

# REACHING HEALTH TO THE GRASSROOTS

*THE JAN SWASTHYA RAKSHAK SCHEME*

*OF THE*

*GOVERNMENT OF MADHYA PRADESH*

*A PARTICIPATORY INTERACTIVE REVIEW  
JULY - DECEMBER, 1997*

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(SEE ALSO SUPPLEMENT : PEER REVIEW OF JSR MANUAL)

## 1. BACKGROUND

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

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

### 1.1 Policy initiatives

The Bhore Committee report (1946) which formed the blueprint of post independence - health care service development, had suggested the formation of village health committees and voluntary health workers who needed suitable training (19). In 1975, the Srivastava report, 30 years later suggested the utilization of part time, semi professional workers from the community who could be trained in the management of common ailments and in basic preventive and promotive services (20). The fourth Chapter of the report entitled "Health Services and Personnel in the Community" is an excellent concept paper on the significance of community based semi professional health workers (See Appendix 5a).

A few years later the ICSSR/ICMR Health for All study group (1981) reiterated once again the need for Community Health volunteers with 'special skills', ready availability, who see health work not as a 'job' but as a social function (21).

Finally, the National Health Policy (1982) included a policy statement on 'Health volunteers selected by communities and enjoying their confidence and to whom certain skills, knowledge and use of technology could be transferred' (22).

### 1.2 CHW - The Indian Experience (GOI)

In 1977, the Janata Government launched the Community Health Worker (CHW) scheme, which focussed on CHWs selected by the community, having 6th standard education, and trained informally in the PHCs for 3 months (4). They were paid a stipend during training and an honoraria of Rs. 50/- per month after the training, when they began work. Further details and a comparison with JSR scheme is provided elsewhere in the report. (See Page 12).

The CHW scheme was a massive operation and was subject to some mid course reviews (23) which identified problems including the lack of adequate preparation; the lack of pilot or feasibility studies; the reduced support of the community; the inability of the



community to takeover the scheme; the non-payment of honoraria and the non replenishment of kit boxes; the lack of professional enthusiasm with the challenge of the scheme at all levels; the predominant selection of males as CHW and their subsequent cooption by the system and finally the problem of the whole scheme becoming a subjudice matter due to litigation by CHWs about enhancement of their honorarium, thus becoming non functional!

### 1.3 CHW - the Indian NGO experience

Prior to 1977 and also after it, many Community Health projects in the voluntary / non governmental sector in the country experimented with community based health workers. Some examples are the CHWs of Jamkhed; the village health workers of the Indo Dutch Project; the lay first aiders of VHS-Adyar; the link workers on the tea gardens in South India; the Family care volunteers and Health Aides of RUHSA; the MCH workers of CINI-Calcutta; the Swasthya Mithras of Banaras Hindu University-Varanasi; the Sanyojaks of Banwasi Seva Ashram, Uttar Pradesh; CHW course of St. John's Medical College - Bangalore; the Rehbar-e-sehat scheme of Kashmir government; the CHVs of Sewa Rural and the Community Health Guides of many other projects. (24)

An overview of these CHWs in the voluntary sector show that they were predominantly women; were mostly voluntary or link workers with minimum support; most of them were mature married volunteers; care had been taken by the project to prevent the cooption by village leaders and there was representation of all segments; the participation of the community in identifying the CHWs and their supervision was a goal itself; the training programmes had innovative components and methods (28) and projects had well trained and highly mobile field and supervisory staff; and many projects had women on action/advisory committees or local womens groups supportive of the process. (24)

### 1.4 CHW - The Global experience

At a Global level also, since the late sixties and early seventies, the experiments of training community health workers of various types took place all over the world. Significant initiatives were taken in Mexico, Guatemala, Jamaica, Venezuela, Brazil, Ghana, Nigeria, Sudan, Ethiopia; Kenya; Tanzania, Iran, Afghanistan, China, Bangladesh, Thailand, Malaysia, Indonesia, Philippines and Papua New Guinea. The terminologies were vastly different but the basic framework was similar. These included community / village health workers; the community health aides; barefoot doctors; community health agents; rural health promoters; national health guides; family health educators; aid posts or orderlies; secouristes; hygienist; health auxiliary and health post volunteers. A review of these experiments showed a remarkable diversity in framework and approaches. (25)

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

The duration of training ranged from 5 days to 10 weeks to 6 months and even upto three years for different cadres. The location of training varied from subcentres and local health



centres to county and rural hospitals and in some instances there were training centres and national project headquarters. Training methods included lectures, discussions, demonstrations, role playing, field visits, practicals, learning by doing and story telling and dialogue. Finally the evaluation methods ranged from written tests, practicals, oral tests, quiz, field performance reviews, role playing and trainer observations. (25)

### 1.5 The JSR Scheme in context

The concept of the community based health worker has been in vogue, therefore, for many decades with a wide variety of experiments at governmental and nongovernmental level in a wide variety of countries. The Madhya Pradesh Government's initiative - the Jan Swasthya Rakshak scheme - is a significant development against the background of a series of similar initiatives all over the country and the world. This has now been in existence for 22 months.

A critical overview of the scheme at this juncture will not only be an important mid course assessment of the initiatives but will also be an opportunity to assess the experience against the backdrop of a wealth of previous experience so that we do not reinvent the wheel but ensure that the scheme evolves in a way most suited and relevant to the local realities and challenges.

#### **The challenge before us**

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

*-- Srivastava Report, GOI, 1975.*



## 2.1 Brief profile of Madhya Pradesh

**MADHYA PRADESH**

▼ - DISTRICTS SELECTED FOR FIELD STUDY.

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, 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. (Appendix 3).

## 2.2 Objectives of the Jan Swasthya Rakshak Scheme

1. To improve the health in rural areas, by providing a trained worker who can give first aid care and treat small illnesses scientifically, in the village itself. Efforts are to be made to have both males and females in this scheme.
2. To provide a trained worker in the village who can assist in the implementation of National Health Programmes and health schemes of the Government.

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

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

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

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

Besides the provision of health services to rural areas, by recommending that only unemployed, educated youth who belonged to families below the poverty line be chosen for training, the scheme hoped to provide an occupation to atleast some of them and



thereby a means of livelihood. All financial assistance for training, including stipend, contingency and loans for setting up the clinic are to come from the IRDP and the health department has to impart the training and provide all necessary technical assistance.

### 2.2.1 Community Health Worker / Guide / Volunteer

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

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

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

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

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

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



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

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

### 2.2.2 JSR Scheme versus CHW scheme

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

1. increased duration of training - six months (it was three months in the CHW Scheme);
2. increased stipend from Rs.200-00 to Rs.500-00 per month during the training period with funds coming from TRYSEM (it was Rs.200/- in the CHW scheme and the funds were not from TRYSEM);
3. no monthly honorarium is to be paid to the JSRs. Instead, JSRs who successfully complete the course are to be given a registration certificate which will allow them to 'practise' in the village which nominated them for JSR training. Guidelines which state that they are to provide curative care only for illnesses mentioned in their training manual and for which they have been given training as well as the drugs they can use for treatment of these minor illnesses have been established. To assist in the establishment of their practise, JSRs who successfully complete their course are eligible to obtain a loan with subsidy from IRDP under TRYSEM;
4. only those who have passed upto 10th standard are eligible for JSR training (CHW scheme permitted those with formal education upto 6th standard and above);
5. whenever qualifications and other criteria are similar, women are to be given preference over men in the selection process.

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



TABLE 2 : Comparison between CHW and JSR Schemes

Criteria	CHW Scheme	JSR Scheme
Year	1977	1995
Training duration	3 months	6 months
Goal	one CHW/ 1000 population	one JSR / village
Eligibility	upto 6th Standard	upto 10th Standard
Stipend during training	Rs. 200 per month	Rs. 500 per month
Honoraria	Rs. 50 per month	Loan - subsidy
Practice	Informal	Certified
Content of manual (special)	<ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Minor Ailment by Ayurveda/Yoga/Unani/Siddha/Homeopathy/ Naturopathy/ Medicinal Plants (See Appendix 5)</li> </ul>	<ul style="list-style-type: none"> <li>• Working with community</li> <li>• Anatomy / Physiology</li> <li>• Dengue/Filariasis</li> <li>• STD/Blindness</li> <li>• Patient examination</li> </ul>

Further details of the present JSR Scheme are given in Appendix 3.

The aim of the present review was to assess the JSR scheme and suggest ways and means to improve the overall performance of JSRs in context of prevailing situation in State, where services of trained health personnel are not available at the time of need especially in rural areas.

### 2.3 Terms of Reference of the present review

- Document the **profile of the JSRs** in five districts in different regions of Madhya Pradesh.
- Examine the **process of selection of the JSRs** by the community.
- 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.
- Evaluate the system of examination** for certification of the JSRs and suggest modifications if necessary.
- Document in the randomly selected five districts of the state, the perception of the local community and panchayats of the services provided by the JSRs in their village.

- vi. Examine the functional linkages that JSR have with health staff after training.
- vii. Prepare final report to strengthen JSR scheme in Madhya Pradesh.

## NOTE

**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 practice 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. (Items v and vi of the TOR are therefore only indirectly addressed in the Review because of the local field realities and situation of the scheme at the time of this Review)**



### III. METHODOLOGY OF REVIEW PROCESS

The development of the methodology for this Review 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. Field Evaluation

- i. Identification of levels of administrative set-up;
- ii. identification of functional areas of study;
- iii. sources of data;
- iv. development of instruments;
- v. sample size and design;
- vi. collection of data; and
- vii. analysis and interpretation of data.

#### 2. Peer review of training programme

- i. Evaluation of training manual and programme objectives by NGO groups with prior experience in similar activities.

#### 3. Workshop of interested and key partners on field review report of JSR Scheme

- i. Workshop to discuss review findings

By adopting this three step methodology it was felt that inputs of a large number of individuals could be obtained in short time within the time and budgetary limitations.

### 3.1 FIELD EVALUATION

#### 3.1.1 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. Consumers and their representatives

### 1) Village level

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

### 2) Block level

- a) Block Development Officers
- b) Block Level Presidents

### 3) District level

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

Every 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 in some places which we surveyed, had left for the Congress convention at Calcutta which was being held at the same time, we were unable to elicit their views.

### 3.1.2 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 the 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.

### 3.1.3 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 and 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 3 : 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
	B.M.O.	9
	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

### 3.1.4 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 6a to 6g). A number of areas were common to some schedules. They were introduced to obtain information from different respondents on the same dimensions of the scheme.

The schedules contained structured and open-ended 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 semistructured interviews.

### 3.1.5 Sample size and design

The present review was being undertaken mainly to provide midcourse corrections and suggest ways and means to improve the overall performance of JSRs. In the absence of any regular monitoring system and because of the logistical limitations even though a structure was made the process was envisaged more as a qualitative review rather than a quantitative review. Within this limitation, the diversity and vastness of the state warranted our obtaining 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 five regions of Madhya Pradesh, two districts each were initially selected randomly. From these two districts, 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. In each of the PHC unit, effort was made to visit at least 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 training process at Piparia Block PHC also. The final list of Districts, PHCs and villages visited are given below:

TABLE 4 : Districts, Block Primary Health Centres and villages visited during the Review

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. Ater (Hamlet) 2. Johri Kotwal
Bilaspur	1. Balloda	1. Chhapra 2. Bachhao
	2. Pangad	1. Menhdi
Rewa	1. Govind Garh	1. Agdal
	2. Sirmor	1. Kirori 2. Rajgad
Hoshangabad	Piparia	1. Gadaghat 2. Alipar Kheda
Dhar	1. Nalchha	1. Panela 2. Patliyapur
	2. Sardarpur	1. Badadi 2. Karchi/Ruprel



Below is a short summary of the selected districts.

### **District Profile:**

A District profile of Madhya Pradesh was compiled from secondary sources of data, to locate the findings from the sample districts in a broader state context.

- \* All the selected districts visited except Hoshangabad had a higher percentage of rural population as compared to the percentage of 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.

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)
<b>Madhya Pradesh</b>								
<b>Total</b>	66,181,170		28.85	14.55	23.27	931	37.2	5.0
<b>Rural</b>	50,842,333	76.82	19.73	14.80	28.82	943		
<b>Urban</b>	15,338,837		58.92	15.72	4.87	893		
<b>Districts</b>								
<b>Bhind **</b>	967,857	79.40	23.55	22.17	0.15	813	39.0	5.8
<b>Rewa **</b>	1,318,172	84.77	22.81	15.38	13.56	946	40.9	5.8
<b>Dhar **</b>	1,187,702	86.86	15.64	6.85	59.45	960	37.2	5.1
<b>Vidisha **</b>	775,303	79.90	19.54	21.68	5.23	872	40.1	5.6
<b>Hoshangabad **</b>	920,695	72.66	26.32	16.84	22.20	904	38.0	5.4
<b>Bilaspur **</b>	3,148,763	83.00	20.92	19.12	26.33	990	36.7	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) - Bibliography (18)

### 3.1.6 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.

### 3.1.7 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. Information was thereby obtained on the selection process, training process, training manual, examination system, profile of JSRs and views of various categories of people on the scheme and its objectives.

## **3.2 PEER REVIEW OF TRAINING PROGRAMME**

The training manual and programme objectives were distributed to a large number of non-governmental / voluntary organisations with experience in similar activities for their review and comments. Their comments were analysed and collated. By this method, inputs of a large number of individuals (See Supplement) were obtained on the scheme.

## **3.3 WORKSHOP OF INTERESTED AND KEY PARTNERS ON REVIEW REPORT OF JAN SWASTHYA RAKSHAK SCHEME**

After the review in the field, a preliminary report of findings was prepared. This was presented to and discussed in depth amongst an invited group of participants and key players, which consisted of representatives from the Madhya Pradesh government, Health Department, IRDP, District administration, UNICEF-Bhopal, and invited NGOs (Appendix - 7) at a workshop arranged specifically for this purpose. The comments, suggestions and recommendations of these group of participants are mentioned in depth in the section "report of the discussions of interested and key partners".



## 4. FINDINGS

During our Review visit to the various districts, we were able to contact a total of 101 JSRs who belonged to either the first or second batch of trainees. Given below is a profile of the JSRs included in the study and from whom various details and responses were elicited. While this profile gives us an idea of various characteristics of the JSRs included in the study, care must be taken not to extrapolate these findings to the wider population of JSRs because of the nature of the sample studied.

### 4.1 PROFILE OF JAN SWASTHYA RAKSHAKS (included in the Review)

#### 4.1.1 Age and Sex distribution

TABLE 5 : Age and Sex distribution of JSRs who were contacted during review exercise.

Age (Years)	S E X		Total	Percentage
	Female	Male		
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

16.8% 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).

#### 4.1.2 Selection of Females : some problems

The sample of 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);
- \* the elders do not permit them to seek work outside the house;
- \* it is not safe for them to travel alone and there might be times when they may have to travel alone at nights;
- \* no hostel facilities at training venues;
- \* they get married at an early age and are not permitted to volunteer for this work;

- \* they have small children and they have to take care of them as well as the other family members.

#### 4.1.3 Distance from village of JSR to training places (Block PHC)

TABLE 6

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	31	30.8
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 - a further deterrent to women participation, 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. If hostel facilities are arranged at the site of training these problems could be obviated.

#### 4.1.4 Distribution of JSRs by District and batch of training

TABLE 7

District	Batch		Total
	I	II	
Vidisha	0	4	4
Bhind	5	8	13
Rewa	16	30	46
Bilaspur	20	14	34
Dhar	1	3	4
Total	42	59	101

41.58% of the JSRs belonged to the first batch of trainees and 58.42% to the second batch. 45.54% of the JSRs in our sample were from Rewa district and 33.67% from Bilaspur. The number of JSRs from each district varied because of various reasons like difficulty in contacting JSRs, non-interest, being away on some other work and non-communication of information to JSRs by district and block health authorities.

#### 4.1.5 Marital status of JSRs

TABLE 8

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.

#### 4.1.6 Education status of JSRs

TABLE 9

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.

#### 4.1.7 Occupation distribution of JSRs

TABLE 10

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 a large percentage (37.6%) did not have any occupation.

All JSRs were resident in the village selected.

## 4. 2 SELECTION PROCESS

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, we found that 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 publicity.

TABLE 11 : Sources of Information on JSR Scheme (for JSRs)

Source	Frequency
Gram Panchayat	67
Sarpanch,	33
Radio	3
Newspaper	2
Panchayat Secretary	1
TV	1
TOTAL :	101

67 heard of the JSR Scheme at the Gram Panchayat; 33 were given information by the Sarpanches. Media was a source in very few cases (6) indicating possibly its limited use and reach.

The JSR nominee from 8 (40%) of the villages that we visited, were 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. However, information provided by JSRs given in the following table reflects that, 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.

TABLE 12 : 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

Some areas adopted novel methods to select JSRs. Thus to obtain the most ideal person, in Pipariya PHC region, Gram Swasthya melas (health camps) were arranged in the villages of the district where adequate information was then given to the village leaders and villagers about the scheme and the need to select the most appropriate candidate. This greatly helped in identifying the right candidates.

It was not that all selections were arbitrary. In some villages, the Gram Sabha did meet and chose the most appropriate candidate. It must be kept in mind though that very often the attendance in the Gram Sabhas is extremely poor and in reality a handful of leaders take most of the decisions. The poor attendance at the Gram Sabha thus becomes a stumbling block to free and fair selection - by being absent most villagers were unaware of the scheme or its objectives and out of ignorance of the scheme, the most appropriate candidates do not apply. 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 specially if the villagers are not going to benefit from the scheme because of a disinterested and poorly trained JSR.

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. Opinion of the community and of teachers, anganwadi workers or other government functionaries who are familiar with the residents of the village should be taken into consideration. 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.

### 4.3 TRAINING

#### 4.3.1 Training of trainers

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 Indore, Rewa or Bhopal. In one of the PHCs, since the BMO could not attend, the medical officer was deputed.

The training in these centres 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 “don’t’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 effect content far overshadowed the focus on process of training.**

In none of the 11 Block PHCs visited, did the trained person conduct any training for other JSR 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 at PHCs 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).

### 4.3.2 Training at PHCs

The JSR training programme clearly outlined the schedule of training to be followed (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, a very practical proposition but with many limitations.

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. None of the other centres received any contingency funds for the purchase of training materials.

All PHCs were able to identify a room for training purposes which could accommodate 30 people but lacked adequate facilities for conduct of proper training. 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 and none 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 an **urgent need for providing 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. The respective staff explained /



demonstrated the various activities conducted in each of these sections to the trainees. The trainees were taught how to dispense drugs, 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. At least 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. What we fail to understand is, if this is so, then why should they be trained on injection giving methods and why were they 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 boiled and 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.

### 4.3.3 View of JSRs on training process

Analysis of the view of the JSRs on various aspects of the training process are given below:

#### Training Methodology

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

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

- \* All JSRs felt that the training subjects were properly addressed and they were free to discuss with their teachers any problem they faced.
- \* Only 72.3% (73) of JSRs mentioned that they received written material ( handouts, notes, etc.) during the training process.
- \* 87% (88) of JSRs found the material that was provided to them as handouts useful in their training.
- \* 93% (94) JSRs mentioned that they were satisfied with the training received.
- \* 97% (98) JSRs said that training addressed local needs.
- \* 68.3% (69) felt that the training was appropriate for the perceived functions of JSRs.
- \* 91.1% (92) JSRs expressed there were sufficient number of trainers during their training process.

