation the trainers had from the JSR Scheme. Besides this, provision of health care for minor illnesses (72%), referral of emergencies in time (18%), acting as a link person between community and health department (9%), were the other main responses. Carrying out their duties sincerely and as recommended and taught to them (63%) was the expectation from JSRs which was mentioned most frequently by the trainers. Not becoming injection doctors or "quacks" was the other main expectation (54%). Two groups (18%) also mentioned improvement of environment of the village as one of their expectations of the JSRs.

TABLE 7 : Treatment of ailments to be treated by JSRs as identified by trainers

Ailments	Percentage
1. Diarrhoea	100
2. Fever	100
3. Minor ailments	45
4. Malaria	18
5. First aid	18
6. Coughs & colds	9
7. Eye discharges	9

From the above, it is clear that the trainers do not want JSRs to go beyond their brief from training.

Since the JSRs had not yet started practising, it was not possible to elicit their level of functioning and discuss about their referrals to the PHC. Three groups (27%) mentioned that they do receive referrals from JSRs.

According to the trainers, all the JSRs took part in the Pulse Polio campaign and some even in the blindness camps. About 45% do assist the health team during immunisation / family planning activities when the health team visits their villages. Others are not conducting any health related activity or assisting the government in the implementation of National Health Programmes or any of their other identified activities.

Using and giving injections as the main treatment (72%), using drugs beyond what they are permitted (45%), going beyond their brief (27%) were the main worries of the trainers regarding the JSR Scheme. The attitude of "just waiting to start practise" and becoming "doctors" troubled one group of trainers. Four groups (36%) went to the extent of saying they were worried that **they were assisting in the production of "quacks"**. Three groups (27%) mentioned that once certified, the JSRs **would only do curative work and will not be interested in preventive and promotive activities.** Because of poor and delayed administrative actions (issuing of certificates, loans, holding of examinations), three groups (27%) mentioned that the JSRs were **losing interest** and moving over to other fields and jobs. One group mentioned that based on the population in which the JSR was to practise (the village that recommended him for training) he **would not be able to earn sufficient** amount even if he took a loan and opened up a shop. A view that was expressed by one group where many of the JSRs who came for training lacked interest was - **"poor, uninterested and unfit selection of members for JSR training** as was often the case now would be determental to the scheme in the long run". This group also mentioned that non-release of funds allotted for training purposes, and contingency amounts decrease the quality of training given as **teaching aids and audio-visual materials could not be purchased.**

B. TRAINING PROCESS

Prior to starting the training of JSRs, the Block Medical Officers of all Block PHCs where training was to be given were invited for a training of trainers programme. In our sample, 10 BMOs underwent training at medical colleges at either Indore, Rewa or Bhopal. In one of the places, since the BMO could not attend, the medical officer was deputed. The training was of varying duration - 5 hours to 4 days (supposed to have been for 4 days officially) and quality. The training at Rewa was of 4 days duration and well planned and the one at Indore for 3 days. Emphasis was more on "dont's" than do's (do not tell them this, do not teach beyond this level, etc...) or a revision of technical contents of the course. Also, in one of the training centres, the training consisted of "you know what to do, you are experienced enough" and the whole training was completed in a few hours. There was absolutely no mention or reference to teaching methodology how to conduct training effectively or adult education techniques at any of the Centres.

In none of the 11 Block PHCs visited, did the trained person conduct any training for other trainers (other PHC staff) or impart any information of the training process to the other trainers. This is of immense relevance as training of JSRs was mainly conducted not by the BMO (who did take a few sessions/classes as and when he found time from his many duties) but by the other medical officers and PHC staff (health assistants, supervisors, LHVs, laboratory technician, compounder, etc.)

The JSR training programme clearly outlined the schedule of training to be followed (see training manual - p.222 to 232). A total of 145 lectures were to be taken during this period. The 26 week period of training included a posting of 10 weeks at the sub-centre nearest to the village of the JSR.

The posting at the PHC was to be rotational amongst the various sections and also included daily clinics.

All the PHCs in our survey found it extremely difficult to adhere to the mentioned training schedule. The reasons were varied and often trivial. They included the extremely busy schedule of the BMO, non-deputising of his sessions to others, non-involvement of BEE in training (18%) - (the manual mentions he is to be warden of the hostel and hence no other duty was assigned to him). But, by far and large it was the extremely busy schedule of the BMO (including court cases and travels for other reasons) which was most disruptive of the training schedule. Very often, the BMO had handed over his responsibility to the BEE or other senior PHC staff for coordinating the training process. The 10 week posting at the sub-centre level ranged from 0 weeks to 8 weeks in actuality. During this period, the JSR was supposed to observe and note all the activities carried out by the MPW (F & M). This part of the training was often a formality and quite non-productive to the JSR - since the MPW hardly took interest in training of JSR in most places. A possible reason for this could be that the MPWs were not clearly briefed about their role and responsibilities in the scheme. An interesting feature noticed in two centres (18%) was that training times were adjusted to the timings of the bus coming to the village.

One has to admit that often the BMO has many responsibilities. It was heartening to note that inspite of their busy schedules in three centres (27%) they did find sometime during the day (usually late evenings) to take their lectures. Also interesting was the conduct of exam oriented training and refresher classes including mock examinations at 8 centres (72%).

The training was not of uniform standard in the various PHCs. Only one centre had received contingency funds which were utilised to buy charts and furniture. Another centre also received the funds but no purchases were made and since the BMO was transferred, we were unable to determine how those funds were utilised.

All PHCs were able to identify a room for training purposes which could accommodate 30 people. Because of lack of furniture in all training centres except one, as mentioned earlier, the JSRs had to sit on the floor. None of the rooms had adequate ventilation and fans - and the trainers did complain of heat and humidity. Blackboards were available only in 2 (18%) PHCs. None of the PHCs had any other audio-visual equipment. In none of the PHCs was assessment carried out of the training given or the methodology adopted for training. There is a need for furniture, teaching aids and blackboards to enhance quality of the training.

In all the PHCs, the trainees were rotated between OP clinic, ward, compounding section, laboratory, injection room and dressing room. In each of these sections, the respective staff explained / demonstrated the various activities conducted to the trainees. The trainees were taught how to dispense, how to stain slides (not read), how to dress wounds and how to give injections. However, it was the last mentioned activity in which the trainees showed maximum interest. Atleast in three (27%) centres we were told by the LHVs how the trainees would gravitate to the injection room, even if posted elsewhere, ask various questions on injections, show tremendous enthusiasm and pester the staff for allowing injections to be given by them. Thus, training on injection administration became a reality even though the JSR training manual clearly states that the JSRs are not to use injections in their practise. Also, if this is so, then why should they be trained on injection giving methods and posted to the injection room?

We are extremely worried on the quality of training in these rotational postings. The register maintained by the compounder is illegible in most PHCs. In one Centre, because the compounder could not find paper, he was dispensing the tablets to the hands of the patients' relatives. The dressing rooms in 6 (54%) centres had used and discarded cotton waste and bandages scattered on the floor or just outside the room. The autoclave for boiling syringes had carbon particles and was black and sooty in 10 (90%) centres. Worse, in every centre we found plastic disposable syringes, needles and IV sets being reused. A trainee exposed to such a pathetic situation needs to be told and taught what not to do - rather than what to do! On questioning the technicians, compounders, and other staff, we found out that the doctors never accompanied the trainees to these sections and their training was done only by the paramedical staff.

None of the centres had any concrete plans for regular supervision of the activities of JSRs once they set up practise. In fact, no group had given any thought to future supervision, follow-up, refresher classes, attendance at monthly meetings, etc.. This was

not even told to the MPWs of the sub-centres where the JSRs were supposed to have had their field training. It was as if "we have done our job of training - our responsibility ends there". On probing though, most BMOs did agree on the need for some sort of follow-up of JSR training activities and 36% of the PHCs were categorical that the JSR performance should be monitored on a regular basis. Even the training manual clearly mentions the need for supervision and how this is to be done. During our Review, in none of the PHCs we found a schedule/plan or a written check-list for supervision. Also since the JSRs had not yet started working, none of the PHCs had started maintaining any records of supervisory activities. Possibly, once the JSRs start practising, monitoring and supervision may become a regular feature.

3. TRAINING MANUAL

The training manuals were not obtained in time for the first batch in 6 (54%) of the PHCs, the delay period being ten days to two months. Because of this, it is likely that the first batch trainees in these centres were not able to obtain optimum training - as a technical subject like medicine is extremely difficult to follow without the text-book. This may also be one of the reasons for the poor performance in the examination of the first batch trainees (total pass percentage < 30%). In all the centres, manuals were obtained in time for the second batch of trainees.

All respondents felt that the manual covered all locally prevalent health problems which could be managed by JSRs and that the manual respected local customs/culture. Though all the respondents found the manual appropriate for the work envisaged from JSRs, some of the suggestions for improving the manual were as follows:

⇒ the contents are theoretical; more emphasis should be given on practical aspects, specially on management of illnesses;

⇒ increase contents in Paediatrics and Orthopaedics.

On direct questioning on whether Anatomy/Physiology was very detailed, all the respondents felt it was not so and that it was necessary to study basic sciences to that degree so as to understand well the functioning of the human body. This would facilitate understanding disease causation and how the body gets affected in illness and what happens during the recovery process. In fact, one respondent felt that these subjects should be given in greater depth.

D. JANASWASTHYA RAKSHAK MANUAL - COMMENTS OF THE EVALUATORS.

1. The contents of the Manual are easily understandable to a matriculate, simple in presentation and with no ambiguity.

2. Chapter 1 on Duties of JSR is comprehensive, yet medicalised, with
    * focus on Tb, Leprosy and AIDS;
    * elaborate duties in area of Malaria, Water purification, MCH.

    These are overlapping and duplicating the roles of ANMs and MHWs.
    Some degree of differentiation of activities is required to avoid duplication of activities and obtain maximum benefits of the different cadres of field workers.

3. Chapter 2 - Health team in community focuses more on disease than on Health (except MCH area). A shift in focus to more health promotive activity is required.

4. The Section - on Anatomy Chapter 3 is more elaborate than required and confusing because of the Latin/English names used. Also the translation/presentation of terms is not accurate, e.g., for SKULL, MANDIBLE, AORTA, and illustration of brain (p.37), in section on female genital tract, etc.

5. This section needs to be revamped thoroughly and presented as HUMAN BIOLOGY including structure and function in a simpler manner.

6. Chapter 4 - presents the Agent - Host - Environment concept well but needs elaboration with examples to make it more understandable. The three levels of Prevention also needs to be added to this Chapter and given due emphasis.

7. Chapter 5 - is adequate. Chapters 6 to 8 dealing with Malaria, TB, Typhoid, Filaria and Dengue
    * offer only medicalized/patient oriented preventive measures
    * have no socio-economic, cultural/other roots of these diseases discussed
    * need elaboration on 'Community Action' for prevention/control.

8. Chapters 9 to 13 are too elaborate and need to focus down to essentials for the JSRs to help them learn their roles/duties adequately and maximally.

9. Chapter 14 - (p115) has a highlighted foot note whose message is contradictory to matter in text. ["ALL CHILDREN less than 2.5 kg need to be seen by a Doctor" - box mentions 2.0 kgs.)

10. Chapter 15 - the presentation/details of dehydration and rehydration are too clinical. Common and noticeable signs of dehydration / rehydration like urination, cry, activity etc., of child also needed to be added. Practical knowledge of home based ORS and that rehydration is 'thirst' based need to be included.

11. Chapters 16 to 19 are elaborate, but good. Some simplification may make it easier to comprehend.

12. Chapters 20 and 21 need to be revamped, helping JSRs understand and utilize Traditional and Local practices safely for minor ailments and first-aid, utilizing WHO and GOI manuals on these. The 'symptomatic' use of Allopathic, Homeopathic and Ayurvedic medicines can be supplemented with safer, locally available resources.

13. The "Appendix" - Anusuchi -3 on medicines always to be available with JSRs include drugs like Analgin and Decadron which are not recommended. Also, medicines like Magnesium hydroxide, Benzyl Benzoate, Sulfacetamide drops in text are not mentioned here. The three Homeopathic and three Ayurvedic drugs also do not find any mention in the list. These discrepancies need to be taken care of to avoid confusion and contradictions.

14. The lecture schedules of 145 hours show an unwarranted medicalization, offering 110 hours of Medical College subjects, of which 26 hours of Paediatric and Obstetrics & Gynaecology seem proper.

15. Thirty hours of Community Health and 5 hours on Health Education are inadequate to prepare the JSRs for their roles in the community. National Health Programmes do not find the place in the lecture schedule they deserve, except Malaria, Immunization and MCH. Relevant Sociology subjects are missing from the manual and need to be added.

16. The Disease and Medical Orientation of all the chapters needs to be made Health and Community activity oriented, bringing in the principles enunciated in Chapter 4 and evolving avenues for practise - to make it a practically useful manual for the JSRs.

The high failure rate of the JSRs was attributed to inadequate training and preparation by JSRs (9%), not enough of hard work and commitment (9%) and the examination process (18%). Five respondents (45%) said their centre did not have high failure rate and were happy with the performance of their trainees.

E. SUGGESTIONS BY THE TRAINERS FOR IMPROVING THE TRAINING PROCESS:

◊ more appropriate selection of trainees - motivation to be an important criteria;

◊ Involvement of the health staff in selection which is to be based on fixed scalable criteria

◊ more staff members (fill up vacant MO posts so that BMOs can devote more time to training process)

◊ Provide audio-visual aids (these were to be obtained from one time grant of funds which 90% of the centres did not receive).

◊ Provide appropriate training to all trainers so that they could give better quality training.

◊ Hostel facilities (to facilitate regularity and attendance). This was to be arranged from contingency funds which were not received by 81% centres.

◊ Release of funds and stipends on time to maintain interest and commitment

◊ Improve Review process - make it less theoretical and more practical

◊ Include more information on National Health Programmes in their curriculum.

