A REVIEW AND CONSULTATION REPORT ON

JANA SWASTHYA RAKSHAK YOJANA OF MADHYA PRADESH

PART 1- THE STUDY REPORT

JULY –NOVEMBER 2001

COMMUNITY HEALTH CELL TEAM

BANGALORE

SUPPORTED BY DFID, NEW DELHI

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Finally, this study was the fruit of DFID's initiative. We are especially thankful to Mr Tim Martineau.

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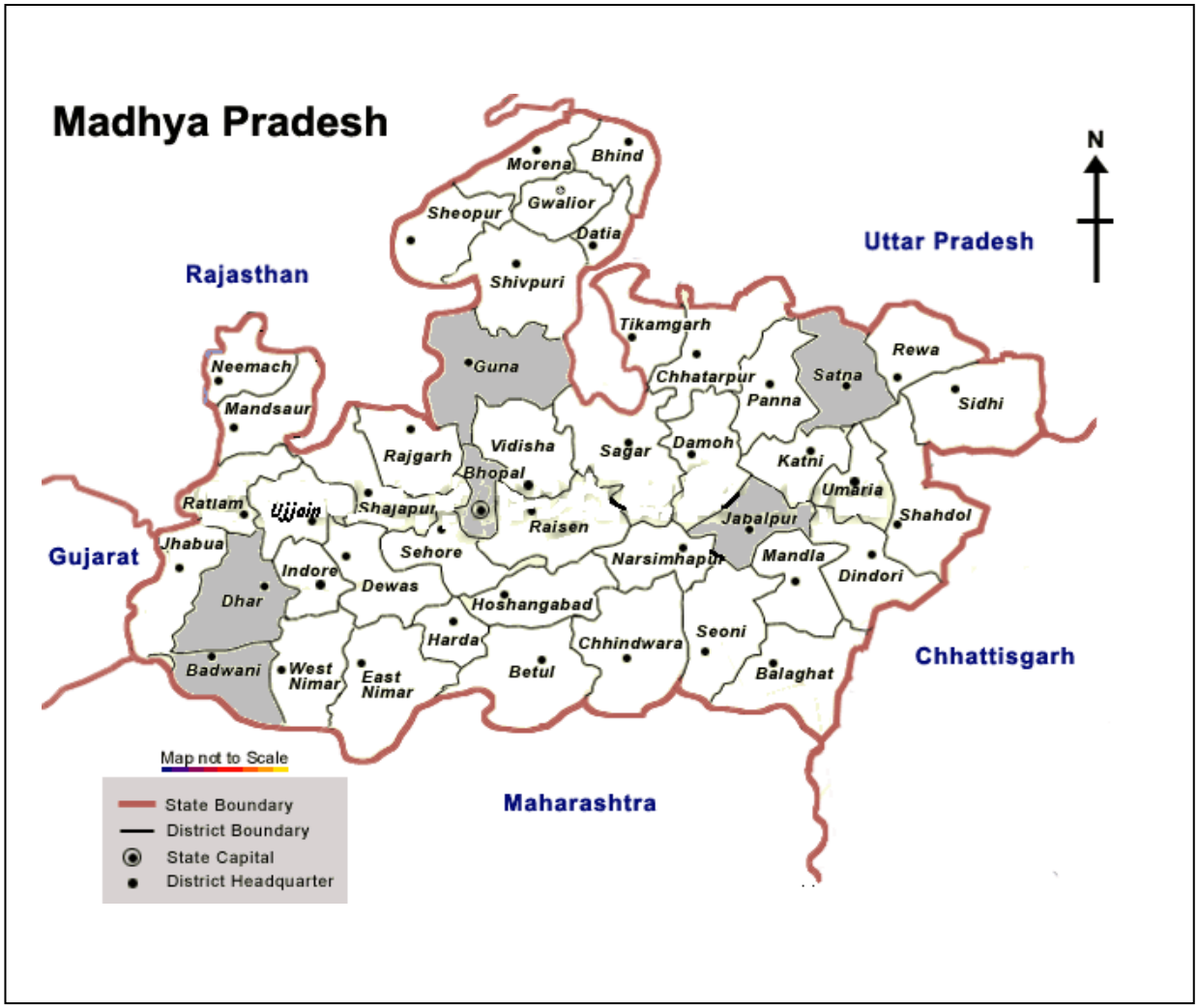
MAP OF SELECTED DISTRICTS OF MP



ABBREVIATIONS

ANM	Auxiliary Nurse-Midwife
AV	Audio-visual
AWW	*Anganwadi* Worker
BMO	Block Medical Officer
CBO	Community-based Organization
CD	Compact Disk
CEO	Chief Executive Officer
CHC	Community Health Center
CH Cell	Community Health Cell
CME	Continuing Medical Education
CMHO	Chief Medical and Health Officer
DFID	Department For International Development
DFO	District Forest Officer
DHO	District Health Officer
DHS	Department of Health Services
DTC	District Training Center
ET	Entry Test
GR	Government Resolution
GS	*Gram Sabha*
GSS	*Gram Swasthya Samiti*
HMO	Health Maintenance/ Management Organization
HS	Health Services
I/C	In-charge
IEC	Information, Education, Communication
ISM	Indian System of Medicine
JP	Janpad
JSR	*Jana Swasthya Rakshak*
JSR-T	*Jana Swasthya Rakshak-Trainee*
JSR-W	*Jana Swasthya Rakshak-Working*

MIS	Management Information System
MOPHC	Medical Officer, PHC
MPW	Multipurpose Worker
MR	Medical Representative
NGO	Non-Government Organization
NHP	National Health Program
OBC	Other Backward Castes
PHC	Primary Health Center
RCH	Reproductive and Child Health
RFWTC	Regional Family Welfare Training Centers
RGM	Rajiv Gandhi Mission
RKS	*Rogi Kalyan Samiti*
RMP	Registered Medical Practitioner
SC	Scheduled Castes
SJSGY	Swasth Jeevan Seva Guarantee Yojna
SHG	Self-Help Group
SHP	State Health Program
SS	*Swasthya Samiti*
ST	Scheduled Tribes
TBA	Trained Birth Attendant
ToT	Training of Trainers
VHG	Village Health Guide
ZP	Zilla Panchayat/Janpad

EXECUTIVE SUMMARY

THE CHALLENGE

Reaching primary health care to village and Adivasi communities all over India has been a major challenge for the central and state governments in India.

In the early 1970s, inspired by experiments in the voluntary / ngo sector and on the recommendation of the Srivastava Report the Government of India launched the Community Health Workers Scheme (see box 1).

> 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....."
> - **Srivastava Report, 1974**

Due to political exigencies, professional neglect and lack of sustained policy support and initiative, a large half number of the CHWs continue to 'exist' in the country on paper drawing a small monthly stipend due to legal requirements, but not functional in any other way. The unfulfilled agenda continues into the next century.

The state of Madhya Pradesh, responding to its own health situation and challenge, which includes a high unmet need of primary health care in the vast rural / adivasi areas of the state, launched the Jana Swasthya Rakshak Scheme in November 1995, under the Integrated Rural Development Programme for unemployed youth to provide round the clock curative and preventive and promotive health services in every village of Madhya Pradesh.

> Objectives of JSR Scheme
> "To improve the health in rural areas by providing a trained worker who can give first aid and treat small illnesses scientifically, in the village itself. Efforts are to be made to have both males and females in the scheme. To provide a trained worker in the village who can assist in the implementation of National Health Programmes and health schemes of the government..."
> **- JSR Scheme Booklet, 1995**

Initially, the Scheme was only supported by the Health Directorate as a technical resource group but a few years after the launch and a review in 1997, the scheme gradually developed closer links with the health directorate.

In July 2001, the Government launched the more ambitious Rajiv Gandhi Mission entitled Swasthya Jeevan Seva Guarantee Yojana (SJSGY) of which JSR scheme became an important component and one out of seven guarantees of services to be provided by the state government within a specified time framework at village level. (see Box 3)

SJSGY

- Providing a trained JSR in each village in June 2002.
- Providing a TBA in each village by June 2002.
- Provision of Universal Immunization.
- Three Ante-natal checks for pregnant women.
- Provision of safe drinking water-supply.
- Provision of nutrition cover to infants, <3 children, pregnant and lactating women.
- Sanitation in terms of solid waste management and waste water disposal in the village.
- A Village Health Register also leading to a Village Community Health Plan
- Development and Implementation of a District Community Health Mission Plan.

- SJSGY Booklet, 2001

THE EARLIER REVIEW

In 1997, a Review of the Jana Swasthya Rakshak Scheme was organised by the Madhya Pradesh government supported by UNICEF, after part of the training phase was over. The participatory, interactive review facilitated by Community Health Cell (CHC), Bangalore and entitled "Reaching Health to the Grassroots" was conducted between July-December 1997 and made important recommendations on the objectives, administration, selection, linkages, logistic support, communication, training, criteria for certification, supervision-monitoring-evaluation, examination; core project team and peer support.

In 2001, this, second Review was undertaken at the request of DFID and with full cooperation of the government of Madhya Pradesh especially, the new (SJSGY). The initial term of reference was expanded by the review team so that various policy options and perspectives could be provided for mid course correction and creative modification of the ongoing scheme.

Six researchers toured six (6) districts that were selected on the basis of HDR as well as to get a representative sample of the diversity of Madhya Pradesh). The teams studied 2 blocks per districts, 1 CHC and PHC per block, 2 villages per CHC/PHC were selected. The Review started in end of July 2001 (initial exploration) and the field investigations were done in three weeks in September.

Qualitative techniques including direct interviews, focus group discussions, case studies and opinion polls were the main tools. The 226 JSRs contacted responded to semi-structured questionnaires. The team interviewed all levels of stakeholders from senior government officers to JSR and community members. The respondents included district collectors, CEOs, nodal officers, media officers,CMHOs, BMOs, MOPHCs, health department staff including ANM/AWW supervisors and

old CHWs, PRI leaders, village community including users, NGOs, JSR-Trainers and JSR-workers and the other village-level health care providers including Bengali doctors and medical shops.

The Review also looked at the revised JSR manual and outlined further additions and modifications. In addition, to support the policy process, it studied all the JSR related government orders; provided check lists of medicines recommended for JSR use; possible roles of JSRs in National Health Programmes; list of recommended skills; and policy options to evolve the scheme further.

After analysing the data and all the documents, the key findings and recommendations are:

FINDINGS OF 2001 REVIEW

JSR Scheme

- The programme is in full pace but the community is not aware of it.
- High attrition (90%) mars the programme right from training phase. The few survivors – the practicing JSRs – are providing only curative care, that too of dubious quality.

Pace of the programme

The targets of training JSR are being achieved far too quickly, affecting quality.

Selection of JSRs

It is amply true that both the JSRs and the Grampanchayats think about recruitment rather than selection of JSR. The DHS has only administrative, not technical control, over the selection process.

Selection of women JSRs

Women are nearly missing except in one district where AWWs were selected. The problems are in the scheme framework, not just selection bias. Going entirely by education level keeps out women candidates.

Promoting quackery

- Many of the small number of JSR who are active in the field are becoming like private practitioners pushing saline and injections.
- Many quacks and unregistered practitioners have managed to get selected for JSR course to legitimise their practice.

Training

The training course is highly congested. Skill and attitude training was not adequately designed. There was a variance in clinical training from very simple empirical approach of diagnostic to getting trained for IV injection. The link between Objectives-training-practices was very weak. No plans for CMEs.

Linkages and preventive programmes

JSR's linkage with PHC is inconsistent and inadequately planned.

Learning tools

Right now there are no self learning – interactive tools except the reading of the manual. No learning by problem solving or doing except injection training and some dressings.

Role of RFWTC

The RFWTCs were well equipped with facilities and motivated training faculty.

Uses of drug

The JSRs are trained for very few drugs. Inevitably, this absence of necessary information leads JSRs to emulate quacks to build credibility. In addition, no one uses other remedies including the ISM.

Role of NGOs

No NGO seems to be involved in the scheme.

Flexibility

No special provision in the Scheme for innovations and alternative experiments in training and programme design or field implementation.

RECOMMENDATIONS

These are summarized in two complementary groups. Recommendations on the **process** of redesigning the scheme and recommendations on the **content** of the redesigned scheme.

A: PROCESS

Phase I : Pause, Consultation and Redesign (3 months)

Given the considerable problems of the existing scheme, new selections and training should be stopped and the field implementation of the scheme paused until redesigning of the scheme has been completed.

Organizing public consultations about the scheme (including suggestions for redesigning it), involving various interested actors including health NGOs, community based organizations and panchayat representatives could be arranged at the regional level and then at state level.

Formation of a JSR cell or task committee, which would redesign the programme in a time bound manner based on suggestions received during consultations. This cell should include experts from national/state level health NGOs / networks.

Phase II : Groundwork for relaunching the scheme (3 months)

Preparation of community awareness material : Village health committee orientation material and guidebook for JSR trainers Formalizing modified selection criteria and legal provisions for JSRs.

Organizing parallel groundwork activities

- Orientation of master trainers who would train the trainers

State level information campaign about the scheme, addressing village panchayats

- Dissemination of public awareness material
- Invitation and identification of NGOs / CBOs interested in helping the scheme in their areas.

Phase III: Relaunching the scheme at the field level (3 months)

- Conducting parallel activities at the community level **:** Inviting applications from village panchayats interested in the scheme (should fulfil basic conditions including formation of Village Health Committee)
- Investigation of functioning of existing JSRs in villages / areas from which applications are received. Joint decision to be taken by Panchayat and public health functionary about status of existing JSRs.
- Training of JSR trainers at district / block level.
- Orientation of Village Health Committee members including modified JSR selection criteria.
- Commencement of selection of new JSRs by Gram Sabhas using modified selection criteria; all trainees should be certified by Village Health Committee and block level public health functionary.

B: CONTENT

Overall framework of the programme

- The redesigned scheme should be put in a system framework and should be well integrated with the public health system. There may be a 'Collaborative model' with
- Community ownership in opting for the scheme, selection of JSR and monitoring
- NGO / CBO involvement for local supervision and community anchoring processes
- Government health system to give resources for training, work-linked honorarium, basic medicines and referral support, control of quacks.
- The programme should be anchored in the community, pace of the programme should be decided by community willingness to take up the scheme and not a top-down 'drive'.

Selection process and criteria for JSRs

- The Gram Sabha should recommend candidates but the village health committee / health department should ensure that the candidate is not an existing quack or non-resident JSR; some technical criteria for selection should be developed
- Women should be selected in most of the new villages; deterrents for selection of women should be removed including by lowering of the educational criteria for them; AWWs may be encouraged to become JSRs in consultation with ICDS.
- SC /ST / OBC should be encouraged; age group should preferably be 25-40.

Training process

- The training content could be split into two or three phases; basic to advanced, and the manual could be redesigned accordingly; continuing medical education should be organized.
- More practical and clinical content is required along with attitude forming processes like exposure to NGOs; need for extra reading material, may be JSR library at CHC.
- Less didactic and more problem solving approach, participatory training, training aids including audio visuals, proper venue, better trainers with more time, skill and involvement in training.
- Manual needs to be reworked with changes in content focus on attitudinal / social issues related to health and health care; availability of manual to both old and new JSRs.
- RHFWTC need to be involved from curriculum design down to field level training and monitoring; involve Open University, PSM departments and NGOs like MPVHA.

Medicine supplies and practices

- Prepare essential drug list, may be 3 level list (10 / 20 / 40 drugs) for basic to advanced modules; basic drugs (sub centre kit) to be supplied free by PHC to JSRs.
- Additional supplies from low-cost non-profit pharmaceuticals like LOCOST
- Encourage home remedies in first module, strengthen non-allopathic systems as per level.
- Action against quacks to cut down overuse of injection – saline; campaign to stop demand and prescription of irrational drugs in both private and public sector.

Community anchoring, monitoring and legal issues

- Need for widespread public information by posters etc.; rate lists and services of JSR to be publicly displayed; create mechanism for monitoring and control by Gram Sabha.
- 'Gram Swasthya Kendra' board and space by Gram Panchayat.

- Legal protection is necessary; guidelines for work only in self-village and use of defined remedies and procedures; periodic re-licensing based on technical and social performance.

Linkages and support from public health system; supervision

- Systematise linkages with ANM / MPW and PHC; involve JSR in NHPs and Government should give honorarium for the same which may be routed through Panchayat; adequate public funds to be made available for various forms of support.
- Discourage quack connection and links with private doctors.
- Develop simple reporting system and relevant, short record formats.
- Technical monitoring by public health system combined with social monitoring by Gram Sabha / Village Health Committee.

THE REVIEW : FINAL PRESCRIPTION

HALT, REVIEW AND REDESIGN

- The choice of right model JSR
- Think of JSR as a system, rather than individual PMPs
- A special JSR cell
- Legal provision, better identity (logos?)
- NHP support-logistical and financial
- Control quack practice
- Technical reforms
- Comprehensive task-list and problem-oriented training
- Select district centers for training
- Work out drug list for primary care, make rate lists
- Vigorous efforts for inclusion of other healing systems
- Work out monitoring lines and modalities, simple MIS
- Improve training, institute CME.

TAKE IT TO THE COMMUNITY

- Educate the village bodies and people about the scheme
- Provide village public space for 'JSR center' and standard equipment
- Try links with district RKS and other schemes
- Involve NGO in experiments – training, management, GSS involvement.

PART1: INTRODUCTION

VILLAGE-AN UNFULFILLED AGENDA IN HEALTH CARE

Villages-millions of villages-- are where most people stay even in this century in several countries in Asia, Africa and South America. Several health problems are rooted in the conditions of villages but an entirely different rural economics precluded the possibility of putting 'doctors' in these millions of villages. Modern Health services in such countries have always grown top-down through efforts of the State and have various levels of depth. In rural-predominated countries world over, the village remained the enigmatic issue in health services. In China a durable & comprehensive health care facility at the village level was a major success in the framework of its revolution. Several developing countries tried versions and variations of the Chinese lesson in seventies and especially post-Alma Ata. David Werner's pathbreaking book *Where There is No Doctor* arrived around this time. Seventies was the happening decade in health care at the grassroots. HFA & primary health care at Alma Ata gave a new framework for such efforts.

PAST EFFORTS & FAILURES IN INDIA

India's major effort at solving this problem came around in 1977, post-emergency and on the background of JP's movement. But presumably there were efforts within Central ministry towards making such a scheme. The Community Health Worker (CHW) scheme launched in 1977-78 in most states of India was a major effort for reaching the villages. There was a matching effort by NGOs in India for evolving models for such a scheme Jamkhed, Narangwal were new paradigms in health care. Along with the CHW came the AWW and the latter has persisted till date.

CHW scheme evolved till early eighties but started a downhill course thereafter. The shifting of the scheme to the family welfare dept was a major devolution where it would be monitored largely by the language of demographic performance. Health and medicines inputs soon became redundant in its new home. Till date CHW unions-or whatever is left of them- are struggling to ensure that atleast the 50 Rs a month stays intact.

The failure of the CHW scheme, needs to be studies against two parallel programmes—a) the Chinese barefoot doctor and b) the ubiquitous untrained 'quacks' (derogative regretted, they are a crying need answered by non-state forces) in the entire country. About half a million CHWs continue to 'exist' in the country on the pages of Health Ministry's reports ($) . Very few of them are functioning in any sense. The scheme withered away, leaving a question-mark on the primary care front of the country.

The unfilled agenda continues in this century too. Both the 10th Five-year plan and National Health Policy Draft mention the need to address the issue.

THE CHALLENGE: QUESTIONS AND CONSTRAINTS

1. The new effort if any is a more complex task since the past experience of the CHW scheme puts several constraints. New schemes of similar nature may attract legal battles when the old CHWs are struggling for more honorariums. Any new scheme will have to seamlessly merge with the old scheme, or at least steer clear of it.
2. On the background of fiscal discipline, need to downsize Govt. apparatus, inefficiency of state health systems (without reflecting on private system inefficiencies), any new scheme of employing staff on large scale (part time or full time is no matter) faces a stiff resistance.
3. Even if such a scheme is put in place as a special case, there is no guarantee that it will not go the CHW way (ANM and MPW systems are not particularly successful is another matter), since that will be part of the system that is not delivering goods already. The condition of primary health canters, and subcenters is already pathetic and the causes are not entirely financial.
4. The country has a large private sector, and the rural Private sector is bursting with quacks dotting the rural centers. A new CHW-like scheme can get catch the quack-germ and go haywire. Regulatory mechanisms are nearly absent for rural areas and in the absence of alternatives, no state Govt. can weed out quacks; it is politically impossible and socially not feasible. If any new CHW system can work as a feeder/tout to the private sector thanks to the pathetic weakness of public hospitals.
5. IMA and doctors' bodies are urban-metro centric, but the heavy concentration of the private sector in cities is dependent for fodder on the hinterland. Any serious effort on a CHW like scheme can jeopardize the economics of private-urban equation. For survival of this sector more developments must happen at secondary and tertiary level than at primary level. The dominant and vocal doctor-bodies are therefore against such schemes. On the other hand they are powerless against the wily quacks and have chosen to co-opt this sector for survival. When the issue of unserved areas is argued, the doctors bodies ask for creating facilities in the villages so that doctors can go there (practically this will never happen since villages will always be relatively far backward compared to cities). They also cite the trickle effect and the increasing number of medical colleges.
6. It is suitable for State Governments to start short medical courses for stating this cause of unserved areas and create new pastures. This is seizing the difficult problem from the *numbers* end rather than the *distribution* end.
7. The advent of Consumer Protection Act in medical sector, and renewed efforts the clinic/hospital registration acts by several states, however relevant, psyche the health administrations against CHW-like systems.

The issue therefore is framed: How to institute a working village level health-care-system on large scale:

a) In the framework of existing Public Health system

b) Without making it look like a monthly-payment scheme on large scale

c) Making it draw some sustenance also from the community (rather than the state alone, and make it economical and resource-efficient) without burdening the poor or making it irrelevant for poor unserved areas.

d) Ensuring that it will be sustainable

e) Preventing quack influence on the scheme

f) An optimal combination of curative and preventive-Promotive health, an optimal combination of allopathic, ISM and other alternative healing systems.

g) Making it legally relevant and safe

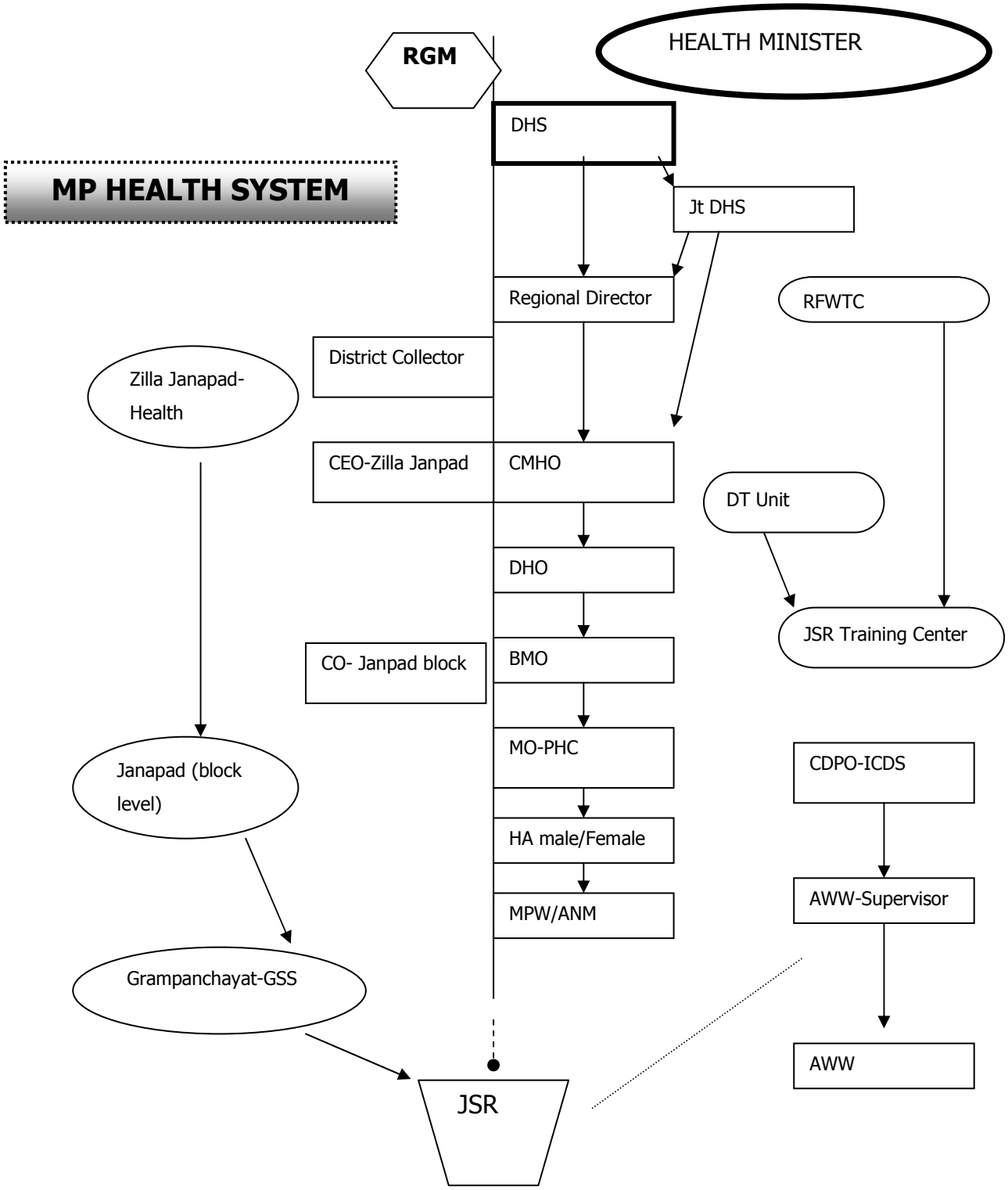
h) Framing it in the new concerns of gender

i) Bringing in the contexts of national health initiatives

j) And finally how to make this a politically safe, pertinent, and 'popular'

Instituting any such new scheme/programme is therefore dealing with a matrix of challenges, choices. It calls for new thinking on the background of past failures and new socio-political and technology environment. It involves a deft exercise in positing the solution with a flexible approach, accepting some constraints and offsetting them against more significant gains; of choosing a path of experimentation rather than straightjackets that finally become deadwood and obstacles.

How does the JSR scheme appear in this context, is the issue before us.


MP HEALTH SYSTEM
RGM
HEALTH MINISTER
DHS
Jt DHS
Regional Director
RFWTC
District Collector
Zilla Janapad-Health
CEO-Zilla Janpad
CMHO
DT Unit
DHO
JSR Training Center
CO- Janpad block
BMO
MO-PHC
CDPO-ICDS
Janapad (block level)
HA male/Female
AWW-Supervisor
MPW/ANM
Grampanchayat-GSS
AWW
JSR

HOW THE STUDY STARTED

WHY THE STUDY

This study is a result of DFID's initiative on the JSR scheme. Since the scheme is already halfway, DFID wanted to see some of its prime concerns about the scheme reviewed.

TOR AND CONCERNS

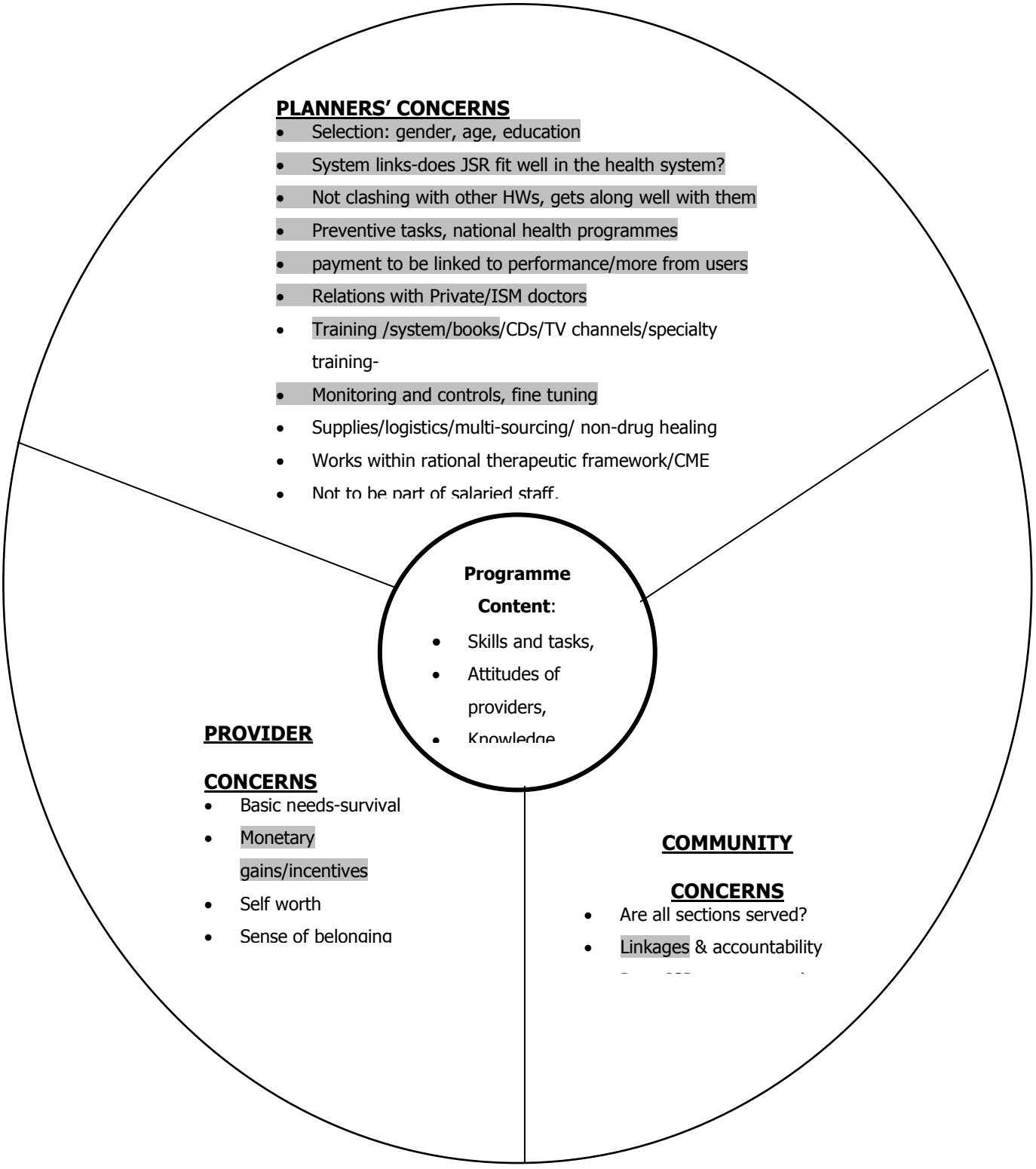
The concerns are listed in table given on page 21. Selection (esp women), training, linkages, remuneration, preventive programmes were of special importance to DFID.

ROLE OF CHCELL

The CHCell team added it own points for study.

FIRST CONTACT HEALTH CARE: FACTOR MAPPING

(Shaded areas are issues listed by DFID, others are listed by the study team)



Issues listed by DFID	Sub-issues	Possible exercises/possible methods
1) Selection of new candidates	Male female proportion?	• IV JSR, • IV programme officers • FGDs with users esp. women for health problems
	Education	• Assessment of desired Knowledge, Attitudes, Skills (KAS) of JSRs. Administering tests for required tasks if time permits • Availability of new candidates in villages
2) Preventive services		• larger list from free-listing responses from programme officials/JSR/MOPHC etc • Work out doable bits from NHP task-list
3) Training		• Appraisal of current training system-books, methods, institutes: Observation and IV trainers • FGDs with JSRs,
4) Supervision		• Appraisal of current supervision: technical tasks and social aspects of JSR programme • Suggesting outline of suitable record keeping system. Coding for illnesses and remedies. • Outlining a two-way communication system between JSR and JSR guiding-group in Health dept: FGD with Programme officers, JSRs
5) Village level; linkages/convergence	With other village HWs & Services convergence	• Task-list matrix of HWs/JSR, finding common areas of work • Exploring common platforms for some tasks • Exploring areas of conflicting interests
	With Community	• Appraising quality of routine contacts at clinics: OB • Exploring areas/opportunities of new contacts-Gramsabha?
6) ISM relation		• Task analysis of ISM (freelisting) • Exploring learning opportunities in ISM
7) RMP relation		• Task analysis of RMP (freelisting), • (Can we bring RMPs in the fold of JSR programme)
8) Linkages with health system	PHC/CHC	• Defining training/CME linkages: IV programme officers/JSR • Defining Referral linkages: IV programme officers for protocols • Detailing NHP linkages: IV programme officers
	Pr Med Pract	• IV Pvt Medical Practitioners: (Q is do we feel JSR should bank upon Pvt Medical Practitioners for support? That can be pitfall)

9) Incentives	Appraising current levels	• Assessment of local earnings of 'co-eds' staying in the village (FGD), and IV co-professionals if any. • Profiling aspirations of JSR (what they can take). IV JSR • Current family spending on comparable health problems (what people can give). Ref recent surveys. IV families • Modes of payment
	Preventive service payment	• Ref list of feasible preventive tasks developed in row 2 • Prepare operational models of listed tasks • IV JSR and health officers on costs/compensations in each case (For instance what does a school health screening cost per student?)
	marketing of public health goods	• List marketable/available public health goods • Outline strategy for marketing • Identify pitfalls/ solutions
10) JSR literature review		•
10) Meeting/inviting opinions of other health groups		• IV voluntary organizations in the state on all the above points • Workshop with development NGOs
(FGDs) Focussed Group Discussions, OB: Observation, IV: Interview, NHP: National Health programmes, PMP: Private Medical Practitioner, RMP: Registered Medical Practitioner, ISM: Indian system of medicine,		

PART 2: HEALTH PROFILE OF MADHYA PRADESH

JSR scheme was designed as a special response to the conditions prevailing in MP: a) vast number of villages without easy access to medical care b) Resource constraint in terms of trained personnel and finance. C) Health status and needs of rural people. Let us therefore briefly look at MP's health system.

