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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JSR Review
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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.

II. INTRODUCTION

2.1 Brief profile of Madhya Pradesh

Madhya Pradesh with the largest land mass amongst Indian states presents a fascinating hue of cultural and geographical diversity. A total of 71,256 villages with varying population are scattered over this region and 76.82% of the State's population is rural-based. The State is divided into six regions, each with its own different characteristics (Appendix 1). To provide "Health Care for All by 2000 AD" in such a situation is a daunting task indeed. There continues to exist large unmet felt need for health services. As in rest of India, rural health care is a perpetual problem. Notwithstanding the vast network of Block and Sector PHCs and subcentres, a large percentage of rural population is unable to obtain comprehensive health care. A comparison of rural and urban birth rates (35 and 24.3 per 1000 population), crude death rates (12.6 and 7.3 per 1000 population) and Infant Mortality rates (105 and 75 per 1000 live births) reveals the extent of health problems and needs lying unfulfilled specially in rural areas. The above figures mask the wide inter-district variation (Appendix 2).

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
TOTAL		24	100.00

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

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

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

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

2.2.2 JSR Scheme versus CHW scheme

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

1. increased duration of training - six months (it was three months in the CHW Scheme);

2. increased stipend from Rs.200-00 to Rs.500-00 per month during the training period with funds coming from TRYSEM (it was Rs.200/- in the CHW scheme and the funds were not from TRYSEM);

3. no monthly honorarium is to be paid to the JSRs. Instead, JSRs who successfully complete the course are to be given a registration certificate which will allow them to 'practise' in the village which nominated them for JSR training. Guidelines which state that they are to provide curative care only for illnesses mentioned in their

training manual and for which they have been given training as well as the drugs they can use for treatment of these minor illnesses have been established. To assist in the establishment of their practise, JSRs who successfully complete their course are eligible to obtain a loan with subsidy from IRDP under TRYSEM;

4. only those who have passed upto 10th standard are eligible for JSR training (CHW scheme permitted those with formal education upto 6th standard and above);

5. whenever qualifications and other criteria are similar, women are to be given preference over men in the selection process.

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)	• Mental Health • Minor Ailment by Ayurveda/Yoga/Unani/ Siddha/Homeopathy/ Naturopathy/ Medicinal Plants (See Appendix 5)	• Working with community Anatomy / Physiology • Dengue/Filariasis • STD/Blindness • Patient examination

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

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

ii. Examine the **process of selection of the** JSRs by the community.

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

iv. **Evaluate the system of examination** for certification of the JSRs and suggest modifications if necessary.

v. 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)
Madhya Pradesh								
Total	**66,181,170**		**28.85**	**14.55**	**23.27**	**931**	**37.2**	**5.0**
Rural	**50.842.333**	**76.82**	**19.73**	**14.80**	**28.82**	**943**		
Urban	**15,338.837**		**58.92**	**15.72**	**4.87**	**893**		
Districts								
Bhind **	**967,857**	**79.40**	**23.55**	**22.17**	**0.15**	**813**	**39.0**	**5.8**
Rewa **	**1,318,172**	**84.77**	**22.81**	**15.38**	**13.56**	**946**	**40.9**	**5.8**
Dhar **	**1,187,702**	**86.86**	**15.64**	**6.85**	**59.45**	**960**	**37.2**	**5.1**
Vidisha **	**775,303**	**79.90**	**19.54**	**21.68**	**5.23**	**872**	**40.1**	**5.6**
Hoshangabad **	**920,695**	**72.66**	**26.32**	**16.84**	**22.20**	**904**	**38.0**	**5.4**
Bilaspur **	**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.

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

16.8% 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 "dont's" than do's (do not tell them this, do not teach beyond this level, etc...) or a revision of technical contents of the course. Also, in one of the training centres, the training consisted of "you know what to do, you are experienced enough" and the whole training was completed in a few hours.

