Making of a Primary Health Centre

The Sewa Rural Experience

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THE SEWA RURAL EXPERIENCE

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Foreword

It is an immense pleasure for my colleagues and me to share our experiences of developing an effective Primary Health Centre (PHC) in a unique collaboration with the Government. The PHC is one of the many activities undertaken by SEWA Rural (SR) for uplifting the rural poor and tribal population in Bharuch District. SR conducts programmes such as hospital, community health, education, technical training and women's development. The successful more than a decade long PHC experiment at Jhagadia has, along with serving the poor, been a possibility to promote many innovations.

Our collaboration with the Government goes back to the early days of starting SR. During 1984-85 SR was involved in providing healthcare services almost like a functional PHC under a Government of India and USAID project in collaboration with State Government. However, the decade 1989-99 was a special one when the Government handed over the formal PHC of Jhagadia to SR, giving us liberty to make changes at both structural and operational levels. It was a challenge since we had many concerns internally about fulfilling the task without compromising our institutional values. It was a very satisfying experience and our colleagues showed immense maturity and patience in operationalising the Government collaboration as well as in taking over the PHC and developing it as a model.

For the last ten years we have been involved in different tasks allocated to a PHC as well as in bringing about many changes that can make health service delivery for the poor regular and effective. We have worked in the community, clinics and district and have participated at state-level reporting meetings with equal seriousness and ease. This has been a new learning experience, which we thought should be shared with the Government and others, particularly those who have been considering collaborating with the Government on healthcare delivery.

We had many discussions on the form and content of sharing our experiences of collaboration. UNNATI, Ahmedabad, and the Government Medical College, Vadodara, were invited to facilitate the documentation of our experiences. To make the exercise a learning event for all, plans were made to include the process involved in taking charge of the PHC, the process of resolving internal concerns as well as developing an appropriate structure and a system. We also decided to include our achievements and impacts. To capture the impacts, both participatory and formal research methods were used.

At the end of the entire process, it was encouraging to know that our model had been accepted and the Government had handed over 3 Community Health Centres (CHC) and 1 PHC for NGOs to manage. There are other NGOs who are willing to take up such activities. We hope that many more such partnerships will materialize. I hope this document will add to the debate on collaboration between Non-Government Organisations (NGO) and Government (GO) on healthcare delivery.

An NGO can retain its autonomy and values if it is clear in its mission and approach. At no point of our active collaboration with the Government did we compromise the quality of service, our values and commitment, though it entailed many extra hours of hard work that our colleagues put into the project.

I would like to extend my sincere thanks to all Government officials and friends who made this collaboration a meaningful engagement.

December 2003

Dr. Lata Desai
Managing Trustee

Preface

Documenting the decade-long experience of the Society for Education Welfare and Action - Rural (SEWA Rural) collaboration with the Government in making an effective PHC has been an honour and a learning experience. A technical team from the Department of Preventive and Social Medicine (P&SM), Vadodara Medical College (VMC), and participatory research facilitators from UNNATI [Ahmedabad] jointly prepared this document. SEWA Rural (SR) actively participated in the entire process, including designing the study and field-level data collection.

This is a rare and desirable convergence of two research methodologies to bring out people's perceptions, knowledge and hard data on efficiency and effectiveness. Participatory research methodology has been used to derive an understanding of organisational processes, community and other stakeholders' perception, staff motivation and interface with the Government.

The technical study looked into the quality and coverage of services as compared to control areas. Three nearby Primary Health Centres (PHC) and the population covered by them were chosen as control area. The socio-economic characteristics of both the areas were matching in terms of proportion of tribal population, income level and literacy. The technical team also observed the clinical aspect of immunisation and antenatal care (ANC) clinics. Participatory Rural Appraisals (PRAs) were conducted in both control and SR areas, which included the coverage of services, level of acceptance of staff by the community, level of community education and awareness as well as motivation of field-level staff. Besides, in-service data, reports and records were also studied. Discussions were held with supervisors, health workers, anganwadi workers and dais. Government officials, nearby private practitioners, donor representatives were interviewed to get their point of view on SR's collaborative effort with Government and its impact.

The present report is an assimilation of both technical assessment and participatory processes conducted at different levels of functioning of the PHC. Several meetings were held with the research team to evolve the structure of the report. Since a lot of effort was made by SR to make a model PHC, the report has been titled 'Making of a PHC - The SEWA Rural Experience'. Earlier research has revealed that people's access to a PHC in the tribal area is very low. Many researchers have also documented that the existing financial allocation is a major constraint in providing adequate healthcare service. However, the SR experience has proved that if proper planning and staff motivation is maintained along with flexibility in the use of budget heads, PHCs can be run effectively within the existing Government provisions. This was possible primarily because of the nature and design of operationalising the programme. It brings important learning lessons, which this document captures and we hope it will be of use to both GO and NGOs to strengthen people-centered healthcare services.

Our sincere thanks to all staff members of the Community Health Project (CHP) of SR and Government PHC staff members in the control area for giving their valuable time to share their experiences with us. Staff members of participatory Primary Health Centres enthusiastically responded to the study questions. We are thankful for their contribution. We sincerely thank Mr. R.M. Patel, Commissioner of Health, Dr. K.N. Patel, Additional Director of Health Services and Regional Deputy Directors for facilitating and encouraging the process of evaluation. We also extend our gratitude to the villagers in both SR and control areas for answering our questions and participating in the PRA exercises. Nursing students of College of Nursing [Ahmedabad] helped in conducting the survey and we are thankful to them.

Dr. Pankaj Shah and Dr. Shobha Shah enthusiastically and willingly coordinated the two teams and made all arrangements for giving a final shape to this document. We extend our gratitude to them and to Dr. Lata Desai and Dr. Anil Desai who have been a constant source of inspiration in the documentation process as well as extending their supportive hand. It should be specially mentioned that Dr. Lata Desai personally supported the involvement of a woman participatory facilitator to coordinate the team.

From UNNATI, Alice Morris, Binoy Acharya, Hemal Joshi, Murli Srinivas and from the P&SM Department, Vadodara Medical College, Dr. P.V. Kotecha, Dr. V.S. Mazumdar and Dr. Seema Nigam were the principal team members involved in the documentation process.

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Abbreviations

ABER	Annual Blood Examination Rate
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife [= FHW]
API	Annual Parasite Incidence
ARI	Acute Respiratory Infection
AWW	Anganwadi Worker
BCC	Baroda Citizen's Council
CAPART	Council for Advancement of People's Action and Rural Technology
CBR	Crude Birth Rate
CDPO	Child Development Project Officer
CDR	Crude Death Rate
CH	Community Health
CHC	Community Health Centre
CHP	Community Health Project
CHV	Community Health Volunteer [+VHW]
CINI	Child in Need Institute
CMR	Child Mortality Rate
CP	Community Participation
CPR	Couple Protection Rate
CSM	Corn Soya Milk
CuT	Copper – T (an Intra Uterine Device)
DDO	District Development Officer
DHO	District Health Officer
DPT	Diphteria, Pertusis, Tetanus
DWCRA	Development of Women and Children in Rural Areas
FHW	Female Health Worker [=MPHW (Female); ANM]
FP	Family Planning
FRCH	Foundation for Research in Community Health
FRU	First Referral Unit
GO	Governmental Organisation
GOI	Government of India
GTK	Gramin Tekniki Kendra
HE	Health Education
HNE	Health and Nutrition Education
ICDS	Integrated Child Development Service Scheme
IMR	Infant Mortality Rate
INC	Intranatal Care
KAP	Knowledge Attitude Practice
MCH	Maternal (or Mother) and Child Health
MMR	Maternal Mortality Rate
MO	Medical Officer
MPHW	Multipurpose Health Worker (Male)
MTP	Medical Termination of Pregnancy
NGO	Non-Governmental Organisation
NNMR	Neonatal Mortality Rate
NREP	National Rural Employment Programme
ORS	Oral Rehydration Solution

ORT	Oral Rehydration Therapy
OT	Operation Theatre
OTC	Opinion leaders' Training Camps
PEM	Protein Energy Malnutrition
PHC	Primary Health Centre/Primary Health Care
PNC	Postnatal Care
PNMR	Perinatal Mortality Rate
RCH	Reproductive and Child Health
RMO	Resident Medical Officer
RTI	Reproductive Tract Infection
SEWA Rural	Society for Education Welfare and Action Rural
SR	SEWA Rural
SPR	Slide Positivity Rate
SSC	Secondary School Certificate
TBA	Traditional Birth Attendant
TT	(Inj.) Tetanus Toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker [= CHV]
VOP	Voluntary Organisations Project
WHO	World Health Organization

Chapter 1

The Organisation: Origin, Progress and Key Principles

Origin

SEWA Rural (SR) came into existence on October 26, 1980. It was the commitment of a group of young doctors and professionals led by Dr. Anil Desai and Dr. Lata Desai who were trained abroad and returned to India to uplift and empower the rural poor. Their enthusiasm to live and work in remote tribal villages with the poor set the beginning of this organisation. In the process the group visited different areas of Gujarat to select the location for future activities, deliberately deciding against settling down in their home district in south Gujarat. The rural tribal area of Bharuch District was selected as it was economically very backward and very few voluntary organisations were at work. The industries around Ankleshwar appeared to be a potential source for future collaboration for economic activities. Of course, the river Narmada was also a source of inspiration in more ways than one.

Many members of the group were medical professionals and they believed that curative services were an integral part of preventive health services and one of the felt needs of the community. Therefore they decided to begin with a small hospital. The Kasturba maternity home run by a local charitable trust at Jhagadia was godsend. The trust appreciated the vision of the young professionals and handed over the management of the maternity home to SR. This maternity home was converted into a 40-bed community hospital. At the time of starting, there were four full-time doctors, six visiting consulting doctors, X-ray facilities, a laboratory (lab) and an operation theatre (OT). Resources were raised through loan, donations and personal contribution of the founder members to develop the facilities.

During the first two years the team managed the hospital efficiently. In an area where quality health service was not available easily to the people, the successfully run hospital

Socio-economic Context

SR works in a predominantly tribal area. The adult population is largely marginal farmers and landless labourers with more than one-third living below poverty line. Literacy in these areas was as low as 30 percent and female literacy around 20 per cent in 1980. As basic health services were practically non-accessible to most of the rural people, the morbidity and mortality rates were comparatively very high. Awareness about the basic concepts of health and hygiene was also significantly lacking. Preventable diseases like anemia, infection and tuberculosis caused a large number of deaths among infants and women. The infant mortality rate (IMR) was 172, while the maternal mortality ratio was more than 700 per 100,000 live births. The mortality rate was much higher among women in all age groups than that among men. Almost 68 per cent women died by the age of 45 as compared to 52 per cent among men.

with an environment where poor people feel comfortable to seek services, established its credibility among the local community. The medical services were free for the poor and a nominal amount was charged from those who could afford it.

Progress

Soon the medical work spilled beyond the hospital walls and on October 2, 1982, a Community Health Project (CHP) was initiated in 10 villages covering a population of 11,000. The programme was built around a mobile dispensary, which had a team of nurses, doctors and compounder. The mobile provided curative health service. The focus was also on maternal and childcare and tuberculosis (TB) follow-up. SR, through a liaison with the State Government in 1983, got the technical and administrative control of the entire village-level health functionaries which included anganwadi workers (AWW), dais and community health volunteers (CHVs) of those selected villages.

In 1984, SR received a Government of India (GOI)/United States Agency for International Development (USAID) fund to address both curative and primary healthcare covering 39 villages (gradually increased covering a population of about 40,000) in the Jhagadia Block. The issue of duplication of services under USAID funds came up as they were already supporting the healthcare services in entire Bharuch District. After deliberations jointly with the District authorities as well as the State and Central Government, an agreement was made whereby the State Government/District Panchayat would finance the primary healthcare services at the village and middle level while USAID would support the staff at the headquarters. With the responsibility of providing total healthcare as per the PHC sets up, SR was required to undertake all the national health programmes as per the Government norms and meet all targets set by them. After lots of persuasion, SR was given the freedom to devise its own system to plan/implement the programmes, to recruit its own staff and provide extra training that the staff might require. This agreement was for five years starting from April 1984. This was a historic agreement because never before had such an arrangement been made by a Government with a voluntary agency in India. The programme was expanded gradually in 1986 from 21 to 39 villages.

After five years of managing a successful programme for providing comprehensive healthcare to a population of 40,000, the Government was pleased to formally entrust the management of the same PHC in Jhagadia to SR in 1989. Under the new agreement which was also unique in many ways, the State Government would provide 100 per cent grant to SR as per norms for managing the Jhagadia PHC for the next 10 years. The PHC area was modified to cover 30 villages (population of 40,000) in which one new large village was added in the place of ten smaller villages. These were handed back since they were closer to the adjoining PHCs.

The three-tier comprehensive health service programme of SR thus included Out Patient (OPD) and Inpatient Departments with referral linkages at the base hospital, a comprehensive package of community-based primary healthcare services at the doorstep and awareness-building programmes in the community. The hospital was gradually expanded to 75 beds with 10 full-time doctors providing specialized care in obstetrics, gynecology, surgery, ophthalmology, pediatrics, anesthesia and general medicine. All laboratory investigations, X-ray as well as ultra sound facilities are available. Patients from about 1500 surrounding villages avail the services of the hospital in addition to people from the Jhagadia PHC area. The ophthalmic service expanded to the comprehensive community eye care programme in 1992, including components of community-based rehabilitation for the blind. A separate OPD, particularly for the patients coming from the Jhagadia PHC's project area, was also tried out so as to ensure a proper feedback, special counselling and adequate follow-up of the patients. Thus the hospital was instrumental in providing a strong backup support to the Community Health Project and in building credibility of the field staff.

Outreach services at the village level included antenatal care (ANC), intranatal care (INC), postnatal care (PNC), immunisation, growth monitoring and supplementary nutrition of young children under Integrated Child Development Service Scheme (ICDS), family planning (FP), school health, control of communicable diseases like malaria and tuberculosis, health education and, most importantly, treatment of minor ailments and referral of high-risk cases.

A formal research wing was initiated in 1988 to develop an understanding of issues of operational importance in community health and is oriented towards making healthcare services more effective and poor-friendly. The organisation preferred candidates from the local community and, after providing training and retraining to meet the different needs of the organisation, they were recruited as staff e.g. the nursing cadre and other assistants at the lab., OT, X-ray and administration. A training centre was formally established in 1990 to cater to the training needs primarily of other voluntary organisations in different aspects of community health. The centre draws from the rich experience of health services provided at community and hospital levels. The centre was also approved for the posting of students from different academic institutions, medical interns and Government functionaries from India and abroad. The training largely consists of technical, managerial and other practical aspects of primary healthcare.

As the health services were getting established, SR began addressing other socio-economic issues. This was part of the organisation's approach to bring about an integrated development of the rural, poor community. Coaching classes for school children from weaker sections were started in 1985 to help them cope with the school and avert drop-out. Other social sector activities were launched in 1986, which included introducing home-based income generation activities like papad making, savings and credit to arrest indebtedness by exploitative money-lenders and overall education and development of women, adolescent girls, to improve their overall status in society.

A technical training centre for youth called Gramin Tekniki Kendra (GTK) was set up in 1986 to train about 70 young boys every year in various occupations like welders, fitters, turners and other technicians. All the boys trained at this centre have been gainfully employed in nearby industrial centres, Ankleshwar and Bharuch.

Key Principles

SR integrated three basic principles namely Social Service, Scientific Approach and Spiritual Outlook in all its work. SR aims to reach the poorest person (i.e. the poorest of the poor), may they be women, children or aged. Since they are at a higher risk, weaker, dependent and often oppressed, SR feels that Social Service cannot be neglected.

Emphasis is given to the person who is being served and also to the person who is serving. While the organisation extends its service to the poor, it feels that character building and self-development of the person who serves is very important. The organisation has laid emphasis on training and developing locally available human resources at all levels to contribute their potential to serve the community.

Emphasis is placed on achieving and maintaining a high quality of work. In terms of services delivered at the village level, particularly in health service, the staff and volunteers are not expected to compromise on the quality of services. Maintaining honesty and integrity is of utmost importance to the organisation. In spite of the eagerness to reach out to the poor and maintaining values as well as work quality, SR was extra careful not to develop an arrogant attitude. The organisation does not hesitate to take the responsibility for errors, no matter where the error has occurred.

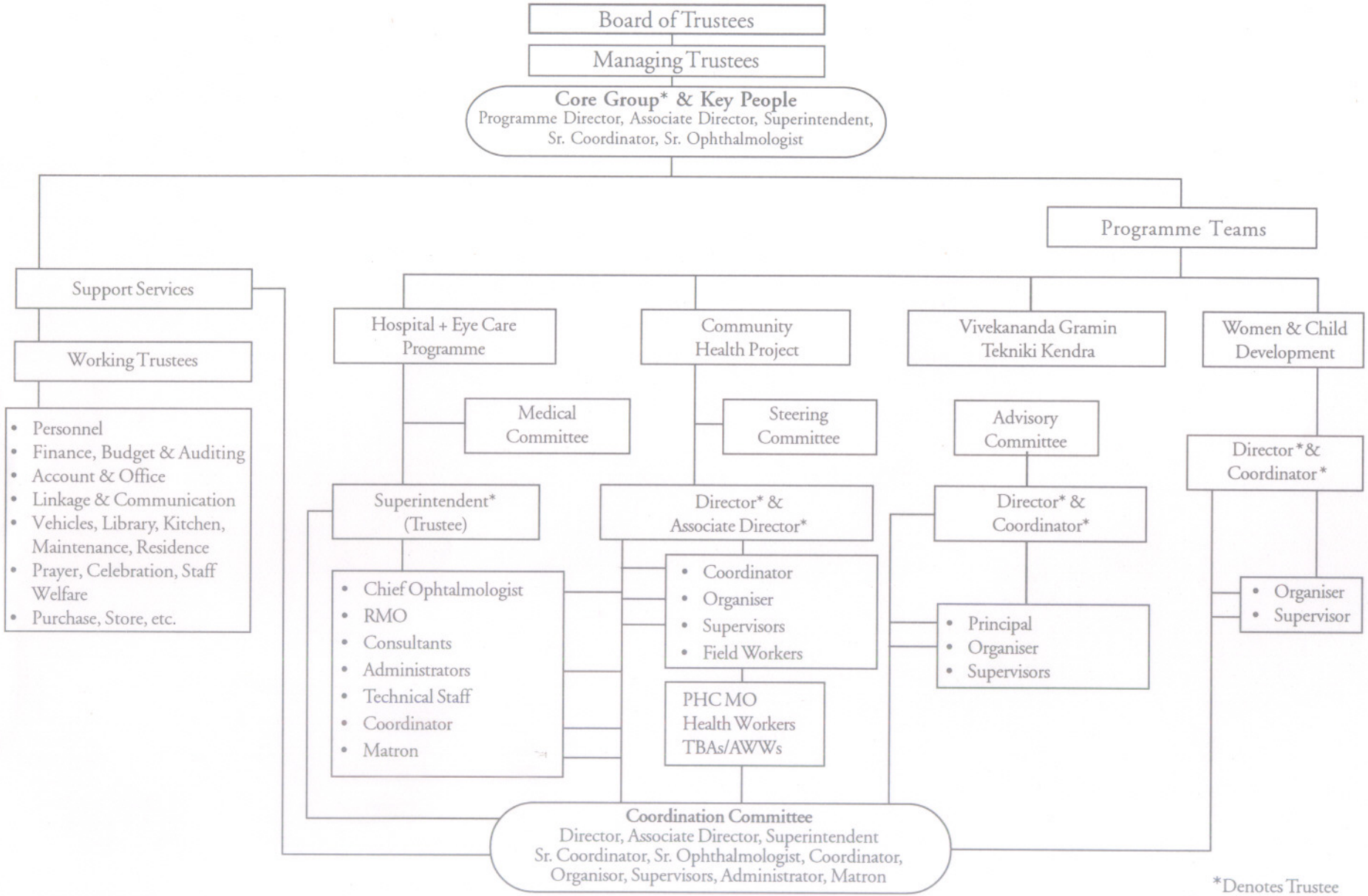
Another value upheld by SR has been equality of all patients. In the earlier years of operation there was pressure on SR to provide preferential treatment at the hospital by several community leaders and economically better-off persons. This has been particularly strong among the local well wishers and supporters of SR's work. SR made it clear that in a hospital a patient is a patient, no

one can receive preference over the other. SR also never entertained recommendation by local leaders and power groups for accessing services. SR never gave in to the pressure although it created ill-feelings among some local leaders. Over the years the local community has started appreciating the principles of SR.

The staff of SR has also been orientated towards maintaining gender equity in the organisation. Women on the staff are encouraged to assume higher responsibility in management positions and programmes.

The organisation is open to work in collaboration with all sectors, be it Government, private, foreign institutions, public trust, academic institutions and even individual well wishers. In building linkages and getting support, SR has never made a compromise on its basics values.

Team work is another practised value in SR. The programmes are not dependent on one person. Over the years there is an attempt to practise delegation of responsibility and decentralized functioning.


Board of Trustees
Managing Trustees
Core Group* & Key People
Programme Director, Associate Director, Superintendent, Sr. Coordinator, Sr. Ophthalmologist
Programme Teams
Support Services
Working Trustees
Personnel
Finance, Budget & Auditing
Account & Office
Linkage & Communication
Vehicles, Library, Kitchen, Maintenance, Residence
Prayer, Celebration, Staff Welfare
Purchase, Store, etc.
Hospital + Eye Care Programme
Community Health Project
Vivekananda Gramin Tekniki Kendra
Women & Child Development
Medical Committee
Steering Committee
Advisory Committee
Director* & Coordinator*
Superintendent* (Trustee)
Director* & Associate Director*
Director* & Coordinator*
Chief Ophtalmologist
RMO
Consultants
Administrators
Technical Staff
Coordinator
Matron
Coordinator
Organiser
Supervisors
Field Workers
PHC MO
Health Workers
TBAs/AWWs
Principal
Organiser
Supervisors
Organiser
Supervisor
Coordination Committee
Director, Associate Director, Superintendent
Sr. Coordinator, Sr. Ophthalmologist, Coordinator,
Organisor, Supervisors, Administrator, Matron
*Denotes Trustee

Chapter 2

The Review Study: Objectives, Methodology and Process

This review is primarily undertaken to critically learn about the experiences of running a Primary Health Centre (PHC) of the Government for ten years.