The general Indian pattern of health services holds good for MP, only that it is sparse. The usual pattern of service facilities down the district-village line is District Hospital-CHC-PHC-Subcenter. The last unit is for five thousand populations, and in tribal areas for 3000 population. The line ceases here and health peripatetic workers are the last hands of the health system for villages. Aanganwadis dot almost every village but these serve only the child-welfare services. The old CHW programme is nearly defunct. The CHCs, esp. after the RKS, are working at many places we observed CHCs are doing surgeries. PHCs are established, but mini-PHCs (new PHCs) are underdeveloped. For curative care, village people are dependent on the PHCs and above.

The vast gap of services, is filled and being filled by private practitioners. Almost everywhere we saw Pvt Med Practitioners, including untrained doctors-called by media and policy experts as *Jholachaap*. This implies that an alternative was long due. In one small bazzar center in Bhopal dt, A team membersaw that a mini-PHC was devoid of patients and the next door Bengali doctor had his clinic full of patients-men, women and children. Many patients buy their medicines from medical stores and the stores do comply. [1]

JSRs as practitioners or health workers can not work in a vacuum. They need a niche in the rural health system. On one side they need linkages with PHC. On the other side-As practitioners -- they have to compete with the "jholachhap doctors" and Bengali doctors. Generally, every bazaar center (center of 15-20 villages) and major village has these Pvt Med Practitioners. In a village center (town?) of 10000 population, we counted 22 such Pvt Med Practitioners. This block of two-lakh population has, so says the Health Assistant, "200 Pvt Med Practitioners". If anybody thought of JSRs as professionals earning on clinical practice, the norms/models/role models/practices are established and there is some tough competition to face.

[1] This system is legalised in Philippines as not only medical stores but even genereal stores sell some medicines directly without prescription. Getting rid of a doctor thus saves some money for the poor villagers

SOCIO-ECONOMIC AND DEMOGRAPHIC PROFILE OF MADHYA PRADESH[2]

Madhya Pradesh, called **MP** in short, spreads over 443 thousand square kilometers. It accounts for 14 % of India's land and 8 % of India's population. It was divided into 61 districts including the districts now in Chhattisgarh. Population density in square kilometers is 149 in 1991, more than double than 1951, when it was 60. Though it is low compared to other states in India.

Economic features: Agriculture is the main livelihood for most in the state. Agriculture provided livelihood to 76 % of the working population. (Census, 1991). The major crops include wheat, rice, *jowar, bajra,* sugarcane, maize, cotton, groundnut, soyabean, pulses, gram, and *tu*r.

Industry is scattered in MP, mainly surrounding some of the major towns. MP is a major producer of cement in India. MP is also the second largest producer of minerals in India including coal, iron ore, and manganese. Other industries are food processing, petrochemical, automobile and electronics. MP had taken an early lead in optical fiber production for telecommunication

According to the Planning Commission, 41 % of the rural and 48 % of the urban populations in MP were below the poverty line in 1993-94 (CSO, 1999).

Demographic features: MP had a population of 66.2 million in 1991, up from 52.2 million in 1981. The population sex ratio was 931, marginally higher than the average for India (927). It has decreased from 971 in 1951. (Census 1991) Also, the proportion of the total SC population is 14 %, slightly lower in MP than in all of India (16 %). The state, however, has the highest ST population in India apart from the Northeastern States. It has increased to 23% in 1991 from 20% of the total population in 1971. Together, SC & ST make 39% of population.

Literacy rate for population of age seven and above was 44% compared with 52% for India as a whole. (Census 1991) 57% for males and 28% for females in MP compared with 64% and 39% for males and females, respectively, for India.

HEALTH STATUS OF PEOPLE IN MP

Health Indicators: Crude Birth Rate in Madhya Pradesh was 30.7 per 1,000 population in 1998 and the total fertility rate was 4.0 children. (SRS) Both these rates are fourth highest in the country, lower only than those for Uttar Pradesh, Rajasthan, and Bihar are.

Infant Mortality Rate in 1998 (SRS est., 1998) was 98 per 1,000 live births - the highest along with Orissa in the country. In India, the IMR was 72 per 1,000 live births. The life expectancy in MP was 54.7 for males and 54.6 for females for the period 1991-96, which is lower than that for all of India (59.7 for males and 60.9 for females).

[2] The profile is about the MP state including Chhattisgarh because most of the available data is for the period Chhattisgarh state was established.

Table 1 ***Health Indicators in MP,*** *Source: SRS, 1997*

Indicator	Reference period	M.P.	All India
Life expectancy at Birth (in years)			
Male	(91-96)	59.24	60.6
Female	(91-96)	57.96	61.7
Crude Birth Rate	(1997)	31.9	27.2
Annual Pop. Growth Rate	(1981-91)	2.68	2.39
Crude Death Rate	(1997)	11	8.9
Infant Mortality Rate per 1000 live birth	(1997)	94	71

HEALTH INDICATORS FOR WOMEN AND CHILDREN:

Table 2 Nutrition in Women and Child's Health

Indicator	**In MP %**	**In India %**
Women with anemia.	54.3	51.8
Women with moderate/severe anemia	16.6	16.7
Children age 6-35 months with anemia	75.0	74.3
Children age 6-35 months with moderate/ severe anemia	53.0	51.3
Children chronically undernourished (stunted)	51.0	45.5
Children acutely undernourished (wasted)	19.8	15.5
Children underweight	55.1	47.0

Source NFHS2, 1998 (excluding the data of Chhattisgarh)

Table 3 Health Indicators for Women and Child's Health

Indicator	Total (in%)
Preg women with some ANC	60.0
Preg. Women with full ANC	22.4
Institutional delivery	22.6
Safe Delivery	29.3
Child with Complete Immunization	50.3
Child with no Immunization	9.9

Source: RCH Annual Survey, 1998

HEALTH INFRASTRUCTURE

Most of the people (62%) seek health services from private doctor, poor or not so poor. (NFHS2, 1998) Only 10% use CHC/PHC for their health problems.

Others using the public health services (22%) prefer the Govt. or a municipal Hospital situated in a district headquarter.

Few people do take self-medication or approach the nearby source like sub centers, drug store, traditional healers or other 'pathy' doctors.

Table 4 Utilisation of Health Services

Indicator	**Rural HH**	**Poor HH**
Public medical sector	**34.5**	**36.6**
Govt. Hospital/Disp.	21.5	23.5
CHC/RH/PHC	10.0	11.2
Sub Center	2.3	1.6
Others	0.9	0.3
NGO/Trust	**2.9**	**3.2**
Private medical sector	**62.2**	**59.8**
Private hosp/clinic/pvt. doctor	60.7	58.6
Vaidya/hakim/homeopath	0.6	0.2
Others	0.9	0.9
Others	**0.5**	**0.5**

Source: NFHS2, 1998

There is no major difference between the urban (66%) and rural (62%) community in seeking health services from private sector. However, there is a big gap in the availability of doctors and hospital beds in rural and urban areas. Urban areas have 18 times more doctors and 36 times more hospital beds than in rural areas. This is substantially high more than double than the average disparity in India.

Table 5 Health Infrastructure in Rural and Urban Areas of Selected 9 States

	Doctors Per 100,000 Population			Hospital Beds Per 100,000 Population		
State	Rural	Urban	Urban/ Rural disparity (times)	Rural	Urban	Urban/ Rural disparity (times)
Kerala	39	117	3	198	481	2
Punjab	76	260	3	68	233	3
Gujarat	20	115	5	22	346	16
Maharashtra	24	117	5	21	308	15
West Bengal	27	155	6	17	264	16
Andhra Pradesh	13	144	11	9	203	23
Tamil Nadu	18	202	11	12	237	20
Madhya Pradesh	*3*	*55*	*18*	*4*	*145*	*36*
All India			8			15

Source: Health Expenditure Patterns in selected major States, by Ravi Duggal, 1995

Govt. of MP has recognized that the major problem of extending medical and health care to the people of this State are large distances and poor network of communications.

GoMP has made efforts to increase the no. Of sub health centers, primary health centers and community health centers in the rural areas. The M.P. Govt. has planned to establish 201 new Community Health Centers with adequate staff, equipment, medicines and other para-medical facilities, 340 CHC's building to ensure that there is a CHC at each block headquarter where such facilities does not exist at present. To reduce the patient load in district & other specialized hospital, it is proposed to upgrade selected sub-divisional level health institution into 100 bedded Rural Hospital with all diagnostic and treatment facilities. (FRU).

RKS

RKS, a government led NGO, at every level down to PHC, is playing a significant role of mobilizing community resources with administrative reforms in hospitals. Mainly RKS implies raising and using funds locally. We saw several such reforms in various DH and CHC. This is very positive and innovative development at the FRU level.

PROVISION FOR HEALTH SECTOR IN THE NINTH PLAN (1997-2002)

The thrust areas of the Ninth Plan have provisions of basic minimum services, women, and disadvantage groups empowerment, people's participation process and self-reliance.

Apart from its top-priority to ubiquitous "relentless population growth", the Ninth Plan has expressed its commitment to "... major share of public investment … (in) health care services, placing greater emphasis … on community-based systems." It has also stated " … that training of medical professionals, willing to work in rural areas, through innovative medical schooling systems would be given attention."

The Ninth Plan also highlights the need of decentralized planning and implementation and for 'devolution of funds'.

The Ninth Plan has increased its outlay for Social Sector substantially to 8077 crores (from 19% in 8th Plan to 42% of the total in the Ninth Plan). This shift in its priorities reflects the emphasis on basic minimum services at the national and at the state level. Basic Minimum Services includes capital investment for equipment and buildings for Primary Health Care. It also commits to increase the coverage of ICDS in rural and urban areas. The outlays for basic minimum services during the Ninth Plan would be 40% of the entire social sector.

EVOLUTION OF THE JSR SCHEME

Considering the cue of the Ninth Plan, the peoples' felt need of easy accessibility of health service with their participation in planning and implementing the health action, Rajiv Gandhi Mission introduced an innovative JSR scheme in 1994-95. After reviewing a varied impact of the project by RGM, the GoMP announced a SJSGY in July 2001.

SJSGY has three key factors:

- SJSGY is a rights-based "framework of a guarantee by the government": a basic minimum health service would mean provision of a package of essential health services and other health related needs like nutrition, safe drinking water and sanitation.
- SJSGY Planning and implementing at the district, panchayat and village level with he devolution of funds.
- Community control and creation of community level skills in managing and/or providing basic health care and prevention

The SJSGY is expected to reduction of infant mortality, reduction of maternal mortality. universal immunization, reduction of birth rate, universal safe water coverage, universal sanitation coverage and universal nutrition coverage to young children.

The SJSGY includes a District-level Program for Health. It will be built on the basis of a collective problem definition through a Peoples' Survey of Health. The survey will map the current status of health provision, providers, burden of disease and the status of the key determinants of health. These will form the basis of a Village Health Register that would be used at the Panchayat level. Village-level health indicators contained in the Village Health Register will be aggregated to form district level Health Plans.

The district level the SJSGY will be guided by a district health committee headed by the Chairperson of the ZP. It will be implemented by an Implementation Committee headed by the District Collector The District Health Official will be the Congener of both Committees.

1. Collector (Chairperson and Mission Leader)
2. Chairperson Health sub-Committee of Zilla Yojana Samiti
3. Chairperson Health Committee of the Zilla Panchayat

- CEO ZP,
- EE PHED,
- District Women & Child Development officer,
- Civil Surgeon
- District Head of all Health Programs
- Mass Media Officer (health)
- Public Relations Officer
- Two Block Medical Officers
- Two representatives of NGOs in health sector
- Two representatives from Private Health Practitioners
- CMHO, Congener

SJSGY will be funded through the pooled resources available (a) by converging the funds within health sector and (b) by provisions for determinants of health like nutrition, sanitation and drinking water. In addition, funds will be made available as a District Level Community Health Action Fund for the SJSGY.

Implementing SJSGY: Key Components of the SJSGY are the following:

A Core Set of Services to be guaranteed by the state government within a specified time-frame at the village level:

- Providing a trained JSR in each village by June 2002.
- Providing a TBA in each village by June 2002.
- Provision of Universal Immunization.
- Three Antenatal checks for pregnant women.
- Provision of safe drinking water -supply
- Provision of nutrition cover to infants, <3 children, pregnant and lactating women
- Sanitation in terms of solid waste management and waste water disposal in the village

1 A Village Health Register leading to a Village Community Health Plan

2 Development and Implementation of a District Community Health Mission Plan

Gram Swasthya Samiti Implementing SJSGY will be the responsibility of a Gram Swasthya Samiti created under the GP at the village level. It will have a mandate for health action as well action for safe water supply, sanitation and nutrition.

Gram Swasthya Samiti is a "stakeholders' committee constituted by the Gram Sabha under the Panchayat Raj Act that incorporates Gram Swaraj. Gram Sabha will determine the number of members of the standing committee on health. The number of members prescribed under the Act is 12 of which fifty % of the members shall belong to Scheduled Castes, Scheduled Tribes and Other Backward Classes, two third of which shall be from Scheduled Castes, Scheduled Tribes and remaining one third from other Backward Classes. The standing committee on health shall have at least one-third women members.

The Health committee under the Act shall have a president who shall be elected by the members of the committee form amongst themselves. The president shall be elected amongst the members belonging to Scheduled Castes, Scheduled Tribes, Other Backward Classes, Other Category and from amongst women members by rotation. The term of president shall be one year.

The Act also provides that the health committee shall elect from amongst the members of Gram Sabha a Secretary by two-third majority of members of the committee. *If there is " resident **Jan Swasthya Rakshak** in the village he shall be nominated as Secretary of the Health Committee.*

VILLAGE HEALTH PLAN

In all the 51,806 villages, a Lok Sampark Abhiyan on Health held in February made an effort to prepare a database on the health status of each village. It still becomes a good starting point. This survey would help in preparing the Village Health Register. Using this data, the GSS will be able to carry out its mandate on health covering safe water supply, sanitation, and nutrition. The GSS can also access resources that are collected by the Gram Vikas Kosh apart from the support provided by the GoMP.

PART 3: MATERIAL AND METHODS

THE CHCELL TEAM

The CHCell team consisted of consultants working in the field of primary care. The team had following members:

1. Dr Ravi Narayan
2. Dr Dhruv Mankad
3. Dr Shyam Ashtekar,
4. Prof Mohammed
5. Dr Abhay Shukla,
6. Dr Shashikant Ahankari,
7. Shri Amulya Nidhi

PREPARATORY VISIT

Two preparatory visits were conducted. The first, by Dr shyam ashtekar in March 2001. This was an interview with RGM officials. Health dept and a filed visit to PHC/CHC and JSR villages and a Bengali doctor. The purpose was to understand the likely tasks and nature of the JSR programme. This helped to build a rapport and also to frame the TOR. Concept of the study was shared with the RGM CH.

The second visit by the team members (Dt Rajgarh, block Khilchipur) came about in July 2001. During this visit the team observed some training sessions, met working JSRs, trainers, Health officers, RFWTCs etc. This gave the team a feel of the programme. It also helped frame actual methods and questionnaires. Logistical planning was done after this visit.

Sufficient time was allocated between each visit to internalize the issues. Email exchange on methods and questions helped sharpen the study tools.

SELECTING DISTRICTS

The main aim of the review exercise was to consult various stakeholders. Since, JSR Scheme was implemented all over Madhya Pradesh, the team decided to visit various places to collect relevant information.

Following the preparatory visit's experience, sample districts were selected purposefully based on the following three criteria:

- Human Development Index
- Region representation
- Tribal population

Feasibility was another factor considered. Since the stakeholders are present at the district, block and village levels, samples of all the three locations were essential. In addition, RFWTCs were also

selected because curriculum designing, TOTs and the manual had major contributions from the faculty.

Considering these criteria, we studied the following

- 6 districts, 2 blocks per districts, 1 CHC and PHC per block, 2 villages per CHC/PHC
- 3 Regional Family Welfare Training Centers

Some changes were made after consulting Dr Agnani, RGM. He was asked for his opinion about the better districts in the JSR Scheme. The purpose was to look at what innovative, best practices were implemented and initial problems solved.

After the deliberations among the team members and RGM 6 districts were selected based on HDI. The blocks, the PHCs and the villages were to be selected in consultation with the CMHO of the selected districts. Districts, blocks and villages visited by the teams are:

District	**Block**		**Villages**		**Team No.**
	Name	**No**	**Name**	**No**	
Barwani	Silavad Sendhwa	2	Seganva, Avali, Rehagun, Bhutkira, Devali, Shely, Warla	6	1
Dhar	Bagh Dhar Dhamnod Kukshi Nalcha	5	Bagadi, Bagadi phata Dhamnod, Ali, Lonera, Patlipur	5	2
Jabalpur	Barela Majholi	2	Kalgodi, Barha Pipariya, Khabra	4	3
Satna	Nagod, Suhawal Majhgawan Maiher	4	Umari Patelan, Sanwalia, Kothi, Hiroundi -	4	3
Guna	Aron Raghogad	2	Salaya, Miana, Shirsee, Nandner	4	4
Bhopal	Bairasia Phanda	2	 Gandhinagar	1	5

TIME FRAME

The study was started in July 2001 (initial exploration); the field investigations done in September 2-27 and analysis took another 8 weeks. The logistics for visiting selected Districts was decided on the assumption that the team would cover the selected locations and the stakeholders in districts 3 days. One buffer day was allowed to complete the logistics or for communicating among the teams for any changes.

SOURCES OF DATA

The evaluation involved all the possible stakeholders at each level. A list was prepared and they were clubbed as a Group based on their interaction level with the JSR Scheme, their stake level

and their interests in the actual functioning of the Scheme. The number of respondents with their Groups is:

Level	**Stakeholders**
District, Blocks	Collector, CEO, Chairperson ZP, Janpad, members of JPSS
Village	Community, GP, GSS, Teachers, Users
District, Block CHCs , PHCs	CMHO, DHO, BMO, MOPHC
District, Block, PHCs	RFWTC, Trainers, Training I/C
Block, PHCs, Villages	ANM, MPW, Supervisors
Villages	AWW, TBA, Trainee or Practicing JSR
Block, PHCs, Villages	Pvt Med Practitioners, Bengali Doctors, Practicing VHGs, Pharmacists
All the levels	NGO, Journalists

ISSUES COVERED

SCHEME /SELECTION

Gender, Education/ Other social factors, Distance factors, Non clinical Role, Who selected?

TRAINING/T/JSR

Venue, Schedule, Method and Content, Changes, Trainers, TOT, Manual

WORK-CONTENT

Tasks, Illnesses, referral &workload, Records & reports, NHP, Use of medicines & skills, Problems/suggestions

COMMUNITY

Links, NHP Linkage, GP/GS/GSS, Links with PMP, Users, PHC, Supervision/Referral, Feedback/Report, Economy, Fee/Income, Honorarium, Depot holdership.

DATA COLLECTION METHODS

This is a qualitative study, doing an in-depth inquiry of the programme over a small sample. Intensive consultation was done on the methods and samples. Interviews, observations, FGDs were the main instruments. All narration are recorded on field diaries and some photographs and documents also collected.

Interviews

The main objective of the evaluation was to consult the stakeholders of JSR Scheme. It was decided to have Focus Group Discussions with the Groups identified and direct interviews with individual members. A set of issues addressed while interviewing the respondents was prepared. An exhaustive list of questions related to each Group was prepared as given in Volume2.

Opinion Poll:

Since the interviews would give the qualitative information about the trends among the geopolitical levels, it was decided to collect opinions from the key informants representing the

Groups. A questionnaire was designed with 3 questions focusing on their suggestions. The respondent should be involved in the JSR Scheme. See Volume2

JSRs' perceptions:

The JSRs are the pivots around which the Scheme has evolved. Their perceptions, opinions, experiences and knowledge form the main plank of the study. This was the outlook of the Evaluation Team. An exhaustive questionnaire was designed for Trainee JSRs and the Practicing JSRs. (Pl See Volume2). Total of 204 Trainee JSRs and 22 of Working JSRs have responded. (The Working JSR actually means one who has taken training earlier. The nomenclature comes from the process—the PHC/CHC MO was asked to name any working JSR in the area, hence the name working-JSR Some of them are not actually not working as JSRs)

Case Studies:

The family background, social milieu, their operational area, and their links with the various health care providers and with the community form the basis on which the JSR model can be built up. Profiles of Practicing or Trainee JSRs give insight to these aspects. See Volume2. Case studies are presented.

Consultation in the group:

At the end of each leg the team held discussions and at the end of the field study, the 4 members sat at Bhopal for two days discussing various concerns and issues investigated. The exercise is presented in a table format. It was then circulated on email and finalized. The last consultant added his remarks on email.

Study of documents

Documents of the JSR scheme, mainly Govt. orders and books published were studied.

ANALYSIS AND REPORT

- The response sheets from JSRs were rendered into standard phrases evolved on perusal of sheets. For instances responses to the question "what is your dream" evoked answers like want to become a doctor, do daktari in village, run a clinic, doctor-*jaise banoo* etc. These were converted into the key phrase "become doctor". This rendered the data treatable in Excel format.
- The major challenge was in interviews. The consultants evolved together a free-list of questions for each category of respondents, which was used as guiding list for interviews. Each consultant into a word format converted the field diaries in a 4-Column table style (issue-subissue-response-remark). The statements were again combed by one researcher, split into issue-wise rows and then sorted by category. This gave us a bunch of responses from various respondents on each issue. Scanning this enabled us to write the major opinion, variants and nuances. This was used in writing the results and discussion. The full text was shared with all the team before finalization.
- Two consultants studied the JSR manual and a separate review is enclosed.

- The documents circulated by the Directorate of Health Services in Bhopal were studied separately and the major points are listed in table.
- There were several quotable quotes that describe the situation aptly and lively, we have used in them in places in Hindi with an English version wherever necessary.
- Several photographs of JSR situations, health institutes/health system and NHPs have been taken by the team, and in a Qualitative study like this, we wish to reproduce. Pictures tell what thousand words may not. Some of them can betray identities; the choice is therefore kept to minimum.

PART 4: RESULTS AND DISCUSSION

THE JSR SCHEME

"The scheme is good, every village will have a medicalka aadami, but nobody (JSR) works, the JSR is a homeless bird" ---A pradhanpathak of Kuxi high school sitting in a discussion in Janpad in Kuxi)

JSR scheme was a response to the gaps in health care services, which could be filled up. Why not train some youth from the villages in basic medical care and let them earn a living in their villages was the basic plank of JSR scheme when it was started in MP in 1995-96. TRYSEM loan was promised, but was rarely given. A CMHO quipped: "*Seekho, loan le lo aur dookan kholo !*" (Get trained, take a loan and open a shop). In 2000, the scheme was re-launched as part of the health guarantee scheme - SJSGY, placed in hands of the GS. So the scheme was constructed as part of the primary health care effort. To date some 15000 JSRs have been trained in various districts.

In this study several respondents --mainly officers-- have hailed the concept. They also affirm that it exists only on paper. In the recent Lok Sampark Abhiyaan too, nobody talked about the scheme. A media source corroborated this. In the entire tour of the State, none of the team members came across a single slogan- wall writing, poster, and pamphlet about JSR in any villages. Several villagers we met did not know what this scheme was. In Dhar district, where Smt Soniya Gandhi launched the JSA scheme in July, the CEO of Zilla Janapad felt it was a 'mixed' picture.

Opinion poll indicates that there is a lack of preparedness / preparation of community for the JSR Scheme.

An important and positive outcome of this study is that respondents from all levels recognise the need of a health care provider in unserved villages, and indirectly appreciate the launching of the JSR scheme. However neither the public health system nor the providers - not even the community - are happy about implementing the scheme and sharing information about it.

At the level of PHC staff, some confusion about the old CHW and the new JSR scheme exists.

In media reports, and in elite circles, the oft-repeated phrase of " neem hakim, khatara-e-jaan" signifies a cynical view of the scheme. But the common villager expressed the need for a village based health care provider in no uncertain terms. That is the real mandate to the JSR scheme.

SELECTION

"I was told about selecting the JSR in 18 villages (6 SCs and 3 villages per SC) I don't know the role of JSR and their objectives. How can they become Dr in such short course?".. MO/PHC

"Problems are at every level".. A CMHO

All the 22 JSR-Ws have responded that the gram panchayat and/or Sarpanch selected them. In a sense this is true because the Sarpanch has to sign the '*avedan*' (application) of the candidate. The JSR-Ts also have responded similarly. The usual process is: a prospective candidate getting news of the scheme from either PHC staff or the Janpad at the block level; making an application to the gram panchayat and getting an approval. At places, there was some competition for the selection, decided often in favour of merit. But in majority of places, the selection seems to be uneventful and without much competition.

Women have been nearly left out, unless like in Guna where the District collector was keen on AWWs getting the training. In Satna district, women SHGs however said that they were not aware of the scheme, leave alone women-preference. Otherwise they had suitable women candidates.

The interviews underline similar trends, the candidate makes an application to gram panchayat/ Sarpanch and then gets an approval for the same. If more candidates presented themselves, higher education/more marks settled the issue.

What is not evident is the role of GS. Is the GS really involved, and does it have choices? Are the choices exercised? These are moot questions. The selection process seems limited to giving an application to Sarpanch/gram panchayat and getting it approved.

The role of medical officers in selection is weak.

From field /interviews and observations various JSR-background features appear.

Gram panchayat and Sarpanch figure frequently, as selectors and the Sarpanch is a proxy for gram panchayat. In rare cases GS (3 different districts-Satna, Jabalpur, Dhar) is clearly mentioned. In one case of GS, it was called because of selection-problems (caste? Or factionalism?). In the second case, it is because of NGO influence. In the last case, GS met to discuss merit. Nomination happened in two cases. In some cases CMHO + district committee have exercised the power and set aside gram panchayat nominates. In some cases the Sarpanch has sent candidates from other villages.

The Survey team (Lok Sampark Abhiyaan) had a role in preparing a list of candidates in one district. In another district, CMHO was the key person in selection as he says "Anyone with a 10th Std. Pass, applies to him directly or through the Sarpanch. It is the selection committee consisting of CEO,

Janpad, BMO, SDO (Is the representative also a member? At a CMHO office, the LDC was called and he said, "No. Gram panchayat has no role. No meetings take place for selection." But there is no complaint from panchayats about political interference in the selection process."

Opinion poll confirms the findings about JSR selection. Also, the respondents felt that selection at panchayat level is without much interest, and politics is also involved.

It is clear that A) Poor candidates have also been selected. B) Practising Pvt Med Practitioners have managed an entry C) some selected JSRs are practising in adjoining villages; also non-residents have been selected. D) Some JSRs are relatives of Sarpanch / member, or Pvt Med Practitioner (particularly so in Bhopal district). The last three observations are disturbing, indeed.

How to select JSRs? Are there some criteria that can assure a better performance, sustained work etc? This is an unresolved issue and the MP-JSR scheme can not be entirely blamed for that. Some general framework for selection that emerges is: a woman, who has borne a child or two, some one who has done some previous work including education, a willingness to work despite low or no monetary return, a community loving person. How to ensure that women come forward is a proven difficulty in MP. Partly it is purdah, lack of education and the workload in homes. Partly the system has not done enough efforts.

The design of the scheme decides how JSRs will later function; the selection by itself can not steer the programme. Important issues are training, linkages, supports, monitoring and incentives.

DISTANCE

Nearly 67% of JSR-Ts belong to the same village. Surprisingly 33% come from some distance. About 19% trainees stay more than 3 Kms away from the village of their work. Some candidates hail from villages as far as 8-25 Kms. whether this last anomaly is a misconceived response to the question of distance or is true: this is not possible to resolve here. Several Pvt Med Practitioners in Bhopal, residing far away, have gained entry in the Scheme. This is just to get one more certificate—this one from the Govt.

Similarly not all JSR-Ws are from the village which has selected him. Of the 22 studied, 16 are local candidates, another 2 within 2 km., 4 stay beyond 4km. We found 2 JSRs 'commuting' 12 km.'for work'. What were the reasons in selecting such distant candidates is unknown. Paucity of educated candidates in the village could be one reason. Entry of non-resident Pvt Med Practitioners may also be a cause.

The compulsion to select distant candidates is possibly due to non-availability of 10th educated candidates in the respective village. This clearly begs for community control for selecting a local candidate. In addition, a change in conditions of educational qualification is pertinent. Rather than selecting a distant candidate just because they are somewhat more educated. A local candidate with

a lower qualification would ensure availability of the JSR. The handicap of distance is too much to offer any advantage over education.

ASPIRATIONS FOR BEING A JSR

About 38% of JSR-Ts could not word their expectations. " To gain knowledge" was the next common statement. About 8% have frankly expressed the desire to become a doctor. They also mention about earning and better future. This is understandable as they have family to support and few other options.

Some statements relate to social service or serve the poor/patients/village etc. Little less than half have actually stated the desire to serve the cause of community health in various phrases. So it is not entirely true that everyone has come to become a 'doctor' at least on the response sheet. Probably the desire to earn is a hidden agenda but no less legitimate. How to convert the positive expectations into actual gains for the programme is something to be seen.

"Aage chalkar kuchh kaam milega, yah ekhi asha hai": Premsingh Thakur, a JSR trainee.

From the interviews "Look for a job" ,"permission for allopathic practice" etc. recur. To "develop the village" was another faint response.

EDUCATION OF CANDIDATES

Majority of JSR-Ws is either 12th or graduates. This probably implies that among the available candidates in the village the higher educated boys were selected. Thus, the selection was merit and not preference based. So 10th passed candidates could have been selected.

Over half of the trainees in both men and women are 12th educated. Graduates and post-graduates make about 35% (This group can be a source of attrition.). The lowest qualification, which is 10th, comprise 14% of the trainees. The education pattern is similar for men and women trainees.

Selection of higher-educated candidates may jeopardise the stability of the programme as the higher educated will fly off to other courses and opportunities sooner or later. It also has a negative effect on selection of women since in most villages the men will be more educated. If the selection peg is education alone, women will be mostly sidelined.

GENDER

"Woh purdahwali kya karengi?" ..On asking why not select women as JSRs..Zilla Janpad Adhyaksha

Daughters will go to another village and daughters-in -law are in purdah, in all castes alike. Purdahwali is not able to work, but non-purdah women will be able to do something.

Among the JSR trained so far, men predominate--85 %. The men-preponderance in JSR programme betrays the hidden bias of the programme. There is no effort of consulting various sectors of the health system about how women can be enrolled. Even community is unaware of women-preference. So is it with selectors.

The new trainee sample of 204 also is male dominated, especially if we omit the AWWs selected because of special initiative by the Collector, Guna. Why is the programme keeping out women? It is a host of factors - the educational difference between available men and women in the area, lack of special emphasis/bias for women selection, training requirements (e.g. months away from home). But probably the most poignant cause came from an ANM. She said "a family values a girl as useful person in several ways in the family chores, while an educated boy is often good for nothing, if not farming nor doing any other work; they are loafing around, and parents therefore coax them take such a course rather than roam here or there". Though this takes a dim view of the boys' social/familial profile at this age, there is some truth in it in the context of a 10th passed jobless boy in most villages in India. Agriculture is poor employment, and there is no other job around that can fill his mind. This one—of becoming a doctor—is enticing.

The 10th passed-aspirant-young-man is in the entrepreneur mode of life. His view of JSR work is ambitious; of a future breadwinner. The current JSR programme is failing to answer this aspiration. The result is either high attrition or distortion of the JSR model itself into quack-mode at the earliest.