◊ Provide each JSR with a copy of "Where there is no Doctor" (this was to be provided to each candidate from contingency funds - but was not ordered except at 1 centre)

◊ Increase internal assessment marks, so that the trainers (BMOs) can have more control over the trainees. (Note: Internal assessment is not meant to control, it should be formative)

◊ Simplify administrative procedures. Right now it has too many authorities and levels involved in its control which affects training.

F. *SUGGESTIONS BY THE TRAINERS FOR IMPROVING THE FUNCTIONING OF THE JSR SCHEME*

All the trainers were asked for suggestions for improving the functioning of the JSR Scheme. Their responses are given below. Some were mentioned by more than one training unit.

◊ Improve administration. Right now too many departments are involved. These need to be streamlined to avoid bureaucratic delays.

◊ Release training funds, contingency funds and stipends on time. This will enhance commitment from all concerned.

◊ After completion of the training period, regular contacts should be maintained with JSRs. One group suggested they could be called at sector level meetings once every 2 months. Another group suggested that they should attend the monthly meetings at the PHCs.

◊ Strict supervision of JSR, specially at field levels is required. Regular refresher courses should also be arranged.

◊ TA/DA to be provided to JSRs to attend the above meetings.

◊ The JSRs be given a regular monthly emolument (like the old CHW Scheme) to increase their commitment to their functions specially preventive and promotive activities.

◊ Every contact of health team with JSRs be utilised to enhance their skills.

- ◊ Have more staff at sector PHC. Training of JSRs did suffer considerably because of shortage of staff specially in those PHCs where there was only 1 MO. Very often the MO, LHV and BEE all would be on travel.

- ◊ To overcome the above problems, have training at District level. The staff there have experience and facilities are better.

- ◊ The other advantage of District level training would be the compulsory hostel stay which would greatly assist in regular attendance.

- ◊ Modify selection process - so that the most deserving and committed candidates are selected. Introduce criteria based selection process.

- ◊ Since it is extremely difficult to register girls who have passed 10th standard, minimal qualifications for them should be reassessed and reduced to 8th standard, especially in Tribal areas.

- ◊ JSRs need enhanced visibility. Their role and activities need to be clearly explained to villagers, so that their services are maximally utilised.

VI. EXAMINATION PROCESS

Two batches of JSRs had completed their training and taken examinations at the time of our conducting the Review of the Scheme. The first batch had their examinations at the end of their training period. For the second batch, the examination was held four months after completion of their training. The results of the first batch (November 1995 to June 1996) were announced within two months of their examinations. Unfortunately, the second batch (August 1996 to February 1997) results were not announced even 3 months after their examinations. It must be mentioned here that the Block PHCs where training was held were informed only 3 days prior to the examination date (II examination) and it was a herculean task for them to inform all the candidates of the examination date. In the bargain, some trainees specially the failed trainees of the I batch (who did not receive any further training) could not take the examination as they were not informed on time. Obviously, this led to a lot of disappointment and bitterness. The solution lies in streamlining the whole process, with fixed, dates, announced in advance.

Pattern of Examination

As mentioned earlier, the internal assessment carried 100 marks and external examination 400 marks (2 papers). To be declared successful, a candidate had to obtain a minimum of 50% in internal assessment and each of the 2 external examination papers.

The first examination consisted of one sentence to short answers (Appendix 5) and measured the theoretical knowledge in great depth. There was also a feeling "it was tough" and that it did not evaluate the capability of the trained JSR appropriately. There were very few questions related to their future proposed functions and practical applications. It was at too high a level for JSRs specially considering the scope of their future activities.

The second examination was a multiple choice type of paper, with no negative marking (Appendix 6). The questions though very simple and easy to figure out had the advantage of assessing the practical knowledge that a JSR would require and was more evaluative of their future functions. It definitely had less theoretical component. In our discussions with the JSRs, who had taken both the examinations, we were informed that they found the second examination very simple, were able to complete it much before time and were able to answer all questions unlike in the first examination where there were quite a few questions which they were unable to answer.

There was one major administrative problem with the second paper. The districts were sent a copy each of the question paper and they had to photocopy adequate numbers for every JSR undertaking the examination in their district. This entailed photocopying 12 pages for each candidate, a total of 7000-8000 pages in each district. With the meagre funds and limited facilities for photocopying at district headquarters, this was a major problem in some areas. To prevent leakage of papers, they could not photocopy a day or two before the examinations. Also being unaware of the pattern of question paper, they had anticipated a 2 page question paper as in the first examination. Practical problems like the above should be avoided in future. Also, by utilising all available photocopying

machines in the district headquarters, chances of the paper leaking were magnified greatly, specially since so many people were dealing with the photocopying part. Ideally, printed question papers should be distributed. This would avoid problems like the above mentioned one.

The pass percentage in the first examination varied between the various districts. Since JSRs of each district were evaluated locally, one reason for this could have been the criteria adopted for Review. To avoid bias and for uniform Review, MCQ type of papers would be ideal; but they have their own limitations and in case the MCQ pattern is combined with short answer questions, centralised evaluation should be adopted so that marking is uniform.

During our Review survey, the JSRs were administered case studies which simulated conditions they would encounter during their practice (Appendix 4). This was done with the intention of trying to find a more appropriate method of examining their knowledge and skills and overcome some of the criticisms of the examination patterns adopted so far.

A detailed report of the performance of JSRs in the Review process based on this format is given below:

Review of knowledge of JSRs

As the JSRs had not yet started practising, it was not possible to examine their effectiveness in the field when they provide services.

Their competence at the end of the first course to be certified as JSR was determined by a written test which was felt to be very theory oriented by most and which did not assess their competence in a comprehensive manner (Appendix 5). As time did not permit our examining their clinical competence and curative knowledge, it was instead decided to administer a questionnaire to them which would simulate conditions that they were likely to face in reality (Appendix 7). Determining their level of response to this questionnaire presumably would be able to give a clearer picture of their competence and possibly be helpful in providing a better method to assess their knowledge, attitude and practices.
The results of this Review were as follows:

TABLE 7-A : Marks received in the Review questionnaire:

Marks Received (Maximum 100)	% of candidates
<30	1.15
31 - 39	11.50
40 - 49	22.58
50 - 59	29.89
60 - 69	27.58
>70	2.30
Total	100.00

The performance was similar in all districts with some performing well and some faring poorly in each district.

The Review revealed the following knowledge attitudes and practices:

TABLE 7-B : Knowledge, attitude and practices of JSRs.

Condition	Knowledge	Attitude	Practice
1. Diarrhoea	Good	Good	Good
2. Protein/energy/ malnutrition	Good	Poor	Poor
3. Tuberculosis	Good	Poor	Poor
4. ARI	Good	Good	Good
5. Family Planning	Good	Good	Good
6. Epidemics	Poor	Poor	Poor

It is worth noting that all the attitudes and practices were curative oriented and KAP of prevention was minimal, revealing the need of focussing on these deficiencies during training. Preventive has to be emphasized in the manual, training of trainers and in the teaching/learning of the trainees.

VII. VIEWS OF THE JAN SWASTHYA RAKSHAKS ON JSR SCHEME

As part of the Review process, the JSRs were asked to give their views to certain identified issues covering the whole gamut of activities of the Scheme in a questionnaire form (Appendix 4). During our Review visit to the various districts, we were able to contact a total of 101 JSRs who belonged to either the first batch or second batch of trainees. Given below are the various details and responses of these 101 JSRs on various issues pertaining to the JSR Scheme.

TABLE 8 : Age distribution of JSRs who were contacted during Review exercise

Age (Years)	Frequency	Percentage
15 - 19	1	1.0
20 - 24	22	21.8
25 -29	39	38.6
30 - 34	22	21.8
35 - 39	11	10.9
40 - 44	3	3.0
45 - 49	2	2.0
>50	1	1.0
TOTAL :	101	100.0

16.9% of the JSRs were above the upper age limit of 35 years. (most of these are old CHWs, who have been nominated for JSR training).

TABLE 9 : Age and Sex distribution of JSRs who were contacted during Review exercise.

	SEX			
Age (Years)	Female	Male	Total	Percentage
15 - 19	0	1	1	1.0
20 - 24	2	20	22	21.8
25 - 29	1	38	39	38.6
30 - 34	0	22	22	21.8
35 - 39	0	11	11	10.8
40 - 44	0	3	3	3.0
45 - 49	0	2	2	2.0
>50	0	1	1	1.0
TOTAL :	3	98	101	100.0

16.9% of the JSRs were above theupper age limit of 35 years. (most of these are old CHWs, who have been nominated for JSR training)

The 3 females in this evaluative process was quite reflective of the actual percentage of females who underwent training to become JSR. Females do not volunteer to undergo JSR training. This is unfortunate as more than 60% of the JSRs activities are CSSM & RCH related. The reasons given by the trainers and community leaders for their not volunteering are as follows:

* no qualified candidates; (most girls stop studying after VIII standard as most villages do not have a high school);
* it is not safe for them to travel alone;
* there might be times when they may have to travel alone at nights;
* no hostel facilities;
* they get married at an early age;
* they have small children and they have to take care of them as well as the other family members;
* the elders do not permit them to seek work outside the house.

TABLE 10 : Distance from village of JSR to training places (Block PHC)

Distance (Kms.)	Frequency	Percentage
0 - 4	12	11.9
5 - 9	21	20.8
10 - 14	15	14.9
15 - 19	7	6.9
20 - 24	15	14.9
25 - 29	10	9.9
30 - 34	10	9.9
35 - 39	5	5.0
40 - 44	5	5.0
>45	1	1.0
Total:	101	100.0

30.8% had to travel more than 25 Kms. one way to reach the Block PHC where training was being given. Not only did this mean a long travel time but also higher cost of travelling. Additionally, it also meant that their time of reaching the PHC was absolutely dependent on the bus timings - usually leading to their decreased time for training at PHC.

- Distn of JSR by Dist & batch

Dist	Batch 1	2	Total
Vidhisha	0	4	4
Bhind	5	8	13
Rewa	16	30	46
Bilaspur	20	14	34
Dhar	1	3	4
	42	59	101

TABLE 11 : Marital status of JSRs

Marital status	Frequency	Percentage
Married	88	87.1
Unmarried	13	12.9
TOTAL :	101	100.0

87.1% of the JSRs in our sample were married. Married JSRs are less likely to leave the village in search of greener pastures.

TABLE 12 : Education status of JSRs

Education status	Frequency	Percentage
PG	2	2.0
Graduate	16	15.8
PUC	28	27.7
SSLC	55	54.5
TOTAL :	101	100.0

45.5% had qualification higher than the lowest level prescribed. Though advantageous in many ways, it could also lead to their searching for more permanent, more lucrative offers.

TABLE 13 : Occupation distribution of JSRs

Occupation	Frequency	Percentage
Agriculture	54	53.5
Carpenter	1	1.0
Labourer	7	6.9
Service	1	1.0
Nil	38	37.6
TOTAL :	101	100.0

Majority of the JSRs worked as agriculturists, but large percentage (37.6%) did not have any occupation.

TABLE 14 : Residential status of JSRs in village selected.

Resident in village	Frequency	Percent
Yes	101	100.0
No	0	0
TOTAL :	101	100.0%

All JSRs reside in the same village which nominated them for training.

TABLE 15 : Sources of Information on JSR Scheme (for JSRs)

Source	Frequency	Percent
Gram Panch	62	61.3
Gram Panch, Newspaper	2	2.0
Gram Panch, Radio	3	3.0
Panchayat Secretary	1	1.0
Sarpanch, Panch	32	31.7
Sarpanch, TV	1	1.0
TOTAL :	101	100.0

61.3% heard of the JSR Scheme from Gram Panch; 31.7% were given information by the Sarpanches. For the others, the source was either Gram Panch or Sarpanch along with radio (3) / newspaper (2) and TV in (1) case.

TABLE 16 : Source of Selection of JSR

Source of selection	Frequency	Percentage
Gram Panchayat	83	82.2
Janpad Panchayat	14	13.8
Sarpanch	3	3.0
Sarpanch Secretary	1	1.0
TOTAL :	101	100.0

82.2% of the trainees were selected by the Gram Panchayat and 13.9% by Janpad Panchayat.

TABLE 17 : Additional number of applicants

No.	Frequency	Percentage
0	66	65.2
1	9	8.9
2	7	6.9
3	2	2.0
4	3	3.0
5	5	5.0
7	3	3.0
8	2	2.0
9	1	1.0
>10	3	3.0
TOTAL:	101	100.0

In 65.2% cases, there was only one single candidate who was nominated for JSR training. In 14 (14%) cases, there were 5 or more applicants.

Training Methodology

The training methodology consisted of postings in ward, field, laboratory, injection room, OPD, pharmacy, dressing room along with lectures, demonstrations and discussions.

11 (10.9%) of the respondents did not answer this question. The trainees in most places were divided into groups of 6 and they rotated amongst the various departments.

Our observation during the Review visit to the Block PHCs mirrored the same findings.

TABLE 18 : Number of JSRs registered in a batch for training at the Block PHC

No.	Frequency	Percentage
14	1	1.0
26	2	2.0
27	1	1.0
28	8	7.9
29	11	10.9
30	60	59.4
35	18	17.8
TOTAL :	101	100.0

Majority (59.4%) of the JSRs belonged to batches consisting of 30 trainees. There was only 1 JSR who belonged to a batch consisting of 14 trainees.

TABLE 19 : Explanation of training subjects

Proper explanation	Frequency	Percentage
Yes	100	100.0
No	0	0
TOTAL :	100	100.0

All JSRs felt that the training subjects were properly addressed and they were free to discuss with their teachers any problem they faced.

TABLE 20 : Distribution of written material

Distributed	Frequency	Percentage
Yes	73	72.3
No	25	24.7
No response	3	3.0
Total:	101	100.0

72.3% mentioned that they received written material (notes, etc.,) during the training process.