TABLE 13 : 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 inadequate.

TABLE 14 : 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 15 : 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 16 : 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. 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 in gynaecologic disorders.

TABLE 17 : 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 18 : 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

When asked to grade the training process, 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.

The JSRs opined on measures for improving the training process. These 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.

#### 4.3.4 Suggestions of 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 Examination 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 distributed 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 and the BMOs should be clearly explained about this).
- ◇ Simplify administrative procedures. Right now it has too many authorities and levels involved in its control which affects training.

#### 4.4 TRAINING MANUAL

##### 4.4.1 Issuance of training manual

The training manuals were not obtained in time for the first batch in 6 (54%) 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 less than 30%). In all the centres, manuals were obtained in time for the second batch of trainees.

##### 4.4.2 Comments of trainers

All 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.

#### 4.4.3 Comments of JSRs

TABLE 19 : 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.

#### 4.5 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 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.

##### 4.5.1 Pattern of Examination

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 were told to photocopy adequate numbers for all JSRs taking 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 in the various districts. Since JSRs of each district were evaluated locally, one reason for this could have been the criteria adopted for marking. To avoid bias and for uniform marking, 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 the marking is uniform.

#### 4.5.2 Views of JSRs

TABLE 20 : Views of JSRs on the Examination 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 examination process while 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 examination 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.

TABLE 21 : 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).

#### 4.5.3 Views of trainers

The trainers mentioned that both the examination types (I and II) had their advantages and disadvantages. They also felt that both types were not ideal and a better system needs to be evolved. In all the centres, the trainers mentioned the logistic problems faced in the conduct of the second examination (photocopying) and inadequate funds allotted for the conduct of the examination. The high failure rate of the JSRs in the first examination 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.

#### 4.5.4 Results of review of knowledge of JSRs by evaluation team

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 and did not cover all chapters of the manual equally (See Appendix 8c). 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 10). 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 22 : 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

35.23% of the JSRs received less than 50 marks.

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

The review also revealed the following knowledge attitudes and practices of the JSRs for certain conditions.

TABLE 23 : 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. Prevention needs to be emphasized in the manual, training of trainers and in the teaching/learning of the trainees.

## 4.6 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 supervision 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.

### 4.6.1 Perception on objectives

TABLE 24 : The trainers mentioned the following as the 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.

### 4.6.2 Expectations from JSRs

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 from the JSRs.



#### 4.6.3 List of ailments identified by trainers which could be treated by JSRs.

TABLE 25 : 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 of training.

#### 4.6.4 Functioning of the JSR scheme

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%) did mention that they do receive referrals from JSRs who have completed training.

According to the trainers, all the JSRs took part in the Pulse Polio campaign and some even in the eye 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 detrimental to the scheme in the long run”. This group also mentioned that non-release of funds and contingency amounts allotted for training purposes, decrease the quality of training given as **teaching aids and audio-visual materials can not be purchased and used for training purposes**.

#### 4.7 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 the 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.

From the above findings and recommendations, 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. Some suitable educational materials have already been produced by local groups like the MP Voluntary Health Association (see Appendix - 12). Similar materials should be identified. 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.

#### 4.8 PERCEPTION OF COMMUNITY MEMBERS ON THE JSR SCHEME

80% communities surveyed were not aware of the scheme, its objectives, its functions and only in 15% communities the person selected as JSR from their village was known to the members contacted.

Two (10%) communities selected the CHW of the old scheme for JSR training.

Only 4 (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.

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

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

#### 4.9 PERCEPTION OF COMMUNITY LEADERS ON THE JSR SCHEME

##### i. Village level leaders

In 5 (25%) communities, even the panchs were not aware of selected JSR.

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

Leaders of 6 (30%) communities said they have health committees. Further questioning revealed that these committees do not meet frequently and separately, but their meeting is held along with the general meeting of Gram Panchayat.

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

All members expressed that JSRs need encouragement in their activities but they were not sure how this could be achieved.

In 12 (60%) communities, community leaders said that JSR met them after completing the training.

Some 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 visited, the Zilla panchayat president was 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 (Appendix 11) 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.

#### 4.10 PERCEPTION 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 besides providing a trained resource in the villages itself. At present, even for minor health problems, the villagers have 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 JSRs 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 at the top, can have severe repercussions 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 is very important in the 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.

#### 4.11 PERCEPTIONS OF THE PRESIDENTS OF DISTRICT HEALTH COMMITTEES ON JSR SCHEME

Because of the Congress party 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 practice, 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 in the MPW cadre.

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 free instead of being "bought" by the JSRs.

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 and the villagers will come to "know them" and seek their services. She felt that 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 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 on 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 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 there 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.

#### **4.12 FINDINGS OF THE PIPARIYA BLOCK REVIEW**

As mentioned earlier, we visited Pipariya block CHC in Hoshangabad district because we were given the information that there was a whole batch of only female JSRs who were undergoing training here. Since in all other places, it was extremely difficult to get female volunteers, there being not more than 2 or 3 in a single batch, we were curious to know how villages in Pipariya block were able to stimulate so many female volunteers. This was of direct relevance to the programme as there is a large component of RCH in the JSR scheme and female JSRs are therefore more suited to the programme needs.



During our visit, we found that two types of training being given here. There was a small batch (17) of JSRs comprising male and female trainees and another batch of exclusive female trainees undergoing RCH training. The second batch of trainees belonged to a pilot project which was being implemented in a few selected districts all over India and funded by an international donor agency, the objectives of which were quite similar to the JSR scheme but which focussed exclusively on the provision of RCH services. The duration of training was much longer (about 1 year), the stipend better and they were all provided with a functional kit very early in the training period.

The socio-cultural dynamics in Hoshangabad district are quite different from the northern districts of Madhya Pradesh. Even then, it was interesting to hear about how the training programme managed to rope in female volunteers from all the target villages. The procedure adopted by the district health office and Pipariya CHC was to organize a two day "Swasthya Mela (health camp)" in each village during which they gave adequate information to the village leaders and villagers about the scheme and the need to select the most appropriate female candidate only for the successful implementation of the programme objectives for the ultimate benefit of the villagers. Surprisingly, by this process they were able to attract volunteers from each village. A marginally better stipend, assured hostel facility and a higher overall female literacy in the district may have been additional reasons. Since we were unable to visit the villages of this project we were unable to obtain the views of the villagers and village leaders. However, our discussions with the female JSRs as well as the staff of Pipariya CHC revealed that it was the "health camp" which was largely responsible for stimulating so many females to volunteer for this scheme.

As far as the training process was concerned, there was not much difference between the training being given in Pipariya CHC and other PHCs. Overcrowding, lack of adequate facilities, shortage of teaching staff and inadequate involvement of all CHC staff in the training process were some of the major problems encountered. On the positive side was a greater involvement of the field staff in the training process, construction of a big shed for exclusive use of the training process, hostel facilities and the provision of kits to all trainees during the training process itself. A lot of this was possible because of timely and extra funding (in addition to the JSR training funds) provided by the donor agency. Our talks with the trainees revealed the same aspirations (absorption by the Government - permanent, salaried jobs) and similar worries and problems as trainee JSRs in other PHCs. In addition, they were quite worried as to why no examination was yet conducted for them (even after 1 year) and what sort of certificate would they be given (? similar to JSR; ? permission to practice, etc.). The other major findings were as follows:-

- ◇ Age distribution of these trainees is similar to that of JSRs (in our sample) except in the age group <20 years where RCHWs are 18% compare to 1% in the JSR sample.
- ◇ Distance from Pipariya to respective villages of RCHWs was similar or even more when compared to other JSRs. But this was taken care of by providing hostel facilities to trainees at Pipariya CHC.
- ◇ Largely belonging to the younger age groups, 40% of RCHWs were unmarried as compare to 13% JSRs.



- ◇ 85% RCHWs had studied upto SSLC. Some had higher qualifications. 15% had studied upto middle school only.
- ◇ The sources of information for RCHW training was similar to that of JSRs i.e., Gram Panchayat and Sarpanch except in 5% cases where health workers and literacy mission people provided the information.
- ◇ 70% RCHW graded their training programme as very good to good.
- ◇ There were a lot of training materials available unlike in other PHCs. A video-TV, flipcharts and similar training materials were used to impart RCH training.
- ◇ The trainees felt the need of more training in the conduct of labour, gynaecological problems, antenatal care, management of malaria, leprosy, microscopic investigations and IV administration.

The major lesson learnt by our visit to Pipariya CHC was that given enough interest and provided enough efforts were made and necessary facilities provided, it is possible to stimulate women with the necessary qualifications and criteria to undergo JSR training.

#### 4.13 PEER REVIEW OF TRAINING PROGRAMME

As mentioned in the methodology, the manual and programme objectives were circulated to NGO groups with prior experience in similar activities for their comments. Their feedback is summarised in this section.

##### A. GENERAL COMMENTS

Most of the reviewers mentioned that the launching of a state-wide village health worker programme in today's context is definitely a commendable step taken by the Government of Madhya Pradesh and this highly needed scheme deserves to be implemented extensively.

However, most reviewers felt that the creation of this new cadre is not conceptualized or if it is then it has been done very hazily and also there is a lack of clarity about the roles and responsibilities of the JSRs.

The other issues raised by the peer group are given below:

- \* the concept of such a worker and the new stated focus on RCH are very interesting and encouraging. However, the actual contents of the job description and the manual revealed that there was not much that was new about the contents and the role of the JSR vis a vis the health care system was still that of a subordinate helper at the village level.
- \* Jana Swasthya Rakshaks cannot work in isolation primarily because they do not enjoy credibility as a healer. The priority health needs of the people cannot be fulfilled by

them. They can function as link workers in the reflected glory of the credible health care delivery system.

- \* A crash curriculum in the indoors, does not imbibe required skills. They learn by doing. The inwork training adapted to the local situation by a visionary trainer is required. Abstract learning is difficult for them.
- \* Preparing a handbook for a skills list with photographs/illustrations as a compendium to the manual may prove helpful.
- \* The legal status of CHWs using allopathic medicines needs to be studied.
- \* The MP PHCs have to serve large populations and there is general lack of enthusiasm for CHWs at that level. The six months training model is expensive and poor on cost-benefit. Given a choice, it would be more worthwhile to develop distance training material, interactive training tools at some institutes and short-term contact training facilities for skills and attitude training. The training could be staggered with inbuilt evaluation. Also, however urgent the task, the backroom preparations have to be thorough and effective, otherwise the end result would be one more wasted opportunity.

## B. COMMENTS ON THE MANUAL

The curriculum-cum-manual has been prepared the first time by any government machinery so soon and with a different vision than the usual vertical programme based technical skill development manuals have. This sincere effort is a very credible and positive sign. However, its hastiness reflects in the overall nature of the manual.

The manual should assist the JSRs to tackle a wide range of health related problems in their communities, serve as a reference manual and assist them to function effectively in the future. It should enable each JSR to acquire a range of understanding and skills to carry out various health activities in her/his community. When seen in this context, most peer group reviewers found the manual falling far short of expectations and suffering from many deficiencies at every level. Their comments are summarised in the table given below.

No.	Issue	Comments
1.	Good aspects	The first aid section, child nutrition, domestic cleanliness etc., are treated in a better manner than other sections.
2.	Approach to the role of JSR	Such a manual would be expected to have a decisive influence in defining the role of the JSR and shaping the attitudes of thousands of future JSRs. What comes across is that the JSR is a peripheral govt. functionary whose main job is to implement govt. health and F.P. programmes and to keep records. Caring for the sick is a very low priority and awareness generation on health issues or articulating the needs of one's community relation to health issues is not even mentioned. The section on working in the community never mentions anything about trying to understand the priorities of people vis-a-vis health or the problems they face with the Govt. health infrastructure.  This is no mention of the special relevance and role of the JSR as a community health worker, and there is no clarity about the roles and



		<p>responsibilities of the JSRs. The JSR appears as the lowest rung of government health service rather than a front-line person involved in promoting health in her/his community.</p> <p>In the tradition of our educational system, there is a lot of emphasis on acquiring (largely abstract and often irrelevant) knowledge, and very little emphasis on practical skills and not even an attempt to deal with attitudes.</p>
3.	Contents	<p>Inadequate, especially clinical chapters. The structure of the book is disjointed and there is extremely uneven level of detail regarding various topics. Human biology needs trimming of some areas and addition in certain areas. There is no balance between state driven health services and the demand driven services; the former are more than the latter. If they would "practice" then they would do <u>more</u> of what they were trained <u>less</u>.</p>
4.	Objectivity	<p>Nowhere have clear learning objectives been defined and so the text is not fine tuned to the needs and often much material is given without clearly defining its relevance. It overshoots or underserves the purpose of most topics. Ideally, each chapter should start with learning objectives and a brief introduction.</p>
5.	Approach to health and disease	<p>The entire approach to understanding health and disease is extremely piecemeal and superficial. One repeatedly gets the impression that the JSR is just supposed to follow set procedures or take adhoc measures rather than creatively thinking to make diagnosis, identifying health problems in his/her village or understanding disease in either an individual or community. Thus even the understanding of the human body and disease laid out in the book suffers from serious deficiencies.</p> <p>There is not even a mention of basic concepts like infection, immunity, inflammation which are essential for an elementary understanding of disease and healing.</p> <ul style="list-style-type: none"> <li>* Categories of micro-organisms are mentioned (eg., viruses, bacteria) without ever describing what they are, how they are seen, etc. Such a simple and practically relevant concept like : by and large bacterial diseases can be treated by anti-microbials whereas common viral diseases cannot; is never mentioned.</li> <li>* The fact that much disease is caused by social conditions and factors is never dealt with systematically; where environmental causes are mentioned it is in a largely victim - blaming and condescending fashion (eg., chapter 5).</li> <li>* Anatomy, physiology and epidemiology should be taught with the respective health problems rather than as separate topics as in Chapter 3 and 4.</li> <li>* Similarly, what health education will have to be provided to the patients, patients' relatives and the community should be covered with the respective health problem.</li> <li>* There should be a separate chapter on common gynaecological problems like white discharge, excessive bleeding, etc.,</li> </ul> <p>Apart from minor ailments that can be treated by a CHW, there must be advice on what CHW must do in various serious/moderately serious illnesses at the village level as first aid. There are atleast 25-30 important illnesses in which CHW has some role of detecting diseases early, limiting damage, follow up. There could be a section on what to do in such matters. Detection of hypertension, diabetes, PID, Peptic ulcers, cancers, mental</p>

		<p>illnesses, tuberculosis etc., must be prominently discussed, not just mentioned.</p> <p>There is need to orient CHWs on geriatrics, herbs in health, occupational medicine, village toxicology (first aid), etc.</p>
6.	History and Examination	<p>The diagnostic system is totally absent. Without this, how is the person expected to practice "first contact care" is an enigma. The entire concept of a distinction between a symptom and a disease is never made which is the basis of making a diagnosis, even at an elementary level.</p> <p>History taking is dispensed of in a few lines (paradoxically under the heading - points for examination). There is no concept of presenting or major complaint nor special points to be enquired regarding particular complaints (eg., cough, pain abdomen).</p> <p>An extremely detailed protocol of physical examination, which one presumes is to be applied to all patients without discrimination is given in the manual. There is no mention of the distinction between symptom and disease (eg., fever vs. malaria) nor sign versus disease (eg., jaundice vs. hepatitis). Thus there is no clarity on how to approach a diagnosis and the entire description of physical examination does not seem to lead anywhere.</p> <p>The protocol for physical examination runs into two and a half pages without any demarcation into systems or prioritisation based on the patients presentation.</p> <p>There is absolutely no description on how to go about conducting any of the examinations; eg., of the throat, chest, abdomen. The JSR is just instructed to examine tonsils, thyroid, liver, spleen, lungs etc., without a clue of how to do this. The text is unencumbered by any explanatory diagrams.</p> <p>Taking of pulse is repeated at <b>three different places</b> in the protocol! On the other hand, simple points like examining the tongue for pallor, palpation of the abdomen for tender areas, pedal edema are not mentioned. The significance of any abnormality in the all important pulse, is never mentioned so it appears to be just a magical ritual to be followed for its own sake! In fact there is no guideline on interpreting any of the findings arrived at after the detailed rigmarole of examination. This chapter ends with a pedantic instruction to give more importance to detailed history taking than to physical examination. This is unfortunately contradicted by the authors themselves who devote exactly two lines to points to be enquired in history and devote two and a half pages to physical examination.</p>
7.	Clinical medicine and treatment	<p>The entire subject of clinical medicine for the JSR seems to be treated as the lowest priority even though it may be a high priority for both the community and the JSR. This is reflected in devoting just 6 pages to treatment of minor ailments whereas anatomy/ physiology runs into 22 pages and record keeping into 17 pages!</p> <p>There is a totally 'cookbook' approach of 'for this - do this' which is not only grossly inadequate but also instills irrational treatment practices from the very inception of training.</p> <p>There is a mixture of allopathic, ayurvedic, homeopathic and home remedies advised but none of these modes of treatment, let alone their integration, has been discussed anywhere in the book.</p>



		<p>Despite the previous detailed description of anatomy, there is no attempt to deal with diseases system-wise which would make it somewhat more logical. The reason for the particular ordering of ailments is obscure till one realises that the table is translated from an (english) alphabetically listed table of simple ailments starting with abscess and constipation and going upto vomiting and worms!</p> <p>In fact, there is no description of any of the diseases mentioned - which is the affected organ/system, what is the derangement, natural history, basis of treatment, complications etc. For a six-month full time course this seems to be grossly inadequate clinical information. There is no mention of many common problems like sore throat/tonsilitis, amoebic dysentery, pyoderma, infected wounds, trachoma, simple dysmenorrhea etc. The scanty and disjointed information given is also confusing and at times incorrect. Many things are treated simplistically, ear pain for instance. This could be an ASOM as well, which needs different treatment. Same thing about "khansi"; Management of this solely depends upon the underlying illness. All this needs to be specified otherwise the CHWs are likely to loose credibility.</p>
8.	Illustrations	<p>Highly inadequate, needs many more pictures, especially photographs. Many of the diagrams do not have labels and explanatory captions. Quality of diagrams needs to be improved.</p>
9	List of medicines	<p>Needs to be expanded (anusuchi 3). Information about each medicine has to be included in easy to read format. Reference should be made to the WHO-SEARO list.</p> <p>9a) List of medications to be used by the JSR:</p> <ul style="list-style-type: none"> <li>* This list does not contain most drugs recommended in Chapter 20 (whether correctly recommended there or not) : Magneisum Hydroxide tab., Menthol, Eucalyptus oil, Sulfacetamide eye/ear drops, Lashunadi Vati, Mahayograj guggulu, Coloi 6(?), Mag Phos 6, Benzoic Salicylic oint., Cyana 30, etc.</li> <li>* This list does not contain certain basic medications which can be quite useful for treating a range of ailments eg., Metronidazole, Aspirin/Ibuprofen, Mebendazole, Vit.A, Gentian Violet, etc.</li> <li>* This list contains certain drugs which are either hazardous or redundant and surprisingly, precisely these have been mentioned by brand name rather than scientific name (hopefully just an accident) : Analgin : A drug widely banned, for which safe and inexpensive alternatives exist. Avil : Does this refer to tablets or injections? What are the specific indications? Decadron : In either tablet or injection form what are the indications for use by the JSR? Are we not promoting irrational therapy by putting this on the basic drug list? Neosporin powder/oint. - Costs much more than, and is probably as effective as Gentian Violet or plain Neomycin.</li> </ul> <p>9b) <u>Herbal medicines</u>:</p> <p>Almost absent. Mentioned only in one or two places. Often it is difficult to endorse herbs in a govt. sponsored scheme. But this must be overcome with a consensus of Govt. Vaidyas and other experts.</p>