The interviews confirmed the male bias. There is evidence of stability if the 'bahu' is selected (At one PHC, 3 out of 12 SC staff, 3 were couples—6 SC staff—and two couples were staying in the village for over 10 years)

There is a virtue in making the programme a woman-centred one. First of all, they would come in the JSR frame only after 25+ years of age, because of marriage, village shifting, and child bearing. That makes them more mature candidates. Secondly, often they are not the only breadwinners of the family, for the husband is traditionally the money earner even if stereotyped. The aspiration of earning is for supplementary income, not running the family. Even if this is rather unjust to women and their work is less valued, the programme can use the virtue and bring some sanity in the JSR programme.

That women JSRs would bring a depth to the programme content is another important matter. Women's Health, Child Health. FW etc can benefit from women-JSRs. Men JSRs will make it an entirely curative 'pills-for-ills' programme.

Although, it is tempting to make JSR an all-women programme, the situation in MP is already made. It is a fact that the selection so far and future trainees are mostly young men and not women. The high attrition can be a blessing in disguise in this context.

The AWW enrolment is a positive development in this direction. Half-employed and poorly paid by the system, AWWs can benefit from this programme and in turn do a lot of good to the entire programme. But not all AWWs are ready candidates for JSR, as only 10% are somewhat educationally qualified.

To bring in more women in any such programme, relaxing educational limits, accommodation facilities, other supports, and some form of regular income are mandatory.

AGE

The age range of JSR-Ws is 21-46 years. The higher end is largely because of old CHWs in the study sample. Otherwise the range is 21-38 years. The average is 29 years, which means the average candidate is past his new job seeker age.

For JSR-Ts the mean ages are 24.5 years and 29 years for men and women. The older candidates are mainly some CHWs and AWWs.

The age signifies entry of mid-twenty year age group candidates. That means the candidates can stay in the programme if the programme itself is sustainable.

New trainees are generally younger aspirants for any new opportunity around. The JSR programme, from previous experience, is poor on holding incumbents. While young age entrants are good for training/learning of academics, their life experience is less than a rich one. It also implies future loss of candidates if the programme does not ensure its sustainability.

There can be almost a generation gap in the 20+ group and the 30+ group in terms of learning abilities, life-experience and both the groups demand different kinds of training-learning mechanisms.

SC/ST

Of the 22 JSR-Ws, 10 are SC/ST. Of the trainees about 26% belong to SC and ST groups, SC predominating. Some respondents had reservations about caste as selection criterion. Says a CMHO, "Supervising JSR is a problem if SC/ST are preferred. False report and false work are problems. Criteria for selection should be beyond caste: BPL from any caste to be preferred. JSR must be committed with good moral. JSR should have high education so that people demand service and are compelled to serve."

Caste can be important from three angles, a) social justice in selection, b) ensuring access to SC/ST community c) SC/ST will value the opportunity than the others who have more avenues. Several interviews have suggested that SC/ST candidates will be better JSRs.

Will caste change either way affect the quality of services of a JSR? There is no reason to believe that. Good training will obviate if at all any such inequalities exist.

OLD CHWS

"Achha, ye naye nahi, woh pachas rupiya waale chahiye?"(Oh! not the new ones, you want the fifty rupeewalahs!!)—On asking an MPW about showing us old CHWs in the PHC area

"Role of JSR is too much (as compared) than CHV". A BMO

It looks as if old CHWs are hardly counted for this programme. Only 2 of the trainees are old CHWs. Because of confusing nomenclature (both new and old schemes are JSR in Hindi), we were shown two old CHWs as JSR-Ws in Morena district. Both practising like Pvt Med Practitioners was another matter. But in general the JSR programme from 95-96 is distanced from the old CHW. The typical old-CHW is in forties, trained in 1978-85 period, educated about 7th, has a full family to look after, and almost never heeded by the health system so far. The fifty Rs. (paid 600 once annually for convenience of administration) have kept his thin thread with the health system, but that is all. The old CHW, says one GR, needs to be given preference in selection. We saw in a village of Aron-Guna that the health system or the gram panchayat did not even think of the old CHW for JSR in village. He was a typical plus forty man of family, a farmer with two grown up boys and bahus. His kit bag now contains important land–records in place of medicines.

A CMHO saw no difference between the CHW and JSR. ("Training of JSR is not much different from VHGs, their training is basically similar.)

Could such a CHW-elder, even if trained in the new programme befit the JSR role model? This should have been left to Grampanchayat-nominations and entry tests with sufficient notice. They have been bypassed, and it looks they do not look upon themselves as natural candidates for the new programme.

However, if there were a functioning CHW programme, the JSR programme could have updated the same. Irony is that the current JSR programme is treading the same path of training and linkages, only minus the 50 RS a month honorarium. Two programmes, 20 years away from each other, the first one jinxed and second following the same. There is a lot to learn for the new programme from the old one—mainly failures.

For some old CHWs, like the two we met in Morena, not getting in the JSR scheme has hardly mattered and they have clinics with injection practice. Those who were smart made their clinics in eighties, those who did not can not do it even now. So if clinic is the test for a functioning JSR/CHW, the CHWs are not good candidates for becoming JSRs.

TBA SELECTION

"Agar dai ne chhoda ho jachha bachha ka kaam, hami ko karna hoga.."
an Official slogan on AWW in Shivpuri village

Several Government Resolutions direct the health machinery to select TBAs or TBA family members. Nowhere we found this given an effect. TBAs, the typical old woman without much as literacy had anyway nothing to do with the new JSR training. If it meant women members, all the factors and biases listed above in gender are notable. That has remained only a wish.

Then there is some trouble on the TBA front itself, as we noticed a Govt. slogan on an ICDS centre that mentioned TBAs abandoning the traditional lowly valued work.

AWW AS JSRS

"I thought it was a good idea, women and children need health services more—A district Collector

". In a district of 2000 villages, about 100 are 10th educated ": A district Collector

"Aarey woh daliyawali kya kaam karegi?(What work the 'porridge cooking' babysitter can do?" - Janpad Adhyaksha

Communities at Jabalpur and Dhar found the AWW helpful Anganwadi. They refer children to her for treatment. In Dhar she belonged to the same village. The community expressed that she can be trained as a JSR also. She belongs to the same village and should be equipped with medicines.

The senior bureaucrats and the medical community have different views among themselves. Some would prefer the AWW than the existing candidates as JSR. In Guna, the Collector has taken an initiative to send the AWW for the training. The Training Centres at Gwalior and Jabalpur also suggest AWW as the RFWTCs have already trained the AWW to some extent. Few are skeptical about their effectiveness because they have a limited knowledge about illnesses and medicines (but can be trained).

Those who disagree do so because of their social constraints, work schedule and educational status. They doubted whether there are AWW of VIII standard in tribal area. Similarly, in other area

the AWW also follow the Purdah practice and they would not be provide health care service to men. The AWW also have heavy workload according to a group of AWW supervisors in Dhar. " Already they are *pareshan* working for ICDS, *Teekakaran*, ANC and surveys, SHG etc" Purdah is significant problem in case of many AWWs, according a senior PHC staff.

The main problem with AWW doubling up as the new JSR is that only 10% AWWs are 10th trained. Some AWWs have just about primary education.

Differences between AWW scheme and JSR scheme

	AWW scheme	**JSR scheme**
Tasks	Care of children and women, traditionally already women's tasks	Medical treatment of all adults, men, women, children, *bade-boodle*-- traditionally a man's job, BUT the preventive tasks is visibly a nurse's job
Defined space	Within a well defined space- *chardiwari*	Exposed to market and entire society
Starting plank	No starting problems.	Some capital, clinic space is essential
Income	Small but definite, supplementary yes, but there will always be some woman to work for it.	Earning fees from clients is the main source in scheme design. This is difficult in a village even for men, not to speak of women-*bahus*.
Selection problems	Can do with small education (most AWWs have only primary education)	Educated young daughters are going away after marriage, new educated *bahus* are family-bound till they have 2-3 children, can be available only after 5-10 years after marriage.
Legal hassles	Safe, no problem	Professional hazards are inevitable. No defined legal support or mechanism of back up.
Panchayat management	Minimal to nil	Major involvement, continuous negotiation through GSS

PREVIOUS HEALTH EXPERIENCE OF TRAINEES

About 82% of trainees had no previous experience. Nearly 3.5% had either worked with a private doctor or at a medical store. Some were CHWs Depot holders from malaria and some belong to Aanganwadis.

The predominant section is of inexperienced candidates. This is good in a way because the programme can model them as JSRs rather than try to undo the habits of 'experienced' private doctors. Yet the experience of a depot holder, AWW or NGO is a favourable factor as they are

someway linked to the public health system. On the other hand inexperience also entails a lot of responsibility on the training system.

SELECTION OF PVT MED PRACTITIONERS AS JSRS

Are already practising private doctors (Pvt Med Practitioners) getting selected? And is it good or bad if they are selected? None among the 22 JSR-Ws were previous Pvt Med Practitioners, but the fact remains that 2% of JSR-Ts are already Pvt Med Practitioners.

The number is not too big to blame the entire programme. It is difficult to stop this from happening since village panchayats can opt for such candidates with even good intentions of helping someone who is helping them. The possibility of survival is also greater for such candidates than other ones. Fortunately not every village has such candidates to offer. This becomes a limiting factor (some cases of a village selecting a distant candidate are seen and can be curbed). In the end more of them will survive and find a foothold.

Yes, there are some Pvt Med Practitioners mingling with the scheme. The trouble is not in numbers, but in the influence of even small numbers in every batch, the role-model contagion, even colouring the views of AWWs. So more worrisome is the fact that even non Pvt Med Practitioner JSRs are adopting themselves to the Pvt Med Practitioner-quack slot and becoming inseparable from the former Pvt Med Practitioners. The emphasis should be on the system and process of the JSR scheme, rather than on Pvt Med Practitioners or people who joined it.

Typically, the Pvt Med Practitioner turned JSR or JSR turned Pvt Med Practitioner for that matter, would hardly look beyond injection-saline as the mainstay, care little for preventive-promotive, the National Health Programmes, the sub-centre staff and the PHC MOs. The aim is for earning a certificate, a piece of paper to brandish in any future trouble. It is not the training; it is the ratification that matters for Pvt Med Practitioners. This needs attention.

While it is easy to point out this 'fatal' attraction, the remedies are no easy to find in a programme that makes enterprise its only plank of sustenance. Several things need to be tried before arriving at community needs (see Group-consultation in part 4). a winning formula that will ensure sustenance of JSRs, in the framework of the programme.

TRAINING[3] AND TRAINEES

DISTRICTS AND BLOCKS

The interview trainees (204) are from 6 Districts and 19 blocks. Over half of these trainees are from Bhopal and Jabalpur districts. The other half belong to blocks of Barwani, Bairasiya, Fanda and Mazauli.

TRAINING VENUE

PHC and CHC comprise 3/4th of the training venues. In Guna and Bhopal the district place was the training venue for some time. The district hospital was used in Bhopal for training JSRs.

In terms of access, perspective and friendliness PHC/CHC are optimum arrangements. For clinical experience the DH and the CHC are better. The DH could end up strengthening the doctor model-JSR. However, the main handicap is lack of the training team at the PHC /CHC. Actually this is a major constraint of the current programme that the overworked medical officer of CHC/PHC is saddled with JSR training.

In Jabalpur, the Govt. Nursing College in the DH was the JSR-training venue. This is exceptional, due to ~~highly~~ a motivated team at the district level including CMHO, DPHN, Principal Nursing College, and Principal RFWTC. The several advantages- the accommodation, AV aids, training team, closeness to DH and the clinical work, discipline in training, professional approach as trainers. This training centre has a reputation, and we saw four candidates waiting for the DPHN to allow them to take their JSR training here from distant blocks of the district. Can the programme take a cue from this?

PHYSICAL FACILITIES

In most places, there is no special venue for classroom. OPD-clinic, corridor, empty ward are usual places. There was not even durree supplied in many places. In places blackboard also was not available. (One MO confessed that he would buy it from contingency!). In many places we saw them huddled in small rooms, or taking the sitting stool for training hours. Posters or AV aids were nearly absent.

Accommodation was possible in DH. At most places, students rented private rooms and thus went the stipend they earned. There were JSR-Ts who travelled daily on bicycle from their villages situated as far as 25 kms. In some places lunch was the casualty for the JSR-Ts had no money or time left for cooking. Women candidates had difficulties because of this.

[3] Here we are discussing only official training venues. However, it is noteworthy that we found newspaper advertisement and wall posters of private 'J S R' training classes in three cities. Apparently, one such class charges Rs. 13,000 as training fee.

Most places did not have public toilets. If at all, they had to use the ward toilet. This was another major problem for the women candidates. Rarely, any health facilities have toilets for the staff. This underlines the existing gender bias in the HS.

Can a CHC be converted as a regular training centre with mandatory though modest physical and training facilities? This will entail some cost and pace the JSR training.

TRAINING CALENDARS

In the various blocks training calendars has started differently. This is according to local conveniences but creates a variable gap between course completion and the final tests.

HOURS OF TRAINING

Nobody has time to train, Training is done mainly by paramedics, no doc wants to do this training, JSR boys just sign the register and go to pvt docs to learn.. A Lab technician CHC

The official training timetable given in the manual reads thus: 9-12 clinical (OPD+ ward etc), 12-1 lecture, 1-3pm lunch and rest, 3-4pm lecture. 4-5pm clinic (OPD). This more or less suits PHC/CHC work schedule. In one venue the afternoon sessions was inoperative. In JSR training at the Jabalpur Nursing school, there were full sessions attended by trainers both in the morning and the afternoon.

The pattern seems to be: sitting in OPD/Lab/dressing room in the morning hours and some actual discussion/reading in the afternoons. At some places there was no mention of afternoon training.

BATCH STRENGTH

The batch strength was 7-75, so go the JSR-W responses. The lower figure speaks of poor-selection process and a compulsion to start training, while the latter speaks about district-centre batches. The average 22+ is the optimum for participatory training and the PHC/CHC facilities. One of the trainers suggests that the optimum batch strength is 25. The usual CHC sitting facilities can not accommodate more.

METHODS OF TRAINING

Trainees spend their prime-time morning in the 'clinical sections'- which is OPD and wards. Here, observation and some hands-on training are the main methods. Trainee-JSR actually watches clinical work--examination of patients, lab tests, and injections/saline, dressing, stitching wounds, childbirth etc. This is, for clinical training, the best method of learning and teaching. This saves active trainer-time that the PHC is already short of. Unfortunately, this also underlines the doctor-role model and the injection/saline procedures as the mainstay of health work.

In the classroom the predominant method is manual reading or lectures.

Interviews have reviewed that nearly all of them, AWWs included wanted to learn injections and saline. One medical Officer quipped that "they never leave the injection room". Post-mortem examination was used as a method of training at one CHC.

Fieldwork has been mentioned by some trainees, which meant going with sub centre staff doing home visits or vaccination clinics. Many trainees have mentioned a subject (like anatomy) instead of the method of training. The "topics" have recurred in various responses on methods, skills etc. scant mentions of audio-visual methods, body mapping also is found.

In interviews, most of the trainees and the trainers at the CHC/PHC level recognised that there is a need of AV aids and models to make the training effective.

Opinion poll expresses that the JSRs should be trained by experienced trainers of which there is a shortage

TRAINERS

"BMO ko to marneki fursat nahi, training kahanse"..- Health Assistant

The medical officer PHC/CHC is the main trainer, and often the sole one. At district places, other trainers from the DH can be involved. At times and in some places the Second MO has helped. Nurses, BEE, other health staff share some training tasks. In general, the trainers have little time and mental space for the JSR training. A CMHO observed that there should be a separate training team.

The trainer-trainee relation is different everywhere. In more than one place, the MOs train them all in injections and saline-infusion. In one CHC, the MO took them on rounds and created bonds to increase his network through JSR. This, ostensibly, has helped him with more patients and more earnings. In other CHC, the MO was completely frustrated by the batch, the worthlessness of training and the quackery that lay in future. He was barely able to give an hour or two per week for training, immersed as he was in other administrative work. The CM visited his PHC once, and the latter was briefed about the difficulties in the programme and possible dangers of such a scheme.

A typical interview with trainers

Problems	Funds are not coming timely
This batch	40, only 20 turn up. It is 2 and half months. The timing is 9-1 pm. The boys leave at 1pm, some of them share and stay in private room
Other trainers	Nobody is interested, only a team member can give some time-one hour in two days. Other MOs are just not responsible for this programme
Methods of training	I like training; A team member even tried the quiz type for ORT, which they like very much. They are attentive when I teach.
AV aids	None, even district IEC has nothing, not even blackboards
Time	Very difficult. I have several things to do, no breathing time. This is a busy and VIP place. With difficulty I can give 2 hrs every week.
Ed of JSR	All 10th
Women	None
Previous batch	Oct 2000.only one batch so far. The statistics are 95- 3/15, 96 --17/25, 2000—24/- result awaited.
Passed	So far only 20 have passed in this block, that was from an old batch. The Oct 200 batch gave final exam but results are awaited even after 2 months
Exam venue	Guna--the district place.
Exam	Gap between training and exam
Anybody for training from district?	None, never
Manual	Yes, and it is ok, but needs modifications
Records/report of JSR	Nothing
Any follow up after training	Nobody comes; esp. the failed ones never come.
ANM/MPW linkage	None, except some medicines are given by them to the JSR
Posters for health education	None, even we have little of that. Whatever we have, goes to JSRs through MPWs
Practical training	We call them and show the procedures-dressing, dispensing, pathology lab
JSR aspirations	They look upon this as a livelihood, think it is daktari
Preventive programmes	No JSR is interested, since there is no payment
If we give honorarium?	Will make a difference
Other problems	No linkage No follow up- nobody turns up to the PHC for entire year. I am yet to see the 97 guys myself Have become independent Consider themselves superior to sisters

Facilities	Nothing, sit on the floor, there is no *durree*. The stipend-grant is yet to arrive
National Health Programmes	No-nothing
Health education	Nothing
How many JSRs are active in this block	Hardly 12

Another trainer-PHN Guna

Issues	Response/Observations
Policy/ Scheme	Good scheme, In six months training village level health worker can be trained upto the need.
Selection	Female should be preferred. If there is female JSR all National Health Programmers can be implemented through her. But in villages presently male JSRs have been preferred because they can start practice and earn money, while women cannot do practice on their own.
Education	10th pass candidates are rarely available in villages. So this condition should be relaxed. Entrance test will be better.
Linkage with AWW	AWWs should be preferred. AWW + JSR will be best model. AWWs are already known in the village, In their duties most of the MCH program is covered.
Training	Experience of last 5-10 yrs as trainer in MPW training centre. Manual- good
Methodology	Lecture, Demonstration. They have performed role models. Use of flipcharts, Blackboards. OHP, Projector, TV-VCR not used so far. 9a.m. to 3 p.m. continuos lectures at one place.
Practical training	For practical training they have been posted in Guna District Hospital in various departments. There is demand of training for injections.
Time - table	Some lectures on attitude building, social behaviour should be included. Both of them teach on these subjects.
Women's Health	Exam of pregnant woman has been taught. No need to train about conducting deliveries, because there will be one trained Dai in every village.
Examination	They have conducted monthly tests so far. After three months full paper of 100 marks. Final exam will be after six months.
Suggestions	In service training's, reorientation training should be conducted. TA/DA should be given.
Feed back	AWW--Supervisor--CDPO--DPO—Female MPW- Supervisor- BMO-CMHO

Future	If good feedback and proper utilisation will be done, then bright future.
Honorarium	Minimum Rs. 500/-permonth should be given

SUBJECTS COVERED AND DESIRED

Immunisation and malaria overweigh all the other topics. Anatomy, ANC, MCH are also there. Practical topics like dressing, PBS, sanitation, also figure. The list also includes officially forbidden things like injections and saline. The free list extends to 113 topics. The range of subjects looks quiet impressive but Ayurveda is nearly missing. The subjects mentioned very closely resemble the list in the JSR manual, since manual reading is a common factor. The training is in various phases; for some it has just started.

However covering the manual is not all. Many trainees feel it is not enough, some feel it is useless. There are many interviews insisting about diagnostics, protocols, treatment details, medicines, pharmacology etc. to make them useful in a village. In general, it is not the list of subjects, but also the range and depth of subjects, orientation and problem solving that are important.

A CASE STORY OF JSR TRAINING

This is based on interview with Dr. V. who is a specialist in ABC working here since last 5 years. This CHC covers total of 236 villages in this block of which 227 are occupied.

JSRs have been trained here in previous batches (1995 – 19; 1996 – 18; 1997-98 – 7). All of these are males. He was unable to give the break-up of SC/ ST and seemed only vaguely aware of need to give preference to them. The MO was unable to clearly say how many of the trained JSRs are functional. He vaguely said –'less than half'. When asked further to name active JSRs he specifically mentioned only two.

Other medical Training of trainees

Some of the working and some trainees have had other training opportunities: a clinic, Pvt. hospital, medical store, even at PHC. The period was from 6-month s to 2 years. Some trainees will look for such training afterwards. Most of them consider some other training cable essential.

Functioning of existing JSRs

About assistance in public health activities, he said we want them to come for monthly meetings but they do not come. Only 2-3 come for such meetings as no travel cost is given. A few who are active help in Pulse polio and immunisation? He said that they do not have any effective monitoring system for JSRs. Many of them are depot holders and have chlorine tablets, ORS packets, and Nirodh and OC pills. No loans have been disbursed to JSRs in recent batches.

Present batch of JSR trainees

There are 48 trainees in the present batch being trained at this CHC. Selection has been done primarily on three criteria – Age, education and place of residence. Of these 3 are women. The

training started on 16 July but the full batch was constituted by the end of the month of July. According to him, about 28-30 of the trainees come regularly.

Training

His major complaint was that there is no place to train the JSRs. From 10 am to 12 noon, they stand in groups in various rooms –Injection room, X-ray room, Lab / malaria slides, Ophthalmic room, Dressing room, TB, Registration, OPD. He was unable to say what the trainees do in rooms like injection, X-ray, registration, he was not clear. He said that since these are activities going on at the CHC, the JSRs should see them.

Classes are held from 12 to 1 noon. This is done in one of the OPD rooms, which he feels is not really adequate. When A team member asked him which topic is being taught currently, he did not know. *He said about half of the trainees do not have the training manuals yet.* He said ' two JSRs share one manual'. Among 48 trainees there are 28 manuals. There are no training charts, models etc. for JSR training. According to Dr. V. the attendance of the trainees is not very regular. But they take 75% attendance as a criterion to give allowance.

For Ayurvedic training, since the last batch they are sent for 1 month to Ayurvedic hospital in Bhopal.

Suggestions

JSRs should be used for motivation for immunization, FP camps etc. Instead " *Apna kaam chhod kar daktary karne lagte hain*. I.V. *dene lagte hain*. *Hamara koi* control *nahin*." (Instead of their assigned tasks, they start functioning as a doctor, give I.V. We have no control.)"*Bataai gayi davaon ke alava bhi dava dene lagte hain. Koi* guideline *nahi hai.* Guideline *hona chahiy*e." (They give medicines other than the one they are trained for. There is no guideline. There should be a protocol.) According to the trainer:

- Training should not be at block level. It should be delegated to PSM departments.
- BMOs do not have time for such training and are not so keenly interested in it.
- There should be separate space at block level, flip charts, training facilities.
- Some honorarium should be given to JSRs.

Comments from other MOs in the CHC - the training venue.

- They are preparing quacks. IV fluids *bhi laga rahe hain*." (They are also giving I. V. fluids.) At least they should participate in National Health Programmes.
- Some minimum honorarium should be given so that a link is maintained. Otherwise "*Woh apni* practice *mein zyada* interested *hain*." (They are more interested in their practice.)
- 6 months is too short a period for training. It should be increased to 1 year. Education should be 12th pass.

- Selection is faulty. "50% *apne gaon ke nahin hain*.(They do not belong to the village they are selected from.) " People from the actual villages will not benefit. About 50% are from Bhopal city or villages other than their own, who have taken a letter from the Sarpanch of some village

OPINION ABOUT TRAINING

We are preparing quacks, I feel helpless, PL do not quote my name"—a BMO trainer

The "good" opinion prevails in the response-sheets and perhaps this is expected as a safe word on records. However 7 trainees have expressed that it is of no use. Perhaps the true opinions of trainees can not be known through a written questionnaire. In the interviews many trainees have opined about poor training conditions and content.

In the Opinion poll, the respondents have expressed that there is alLack of training in proper referral. Also they feel that there is too much focus on training on medicines and injections. There is inadequate attention to community level action and community mobilization.

INTERIM TESTS

More than half have just begun the training hence there is no interim test. Others have mentioned of a monthly and three monthly interim tests. There are mentions of both oral and written tests.

Interim tests have two purposes - a) to remind and to familiarise them about final test formats, b) Improve the training process after the feedback. The latter is more important. We felt, after looking at the process that none of these purposes are well served. This is a part of formative assessment. Therefor there is a need for the trainer-trainee dialogue guiding the trainee for better learning. At the same time, the results should also lead to dialogue among the trainers for a better training inputs. There is a need for more inputs and resources to carry out this feedback effectively.

SKILLS-ACQUIRD AND DESIRED

Pulse, temperature and PBS are common skills acquired according to JSR-T. Check up, history taking, breath counting, weight, ORS. Dressing, injection, ANC check-up are some of the other skills acquired. The concept of skill is not very well defined. Skills are facility of doing something with hands, communication or use of instruments. In the acquired skills list, JSR-Ts have mentioned a full spectrum of necessary skills they should acquire. Interestingly the list includes several skills not mentioned in the JSR manual.

The foremost amongst the desired skills are giving injection and saline has 79 and 50 of the Trainee-JSRs expressed it. Others may have not mentioned it. Stitching wounds is a next prominent

topic mentioned. The list makes an interesting repertoire of skills that are directly and indirectly required for making a JSR effective in the village setting.

Elementary diagnostic skills like pulse, Temperature, blood smear, breath count, are the main responses. Trainees also mention in general terms "Medical Treatment". There are some other skills that can be clubbed as preventive-promotive (sanitation, Water purification, Health Education.) Some 8 trainees have learnt about injections and many more probably have declined to put it on paper.

Among the desired skills a thumping majority underlines injections and saline. Some trainees have mentioned even a surgery, ultrasound, vacuum extraction of baby, X-Ray, ECG, Computers The use of stethoscope is barely mentioned but may be a subdued desire. Some trainees have frankly expressed to learn skills of a doctor. The list thinly expresses preventive-promotive skills. The list makes 422 items of interesting clinical and other skills that JSRs desired to learn.

Healing calls for both knowledge and skills, not to speak of attitudes. Diagnosis also calls for lot of skills and hand skills too. It is skills that giving the main healing touch the sacred contact between the healer and the healed. Skills - especially handskills - are therefore central to any learning of healing. Allopathy at primary care is not just tablets and syrups. It has several other components. More so about other healing systems (except Homeopathy, which is drug-inquiry, based). There are entirely hand-skills systems like accupressure/ puncture and massage, and physiotherapy. Here the JSR can learn lot more and get an edge over the quack-Pvt Med Practitioners. The desired-skills listed by the JSRs are noteworthy and more can be added to the repertoire to make a truly different scheme than a quack-making scheme. The JSR cell should think and do positive action on this, and sooner before the JSRs are lost from the programme or to the quack-pool. (See Volume2 for some list for primary care skills).

TREATMENT OF DIARRHOEA

ORS, home fluids and SSS predominate in the responses. The mention of tablets like metro, furazolidine, norflox etc. possibly suggests that they have also considered adult diarrhoea. Or are they giving it to a child also? The ORS/HF response is heartening. One team found that no trainee could tell the correct formula for SSS.

From interviews ORS is a common response, but is SSS-mention is infrequent. Injectable antibiotics are prominent on their minds. DNS+ polybion is also mentioned.

FEVER DIGNOSES AND MALERIA DIGNOSES

This question has resulted in a plethora of responses. Predominate mention is of fever chills and PBS. The training doesn't include any protocol and fever diagnoses and hence the responses are understandable. The pattern seems to be to think that every fever is malaria.

The same pattern repeats in the question of malaria diagnosis. The sum total is fever= malaria. This equation is deep rooted in the health services, no wonder it surfaces here.

From interviews malaria dominates the responses, pneumonia coming next.

An interview with trainees

Time table	5 months here, one month for practical at SC 9-12 we sit in OPD, 12 to 1.30 pm theory lectures, 2.30 t 5 pm again theory lectures
Selection	Village GS met, and decided from 4-5 candidates on basis of merit
Stipend	not yet
Some say you come for the 500 pm stipend	No, we have better wages back home 40 daily. And we have to spend in travel (10-20 RS daily) and the chai-pani
Want to learn what	Stitches, inj, saline, and some medicines (pain/ulti/petdard/anemia/lm/) they name medicines. diclofenac, baralgan, lomofen, dependal etc
what about the medicins taught here	Less than what the grocers shop (they keep all the above, even applicaps). How can we tell people to go get it from the *kirana*?
Kirana dookan in every village?	No, but 2-3 km away anywhere.
Why not buy medicines?	No permission, there is no 'ROK'; *'fir bhi'*
Training	Less than the grocer's knowledge of medicines
Any illnesses you want to learn	*Ulti, dast*, malaria, typhoid, *foda funsi*, malnutrition, measles, white discharge (the last one upon asking a girl.. there are three girls)
Current medicines	Bl powder, ORS powder, paracetomol, chloroquine, condom that is all
Practical	*Patti*, *chiti nilkalna*, watching the ward work. 9-12 and 4-5. We sit in the OPD in batches of three.
Any CHW in this training	There is one, he has only ORS packets, para, chloroquine and bleaching powder from the Govt.
Expenses in training	10 RS for bus fare, 10 for *chaipani*, so 20 everyday. That takes care of the stipend
Fees of Pvt. docs	At least 50 RS taking all costs (fees/travels)
What fees do you expect from people	10-5 RS. But people already know us, so may not pay fees, so we should get some honorarium
How many farmers in this batch	About half of them, others do wage labour
Women	3 in the batch, one married. The other girls! (What will they do after the are married off to another village?)
What about previous JSRs	70% are not working (*band kar diya*)
How many can afford to attend training	Most of us. But after 4-5 months like this we should be able to earn something.
Suggestions	*Hamari* value *badhana chahiye*

TREATMENT OF MALARIA

Most trainees are yet to learn this topic hence there is a major component of non-response. The mention of malaria tablet is round about. Some trainees have named Chloroquine and some Paracetamol tablet.

FINAL TESTS

"I was surprised how I passed" a JSR in Bhopal

"Do not keep the training centre as the exam centre and you'll see the difference" Principal RFWTC

Final tests are conducted by the dept once in a year, and may happen anytime after the training. The final test consists of a written paper and requires 50% marks to pass. There is no practical test. The papers are cyclostyled and photocopied and some are unreadable.

According to a senior trainer, there is lot of malpractice in exam as it is conducted in the training venue itself. The exam venue should be at district place and well supervised. He advised printing the papers and sending them sealed. It should be like the MPW tests, which have much lower incidence malpractice; the results are 'harder'. Upon the issue of MCQs, he feels they should be only 40% and 60% should be essay type as the latter call for creative writing and are less-copy-friendly.

CERTIFICATES

The Janpad issues a certificate to the candidates who have passed the final tests. Many working JSRs could show the certificate and they had preserved it well. (In some places they had additional certificates to bolster, like the naturopathy council, Electrotherapy (?) etc.). One JSR, belonging to SC, had started using all medicines without test result or certificate. In Jabalpur, 138 certificates had not been collected, showing that there is no much ado/interest about certificates or that the JSRs may have left the 'scheme'. (No one needs to declare that he is abandoning the ship, there is no paperwork about that) In a small village, such a certificate is hardly asked for, but carries value if properly displayed.

The certificate is official, but not exactly legal. However the humble list of permitted medicines for JSR's hardly attracts legal problems. In reality, at least some JSRs use several medicines that can easily attract penalty.

FAILURES AND RE-TESTS

Failed candidates generally do not return to training. A CHC pharmacist said that boys are not interested in it because of the 100 Rs for exam fee. Probably it is due to lack of promise in the scheme, rather than the fee itself.

DEVELOPING JSR WORK

The question has evoked the range of answers. Many have mentioned health-education, but what dominates is medical treatment. Other responses include village development, social service etc.

DESIRED IMAGE

"Doctor banoo aur gaonmein clinic Kholu" (Want to become a doctor and open a clinic in the village.).. many JSR trainees

Many have humbly confined themselves to a JSR- image. Some want to graduate to a compounder but most have desired to be seen as doctors. Lady doctor, family doctor, JSR-doctor are other variants of the same.

However, **the Opinion poll** expresses the general apprehension about *Jhola chhap* doctor image will increase. Several respondents feel that the Diagnostic and therapeutic procedures will become more irrational.

TRAINING OF JSR-WS

From the interviews it appears that at CHC level, the training was more organized. At PHC the training is MO-dependant. Probably it is the availability of more trainers rather than PHC/CHC venue.

