Partners in Progress

An experiment in
NGO-Public Sector collaboration
for the promotion of Quality of Reproductive Health Services

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Rural Women's Social Education Centre (RUWSEC)

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Intervention-Research project on " Implementing Cairo: an experiment in NGO-public sector collaboration for the promotion of quality of Reproductive Health services

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Background

The International Conference on Population and Development

In the year 1994, the Programme of Action of the International Conference on Population and Development (ICPD), Cairo called for a major paradigm shift in the manner in which population programmes were conceived and implemented – from being driven by demographic targets to being oriented towards upholding women's reproductive rights and ensuring better reproductive health for women of all ages. This meant that countries had to offer a wider package of services not only to mothers and mothers to be but to all women to improve the technical quality of services and to be more client-focused.

Collaboration between NGOs and the public sector has been widely identified as an important strategy towards implementing the commitments made in Cairo, including by the government of India. The technical expertise of the public health sector combined with NGOs' insights into the health needs of poor women as well as barriers to their accessing health services could go a long way towards making services gender sensitive and client-oriented.

In it's report the ICPD states:
" Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

With reference to the family planning services, the ICPD Programme of Action recommends

"Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continuous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured; Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counseling. "

In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life

and personal relations, and not merely counseling and care related to reproduction and Sexually Transmitted Diseases.

However, Reproductive Health eludes many of the world's people because of such factors as:

- Inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services;
- The prevalence of high-risk sexual behaviour;
- Discriminatory social practices;
- Negative attitudes towards women and girls;
- Limited power that many women and girls have over their sexual and reproductive lives.

Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues, which are often inadequately addressed.

Reproductive health-care programmes needs to be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services.

Governments and other organizations need to take positive steps to include women at all levels of the health-care system.

Governments should promote much greater community participation in reproductive health-care services by decentralizing the management of public health programmes and by forming partnerships in cooperation with local non-governmental organizations and private health-care providers. All types of non-governmental organizations, including local women's groups, trade unions, cooperatives, youth groups and religious groups, should be encouraged to become involved in the promotion of better reproductive health."

[Report of the International Conference on Population and Development, (Cairo, 5-13 September 1994)]

"India's health programme is low in quality, and barely responsive or beneficial to women. Concepts such as client-orientation and meeting community needs that abound in the Government rhetoric about reproductive health can hardly be seen in the services that are delivered. Implementing the ICPD Programme is difficult in an environment where privatization is driving up health costs, social sector budgets are being cut, work opportunities are shrinking and food security is growing." *['Weighing up Cairo- Evidence from Women in the South- Gita Sen, Anita Gurumurthy, Vanita Mukherjee, Vimala Ramachandran 2000]*

India has made positive move towards the goals of the ICPD Programme of Action but has a long way to go.

The Health Care System – Tamil Nadu

'Tamil Nadu has a reasonably good network of Primary Health Centers (PHCs) and subcentres, which cater to the rural population. In 1994 the state ranked fifth in population size served per subcentre (4,236 persons) and also in population size served per PHC (25,614). Each subcentre and PHC serves an area within a radial distance of 2.13 kilometres and 5.25 kilometres, respectively. *(GOI, MOHFW, Rural Health Division 1994).*

Tamil Nadu state has 1409 Primary Health Centers and 8682 Health Subcenters *[1999-2000 Directorate of Rural and Medical Health services]*. In 1991 Tamil Nadu had a ratio of one doctor per 1,230 persons, ranking third after Kerala (1:760) and Karnataka (1: 1,020). The state's per capita expenditure on health is Rs 86.10 per annum. This is exceeded only by that of Punjab's (Rs 106.28) and Kerala's (Rs 95.79) *(CMIE 1994).*

Ninety- two percent of rural mothers and 97 percent of urban mothers are immunized against tetanus during pregnancy. More than 80 percent of all pregnant women receive iron and folic acid tablets; and in 1992-93, 60 percent or more had an antenatal checkup by a doctor. Forty-nine percent of the deliveries in rural areas and 90 percent in urban areas take place in a health facility *(IIPS 1995).*

Overall, the health and family welfare services in Tamil Nadu are better distributed than in most other major states of India.' *('Quality of Care'- S.Ravindran).*

"However there are certain worrying trends in the area of reproductive health. For example the Infant Mortality Rate (IMR) stands at 53 out of every 1000 child deaths. Of them 33 happen within days of birth. This neo natal mortality accounts for more than 60 per cent of the IMR. Thus though the state has been able to reduce the death of infants over the years, it has not been able to do much about neo-natal deaths. This has been attributed to social behaviours, such as low nutritional status of women, lack of proper medical attention, access to information and failure of public health institutions. Though the state has made substantial achievements on the development front, it has now come to stage from where improvement will be extremely difficult if it does not look at social inequities and the failure of institutions." *(Hindu, 8/1/2001)*

"Efforts are being made to provide more comprehensive health care to couples in the state, this is evident in the fact that during the past seven to eight years, immunization services, antenatal checkups, visits of the health workers to the villages, and the mothers' meetings, to discuss issues ranging from the benefits of maintaining a balanced diet during pregnancy to the advantages and disadvantages of the various methods of family planning and so on, have all increased significantly.

The workers of both the PHCs and the sub-centers, are given training in the new approach, which includes hitherto neglected topics such as quality of care, informed choice, assessment of community needs, and participatory learning and awareness building.

The health workers in Tamil Nadu are aware of the fact that there is a drive to lower infant mortality in the state and that they have to attend to pregnant women and provide all immunizations to the infants. A high degree of concern for lowering maternal mortality is also visible at all levels. The health workers encourage pregnant women to deliver the infant in an institution rather than at home.

There are clear signs of some shift in the orientation of the public sector functionaries engaged in the task of promotion of family planning and lowering of fertility rates. There has been some movement towards modifying the training grassroots level workers and also towards providing them with backup support of well-trained senior health care providers." *[The community Needs Based Reproductive and Child Health in India: Rajasthan and Tamil Nadu -Leela and Pravin Visaria 1999]*

This study is evidence to the changing scenario in Tamil Nadu vis-à-vis Maternal and Child Health and Family Planning services. However Reproductive Health services at the PHCs are yet to be implemented. This report details an attempt by RUWSEC to implement the concept of quality RH services through the collaboration between the NGO and the Public Sector in two PHCs, which was selected for the programme.

The organization -Rural Women's Social Education Centre

Rural Women's Social Education Centre (RUWSEC) is a grassroots women's organization that operates from Chengalpattu, near Chennai. It works primarily with socially and economically lower population groups in the villages within Thirupporur and Tirukazhukundram Blocks of Chengalpattu, sub-district of Kanchipuram district. In 1999, RUWSEC's community-based activities included 98 villages with a total population of about 30,000. Ninety percent of the population belongs to Scheduled Castes (SCs), and 10 percent to Other Backward Castes (OBCs). Outreach through other activities extends to a population of about 50,000.

RUWSEC was founded in 1981 by a team of 13 women, 12 of whom were from the local villages and had previously worked as literacy teachers with the National Adult Education Programme. Achieving women's well being through women's empowerment has been the focus of RUWSEC's work since it's inception.

The organization carries out a range of activities, which include:

- Community-based action for health promotion through a community health worker, formation of a local women's "sangham" (association) and leadership training for village women
- Publication and distribution of popular education material on health
- Education and empowerment programmes for adolescents
- Work with men for gender sensitisation and on reproductive health issues
- Community-based interventions for prevention of gender violence against women
- Health education and training for other NGOs and annual health festivals
- Creating an information base on the health of rural poor women.
- Action/research projects on specific health problems/interventions
- Reproductive health services through a clinic and hospital

Evolution of the NGO-Public sector Collaboration programme

The organization has sought to lobby and pressure for changes in the existing health services system from its very inception. In the initial stages RUWSEC mobilised women's groups or *Madhar sangams* from the community who would pressurise the local health functionaries to make regular domiciliary visits, hold regular antenatal clinics, or demand that they treat poor rural women with a modicum of respect. However, these did not make much long-term impact as there was a frequent turnover of doctors at the health centers, and the process would have to start all over again.

In 1988-89, RUWSEC embarked on a systematic documentation and intervention system for health care. A Tamil publication, 'Women and the health care system' documented the existing hierarchy in the medical system, its attitude and values, and the interaction

between the health functionaries and the typical client – a poor, Dalit woman- and the consequence of the meetings.

In 1994, when national and local meetings were being held in preparation for International Conference on Population and Development [ICPD], RUWSEC undertook an experimental study on the quality of health services provided in Primary Health Centers [PHCs], in which three NGOs from Tamil Nadu participated- RUWSEC, World Vision and Women's Resource Centre. The method adopted was one of participant observation, with activists going as patients. Sixteen health facilities were studied, and the results collaboratively collated and compiled in a workshop held for this purpose.

In 1995-96, in a study in Tirukazhukundram block, a participatory exercise involving the local community, in monitoring and assessment of the health facilities that served them was carried out. This study was a modest exercise to ascertain how well equipped the country's health service infrastructure was to make the transition to the Reproductive and Child Health Programme [RCH]. The study team constituted women and men from the villages of Tirukazhukundram block, so that the findings of the study could be used to initiate local action to improve the facilities.

The study found that the network of sub centers needed to be made more functional, and adequately staffed. The study found that many of the sub centers were lying locked, others were functioning mainly as store houses, and those that were functional, were poorly equipped in medical infrastructure with not even drugs being made available in the centers. A wide range of tasks needed to be carried out at the sub centre level towards operationalising the essential RCH components including counselling, community health education, contraceptive distribution, screening, referral of pregnant women with reproductive health problems amongst others.

"This limited study shows that even in a relatively well-equipped state such as Tamil Nadu, much needs to be done to set the house in order before the ambitious transition to a comprehensive reproductive health care package could begin."

['How far are we from implementing Cairo? 'An assessment of facilities for reproductive health care in government health facilities serving a rural population'- T.K.Sundari Ravindran, P.Komala, K.Anandan].

Following this study, RUWSEC staff initiated weekly review meetings with the PHC staff. Meetings were also held with the local health officials, and the PHC staff, to share the details of the study and to create an opportunity for sharing of information, future plans and strategies. All these studies and the information gathered through them, motivated an "Intervention-Research project on "Implementing Cairo: an experiment in NGO-Public Sector Collaboration for the promotion of quality of reproductive health services".