10.	Missing sections:	<ul style="list-style-type: none"> <li>* A chapter on the Public Health System : The staff and their functions at least at PHC and sub-centre levels, and some overall idea about National Health Programmes.</li> <li>* A more detailed chapter on basic epidemiology, linking it with preventive strategies and describing in some detail environmental and social causation of disease. (The present chapter is exactly 2 pages).</li> <li>* A chapter on local and traditional remedies or its appropriate integration in relevant chapters.</li> <li>* A chapter on basic pharmacology and some details about commonly used medications; some description on non-allopathic systems and home remedies.</li> <li>* A glossary with all the technical terms used in the book explained in clear Hindi.</li> <li>* Lacking. Some simple tools of diagnostics are mandatory if they are expected to do clinical work independently.</li> </ul>
11.	Role of CHWs in illnesses and procedures	There seems to be some confusion about what the CHW is expected to do about many things. For instance, there should be a clear direction as to which illnesses he/she should treat and what is the responsibility in other problems. If this approach is developed properly, many unnecessary details will go away and many vital details will demand inclusion. This needs to be planned.
12.	Disease description	Inadequate and sketchy. Readers must understand some intricacies rather than 'do as directed' (see typhoid, dengue, etc.) Another example is AIDS section - which fails to carry any details of the clinical features and gravity of the illness. Such descriptions serve little purpose.
13.	Technical errors	Some things seem to be wrong or missed in its real meaning, for instance on pp.109, Pregnancy toxemia is indicated to be an infection ( <i>Sankraman</i> ).
14.	Language and style	Needs to be rewritten in a more readable form. The language fluctuates between sanskritised, over by technical Hindi and technical English translated into Devanagari (often erroneously). There are attempts to use simpler Hindi also in a few places but by far and large, the penchant to use formal words makes the language lifeless, stiff and administrative.  Cryptic writing is no good for readers who are going to practice as health workers. Separate ideas should be presented in separate paragraphs.  There is no clear sequence of section numbers, headings/sub-headings in almost all chapters. There should be a clear style of headings, sub-headings and section headings and consistently followed numbering. The chapters should end with a brief summary. In general, the manual will need a lot of editing to make it simple and appealing.
15.	Layout	Monotonous! Needs to be made more lively and pleasant. Columns would break the text into readable sections. Type size is good but lacks beautification.
16.	Giving statistics	Speak for the village. National statistics is difficult to comprehend. For instance, see chapter on <i>Andhatva Niwaran</i> . How many cataract cases are expected in the village is more important than MP figures.
17.	Textual errors	Almost every page has some typing error. This needs to be taken care of.
18.	Follow-up, monitoring, Evaluation	There is no record format for CHWs clinic records. Proper supervision is not possible without this. Also, there is no mention of how drug supplies will be obtained and dispensed as well as the maintenance of drug-related records.



## V. SUMMARY OF KEY FINDINGS

### 5.1 OBJECTIVES

- \* In the Department of Health, the objectives of the JSR scheme were known to all. Those mentioned most often 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 readily 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 setback ultimately slowly leading to trained JSRs seeking other avenues of employment and income.

## 5.2 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.
  - \* Very little publicity was given to the scheme before implementation (only 3 out of 101 JSRs had heard/seen information of scheme on Radio/TV). No local communication methods were used to publicise the scheme prior to the selection process.
  - \* 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 /non-committed candidates" 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 (figures from PHCs are similar).

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
- \* Inappropriate selection (non-motivated, non committed) of candidates is leading to attrition of number of JSRs.

## 5.3 TRAINING

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

**There are no clear-cut objectives of learning at any level of training** (PHC, sub-centre, community).

- \* The training of trainers of this scheme though planned well 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 involved in the training process.
- \* 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 of JSRs during training 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, this training component 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 and superficial.

- \* 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). The technical and clinical quality of training were affected where BMOs did not participate actively and whole-heartedly.
- \* Many places held refresher classes and examination oriented training sessions.
- \* Advantages / disadvantages of District Training (as perceived by us).

## **5.4 TRAINING MANUAL**

- \* Some chapters (environment, personal hygiene) are informative and useful for trainees who will provide first contact care.
- \* There are hardly any diagrams/pictures/photographs to clarify things.
- \* None of the chapters have objectives of learning defined at the outset.
- \* Most chapters have medical orientation and not community activity orientation.
- \* The Anatomy, Physiology sections have a lot of unnecessary, detailed information for training at JSR level.
- \* There is poor emphasis on social, cultural preventive and promotive aspects of health and disease.
- \* There is no mention about inflammation - healing infection - immunity as basic defensive responses of human body. Without this, it is not possible to understand the supportive role of external interventions like drugs, immunisation, environmental interventions, etc.
- \* Discrepancies exist in some areas as in the drug list.
- \* The diagnostic system is totally absent. Since the JSRs are to provide curative service, this section is a must.
- \* The health education messages are sometimes incorrect and are inadequately emphasised.
- \* BMOs and the PHC staff found the manual to be comprehensive and good by far and large, and they had 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.

## 5.5 EXAMINATIONS

- \* Internal assessment : At most training centres, usually 3 to 5 tests were held at regular intervals on portions covered during that period. It consisted of objective, short answer 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 to be tough. It did not sufficiently examine what the candidates knew and there was inadequate evaluation of the skills required by them. It was set by medical college teachers and did not involve field based personnel.
- \* The second External Examination was found to be very simple (all will pass). This was the view of everyone interviewed. It was of the MCQ type.
- \* 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 and the 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.
- \* The question papers (second examination) had to be photocopied at the examination venues - thousands of pages, expensive, time-consuming, difficult process. Additionally, leakage chances were very high.

## **5.6 FUNCTIONS OF JSRs**

- \* None of the JSRs have set up their practice (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", (injection, IV based with liberal use of antibiotics of all generations).
- \* 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 are to certify. The CEO has still not signed in many districts.
- \* Not one loan has been sanctioned to date to JSRs in areas visited by us.
- \* JSRs do help in immunization activities, but their interest is waning.
- \* A few 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 to be carried out by them 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.

## **5.7 "FEE FOR SERVICE"**

- \* Except the old CHWs who have now received training, no JSR was found to be providing curative care.
- \* 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 and are very used to receiving "injection treatment" for all their health problems.
- \* 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.



## 5.8 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.

## 5.9 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 that is to be implemented in the whole state needs adequate lead time for appropriate implementation and also wide-scale publicity to create awareness. Unfortunately, the scheme was implemented within a very short period and hardly had any gestation time. Obviously this ruled 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 having superficial information about the scheme. This impedes their proper involvement in the scheme.
- \* None of the centres 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 centres 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 the training process.
- \* 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 received 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.

It is likely that the non-disbursement of stipend, contingency and training funds was due to a multiplicity of factors - lack of funds, low priority in TRYSEM, poor and delayed work of district health department, excessive bureaucracy and bureaucratic apathy.

- \* Manuals did not reach till quite some time for first batch. The second batch received it on time.
- \* Most 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 any future review of JSR services.

## 5.10 SOME CONCERNS

- \* Only 3 out of 24 (12.5%) functions of JSRs are curative based. The remaining 21 (87.5%) are preventive / promotive (non remunerative).
- \* The certificate to be given to JSRs, does not state that the JSR can "practise" (and therefore prescribe drugs). This could lead to problems later (the Pharmacy Association has already raised this issue).
- \* Continuing education and institutional support for improving the quality of JSRs by their constant professional enrichment has not been planned for.
- \* The attendance was poor and irregular in some centres. The main reasons were - festival time, farm work during certain seasons, long distances to travel, non-receipt of stipend and therefore no funds for bus tickets, lack of interest and lack of commitment.
- \* **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 practice.



- \* 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 planned breakdown may not always be useful or necessary 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. Also in many areas, officials are asking for expenditure 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 many 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.

## VI. REPORT OF THE WORKSHOP OF INTERESTED AND KEY PARTNERS (SEPTEMBER 1997)

The field study findings and recommendations were presented to a select group of invitees (Appendix - 7) following which extensive and in-depth discussions were held on various issues pertaining to the scheme as well as the problem faced in its implementation with the intention of streamlining its functioning. The items discussed ranged from ways to identify a set of objectives for the JSRs different from that of the MPWs to ways of legitimizing the entire experiment in the eyes of the medical fraternity who at present look at it with a certain amount of hostility.

### 6.1 Objectives and administration

None of the participants had any doubt that under the existing circumstances it is a highly needed scheme and deserves to be implemented extensively. However, the findings did reveal that the creation of this new cadre of health workers was not clearly conceptualized possibly due to the haste in its implementation. There was no clarity about their roles and responsibilities of the JSRs whether they are the lowest rung of the Government health hierarchy or the implementors of Government health schemes with a little bit of a need-based service or independent practitioners or combination of all? Clarification of this issue is likely to help in the reduction of hostility.

The operational process was also found to be riddled with problems - whether it was selection, training and certification or logistics of TRYSEM loan and kit supply. Worse, even though well-outlined in the training manual, there was absolutely no involvement or concern of any of the involved departments in the planning of future supervision/regulatory mechanisms or maintenance of regular contacts with the JSRs once they start practicing.

To facilitate better coordination and to streamline its functioning, the group felt that the programme should be located in the health department. The group recommended that the day to day programme management at the state level is to be guided by a Health Committee under the leadership of the Commissioner, Health Department. Other members of the Committee include representatives of:

- the Health Department
- IRDP
- Rajiv Gandhi Mission for the Control of Diarrhoeal Diseases
- Dept. of Women and Child Welfare
- Zilla Panchayat
- UNICEF; and
- representatives of people's organizations.

At the district level, a district level health management committee consisting of Zilla Panchayat President, the Chief Executive Officer/Collector, the President of the District Health Committee and the District Chief Medical Officer (Convenor) will oversee the functioning of this scheme. The task manager for supervision will be the Joint Director of the Health Department.



It was also decided that the programme objectives will be redefined with new job responsibilities and defined job charts for key functionaries.

## 6.2 LINKAGES

Till date, no efforts have been made for inter-sectoral coordination and forming linkages with related sectors for gainful and appropriate use of available trained manpower (JSRs). The group recommended that efforts are to be made for consciously engineering linkages with professional bodies, medical bodies, NGOs and other relevant sectors. The availability of JSR services will be advertised to other sectors like sanitation, PHED, etc. and for any services rendered, the organisations will be asked to remunerate JSRs appropriately. It is hoped that by this, their image as professionals will be enhanced and would also ensure that they are not dependent on bureaucratic benevolence.

## 6.3 LOGISTIC SUPPORT

To strengthen the logistic support to the scheme, recommendations for training, finance, procurement of material, sanction of loans, communication, supervision, etc. and the funds required for all these activities needs to be reexamined. All efforts should be made by the State to ensure complete logistic support for the scheme. This support should also include redesigning of the kit and its timely delivery as well as networking possibilities. Exhaustive instructional and self-learning material as well as information on networking with various organizations will also be included in the kit so that the JSRs can refer to these when in need.

## 6.4 COMMUNICATION

One of the weakest sectors of the scheme, this will also require a thorough overhauling. To make the scheme known to a greater audience, detailed information about the scheme needs to be directly sent to all Zilla Panchayat and Janpad members with a request that they widely advertise the scheme in all their meetings and functions and during their contacts with the villagers. A handbook containing all information on JSRs needs to be prepared for the information of the public. Briefs on their activities should also be regularly issued in the "Panchayat Gazette". A certain ambience elevation through linkages with professional bodies and NGOs needs to be built. Resources for the above activities can be met through the creation of funds for communication activities at district level and state level.

All Gram Sabhas, Janpad Panchayats and Zilla Panchayats should be asked to discuss the JSR scheme, its functions and usefulness to the communities at their meetings so as to bring widescale awareness. Local communication means like folk music, Kalapathakas, etc., should also be made use of for advertising the scheme and for informing the public.

The group also recommended that to facilitate constant upgrading of knowledge and skills of JSRs, NGOs providing free health related literature and information for health workers be provided with a list of JSRs and their addresses to facilitate direct mailing.

## 6.5 TRAINING

Recognising this as the most important component of the scheme and a very important factor for its success and also realizing that the training conducted so far was far from perfect, the group conducted extensive discussions to analyze the problems, find solutions and suggest ways to improve the overall quality of training.

The training for the first two batches was conducted at the Block PHC / Subcentre. This was found to be unsatisfactory on various counts and it was decided that training be conducted at the District level only. However, as mentioned earlier, this may not be ideal and satisfactory on all counts. Various suggestions were made by different members during the group discussions on what would be the ideal method and venue to impart training to the JSRs. Consensus was difficult. However, keeping in mind the logistics involved and the problems and inadequacies at District level / Block PHC level for many aspects of training, a 4 phase programme based on definite guidelines for different field levels which can be adopted is outlined below:

### SUGGESTED JSR TRAINING METHODOLOGY

TABLE : 26

Nature of training	Phase	Venue	Period
Problem identification	Phase I	DTC	2 months
Community experience	Phase II	Back in village	1 month
Problem evolving	Phase III	DTC	2 months
Community experience and (PRA and final evaluation)	Phase IV	Back in village	1 month

To determine the contents of training, the group felt that the training needs should first be determined and the learning objectives should be based on task analysis, knowledge and skills analysis. For ideal training to be conducted, tutor and learner guides needs to be provided with all tasks clearly defined in a step-wise fashion. Also, the training needs to shift from content orientation to process orientation and a balance needs to be achieved between lectures and skills development, the present system being highly lecture-biased. It was suggested that adopting a problem-based and integrated approach would be more suitable for achieving this balance.

At most centres, the trainers were found wanting and this had a direct bearing on (the poor) quality of training imparted. It was felt that training of trainers should include training on adult education methods as this requires additional skills. A team of 4 trainers has been given this training in all districts under RCH programme and their services needs to be utilised for TOT of JSR scheme.

To encourage more female and tribal applications (for JSRs), efforts need to be made to provide all necessary facilities like hostels and secure training areas. Further, age limits should be removed and the education limit reduced to VIII standard pass.



The group also suggested that alternative possibilities of training on a turnkey basis should be investigated. Methods suggested were handing over training to locally capable and competent NGOs or mission hospitals wherever possible.

The training manual requires many changes as has been mentioned in the findings and recommendations sections. The group suggested that the task be handed over to a group of experts well versed in this activity.

Finally, to enhance the skills and to continuously upgrade the knowledge of JSRs, the group recommended that regular refresher courses should be arranged for them, preferably through an Open University.

## 6.6 CRITERIA FOR RECERTIFICATION

The group recommended that every successful JSR should be instructed to seek recertification on a periodic basis (preferably every 5 years). This should be made contingent on:

- ⇒ the approval of her/his continuation as a JSR by the Panchayat
- ⇒ having attended at least one refresher course
- ⇒ having attended at least 4 Gram Sabha meetings
- ⇒ her/his being active and carrying out designated functions.

## 6.7 SUPERVISION - MONITORING - EVALUATION (SME)

As often happens in many training programmes, once the training is over, all links between the trainee and the training group snaps, to the detriment of both groups. This is all the more unfortunate for a scheme like the present one where continuous upgradation of skills and further honing of acquired skills is so essential. Even though SME is inbuilt into the scheme, in practice, it is being completely neglected. The group discussed various ways by which this could be made a reality. Also, to make later evaluations more meaningful, it is very necessary that qualitative, quantitative and process indicators be evolved right from the beginning. All health staff should play a role in SME activities, specially the field based staff. As mentioned earlier, recertification would depend on the JSR attending refresher courses along with other criteria.

The SME component, much underplayed till now, needs not only to be strengthened immediately, but should also be made an integral part of JSR training and future activities.

## 6.8 EXAMINATIONS

Since training is being conducted at many centres scattered throughout the State, conducting a common end-of the course examination posed many hurdles. Bureaucratic delays further compounded the problems and the declaration of results was unduly delayed. As mentioned earlier, lack of clarity on their exact status in the health system resulted in the JSRs being examined in a "very medical and theoretical format" rather than on the (processes) practical skills and knowledge more appropriate to their field based functions.

- \* To overcome all the above mentioned problems, the group recommended that the conduct of the examination should be handed over to a “professional examination body” on a turnkey basis. In future, the examination could have a judicious mix of short answers, MCQs and simulated case studies.



## VII. RECOMMENDATIONS

Various recommendations are given under each heading earlier. Attention is drawn to them. The most important ones are highlighted once again.

### I. OBJECTIVES

1. To achieve the objectives of the scheme, it is necessary to *have further clarification* of job responsibilities, functions and functional linkages of the JSRs.
2. The JSR should ultimately become a *resource person* in health for the community *under Panchayat supervision*.

### II. ADMINISTRATION

For better coordination and streamlining of the functioning of the scheme, the programme should be located in the Health Department. There has to be a *health project committee* to organise the scheme, with appropriate *representations from all other related sectors*.

### III. SELECTION

1. Every effort should be made to select *more female candidates*.
2. *Widescale and effective publicity* should be given to the scheme at community level specially before selection of trainees.
3. To enhance selection of female candidates, *reduce education limit to VIII standard pass* and remove age limits, especially for women and tribal candidates.

### IV. LINKAGES

Develop *linkages with all sectors* (intra and inter sectoral) at the village level and at all other levels.

### V. LOGISTIC SUPPORT

*Adequate and timely availability of funds* for the smooth functioning of the scheme should be assured.

## VI. COMMUNICATION

Communication about the scheme should be enhanced at all levels

- village
- panchayats
- taluk
- district
- inter and intra departmental

*Use appropriate, effective, local media.*

## VII. TRAINING

1. The venue(s) of training should be *suitable for problem identification, community experience, problem solving* and other relevant aspects of training should be given their due consideration.
2. Learning objectives for each function of JSR should be clearly defined. The *training* should shift from content orientation to *process orientation using integrated and problem based approach*.
3. The *training manual needs to be rewritten*, rectifying the various lacunae pointed out keeping in mind the level of trainees and the knowledge and skills required for their effective functioning.
4. Regular refresher courses and continuing education preferably through an open University should be arranged ( *distance learning modules approach supported by contact workshops*).
5. To facilitate more female and tribal applications, *all necessary supportive facilities including hostels* should be *provided*.

### I. CRITERIA FOR CERTIFICATION

*Recertification on a periodic basis* (preferably every 5 years) by health trainers contingent on defined criterias should be made mandatory and linked to continuing education (see VII-4 above)

### II. SUPERVISION - MONITORING - EVALUATION (SME)

1. The SME component much underplayed till now needs to be strengthened and made an integral part of JSR training and future activities. Even though JSR will be under Panchayat, *technical*



*supportive supervision* can be built into scheme linked to the health training/health centres.

2. To make later evaluations more meaningful, *qualitative and quantitative indicators to measure process and impact* need to be evolved and data for these indicators collected in collaboration with JSRs, Panchayats and the PHC Health team.