TABLE 21 : Usefulness of written material provided to JSRs

Usefulness	Frequency	Percentage
Yes	88	87.2
No	6	5.9
No response	7	6.9
TOTAL:	101	100.0

87% of JSRs found the material that was provided to them as handouts useful in their training.

TABLE 22 : Opinion of JSRS on training

Satisfied	Frequency	Percentage
Yes	94	93.1
No	7	6.9
TOTAL:	101	100.0

93% JSRs mentioned that they were satisfied with the training received.

TABLE 23 : Grading of Training process

Grade	Frequency	Percentage
Very good	9	8.9
Good	60	59.4
O.K.	25	24.7
Not very good	5	5.0
Not good at all	2	2.0
TOTAL :	101	100.0

68.3% JSRs rated their training as good or very good. 24.7% felt it was OK and only 7% did not give a good rating to the training process.

TABLE 24 : Did training address local needs?

Addressed local needs	Frequency	Percentage
Y	98	97.0
N	3	3.0
TOTAL :	101	100.0

97% JSRs said that training addressed local needs.

TABLE 25 : Appropriateness of training material (for JSR activities)

Appropriate	Frequency	Percentage
Yes	69	68.3
No	24	23.8
No answer	8	7.9%
TOTAL :	101	100.0

68.3% felt that the training was appropriate for the perceived functions of JSRs.

TABLE 26 : Physical space for JSR training

Sufficient space	Frequency	Percentage
No	13	12.9
Yes	88	87.1
TOTAL	101	100.0

87.1% mentioned that there was sufficient space for training. But as mentioned earlier, our observation revealed that though sufficient space was available, the facilities for training were non-existent and there were no chairs, fans, etc.

TABLE 27 : Sufficiency of Trainers

Sufficiency	Frequency	Percentage
Yes	92	91.1
No	7	6.9
No answer	2	2.0
TOTAL :	101	100.0

91.1% JSRs expressed there were sufficient number of trainers during their training process.

TABLE 28 : Use of Teaching Aids during training process

Use of teaching aids	Frequency	Percentage
Yes	73	72.3
No	18	17.8
No answer	10	9.9
TOTAL :	101	100.0

17.8% JSRs mentioned that no teaching aids were used during the training process. This is likely as some Block PHCs did not even have a blackboard to use for training.

TABLE 29 : Sufficiency of material in training manual to deal with local illnesses.

Sufficiency	Frequency	Percentage
Yes	67	66.3
No	34	33.7
TOTAL :	101	100.0

33.7% JSRs felt that the manual did not have sufficient information to deal with local illnesses, even though 97% mentioned that training addressed local needs. The manual thus requires to be carefully evaluated to detect the deficiencies.

TABLE 30 : Suggestions for improving manual

Suggestions	Frequency	Percentage
1. Information on drugs	23	22.77
2. More information on techniques of injections and names of injections	13	12.87
3. More detailed explanation	11	10.89
4. Information on more diseases (including minor ailments)	8	7.92
5. More pictures	2	1.98
6. Management techniques of diseases in rural areas	2	1.98
7. Information on diseases like ENT and Dental disorders	1	0.99
8. More information on local herbs and their use	1	0.99
9. Provide other books	1	0.99

As can be seen from the above table, the JSRs were keen to obtain more practical knowledge, which drugs to use in different conditions, names of different drugs, more information of injection techniques, names of different injections and more information on different diseases including minor illnesses. Only one JSR evinced interest on local herbs and their uses.

TABLE 31 : Areas identified by JSRs which require more training

Subject Areas	Frequency	Percentage
1. AIDS	31	26.73
2. Injections (including IV)	17	16.83
3. Drugs	16	15.84
4. Anatomy	13	12.87
5. Surgery	12	11.88
6. Prevention of diseases	8	7.92
7. Family Planning	1	4.95
8. Tuberculosis	2	2.97
9. First Aid	2	1.98
10. Diarrhoea control	2	1.98
11. Malaria	3	0.99
12. Gynaecological diseases	5	0.99
13. Balanced diet	1	0.99
14. Orthopaedics	1	0.99
15. Children's diseases	1	0.99
16. Ayurveda - Homeopathy	1	0.99

Anatomy was one subject which 13 JSRs identified as an area which requires more training. As mentioned earlier, information and use of drugs and injections, names of drugs and injections to be used in specific conditions, were the other main areas identified. Though JSRs are to treat minor illnesses and provide first aid when necessary, 12 JSRs wanted more training in surgery and 5 on Gynaecologic disorders.

TABLE 32 : Availability of JSR Kit

Availability	Frequency	Percentage
Yes	11	10.9
No	88	87.1
No response	2	2.0
TOTAL:	101	100.0

87% JSRs did not receive the kit which was to be given to them to assist in their functions. Like delayed payment of stipend and nonpayment of contingency funds, this is also an administrative problem which needs to be studied further and streamlined.

TABLE 33 : Distribution of marks between External Examination & Internal Assessment.

Correctly distributed	Frequency	Percentage
Yes	81	80.2
No	12	11.9
No response	8	7.9
TOTAL :	101	100.0

80.2% respondents mentioned that the pattern of mark distribution between Internal assessment and external examination was correct (100 marks for Internal assessment and 400 marks for external examination).

TABLE 34 : Views of JSRs on the Review process & suggestions for its improvement.

Views / Suggestions	Frequency	Percentage
1. Appropriate	22	21.78
2. Examination of skills to be done also (practical)	16	15.84
3. Monthly test	11	10.89
4. Announce examination date early (atleast one month in advance)	2	1.98
5. Conduct examination on time	2	1.98
6. Examination at training centre (Block PHC)	5	4.95
7. Objective + Essay type	6	5.94
8. Viva type of examination also to be given	2	1.98
9. objective type questions only	5	4.95
10. Cover all chapters	2	1.98
11. Review to be done at district level	4	3.96
12. Trainee to be given chance to go through answer script	1	0.99

41 (40.6%) JSRs had no suggestions on the Review process and 22 (21.8%) felt that the method of examination was appropriate. The main suggestions of the remaining JSRs were as follows :

16 (15.84%) JSRs wanted examination of skills in the Review process; 4 (3.96%) wanted a combination of objective and essay type. 5 (4.95%) JSRs wanted examination to be conducted on time and 6 (5.94%) wanted the date to be announced early. Another 5 (4.95%) JSRs wanted examination to be conducted at their training centre.

The JSRs also mentioned the following views which though not related to the Review process are important to their training process.

These views were :

* having a full time teacher conducting the training;
* increasing the duration of training to one year;
* payment of timely stipend;
* material (kit) to be given at the end of the course;
* explaining with posters and charts;
* training for trainers; and
* training by doctors only.

From the above, it is clear that more than 80% JSRs found the training process, the trainers and the manual appropriate and adequate. Though physical space for training was adequate, there is need for more audio-visual aids and charts as well as furniture and fans. Funds were earmarked for this, but unfortunately not disbursed to 90% of the training centres. The JSRs mentioning that stipend be given on time and that they be provided with a kit after completion of course were genuine needs and administration needs to gear up to avoid such tardy implementation. Our group discussions with the JSRs revealed some more insights which they had not put in writing. The first batch trainees felt their examination process was much tougher and not appropriate for JSR level specially when compared to the second examination. The trainers also concurred with this view. Secondly, most of the JSRs had the impression that undergoing the training process was a prelude to the Government absorbing them subsequently as multipurpose workers or in some such posts. Some of them were told so by their leaders during the selection process and others held on to this belief hoping things would ultimately work out. It was difficult to convince them that the Government just does not have the type of resources that would be required to absorb all of them or even for paying a monthly honorarium and hence the permission being given to the JSR to practise.

There were very few female trainees. This is unfortunate because many of the activities of the JSR are MCH related. Group discussions revealed the inherent socio-cultural problems which prevented their volunteering.

The selection process as revealed in their written views did not clearly reveal the extent of bias and malpractise that went on in a few areas as was mentioned to us by a few JSRs during oral discussions. But it was heartening to note that there were also many JSRs who were selected because of their commitment, capability and merit.

The JSRs are eagerly looking forward to starting their practise. They await right now their certificate, kit and some of them - a loan.

VIII. PERCEPTION OF COMMUNITY MEMBERS AND THE COMMUNITY LEADERS OF THE JSR SCHEME

A. COMMUNITY MEMBERS

80% communities surveyed were not aware of the scheme, its objectives, its functions and only 15% communities know the person selected as JSR from their village.

2 out of 20 communities selected the CHW of the old scheme for JSR training.

Only 20% communities responded that they have health committees but they were not aware whether the health committees ever met.

As all trained JSRs have not yet started working, communities do not have any idea of their functions and services and service charges to be paid by them to the JSR.

15% communities expressed that for preventive and promotive work, government should pay the JSR some remuneration.

In 10 out of 20 (50%) communities surveyed, the selected JSR was related to the sarpanch or panch of the Gram Panchayat.

B. COMMUNITY LEADERS

i. Village level leaders

In 5 out of 20 communities, even panchs were not aware of selected JSR.

In all communities, panchayat members got information on selection of JSR from Janpad Panchayat.

Leaders of 30% communities said they have health committees.

These committees do not meet frequently and separately, but their meeting is along with the general meeting of Gram Panchayat.

Community leaders were aware of objectives of JSR scheme upto certain extent.
In all communities, some panchayat members were involved in selection process of JSR and expressed their satisfaction with the process and person selected.

All expressed that JSR needs encouragement in his activities but they were mot sure how this could be achieved.

In 60% communities, community leaders said that JSR has met them after completing his training.

In few communities, leaders expressed that there should be workshop/seminar on schemes and plans for panchayat leaders. This would help leaders understand their responsibilities / working pattern of scheme and their plans and limitations.

ii. Block level leaders

In all Janpads, president of Panchayat was involved in recommending the person for training selected by Gram Panchayat.

Health committees of Janpad Panchayat never visited and supervised the training in any of the Block PHC.

In most of the Janpad Panchayats, elected members are not clear of the scheme and its objectives and functioning.

iii. Zilla level leaders

Some of the district health committees are not aware about the scheme and its objective and functioning.

In one of the districts visits, Zilla panchayat president is quite interested in the successful implementation of the scheme. In other districts, even presidents are not very clear about the functioning of the scheme and have not taken proper steps to implement the scheme.

There exists a lot of gap on information about the scheme among and within panchayat agencies.

Lacunae exist in passing of this information from Executive officers to elected bodies at various levels. Information received by them is not transmitted or communicated to the Panchayat leaders or committees.

All the CEOs were supportive of the scheme and its objectives. One of the CEOs expressed the limitations of the TRYSEM scheme to give loans to all applicants as the funds received were not adequate even for 1/3rd of all type of applicants. Also the amounts to be released as loans for other professions were much lower. Two CEOs were critical of the selection process and mentioned that since 2 departments are involved, many hindrances are likely to occur in its proper implementation.

IX. VIEWS OF C.M.OS ON THE J.S.R. SCHEME.

Our interviews with the Chief Medical Officers (CMOs) revealed that all of them thought the JSR scheme was a good scheme and would assist in reducing the health problems of the community by providing a trained resource in the villages itself. At present, even for minor health problems they had to come to district hospitals, towns or consult private practitioners who often charged them heavily. These problems would be obviated to a large extent.

Another positive feature of the scheme cited by them was the assistance, the present field functionaries would obtain from the JSRs in the implementation of National Health Programmes and other preventive and promotive activities.

They were in full agreement with the functions envisaged of the JSR but did mention that there was lot of overlap with other health functionaries. Four of the CMOs also mentioned that from reports that they received of the interest shown by JRS on "Injections and IV fluid administration", and keeping in mind ground realities and expectations of rural people, they were sure that the JSRs would use "injections" and even provide irrational treatments and try tackling problems beyond their brief or training. Much as they were convinced of the need of the scheme to provide health care specially for those who have difficulty in reaching/obtaining curative care because of the distance/transport limitations, etc., they are also worried that they are helping in the production of "potential quacks". These contradictory viewpoints do not brood too well for the JSR scheme, for the above position and ambivalence can have severe repurcussions all down the line.

The CMOs did find the training duration, manual, curriculum and training methodology to be adequate and appropriate. Two of the five CMOs mentioned the need to hold the training at district level because of the facilities available (training centre, staff, hostel, etc.). They also mentioned this would improve the quality of the training. This does indicate that the CMOs were aware of the lesser than expected quality of training being given to JSRs at some block centre PHCs.

As to the acceptability of the JSRs in the village all the CMOs mentioned that there would be no problem and in fact because the JSR belonged to the same village and would take care of the villagers needs, they would find easier acceptability than outsiders.

The high failure rate (>70% on an average) in the I Batch examination was attributed to the inappropriate questions asked and inadequate preparations by the JSRs.

The ability of the CMO and staff of his office to interact appropriately with the IRDP officials was very important in smooth functioning of the programme and release of funds and stipends. Our survey revealed that when these relationship was cordial and successful, funds for contingency and stipends were made available more easily unlike in 2 centres where there was hardly any interaction. The interest of the CMO in the scheme is very important for its successful implementation as this becomes a measure for other implementators in the department to follow. This will be all the more important, once the training is based at District level as is planned from the III batch.

3 Panchayat Areas — Vidhisa - M; Bhind - M; Rewa - F

X. VIEWS OF THE PRESIDENTS OF DISTRICT HEALTH COMMITTEES ON JSR SCHEME

Because of the Congress convention at Calcutta which was taking place at the same time as our Review survey, we were able to meet only two presidents of District Health Committees as the others were participating in the convention.

The President of Vidisha District Health Committee was a very well informed young lady. She was fully conversant with all the objectives of the scheme and functions of the JSRs and what the Government hoped to achieve from the implementation of the scheme.