The programme – Planning and Process

Objectives

The ***Objectives*** of this programme were:

- ✓ To improve the quality of RH services at the PHC and the sub centre level in a select area.
- ✓ To gain insights into the potential for NGO-public sector collaboration on a wider scale, for the promotion of RH services: to this end, to identify the strengths and limitations of the collaborative process, and mechanisms to deal with bottlenecks.

Towards achieving the objectives, a broad based plan perspective was drawn up. These included:

- Identify activities to improve the quality of MCH/FP and other gynaecological services available to women in the PHCs and subcentres in consultation with the health sector functionaries at the state and district level, and with a cross-section of users of services.
- Facilitate and/or carry out activities identified, in collaboration with the PHC and subcentre staff and with the local community in a select area. This, if necessary, may include material and human resource inputs, and will call on the participation of the local Panchayats and local leadership.
- Document the entire process.

The process

This project began in June 1998. RUWSEC initiated a series of meetings with various officials of the Department of Public Health (DPH) regarding the programme that RUWSEC planned to undertake and subsequently to carry out the project. Permission had to be sought from the Deputy Director of Health Services for Kanchipuram District, where the programme is being implemented. Six months lapsed before official permission to work with the local Primary HealthCentres PHCs was received. However RUWSEC received a positive response from the staff at the Primary Health Centers during the preliminary meetings with them.

Selection of the Primary Health Centers

Two primary health centers at Nerumbur and Tiruporur were selected after a scientific understanding of the PHCs, where RUWSEC is operating. The two PHCs were chosen on the following premises:

- They were located within RUWSEC's area of work i.e. within Tirukazhukundram and Tirupporur blocks.
- RUWSEC workers were present in areas that fall within the jurisdiction of these two health facilities.
- The absence of any major health facility in these areas other than the PHC.
- The substantial population covered (at the time of the study) by these facilities, Nerumbur [18,372] and Tirupporur [42,372].
- Accessibility of these facilities by local bus services.

Status of the Primary Health Centres

The RIWSEC staff carried out a preliminary observation analysis of the two PHCs that were selected for the project. A brief note on status of the two PHCs that were the nodal points from where the NGO public sector collaboration was carried out:

The Primary Health Centre, Nerumbur

Nerumbur PHC is located in Tirukazhukundram Block of Chengalpattu sub-district of Kanchipuram district. It is situated about 20 kilometres from Chengalpattu town and about 80 kilometres from Chennai city. Nerumbur PHC serves a population of about 18,372 at the time of this study. When the programme started there were five Health Subcentres (HSCs) under the PHC, which were located at Perumbedu, Perambakkam, Lattur, Irumbulicheri and Pandur villages. Subsequently, during the middle of the programme, the PHC was upgraded and had to cover a population of 53,438 with 13 subcentres and ten additional staff.

Nerumbur serves the interior hinterland of rural Chengalpattu. The topography in and around Nerumbur, did not boast of any visible private practitioners or pharmacies at the time of the programme. The PHC is located a little less than ½ a kilometre from the bus stand at Nerumbur. Buses are infrequent, irregular and ply only at specific times, one bus in an hour and a half to two hours. The roads are in very poor condition and some locals mentioned that many a woman has delivered on the bus in this area. Some of the villages that fell under the purview of the PHC do not have access to any transport services, and many villagers walked/cycled about 5 kilometres to reach the centre from some areas.

The timings of the PHC are from 9 a.m. to 5 p.m. However most visitors to Nerumbur PHC, came between 8.30 a.m. and 12 p.m., as the medical officer in charge of the PHC, generally visited the center during this time. However some of the staff such as the pharmacist and the Auxiliary Nurse and Midwife (ANM) stayed until 3 - 4 p.m.

The PHC delivered only preliminary health cure to the patients. Medical equipment was non-existent and even basic testing services such as laboratory tests (exception was malaria), blood tests and x-rays could not be carried out at the PHC. Patients, who could not be treated at the PHC, were referred to Chengalpattu Medical College and Hospital [CMC], located at Chengalpattu town at a distance of 20 kilometres from Nerumbur.

The PHC did not seem to have a proper stocking pattern for essential drugs and medicines. Most of the medicines and drugs required for a proper functioning of the PHC were allotted annually by the Department of Health. However if any specific drugs were required urgently, an invoice would have to be raised, which would have to processed from the Department of Health and allotted only on specific dates, sometimes only once in two months. The quantity of drugs stored at the PHC did not seem to follow a scientific pattern and appeared extremely ad hoc in the stocking and distribution of the medicines. The range of drugs allocated to the PHC did not seem to take into the account the needs of the PHC and one noticed a "top down approach" in the drug distribution set up instead of the "bottom up approach" as should have been the case. Thus medicines distributed at the PHC covered a very narrow range of ailments and problems.

None of the Village Health Nurses (VHNs) stayed in the sub centres. Even the additional 6 VHNs who were transferred to this PHC did not stay in their sub centres. As a result of this, deliveries, if at all, were conducted only during the daytime.

The labour room in the PHC was not functional. Moreover the ambience in the PHC left a lot to be desired. Rusted furniture lay around the waiting rooms and the PHC did not have water services in the toilet or for drinking purposes. No deliveries were conducted in the PHC. Services for Medical Termination of Pregnancy were not available. Family planning services included distribution of condoms, oral pills, intra-uterine device [IUDs] of which only one kit was available, as against a stipulation that each VHN should necessarily require an IUD kit. No ambulance or van was available in the PHC. For services such as operations, x-rays, scans, blood bank, deliveries, laboratory tests for gynaecological problems and in case internal examination required for a reproductive health problem, the clients were referred to Chengalpattu.

The Primary Health Centre, Tirupporur

Tirupporur PHC is located in Tirupporur block of Chengalpattu sub-district of Kanchipuram district. Situated about 25 kilometres from Chengalpattu town and about 40 kilometres from Chennai city, Tirupporur is well connected by bus from both these places. The areas around Thirupporur have some private practitioners and pharmacies. Tirpporur could also be termed as a semi rural belt. A number of pharmaceutical companies and export organizations are located in and around Tirupporur.

The PHC is less than ½ a kilometre from the main bus stand. Bus services are more frequent one bus every 30-40 minutes. The bus services connected the PHC to the Chengalpattu town and to Tambaram, a suburb of Chennai city, and the bus service also

covered most of the area coming under this PHC, except some villages, where buses could be accessed at specific times only.

The PHC serves a field population of 42,372. The average number of out patients in the PHC every month is 3,500. There were seven health subcentres [HSCs] under this PHC at Payanur, Kannampettai, Illalur, Pattipulam, Thandalam, Thaiyur, Nemelli villages.

Tirupporur PHC is better equipped than Nerumbur and on a subjective analysis, the health delivery system seemed to be better organized than what was noticed at Nerumbur PHC. The PHC building was old but had a lot of shade around the PHC. As a result there was a lot of waiting space for patients. There was a common toilet, which could be used by both staff and visitors. At the time of this study a new building was being constructed next to the present one. By the end of this project the PHC had started functioning from the new building, with improved infrastructure like running water, electricity, toilets, labour room with separate and attached toilets.

However, Tirupporur PHC also seemed to have the same setbacks that Neurmbur had. Referrals were made to Chengalpattu Medical Hospital, situated at Chengalpattu town.

The PHC also delivered basic and primary health needs to the clients and the patients. Tirupporur was equipped with a laboratory service, which started operations in 2000. A laboratory technician was assigned to the center to carry out antenatal tests. However neither was the necessary equipment available nor was she trained to conduct the tests. The lab was also short of necessary equipment and chemicals required for testing services. Deliveries ("only about one or two a month") were conducted in the PHC. The Auxiliary Nurse and Midwife [ANM] did not conduct deliveries after 5 p.m. The PHC was highly short charged on infrastructure facilities like beds and toilets. The labour room did not have an attached toilet, as the common toilet used by staff and visitors alike was the only one available. The PHC did not have running water and water was obtained from a well in the compound.

Drugs supplied to the PHC (according to the staff) were not in proportion to the visitors to the center and the range of drugs supplied was also very limited. Here again "a top down approach" of drug and medicine distribution was followed.

Six out of the 7 village health nurses in this PHC, stayed in their sub centers of the village from where they commuted. One VHN mentioned that there was no sub center in her village. The VHNs felt that the sub centres were not located in the center of the villages and as result the villagers found it difficult to access the sub centre. The nurses stated that the subcentres were in a state of disrepair and needed to be maintained properly and regularly.

Patients were usually referred to Kelambakkam PHC [about 6-8 kilometres from the PHC] in Tirupporur block, to the Chengalpattu Medical Hospital, and in a few cases to hospitals in Chennai. At the time of the study referrals were made for Medical Termination of Pregnancy, x-rays, scans, blood banks, laboratory tests except for

Malarial parasites. Family planning services included condoms, oral pills and IUD but no kits were available at the PHC.

The village health nurses maintained the official record in both the centers. The health inspectors and other staff assisted in the monitoring of the services and reporting to the command chain on the workings of the PHCs.

Personnel manning the PHC		
Staff – designation & present roles	**Nerumbur PHC**	**Tirupporur PHC**
on deputation Medical officer- general practitioner [GP]; ophthalmologist [OD]	2 [male]= 1GP + 1 OD	1 GP [female]
Pharmacist	1	1
Male Nursing Assistant [MNA]: cleaning & dressing wounds	1	1
Female Nursing Assistant [FNA]: assists in conducting deliveries	-	1
Auxiliary Nurse & Midwife [ANM]: gives injections and attends deliveries in the PHC	1	1
Health supervisor: supervision of health inspectors, health campaigns	1	-
Health inspector [HI]: in charge of health campaigns, statistics	1 [2 vacancies]	4
Cook cum water man/woman [CCW]: gives outpatient chits, gets water, general assistance	1	1
Sector/ Supervisory Health Nurse [SHN]: supervision of village health nurses [VHN]	1	1
Village health nurse [VHN]: mother and child health [MCH] and family planning [FP] programmes	6	7
Sweeper: cleaning	1	1
Total staff*	**15**	**19**

**The details of staffing pattern given above is data at the time of preliminary interviews. Details regarding various roles of the staff were self reported or reported by other staff.*

On the upgradation of the Nerumbur, the staff strength increased to 25. (Induction 10 new staff members [VHNs 6, Supervisory Health Nurse 1, Health Inspectors 3].