#### X. EXAMINATIONS

1. The conduct of the examination should be handed over to *independent professional examination bodies* on a turnkey basis (this could be a credible NGO trainer or a medical college PSM department, etc.)
2. The examination should *assess process (practical skills)* and knowledge by a judicious mix of short answers, MCQs and simulated case studies.
3. To reduce wastage in training effort and to enable candidates, who had failed in the earlier examinations, *short courses* should be conducted to help them pass subsequent examinations.

#### XI. CORE PROJECT TEAM

A *core project team* should be formed who will train the trainers, monitor the JSRs in the field, ascertain feedback from JSRs, community representative and PHC health teams and continuously innovate and introduce improvements in the scheme.

#### XII. PEER SUPPORT

The Core Project team should be *supported by a peer group of trainers* from government and non government backgrounds who are training in the Hindi belt and who will form a supportive network - sharing experiences and innovations and helping in the constant reorientation of the training process and manual, to enhance their relevance and impact.

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## NATURAL REGIONS AND CHARACTERISTICS

Regions	No. of districts	Sample District	Characteristics
1. Western	15	Dhar, Vidisha	<ul style="list-style-type: none"> <li>◆ High migration to Urban;</li> <li>◆ Large scale of tribal displacement</li> </ul>
2. Maha Koshal	09	Hosangabad	<ul style="list-style-type: none"> <li>◆ Dry land farming</li> <li>◆ Predominantly tribal</li> <li>◆ Migration during lean period</li> </ul>
3. Chambal	05	Bhind	<ul style="list-style-type: none"> <li>◆ Caste tensions</li> <li>◆ Social oppression</li> <li>◆ Feudalism</li> </ul>
4. Bundel Khand	05	--	<ul style="list-style-type: none"> <li>◆ Land ownership highly skewed</li> <li>◆ IMR highest in the State</li> </ul>
5. Baghel Khand	04	Rewa	<ul style="list-style-type: none"> <li>◆ Heavy industrialisation</li> <li>◆ Displacement of tribals</li> <li>◆ Unskilled labourers</li> </ul>
6. Chhattisgarh	07	Bilaspur	<ul style="list-style-type: none"> <li>◆ Highly tribal population</li> <li>◆ Land holding highly skewed</li> </ul>



## APPENDIX - 2

### 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)
<b>Madhya Pradesh</b>								
<b>Total</b>	<b>66,181,170</b>		<b>28.85</b>	<b>14.55</b>	<b>23.27</b>	<b>931</b>	<b>37.2</b>	<b>5.0</b>
<b>Rural</b>	<b>50,842,333</b>	<b>76.82</b>	<b>19.73</b>	<b>14.80</b>	<b>28.82</b>	<b>943</b>		
<b>Urban</b>	<b>15,338,837</b>		<b>58.92</b>	<b>15.72</b>	<b>4.87</b>	<b>893</b>		
<b>Districts</b>								
Morena	1,359,632	79.48	14.88	19.87	6.83	826	41.2	6.0
<b>Bhind **</b>	<b>967,857</b>	<b>79.40</b>	<b>23.55</b>	<b>22.17</b>	<b>0.15</b>	<b>813</b>	<b>39.0</b>	<b>5.8</b>
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
<b>Rewa **</b>	<b>1,318,172</b>	<b>84.77</b>	<b>22.81</b>	<b>15.38</b>	<b>13.56</b>	<b>946</b>	<b>40.9</b>	<b>5.8</b>
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
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
<b>Dhar **</b>	<b>1,187,702</b>	<b>86.86</b>	<b>15.64</b>	<b>6.85</b>	<b>59.45</b>	<b>960</b>	<b>37.2</b>	<b>5.1</b>
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
<b>Vidisha **</b>	<b>775,303</b>	<b>79.90</b>	<b>19.54</b>	<b>21.68</b>	<b>5.23</b>	<b>872</b>	<b>40.1</b>	<b>5.6</b>
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

Particulars	Total Population	Rural %	Female Literacy Rate Rural	Rural			Total (Rural & Urban)	
				SC	ST	SR	CBR (1984-90)	TFR (1984-90)
<b>Hoshangabad **</b>	<b>920,695</b>	<b>72.66</b>	<b>26.32</b>	<b>16.84</b>	<b>22.20</b>	<b>904</b>	<b>38.0</b>	<b>5.4</b>
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
<b>Bilaspur **</b>	<b>3,148,763</b>	<b>83.00</b>	<b>20.92</b>	<b>19.12</b>	<b>26.33</b>	<b>990</b>	<b>36.7</b>	<b>5.0</b>
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

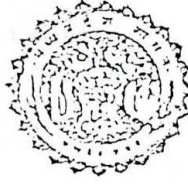
SC - Scheduled Caste    ST - Scheduled Tribe    SR - Sex Ratio    CBR - Crude Birth Rate  
TFR - Total Fertility Rate

\* \* Districts visited by Study team

Source : Health Monitor 1994 & 1995 (FRHS)



गोपाल शरण शुक्ल  
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### 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 करने 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 रक्षकों का चुनाव करना होगा।
- (2) जनपद पंचायत: जनपद पंचायतों को अपने क्षेत्र की ग्राम पंचायतों से जनपद पंचायतों से जन स्वास्थ्य रक्षकों का चुनाव शीघ्र करना होगा।
- (3) जिला पंचायत : जिला पंचायत को तत्काल सभी ग्राम पंचायतों एवं जनपद पंचायतों की बैठक बुलाकर योजना समझानी होगी, और प्रशिक्षणार्थी जन स्वास्थ्य रक्षकों का चयन पूर्ण करना होगा। जिला पंचायतें प्रशिक्षण कार्यक्रम की निगरानी भी रखेंगी, प्रशिक्षण के उपरान्त जन स्वास्थ्य रक्षकों के पंजीकरण का कार्य तथा समय-समय पर उनके निरीक्षण का कार्य जिला पंचायतों को करना होगा।
- (4) जिला ग्रामीण विकास अभिकरण : प्रशिक्षण के लिये धन राशि ट्राइसेम योजना से दी जायेगी, यह राशि जिला ग्रामीण विकास अभिकरणों द्वारा विमुक्त की जायेगी, प्रशिक्षण के उपरान्त पात्रता होने पर जन स्वास्थ्य रक्षकों को स्वयं का व्यवसाय प्रारम्भ 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 माइयूल 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 : विकास खंड स्तर पर प्रशिक्षण एवं परीक्षा आयोजित करने की संपूर्ण जिम्मेदारी विकास खंड चिकित्सा अधिकारी अधिकारी की होगी।
- (7) बहुउद्देशीय स्वास्थ्य: ग्राम स्तर पर जन स्वास्थ्य रक्षक सनस्त राष्ट्रीय स्वास्थ्य कार्यक्रमों में प्रभावी भूमिका अदा कर सकें, इसके कार्यकर्ता 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 हों.
- 1.2 गांव में ऐसे प्रशिक्षित व्यक्ति उपलब्ध कराना जो राष्ट्रीय स्वास्थ्य कार्यक्रमों एवं शासन की स्वास्थ्य योजनाओं को लागू करने में सहायता कर सकें.

### 2 अनिवार्य योग्यता

- 2.1 दसवीं परीक्षा पास.
- 2.2 उसी गांव का निवासी हो जहां उसे स्वास्थ्य रक्षक के रूप में कार्य करना है। उसी गांव का निवासी न मिलने पर ग्राम पंचायत 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 हों.
- 4.5 जिस ग्राम के लिए केवल एक ही योग्य आवेदक होगा उसका चयन प्रशिक्षणार्थी के रूप 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 की योजना के तहत स्वास्थ्य रक्षक का कार्य कर रहे हैं ऐसे व्यक्तियों को प्राथमिकता दी जाएगी तथा उसके लिए आयु सीमा का बंधन नहीं रहेगा परन्तु उन्हें अन्य योग्यताएं पूर्ण करनी होंगी.

4.6(घ) एक ही लिंग के आवेदकों में उस आवेदक को प्राथमिकता 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 होगा।

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 भेजेगें।

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 नहीं 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 शिष्यवृत्ति दी जायेगी।

## 6. परीक्षा

6.1 प्रशिक्षण के अंत में शासन द्वारा निर्धारित 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 प्रशिक्षण केन्द्र द्वारा पुनः छः माह का प्रशिक्षण दिया जा सकेगा। परन्तु उसे पुनः प्रशिक्षण के समय कोई शिष्यवृत्ति देय नहीं होगी. पुनः प्रशिक्षण के बाद प्रशिक्षणार्थी एक बार पुनः परीक्षा में बैठ सकेगा.

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 होने 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 अनुमति 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 प्रारूप '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 कर्तव्य

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 दम्पतियों की पंजी प्रारूप "त" में।
- 10.4 पेयजल स्रोतों एवं उनके शुद्धिकरण की पंजी प्रारूप "थ" में।
- 10.5 टीकाकरण एवं वजन पंजी प्रारूप "द" एवं "ध" 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 पश्चात् 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 स्वास्थ्य 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 स्वास्थ्य 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 कर्तव्य

1. समस्त राष्ट्रीय कार्यक्रमों में स्वास्थ्य 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 स्वास्थ्य 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 के समय ध्यान देने योग्य- पांच साफ-सफाईयों 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 विके।
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 स्वास्थ्य 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 दक्खों 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 रेफर 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 दंपतियों की अद्यतन सूची रखना तथा उन्हें परिवार नियोजन के साधन अपनाने के लिये प्रेरित करना।
20. गांव के सभी पेयजल स्रोतों में प्रति सप्ताह नियमित रूप से क्लीनिंग 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।

# **HEALTH SERVICES AND MEDICAL EDUCATION**

**— a programme for immediate action**



**REPORT OF THE GROUP ON  
MEDICAL EDUCATION AND  
SUPPORT MANPOWER**



# COMPOSITION OF THE GROUP ON MEDICAL EDUCATION AND SUPPORT MANPOWER

Dr. J.B. Shrivastav, Director General of Health Services.	Chairman
Dr. C. Gopalan, Director-General, Indian Council of Medical Research, New Delhi.	Member
Prof. V. Ramalingaswami, Director, All India Institute of Medical Sciences, New Delhi.	- do -
Dr. P.N. Chuttani, Director, Post-Graduate Institute of Medical Education & Research, Chandigarh.	- do -
Shri J. P. Naik, Member-Secretary, Indian Council of Social Science Research, New Delhi.	- do -
Shri C.R. Krishnamurthi, Director, Ministry of Health and Family Planning.	- do -
Dr. Sharad Kumar, Deputy Director General of Health Services (Medical).	Member-Secretary

(i)

## HEALTH SERVICES AND PERSONNEL IN THE COMMUNITY

4.01 The first assistance that any community needs in the form of health services should be provided within the community itself.

4.02 For some of these services, it is necessary to provide paid and trained professionals in public service. Some other services may be provided by fully trained professionals who are self-employed. It is, however, erroneous to assume that these services should be provided only by these two categories of professional staff. At the community level, what is needed most is not professional expertise so much as nearness to the community, its confidence, emotional rapport with the people, willingness to assist, low cost, and capacity to spare the needed time. It is, therefore, necessary that some of these services should be provided by the members of the family itself and also by part-time trained para-professional persons who operate on a self-employment basis. Even in societies which are affluent enough to provide all health services through fully-trained professional persons, either in public service or in self-employment, it is now becoming increasingly evident that the quality of life and of the health services will improve through the introduction of suitably trained part-time para-professional persons working on a self-employment basis. For developing countries whose resources are extremely limited, this method of providing health services is not only desirable but also inescapable.

4.03 It may be recalled that, in the past, almost all health services used to be provided by part-time para-professional persons from the community itself who worked on a self-employment basis. The practitioner of indigenous systems of medicine trained in a family tradition or the village dais who still perform the bulk of deliveries are instances of this practice. While the advantages of the



system, such as its closeness to the community or low cost, are obvious, its main weakness lies in the fact that the training provided is limited and unrelated to modern developments in the medical and health sciences so that it often leads to quackery. The modern system which employs only the fully trained persons on a professional basis is no doubt very competent from a technical point of view. But it lacks some of the emotional, psychological and social advantages of the traditional system and is so costly that we will not be able to universalize it. What is necessary, therefore, is to combine the good features of both the systems. If we carefully select the individuals and train them, according to the best knowledge and skills made available by the latest developments in medical and health sciences, a large number of people from the community itself would be available for providing the elementary health and medical services needed by the community. Such a programme would serve three important purposes: (1) It would create an agency which is close to the people, has their confidence and is economical to operate, for providing the immediate, simple and day-to-day medical and health services needed by the community; (2) it will also create the foundation on which a superstructure of fully-trained and professional referral services can be advantageously built; and (3) it would have created a pattern of medical and health services which would be qualitatively better than the present system and still remain within the financial resources that are likely to be available in the near future.

4.04 Various steps will have to be taken to organise the large number of para-professionals who will be needed in every community to provide the first essential, simple and day-to-day health and medical services. Aptitude for such work is often developed within the family itself through participation in the provision of such services or in attending upon sick persons. This motivation would have to be strengthened further through the education system which should provide a core of health education to every student and also require him, as a part of work-experience or social service, to nurse sick persons in his own family or outside and also to participate in the development of services of a promotive or preventive character. This will enable a large number of individuals to discover their own interests and aptitudes. Many of them may later become para-professionals by acquiring the specialised skills necessary and operate on a part-time self-employment basis or become full-time professionals within or outside the public services.

4.05 It would also not be proper to regulate the number of such workers. Such a step would lead to the creation of a scarcity and monopoly situation with well-known adverse consequences. It should, on the other hand, be open to any individual with the necessary aptitude, background and talent to acquire the necessary skills and to provide the services. In fact, the more such trained people in a community, the better for all concerned.

4.06 In every community, we should have trained local, semi-professional,

part-time workers of at least the following categories:-

(1) An adequate number of dais to provide maternity services (some of them could also be trained to provide the whole range of MCH services including family planning).

(2) A large number of family planning workers from among adults, young men, house-wives and public functionaries.

(3) Persons who will be able to dispense a set of specific remedies selected from all systems of medicine for ordinary, common ailments.

(4) Persons who have been trained in the skills needed in programmes for the control of communicable diseases and whose services can be harnessed readily in case of emergencies.

(5) Persons who can help to develop promotional and preventive health activities (especially those relating to improved nutrition, environmental sanitation, control of common diseases, yoga, physical exercises, and so on).

4.07 These skills could be imparted to selected young persons from the community who may have the necessary aptitudes. One important group which may be considered in this context is that of the primary school teachers who now number about 2.5 million and are present even in the remotest rural areas and who have considerable acceptability and status in the community. Another important group would be that of educated housewives. An increasing pool of educated women is now becoming available even in rural areas (the census of 1971 records 1.5 million women in rural areas who are enumerated as housewives or non-workers but who are educated up to matriculation and beyond) and these form a large and useful pool for the training of such workers, including those for family planning. These workers, it may be pointed out, need not necessarily be multipurpose.

4.08 We would like to emphasize the point that periodical retraining of these personnel is extremely important as well as to provide them with necessary guidance and counselling in their day-to-day work. The referral services should also be made available to them. In fact they should be looked upon as important links between the community and the trained professionals and the organized referral services.

4.09 This emphasis on the creation of a large band of semi-professional and part-time health workers in the community itself is proposed merely as a second-level supplementary personnel to fully-trained professionals and not as a substitute for them. Where doctors or other personnel trained in indigenous or modern system of medicine are



available, their services should be fully utilised, not only to provide health care to the people in the way best suited to each case, but also to train (or retrain) and assist other workers, honorary or part-time, of a semi-professional character. We visualize that these two cadres would work closely together in an integrated fashion, the para-professional personnel in the community relieving the trained professionals of the innumerable small things over which their time would otherwise be wasted and the trained professionals taking over the more complicated cases direct and also providing referral and guidance services to the para-professional people.

4.10 It would not be desirable to try to convert these para-professional workers into a cadre, to give them remuneration from State funds or to supervise them. This will alienate them from the people and convert them into petty bureaucrats with all their faults. The general policy should be to leave them free to work with the community on the basis of the trust and confidence they can generate. The investment of the State in the organization of this group of para-professionals within the community should be limited to the provision of training and retraining, free of cost, on as large a scale as possible and to the provision of guidance and counselling through health workers, the proposed health assistants and doctors. Where necessary, the State should make supplies of materials (such as specified remedies) available at reasonable prices and on an assured basis. The overall financial investment on all these items would be comparatively small; but the returns therefrom would be far greater.

4.11 These proposals might perhaps cause an adverse reaction in certain quarters on the ground that they would create, and let loose on the community, a large number of quacks who, in the long run, may do more harm than good. But a close examination will show that this will not be the case. The role assigned to these para-professional functionaries in the fields of promotive or preventive aspects of health and family planning are basically educational and are capable of doing immense good without any untoward implications. Some apprehensions may arise with regard to the role in curative aspects of health. But here, as we have emphasized, their function will be limited to the use of a few specified remedies for simple, day-to-day illnesses. There are also several safeguards in these proposals such as careful selection, provision of training and retraining, guidance and counselling and also periodical evaluation. Care has also been taken to ensure that they supplement the work of the professionals and not work in conflict or in competition with them. All things considered, we share no apprehensions on the subject and actually feel enthusiastic about most features of the scheme.

4.12 The details of several problems will have to be worked out before

the scheme becomes operational. For instance, we will have to decide upon

- selection criteria for workers;
- the duration and content of their training and retraining,
- the provision of guidance and counselling, including periodical evaluation,
- the preparation of materials for these personnel in simple terms and in all the Indian languages, and
- determination of the institutions where their training, etc., will be conducted, including the training for the trainers.

We recommend that these details should be worked out by the Director General of Health Services, once the programme is accepted in principle by Government.

4.13 It is obvious that the scheme cannot immediately be started all over the country. Similarly, it would also be futile to start it in a few areas only. What is needed is a fairly large beginning and a fairly rapid generalization in the light of the experience gained which should be evaluated continuously. We, therefore, recommend that

(1) All the details of the scheme should be worked out by the Director General of Health Services as early as possible;

(2) After early consultations with the States, the scheme should be finalized quickly and at any rate before the end of the current year;

(3) The necessary financial provisions for the scheme should be made in the Central and State budgets for 1976-77 as a centrally-sponsored scheme of the Fifth Five Year Plan;

(4) The work of the scheme should begin in selected areas in each State/Union Territory in 1976-77; and

(5) The scheme should be expanded to cover a fairly large part of the country by the end of the Fifth Plan and the entire country by the end of the Sixth Plan.

4.14 These bands of community-level health workers, once created, will form the links between the people at large and the multipurpose workers functioning at the sub-centres and the doctors at the PHC level. This will make a much better utilization of their time and energy possible.



Their training should, therefore, be adequate to ensure that, while they can freely offer services within a well-defined sphere of simple, urgent and day-to-day needs of the community, they would be able to decide when a case needs referral or consultancy from trained professional staff and take action accordingly without hesitation or delay.

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# **Manual for Community Health Worker**



Ministry of Health and Family Welfare, New Delhi



## FOREWORD

On 2nd October, 1977 a massive programme was launched by the Government of India for the delivery of health care in the rural areas through Community Health Workers. These workers are selected by the people of the community to which they belong, and they serve a population of about 1,000. They are trained to educate the people in the villages as to how to keep healthy and how to prevent disease by taking the necessary immunizations, drinking safe water, eating nutritious and clean food, maintaining personal and environmental hygiene, and utilizing the available services for maternal and child health, family planning and medical care.