Objectives

1. To critically assess the experience of running a PHC.
2. To assess the achievement in terms of coverage, quality of service and impact.
3. To study the community perception of SR and its functioning.
4. To review the effectiveness of the strategy and methods adopted in the PHC programme.
5. To document a decade-long experience of working with the Government system. (NGO-GO collaboration)
6. To explore the scope of replicability of SR's innovations among NGOs as well as in the Government system.
7. To prepare the document so that it can be used for advocacy for policy changes on Primary Health Centre management and service delivery.

Methodology and Process

The review and documentation process began in January 1999 with a discussion on the scope of the review. SR invited UNNATI and Vadodara Medical College to jointly undertake the exercise. At this meeting the Terms of Reference (ToR) was developed which articulated the objectives (as mentioned above) and elaborated on the methodology to be adopted.

It was decided that the review would be done using participatory methods. To arrive at the type of methods to be used, discussions were held on February 1 and 9. The methodology adopted in the review is as follows:

There were various suggestions on the method to be adopted. Since this is both a review study and documentation of

experiences to share learning and insights, it was thought that a participatory methodology that would document the process and assess the effectiveness and impact need to be identified. The study would therefore include techniques like community-level meeting, semi structural discussion with staff, ranking of service, questionnaire survey among PHC staff and users of the services.

A major debate was on whether to have a control area or not. In the beginning it was thought that since the review would focus on documentation of experience and learning there was no need to have a control area. However, while the review process was on, SR decided to compare the effectiveness of services and impact with another three PHC areas of the same Taluka as independent baseline data was not available. It was then felt that a control area would provide a point of comparison and information to SR on the base of which they could perhaps plan for expansion if they felt appropriate. The control areas identified were Panetha, Avidha and Dharoli and selected villages under these three PHCs. These three PHC areas are similar to those in the Jhagadia PHC area where SR works.

In the 1989 review SR used the KAP method to evaluate the impact of its programme at the community level. Therefore to make it comparable it was decided to use the same method to understand the impact of the PHC programme at the community level.

A team of medical professionals made a technical assessment of the quality of services.

1. **Community Survey (KAP)**
   SR covers 30 villages, with a population of 40,000 working through 8 sub-centres. 14 villages were chosen on a random sample basis. These villages fell under 6 sub-centres. At each village 10% of the households (approximately 50) were studied in the questionnaire survey. The details of the villages and population covered are given in Annexure 6.

   The survey questionnaire for the community was prepared in two sections. The first section included questions for collecting general information of the household and was administered to all the households.

   The second section was divided into five parts. Each part had questions that were related to a specific programme and only households which were accessing this particular programme were asked to respond. It had questions relating to child health, antenatal and postnatal care, family planning and treatment of long-term disease.

   The questionnaire was administrated by a group of trained nursing students. The same questionnaire was also used in the control area. In the control area within the 3 PHCs, 14 villages were selected on a random basis. At each village 10% of the households were covered. The same team administered the questionnaire in the control area also. The questionnaire is given in Annexure 6.

2. **Measuring the Skill, Attitude and Behaviour of the PHC Staff**
   The health staff included supervisors, male health workers, female health workers, anganwadi workers and dais. Information on their skill, attitude and behaviour was sought through interviews, focus group discussion and questionnaire. All the 6 supervisors, 14 health workers, 7 out of 40 anganwadi workers and 10 out 40 dais were covered.

   In the control area similar information was collected from the health workers, anganwadi workers and dais working in chosen PHCs.

3. **Community Meeting**
   To understand the perception of the community on the health programme, community-level meetings were held at six villages. Focus group discussions were conducted with both male, female and mixed groups. The level of awareness and behaviour on healthcare practices, relationship with health workers and the quality of services received are some of the issues understood

through the community meetings at the 3 villages in the control area.

4. **Interviews with External Stakeholders**
Some of the key stakeholders who are not the beneficiaries were identified and listed, which included the private medical practitioners at Jhagadia, trustee members, Government officials like CDHO, CDPO and Health Commissioner, foreign funding agencies (UNICEF), corporate philantrophist, organisation and some associated individuals. The interviews focused on their relationship with SR, how they have contributed to its work/growth, and how they see SR, in the coming years.

5. **Observation of Programmes**
A team of medical professionals observed the immunisation and ANC clinics at the sub-centre. The same team also observed the immunisation in the control area.

6. **Attending Meetings**
The review team participated in the Annual Review Meeting held on June 1, 1999 to understand the process of internal review. The review team also participated in the CHP staff meeting held on August 30, 1999 to observe the methods of review.

7. **Data from Existing Records and Documents**
Existing records of SR work were used to understand the structure and functioning of the organisation. Data on the outreach programmes available with SR were analysed to understand the coverage and impact of each programme over the years.

Chapter 3

Taking Charge of PHC: Government Collaboration

The formal PHC has been under SR for 10 years but the collaborative experiment had started in 1984. This is an unprecedented example of collaboration between an NGO and GO in many ways. In the process of running the PHC, the organisation has introduced many innovations to make the programme effective and poor-friendly. This chapter details out the process of gradual evolution in three phases and highlights the salient features, which were found to be crucial in the successful collaboration and running of the project. SR collaboration with the Government is a special case. It is one of its kind in India, where a voluntary organisation has been handed over the responsibility of running a PHC with a hundred per cent grant-in-aid.

Many health practitioners have been critiquing the effectiveness of Government PHCs, while in SR the professionals thought of demonstrating the running of a PHC. It was thought that by adopting a Government PHC along with its working structure and targets, it would provide opportunity to bring changes from within. Hence SR did not think of critiquing the Government health systems and complaining to higher Government officials only as its primary task as in the case of many other autonomous institutions. Developing relevant, effective and feasible healthcare service delivery from a PHC set up was the primary goal. It was thought that such an experience will go a long way in bringing about policy level changes to develop effective Government PHCs. SR also viewed that since it is already working in the area of primary healthcare, adopting a PHC will help to minimize duplication of services as well as confusion among the workers and the community.

SR has been collaborating with the Government since 1982. The collaboration experiment of PHC can largely be viewed as evolution through different phases having natural extension in a third phase. Conscious and deliberate efforts

Driving Force

- Minimise duplication of services and resources
- Develop a model PHC that can be replicated
- Bring policy changes in management of Government PHCs which can effectively address the needs of the poor
- Bring changes through practice rather than just advocacy

were put in by the SR team members during these different phases to ensure that the nature of responsibility, monitoring mechanism, reporting system and funding arrangements between SR and Government has been clearly defined and passed in various Government resolutions (Annexure 1).

First Phase (1982-84)

In the first phase with the initiative of SR, in 1982, only village-level functionaries (community health volunteers, anganwadi workers and traditional birth attendants) of 10 villages covering a population of 10,000 in Jhagadia Taluka were placed under the technical and administrative control of the organisation.

Highlights of 1989 Government Resolution for Taking Over the PHC

- At the first stage the management of the PHC at Jhagadia was entrusted to SR for 10 years.
- The State Government agreed to finance the entire PHC services in the SR project area. The service would be run on the same lines as that of the Government but managed entirely by SR.
- The organisation was required to fulfil all targets set by the Government for various health services.
- District Panchayat (DP) Bharuch will take over the management of the PHC if the organisation either does not want to manage the PHC at the end of the project or discontinues its activity.
- The organisation could accept employees from DP on deputation. If the organisation wants to recruit the employees on its own selection process, it can do so by following the recruitment resolution of the concerned vacancy of either Government or the DP whenever possible.
- When the organisation wants to appoint the employee by following its own criteria the organisation is required to have either District Health Officer (DHO) or District Development Officer (DDO) in the selection committee.
- Whenever the collaboration is discontinued, the Government will try to absorb the employees appointed by the organisation provided they satisfy the necessary recruitment criteria like age limit and education qualifications at the time of their appointment in SR.
- Similarly whenever the collaboration is discontinued, the employees appointed by the organisation who do not fulfil the recruitment criteria will be absorbed by the organisation in their other activities.

Second Phase (1984-89)

In 1984, USAID and the State Government/zilla parishad of Bharuch District, witnessing the success of SR, agreed to support SR's community health project in 39 villages (population of 40,000) along with middle level staff, medicine, material and equipment. A functional PHC was granted and total healthcare responsibility was given to SR. (Voluntary Effort In Community Health - Review of the Community Health Project of SEWA-Rural by Renu Khanna, N.R. Mehta, Anil Bhatt). This arrangement continued till 1989. In this phase SR was granted complete autonomy to recruit staff and make budget items as well as to plan and execute the outreach activities.

Third Phase (1989-99)

In 1989 after completing five years of providing total healthcare services to 39 villages (population of 40,000), the Government positively granted SR's request to formally hand over the total responsibility of a formal PHC at Jhagadia. This entails complete management of the PHC as per the norms of the Government. However, SR could persuade the Government to allow more flexibility and autonomy in bringing out the innovations with relevant changes in the basic structure and system. SR was also given autonomy to set its own targets. This also led to integration of the PHC and anganwadi staff, revision of management information systems and reprioritization of programmes. The Government resolutions and agreement clearly laid out powers, roles and responsibilities of different stakeholders which was further endorsed in the meeting held at the Health Commissioner's office in 1992 and 1997 (Annexure 2).

However, this is not the end of the collaboration in the PHC experiment. SR in 1999, is entering a new phase of collaboration with Government and United Nation's Children Fund (UNICEF), where it plans to set up a First Referral Unit (FRU) covering the entire Jhagadia block (population

of 160,000) under the Safe Motherhood Programme. Again here, the emphasis is to develop a model FRU as a natural opportunity to upscale the lessons learnt so far at the district and state level. SR at present is interacting with the six PHCs and the entire health machinery of Jhagadia Taluka through motivating and supporting them to bring about innovations, particularly in the area of safe motherhood and newborn care at the community level.

Internal Preparedness

The decision of collaborating with the Government in 1984 and taking over a PHC in 1989 happened over many internal debates and dialogues raising serious concerns and apprehensions. The first concern was that collaborating with the Government in a formal way will affect the autonomy of the institution and the programmes would be subservient to Government rules and orders. It was felt that Government intervention might affect the principle of serving the poorest. The second concern was that the Government collaboration would bring 'Government culture' and would affect the spirit of voluntarism. The third concern was with reference to the relationship with the community. SR views the community as an active partner in the programmes and encourages people to contribute time and money. It was apprehended that by taking up Government programme the community might look at SR just as a service delivery agency and the equation that was built with the community might be affected. The fourth apprehension with regard to retaining the character and outlook of the service providers i.e. staff. Many feared that exposure to Government working style, salary, formal training and interaction with Government staff might affect the overall mentality of the staff, which SR has so carefully nurtured and developed. The fifth concern was with regard to how the NGO fraternity will view SR. Would SR be not branded as siding with Government?

These concerns were not easy to resolve. The staff was engaged in debates to understand the overall objective of reaching the poorest of the poor and to develop mechanism to preserve the value and culture of the organisation. However, the staff's overall commitment to identify issues and to work on it on a continued basis created an internal environment of consensus, spirit and mandate to go forward for the collaboration with the Government. One of the core group members having experience of working with Government as well as SR's long-term association with positive minded Government officers made the process facilitating.

Government Granting Relaxations and Flexibility for...

- Recruitment Criteria
- Introduction of User's Fees:
  - Delivery Pack
  - Medicines during health camps
- Allowing Flexibility in Programme Prioritization
  - Routine Health Check-up of ICDS and School-going children by workers themselves instead of doctors
  - Strategy of Orientation Training Camps changed
  - Sub-centre as a Unit and Joint Responsibility by Male and Female workers
  - Integration of ICDS and PHC supervisors
- Target Setting and Planning by Workers
- Separate Reporting and Monitoring System granted for SR PHC
- No direct control and supervision of SR PHC Staff by Government.

The Process of Taking Over

To make the collaboration meaningful, effective and satisfactory several steps are taken. The first one is to understand the basics of Government system and procedures. SR spent considerable time in understanding the PHC functioning and its system of reporting, supervision and programme and financial monitoring. A Senior Medical Officer and Coordinator stayed for two days in the PHC best managed by the Government in the early eighties. They tried to learn the details of its day-to-day working. SR has provided additional time and energy for orienting its staff and developing a collective vision. The Government has its own fixed system. During the initial years SR had to fulfil such requirement of the Government. It took the Government about 5 years to appreciate the

transparency, flexibility and innovations of SR. For this a lot of time and energy was spent to share and to make these innovations acceptable by key Government functionaries who are pragmatic and supportive of such a collaborative move. Once the principle of flexibility is accepted by the Government the modalities were required to be built in so that such flexible norms are known to the officials at all levels.

Recruitment Process

In the Government the recruitment process is largely centralised and at times prone to pressures and pulls from outside. At SR the recruitment process is very open and fair and gives emphasis on the individual's merits and performance, apart from other things like commitment and inclination towards empathy, social service and preference for candidates coming from economically poor family. SR's demand to have flexibility in recruitment criteria was eventually accepted by the Government. Preference is given to promising candidates from the local area even though they may not fulfil all the norms. Heads of the various departments concerned are actively involved in such selection process. Due attention is given to rooming in of the selected candidate. An SR staff is assigned to spend time with the selected candidate to make him/her familiar with overall working environment of the organisation, its different programmes, its systems, its formal and informal work culture, ethos and values, and specifically his/her roles and responsibilities. No doubt, only those who possessed the required Government criteria for recruitment were eligible for consideration since they had to be absorbed into Government system after the completion of the SR project. The rest were to be eventually absorbed in SR.

An Example of Target Setting Exercise for Family Planning based on Couple's Needs and Perceptions

- Unprotected couples not to be pressurised for **Operations** even if they have two or more children when:
  - Having only female children
  - Age of last child is already 10 or more years
  - Age of last child is less than one year old
  - Health of last child is not good
- Unprotected couples not to be insisted for **Spacing Methods**:
  - Wants to have another child for varied reasons and age of last child is already more than one year old
  - Because of local custom and culture family likes to have first baby in the very first year, Newly weds are encouraged only to try out Nirodhs or Oral pills

Planning and Target Setting Exercise

In the field workers are actively involved in planning and setting the targets. The targets are set based on their past performance and the field reality. The targets are used as guide post in the process of understanding the success or failure of programmes rather than as end points. The exercise of analysing the work and setting of targets based on these criteria is done by workers themselves in the beginning of every year. This helps them to review their own work at regular intervals with better understanding, as figures come live rather than remaining just passive and mere dry numbers meant only for reporting to higher authority. It is encouraging to note that by making a paradigm shift to 'target free approach' Government is also trying to incorporate process for decentralized target setting and work planning based on needs assessment.

Management Information System (MIS)

A well-known problem with the PHC system is the high level of duplication and the irrelevance built into the Management Information Systems. SR has succeeded in simplifying it for easy operation. For instance, virtually all data is recorded by the workers in a single villagewise register covering all the programmes throughout the year. The procedures for data recording and analysis are designed in such a way that monthwise and activity- wise data covering all the programmes are generated easily and with in-built checks and controls. Apart from reporting to higher level, this also helps the sub-centre team in reviewing and planning its own work. Another important issue is programme monitoring. Government agreed to the request of SR that the performance of the SR PHC will not be measured in their standard ***target and achievement*** format at par with other PHCs every month. After a great deal of

persuasion, SR's proposal to be monitored separately and through quarterly review instead of monthly was eventually accepted by the Government (Annexure 2). For making this possible, SR developed alternate parameters based on ***quality and coverage*** and made repeated efforts to convince department at both district and state level about SR's genuine and professional efforts. The agreement was arrived after long deliberations and subsequent verification that the proposed alternative reporting is sound enough to monitor the work. Hence, just demanding an alternate system does not lead to a sanction but it requires hard work and an understanding of ground level realities to develop and demonstrate the alternative with sound-proof system to receive the legitimacy.

Innovative Intervention

It was encouraging to see that SR could introduce several interventions in the content as well as structure of different programme (Annexure 8). This was possible because of a series of micro-level interventions and innovations like fixing convenient timings and fixed days for service delivery, ensuring curative care (felt need of the community), strengthening village-based health volunteers, integration of ICDS and PHC staff, use of pre-sterilized delivery pack for home delivery, making sub-centre as a team unit, involvement of all levels of workers in target setting and micro planning and simplified MIS. It also brought out the fact that with appropriate reallocation of funds, it is possible to effectively manage PHC with the present resources.

A typical Meeting of CHP staff at SR includes....

- A prayer and inspirational reading
- Appreciation of an individual's good performance
- Learning from both positive field experiences and any shortcomings as shared by workers themselves
- Difficulties and problem solving
- Session on the continuing education
- Performance review and planning for the next month by respective sub-centre teams
- Review of critical cases and deaths in the field
- Replenishment of medicines and other supplies

Source: Observation of the review team.

Monitoring Meetings

Another programmatic innovation has been SR's team approach and attempt to rigorously follow schedule of meeting to monitor the details of running a PHC programme. The medical doctor, supervisors and health workers used to meet every week for a whole day during the initial years. When the system gradually got settled down and supervisors started taking up more and more responsibilities, in a move towards decentralisation, this meeting was then changed to once a month in the later part of the project years. This meeting is used for sharing field experience and planning activities for the coming month at the sub-centre level. While sharing the experiences and incidents from the field, the workers not only share the good points but also admit their mistakes. This was encouraged not as a *"fault finding"* but as a *"fact finding"* process used for problem solving and learning from each other. The staff is also provided training on relevant issues/diseases. During the post lunch sessions, each sub-centre team lists down all deaths and complicated cases of maternal, child health and other critical cases that they have faced during the month. A specialist along with the health workers discuss measures if any that could have been taken to prevent untimely deaths. Moreover, he/she also provides necessary guidance and support for handling critical cases in the future. Lastly, it is also ensured that medicines and other necessary items are replenished to each worker at the end of the meeting.

Since the Government works through department orders and resolutions SR has always been particular with regard to pursuing the written official orders with all details.

Accounting System

Government accounting system is apparently different from SR's. Despite repeated reminders it was not formally audited by Government Auditor's till the completion of the project. At SR all the financial transactions are correctly and properly reflected and adequately justified. The system is open to all scrutiny. A detailed guideline has been prepared for procedures relating to the purchasing, storing and indenting. Such systems

help in building the integrity and preserving the value and do not put any constraint on the organisation.

Maintaining Motivational Level of Staff

The organisation had a team of committed medical professionals who were willing to stay in a rural area. There are other examples where voluntary agencies had made efforts to provide health services in rural area. Urmul's effort in Rajasthan is an example. However, the programme could not be sustained because they found it difficult to get professionals who were willing to stay for a long period. However, SR was able to build a team of medical professionals who are committed and willing to stay in rural areas which has been a very positive influence on the other members of the CHP staff.

Staff motivation can be enhanced by closely working as a team. As more and more powers are delegated, the workers have a sense of involvement in the decision making and have a sense of owning the programme as well as its results. There is an explicit understanding that in success as in failure the team as a whole is responsible and not an individual. This has been made possible through regular meetings, workshops and common events.

Chapter 4

Organisational Structure and Systems

To carry out CHP activities, SR arrived at a functional organisation structure in consultation with staff members. In order to integrate the project with the overall organisational thrust and ideology, one of the senior doctors was assigned the responsibility as the medical officer of the PHCs. It was not a formal appointment but the doctor who was managing the CHP who has taken the responsibility to fulfil the tasks of the PHC. In setting up the organisational system, on-going reporting and interactions with the Government is a major area to resolve. SR, particularly the assigned PHC medical officer, took this on its stride considering the overall purpose of the project. This action from a senior professional colleague has set the environment in developing systems at all levels which suit SR culture as well as comply with the Government requirements.

For every village with a population of about 1000, one AWW, 1-2 dais and one community health volunteer were designated. For a cluster of 4-5 villages (sub-centre) a team of one male and one female health worker were appointed to provide all outreach services that include antenatal care (ANC), postnatal care (PNC), immunisation, growth monitoring and supplementary nutrition of young children under ICDS, family planning (FP), health education, control of communicable diseases like malaria and tuberculosis and treatment of minor ailments. Male and female health workers were not assigned separate tasks as done in Government, rather both were encouraged to be a mutually supportive team and be responsible for the overall health of their respective sub-centre area.