Research studies undertaken at the two PHCs

A preliminary observation study by the RUWSEC revealed key elements in the functioning of the health centres. However there were certain areas of information that were still required to assist the health in the NGO collaboration exercise that was the core focus of the whole programme. The data that was collected was of an informal nature and a more formal structuring of data collection was required to help initialising the interface between the NGOs and the PHCs. For example it was necessary to understand the needs of the patients who came to the PHCs, their expectations of the PHC, and their opinion about the services that were offered at the PHCs. Moreover, RUWSEC also wanted to understand the opinion of the administrative staff of the delivery services, their aspiration levels, the current infrastructure of the PHCs in terms of stocking of drugs, RH services, medical equipment available at the PHC, their outreach programme etc.

One important component of the programme was to understand the RH services delivered at the PHC. With a large number of women preferring institutional deliveries, the need to improve delivery services is extremely important. In case of an emergency other factors like bad roads, infrequent bus services or total lack of bus service or any other means of transport can cause delay in accessing obstetric care and consequently cause danger to the mother and child.

Towards this end, RUWSEC carried out two research studies at the PHCs.

- The user perception
- The Staff perception study

A pilot study was undertaken for the user perception study with a sample of 10 patients at Nerumbur before the actual study. The questionnaire was formulated in English by the coordinator of the programme and a consultant and then circulated amongst RUWSEC staff members for feedback before doing the pilot. The questionnaire was fine-tuned and the language simplified for the patients to understand the questions that were being directed at them. This was subsequently administered to the clients who visited the PHC. As a result of this pilot, some changes were made regarding the terms used during the interview. Some of the terms were highly technical and therefore had to be simplified. The interview was to be conducted in two parts; before and after meeting the medical officer. During the pilot The RUWSEC team realised that this was not possible every time, as they did not wait after meeting the medical officer.

The user perception study

Objectives

The objectives of the user perception study were specified as follows:

- Demographic details of the client/patient
- Reasons for visiting the center
- Opinion regarding timing, location and choice of the PHC
- Type of treatment delivered at the PHC
- Post delivery treatment, drugs/referrals etc
- Cost of the treatment
- Satisfaction levels of the health delivery system
- RH services

Methodology

The study was conducted among the patients who came to the two PHCs. A detailed structured questionnaire was administered to the target group that visited the PHC. If the patient was a child, the adult accompanying the child was interviewed.

A non-judgmental sampling was used since the scope and sample of the study was not very large.

The interviews with the patients were conducted in the months of February, March and April of 1999. The interviews with clients were carried out on 4 days each, in the 2 centres in1-½ months. About 7 women and 3 men were interviewed on a day. The criteria for selection as far as possible was also that the client had sufficient time to interact with the interviewer before he or she went to meet the medical officer.

Proposed sample size

PHC	**Male**	**Female**	**Total**
Nerumbur	20	30	50
Tiupporur	20	30	50
Total	40	60	100

Actual sample size

PHC	**Male**	**Female**	**Total**
Nerumbur	11	26	37
Tirupporur	13	25	38
Total	24	51	75

Questionnaire[Annexure 1]

The questionnaire consisted of open-ended questions only. Demographic details such as name, age, village, education, occupation, marital status family etc were included.

The questionnaire was structured in such a way that it was administered in two parts. While one section of the questionnaire in terms of general information such as reason for visiting PHC, convenient timings, place and location were administered before the patient visited the doctor, questions such as information sought on the satisfaction of the health care delivery, type of treatment effected, the kind of drugs prescribed, and the sharing of health information by the doctor were asked after the patient visited the doctor. Moreover questions on RH services were also asked after the patient visited the doctor.

In most cases it was possible to follow this method but some of the patients were in a hurry to leave as buses are infrequent and ply at specific times only. Therefore, though 90 persons were interviewed only about 75 interviews were included for the purpose of this report, as they were not complete.

In a few cases, interviews were completed while they waited for their turn. The reasons for this were that the queues were sometimes long, the medical officer was late and the patients were anxious to leave as soon as possible. In such situations, the entire interview was done before the patient met the medical officer and therefore some of the questions were not answerable.

Analysis and interpretation

Appropriate statistical tools were employed for the analysis of the questionnaires.

The findings of the research was as follows:

Findings

Profile of the patients

About 25% of all respondents who were interviewed were in the age group of 20 to 30 years, followed by 20% between 30 to 40 years and 16% were 40 to 50 years. Three fourths of the respondents were women. More than half of the sample size of (58%) 75 persons was illiterate and only 1% had completed higher secondary [12^{th} class]. A little more than half were agricultural labourers, 22.67% were unemployed, and 14.67% were engaged in home-based work.

Timings of the PHCs

Most of the respondents felt that the timing of the both the PHCs (which worked from 9 am to 5 pm) was convenient. Two third of the total respondents said that the timings of the PHC were convenient.

Reasons for choosing the PHC

Proximity to the PHC, seems to be the overreaching response for choosing the PHC as the central point for health treatment.42.11% of the visitors to Tirupporur PHC and 59.46% to Nerumbur PHC responded that *proximity* was their reason for choosing this facility.

The next level of response was that the PHCs delivered inexpensive health care. About thirty seven percent of the total sample, with 44.74% of the visitors to Tirupporur PHC and 29.73% to Nerumbur said that they had come to the facility because they *did not have the money* to go elsewhere.

Only 4% of all visitors said that the reason for choosing the PHC was good treatment and 8% said they had come to the particular PHC for other reasons (regularly visit this center, lucky PHC, faith that will be cured, mother in law's advice)

Mode of travel and accessibility

Mode of travel	**% Total**	**Tirupporur % total**	**Nerumbur % total**
By walk	64	75%	50%
By bus	29.3	15%	43%
Cycle/bullock cart	6.7	10%	7%

" I have a stomach ache. I walked from Pandur. It is very difficult. We don't go to other centres because money is a constraint."

Almost two thirds of the patients who visited the PHC had come walking to the center. While 43% of people who visited the Nerumbur center came by bus, only 15 percent who visited Tirupporur used the public transport system. This was despite the fact that they were suffering some from of ailment or the other. Of these, half of them were women, 36% from Tirupporur and 58% from Nerumbur. It is interesting to note that both the PHCs show different variations in terms of travel and accessibility. Nerumbur, as has been earlier mentioned is located in the rural hinterland of Tamil Nadu. Moreover private health care is non-existent in Nerumbur as opposed to Tirupporur, which has a sprinkling of private practitioners. Infrastructural services in terms of bus/private carriers or an ambulance are sadly lacking in the interiors of rural Chengalpattu.

Reasons for visiting the PHC

Reasons	**% Total**

Fever	15%
Body pain	13%
Leg injuries	13%
Headaches	11%
Cough & Cold	7%
Antenatal check up	3%
White discharge	3%
Others (backache, toothache, diarrhoea, asthma, ear pain, tumor etc	35%

It is interesting to note that patients displayed a variety of ailments when they visited the PHCs. This ranged from fever and body pain to asthma and diarrheoa. It is also interesting to note RH related problems comprised only 6 % of the patients who came for an alleviation of their ailments. All the women who came for an antenatal check up visited only the Tirupporur PHC.

Waiting period in the PHC

Waiting time	**% total**
No waiting time	35%
Less than 5 minutes	24%
15-30 minutes	16%
More than 30 minutes	25%

Doctors are generally quite efficient in offering health services to the clients. A third of the patients mentioned that they did not have to wait at all for their turn to "see" the doctor. One limitation of the study was that it did not take into account the movement of traffic and the queuing system at the doctor's room. However, by and large, if the doctor were not at the PHC, the staff would ask the patients to come in at the time when he was available. Otherwise the above table suggests that there was a minimum waiting period for the patients who came for treatment.

Type of treatment

	% Total	Tirupporur %	Nerumbur%
Tablets	48%	40%	57%
Injections	10%	13	6
Tablets and injections	26%	32	19
Anti natal tests	4%	5%	NIL
White discharge	3%		7%

Others (bandaged, iv fluids, tablets, injections etc)	9%	10%	18%

" I have diarrhoea…. I kept sitting for an hour and my legs went numb. Doctor did not say anything. Wish to go to another hospital but cannot afford it."

" I thought I will receive injection but did not."

Only 4% of the respondents had come to the PHC for RH services care. The type of treatment delivered to the patients was the most basic type of service in terms of tablets and injections. Problems indicated did not specify any women related health problem nor was the treatment given for women related diseases.

Most of the patients, clients who came to both the PHC, complained only of indicative symptoms of their sickness or ill health. They were not in a position to even identify simple ailments like a common cold. Moreover they were not aware of basic health information and needs such as vitamin enriched/energy foods. Hospital to them meant injections/intravenous glucose and or tablets. Once this was given, they were satisfied with the health delivered. A medical officer who prescribed ample tablets, injections, was considered a 'good' doctor. This was also reported by a medical officer while discussing shortage of drug supplies to the PHC. This irrational or over prescription seemed to be the standard practice in the PHCs whenever drugs/ injections were available. It was fairly regular practice for a doctor to prescribe a 'placebo' injection.

In a similar vein one of the interesting incidents that was recorded at the Tirupporur PHC underlines the kind of treatment that a patient expects. A doctor on deputation was given the reputation of being 'tight-fisted' as he proscribed medicines and injections to the optimum. Patients were dissatisfied with the treatment that he was extending to his clients.

In terms of RH services, most services were restricted to specific days of the week. For example, the antenatal care was done only on Tuesdays and sometimes on Thursdays. During RUWSEC's observation visits, pregnant women were turned away because they had come on the 'wrong' day.

Was the necessary treatment given?

More than three fourths of all visitors (78.67%) felt that they had been provided the necessary treatment.

Treatment: Satisfaction level [Annexure:4]

The patients were asked a simple yes/no response to the query whether they were satisfied with the treatment given to them. (see annexures for tables)

Some of the brief points of the level of satisfaction of the patients

" We cannot ask anyone questions…"

- 68% of all the clients mentioned that they were satisfied with the treatment. The discontent note was 32%, which reflects the level of health care system that the PHCs deliver.

- 50% of the male clients of the total sample were unhappy with the kind of health support that they were receiving form the PHCs.

- Of the women, the discontent level of women from Tirupporur was higher at 33% than at Nerumbur at 19%. This may be attributed to the fact, that health infrastructure at Tirupporur were better (the presence of private practice) or that women were better informed on health matters than the women visiting Nerumbur.

- Discontent levels were further probed to pin point the quantum of discomfort level with the services and the staff at the PHC. The discontent level was higher if the type of ailment/complaint that the patient had was of a higher order. For example, 75% of the visitors with cold and cough were happy with the medicines prescribed by the doctor. However only 33% of patients with orthopedic complaints, mainly lower backache said that they were satisfied with the treatment received for their complaints. 50% of those with body pain, and 60% of the visitors with injuries to the leg, mentioned that they were satisfied with the suggestions and treatment given by the doctors.