According to her, the scheme was a good idea and will be very useful to the villagers, specially those that are remote and without approach roads. She found the training in her district to be satisfactory but mentioned that "those who are interested only will learn". One of her worries was since the training was given in Government centres, the villagers will identify the JSRs as "Government Employees" and ask for free treatment and free medicines. Since they had not yet received the certificate or kit nor the loans to set up practise, they were unable to start their practise, were slowly losing interest and even drifting to other jobs. Her recommendation was that the Government should fix a pay for them so that their commitment increases and they will work with devotion. The other alternative recommended by her was to increase their period of training to MPW level and provide them jobs by filling up existing vacancies.

She also suggested regular reviews of the scheme and constant supervision to maintain quality of service and also to make JSRs feel that they are cared for and part of the health team.

One of their major likely problems would be the wordings in their certificate. It does not mention that the JSRs can "practise" and hence legally their right to practise and giving of drugs can be questioned.

She also felt that loans to JSRs should be given with no conditions attached so that they could utilise it most appropriately. For example, the loan specifies the quantity of drugs to be bought and amount to be spent on drugs - many of these are available at the PHC and could be obtained from there, instead of being "bought".

At present most villagers are ignorant of the scheme and the functions of the JSRs. She wanted JSRs to be given prominence in all village meetings/affairs as for example in "Mahila Jagruti Sibirs", so that they would get an identity, the villagers will come to "know them" and seek their services. She felt along with their certificate they should be given a "nameboard" which they can put up at their "shop", so that people can come to know of their qualifications and avail of their services.

The President of Health Committee at Bhind was also a very dynamic young lady. She is very active and supportive of health programmes and camps in the district and her excellent ability to communicate to masses is made good use of by the health department

in the district. Unfortunately, no one from the department had given her any information about the JSR scheme and she had no idea of its objectives or functions. She took to task the nodal officer for JSR scheme in Bhind for the department not keeping her informed and asked for all relevant documents and files. This clearly reveals that even elected representatives are not getting necessary information of the various schemes.

She had been able to garner enough support including financial for eye and disability camps and it was unfortunate that her help was not sought by the health department in their funding problems from IRDP. Worse was not giving her information of the scheme, for when it was explained, she was very supportive of the scheme. We feel, this is not an isolated happening; in two places we found even the Zilla Panchayat President was having a very sketchy idea of the scheme.

She felt that the scheme has not been given good publicity and because of this may not find optimum utilisation. She mentioned that they are many loan applicants under TRYSEM from the various professions and also that there are many committee members with their own priorities. Hence the money meant for this scheme should come under the head of Health Department so that the budget is clearly earmarked for the scheme and not diverted for other activities.

She also suggested streamlining the administration to speed up the examination pattern, announcement of results and release of stipends.

Clinic Rooms in villages for Practicing

XI. SUMMARY OF KEY FINDINGS

1. OBJECTIVES

* In the department of Health, the objectives of the JSR scheme were known to all. Majority of responses mentioned were:

    i. to provide first aid care in injuries and treat minor symptoms and diseases

    ii. to assist in the implementation of National Health Programmes

    iii. to refer serious cases in time

* As far as the village leaders are concerned, they mainly mentioned the first function and on prompting agreed with second and third.

* Eighty percent of communities surveyed are ignorant of the functioning of the scheme and only 15% of the communities know the person selected as JSR from their village.

* There was a lot of attrition of information by the time it reached the Gram Panchayat and Block PHC level. This transmission loss happened at each level of onward transmission - from state capital to district; from district to block level; from block to gram level. The reasons could be many - from lack of interest to wilful non-transmission of information to the concerned persons. With the elected representatives still not fully cognizant of their rights and responsibilities and with bureaucratic officials not yet fully adjusted to the changed circumstances and actively accepting the changed power equations at district and block levels any new programme introduced at this stage is bound to have a few hiccups.

* The other major problem was the inadequate funding of activities of the scheme. The JSR scheme is a health related project dependent upon IRDP for funding of its activities. DRDA - with many committee members including MLAs, MPs, each with their own priority projects has very little funds left after these "individual" needs are met. Hence the funds dependent components of the JSR scheme always suffered in each district - leading to non-disbursement of contingency funds and training grants to most training centres, delayed payment of stipends and non-granting of a single loan application (under TRYSEM) till the time of our field Review. Because of this and non receipt of certificates and kits even after successful completion of course, none of the JSRs have "started practising" and the second major objective of the scheme that of employment generation has received a serious set back ultimately slowly leading to trained JSRs seeking other avenues of employment and income.

1. SELECTION PROCESS

* Selection process was done according to guidelines - but by far and large, the selection of candidate was inappropriate for the following reasons:

* Selection of "family" - in 10 out of 20 communities surveyed, the selected JSR was related to the sarpanch or panch.

* Selection of person with recommendations

* Selection of practising CHWs (old scheme) in 10% of the villages surveyed who are already using :injections" / drug cocktails.

* Selection of "overqualified candidates" /non-committed who will join other professions at the first opportunity; specially if it provides a permanent income.

* Hardly any females were selected even though JSRs functions are mainly MCH related; 3 out of 101 in our sample of JSRs.

Reasons for the non-selection of females are :

* women do not volunteer
* not enough qualified women
* "purdah system" - permission not granted by family members
* travel problems.
* no appropriate boarding and lodging facilities(no hostels)
* children - family problems
* lack of "safety" - and harassment

3. TRAINING

This seems to be one of the weakest sectors of the scheme.

* The training of trainers of this new scheme though planned was often cursory (4-5 hours in lecture). The training was given in medical colleges by medical college faculty to the BMOs of the Block PHCs where training was to be held. The training in Rewa was of 4 days duration and about 3 days at Indore. The training focussed mainly on technical aspects and what level of information was to be given to the JSRs (more of what not to tell them). There was little or no community component - possibly because the faculty must have rightfully felt that BMOs have more experience on this aspect. **However, unfortunately the training did not deal with methods of training JSRs and adult learning principles - both of which could have greatly facilitated the training process. Training should include methods to enhance motivation and appropriate use of audio-visual aids.**

* The trainers did not train other PHC staff after returning from their training

* Except one centre which had received "training" and contingency funds from which charts were bought for training, rest of the centres had no audio-visual aids

except a blackboard. Some centres did not even have this and training was mainly done through oral lectures and demonstrations.

* On paper it has been shown that training has been done as per schedule. In reality, it was done as per the convenience of BMO - who had to struggle to find enough time to conduct training. In many centres, it was conducted after morning outpatients which often goes on till 2 p.m.

* Very often the BMO and sometimes the CHV/Supervisors/BEE are also on field programmes or court cases, etc., The training does get disrupted at Block PHC because of this and hence such centres should have adequate MOs and other staff.

* The manual is very curative based and does not emphasize preventive and promotive aspects. There is also very little reference to sociology. The national health programmes need to be dealt in greater details.

* Attendance varied and was between 50-80%, being poor in some centres for various reasons like distance, disinterest, lack of hostel facilities, non-receipt of stipend, etc.

* Training was mostly done via lectures/ health centre postings/field postings.

* Field posting entailed accompanying the subcentre staff during rounds. It was done very haphazardly and the field worker was never explained/prepared for the task or given any further training to train the JSRs appropriately in the field. For the trainee JSRs it mainly consisted of accompanying the health worker on his/her rounds and carrying the vaccine box for the health worker.

* Though most topics were covered, "practical and hands on training" was very poor.

* In most centres, training was mainly conducted by LHVs, health supervisors and the BMOs. Technical subjects were mainly taken by BMOs and sometimes MOs. The BEE was not involved in 2 of the 11 centres visited as the manual did not specify any training role for him. (except that of warden of the hostel)

* BMOs and the PHC staff found the manual to be comprehensive and good by far and large, and there were very few suggestions like making it more practical and adding more details in some subjects like Anatomy for its improvement.

* Even the chapters on basic subjects were found OK (i.e., not too much). Universal feeling was that if the JSRs had to function well, they needed this degree of information.

* The JSRs found the manual to be good and adequate. A few mentioned that the manual did not cover "practical" / how to manage type of information and 23% wanted more information on drugs and injections.

* Those who saw the book : Where there is no doctor" found it will complement the manual in the training process and rectify the defects existing in the manual.

* Many places held refresher classes and examination oriented training sessions indicating the concern of health centre staff for their trainee JSRs.

4. EXAMINATIONS

* Internal assessment : usually 3 to 5 tests were held at regular intervals on portions covered during that period. It consisted of objective, short notes type and the marking was fair. Each centre adopted its own technique of assessment.

* The first External examination was very theory oriented and most trainees found it tough. It did not examine what the candidates knew and instead it tried to evaluate what the trainees did not know.

* The second External Examination was found to be very simple (all will pass). This was the view of everyone interviewed.

* The second examination was held 3-4 months after completion of the training course. Hence, many candidates did not receive information of the examination on time, missed their examination and are now losing interest in the scheme also.

* Evaluation was fair at District level. "Copying" was usually not permitted, specially first test was conducted very well. There was some laxity during second examination as revealed by the trainers.

* Results are announced many months after the examination is conducted. This entails trainee JSRs visiting the centres often to find out whether the results have been announced. For some, this is expensive and for most, time consuming. Administration needs to buck up in this regard.

* The examination tests only theoretical knowledge. No assessment is carried out of practical skills or applied knowledge. There are no problem solving type of questions.

5. FUNCTIONS OF JSRs

* None of the JSRs have set up their practise (shop) in areas visited by us.

* Those providing curative care are old CHWs who were sent for training, two of whom have their own "clinics".

* The Certificates have not yet been distributed. This in spite of exams being conducted more than a year ago. The delay was for various reasons. Standard format has now come from Bhopal - the CMO/CEO sign it. The CEO has still not signed in many areas.

* Not one loan has been sanctioned to date to JSRs in areas visited by us.
* JSRs do help in immunization camp activities, but their interest is waning.

* Similarly, some JSRs are also referring cases to PHCs and it is likely that once they start "practising" they will be more helpful to the villagers.

* In a few places, they have been made depot holders and distribute bleaching powder/chlorine tablets, ORS packets, etc.

* The other health preventive and promotive activities like chlorination of wells, registration of births and deaths, motivating for family planning are presently not being performed by JSRs in areas surveyed by us.

6. "FEE FOR SERVICE"

* Except the old CHWs who have now received training, no JSR was found practising

* The villagers do agree that they should pay for the service, but JSRs clearly expressed that unless they inject, they will not receive any fees and villagers are reluctant to pay for only consultations or oral medicines.

* JSRs lack money/funds to buy any equipment and it is not surprising that they have not yet started practising.

* Some trainers doubted whether JSRs can earn enough from their practise as they basically would be catering to a total population of around 1000-1500 villagers and competing against "established practitioners". Hence it can only be a part-time activity.

7. SUPERVISION

* This has been planned in the scheme and mention of it has been made in the manual. But what was disturbing was the absolute lack of planning/interest in this activity at Block PHCs with none of the centres having chalked out a programme or given a thought as to how this will practically be carried out once the JSRs start practising.

* Presently there is hardly any further contact between the training centre and JSRs once they have completed their course. Even at village level, there is hardly any contact between field workers and JSRs.

8. ADMINISTRATIVE DETAILS

* There was very little time between announcement of JSR scheme and its implementation at block PHC level.

* A scheme like the JSR scheme to be implemented in the whole state needs adequate lead time for appropriate implementation and wide-scale publicity to create awareness. Unfortunately, the scheme was implemented within a very short period and hardly had any gestation time. Obviously this rule out any pilot project which would have allowed for any corrections/changes.

* The scheme was to be widely publicised through posters, radio, TV and at panchayat meetings. On enquiring from the villagers in the areas we visited, we realized that no such activities were carried out. Oral discussions with JSRs revealed that only 3 of them had heard about the implementation of the scheme on radio and 1 of them had seen information about the scheme being given on TV. The scheme was implemented in a hurried manner with inadequate preparation.

* There is a lot of attrition in transfer of information from state level downwards to village level. Often the Panchayat leaders were found to be ignorant or with very superficial information about the scheme. This impedes their proper involvement in the scheme.

* No centre had received the Rs.5,000/- for training materials that they were supposed to receive Kits were not distributed in 90% of the training centres visited.

* Contingency amount was not released in 81% areas for the first batch training and in all centre for second batch training. Hence, it was not possible to make hostel arrangements or buy audio-visual items for training. This money was also meant to be disbursed to staff for conducting the training and hence they were also unhappy and had lost interest in training.

* Stipend was not disbursed in time in most areas. Because of that, many students had problems. Some received their stipend much after the course was completed. Many from second batch have still not receive their last instalment. The trainees had to make repeated trips to the PHCs to collect the stipend.

* The loans were to come from TRYSEM which also caters to many other activities and trainings for other professions. The JSR activities which come under health category (not a priority area for most) requires the largest amounts under loans and subsidies for disbursement and often is a casualty for that reason itself. It is therefore not surprising that no loans have been sanctioned to date.

* Manuals did not reach till quite some time for first batch. The second batch received it on time.

* The CEOs/Panchayat Presidents are not aware of details of scheme implementations like, loan sanctioning, the amount of subsidy, kit distribution, etc.

* At present, no department (health or IRDP) has all the details of all the trainees - their total number district wise, their profiles, the number that have passed, the number who have applied for loans, etc. This is very important and necessary information specially for future Review of JSR services.

9. CONCERNS

* **Loss in terms of numbers** - trained JSRs shifting to other fields/professions because of delay in sanctioning of loans and issuing of certificates to them.

* Many who failed first external examination have not come back or taken examination again.

* Without funds, the JSRs are not able to set up their practise.

* Many in the health department including the trainers are worried that **JSRs will cross their brief, use IV injections**, give treatment for diseases for which they do not have permission or have not received training, use drug combinations in short, practise "**quackery**". Their other fear is once they get busy in their practises, they will not give any attention to preventive and promotive activities.