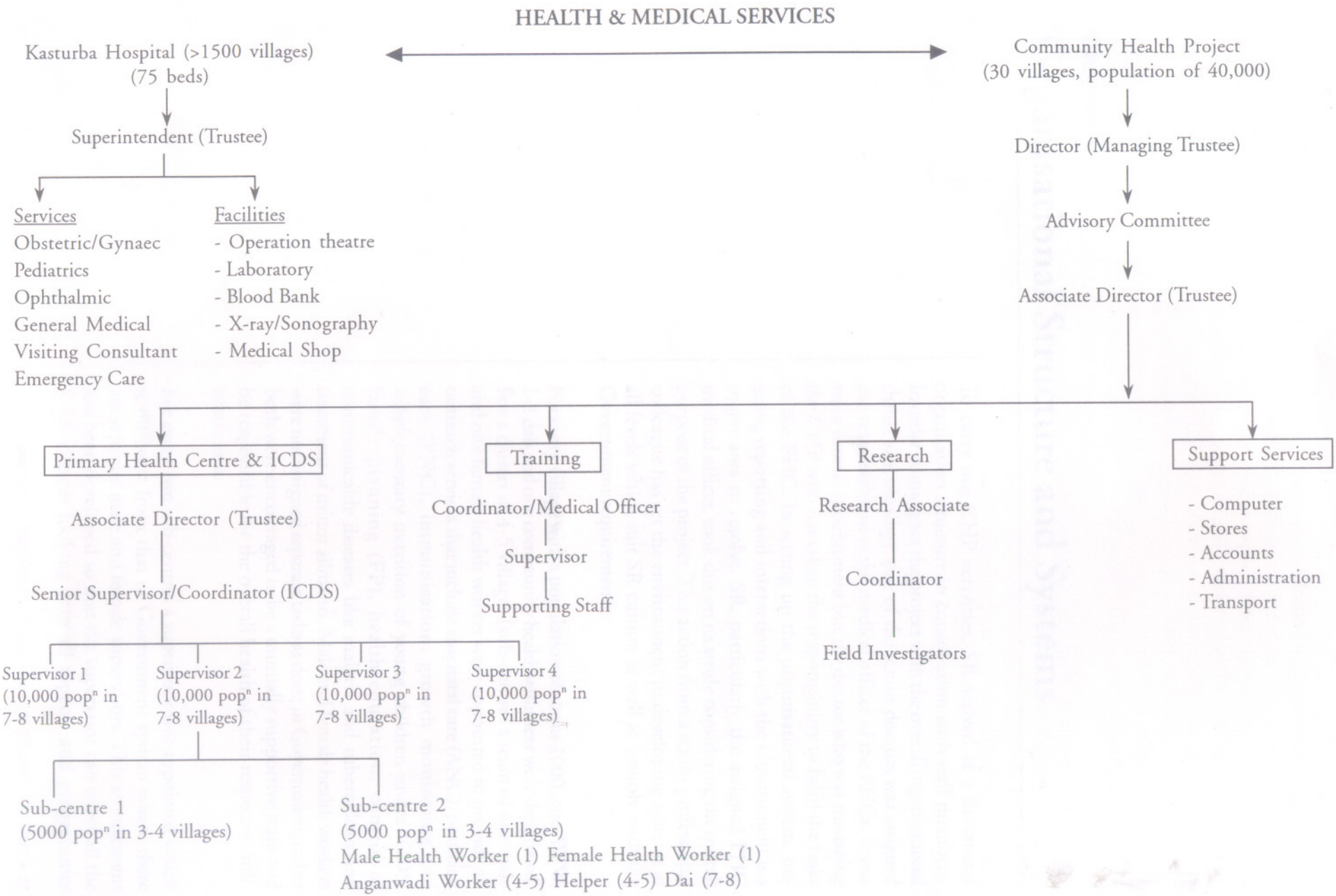
For every two sub-centres a supervisor was appointed which is different from that of Government system where there are separate male and female supervisors. This arrangement has been developed so that the supervisor can cover all the 8-10 villages looking into all aspects and programmes

whereas in the Government both the supervisors have to cover larger number of villages, simultaneously carrying out specific supervisory tasks. The anganwadi supervisor (Mukhya Sevika) was also integrated into this system. All the supervisors, whether male or female, were given necessary orientation on all the responsibilities, including health and ICDS.

In addition to the routine, the organisational culture encouraged the staff members to maintain functional horizontal linkages, particularly in the activities like training, research and referral services. This provided a sense of fulfilment, as the staff was organically associated with all the functions of the organisation. Because of the space provided to the staff, many PHC staff took interest in other activities of the organisation and later were promoted to take new charges. For example, two male health workers were promoted to the level of office administrator and eye camp organiser.

The PHC received support from the existing SR support services, which included computer, stores, accounts, administration and transport. Services were sought from these departments and for some items payment was made from the PHC budget. Even though there was no budget available for computer and transport, the PHC continued to receive these services. Since Government has a different requirement for financial reporting, the accounts department was oriented accordingly and all openness has been maintained to build transparency and accountability. The salary structure and staff eligibility was developed as per SR norms and not as practiced by the Government. As SR has a consolidated salary package, it resisted reporting the salary and other payment to staff in the prescribed format of the Government. However, in order to practise its own system, it has to continuously maintain transparency in accounting practices.

An active Board of Trustees governs SR. Some of the Trustees are involved in senior management positions of different programmes, including the PHC. There is also an advisory committee, which includes Government functionaries, key persons of SR and expert in the area of community and public health. The advisory committee provides technical, managerial and facilitating support to various aspects of the programme.


HEALTH & MEDICAL SERVICES
Kasturba Hospital (>1500 villages)
(75 beds)
Superintendent (Trustee)
Services
Obstetric/Gynaec
Pediatrics
Ophthalmic
General Medical
Visiting Consultant
Emergency Care
Facilities
- Operation theatre
- Laboratory
- Blood Bank
- X-ray/Sonography
- Medical Shop
Community Health Project
(30 villages, population of 40,000)
Director (Managing Trustee)
Advisory Committee
Associate Director (Trustee)
Primary Health Centre & ICDS
Associate Director (Trustee)
Senior Supervisor/Coordinator (ICDS)
Supervisor 1
(10,000 popⁿ in
7-8 villages)
Supervisor 2
(10,000 popⁿ in
7-8 villages)
Supervisor 3
(10,000 popⁿ in
7-8 villages)
Supervisor 4
(10,000 popⁿ in
7-8 villages)
Sub-centre 1
(5000 popⁿ in 3-4 villages)
Sub-centre 2
(5000 popⁿ in 3-4 villages)
Male Health Worker (1) Female Health Worker (1)
Anganwadi Worker (4-5) Helper (4-5) Dai (7-8)
Training
Coordinator/Medical Officer
Supervisor
Supporting Staff
Research
Research Associate
Coordinator
Field Investigators
Support Services
- Computer
- Stores
- Accounts
- Administration
- Transport

Chapter 5

Community-based Health Programmes: Coverage and Impact

The main objective of the project is to provide quality health services to the poorest of the poor of the community. Under the PHC programme, 30 villages covering a population of 40,000, a package of comprehensive primary healthcare was provided to the community for the last ten years as per the standard Government-managed primary health centre. Some of the important outreach services include healthcare services to women and children, treatment of minor ailments, control of TB and malaria and family planning.

Understanding the various aspects of the project in the right perspective

1. The Community Health Project in SR includes the Primary Health Centre, the ICDS and a research and training centre.
2. These services are provided to the villages and are fully supported by the SR referral hospital based in Jhagadia.
3. CHP Programme was expanded in a phased manner. It was started in 1982 at 10 villages with a population of 11,000 after conducting a baseline survey. In 1984 and 1986 it was gradually expanded to 21 and 39 villages with a population of 18,000 and 40,000 respectively. Functional Primary Health Centre was granted under the US AID project during these years. So the collaboration with the Government begun practically in 1984. In 1989, CHP was recognized as a formal primary health centre covering 30 villages having a population of 40,000. Since then the population remained almost stable.
4. The baseline survey data of original 10 villages as well as in-service data of the first year (1983-84) has been used in the tables for comparison. Since then, the figures mentioned in various tables have been largely obtained from already analyzed in-service data except the data collected by the study team in 1999-2000.
5. While providing comprehensive healthcare services within the Government structure during the entire course of 15 years, field interventions and innovations are introduced in the structure as well as content of primary health programme to the extent possible.
6. The Government programme mainly addresses the needs of pregnant and lactating women. The focus remains on fifteen months rather than the entire life-cycle of the women. However, SR provided special focus on reproductive health for women and children in the project. In SR, efforts have been made to address women's health issues in a holistic way, besides following the standard programme of the Government. The healthcare services for women include maternal healthcare, treatment of other health problems as well as addressing reproductive health issues.
7. Small Studies are conducted to identify health needs, concerns, beliefs and health seeking behavior of women and community about vaccin ation, nutrition, family planning, birth practices.
8. Training centre was established to disseminate the lessons learnt in the course of work with other organisations/Government as well as non Government and academic institutions.
9. While Government grant covered all routine PHC work, the fund for additional services, innovations, research, documentation and training work was granted by the Ford Foundation, leading to some overlap in staff as well as resources.

In this chapter we have reviewed the coverage and impact of the health services provided by SR, based on the indicators derived from the in-service data available, along with the findings of the qualitative survey conducted as part of the evaluation.

In-service data, as seen in table 5.1, indicate that by the end of the first phase of five years (1989) utilization of services in general has reached the desired goal of Health for All by 2000 (HFA). During the second phase of 10 years, efforts were made to improve the quality of services and to increase the health awareness among the family and community so that people can understand the importance of having good health, measures to preserve it, to identify risk factors at the earliest and to take the complicated cases to hospital where quality of services are available.

Table 5.1 Achievements at a Glance

Parameters	SEWA Rural PHC					Gujarat Rural 1999[3]	HFA by 2000[3]
	1982-83[1]	1984-85[2]	1988-89[2]	1994-95[2]	1999-2000[2]		
Villages Covered	11	21	39	31	30	-	-
Population	11,000	18,768	35,706	38,637	40,213	-	-
A. Vital Statistics							
CBR	30.0	22.7	27.0	22.0	19.92	27	21
CDR	12.7	8.6	12.5	8.9	8.33	8.8	9
MMR	NA	6.2	5.3	4.6	0	4-6	<2
IMR	172	87	89	62	41	70	<60
NMR	-	63.0	45.7	43	24	45	35
CPR (%)	37.0	55.2	61.8	69.5	71.2	56.6	60
B. Maternal Care							
Antenatal care (%)	< 25	44	75	76	91	-	85
Institutional Delivery (%)	-	<10	16	24	35	21.8	-
Delivery Conducted by Trained Person (%)	20	80	90	86	93	-	-
Postnatal Care (%)	<25	NA	NA	95	96	-	-
C. Child Care							
(1) Malnutrition							
Prevalence of vitamin A deficiency	High	High	Moderate	Low	Low	-	-
Babies with Birth Weight <2.5kg (%)	NA	NA	NA	66	47	-	10
Severe PEM (%)	16.0	12	11.5	1.8	2.5	-	-
(2) Immunization Coverage (%)							
DPT (%)	<10	44	79	96	99	-	85
Measles (%)	NA	25	73	91	98	-	85
D. Epidemics of measles, diarrhoea whooping cough, etc.	Frequent	Frequent	Sporadic cases	Sporadic cases	Sporadic cases	Sporadic cases	Sporadic cases

[1] – Baseline survey
[2] – In-service records
[3] – Basic Health Statistics Gujarat 1999-2000

1. Maternal and Newborn Care

Maternal and newborn services are considered together because, apart from being conceptually a continuum even the provision of these services is difficult to separate. Maternal and Child health services conventionally form a major part of primary healthcare programme. SR has been implementing the MCH programme in the form prescribed by the Government. However, SR has introduced some modifications over the years and maternal and child health services have developed into a standardized package. Maternal care includes antenatal care (ANC), care during delivery - intranatal care (INC) and care of mother for 42 days after delivery - postnatal/ postpartum care (PNC). Newborn care (NBC) is simultaneously provided to neonates up to one month.

Antenatal Care

Efforts have been made to provide quality services through creating health awareness among mothers and their families. SR has introduced the pictorial maternal card (Annexure 8 and 9) for health education and awareness of family. It gives pictorial depiction of the services that have to be availed during pregnancy and after childbirth as well as knowledge about the risk factors and the actions to be taken by the family. The card also helps in monitoring the health status of the mother and the healthcare given by health workers. This pictorial maternal card has been found effective. High-risks mothers are referred by health workers to the hospital with this card along with referral slip. This card contains the history of the pregnancy and the services that have been provided at home. This information helps the doctors to provide quick and proper medical treatment in the hospital.

The critical components of quality antenatal care are....

- Early registration - <12 weeks
- Minimum 3 check-ups of pregnant mother – within 24 weeks, 24-28 wks, after 36 wks
- Regular monitoring of blood pressure and hemoglobin
- Advice for proper nutrition and avoidance of tobacco and alcohol
- Utilization of full course of iron folic acid tabs and TT injection at proper intervals
- Identification and referral of high risk mothers
- Preparation for delivery

As shown in figure 5.1, in 1982-83, ANC registration was 25 per cent, which went up to 90 per cent after phase 1 and has maintained the level throughout the project period. It is encouraging to note that around 60% of pregnant women were registered within first trimester as seen in figure 5.1. Secondly, during phase 1, though 25 per cent of mothers had their 3 ANC check-ups, abdominal examination of the mother at an appropriate interval (within 24 weeks, 24-28 wks, after 36 wks) was rarely given the attention. The identification and timely referral of high-risk mothers was less than 11 per cent, which has gone up to about 80 per cent during the period of phase 3, as shown in figure 5.2. The complete coverage of mothers by iron folic acid tablets as well as TT injection has reached more than 90 per cent during

Registration of Pregnant Mothers (%)

(n = 953)*

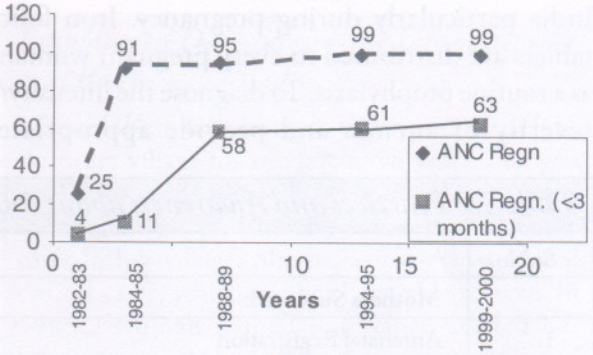


Fig. 5.1

Quality Care of Pregnant Mothers (%)

(n = 953)*

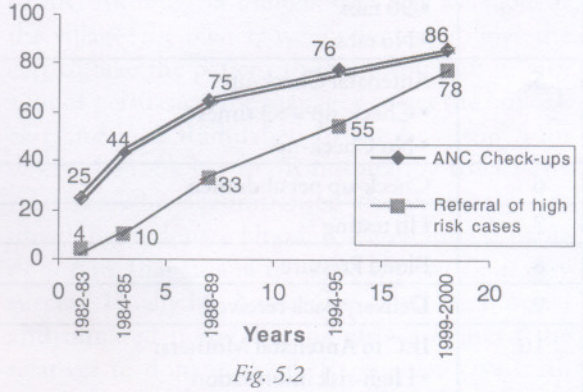


Fig. 5.2

*Average over the last ten years.

Source: In-service Data (except Baseline Data for 1982-83)

Critical components of Preparation for Home Delivery by a family

- Expected date of delivery known
- Procurement of pre-sterilized delivery pack
- Packet of clean cloths made ready in advance
- Trained dai of the village informed in advance
- Readiness for referral if any complication develops at the last minute
  - Which hospital? Where Caesarean facility is available
  - Which vehicle? Availability of local transport
  - Who would accompany?

the end of phase 1 and has been maintained till the end of the project period. Thus the percentage of women covered satisfactorily for ANC check-up (encompassing all the critical components) has increased from less than 25 per cent in 1982-83 to >80 percent in 1998-99, as shown in figure 5.2. It has been maintained at around 85 per cent for the last five years.

Anemia is a major problem faced by women in India particularly during pregnancy. Iron folic tablets are distributed to every pregnant woman as a routine prophylaxis. To diagnose the intensity/ severity of anemia and provide appropriate treatment, SR introduced the system of testing Hb level using copper sulphate solution in 1993-94. This helped them to get the result on the spot in the form of mild, moderate or severe anemia, which, though not very accurate, was sufficient to start therapeutics, iron folic supplement and follow-up, or referral, if required. During 1993-94, to tackle anemia caused by malaria parasite, antimalarial prophylaxis was started from the 4th month of pregnancy. This has also helped in reducing incidence of miscarriage, still birth, pre-term deliveries and low-weight babies.

The primary survey findings as described in table 5.2 below shows that the practices and awareness among mothers and community about various aspects of antenatal care have increased significantly.

These survey findings of antenatal care in the case of (SR) and control area also collaborate the quality of services given in SR. Although there is a general trend of improved coverage of maternal services in both groups, the SR PHC has performed significantly better as compared to the control area PHC. The observation of ANC at sub-centre clinics in SR area and control area

Table 5.2 Practices and Awareness about Antenatal Care

Sr.No.		SR PHC	Govt. PHCs	p value
	Mothers Surveyed:	70	97	
1.	Antenatal Registration	70 (100%)	72 (74.2%)	
2.	Antenatal Registration Within 3 months	30 (53.6%)	22 (31.4%)	.0121
3.	Injection TT (Adequate doses)	69 (98.6%)	62 (63.9%)	
4.	Tablet Iron Folic Acid received • 90 tabs • No tabs	 47 (67.1%) 3 (4.3%)	 14 (14.4%) 33 (34.0%)	
5.	Antenatal Check-up: • Check-up = >3 times • No Check-up	 39 (55.7%) 4 (5.7%)	 17 (17.5%) 15 (15.5%)	
6	Check-up per abdomen	65 (92.9%)	44 (45.4%)	
7.	Hb testing	65 (92.9%)	35 (36.1%)	
8.	Blood Pressure	47 (67.1%)	28 (28.9%)	
9.	Delivery pack received	49 (70.0%)	12 (12.4%)	
10.	**IEC to Antenatal Mothers:** • High-risk information • Advice about nutritional diet	 41 (58.6%) 58 (82.9%)	 26 (26.8%) 37 (38.1%)	

Source: Primary Survey, 2000

showed that the quality of services is far better in the SR area compared to those in the control area.

Intranatal Care

Preparation for home delivery by family is a critical component for safe motherhood and child survival. It has helped to conduct home deliveries scientifically by trained person as well as timely referral of high-risk mother.

Place of Delivery (%)
(n = 851)*

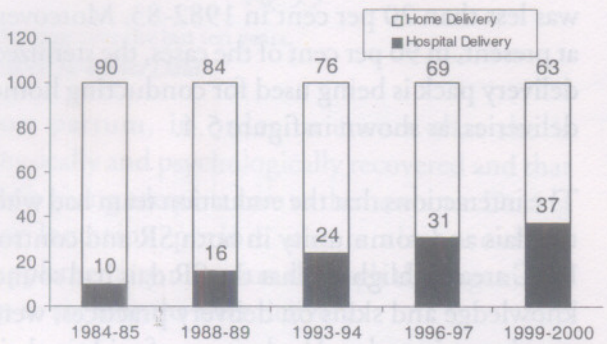


Fig. 5.3

*Average over the last ten years.
Source: In-service Data

Role of Dais/TBAs

As home delivery is preferred in these areas (more than 80% of the women deliver at home), dais, the traditional birth attendants (TBA), play a critical role in performing deliveries at home. SR has been able to mobilise their potential to the maximum so that they can conduct normal deliveries safely at home and identify and refer complicated ones to the base hospital on time. As seen in figure 5.3, the hospital delivery increased from less than 10% in 1984-85 to about 37% in 1999-2000, and most of them were complicated cases. SR has identified the practicing dais from all villages and has provided intensive and practical training on technique of safe delivery. There is also a provision for continuous learning through monthly meetings where experiences are shared and short training provided using exhibitions, visual aid and discussions.

A major contribution of SR has been the development of the disposable delivery pack for facilitating the process of safe delivery. The pack contains pre-sterilized instruments for a birth attendant and is simple to use. The pack was developed by SR and has been in use since 1987. The pack is given to pregnant women in the third trimester along with education on contents and its importance. In the initial years the kit was distributed free of cost, however later a token amount was charged. In spite of the charge the kit is being used and is effective.

There is a card inside the delivery pack with five key questions: Was kalla performed? Was breast-feeding initiated? Was a mackintosh used? Was the safe delivery kit used satisfactorily? Was a clean cloth available at the time of delivery? The FHW also checks if the baby's umbilical cord has been tied with the red thread provided in the kit. These observations and questions are asked by the health worker on her first postnatal visit, if answered satisfactorily, the TBA is paid Rs. 10 by SR. If the TBA brings the high-risk mother to the hospital, she is paid an additional Rs. 50 as an incentive since 1996-97.

Empowered Dai - Saving the Life of Mother and Baby

Nirmalaben has been working as a dai in Borindra village for the last seven years. She was an AWW in the same village and had undergone training in SR and has been handling delivery cases in her village. She has come across several critical cases, which she has been able to save. In 1996 a woman named Ramilaben started her labour pains. She was an Adivasi woman and she was bleeding profusely. Ramilaben's husband had gone out to work and nobody was willing to take a decision. She decided to take Ramilaben to SR. Although a bullock cart was available at the village, the owners were reluctant to give the cart to take the patient to the hospital. But with a lot of persuasion she managed to get the bullock cart and take Ramilaben to the bus stop from where she took her to SR hospital by truck. The relatives who accompanied the patients were unwilling to donate blood. A search for a suitable donor in Jhagadia was made but without any success. Finally her husband reached the hospital and donated blood and he also convinced the relatives to donate blood. Ramilaben gave birth to a healthy baby and thus the efforts of the dai helped to save the life of both mother and baby.

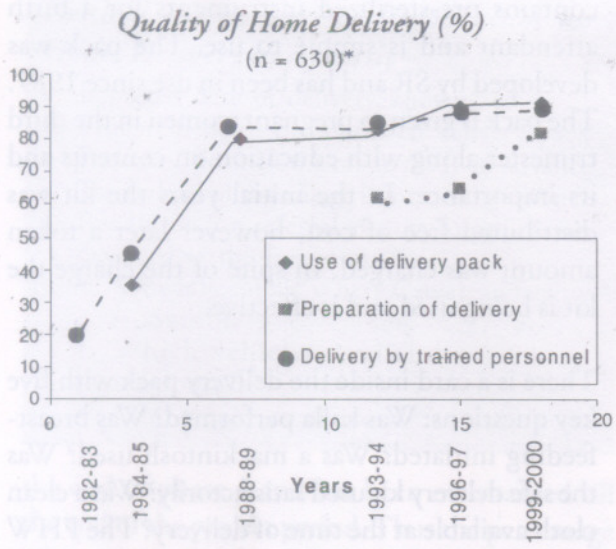


Fig. 5.4

*Average over the last ten years.

Source: In-service Data (except Baseline Data for 1982-83)

Knowledge Skill and Delivery Practices of Dais: Community Assessment

Dais in SR area

- All dais are trained
- Dais knew the importance of delivery kit and use it
- 90 percent of the pregnant women had the delivery pack.
- They take interest in registering women for ANC
- They conducted regular check-up and follow up of cases
- Dais work in coordination with FHW and anganwadi worker

Dais in Control Area

- A large proportion of dais are untrained
- Awareness on risk symptoms is very low
- Delivery packs are not available
- Motivation level is very low
- Work in isolation

Dais: Self Assessment

- 'We feel we are an important part of the healthcare system'
- 'We are trying to encourage younger people to get trained but it is very difficult'
- 'We know our limits and we do not try to force delivery. In case of complication we refer to SR'
- 'Our work is higher priority than our housework, God and mothers will give us strength and blessing to carry on with our work'

Source: Focus Group Discussions with Dais

The successful utilisation of the kits is also ensured through a health education campaign aimed not only at pregnant women, but also to other family members, including male persons and neighbours. Gradually, the entire community is becoming aware of the advantage of using a safe delivery kit.