There was absolutely no mention or reference to teaching methodology how to conduct training effectively or adult education techniques at any of the Centres. In 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. Atleast in three (27%) centres, we were told by the LHVs how the trainees would gravitate to the injection room, even if posted elsewhere, ask various questions on injections, show tremendous enthusiasm and pester the staff for allowing injections to be given by them. Thus, training on injection administration became a reality even though the JSR training manual clearly states that the JSRs are not to use injections in their practise. 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 mot 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 JRS on "Injections and IV fluid administration", and keeping in mind ground realities and expectations of rural people, they were sure that the JSRs would use "injections" and even provide irrational treatments and try tackling problems beyond their brief or training. Much as they were convinced of the need of the scheme to provide health care specially for those who have difficulty in reaching/obtaining curative care because of the distance/transport limitations, etc., they are also worried that they are helping in the production of "potential quacks". These contradictory viewpoints do not brood too well for the JSR scheme, for the above position and ambivalence at the top, can have severe repurcussions all down the line.

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

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

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

The ability of the CMO and staff of his office to interact appropriately with the IRDP officials 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 they are many loan applicants under TRYSEM from the various professions and also that there are many committee members with their own priorities. Hence the money meant for this scheme should come under the head of Health Department so that the budget is clearly earmarked for the scheme and not diverted for other activities.

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

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 Piparia 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 Piparia 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 Piparia 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

		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. 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.
3.	Contents	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 more of what they were trained less.
4.	Objectivity	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.
5.	Approach to health and disease	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 measurres 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. There is not even a mention of basic concepts like infection, immunity, inflammation which are essential for an elementary understanding of disease and healing. * 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. * 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). * Anatomy, physiology and epidemiology should be taught with the respective health problems rather than as separate topics as in Chapter 3 and 4. * 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. * There should be a separate chapter on common gynaecological problems like white discharge, excessive bleeding, etc., 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 illnesses, tuberculosis etc., must be prominently discussed, not just mentioned.

		There is need to orient CHWs on geriatrics, herbs in health, occupational medicine, village toxicology (first aid), etc.
6.	History and Examination	The disgnostic system is totally absent. Without this, how is the person expected to practice "first contact care" is an emigma. 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. 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). 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. The protocol for physical examination runs into two and a half pages without any demarcation into systems or prioritisation based on the patients presentation. 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. Taking of pulse is repeated at **three different places** 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.
7.	Clinical medicine and treatment	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! 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. 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. 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! 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 woulds, 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.
8.	Illustrations	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.
9	List of medicines	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.. 9a) List of medications to be used by the JSR: * 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. * 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. * 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. 9b) <u>Herbal medicines</u>: 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.
10.	Missing sections:	* 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. * 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).

		* A chapter on local and traditional remedies or its appropriate integration in relevant chapters. * A chapter on basic pharmacology and some details about commonly used medications; some description on non-allopathic systems and home remedies. * A glossary with all the technical terms used in the book explained in clear Hindi. * Lacking. Some simple tools of diagnostics are mandatory if they are expected to do clinical work independently.
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 (*Sankraman*).
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 *Andhatva Niwaran*. 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 renumerative).

* 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 s 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 renumerate 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***.

VIII.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)