* The scheme defines how the loan money is to be utilised by the JSRs. The breakdown given may not always be useful to all JSRs. Some of them may not require funds for rent or furniture. They may not require to purchase the amount of drugs specified. There should be **flexibility** in the way the loan can be utilised. Officials are asking for these receipts before they sanction the loan - an improbable happening - for how is the JSR to obtain the receipt without paying? He needs the loan amount to make the payments! Also, the amounts specified to be spent specially for drugs - requires JSRs to purchase large amounts of drugs - which he may not be able to utilize or which he could obtain from the PHC. The TRYSEM loan mechanism for JSRs thus seems irrational in some areas.

* No provisions have been made in the scheme for regular contacts between JSRs and the health system and for refresher courses for JSRs. These activities are very important for the maintainance of quality of service of JSRs.

* At present, no department (Health or IRDP) has all the details pertaining to the trainees, their total number district wise, their profiles, the number that have passed, the number who have applied for loans, etc. This, very important information necessary for any evaluation of the scheme on a later date is not presently available.

RECOMMENDATIONS

A. Selection Process

B. Training

C. Examinations

D. Supervision

E. Functions of JSRs

F. Administrative Details

XII. RECOMMENDATIONS

A. SELECTION PROCESS

* Widely publicise the scheme through health camps/health melas and local means of communication before seeking applications for JSR training. With greater awareness, it is likely that more and appropriate candidates will apply.

* Discourage applications of people who are already practising "quackery" - (e.g., using injections, IV fluids, etc.)

* Reduce the minimum eligibility to VIII standard pass (instead of X standard) specially for women and tribal candidates.

* Assure proper hostel accommodation and proper training hours so that women candidates are encouraged to apply.

B. TRAINING

* Identify what the trainees have to learn / do at Block PHC and sub-centre field postings and to set clear-cut objectives of learning at all levels of training.

* Training to be conducted by Doctors mainly and by other staff who directly deal with certain activities at the PHC (e.g., LHV, ANMs, BEE). The doctors should supervise training at all levels. If training is at the district, there can be other educators also.

* Hostel accommodation to be provided at training venue (District and block) so as to improve regularity of attendance and avoid absenteeism. This might also lead to more females applying for JSR training.

* **Emphasize preventive and promotive aspects** along with curative aspects. Include sections on health education and sociology.

* Have guest lecturers and experts address the JSRs and take certain training sessions (specially on homeopathy and ayurveda).

* Enhance emphasis on locally prevalent problem and national health programmes.

* Conduct the initial first 13 weeks for theoretical/clinical training at district level as planned for III batch. For the field based training send them to the Block PHCs for 6 weeks and subcentres for 2 weeks (8 weeks). Have the trainees come back for last 5 weeks to District Centre once again to consolidate curative/preventive/promotive training and prepare for examinations.

* Introduce intersectoral cooperation and activities into the training curriculum.

* Improve the quality of training by making use of charts and other audio-visual aids.

* Make the manual more "practical" giving greater details on symptoms, treatment, drugs to be used and with greater emphasis on national health programmes. Make necessary changes as suggested in comments of the evaluators on the manual. Surface Anatomy and Human Physiology can be demonstrated and practically done by using the trainees themselves.

* Provide the book :Where there is no Doctor" to each trainee at the beginning of the course and refer to it during training as a "practical community reference book".

* During the training process, give emphasis to problems that are encountered at village level.

* Periodical tests should be regularly conducted to assess progress of trainees. Their average should be taken as internal assessment marks.

* Have a detailed plan for continuing education and institutional support for further development of JSR and to improve their quality of service.

C. *EXAMINATIONS*

* Hold the examination immediately after completion of the course. The dates should be fixed atleast 3 months in advance and should not be changed under any circumstances.

* Field based personnel who have full knowledge of the objectives of the JSR scheme and functions of the JSR should be part of the team setting the question papers for the examinations.

* Give simulated case studies to assess their knowledge rather than only objective type questions. A suggested examination pattern is given below:

i. Objective type questions	- 50% marks
ii. Short answers	- 25% marks
iii. Problem solving	- 25% marks

Examples of problem solving questions are enclosed (Appendix 7).

* Print the required number of question papers and send to various examination centres. This is to obviate the problem of photocopying question papers at all centres as they neither have the facilities nor the funds. This will also prevent leakage and avoid malpractice.

* Give guidelines to various training centres on the proposed 3 "Internal Assessments".

* Results to be announced within 15 days of completion of the examinations.

* Appropriate arrangements to be made for preventing copying by trainees during the examinations.

E. SUPERVISION

* Send instructions from the concerned Health Officials to the implementing agencies and training centres to be sent requesting that the "supervision" activities for the JSRs should be planned in advance and become an integral portion of the training of JSRs.

* Give emphasis to supervision during the training process.

* A guide (instructions) on monitoring and supervision of JSRs by the PHC should be circulated to all PHCs.

F. FUNCTIONS OF JSRs

* JSRs need enhanced visibility. Their role and activities need to be clearly explained to villagers at various village meetings so that their services are maximally utilised.

* JSRs must devote sufficient time to preventive and promotive activities once they start practising. Their importance needs to be stressed to the JSRs.

* There is a lot of overlap of JSR activities with the activities of the multipurpose worker, dai and other field based personnel. These need to be streamlined and rectified for the most efficient use of limited resources.

* Modify the drug list for JSRs. They are at present clear-cut deficiencies in the list. Drugs like Analgin should not be used any more and Decadron has very specific uses but can be easily misused. Drugs mentioned in the manual for JSR use do not figure in the list of drugs to be maintained by JSR. This needs rectification.

* JSRs should interact with other health functionaries as well as with functionaries of related sectors at local level.

G. ADMINISTRATIVE DETAILS

This is one area which really needs to tone up. Hasty implementation of the scheme after conceivement without adequate preparation has affected the quality of training and raised many administration related problems.

* Widescale publicity should be given to the JSR scheme so that the end-users (villagers) are made aware of its objectives and functions and start demanding/utilizing the services provided. It will be more effective and appropriate

to use local means of communication (tom toming, camps, etc.) rather than making use of TV or radio.

* One nodal person needs to be identified at the district level (other than the CMO, e.g., Media Officer) to coordinate the whole programme and ensure its smooth functioning. All necessary details of all trainees should be maintained at the nodal office of the district for future reference. Maintain all necessary details of all trainees at the nodal office of the district for future reference.

* Streamline the disbursement of stipends, contingency funds and training grant so that they are made available on time.

* Distribute certificates and kits within a specified date after completion of the training.

* Provide appropriate assistance to successful trainees for loan application and obtaining the loan under TRYSEM.

* **Reexamine the process of sanctioning of the loan** under TRYSEM. A group competent in **Accounting** and **Financing** needs to examine it in detail and suggest feasible alternatives which can be practically implemented.

* Workshops with participation of Panchayat representatives and concerned officials (from health and IRDP Departments) on the JSR scheme need to be organized in all blocks and districts as soon as possible. This will greatly facilitate transfer of information and creation of awareness of the scheme among elected representatives and concerned officials.

* To prevent attrition of information it may be necessary to communicate directly with Panchayat, Block and Zilla representatives on issues regarding the scheme.

* Plan and implement the distribution of manuals better, so that all training centres receive them before the training course is started.

* Provide a nameboard along with the certificate to all successful JSRs to help in giving them an identify.

SOME CONCERNS

Attrition of JSRs

Training of each JSR costs the state a substantial amount (time and money). All preventive efforts need to be taken to ensure that they do not dropout during training or are not lost after training. This would require:

* proper selection
* building commitment
* appropriate training and training facilities
* correct evaluation
* timely registration and provision of kits
* assistance in obtaining loan
* regular assistance and supervision
* continuing education and refresher courses.

Small number of women candidates

The activities of the JSR are to a large extent CSSM/MCH activities. Women JSRs would therefore be most appropriate to carry out these functions. There are also other advantages like stability, not being lost to other professions, etc., when a village selects a woman to undergo JSR training. **However, very few women apply**. The challenge lies in overcoming their resistance and convincing the community of the benefits they will accrue if a woman becomes their JSR. Steps need to be taken to address these challenges.

Preventing unethical practise

If JSRs go beyond their brief, start treating diseases for which they have not been given the competence, use drugs illogically, have an injection - IV based practise then there will be very little difference between them and the present "quacks" scattered all over Madhya Pradesh.

How do we assure that the JSRs carry out their duties with commitment and ethically, not only focus on curative medicine but give due emphasis to preventive and promotive aspects are other major challenges which need to be addressed.

APPENDIX 1

गोपाल शरण शुक्ल
प्रमुख सचिव

अ. शा. पत्र क्र.
एफ-2-2-17/मेडि 5/95
भोपाल, दिनांक 30-9-95
मध्यप्रदेश शासन
लोक स्वास्थ्य एव
परिवार कल्याण विभाग.

विषय: जन स्वास्थ्य रक्षक योजना

प्रिय महोदय,

जन स्वास्थ्य रक्षक योजना की एक प्रति इस पत्र के साथ संलग्न कर आपको भेजी जा रही है. ग्रामीण क्षेत्रों में स्वास्थ्य सुविधाएं उपलब्ध कराने की यह एक अभिनव योजना है,के क्रियान्वयन के लिये निम्नानुसार जिम्मेदारियों का निर्वहन करना आवश्यक होगा:-

(1) ग्राम पंचायत : ग्राम पंचायतों को तत्काल अपने क्षेत्र के सभी गांवों के लिये प्रशिक्षणार्थी जन स्वास्थ्य रक्षको का चुनाव करना होगा.

(2) जनपद पंचायत: जनपद पंचायतों का अपने क्षेत्र की ग्राम पंचायतों से जनपद पंचायतों से जन स्वास्थ्य रक्षकों का चुनाव शीघ्र कराना होगा.

(3) जिला पंचायत : जिला पंजायत को तत्काल सभी ग्राम पंचायतों एवं जनपद पंचायतों की बैठक बुलाकर योजना समझानी होगी. और प्रशिक्षणार्थी जन स्वास्थ्य रक्षकों का चयन पूर्ण कराना होगा। जिला पंचायतें प्रशिक्षण कार्यक्रम की निगरानी भी रखेगी. प्रशिक्षण के उपरांन्त जन स्वास्थ्य रक्षकों के पंजीकरण का कार्य तथा समय-समय पर उनके निरीक्षण का कार्य जिला पंचायतों को करना होगा.

(4) जिला ग्रमीण विकास अभिकरण : प्रशिक्षण के लिये धन राशि ट्राइसेम योजना से दी जायेगी. यह राशि जिला ग्रामीण विकास अभिकरणों द्वारा विमुक्त की जायेगी. प्रशिक्षण के उपरांन्त पात्रता होने पर जन स्वास्थ्य रक्षकों को स्वयं का व्यवसाय प्रारंम्भ करने के लिये एकीकृत ग्रामीण विकास कार्यक्रम के अंतर्गत ऋण दिलाने का कार्य भी जिला ग्रामीण विकास अभिकरण करेंगे।

(5) मुख्य चिकित्सा अधिकारी : मुख्य चिकित्सा अधिकारी अपने जिले के प्रशिक्षण कार्यक्रम के प्रभारी होंगे उन्हें जिला ग्रामीण विकास अभिकरण के साथ समन्वय करके प्रशिक्षण कार्यक्रम निर्धारित करना होगा। प्रशिक्षण हेतु माड्यूल उन्हें लोक स्वास्थ्य संचालनालय से प्राप्त होंगे। प्रत्येक विकास खंड स्तरीय प्राथमिक स्वास्थ्य केन्द्र पर प्रशिक्षण संबंधी सभी व्यवस्थाएं करना उनकी जिम्मेदारी होगी. मेरा आग्रह है कि प्रत्येक जिले में डी. एच. ओ. स्तर के किसी अधिकारी को इस कार्यक्रम का प्रभारी बनाया जाये प्रशिक्षण के अंत में परीक्षा आयोजित करने की जिम्मेदारी भी मुख्य चिकित्सा अधिकारी की होगी

(6) विकास खंड चिकित्सा अधिकारी : विकास खंड स्तर पर प्रशिक्षण एवं परीक्षा आयोजित करने की संपूर्ण जिम्मेदारी विकास खंड चिकित्सा अधिकारी की होगी

(7) वहुउद्देशीय स्वास्थ्य कार्यकर्ता: ग्राम स्तर पर जन स्वास्थ्य रक्षक समस्त राष्ट्रीय स्वास्थ्य कार्यक्रमों में प्रभावी भूमिका अदा कर सकें, इसके लिए बहुउद्देशीय स्वास्थ्य कार्यकर्ताओं को उन्हें लगातार मार्गदर्शन देना होगा तथा सहयोग प्रदान करना होगा।

जन स्वास्थ्य रक्षकों का प्रशिक्षण प्रत्येक विकास खंड में 19 नवम्बर से प्रारंभ किया जाना है. अतः कृपया प्रशिक्षणार्थियों का चयन एवं प्रशिक्षण की व्यवस्था आदि की तैयारी शीघ्र पूरी करके मुझे सूचित करें.

भवदीय

(गोपाल शरण शुक्ल)

जन स्वास्थ्य रक्षक योजना

जन स्वास्थ्य रक्षक योजना के निम्नलिखित उद्देश्य हैं:-

1.1 ग्रामीण क्षेत्रों में स्वास्थ्य के लिये ऐसे प्रशिक्षित व्यक्ति प्रत्येक गांव में उपलब्ध कराना जो प्राथमिक स्वास्थ्य सेवा उपलब्ध करा सकें एवं छोटी-मोटी बीमारियों का वैज्ञानिक इलाज गांव में करा सकें. प्रयास यह किया जाएगा कि इसमें महिला एवं पुरुष दोनों हो.

1.2 गांव में ऐंसे प्रशिक्षित व्यक्ति उपलब्ध कराना जो राष्ट्रीय स्वास्थ्य कार्यक्रमों एवं शासन की स्वास्थ्य योजनाओं को लागू करने में सहायता कर सके.