As shown in figure 5.4, preparation of delivery was found satisfactory in almost 80% of the women. Secondly, trained persons have been conducting more than 85 percent of the home deliveries safely for the past 15 years, whereas it was less than 20 per cent in 1982-83. Moreover, at present, in 90 per cent of the cases, the sterilized delivery pack is being used for conducting home deliveries, as shown in figure 5.4.

The interactions that the evaluation team had with the dais and community in both SR and control PHC area highlighted that the SR dais had sound knowledge and skills on delivery practices, were greatly motivated and had a sense of pride in their work. All the dais in the SR area use this kit. In the control area we found very few pregnant women had the kit. Dais were not therefore using the kit. This kit has gone a long way in helping to conduct home delivery aseptically. Following its successful experimentation by SEWA Rural, the Government of Gujarat has introduced this pack all over the state.

Postnatal Care

Hospital delivery has been increased to 35% from 10% (figure 5.3). The coverage of postnatal visit within the first week of delivery is being maintained around 90 percent. There is a higher number of visits in the SR area as compared to the Government area, as seen in table 5.3. The follow-up is particularly done to look for post partum bleeding and purpurial sepsis. In postnatal care, SR gives vitamin A supplement, which is not the practice in the standard maternal service of the Government. This is reflected by the actual survey findings (table 5.3). It is given to supplement vitamin A to already deficient mothers which get depleted because of pregnancy and delivery. Nearly all mothers now recieve vitamin A supplement, which is seen in figure 5.5. The mother is followed up further up to six weeks

Vitamin A Supplement in Postnatal Care (%)
(n = 851)*

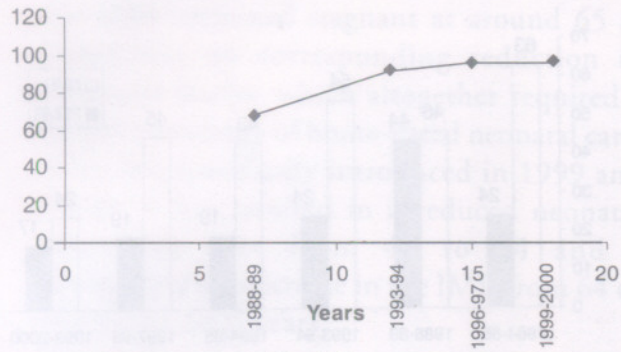


Fig. 5.5

*Average over the last ten years.
Source: In-service Data

post partum, in order to ensure that she is physically and psychologically recovered and that she is giving adequate care to the newborn. During her lactation period, she is also provided supplementary nutrition through the anganwadi up to six months after delivery.

Newborn Care

The importance and relevance of neonatal care is realized from the fact that 70 to 75 per cent of all infant deaths occur in the neonatal period. Two-thirds of these die during the first seven days, mainly because of low birth weight and infection. As around 70 per cent of babies are born at home and IMR/NMR remained stagnant for five consecutive years, a special programme for homebased neonatal care was introduced in 1996-97. SR has developed a special package of newborn services which can be managed at home. Every newborn child is monitored for 7 consecutive days after birth and then on the 14th, 21st and 28th day. All serious cases are immediately referred to SR hospital. A system has been developed to record the weight of the child within a day after birth by the anganwadi workers.

Critical Components of Newborn Care

- Promotion of use of sterile delivery packs at birth
- Drying and wrapping babies at birth
- Exclusive of breast feeding from day 1
- Birth weight on day 1
- Checking of newborn for danger signal everyday for 1st week and then every week for one month (total 10 visits)
- Education and awareness of family members for danger signs (feeding problems, infections, poor activity, etc.) by putting pictorial posters on the wall at home
- Early identification and referral of critical babies to hospital

Mothers and family members are made aware of the ill-effects of the traditional feeding practices and are encouraged to start breast-feeding within an hour after birth. To guide the AWW, to educate the mothers and family and to keep the record, a booklet, pictorial posters as well as a record card have been prepared and used (Annexure 8 and 9).

Table 5.3 Post-Partum and Newborn Care

Sr. No.		SR PHC	Govt. PHCs	p value
	Mothers Surveyed	70	97	
1.	Place of Delivery • Home • Hospital	 46 (65.7%) 24 (34.3%)	 86 (88.7%) 11 (11.3%)	 .0003
2.	Delivery conducted by trained personnel	62 (88.6%)	71 (73.2%)	.014
3.	Postnatal visit made (1st week)	57 (81.4%)	32 (33.0%)	
4.	Breast-feeding started 1st day	57%	43%	
5.	Birth weight taken 1st day	92.9%	27%	
6.	Vitamin A supplementation to mothers	Given	Not given	

Source: Primary Survey, 2000

Village dais are trained in delivery technique and equipped with delivery kit. Monthly meetings were held to review the situation and to refresh their learning. Because of these multiple interventions and special support provided for newborn care in the last two years (1999-2000), the neonatal mortality rate came down to 24 and infant mortality rate to 41 (1999-2000) from 45 and 64 (1997-98)

Child and Infant Mortality Rate
(n = 835 live births)*

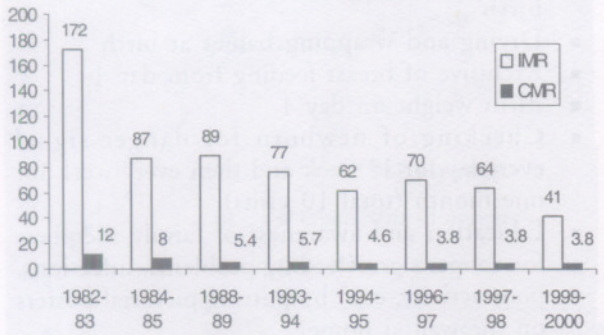


Fig. 5.6

Neonatal and Post-Neonatal Mortality Rate
(n = 835 live births)*

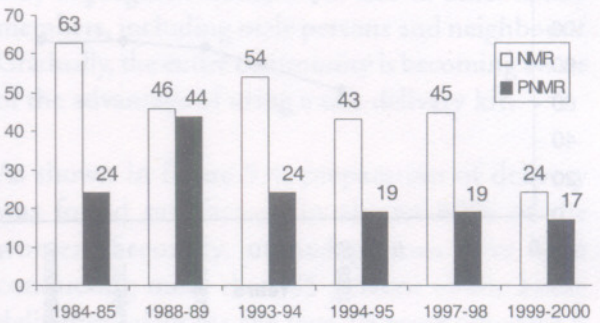


Fig. 5.7

*Average over the last ten years.
Source: In-service Data (except Baseline Data for 1982-83)

respectively (figures 5.6 and 5.7).

The community is encouraged to start breast-feeding at the earliest after delivery and this was reflected in the study findings where 43 percent of the mothers began breast-feeding within the first hour as compared to only 10 per cent in the control area. The birth weight was taken in 92 per cent of the cases in the SR PHC area as compared to only 27 per cent in the control area as seen from the survey findings detailed in table 5.3.

Distribution of baby blankets to prevent hypothermia, antibiotic injections being administered by FHW as per advice of the doctors, community participation for nutritional supplement like milk and extensive training using tailor-made modules on newborn care have all contributed to the reduction in infant mortality rates.

Technical Skill and Knowledge of Health Workers

The female health worker is the backbone of the ANC and PNC services. They work at the village level and are responsible for ANC and PNC, immunisation and treatment of minor ailments. In case of complication, they refer the patients to the hospital and in some cases the worker accompanies the patients to the hospital.

The health worker's technical skill and knowledge and counseling offered at SR are better as seen from the observations made by the evaluation team.

2. Child Health Services

SR, while collaborating with the Government in 1984-85 for providing comprehensive healthcare services (PHC Responsibility), had also taken the charge of the Integrated Child Development Scheme (ICDS) in its project villages.

A clear indicator of the effective and good quality of childcare services provided by the organisation is seen in the decline in the child mortality rate (CMR) from 12 (1982-83) to 3.8 (1999-2000) as well as a reduced infant mortality rate (IMR) from 172 (1982-83) to 41 (1999-2000) (figure 5.6).

In the initial years there were sharp changes in the mortality rates, which could be explained by accuracy and completeness of health related data during that period. The number of villages and population covered have also been increasing at various stages. The changes since taking full control in 1989 with a stable population are gradual. Because of the emphasis on certain measures like immunisation, oral rehydration solution (ORS), weaning and prompt referral, there was an early decline in the post neonatal mortality rate (PNMR) (from

52 in 1982-83 to 24 in 1993), as seen in figure 5.7. There was no further decline in PNMR. So IMR remained stagnant at around 65 as there was no corresponding reduction in neonatal deaths, which altogether required a different strategy of home-based neonatal care. This was specifically introduced in 1999 and 2000. It has resulted in a reduced neonatal mortality rate from 45 to 24 and a corresponding decrease in the IMR from 64 to 41 in the final years.

In case of child death, details are filled in a form to ascertain the cause of death and to analyze whether something more could have been done to prevent it. A meeting is held at the place of death - village/hospital to analyse the case and to explain to the concerned person/ community the cause of the death and possible ways of preventing such deaths in the future. At the end of one year, the information about the deaths is analysed separately for infants (below 1 year) and children (age group 1-4), and the predominant reasons for the deaths are listed. Efforts to reduce deaths are then discussed and intervention strategies are changed accordingly. As shown in figures 5.6 and 5.7, all these modifications and innovations, both technical and programmatic, at different levels have led to changes in the health status of the children (IMR and PMR) and achieving the target well ahead of the time.

ICDS

The main thrust of the ICDS is the health and development of pre-school children and mothers. The major activities under this programme include providing supplementary nutrition to pre-school children and to pregnant and lactating mothers, pre-school education, health and nutrition education to mothers, growth monitoring, immunisation and treatment of minor ailments. These activities are carried out with the help of anganwadi workers (AWW) at the village level. A helper assists the AWW.

More than 95 per cent of the children in the eligible age group (under 6 years) are registered under the ICDS programme as per the in-service records. Vitamin A coverage (200,000 IU every six months) has been maintained at about 95 per cent, which has helped in reducing the incidence of vitamin A deficiency in the area. However, in terms of utilization of the supplementary nutrition services, there was a decline from 76 to 68 per cent among children and 70 to 42 per cent among mothers during the ten-year period. One of the main reasons for this decline has been the irregular supply of necessary raw material from the Government, and secondly the mothers found the timing inconvenient as well as the taste of food not to their liking. SR has made modifications in the daily routine and timings of the anganwadi so that it is convenient for parents to access the services. On many occasions villagers are motivated to contribute towards this scheme. At many villages there is no adequate space to run the anganwadi. With the support of the Gram panchayat and the community, SR has been able to construct health posts in 18 villages, which are used as anganwadis.

The local people believed that the child should be fed only on mother's milk until it starts walking, and no other food items or nutrients were given to infants in general. Such beliefs

Anganwadi worker

- Stays at the village
- Concerned about overall growth of children – physical, mental, social etc.- weighs the children regularly
- Provides primary medical treatment for minor health problems
- A key contact point between community, paramedical and hospital
- Willing to support community initiative
- Skilled and highly motivated
- Helps in curing minor ailment
- Timely identification and referral of malnourished children, treatment and their follow-up
- Link persons for all village-level activities
- Plays a key role in newborn care which has been instrumental in reducing the IMR

Source: Focus group discussion

Malnutrition (%), PEM III and IV

(n = 3983)*

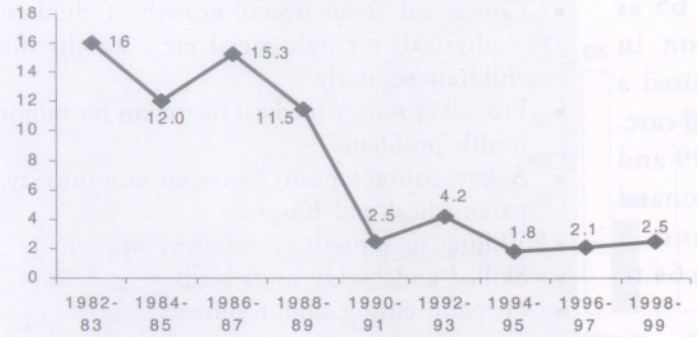


Fig. 5.8

*Average no. of children below the age of 6.

Source: In-service Data (except Baseline Data for 1982-83)

affected the growth of the child. Pictorial cards and roller boards were used to educate the mothers about child nutrition and growth monitoring and weaning of child. Nutritional demonstrations are also conducted which have been found very effective to change their attitude and improve their health and nutritional practices. Health check-up and screening of all the children have been done regularly by the team of paramedical male and female health workers. High-risk children are seen by doctors and treated in time. These efforts help to prevent malnutrition and in case they are already in PEM grade III and IV they are able to improve through timely treatment. All these inputs have helped to bring down the prevalence of malnutrition among children, as seen in figure 5.8.

The proportion of children that were malnourished was 16 per cent in 1982-83 and this came down to 11.5 per cent in 1988-89, 4.2 per cent in 1992-93 and then remained between 2 and 2.5 per cent from 1994 onwards, as shown in figure 5.8. There is a dramatic fall in the prevalence of vitamin A deficiency.

Immunisation

Immunisation is one of the key health components, particularly for maternal and child health. The immunisation programme of the Government aims at primary immunisation against 6 major diseases - tuberculosis, polio, diphtheria, pertusis (whooping cough), tetanus and measles. In 1982-83 the coverage of all primary vaccination was less than 10 per cent. During this period, there were frequent epidemics of measels and whooping cough, and many children were dying of post-measles complication. So SR introduced measles vaccine in its programme in 1985, well before the Government included it in its EPI (Expanded Programme of Immunisation) in 1987.

Various efforts are made to educate the community about the importance of vaccination in general and treatment of post measles complications in particular. The community never treated measles with medicine since they believed that the mother goddess 'Mataji' would save the child. The CHP staff educated the community on measles, the damage it can cause to the child and how this can be avoided through timely treatment. While the people continue to believe in the 'Mataji' they started taking medical care.

SR's approach with respect to vaccination has been professional, blending with a good understanding of the community's perceptions. Right from the beginning, planning has been meticulous, training rigorous and accompanied by tremendous efforts at creating awareness in the community. This has been done through understanding community perception and creating awareness through education at the village level. Among children in the age group 1-4, in-service data reflects that there are no deaths due to post measles complication, tetanus or diphtheria, no case of polio has been reported since 1986 and there were only sporadic cases of measles and whooping cough for almost a decade.

As shown in figure 5.9 the target of Health For All by 2000 was achieved for vaccination in SR areas by 1989-90 - a decade ahead of the targeted date. The coverage of all six primary vaccines had reached to almost 100% from the base line in

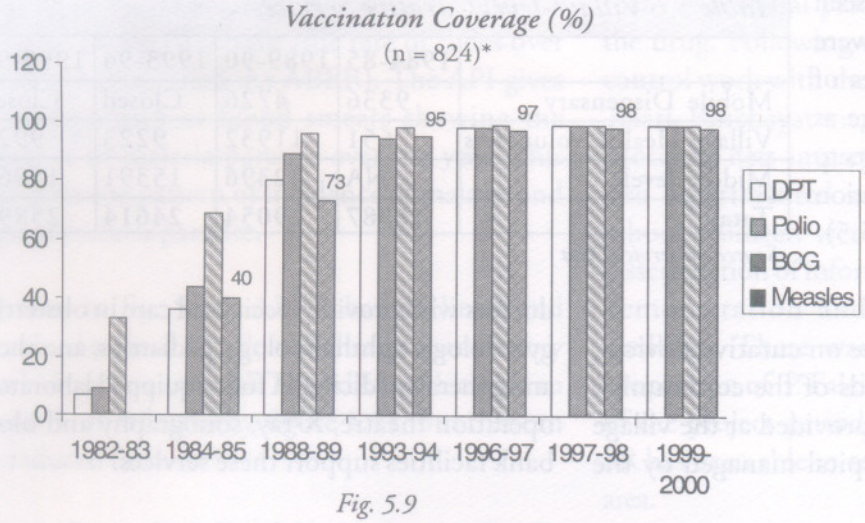


Fig. 5.9

*Average over the last ten years for children between age 1 and 2.
Source: In-service Data (except Baseline Data for 1982-83)

Table 5.4 Immunisation Coverage

Sr. No.		SR PHC	Govt. PHCs	p value
	Children Surveyed (age 1 to 2)	66	81	
1	Vaccination status • Complete (all primary vaccines)	62 (93.9%)	60 (74.1%)	.0014
2.	Vaccine card available	53 (80.3%)	42 (51.9%)	.0003

Source: Primary Survey, 2000

1982-83. A comparison also shows that the immunisation coverage in SR PHC was significantly greater than in the Government PHCs, which is shown by the survey findings in table 5.4.

Though the vaccination programme started with the camp approach in the beginning, it became a matter of monthly routine after about five years. A vaccination schedule has been fixed and the community is aware of this schedule. At the village level, vaccination is carried out during the first three days of the month, maintaining the cold chain. During these three days, all the sub-centre teams cover their respective villages with the help of village-level volunteers (AWW and TBAs). In the base hospital at Jhagadia, the vaccination clinic is scheduled for a fixed day of the week. This schedule is followed meticulously and it is very rare that these schedules are changed. Even if it has to change, all efforts are made so that everyone is informed well in advance. SR did face shortage of vaccines at times but they overcame these shortfalls and delays by direct purchase from the market.

The vaccination programme at SR serves as a model to demonstrate how such a programme can be organised and carried out. (See Renu Khanna, N.R. Mehta and Anil Bhatt, 1989 "Voluntary Effort in Community Health": Review of the Community Health Project of SEWA Rural)

Observation of quality of vaccination in SR and control area was also done at one sub-centre. The observation was done in

Table 5.5 Skill, attitude and behaviour of the staff

Points observed	SEWA Rural	Control area
Confirmation of dose	Done	Not done
Use of Sterilized syringe	Yes	Yes
Correct dose of vaccine	Yes	1 case only
Correct storage of vaccine	Yes	1 case only
Correct technique used	Yes	No
Explanation of side-effects	1 case only	No
Awareness on vaccination	Yes	No
Date of vaccination recorded	Yes	1 case only
Next date of vaccination noted	Yes	No

Source: Observations by the Team

3 cases in both areas. It was seen that SR health workers were using the right techniques of administration and storage as well as making special efforts to create awareness on vaccination among the parents (table 5.5).

Table 5.6 Village-level Curative Services

	1984-85	1989-90	1993-94	1998-99
Mobile Dispensary	9336	4726	Closed	Closed
Village Health Volunteers	7651	11932	9223	9929
Middle level	NA	22396	15391	15964
Total	**16987**	**29054**	**24614**	**25893**

Source: In-service Data

3. Curative Services

SR places great importance on curative services, as it is one of the felt needs of the community. These services have been provided at the village level as well as in the hospital managed by the organisation.

Village Level

Initially (1982-84) curative service was initiated through the mobile dispensary with a team consisting of a doctor, nurse and compounder on a weekly basis. Gradually, community health volunteers (CHV), took over this responsibility of providing curative care for minor ailments at the village level on daily basis. Paramedical workers were also trained and encouraged to provide curative care at the village level. Eventually the mobile dispensary was discontinued in 1989. As shown in table 5.6, around 25,000 to 30,000 patients (in a population of about 40,000) are treated annually by about 40 village level volunteers and paramedical workers.

The diseases treated at the village level were common illnesses like diarrhoea, dysentery, fever/ malaria, common skin infection, common cough and cold and minor injuries. This treatment is made available to the village people at their doorstep without them losing the entire day's wages. It provides medical services free of cost to the poor. The CHVs were also trained to know when to refer a case of advanced illness to a nearby hospital.

Hospital Level

Kasturba Hospital managed by SR provides valuable referral support. The hospital provides consultative services in OPD and has 75 beds for in-patients. At present there are 10 full-time doctors who provide specialised care in obstetrics, gynecology, ophthalmology, pediatrics, anesthesia and general medicine. A fully equipped laboratory, operation theatre, X-ray, sonography and blood bank facilities support these services.

4. Communicable Disease Control Programme

SR has been taking active measures in its project villages towards control of communicable diseases. Special focus has been given to malaria and tuberculosis control. These programmes are being implemented since 1984-85. SR has been able to make these programmes effective through education and awareness creation in the community, community participation and introduction of innovations.

Malaria Control Programme

The malaria programme in the project villages was initiated in 1984-85.The awareness on the disease among the community was very low in the beginning of the programme. They believed in superstition and people afflicted with malaria were taken to the 'Bhuva' (local healer). The community was not willing to accept treatment or give blood sample for testing. There was no facility for treating fever and malaria at the village level. To overcome this, SR provided training to health workers and village volunteers to provisionally diagnose malaria, take blood samples and to provide presumptive treatment.

Annual Blood Examination Rate (ABER), Slide Positivity Rate (SPR), Annual Parasite Incidence (API) and proportion of Falciparum infection are important indicators to reflect the situation of malaria in a community. To estimate the ABER collection of blood smear from all possible cases

of malaria-like fever, a door-to-door screening was done on fortnightly basis (the rate of slides over the year being called the ABER). The API gives the proportion of blood smears showing the presence of malaria parasite over the year. This also gives the pattern of incidence of malaria and type of malaria parasite.

As seen in fig. 5.10, ABER has declined and remained around 12, which indicates a satisfactory level of malaria control. The API has declined to about 5, as reflected by figure 5.11, but this can be reduced further.

Although over the years the incidence of malaria was gradually declining there was a spurt in the malaria positive cases, especially of P. Falciparum, during the early nineties, as seen in figure 5.10. This motivated SR to take up a vector control research study in 1994-95. In the study area, the intensive work included meticulous collection of slides, bio-engineering techniques to prevent water collection, distribution of fish seedlings, and ensuring timely treatment. In the control area the work was done at a regular pace. The intensive effort in the study area led to a decline in malaria positive cases. Another study conducted to find out the level of drug resistance to chloroquine proved that the malarial parasites were still sensitive to the drug. Following this, SR worked on vector control work with the participation of Sarpanch, Talati, Panchayat members and the community. Mosquito nets impregnated with insecticides was also experimented with in a few villages. The school children were actively involved in the dissemination of information through posters, live demonstration and in distribution of fish seedlings. There was a 50% reduction in the proportion of P. Falciparum infection at the end of the project period and through these efforts SR has been able to control malaria in its project area.