TRAINING OF TRAINERS (TOT)

The RFWTCs have conducted 3-day sessions for JSR-trainers, but that was 3 years back. The training was mainly about method of training, rather than 'content-contextulalised' according to one TOT-trainer. The "MOs come for meeting their friends and relatives in the city and not the TOT " was another remark. Another prominent trainer said that TOT happened three years back and it was not contextulalised. Several trainers said they had not attended TOT. ON asking whether TOT staff actually came to observe/guide JSR training in various centres, the answer was negative both at RFWTCs and the CHCs.

Without the active link of TOT staff and JSR /training and practices, there can be no contribution of TOT to the scheme. The TOT staff lamented this. The Jabalpur RFWTC advises that the centre staff visit the training sessions once a month in every district.

In Jabalpur, there was much enthusiasm about TOT and JSR training and the JSR cell should profit from consulting the Jabalpur team. The TOT outline here was thus: 2 days workshop. A micro-teaching plan with presentation on a topic. Pre and post evaluation carried out. Participants were enthusiastic and learnt new skills.

In RFWTC Gwalior, a senior member insisted that attitude building was important for JSR programme, at least one day should be given for that in actual training.

JSR MANUAL

(In the Volume2 there is a detailed note about the JSR manual)

In Barwani district the manual was not available to trainees, apparently the request was sent, but it was met with a counter enquiry about the stock of previous 'yellow' manual. In the end, trainees suffered. Surprisingly even in one block of Bhopal the manual had not reached. It has reached other places in the study. Wherever available, trainees were found using the manual.

Old JSRs have not been given the manual, which is inexplicable. Some JSRs and teachers liken the manual. One JSR trainee said he read it every evening. The new manual had not reached training sessions in Barwani and parts of Bhopal.

Some RFWTC teachers felt that the manual needs to be improved, more protocols on MCH be included and more medicines added. However, one senior IEC Officer had difficulty in remembering the manual, finally he said.. "Oh the coloured cover .yes I have seen it".

From interviews only one JSR praised it. However some JSRs who were Pvt Med Practitioners said it was of no use.

Other books

After the training, JSRs seek other books. Common title is "allopathic guide". WTND did find one user.

IN one RFWTC, a TOT resource person held out his own book as an alternative and actively promoted it in the JSRs and "other doctors". We did some perusal of this book, and found that on clinical issues it has more relevant and useful info than the official manual, nut it is mainly clinical. It does not recognise the barriers for injection/saline. It also has several incorrect details. In Barwani region, this book was popular among trainees. Its price is quite affordable (Rs. 75/-) The author said he got some money from selling this book.

In Bhopal, bookshops have plenty of such titles and they come quite cheap. They address the need of a general practitioner and JSRs tend to club themselves as Pvt Medical Practitioners or nobodies.

OTHER TRAINING OPPORTUNITES

Some trainee and working JSRs are linked to Pvt Med Practitioners; some have worked in medical stores. In some cases the Pvt Med Practitioner-connection came after the JSR training. Most 'survivors' have some kind of training in a private hospital/clinic. IN Bhopal, some working Pvt Med Practitioners with modest formal medical training actually seized the opportunity of this Govt.-run course and proudly presented themselves for interviews. Most trainees expressed the need/desire to do a stint at some clinic. Interviews corroborate the responses.

GENDER FACTORS IN TRAINING SYSTEM

The current trainee batches have very few women, and there are several reasons for their near-absence. The scheme holds no promise for them as did the AWW is one major reason. (In the latter case, women stayed away from homes for months.) The JSR training presents several difficulties for them, for one it is mainly all-men-situation. Families are bound to feel insecure about it. There are no lodging and food facilities. Even the AWW batch in Guna was uncomfortable about the somewhat special facilities in Guna.

WORKING OF JSRS

CODE OF CONDUCT

Half of the 22 were aware of some code of conduct. But when asked to describe, most of them ended up saying about some task. The COC itself is weakly structured as given in the book (see notes on JSR manual). The COC should be a major instrument of self-control and social control of JSRs, to be displayed on the clinic wall or Grampanchayat.

Even if it exists, at best it remains on paper. There is no public space for JSR work so no one can enforce that JSRs display it. Grampanchayats can however display it, along with rates of services.

The COC must be more comprehensive (see notes on manual). The training session should have a special hour for this; but more importantly we need have role models among working JSRs and MO-PHCs to emulate. The Continuous Medical Education journal can publish pertinent real stories with names and places to influence JSR conduct, and also bad stories without identity.

ATTRITION

"These new boys are after some career, can not stay in such jobs"..Chairman, of a Zilla Janpad

"If they get a better job somewhere they will leave".. A CMHO

"Many of us have joined the EGS scheme"—a JSR

It appeared to us in various interviews that only 10% of JSRs trained so far are active. Many have never started off, and some shifted to other 'jobs'. (GS /shikhsakarmi was a usual alternative). A JSR turned Sarpanch quipped that there is 'no future' for this scheme. One JSR-W was reluctant to say that he has both the jobs. This can be encouraged.

From one interview attrition seems to have hit even during training. In Silavad, the coming and going of trainees for various reasons is pathetic.

The opinion poll highlights that a lack of continuity and constant flux may make the scheme unable to fulful the needs of the health service in the real sense.

The earlier scheme was an entrepreneurial affair, and the same is true of the 2001 scheme. That is quite demanding in a single-village framework, without the professional paraphernalia, often without a loan, and without legal status. 'Making money' in one's own village on some paltry medicines is not easy. Most survivors had the grit to do it as a jholachhap doctor, acquiring all the odd skills for such a queer job, a 'kalka chhora' turned doctor in six months and asking for money. Many just failed to make it.

If the ubiquitous 'Bengali doctor' (BD) was the model for the JSR programme, only few JSR-boys could make it. The programme has a high attrition rate. It is a difficulty but an opportunity too—to make a better programme than shape it like the BD.

It is particularly intriguing that all schemes started by the State Govt. at the village level involve some payment--EGS, Shikshakarmi etc. AWW was already a paying scheme. CHW was paid even if paltry. Whatever the thinking behind this scheme, this is the only scheme without monthly payments. Flight to other schemes was therefore expected. Very rarely, some JSRs have continued JSR work even after taking new assignments.

TASKS

The JSR-Ws list medical treatment, and malaria treatment as the leading tasks. Water-treatment with bleaching powder is the next. Healing, National Health Programmes, family welfare tasks, immunisation (attending sessions), registration of vital events, MCH are also mentioned. This

shows that the JSR role is not lost on them altogether, there could be other reasons why these are not actually practised.

'PRACTICE'

"We are told that we are not allowed to practice"—A JSR in Barwani

The BMO called us, the police inspector was there too, and told us you can not practice and threatened- A JSR in Barwani.

"All the boys here are doing high practice" - Health Assistant

Practice - which is medical practice of treating patient on fees—is the overt and covert main plank of the JSR theme. The planner, the provider, and the users are unanimous about this. Not everyone will utter it and may camouflage it under various descriptions. From even peoples' point of view the test of JSR is in his/her capacity to fulfil needs of medical relief, he is their 'doctor' for all practical purposes (See for instance the schoolboy in a village saying about the just trained JSR Komal Kushwaha" *Komal daktar ne injection lagaya*"). In plain words, that is medical practice. The JSR is trying to do what his village people rightfully expect him to do.

That the other aspects of JSR scheme are not fulfilled needs to be discussed, but what is the situation regarding the quintessential 'practice'?

According to many respondents, the number of 'practising' JSR is small-about 10% of total trained candidates. Most JSRs are not finding feet, as is evident from the reportedly 'working' JSRs. There are various adverse factors in the village system against this. From the users, the main utterances are related to medical relief. In one village, the user complained that the JSR is not ready to 'practise'. Looking at the harsh reality of 'practice' let not the JSR scheme be villainies. If people need and want it, the scheme should be improved to serve their felt needs apart from the planner-perceived objectives.

Planners and administrators are equivocal about the list of medicines. Several trainers feel that JSRs need more medicines while others feel 'none more'. But finally the list is ' far less than a grocer's list'.

TIME GIVEN EVERYDAY

"Half-day's work" is the usual response. About half the JSR-Ws have not answered, and are probably not very active. There can be no fixed timing for patients in a village. Many of them go when called as they operate without a formal clinic. Secondly there is little programmed work, as the scheme is not really linked to the public health system. So what remains is some patients, spread over the day. Is it a full time job/employment? Most of them feel - NO.

CLINICAL WORK AND CLINICAL PROBLEMS

Fever is the most recurring illness mentioned by JSRs-Ws; diarrhoea, vomiting, coughs cold etc. coming next. JSRs have mentioned about 34 entries in illnesses.

JSR scheme has failed to touch the hardcore problems like TB, Reproductive health problems, dental, mental, chronic illnesses like anaemia, or National Health Programmes services. The scheme is not designed for such problems, though the manual mentions them. The fact is that JSRs are generally not exposed to such clinical experience. In the clinical domain, these areas await good action from JSR scheme--diagnostics and action protocols for these hard core problems.

WORK PLACE

Most of the JSRs work at home. Some have a clinic. Some do home visits. JSR Scheme does not provide any clinic space. Since the JSRs are supposed to do both clinical and community work, some kind of formal space for clinical work is mandatory. A mobile JSR with a kit bag is also possible but this is an infrequent pattern.

PATIENT ATTENDANCE

The average number of patients attending is 0 to 8. The monthly average is 48. This volume of clinical work needs to expand. For a JSR model requiring earnings this could be insufficient volume.

WOMEN PATIENTS

Even though all JSRs are men, every month about 15 women (and 33 men) seek JSR services. However this may not mean reproductive services and probably general illnesses. Keeping patients' register is mandatory for JSRs; but only about half of them keep register. Among the sample of 22 JSRs in this study only about half are in actual practice. There is no systematic record anywhere either in the scheme or in the field.

SERVING DEPRIVED SECTIONS

From the written responses, JSRs mention that weaker sections are taking their services, but lack medicines are a hindrance. One JSR mentions that it is only poor people who come to him. In several interviews with users, poor people do seem to buy services from JSRs as otherwise they will have to spend on travel and access PHC/Pvt Med Practitioner. The cost of JSR services—and no travel costs—plus *Udhari* are attractive enough even for the poor. Educating people on needless injections/saline should mend the matters further.

REFERRALS

PHC is the most frequent place for referral, CHC coming the next. The listed causes for referral show a good range of problems (38)- fever, diarrhoea, abdominal pain and some NHP causes like FW, TB are also seen. Together the 22 JSRs have referred 76 patients in the last month.

The Pvt Med Practitioner-link of JSRs looks weak but the study brings out clear cases of such links. In Dhar, a JSR says he sends patients to particular doctors and they send him commission

(which he says he distributes back to patients) and also send back the patients with advice to take more injections and IVs at JSR's clinic. Some 3 of the 22 JSRs say they refer patients to Pvt Med Practitioners. JSRs do not seem to be very enthusiastic about Pvt Med Practitioner links.

Referral is potentially a sound link between JSR and PHC/CHC and referral chits and recognition/compliance by the latter will go a long way in instituting linkage. It will brighten JSR image both in people as well as the public health system.

PREVENTIVE WORK AND NATIONAL HEALTH PROGRAMMES

The answers JSRs gave show that they are aware of the preventive aspects and of the National Health Programmes. In actual practice, there is hardly any NHP work except malaria. The reasons are clear; there is no logistical and funding support for NHP work.

The Public Health System has to seriously try on this front. One will have to list doable tasks, work out logistical and monetary support before expecting work on this front. See Volume2 for what are the possible tasks a JSR can undertake with the help of the Public Health system.

LINKS, SUPPORTS, SUSTAINANCE

LINKS

JSR-Ws have a feeble link with the health system whatever link they have it is mainly with the MPW and ANM. Only half of them had some contact with the field staff in the previous month. The substance of the contact and linkage is not described. But it could be through supply of some consumable like condoms, chlorine tablets, and chloroquine tabs. etc and immunization clinics. Since the JSRs are not getting any compensation from the Government there is no formal arrangement for linkage.

The PHC contact has also been weak. Most of JSR-Ws have attended some of the PHC meetings. Subjects discussed in the meeting include National Health Programmes; but more than half the JSR-Ws do not mention any subject.

No JSR got any TA/DA for attending these meetings. Travelling costs could be a major burden on the poor JSR-Ws. Some material like consumables and posters is presumably supplied at the time of these meetings. Most JSR-Ws are silent on what they could suggest to improve the meetings for them. One demand is about inviting "Other Doctors". They also mention income from Govt., TA/DA, more training and solving actual problems of JSRs.

There is little of help from PHC. Some responses include supply of some consumables. Most JSR-Ws have little to suggest about how PHCs could help them.

From interviews, the responses appear to confirm above pattern. ANM/MPW is the key figure, but the links are not structured. Personal relations with JSR and occasional assignments from PHCs (pulse polio for instance) are all that count. Referral of patients is another major link with

PHC/CHC. Often the MPW is practicing and this could be a potential area of conflict/cooperation rather than linkage.

What kind of links and supports and how much support has to be considered in tandem with monitoring aspects. NHP is the main and broad avenue for links. Maintaining village health data, and using it for local health plan is another area for interaction. CME at PHC/CHC or through a house journal is another major mechanism for linkages.

MONITORING

No scheme can work without monitoring: A district collector

Monitoring involves a two way process—feedback from JSRs and communication/messages from the PHC. There is no formal link between JSR and the PHC. PHC staff collects no records, and JSR-Ws are keeping only scribble-books at places. The manual prescribes a record format, but no one follows it.

Government circulars have asked MOs to call the JSRs for monthly staff meetings. Some JSRs have attended these meetings. But this can not go on for long since the travel costs are borne by the JSRs and there are no apparent benefits to them from the meeting.

Obviously there is little or no monitoring, as 16 out of 22 JSRs are either silent or denying existence of any monitoring. The scheme does not provide for any monitoring save a circular from the DHS about inviting JSRs for monthly meetings.

From the interviews many JSRs actually express a desire for guidance and training. A senior RFWTC teacher felt that interesctoral (health, education, and women's welfare) team of monitoring will be effective. In his opinion, select MOs in district should be entrusted the job of monitoring the scheme.

The gram panchayat /GS is a non-technical body and the latter is hardly operational. Since the gram panchayat is also not paying the JSR, there is no formal accountability. One suggestion (by a CMHO) is for a bond given by JSR before training stating a) locational restriction for practice and b) NHP work. He also suggested that the JSR should be on-contract with gram panchayat or gram panchayat be given a grant for modest remuneration to JSRs. The gram panchayat and GS need to undertake some of the monitoring. Ensuring that JSRs get some mandatory services at fixed rates is possible.

Monitoring is crucial to this scheme else it will degenerate into a chaotic quack system (?) created by the Govt. itself. Govt. will have to put some funds on this and some special task-staff (may be from existing staff). Three clear areas for monitoring are a) clinical work b) National Health Programmes c) social aspects like costs. The GS can undertake this last part while the first two need

to be regularly monitored. The details of this need to be worked out. Mainly it will be some work protocols, mandatory records, staff visits.

CONTINUOUS MEDICAL EDUCATION

Apart from the monthly meetings of PHC/CHC staff, (some of the JSR-Ws have started attending these meetings recently) there is no continuous medical education. Even the new book has not been given to the working JSR-Ws trained earlier.

From **Opinion poll**, the responses expressed that a lack of continuing education may cause local problems due to wrong treatment practices.

Continuous medical education is an important part of any such programme. It can work through National Health Programmes channels, and a house journal is strongly recommended. This will include exchange on all aspects of the programme. The new editions of manual need to go to even old JSRs and this book should be better than the available books in the market.

SUPPLIES

"He came from training but did not bring any medicines" - a user in Barwani

JSR-Ws get very few medicines/consumable from PHC/CHC. ORS, Chlorine tablets, chloroquine and slides are the main supplies. Other medicines are bought from the medical stores.

Interviews with private medical storekeepers are revealing. Obviously, all the tablets/injections which, JSRs use, are from medical shops. The rules of the games are like for all other Pvt Med Practitioners. Some medical stores specialize in such matters. One such quoted below:

Issues	Response
No. of JSRs purchasing medicines	About 5-10 JSRs purchase medicines from his shop. There are 10 more shops, From various shops as per his opinion 30 JSRs might be purchasing. Other stores are also selling them medicines.
Frequency and payment	They come to the shop twice in a week. Every time they pay Rs. 200-300/- or so. In a month they purchase medicines worth Rs. 1500/-
Opinion	Better than Bengali docs, JSRs have two wheelers. Travel in the villages and render door to door services. Most of them have experience in working in private hospitals.
Complaints	So far no complaints from any dept.
Referrals	If they have some problems/complications they bring patients to the CHC.
His business	No impact on his business. He gives medicines on credit.
Common lists	Crocin, Dependal-M, Vikoryl, Clhoroquine, Septran, Ibupara, Diclopar, Ampicillin, Amoxycillin, Taxim, Cifran, Norflox-TZ Syrups- Septran, Paracetamol, Ampicillin, Antidiarrheal Injections- Ampicillin, Cefatoxim, Diclofenac, Dexamethasone, Genticine, Oxytetracycline, Dicyclomine,IV fluids.

In the **Opinion poll** the respondents are worried that the impossibility to serve without availability of drugs.

PUBLIC SECTOR LINKAGES-PHC/SC

Woh (JSR) to neta hai, hum pade noukar (JSR is a leader, and we are just servants):.. An ANM from a Dhar CHC "JSR? Woh Bechara kya karega, uski apnihi nahi banati" (JSR, what will the poor guy do? He is himself helpless).. Another ANM from same district

Views of MPW/ANMs about JSR scheme

Issues	Observation/ Response
Duties of JSR	Immunization, Chlorination of wells, Depot holder of Tab Chloroquin, Chlorine, Furazolidine, ORS packets. Births and Deaths registration. He is expected to help in implementation of National Health Programmes. But he is interested in his practice and does not give time to other work
Code of conduct	It is written in manual. They are not allowed to practice injections etc., but they give injections and do irrational practice.
Selection	Well to do JSRs will not work; they are just for namesake. JSRs from poor families, OBC, BC s should be selected. But 10th pass candidates from these communities are not available, so it should be relaxed. 10th attended should be recruited. There is political intervention and partiality in the village. So no proper selection.
Training	It is going on somehow. Actually nobody is taking classes. Many officers are corrupt. They are not interested in solving health problems of the community. Actually there should be separate hall for lectures, but it is not available. Trainers get separate money for teaching. BMO does not involve them (ANMs) in training process. Supervisors should be given responsibility of training. They can train more efficiently than doctors can as they go in the field regularly.
Stipend	Most of the money is spent on travelling. Few are living in rented rooms.
Remuneration/ Hon.	Some honorarium should be given, otherwise they will not work.
Monitoring	Monitoring is must. It can be done at every level. In the pulse polio program Rs. 90/- were paid to volunteers who helped. Like this performance oriented money should be given. They can not come to meetings unless they are given TA/DA
Future	Some JSRs will earn money. But it will not be a solution for health problems of the villages.

INCOME

" Chaar barass pahilehi kaam chhod diya, Udhari ka bada problem hai, mere batchwale lagbhag sabhine kaam Chhoda(stopped working 4 years back , credit-dues are a major problem ; most of our batch has stopped working): A JSR who gave up long back

"kab tak jebse karenge? Kuch mandeya milna chahiye" (How long we can work from our pockets? Need some honorarium): A JSR still trying

"Bahot high practice hai sir, chaar-pahiyawali gaadi hai uske paas" (. Has very high practice, has a 4 wheeler): Health Assistant describing one successful JSR in his area…

More than half of the responding JSR-Ws have nothing to say about it, taking no income and no response together. For the remaining, 2-5 Rs per patient-contact is common, some others earn above 10 Rs, some even mention 40 Rs. On the lower end, it is 1 Rs.

Of monthly income, 9 have nothing to mention; while 553 is the average for others.

It can be safely assumed that the non-earners are truly so, and not many earn much. But some do use saline and injections and charge just as much as other Pvt Med Practitioners. Interviews from other sources report higher incomes for the 'successful' JSRs.

"You can write 1000 Rs" was one JSR's response in Guna district, while the volume of his work was daily 1-3 saline, few injections etc. This can easily fetch 100 Rs profit daily, which makes 3000 a month. Even some beginners have started earning. Since injection is the norm and usual fees are 10-20 Rs, 3000 is not an unsafe prediction for these JSRs.

Only 2 out of 22 feel that the income is enough. Others have stated various negatives like no income, no benefit etc.

Most JSR-Ws feel some honorarium/Salary is necessary for sustenance. Some have suggested Govt. supply of medicines. A JSR-W has asked for permission to practice.

From interviews it appears that, the range of monthly income is from 500-5000 (average 2000 pm). The extreme upper end is allegedly due to high incomes from saline by a particular practicing JSR. Charges vary from 4-5 for tablets, 10-30 for injections, saline 40-70 Rs. *Udhari* (unpaid fees) appears to be is a major problem.

The bleak story is that 90-95% of JSRs, who never make such incomes, just fail to get started, and are simply lost from JSR scheme. Many have pathetic stories to tell. Poignant remarks such as "

jebse kabtak kaam karenge? (How long we can we keep loosing money on this?) " '"Udhari bahot hai" are tell tale.

A district collector says

It is a good scheme particularly for inaccessible areas. No one – doctors, other staff do not go to such area. We only respond to information about deaths due to diarrhea etc. A JSR can serve this area. However, main problem is its financial feasibility. Would the JSR earn enough to remain in their village? Also their education level is also a problem in the tribal area. Educated candidates are not available. Also, can such villagers afford to pay them? A solution is to have a JSR for a cluster of villages - 4/5 villages so that they get enough patients.

HONORARIUM

All the respondents insisted about some honorarium for JSRs. The JSRs wanted it for sustenance; the PHC staff wanted it to be able to officially ask the JSRs to help in National Health Programmes and for monitoring/control. The only opposition came from a RFWTC-principal, who feels that honorarium, would defeat the very purpose of JSR scheme. The policy-making senior officers are also against any honorarium.

"How much honorarium?" we asked. The average expectation seems to be about 1500 Rs a month. This works to about daily wage earned over one month.

One Janpad Adhyaksha suggested a house tax for JSR support.

The issue of honorarium is one of the central issues in this scheme. Policy is generally against such payments and adding any more cadres to the State's burden. With the prevailing inefficiency, why add one more scheme with recurring expenses? This argument can not entirely be wrong.

There are counter arguments—why should only the JSRs work free? How can we control the scheme if there is no financial incentive? How can JSR sustain in a 1000 sized population merely on clinical practice—3-4 patients per day? He would rather sit in a bazaar town and do as other Pvt Med Practitioners do. Otherwise he has to be given a cluster of 2-3 villages, (which defeats the aspects such as access and community control). An entirely self sufficient village level health care is unlikely in current Indian village economics, and there can be no lifelong volunteers in thousands. Secondly, even if such income is realized at some places, the JSR will not look after the preventive-promotive aspects and thus defeat the purpose of 'janswasthya'. Some kind of support is therefore necessary for sustenance of the JSRs and for health promotion-prevention.

"How much and How to pay" are the real issues. No approach is entirely perfect; there are known risks and problems for each. A pragmatic solution to this problem, (apart from other technical aspects of the programme) is central to success of the scheme.

LOAN

"Kahanka loan saab, pareshaan hai hum" (What loan? ..nothing! that is the worry!) A JSR-W in Dhar

Bank loan? 27000 was promised through TRYSEM, very difficult to get[4]. The process is get a certificate, go to gramsevak (mantri), make a subsidy case, then go to bank and then bank does not find all this creditworthy. At most 5 out of 50 got it: A BMO

Except one nobody has got the TRYSEM loan. It could have been worth while to explore how even one could get it. Interviews have it that there are several difficulties in getting the loan because of lack of funds, among many other factories, there is an understandable frustration among JSRs.

USE OF KITS

The JSR kit contains cotton, slide box, bandage, scissors, tape, forceps, artery forceps, pencil, gauze, forms, tongue depressor, and torch. Not every JSR received it. Many have not used the kit. The useful part was the bag itself, as a carrier for medicines. The instruments were hardly used. Most kits of JSR-Ws we opened contained injection-material and some purchased medicines. Some JSRs have purchased a stethoscope, BP machine, thermometers, even weighing machine, and saline stand.

Giving a full bag may be a waste, as many JSRs go out of work. If medicines are distributed with the kit, JSRs might consume it for once and again look for more supplies. If a kit is replenished from Govt. stocks, people may never pay JSRs and always ask for free stock medicines. The best way is to decide according to the chosen JSR model.

RELATION WITH VILLAGE BODY

Most JSRs know about the Gram Swasthya Samiti and can mention how many members GS has. 8 out of 22 JSR-Ws have mentioned about GS meetings. But the respondents have various things to say about what GS does and should do. No definite picture emerges about the role and functioning of GS in the context of JSR scheme.

From interviews except for 2, GS is not mentioned. For the 2, GS is working-discussed water safety/immunization campaigns.

Gram panchayats and GS seem to have discussed the JSR Scheme in some way, but only some of them are able to word what was discussed in those meetings.

[4] In our field study , no-one said he got the loan

JSR-Ws seem to have a raised some health issues in the GS /Grampanchayat. One demand was about establishing a sub center in the village. Another discussion was about medicine Cost, even age of marriage.

RELATION WITH PVT MED PRACTITIONERS

In the responses, the Pvt Med Practitioner relation looks thin. In in-depth interviews many types of relations show up. Some Pvt Med Practitioners get into the JSR programme for Govt. approval, others send their sons into this programme to run the family business; some others send patients to Pvt Med Practitioners for a consideration, and many become quacks themselves. Others have to compete with Pvt Med Practitioners to get and retain a share of clinical practice. A CHC staff member said that 4 of the 5 MOs do Pvt Med Practitioner at home, and have links with JSRs.

During the **interviews**, we learnt that sadly the CHC itself is often a place for private practice. In MP CHC *table private practice* is not common, but most MOs call the patients at their homes (often the official quarter) and charge money.

This is a dangerous area for JSR scheme- tomorrow if not today. If they are not able to heal, they may work just as touts for Pvt Med Practitioners and may exploit the villagers. The trends of CHC using the JSR as its 'links' are already there. According to a CHC CMO, they (the policy makers) do not know what work to expect from whom, if you tell the CMOs to train JSRs, this is what is expected" But then if not the CHC/PHC where will be the JSR scheme anchored? This is a system problem and not particularly JSR scheme problem.

A Case study: Bengali doctor

Dr Biswas hails from West Bengal, led by some relative BD working in this area. He has some degree from Barashat area of W Bengal. He works here for 12 years and earns about 1000 daily. He has used 50 oral medicines, also Ayurvedic and about 25 injections and saline. He can do all small jobs like tooth extraction, wound repair etc.. He refers difficult cases, assists TBAs in deliveries if need be-only with a Pitocin injection. He (BD is always a he-man !) has a sizeable clientele everyday. When we visited him, although it was a lean time of the year, but 9 patients were sitting in his small OPD. (1 with PUO, 2 with deramtitis, 1 for white discharge and 1 child with diarrhea, 1 for wound dressing). Mothers had brought their babies for some treatment. He does not give any injections to infants. Charges about 20-35 Rs for every episode. He knew the side effects (eyeball rolling) of Perinorm. He also makes motorbike visits.

His 3 wastebaskets were full of injections - vials and ampoules.

We asked him if he has any books, NO! But one can always study, he said. There was no degree on the wall, but a wood carved plate, reading Dr B M Biswas, that is all. He stays next door, has a family and many relatives in this area - all BDs. Well-connected and street smart !

ABOUT USERS

Most JSR-Ws state that all sections of the village society use their services. Some say that the major limitation is lack of medicines rather than people approaches. One JSR-W says there are many Pvt Med Practitioners in the village hence people are not using these services. Another JSR says only poor people use these services.

MEDICINES USED AND DESIRED

MEDICINES DESIRED BY JSR-WS

"The medicines they teach us are fewer than the village grocer". JSR_Ts

"More medicines should not be included in the scheme". Trainer, RFWTC

Although the JSR manual teaches only about 15 allopathic medicines (6 external applications including gauze, and 9 internal)[5] from allopathy about 45 medications find a mention in the 'desired' list of JSR-Ws. Among them Paracetamol, chloroquine, ORS and cotrimoxazole are the commonest. Thanks to the previous manual a banned medicine --analgin --is found lingering in the list. Questionable medicines like betnesol, B plex, sinarest also appear. Injections like dexamethasone, diclofenac, gentamycin and tetracycline show up. There is also a mention of injection TT. One can only wonder about whether they can ensure cold chain.

Among the medicines JSR-Ws want to use, antibiotics/antimicrobials, and painkillers, steroid are the principal items, though 15 out of 22 either remain silent or do not want more medicines.

MEDICINES DESIRED BY JSR-T

Many trainees that are beginners have said "Not yet". Injections and saline are dominant desire. Antibiotics are variously mentioned in illnesses like TB Typhoid etc. Somebody has desired " A Safe Antibiotic"! Several illness – wise medicines have been mentioned. These make an interesting list of about 25 health problems ranging from pains to childbirth and emergencies.

INJECTIONS AND SALINE

Many of the JSR-Ws actually and commonly use injections. *No injections, so no patients, is deeply engraved on everybody's mind. This is a hard core problem in the rural medical practice*.

Several steps and tricks are necessary to wean away people and JSRs from such practice. However the use of injections by JSRs can not entirely be banned. The main concern is to decide what injections and for what conditions. Among the 22 JSR-Ws 5 use injections while 12 JSRs do not use injections at all. Among the remaining 10, two find it necessary for scorpion bites alone. Two

[5] **External applications include:** Gauze bandage, neosporin powered, tin Iodine, savalon, benzyl benzoate, gentian violet, and the **internal medications are**: chloroquine, avil, paracetomol, cotrimoxazole ORS, ironFA, antacid, mebendazole, OP.

JSRs give injections only on Pvt. Medical practitioners' advice (is this just a defense statement?). Eleven injections are in common usage including antibiotics (ampi, genta, and even taxim) anti malarial, painkiller and anti-spasmodics. About 14 conditions are listed as injection-worthy.

From interviews and observations, some additional injections pop up- cipro, stemetil, deriphylline, Bplex, paracetomol, penicllin, etamsylate, etc.

Saline infusion, although not officially advised, is mentioned in the JSR-W responses. Ten out of 22 JSR-Ws use saline and they use injections too. The ones who currently do not use injection/ saline are probably not really working and have been interviewed as 'past-JSRs'. Understandably some JSRs may have chosen to avoid to mention injection/saline. Common clinical conditions like fever, diarrhea, vomiting etc 'deserve' a saline infusion.

Says a JSR-T, that inj Dexamethasone is like a potato, can go with any illness or medicines.

In a Morena village, an old CHW of 1985 batch has set up a clinic. He uses lot of injections. The photograph of the wastebasket is telltale –full of used vials and ampoules. (He was slightly concerned when we took a photograph of this basket.)

A case story of a fresh JSR

KK is from backward caste, chosen by the gram panchayat over a high caste candidate, thanks to higher education. He has just completed the training (June 2001) and yet to get the certificate. He has already started practicing and uses 1-2 injections for every patient. He and his family feels blessed because of the injections he can give; for which otherwise the villagers had to travel long distances on foot and pay a lot more. That brings him 10-20 Rs a patient. We met several 'happy' users but also met one ailing man who cautioned us to control the JSR's injections. "I have a family to care and can not afford to die of wrong injections of a half trained village boy" is his remark.

At one PHC on way to Kuxi, we stopped to see the MOs. The compounder was washing the syringes before giving the injection. The 'simple and humble aseptic precaution' was to pull some water from the bowl and then squeeze it off, then fill it with the injectable. Some JSRs are quick to learn this 'easy technique'. But one JSR uses disposable syringes and needles, "they come cheap" says he.

There is great scope for reorientation, protocols in this area of injection/saline use.

ISM REMEDIES

.. ISM component is important, but only allopathy is stressed—A CEO

"No use. It (ISM) is a waste." A BMO

About 30 Ayurvedic medicines and herbal remedies have been listed by JSRs. But not all of them use these medicines. 7 out of 22 JSRs do not use any and others use very few such remedies. The manual section on Ayurveda mentions several home remedies and about 74 marketed remedies. The working JSRs mention about 10 of this list. The mention is occasional and scant.

The medical worth of Ayurveda (ISM) is not fully used by the JSR scheme. The training component is poor and the supply logistics is absent. Ayurvedic remedies can be socially acceptable and JSRs can prepare some of them. The fixation to allopathic medicines is questionable and counterproductive. Ayurveda is also rich in medical as well as non-medical healing ways and JSR programme needs to use this. Actually, the JSRs should be able to choose medicines from various systems on the criteria such as affectivity, cost, safety, acceptability, and availability. The current rejection seems to stem from system-inaction/bias.