2 अनिवार्य योग्यता

2.1 दसवीं परीक्षा पास.

2.2 उसी गांव का निवासी हो जहां उसे स्वास्थ्य रक्षक के रुप में कार्य करना है। उसी गांव का निवासी न मिलने पर ग्राम पेचायत उसी पंचायत क्षेत्र के किसी निवासी का चयन कर सकती है।

3 आयु सीमा

3.1 35 वर्ष अधिकतम

4 चयन प्रक्रिया

4.1 शासन द्वारा योजना का समाचार पत्रों, रेडियो एवं टेलीविजन पर व्यापक प्रचार किया जावेगा.

4.2 ग्राम पंचायतों द्वारा ग्राम पंचायत कार्यालय एवं गांव के प्रमुख स्थानों पर नोटिस चस्पा करके प्रचार किया जायेगा.

4.3 ग्राम पंचायत द्वारा नियत दिनांक को स्वास्थ्य रक्षक बनने के इच्छुक व्यक्ति सादे कागज पर आवेदन लिख कर ग्राम पंचायत कार्यालय में ग्राम पंचायत की सामान्य प्रशासन समिति के समक्ष उपस्थित होंगे। आवेदन के साथ दसवीं कक्षा की अंकसूची संलग्न करेंगे.

4.4 ग्राम पंचायत की सामान्य प्रशासन समिति सभी आवेदनों का परीक्षण करेगी। स्वास्थ्य रक्षक के लिये प्रशिक्षण प्राप्त करने के लिए चयन हेतु केवल उन्हीं आवेदनों पर विचार किया जायेगा जो न्यूनतम योग्यता पूरी करते हों तथा जो आयु सीमा संबंधी योग्यता पूरी करते हो.

4.5 जिस ग्राम के लिए केवल एक ही योग्य आवेदक होगा उसका चयन प्रशिक्षणार्थी के रुप में कर लिया जायेगा।

4.6 जिस गांव के लिए एक से अधिक योग्य आवेदक होंगे उनमें चयन निम्नानुसार किया जायेगा:-

4.6(क) साक्षरता मिशन के स्वैच्छिक अनुदेशक को प्राथमिकता दी जायेगी.

4.6(ख) महिला आवेदक को पुरुष आवेदक पर प्राथमिकता दी जायेगी।

4.6(ग) जो व्यक्ति पूर्व से भारत शासन कीयोजना के तहत स्वास्थ्य रक्षक का कार्य कर रहे हैं ऐसे व्यक्तियों को प्राथमिकता दी जाएगी तथा उसके लिए आयु सीमा का वंधन नहीं रहेगा परन्तु उन्हें अन्य योग्यताएं पूर्ण करनी होंगी.

4.6(घ) एक ही लिंग के आवेदकों में उस आवेदक को प्रथमिकता दी जायेगी जिसने दसवी कक्षा की परीक्षा में अधिक अंक पाये होंगे।

5. प्रशिक्षण

5.1 चयनित प्रशिक्षणार्थियों को शासन द्वारा निर्धारित प्रशिक्षण केन्द्रों पर प्रशिक्षण लेना होंगा।

5.2 ग्राम पंचायत चयनित प्रशिक्षणार्थियों के नाम एवं पते विकास खंड चिकित्सा अधिकारी को भेजेगें तथा विकास खण्ड चिकित्सा अधिकारी इन्हें जिले के मुख्य चिकित्सा अधिकारी को अग्रेषित कर देंगे. मुख्य चिकित्सा अधिकारी यह नाम और पते उनके जिले के लिये निर्धारित प्रशिक्षण केन्द्रों को भेजेगे।

5.3 प्रशिक्षण केन्द्र द्वारा सभी प्रशिक्षणार्थियों को प्रशिक्षण में सम्मिलित होने के सूचना डाक द्वारा तथा संबधित विकास खंड चिकित्सा अधिकारी द्वारा दी जायेगी.

5.4 प्रशिक्षणार्थियों को प्रशिक्षण केन्द्र तक आने जाने के लिये कोई यात्रा व्यय नही दिया जायेगा.

5.5 प्रशिक्षणार्थियों को प्रशिक्षण की अवधि में रहने तथा भोजन की व्यवस्था स्वयं करनी होगा. इसके लिये कोई भत्ता नहीं दिया जायेगा.

5.6 प्रशिक्षणार्थियों को नियत दिनांक को प्रशिक्षण केन्द्र पर उपस्थिति देनी होगी. देर से आने वाले प्रशिक्षणार्थियों को स्वीकार नहीं किया जायेगा.

5.7 प्रशिक्षण की अवधि में कोई छुट्टी नहीं मिलेगी.

5.8 प्रशिक्षण 6 माह का होगा.

5.9 यदि प्रशिक्षणार्थी को ट्राइसेम योजना के अन्तर्गत पात्रता होगी तो उन्हें प्रशिक्षण के दौरान पांच सौ रुपये (500/-) प्रतिमाह शिष्यवृत्ती दी जायेगी।

6. परीक्षा

6.1 प्रशिक्षण के अंत में शासन द्वारा निधार्रित संस्था द्वारा एक परीक्षा ली जावेगी.

6.2 परीक्षा में उत्तीर्ण प्रशिक्षणार्थियों को प्रशिक्षित स्वास्थ्य रक्षक का प्रमाण-पत्र उस संस्था द्वारा दिया जायेगा.

6.3 अनुत्तीर्ण प्रशिक्षणार्थियों को प्रशिक्षम केन्द्र द्वारा पुनः छः माह का प्रशिक्षण दिया जा सकेगा। परन्तु उसे पुनः प्रशिक्षण के समय कोई शिष्यवृत्ति देय नहीं होग. पुनः प्रशिक्षण के बाद प्रशिक्षणार्थी एक बार पुनः परीक्षा में बैठ सकेंगे.

6.4 दूसरी बार भी परीक्षा में अनुत्तीर्ण होने वाले प्रशिक्षणार्थियों को पुनः परीक्षा में बैठने की पात्रता नहीं होगी.

6.5 परीक्षा में उत्तीर्ण होंने के लिए न्यूनतम अंक 50% होना आवश्यक होगा।

7. पंजीयन

7.1 स्वास्थ्य रक्षक प्रमाण पत्र पाये हुए व्यक्ति प्रारूप "क" में पंजीयन हेतु जिला पंचायत को आवेदन कर सकेंगे।

7.2 पंजीयन एक ग्राम के लिये ही किया जायेगा।

7.3 पंजीयन संबंधित ग्राम पंचायत की अनुशंसा पर किया जायेगा।

7.4 पंजीकृत व्यक्ति उस ग्राम में अनुसूची-1 में दिये गये कार्य करने के लिये अधिकृत होंगे, जिस गांव के लिये उन्हें पंजीकृत किया गया है।

7.5 प्रत्येक जिला पंचायत प्रारुप 'ख' में स्वास्थ्य रक्षकों की एक पंजी रखेगी जिसमें सभी पंजीकृत स्वास्थ्य रक्षकों का नाम दर्ज किया जायेगा। प्रत्येक ग्राम के लिये इस पंजी में एक पृथक पृष्ठ होगा।

7.6 जिला पंचायत पंजीकृत स्वास्थ्य रक्षकों को प्रारूप 'ग' में एक पंजीकरण प्रमाण-पत्र जारी करेगी।

8. स्वास्थ्य रक्षकों के कर्त्तव्य

8.1 अनुसूची-1 में दिये गए कार्य निष्ठापूर्वक करना।

8.2 अनुसूची-2 में दिये गए कोड आफ कंडक्ट का पालन करना।

8.3. राष्ट्रीय स्वास्थ्य कार्यक्रमों में शासन की सहायता करना।

8.4 अनुसूची-3 में दी गई दवाएं सदैव अपने पास रखना।

8.5 शासन द्वारा समय-समय पर जारी निर्देशों का पालन करना।

9. निरीक्षण

9.1 पंचायतों के निर्वाचित प्रतिनिधि, मुख्य चिकित्सा अधिकारी अथवा उनके द्वारा अधिकृत

कोई अन्य चिकित्सा अधिकारी स्वास्थ्य रक्षक के कार्यालय एवं उसके रिकार्ड का निरीक्षण कर सकेंगे।

10. रिकार्ड

स्वास्थ्य रक्षक निम्नलिखित रिकार्ड रखेगा :

10.1 देखे गए मरीजों की पंजी प्रारूप "घ" में।

10.2 ग्राम में होने वाले जन्म, मृत्यु, गर्भधारण एवं विवाह की पंजी प्रारूप "च, छ, ज, झ" में।

10.3 लक्ष्य दम्पत्तियों की पंजी प्रारूप "त" में.

10.4 पेयजल स्त्रोतों एवं उनके शुद्धिकरण की पंजी प्रारूप "थ" में।

10.5 टीकाकरण एवं वजन पंजी प्रारूप "द" एवं "घ" में।

11. पंजीयन का रद्द किया जाना

11.1 विकास खंड चिकित्सा अधिकारी सूचना मिलने पर अथवा अन्यथा जांच करने पर यदि यह पाता है कि स्वास्थ्य रक्षक द्वारा अपने कर्तव्यों का निर्वहन ठीक प्रकार से नहीं किया जा रहा है और यदि वह स्वास्थ्य रक्षक को सुनवाई का अवसर देने के पश्चात इस निष्कर्ष पर पहुंचता है कि उस व्यक्ति के स्वास्थ्य रक्षक के रूप में कार्य करने से ग्राम के लोगों के स्वास्थ्य को हानि होने की संभावना है तो वह जिला पंचायत से ऐसे स्वास्थ्य रक्षक का पंजीयन रद्द करने की अनुशंसा करेगा और ऐसी अनुशंसा प्राप्त होने पर जिला पंचायत द्वारा ऐसे स्वास्थ रक्षक का पंजीयन रद्द कर उसका नाम स्वास्थ्य रक्षकों की पंजी से निकाल दिया जायेगा।

11.2 पंजीयन रद्द होने के पश्चात् ऐसे व्यक्ति को स्वास्थ रक्षक के रूप में कार्य करने का अधिकार नहीं होगा।

12. सामान्य :

12.1 प्रशिक्षण की अवधि में शिष्यवृत्ति ट्राइसेम योजना से दी जायेगी।

12.2 प्रशिक्षण के अंत में ट्राइसेम योजना से एक टूल किट भी दिया जायेगा जिसमें अनुसूची-4 में दी गई सामग्री होगी।

12.3 प्रशिक्षण संस्था को ट्राइसेम योजना के अंतर्गत देय राशि, प्रशिक्षण केन्द्र को दी जायेगी, जिसे वे शासन के निर्देशों के अनुसार व्यय कर सकेंगे।

12.4 पंजीकृत स्वास्थ्य रक्षकों को पात्रता होने पर अपना व्यवसाय शुरू करने के लिये एकीकृत ग्रामीण विकास कार्यक्रम के अंतर्गत ऋण दिलाया जायेगा।

अनुसूची-1

स्वास्थ्य रक्षकों के कर्त्तव्य

1. समस्त राष्ट्रीय कार्यक्रमों में स्वास्थ विभाग के अधिकारियों एवं कर्मचारियों से सहयोग करना तथा उनके द्वारा दिये गए निर्देशों का पालन करना।
2. क्षेत्र में कोई गंभीर बीमारी अथवा महामारी की सूचना तत्काल स्वास्थ केन्द्र को देना।
3. ग्राम स्वास्थ्य समिति की बैठकों की व्यवस्था करना तथा स्वयं बैठकों में उपस्थित रहकर लोगों को स्वास्थ्य संबंधी महत्वपूर्ण जानकारी देना।
4. गांव में ग्राम पंचायत की सहायता से साफ-सफाई की व्यवस्था करना।
5. गांव के लोगों को ओ.आर.एस. का घोल बनाने तथा अतिसार से बचाव और उसके इलाज की सही जानकारी देना।
6. विवाह, गर्भवती महिलाओं, जन्म तथा मृत्यु का पंजीयन करना।
7. सभी गर्भवती महिलाओं की तीन बार प्रसव पूर्व जांच करना तथा आवश्यक होने पर उन्हें अस्पताल ले जाने की सलाह देना।
8. सभी गर्भवती महिलाओं को अस्पताल में प्रसव कराने के लिये प्रेरित करना, यदि वे अस्पताल में प्रसव के लिये तैयार न हो तो प्रशिक्षित दाई से प्रसव कराने की प्रेरणा देना।
9. सभी गर्भवती महिलाओं एवं उनके परिवार के लोगों को प्रसव केसमय ध्यान देने योग्य- पांच साफ-सफाइयों की जानकारी देना।
10. सभी गर्भवती महिलाओं को टिटेनस के दो टीके लगवाने तथा आयरन फोलिक एसिड की गोलियां खाने की प्रेरणा देना।
11. जन्म लेने के दो दिन के भीतर सभी बच्चों का वजन लेना, माह में एक बार 6 वर्ष तक की उम्र के सभी बच्चों का वजन लेना तथा बच्चों के माता-पिता को पोषण की जानकारी देना।
12. इस बात का विशेष ध्यान रखना कि गांव में केवल आयोडीन युक्त, पिसा हुआ, थैलीबन्द नमक ही बिके।
13. निमोनिया होने पर तत्काल बच्चों का उपचार करना तथा आवश्यक होने पर उन्हें अस्पताल भेजना।
14. बुखार होने पर मलेरिया का इलाज करना तथा रक्त पट्टी बनाकर स्वास्थ केन्द्र भेजना।
15. यदि गांव में किसीको खसरा निकले, तो सभी को यह समझाना कि खसरे के बाद दस्त एवं निमोनिया से मृत्यु की संभावना बहुत अधिक होती है तथा ऐसे प्रकरण आने पर उनका तत्काल इलाज करना।

16. गांव के सभी बच्चों को टीकाकरण सारिणी के अनुसार समय के टीकाकरण करवाना।

17. जिन छोटी-मोटी बीमारियों के इलाज के लिये उसे प्रशिक्षित किया गया है तथा जिनका विवरण स्वास्थ्य रक्षक मैनुअल में है, उनका इलाज करना, तथा अन्य सभी बीमारियों के मरीजों को तत्काल स्वास्थ्य केन्द्र रेफ़र कर देना।

18. गांव के लोगों को परिवार नियोजन के साधनों के विषय में समझाना तथा कंडोम एवं ओरल पिल्स उपलब्ध कराना।

19. गांव के लक्ष्य दंपत्तियों की अद्यतन सूची रखना तथा उन्हें परिवार नियोजन के साधन अपनाने के लिये प्रेरित करना।

20. गांव के सभी पेयजल स्त्रोंतों में प्रति सप्ताह नियमित रूप से ब्लीचिंग पाउडर डाल कर शुद्धिकरण करना।

21. गांव के लोगों को पीने के पानी में क्लोरीन की गोली डालकर उपयोग करने की सलाह देना।

22. गांव के लोगों को कम उम्र में विवाह न करने की प्रेरणा देना।

23. शासन तथा पंचायती-राज संस्थाओं द्वारा समय-समय पर आयोजित प्रशिक्षणों में भाग लेना।

24. शासन तथा ग्राम पंचायतों द्वारा समय-समय पर सौंपे गए अन्य कार्य करना।

4. क्या आपको प्रार्थीओं की संख्या के बारे में पता है ? हाँ/ना

5. यदि हाँ, तो संख्या बताइए .....