Incidence and Prevalence of Malaria (ABER and P. Falciparum)

(population = 40,000)*

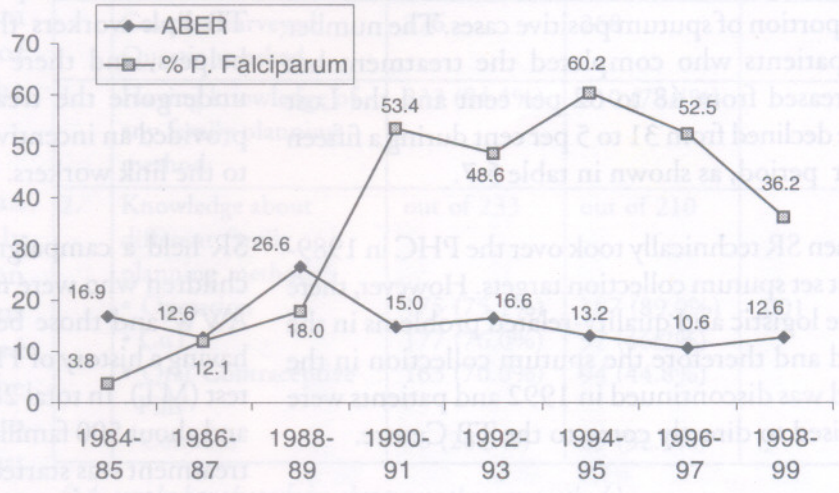


Fig. 5.10

Incidence and Prevalence of Malaria (API and SPR)

(population = 40,000)*

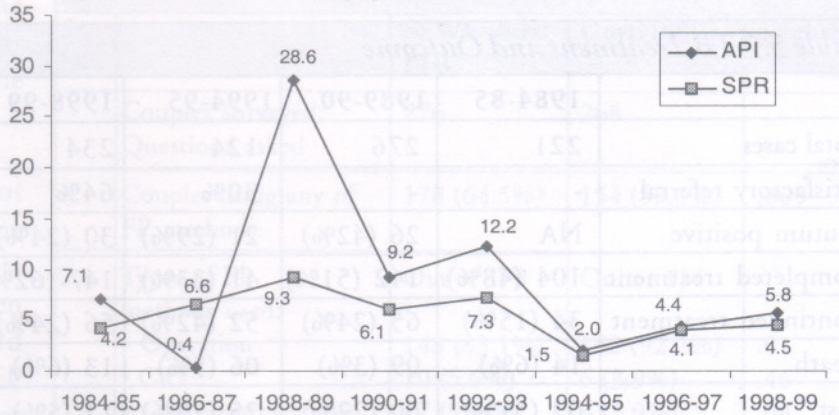


Fig. 5.11

*Average over the last ten years.

Source: In-service Data

Tuberculosis Control Programme

The main objective of this programme has been to achieve complete detection of cases and to ensure complete treatment of these cases. When SR started working, there was a high prevalence of TB, particularly among the young wage-earners, both men and women. SR began addressing the problem in 1982 by starting a TB Centre in hospital and outreach through the mobile dispensary. The TB Centre catered to patients from the entire Bharuch District and bordering districts.

In 1984, SR started intensive efforts for detection of cases, treatment and follow-up through village-level health volunteers and field paramedical workers. This has led to a decrease in the proportion of sputum positive cases. The number of patients who completed the treatment has increased from 48 to 62 per cent and the Lost rate declined from 31 to 5 per cent during a fifteen year period, as shown in table 5.7.

When SR technically took over the PHC in 1989-90 it set sputum collection targets. However, there were logistic and quality-related problems in the field and therefore the sputum collection in the field was discontinued in 1992 and patients were advised to directly come to the TB Centre.

The postcard system was used to follow up tuberculosis patients. The TB Centre maintains a tag of the TB patients under treatment. Postal reminders are sent when a patient fails to turn up on a given date. The postcard has helped the head of the family or the person responsible for taking timely decisions and restart the treatment. The middle-level workers also personally try to track down defaulters.

The Government introduced the Directly Observed and Treatment under Supervision (DOTS) programme in 1996. SR also implemented the programme in its project area. This programme entailed regular provision of treatment under direct supervision of a health worker till the patient is declared cured. The female health worker and the multipurpose health worker (male) were given the responsibility of giving the medicine on three specific days of the week with the help of link workers. Among the TB link workers there are active AWWs and helpers, and there are TB patients who have undergone the treatment and got cured. SR provided an incentive of Rs. 25 per patient cured to the link workers.

SR held a campaign in 1997 during which all children who were malnourished as reported by AWW and those below 10 years from families having a history of TB went through the Mantoux test (MT). In total 288 MT tests were conducted and about 500 families were screened and medical treatment was started for 74 children.

Table 5.7 TB Treatment and Outcome

	1984-85	1989-90	1994-95	1998-99
Total cases	221	276	124	234
Satisfactory referral	-	-	30%	64%
Sputum positive	NA	26 (42%)	21 (29%)	30 (24%)
Completed treatment	104 (48%)	142 (51%)	41 (33%)	147 (62%)
Continued treatment	34 (15%)	65 (24%)	52 (42%)	56 (24%)
Death	14 (6%)	09 (3%)	06 (5%)	13 (6%)
Lost	69 (31%)	60 (22%)	25 (20%)	12 (5%)

Note: The total number of cases includes cases at the beginning of a month, new detection and those that resumed treatment.

Source: In-service Data

5. Family Planning

This programme forms the main part of the Government PHC service. Though SR recognizes that population control is an important issue, it feels that in order to provide better family planning (FP) services, the quality of other healthcare programmes and awareness creation is important. SR has integrated this programme into other important programmes like maternal and child health, immunisation and curative services. As

family planning was part of the overall PHC responsibility, the organisation had to fulfil certain targets set by the Government. SR devised a method of setting its own targets for internal monitoring based on ground realities and the felt needs of the eligible couples from 1995-96. These targets were generated by the workers themselves, which helped them to own the responsibility of achieving them. The targets were assigned not to an individual worker but to the entire sub-centre team. It is heartening to note that they have been able to meet their targets with ease. The couples themselves started to come forward to accept one or another of the family planning methods. A special programme for newly weds was also introduced to sensitise them about sensitive aspects of reproduction and the importance of spacing.

SR has consciously made an effort to ensure that family planning does not impinge on other health activities. Efforts are also made to try to spread out the programme over the entire year instead of rushing to meet the target during the last quarter. Every week a day has been fixed at the hospital to address the FP needs of the community. By having this system, SR has assured the community and health workers of these services throughout the year.

The FP drive of SR has got better acceptance among the community. Health workers with high sensitivity have been motivating people and convincing them to accept FP methods. The programme has created a fair level of awareness among the people on various methods of FP and has gained acceptance. As seen in the survey findings in tables 5.8 and 5.9, the couples under SR PHC area reflect a higher knowledge and acceptance of different FP methods as compared to the Government PHCs. The knowledge and utilisation of spacing methods in particular is found to be significantly higher as seen in these tables. Over the years SR has observed that the couples prefer to undergo sterilization operation once they have the desired number of children. The preference for son is still high. There is a certain degree of reluctance to adopt spacing

Table 5.8 Knowledge about Different Family Planning Methods among Couples of Reproductive Age

Sr. No.		SEWA Rural PHC	Govt. PHCs	p value
	Couples surveyed: Questions asked	276	268	
1.	Having knowledge of any family planning method:	233 (84.4%)	210 (78.4%)	
2.	Knowledge about different family planning methods*:	out of 233	out of 210	
	• Operation	175 (75.1%)	187 (89.0%)	.001
	• CuT	177 (76.0%)	97 (46.2%)	
	• Oral Contraceptive Pills	163 (70.0%)	94 (44.8%)	
	• Condom	66 (28.3%)	69 (32.9%)	.3

*(*As couples have knowledge about more than one method.)*

Source: Primary Survey, 2000

Table 5.9 Practices of Different Family Planning Methods by Couples

Sr. No.		SEWA Rural PHC	Govt. PHCs	p value
	Couples surveyed: Questions asked	276	268	
1.	Couples using any of FP methods:	178 (64.5%)	154 (57.5%)	.009
2.	Types of FP methods used:	Out of 178	Out of 154	
	• Operation	148 (83.1%)	142 (92.2%)	.01
	• CuT	10 (5.6%)	6 (3.9%)	.46
	• Oral Contraceptive Pills	17 (9.6%)	6 (3.9%)	.04
	• Condom	1 (0.6%)	0 (0%)	.3

Source: Primary Survey, 2000

Impact of Family Planning Services

(population = 40,000; n = 245 sterilizations)*

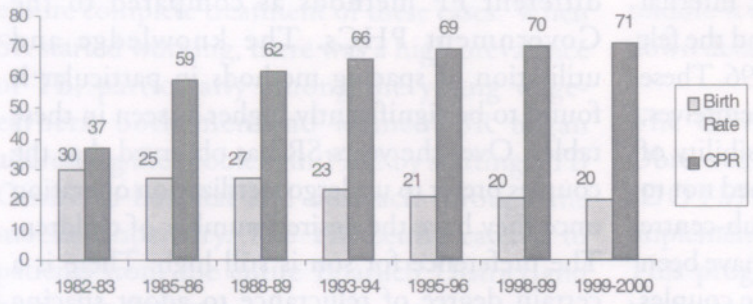


Fig. 5.12

*Average over the last ten years.

Source: In-service Data (except Baseline Data for 1982-83)

Quality of Family Planning Services

(population = 40,000; n = 245 sterilizations)*

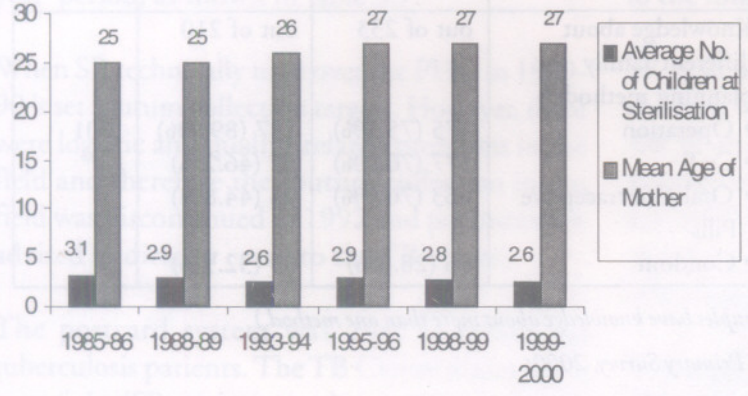


Fig. 5.13

*Average over the last ten years.

Source: In-service Data

methods, particularly for CuT, because of its perceived side-effects and use of condoms is not popular because of its inconvenience.

However, before conducting FP operation a thorough medical check-up and screening is done. In case there is a medical problem they are provided treatment at SR hospital and advised to come at a later date once they are fit. The eligible couples are counseled if they face some emotional difficulties. There are instances when SR staff have advised the couples not to adopt terminal family planning devices where the last child is not keeping well. Over the years the community has realized that for SR the overall benefit to the couple is more important than simply achieving numbers. This is generally not heard in case of a Government PHC family planning campaign.

SR provides services for Medical Termination of Pregnancy (MTP). More and more women, particularly unmarried pregnant girls, are coming forward to avail this service instead of going to untrained practitioners.

Many a times, the organisation could not meet the Government targets since the basis on which the family planning targets were generally calculated/assigned was not matching with local characteristics. However, SR took into consideration the current birth rate, the Couple Protection Rate (CPR), child pattern and couple's preferences when setting targets for various FP methods. As a result, SR has achieved satisfactory results in terms of impact on Couple Protection Rate (CPR) and birth rate. SR has been able to maintain a Couple Protection Rate of about 69 per cent and a birth rate of about 21 since 1995-96, the goal which was to be achieved under HFA by 2000 AD (see figure 5.12). The higher CPR was also reflected in the information derived from the study and control area survey in table 5.8. The mean number of children at the time of accepting a permanent method was around 2.6 which is significantly less than in other Government PHC areas (see figure 5.13).

SR also started an infertility clinic in 1997 and a senior OBGY specialist comes from Vadodara to this clinic on a weekly basis. In general, more than 100 new couples are availing themselves of these services and 10 couples are benefitting every year.

6. School Health Services

The information on the programme is available from 1990-91. 8555 children were registered cumulatively up to 1990-91. After this, the number of children registered was around 1800-2300 per year (see table 5.10).

SR conducted medical check-ups at school, where more than two thirds of the registered children were examined/screened for different morbidities by a team of trained paramedical workers (see table 5.10). Coverage of the programme is dependent on the attendance at school. The problems diagnosed were anemia, worm infestation, dental problems, skin and eye problems. The majority of them are treated at school level immediately and other cases are referred to SR hospital for further investigation and treatment by specialists. After the case is referred, the male and female workers regularly follow up the cases. As part of this programme, the parents were contacted and given education on the problem faced by their child.

As part of the school check-up, students in standards 1, 4, 5 and 10 are given DT and TT injections to provide immunity against diphtheria and tetanus. During school visits SR staff provide education to the children on various diseases and also conduct exhibitions. During their regular village visits, they go to the school and, depending on the seasonal morbidity, they provide education on respective diseases.

SR has over the years made some efforts to involve school children in various health programmes at the village level. The involvement of school children in health programmes has been good. The children helped to write health-related slogans on the village walls. They are also involved in the malaria vector control programme and in health campaigns, health fairs and camps, including eye camps.

SR also involves school children to disseminate information on diseases at the village level. For publicity and to get the village together for programmes like pulse polio, vaccination and health education, the organisation has effectively taken the help of the school children. This way, information is also conveyed to their parents. To increase the involvement of children in the health programme, SR staff use games, story telling, songs and other interesting methods.

7. Reproductive Health Services

The additional component like adolescence health and development, care of unwed pregnant girls, programme for newly married couples were introduced during the last 10 years of services. In an effort to broaden its reproductive health focus, SR undertook a community-based study of women's health problems (Annexure 10). The results showed that RTIs and menstrual problems are a major concern. Based on their findings and in the light of the increasing number of reported cases of RTIs at the hospital, SR made some effort on an experimental basis to reorganise its community-based work in a smaller area, with the aim of improving and studying the accessibility and quality of reproductive health services for both men and women.

Table 5.10 Coverage Under School Health Programme

	1984-85	Up to 1990-91	1992-93	1994-95	1996-97	1998-99
Total Registration	NA	8555	1870	2128	2156	2312
Total Examined	NA	6196	1423	1306	1488	1582
% covered	NA	72	76	61	60	68

Source: In-service Data

Chapter 6

Making a Difference: Factors and Processes

SR could introduce several interventions which were innovative in the content as well as the structure of different programmes (Annexure 8). Over a period of time the State Government got convinced and accepted some of SR's successful and effective micro level innovative interventions. The State Health Directorate tried to introduce these positive experiences wholly or partly in the larger state health system so as to update them at the macro level. This was made possible because of frequent interactions and practical demonstrations by SR teams. The process, systems and innovative interventions adopted by SR have helped to make a difference in the health status in Jhagadia Taluka. This chapter describes some of these innovative interventions.

1. Motivation and Capacity Building

One of the distinguishing features of SR is having a team of medical professionals who are committed and stay in the rural areas. This has been a very positive influence on the other members of the CHP staff. CHP staff being part of SR get influenced by the mission of the organisation which are: Reaching out to the poor, value-based work and self-development of all involved in work. These elements percolate and act on the functioning of all programmes. There is some elaboration of this below.

a. Spiritual Outlook

All along, SR has felt and emphasized Man Making. Man to be served and Man who is serving both are important. Moreover, small but significant inputs are interwoven so as to imbibe the spiritual outlook in a day-to-day functioning which gradually builds up that real inner anchor, so to say, to continue the path of social work with a sense of fulfillment and joy in the true spirit of Karmayoga. This provides the necessary courage and inspiration towards influencing a greater change for the better; both at the outer level i.e. in the larger society and simultaneously within self. Ultimately this brings

in and imparts the essential grit and stamina to continue to positively withstand the stress and struggles of life, work and organisation. The process is rather slow but emphasized over and over again. It takes a form of inspirational readings in the beginning of most discussions and meetings, prayer or maintaining silence for a couple of minutes, elucidating elements of mission in relation to achievements, difficulties, or failures of either an individual, group or organisation encountered during the programme implementation. For this, SR draws upon the rich diversity of Indian culture and heritage and spiritual literature encompassing all major religions. In addition, sharing and learning from other voluntary initiatives, training and academic institutions also help in clarifying and fortifying the same process.

Another distinguishing feature of SR has been its emphasis on certain values and their consistent and tireless effort to ensure that these values and ethics percolate to all members of the organisation. Messages conveying these ideals are sought to be given, at almost every opportunity, by various ways: personal example, quotes from the lives and writings of saints and great men and women, analysis of events and decisions, and a matching system of rewards and disincentives. This is done at work, at meetings in training sessions and in informal interactions. The effort is always to keep the poor at the centre of activities, and to remind each other that this must not, at any cost, be sacrificed. At the same time, the dignity of work of whatever kind is emphasized, as also the virtues of team work. Responsibilities are shared, and especially with major mistakes, there is a public expression of the fact that every one in the hierarchy, including the head of the organisation, are responsible. On the other hand, a job well done is publicly commended while emphasizing that it would not have been possible without contributions from all members of the team. An attempt is made to retain a family atmosphere in spite of a growing organisation.

b. Guidance and Support

The staff at SR receives guidance and support at work. The medical officer of the CHP programme listens to the experiences of the field staff with great interest. They are able to share the problems they face at the field level. Depending on the need, they are provided support to carry out their work at the village level. On a monthly basis the health workers, supervisors and the medical officer meet at SR. It is interesting to note that they not only share their good experiences but also the shortcomings and mistakes in their work. Time is spent on sharing the village-level events and incidences of the previous months. During the discussion the medical officer provides guidance on health-related problems found by the workers and help them find solutions. Apart from the training provided by the doctors on curative health, the health workers are also given training before taking up a special assignment like school health programme. During the field visits, doctors provide guidance to health workers. The work at SR is considered an opportunity to learn and grow. They are provided exposure to hospital work as well as opportunities to take responsibility. The field workers are given hospital placement once in three months. This gives them an opportunity to understand the working at the referral level and hospital staff also gets a chance to know in detail various incidences from the field, and based on that, they can provide the necessary medical support. They are also taken on educational trips so that they can see what happens in other systems. SR has developed a feedback mechanism in which there is a suggestion box in each department. Every fortnight a session is held in which the suggestions and complaints are looked into. This helps in creating an atmosphere, which is open, where everyone gets an opportunity to ventilate his/her feelings. In terms of personal crises SR provide support to families. They also take up activities with family members of the staff.

c. Self Development

Self-development is one of the critical elements of SR's mission. Moreover, the staff at all levels (from dais to doctors) are encouraged to attend various seminars, workshops and training programmes at regional, national and international levels towards professional development and capacity building. Many a time the staff is invited as resource person to present and share SR

experiences at such levels. At SR various mechanisms have been created for appreciating and rewarding good performance. This is shown in the form of growth in career, awarding key positions and responsibilities in the organisation. Three of the staff members are promoted and awarded the position of trustees being part of important decision-making processes.

SR has used the locally available human resources and developed their skills to improve the delivery of health services through motivational capacity building and training. It is aware that it is very difficult to get trained people to stay and work in rural areas. SR has made a good effort to overcome this by using locally available human resources to their full potential. The health workers from the local areas have good rapport with the community. All the health workers stay at the sub-centre quarters or in the village.

d. Trained Dais

Practising dais from every village are selected and trained. This training focuses on safe delivery, use of delivery kit, identification of risk symptoms, and creating awareness in them on the limits to which they can try to conduct the delivery at the village. They are aware at what point they should refer the patient to the hospital. The training has provided them with kit and given them better recognition among the village community. To supplement this training and to keep their understanding and skills up to date SR also provides training to dais from time to time. Every month during the review and planning meeting, training is also provided on various aspects of safe childbirth. This type of skill development is not done in the Government system.

The dais working with SR feel that they are an important part of the healthcare system in villages. They do it as a service to the community. They feel that they have contributed to the decrease in maternal and child death, hygiene delivery and personal care, counselling on safe delivery and also in case of TB patients. Their work is given a higher priority than their own housework. They fully believe that God and mothers will give them strength and blessings to carry on with their work.

e. Anganwadi Workers

The anganwadi worker has two roles to play in a village, as a teacher and as the first contact point for health service delivery. The anganwadi timing is from 8.30-12.00. After this on a regular basis they make house visits. As a daily average they visit 5 houses in the village. During these visits they provide health education. A timetable has been set for weighing children at the anganwadi. It has been fixed that children below 2 years will be weighed between 20th and 27th of every month and children above 5 years once in 6 months.

The AWWs are able to identify the Grade III and IV malnourished children and are able to take immediate action. The early detection has resulted in children being able to come out of Grade III and IV without much physical and mental handicap.

They also remind the community of the dates for immunisation. They follow up TB patients and provide treatment for minor ailments like fever, headache and stomach disorder to the community. In case of severe disease the AWW refers the patient to SR. They fill out the reference slip or write a note and follow up these cases.

They are paid a salary of Rs. 500 per month. SR also provides incentives to AWWs for specific work. Newborn care for a whole month gives them Rs. 20 per case and for follow-up of TB cases which have been completely cured they get Rs. 25 per month per case as an incentive. Similar incentives are also provided for follow-up of high-risk mothers.

They have been able to get the cooperation of the community in various ways. The community helps out during functions at the anganwadi. When the supplies do not come on time they provide food grains to prepare the food. At the village level they provide support in organising meetings and trainings.

They sometimes face resistance from the community when they try to refer patients to the hospital. In many cases they have to create awareness on the seriousness of the situation and

pressurise them to take quick action.

The AWWs feels that it will be difficult for the community to function without them. They said

- Who will tell the women about vaccination?
- Who will take care of the children when women go to work?
- What will happen to the children's lunch?
- Who will check-up the women when they are pregnant and give them the TT injections?

2. Linkages and Collaborations

SR has been able to build several linkages and collaborations with different sections of the society like the Government, policy makers, academic institutions, the industry, foreign agencies, local community as well as voluntary sectors. The idea is to use the combined strength of different sectors for the improvement of the underprivileged section of society.

a. NGO-GO Collaboration

Most voluntary agencies do not want to work with the Government. They feel that while working with the Government they lose their independence. This is particularly so when it comes to providing health services. The Government asks them to implement the programme designed by the Government without any change and funds are provided for this. The impact of the agency is not different from that of the Government.