Each Community Health Worker is provided with a kit containing a few simple medicines so that he or she can give immediate treatment for common minor ailments and provide first aid before referring the sick or injured to the Subcentre or Primary Health Centre for medical care.

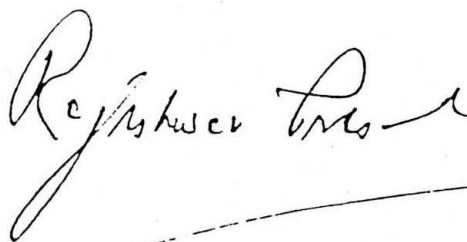
The Manual for the Community Health Worker is meant to serve as a guide and reference book for the Community Health Workers, to enable them to carry out the tasks which they have been trained to perform. It contains chapters on maternal and child health, family planning, nutrition and the control of communicable diseases including immunization and environmental sanitation. It also contains chapters on rendering first aid to the injured and simple treatment of minor ailments.

Our country has a wealth of knowledge in various traditional systems of medicine, and chapters on these systems have also been included in the Manual, so that in those areas where indigenous systems of medicine are popular, the Community Health Workers can be trained to use these traditional remedies.

The second edition of this Manual has incorporated suggestions received from several individuals and institutions. It also contains two additional chapters on Naturopathy and Medicinal Plants which, it is hoped, the Community Health Workers will find useful.

In the task of promoting and maintaining the health of our people, it is necessary for the Community Health Workers and the Government Health Workers to coordinate their efforts and to develop a deep sense of dedication to the community which they serve.

We have great expectations from the Community Health Workers and feel sure that they will serve as an important link in the chain of delivery of health care to our people.



(RAJESHWAR PRASAD)

Secretary to the Government of India  
Ministry of Health and Family Welfare

New Delhi  
October 2, 1978

## Activities of Community Health Worker

Note: A Community Health Worker will be expected to cover the population of a village or, if the village is a large one, a population of about 1,000. He/she will receive technical guidance from the Health Worker (Male/Female).

After training, the Community Health Worker will be able to carry out the following activities:

1. **Malaria**
  - 1.1 Identify fever cases.
  - 1.2 Make thick and thin blood films of all fever cases.
  - 1.3 Send the slides for laboratory examination.
  - 1.4 Administer presumptive treatment to fever cases.
  - 1.5 Keep a record of the persons given presumptive treatment.
  - 1.6 Inform the Health Worker (Male) of the names and addresses of cases from whom blood slides have been taken.
  - 1.7 Assist the Health Worker (Male) and the spraying teams in spraying and larvicidal operations.
  - 1.8 Educate the community on how to prevent malaria.
2. **Smallpox**
  - 2.1 Identify cases of fever with rash and report them to the Health Worker (Male).
  - 2.2 Inform the Health Worker of infants aged zero to one year requiring primary vaccination as follows:
    - 2.2.1 In the intensive area inform the Health Worker (Female).
    - 2.2.2 In the twilight area inform the Health Worker (Male).
  - 2.3 Assist the Health Worker (Male/Female) in arranging for primary vaccination.
  - 2.4 Follow up cases who have been given primary vaccination.
  - 2.5 Educate the community about the importance of primary vaccination.
3. **Communicable diseases**
  - 3.1 Inform the Health Worker (Male) immediately an epidemic occurs in his/her area.
  - 3.2 Take immediate precautions to limit the spread of disease.
  - 3.3 Educate the community about the prevention and control of communicable diseases.
4. **Environmental sanitation and personal hygiene**
  - 4.1 Chlorinate drinking water sources at regular intervals.
  - 4.2 Keep a record of the number of wells chlorinated.
  - 4.3 Assist the Health Worker (Male) in arranging for the construction of the following:
    - 4.3.1 Soakage pits
    - 4.3.2 Kitchen gardens
    - 4.3.3 Compost pits
    - 4.3.4 Sanitary latrines
    - 4.3.5 Smokeless chulhas.
  - 4.4 Educate the community about the following:
    - 4.4.1 Safe drinking water
    - 4.4.2 Hygienic methods of disposal of liquid waste
    - 4.4.3 Hygienic methods of disposal of solid waste
    - 4.4.4 Home sanitation
    - 4.4.5 Kitchen gardens



- 4.4.6 Advantages and use of sanitary latrines
- 4.4.7 Advantages of smokeless chulhas
- 4.4.8 Food hygiene
- 4.4.9 Control of insects, rodents and stray dogs.
- 4.5 Educate the community about the importance of personal hygiene.
- 5. **Immunization**
  - 5.1 Assist the Health Worker (Male/Female) in arranging for immunization.
  - 5.2 Educate the community about immunization against diphtheria, whooping cough, tetanus, smallpox, tuberculosis, poliomyelitis, cholera and typhoid.
- 6. **Family planning**
  - 6.1 Spread the message of family planning to the couples in his/her area and educate them about the desirability of the small family norm.
  - 6.2 Educate the people about the methods of family planning which are available.
  - 6.3 Act as a depot holder, distribute nirodh to the couples, and maintain the necessary records of nirodh distributed.
  - 6.4 Inform the Health Worker (Male/Female) of those couples who are willing to accept a family planning method so that he/she can make the necessary arrangements.
  - 6.5 Educate the community about the availability of services for Medical Termination of Pregnancy (MTP).
- 7. **Maternal and child care**
  - 7.1 Advise pregnant women to consult the Health Worker (Female) or the trained dai for prenatal, natal and postnatal care.
  - 7.2 Advise pregnant women to get immunized against tetanus.
  - 7.3 Educate the community about the availability of maternal and child care services and encourage them to utilize the facilities.
  - 7.4 Educate the community about how to keep mothers and children healthy.
- 8. **Nutrition**
  - 8.1 Identify cases with signs and symptoms of malnutrition among pre-school children (birth to five years) and refer them to the Health Worker (Male/Female).
  - 8.2 Identify cases with signs and symptoms of anaemia in pregnant and nursing women and children and refer them to the Health Worker (Male/Female) for treatment.
  - 8.3 Assist the Health Worker (Male/Female) in administering vitamin A solution as prescribed to children from one to five years of age.
  - 8.4 Teach families about the importance of breast feeding and the introduction of supplementary weaning foods.
  - 8.5 Educate the community about nutritious diets for pregnant and nursing women.
- 9. **Vital events**
  - 9.1 Report all births and deaths in his/her area to the Health Worker (Male).
  - 9.2 Educate the community about the importance of registering all births and deaths.
- 10. **First aid in emergencies**
  - 10.1 Give emergency first aid for the following conditions, refer these cases to the Primary Health Centre as necessary and inform the Health Worker (Male/Female).
    - 10.1.1 Drowning
    - 10.1.2 Electric shock
    - 10.1.3 Heat stroke
    - 10.1.4 Snake bite

## ACTIVITIES OF COMMUNITY HEALTH WORKER

- 10.1.5 Scorpion sting
- 10.1.6 Insect stings
- 10.1.7 Dog bite
- 10.1.8 Accidents.
- 10.2 Carry out procedures in dealing with accidents.
- 10.3 Keep a record of first aid given to each patient.
- 11. Treatment of minor ailments
  - 11.1 Give simple treatment for the following signs and symptoms and refer cases beyond his/her competence to the Subcentre or Primary Health Centre:
    - 11.1.1 Fever
    - 11.1.2 Headache
    - 11.1.3 Backache and pain in the joints
    - 11.1.4 Cough and cold
    - 11.1.5 Diarrhoea
    - 11.1.6 Vomiting
    - 11.1.7 Pain in the abdomen
    - 11.1.8 Constipation
    - 11.1.9 Toothache
    - 11.1.10 Earache
    - 11.1.11 Sore eyes
    - 11.1.12 Boils, abscesses and ulcers
    - 11.1.13 Scabies and ringworm.
  - 11.2 Keep a record of the treatment given to each patient.
- 12. Mental health
  - 12.1 Recognize signs and symptoms of mental illness and refer these cases to the Health Worker (Male/Female).
  - 12.2 Give immediate assistance in emergencies associated with mental illness.
  - 12.3 Educate the community about mental illness.



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(C.R. KRISHNAMURTHI)

Joint Secretary

Ministry of Health and Family Welfare

New Delhi  
October 2, 1978

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# 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 ?



क्या आपको प्रार्थीओं की संख्या के बारे में पता है ?

हाँ/ना

5. यदि हाँ, तो संख्या बताइए .....

रा 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 प्रशिक्षकों 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

## प्रशिक्षण 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 एड्स (क्लोक बोर्ड, फिलिप चार्ट, स्लाइड प्रोजेक्टर आदि) प्रयोग किये गये थे ? हाँ/ना
4. क्या आपके पास आपके कार्य सम्बन्धित सामग्री मौजूद है ? हाँ/ना

### ट्रेनिंग मैनुअल :

1. क्या ट्रेनिंग मैनुअल में स्थानीय जरूरतों के मुताबिक सामग्री पर्याप्त और ठीक है? हाँ/ना
2. क्या मैनुअल में दी गयी सामग्री ज.स.र. प्रशिक्षण के लिये सही है ? हाँ/ना
3. मैनुअल 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 ?

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

JSR (W)

नाम ..... आता ..... 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 दुखार 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, ब्लिचिंग 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

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Issues to be discussed in group discussion with Community Members

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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 <sup>you</sup> 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

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

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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

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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 SchemeGovt. of Madhya PradeshJuly - August 1997Issues to be discussed with trainersName 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?

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 is 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?

Ref: CHC: JSR/97

16th September, 1997

Fax. No: 0755 - 563623

Dr. Y.N. Mathur, Project officer, UNICEF, E-1/191, Arera Colony, Bhopal - 462 016,  
Madhya Pradesh.

### REVIEW OF JAN SWASTHYA RAKSHAK SCHEME - GOVT. OF M.P.

DATE : 18 - 19 SEPTEMBER 1997

VENUE : Conference Hall, Manipal Hospital, Airport Road,  
Bangalore - 560 017.

ORGANISED BY : Community Health Cell and Associates.

CONTACT PERSON : Dr. Pankaj Mehta, H.O.D, Community Health Department,  
Manipal Hospital (☎ : 5266441 - Extn. 270)

#### PROGRAMME

18th September 1997 (Thursday)	Session I	
	Chairperson : Dr. C.M. Francis, Consultant, Planning & Management, CHC	
9.30 a.m. - 10.0 a.m.	Welcome and Introduction of participants	CHC / Participants
10.00 a.m. - 10.15 a.m.	The Review Process - An Overview	Dr. Ravi Narayan, CHC
10.15 a.m. - 10.30 a.m.	Background to the introduction of JSR Scheme	Mr. R. Gopalakrishnan, Secretary to Chief Minister, Govt. of Madhya Pradesh.
10.30 a.m. - 11.15 a.m.	Presentation of Review Findings	Dr. Pankaj Mehta Mr. As Mohammad

11.15 a.m. - 11.30 a.m.	- COFFEE -		
11.30 a.m. - 1.00 p.m.	Discussions on the evaluation report	Participants	
1.00 p.m. - 1.45 p.m.	- LUNCH -		
	Session II Chairperson : Dr. D.K. Srinivasa, Consultant, Rajiv Gandhi University of Health Sciences		
1.45 p.m. - 3.00 p.m.	Presentation on other voluntary sector/Govt. experience in the provision of rural health care through voluntary health workers and their training process	Invited trainers from Voluntary sector/Govt. projects.	
3.00 p.m. - 3.30 p.m. 3.30 p.m. - 4.30 p.m.	- TEA - Implications of these experiences for the JSR Scheme	Participants	
19th September 1997 (Friday)	Session III		
9.15 a.m. - 9.45 a.m.	Review of Day One / process for Day Two	Participants	
9.45 a.m. - 10.45 a.m.	Group discussions on modifications required in the implementation of JSR scheme: Group 1 : Selection, training, evaluation Group 2 : Supervision, Administration, other issues	Chairperson/Rapporteurs for Groups 1 and 2 will be chosen by the group	
10.45 a.m. - 11.00 a.m.	- COFFEE -		
	Session IV Chairperson: Mr. R. Gopalakrishnan, Secretary to Chief Minister, Govt. of Madhya Pradesh.		
11.00 a.m.- 12.30 p.m.	Presentation of Reports and discussion on them.		
12.30 p.m. - 1.30 p.m.	The JSR scheme : The Way Ahead	A summing up	
1.30 p.m.	- LUNCH -		



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 skin
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 - 8C (Paper I: See annexure 8ab)

Analysis of JSR Examination Questions against  
topics in JSR Manual

Chapter No.	Topics in Manual	JSR Exam I	JSR Exam II
1.	Responsibilities 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.	Nutrition/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 ?

- Dr. A.R. Sreedhara,  
CHC.



## प्रश्न पत्र - 1

समय - 2 घण्टे  
कुल अंक - 200

1. नीचे दर्शाये बिन्दुओं में जनस्वास्थ्य रक्षक के क्या कार्य हैं :
  - A — स्वास्थ्य जन एवं जन समुदाय के साथ कार्य करना
  - B — मातृ शिशु एवं परिवार कल्याण कार्यक्रम क्रियान्वित करना
  - C — संचारी रोगों की रोकथाम करना एवं सामान्य बीमारी, दुर्घटना का इलाज
  - D — उपरोक्त सभी
2. जन स्वास्थ्य रक्षक, स्वास्थ्य जन एवं समुदाय को किस तरह मदद करेगा :
  - A — स्वास्थ्य शिक्षा एवं स्वास्थ्य कर्मों के साथ तालमेल रखना
  - B — पंचायत एवं ग्रामीण स्वास्थ्य समिति के सदस्यों को परिवार कल्याण कार्य में लगाना
  - C — लोगों को स्वास्थ्य कार्यक्रम समझाना एवं उनकी बाधा दूर करना
  - D — उपरोक्त सभी
3. त्वचा के कार्य कौन-से हैं :
  - A — शरीर की रक्षा करना
  - B — तापमान नियमित करना
  - C — दवाई पहुँचाना
  - D — उपरोक्त सभी
4. त्वचा सूर्य के प्रकाश से कौन-सा विटामिन बनाती है :
  - A — विटामिन ए
  - B — विटामिन डी
  - C — विटामिन इ
5. मांस पेशियाँ कितने तरह की होती हैं :
  - A — ऐच्छिक
  - B — अनेच्छिक
  - C — हृदय की
  - D — उपरोक्त सभी
6. स्पाइनल कार्ड शरीर के किस भाग में होता है :
  - A — खोपड़ी के अन्दर
  - B — रीढ़ की हड्डी के बीच में
  - C — पैरों की हड्डी में
  - D — हाथ की हड्डी में

7. अग्रवाह में कितनी हड्डी होती हैं :  
 A — एक  
 B — दो  
 C — तीन
8. पट्टला हड्डी कहाँ होती है :  
 A — कोहनी में  
 B — घुटने में  
 C — कलाई में
9. जोड़ कितने प्रकार के होते हैं  
 A — अचल  
 B — सचल  
 C — दोनों  
 D — कोई नहीं
10. पेन्क्रियाटिक डक्ट शरीर के किस भाग में खुलती है :  
 A — आमाशय  
 B — ड्यूओडीनम  
 C — छोटी आंत  
 D — बड़ी आंत
11. बड़ी आंत की लम्बाई छोटी आंत से कम होती है :  
 A — सही  
 B — गलत
12. आमाशय में पाचन क्रिया होती है  
 A — पूर्ण  
 B — अपूर्ण  
 C — नहीं होती
13. छोटी आंत की दीवार सिकुड़ती है, फैलती है (पैरास्टालिसिस मूवमेन्ट) इसमें :  
 A — खाना पचता है  
 B — खाना आगे सरकता है  
 C — उपरोक्त दोनों कार्य नहीं होते  
 D — उपरोक्त दोनों कार्य होते हैं

14. नवजात शिशु एक मिनट में कितनी बार स्वांस लेता है :
- A — 20 बार
  - B — 30 बार
  - C — 40 बार
  - D — 50 बार
15. विसर्जन क्रिया में कौन-से अंग भाग लेते हैं :
- A — गुदें
  - B — त्वचा
  - C — फेफड़े
  - D — सभी
16. संक्रमण से रक्त के कौन-से कण रक्षा करते हैं :
- A — सफेद कण
  - B — लाल कण
  - C — दोनों
  - D — कोई भी नहीं
17. बल्ड प्रेशर (रक्त चाप) नापने के लिए कौन-सा उपकरण उपयोग में लिया जाता है :
- A — हीमोग्लोबिनोमीटर
  - B — स्फीग्मोमैनोमीटर
  - C — थर्मामीटर
  - D — कोई भी नहीं
18. सामान्यतः महिला की गर्भाशय में गर्भ नली कितनी होती है :
- A — एक
  - B — दो
  - C — तीन
  - D — दस
19. किस संस्थान को मास्टर आफ सिस्टम कहते हैं :
- A — पाचन संस्थान
  - B — नाड़ी संस्थान
  - C — रक्त संचार प्रणाली
  - D — श्वसन संस्थान
20. शरीर में रोगाणु किस प्रकार पहुँचते हैं :
- A — त्वचा से
  - B — श्वसन नली से
  - C — प्रजनन अंगों से
  - D — सभी से



21. संचारी रोगों के होने के लिए किन बातों का होना आवश्यक है :
- A — रोगों के कीटाणु (एजेन्ट)
  - B — मनुष्य (होस्ट)
  - C — वातावरण
  - D — सभी
22. संचारी रोग कैसे फैलते हैं :
- A — पानी एवं भोजन से
  - B — हवा से
  - C — सम्पर्क से
  - D — सभी से
23. निम्नलिखित में वाईरस से कौन-सी बीमारी होती है :
- A — हैजा
  - B — पोलियो
  - C — आँव की बीमारी
  - D — सूत्रकृमि
24. निम्नलिखित में से कौन-सी बीमारी कीटाणु (बैक्टीरिया) से होती है :
- A — टाईफाइड
  - B — पीलिया
  - C — खसरा
35. हवा से फैलने वाला रोग कौन-सा है :
- A — पीलिया
  - B — हैजा
  - C — खसरा
  - D — एड्स
26. दूषित जल से फैलने वाला रोग कौन-सा है :
- A — अतिसार
  - B — कुष्ठ रोग
  - C — टी.बी.
  - D — गलसूजा
27. यौन सम्पर्क से फैलने वाला रोग कौन-सा है :
- A — निमोनिया
  - B — आंतशोथ
  - C — सुजाक
  - D — मलेरिया