स **प्रशिक्षण प्रक्रिया :**

प्रशिक्षण के तरीके : प्रशिक्षण के तरीकों की लिस्ट दें .....

1. प्र.स.क., नाम जहाँ पर प्रशिक्षण हुआ। प्र.सं.क. ..... स.क. .....

2. प्रशिक्षण की अवधि .....से .....

3. प्रशिक्षणार्थियों की संख्या .....

4. क्या प्रशिक्षण के विषय अच्छी तरह समझाये गये / दिखाये गये ? हाँ/ना

5. क्या आपको प्रशिक्षण के दौरान नये ज्ञान और कौशल का प्रयोग करने का अवसर मिला? हाँ/ना

6. क्या आपको प्रशिक्षण के दौरान प्रशिक्षों के साथ विचार और प्रश्न करने का पर्याप्त अवसर मिला ? हाँ/ना

7. क्या आपको लिखित सामग्री मिली ? हाँ/ना

8. क्या लिखित सामग्री उपयोगी थी ? हाँ/ना

9. क्या प्रशिक्षणार्थियों को प्रशिक्षण का मूल्यांकन करने का अवसर मिला ? हाँ/ना

10. क्या ज. स. र. प्रशिक्षण से सन्तोषजनक है ? हाँ/ना

11. प्रशिक्षण का मूल्यांकन कीजिये :

बहुत अच्छा अच्छा ठीक

कम बहुत कम

क्षण की सूची (Content)

1. क्या प्रशिक्षण स्थानीय जरूरतों के मुताबिक पर्याप्त और सही था ? हाँ/ना

2. क्या प्रस्तुत की गयी सामग्री ज.स.र. की कौशलताओं और शिक्षा स्तर के मुताबिक उचित है ? हाँ/ना

Resources - (रिसोर्स)

1. क्या प्रशिक्षण कार्यों के लिये पर्याप्त जगह है ? हाँ/ना

2. क्या प्रशिक्षण के लिए पर्याप्त प्रशिक्षक हैं ? हाँ/ना

3. क्या ऑडियो विजुअल एडस (क्लेक बोर्ड, फिलिप चार्ट, स्लाइड प्रोजेक्टर आदि) प्रयोग किये गये थे ? हाँ/ना

4. क्या आपके पास आपके कार्य सम्बन्धित सामग्री मौजदू है ? हाँ/ना

ट्रेनिंग मैन्युअल :

1. क्या ट्रेनिंग मैन्युअल में स्थानीय जरूरतों के मुताबिक सामग्री पर्याप्त और ठीक है? हाँ/ना

2. क्या मैन्युअल में दी गयी सामग्री ज.स.र. प्रशिक्षण के लिये सही है ? हाँ/ना

3. मैन्युअल को और अच्छा बनाने की सलाह :

4. किस विषय और कौशल में आपको प्रशिक्षण की और जरूरत है ?

....

....

....

घर के लिये सामग्री :

1. क्या आपको घर के लिये किट दी गयी थी ? हाँ/ना

मूल्यांकन प्रक्रिया :

1. मूल्यांकन प्रक्रिया के बारे में अपने विचार दें।

2. इसको और अच्छा बनाने के लिये सुझाव दें।

3. क्या आप सोचते हैं कि अंकों का बटवारा प्रश्न–पत्रों और आंतरिक मूल्यांकन में सही है ? हाँ/ना

4. परीक्षा प्रक्रिया को और सही बनाने के लिये कोई सलाह ?

- Personal chat
- Selection Area
- Trip Areas
- Trip content
- Resumes
- Trip Manual
- Exam Areas.

जन स्वास्थ्य रक्षक योजना की समीक्षा
(म.प्र. सरकार)

जुलाई-अगस्त 1997

अ. स्वयं की जानकारी :

नाम ..... आयु ..... वर्ष ..... लिंग – स्त्री/पुरुष

ग्राम ..... प.स्वा.क्र. ..... जिला .....

विवाहित/अविवाहित .....

शिक्षा स्तर ..... मुख्य व्यवसाय

1. क्या आप इस गाँव के ग्रामवासी हैं ? हाँ/ना

2. यदि हाँ, तो कितने सालों से .....

3. यदि नहीं, तो आपका निवास स्थान यहाँ से कितनी दूर है ? ..... कि.मी.

4. आपके निरीक्षण स्वास्थ्य केन्द्र का नाम बताइये .....

5. निरीक्षण स्वास्थ्य केन्द्र की आपके गाँव से दूरी .....

ब. चयन प्रक्रिया :

1. आपको ज. स. र. (जन स्वास्थ्य रक्षक) योजना के बारे में कैसे पता लगा ?

2. आपकी चयन प्रक्रिया कहाँ हुई ?

3. क्या आपकी चयन प्रक्रिया में ग्रामवासियों ने भाग लिया था ?

जन स्वास्थ्य रक्षक योजना की समीक्षा (म.प्र. सरकार)

JSR (W)

नाम ..... ग्राम ..... जिला .....

1. आप कितने माह से ज.स.र. के रूप में काम कर रहे हैं .....

2. अपने इलाके की सामान्य बीमारियों/स्वास्थ्य संबंधी समस्याओं के नाम बताइए।

a ..... e .....

b ..... f .....

c ..... g .....

d ..... h .....

3. स्वास्थ्य रक्षक के रूप में अपने नियमित कार्यक्रम बताइए।

4. क्या यहाँ पर कोई क्षेत्रीय विश्वास/रूढ़ि/प्रथा है, जो ग्रामवासियों को आपसे मदद लेने में सहायता/बाधा डालता है ?

4a. यदि हाँ तो उसका विवरण दें।

5. क्या आपके गाँव में कोई समस्या/कारण हैं जो ग्रामवासियों पर आपसे मदद लेने में बाधा डालता है ?

6. यदि हाँ तो उसका विवरण दें।

7. ऐसी 5 सामान्य बीमारियों के नाम लिखिये, जिनके लिए ग्रामवासी आपके पास आते हैं ?

a ..... d .....

b ..... e .....

c .....

8. आप लगभग कितने घंटे प्रतिदिन ज.स.र. के कार्य में लगाते हैं .....

9. आप ज.स.र. के कार्य कैसे करते हैं ?

– दिन के एक खास समय में

– दिन में किसी भी समय

10. क्या ज.स.र. के कार्य आपके मुख्य व्यवसाय में बाधा डालते हैं ? हाँ/ना

11. क्या ज.स.र. के कार्य आपके व्यवसाय से होने वाली आय में बाधा डालते हैं ? हाँ/ना

12. यदि हाँ तो आय बढ़ी/घटी है ? .....

13. क्या आपने ट्राईसेम से कर्जा लिया है ? हाँ/ना

14. कर्जा लेने में अपने खर्चे और किसी परेशानी का विवरण दें :

15. ज.स.र. के कार्यों से आपको एक माह में कितनी आय होती है ?

कुल आय : .....

16. अपने गांव के दूसरे स्वास्थ्य कर्ताओं की सूची दें :

– टी.बी.ए. – हकीम

– वैद्य वगैरह – MPW (बहु कार्यकर्ता)

– डॉक्टर – MPW (M) (बहु कार्यकर्ता M)

17. क्या आप इनसे सलाह या विचार करते हैं ? हाँ/ना

18. यदि हाँ तो किसके साथ ?

19. प्राथमिक स्वास्थ्य केन्द्र के कर्मचारियों के सहयोग के बारे में बताइए

बहुत अच्छा　　अच्छा　　ठीक है

कम　　बहुत कम

20. आप कौनसी औषधि अधिकतम प्रयोग करते हैं ?

21. आप कौनसी औषधि बिल्कुल प्रयोग नहीं करते ?

22. आप सदैव रखी जाने वाली दवाओं के अलावा और कौनसी दवा रखना चाहेंगे

23. क्या आप सदैव रखी जाने वाली दवाओं के अलावा भी किसी और दवा का उपयोग करते हैं ?

24. आप डेकाड्रान किस–किस बीमारे के लिये उपयोग करते हैं ?

25. क्या आपकी कोई समस्या है, जो आपको पूरी तरह से कार्य करने में बाधा डालती है ?

हाँ/ना

26. यदि हाँ तो विवरण दीजिये :

निरीक्षण विवरण :

1. आपके कार्यों का निरीक्षण कौन करता है :

– प्र.स.क. डाक्टर MPW(F)

– HA हेल्थ असिस्टेंट BEE (बी.ई.ई.)

– MPW (F) म.प.व. Any Other दूसरा कोई – विवरण दें

2. आपके निरीक्षणकर्ता आपको कब–कब और कितने दिनों बाद मिलने आते हैं ?

3. पिछले निरीक्षण के दौरे के समय क्या कार्य किये गये ?

4. क्या निरीक्षणकर्ता ने पिछले दौरे के समय आपको कोई प्रशिक्षण दिया ?

5. आप अपने प्राथमिक स्वास्थ्य केन्द्र कब–कब जाते हैं ?

6. अपने निरीक्षण केन्द्र जाने के मुख्य कारण बताइये ?

7. क्या आपके गाँव में स्वास्थ्य समिति है ?

8. यदि हाँ तो समिति की बैठक कितनी जल्दी होती है ?

9. क्या ग्राम समिति आपके कार्यों का निरीक्षण करती है ?

10. स्वास्थ्य समिति से आप क्या सहायता चाहते हैं ?

11. आपके गाँव में जो दूसरे सरकारी कार्यकर्ता/संस्था विकास कार्य कर रहे हैं, उनकी सूची दीजिये।

12. क्या आप बीमारी के इलाज के अलावा जो कार्य करते हैं, उस काम के लिये कहीं से कोई प्रतिफल मिलता है ?

13. यदि हाँ तो कितना और कहाँ से ?

14. क्या आप बुखार के लिये ब्लड पट्टी बनाते हैं ? हाँ/ना

15. क्या आप बलगम की स्लाइड बनाते हैं ? हाँ/ना

16. क्या आप मूत्र की जाँच करते हैं ?

Logistics :

1. आप दवाएँ इत्यादि कहाँ से खरीदते हैं ?

2. क्या आपको इस्तेमाल करने वाली वस्तु फिर प्रा.स. के मिलती है?
(कंडोम, ब्लीचिंग पाउडर, स्लाइड्स इत्यादि)

3. गंभीर अवस्था में बीमार को ले जाने के लिए क्या गाँव में कोई सवारी मिलती है ?

Review of JSR Scheme (Govt. Of Madhya Pradesh)

Check-list to assess working JSR's activities (JSR)

I. Certificate

1. Certificate : Available : Yes / No
2. Manual : Available : Yes / No

II. Drugs

Name of drug	In stock beginning (June 1997)	Used in June	Added in June	Stock as of 30/6/97
1) Chloroquine				
2) Cotrimoxazole				
3) Analgin				
4) ORS powder				
5) Iron & Folic Acid				
6) Paracetamol				
7) Avil				
8) Decadron				
9) Condoms				
10) Oral pills				
11) Neosporin powder				
12) Gauze bandage				
13) Savlon				
14) Chlorine tablets				

III. Patients' Illness Register:

1. Maintained : Yes / No

2. Total No. Consulted: < - 1 1 - 5 6 - 14 15 - 20 > 21
   M F M F M F M F M F

3. Diseases seen (details)

4. Total No. Of Illnesses : Total No. Of Correct PX according to Diagnosis

5. Total No. Referred : _____

IV. Birth Register

1. Maintained : Yes / No
2. No. of Births : (in months)
3. Delivery Conducted at :
4. Who Delivered?

   Dai TBA ANM JSR

5. Any difficulty during delivery ?
6. Weight of baby :

   < 2 kgs 2 - 2.5 kgs > 2.5 kgs

V. Death Register

1. Maintained : Yes / No

2. Age at Death		3. Cause of death
Sl.No	Age (years)	Cause

4. Health personnel consulted before death:

VI. Marriage Register :

1. Maintained Yes / No

2. No. of Marriages :

VII. Antenatal Register

1. Maintained : Yes / No
2. Total No. :
3. No. being appropriately managed:

VIII. Eligible Couple Register

1. Maintained : Yes / No
2. No. of Couples on register :
3. No. adopting temporary measures :
4. No. adopting permanent measures :

IX. Chlorination (In one week)

1. No. of wells in the village :
2. No. chlorinated :

X. Immunization Register:

1. Maintained : Yes / No
2. Total No. of Children :
3. No. immunized on time :

XI. Growth Chart Register

1. Maintained : Yes / No
2. No. Of Children :
3. No. Whose charts are maintained correctly :

Community Members (CM -1)

Review of Jan Swasthya Rakshak Scheme

(Govt. Of Madhya Pradesh)

July - August 1997

Issues to be discussed in group discussion with Community Members

---

Name of village: Name of sub-centre:

Name of PHC: District::

A1. What are the major problems in your village?