However, the SR collaboration with the Government is a special case. It is the only experiment in India in which a voluntary organisation has been handed over the responsibility of delivery of total healthcare to 30 villages. Government has made resources available to SR to implement Government healthcare schemes with the freedom to bring about innovations in the methodologies and in the process of implementation. Some of the innovations have been accepted by the Government and replicated in their systems.

The organisation has completed 10 years and has handed the PHC and the ICDS back to the Government. This does not mean that the collaborative effort of SR and Government in providing healthcare services has come to an end. The organisation is entering into a new phase of collaboration with the Government. The Government of Gujarat is putting great emphasis on a Safe Motherhood Programme, which coincides with the approach as well as mission of SR. Under this programme, the Government aims to set up 80 First Referral Units (FRUs) to begin with in all the districts of Gujarat, with each FRU covering a population of 100,000 to 200,000. SR will be the FRU for Jhagadia Taluka. The organisation covers a population of about 200,000. Emphasis in this phase is to grow into a model FRU in Gujarat. The experience of SR will be used to make the other 79 FRUs more effective.

b. Linkages with Policy Makers and Planners at National and International Level

SR was fortunate to have frequent opportunities to influence policy makers, planners and implementing agencies at various levels through the formal and informal interactions. The subjects, contents and topics varied from direct programmatic interventions to overall management and operational issues in the area of healthcare delivery systems. These were made possible through several levels of interactions, consultative meetings, besides participating in many committees as members on invitation. SR also participated as a member of the advisory committee at the district and state level related to malaria, AIDS, RCH and Health Sector Reforms. This gave an opportunity to introduce some effective innovations at technical and management levels in various forms. In addition, SR staff members are regularly invited to make presentations and act as resource persons at many technical, consultative and management conferences organised by national and international agencies. The former includes Ministry of Health & Family Welfare, National Institute of Health & Family Welfare, National Institute of Public Cooperation & Child Development, Indian Medical Council, National Neonatology Forum while the latter include WHO, UNICEF, Ford Foundation, MacArthur Foundation, UNFPA and Population Council. SR is also taking an active role in networking and

interacting with several organised bodies like Gujarat Voluntary Health Association, Federation of Charitable Hospitals (Gujarat) and Jana Swasthya Sabha, a voluntary initiative involving people, NGOs, smaller voluntary groups of State as well as national level to prepare a charter on people's health.

SR and UNICEF are working in collaboration to operationalise an FRU at Jhagadia. The aim is to make it a model for Gujarat and they are working together, keeping in mind the constraints faced by other FRUs. UNICEF will be supporting SR to build innovation into the FRU, like providing a counsellor at SR to create awareness on risks and danger symptoms, to provide for quick transportation of patients to the FRU, build linkage with the community and documentation of complicated cases through case studies, follow-up and monitoring.

c. Linkages with the Voluntary Sector

The training centre at Jhagadia draws from the rich experiences of the Community Health Project and the hospital and thus is an important means of dissemination of SR experiences over the years. Regular training programmes are conducted by a team of full-time trainers, and supported by a faculty of experts from both SR and other organisations. The training of workers of other voluntary organisations takes different shapes depending upon their needs, kind of health workers to be trained and long-term objective of respective organisation. It also provides to SR members the education and insight in real health problems of different parts of the country. Staff from more than 200 voluntary organisations from across the country have been trained and oriented at SR, thus carrying and spreading the knowledge and skill gained from SR's experience. Thus SR's micro innovations get introduced in various health programmes of NGOs who come for training to SR regularly.

d. Influencing the New Generation

Many young people are willing and capable to conceive ideas and are ready to work to reduce the suffering of our people but elders, teachers and leaders are failing to provide a role model to which they can look up. During the last decade, more than 600 students from around 75 universities and academic institutions of India and abroad have availed themselves of formal or informal training at SR. More than half a dozen of them have started their own organisation and work for the needy people in other rural areas.

Many universities and academic institutions send their graduate and post graduate students to SR for field placement of one week up to six months. The main purpose of such posting is to make students from different disciplines study and understand the issues and realities linked to rural healthcare and development. This provides SR a natural opportunity to share its experiences and wisdom with youngsters who are full of energy and enthusiasm. It is heartening to note that students from a wide range of disciplines from within and outside the country, after completion of their studies, have got inspired to take up such a challenging but fulfilling career. The students also contribute their creativity and enthusiasm to the training as well as to the overall function of SR while themselves benefit from the rich field work. It includes intern doctors of all medical colleges of Gujarat, postgraduate students of Tata Institute of Social Sciences (Mumbai), students from the Faculty of Social Work and Home Science of M. S. University (Vadodara), students of rural studies of different vidyapiths and colleges of Gujarat, trainees from International Services Association (Bangalore) and undergraduate medical students and graduate students from various universities of USA, the UK, Canada and Germany.

The process of influencing the younger generation takes place when the teaching institutions, and sometimes individuals themselves, place their students at SR in a formal or informal way for a specific period of time. There are interesting and commendable instances which denotes the process of influencing the youngsters or them being influenced while in SR. Many become part of SR largely due to their own interest and involvement in the development of the poor. The stay in SR either stimulates or accelerates the dream to do similar work elsewhere in their respective fields.

It has resulted in the situation like doctors getting involved in hospital services and community health, professionals joining another group doing comparable work, individuals contributing in health training drawing from rich field experiences of SR, initiating a technical training centre in another industrial area, becoming major administrative support in a community hospital in one's own home town or a voluntary organisation, initiative to combat child labour and experimenting with innovations in creative education. There is also an ongoing sharing and learning as well as supportive relationship between these young innovators and SR which continues to enrich both sides. It gives special fulfillment to key people of SR as this kind of development enables the expansion of work accompanied with genuine decentralization and freedom without additional burden on SR. The mission of reaching out to the poor gets multiplied in several fields and places of Gujarat.

e. Linkages with the Community

SR has made efforts to build linkage with the community. They hold formal and informal meetings at villages and discuss general issues. They have taken interest in other problems facing the village like hand pumps repair and to get admission for children in school. They take part in village social events. They have built a good relationship with adolescent girls through discussions and this way they have created an entry point for health as well as sex education among these groups. They also prepare and circulate Arogya Patrika for dissemination of information on health and local issues. The relationship of SR with the community is not of a receiver and giver. There is also a degree of duty and responsibility associated with the relationship.

The level of participation of the community in various activities is reflected in a few programmes. The community was consulted in all stages of planning, implementing and monitoring. The Malaria Control Programme is one such example. Considerable input was required at the village level for the prevention of malaria. This led to selection and training of volunteers who were also paid a stipend for the work. In 1995, at Jhagadia village, the Panchayat and SR worked out a strategy where a vector control programme for malaria was launched. The Panchayat paid for the labour and SR provided the technical guidance. They also published a 'malaria patrika' and organised an exhibition on the issue. Every year SR writes to all the Panchayats before the monsoon and reminds them of preventive measures through mosquito control and cleanliness. In order to sustain such activities, village Sarpanch, Talati and members were called to SR for a planning meeting.

Anganwadi buildings are constructed with the help of Panchayats. At 16 villages, anganwadi centres were built. Although the buildings have been completed they have not developed a system of maintenance with participation from the community. All these centres lack financial resources for maintenance.

f. Linkages with the Private Sector

SR has linkage with more than 30 medical practitioners in the area and provides support and referral services. SR organises frequent meetings with them to share the new health initiative as well as to share problems encountered by private practitioners and solutions are discussed together to strengthen the ties. Lectures on interesting health topics are organised by inviting outside experts.

g. Linkages with Academic Institutions

SR also has linkages with the various medical colleges in Gujarat, particularly with the colleges in Surat, Karamsad and Vadodara. The students from these colleges visit, stay and work at SR, as interns. They learn the work culture and also get an understanding of SR's programmes. They get an opportunity to get field exposure. They provide feedback on their experience to their teachers. This linkage is ongoing.

3. Perception of Stakeholders

a. Community

The community looks at SR as a hospital for the poor. They are aware of the various programmes of SR like childcare, anganwadi, immunisation, ANC and PNC, treatment for TB and eye camp.

'The health worker in the village writes a chit/slip for us, which we take and show at the hospital. This helps us to get subsidized fees. For delivery, we have to pay only 50 per cent of the cost. Food is provided to patients free of cost and if the patient's house is far away, accompanying family members receive food on payment of two rupees.'

Community members have said 'Ten years ago, SR was working in only 20 villages and fees were not charged, medicines were available from the hospital free of cost and special treatment was given. The situation was manageable but now we have to spend a lot of time to run here and there for diagnosis'.

In the control area, people knew about SR. Patients are referred to SR hospital from the control area.

The community in SR project villages is dependent on the health worker for treatment of minor ailments and also for follow-up of many programmes and appreciate the work done by the health worker. They feel that without them the community will find it difficult to get proper healthcare. They want SR to provide immunisation, ICDS and MCH services. They felt that in the absence of the health workers from SR no one will be able to conduct check-up of women, take blood tests and remind them about immunisation.

In contrast, in the control areas the community does not have faith in the Government health workers who hardly make any visits. Even when they visit, the villagers do not see them as they visit only certain houses at the village. They don't have the drugs that are required by the community. They do not maintain a close relationship with the community. None of the Government health workers stayed at the sub-centre. No meetings are held at the village level and in all the control villages the last meeting held with the community was six years back.

In control area village Gundecha people report that the PHC staff are not regular, they do not have any fixed schedule for immunisation, they do not visit all the houses for check-ups of pregnant women and no health meetings have been held till date. They only visit the anganwadi and they go back, which indicates that relationship between health workers and the community is weak. They are seen by the community as outsiders, which can pose a threat if they complain about the services. Some young men of the community followed us to the vehicle and narrated the deplorable state of health services they received. The health workers never visited the village. They felt that women were able to access maternal services but the rest of the community did not benefit from the PHC services.

Community participation in health education in the SR project village is very high. The impact of health education is evident from their knowledge of symptoms and causes of various common diseases.

In contrast, in two villages of the control area they were not aware enough to tell even simple home remedies for treatment of diarrhoea. As soon as some one falls ill in the household they are immediately taken to doctor. However, in the third village, Gundecha 3, which was under Avidha PHC the situation was slightly different. Eight years back this village was part of SR's project area. They still remembered how to prepare ORS, which was part of the health awareness programme of SR.

In the SR villages if there was any illness in the household they approached the health worker first. In case of fever and diarrhoea, before meeting the HW, they would take immediate action at the household level so that the condition of the patient does not worsen. 'We do not have any dangerous illness as we get primary treatment for minor ailments at the SR sub-centre. For any treatment, in the absence of the health worker we go to the private doctor. In case of delivery, dai is called. If there is an emergency then we call SR for a vehicle and they do send us the vehicle. Delivery charges are not taken. We approach SR in serious conditions like severe diarrhoea, vomiting, high fever, malaria. There is no other doctor in the village, so we have to depend on SR only.'

'The health worker in the village writes a chit/ slip for us, which we take and show at the hospital. This helps us to get subsidized fees. For delivery, we have to pay only 50 per cent of the cost. Food is provided to patients free of cost and if the patient's house is far away, accompanying family members receive food on payment of two rupees.'

Community members have said 'Ten years ago, SR was working in only 20 villages and fees were not charged, medicines were available from the hospital free of cost and special treatment was given. The situation was manageable but now we have to spend a lot of time to run here and there for diagnosis'.

In the control area, people knew about SR. Patients are referred to SR hospital from the control area.

The community in SR project villages is dependent on the health worker for treatment of minor ailments and also for follow-up of many programmes and appreciate the work done by the health worker. They feel that without them the community will find it difficult to get proper healthcare. They want SR to provide immunisation, ICDS and MCH services. They felt that in the absence of the health workers from SR no one will be able to conduct check-up of women, take blood tests and remind them about immunisation.

In contrast, in the control areas the community does not have faith in the Government health workers who hardly make any visits. Even when they visit, the villagers do not see them as they visit only certain houses at the village. They don't have the drugs that are required by the community. They do not maintain a close relationship with the community. None of the Government health workers stayed at the sub-centre. No meetings are held at the village level and in all the control villages the last meeting held with the community was six years back.

In control area village Gundecha people report that the PHC staff are not regular, they do not have any fixed schedule for immunisation, they do not visit all the houses for check-ups of pregnant women and no health meetings have been held till date. They only visit the anganwadi and they go back, which indicates that relationship between health workers and the community is weak. They are seen by the community as outsiders, which can pose a threat if they complain about the services. Some young men of the community followed us to the vehicle and narrated the deplorable state of health services they received. The health workers never visited the village. They felt that women were able to access maternal services but the rest of the community did not benefit from the PHC services.

Community participation in health education in the SR project village is very high. The impact of health education is evident from their knowledge of symptoms and causes of various common diseases.

In contrast, in two villages of the control area they were not aware enough to tell even simple home remedies for treatment of diarrhoea. As soon as some one falls ill in the household they are immediately taken to doctor. However, in the third village, Gundecha 3, which was under Avidha PHC the situation was slightly different. Eight years back this village was part of SR's project area. They still remembered how to prepare ORS, which was part of the health awareness programme of SR.

In the SR villages if there was any illness in the household they approached the health worker first. In case of fever and diarrhoea, before meeting the HW, they would take immediate action at the household level so that the condition of the patient does not worsen. 'We do not have any dangerous illness as we get primary treatment for minor ailments at the SR sub-centre. For any treatment, in the absence of the health worker we go to the private doctor. In case of delivery, dai is called. If there is an emergency then we call SR for a vehicle and they do send us the vehicle. Delivery charges are not taken. We approach SR in serious conditions like severe diarrhoea, vomiting, high fever, malaria. There is no other doctor in the village, so we have to depend on SR only.'

b. Community Leaders

Priyavardhanbhai is a key local person who has conceived the idea of having a hospital for the rural people at Jhagadia village in 1953. He met the founder members of SR and was the instrument in bringing SR to Jhagadia. SR is seen as an organisation, which has not changed its philosophy of work over the years. Priyavardhanbhai emphasizes the fact that even though the Government workers and officials were absent in the 39 villages, good health service is being provided. He feels that the impact of SR's work is better than that of Government work. 'It is an unique experiment in India. There are problems at various levels but this can be sorted out. SR is providing a service while others are doing jobs, hence there has to be a difference between the two.' However, he was not aware that SR has decided to return the PHC to the Government. He strongly felt that they should not do this. If they cannot increase their work, they should not decrease their present level of work.

c. Health Workers

Health Worker in SR

- Excellent knowledge-base and diagnostic skills
- Capable of providing treatment for minor ailment
- Stays in the respective sub-centre villages, therefore well accepted by community
- Follows referral system judiciously
- Feels that the hospital can be better responsive in handling delays and simplifying complex procedures

Health Worker in Control area

- They appreciate simple system and overall mechanism to carry out the programme
- They feel they have potential and in a environment like SR they can work
- They need to be listened to and provided with appropriate support and guidance like in SR

Source: Focus group discussion

d. Health Supervisors: A Uniform Cadre

The supervisors at the middle level is the link between the field-level workers and SR hospital and other services. This they do through meetings at the sub-centre and at SR. They attend the CHP staff meeting at SR. The medical officer is also present during this meeting. On a monthly basis at the sub-centre they hold meetings to review their work and plan the activities for the coming period. This is not done in the Government PHC system. The supervisors also meet on a weekly basis to discuss their field experience. They maintain contact with the health workers, anganwadi workers and dais. They provide guidance and training to the field workers. They visit the villages in the evening and even at night and build rapport with the community. They are present in all programmes held at the village level. The community knows them by name, and they know that the supervisor can help them to get treatment at SR hospital and also in getting their subsidy at the hospital. To the community the supervisor is the doctor.

The supervisors do face problems during their work. They face the problem of poor response from the community for some of the programmes. Drinking is prevalent and some members of the community create problems after drinking. At many villages there is infighting and this affects their work. Many times the parents referred to hospital by the supervisor abuse them when they don't get proper attention and quick treatment at the hospital.

At the sub-centres the supervisors feel that the infrastructure facilities are poor. The building in some sub-centres needs to be repaired but compared to some of the buildings in the Government the condition is good. Water scarcity is also a problem they face so sometimes the programmes suffer.

They have tried to motivate the community to send some of the younger girls for dai training. But the response has been very poor. Many dais in SR villages are old and they need to have a new group who can go along with old persons and get practical training. But this is not happening. They also feel that the routine work itself takes a lot of their time. When they have to arrange camps or run a campaign, particularly when

Government sends notice, the workload is too much to handle and the routine work gets disrupted. They have to monitor many programmes so sometimes follow-up cannot be done properly.

Source: Focus group discussion

e. Health Commissioner

Many see SR as a successful experiment. The Health Commissioner feels that they have proven that they can run the PHC and it is a successful experiment. NGOs should come forward and take up such activities. Even though SR wants to return the PHC, he strongly felt that they should continue.

When they encountered problems with the Government system, they received support from the higher authorities in the health department. SR faced problem in dealing with the Zilla Parishad for releasing the funds for the PHC. Many times they had to use their own funds to overcome these delays. They made a request to the Health Commissioner to look into this matter. He personally took interest and solved this problem by allowing the funds to be released directly to SR. However, in terms of reporting and monitoring they had to follow the Government system. Nothing was done to make the reporting for SR easier.

f. Government Health Officers

The CDHO shared that he looks at SR as an organisation that followed a different kind of practice as compared to the Government. (1) They do not have to follow Government system of providing healthcare strictly. For example, in Government, emphasis is laid more on preventive than curative but SR has given weight to both and it also taken up other activities like education and income generation. (2) Salaries are less as compared to Government (3) For maintenance of records SR follows different systems. (4) Controlling of quality and monitoring of targets in SR is not with DHO but with Director only. (5) They can fire their employees in cases of poor work or misconduct whereas in Government we face problem of union. (6) SR has its own set of rules and regulations as compared to Government. So even if they work under Government rules and regulations the programme run differently. Apart from all the above different practices, he sees it as an organisation that has been able to make innovations in the programme in terms of management systems, technical and health education. They would like to replicate this model in other Talukas.

The Government also looks upon SR as an organisation having a team of well trained field level workers. The training component in the Government system is not strong while it is available with SR. They feel that SR can be complementary and Government can make use of this resource so that their programme can also benefit. This is one of the functions that Government expects from SR as an FRU.

The CDPO of Bharuch sees SR as different from the Government. They are working in a cluster of villages and they are able to work better and monitor the anganwadi. Even with a vehicle the CDPO finds it difficult to visit the balwadi (168) once in three years whereas the SR staff have been able to motivate children as well as parents to come to the balwadi through promotional activities. They are able to put extra effort and input to make arrangements for picnics, exhibitions and competitions for children to create awareness. They also give incentives to AWW for maternal care, which the Government cannot provide.

g. Former Staff of SEWA Rural

For those who worked in SR for years they cherish the time they spend in the organisation. Many of them have spent the best years of their career in SR learning and growing with the experience. Even today they have an emotional attachment to the organisation and a visit to SR is like going back home.

h. Private Practitioners

A private practitioner in Jhagadia sees SR as a specialised hospital and as complementary to his work. The type of patients who visit SR and his clinic are different. Those who come to his clinic do not want to spend time in the queue and

belong mostly to higher class. He has a good relationship with SR. In case of emergencies like snakebite, dog bite, dehydration and complicated delivery case, he refers the patients to SR. In case of pregnancies he makes it a point from the very beginning to refer them to SR. Even during his home visits, if there are any serious cases, he refers them to SR. On request SR also sends a vehicle/ ambulance for his patients even to transport them to Vadodara and Bharuch.

He visits SR regularly, particularly when his patients are being treated there, and discuss with SR doctors as a friend. He also attends the regular doctor's forum to discuss various health issues on a regular basis.

i. Donors/Corporate

Piyush Desai, the proprietor of a tea company Vagh Bakri, personally knows the key members of SR. He provides financial support to SR programmes. On an annual basis for the last 10 years he has been donating Rs. 25, 000 or more for the health programme. His relationship with SR goes beyond just providing funds. He sees it as a service-minded and committed organisation. SR had approached him for a donation to the eye hospital but he could not provide support to this project because the Trust run by his family does not have provision for donating to large projects. Piyushbhai said: 'SR is an organisation without any political involvement. We are encouraged to give donations to SR because it has a committed team and is service minded and there is no politics unlike in other organisations.'

j. UNICEF

When the Government of Gujarat was looking for an organisation to start FRU its first choice was to upgrade the CHC at Jhagadia. Dr. Siddarth at UNICEF thought that there was no NGO which fulfilled the prerequisites for an FRU better than SR. 'SR was an NGO with a functioning hospital, has the experience in providing healthcare to women and has linkage with the Government.' He was very closely involved in putting pressure on GoG to accept SR as the FRU and also to shift the equipment from the CHC to SR.

4. Innovative Interventions

SR has been working within the Government system for the last 10 years but has been able to achieve better utilization of its services and better health status in the project areas. It has been able to achieve this because of several managerial, technical and process innovations it has introduced in the programme.

Innovative Interventions

- Universal use of pre-sterilized delivery pack
- Dai incentive for high-risk referral
- Pre-sterilized delivery pack by health worker at home
- Incentive for dais for high-risk referral
- Target setting in family planning:
  - Team effort in target achievement
  - Once-a-week operative camps on a scheduled day
  - Involvement of field workers in target setting exercise based upon ground realities and micro-planning.
- Comprehensive MIS:
  - Reporting in a single format rather than multiple and overlapping reporting formats
  - Reporting from a sub-centre as a unit rather than an individual worker reporting
  - Recording service utilization under the heads of Project and Non-project beneficiaries
- Experimentation with impregnated mosquito bed nets for malaria control
- Use of SR's video *Kali Kem Mari* into several Govt. Training Programmes for Health Workers as First Referral Unit under Safe Motherhood Initiative.
- Recognition of SR centre for posting/training of
  - Intern doctors
  - Female health workers
  - PHC medical officers

Source: In-service Data

a. Innovations in Managing PHC

Decentralized Target Setting, Planning and Monitoring

The health workers, in consultation with beneficiaries and community, set the targets at SR. The target for the year are set by using certain criteria and by looking at ground reality unlike in the Government health programme where a standard target is set for all the PHCs. For example, an important basis for setting the target

for the MCH programme is the previous year's birth rate of the area. Similarly, family planning targets are set based on identifying eligible couples and looking into their needs rather than taking the whole group of target couples together.