28. जल शुद्धीकरण किया जाता है :  
A — क्लोरीन की गोली से  
B — क्लीचिंग पाउडर से  
C — पानी उबाल कर  
D — सभी से
29. क्लोरीन की एक गोली (0.5 ग्राम) से कितने लीटर पानी शुद्ध किया जाता है :  
A — 50 लीटर  
B — 5 लीटर  
C — 20 लीटर  
D — 100 लीटर
30. सामान्यतः कुएँ में कितने बार क्लीचिंग पाउडर डालते हैं :  
A — माह में एक बार  
B — सप्ताह में एक बार  
C — वर्ष में एक बार  
D — दैनिक
31. मादा एनाफिलिस मच्छर के काटने से कौन-सा रोग फैलता है :  
A — फायलेरिया  
B — मलेरिया  
C — कालाजार  
D — टाइफाइड
32. क्यूलेक्स मच्छर से कौन-सी बीमारी होती है :  
A — हैजा  
B — टी.बी.  
C — फाइलेरिया  
D — प्लेग
33. मक्खियाँ कौन-से रोग फैलाती हैं :  
A — टाइफाइड  
B — पेचिश  
C — अतिसार  
D — सभी
34. कुत्ते के काटने से कौन-सा रोग होता है :  
A — अलर्क रोग (रेबीज)  
B — मम्प्स  
C — खुजली  
D — गलाघोटू (डिप्थीरिया)

35. कृमि एवं अतिसार की बीमारी नहीं होती यदि :  
 A — शौच के बाद साबुन पानी से हाथ धोने से  
 B — भोजन के पहले साबुन पानी से हाथ धोने से  
 C — नाखून छोटे एवं साफ रखने से  
 D — उपरोक्त सभी
36. मलेरिया के रोगी में कौन-कौन से लक्षण होंगे :  
 A — कंपकपी देकर बुखार आना  
 B — सरदर्द बदन दर्द होना  
 C — बुखार उतरने पर पसीना आना  
 D — उपरोक्त सभी
37. एक वयस्क संभावित मलेरिया रोगी को क्लोरोक्वीन की कितनी गोली देना चाहिए (150 मि.ग्रा. बेस)  
 A — एक गोली  
 B — दो गोली  
 C — तीन गोली  
 D — चार गोली
38. एक से चार वर्ष के बच्चे को संभावित मलेरिया होने पर क्लोरोक्वीन (150 मि.ग्रा.) की कितनी गोली देना चाहिए :  
 A — दो  
 B — चार  
 C — एक  
 D — आधी
39. क्षेत्र में पॉजिटिव मलेरिया रोगी के घर कितने दिनों तक जाना चाहिए :  
 A — प्रतिदिन पांच दिन तक  
 B — हर पांचवें दिन  
 C — सप्ताह में एक बार  
 D — माह में एक बार
40. क्लोरोक्वीन देने में किन बातों का ध्यान देना आवश्यक है :  
 A — रोगी गोली खाली पेट न लें  
 B — रोगी गर्भावस्था में न हो  
 C — 0-1 वर्ष का शिशु न हो  
 D — उपरोक्त सभी



41. बी.एच.सी. छिड़काव से किस तरह मच्छरों से बचाव होता है :
- A — मुक्त हवा में मच्छर मर जाता है
  - B — दीवार पर छिड़की दवा 3 सप्ताह तक असर करती है
  - C — सारे घर में छिड़कने से मच्छर भाग जाते हैं
  - D — सभी
42. बुखार के मरीज मिलने पर क्या कार्रवाई करें :
- A — पतली रक्त पट्टी बनाना
  - B — गाढ़ी रक्त पट्टी बनाना
  - C — दोनों तरह की रक्त पट्टी बनाना
  - D — दोनों तरह की रक्त पट्टी बनाना एवं क्लोरोक्विन की गोली देना
43. टी.बी. की बीमारी किस जीवाणु से होती है :
- A — वारडीटेला परट्यूसिस
  - B — माइक्रोबैक्टीरियम ट्यूबरकुलोसिस
  - C — माइकोबैक्टीरियम लेप्री
  - D — गोनोकाकस
44. क्षय रोगी (टी.बी.) की रोकथाम के लिए कौन-सा टीका लगाया जाता है :
- A — डी.पी.टी.
  - B — मीजल्स
  - C — बी.सी.जी.
  - D — टीटेनस टाक्साइड
45. एक बीस वर्षीय युवक को निम्न लक्षण होते हैं; वह शीघ्र ही थक जाता है, लगातार 15 दिन से खाँसी है, कभी-कभी खून आता है, भूख कम लगती है और रोजाना शाम को ज्वर आ जाता है। उसे निम्नलिखित में से किस बीमारी की सम्भावना है :
- A — कुष्ठ रोग
  - B — अस्थमा (दमा)
  - C — टी.बी.
  - D — उपरोक्त में कोई भी नहीं
46. टी.बी. के मरीज को कौन-सी दवाई नहीं दी जाती :
- A — स्ट्रेप्टोमाईसिन
  - B — रिफाम्पीसिन
  - C — थायोसिटेजोव
  - D — ट्रेटासाइक्लिन

47. टी.बी. की बीमारी का असर शरीर के किस अंग में सबसे अधिक होता है :
- A — आमाशय
  - B — पैनक्रियाज
  - C — फेफड़ा
  - D — गुर्दा
48. टी.बी. की बीमारी की जाँच के लिए सबसे उपयुक्त तरीका कौन-सा है :
- A — पेशाब की जाँच
  - B — एक्सरे
  - C — बलगम की जाँच
  - D — खून की जाँच
49. टाइफाइड की बीमारी दूषित पानी से होती है :
- A — सही
  - B — गलत
50. फाइलेरिया रोग के उपचार में कौन-सी दवाई दी जाती है :
- A — क्लोरोक्विन
  - B — डाईइथाइल कर्बामेजीन
  - C — ब्रूफेन
  - D — कोर्ट्राइमेक्साजोल
51. डेंगू (अस्थिमज्जा ज्वर) का कारण क्या है :
- A — विषाणु (वायरस)
  - B — फंगस
  - C — जीवाणु (बैक्टीरिया)
  - D — परजीवी (पैरासाइट)
52. डेंगू (अस्थिमज्जा ज्वर) की रोकथाम के लिए कौन-से प्रयास कारगर सिद्ध होंगे :
- A — मरीज के कमरे में मच्छर न आ सकें
  - B — मच्छर नाशक दवाई का छिड़काव
  - C — दर्द निवारक दवाओं का सेवन
  - D — उपरोक्त सभी
53. कुष्ठ रोग संक्रामक रोग है :
- A — सही
  - B — गलत

54. निम्नलिखित में से कौन-सा कुष्ठ रोग का लक्षण है :
- A — चमड़े पर कोई पीला या लाल रंग का धब्बा
  - B — त्वचा पर सुन्न धब्बा एवं पसीना न आना
  - C — तंत्रिकाओं का मोटा होना
  - D — उपरोक्त सभी
55. कुष्ठ रोग कीटाणु से होता है :
- A — सही
  - B — गलत
56. किस प्रकार के कुष्ठ रोग का इलाज लम्बे समय तक (6 माह से अधिक) चलता है :
- A — पासीवैसीलरी
  - B — मल्टीवैसीलरी
  - C — दोनों का
57. कुष्ठ रोगी को इलाज के दौरान कहाँ रखना चाहिए :
- A — परिवार
  - B — अस्पताल में
  - C — गाँव के बाहर
58. अपने प्रदेश में अंधत्व के मुख्य कारण कौन-से हैं :
- A — मोतियाबिन्द
  - B — दृष्टि दोष
  - C — विटामिन ए की कमी
  - D — उपरोक्त सभी
59. एक वृद्ध महिला उम्र 60 वर्ष को धीरे-धीरे कम दिखाई देने लगा यहाँ तक कि एक दिन नजदीक में खड़े नाती द्वारा हाथ हिलाने पर वह समझ नहीं पाई, उसकी आँखों की पुतली सफेद दिखाई दे रही थी। आँखों में कोई लालिमा भी नहीं थी, उसे कौन-सा रोग हो सकता है :
- A — मोतियाबिन्द
  - B — दृष्टिदोष
  - C — आँख का संक्रमण
  - D — विटामिन ए की कमी
60. मोतियाबिन्द में आँख के किस भाग में पारदर्शिता कम हो जाती है :
- A — कार्निया में
  - B — लेन्स में
  - C — रेटिना में
  - D — सभी में



61. मोतियाबिन्द के मरीज की आँख में बहुत दर्द होता है :  
A — सही  
B — गलत
62. मोतियाबिन्द के आपरेशन में लेन्स को निकाल दिया जाता है :  
A — सही  
B — गलत
63. मोतियाबिन्द का इलाज दवाई से सम्भव है :  
A — सही  
B — गलत
64. दृष्टिदोष के मरीज को दूर अथवा पास की वस्तु देखने में परेशानी होती है :  
A — सही  
B — गलत
65. दृष्टिदोष की तकलीफ चश्मा लगाने से दूर की जा सकती है :  
A — सही  
B — गलत
66. आँख आने की बीमारी के कौन-से लक्षण हैं :  
A — आँख में लाली एवं जलन  
B — आँख से स्राव जाना  
C — रोशनी में आँख खोलने में तकलीफ  
D — उपरोक्त सभी
67. आँख आने की बीमारी किस तरह फैलती है :  
A — जल द्वारा  
B — कीट द्वारा  
C — सम्पर्क से  
D — सभी
69. सुजाक की बीमारी का क्या इलाज है :  
A — नारफ्लाक्स 800  
B — क्लोरोक्वीन  
C — पैरासिटामोल  
D — सभी

70. क्लेमाइडिया का इलाज क्या है :
- A — डाक्सीसाइक्लीन
  - B — डेकाड्रान
  - C — एनालजिन
71. इन्द्रिय पर दर्द रहित घाव किस बीमारी में होता है :
- A — सुजाक
  - B — क्लेमाइडिया
  - C — सिफलिस
  - D — सभी
72. गर्भवती माता को सिफलिस की बीमारी के कारण उसके गर्भस्थ शिशु को भी सिफलिस होने की संभावना रहती है :
- A — सही
  - B — गलत
73. यौन रोग होने पर दोनों सहभागियों का इलाज आवश्यक है :
- A — सही
  - B — गलत
74. कक्ष्या किससे होता है :
- A — कीटाणु
  - B — जीवाणु
  - C — विषाणु
75. एड्स की बीमारी किस तरह फैलती है :
- A — संक्रमित व्यक्ति से असुरक्षित यौन सम्पर्क द्वारा
  - B — संक्रमित व्यक्ति का रक्त देने से
  - C — संक्रमित माता से शिशु को
  - D — उपरोक्त सभी
76. सिफलिस एवं एड्स एक ही मरीज को होना संभव है :
- A — सही
  - B — गलत
77. एड्स की बीमारी किस कारण फैलती है :
- A — साथ खेलने और खाने से
  - B — खाँसने या छींकने से
  - C — चुम्बन लेने से
  - D — संक्रमित व्यक्ति का खून देने पर

78. जनसंख्या वृद्धि के कारण क्या हैं :
- A — जन्मदर एवं मृत्युदर में अंतर
  - B — कम उम्र में विवाह एवं पुत्र के प्रति आकर्षण
  - C — परिवार नियोजन के साधन अपनाने के प्रति उदासीनता
  - D — सभी
79. दो वच्चों के जन्म में कम से कम कितना अंतर होना चाहिए :
- A — एक वर्ष
  - B — दो वर्ष
  - C — तीन वर्ष
  - D — पांच वर्ष
80. लड़कियों में शारीरिक परिवर्तन किस उम्र में होता है :
- A — 9 से 10 वर्ष
  - B — 11 से 13 वर्ष
  - C — 15 से 18 वर्ष
  - D — 18 से 21 वर्ष
81. लड़कों में शारीरिक परिवर्तन किस उम्र में होता है :
- A — 9 से 10 वर्ष
  - B — 10 से 12 वर्ष
  - C — 13 से 15 वर्ष
  - D — 18 से 21 वर्ष
82. बीज कोष (टेस्टीज) का क्या कार्य है :
- A — वीर्य बनाना
  - B — शुक्राणु बनाना
  - C — इन्सुलिन बनाना
  - D — इनमें से कोई नहीं
83. डिम्बाशय (ओवरी) का क्या कार्य है :
- A — स्त्रीबीज (ओवम) बनाना
  - B — इस्ट्रोजन हार्मोन बनाना
  - C — प्रोजेस्ट्रान हार्मोन बनाना
  - D — सभी
84. प्रत्येक माह में कितने डिम्ब (स्त्रीबीज) निकलते हैं :
- A — एक
  - B — दो
  - C — तीन
  - D — चार



85. गर्भनिरोधक गोलियों के एक पैकेट में कुल कितनी गोलियाँ होती हैं :
- A — बीस 20
  - B — अट्ठाइस 28
  - C — तीस 30
  - D — दस 10
86. गर्भनिरोधक गोलियाँ गर्भ कैसे रोकती हैं :
- A — महिला डिम्ब निकलने की प्रक्रिया में बाधा
  - B — सरवाइकल म्यूकस में परिवर्तन
  - C — शुक्राणु की गतिशीलता का प्रभावित होना
  - D — कोई नहीं
87. गर्भनिरोधक गोलियाँ किस दशा में बिल्कुल नहीं लेनी चाहिए :
- A — रक्तस्राव जिसका कारण ज्ञात न हो
  - B — पीलिया/लीवर की बीमारी
  - C — कैंसर की बीमारी एवं डायबीटिस
  - D — सभी
88. रामसिंह की घरवाली हाट बाजार से लौटते हुए स्वास्थ्य केन्द्र में रुकी। केन्द्र पर गर्भनिरोधक गोलियों के चित्र को देखते हुए नर्स दीदी से गर्भ निरोधक गोलियों का पैकेट ले आई लेकिन खाने का तरीका नहीं पूछा। आप उसे क्या सलाह देंगे, गोली माहवारी के
- A — प्रथम दिन से लेना
  - B — पाँचवें दिन से लेना
  - C — चौदहवें दिन से लेना
  - D — अट्ठाइसवें दिन से लेना
89. रामसिंह की घरवाली ने आपके कहे अनुसार गोलियाँ खानीं शुरू कर दीं। इस बीच वह एक दिन जब गाँव के बाहर बहन के घर गई तो पैकेट ले जाना भूल गई और अगले दिन वापस आकर आपसे पूछा कि वह क्या करे आप क्या राय देंगे :
- A — एक गोली नियमित खाते रहे और भूली हुई गोली की चिन्ता न करे
  - B — भूल हुए दिन की और आज के दिन की गोली दोनों साथ ले ले
  - C — गोली खाना ही बंद कर दे और मासिक धर्म शुरू होने के बाद नया पैकेट लेकर गोली खाना शुरू करे
  - D — कोई राय नहीं देंगे
90. रामसिंह की घरवाली ने एक माह तक नियमित गोलियाँ खाईं। वह चाहती है कि अगले माह भी परिवार कल्याण का यह साधन जारी रखे। गर्भनिरोधक गोलियों का नया पैकेट वह किस दिन से शुरू करे :
- A — पिछली गोली का पैकेट खत्म होने के अगले दिन से
  - B — माहवारी के पाँचवें दिन
  - C — माहवारी बंद होने पर
  - D — एक सप्ताह बाद

91. कापर-टी लगवाने हेतु महिला को अस्पताल में भर्ती करवाना पड़ता है :  
A — सही  
B — गलत
92. कापर-टी लगाने के पश्चात् पहला अनुसरण कब करना चाहिए :  
A — एक सप्ताह के अन्दर  
B — दो सप्ताह के अन्दर  
C — तीन सप्ताह के अन्दर
93. साधारण परिस्थितियों में कापर-टी लगाने के बाद कितने समय तक यह प्रभावकारी रहता है :  
A — 6 माह तक  
B — 1 वर्ष तक  
C — 3 वर्ष तक
94. निरोध एड्स एवं यौन रोग की बीमारी रोकने का भी एक साधन है :  
A — सही  
B — गलत
95. एक निरोध का उपयोग कितनी बार किया जा सकता है :  
A — एक बार  
B — अनेक बार  
C — जब तक फट न जाय
96. दूरबीन द्वारा महिला नसबन्दी आप्रेशन के लिए कितने दिन अस्पताल में भर्ती करना पड़ता है :  
A — उसी दिन वापस घर भेज देते हैं :  
B — तीन दिन बाद  
C — पांच दिन  
D — सात दिन
97. पुरुष नसबन्दी आप्रेशन के हितग्राही को सात दिन अस्पताल में भर्ती रहना पड़ता है :  
A — सही  
B — गलत
98. क्या पुरुष नसबन्दी के तुरन्त बाद वीर्य में शुक्राणु आना बंद हो जाते हैं :  
A — हाँ  
B — नहीं

99. कापर-टी लगाने के बाद अनुसरण में निम्न में से किन-किन बातों का परामर्श देना चाहिए :

- A — प्रथम सप्ताह में कमर में थोड़ा दर्द
- B — पहली एक-दो महावारी में सामान्य से थोड़ा अधिक रक्त जाना
- C — बीच में कभी-कभी खून के धब्बे दिखना
- D — सभी

100. नवविवाहित के लिए कौन-सा साधन उपयुक्त नहीं है :

- A — कापर-टी
  - B — ओरल पिल्स (खाने की गोली)
  - C — निरोध ।
-



जनस्वास्थ्य रक्षक परीक्षा प्रश्न-पत्र प्रथम  
उत्तर-कुंजी

प्र.	उत्तर	प्र.	उत्तर	प्र.	उत्तर	प्र.	उत्तर
1	D	26	A	51	A	76	A
2	D	27	C	52	D	77	D
3	D	28	D	53	A	78	D
4	B	29	C	54	D	79	C
5	D	30	B	55	A	80	B
6	B	31	B	56	B	81	C
7	B	32	C	57	A	82	B
8	B	33	D	58	D	83	D
9	C	34	A	59	A	84	A
10	B	35	D	60	B	85	B
11	A	36	D	61	B	86	A
12	B	37	D	62	A	87	D
13	D	38	C	63	B	88	B
14	C	39	A	64	A	89	B
15	D	40	A	65	A	90	A
16	A	41	D	66	D	91	B
17	B	42	D	67	D	92	A
18	B	43	B	68	C	93	C
19	B	44	C	69	A	94	A
20	D	45	C	70	A	95	A
21	D	46	D	71	C	96	A
22	D	47	C	72	A	97	B
23	B	48	C	73	A	98	B
24	A	49	A	74	C	99	D
25	C	50	B	75	D	100	A

## प्रश्न पत्र - 2

समय - 2 घण्टे  
कुल अंक - 200

1. स्वच्छ प्रसव कराने के लिए निम्नलिखित में से कौन-सी बात आवश्यक है :  
 A — गोबर से लिपी जमीन  
 B — स्वच्छ धरती  
 C — जानवरों के बांधने की जगह  
 D — घर का अंधेरा कमरा जहां हवा और रोशनी न आती हो
2. स्वच्छ प्रसव कराने के लिए निम्नलिखित में से कौन-सी बात आवश्यक है :  
 A — साबुन से धुले हुए स्वच्छ हाथ  
 B — राख से धुले हाथ  
 C — तेल-घी से लिपे चिकने हाथ  
 D — मिट्टी से धुले हाथ
3. सुरक्षित प्रसव कराने के लिए नाल काटने के लिए निम्नलिखित में से कौन-सा साधन अपनाना चाहिए :  
 A — घर में उपलब्ध हँसिया  
 B — नई स्वच्छ ब्लेड  
 C — रसोईघर का चाकू  
 D — धारदार औजार
4. सुरक्षित प्रसव के लिए नाल बांधने के लिए कौन-सा साधन उपयुक्त है :  
 A — नया स्वच्छ धागा  
 B — कपड़े की चिन्दी  
 C — सुतली  
 D — रबर बैंड
5. सुरक्षित प्रसव के लिए कटी हुई नाल पर क्या लगाना चाहिए :  
 A — कुछ नहीं  
 B — गोबर का लेप  
 C — कड़वा तेल  
 D — मलहम
6. निम्न में से कौन-सा गर्भावस्था का लक्षण नहीं है :  
 A — मासिक धर्म का नहीं आना  
 B — सुबह उठने पर मिचली आना  
 C — स्तनों एवं पेट का बढ़ना  
 D — मासिक धर्म का नियमित रहना