SUGGESTIONS AND OPINIONS

SENIOR HEALTH OFFICERS

Yeh to dhokhadhadi hai ! Bhagwan kare Achchha hi Achchha ho ! (It is adangerous scheme, may god save us all)- A CMHO about the JSR Scheme

At the regional, district and block level several officers indicated in various ways including body language that there was little if any consultation with them anytime on this scheme. "The scheme" one officer said, "was made by officers sitting in AC rooms". Valuable suggestions could have flowed from an interaction between field officers and the scheme-makers. Even RFWTCs are uneasy about the training and the scheme. There is little participation from the RFWTCs beyond occasional ToTs sometime back. One officer was incredibly stiff and uneasy while talking about the scheme, chose to give only "officially correct" answers and actually said that everything is going on according to the plan in the district. In reality his district, seen as model and better district had quite pathetic conditions about JSR training and working JSRs. "The higher officers do not tolerate any questioning on this scheme" was another remark. (But one BMO told us that he actually told the CM in his visit to the CHC that the scheme is faulty).

There should have been an interaction with health officers while conceptualizing the scheme. It was also necessary for involving the BMOs, BEEs, MOs, CDPOs in the process of the scheme. There is a feeling that it is just pressing the accelerator without looking back on what is happening to the JSRs in their villages. Some kind of resistance is expected for any new initiative, but at least some critical mass of officers need to support the scheme. JSR scheme seems to be wanting even a minimal support and involvement from these field officers.

A senior trainer suggested that a training-planning committee at the regional level should be constituted for reviewing the syllabus and even the budget.

JSRs ABOUT THE SCHEME

Responses are full of negatives like "no money/ no capital, lack of medicines/ equipment, no permission for injection/saline, can not prevent illnesses, difficulties in diagnosis, poor training, no patients, no support, no clients, Pvt Med Practitioner threats, *Udhari*, etc". These responses meaningfully profile the lacunae of the scheme.

All these complaints are true and decisive for outcome of the scheme.

DISTRICT/BLOCK FUNCTIONARIES

Among the administrative side, district collectors and some CEOs are well aware of the scheme. The JSR scheme is politically important scheme. All district collectors are responsibly involved in the scheme. The team interviewed some officers. The officers were aware of the complexity of the issue, and the larger system-problems that were plaguing the scheme.

Almost all levels of District/Block level officers as well ZP/Janpad representatives suggested that the JSR must be given some honorarium.

From almost all the districts, the senior officer also expressed the need for a supervision system for selection, training and working of the JSRs. They also suggested that the JSR would be registered and trained JSR should get bonus points for EGS selection.

They suggest that the training should be preferably at the district/block level and not at the PHC level because this increases the workload of the Mos. They do not get time for preparation of the lessons etc.

One such interview is given below.

First Reaction	Dhar is doing well in MP on this programme. Slow going scheme, training quality poor, problem is --what to do after training, but some CHCs may be doing OK
Selection	Often it is tussle between the Sarpanch/Dy Sarpanch (in case of tribal panchayats) AND the Govt. staff. It is part of decentralization. If the people have their way; staff does not like it and the vice versa. Either way it becomes a point of friction for long, that may affect work of JSR later too. AWW should also be selected/trained. Majority caste member should be selected.
Nepotism in selection?	Some favoritism is likely
Selection process	Should combine both GS and staff views
Any complaints about selection?	May be coming to the CMHO. But not yet
Publicity of the scheme	Usually it is just a letter to the Grampanchayat. Public media not involved, no advertisements for lack of funds. But radio could have been involved (*an afterthought*)
Coverage	1487 villages, 1300 persons trained so far under the TRYSEM. This is the last batch in Dhar.
Loans	No more now. In 95-96 some got it. 1300-1400 was given from TRYSEM
Training	Needs to be perfect, and practical. The exam should have also practical part.

Stipend	This becomes a problem in selection, many students come because the 3000 Rs, it is free time, bad season, some cash. I feel there should be no payment for training, let those who want knowledge come and prove their sincerity in work.
Kits	Yes, Govt. gave them kits
Selection of women	Yes, now the entry is relaxed to 8th std, AWW selection is a better way, she is quite competent
Preventive tasks?	A silence. Community awareness is not there for preventive.
Funds	Yes, we have no problem
Political interest	Not much really
Inj /IV	Community wants its a social problem
Legal	Can be a problem
Payment	No payment to JSR, some get it through the Malaria Link worker scheme (500Rs pm)
Suggestions	Impact evaluation before and after training

SARPANCH, GRAM PANCHAYAT MEMBERS, VILLAGE PEOPLE

"People do not know that the JSR does not get salary from Govt."—a ZP chairman on JSR woes

"Koi saath baithana nahin chahata nahin to chunega kaise ! Jhagadehi hote hain, nirnay kaha ?"(people are not willing to come together..they fight..How will they take decisions?) - an elder from Rehagun village

Villages are not quite seized about the scheme. In fact, a lay person does not know about the JSR scheme. We had to variously describe the scheme so that they finally recognise somebody is a JSR in their village. (This is a 'nemesis'). There is no propaganda about the scheme, no wall writing, no posters, no slogan even in grampanchayat. Unsung and unwept the JSR scheme is.

Asked about the work of such boys in villages, who have a JSR-W, the answers are about illness-treatment, nothing else. Some users are happy about having someone like that in the village and that they do not have to carry the sick on their backs to the town. Some are cautious about these "*kalaka chhora turning daktar in six months at the sarkari davakhana*." Some users have thrown a bouncer on the JSR scheme; for instance see this one from a Barwani villager—"If I had money, I would rather go to the town-doctor than this JSR, I go to him because I have no money to pay at town".

Grampanchayats are not quite aware of the scheme, and so is the average villager. In one village, we discovered that the Dy Sarpanch, a ST and wage labourer himself, was not fully aware of the scheme despite the fact that his own boy has been selected for the forthcoming training. In Lunera in Dhar, another member of the gram panchayat was also faintly aware of the process, though his mazara had a JSR who had given up work four year ago. In the same village, the small

high school staff (also the headmaster) was unaware of the selection, though he had heard about the scheme. After asking him about 10th pass girls in the locality, he comments " why not girls, there are such girls". He was apologetic about not knowing the scheme fully. (A headmaster could be a natural member of the Janpad selecting committee).

In some gram panchayats, it is the Mantri (gram panchayat secretary) selected the JSRs, from the list of applications.

In a village in Guna, the practicing JSR-W is also Dy Sarpanch and the Sarpanch is a SC woman. After telling him about our desire to meet her, he laughed at the idea saying she is good for nothing and just a pawn in his party. This man JSR belonged to BJP. We asked him if this scheme will politically benefit/ harm the ruling party. He said, all party members have availed of the scheme and can not favour or disfavour the ruling party. Politically, at the village, it is unimportant.

OTHER PHC STAFF

In general JSR training is faltering. Two interviews are telltale; one of them unwittingly admitting the stark realities. The other was purposefully told in anguish. Names can not be quoted. In one training center, the staff members were very critical about the training and the JSRs. "Paramedics like us are asked to train.. What do we know about illnesses? MOs are not interested. "The JSRs are not working, just telling lies about preventive work". According to one of the staff member, there should be special trainers and they should take centers in rotation. Also "stress use of herbal remedies" was his advice.

In another PHC, the HA was the only staff available around at 10 am. He was very enthusiastic and outspoken. "Only coward JSRs will not practice" was his pet sentence. He felt that most of the JSRs around are doing 'high practice'. According to him, all JSRs are doing very well and earning by "high practice". "Some have bought four wheelers". (We could not go to these villages because of bad roads). Later, he said the MOs have taken money from these boys' stipends and no one is teaching them. (He alleged trainees was underpaid stipend, taking receipts for full payment, part going to MO's pockets.). "The BMOs have no time for training these boys and there is no training at all". One JSR trainee said he goes at 11 am, sits and comes back at 1-pm.

AWW SUPERVISORS

Although, all others are enthusiastic about AWW as JSRs, the AWW supervisors are skeptical about this for two reasons, a) there are not many AWWs that can qualify for a JSR training in several districts except Indore b) AWWs are not available for this work till afternoon c) Unless there is fixed honorarium, women can not work in such scheme. (Women may not get fees from patients as men JSRs can possibly get).

VIEWS FROM JSRS-PAST AND PRESENT

From interviews out of 22 interviewed JSRs, 4 have mentioned about some National Health Programmes; mainly malaria, immunization, and about depot holding.

POLITICAL OPINION ABOUT THE SCHEME

Interview with a Janapad Adhyaksha: Shri Ramsingh

Scheme	Only on paper..not on ground, sirf a report
Suggestions	Honorarim.500 at least
Fund-flow	No problem Actually Janpad/villages can generate resources, but the policy should come from Bhopal, otherwise people may not like another tax
Medicine supply	not many medicines does he get
problems	Govt. docs and nurses are not sincere, they do not stay at HQs, docs do private practice
Training	hasan type something goes on, need to train them about medicines
Reforms	Medicines, better training, money The Govt. doctor gets 15000 and does not work (he is talking about the PHCs not this CHC), why should a JSR work without money.
selecting women	Reservation will not work; reservation has made women Sarpanchas and sarpanch-patis. It has not helped. Education alone will get more women, from 60-62 JSRs now 7 are women
JSR and AWW	JSR is more imp than the AWWs, the latter is just for daliya-cooking, JSR should give medicines
Popularity of the programme?	No, no one is interested, no faith in JSR, Bengali's have earned faith of people, outside docs are more respected (than the local lads). There is no practical training. It is not a visible programme
any Good JSR	Yes, in Longsari, he runs a dispensary. Inj saline everything. He has worked with a doctor earlier
National Health Programmes	Nothing
Can JSR get a room in the village for his work	Yes, possible. GS school works only for 2 hrs. That can be used. But the main thing is money for the responsibilities Govt. gives him. Today the JSR is not self-reliant
new trainees	Do not learn, only come to eat. The 500 Rs
Comments	No future

Interview with a ZP Adhyaksha

The scheme?	Looks around, does not know the administrative details it seems, someone from the hall gets up and starts telling him. Too many Programmes, difficult to even understand. Each dept should know better
Selection	Gram panchayat do it. Non-SC villages
Tasks	Treatment of Choti-moti illnesses
Success?	No it is not working, the training is not good, only those who are working as RMP should get such training, since they are working already. The will to learn is imp.
Women selection	The Dais are already there. (I remind him it is not JSR).. silence
AWW-JSRs	Now a batch is training in Guna
Your opinion about JSR	Will misuse everything Characater-*naitikata* is crucial factor
But there is gram panchayat to check	The Sarpanch will only give name of JSR, what else he can do/
What does JP Zilla do	Watch that is all. It is the gram panchayat really, it is independent-*swayattata*
Why no potential?	Only kit, no honorarium (says one around, which shri XXX echoes
Is JSR visible	We rarely see them
Women	Purdawali kya karegi?
Impact of the programme	Can not give employment. These new boys are after some career, can no stay in such jobs. Many have fled to GS as it offers some 1000 rs.
Control	None. In GS we have control, can take action on erring boys
Suggestions	Hon is imp, and control (ankush) is imp.
An impression of JSR	Laughs.. I will not go to a JSR, will you if you fall sick? It is like having a monkey shaving you, you have to accept that nose-ears are likely to go *(bandar dadhi banata hai, naak-kaan to kategi)*

CASE STORY OF A DROPOUT: A JSR TURNED EGS GURUJI

ABC from Lonera is in hurry to go to the nearby mazara for his GS job. He was trained in a Dhar PHC in 97-98. The population of three mazaras (hamlets) together is 1100. He has a small farm of 2 bighas, a buffalo. He hails from ST and has a family of 5, he has a wife 9non-literate), a daughter of 2 years, a mother, a younger brother at school. He tried 'practice' after the training, bought some medicines and injections. The people used to go either to the nearby Bengali doctor or the practicing-visiting-MPW for injections. He had no place to set up clinic. No loan came. The kit he got from the PHC was rarely opened and most of the instruments were never unpacked. He had already applied for GS and was selected. So in about 2-3 months of JSR training, he started working as GS guruji for 500 pm, that gave him something. JSR was a forgotten affair for the village. Some villagers know he was trained. He has not met MPW or ANM for last six months, and the only time he met was for some medicines for the sick baby.

His wife had a serious problem of infected ear (mastoid abscess). He took her to various doctors, spent money and is now advised surgery that he can not afford. The BD nearby has given him some medicines that he can pull on with. During these sicknesses, he never went to the PHC/CHC even for advice. In fact after training he has rarely gone to the PHC. This is just another case of the 90% dropouts.

Interview with the above JSR

The population	About 1100 taking three mazaras together, I from one Lonera mazara
Training year	97-8, six months. It is already five years
batch	15 of us
working	No
What r u doing now	GS Guruji- five years already
What are others doing?	Just give cholrine (means here chloroquine) tablets
Any kit	Yes, it is kept inside, brings and shows. We photograph. It has cotton, slide box, bandage, scissors, tape, forceps, artery forceps, pencil, gauze, forms, tongue depressor, and torch
How many hours did you work as JSR everyday	Oh, once in 2-3 days.. Hardly any work.
Supply from dept	Only chloroquine they gave last year, and the slides. Nothing now.
Used the kit	Not for last six months, when I did open that time.
Any survivors of your batch	None
The manual	Read it

Marriage	Yes, has one daughter.
Ed	12th (1996)
Farmer?	Yes, 2 bigha, one buffalo,
Family	One brother, mother, wife and daughter. Wife is non-literate
Remember anything that was taught	Malaria, then eyes, fractures etc. Like we should give septran for sore eyes (?)
Problems	No medicines, stipend we got but not the TRYSEM loan. People do not pay, udhari is problem. One private Bengali doctor came and stayed here for a month, doob gaya and went off. Now he stays at Jirapur
Will you work again as JSR?	If I get medicines, and loan of 5-10000 Rs. Then it will run on its own
Did you use Injections?	Yes, Genta, Streptomycin (somebody prescribed it for a TB pt and I juts gave it here), Chloroquine, decadron for tooth pain. I tried for 2-3 months, gave up. *He shows all these injections*
tablets	Para, chloro, ibuprofen, septran,bought it from medical store (gayatri stores)
Working pattern	Used to go to the caller's house. Ghar-ghar!
Records?	None
About GS?	10.30 am to 4 pm, except Sunday
What work do you like -- JSR or EGS?	JSR work was good, but no sustenance
Contact with MPW?	Last month..for my baby who had funsi (boil) in the ear. Otherwise no contact so far
ANM?	There was one before; now transferred before 6 m. I hardly know the new one. Kavita is her name.
Contact with the PHC doctor	Thakursaab, one year ago I met him, No-one called me. No contact even with the private docs
The fate of new JSRs?	Same as mine. Money problem..Nothing for medicines. What can we give to the patient?
Where do you go for medical treatment	Private docs. For my wife--ear problem—I went to bhagadi just 3 days back. Paid 75 rs for one injection and some tablets. This problem is 1&half month old, had big abscess. Had to cut it and paid 600 Rs to the Bengali doc. The ENT doctor in Dhar was asking for 6000 Rs, which I do not have. (the wound has healed now,, I photograph)

IMPACT AND POTENTIAL

IMPACT

"They can prevent some morbidity but not any deaths"—A BMO

The IMR has remained the same in the last five years, so JSR scheme has no role in that..Health expert

It is not fair to measure the success of such scheme in terms of mortality differences, but in how they have actually alleviated the sufferings of people, how and how much they saved the hard earned money of their village folks. Such a study has not been planned so far. The impressions are, they have treated some morbidity, much in the way ordinary private doctors do in rural areas, perhaps at a significantly lower costs. The long-term impact of JSR scheme on MP's health system is not fully gauged. The high drop out rate conceals a large addition to the rural PMP pool as the entire state is training JSRs at several places. Even if 10% survive in whatever form, it could be substantial addition to the PMP pool. That sadly it is an MP version of the Bengali doctor, something that could be different.

A dispassionate analysis of the possible impact of even quack-distribution in unserved areas may be favourable. The first shots of antibiotics, anti-inflammatory medicines can have an impact on morbidity outcomes, just as the 4 tab presumptive dose of Chloroquine is construed to achieve in NMEP. Various authors have appealed to take a kinder view of the quack-system for they operate in a complex situation where few other things work. That becomes a great melting pot where BDs, MPWs, Old CHVs, new JSRs, RMPs and mobile drug-peddlars look alike. It has an impact.

JSR scheme intended to make a much wider change than that. In that context however, the scheme has failed make even primary things.

POTENTIAL

Vast number of villages in MP is without access to health care. The distances are already long and bad roads are more tormenting to the sick, esp in rainy seasons. Men, women, children all need good medical care at affordable cost. The Pvt Med Practitioners are there at clusters- 10-15 km away from such villages. The average cost of treating an illness at these clinics can be 50-100 Rs, sans the travel costs. Bengali doctors without much formal training and language handicaps dot the rural bazaars and bigger villages. "If untrained Bengali doctors can answer the need, why not our boys with some good training and support?" was the pragmatic premise of the JSR scheme. Apart from the medical relief at affordable cost, the scheme aims at improving outreach of National Health Programmes. The advent of SJSGY makes JSR all the more relevant and fitting. Great potentials indeed, for human needs of a backward state, of employing youth, of giving a broad base to the health system, of providing alternative to the ubiquitous quacks.

The promise is fading into some weird scheme, mainly because there is no clear-headed plan and no steering of the scheme. The health infrastructure is unhappy about it's implementation, the hard-nosed political leadership staying away from the scheme, bureaucrats not surefooted about it, JSR candidates—good boys from villages—suffering from a poorly framed and groomed scheme. The scheme is coming unstuck, sadly.

However it is possible to redesign it, slow the pace, look at its terrain and details and processes, educate people and users, build supports within and outside the health system for a potentially good option, do some brainstorming about the choices and the risks and finally choose the optimal path. If this scheme is rebuilt, it can be an example to several states in India that are looking for a viable option on primary care at the village. The 10th plan draft and the National Health Policy draft are struggling for words to put such an option back in place after the debacle of the CHW scheme. A new JSR scheme --and not this one--should serve to provide some new lines to this issue.

LEGAL STATUS OF JSRS

"We were called by the PHC MO and told us that you can't practice. The Police Inspector was also present. (There was an inquiry from DHS that how many doctors are practising). He threatened us. We were afraid of drug-reaction."..

A JSR

In some places, JSRs have asked how can they get permission to use medicines/ practice. In one place the JSR actually went pale thinking the interviewers were police in civil clothes. He had to be reassured. Instances where police have threatened the JSRs are reported. This situation can inject fear of extortion. Pvt Med Practitioners can have a better access in police stations and can book the JSRs as potential/actual rivals.

The JSR programme intends that JSRs earn for themselves and not bank on Govt. for support. Yet it makes no preparations for a professional JSR-the list of medicines is short (less than what the village grocer keeps for sale); the certificate hardly confers any legal status for use of medicines. When we interviewed higher officers, this issue was not big on their mind. We looked for a new copy of the medical practitioners' act of MP, but it stands repealed and was not available. There could be some section in the act to support JSR activity. The Govt. needs to make a good effort and bring the JSR scheme under some legal cover, so that it becomes stable in several ways.

NOMENCLATURE

I went to a group of youth in a roadside Morena village, asked them about who is the JSR in this village. They were startled by the long name "Jana Swasthya Rakshak". "*Kya Cheez, Hindi me bolo Sir*" was one reply and a loud laughter followed. (There was actually an old CHV working in this

village--practicing fully and running a busy clinic. The old ones are also called as the same Jana Swasthya Rakshak.) That did not help me. Somebody then I described the scheme and they weighed a hand at a clinic some 200 ft away and shouted one name, and a dhoti clad CHV with a stetho hanging on him came out.[6]

No villager knows JSRs as JSRs or jana-swasthya-rakshak. The usual names are *dawawala, woh daktar*, etc. That is a lesson for us in communication. We have been planting administrative names or 'concepts' on people. People call a spade a spade. Anybody who gives them medicines is a doctor for them. The name sister (for a nurse) is fortunately popular. Some imaginative nomenclature is necessary. Perhaps, the name will be popular if the scheme itself is functional. The Hindi shortform JASWAR is good enough (people may make it JASWAR-doctor) as it sounds Hindi.

VENUE FOR JSR ACTIVITIES

Some JSRs have asked for a ' Village Swasthya Bhavan'. Many JSRs do home-visits for treating the ill (which is good in one way) or open their own shops One JSR worked from his grocery shop. In Badajira, the village members have constructed a clinic for the JSR (A rare case).

- *The idea of making available a village-room is welcome. It will have several advantages:*
- *Reduce the capital cost requirements/need for Loan,*
- *Give JSR a permanent place to work*
- *Make the JSR accountable to village people,*
- *People can expect standard facilities and rates at that place,*
- *Linkage for National Health Programmes will be easier in a public space, the room can be used for several health functions*

IRRATIONAL PRACTICE

"Yeh Jan Swasthya Bhakshak scheme hai!" When asked to elaborate he (the MO PHC) said they are acting like quacks and harm instead of heal.

[6] In another Morena village, we changed the word to VHG (the PHC staff calls them as VHG), just to test an administrative word again. The villager-the Sarpanch's brother in this case- went blank for a moment and then his eyes sparkled, "you mean VAIDJEE" Oh, there is no Vaidjee in this village. We rolled in laughter at the way people adopt tongue twisting-administrative words that we are so fond of thrusting on them. Incidentally, that happens to be the best adoption to date of a God-forgotten-scheme of India. It will be pertinent to note here that this name was changed several times-VHW/CHW/VHG/CHG/ CHV.. Alas.! Was he/she a worker, a volunteer, a guide or was it a village or a community? What a confusion!

"Bandarse dadhi banani hai, naak-kaan to katnihi hai" (You are asking a monkey to shave you with a razor, cutting the nose or ear is no surprise)

These two are two comments one can never forget about JSRs. Irrational practices will hurt in several ways. JSRs are using several medicines and injectable, just like any Pvt Med Practitioners that abound. Pain killers, steroids, antimalarials, antibiotics are all there. Some relief of symptoms, some subjugation of infection/inflammation may happen with that. Users have acclaimed the 'cures'.

"There is some strange wisdom in some of these practices. The ubiquitous chloroquine injection is one such matter. Chloroquine orally is bitter and causes stomach upset. The injection bypasses this problem. But that can also give fatal reactions. When so many JSRs are using the injection everyday, how come no untoward effects are showing up? (Or there is not report?). So are some other injectables like ranitidine and reglan commonly used. I pray these things stop one day, and let reason dawn on them" (from a field diary).

"Irrational practice is common, but so many doctors are doing it. It is not possible to control JSR-malpractice it without curbing malpractice of others. The collector has to do something". observes one medical officer.

The irrational practices are too glaring and too common to ignore even for any sympathizers. How do we bring these things under control? Is it possible? Is it well nigh a runaway horse? Is it because they are not being paid by the state? (But even MPWs are doing malpractice).

And why so much demand for injections and saline? Is it because people want it that way? But then who started it—doctors or people? Anyway, why people want it? Is there something sinisterly attractive in injection-saline? Is it the healing touch people are rooting for? Is it some pleasant pain sick people want to experience? Is the cost of irrational treatment some perceived compensation for neglect of the family and the beloved? ***Several layers of health science--medical, psychological, social, etc need to be studied before giving stock answers on misuse of injection-saline.*** *The JSR is merely answering a social need, according to Collector Dhar.*

Some part of irrational practice can be surely corrected with better training on pharmacology, more choices from allopathic as well as other healing systems, more leverage in the hands of users and monitoring mechanisms, better administration of drug-stores and market. Public education on the scheme and also understanding the rightful concerns of JSRs. This aspect is beyond the ambit of this study, but surely calls for a in-depth research.

ROLE OF NGOS

NGOs are not in picture in the JSR scheme so far. An expert wondered why there is no pilot project on JSR scheme and felt that there should be a platform for NGOs in this context.

One CMHO observed that there are "no NGOs" here, while another said, "there are no guidelines on involving NGOs". At the highest level in Bhopal it was affirmed, "CMHOs have been instructed to involve NGOs at local level"

One expert quipped that NGOs have too much money and peoples' movements have no money.. Both are problems. This was presumably about non-involvement of peoples' movements in the scheme.

MP has a good network of NGOs working at grassroots and has a rich pooled experience. This needs to be put to effective use.

FUTURE OF JSR SCHEME

"Unka bhavishya par prashnachinha hai.".. (*There is a question mark on their future!): A BMO*

"Inka Koi bhavishya nahi"(they have no future!).. Janpad Adhyaksha

Several respondents fear that this scheme has no future. It sums up several genuine concerns in one statement. Already about 90% attrition does not auger well. The rest ('survivors') are living by irrational practices. The aspirations are about making money, becoming a doctor rather than comprehensive health of the society. The scheme is caught in a wrong groove. Vigorous efforts are necessary to pull it out of this groove and place it on some path of reason and health of the village.

It is one thing talking about high goals and lofty ideals, but on the ground we will have to decide on some doable tasks. Supporting right actions, instituting controls to guard against wrong practices, vesting some control among users, better training and Continuous Medical Education, concerted effort on National/State Health Programmes are important. It is a fledgling scheme and someone has to nurse the scheme to some level.

One critical exercise is to choose the right, accept the inevitable risks and optimize on that rather than try to combine the best lines from every model and reach nowhere or 'fall between two stools'. Model. (It may look too late as half of the villages are covered. But the attrition makes for case for almost a redesigned scheme for old and new villages!) The JSR scheme needs a thorough brainstorming, but finally it takes a 'one handed expert[7]' to steer the scheme. Every model has some frail joints and every path has pifalls. CHW experiments have ample proof of the fact there is no perfect model for the large scale that any Govt. to follow. Several poetic models have crumbled while survivors have held some messages. One such message is about healing. Healing is essential to any health worker model, and two, never ignore that there is some economics in any such schemes.

[7] Experts excel in telling pros and cons...on the one hand and on the other hand style. *President* Roosevelt insisted that he wants a 'one handed economist', someone who would take an overview of pros and cons but finally work in some direction.

COMMENTS ON JSR EXAMINATIONS

EXPECTED ANSWERS

- Most answers are short, even the descriptive ones. The descriptive are just around 19%. Overall the answers expected are well defined.
- The MCQs are often with 2-3 options, so very leading and 'easy', may not test knowledge.

COMMENTS

- We found about 70% questions are reasonable for testing knowledge from the book-syllabus
- Some answers need to be in practical test, rather than in written
- About 20% Qs are quite simple, and almost test lay information
- Other Qs fall in categories like incorrectly framed, needless, vague etc.
- Most candidates therefore can easily get 20-30% marks without much study. That leaves very little margin required for passing (qualifying 50%)

SUBJECTS

- MCH & FW take about 45% of the questions. Important subjects, but since most JSRs are men, the test does not really test the areas they may cover in work later. Some kind of mismatch this, but is built in the programme.
- National programmes rightfully take a big share of over 73%. Child health, mother's health are major among them. Ofcourse the tasks involved in NHPs are both clinical and non-clinical.
- Clinical work takes a back seat in the exams, neglecting professional requirements of JSR
- It is noteworthy that there is little info asked on drugs-side effects etc.
- Although any test is a sample test, the sample has to represent the range and depth required for work they are expected to do. In this view, though the list of subjects is wide (manual-wide), it is not very much linked to JSR's actual works in the village.
- There is also no practical test, which is time consuming but mandatory since there are several tasks to do in the village.

PART 5: RECOMMENDATIONS FROM THE TEAM

ToR	ISSUES	KEY FINDINGS	RECOMMENDATIONS FOR SHORT TERM ACTIONS	RECOMMENDATIONS FOR LONG TERM ACTIONS
A	JSR Scheme- overall impression	Program in full pace Community not aware of program Wider range of curative care provided by practicing JSR	Pause selection and training IEC campaign	
		Skills like injections acquired and used by JSR with inadequate caution	Redesign the JSR Scheme Start controlling the quack sector Prepare Clinical protocols	
		Inadequate linkage with the health system		Put the scheme in a system framework Integrate finely with the health system
A	System framework of the scheme	1. Scheme as an extension of PH Center with no work-linked, referral and supervision system	Govt. health system to give resources for training, work-linked honorarium, basic medicines and referral support, control of quacks	Collaborative model with community ownership, NGO/ CBO involvement for local supervision and community anchoring processes
				Can think of a Nigam or HMO
A	JSR as professional model:	VHG model as trainers' perception v/s practitioner as trainees' perception		On social partnership model, with NHP work in partnership with DHS, providing service with partnership with users etc. Potential partnership with other organizations: gram panchayat/ CBO, SHG, YG, NGO
A	Pace of the program	Targets are achieved quickly	Pause, look for quality & depth of program, evaluate, look at external factors too	Pace should be decided by community willingness to take up the scheme, not administrative compulsions
A	JSR Cell	No core team with the JD for the scheme	Make a think tank in the DHS including major NGOs representatives.	
A	NGO Role	No NGOs involved in the scheme	Community awareness	
			Training participation: curriculum building, designing training and as resource person	Designing/experimenting- a HMO model run by gram panchayat, NGO, Private Hospital NGO network on JSR scheme for local supervision and community networking Networking JSRs House journal-CME

A	Selection of JSRs	Recruitment rather than selection	Develop some technical criteria for selection	
			Observer from health dept/NGO to steer Recommend candidates through GS	
		Administrative control by DHS but no its Technical control	Health committee and health dept. to ensure he is not an existing quack or 'non-resident villager'	Final selection through Entry test
A	Women selection	Inadequate efforts for women's selection except AWWs in one district	Select women in all villages, if there is extra post in the same village, take the man	Redesign all aspects of JSR scheme to suit women participation.
		Higher Education level is an obstacle to select women candidates	Lower education condition to 8^{th}; let entry test decide the rest. Prepare books for entry test	
		Current JSR system has inbuilt bias against women	Understand key deterrents for women-selection	
A	JSR couple	No concrete examples seen		Feasible, need to develop a protocol for entry test Women should lead, man can be pillion
A	AWW as JSR	May work well in some cases (only about 10% AWWs will qualify for education)	Involve the ICDS dept in the decision	evaluate the existing workload of AWWs and their willingness to do additional work encourage, with bonus marks for after entry test
A	Age	25-30 male workers, 25+ AWWs	25 - 40 to favor married women	
A	Caste angle	No preference for SC/ ST/ OBC		Encourage ST/SC/OBC Bonus points in ET School leaving certificate as SC/ ST/OBC documents
A	Quack-entry in selection	5-10% of trainees are previous quacks,	no need to eliminate, but rigorous after-control is necessary	
			Quietly take severe action against quacks to demotivate quack-turned JSR	Regulation of private practice
A	Preventive programmes	Inconsistent link of JSR with PHC.	NHP/SHP support	
		No specific program for such links except for pulse polio program, depot holding etc.	Health Education incl. School Health Education on some honorarium	Preventive programs against addictions, pan masala, child marriage etc Health Promotion activities like games, yoga, exercise on some honorarium
A	Funding	Funds available for training	Funds for special training inputs, innovations,	For experimenting & JSR system development at all levels;
				Provide public space for JSR clinic
B	Training content	Course congested	Split the course in two	

		Less focus in the Manual on range of JSR practice Skill and attitude training not designed	Redesign manual accordingly	
		Variance in Clinical training	Include alternative healing methods	
		Very Weak link between Objectives-training-practices		More practical and clinical content; attitude forming by exposure to NGOs / model JSRs; three level training (literate / 5-8 St. pass / High school ed.) Enhance clinical training
B	Training venue	Variance in performance and trainers expectation	Special trainers from districts. DTT should coordinate training; location part in CHC and part in SC and village setting	Think of special training units at district levels
			Involve NGOs	Exposure to NGO also; involve local health NGOs in training.
B	Method of training	Didactic approach	Less didactic, more problem solving approach Participatory method for decision making Participatory,	
		Mainly without AV aid	AV aids	
		Skills self-learnt	Tutor for hands on training	
B	Manual	Not enough, lacks both range and depth	Rework with changes in venues, trainees, curriculum, content, methods attitudinal / social issues in mind	
B	BMO's role	Time and skill constraints	Valuable for organizing Training	
B	CME	CME only through MRs and through peers rarely through professionals No scope for upward mobility		Regular revision / refresher meetings House Journal specialty/advance training
B	RFWTC role in training	Well equipped with training faculty and facilities	Need to involve RFWTCs down to filed level-training and monitoring Involve RFWTC for curriculum setting, methodology and monitoring	
B	Exam papers	Too theoretical		Revamp, Include practical tests-internal need to judge attitudes more problem based questions rather than information based
		Not well printed		Print papers clean