- Four women who had come for antenatal tests* to Tirupporur PHC mentioned that they were extremely satisfied with the type of treatment that they had received at the PHC. However two women, who had gone

- Two women visitors to Nerumbur PHC with complaints of white discharge were not satisfied with the treatment of their complaint.

- Interaction between the doctors and the patient were gauged in a simple question of whether the doubts of the patients were cleared or not. 48% of the sample size mentioned that the doctor clarified their doubts. This means that more than half the sample was not satisfied with the doctor's response. Sharing of medical and health information is restricted to the minimum by the doctors in charge of the PHCs.

Reproductive health and the PHCs

This segment was the most important component of the questionnaire, since RUWSEc's aims and objectives have to be extending the concept of quality health care to the

communities. The section probed areas such as the role of the physician in the RH services, antenatal care delivered, family planning services extended at the centers and the inference of how suitable it would be to start delivery services in the centers.

The responses were interesting and revealing of the role of the PHCs in the RH services:

" I have not got periods for eight months. I want to go to CMC [Chengalpattu Medical college and hospital] but cannot afford it right now. The doctor has referred me to CMC. No treatment here. He did not examine me or counsel me."

- Two thirds of the respondents \were not aware that deliveries could were conducted at the PHCs. Only a third of the respondents mentioned that they had heard that deliveries were conducted at the PHCs. The wide gap in awareness of such a service reveals that a vast majority of the people accessing the PHC does not know that such a service could be accessed at the PHCs.

- Questions were also asked on where deliveries were taking place in their families. Government institutional deliveries constituted 57% of the sample responses, while deliveries at home was 15%. 28% did not answer the question. Most of the institutional deliveries were conducted at the Chengalpattu Medical College (34.67%) and Kelambakkam PHC (16%). 5.33% of the respondents explained that deliveries had taken place in Tirupporur. None of the respondents mentioned Nerumbur as a center where they had taken their relatives for delivery services. Seventy two per cent of the respondents were seeking reproductive health services that were effective and cheap. That is why they had gone to the Government hospitals or had undertaken to have the deliveries at home. This reflects the immediate and urgent need to strengthen the breadth and spread of quality health care and RH services in rural Chengalpattu. The study unfolded that the NGO public sector collaboration needs to be continued on a sustained basis for a positive impact on rural communities.

- An overwhelming 97.33% of the respondents enthusiastically echoed the prospect that having a fully equipped maternity ward would definitely benefit the communities. The study brought into focus that the needs of the people did not match the services delivered at the PHCs. Maternity wards, that are part and parcel of any hospital which cares for women's well being is non existent in these PHCs. The collaboration helped bridging the gap the dynamics of the health care system in the two centers.

- About 80 per cent of all the respondents said that they were not aware of the family planning services provided at these two PHCs. This indicator helped RUWSEC in firming up its plans for positive intervention in health care needs.

Facilities required to improve the PHC

Facilities required	**Nerumbur**	**Tiruppur-**	**Total Number of responses**
Increase number of staff: doctors, nurses, supervisors	21	11	32
Ambulance	9	9	18
All facilities so that one does not have to go elsewhere	6	8	14
Counselling	5	8	13
Maternity ward	4	9	13
Phone	5	6	11
Laboratory services	4	6	10
Operations	5	5	10
Family planning services	4	5	9
Abortion services	4	5	9
Visitors should be treated with patience, politeness	1	3	4
24 hours facilities	1	1	2
Total responses	69	76	145*

- *(Multiple responses. Most respondents mentioned more than one facility required to improve services.)*

Almost all the respondents of the sample were equivocal in their assertion that the PHC must be improved for better health deliveries. Respondents felt that the staff of the PHCs must be strengthened and numbers increased across all cadres. Other services included ambulance, counseling, maternity wards, family planning services etc.

Some of the suggestions by the patients and the families that visited the hospital:

" All facilities should be available here so that we do not have to go elsewhere"

" Staff should be polite and talk with respect to the patients"

" Staff should be available at all times and attend to the patients with patience and care."

" Facilities for examination and treatment of women's diseases."

"Inpatient (bed) facility should be available."

" There should be a private/separate examination room."

" The doctor should speak properly."

" The medical officer must visit the villages."

" The PHC should be open during the scheduled hours."

" There should be toilets, medicines for various problems, lady doctor, blood tests"

"Treatment for women specific problems."

Staff perceptions study

RUWSEC simultaneously carried out a staff perception survey to gauge the kind of the services that the staff provided to the clients who visited the hospital. The survey also tried to understand the needs of the staff in extending quality health care to the communities.

Objectives

The information areas covered under the survey were as follows:

- Areas covered by the PHC
- Staff strength
- Infrastructural facilities available
- General health care facilities extended
- Reproductive health services
- Village visits
- Maintenance of records
- Referrals

Methodology

The study was conducted with the staff members of the PHCs in the months of February, March and April of 1999, beginning in the middle of February and ending early April.

The staff was administered the questionnaire as per their availability at the health center during this period.

All the 34 staff members of the PHC were interviewed, 15 at Nerumbur PHC and 19 at Tirupporur PHC.

The same questionnaire was also used as a checklist during the observational visits made by the interviewers.

Questionnaire [Annexure 2]

The questionnaire was of the open-ended variety and in-depth in nature. Some freewheeling questions were also raised during the interview.

Findings of the survey

Nerumbur PHC

The morale of the staff was moderate. They were neither very cynical about their jobs nor overtly enthusiastic about it. But once RUWSEC started initiating the project there was a visible change in the attitude of the staff. The staff underlined that if some of the infrastructure was strengthened, it would go a long way in delivering health care needs to the people.

- Shortage of essential drugs and other essential supplies like bandages was cited as a major obstacle to providing services. Even if the nurses gave prescriptions to collect medicines from other hospitals, shortages were reported in those areas too. Insufficient budget allocation by the State Government was reported as the prime barrier for such a huge problem.

- Starting of laboratory services was of prime importance as there was a high incidence of leucorrhoea in the area. Patients had to be referred for all tests to the Chengalpattu Medical Hospital. Labour room was not functional because of lack of water facility and electricity.

- The Village Health Nurses and other field staff said that they needed more medicines in the villages. They also said that the medical officer should visit patients in the villages whenever necessary.

- The staff also felt that the center should be equipped with physical infrastructure like a van or an ambulance. Phone connectivity should also be available in the Village Sub Centers.

- Some of the PHC staff including the medical officer strongly felt that the village health nurses should stay in the village subcentres for the center to function effectively.

- Doctors with Diploma in Gynecology and Obstetrics [DGO], child specialists etc. should be recruited and made to visit the PHCs, if not everyday, at least on specific days.

- The Medical officer said that he received no help from the Panchayat to improve the center. The PHC was also forced to pay the land taxes to the panchayat for maintenance and upkeep, which was not provided for by the panchyat union.

Tirupporur PHC

Though Tirupporur PHC was larger than Nerumbur, most of the problems and lack of infrastructure that was mentioned by the staff in Nerumbur was also echoed at Tirupporur.

- A new building was being constructed at the Tirupporur and the medical officer opined that it would have better facilities like toilets, running water. The status of the old building at Tirupporur was that the labour room had no bed and there was a shortage of delivery kits in the centre.

- Shortage of drugs was felt to be a major obstacle. The range of drugs was also very limited. Medical equipment for Deliveries was also not available at the center.

- The staff felt that DGOs should be appointed for the PHC.

- The medical officer also felt that the Auxiliary Nurse and Midwife should be trained and her skills in conducting deliveries improved so that deliveries could be conducted in the center.

- The staff and the doctor felt that lab tests were carried out only for malaria but it was important to have tests for pregnant women. The medical officer indicated that counseling services would be very useful in improving services due to the large inflow of outpatients.

- The staff also recommended a van for emergencies and maintenance of the proper sub Centre at the respective locations. The staff also felt that they should have an ayah to assist them in the field.

- The staff felt that the doctor should visit the patient when necessary and understand and empathise with the staff.

The responses of the staff mainly highlighted improving infrastructural changes and other policy changes to improve quality of care. They did not talk about any attitudinal changes, except about the minor frictions between the doctor and the nurses.

The Programme – Implementation and Intervention

The above researches threw light on the primacy of making health care services more effective and responsible to the communities. From the consumer research study it was revealed that the patients had needs that did not converge with the services offered. While most of the needs were of a nature which could not be provided by the NGO and required government intervention, some of the services like counselling, lab testing services could be offered by the NGO to help the public sector PHC in fine tuning its services to the needs for the people who visited the hospital.

Some of the other important suggestions that came from the staff of the PHCs were the inaction of the Panchayat Unions, which did not in any way help the PHCs help in its maintenance. Of course the staff from both the PHCs maintained that there was a constant shortage of medical accessory products, such as drugs, beds etc.

Subsequently RUWSEC initiated two services at the two PHCs, which arose out of the research studies. It is important to note, that during the course of the programme the administration brought about certain changes in the two centres, which were quite independent of this programme. At Nerumbur PHC subsequent to the baseline study, the PHC was upgraded to cover a larger population from 18,372 to 53,438 with increase in the number of staff from 15 to 25. At Tirupporur after the baseline study the PHC shifted to the new building within the same compound but with better infrastructure like toilets, running water, electricity. In both the centres it was difficult to ascertain if there was any increase in the number of clients to the PHC because of the services like laboratory and counselling services being carried out.

RUWSEC zeroed in on starting lab testing and counseling services as the two services that could be commenced at the two PHCs. Discussions were held with the medical officers and with other staff members of the PHCs and based on their recommendations and needs assessment of the clients, the two activities were started and carried on for almost 21 months.

PHC –NGO Interface

- **Counselling Services [Annexure 3]**

Counselling services was activated in June 1999 and was provided by RUWSEC's health workers twice a week in each health centre. Initially only women counsellors were present at the centres. Therefore, many of the male visitors were hesitant to approach the

counsellor. In November 1999, 2 male members working in the 'Programme for Sensitising men on issues of Gender and reproductive health' were placed as counsellors in the health centres.

The counselors were RUWSEC health workers and male volunteers who belonged to the local villages. They had several years of experience in the field as health workers and were well versed with the needs and concerns of the people. Since they were residents of the communities, their participation increased the accessibility of the clients/visitors visiting the PHC.