IX. 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.

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)
Madhya Pradesh								
Total	**66,181,170**		**28.85**	**14.55**	**23.27**	**931**	**37.2**	**5.0**
Rural	**50.842.333**	**76.82**	**19.73**	**14.80**	**28.82**	**943**		
Urban	**15,338.837**		**58.92**	**15.72**	**4.87**	**893**		
Districts								
Morena	1,359,632	79.48	14.88	19.87	6.83	826	41.2	6.0
Bhind **	**967,857**	**79.40**	**23.55**	**22.17**	**0.15**	**813**	**39.0**	**5.8**
Gwalior	582,163	41.21	16.46	23.84	5.23	818	35.1	4.7
Datia	307,352	77.55	16.08	27.23	1.95	840	39.5	5.8
Shivpuri	960,907	84.81	9.36	19.87	12.78	848	42.6	6.3
Guna	1,054,741	80.50	10.12	18.80	14.03	875	41.4	5.9
Tikamgarh	781,815	83.10	15.39	23.42	4.60	868	42.1	6.1
Chhatarpur	934,552	80.70	14.12	25.11	4.45	855	42.6	6.6
Panna	598,378	86.98	14.85	20.97	16.39	901	42.2	5.9
Sagar	1,166,357	70.79	26.83	21.47	11.33	884	39.6	5.5
Damoh	735,203	81.86	23.52	20.14	14.76	908	40.1	5.3
Satna	1,176,220	80.27	22.19	18.23	16.05	929	40.7	5.7
Rewa **	**1,318,172**	**84.77**	**22.81**	**15.38**	**13.56**	**946**	**40.9**	**5.8**
Shahdol	1,375,673	78.89	12.85	7.20	54.26	961	39.3	5.3
Sidhi	1,284,586	93.53	11.40	11.52	31.99	934	44.3	6.7
Mandsaur	1,195,939	76.90	19.88	17.35	5.69	951	33.5	4.1
Ratlam	662,151	68.13	13.94	15.19	32.72	956	35.2	4.6
Ujjain	836,403	60.47	13.76	30.25	2.60	936	32.1	4.2
Shajapur	850,362	82.30	13.58	24.64	2.68	920	36.6	5.1
Dewas	766,147	74.11	16.20	19.55	18.50	933	37.0	5.0
Jhabua	1,032,325	91.32	6.83	2.79	91.14	983	45.4	7.0
Dhar **	**1,187,702**	**86.86**	**15.64**	**6.85**	**59.45**	**960**	**37.2**	**5.1**
Indore	561,397	30.58	22.53	19.82	12.09	919	29.6	3.6
West Nimar	1,722,871	84.95	17.58	9.76	53.00	956	38.4	5.3
East Nimar	1,037,491	72.47	21.04	12.26	36.09	940	38.5	5.2
Rajgarh	825,926	83.19	9.46	18.70	3.68	927	37.7	5.3
Vidisha **	**775,303**	**79.90**	**19.54**	**21.68**	**5.23**	**872**	**40.1**	**5.6**
Bhopal	270,677	20.03	15.15	21.68	4.26	873	32.5	3.8
Senor	690,025	82.01	15.07	21.73	11.53	901	41.2	6.0
Raisen	738,645	84.28	20.45	17.56	16.37	884	39.1	5.3
Betul	961,551	81.38	26.71	9.58	44.58	981	39.0	5.6
Particulars	Total Population	Rural %	Female Literacy Rate	Rural			Total (Rural & Urban)	

			Rural	SC	ST	SR	CBR (1984-90)	TFR (1984-90)
Hoshangabad **	**920,695**	**72.66**	**26.32**	**16.84**	**22.20**	**904**	**38.0**	**5.4**
Jabalpur	1,443,501	54.47	26.06	12.50	28.04	939	34.1	4.2
Narsimhapur	663,708	84.50	36.55	17.10	14.37	915	34.6	4.6
Mandla	1,192,213	92.33	18.57	4.98	64.87	993	36.5	5.0
Chhindwara	1,206,351	76.90	23.58	11.38	42.10	967	37.0	5.3
Seoni	906,024	90.53	27.14	10.81	40.16	980	35.7	5.0
Balghat	1,236,083	90.50	36.27	8.19	23.16	1,009	32.8	4.2
Surguja	1,831,471	87.94	12.50	5.09	59.22	969	38.2	5.3
Bilaspur **	**3,148,763**	**83.00**	**20.92**	**19.12**	**26.33**	**990**	**36.7**	**5.0**
Raigarh	1,559,232	90.53	23.48	11.13	51.16	1,009	32.5	4.3
Rajnandgaon	1,213,184	84.25	22.24	9.64	28.84	1,021	36.2	5.0
Durg	1,551,734	64.73	33.01	13.51	16.05	1,010	33.6	4.2
Raipur	3,136,420	80.26	24.40	15.06	21.58	1,007	34.4	4.6
Bastar	2,109,431	92.87	11.79	5.51	71.17	1,007	35.9	5.0

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

* * Districts visited by Study team

Source : Health Monitor 1994 & 1995 (FRHS)

XII. RECOMMENDATIONS

A. *SELECTION PROCESS*

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

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

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

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

B. *TRAINING*

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

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

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

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

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

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

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

* Introduce intersectoral cooperation and activities into the training curriculum.

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

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

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

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

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

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

C. EXAMINATIONS

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

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

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

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

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

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

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

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

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

E. SUPERVISION

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

* Give emphasis to supervision during the training process.

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

F. FUNCTIONS OF JSRs

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

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

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

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

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

G. ADMINISTRATIVE DETAILS

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

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

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

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

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

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

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

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

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

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

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

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

SOME CONCERNS

Attrition of JSRs

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

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

Small number of women candidates

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

Preventing unethical practise

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

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

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