B	Exam process	Too close to training venue,		Conduct at district HQ Fixed dates twice a year.
		Several batches were dropped		
		No formative assessment		Formative assessment
		Knowledge not trainees' goal. Copying reported		Results based on points or grades incl. skills, attitude tests
B	Other books	Need for extra reading felt by trainees and trainers	Make a JSR library at CHC and stock additional books	
		No trainers manual	List recommended books	Prepare manual for trainers
B	Use of Infotech	No self-learning, interactive tools	Develop CDs as a self-learning and self assessing process, interactive diagnosis exercises	
		No MIS software		Records and MIS for analysis at CHC level
B	Role of other institutions	No institute with expertise in education and grass-root work involved	Involve Open University health NGOs like MPVHA/ PSM departments	
B	Drugs used	Trained for very few drugs. Leads JSRs to quackery to build credibility.	EDL based on Prepare separate list for each module (Three level 10 / 20 / 40 drugs)	
		No one using other remedies	Encourage home remedies in the first module: herbal + accupressure	Add Other systems in basic or advanced or specialist training (Ayurveda, Homeopathy, Acupuncture, Yoga) as per the additional time, skill and knowledge required
B	Drug supply	Access to Irrational drugs by JSR high Existing supply system inaccessible and costly	Publish approved list for JSRs to begin with Basic drugs (sub center kit) to be supplied by PHC to JSRs free	Develop local stores with support from quality drugs supplied by non-profit pharmaceuticals like LOCOST, Vadodara, Gujarat
B	Injections /saline	Irrational use of injection	Revamp the protocols, allow program-required injections & ADR treatment injections	
		Charges more than the cost as a source of income particularly for quacks	Publish rate list start action on quacks , quietly to begin with	
		High public demand		campaign to stop irrational drugs used both in private and public HS
B	Ayurveda	Not yet introduced in several batches	Home remedies as basic I module leading to Ayurveda in Basic II module and also as a advanced training focus on simple herbal remedies rather than marketed preparations	

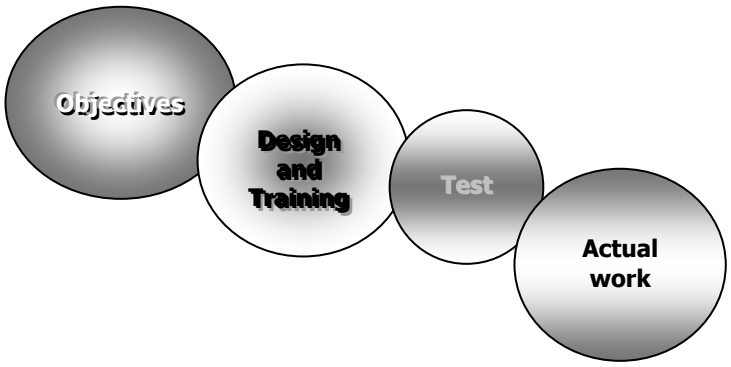
C	Community control	No control by community	Public information by posters, messages on walls, rate lists and services offered to be displayed in gram panchayat, school, Anganwadi, SC, Janpad etc	Directed to protect users create administrative tools for gram panchayat control
C	Community IEC	Community not aware of the role of JSR, responsibilities of gram panchayat/ GSS/ GS	Ongoing community IEC work should help	Design Specified IEC for awareness building
C	Legal issues	No legal status for JSR for social partnership	Legal protection is necessary- based on self-village based work and drug-use Issue clear GR on use of remedies	look for provisions for certificate courses for JSRs
C	Relicencing	No provision for continuous testing for JSR		Necessary every three years based on both technical performance and community feedback
C	Area size (to make the scheme fee-sustainable)	Great variance in coverage area for JSR. Not sustainable as fee based model	2000, ideally for sustenance on fees let it be decided by GS/gram panchayat if it can support the JSR differently (like insurance)	
C	Village selection	Targets achieved quickly Community not prepared	Take villages as they ask & prepare for the scheme make it a ongoing scheme, not the fight to finish kind of scheme	
C	Links with Other PMP	No system for links with private medical practitioners	discourage quack connection	Internship in trust hospitals, PHC, CHCs and Civil Hospitals.
C	Linkages with ANM/MPW	Inconsistency with linkage with ANM/AWW	As colleagues, to mobilize community to uptake NHP linked services of staff	
			Prepare a simple reporting system	
C	Clinic site	Clinic space invested by JSR increases the cost	gram panchayat space must be available, but let them work also from home for odd hour services	
C	Boards System-identity,	Identity no different from "Zola Chhap Doctors"	'Gram Swasthya Kendra' board specifying name of JSR; may be prepared by gram panchayat in standard format; let gram panchayat/ HMO decide	
			A logo OR a standard kit with a logo gives a work-related identity	
C	Clinical work JSRs doing now	Not satisfactory Empirical decisions		Increase both depth and range—through training /support

C	Clinic model	Variance in clinical model depending on what JSR can afford		Develop a standard set - an HMO.
				Let RKS like bodies build the centers if and when possible. this will give some credence to the JSR as system
D	Clinic records	Variance in clinical record: nil to professional	Work out simple, standard, user friendly, relevant, scannable, analysable, small MIS friendly record-formats	
D	Supervision monitoring, Quality control	No supervision system	Supervision/ monitoring: Social: village. Health committee / Gr. Sabha Technical: public health system	Legal/ Support: NGO/ CBO
E	Honorarium for JSRs	Near consensus about need for honorarium to JSR	NHP linked honorarium	JSR should be supported by public health system through Panchayat for health promotion, health education
E	Minimum income for surviving as JSR	1500 plus[$] Only fee based model financially unsustainable	As a part time activity from various sources (fees + NHP link + HE/HP activities)	
E	Survival rate --Working JSRs out of trained	~10% survive. Varies somewhat from area to area	Above recommendations to improve survival rate	
E	Social marketing of preventive services/ goods	Variance in social marketing through JSR Community not aware	Basic preventive services are practically never sold by the public health system and should not be	Possible only if a regular clinic space is available List articles/services other than basic preventive services that the community can buy or the JSR can sell

[$] Here the calculation is : Min wage for skilled laborer @ Rs. 100 per day ; Time required = 2 hours for clinical tasks, no of patients seen - treated or referred = 12 ; Therefore cost = 100/8*2 = 25 Therefore the JSR can charge Rs. 2 to 3 per person as service charge

OVERALL COMMENT

The four circles of **objectives, Design & training, test, actual work** have to reasonably overlap/match in any such programme. Unfortunately, in the JSR programme there *is poor linkage* between these four circles. The programme needs to do a coordinated effort on this.



SHARING CONCERNS

The draft report was presented before MP Govt officials on 4th Dec 2002. Those attending included: Shri Gopal Krishnan (Pr Secretary to the Chief Minister and RGM), Shri Manohar Agnani (Secretary RGM, Community Health), Smt Alka Sirohi (Secretary, Dept Health), Dr P K Bajaj (Director Medical Education and Research), Dr Yogiraj Sharma (Director, Health Services), Shri Manish Shanker and Smt. Pooja Gour (Sanket). The JSR study team including Dr Ravi Narayan was present. The meeting was held at Hotel Palash between 9.30 am to 1 pm.

One week before the meeting, draft of the study report was sent to all participants. A PowerPoint presentation is available on the CD.

Dr Ravi Narayan briefed about the team and the study process. Dr Dhruv Mankad explained the methodology and the samples. The PowerPoint presentation by Dr Shyam Ashtekar, field coordinator of the study team briefed the meeting on the basic outline of the study, major findings and problems of the scheme, the recommendations and necessary reforms. Dr. Abhay Shukla read out a note on recommendations. Dr Shashikant Ahankari summed up and thanked the MP Govt officers for help.

The govt officials agreed that selecting the women as JSR would sustain the scheme with the right perspective. She would be able to provide the service to the community and continue to link it with the PHC. The govt officials also noted that the training process needs to be strengthened. The training should be withheld for at least three months. Also they felt that the training with more skilled trainers accessing the resources available in the RFWTC and in the medical colleges. They also shared that the manual should be improved and only a good quality standard manual should be used for training the JSRs. The govt officials and others shared the concern that practicing JSRs are influenced heavily by quackery and needs to be tackled as a public health problem.

Everyone agreed that the key concern about the scheme is the community awareness about the scheme and their involvement in JSR selection and beyond.

At the end, there was a consensus that the lessons learnt during the review should be shared widely with all those concerned about the health of the people of MP.

REFERENCES

1. Census of India, 1991, Registrar General and Census Commissioner of India, New Delhi.
2. Central Statistical Organization. (CSO) *Selected Socio-Economic Statistics, India 199*8. Department of Statistics and Programme Implementation, Ministry of Planning and Programme Implementation. New Delhi.
3. Duggal Ravi, *Health Expenditure Patterns in Selected Major States, Radical Journal of Health*, Vol. I, No. 1, (New Series), January 1995, pp.37-48
4. Government of Madhya Pradesh, Directorate of Health Services, *Rapid Household Survey - 1998* http://www.mo.nic.in/DHS/surveyfind.htm,October 2000
5. Government of Madhya Pradesh, State Planning Board, Ninth Five Year Plan (1997-2002) http://www.mp.nic.in/planning/planning.htm, October 2000
6. Human Development Report, 1998 (HDR 1998) Directorate of Institutional Finances, Government of Madhya Pradesh, Bhopal.
7. National Family Health Survey 1998, International Institute for Population Sciences (IIPS) and ORC Macro. 2000. *National Family Health Survey (NFHS-2), 1998 Indi*a. Mumbai
8. Office of the Registrar General. 1999. (SRS 1999a) *Sample Registration System: Statistical Report 1997*. India. New Delhi.
9. Office of the Registrar General. (SRS 1999b). *SRS Compendium of India's Fertility and Mortality Indicators, 1971-1997 (Based on the Sample Registration System*). New Delhi.

Appendices

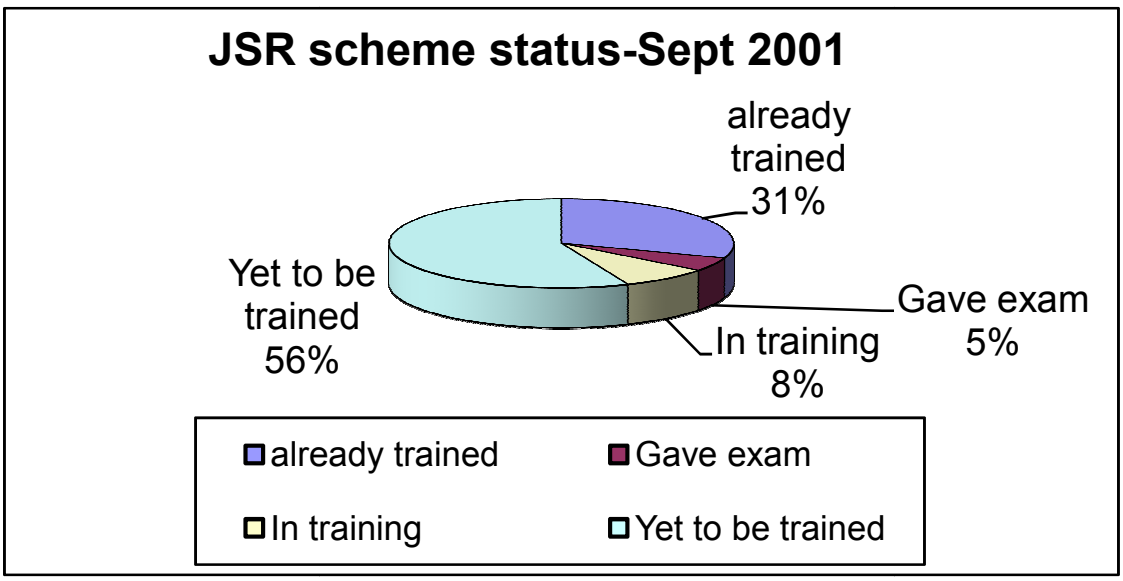
APPENDIX 1: DISTRICT-WISE DATA OF TRAINING OF JSRS.

District	Total Villages	Already trained JSR	JSRs Just Gave exam.	Under training JSR	JSRs Yet to be trained	Row Total: Villages with a JSR	% of remaining villages
Baitul	1328	587	187	21	633	1428	47.7
Balaghat	1269	445	60	70	704	1279	55.5
Bhind	877	349	62	51	415	877	47.3
Bhopal	511	203	30	93	185	511	36.2
Budwani	693	200	60	205	228	693	32.9
Chhatarpur	1076	320	60	156	540	1076	50.2
Chindwada	1903	689	39	120	1055	1903	55.4
Damoha	1205	329	179	169	528	1205	43.8
Datiya	521	180	0	62	279	521	53.6
Dewas	1058	412	0	60	586	1058	55.4
Dhar	1487	392	50	43	102	587	6.9
Dindori	896	52	40	150	654	896	73.0
Guna	2059	346	202	132	1379	2059	67.0
Gwalior	587	202	30	11	344	587	58.6
Harda	496	192	31	53	220	496	44.4
Hoshangabad	924	463	60	65	341	929	36.9
Indore	624	157	30	0	437	624	70.0
Jabalpur	1421	446	0	60	915	1421	64.4
Katni	836	363	0	60	413	836	49.4
Khandwa	1060	321	95	70	574	1060	54.2
Khargaun	1191	501	40	70	580	1191	48.7
Mandla	1212	651	77	71	413	1212	34.1
Mandsaur	853	224	49	114	466	853	54.6
Muraina	751	390	0	30	331	751	44.1
Narsinghpur	1040	358	40	176	466	1040	44.8
Neemach	722	297	11	47	367	722	50.8
Panna	939	180	30	24	705	939	75.1
Raisen	1439	352	7	70	1010	1439	70.2
Rajgarh	1664	376	58	220	1068	1722	64.2
Ratlabh	1051	170	91	173	617	1051	58.7
Riwa	2352	371	240	0	1741	2352	74.0
Sagar	1868	419	60	138	1251	1868	67.0

Satna	1784	427	60	70	1227	1784	68.8
Shahdol	1381	678	70	79	554	1381	40.1
Shajapur	1068	432	60	70	506	1068	47.4
Shivpuri	1326	349	50	226	701	1326	52.9
Shyopur	542	290	31	38	183	542	33.8
Sidhi	1822	325	45	140	1351	1861	74.1
Sihor	1011	273	60	131	637	1101	63.0
Sivani	1585	757	70	70	688	1585	43.4
Tikamgarh	863	160	60	70	573	863	66.4
Ujjain	1092	328	60	70	634	1092	58.1
Umriya	594	129	36	83	346	594	58.2
Vidisha	1522	279	60	395	788	1522	51.8
Zabua	1313	217	0	0	1096	1313	83.5
Column Total	51816	15581	2580	4226	28831	51218	55.6
Original Doc	51860	15481	2580	4254	29831	52146	

COMMENTS

- About half the villages are yet to be covered in the programme
- It is possible that the candidates for the new villages have been selected, if not there is scope for new strategies in selection and training them
- Because of high attrition, it is now necessary to take stock of JSR's actually working.
- It can be estimated that at 10% 'survival' rate, the actual working JSRs can be around 300, at 20 % survival rate it is around 600.



APPENDIX 2: GIST OF GOVT[#] ORDERS ABOUT JSR PROGRAMME

Date	Subject	Relevant details
17-8-98	New JSR scheme	**Start JSR**, Training, no honoraria, entire MP, through RCH scheme, stipend in training period. 500 pm, other budgets, New module for training, training on sector level PHC, every month will have a fortnight of theory at PHC , TOT at RFWTC and one fortnight for practical training at SC, every block should select 10 JSRs, Selectors include Janapad panchayat, teachers, Sector MO, Tribal W officer, DFO, Select one per village, only Non VHG villages, Preference resident of village,, below 35yrs, 10th std, Prefer VHG
23-9-99	TBA preference	**Select/Prefer** TBA family members for JSR selection
29-9-98	TOT	deputation of Sector MOs for **TOT**, 3days at RFWTC
26-11-99	selection	**Select/Prefer** TBA family members, old VHGs (relax age limit), Entirely voluntary, Start with tribal Dts, (Ed standard lower for Bastar 8th, Max 15 per block, training at DTC level, 6 months, Include Ayurveda, Practical training at Subcenter by MPW/ANM/Sector Supervisor, **Pay** 500 pm as stipend, upon >80% attendance at training, Budget Rs 300 per candidate for other use..(mainly rent, **Rent** houses for students, for men women separately, Give tool (medicine) **kit** at the end **Monitoring** JSR-training by Zilla Panchayat health committee Accounts every month by CMO
11-5-00	Evaluation	**Evaluation** of certified JSRs working in the villages to be done by CMHO..what work JSR is doing and about National HPs by JSRs
26-6-2000	6th training session of JSRs	Start in **all districts** by July 2000, Scheme by State planning board, training at Block PHC, batch of 20-30, Theory & practical, district target 50-60 JSR, selection frame remains the same.
18-8-2000	JSR manual	Give the copy free to trainees (Not the previously trained JSRs)
21-8-2000	cabinet decisions about the JSR scheme	**Selection** list village-wise list of prospective/likely candidates, preference for women, AWWs List suitable private nursing homes, get prior sanction for the Nursing homes. Keep follow up by three-monthly meetings of JSRs at the respective PHC
13-9-2000	Selection	Get full participation of **Grampanchayat** in JSR selection 5 months allopathy+1 month Ayurveda training, The regional health officer will remain the nodal officer for the scheme
22-9-2000	ISM dept	Cabinet decision says that **ISM** dept should be fully involved in the **Gramsampark abhiyan**

[#] Orders from Dept of Health Services and Family Welfare, Government of MP

22-1-1	JSR/TBA	**Information** sought about JSR/TBA training in the districts
12-2-1	Follow up by CM	Invite **monthly meetings** of JSRs at block level, inform the JSRs about the health FW schemes, assess/evaluate work done by JSRs in this context, PHC to have live links with the JSR, make the only depot holders for FW in the village.
27-2-01	Social marketing of health material	Refers to previous orders about JSR to be made **depot holders** for FW and other programmes, ALSO **lists medicines** for primary care for social marketing (Chloroquin/Cotrim/analgin/ORS/Chlroine tab/Paracetamol/Avil/Neosporin powder & ointment/Savalon/Gauze & bandages/FW material OP & condoms/ IFA tab/
19-2-01	Social marketing	Minimum fee for **social marketing** of FW material to be Rs 10
23-3-01	linkages	Reiterate **3-monthly** & also **monthly** (?) meetings of JSRs at PHC, making them depot holders for FW material and listed medicines
10-4-01	7th training session	**Selection**-women, TBA family members, Non BPL as well as BPL candidates, one per village, resident, old VHG, **Training:** 6 m, at Block HQ, fortnight each for Theory & practical, one month Ayurvedic
26-4-01	Retraining failed candidates	Cabinet decision says **retrain the failed** JSR-candidates for 6 months, without stipend, give them certificate after passing
28-6-01	Tribal areas	**Lower educational std** from 10th, make a list of available candidates, send the lists, so that DHS can take the decision about lowering entry std for JSR selection in tribal areas.
4-7-01	Social marketing, and failed candidates	**Evaluation:** Points for Block level report: No of functioning JSR in the block/No of Depot-holder JSRs/Remark points for Dt level report: Total No of failed JSRs/No retrained/ No of retrained JSRs who took the re-exam/No JSRs who failed the Re-exam/Remark
13-7-01	AWW as depot holder	**AWW to be depot holder** of ORS in non-JSR villages
6-8-01	Cabinet decisions	Select **women**, **AWW, SC/ST**, make them depot holders, Monthly/3 m meetings of JSR at PHC.. report on these points
21-8-01	Ayurevda	Every district should **involve 2-3 Ayurveda doctors** to participate for one month in the JSRs training. Give them honoraria, Send the list of such Ayurvedic doctors to the DHS

APPENDIX 3: LIST OF MEDICINES USED BY JSRS

o	*Form*	LIST *OF MEDICINES JSR-WS USE
1.	Cap	Megapen
2.	Cap	Tetracycline cap.
3.	Cap	Amoxycillin
4.	Cap	Ampi-Clox
5.	Inj	Ranitidine
6.	Inj	Alprax
7.	Inj	Amikacin,
8.	Inj	Ampicillin,
9.	Inj	Anafortan
10.	Inj	Asthalin,
11.	Inj	Avil
12.	Inj	Benzyl penicillin
13.	Inj	betnesol
14.	Inj	Bplex
15.	Inj	D5
16.	Inj	Calcium sandoz
17.	Inj	calmpose
18.	Inj	Cefotaxime
19.	Inj	cephalexin
20.	Inj	Chloroquine,
21.	Inj	Ciprofloxacin
22.	Inj	DNS
23.	Tab	Cobadex
24.	Tab	Septran,
25.	Tab	Decadron
26.	Tab	Deorange
27.	Tab	Deriphyllin
28.	Tab	Deriphylline
29.	Tab	Dexamethasone
30.	Tab	Diclofenec,
31.	Tab	diclomin
32.	Tab	Diclopar
33.	Tab	Dicyclomine
34.	Tab	Digene
35.	Tab	digestives
36.	Tab	Doxycycline
37.	Tab	enteroquinol
38.	Tab	entrofuran
39.	Tab	enzyme
40.	Tab	EP forte,
41.	Tab	Ethamsylate,

42.	Tab	Evelan cream (?),
43.	Tab	Everon?
44.	Tab	Flaxon
45.	Tab	Gasex,
46.	Tab	gramonex
o	**Form**	**List*of medicines working JSR's use**
47.	Tab	Gripe water
48.	Tab	Himalaya drugs ?
49.	Tab	Ibugesic
50.	Tab	Iron capsules
51.	Tab	Lassix
52.	Tab	livina,
53.	Tab	lomofen,
54.	Tab	loperamide,
55.	Tab	Mebendezole
56.	Tab	Metchlopromide
57.	Tab	Metrodinazole,
58.	Tab	Mexaform
59.	Tab	Norfloxacin
60.	Tab	Optoneuron
61.	Tab	Oxytetracycline
62.	Tab	Paracetamol,
63.	Tab	Perinorm
64.	Tab	Polybion
65.	Tab	Primaquine
66.	Tab	Quinine
67.	Tab	RB tone
68.	Tab	Rcine
69.	Tab	Reglan
70.	Tab	Rinosted (?)
71.	Tab	Roxithromycin
72.	Tab	some Ayurvedic med.
73.	Tab	Stemetil,
74.	Tab	syn-spas
75.	Tab	sypalfin
76.	Tab	T.T.
77.	Tab	Taxim

*This list is compiled as pooled from JSR-W interviews

APPENDIX 4: LIST OF MEDICINES AND THEIR ECONOMY BRANDS FOR JSRS

Generic name (mg)	Economy brand names[8]	Price Rs per Tab/cap/pack	Locost[9] price per T, for bulk & (strip pack)
Albendazole 400mg	Albrodo, albendol, alford	8.00/ 8.90	1.00 (1.20)
Alluminium Mag salt	Centacid MPS, Embesil, Logascid	0.15 to 0.21	0.07 (0.12)
Amoxicillin 500 mg	Amoxybid, PureMox, Cidomex,	3.10--3.5 0	1.90 (2.10)
Aspirin* 325 (in combinations)	Micropyrin, Disprin	0.25	0.08
Low dose aspirin 75 mg	Lodosprin, delisprin	0.50, 0.60	
Bisacodyl (laxative) 5mg	Bidlax-5, Julax M	0.16, 0.60	
Hyoscine Butyl Bromide	Belloid, Buscopan	1.70,1.75	
Calcium	B-Cal, Calciriv-Z, , Omical, Cal-De-Ce	0.25 -- 0.32,	0.07
Chloramphenicol eye applicaps	Paraxin, Chloromycetin	0.50, 0.70	
Eye drops (sulpha or ciproflox)	Optisol, Syncula, Ciprowin, Ciprobid,	4.00-6.00	
Chloroquine 250	Laquin, Mellubrin	0.35, 0.60	0.35 (0.39)
Ciprofloxacin 500	Ciprozol Ciprocap, Ciprolet, Ciprotum	0.3.00—4.00	1.70
Codeine Linctus 60 ml		24.00	
Cotimoxazole SS	Ciiplin, colizole, kombina	0.65, 0.80	0.37
CPM 4mg	Cadistin, Piriton	0.05—0.10	0.04
DEC 50mg	Heterazan, Banocide	0.25, 0.30	0.15 (100 mg)
Syrup	Heterazan	12.80	
Domperidone 10 mg	Nudom, Domeperi DT	1.25, 1.5	
Doxycycline 100mg	Doxycyclin, LAA	1.60	0.85
Eardrops antifungal-antibiotic 5ml	Mycotic, candibiotic	16.75, 18.50	
Erythromycin 250	Erase, Erolcid, Restomycin	2.65, 2.75, 3.00	
Famotidine 20mg	Peptac, Famon, Famtac	0.40	
Phenazopyridine	Pyridactil	0.60	
Iron mg + Folic acid	Macrofolin Iron, Fervit,	0.14, 0.26	0.07
Furazolidine 100mg	Fudon,Furoxan	0.22	0.10
Gama Benzene HC 100 ml	Scabex, scaboma	18.00	100.00 (4.5 L)
Ibuprofen 400mg	Ibugesic, Ibysynth, Emflam, Brufen	0.55 – 0.60	0.37
Isobarbide 10mg T	Ditrate, cardicap	0.10, 0.11	
Mebendazole 100 mg	Mebazole, Helex	0.60, 0.85	0.17
Methyl Ergometrine 0.125mg	Ematrin, Uterowin	2.00	
Metronidazole 400mg	Aldezole, Unimezole, Metrodana, Flagyll	0.63	0.38

[8] As given in 'Drug Today', and quoted in 'Health & Healing- a manual for primary care'

[9] LOCOST: Po Box 134, Vadodara 390001, **Office** Premananda Sahitya Sabha Hall, Opp Lakadi Pool, Dandiya Bazaar, Tel 0265 413319, Fax 830693 email: locostdrugs@email.com web: www.loscotdrugs.com

OC medium dose	Mala D	2.00	
Oral Penicillin	KAYPEN (PHME:125MG), PENIVORAL (V:65)	0.87, 0.64	
ORT	Prolyte, Leclyte W, Emlyte	5.91, 6.02, 8.20	4.00
Paracetomol 500mg	Parazine,Patmin, Ifimol, Cetanil, Bepamol,	0.16, 0.19, 0.30, 0.34, 0.40	0.14 (0.20)
Primaquin 7.5	Malarid, PMQ-INGA	1.09. 1.20	
Promethazine 25mg	Thazine, Promet, avomine	0.83, 1.01	
Providone iodine 100ml	Vokadine	26.00	
Salbutomol 2mg	Salbetol, Asthalin	0.11, 0.13	0.10 (4 mg T)
Soda-mint		0.05	
Tetracycline 250	Subamycin, Achromycin, Tetramac	0.64, 0.80,1.00	
Tinidazole 300mg	Amebamagma, Tinicide, Camitol, Trag	0.80, 0.90, 1.20, 1.23	
Vit A 50000 iu	A-vit, Aquasol-A, (Arovit drops 7.5ml)	1.10, 1.20, (10.76)	1.50
Vit B1 (thaimin1) 100mg	Berin	1.00	
B2 Riboflavin 100mg	Lipabol	0.50	
B6 (Pyridoxin) 100mg	B-long	1.50	
B12 (Cynocobalamin) 250 mcg	Vitacure	1.20	
Folic Acid 5mg	Flitab, FH-12, Foli-5	0.67, 0.72	
Multivitamin	Vimgran, Manavite	0.23, 0.27	
Vit C 500	Cell-C, Celin, Redoxon	0.80 -- 0.82	
Vit D	Alphadol, Alphaset	1.62, 4.75	
Whitfiled ointment 5gm tube		5.00	7.00 (25 gm tube)
All prices are for single Tab/ Cap/ Pack, but buy as per the number prescribed, esp anti-infective drugs			

APPENDIX 5 : ANALYSIS OF EXAM (2 PAPERS) HELD IN JUNE 2001

Expected type of answer	**Fr**	**Percent**
Descriptive	26	18.7
Listing	38	27.3
MCQ	50	36.0
Naming	23	16.5
Unclassifiable	2	1.4
Total	139	100.0
Comment	Fr	Percent
Incorrect	3	2.2
Needless	6	4.3
OK	97	69.8
Rather simple	28	20.1
should be practical	2	1.4
Vague	1	0.7
Why	2	1.4
Total	**139**	**100.0**

Subject	**Fr**	**Percent**	**Group**
Human biology	4	2.9	Human Biology
Nutrition	3	2.2	Human biology
Child health	37	26.6	NHP
EPI	10	7.2	NHP
FW	9	6.5	NHP
Mother Health	9	6.5	NHP
NMCP	9	6.5	NHP
AIDS	7	5.0	NHP
NTCP	7	5.0	NHP
NBCP	6	4.3	NHP
NLCP	6	4.3	NHP
Birth	2	1.4	NHP
STDs	1	0.7	NHP
Minor illnesses	9	6.5	Other illnesses
First Aid	4	2.9	Other illnesses
Comm illnesses	10	7.2	Other illnesses
Role	2	1.4	Role
Sanitation	4	2.9	Village improvement
Total	**139**	**100.0**	

APPENDIX 6: TERMS OF REFERENCE

A Explore selection criteria and objectives of JSR
   a) for increasing women's participation
   b) for assessing education standard and age mix
   c) for exploring level and range of preventive services JSR should provide

B Assess training and supervision
   a) For assessing the quality in training method and of trainers
   b) Assessing changes recommended in the previous review

C Explore relationship of JSR with village level structures for analyzing the
   a) Linkages with AWW and TBA
   b) Convergence of service delivery approaches of different programs
   c) Scope strengthening institutional relationship between JSR and village communities
   d) Scope for JSR to work with RMPs and ISM practitioners

D Appraise current linkage of JSR with overall health system considering
   a) Supervision of JSR, their referral system
   b) Feedback systems for epidemic alertness, NHP coverage

E Assess current incentives (formal, informal including perverse) including
   a) Current level and sources of income and whether it is adequate as a full time income
   b) Options for JSR involvement in NHPs
   c) JSR's role in social marketing of public health goods

APPENDIX 7: AN OPINION POLL ON THE JAN SWASTYA RAKSHAK (JSR) SCHEME

As a complementary exercise, in addition to the formal JSR Review described in this report, an opinion poll ws also carried out to ascertain qualitatively the strengths and weaknesses of the Scheme and suggestions for immediate improvement as well as long term policy issues that needed to be addressed.

An English and Hindi version of a simple opinion poll (see annexure to this opinion poll report) was distributed by the team members during the field visit to all those who were willing to put their suggestions down on paper. At the end of the exercise 40 forms were received. In a section of the opinion poll form respondents were invited to mention the capacity in which they were involved in the JSR Scheme to help us contextualise their suggestions. The respondents included administrators (6); trainers (16); doctors/health service providers (26); NGOs/civil society (9) and other capacities including researchers (3). To maintain confidentiality in the poll signature at the end of the form ws made optional but 18/40 signed it both indicating a high level of enthusiasm and transparency. The sample included collector, panchayat leaders, DHOs, PHC-Mos, MPWs and trainers. It was decided to use the opinion poll qualitatively and not quantitatively because of the opportunistic nature of the sample (self selected volunteers). A qualitative check list of expectations and suggestions for the JSR Scheme to be available to policy makers and administrators in Madhya Pradesh who deal with the JSR Scheme at different levels, to address or utilize as they operationalise the scheme, was built up. Similar suggestions in each section have been amalgamated into broader categories or shown as sub-categories or items.

A : STRENGTHS OF THE SCHEME

Health Services available in the community

Health person available, easy reachability, local grassroots level presence, primary health care at every village, trained person at village level, direct intervention at community level.

Variety of services at village level

Personal Hygiene awareness; treatment of minor ailments and illnesses at low cost; health education; proper treatment at early stage of illness; medical help in emergency; awareness and management of Diarrhoea and Malaria at village level; MCH and family welfare services at village level; help various national programmes being effective at community level; good agency for monitoring health programmes at village level; referral in time to right person at right level; provide information on government programmes.

Linkage with government health services

Strong link between health services and community; enhance access and availability and affordability of government programmes; field link for national programmes; keeps government health services informed about village level problems and disease.

Community mobilization and cooperation promoted

Local problems – local solutions; helps government in its aim for community coordination and cooperation; village panchayat level mobilization and involvement is enhanced.

- **Potential for utilizing training resources, trainers, institutions and partnership with and other resources of government, NGOs and civic society is enhanced.**

B : PROBLEMS OF SCHEME / CONCERNS ABOUT SCHEME

Selection problems

- Every village not having 10th pass candidate;
- Participation of women, very little
- Wrong selection of candidates – not suited for JSR
- Working quacks take training of JSR to authenticate practice.

Lack of Community Preparation

- Lack of preparedness / preparation of community
- Selection at panchayat level without interest, and politics is also involved
- Lack of coordination at village level after training – no links with panchayat after training.

Training concerns

- Should be trained by experienced trainers of which there is a shortage
- Training centres not well equipped
- Teaching of subjects in curriculum not properly done
- Lack of training in proper referral
- Too much focus on training on medicines and injections
- Inadequate attention to community level action and community mobilization

Problems of Support

- Impossibility to serve without availability of drugs
- Needs continuing education and supportive supervision
- Non availability of funds to support training in a timely manner may affect scheme.

Problem of financial remuneration and security

- Difficulty to work without payment or monetory help
- Needs some financial or monetary incentive from government or panchayat.