The counselors received trainings regularly throughout the project period in order to improve their counseling, documentation skills and also to provide a place for them to share their experiences with each other and provide mutual support.

Components of counseling

RUWSEC started the counseling services on a wide range of issues. The counseling was related to the patient's needs as also to those aspects that were not verbalized. Thus for example, though majority of the patients came to the center with problems like diarrhea, cold, cough, fever, white discharge amongst others, counseling was provided for an amelioration of the sickness that they were suffering from. However, advice was also provided on RH matters such as antenatal and post natal care, contraception, vaginal discharge, substance abuse, immunisation, Sexually Transmitted Diseases, common ailments like fever, cold, cough, headaches, asthma and others.

Women who had come to the centres with injuries because of domestic violence were referred to the group working on the issue of violence. Women who wanted their husbands to be counseled were given the option of the male counselor.

Information was shared and imparted on the curative power of home remedies prepared from locally available herbs/ medicinal plants for simple ailments that the people could prepare themselves. This was done with the intention of enabling the local members of the community to be able to identify and understand the medicinal value of plants growing all around them and enabling them to relearn and recall herbal remedies for problems like cold, cough, fever, white discharge and other gynecological problems, which was quite prevalent previously but not very popular.

The counselors were highly motivated and personally intervened whenever the situation demanded such assistance. For example, the counselor arranged for transport through the local village in emergency situations for taking the patient to the government hospital at Chengalpattu.

The counsellors initiated small group meetings about menstruation, vaginal discharge, and contraception at the PHCs for adolescent girls when they came in groups to the centre. RUWSEC's illustrated publications about 'Our Bodies', menstruation, pregnancy and care and other pamphlets were very popular, especially amongst the adolescent boys and girls who visited the centres. These were disseminated as widely as possible and also placed in the local library and in the health center for reference.

Preparation of updating of Communication materials was an ongoing process. RUWSEC's illustrated publications were also used for counseling.

Number of clients

From June 1999 –March 2001, the period of the programme, around 8100 visitors underwent the counseling services of RUWSEC, of which around 5200 were women including adolescents and around 2900 men including adolescents. These services covered on an average about 370 persons each month.

o Laboratory services

The initial observation study by RUWSEC had revealed that laboratory services were not available at the centers except for Malaria. The staff as well as the clients had cited this as a service that could help in proper scientific identification of ailments instead of depending on mere physical analysis. The services began in July 1999. Lab tests were conducted one day a month at each of the two PHCs of Nerumbur and Tiruporur. When the lab tests became operative in the two centers, the nurses in the centers were not equipped to handle even simple ones like a smear test for infections. The lab tests enthused the staff to learn from the RUWSEC who helped them upgrade their skills.

It is interesting to note that RUWSEC initiated unique ways of announcing the dates of the lab tests at the two centers. In addition to the PHC staff and medical officer announcing the dates to individuals visiting the center or their visit to the villages, RUWSEC experimented with innovative ways of announcing these services to the women in the villages. Notices announcing the lab test dates for each PHC for the whole year were put up in these two health centers as well as at bus stops, at shops in central market areas. Printed notices were also distributed in the villages through RUWSEC's health workers and through the clinic.

The local women leaders in Panchayat who came for the workshop every month were given the dates of these tests and reminded to pass it on the message in their villages.

RUWSEC also experimented with the services of the local village announcer, who went around the villages with a small drum or 'tumku', making announcements.

Despite these efforts the numbers of persons accessing services in some months was as low as 6 or 8 persons. Though reasons for the low turnout was not studied, it could be inferred that the lack of escorts that women, especially pregnant women, prefer while visiting a health center may have been the primary for such a situation.

RUWSEC will however continue to try and ascertain the reasons for the poor attendance and also reasons why the majority of the women accessed laboratory services in the later months of their pregnancy (in the $6^{th,}$ 7th, 8^{th} and 9^{th} months).

Number of clients

During the period from July 1999-March 2001, more than 620 persons accessed lab services in the two PHCs. Twenty-eight persons on an average came for these tests every month, a majority for the antenatal tests.

Tests that were conducted

The laboratory tests that were carried out were for urine albumin, sugar, gravindex (for confirmation of pregnancy), blood grouping, hemoglobin, trichomonas vaginalis (TV), gonococcal infection and candidiasis.

Personnel and process

RUWSEC's laboratory technician conducted these tests. The results/ readings were handed over immediately and in some cases through the VHN or RUWSEC's health workers.

A counselor from RUWSEC was present during these tests. The women who came for these antenatal tests were counselled before the tests and after they received their results. Information about the tests, the importance of the tests, of what the results mean, and clarifying the doubts of the clients and information regarding follow up wherever necessary were systematically provided to the patients.

Every three months, skits and exhibitions were held at the PHCs on the day of the lab tests about pregnancy care, immunisation, spacing, and contraception, and violence. The tests were organized by the staff members of RUWSEC' working with community based reproductive health programme for women.

Training of PHC personnel

At Tirupporur, the medical officer at the center requested that the lab technician of the PHC be trained to conduct these and other tests. The PHC lab technician therefore worked along with RUWSEC's lab technician, who provided him some training through the experience that she had gained in her capacity as a health worker. It was also suggested that hospital technician could be trained at the laboratory in RUWSEC's clinic and hospital on specific days. However this was not possible as the PHC technician's schedule was very rigid and therefore could not take off the extra time for training.

- **Evaluation**

Evaluation of the two projects was undertaken during May/June 2000. Exit interviews were carried out at Nerumbur and Tirupporur PHCs to document the feedback of the users of services such as counselling and laboratory services. One hundred and thirty persons were interviewed about the counselling services, of which 60 were interviewed in

Tirupporur and 70 in Nerumbur. Llab testing services, feed back was received from 58 respondents of which 31 were from Tiruporur and 27 were from Nerumbur.

Highlights of the evaluation process:

- In Nerumbur a total of 70 persons were interviewed for the evaluation programme. Of them about 20 clients who had been regularly visiting the PHCs with complaints of cold and fever were interviewed. The patients mentioned that the counsellor had given them information about simple home remedies/Siddha treatment. The patients had tried this treatment and found it very effective and were extremely pleased. Seventy-five percent said they had never received such a counselling before. Twenty-five percent said that it was extremely useful to have counselling in the centre but also added, with reference to the information on alternative healing systems, that it was inconvenient to go looking for leaves and plants to prepare the medicines. They found it easier to be treated by the doctor's tablets.
- At Tirupporur all the 70 persons interviewed said they had found the counselling very useful.

" It was an opportunity not available in other centres"

" It was also an opportunity to open up and express my problems freely"

"I found the counselling about home remedies/siddha very useful. I tried it at home and it was very effective"

" The counselling about other healing systems is a nice way of recalling healing systems that were popular during grandmother's time but are almost forgotten"

" The doctor does not give us a clear and detailed explanation but the counsellor does"

One woman who was suffering from excessive vaginal discharge (white discharge) had made a couple of visits only to return disappointed without any treatment. This time the counsellor explained the treatment to her based on Siddha, which she could easily try out. " This kind of counselling is not available in any health centre. It would be good to have it in all hospitals".

" It would be good if the counsellor was available on all days of the week and if a separate room was available and there was more privacy". *

" We get complete information about the causes, prevention, treatment of our health problems".

" I feel shy to tell the doctor but we are able to speak openly with the counsellor".

" There are a lot of restrictions on a lot of food during pregnancy but I learnt that I could actually eat those things".
"These tests are available only in specific government health centres or one has to spend a lot of money in a private hospital". " Here it is free and the counselling given during the tests is also useful for us".

* At the time of this evaluation, the counselling was given in the lobby. No room was available for counseling at either of the centres. Thereafter the counsellor and the PHC staff managed to set aside a small room for counselling in Tirupporur. In Nerumbur there was a shortage of space, therefore RUWSEC partitioned a room thorough a cloth curtain and demarcated the space for counselling thereby ensuring privacy to the patients too.

Material inputs

Apart from counseling and laboratory services, another felt need in these two centers was infrastructure - from water to drugs to beds.

Some of medical accessories were provided by RUWSEC, others were facilitated through individual donations. Throughout the process RUWSEC tried to involve the local youth, women leaders and other members of the community to monitor, and advocate the quality of services and take initiative to improve these services, especially through the panchayats.

Some drugs, a cot, bed, rubber sheets, cradle, delivery kits, screens for counselling were donated to the centres. These were based on needs that were shared with RUWSEC during visits to the PHC by the counsellors or coordinator of the programme. RUWSEC's staff also facilitated the donation of a cot to Nerumbur PHC from a private donor. In addition RUWSEC also gave some monetary support for repair of the water pipes so that the toilet at the Nerumbur PHC could be made functional. Consequently this has been well maintained by the staff and is being used by the clients and staff.

RUWSEC has tried to keep material inputs at the very minimum, contributing for the purchase of some very basic infrastructure. However the medical officers and the staff of the centres appreciated RUWSEC's efforts and cooperated with the RUWSEC team in improving quality of care in the centers.

PHC Staff- NGO Collaboration – personnel issues

One of the key elements in the NGO public sector collaboration was to involve the local administrative and political representatives in the health process. RUWSEC had already implemented a Panchayat training programme for the women ward members. In a cross dialogue process, the health workers suggested that a meeting be held between the health workers and the staff at the PHC to work out a holistic health programme for the communities. These meetings also provided the opportunity for the women leaders in Panchayat Raj Institutions to interact with the health workers, an opportunity to discuss problems and challenges faced by them in their villages/areas and resolve them in a mutually beneficial manner.

Meetings with the health centre staff - the village health nurses [VHNs], the health inspectors [HI], and the sector health nurse [SHN] - were scheduled every third month as per the convenience of the health workers and with the permission of the district level health authorities.

A preliminary meeting was held in January 1999 for the PHC staff, to introduce this programme to them, assess areas of intervention in their PHCs for improvement of quality of care and to dialogue with the staff regarding the possibilities and areas of collaboration in the future. A total number of 19 staff members from Nerumbur and Tirupporur PHC participated in this meeting. It was decided at this meeting that trainings/meetings/workshops for the PHC staff would be held once in every three months at RUWSEC's training center for feedback regarding the project, upgradation of skills and for discussions with local leaders and community groups to facilitate local participation.

In April 1999, during the first meeting, the PHC staff and women leaders in the panchayat [who were attending workshops 'to monitor the health centers and be advocates for reproductive health' at RUWSEC] participated in this workshop.