7. राधा की उम्र लगभग 40 वर्ष की है। पिछले गर्भ के दौरान उसे रक्तस्राव हुआ था एवं मृत बच्चा पैदा हुआ था। अब पुनः गर्भवती होने पर आप उसे क्या सलाह देंगे :  
 A — आपसे हर माह जाँच करवाती रहे  
 B — गाँव की दाई से सम्पर्क करे  
 C — महिला स्वास्थ्य कार्यकर्ता से तुरंत सम्पर्क साधे
8. सामान्य गर्भवती महिला को कितनी आयरन (लौह) फोलिक एसिड गोलीयाँ देना चाहिए :  
 A — 60  
 B — 80  
 C — 100  
 D — 120
9. खून की कमी वाली गर्भवती महिला को क्या आयरन (लौह) फोलिक एसिड की अधिक गोली देना चाहिए :  
 A — सही  
 B — गलत
10. प्रसव के बाद रक्तस्राव में महिला को कितने समय के अन्दर अस्पताल पहुँच जाना चाहिए :  
 A — 2 घण्टे  
 B — 12 घण्टे  
 C — 1 दिन  
 D — 2 दिन
11. गर्भस्थ शिशु की दिल की धड़कन सामान्यतः कितनी होती है :  
 A — 70 से 80  
 B — 100 से 140  
 C — 160 से 200  
 D — 200 से अधिक
12. सुशीलाबाई की उम्र 24 वर्ष है यह उसका दूसरा गर्भ अभी 6 माह का है। पिछले माह में उसका वजन 5 किलो बढ़ गया है। इसके साथ ही उसको सिरदर्द रहता है (शायद उच्च रक्तचाप के कारण) उसको आप कहाँ रेफर करेंगे :  
 A — उप स्वास्थ्य केन्द्र  
 B — प्राथमिक स्वास्थ्य केन्द्र/सामुदायिक स्वास्थ्य केन्द्र  
 C — दाई के पास
13. प्रसव के बाद रक्तस्राव 500 मि.ली. से ज्यादा होना खतरे की बात है :  
 A — सही  
 B — गलत



14. क्या प्रसव के पश्चात् महिला को बुखार, पेडू (पेट के निचले भाग) में दर्द एवं योनि से बदबूदार स्राव खतरे की निशानी है :  
A — सही  
B — गलत
15. प्रथम प्रसूता यदि प्रसव में 24 घण्टे से अधिक तथा बहुप्रसूता 12 घण्टे से अधिक रहती है तो उसे तुरंत रेफर कर देंगे :  
A — सही  
B — गलत
16. शिशु मृत्यु के मुख्य कारण क्या हैं :  
A — समय पूर्व जन्म/कम वजन  
B — जन्म के समय श्वसन अवरोध  
C — धनुषवाय एवं संक्रमण  
D — उपरोक्त सभी
17. जन्म के बाद नवजात शिशु को पैर पकड़कर उल्टा लटकाना चाहिए :  
A — सही  
B — गलत
18. कम वजन वाले बच्चे को पहला स्नान जन्म के तुरन्त बाद करा देना चाहिए :  
A — सही  
B — गलत
19. फातिमा बी का बच्चा जन्म के समय एक किलो 800 ग्राम (1.8 kg) वजन का हुआ है। आप उसे क्या सलाह देंगे :  
A — घर पर ही देखभाल करेंगे  
B — दाई के पास भेज देंगे  
C — महिला स्वास्थ्य कार्यकर्ता के पास भेजेंगे  
D — शिशु रोग विशेषज्ञ को रेफर करेंगे
20. बच्चे को जन्म के पश्चात् स्तनपान कब शुरू कराना चाहिए :  
A — जन्म के तुरन्त बाद  
B — 4 से 6 घण्टे के बाद  
C — 24 घण्टे के बाद  
D — तीसरे दिन के बाद

21. निम्नलिखित में से कौन-से लक्षण नवजात शिशु में खतरे वाले होते हैं :
- A — जन्म के समय ढाई किलो (2.5 kg) से कम वजन/समय पूर्व जन्म
  - B — नवजात में पीलिया एवं चूसने/पीने में समस्या
  - C — दौरे आना
  - D — उपरोक्त सभी
22. जन्म के समय कम वजन वाले बच्चे को विशेषज्ञ के पास ले जाते वक्त ढंग से लपेटना चाहिए ताकि उष्मा की हानि न हो :
- A — सही
  - B — गलत
23. आभावाई को हाल ही में प्रसव हुआ है और वह आपसे बच्चे की खुराक के बारे में सलाह लेने आई है आप उसे प्रथम चार माह के लिए क्या सलाह देंगे :
- A — केवल माँ का दूध
  - B — माँ का दूध एवं पानी
  - C — गाय या बकरी का दूध
  - D — दूसरे माह से दाल का पानी
24. माँ का पहला दूध बच्चे के लिए हानिकारक है :
- A — सही
  - B — गलत
25. सायरा बी का बच्चा पैदा होने के बाद ठीक से सांस नहीं ले रहा, इस हेतु निम्न उपाय किया जाना चाहिए :
- A — बच्चे को उल्टा लटकायें
  - B — बच्चे की पीठ थपथपायें एवं गरम ठंडे पानी के छींटे मारें
  - C — बच्चे के पैर मोड़कर पेट पर जोर डालें
  - D — उपरोक्त में से कोई नहीं
26. विटामिन ए की कमी किस उम्र में अधिक होती है :
- A — 6 माह से 3 वर्ष
  - B — 3 वर्ष से 5 वर्ष
  - C — 5 वर्ष से 7 वर्ष
27. विटामिन ए की कमी से कौन-सी बीमारी होती है :
- A — रिकेट्स
  - B — अन्धता
  - C — स्केबीज
  - D — बहरापन

28. खाने के किन सब्जी/फलों में विटामिन ए अधिक मात्रा में होता है :
- A — हरी पत्तीदार सब्जियाँ
  - B — गाजर
  - C — पका आम एवं पपीता
  - D — उपरोक्त सभी
29. 9 माह के शिशु को विटामिन ए की खुराक कितनी मात्रा में देना चाहिए :
- A — 1 लाख यूनिट
  - B — 3 लाख यूनिट
  - C — 2 लाख यूनिट
  - D — 50 हजार यूनिट
30. किरेटोमलेशिया और बिटॉट्स स्पॉट किस की कमी से होता है :
- A — प्रोटीन की कमी
  - B — विटामिन ए की कमी
  - C — विटामिन सी की कमी
  - D — आयोडीन की कमी
31. बच्चे को विटामिन ए की तीन वर्ष की आयु तक कितनी खुराक पिलानी चाहिए :
- A — 3 खुराक
  - B — 5 खुराक
  - C — 7 खुराक
  - D — 9 खुराक
32. हमीद के डेढ़ साल के बच्चे को एक हफ्ते से सर्दी, खांसी और हल्का बुखार चल रहा था। कल से बच्चे ने दूध पीना कम कर दिया और बुखार भी तेज हो गया। जाँचने पर यह पाया गया कि उसकी सांस तेज चल रही थी आपके विचार में निम्न में से कौन-सा रोग है :
- A — टी.बी.
  - B — मलेरिया
  - C — निमोनिया
  - D — उपरोक्त में से कोई नहीं
33. निमोनिया में 10 माह के शिशु की श्वसन दर प्रतिमिनट क्या होगी :
- A — 20
  - B — 30
  - C — 40
  - D — 50 से अधिक



34. निमोनिया के लक्षण क्या हैं :
- A — पसली तेज चलना
  - B — बच्चे ने खाना-पीना बंद कर दिया हो
  - C — बच्चे को नींद अधिक आती हो, जागने में दिक्कत हो
  - D — उपरोक्त सभी
35. निमोनिया के इलाज में कौन-सी दवा देंगे :
- A — कोट्राइमेक्साजोल
  - B — मेवेन्डाजोल
  - C — उपरोक्त दोनों
  - D — उपरोक्त में से कोई नहीं
36. खांसी का उपचार कैसे करेंगे :
- A — घरेलू उपचार द्वारा (अदरक, तुलसी शहद)
  - B — पैरासिटॉमाल की गोली
  - C — उपरोक्त में से कोई नहीं
37. दस्तों की संख्या से अधिक महत्वपूर्ण है उसका स्वरूप और गुण ।
- A — सही
  - B — गलत
38. अगर दस्त के साथ खून/आँप आता है, तो उसे क्या कहते हैं :
- A — डायरिया
  - B — डिसेंट्री (पेचिस)
  - C — कृमि रोग
  - D — टायफाइड
39. दस्त रोग के लक्षण क्या है :
- A — बार-बार गटा पखाना आना
  - B — पेस्ट जैसे पखाना
  - C — बार-बार पतला पखाना
  - D — उपरोक्त में से कोई नहीं
40. दस्त रोग से रोगी की मृत्यु किस कारण होती है :
- A — निर्जलीकरण
  - B — आंतों की छाले
  - C — लिवर में सूजन
  - D — उपरोक्त तीनों

41. निर्जलीकरण के लक्षण क्या है :
- A — अधिक प्यास एवं सूखी जवान
  - B — धंसी हुई आंखें एवं पेशाब कम आना
  - C — बच्चे में सुस्तपन/बेहोशी
  - D — उपरोक्त सभी
42. माँ का दूध पीते हुए बच्चे को दस्त के दौरान माँ का दूध देते रहना चाहिए :
- A — सही
  - B — गलत
43. बच्चों में दस्त का सबसे महत्वपूर्ण इलाज क्या है :
- A — सामान्य से अधिक तरल पदार्थ
  - B — एन्टीबायोटिक
  - C — बच्चे का खाना बंद कर देना
  - D — सामान्य से कम तरल पदार्थ
44. दस्त के रोगी को सामान्य भोजन देते रहना चाहिए :
- A — सही
  - B — गलत
45. ओ.आर.एस. के पैकेट को कितने पानी में घोलना चाहिए :
- A — 250 मिली लीटर
  - B — 1 लीटर
  - C — 1.5 लीटर
  - D — 100 मिली लीटर
46. ओ.आर.एस. के घोल को बनाने के बाद कितने समय तक उपयोग में लेना चाहिए :
- A — 1 घण्टा
  - B — 12 घण्टा
  - C — 24 घण्टा
  - D — उपरोक्त में से कोई नहीं
47. ओ.आर.एस. का घोल बनाने के लिए पानी को उबालकर उपयोग में लेना चाहिए :
- A — सही
  - B — गलत
48. आपके क्षेत्र में बड़ी संख्या में उल्टी दस्त होने पर क्या उपाय करेंगे :
- A — ओ.आर.एस. के घोल पिलाने की सलाह
  - B — निर्जलीकरण न हो इसलिए तरल पदार्थ लेते रहने की सलाह देंगे
  - C — पेयजल की शुद्धता का परीक्षण एवं स्वास्थ्य केन्द्र को सूचना देंगे
  - D — उपरोक्त सभी

49. निम्नलिखित में से किस बीमारी का टीकाकरण से रोग प्रतिरक्षण नहीं होता :

- A — खसरा
- B — पोलियो
- C — टिटेनस
- D — एड्स

50. किस उम्र में बच्चे को डी.पी.टी. टीकाकरण की पहली डोज दी जाती है :

- A — जन्म के समय
- B — डेढ़ माह
- C — 6 माह
- D — 9 से 12 माह

51. किस उम्र के बच्चे को खसरे का टीका लगाया जाता है :

- A — जन्म के समय
- B — डेढ़ माह
- C — 6 माह
- D — 9 से 12 माह

52. डी.पी.टी. और पोलियो के दो डोज के बीच कितना अंतर होना चाहिए :

- A — एक सप्ताह
- B — एक माह
- C — 6 माह
- D — 1 वर्ष

53. डी.पी.टी./पोलियो का प्रथम बूस्टर डोज किस उम्र में दिया जाता है :

- A — 9 से 12 माह
- B — 18 से 24 माह
- C — 24 से 30 माह
- D — 5 वर्ष

54. डी.पी.टी. की बूस्टर डोज किस उम्र में दी जाती है :

- A —  $1\frac{1}{2}$  वर्ष
- B — 5 वर्ष
- C — 10 वर्ष
- D — 16 वर्ष

55. गर्भावस्था में किस समय पहला टिटेनस टाक्साइड का टीका लगाया जाता है :

- A — जैसे ही गर्भ का पता चले
- B — तीन माह
- C — 6 माह
- D — 9 माह



56. बच्चे के पैदा होने के बाद तुरन्त कौन-सा टीकाकरण किया जाना चाहिए :
- A — खसरा
  - B — बी.सी.जी./पोलियो
  - C — डी.पी.टी
  - D — टिटनेस
57. गर्भावस्था में टिटनेस का दूसरा टीका कितने अन्तराल के बाद लगाना चाहिए :
- A — एक सप्ताह
  - B — दो सप्ताह
  - C — एक माह
  - D — दो माह
58. पोलियो का टीका इंजेक्शन के द्वारा लगाया जाता है :
- A — सही
  - B — गलत
59. मामूली सर्दी, खांसी, बुखार और दस्त के दौरान बच्चे का टीकाकरण किया जा सकता है :
- A — सही
  - B — गलत
60. जमनाबाई की बच्ची को निर्धारित समय पर बी.सी.जी. और डी.पी.टी./पोलियो की पहली खुराक दी गई उसके बाद वह अपने मायके चली गई जहाँ से वह तीन माह के पश्चात् लौटी। इस समय बच्ची की उम्र लगभग 6 माह है आप उन्हें टीकाकरण के सम्बन्ध में क्या सलाह देंगे :
- A — बची हुई डी.पी.टी./पोलियो की डोजें एक-एक माह के अन्तर पर देंगे
  - B — पुनः दुबारा से पूरे टीके शुरू करवायेंगे
  - C — नौ माह की उम्र तक इन्तजार कर खसरे का टीका देंगे
  - D — उपरोक्त में से कोई नहीं
61. वहीदा का दो महीने का लड़का डी.पी.टी./पोलियो की प्रथम डोज के बाद अगले दिन कुछ चिड़चिड़ा हो गया। देखने पर आपने पाया कि उसे हल्का बुखार और इंजेक्शन लगने के स्थान पर छूने पर दर्द था, आप क्या करेंगे :
- A — पैरासिटामाल की गोली
  - B — सांत्वना एवं समझाइश कि यह डी.पी.टी. की सामान्य प्रक्रिया है
  - C — उपरोक्त दोनों
  - D — उपरोक्त में से दोनों नहीं
62. टीकाकरण सत्र के दौरान टीकों को खोलने के पश्चात् कितने घण्टे के अन्दर इनका उपयोग कर लेना चाहिए :
- A — 4 घण्टे
  - B — 12 घण्टे
  - C — 24 घण्टे
  - D — कोई सीमा निर्धारित नहीं

63. टीकाकरण के लिए प्रत्येक बच्चे को एक कीटाणुरहित सिरिंज व सुई का इस्तेमाल करना चाहिए :  
A — सही  
B — गलत
64. बच्चे का बढ़ता वजन उसकी शारीरिक वृद्धि का सूचक है :  
A — सही  
B — गलत
65. शिशु किस माह में हाथ पकड़कर बैठने लगता है :  
A — 3 माह  
B — 6 माह  
C — 9 माह  
D — 12 माह
66. किसी गर्भवती या दूध पिलाती महिला को अन्य महिलाओं की अपेक्षा अधिक भोजन की आवश्यकता होती है :  
A — सही  
B — गलत
67. स्तनपान के क्या फायदे होते हैं :  
A — दस्त रोग एवं अन्य बीमारियों से बचाव  
B — कुपोषण से बचाव  
C — पैसों/समय का बचाव  
D — उपरोक्त सभी
68. नवजात शिशु को माँ के दूध के अलावा बच्चे को शहद, घुट्टी, ग्लूकोज का पानी भी देना चाहिए :  
A — सही  
B — गलत
69. शिशु को किस माह से कुचला-मसला भोजना देना चाहिए :  
A — 3 माह  
B — 5 माह  
C — 7 माह  
D — 1 वर्ष
70. बच्चे को ऊपरी दूध बोतल और निपल से किसी हालत में नहीं पिलाना चाहिए :  
A — सही  
B — गलत

71. एक वर्ष के बालक को प्रतिदिन 5 से 6 बार ठोस भोजन देना चाहिए :  
 A — सही  
 B — गलत
72. माँ का दूध बच्चे को किस उम्र तक पिलाना चाहिए :  
 A — 6 माह  
 B — 12 माह  
 C — 18 माह  
 D — जब तक दूध आये
73. भोजन में केवल आयोडीन युक्त नमक का ही उपयोग करना चाहिए :  
 A — सही  
 B — गलत
74. कुपोषण के क्या लक्षण हैं :  
 A — वजन का बढ़ना रुक जाना  
 B — चिड़चिड़ापन/सुस्त हो जाना  
 C — बार-बार बीमार पड़ना  
 D — उपरोक्त सभी
75. गम्भीर कुपोषण के लक्षण क्या हैं :  
 A — बच्चा आयु के आधार पर छोटा और पतला होता है  
 B — पाँव में सूजन आ जाती है  
 C — हड्डियों का ढांचा जैसा दिखता है  
 D — उपरोक्त में से कोई भी
76. खून की कमी की पहचान किस प्रकार की जा सकती है :  
 A — त्वचा और नाखूनों का रंग फीका पड़ना  
 B — जल्दी थक जाना  
 C — निचली पलक की भीतरी सतह का रंग फीका पड़ जाना  
 D — उपरोक्त सभी
77. सामान्य व्यक्ति में नाड़ी एक मिनट में कितनी बार महसूस होती है :  
 A — 60 से कम  
 B — 70 से 80  
 C — 90 से 100  
 D — 100 से अधिक