Distortion in role and identity

- May focus on injections / saline practice rather than other activities
- Jhola chhap doctor will increase and loot the poor villagers
- Diagnostic and therapeutic procedures will become more irrational
- Will add to the existing quacks in the community
- May begin to practice like doctor and create complications.

Continuing problem

- JSR leave work if they get other job
- No feedback from JSRs and lack of continuity after training
- Lack of continuing education may cause local problems due to wrong treatment practices.
- Finally lack of continuity and constant flux may make the scheme unable to fulful the needs of the health service in the real sense.

C : SUGGESTIONS FOR IMMEDIATE IMPROVEMENT

Training

- Should be at District Training Centre
- Exams should be held at DTC / RTC
- Training should be by clinical or public health doctors (experts)
- Should work in PHC for a while after training
- Practical experience of how to handle problems not only theory should be given
- Should be participatory with audio visual aids
- Should be attached to experienced doctor / NGO before independent in.

Selection

- More females should be selected
- More needy persons should be selected
- Person selected should be of that village or should stay in it
- Every village should have one male and one female JSR
- Local worker who is interested in service should be selected
- Middle school should be basic qualification
- Pre-evaluation by simple entrance test and practical skill level assessment.

Support and Supervision

- Should be recognised by Sarpanch and gram sabha after training
- Supportive supervision and constant training by PHC staff
- Should be linked part-time with PHC or NGO.
- Should have drugs for seasonal diseases
- Should get basic medicines and health education materials for village work.

Financial security

- Should be paid per month; or
- Should be given some financial assistance and or incentive.

JSR Role Clarity

- Should be responsible for all health problems in the village
- Health education should be important skill
- Should be resident in village and available during need / emergency
- More female JSRs will enhance the focus of activity on women and children.

Directorate level

- Put a think-tank at directorate level to look at scheme in all aspects
- Evolve a comprehensive training – retraining – monitoring system for JSR scheme
- Prepare protocals for clinical / community problem solving
- Prepare IEC protocols for campaigns to increase awareness.

D : LONG TERM POLICY OPTIONS OR INITIATIVES

Role / Scope

- More participation of community in selection, financial support and utilizationof service
- Monthly involvement of health committees in planning and monitoring of JSRs.
- (JSR as local community health workers / volunteer linked to panchayat raj institutions).

Training

- Duration of training should be for one year
- Trainers must be free of other work during training phase
- Should be trained in Indian systems of medicine as well
- Field visits in the community where they will eventually work
- Training should be need based.

Support / Security

- Should have regular updating of skills and knowledge
- Should be paid or given financial assistance from panchayats
- Health department should monitor closely – use of essential drugs and limiting practice with other drugs.
- Should be paid for involvements in different national programmes
- Financial incentives to JSR through co-payment systems.

Long term sustainability

- Recognition of good workers
- Disincentives to others who misuse scheme or take unnecessary risks / irrational practices.
- Refresher course atleast once a year or at regular intervals.
- A good supervision, continuing education and regulatory mechanism is essential to prevent distortions and deviations.

TO SUMMARISE

the above suggestions and perceptions are very similar to those we have listed out in the main body of the report. What they indicate and endorse are two main conclusions.

1. There is a wide consensus of opinion recognising the need, scope, challenge and relevance of the JSR cadre in Madhya Pradesh's health system development.

2. There is also a wide consenses of opinion that as the process stands today there is wide scope for urgent action as well s long-term policy consensus to prevent the scheme from getting deviated or distorted from its basic philosophic assumption of being a relevant Primary Health Care human resource responses for every village in Madhya Pradesh.

Jana Swastya 'Rakshaks' and not **Jana Swasthya 'Nakshaks'** is the challenge ahead!

APPENDIX 8: JSR SCHEME - A REVIEW

Text of the PowerPoint presentation

Slide 1	JSR Scheme - A review	
Slide 2	CHC	
Slide 3	Changing Reality	• JSR SCHEME...
		• Aims to address village level gap of health care - a nationwide problem
		• Aims to promote health, increase outreach of health care & National Health Programmes
Slide 4	Approach of JSR Scheme	• Train & certify village youth, one time kit ..
		• Provide clinical, preventive, Promotive health services
		• Started from 1994-95, now part of SJSGY
Slide 5	'Epidemiology' of CHW	• Several variations in developing countries
		• Chinese model as barefoot doctor (now Rural Doctor)1952
		• Indian programme started in 1977, now nearly defunct
		• JSR scheme in 1994
		• Brazil started in 1995
Slide 6		Planners called : (*Margadarshak*) Guides, (*Swayamsevak)* Volunteers), (*Sevak*) worker, (*Doot*) messanger, *Mitra/Saathi/Mithin* (Friend), Auxiliary, helper (*Sahayak)*, paramedic, *Vaidya*,... anything but a doctor Village people simply call '*Daktar*' (So did Mao.. 'barefoot doctor') or a sister/nursebai/*Daktarni* for a woman health worker
Slide 7	Current Profile: JSR	• About 15000 villages covered
		• Training in progress
		• Over half the MP villages yet to be covered
		• High attrition (Guesstimate 90%)
Slide 8	Study in Brief	• Qualitative-Interviews and observations
		• Six districts- Barwani, Bhopal, Dhar, Guna, Jabalpur Satna and also Morena
		• Visits to Panchayats, PHC/CHC/SC, villages
		• Covered all stakeholders
		• 6 researchers, September to November 2001
Slide 9	Study Area	(MAP of MADHYA PRADESH)
Slide 10	Findings1-JSR factors	• 'Education & marks' as main selection pegs
		• Men, most of them
		• High dropout rate
		• Pvt practitioner is the role model for survivors
Slide 11	Findings2- few 'successful' JSRs	• Mainly inj/saline practice like Bengali doctors/any Pvt Practitioner
		• Fees ranging from 2-30 Rs, income 500 to few thousands a month
		• Little NHP work, and little link with/ support from PHC/SC/GP
Slide 12	Findings 3-User factors	• Little programme awareness among users
		• In most villages, JSR sidelined
		• 'patients' usually happy thanks to pricks/saline coming cheaper and nearer
		• Some unwilling to pay
		• Some wary of these 'new quacks'

Slide 13	Findings 4..Training	• Inadequate facilities
		• MOs have little time for training
		• Trainees 'hang around' in injection rooms
		• Manual yet to reach some trainees
		• Manual needs improvements
		• Too small a list of medicines
Slide 14	Findings 5-Linkages	• Most JSRs are defunct-no question of linkage..
		• *For survivors...*
		• Little active link with PHC/SC
		• No serious NHP support
		• GSS barely exists, and JSR hardly connected
		• Some links with Pvt Practitioners and drug stores
Slide 15	Findings 6 -PRI Member Views	• (Many not aware--esp. village GP members)
		• "Scheme relevant..BUT not working, no future.."
		• *Maandeya* is necessary
		• Women not available
		• *neemhakim khatara e jaan..*
Slide 16	Findings 7- Gender	• The programme is male biased-selection, training, demands of working, lack of supports
		• Few (10%) AWWs qualify
		• Women users of JSR services scant, RH services thru JSR nearly absent
		• Purdah, family chores hinder
Slide 17	Findings 8- Health Officers Say	• Little consultative process
		• Producing quacks
		• All kinds of problems in this scheme
		• Some support is necessary for JSRs
		• Monitoring necessary
		• Special training staff necessary
Slide 18	Diagnosis and Prognosis	• VERY RELEVANT --TINA
		• Inadequate design and detailing
		• Little matching of *needs-objectives-training-working*
		• High attrition, and survivors going by irrational practices
		• Poor outcome without serious reforms
Slide 19	Suggestions 1- Policy	• Pause, review, redesign
		• Choose a right model
		• Think of JSR-as a system--not individuals
		• Create special JSR cell
		• Legal provision/identity
		• Special NHP support
		• Control quacks & quackery-within and outside
Slide 20	Suggestions 2- Technical & Managerial	• Comprehensive task-list
		• Expand drug list, make rate lists
		• Include other healing systems
		• Select and improve training systems & manual, institute CME
		• Monitoring and MIS
Slide 22	Suggestions 4-Sustenance	• Help JSRs to get professional knowledge & skills, so that users value them.
		• Give state support through GP, based on NHP/SHP (e.g. school health) tasks,
		• Provide NHP consumables
		• Declare economy drug-list
		• Explore primary care insurance,

		• Increase women participation, SHG support
Slide 23	BTW: Craving for saline and injection	• This is serious problem--not only in India but even the Dragonland..this picture from a township health center in China 1998. This boy had fever! The other woman had cough!
Slide 24		• Two waste baskets
		• Clinic of JSR(old) in Morena
Slide 25	*We are grateful to*	*RGM, District officers, MP Health Dept-,Awes, Panchayat & other leaders, JSRs, Villagers & patients, PRMPs, pharmacists, DFID*
Slide 26	CHC Team	*Dr Ravi Narayan, Dr Shyam Ashtekar, Dr Dhruv Mankad, Dr. Shashikant Ahankari, Dr. Abhay Shukla, Prof. A S Mohammed, Amulya Nidhi*

APPENDIX 10: CHECKLIST OF INTERVIEW QUESTIONS

		Health Secretary/DHS/RGM etc
1	Policy & adm	general impression about this scheme
2	Policy & adm	Fund flow
3	Policy & adm	(CHC report—recommendations..any action-ask particular issues)
4	Policy & adm	NGO participation in TOT
5	Policy & adm	Feedback systems
6	Policy & adm	Logistical/ supplies
7	Policy & adm	Loans?
8	Policy & adm	Kits?
9	Policy & adm	Training rules/schedules/guidelines
10	Policy & adm	Adequate preparation?
11	Policy & adm	Supervision systems
12	Policy & adm	Ownership of the programme
13	Policy & adm	Any cell looking after the scheme?
14	Policy & adm	Training (basic/CME/Refresher/advanced training)
15	Policy & adm	Sustainabilty?..details
16	Policy & adm	Complaints about old jsr.. redress
17	Policy & adm	Pace/phasing/midcourse corrections
18	Role	What role. JSR—A doctor, Bengali Doc, HW, assistant to health system, a community Workers
19	Role	Is it different from CHWs..how
20	Role	Code of conduct
21	Role	Need/vision -> Role definition <– actual role?
22	Role	Volunteers..Professionals..
23	Role	What tasks they are expected?
24	Role	What more training is necessary to answer the community needs
25	Role	What happens to the preventive aspects of jsr role..Can it be realised..How?
26	Role	What happened to the evaluation.. like the one asked by DHS by a letter of 11-5-2000
27	Role	Is the role realised..to what extent (say %)
28	Role	Which parts of the role are realised..Which are less realized?
29	Role	Is it possible to correct the 'wrong' roles some JSR s are assuming.. like quacks..And How?
30	Selection	Risks/advts of male selection?
31	Selection	Difficulties in getting women candidates-distance, family, children, education, safety..
32	Selection	Criteria for selection
33	Selection	Issue of overqualified persons

34	Selection	Do you think of some formula for male: female .. Selection (will selecting both be better?)
35	Selection	What happened to TBA family kin policy?
36	Selection	How to enroll more women?
37	Selection	What about old VHG selection?
38	Selection	AWW selection..implications
39	Selection	What about SC/ST selection?
40	Selection	About BPL/Non BPL selection.
41	Selection	Does BPL/Non BPL make a difference to the work of JSR
42	Selection	Are locality candidates available?
43	Selection	Were lists of likely candidates made by GSS?
44	Selection	Publicity for jsr selection
45	Selection	Is a couple better than single (how to select a couple)
46	Selection	Is GSS/ grampanchayat really involved in the selection process?
47	Selection	About voluntarism..professionalism
48	Selection	Age issue..any comments twenties/thirties
49	Selection	Nepotism? How does it affect work-standards..Does it ?
50	Training	Contents..
51	Training	TOT and further links
52	Training	Venue
53	Training	Physical facilities, AV aids
54	Training	Practical training..
55	Training	Is the training process satisfactory?
56	Training	(Injection/saline training)
57	Training	CME-possibilities..How/periodicity
58	Examination	Does the Exam address to task list?
59	Examination	Failed candidates..policy /implications/
60	Examination	Results of re-exam
61	Examination	Periodic relicensing exam
62	Monitoring	Any report on evaluation /monitoring
63	Monitoring	Who monitors the jsr regularly
64	Monitoring	Redress mechanisms
65	Monitoring	Monthly meetings/ 3 monthly meetings? Content-messages..expectations
66	Monitoring	Getting medicines..costs
67	Logistics	Honoraria for travel to monthly meetings
68	Logistics	Depot holders for NHPs
69	Logistics	getting health education material
70	Clinical work	What are the tasks JSR is expected?
71	Preventive	Any of these tasks realized..
72	Preventive	Other tasks not realized.. causes
73	Preventive	Helping health staff on visits

74	Preventive	Posters/pamphlets/HE aids?
75	Preventive	National Health programmes
76	Preventive	IEC to users/community
77	Preventive	What should be the earning of a JSR?
78	Earning/F	Possibility of earning on preventive services
79	Earning/F	Any attempt at public display/transparency
80	Earning/F	How can JSR help AWW-what tasks
81	Links	How can AWW help JSR-what ways
82	Links	How can JSR help TBAs
83	Links	How can TBAs help JSRs
84	Links	How can ANM help JSRs
85	Links	How can JSRs help ANM
86	Links	Referrals from JSR to PHC/CHC (check with PHC/CHC records- has the work increased?)
87	Stability	Attrition factor—Are old jsrs still in place
88	Legal	Check with various authorities-MP medical Council

		Collector/CEO/ZP chairman/Health com chairman
	Group	**Issue**
1	Policy & adm.	general impression about this scheme
2	Policy & adm.	Fund flow
3	Policy & adm.	Feedback systems
4	Policy & adm.	Logistical/ supplies
5	Policy & adm.	Loans?
6	Policy & adm.	Kits?
7	Policy & adm.	Sustainabilty?..details
8	Policy & adm.	Complaints about old jsr.. redress
9	Policy & adm.	Pace/phasing/midcourse corrections
10	Policy & adm.	Political process around jsr scheme..how..if not why?
11	Role	Code of conduct
12	Selection	Risks/advts of male selection?
13	Selection	Difficulties in getting women candidates-distance, family, children, education, safety..
14	Selection	How to enroll more women?
15	Selection	About BPL/Non BPL selection.
16	Selection	Were lists of likely candidates made by GSS?
17	Selection	Is GSS/ grampanchayat really involved in the selection process?
18	Selection	Publicity for jsr selection
19	Monitoring	Any report on evaluation /monitoring
20	Monitoring	Redress mechanisms
21	Monitoring	Role of community/Grampanchayat/GSS
22	Earning/F	Possibility of earning on preventive services
23	Earning/F	Any attempt at public display/transparency
		ANY SUGGESTIONS?

		CMHO/DTT
	Group	**Issue**
1	Policy & admin	Does this scheme gel with the public health system of MP
2	Policy & admin	Fund flow
3	Policy & admin	Feedback systems
4	Policy & admin	Logistical/ supplies
5	Policy & admin	Kits?
6	Policy & admin	Sustainabilty?..details
7	Policy & admin	Complaints about old jsr.. redress
8	Policy & admin	(CHC report—recommendations..any action-ask particular issues)
9	Policy & admin	NGO participation in TOT
10	Policy & admin	Training rules/schedules/guidelines
11	Policy & admin	Adequate preparation?
12	Policy & admin	Supervision systems
13	Policy & admin	Ownership of the programme
14	Policy & admin	Any cell looking after the scheme?
15	Role	Is it different from CHWs..how
16	Role	Need/vision -> Role definition <– actual role?
17	Role	What tasks they are expected?
18	Role	What more training is necessary to answer the community needs
19	Role	What happens to the preventive aspects of jsr role..Can it be realised..How?
20	Role	Evaluation?. like the one asked by DHS by a letter of 11-5-2000
21	Role	Is the role realised..to what extent (say %)
22	Role	Which parts of the role are realised..Which are less realized?
23	Role	Is it possible to correct the 'wrong' JSR roles some .. like quacks..And How?
24	Role	Any role models in your knowledge (Try to meet this JSR and profile)
25	Role	Any failures..try to contact and interview
26	Role	Code of conduct
27	Selection	Risks/advts of male selection?
28	Selection	Difficulties for women -distance, family, children, education, safety..
29	Selection	How to enroll more women?
30	Selection	About BPL/Non BPL selection.
31	Selection	Were lists of likely candidates made by GSS?
32	Selection	Is GSS/ grampanchayat really involved in the selection process?
33	Selection	Criteria for selection
34	Selection	Issue of overqualified persons
35	Selection	What happened to TBA family kin policy?
36	Selection	What about old VHG selection?
37	Selection	AWW selection..implications
38	Selection	What about SC/ST selection?
39	Selection	Does BPL/Non BPL make a difference to the work of JSR

40	Selection	Are locality candidates available?
41	Selection	Publicity for jsr selection
42	Selection	Is a couple better than single (how to select a couple)
43	Selection	Nepotism? How does it affect work-standards..Does it ?
44	Selection	About voluntarism..professionalism
45	Selection	Age issue..any comments twenties/thirties
46	Selection	About lowering educational standards for entry
47	Selection	Is there a selection process/choice or otherwise?
48	Selection	Can there be a better mechanism selection?
49	Selection	Why should candidates come JSRs..What JSR/community aspirations..
50	Stability	Attrition factor—Are old jsrs still in place
51	Training	Is the training process satisfactory?
52	Training	RFWTC's role in training..present and future
53	Training	TOT and further links
54	Training	Physical facilities, AV aids
55	Training	Methods of training/ training design and organization.
56	Training	Scheduling
57	Training	Subcenter training-time/tasks/trainer/opinion
58	Training	Ayurveda training
59	Training	Hands on training
60	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
61	Training	(Other books)
62	Training	Certificate
63	Examination	About the current process of examination
64	Examination	What changes would you suggest in the exam system
65	Clinical work	What are the tasks JSR is expected?
66	Clinical work	Caste angle.Do deprived sections get treatment in this scheme?
67	Earning/F	Possibility of earning on preventive services
68	Earning/F	Any attempt at public display/transparency about cost control
69	Earning/F	How can JSR help AWW-what tasks
70	Earning/F	Are the new JSRs angling for monthly payment from Govt)
71	Links	How can AWW help JSR-what ways
72	Links	How can ANM help JSRs
73	Links	How can JSRs help ANM
74	Logistics	getting health education material
75	Logistics	Depot holders for NHPs
76	Monitoring	Any report on evaluation /monitoring
77	Monitoring	Redress mechanisms
78	Monitoring	Role of community/Grampanchayat/GSS
79	Monitoring	Who monitors the jsr regularly
80	Monitoring	Monthly meetings/ 3 monthly meetings? Content-messages..expectations

81	Monitoring	Records kept by JSRs
82	Preventive	Other tasks not realized.. causes
83	Preventive	Helping health staff on visits
84	Preventive	Posters/pamphlets/HE aids?
85	Preventive	National Health programmes
86	Preventive	IEC to users/community
87	Preventive	What should be the earning of a JSR?
88	Preventive	Any of these tasks realized..
89		Any suggestions

		RFWTC
	Group	**Issue**
1	Clinical work	What are the tasks JSR is expected?
2	Training	Is the training process satisfactory?
3	Earning/F	How can JSR help AWW-what tasks
4	Links	How can AWW help JSR-what ways
5	Links	How can ANM help JSRs
6	Links	How can JSRs help ANM
7	Links	How can JSR help TBAs
8	Links	How can TBAs help JSRs
9	Clinical work	Desired 'more skills' to learn
10	Clinical work	'Permission limit ' for village treatment..days
11	Clinical work	What more illnesses should find place in the curriculum
12	Preventive	National Health programmes
13	Training	Methods of training/ training design and organization.
14	Training	Subcenter training-time/tasks/trainer/opinion
15	Training	Hands on training
16	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
17	Training	Contents..
18	Training	Practical training..
19	Training	(Injection/saline training)
20	Training	Physical facilities, AV aids
21	Training	Ayurveda training
22	Training	(Other books)
23	Training	Venue
24	Examination	The process..relation of monthly to final exam
25	Examination	Assessment of MCQs sets
26	Clinical work	'desired drugs' apart from the list
27	Clinical work	(frequently used injections by JSR)..information from whom
28	Clinical work	Use of diagnostics..naming symptoms/illnesses

29	Logistics	Frequently encountered illnesses
30	Preventive	IEC to users/community
31	Earning/F	Are the new JSRs angling for monthly payment from Govt)
32	Training	Attitude training
33	Clinical work	frequently referred illnesses
34	Clinical work	Clinical work in terms of National programmes
35	Clinical work	Use of Ayurveda /herbs/home remedies
36	Clinical work	Frequently used drugs from the kit
37	Clinical work	Frequently required skills
38	Training	Scheduling
39	Examination	Practical skills tests..
40	Policy	Training rules/schedules/guidelines
41	Training	Book..use of books
42	Training	other recommended books
43	Examination	Unfair practices if any
44	Examination	Passing level
45	Training	Lesson plan
46	Training	Decision making: instructions based training, criteria based training
47	Training	TOT and further links
48	Examination	Failed candidates..policy /implications/
49	Examination	Results of re-exam
50	Monitoring	Any report on evaluation /monitoring
51	Training	RFWTC's role in training..present and future
52	Policy	Training (basic/CME/Refresher/advanced training)
53	Training	CME-possibilities..How/periodicity

		MO
0	**Group**	**Issue**
1	Policy	Fund flow
2	Policy	Feedback systems
3	Policy	Logistical/ supplies
4	Policy	Kits?
5	Policy	Complaints about old jsr.. redress
6	Role	Code of conduct
7	Selection	Risks/advts of male selection?
8	Selection	Difficulties for women -distance, family, children, education, safety..
9	Selection	Publicity for jsr selection
10	Selection	How to enroll more women?
11	Selection	About BPL/Non BPL selection.
12	Selection	Were lists of likely candidates made by GSS?
13	Selection	Is GSS/ grampanchayat really involved in the selection process?

14	Monitoring	Redress mechanisms
15	Clinical work	What are the tasks JSR is expected?
16	Earning/F	Any attempt at public display/transparency
17	Monitoring	Role of community/Grampanchayat/GSS
18	Policy	Training rules/schedules/guidelines
19	Policy	Adequate preparation?
20	Policy	Supervision systems
21	Role	Is it different from CHWs..how
22	Role	Need/vision -> Role definition <– actual role?
23	Role	What tasks they are expected?
24	Role	What more training is necessary to answer the community needs
25	Role	What happens to the preventive aspects of jsr role..Can it be realised..How?
26	Role	What happened to the evaluation.. like the one asked by DHS by a letter of 11-5-2000
27	Role	Is the role realised..to what extent (say %)
28	Role	Which parts of the role are realised..Which are less realized?
29	Role	correcting the 'wrong' JSR roles ..like quacks..And How?
30	Selection	Criteria for selection
31	Selection	Issue of overqualified persons
32	Selection	What happened to TBA family kin policy?
33	Selection	What about old VHG selection?
34	Selection	AWW selection..implications
35	Selection	What about SC/ST selection?
36	Selection	Does BPL/Non BPL make a difference to the work of JSR
37	Selection	Are locality candidates available?
38	Selection	Is a couple better than single (how to select a couple)
39	Selection	Nepotism? How does it affect work-standards..Does it ?
40	Selection	Age issue..any comments twenties/thirties
41	Training	Is the training process satisfactory?
42	Training	TOT and further links
43	Training	Physical facilities, AV aids
44	Monitoring	Who monitors the jsr regularly
45	Monitoring	Monthly meetings/ 3 monthly meetings? Content-messages..expectations
46	Logistics	getting health education material
47	Logistics	Depot holders for NHPs
48	Preventive	Any of these tasks realized..
49	Preventive	Other tasks not realized.. causes
50	Preventive	Helping health staff on visits
51	Preventive	Posters/pamphlets/HE aids?
52	Preventive	National Health programmes
53	Preventive	IEC to users/community

54	Preventive	What should be the earning of a JSR?
55	Earning/F	How can JSR help AWW-what tasks
56	Links	How can AWW help JSR-what ways
57	Links	How can ANM help JSRs
58	Links	How can JSRs help ANM
59	Stability	Attrition factor—Are old jsrs still in place
60	Role	Any role models in your knowledge (Try to meet this JSR and profile)
61	Role	Any failures..try to contact and interview
62	Selection	About lowering educational standards for entry
63	Selection	Is there a selection process/choice or otherwise?
64	Selection	Can there be a better mechanism selection?
65	Selection	JSRs expectations..What JSR/community aspirations..
66	Training	Methods of training/ training design and organization.
67	Training	Scheduling
68	Training	Subcenter training-time/tasks/trainer/opinion
69	Training	Ayurveda training
70	Training	Hands on training
71	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
72	Training	(Other books)
73	Training	Certificate
74	Monitoring	Records kept by JSRs
75	Earning/F	Are the new JSRs angling for monthly payment from Govt)
76	Policy	Loans?
77	Role	What role JSR—A doctor, Bengali Doc, HW, assistant to PHC, a community W
78	Selection	Formula for male: female .. Selection (will selecting both be better?)
79	Training	Contents..
80	Training	Venue
81	Training	Practical training..
82	Training	(Injection/saline training)
83	Examination	Failed candidates..policy /implications/
84	Examination	Results of re-exam
85	Monitoring	Getting medicines..costs
86	Logistics	Honoraria for travel to monthly meetings
87	Links	How can JSR help TBAs
88	Links	How can TBAs help JSRs
89	Links	Referrals from JSR to PHC/CHC (check with PHC/CHC records
90	Role	Aspirations of JSR
91	Training	Lesson plan
92	Training	Book..use of books
93	Training	other recommended books
94	Training	Attitude training

95	Training	Attendance/ attention
96	Examination	The process..relation of monthly to final exam
97	Examination	Assessment of MCQs sets
98	Examination	Unfair practices if any
99	Examination	Practical skills tests..
100	Examination	Passing level
101	Clinical work	frequently referred illnesses
102	Clinical work	'desired drugs' apart from the list
103	Clinical work	Desired 'more skills' to learn
104	Clinical work	(frequently used injections by JSR)..information from whom
105	Clinical work	'Permission limit ' for village treatment..days
106	Clinical work	Use of diagnostics..naming symptoms/illnesses
107	Clinical work	Clinical work in terms of National programmes
108	Clinical work	Use of Ayurveda /herbs/home remedies
109	Clinical work	What more illnesses should find place in the curriculum
110	Clinical work	Community satisfaction/ meeting the needs?
111	Clinical work	Comparison with other nearby healers..ranking
112	Clinical work	Gender angle..do women use male JSR services..for what.. and what not..then?
113	Earning/F	What are the rates/user fees/ justification?
114	Earning/F	Do they find remuneration engaging?

		ANM/MPW
	Group	**Issue**
1	Policy	Complaints about old jsr.. redress
2	Role	Code of conduct
3	Selection	Risks/advts of male selection?
4	Selection	Difficulties in getting women candidates-distance, family, children, education, safety..
5	Selection	Publicity for jsr selection
6	Selection	How to enroll more women?
7	Selection	About BPL/Non BPL selection.
8	Selection	Were lists of likely candidates made by GSS?
9	Selection	Is GSS/ grampanchayat really involved in the selection process?
10	Clinical work	What are the tasks JSR is expected?
11	Earning/F	Any attempt at public display/transparency
12	Monitoring	Role of community/Grampanchayat/GSS
13	Role	Is it different from CHWs..how
14	Role	What tasks they are expected?
15	Role	What more training is necessary to answer the community needs
16	Role	What happens to the preventive aspects of jsr role..Can it be realised..How?
17	Selection	What happened to TBA family kin policy?

18	Selection	What about old VHG selection?
19	Selection	AWW selection..implications
20	Selection	Does BPL/Non BPL make a difference to the work of JSR
21	Selection	Are locality candidates available?
22	Selection	Is a couple better than single (how to select a couple)
23	Selection	Nepotism? How does it affect work-standards..Does it ?
24	Selection	Age issue..any comments twenties/thirties
25	Training	Is the training process satisfactory?
26	Monitoring	Who monitors the jsr regularly
27	Monitoring	Monthly meetings/ 3 monthly meetings? Content-messages..expectations
28	Logistics	getting health education material
29	Preventive	Any of these tasks realized..
30	Preventive	Other tasks not realized.. causes
31	Preventive	Helping health staff on visits
32	Preventive	Posters/pamphlets/HE aids?
33	Preventive	National Health programmes
34	Preventive	What should be the earning of a JSR?
35	Earning/F	How can JSR help AWW-what tasks
36	Links	How can AWW help JSR-what ways
37	Links	How can ANM help JSRs
38	Links	How can JSRs help ANM
39	Stability	Attrition factor—Are old jsrs still in place
40	Role	Any role models in your knowledge (Try to meet this JSR and profile)
41	Role	Any failures..try to contact and interview
42	Selection	About lowering educational standards for entry
43	Selection	Can there be a better mechanism selection?
44	Selection	Why should candidates offer themselves as JSRs..What JSR/community aspirations..
45	Training	Methods of training/ training design and organization.
46	Training	Scheduling
47	Training	Subcenter training-time/tasks/trainer/opinion
48	Training	Hands on training
49	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
50	Monitoring	Records kept by JSRs
51	Role	What role. JSR—A doctor, Bengali Doc, HW, assistant to health system, a community Workers
52	Training	Contents..
53	Training	Practical training..
54	Training	(Injection/saline training)
55	Links	How can JSR help TBAs
56	Links	How can TBAs help JSRs
57	Links	Referrals from JSR to PHC/CHC (check with PHC/CHC records- has the work

		increased?)
58	Training	Lesson plan
59	Training	Attendance/ attention
60	Examination	Practical skills tests..
61	Clinical work	Community satisfaction/ meeting the needs?
62	Clinical work	Comparison with other nearby healers..ranking
63	Clinical work	Gender angle..do women use male JSR services..for what.. and what not..then?
64	Earning/F	What are the rates/user fees/ justification?
65	Role	Ranking of village level health workers..AWW/TBA/JSR
66	Training	Decision making: instructions based training, criteria based training

		GSS/GP/SHGs
	Group	**Issue**
1	Policy	Complaints about old jsr.. redress
2	Role	Code of conduct
3	Selection	Risks/advts of male selection?
4	Selection	Difficulties in getting women candidates-distance, family, children, education, safety..
5	Selection	Publicity for jsr selection
6	Selection	How to enroll more women?
7	Selection	About BPL/Non BPL selection.
8	Selection	Were lists of likely candidates made by GSS?
9	Selection	Is GSS/ grampanchayat really involved in the selection process?
10	Clinical work	What are the tasks JSR is expected?
11	Earning/F	Any attempt at public display/transparency
12	Monitoring	Role of community/Grampanchayat/GSS
13	Role	What tasks they are expected?
14	Role	What more training is necessary to answer the community needs
15	Selection	What about old VHG selection?
16	Selection	AWW selection..implications
17	Selection	Are locality candidates available?
18	Selection	Is a couple better than single (how to select a couple)
19	Selection	Nepotism? How does it affect work-standards..Does it ?
20	Selection	Age issue..any comments twenties/thirties
21	Training	Is the training process satisfactory?
22	Preventive	Any of these tasks realized..
23	Preventive	Other tasks not realized.. causes
24	Preventive	What should be the earning of a JSR?
25	Earning/F	How can JSR help AWW-what tasks
26	Links	How can AWW help JSR-what ways
27	Links	How can ANM help JSRs
28	Links	How can JSRs help ANM
29	Role	Any role models in your knowledge (Try to meet this JSR and profile)
30	Selection	About lowering educational standards for entry
31	Selection	Can there be a better mechanism selection?
32	Selection	Why should candidates offer themselves as JSRs..What JSR/community aspirations..
33	Monitoring	Records kept by JSRs
34	Role	What role. JSR—A doctor, Bengali Doc, HW, assistant to health system, a community Worker

35	Links	How can JSR help TBAs
36	Links	How can TBAs help JSRs
37	Links	Referrals from JSR to PHC/CHC (check with PHC/CHC records- has the work increased?)
38	Clinical work	Community satisfaction/ meeting the needs?
39	Clinical work	Comparison with other nearby healers..ranking
40	Clinical work	Gender angle..do women use male JSR services..for what.. and what not..then?
41	Role	Ranking of village level health workers..AWW/TBA/JSR
42	Monitoring	Redress mechanisms
43	Selection	Criteria for selection
44	Selection	Issue of overqualified persons
45	Logistics	Depot holders for NHPs
46	Selection	Is there a selection process/choice or otherwise?
47	Policy	Loans?
48	Monitoring	Getting medicines..costs
49	Clinical work	Desired 'more skills' to learn
50	Clinical work	'Permission limit ' for village treatment..days
51	Clinical work	What more illnesses should find place in the curriculum
52	Earning/F	Do they find remuneration engaging?
53	Policy	Sustainabilty?..details
54	Earning/F	Possibility of earning on preventive services
55	Policy	Ownership of the programme
56	Clinical work	Caste angle..as above
57	Policy	Political process around jsr scheme..how..if not why?
58	Role	Recognition of JSR in village
59	Logistics	Frequently encountered illnesses
60	Earning/F	What were people spending on health problems now JSRs are tackling.. What is the saving like?
61	Earning/F	How does the community gauge JSR services: affordable/costly/ same as before

		Users
	Group	**Issue**
1	Policy	Complaints about old jsr.. redress
2	Role	Code of conduct
3	Earning/F	Any attempt at public display/transparency
4	Clinical work	Community satisfaction/ meeting the needs?
5	Clinical work	Comparison with other nearby healers..ranking
6	Clinical work	Gender angle..do women use male JSR services..for what.. and what not..then?
7	Role	Ranking of village level health workers..AWW/TBA/JSR
8	Clinical work	Caste angle..as above
9	Earning/F	Peoples' expenditure on health problems now JSRs are tackling.. What is the saving like?
10	Earning/F	How does the community gauge JSR services: affordable/costly/ same as before
11	Earning/F	What are the rates/user fees/ justification?