The main objective of this meeting was to identify ways to work together in a partnership to improve the quality of care and advocate for reproductive health in their villages and areas. Towards this objective this meeting included presentation of role-plays by the PHC staff and the women leaders in Panchayat.

This was followed by a group discussion to clarify and resolve some of the issues brought forth through the role-plays. The staff and the women leaders as representatives of the community got an opportunity to address problems that they faced and were also provided with ways to resolve them. The meeting also provided an opportunity for the two groups to look at each other's perspective and understand each other better. Until then, they had not been given a platform where they could discuss various issues and try to resolve them mutually and this workshop's goal was to create such a platform to improve their relationship and work towards common goals.

The second and third meetings, scheduled in July and October did not take place because of the health camps that were organized by the government at a very short notice.

A training programme took place in December 1999 on 'Sexually Transmitted Diseases' for the PHC staff as suggested by them during the initial meetings.

Training sessions were to be held four times in a year but only one to one training on 'Siddha' took place during this year. Permission applied for in April/May was finally received only in September.

Training in women-centred midwifery was planned in the month of October and November but the resource person was not available at the time.

Limitations

- Though the staff had repeatedly asked for training, time was always a constraint.

- The PHC staff, especially the VHNs had extremely tight work schedules.

- During the project period the state had introduced several new health programmes through the PHCs, including large camps to be held in the community for health check-ups. The government has several programmes like 'Varummun Kaapu', polio immunisation, which, in addition to their routine work made it very difficult to get dates for training.

- The male health workers said that they were able to visit their field areas only once a fortnight because of various new programmes that had been introduced at the PHC, which required their presence.

- Bureaucratic delays in extending permission also made schedules go awry.

- Lack of interest on the part of higher authorities was another reason for delays.

Community Involvement and Participation

RUWSEC worked closely with local youth throughout the project period to mobilise their services in the health centers, so as to monitor and improve the facilities. On a minimum motivation level the youth were very enthusiastic in their participation. Though RUWSEC had not planned any systematic training programme for them, it plans to revise its future interventions so as to facilitate better participation of the youth and other community groups.

Several attempts were made to work with the local youth groups and local women's sanghams. At Nerumbur, the youth group was willing to contribute time and effort to improve the services in the health centre. The youth group mentioned that they were not aware of the voluntary services that were required at the centre. They were willing to take responsibility to repair the pipes in the centre and restore water supply. They also felt that they could get the panchayat involved and get it to contribute towards repairs and maintenance. However this led to skirmishes due to the political nexus between the medical officer, the panchayat president and the youth. The Medical Officer opposed the involvement of locals and was adamant that if the organisation wanted to carry on with oits work, it would have to do so on its own.

In June 2000 a meeting between the doctor, youth and panchayat ward members was held in the centre and the conflict was resolved o mutually agreed terms. 10 taps were repaired by the youth with financial support from RUWSEC. The women leaders in panchayat in this area also started working closely with the nurses (VHNs) in the villages after this meeting.

The youth group also beautified the PHC by clearing out the unwanted weeds surrounding the PHCs. The medical officer also invited the counselor, who belongs to the local community, to attend the review meetings with the VHNs and attend other health training that is provided for the staff of the centre.

A major activity that was initiated to acilitatef local participation was the training of women leaders in Panchayat to monitor Quality Of Services in Local Health Centres and to be advocates for Women's Reproductive Rights and Health.

(A detailed documentation of this project appears in a separate RUWSEC document**)**

District Administration-NGO collaboration

RUWSEC initiated two meetings in May and October 1999 with Panchayat presidents and Union and District councilors as an awareness generation exercise of the workings of the PHCs and the conditions under which the PHC was functioning.

The objective of the first meeting in May 1999 was to introduce the project to the panchayat members. This was undertaken because the women ward members, who attended the training programme, complained that most of the other members were suspicious of RUWSEC's activities. This meeting, it was felt, would also provide an opportunity to create a positive environment and discuss possible collaborations in the future. The response was very poor and only two presidents attended this meeting.

The second meeting in October was poorly attended with just 3 out of 30 invitees turning up for the meeting, in spite of invitations sent out by the District Collector and the Block Development Officers, which were handed over to them personally by the staff members of RUWSEC. The group then realized that the time and effort that had been put into organizing such meetings did not achieve the desired results.

The meeting with the district and union councilors ended on a positive note with the district councilor taking the initiative to print pamphlets announcing the dates and time of the laboratory tests in the two health centers. The councilors said that they would take concrete steps to improve water supply, garbage disposal and electricity connections in the PHCs. There was some limited involvement on their part towards improving the infrastructure in the PHCs.

RUWSEC did get an insight into the working of the system and the possible obstacles that we may have to overcome. The meeting also brought into focus the low priority given to health issues and lack of accountability on the part of the local representatives where health matters are concerned. RUWSEC also got to know first hand how the majority of our elected representatives are inaccessible.

Costs of implementing this programme

The cost of implementing this programme from April 1998 till March 2001 was Rupees 6,28,970. Salaries and benefits of the staff was about 53% of the total costs. An intervention wise break up of costs is given in the table below. The costs in the table includes honorarium to counsellors and laboratory technician and field costs for each intervention.

INTERVENTION	*INFRASTRUCTURE*	*PERSONNEL*	*FINANCIAL COSTS In rupees**
COUNSELLING	*Screens, counselling material, publications, transportation*	*2 WOMEN+ 2 MEN =4*	*88,800*
LABORATORY SERVICES	*Lab chemicals, solutions for the tests, lab forms, transportation*	*Lab consultant, 1 assistant cum counselor, 4-5 women for doing skits during lab tests = 6-7*	*32,140*
Meetings with health center staff	*Meeting hall, training materials, food/travel expenses*	*Trainers/facilitators/rapporteur coordinator = 4*	*4340*
Material inputs	*Purchase of drugs, cot, bed, cradle,*		*9210*
Meetings with local leaders	*Meeting hall, food/travel expenses*	*Trainers/facilitators/rapporteur coordinator = 4*	*1550*

Training of women leaders in Panchayat including the literacy component.	*Travel, food, teachers' honorarium, travel, trainings for Women in Panchayat and Teachers, stationary, materials, resource persons.*	*Trainers/facilitators/rapporteur/ coordinator*	*156100*

* R*ounded off to the nearest 50*

Lessons from the programme

Obstacles and challenges

Throughout the programme period, especially in the beginning, in 1998, the bureaucracy moved very slowly. There was an initial delay of about six months and several visits were made to various persons in the Department of health services and allied departments, to seek permission to implement this programme. Relationship between RUWSEC and the bureaucracy improved slowly over this period. It was a learning process for RUWSEC too, which also understood the functioning of the bureaucracy. One of the officials in response to this collaborative effort remarked, "You do whatever you want but do not expect anything from us." Most of the officers did not consider a grassroots women's organization like RUWSEC as a health partner. Though the PHC staffs were very keen on upgrading their skills, the higher authorities were very negative about 'their staff' receiving inputs from an organization that works primarily with Dalit women.

There were several moments during the programme when one felt that too much time and effort was being pumped into an initiative without corresponding results. For example the PHC staff-NGO collaboration did not work to schedule. Some of the goals that were set could not be achieved. But being persistent did work in the long run. And there were some instances that showed that RUWSEC's efforts were having the desired effort among the health officials. In one of the centers the RUWSEC counselor was invited to participate in the PHC review meetings and in other trainings for the staff, by the medical officer.

Politics and political nexus between panchayat presidents, local groups and medical officers also slowed down the process.

Some Lessons

This programme was started in 1998 and RUWSEC feels that the programme should continue and should also be enlarged in its scope of providing health care to the communities. The health seeking behaviour of the population in these areas has changed with larger numbers accessing health services where available. RUWSEC ha managed to make inroads in promoting quality of care in the selected two health centers within a specific period of time. This was possible because of the involvement of local women leaders of the Panchayat Raj Institutions who were trained to monitor quality of services in local health centers and advocate women's reproductive health and rights; the intervention of the local youth groups which already exist in the local areas; interface between health providers and the women leaders which provided a platform to express their concerns and sensitise them to each other's problems, thus creating an environment to work together towards common goals of better quality of care.

RUWSEC firmly believes that this project is an essential component towards improving quality of care through local participation. In the future RUWSEC plans to train women in Panchayat Raj Institutions in the same areas where the selected PHCs are located, so that monitoring and participation would be more effective. This would also facilitate working with subcentres of the PHCs selected, which was not possible in the past because the women leaders in Panchayat belonged to areas different from where the subcentres were located.

RUWSEC has received very positive feedback for 'Siddha' counselling, based on healing and treatment with herbs and use of Yoga, Massage etc. RUWSEC believes that we should explore possibilities of working work with local youth and women's groups and local cooperatives to advocate and encourage preparation and use of indigenous herbal remedies, which are easily available in the area.

RUWSEC sees the NGO-Public Sector Collaboration as an opportunity to improve the quality of services as central to the other field based programmes/activities in the future. For example, the upscaling of RUWSEC's community based reproductive health programme involves entrusting core activities to be carried out by a group of midwives, local women leaders and male volunteers in ensuring access to care. Therefore improving the quality of care in local health facilities becomes a vital tool for better living among communities. The Primary Health Centre also proves to be, as seen in the past two years, a convenient place for dissemination of information and health education for adolescents and other IEC activities.

Another important aspect in such a collaborative process was the interest and involvement of the medical officers at the PHCs. RUWSEC realized that in spite of permission granted by the Department of health, a programme could face a lot of challenges from a medical officer. A medical officer in the PHC is also in charge of it's administration. Therefore he or she is the sole decision maker at the PHC level. RUWSEC realized that the attitude of the medical officer could make a lot of difference

to the running of the project. An interested medical officer could encourage new initiatives to involve the PHC in the health services.

Though this programme was implemented only in two centers, covering about 25-30 health care providers, it must be reiterated that initiatives to sensitise these providers would take on the dimensions of another programme. RUWSEC did try to do this through meetings with the PHC staff, and through interfaces between the staff and the community. Working with medical officers is very important as their attitudes and perspectives affect their staff as well as those accessing services.

RUWSEC also realized that the youth could be moulded to become powerful change agents in the quality of health care delivery systems. Though RUWSC had not planned any systematic training programme for them, it plans to revise future interventions so as to facilitate better participation of the youth and other community groups. It also plans to do this in collaboration with the programme on Life Skills Education for young people, which works with youth groups in the villages, the prevention of violence programme and the community based RH programme, which has youth representatives.