Similarly, they have decentralized monitoring. The teams themselves analyze and review the work line. In SR, when targets are not achieved, the search for where and what went wrong and why rather than who is responsible is conducted. The figures are used for understanding successes and failures. The workers bring the figures to life because they link each figure to the field. The exercise helps the workers to make changes in their field approach and provide strength for greater effectiveness. This has helped to significantly increase the workers' involvement and also to provide a positive image to the programme. Such monitoring systems are not seen in Government where the figures are just to be achieved and reported to the higher authorities. It is linked to their promotion and it puts pressure on the workers to even report wrongly.

Meetings

Apart from the annual target setting and monitoring, SR has developed a schedule for meetings at various levels. The main purpose of this meeting is to provide on-going training, motivation, identify problems, find solutions and create a learning environment by sharing the experiences. The medical doctor, supervisors and health workers meet once a month for a whole day. This meeting is used for sharing field experience and planning activities for the coming month at the sub-centre level. While sharing the experience and incidents from the field, the workers not only share good points but also admit their mistakes. The staff are also provided training on relevant issues/diseases. During the post-lunch sessions they list down all cases of maternal and child health as well as critical cases at the sub-centre level. A specialist sits along with the health workers to give direction in each case and to provide guidance and support for handling critical cases. For example, on August 30, 1999 at a meeting of the CHP they had a discussion on all childbirths and death cases which took place during the previous month. The health workers came up with the following table:

Sub-centre	Infant death (0-1 years)	Critical cases (0-1 years)	Child death (1-6 years)
Uchedia	4	1	1
Karchi	3	2	2
Ratanpur	3	2	0
Sultanpur	0	0	1
Jhagadia	1	1	1
Fulwadi	2	2	0
Limodara	1	2	0
Govali	0	1	1
Total	14	11	6

The pediatrician of SR was present and discussed the cases in detail. In a case of death, the reason for the death and what could be done in the future to prevent such death were discussed. The critical cases were discussed and advice on possible line of treatment was provided. There is no provision in the Government system for the PHC staff to have a meeting. Each category only reports to the relevant Government department.

On the 20th of every month all the anganwadi workers meet at SR. These meetings are for review, feedback, sharing of experience and for planning events. The AWW also collects the stock of medicine for the month on this day. The meetings are conducted by the ICDS supervisor. SR organises short training or exhibitions on a specific topic on these days. Similarly, dais have a monthly meeting at SR on every 21st of the month. Apart from review and feedback on this day, they are provided refresher course on safe delivery. They also collect delivery packs/kits for pregnant women of their village. On the 17th of the month SR holds meetings for anganwadi helpers. Here the emphasis has been sharing and learning.

Report System

SR has prepared its own format for reporting for the various programmes. For the maternal and child care a register is maintained at the village level on a daily basis. This information is aggregated

for the month at the village level and further at the sub-centre level. The information from all the sub-centres is then aggregated at the PHC/ICDS level at SR. This helps in monitoring the activities and to find out where they have succeeded and where the failures are. This is used for reporting to the Government. In the Government system the daily registers are not maintained systematically. The information is filled at the end of the month, which is aggregated at the sub-centre level and PHC level for reporting.

Integration of PHC and ICDS

SR has responsibility of the PHC and also for implementing the ICDS. To bring about managerial efficiency they have been able to integrate the two activities. They have recognized/accepted the complementarity of the two programmes and have redefined the tasks and responsibilities of the female and male workers, TBAs and AWWs to avoid conflicts. This has helped them to work as a team to achieve common goals. In the Government system the health supervisors of the PHC programme and ICDS are separate. The PHC supervisors report to MO and ICDS to CDPO. In SR the same supervisor monitors the two and reports to the medical officer. In SR, the health workers, both male and female, are given distinct geographical area/population (4-5 villages) along with clear responsibilities. The AWW and dais become an integral part of this team. This way the organisation has avoided duplication, confusion and conflict at the grass root level. An example of this is that the AWW stays at the village and on a regular basis weighs newborn babies and identifies babies who need referral services and help in newborn care for a week. Through the AWW the community also gets medical treatment at the village for minor health problems.

Supervisors: A Uniform Cadre

Since 1992-93 the tasks of health supervisor and anganwadi supervisor were integrated and one person was responsible for the work of the team (consisting of dais, anganwadi workers and health workers) who finally reported to the medical officer. The health as well as ICDS supervisor was provided training with the help of technical consultants. Again, this helped in avoiding duplication, confusion and conflict at the grass root level.

Convenient Timing for Service Delivery

Preparing a time schedule convenient for the community in accessing services has contributed to effective utilisation of services. SR provides the service at a time which is convenient to the beneficiaries, and not at the organisation's convenience. This is particularly important for house visits, vaccination and anganwadi services. The AWW makes follow-up visits between 8 and 8.30 a.m. or in the evening for antenatal check-up and health education. This is a time when the family is around and they can avail the services.

Similarly, on the day fixed for vaccination, the team makes sure that it reaches the sub-centre by 8 a.m. This time is convenient for the community. They learnt through their experience in providing services that if they delay reaching the sub-centre the parents find it difficult to bring the children since they have to go for work. The change in timing has increased the coverage in providing complete immunisation.

They have also changed the timing of the anganwadi. In the Government system, it functions from 11 a.m. to 3 p.m.. Food is provided around 2 p.m. They found that it was inconvenient for the parents to bring the children at 11 a.m. because they have to go to their work and children have to remain hungry till 2 p.m., which reduces their activity level. To overcome this, they have changed the timing to 8.30 a.m. to 12 noon. The parents drop the children before they go for work and children have their food and reach home around 12.30 p.m.. This has helped them improve the attendance of children at the AW.

Information Dissemination

The organisation uses effectively the black board at the sub-centre and public notice boards for displaying information on events, visits of HW and special medical professional to the village. The sub-centre notice boards also display the targets to be achieved during the month under each

programme. The notice board at the sub-centre also displays the number of children in different age group, names of pregnant women and date of delivery and vaccination information.

When health workers from the control area visited the sub-centre in the SR work area, they gave positive response to the system of information display. Many of them felt it should become a regular practice in the Government system also. They were also willing to initiate this in their own sub-centres.

Strengthening of Village Functionaries

All the villages have at least one trained dai and only in 5 villages the anganwadi worker comes from the neighbouring village. Efforts were made to strengthen the local level functionaries by providing task-specific training like do's and don'ts in conducting home delivery, using delivery kit, etc.

A cadre of maternal and child health workers was created through selections from the HW, AWW, dais and provided them training and support through guidance and supervision treatment of to take up responsibility of common health problems. This way the community can become self-reliant. Such efforts are not present in the regular Government system. In order to provide practical training, female health workers staying at the sub-centre play an important role. When the dai goes to villages to attend a delivery, the FW accompanies her to help the dai make quick decisions during emergencies. She observes the process and assesses the training needs of the dai and accordingly, provide training to improve her skills. This system is not in operation in the Government system.

b. Technical and Process Innovations

Although SR made efforts to improve utilisation as well as the quality of services during the 1989-98 phase, the reduction in the incidence of low birth weight babies, newborn mortality and maternal mortality was very marginal compared to the earlier phase. Therefore, in this phase the organisation focused on providing simple technical inputs into its programmes. It undertook research studies with special focus on maternal nutrition, anemia, newborn care and malaria control. The study findings were used to put simple technical inputs into the programme. Some of them are discussed below.

Postcard System

The postcard system was first used by the organisation to follow up tuberculosis patients. This system is now being used for follow up of high-risk mothers and children. The postcards are sent to the head of family who is responsible for decision making and provides all details relating to the risk involved and actions that can be taken. The organisation finds it an effective method for sharing information and to keep in touch with patients. They have further extended this system to follow up of patients who have under gone tubectomy. This helps the workers to carry out the Government programme with more confidence and helps them to look at patients not as a target to be achieved but as persons to be provided care.

Pictorial Growth/Monitoring Cards

The organisation has come up with cards for monitoring the growth of children along with key information on child health. The information is provided in pictorial form; e.g. the growth card gives tips on how to breast-feed the child. It also provides information on the newborn care and services to be utilised, such as vaccination, and when to utilise them.

Similarly they have a card for ANC and PNC follow-up. The card gives the entire history of the pregnancy and the line of treatment that is being provided. High-risk mothers are referred to the hospital and the card help the doctors in providing quick and proper medical care. In case the delivery is not to be in the project area or the SR hospital the card provides all information for the persons conducting the delivery. The cards also give pictorial symbols, which depict services that need to be utilised during pregnancy and after childbirth, such as ANC check-up, TT injections, iron and folic acid tablets and proper diet.

Special Card for Sickle Cell Disease

In tribal areas there is a high prevalence of sickle cell disease. SR conducted a camp to identify cases of sickle cell disease. After identifying the cases they were provided with the appropriate card indicating whether they have sickle cell disease. The individuals are asked to carry the card with them. The cards are coloured so that the community can use them to find the marriage partner and avoid marriage between two sickle cell individuals. The white card indicates that the test shows negative. The red card indicates that the test result is positive and he/she has the sickle cell disease. A third card is half-red and half-white, which indicates sickle cell trait. Those afflicted by this disease (red card) are given instruction that they should not take a partner who has white or red/white card since there is a high probability that their children will also be afflicted with sickle cell disease. Only possible relationship is between white card and red/white card.

Using $CUSO_4$ for Testing Level of Hemoglobin (Hb)

Earlier the health workers used filter for testing Hb level while providing maternal health services. In this system the results were not available immediately and the patients had to wait till the HW made the next visit. The hospital also had Haemometre, which could give the Hb level very accurately. It was found that the patient had to go to the hospital for test. In both these cases, the treatment for anemia got delayed. SR introduced copper sulphate solution in testing Hb levels. By using this method, the result was made available immediately. If the blood sinks then it is within normal limits and if blood stays at the top, the patient is anemic. Even though it is not a very accurate method it is sufficient to know whether Hb is below the normal or not. This has helped them to start iron and folic acid supplementation immediately and, if need be, to refer the patient to the hospital.

Vitamin A Supplement

In PNC care, SR gives vitamin A supplement and this is not done in the Government system. Vitamin A is stored in the liver for a long time and in the following pregnancy the child will not suffer from vitamin A deficiency. This is being done particularly in prime cases.

Providing Malarial Prophylaxis during Pregnancy

Treatment with anti-malarial prophylaxis of weekly 2 tablets is started from 4 months up to delivery as part of antenatal care. This is not part of antenatal care in the other PHC run by the Government. This has helped in reducing the incidence of miscarriage, still birth pre-term deliveries and low weight babies by tackling anemia caused by malaria parasite. This was discussed with HWs from the control area and when the workers understood the importance of this treatment there was positive response in terms of trying it out in their work area.

Delivery Pack

One of the major inputs of SR has been the development of a delivery pack for facilitating safe delivery. It is a disposable pack to be used only once. This pack contains essential instruments and equipments required by a birth attendant. It is compact and pre-sterilized and has a long shelf life. These delivery packs are simple and can be used even by an illiterate person and are given during the third trimester to pregnant women when they are preparing for childbirth. This has contributed greatly in helping to conduct home delivery aseptically. This is a good example of taking science to the doorstep of rural people.

The Government of Gujarat in two other districts tried out the delivery pack introduced by SR. After the experimental phase the Government has implemented this all over the State. SR has been given the responsibility of training dais in the use of the delivery pack.

5. Community Participation

Community participation can be looked at through the relationship of the community with the organisation, access of the community to the services and the community's control over these services. However, community participation has been viewed by SR more in the nature of

cooperation and support of the community for the village-level activities.

1. Contribution of resources to anganwadi and maintenance of health post. Donation of land for construction of health post and help in the construction by providing labour during construction.
2. Support in organising health education programmes or training in the village.
3. Use of the services provided by the organisation, which reflects the acceptance of and support to the organisation.
4. Use of emergency hospital services during serious ailments and preventive care. Delivery cases are referred to SR hospital. Feedback is provided on the quality of the services.
5. Community support when SR wanted to use new technologies and new products at the field level like the delivery pack, the vector control malaria programme with the Village panchayat and the community.
6. Participation of the community in meetings that are held for target setting, planning, monitoring and evaluation.

With more than 15 years of experience in community health, SR has realised that if services are made available, people will provide their support. However, long sustained community involvement in preventive health is too much to expect with many immediate pressing problems, particularly among disadvantaged sections.

a. Sharing of Cost and Responsibilities

Participation can be of different types ranging from participation in consultation, participation in extending material support and collaboration to ensure success of the programme.

In a large number of programmes like immunisation, child health, maternal health and family planning, the relationship is one of provider (SR) and receiver. If mothers are reminded of the immunisation date then most children will get vaccinated. They would rather have the service delivered at the doorstep than make the effort to go to the sub-centre to get vaccinated. The relationship of SR is stronger with families, particularly with pregnant and lactating women. The men feel that they do not benefit from the activities of the organisation. Experience of Khalodi village shows that male groups were feeling alienated from the programmes.

Every year SR writes to all the Panchayats before the monsoon and reminds them of preventive measures for malaria control. In order to sustain such activities, village Sarpanch, Talati and members were called at SR for a planning meeting.

In the process of target setting, information is shared at the community level. Health workers, in consultation with SR, set the actual targets. The activities planned for achieving these targets, are discussed and planned at the meetings held at the village level. During these planning meetings each village share their concerns.

The onus of the programme and accountability lies with the health worker. Although the community is aware of the problems, they do not feel that they are responsible for bringing about changes. While the SR staff, including health workers, feel that they own the programmes, the community does not feel that they own the programme.

For example, the work for reducing the infant death is the responsibility of either health worker or supervisor. The parents are aware of the issue but they do not feel they can contribute nor do they feel accountable if the targets are not achieved. The parents never approach on their own to access various services that the programmes provide and the SR health workers have to continuously follow up the cases with them.

b. Access to Services

The community find the village-level services easy to access and effective for minor ailment. The community makes use of the immunisation programme, ANC and PNC services, childcare services and anganwadis. Since the villages have trained dais they call them for the deliveries. These

services are free of cost, which suited them well. Only when the health workers are not available or the illness is serious they would think of alternative like private clinics. From the community meeting it was found that 60 per cent of the households access the PHC services. In a previous study on PHCs it was found that in Gujarat generally only 10-15 per cent of the households access the PHC services.

The community finds SR hospital expensive since they have to pay for referral services. The poor use the hospital services only in case of delivery were they found it stable and reasonable. People prefer to go to private hospital/CHC because of poor system of hospital management at SR. They had to wait before they actually got treated.

c. Control over Services

The community is aware of the services available to them. They are also dependent on SR particularly the village-level workers' services for this. They are aware that if the health workers do not come to the villages it will be difficult for them to access primary healthcare. This is particularly so in the case of maternal and childcare and immunisation. The entire delivery system and the link with the community has not been built in a short period. It has been developed over a period of more than 15 years. The community never had to demand for any services and they are confident that the organisation will provide them the services. In this sense the difference between the provider and client is very marginal.

d. Forums to Promote Community Participation

Efforts were made by SR to build community participation in the various programmes. The attempts included formation of Village Health Committees (VHCs), organising Falia and Mahila meetings, formation of Mahila and Yuvak Mandals, training at the village level and Cooperation Day.

Village Health Committee

SR initiated the formation of VHCs to generate community participation for their programmes. The VHCs consisted of persons who helped in the CHP programmes, Sarpanches of the villages and key persons from the community. The objective was to monitor the actual implementation of the outreach programmes and the access to referral services. But these committees could not function for long for reasons not known to neither committees nor the organisation. SR was unable to tackle the community-level problems other than health, which were raised in these committees. With passage of time the attention of the staff also got diverted to other pressing tasks that came up through the organisation. The meeting became infrequent and it became difficult to sustain the interest and thus the VHCs were discontinued.

Falia/Street Meetings and Mahila Meetings

In 1988 SR initiated meetings, which were held in the villages of each sub-centre on a weekly basis. These meetings were called Falia meetings or Mahila meetings when the meetings were held with the women. During these meetings, health education on a specific topic as per the need of the community was provided to the group. The supervisors conducted these meetings and it was thought that the FHW and MPHW would take over the process. This, however, did not happen.

In the initial years, there was good response and attendance at these meetings was good. The responses from women were particularly good and the meetings were interesting. But later it became difficult to get the community together particularly during the peak agricultural season when jobs were available to both men and women. It became easier to provide individual and family-level counselling rather than doing this at the Falia meeting. The end result of this was that the idea of the meeting was abandoned.

Mahila Mandals and Yuvak Mandals

SR created local village-level forums like Mahila Mandals and Yuvak Mandals. However, these forums have not been used effectively to get the community involved in the organisation's activities. The activities of these Mandals were limited to get-together for singing bhajans or organising sports and games at the village level.

This practice still continues at the village level. Many of the persons working in SR are part of these Mandals but enough effort has not been put to use these forums to identify issues and solve them locally.

Gram Sibirs

SR used to organise village-level training to build rapport with the community. The objective was to get support from the community during the camps held at the village level. These programmes were usually for 2-3 days. The SR staff used to stay at the village with the community and these Sibirs helped the organisation to get an understanding of the lives of the people. It provided them experience and learning. But this also had problems, particularly when they involved a large number of people. They found it difficult to motivate them. At present the Gram Sibirs are irregular. The training is provided to small groups on various aspects of health and it serves the purpose of providing health education.

Cooperation Day

The organisation fixed Cooperation Day (CP Day) every month when the staff would go in teams to the villages and conduct activities at the village level like education at school, women's meeting, cleanliness drive, activities with children and camps. However, they found it difficult to continue with this activity. At present the only day they get together is the Annual Day function that SR organises on their campus in which the community also participates.

6. Health Education

Health education is one of the important activities of the CHP. Over the years SR has developed a large amount of educational material in the form of poster, flipchart, cards, video cassettes, slides and puppets for providing education on various health problems (Annexure 9). Much of this material is being used in the training programme for health personnel in various institutions. Along with developing the health education material, training is provided to CHP staff on using this material. On a regular basis on Tuesdays and Fridays the organisation conducted mass education camp at the village level using slide shows and video shows. The momentum for this has come down as this is now done only once a week. However, during the village visit, health education is provided in small groups on special issues like antenatal clinics, causes of infant mortality, etc.

Another highly successful effort has been the development of the role plays and street plays on a specific themes. It has been largely used as a training tool. These mediums are flexible and provide room for much spontaneous innovation from all levels of workers. They are also great entertainers and draw large crowds. In addition, the health education team, along with one or two doctors, conducts health education sessions in the evenings once a week at the hospital campus for the benefit of hospital patients. Street-level meetings are planned in the event of a major health problem, for instance, an epidemic or a maternal death. Exhibitions were also held at various times covering specific themes like women's health.

7. Research

Research is a complementary activity to the various health services provided by the CHP and the hospital. The research programme focuses on issues of operational importance in community health. It is oriented towards making healthcare services more effective. Though formal research has been undertaken since 1988, small studies are being conducted since 1985 to identify the beliefs and health-seeking behavior regarding vaccination, nutrition, birth practices, family planning as well as to study the effectiveness of small interventions.

About 30 small studies and published and unpublished papers have been prepared by SR (Annexures 10 and 11). However, one feels that much more documentation should have been done considering the excellent community linkages and rich field experiences. For one reason or other, this has remained a rather weak area, which keeps nagging the key people in the organisation.

8. Training Centre

The training Centre at SR was set up in 1990 and is part of the CHP programme. It developed as a complementary activity to providing healthcare. The training centre provides in-house training to the health staff of the organisation. The training draws on the experience from the hospital and outreach programme and designs its training programme to create value additions to these programmes.

Apart from training SR functionaries, the centre also conducts training programmes for health workers of other organisations and Government. The duration of the training varies from 5-6 days to a month. In 1997-98, eight trainings were conducted covering primary healthcare, women's health, safe delivery and newborn care and reproductive and child health (Annexure 12).

The centre conducts orientation programmes for medical, nursing, social work students, health staff, teachers and ICDS coordinators. It also undertakes block placement of medical, BRS and nursing students. The block placement is for one month during which the participants get an opportunity to work in the field as well as at the hospital level.

The FHW, MPHW, AWW and dais have undergone formal training from the Government. The Government doesn't conduct any refresher course on a regular basis. Therefore, for continuing education of the health workers, the centre has prepared a curriculum based on the need of each category of workers. The curriculum for supervisor and FHW and MPHW includes various dimensions of health, including child and maternal health, family planning, treatment of minor ailment and specific diseases, record keeping and communication skills. The health workers are instructed how to train the AWWs and dais at the field level.

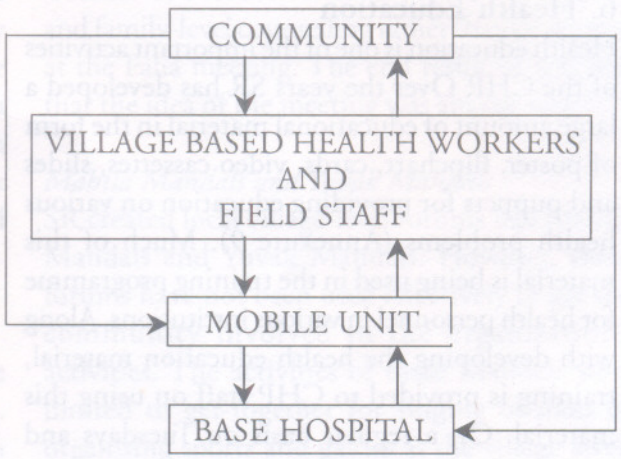
The health workers visit SR on a monthly basis for reporting. The dates are fixed for each category of health workers. Meetings are held at SR every month, on the 19th for the AWW's, on the 20th for the dais and on the 17th for the helpers. On these days they are provided 2 hours training on specific issues.