		JSR-TS
1	Role	Code of conduct
2	Role	Ranking of village level health workers..AWW/TBA/JSR
3	Role	What more training is necessary to answer the community needs
4	Role	Any role models in your knowledge (Try to meet this JSR and profile)
5	Role	What role. JSR—A doctor, Bengali Doc, HW, assistant to health system, a community Worker ?
6	Role	Recognition of JSR in village
7	Role	Any failures..try to contact and interview
8	Role	Aspirations of JSR
9	Role	Volunteers..Professionals..
10	Role	Self-identity..within the village and the health system
11	Selection	Publicity for jsr selection
12	Selection	Is GSS/ grampanchayat really involved in the selection process?
13	Selection	Is a couple better than single (how to select a couple)
14	Selection	Why should candidates offer themselves as JSRs..What JSR/community aspirations..
15	Selection	Criteria for selection
16	Selection	About voluntarism, professionalism
17	Training	Is the training process satisfactory?
18	Training	Methods of training/ training design and organization.
19	Training	Scheduling
20	Training	Subcenter training-time/tasks/trainer/opinion
21	Training	Hands on training
22	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
23	Training	Contents..

24	Training	Practical training..
25	Training	(Injection/saline training)
26	Training	Physical facilities, AV aids
27	Training	Ayurveda training
28	Training	(Other books)
29	Training	Venue
30	Training	Book..use of books
31	Training	other recommended books
32	Examination	Practical skills tests..
33	Examination	The process..relation of monthly to final exam
34	Examination	Assessment of MCQs sets
35	Examination	Unfair practices if any
36	Examination	Passing level
37	Links	How can AWW help JSR-what ways
38	Links	How can ANM help JSRs
39	Links	How can JSRs help ANM
40	Links	How can JSR help TBAs
41	Links	How can TBAs help JSRs
42	Policy	Loans?
43	Policy	Stipend
44	Policy	Training rules/schedules/guidelines
45	Clinical work	What are the tasks JSR is expected?
46	Clinical work	Desired 'more skills' to learn
47	Clinical work	'Permission limit ' for village treatment..days
48	Clinical work	What more illnesses should find place in the curriculum
49	Clinical work	'desired drugs' apart from the list
50	Clinical work	(frequently used injections by JSR)..information from whom
51	Clinical work	Use of diagnostics..naming symptoms/illnesses
52	Earning/F	How can JSR help AWW-what tasks
53	Preventive	What should be the earning of a JSR?
54	Preventive	National Health programmes

		JSR-WS
1	Role	Code of conduct
2	Role	Ranking of village level health workers..AWW/TBA/JSR
3	Role	What more training is necessary to answer the community needs
4	Role	Any role models in your knowledge (Try to meet this JSR and profile)
5	Role	What role. JSR—A doctor, Bengali Doc, HW, assistant to health system, a community W
6	Role	Recognition of JSR in village
7	Role	Any failures..try to contact and interview

8	Role	Aspirations of JSR
9	Role	Volunteers..Professionals..
10	Role	Self-identity..within the village and the health system
11	Role	What tasks they are expected?
12	Role	Is it different from CHWs..how
13	Role	What happens to the preventive aspects of jsr role..Can it be realised..How?
14	Role	Is the role realised..to what extent (say %)
15	Role	Which parts of the role are realised..Which are less realized?
16	Selection	Is a couple better than single (how to select a couple)
17	Selection	Why should candidates offer themselves as JSRs..What JSR/community aspirations..
18	Selection	About voluntarism..professionalism
19	Training	Is the training process satisfactory?
20	Training	Methods of training/ training design and organization.
21	Training	Subcenter training-time/tasks/trainer/opinion
22	Training	Hands on training
23	Training	'Other' sources of training for JSRs (docs/ Bengalis etc)
24	Training	Contents..
25	Training	Practical training..
26	Training	(Injection/saline training)
27	Training	Physical facilities, AV aids
28	Training	Ayurveda training
29	Training	(Other books)
30	Training	Venue
31	Training	Certificate
32	Training	Attitude training
33	Examination	The process..relation of monthly to final exam
34	Examination	Assessment of MCQs sets
35	Clinical work	What are the tasks JSR is expected?
36	Clinical work	Desired 'more skills' to learn
37	Clinical work	'Permission limit ' for village treatment..days
38	Clinical work	What more illnesses should find place in the curriculum
39	Clinical work	'desired drugs' apart from the list
40	Clinical work	(frequently used injections by JSR)..information from whom
41	Clinical work	Use of diagnostics..naming symptoms/illnesses
42	Clinical work	Community satisfaction/ meeting the needs?
43	Clinical work	Comparison with other nearby healers..ranking
44	Clinical work	Gender angle..do women use male JSR services..for what.. and what not..then?
45	Clinical work	Caste angle..as above
46	Clinical work	frequently referred illnesses
47	Clinical work	Clinical work in terms of National programmes
48	Clinical work	Use of Ayurveda /herbs/home remedies

49	Clinical work	Frequently used drugs from the kit
50	Clinical work	Frequently required skills
51	Links	How can AWW help JSR-what ways
52	Links	How can ANM help JSRs
53	Links	How can JSRs help ANM
54	Links	How can JSR help TBAs
55	Links	How can TBAs help JSRs
56	Links	Referrals from JSR to PHC/CHC (check with PHC/CHC records- has the work increased?)
57	Logistics	Depot holders for NHPs
58	Preventive	What should be the earning of a JSR?
59	Preventive	National Health programmes
60	Preventive	Any of these tasks realized..
61	Preventive	Other tasks not realized.. causes
62	Preventive	Helping health staff on visits
63	Preventive	Posters/pamphlets/HE aids?
64	Preventive	IEC to users/community
65	Logistics	Frequently encountered illnesses
66	Logistics	getting health education material
67	Logistics	Honoraria for travel to monthly meetings
68	Monitoring	Records kept by JSRs
69	Monitoring	Getting medicines..costs
70	Monitoring	Monthly meetings/ 3 monthly meetings? Content-messages..expectations
71	Policy	Loans?
72	Policy	Sustainabilty?..details
73	Policy	Kits?
74	Policy	Supervision systems
75	Earning/F	How can JSR help AWW-what tasks
76	Earning/F	Any attempt at public display/transparency
77	Earning/F	Expenditure on health problems now JSRs are tackling.. What is the saving like?
78	Earning/F	How does the community gauge JSR services: affordable/costly/ same as before
79	Earning/F	What are the rates/user fees/ justification?
80	Earning/F	Do they find remuneration engaging?
81	Earning/F	Possibility of earning on preventive services
82	Earning/F	Are the new JSRs angling for monthly payment from Govt)

APPENDIX 9: NOTES ON THE JSR MANUAL

A) PLACING THE MANUAL IN JSR PRORAMME

A manual is an essential part of any technical programme. It embodies the language, style, substance, priorities, and emphasis of the entire programme. It is something to fall back upon and a virtual meeting place for the policy-community and the readers/users. In a programme like the JSR, WE think such a manual needs to occupy a central place. But one needs to look at its biological relation within the entire training system and working pattern of the JSR programme.

Thematically, for a JSR like programme, let us 'place' the manual.

It is central to the initial training course for JSR, and secondly a referring text to buttress the CME effort later.

No manual can, as a stand-alone device, serve as the omnibus book. The overall need assessment for training material is:

Phase	**For trainees**		**trainers**	**Panchayat / users**
	Knowledge/facts/attitudes	**skills**		
The initial course	Textbook/ Distance training material	Skills-handbook, CD/visuals	TOT book	what to expect/ how to manage -
Working phase	House journal/ (channels if available)			

We are not aware at this moment whether other elements of this table are available.

B) WITHIN THE COVERS OF THE JSR MANUAL

Writing such a book is a daunting task, esp if the task framework is nascent, the readers yet to get established, training systems new and not well honed. For the group that began this exercise, it has been a big involvement.

Following criteria are relevant:

- What is the intended task-list of a JSR? -Does the content addresses the tasklist?
- What are the elements it is addressing-knowledge, attitudes, and skills?
- The language, style of communication of the book, user-friendliness.
- Does it fit the bill for a handbook or a distance training material?

C) OTHER BOOKS

PRIVATE BOOKS

In the field study, we found that working JSRs are using some other books, almost keeping aside the manual, and the books include:

- Adhunik Allopathy guide (Harnarayan Kokcha, Pub: Dehati Pustak Bhandar Delhi)
- Swasthya Nirdeshika: OP Bansal
- WTND Hindi: David Werner

GOVT PUBLICATIONS

- Manual for Health Worker (male) is a useful publication, it is a surprise, why MP Govt did not use this book with little updating

ASSESSMENT OF THE SUBSTANCE OF THE MANUAL

Chapter	Page	Topic	Remark
	1	1.1- objectives	Good, curative role has primary place
	10	duties of JSR-	Repetitive, should have been categorized-
	12	Code of conduct	Incomplete (see VVD doc)
	13	medicines	Only 8 internal medicines-severely incomplete list (see VVD doc)
	14	Clinical skills (diagnostic!)	So few? (see knowing CHW)
	15	Technical skills	Some are diagnostic/investigative; while some are first aid. The first aid skills do not say what are skills, only mentions conditions (should be wound wash instead of dogbite as a skill). Some mix up. Skills are activity sequences—like in checking BP or wound suturing.
	16	Motivation skills?	Not very clear, is it same as communication skills?
		Referral skills	these are really diagnostic skills
	17	community skills	are really communication skills
		"The skills"	better grouped as detection skills, hand skills, verbal skills or according to function-diagnosis, therapy, prevention, health education etc
	18-20	Responsibilities	Duplication.. like malaria is separately mentioned while communicable illnesses exist, as a section (is malaria not communicable?). Vaccination also is part of C-illnesses. We would recommend better grouping of responsibilities_ like curative, preventive, promotive, administrative etc or patient services, NHPs, School health etc
			Some language problems like- (Is JSR a Govt. servant? or a volunteer helping Govt?)
	25		needless repetition of first aid problems
	25-26	illnesses list	Better grouping is called for (see manual/red book). One way is feasibility and second way is systemic grouping. And, are these all illnesses to be handled?
2	28	health infrastructure	OK
3		human biology	• Needs a different perspective- needs a better plan/approach. • Lot of needless details-like how many bones/names of bones everywhere. Often goes like Grey's anatomy (anterior organs/post organs/lateral ---etc) • Needs figures at places (see for instance chambers of heart) • A CD may help learning/teaching this section
		circulation	the section 2 is mostly about blood, but wrongly titled as heart/vessels (also there is style problem of subheads- leveling is imp)

	56	Excretion	Is parotid an excretory organ really? (and at health worker's level)
	56		Why talk of weights of kidney?
	57	male genital	no labels to diagram
	61		Needless description of penis
	62	female genital	Why not Hindi names for organs?
	66	Nervous System	Insufficient
	67	questions	Relevant? Need for questions that test for each section comprehensively
4	68-	diagnosis	Objectives not given..why diagnose an illness?
			Poor organization/protocol. It should be systematic- either top to down or system-wise. or general/systematic format
	73		picture of child not matching description (skin)
	78	illustration of pain/abdomen checking	• Wrong side for right handed examiners. • random selection of abd pain points-must be regionwise
5	84	food classification	name category/ common factor- (fonts in hindi are not corrected) अगफ़ादग@ध्यशज– लघ्थलहग, ळब्नऋगल, अगत्थ
			sudden switching from general nutrition to child nutrition
		malnutrition	describe two categories-marasmus/kwashirkor
		treatment of malnutrition	Feeding advice not enough- porridges/addition of oils is not mentioned.
	94	Vit A def	Why rtaOMQaI is not mentioned as an illness? But mentioned on p154
	95		Tourniquet-bleeding in anemia is not relevant/correct
	96	Vit A soln (last line)	Advises to see picture, but where is it?
	99	Iodine	Need to advise on preservation of iodine in salt at home-cover etc. also check facts on salts sold in bazaars-
6	105	programme statistics	Avoid national/regional stats,
		ANC protocol	Needs reorganization
	113		PEToxemia is – saMkmaNa ?
	114		Is FP advice an emergency
			r@tsaMcaar is really KUna donaokI sauivaQaa
	115	3rd para, first sentence	Not clear
		FRU	use one term (pratham stareeya/FRU/)
	116	eclampsia	Is it infective (saMkmaNa)

		ivaYaa@ tta	Actually this is saMkmaNa
	117	kUlho ka ihssaa	What is this? Perineum or vagina?
	119	Risk factors	Incomplete list, and not organized in pre/intra/post natal factors
8	123	preventing child deaths	list of 6 is incomplete without good nutritional practices
	126	Asaamaa nya	Replace this word (abnormal) with
	132	Resuscitation	Rewrite para 2 sentence
		para3	Suction is good help.
9	135	three illnesses	Repeated probably from proof correction
	136	Co-Trimexo-zole	use shortforms for drug-names (also p 140)
	141	diarrhea control-para1	why not SSS, why only ORT,
			Suggest using GarolaU salaa[-na For ORT
		inaja-ilakrNa punaja-ilakrNa	use saUKa saUKnaa / sajalana
10	153	Vit A units	say it in mls (many zeroes intimidate)
	157	point no 6	repetition
	162	milestones-column1	Is it mixed up at places
11	166	STDs	Syndromic approach is helpful.
	167		What about other STDs-LGV, Soft sore/ Herpes Genitalis?
			Is JSR treating STDs? If so with what drugs-see drug list
			Mention syphilis to be imp. cause of repeated abortions
	169	AIDS	symptoms-major minor/child adult
			Stress sex/health education in schools
12		oral pills	If JSR is giving pills, distinction between absolute/relative contraindications is needless(all are CIs)
		oral pills	Is one-month gap not advised these days? (Continuous use for 5 years?)
		Tubectomy	TL by Laparotomy + GA need not be mentioned.
			Why not mention safe period as a method?

13	193	TB	Bacterial name to be shortened if at all necessary. use simple word like TB for the illness what is vaayavalya ?
	194	table	Are TB death rates necessary?
		age of TB incidence	Childhood TB is to be mentioned not glossed over.
	195	last para: symptoms	second sentence should lead para, to avoid confusion
	197	Prevention - para1	Isolation need not be overplayed.
	200	NTCP	15 days to be replaced by 3 weeks (chr cough)
	201	phases of DOT	words like gahna inarMtr need replacements
	202	categories of TB illness	Explain the categories
			Are JSR giving DOT? If so, include the side/untoward effects of drugs. Use English code like SHRZE do not hindiise!
	204-5	Rx cards	Use filled cards, not empty
	207	illustration	Good!
14	214	leprosy	Is JSR treating leprosy? Why discuss dose of MDT?
	222	G worm	Removing steps of wells is mandatory-pl mention that
15	224	eye-fig	wrong labels
			Pl use same words in fig and text
	229		What about other eye-illnesses- FB, dacryo, trachoma, squint, sty
16	230	Disease triad	Aitqalya is Aadmal, vaatavarNa is pirisqatl
	241	Typhoid	Does Typhoid start with catarrhal symptoms?
17	250	water-chlorination	Use after 30mins (2-4 hrs?)
		sanitary latrine	saada SaaOcaalaya (also p 253)
	251	soak pit	soak pit is only for avoiding pools-mosquito breeding, it can not avoid deep-water source contamination. In fact it should be away from borewells. (use illustration)
	254-55	Responsibilities	Is the language right if Govt is not paying JSRs?
		water & sanitation	Illustrations are very pleasant
	256	janak	janak :@yaa matlaba ?
	261	bats	How to prevent contact of dogs with bats?
	264	splenomegaly picture	Swelling yes, but no ascites.

	266	treatment of malaria	• saMBaaivat ko bajaaya gaRhIt caaihyao • Treatment does not even mention paracetamol-why? • Should discuss side effects of antimalarials
	267	tablets-table	Which tablet is this..Primaquine. column-head missing
			Treatment differs for vivax / falciparum (see NMCP litrature)
	269	first line	first line should go to previous page
	270	Illustration	Gives an impression that humans and mosquitoes take 10-15 days each to develop infective forms (gametocytes and sporozoites respectively). Immediate next bite can not infect, and acute stage malaria is yet to develop gametocytes.
	273	neck-rigidity (NR)	Not always present in encephalitis unless there is meningism, but in meningitis it is always there. NR should be tested lying down
			Impregnated bed-nets and guppy fish need mention
	275	Filariasis	JSR can do Filariasis treatment-needs emphasis and details of treatment- also a place in drug list also mention mass treatment
19		CaoTI maaoTI baImaarIyaa	needs classification on CaoTI @yaa maaoTI @yaa (see my classification on this) Only 16 illnesses- how were these selected? any criteria?
	278	Boil	• Aspirin is better than paracetomol for anti-inflammatory effect, but not mentioned, in list! In fact aspirin is a layman's medicine • Why not anti-infective agents like Co-Tr/Tetracycline • small lesions can be punctured/incised and drained/ also herbal treatment for bursting the boil are used (also poultices)
		Constipation	Several herbs are advised-triphala, amaltas etc (see your own Ay section)
		Aaxaop	What is it?
		KaMsaI sadI-	Is not the same. Call for different approaches. Cough needs a protocol to atleast separate URT causes from LRT ones. The treatment here looks like addressing URT cause. **In general, we need to decide whether the illness is mentioned is symptom or diagnosis**
	279	Ear pain	Calls for diagnosis: external ear illness or middle ear infection? Both need different. Drops are not for ASOM with burst drum. Strangely, anti-infective drugs are missing again..

		Fever	• Calls for a systematic approach, all fevers are not malaria. • Fevers can be split on age/cough/non cough, then again into separate conditions. Simple flow charts are available (see CEHAT booklet) • If it is malaria-takes longer than 24 hrs even after chloroquin.
		Headache	In addition Acupressure points are useful, and also increase JSR's rapport with patients
	280	Indigestion	• Illustrated position is for which illness? Indigestion? • Why the illustration shows a naked person?
	280-1	Joint pain/back pain	• Both are different illnesses, can not be clubbed. • Bulleted description is related to PID/spondylysis-which should be referred. Ref is not mentioned, but only bed rest! • Aspirin yes, but why not mentioned in drug list? Mention precautions with aspirin? • Why naked women in illustration? • Mention referral for last bulleted item- TB spine
	281	Abdominal pain	• Needs systematic diagnostic protocol-regionwise. • Need to detect acute abdomen problems • Mag hydroxide is for acidity or constipation. For acidity we need a combination of Mg and Al salts. • Coloin(?) and MagPhos are tissue remedies- then say about strength/dose/period etc.
		milk-Acidity	controversial issue, almost settled in favor of No milk for APDisease
	282	sore eyes	• Pain is mentioned as a risk factor-but generally it is there. need to mention photophobia and corneal ulcer • Do we need eye pad for sore eyes? We believe it is only for Corneal Ulcer
		Toothache	• Aspirin is better than paracetomol • Belladonna/merksol are homeoremedies- listed? Informed? • Look for abscess, caries, tooth-fracture pain etc
	283	Ulcer(skin sore)	• Say it is GaaMva • specify it is skin sore and not peptic ulcer • Several herbal treatments are found useful-aloe, neem, unripe papaya
	284	vomiting	• ORS is not the treatment for any/every vomiting. Domstal can be a symptomatic treatment • Herbal treatments must be mentioned/so also home remedies (several) • Treatment no 3 is for morning sickness, not other causes. • Why the dividing horizontal line? • mention treatment for motion sickness

		kIDo	• Worms? then say poT mao kIDo • saayaanaa ? What is it? Homeo rem? • Why not albendazole/mebendazole?
	286	The list of 20 dangerous illnesses	• Looking back, there are many dangerous conditions even in previous list of CaoTI maaoTI balmaarlyaa • Any criteria for listing dangerous illnesses at the level for JSR? • Symptoms/signs/illnesses all mixed • We think this is list of *some* ACUTE SERIOUS conditions, • But then few chronic serious illnesses (anemia/TB) are also mentioned- like chronic ulcer on skin (non-healing wound), chronic weight loss, inability to take feeds for more than one day. • Pt no1- bahut jaada KUna. Not quite, the site is also imp- ENT bleed, urinary bleed, untimely vaginal bleed in pregnancy etc are imp too. The apparent cause is also imp (for instance snakebite). Big bleed can not be a good criterion. • Random sequence (urine problem listed at 7, another at 17 • Needs systematic listing- top to bottom/or system-wise • Pt 12, says acute pain lasting for 3 days-do we wait so long? • Pt 14, Convulsions-why more than one, why not even one?
	288	Acute abdomen	• Subhead problems- diverse problems fall under this major heading (like poisoning, scorpion, diabetes etc) • Calls for systematic regional-anatomical approach (like rt lower quadrant pain can be appendicular, Rt Upper q can be gall-bladder pain, all q pain can be peritonitis etc. • Distension is not mentioned in signs • tender/ non tender is also important
	288-9	Peptic ulcer	• Milk/ milk products are not recommended except *milk* in pregnancy acidity. • Treatment with antacids is missing, not to mention antibiotics.
	290	Poisoning	Is it a problem only among children?
	291	Scorpion	Two types— • only pain- OR • Pulmonary edema/bloodspit (if this type is found in MP-then mention tablets prazocin) • (is second bite in adults fatal? pl check literature)
	293	Diabetes	• Two types- NIDDM, IDDM • Treatment of even NIDDM may require oral antiD agents. The last para of p 293 gives wrong impression

	294	High BP	• Needs new heading, looks a subhead in diabetes • Deserves to be a screening cause in JSR tasklist- so train them to measure BP, and about primary care/prevention/first aid (also in list of Ktrnaak balmaarlyaa • Treatment for acute high BP-Nifedipine SL • Aaramaka ZMga is relaxation/anxiety free/shavasan?
	295	Obesity	• Separate heading • Define by weight/skinfold • Elaborate exercise-fat burning exercise >15 minute aerobics
	296	Asthma	Not even first aid? talk about inhalation sprays/ salbutamol tab
			• What about other Ktrnaak balmaarlyaa • Needs an epidemiological approach to such a listing, apply some framework and decide tasks in each
21	297	Medicines	• list too poor (only • Tabulate all info-name/indications / dose/ frequency/ duration/ side effects/ toxic effects/precautions/contraindications/ & available cheap brand names (see appendix)
		Sulfa	• Is not same as Cotri... • Remember also syndrome-severe stomatitis- in reaction,
	298	Paracetamol	Dosage-- three times daily
	299	Anti-histaminics	• Heading goes haywire- • CPM is sedative and NOT least sedative • Dosage needs to be tuned to cause- just one tab (motion sickness) or for three –four days (for allergies).
	300	Mag Hydrox	• Combination of Mg+Al is universally recommended for mutually neutralizing effects
		Chloroquin	• The dose schedule is already given in malaria, avoid duplication if possible • Explain side effects, CI, precautions ...everything • Treatment for Presumptive/radical regimens
	301	IFA	Elaborate various aspects listed WE general for all drugs
		Mebendazole	Contraindicated in early pregnancy and infants
	302	Ext applications	Subheads styling
		Mg Hydrox	Repeated (see p 300)
	303	Gention violet	Imp use is vaginitis-esp fungal/candidial
22	304	Coordination with MPW	• gaBa- ka nayaa maamalaa : Strange wording! • Needs task list matrix of various workers. For instance underweight baby is already with AWW, what will MPW do for that? And why JSR should duplicate work?

	305	heading no 2	Needs blue screen like other similar titles
	306	Stock of primaquine/DDS/MV	• Then why not include them in the drug-kit/list and give all relevant information?
		naotaAao Mkao kamama oo lagaanaa	High order, review langauge! (Try to help/ involve!) The next page illustration advises differently
		chapter	Overall good, needs illsutrations!
23		Accidents/ First aid	• Column headings are essential-problem, tretment, referral • Illustrate skills-like helping drowned person
	318	Fractures	• How to recognize fracture? • Ref to CHC, not PHC
	319	Insect bite	• Mentions "treat shock" and also "refer if shock". Instead say "offer first aid and refer" • mention CPM for allergy
		Sprain	How to rule out fracture? Mention signs here or in fracture.
	320	snakebite	• Tourniquet is outdated, use pressure bandage • incision/cuts also outdated • ASV, not eNTIbaInasa
		Gaava	• Tourniquet (r@tbaMd) is dangerous • Stick plaster is generally no good , except for small wound apposition • Stitching/suturing can be taught.
	321		Illustrate all techniques
	322	nosebleeds	proper pressing/cold water splash are usual methods-mention them
		hand-bleeding	illustration misplaced with nosebleed
	335	registration of vital events	Who keeps? Grampanchayat, is it not?
	336	patient registration	• Improve record pattern so that health data is easily complied. • BTW, is svaasQa rxak is same as JSR? Elsewhere it means MPW • The monthly worksheet layout needs improvements-heads and subheads, boxes for figures etc

Part2		Ayurveda	• This chapter has several good points and quite a rich listing of remedies • The specific remedies for illnesses need to be woven into the larger book- not to be segregated in this chapter. Only general principles to be mentioned here. The JSR can not switch from Allopathic system to Ayurvedic system at will, but can practically think of alternatives for each problem faced. This would also take care of needless duplications (see p 10 pages ranging from 363-372)
	353	The list of illnesses	Mentions some problems for no reason-like snake bite/drowning when there is no particular treatment in Ayurveda for these problems.
	354-5	Sanskrit verses	Not necessary/useful
	356-7	Swasthya	Good chapter
	364-5-6-7		• Needless repetition of earlier text from part one/ • Often contrary to part one (see ATT injection), • Only three lines of para2 on p365 & 366, three lower lines on 367 are Ayurvedic
		Snake bite	No Ayurvedic point- repetition of outdated treatment (sadly also in part one)
	370-1	heat stroke & Dog bite-	• Needles repetition, and the only Ayurvedic is too time consuming (paste of *channa* vegetable) • Dog bite-nothing special
	374	list of fever remedies	Say they are alternatives, and give doses/duration
	374-375	malaria	• Plasmodium parasite is confused with anopheles mosquito • Fever mentioned is rather high. (103-6?) • KUna saUKta hO (?) • Hepatomegaly (liver swelling?) is this true? • Fall of BP-only in algid malaria- not all cases • Quinine is not the choice of treatment and • Quinine is not sold as chloroquin • mahajvaraMkuSa iktnao idna ?
	375	Diarrhea	• One LM is not consistent with definition of diarrhea –even in a child • Causes mentioned for Diarrhea are debatable • laMGana for a child?
	378-380	Dysentery	Good repertory for dysentery
	381	Cholera	• Cause is indigestion? • Good repertory- but for a serious illness can we rely on these?
	385	Worms	• Good repertory

	386-388	anemia/jaundice	• Why clubbed? • Causes of anemia are irrelevant, may be except pica • Same thing for causes of jaundice • Jaundice-stools are not always white (only in the rare obstructive, or late hepatitis) • Alternative remedies they are-must be so mentioned. (BTW can we do a priority listing among the remedies) • Why mention blood transfusion?
	389	Cough	• ? Use of word Bayaanak $p • Cause of which cough are listed- all • How to select remedies- good list!
	391-2	cold	Good!
	393-4	Abdominal pain	• Cause must be ascertained before treatment • Causes mentioned are not rigorous
	398-9	Constipation	• Good! • Ichhabhedi is strong at this level of care • castor is also irritant
	403	Ear illnesses	• Types well said • Treatment can not be general/same • Middle ear perforation-instillation of cow-urine may be reviewed.
	406	Nasal illnesses	• Septum deviation is not same as Sinusitis • Treatment options make good list
	407	Eye complaints	• causes of sore eyes/ other illnesses not 'sustainable' • Why discuss cataract if there is no specific Ayurvedic treatment?
	411-3	Women's illnesses	• Big topic, but several problems • very negative about menarche • Sterility treatment needs to be placed in some diagnostic perspective • Enhancing labour by using *chhorna* counting quinine..needs second look, esp when other cheap effective remedies are available, and anyway referral is mandatory • What is laaprvaahl in childbirth? • Leucorrhea is not necessarily bahut Kraba balmaarl • Treatment advises "stay and work at home"-which is very biased in this age. (If women stop farm work?) • Dosages not written/ nor durations given in treatment (see r@tp`dr • Even advises treatment for a male son (Betrays an Ayurvedic's gender bias)

Important general observations
• The layout is not space-economical, one line format wastes space, two column format should save space and also help better visual grasping as reading-span is smaller (see for instance all bulleted or indented items, a word or two and it is over see eg p181, also 413)
• Blue screen for subhead is pleasant and helpful
• Typographic errors abound- almost 1-2 every page.
• Nomenclature problems- Sanskrit names replace English one at many places-the effect is no different—equally difficult to incomprehensive. Spoken language is better in such interactive learning. see :]%tk, (p61), inakTsQa , icaik%sak, inaYaocana 141 saaMnd` ..
• Lot of subheading problems- the matter needs to be properly headed/subheaded. There is no distinction in subheads 1,2,3- stylistically they are all same. That causes comprehension problems. this confusion is also evident on several pages like 196 (TB)
• Some writing protocols are mandatory. A general approach to writing is: • one para for each idea/issue • first sentence of each para should herald the para- highlight/attract • first word of each sentence should flash the sentence- (see my correction on p • Order of word is imp- see for instance last sentence of para 1 of p 48)
• Phrase-making is frequently problematic for instance Immunity is not raoga kI xamata
• Illustration is very scant, forcing authors to be wordy. This hurts effective communication
• Different words for the same concept—for instance/ naaDI ,nabja, / sath prt / caap daba / poSaI kaoiSaka / r@talpta r@txaINata / inaja-ilakrNa inaja-lana
• Too frequent use of pronouns—ya,h,/ [saka even at start of paragraphs. The right word should replace this pronoun in most places (for instance, see page 50-51).
• Too many English words-peristalsis, movement, carbohydrate, bile pigment, epiglottis and countless others like sphincter. epidermis, dermis, capillary blood vessels, ejaculatory ducts, epidydimus, nephrons, vas deferense, urethra, salt, balance, heavy metals, sebaceous gland, resuscitaion, subcostal, collarbone, cornea, conjunctiva keratomalacia, scar, note, chlorinated and so on. • Good Hindi substitutes are available/or can be constructed for effective communication (translation is not a dire duty, it is a solemn cause).
• sentence construction like on p 62 yaaaonI saMBaaogamao ihssaa laotI hO is problematic-needs *hindikaran,*
• Lack of vertical slash dnD in many places (see p 198- 2nd last para has 66 words)
• Use simple spoken words like maaisak Qama- ko bajaaya maahvaarI/ /ivasaMk`aimat ko bajaaya]baalaI gayaI(p 169)
• Use bullets wherever necessary (eg p129. 138, 139, 140)
• Use indent style wherever necessary (eg pp 149)
• Several words are used incorrectly (eg ivakisat samasyaa, (page 150). baDa]ma` see page 136). Asaamaanya jaada page 141). ivaixaPtta bauraAsar see p 167 also gaDbaiDyaa). vyaayaama majadUrI 198
• Make smaller meaningful and easy sentences, review sentences for correct communication eg see page 146 last sentence) (see p 198- 2nd last para has 66 words), see also complex sentences like the last of the 1st para on p 199 about TB.
• Explain logic for actions, for instance why mother should clean baby's nose for better feeding (p 139) (p166 first para)
• Why not mention Ayurvedic remedies with allopathic remedies: like in diarrhea management? This is better if you really men to encourage use of Ayurvedic treatment.
• Avoid use of words lilke kosaosa, raogaI 201
• Problems of addressing the reader (JSR or people?)—(see p226)
• While giving treatment (for instance p 278-281), say whether the various treatments are options OR components of the same treatment package. (One or all advises together?)
• para space is rather large, does not allow visual clustering of points

• In general, we would advise the authors of both/all the sections to work together on each section, share/check ideas and evolve a wholesome, clear and pragmatic approach for each problem. Otherwise duplication, mistakes, contradictions are bound to occur.
• Too few illustrations for a book like this need to fine-tune.
• 'How to use' is not given
• Index is not very helpful as it almost matches list of contents.
• Binding is good, and so is paper and printing.