Based on RUWSEC's past experiences and future vision, the group perceives this NGO-public sector collaboration as very important and central to other programmes implemented by RUWSEC.

Some organisations are involved in training trainers of the health centre staff, including medical officers. They also plan to review the curriculum for training. Therefore RUWSEC could also try to become involved in such activities in the future. Although progress with regard to regular meetings with VHNs was very slow, headway made has been extremely encouraging. We have learnt how slowly the bureaucracy moves, and have just learnt the ropes as to how best to work with it. We feel that it would be very important for us to continue with and expand this area of our work.

The Future

In 2001-04 RUWSEC plans to extend activities to four more PHCs in addition to the present two, bringing the total number of PHCs served to six. The criterion for choosing new PHCs would be areas from where women leaders have come for training.

Activities in each PHC will include

- Counselling for women, men and adolescents.
- Counselling and referral for women affected by domestic violence.
- Laboratory services once a month in each PHC.
- Training PHC lab-technicians wherever they are part of PHC staff.
- Carrying on health education and promotion activities through skits, distribution of public education material prepared by RUWSEC, exhibitions and screening and treatment camps for specific health problems such as RTIs, STIs, cervical cancer screening.

Meetings will be conducted once in 6 months between PHC staff, panchayat leaders, midwives trained by RUWSEC, and youth volunteers trained in gender and reproductive health through RUWSEC's men's programme over the past 6-7 years. This will be to discuss the functioning of the local PHC and of prevailing health problems in the community and to come up with feasible solutions. Even the act of coming together and discussing would be an important achievement to aim for.

Trainings for VHNs have already been conducted on a number of topics requested by them. These will continue to be held once in 6 months.

A group of interested persons selected from among the women panchayat leaders, youth volunteers and midwives trained by RUWSEC will be given specific training on counselling, and gradually take the place of RUWSEC staff in providing PHC-based counselling. These persons will also entrusted with bringing those in need of services to the PHC when this becomes necessary. In many instances, clients, especially women, do not seek reproductive health services unless they have someone accompanying them. Training meetings for those selected will be held once in 6 months.

We hope that other interventions develop through the meetings and discussions of various stakeholders. A fixed amount may be set aside to implement these.

ANNEXURES

Annexure 1: Questionnaire for clients/visitors to the PHC

I. Section I

a) Respondent	b) Patient (if different from respondent)
Name:	Name:
Age:	Age:
Village:	Village:
Education:	Education:
Occupation:	Occupation:
Marital status: (Never married / currently married / currently single)	Marital status: (Never married / currently married / currently single)
Number of living children under 5:	Number of living children under 5:

II. Section II

- What is the reason for your present visit?
- Why did you choose this facility?
- Are the timings of the clinic convenient for you?
- Is the location convenient for you?
- How did you get here? How long did it take you to come here from home?
- How long did you have to wait before getting the service? Was this okay?
- Did you receive any drugs (other kind of treatment) today for your condition?
- Prescription? Both?
- Were you able to get the services you wanted? What were these? What did the doctor say about your condition? (If answer is no to the first question, then, why not; what do you plan to do next?)
- Have you been referred to another facility for your present problem? If yes, which facility? Will you be able to go there? (Are you planning to?) If not, what are the reasons?

- What are the costs incurred for today's treatment? (Bus fare, treatment charges; expected expenses on drugs)

- What is your opinion about the services provided here? ("Gavanippu – nalla irunthatha?)

- Do you have questions or concerns that were not addressed?

- Do you have any comments or suggestions for improving the services?

III. Section 3

- What kind of services do you usually come to this facility for? What are some of the other health facilities you use? For what purposes?

- Do you know of any one who has used this facility for delivery? For family planning services (IUD / tubectomy?)

- Where did you (your wife, women in your household) have their deliveries?

- Do you think it would be useful if delivery services are regularly provided here? Will women find it convenient to come? (Probe for conditions that would make such a service useful / utilizable)

Annexure 2 : Questionnaire for the PHC staff

IMPLEMENTING CAIRO: AN EXPERIMENT IN NGO – PUBLIC SECTOR COLLABORATION FOR THE PROMOTION OF QUALITY OF SERVICES.

RURAL WOMEN'S SOCIAL EDUCATION CENTRE
CHENGALPATTU

Questionnaire

I. Location of Centre :

II. Nature : PHC, Sub center, Taluk Hospital

IV. III Area Supposed to be covered by

⇒ PHC / sub center :
⇒ Actual area covered :
⇒ Sub centers within its Jurisdiction :
⇒ Location of sub Centre :

IV Staff : number

⇒ Staffing Pattern :
⇒ Roles :
⇒ Working hours :
⇒ Actual hours of work :

V. V. Infrastructural facilities

5.1 Building condition – cleanliness in and around, dustbins

Disposal of health center waste

5.2 Waiting space

(stone platforms, chairs/benches, others)

5.3 Water : Yes / No
⇒ Potable :

⇒ Non Potable running tap water :
⇒ Hand pump :
⇒ Well water :

5.4 Toilets : Yes / No

⇒ for staff :
⇒ for patients :
⇒ for visitors :

5.5. Access to center means
of transport : Yes / No

⇒ Frequency

5.6. Ambulance / jeep services
available : Yes / No

⇒ Number :
⇒ Used for : used by:
⇒ If not used, reasons :

VI. VI. General health care facilities

⇒ 6.1 Drugs available :

⇒ Distributed free of cost /
⇒ Prescription given :
⇒ Drugs ordered by :
⇒ Number of times ordered : (annually / biannually / otherwise)
⇒ Basis for order of drugs :
⇒ Shortages, if any (reasons) :
⇒ In case of shortage prescription is
Always given : Yes / No

6.2. Inpatient facilities delivery
cases others, specify : Yes / No

6.3. Laboratory facilities Tests conducted
who conducts the tests. :

⇒ Referrals, if no lab : Yes / No
⇒ Location of nearest Facility : Yes / No
⇒ Staff : Yes / No
⇒ Refer patients to a Particular Facility : Yes / No
⇒ Name of that Facilities : Yes / No

6.4. Operation theatre : Yes / No

⇒ Condition :
⇒ Operation conducted :
⇒ Post operative conditions :

6.5. X – ray, Scan, blood bank : Yes / No

⇒ For what tests :
⇒ Used in what cases :
⇒ If not available nearest location of
⇒ Facilities :
⇒ Whether patient is referred :
⇒ If referred to which facility) :

VII. VII. Reproductive health Services

7.1. Physician : Male / Female
General practitioner / OB / GYN

7.2. Antenatal care : Yes / No

⇒ Blood tests :
⇒ Urine test :
⇒ Blood pressure etc. :

7.3. Delivery care : Yes / No

⇒ Labour room :
⇒ Number of deliveries :
⇒ Conducted :
⇒ Timings of services :

7.4 Medical termination of Pregnancy: Yes / No

⇒ Preconditions attached to MTP
(e.g) Sterilisation) : Yes / No
⇒ Others :

7.5. Family planning : Yes / No

⇒ Methods advised : Yes / No
⇒ Counselling Information given : Yes / No
⇒ IF IUD or such requires
pre-examination : Yes / No

⇒ Whether examined : Yes / No

(If any other medical problem comes to light during FP,
whether treatment is given) : Yes / No

7.6. Problems like white discharge, urinary infection, prolapse etc.
What treatment is given to the women.
In case internal examination is required, is it done?

7.7. Village visits / school programmes : Yes / No

⇒ Who is visited :
⇒ In case of pregnant women :
⇒ Frequency of visits :
⇒ Records maintained :

⇒ School programmes : Yes / No
⇒ For adolescent girls :
⇒ Type of programmes conducted :
⇒ Information given :

VII. Records maintained : Yes / No

⇒ Procedure for maintenance of records:
⇒ Maintained by whom :
⇒ How are the records used, for what
Purposes :

IX. Referrals

⇒ Where are the patients normally
Referred to :
⇒ For what problems are the patients
Referred :
⇒ Are emergency cases transported
to hospital :
⇒ Is the vehicle available at all times
Specify : Yes / No

In case of transportation, is the
facility provided free of cost : Yes / No
Amount Charges : Rs.

X.Opinions / Suggestions of health Centre staff :

(are any changes required according to them; specify, for themselves and for patients)

Annexure 3: Activities of the programme

Activity	Target group	Location	Frequency	Duration	Course duration	Year initiated
Counseling	Visitors to PHCs	Nerumbur & Tirupporur PHC	2 days per week for women and 2 days a month for men	1 day	22 months	1999
Laboratory services	Pregnant women and other visitors to PHC referred by the medical officer/health worker/VHN	Nerumbur & Tirupporur PHC	1 day per month in each PHC	1 day	22 months	1999
Meetings with PHC staff	Health inspectors [HI], Voluntary health nurses [VHN], Sector Health Nurses [SHN]	RUWSEC Training Centre	Once in 3 months	1 day	20 months	1999
Training Workshops for women leaders in Panchayat	Women leaders in panchayat	RUWSEC Training center	2 days in a month	2 days	20 months	1998
PHC Visits and practical training for women leaders in panchayat	Women leaders in Panchayat	RUWSEC Training Centre/PHC	1 day per month	1 day	6 months	2000

Annexures 4 : Tables

Table 1 : SATISFACTION BY AGE

AGE GROUP	NERUMBUR			TIRUPPORUR			TOTAL		
	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL
<10	4	0	4	2	0	2	6	0	6
	100.00	***0.00***	***10.81***	***100.00***	***0.00***	***5.26***	***100.00***	***0.00***	***8.00***
10-20	2	0	2	2	1	3	4	1	5
	100.00	***0.00***	***5.41***	***66.67***	***33.33***	***7.89***	***80.00***	***20.00***	***6.67***
20-30	5	3	8	7	4	11	12	7	19
	62.50	***37.50***	***21.62***	***63.64***	***36.36***	***28.95***	***63.16***	***36.84***	***25.33***
30-40	8	3	11	3	1	4	11	4	15
	72.73	***27.27***	***29.73***	***75.00***	***25.00***	***10.53***	***73.33***	***26.67***	***20.00***
40-50	4	1	5	3	4	7	7	5	12
	80.00	***20.00***	***13.51***	***42.86***	***57.14***	***18.42***	***58.33***	***41.67***	***16.00***
50-60	3	0	3	2	3	5	5	3	8
	100.00	***0.00***	***8.11***	***40.00***	***60.00***	***13.16***	***62.50***	***37.50***	***10.67***
60-70	2	0	2	2	2	4	4	2	6
	100.00	***0.00***	***5.41***	***50.00***	***50.00***	***10.53***	***66.67***	***33.33***	***8.00***
70+	1	1	2	1	1	2	2	2	4
	50.00	***50.00***	***5.41***	***50.00***	***50.00***	***5.26***	***50.00***	***50.00***	***5.33***
TOTAL	29	8	37	22	16	38	51	24	75
	78.38	***21.62***	***100.00***	***57.89***	***42.11***	***100.00***	***68.00***	***32.00***	***100.00***