78. फोड़े फुन्सी होने पर प्राथमिक स्वास्थ्य केन्द्र पर कब भेजेंगे :
- A — कई फोड़े हों
  - B — फोड़ा बड़ा आकार ले रहा हो और 5 दिन से ज्यादा इलाज के बाद भी राहत न हो
  - C — उपरोक्त दोनों
  - D — जब फोड़ा ठीक हो गया हो
79. कब्ज में क्या उपचार देंगे :
- A — ज्यादा भोजन खाने की सलाह
  - B — कम भोजन खाने की सलाह
  - C — मैग्नीशियम हाइड्रॉक्साइड गोलियाँ
  - D — मेवेन्डाजॉल की गोलियाँ
80. कान दर्द में क्या उपचार देंगे :
- A — कान को तीली से साफ करेंगे
  - B — तेल की बूंदें डालेंगे
  - C — सल्फासीटामाइड इयर ड्रॉप्स एवं पैरासिटामाल की गोलियाँ देंगे
  - D — कान को पानी से साफ करेंगे
81. सुरेश को पिछले 24 घण्टे से बुखार आ रहा है। वह आपके पास इलाज के लिए आता है तो उसके इलाज के दौरान क्या नहीं करेंगे :
- A — क्लोरोक्वीन की गोलियाँ देना
  - B — गरम पानी से स्पंजिंग करना
  - C — पैरासिटामाल की गोलियाँ देना
  - D — पीने को तरल पदार्थ देना
82. सिरदर्द के साथ यदि गर्दन में अकड़न, उल्टियाँ और आँखों के आगे अंधेरा छा रहा हो तो ऐसे मरीज को पैरासिटामाल की गोलियाँ देकर घर भेज देंगे :
- A — सही
  - B — गलत
83. मुमताज बी के जोड़ों में दर्द होने पर उसने जोड़ों को गरम पानी और नमक में कपड़ा भिगोकर सेंक किया एवं जोड़ों को आराम देने के उद्देश्य से सो गयी। उठने पर उसे जोड़ों में सूजन एवं दर्द बढ़ गया। आप उसे निम्नलिखित में से क्या सलाह देंगे :
- A — पूर्व की तरह उपचार लेते रहने की सलाह
  - B — दर्द निवारक गोलियाँ
  - C — प्राथमिक स्वास्थ्य केन्द्र पर रेफर
  - D — उपरोक्त कोई नहीं

84. पेट में दर्द होने पर निम्नलिखित में से कौन-सी दवा देंगे :
- एविल
  - आयरन फोलिक एसिड की गोलियाँ
  - मेग्नीशियम हाइड्रॉक्साइड की गोलियाँ
  - सेवलॉन
85. खारिश एवं खुजली के इलाज के लिए निम्न में से कौन-सा उपाय वर्जित है :
- साबुन पानी से नहाना
  - बेंजाइल बेंजाएट लगाना
  - कपड़े बिना धुले पुनः पहन लेना
  - खारिस वाले परिवार के सभी सदस्यों का इलाज
86. अनिल की आँख में पानी आ रहा था। आँख लाल थी और उसमें दर्द हो रहा था। चिकित्सक ने उसे आँखे आना बताया एवं निम्नलिखित में से कौन-सा उपचार करने को कहा :
- आँखों से तेज रोशनी देखते रहना
  - सल्फासीटामाइड अथवा टेरामाइसिन नेत्र मलहम लगाना
  - आँखों को रगड़ना
  - उपरोक्त सभी
87. दाँत के दर्द के इलाज में निम्नलिखित में से कौन-सा बिन्दु महत्वपूर्ण है :
- नमक और गुनगुने पानी से गरारे करना
  - पैरासिटामाल गोली देना
  - मुँह खुला रखना
  - रोगी द्वारा दाँत से लौंग चबाया जाना
88. देवेन्द्र को शरीर पर एक अल्सर हो गया। जन स्वास्थ्य रक्षक से सलाह लेने पर उसे उबले हुए पानी से साफ करके एन्टीसेप्टिक मलहम लगाकर साफ पट्टी बांधी गई। परन्तु दो दिन बाद भी कोई सुधार नहीं हुआ। आगे की कार्रवाई क्या होगी :
- कुछ दिन इलाज पूर्व की तरह जारी रखना
  - प्राथमिक स्वास्थ्य केन्द्र रेफर करना
  - दवाई बदलकर इलाज करना
  - झाड़-फूंक वाले के पास ले जाना
89. उल्टियाँ होने पर निम्नलिखित में से कौन-सा कार्य नहीं करना चाहिए :
- पुर्नजलीकरण करना
  - काफी मात्रा में तरल पदार्थ देना
  - पैरासिटामाल की गोली
  - चावल व अन्य गर्म भोजन बिस्कुट आदि देना

90. पेट में कीड़े होने के बाद निम्न में से क्या उपचार करेंगे :
- A — पैरासिटामाल की गोलियाँ देना
  - B — मेवेन्डाजोल की गोली
  - C — एनालजीन की गोली
  - D — कोट्राईमेक्साजोल की गोली
91. जलने के बाद तुरन्त चिकित्सा में निम्न में से कौन-सा उपचार नहीं करेंगे :
- A — अग को ठंडे पानी में डुबाना
  - B — एन्टीसेप्टिक मलहम लगाना
  - C — शहद का लेप लगाना
  - D — ओरल रिहाइडेशन घोल देना
92. कुत्ते के काटने पर सावुन और पानी से घाव को अच्छी तरह से धोकर एन्टीसेप्टिक मलहम लगायें एवं आगे के इलाज के लिए :
- A — मलहम लगाते रहें
  - B — घाव को पट्टी बांधते रहें
  - C — आलर्जिकोधी इंजेक्शनों के लिए चिकित्सक के पास भेजें
  - D — जल्दी ठीक होने के लिए टीक लगवा दें
93. गाँव में तेज आँधी के बाद कई लोगों को आँखों में तकलीफ होने लगी, शायद धूल या अन्य कचरा आँख में चला गया है। निम्नलिखित में से कौन-से उपचार करेंगे :
- A — आँख को पानी से धोना, आँख में घुसी चीज को निकालना, सल्फासिटेमाइड दवा डालना
  - B — आँख को जोर से मलना
  - C — आँख में दूध की बूंदें डालना
  - D — उपरोक्त सभी
94. हड्डी टूटने पर निम्नलिखित में कौन-सा कार्य करेंगे :
- A — रोगी को सुविधाजनक स्थिति में रखना
  - B — हड्डी को जोड़ने की कोशिश करना
  - C — खरपच्ची और पट्टी का इस्तेमाल करके हड्डी को हिलने न देना
  - D — उपरोक्त सभी
95. लू लगने पर निम्नलिखित उपायों में से कौन-सा उपाय नहीं करेंगे :
- A — रोगी के ऊपर ठंडा पानी डालना
  - B — रोगी को ठंडा पानी पीने देना
  - C — रोगी को धूप में रखना
  - D — रोगी के कपड़े उतारकर ठंडे पानी की पट्टी रखना



96. कीड़े काटने पर कौन-सी गोली देंगे :
- A — एनालजिन
  - B — एविल
  - C — मैग्नीशियम हाइड्रॉक्साइड
  - D — पेरॉसिटैमाल
97. सांप के काटने पर निम्नलिखित में से कौन-सा उपचार नहीं करेंगे :
- A — काटी हुई जगह के ऊपर कसकर कपड़ा बांधना
  - B — कटे हुए स्थान की सफाई न करना व साबुन पानी से न धोना
  - C — एन्टीवीनम इंजेक्शन के लिए प्राथमिक स्वास्थ्य केन्द्र भेजना
  - D — कटे हुए स्थान पर चीरे लगाना
98. सदमें के लक्षण हैं चेहरा पीला पड़ना, हाथ-पैर ठंडे होना, नाड़ी तेज या मंद होना, बहकना, हल्की श्वास आना, उल्टियाँ आना :
- A — सही
  - B — गलत
99. खून बंद करने हेतु कौन-सा उपाय करेंगे :
- A — खून निकल रहा हो तो उसे न रोकें
  - B — रक्त बंध का उपयोग एवं स्थान को दबाना
  - C — मरीज को अनावश्यक रूप से हिलाना-डुलाना
  - D — उपरोक्त सभी
100. चार पंजीयन हैं — विवाह, जन्म, मृत्यु और गर्भधारण :
- A — सही
  - B — गलत
-

जनस्वास्थ्य रक्षक परीक्षा प्रश्न-पत्र द्वितीय  
उत्तर-कुंजी

प्र.	उत्तर	प्र.	उत्तर	प्र.	उत्तर	प्र.	उत्तर
1	B	26	A	51	D	76	D
2	A	27	B	52	B	77	B
3	B	28	D	53	B	78	C
4	A	29	A	54	B	79	C
5	A	30	B	55	A	80	C
6	D	31	B	56	B	81	B
7	C	32	C	57	C	82	A
8	C	33	D	58	B	83	C
9	A	34	D	59	A	84	C
10	A	35	A	60	A	85	C
11	B	36	A	61	C	86	B
12	B	37	A	62	A	87	C
13	A	38	B	63	A	88	B
14	A	39	C	64	A	89	C
15	A	40	A	65	B	90	B
16	D	41	D	66	A	91	C
17	B	42	A	67	D	92	C
18	B	43	A	68	B	93	A
19	D	44	A	69	B	94	D
20	A	45	B	70	A	95	C
21	D	46	C	71	A	96	B
22	A	47	B	72	D	97	B
23	A	48	D	73	A	98	A
24	B	49	D	74	D	99	B
25	D	50	B	75	D	100	A

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

## (FIELD STUDY)

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

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

- सुबह से बच्चे को 5 बार दस्त हुआ है,
- दुखार 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।

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, नापोगे 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 साँस की रफ्तार 40 से अधिक है। आनन्द का परीक्षण, रोग का निर्धारण और उपचार क्रम बताइये ?
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 ?

परिशिष्ट "ग"

## STANDARD PROJECT FOR SANCTION OF LOAN UNDER IRDP FOR JAN SWASTHYA RAKSHAKS

### INTRODUCTION

Government of Madhya Pradesh has recently approved a scheme of Jan Swasthya Rakshaks. This scheme will be launched on 19<sup>th</sup> November throughout the state. A copy of the scheme is enclosed. The scheme is briefly as follows:

One person will be selected for each village by the gram panchayat to work as Jan Swasthya Rakshak for that village. The essential qualifications for the Jan Swasthya Rakshak are :

1. He/she should be a resident of the same village or at least of the same gram panchayat area.
2. He/she should be at least class 10 pass.

After being selected by the gram panchayat they will undergo a 6 months training to be conducted by the health department at the block level PHCs. The training will be done under TRYSEM. At the end of the training an examination will be taken by the Directorate of Medical Education. Those who pass this examination will be given a certificate by the DME, and on the basis of this certificate they will be registered as Jan Swasthya Rakshak. They will be allowed to practice as Jan Swasthya Rakshak in the village for which they have been registered. They will treat minor ailments, and administer first aid to patients in the villages, and will refer more complicated cases to the hospitals. They will also help the government Health System in National Health programmes.

### ECONOMIC VIABILITY OF THE PROJECT

Most of the diseases in the villages are of minor nature which however can lead to serious complication if remain untreated. Almost 28% of childhood mortality is because of a simple disease like diarrhoea. It is estimated that every child less than 5 years of age suffers at least two episodes of diarrhoea every year. Similarly a simple disease like common cold may lead to pneumonia. Another 28% of childhood mortality is because of pneumonia.

Recently a survey was conducted by an NGO in Bilaspur district, which showed that in a period of three months more than one lakh rupees went out of the village on medical services, and drugs. If a qualified person is available in the village he/she can easily make a living. It makes sense for the village people as well. If a person living in a remote village goes to a government health facility located 10-15 kilometer away, he may get free medical attention, but he loses a day's wage, and spends on transport. On the other hand if he pays a Jan Swasthya Rakshak a small sum of money he saves a day's wage, and transport expenses. This added to the effort required, and the mental and physical anguish caused in transporting a sick person to long distances makes payment of user fees to the Jan Swasthya Rakshak, an much favoured option. We have no doubt that competent, and qualified Jan Swasthya Rakshaks will easily make a living from their profession, and will also prove an asset to the village community.

#### LINKAGE OF IRDP AND TRYSEM

The Jan Swasthya Rakshaks will be trained under TRYSEM. They will then be provided financial assistance under IRDP, thus strengthening the link of IRDP with TRYSEM.

#### THE PACKAGE TO BE GIVEN

The package to be given under the scheme to the Jan Swasthya Rakshaks will be as follows :

##### a. Fixed Capital

1. Furniture :	a. One office table	1400.00
	b. One Examination table	1400.00
	c. One bench	1000.00
	d. Two Stools	400.00
	e. Two Chairs	1000.00
	f. One Procedure table	1000.00
	g. One almirah	2500.00
	Total	8900.00



2. One Kit of equipments containing the following :

JAN SWASTHYA RAKSHAK EQUIPMENT KIT		
NAME OF EQUIPMENT	QUANTITY REQUIRED	COST
Weighing machine - Child	1	250
Weighing machine - Adult	1	500
Urine testing equipment:		90
1. Spirit lamp	1	
2. Test tube	5	
3. Test tube holder	2	
4. Benedict's solution	5 bottles	
Haemoglobin testing equipment:		550
1. Pipette	1	
2. Hemoglobinometer	1	
3. Hydrochloric acid	2 bottles	
First aid kit	1	500
Sterilizer	1	1000
Stove	1	500
Thermometer	1	50
Torch	1	50
Measuring tape	1	10
BP equipment	1	1500
Soap	10	100
Towel	2	100
Syringe	10	250
Needle	50	50
Set of instruments for I&D of abscess	1 set	500
Instruments for conducting normal labour	1 set	1000
Bicycle	one	1500
Total		8500

b. Working Capital

1. Rent of one room for clinic in the village @ Rs 100 per month for 12 months amounting to Rs 1200/-.

2. A kit of drugs and other consumables. The kit will consist of the following :

JAN SWASTHYA RAKSHAK DRUG KIT		
NAME OF DRUG	QUANTITY REQUIRED	COST
Aspirin	300	25
Paracetamol	500	75
Chlorphenarimine	300	25
Mebendazole	300	10
Pyrental palmoate	100	5
Metronidazole	300	150
Tetracycline capsule	500	300
Chloroquine tablet	500	250
Benzyl benzoate	1	50
Tetracycline eye applicaps	200	300
Baralgan tablet	200	100
Neosporine ointment	20	500
Neosporine powder	20	500
B-Complex tablet	500	10
IFA tablet	5000	250
ORS	100	300
Contrimoxazole tablet	500	1000
Avil	100	100
Chlorine tablets	60000	3000
Oral pills	300	1000
Condoms	2000	500
Gauge		100
Bandage		100
Cotton		200
Adhesive plaster		100
Tincher iodine		50
Detol/Sevlon		200
Total		9200

Total cost of the package

27800

परिशिष्ट "घ"

MONITORING PROFORMA FOR THE  
JAN SWASTHYA RAKSHAK SCHEME

Form 1 :

Name of district	Name of block	Number of Doctors posted	Number of doctors trained
Total			

Form 2 :

Name of District	Number of blocks	Number of blocks where training has started	Number of JSRs identified	Number of JSRs being trained
Total				



Form 3 :

Name of District	Number of JSRs being trained	Money released as stipend to trainees	Money released to PNC for conducting training	Tool kits distributed	training manuals distributed	Where there is no doctor book distributed
Total						

Form 4 :

Name of District	Name of block	Number of JSRs being trained	Number of JSRs who passed in the monthly internal evaluation
Total			



## POSTERS ON TUBERCULOSIS

### A SERIES OF 10 COLOURED POSTERS ON TB CONTROL : [ HINDI ]

*Which enables village community –*

- To know basic information on TB.
- To identify suspected cases of TB.
- To refer suspected cases for medical examination.
- To realize the importance of regular treatment.
- To be aware of the responsibilities of health department in TB control.



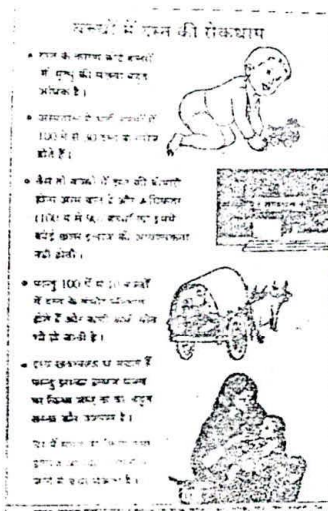
Contributory price Rs. 30/- per set

## POSTERS ON DIARRHOEA

### CONTROL OF DIARRHOEA AT VILLAGE LEVEL :

*A series of 10 coloured posters in Hindi on diarrhoea control informs villagers on –*

- Importance of diarrhoea control.
- Ill effects of diarrhoea.
- Treatment of diarrhoea and preparations of ORS.
- Precautions during diarrhoea.
- Control of diarrhoea at village level.



Contributory price Rs. 30/- per set





## BOOKLETS

एक गाँव की महिलाओं की देखभाल

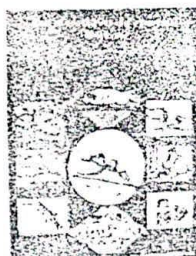


मध्य प्रदेश स्वास्थ्य विभाग  
एन.एम.डी.ए.ओ. प्रकल्प  
इन्दौर - 452 001

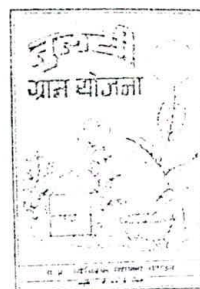
A Booklet in Hindi as a guide on maternal care for a village woman.  
Contributory Price Rs. 3/-



A Booklet in Hindi on "How to control T.B. at village level".  
Contributory Price Rs. 5/-



A Booklet in Hindi on "How to control Malaria at village level" as a guide to Panchayat leaders.  
Contributory Price Rs. 5/-



A Booklet on how to prepare herbal medicine for different diseases.  
Contributory Price Rs. 2.50/-



The book is only a collection of information from tribal traditional healers regarding medicinal plants and its use.  
Contributory Price Rs. 5/-

## LEAFLETS & EYE CARE KIT

### LEAFLETS ON DIFFERENT

#### HEALTH PROBLEMS :

With a purpose of providing simple and relevant information on different health problems. MP VHA published leaflets on the following subjects :

1. TB 2. Malaria 3. Scabies 4. Dental Care 5. Phneumonia 6. Malnutrition
7. Worms 8. Iodine deficiency 9. Anemia 10. Polio 11. Vitamin-A 12. Diarrhoea 13. Immunization

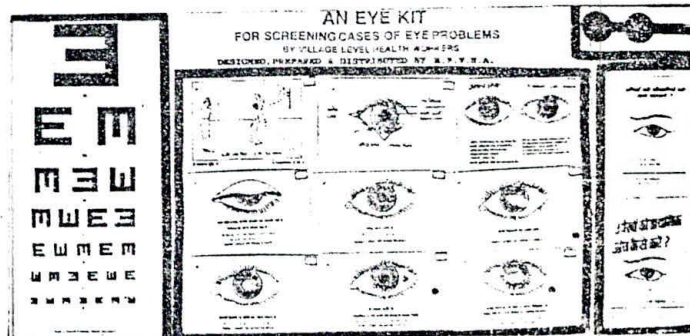
Contributory price of a set of 13 leaflets Rs. 6.50

Cost of each leaflet 0.50 paise

सिद्धि	मलेरिया	खुजली	दन्त कष्ट	प्लेग	कुपोषण
कमि	आयोडीन की कमी	रक्त की कमी	पोलियो	विटामिन 'ए'	दम

Madhya Pradesh VHA,  
9/4 Manormaganj, Street No.5,  
Opp. St. Paul Primary School,  
Indore - 452 001.

Phone : 0731-493 496  
Fax : 0731-493 103





*... The goal of health for all can only be reached through a fully democratic process : it must be a programme of health for the people, health of the people and health by the people....*

*...It is therefore necessary to abandon the existing centralized and top-down approach to the organisation of health services and create a new system of building from below with community based health services. This will be possible in a democratic, decentralized, and participatory system of government in which the people in a community have the authority, resources and expertise to prepare and implement all plans for their welfare, including health. It is this larger system that one should strive to create...*