A2. What are your main health problems?

A. General

1. Are you aware of the JSR Scheme?
2. How did you come to know about it?
3. What is the JSR Scheme?
4. Do you know who is the JSR selected for your village?
5. Were you consulted in his/her selection?
6. Is there a health committee in your village?
7. Does it meet regularly?

B. Functions of JSR

1. What in your opinion are the objectives of the scheme?

2. (a) What are the main responsibilities/functions of the JSR?

   (b) Out of these, which functions does the JSR of your village do?

3. Is there any additional activity that you would like him to do?

   (a) Do you think that the JSR has received adequate training to take care of your common health needs?

4. For which conditions would you go to him?

5. Name some conditions for which you would not go to him but go to see somebody else.

6. Do you feel comfortable discussing your problems with the JSR?

7. Can you contact (get) your JSR easily?

8. Are you satisfied with his examination, services and treatment?

   (a) If not, give reasons:

9. Are you satisfied with his approach/behaviour?

   (a) If not, give reasons:

10. Did he give you medicines or did you have to purchase it from elsewhere?

11. How much does he commonly charge?

12. Do you think this is reasonable?

13. Would you recommend the services of JSR to others' in your village?

14. Does the village committee supervise his work?

15. Suggest means by which the quality of services given by the JSRs can be improved.

16. Do you think that the village should pay some remuneration to JSR for (preventive/promotive and other such work) chlorination, helping build latrines, soakage pit, fever slides, etc...?

17. Has the JSR Scheme decreased your inconveniences in obtaining health care?

18. Do you think that the Government should implement this scheme in every village?

Community Leader (CL - 1)

Review of Jan Swasthya Rakshak Scheme

(Govt. Of Madhya Pradesh)

July-August 1997

Issues to be discussed in individual/group discussion with community leaders

---

Name of village :

Name of Sub-centre:

Name of PHC:

District:

A. What are your main health problems?

Village Health Committee

1. Is there a village committee (or similar mechanism for collective decision-making) for community's health and health related affairs? Yes/No
2. Is this committee statutory? Yes/No
3. Does the JSR member attend this committee Yes/No
4. If yes, what is his status in the committee? (E.g. Secretary, treasurer, member, etc.)

5. What are the functions of this committee?

- Deciding on priorities for local health action.
- Mobilizing local resources for health activities
- Obtaining outside resources for local health activities
- Planning, implementing and supervising health activities
- Employing village health workers
- Supervising non-technical aspects of JSR's work
- Effectively dealing with emergency health situations.

6. How often does the health committee meet?

7. What was discussed in the last meeting?

8. Are minutes of the committee meeting maintained?

9. Are there any other committees in the village?

10. If yes, please give their names:

About JSR

1. How did you become aware of the JSR Scheme?

2. Do you know the objectives of the JSR Scheme?

3. How was the JSR selected?

4. Were you involved in his selection? Yes / No

5. Were you satisfied with the selection process? Yes / No

6. According to you, what are the main functions of the JSR?

7. What functions does the JSR of your village carry out?

8. Are you satisfied with his work? Yes / No
   (b) If no, specify why

9. Does the village health committee supervise the functions of JSR? Yes / No

10. Has the JSR scheme helped in reducing community health problems? Yes / No

11. Do you think health workers' needs to be encouraged in the performance of non-health activities (Environmental, water, etc..)? Yes / No

12. If yes, give details on how this should be done?

13. After completing his course, and before starting his activities, did the JSR come to meet the village leaders? Yes / No

14. (a) Do you believe in the competence of JSR for treating common ailments?
    Yes / No
    (b) If no, specify why : -

15. Give suggestions for improving the functioning of the JSR Scheme.

Review of Jan Swasthya Rakshak Scheme

(Govt. of Madhya Pradesh)

July - August 1997

Issues to be discussed with senior Govt. Functionaries (DHO, etc.) and officers in-charge of Scheme at Bhopal

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1. What is your opinion of the objectives of the scheme?
2. Do you agree with the functions envisaged of the JSR?
3. Do you think that the curriculum is adequate and appropriate?
4. Are you comfortable with his training level?
5. Are you comfortable with the way their training was carried out?
6. What is your opinion about the acceptability of the JSR in the village?
7. In your opinion, in what ways will the JSR's activities improve the health conditions of the community members?
8. What according to you are the reasons for such a high failure rate?
9. Any suggestions for improving the functioning of the scheme?

Review of Jan Swasthya Rakshak Scheme

Govt. of Madhya Pradesh

July - August 1997

Issues to be discussed with trainers

Name of PHC: Name of District:

A. General

1. What do you feel are the objectives of the JSR Scheme?
2. What are your expectations from the JSR Scheme?
3. What are your expectations from the JSRs?
4. What are the common health problems in which JSR can play a role?
5. How would you rate the functioning of the JSRs who are already working?

   (a) very good (b) good (c) fair (d) poor (e) very poor
6. Do these JSRs refer cases beyond their skills in time?
7. Do you receive case referrals from JSRs which they could have managed?
8. Do the JSRs cooperate and help you in your activities in their villages?
9. Do you think the villagers are happy with the functioning of the scheme?
10. Do you have any worries regarding the scheme?
11. Any suggestions for improving the functioning of the JSR Scheme?

APPENDIX 5A

JSR Examination June 1996 Paper No 1 Duration 2 hrs Max marks 200

1. Number of bones in human body
2. What is clavicle
3. What is stomach
4. What is aorta
5. Types of muscles
6. Functions of blood
7. What is prostate
8. Functions of skin
9. What is blood pressure
10. Functions of small intestine
11. Functions of kidney
12. What is protein, fat & carbohydrate
13. What is ORS
14. Drugs used in malaria
15. What are oral pills
16. What is iron & folic acid
17. What is the use of savalon
18. What is the use of paracetamol
19. Use of gauze bandage
20. Function of heart
21. Why is post-mortem conducted
22. What are symptoms of death by hanging
23. How is a case of drowning treated
24. Symptoms & signs of poisonous snake bite
25. What should JSR do in case of epidemic outbreak
26. First aid for dog bite
27. Name the National Health Programmes
28. What advise should JSR give to a TB case
29. What is compost pit
30. Advise to be given to parents of malnourished children
31. Records to be maintained by JSR
32. What is sanitary latrine
33. What is birth & death rate
34. How to chlorinate a well
35. What is filaria
36. Name four viral diseases spread by air
37. Name diseases spread by contaminated water
38. Precautions to be observed while making blood films
39. Symptoms & signs of leprosy
40. Symptoms & signs of tuberculosis
41. Precautions to be observed for drinking tank/pond water
42. Name four contagious diseases
43. What is dengue fever
44. Way for safe disposal of garbage
45. What is tuberculin test
46. What is use of bleaching powder
47. Name four diseases spread by mosquitoes
48. Contraindications for use of oral pills
49. Functions of liver
50. Name three causes of joint pains

JSR Examination June 1996 Paper No 2. Duration 2 hrs. Max marks 200

1. Causes of toothache
2. What is dental caries
3. Treatment of toothache
4. Symptoms & signs of typhoid
5. Treatment of leprosy
6. When to refer a case of headache to PHC
7. Causes of gastroenteritis
8. What are the signs of shock
9. What are the causes of abdominal pain
10. First aid for wet burns
11. Causes of earache
12. Causes of deafness
13. Treatment of foreign body in ear
14. Cause of nasal bleeding
15. What are the main causes of cough
16. Causes of blindness in India
17. What is cataract and how is it treated
18. What to do immediately after an eye injury
19. How to diagnose conjunctivitis
20. How to treat dust/foreign body in eye
21. What is the main objective of Blindness Control Programme
22. How can you help in Eye Camps
23. How to prevent nutritional blindness
24. What is refractory error
25. Give dosage schedule for Vitamin A administration
26. How will you treat pneumonia in a child
27. How will you treat diarrhoea in a child
28. What is polio
29. How to prevent polio
30. Which are the vaccine preventable diseases
31. Main causes of cough in children
32. What is the first food for a new born
33. How to diagnose malnutrition in children
34. What is the responsibility of JSR for safe motherhood
35. Cause of anaemia in pregnancy
36. What are the problems during pregnancy and after delivery
37. Advantages of small family size
38. Where are female sterilization services available
39. Symptoms and signs of gonorrhoea
40. What is AIDS
41. How is AIDS transmitted and how to prevent it
42. Uses of Cu T
43. How will you look after a new born
44. Reasons for population increase in India
45. First aid for sprain
46. Treatment of sun stroke
47. How & when to use splints
48. Symptoms & signs of joint pains
49. First aid for head injury
50. "JSR will meet the community needs", describe in your words

APPENDIX - 6

Analysis of JSR Examination Questions against topics in JSR Manual

Chapter No.	Topics in Manual	JSR Exam I	JSR Exam II
1.	Responsiblities of JSR	1%	0.5%
2.	Working with Community	1%	0.5%
3.	Anatomy and Physiology	13%	8.5%
4.	Disease Transmission	3%	4.5%
5.	Environment Hygiene and personal habits	6%	2.5%
6.	Malaria	3%	4.5%
7.	Tuberculosis	4%	3.1%
8.	Typhoid/Dengu/Filaria	3%	2.1%
9.	Leprosy	2%	2.5%
10.	Eradication of Blindness	7%	5.0%
11.	S.T.D	3%	4.5%
12.	Family Welfare	5%	11.5%
13.	Safe Motherhood	6%	7.5%
14.	Care of Newborn	1%	5.0%
15.	Significant Diseases of Childhood	6%	9.5%
16.	Immunization	2%	8.0%
17.	Child Growth and Development	-	1.5%
18.	Nutrtion/Malnutrition	3%	7.0%
19.	Examination of Patient	1%	1.1%
20.	Treatment of Minor Illness	10%	6.5%
21.	First Aid in Emergency	15%	4.0%
22.	Documentation/Recording	2%	0.5%
		97% *	100%

* 21, 22 Postmortem ?
* 27 National Health Programme ?

जन स्वास्थ्य रक्षक योजना की समीक्षा
(म.प्र. सरकार)

आपके गाँव के एक गरीब परिवार के सदस्य हैं राजा (25 वर्ष)। उसकी पत्नी लक्ष्मी (21 वर्ष) और तीन बच्चे, राधा (3 वर्ष), रागिणि (1½) और आनन्द (4 माह)।

1) दोपहर आनन्द को लेकर लक्ष्मी आपके पास आती है, और बताती है कि :

- सुबह से बच्चे को 5 बार दस्त हुआ है,
- बुखार भी है और
- कुछ भी खाने–पीने से इन्कार कर रहा है

आप इस बच्चे का परीक्षण विधान और उपचार के क्रम बताइये।

2. आप पहले ही राधा और रागिणी में कुपोषण के लक्षण देख चुके हैं। इस माँ और परिवार का परीक्षण क्रम, सलाह और अनुसरण क्रम दीजिये।

3. राजा पिछले दो माह से बीमार है। खाँसी, थकावट और भार में 4 किलोग्राम घटने की शिकायत करता है।

– राजा का परीक्षण का विधान – क्या पूछोगे, देखोगे, नपोगे और करोगे ?

– राजा और परिवार का उपचार, सावधानियाँ, सलाह क्या दोगे ?

4. दस्त होने के दो हफ्ते बाद, लक्ष्मी आनन्द को खाँसी और बुखार की शिकायत से लाती है। आनन्द की सांस की रफ्तार 40 से अधिक है। आनन्द का परीक्षण, रोग का निर्धारण और उपचार कैसे बताईये ?

5. लक्ष्मी और राजा को परिवार कल्याण कार्यक्रम की सुविधाएँ और सलाह पूछते हैं। आप क्या सलाह दोगे। अगर उनको एक साल का एक ही बच्चा होता तो आप उनको क्या सलाह देते।

6. गाँव में कई बच्चों को दस्त लगे हैं और बुखार के साथ खसरे का अनुमान है। ग्रामवासियों को क्या सलाह, उपचार, सावधानियाँ और अनुसरण का उपाय बतायेंगे और कैसे ?

B. Training Process

1. Did you receive any training to become a trainer for this scheme?
2. Is there a schedule to be followed for training?
3. Were you given any additional resources for conducting this training?
4. Was training assessed by anybody?
5. How was the training conducted (method)?
6. Will training be followed up through regular supervision system?
7. Will JSR performance be monitored?
8. Is there an adequate supply of training manuals?
9. Does training manual cover all locally prevalent health problems which can be managed by JSR?
10. Does the training manual contents respect local customs/culture?
11. Is the material in the training manual appropriate for the work envisaged from JSRs?
12. If no, give details/suggestions on how the manual can be improved?
13. What audio-visual aids did you use during the training process?
14. Do you think curriculum for the JSR's in adequate and appropriate
15. What according to you are the reasons for the high failure rate of JSRs?
16. Any suggestions for improving training process?

C. Supervision Process

1. Do you supervise the activities the activities of the JSRs?
2. Is there a schedule/plan for supervision of JSRs?
3. Is it a necessary part of JSR training?
4. How often do you conduct supervision?
5. What activities do you supervise when you meet the JSR in his village?
6. What methods of supervision do you adopt?
7. Are there any written check-lists for evaluating the performance of JSRs?
8. Do you train/demonstrate any technical skills to the JSR during supervision?
9. Do you maintain a record of supervisory and follow-up activities?