Table 2 SATISFACTION BY LITERACY

LITERACY	NERUMBUR			TIRUPPORUR			TOTAL		
	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL
ILLITERATE	19	4	23	11	9	20	30	13	43
	82.61	***17.39***	***62.16***	***55***	***45***	***52.63***	***69.77***	***30.23***	***57.33***
LITTERATE	10	4	14	11	7	18	21	11	32
	71.43	***28.57***	***37.84***	***61.11***	***38.89***	***47.37***	***65.63***	***34.38***	***42.67***
TOTAL	29	8	37	22	16	38	51	24	75
	78.3	***21.62***		***57.8***	***42.11***		***68.0***	***32.00***	

	8			***9***			***0***		

Table 3 SATISFACTION BY OCCUPATION

S.No	OCCUPATION	NERUMBUR			TIRUPPORUR			TOTAL		
		SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOTSAT	TOTAL
1.	VIII. Unemployed	6	0	6	8	3	11	14	3	17
		100.00	***0.00***	***16.22***	***72.73***	***27.27***	***28.95***	***82.35***	***17.65***	***22.67***
2.	**Coolie**	17	7	24	9	6	15	26	13	39
		70.83	***29.17***	***64.86***	***60.00***	***40.00***	***39.47***	***66.67***	***33.33***	***52.00***
3.	**Tenant**	2	0	2	0	0	0	2	0	2
		100.00	***0.00***	***5.41***	***0.00***	***0.00***	***0.00***	***100.00***	***0.00***	***2.67***
4.	**House Wife**	2	1	3	4	4	8	6	5	11
		66.67	***33.33***	***8.11***	***50.00***	***50.00***	***21.05***	***54.55***	***45.45***	***14.67***
5.	**Post Man**	1	0	1	0	0	0	1	0	1
		100.00	***0.00***	***2.7***	***0.00***	***0.00***	***0.00***	***100.00***	***0.00***	***1.33***
6.	**Electrician**	1	0	1	0	0	0	1	0	1
		100.00	***0.00***	***2.70***	***0.00***	***0.00***	***0.00***	***100.00***	***0.00***	***1.33***
7.	**Company**	0	0	0	1	1	2	1	1	2
		0.00	***0.00***	***0.00***	***50.00***	***50.00***	***5.26***	***50.00***	***50.00***	***2.67***
8.	**Panchayat President**	0	0	0	0	1	1	0	1	1
		0.00	***0.00***	***0.00***	***0.00***	***100.00***	***2.63***	***0.00***	***100.00***	***1.33***
9.	**Contract Labour**	0	0	0	0	1	1	0	1	1
		0.00	***0.00***	***0.00***	***0.00***	***100.00***	***2.63***	***0.00***	***100.00***	***1.33***
	Total	29	8	37	22	16	38	51	24	75
		78.38	***21.62***	***100.00***	***57.89***	***42.11***	***100.00***	***68.00***	***32.00***	***100.00***

Table 4 SATISFACTION BY TREATMENT

S.No	TREATMENT	NERUMBUR			TIRUPPORUR			TOTAL		
		SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOTSAT	TOTAL
1.	Tablets	16	5	21	5	10	15	21	15	36
		76.19	*23.81*	*56.76*	*33.33*	*66.67*	*39.47*	*58.33*	*41.67*	*48.00*
2.	Injection	2	0	2	4	1	5	6	1	7
		100.00	*0.00*	*5.41*	*80.00*	*20.00*	*13.16*	*85.71*	*14.29*	*9.33*
3.	Syrup	3	0	3	0	0	0	3	0	3
		100.00	*0.00*	*8.11*	*0.00*	*0.00*	*0.00*	*100.00*	*0.00*	*4.00*
4.	Injection, Tablet	5	2	7	9	3	12	14	5	19
		71.43	*28.57*	*18.92*	*75.00*	*25.00*	*31.58*	*73.68*	*26.32*	*25.33*
5.	Glucose, Tablet, Injection	1	0	1	1	0	1	2	0	2
		100.00	*0.00*	*2.70*	*100.00*	*0.00*	*2.63*	*100.00*	*0.00*	*2.67*
6.	Pregnancy Test	0	0	0	2	1	3	2	1	3
		0.00	*0.00*	*0.00*	*66.67*	*33.33*	*7.89*	*66.67*	*33.33*	*4.00*
7.	Bandage,Tablet	2	0	2	1	1	2	3	1	4
		100.00	*0.00*	*5.41*	*50.00*	*50.00*	*5.26*	*75.00*	*25.00*	*5.33*
8.	No Treatment	0	1	1	0	0	0	0	1	1
		0.00	*100.00*	*2.70*	*0.00*	*0.00*	*0.00*	*0.00*	*100.00*	*1.33*
	Total	29	8	37	22	16	38	51	24	75
		78.38	*21.62*		*57.89*	*42.11*		*68.00*	*32.00*	

Table 5 SATISFACTION BY SEX

SEX	NERUMBUR			TIRUPPORUR			TOTAL		
	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOTSAT	TOTAL
Male	8	3	6	4	9	13	12	12	24
	72.73	*27.27*	*29.73*	*30.77*	*69.23*	*34.21*	*50.00*	*50.00*	*32.00*
Female	21	5	26	18	7	25	39	12	51
	80.77	*19.23*	*70.27*	*66.67*	*33.33*	*71.05*	*73.58*	*26.42*	*70.67*
Total	29	8	37	22	16	38	51	24	75
	78.38	*21.62*		*57.89*	*42.11*		*68*	*32*	

Table 6 SATISFACTION BY DISEASE AND PHCs.

Disease	NERUMBUR			TIRUPPORUR			TOTAL		
	SAT	NOT SAT	TOTAL	SAT	NOT SAT	TOTAL	SAT	NOTSAT	TOTAL
1.FEVER	9	0	9	1	1	2	10	1	11
	100.00	*0.00*	*24.32*	*50.00*	*50.00*	*5.26*	*90.91*	*9.09*	*14.67*
iarrhoea	2	0	2	1	0	1	3	0	3
	100.00	*0.00*	*5.41*	*100.00*	*0.00*	*2.63*	*100.00*	*0.00*	*4.00*
3.PREG TEST	0	0	0	4	0	4	4	0	4
	0.00	*0.00*	*0.00*	*100.00*	*0.00*	*10.53*	*100.00*	*0.00*	*5.33*
4.BODY PAIN	3	1	4	2	4	6	5	5	10
	75.00	*25.00*	*10.81*	*33.33*	*66.67*	*15.79*	*50.00*	*50.00*	*13.33*
5.EAR PAIN	0	0	0	0	1	1	0	1	1
	0.00	*0.00*	*0.00*	*0.00*	*100.00*	*2.63*	*0.00*	*100.00*	*1.33*
6.INJURY IN LEG	2	0	2	4	4	8	6	4	10
	100.00	*0.00*	*5.41*	*50.00*	*50.00*	*21.05*	*60.00*	*40.00*	*13.33*
7.COLD AND COUGH	5	0	5	1	2	3	6	2	8
	100.00	*0.00*	*13.51*	*33.33*	*66.67*	*7.89*	*75.00*	*25.00*	*10.67*
8.TUMOUR	1	0	1	0	0	0	1	0	1
	100.00	*0.00*	*2.70*	*0.00*	*0.00*	*0.00*	*100.00*	*0.00*	*1.33*
9.HEAD ACHE	2	2	4	1	0	1	3	2	5
	50.00	*50.00*	*10.81*	*100.00*	*0.00*	*2.63*	*60.00*	*40.00*	*6.67*
10.WHITE DISCHARGE	0	2	2	0	0	0	0	2	2
	0.00	*100.00*	*5.41*	*0.00*	*0.00*	*0.00*	*0.00*	*100.00*	*2.67*
11.HIPPAIN	0	1	1	1	1	2	1	2	3
	0.00	*100.00*	*2.70*	*50.00*	*50.00*	*5.26*	*33.33*	*66.67*	*4.00*
12.CHEST PAIN	1	0	1	0	0	0	1	0	1
	100.00	*0.00*	*2.70*	*0.00*	*0.00*	*0.00*	*100.00*	*0.00*	*1.33*
13.DOG BITE	1	0	1	1	1	2	2	1	3
	100.00	*0.00*	*2.70*	*50.00*	*50.00*	*5.26*	*66.67*	*33.33*	*4.00*
14.ASTHUMA	0	0	0	0	1	1	0	1	1
	0.00	*0.00*	*0.00*	*0.00*	*100.00*	*2.63*	*0.00*	*100.00*	*1.33*
15.POWER ACCIDENT	0	0	0	1	0	1	1	0	1
	0.00	*0.00*	*0.00*	*100.00*	*0.00*	*2.63*	*100.00*	*0.00*	*1.33*
16.TOOTH ACHE	1	1	2	1	0	1	2	1	3
	50.00	*50.00*	*5.41*	*100.00*	*0.00*	*2.63*	*66.67*	*33.33*	*4.00*
17.BLISTERS IN MOUTH	1	0	1	1	0	1	2	0	2
	100.00	*0.00*	*2.70*	*100.00*	*0.00*	*2.63*	*100.00*	*0.00*	*2.67*
18.WHEEZHING	0	0	0	1	0	1	1	0	1
	0.00	*0.00*	*0.00*	*100.00*	*0.00*	*2.63*	*100.00*	*0.00*	*1.33*
19.SWELLING LEG	0	1	1	2	0	2	2	1	3
	0.00	*100.00*	*2.70*	*100.00*	*0.00*	*5.26*	*66.67*	*33.33*	*4.00*
20.STOMACH PAIN	1	0	1	0	1	1	1	1	2
	100.00	*0.00*	*2.70*	*0.00*	*100.00*	*2.63*	*50.00*	*50.00*	*2.67*
TOTAL	29	8	37	22	16	38	51	24	75
	78.38	*21.62*		*57.89*	*42.11*		*68.00*	*32.00*	