The CHP staff meets once a month for sharing experience, reporting and planning. On these days a 2-hour session is held on a particular topic. The trainings are imparted through slide shows, discussion and lectures. The group also discusses the cases of child and maternal death that have occurred during the previous month as well as the critical cases. During these sessions specialists like a pediatrician/gynecologist is present. This provides the staff an opportunity to learn through diagnosis of each case and also to get advice on how to handle the critical cases at the field level.

9. Referral Services

Baliben Manubhai Vasava gave birth to a baby boy on 10 June 1998 at Ranipura Village. He was a normal baby. After a few months he fell ill and was suffering from high fever. Although treatment was provided at home, he was not improving. He lost weight and the growth card showed that he was in Grade III. Niruben Patel, the AWW of the village, admitted him to SR hospital. He was treated for a week and even after he returned home she followed the case regularly. He gained weight and is 5.5 kg and has moved to Grade II.

As shown in the chart below, SR has evolved a referral system which links the healthcare at the village level to the hospital.



CHP Facts	1989-90	1996-97	1997-98	1998-99	1999-2000
CHP OPD	15735	15170	14954	15270	13541
CHP Indoor	1067	1017	896	1050	848
CHP Deliveries	-	148	166	129	135
CHP Complicated Deliveries	-	62	134	136	135
CHP High-risk Newborn admitted	-	30	42	48	36

Source: In-service Data

All the village workers are provided with referral slips. In case the village workers is not able to provide treatment for the ailment, he/she fills out a referral slip and gives it to the patient with all details including the patients economic condition. The slip when presented at the hospital helps the doctor in providing better treatment to the patient. After the patient is discharged from the hospital the slip goes back to the workers with information about the diagnosis, treatment given and advice on the follow-up. The paramedical workers and village-level workers follow-up the case in the field. All this greatly helps in building the credibility of these workers among the community and also enhances the confidence of the health workers in providing treatment. This is not generally practised in the standard Government PHC.

Patients from more than 1500 villages utilize the hospital services but about 25% of the Indoor and Outdoor patients come from 30 project villages. The patients referred to the hospital by health workers are provided treatment at a separate OPD cell where they are also given health education. Patient hearing is provided and feedback of field work is taken. This acts as a social audit and helps to improve the quality of the services.

Some Observations on the Referral System

The SR field workers use this service very effectively. A look at the case slips for a month in 1998 revealed that they had referred 15 cases, which included high-risk children (grade III and IV) and children with vomiting and diarrhoea to the hospital. Adults referred to SR include cases of anemia, chest pain, TB, skin infection and gynecological problems.

Medical practitioners in non-target areas also have faith in the referral system and refer their patients to SR hospital. We came across many referral slips from private doctors. The private practitioners in the nearby villages see the SR hospital as a support to all medical practitioners.
Source: Team Observation

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Source: Team Observation

Chapter 7

Constraints and Lessons Learnt

Here we outline the some of the limitations and constraints faced by SR during the collaboration period along with the lessons learned form the experience of working with the Government.

Limitations and Constraints

It is true that some of the limitations and constraints faced by SR were expected but many were also unexpected. Many of them could be sorted out adequately and suitably while some remained unresolved. They are briefly described below.

- SR felt that the community participation remained limited in project for several reasons. There was also limited bargaining scope for SR with the community as all the health services were supposed to be delivered free of cost. SR could not elicit responsive accountability from the community during certain vexatious circumstances. Similarly a specific experiment of community participation by forming health committees for health promotion did not take off. SR realised that health is not a priority to people unless there is an emergency or acute illness. Involvement of community could also not be sustained in preventive health measures. The pressure of target achievement also hampered the process. SR felt that the collaboration with Government accentuated the magnitude of this problem.
- There are areas of public health which may not be considered part of primary healthcare but nevertheless they do affect peoples health directly or indirectly like provision of drinking water, combating addiction to smoking, tobacco and masala chewing and alcohol. Besides the construction of sanitary latrines in a few villages, repair and maintenance of hand pumps and health education of adolescents on dangers of tobacco chewing and alcohol, nothing much was done in this regard. There was no planning done in relation to cancer control, HIV and AIDS control. Although there were interesting ideas like involving local practitioners,

Bhagat and Bhuva and integrating allopathy with traditional medicines, but nothing concrete could be done in this regard for one or more reasons. SR felt that they could have played an important role but unfortunately nothing beyond a few initial steps of planning and some preliminary work could be accomplished.

- A few major constraints were observed and experienced by SR working with Government Firstly, the over emphasis on quantitative target achievement at the cost of quality performance resulting in many heart burns and unnecessary wrangles in many Government organised evaluation and review meetings. Secondly, there were frequent delays in the release of grants to meet the recurring expenses of running the PHC, which used to result in, besides financial difficulties, frequent trips to persuade the concerned officers. Though SR could manage the financial shortfalls by mobilising funds from elsewhere, in replicating this model, it is likely to become a major block to NGO-GO collaboration. Unfortunately no systematic approach or solution were forthcoming from Government to overcome this recurrent but avoidable problem.
- SR felt that hardly anything was done from the Government side about involving other voluntary organisations in the PHC management and thereby opening innovative community friendly avenues of replication. This was not done despite a few organisations seriously considering to undertake similar work after seeing the successful SR example. However, at the time of publishing this report it is encouraging to note that the State Government has come forward with schemes to hand over the responsibility of managing PHC and CHC to voluntary organisations.
- There were interesting and at times unfortunate and painful fallouts in SR working with Government over a long period of time. SR had to put up with various difficulties and irritants like repetitive meetings and discussions with newcomers to familiarize about SR and the details of collaboration whenever there was a transfer of senior district officers. Another important point was that SR realised that, unknowingly, over a period of time some of SR functionaries themselves got bureaucratized following a change of their own mindset due to working with the Government. This sometimes resulted in diminished creativity and vigor in SR's overall environment which is very vital for any voluntary organisation. This also contributed in slowly developing a resolution of not extending the collaboration further, even when the other side appeared to be eager for continuation.

Lessons Learnt

The lessons from this experience are interesting and important for several reasons. The collaboration with Government placed SR in a unique situation where the resultant observations and findings are all the more important as they come to light while working within the system. Unlike elsewhere, successful innovations, effective internal systems and referral support, etc. are brought about in spite of working within the Government systems. The NGO-GO collaboration is also the first of its kind in the country which resulted in many operational difficulties. It also brought out strengths and weaknesses of either sides in a fascinating manner and it assumes greater importance because of the long duration of the collaboration.

These ten years of experience have provided insight into a number of issues. The learning experience is primarily found in areas of NGO-GO collaboration. Other areas which make this experiment successful include innovations introduced in the various health systems and programs, building referral linkages and most importantly the process of motivating the staff.

Various lessons can be learned from the development or innovative work during the entire process. This includes conceptualising and planning followed by implementation, outputs and their reviews. Irrespective of this process the learning needs to include features that were not planned, aspirations which remain unfulfilled as well as failure and setbacks while carrying out activities. For convenience, they are all grouped together here. If closely examined, many of them

may be outside the preview of the exercise of making of a PHC.

Suggestions for Fostering NGO–GO Partnership

Willingness to Understand and Appreciate

Both the Government and the NGO must be willing to understand and appreciate the basic value systems and strengths of the other part and be ready to work in a true spirit of partnership.

Principle of Accountability

This aspect must be observed by both parties. The voluntary organisations need to send the financial and functional report regularly, and at the same time Government should be accountable to the voluntary sector in terms of timely sanctions as well as the release of grants and other items on an ongoing basis.

Flexibility and Relaxation

After ascertaining the credibility, efficiency and transparency, there is a need to give flexibility and relaxation in areas such as recruitment criteria, implementation strategies, allowing user's fee from affordable patients, reallocation of budgetary heads, programme prioritization, reporting and monitoring system etc.

Preserving the Innovative Nature of the Voluntary Organisation

Voluntary organisations have an inherent nature of innovation and experimentation and can develop alternative models and methods that are suitable to the people, giving specific attention to the socio-cultural, educational and economic condition of the community. In a standard health delivery system there is very little scope for PHC staff to introduce innovations at the field level. SR was fortunate that in their collaborative experiment the Government provided them the freedom to introduce innovations in the PHC system. Over the years SR has introduced many programmatic and systems-related innovations based on their grassroot level experiences. This helped in maintaining the quality of service and its access to the poorest of people. Government needs to recognize this role of voluntary organisations and encourage them by giving freedom to take up innovative PHC programmes on an experimental basis. For this experiment, a modification is required in the current relationship of so called 'giver and receiver'.

Reallocation of Funds

Financial viability is a major issue in replication of any service programme. It has been a major concern in India that PHCs are not able to provide adequate primary healthcare services. One of the reasons being given is the paucity of funds. However, SR's experience shows that it may not be the total fund allocation but the rigid implementation of budget items, which is a major constraint in effectively managing PHCs. In a standard government PHC budget, more than 80% are spent on salaries while only the remaining part is available for delivery of services and related programmatic activities, which are found to be inadequate. For example, SR saved money on salaries of approved field staff by managing with a smaller number of full time field staff with relatively low salary and utilising services of more village level workers without compromising the quality of the services. It was observed that SR's overall PHC expense would come out to almost the same as that of the Government budget if SR was allowed to replace the same amount of money saved from salaries and allied heads, to cover the cost on purchase of medicines, transportation, stationary, maintenance of equipment and strengthening village level workers. Hence, the SR experiment demonstrates that if reallocation of budgetary heads is allowed at the local level with organised and decentralized planning and management, efficient service delivery by a PHC can be ensured within the existing financial allocations. SR required additional funds for other important aspects including field operational research studies and documentation, which it believed to be crucial for the success of the programmes and was able to mobilize extra funding from other sources (Annexure 13).

Influencing at Policy/Planners Level

In order to make NGO-GO collaboration effective, influencing at the policy/planner level is crucial. SR was fortunate to have the frequent opportunities to influence policy makers, planners and implementing agencies at various levels

through formal and informal interactions. These were made possible through several levels of interaction, consultative meetings and participation in many government committees as their members on invitation. SR participated as a member of the advisory committee at the district and state level consultations related to malaria, AIDS, RCH, Health Sector Reforms (an initiative of the European Union). This gave an opportunity to influence and introduce some effective innovations in Government setup.

Lessons Learnt within the System

Strengthening the Village Level Worker - Dais

Grass root level workers like dais and AWWs can play an important role to improve the health status of the village people. SR has made intensive efforts to strengthen the locally available people and empower them to handle minor health problems of the community. In one of the operational research studies conducted by SR, it was proved that with proper training, support, guidance, ongoing monitoring and performance based incentives, the team of village level health volunteers could successfully deliver almost all the functions of a full time female health worker.

Referral Linkages

Referral Linkages is an essential component of health services. The outreach primary healthcare programme and referral hospital services are both essential and complementary to each other. None of them can work in isolation without the support of the other, if the health objectives are to be achieved. In the regular PHC system the staff does not find adequate referral support in handling complicated cases. These is very little communication between the field staff and the hospital staff. There is virtually no mechanism for follow-up of the patient in hospital. SRs PHC has the strong backing of the base hospital in Jhagadia. This referral system has played an important role in fulfilling the community's felt need for curative care.

Committed and dedicated Staff

The main reason of the success of SR is committed and dedicated staff who stay in the village. Another important factor is that the entire staff is working as **TEAM**. As more and more powers and responsibilities like target setting, activity monitoring, etc. are delegated to the workers, they have developed a sense of involvement in decision making and own the programmes as well as their results. There is an explicit understanding that in success as well as in failure, the team as a whole is responsible - not an individual. This has been made possible through regular meetings, organisation of workshops and several common events.

Influencing the younger generation

During the last decade more than 600 students from about 75 universities and academic institutions of India and abroad have availed formal or informal training at SR. Efforts need to be made to provide an encouraging environment, guidance, support and role models. More than half a dozen of them have started their own organisations and are now working for the needy people in rural areas. This can be seen as an expansion of SR's innovative work in different parts of the State with full freedom and further scope of innovations in new areas.

Some of the effective innovations are worth emulating if the Government is keen to reach out to the poor. These include extensive use of delivery pack for delivery at home, training and involvement of village level workers, motivation and mobilisation of entire staff, referral linkages, health education sessions in villages, etc.

Lastly, while the Central and State Government is considering more involvement of the community and voluntary organisations in development, there is a trend for more private initiatives. SR's experiment is important in more than one way. The Government needs to be sensitive about self-respect and dignity of voluntary organisations and has to get rid of its big brother attitude. Government functionaries are quite unwilling to share and delegate authority in situations where it is necessary, possible and also beneficial to the community. They need to adopt a different mindset if more involvement of the community and voluntary organisations are warranted.

Chapter 8

Conclusions

This is a review of a Primary Health Centre covering a population of 40,000, managed by a voluntary organisation – SEWA Rural – in the rural tribal area of South Gujarat at Jhagadia. SEWA Rural managed the Jhagadia PHC (in Bharuch District) for more than a decade and it was formally entrusted by the Government of Gujarat. It has been a unique and unprecedented collaborative experiment between a voluntary organisation and the Government. The organisation was able to attain several accomplishments, such as achieving most of the targets of Health for All by 2000 AD much earlier, and it has sustained them over a period of time in spite of working within the Government system with its attendant constraints. Furthermore, it introduced several innovations in management as well as in service delivery, many of which were subsequently adopted in the Government system and among many voluntary organisations. The project also brought out strengths and weaknesses on both sides which may be profitably drawn upon if the Government wants to involve more voluntary groups and the community in rural health care, particularly in interior areas, where the Government services are far from satisfactory for more than one reason.

Two research methodologies, technical and participatory, were converged in both case and control villages under this review. The former brought out quality and coverage of services including efficiency and effectiveness of various health programmes based on a sample survey and hard service data. The participatory research methodology was used to derive knowledge and understanding about organisational processes, the perception of the community and other stakeholders, staff motivation and interface with the Government.

The technical review team has effectively showed that the quality and coverage of service utilization has reached high

levels and the impact on most mortality rates has been considerable (IMR was reduced from 172 to 41). Birth rates have also fallen significantly (from 35 to 20) with an increased effective couple protection rate (from 37% to 71%). Most of the communicable diseases and epidemics are fairly controlled. Prevalence of severe degree of malnutrition among children has also been substantially reduced (from 16% to 2.5%). There is a higher level of awareness on various aspects of basic health in the community, as seen from the increase in coverage of maternal care (from <25% to >85%) and immunisation coverage (from <10% to >95%).

A Participatory Rural Appraisal (PRAs) team studied the level of acceptance of staff by the community, the level of community education and awareness, and the motivation of field level staff. It has comprehensively brought out the obvious strong points and characteristics of the voluntary organisation, like excellent community rapport, project detailing, commitment and empathy of health workers, involvement of village level workers, meaningful and effective recording and reporting system without duplication, etc.

All the above has been made possible through a series of micro level interventions and innovations such as establishing convenient timings and predetermined days for service delivery, ensuring quality curative care (felt need of the community), strengthening village based health volunteers, integration of ICDS and PHC staff, use of pre-sterilized delivery pack for home delivery, making the sub-centre a team unit, involvement of all level of workers in target setting and micro planning, simplified MIS system, etc.

Introduction of apparently small and micro level innovations have in fact played a crucial role in the overall achievements and impact of the SR PHC. Moreover, the organisation has largely maintained the atmosphere of liveliness and spirit of voluntarism, despite working in the formal PHC setting of the Government.

However, the whole experiment was not always easy-going. SR experienced several constraints and hurdles while working with the Government. Some of these operational difficulties were expected and could be satisfactorily resolved in due course of time, following continual persuasion and strains, while some issues remained unsettled. There were issues where the Government at last gave some leeway and SR was allowed certain flexibility and relaxation in e.g. recruitment criteria, users' fees, separate monitoring of SR's performance based on impact and qualitative performance and delegation of financial and administrative control.

A few of the somewhat uncomfortable issues that SR had to comply with included undue emphasis and comparisons on target achievements (weight only on quantitative performance), frequent delays in the release of grants and supplies, and interruption in the smooth partnership with the Government due to frequent transfers of senior officials. There were a couple of areas where SR could not deliver on its own expectations and to its own satisfaction. One of them was the inability to raise the comprehensive community participation to its highest level, i.e. involving the community in all stages of planning, implementation, monitoring and reviewing the services and programmes. It was also unable to sustain the village health committees on a long-term basis for the same process. Finally, SR could not do much in effectively addressing other important public health issues, such as the provision of safe drinking water and sanitation, and combating addiction to alcohol and tobacco.

Eventually SEWA Rural chose to hand over the PHC after managing it successfully for more than a decade. Instead, it moved on to specific areas related to maternal and newborn morbidity and mortality, where the collaboration with the Government has continued with different conditionality. The training centre at SEWA Rural has also found the opportunity to share and thereby replicate some of the innovations with several voluntary groups of Western India

who have been coming to Jhagadia for training.

But the rich experience of managing a formal PHC by SR continues to provide many valuable and far reaching lessons for different sectors and stakeholders – be it voluntary organisations, the Government sector, policy makers, multi-national and donor agencies, academic or research institutions, medical colleges, or even private practitioners, students and activists. Anyone who is genuinely interested in aspects of community based primary health care will here find something interesting and insightful.

The important conclusion was drawn that investment in strengthening and empowering the village based cadre of health volunteers (TBAs, AWWs and MCH workers) is quite critical to any community based intervention and in making the services reach the ***last man of society***. It is important to adequately fulfil the community's felt need in making the curative care easily available at the village level with a proper referral linkage. This would enhance the credibility and acceptance of health workers in promoting other preventive and health education/awareness building services. Sincere efforts are required to motivate and mobilize the enthusiasm of paramedical field staff through a ***fact finding*** and not a ***fault finding*** approach on an on-going basis, which would then build a team spirit. This would become the back bone of any community health programme. It is only the ***role modelling*** act of leaders and ***setting an example*** that would disseminate and inspire people all around – not least the younger generation.

In order to foster an NGO-GO partnership in true spirit, a pragmatic understanding and a sense of appreciation about the strengths and weaknesses of either side is required. It is imperative to grant some flexibility and relaxation in bureaucratic norms so that distinct NGO characteristics like innovativeness, creativity and voluntarism are well preserved and nourished. However, paperwork cannot be totally disregarded, especially when working with the Government. But it is the inbuilt mechanisms to maintain transparency and accountability at all transactions and operations which turn out to be of paramount importance in sustaining the credibility and integrity of either side.

It is encouraging to note that the State Government has shown willingness to introduce some of the effective interventions effectively tried out by SR into their larger system. Examples of these are pre-sterilized delivery packs, fixed days for different services, simplified MIS with the sub-centre as a unit, involvement of workers in micro planning and target setting exercises, strengthening the cadres of grassroot workers, etc.

Moreover, it is inspiring to note that the Karnataka Government has also successfully experimented with a few NGO-GO partnership models in recent years, based on the experiences of the SR model, and the introduction of a Reproductive and Child Health (RCH) initiative at national and state levels, following the International Conference on Population and Development (ICPD) in Cairo in 1994. The Government of Gujarat has also lately come forward to entrust the responsibility of managing three Community Health Centres and one Primary Health Centre to voluntary organisations.

Since there has been a stagnation in social indicators of India for several years, and the Government health services are falling behind, there is an obvious need to bring about critical changes in the approach and strategy for improving the quality and coverage of primary health care services, particularly for interior and rural areas. Community initiatives, involvement of voluntary organisations, strengthening of village level workers, decentralisation of health care delivery, among other measures, will make a substantial difference. This review, detailing the process as well as achievements of a PHC managed by SEWA Rural, will provide considerable impetus and momentum in that direction.

Annexures

Annexure 1

Government Resolutions

Given below are relevant extracts from resolutions and orders passed by the Government of Gujarat at various stages of the collaboration of the organisation and the Government:

a. **Sewa-Rural**
Management of certain villages of Jhagadia Taluka of Bharuch district for providing specific health services.

Government Resolution No. MIS-1084-917-B, April 24, 1984.

The Society for Education, Welfare and Action Rural is a voluntary agency providing assistance to the marginal income families of certain villages of Jhagadia taluka. To complement the diagnostic and curative services being provided by it through Kasturbhai Maternity Hospital taken on lease by them for this purpose, this Society (SEWA – Rural) has initiated community-based outreach services after conducting an intensive survey of the above area to identify health problems. For this purpose, it has submitted a project called Community Health Project, which has been approved for financial assistance under the participation by the Government of India, Ministry of Health and Family Welfare (VOP-Section). The Jilla Panchayat, Bharuch, in the year 1982 had initially entrusted 10 villages of the Jhagadia taluka to the organisation for this project.

1. Limodra 2. Karad, 3. Ranipura, 4. Uchedia, 5. Nanasanja, 6. Motasanja, 7. Selod, 8. Vanthewad, 9. Kapalsadi, 10. Vaghpura.

The above organisation having successfully provided rural health services at village level at these villages the Jilla Panchayat, Bharuch, has proposed to hand over another 10 villages for providing the aforesaid rural health services which are as under :

1. Fulwadi, 2. Bhimpor, 3. Untia, 4. Kharchi, 5. Sardarpura, 6. Ratanpor, 7. Pora, 8. Simadhra, 9. Khadoli, 10. Kharia.

The Jilla Panchayat will hand over the amount of grant-in-aid received from Government for services to these 20 villages (i.e. for pay and allowances, medicine, equipment, building, etc.) together with the village-level staff consisting of village health workers, anganwadi workers, helpers, trained dais, female and male multipurpose health workers working at these villages to Sewa-Rural.

The aforesaid staff will be on deputation to Sewa-Rural and under its supervisory control and will be governed by the guidelines/conditions outlined in the resolution passed by the Jilla Panchayat, Bharuch No.119 dated 30-6-85 with the modification that even though the staff will be on deputation to Sewa-Rural and will be under the supervisory control of it, the final administrative control will remain with the Jilla Panchayat and Government and the organisation will not be able to terminate their services or take disciplinary action against these employees.

Government is further pleased to direct that, the Director of Health Services shall pay a visit to this organisation during the course of his normal duties and see the work done by the Sewa-Rural. The State will also closely involve itself in the implementation of the project and also carry out appraisal and evaluation on a periodical basis.

This order will come into effect on 01-04-84.

(sd-) Deputy Secretary to Government, Health & Family Welfare Department, Government of Gujarat.

b. **Sewa-Rural**
Management of certain villages of Jhagadia taluka of Bharuch district for providing specific health services. Corrigendum. Date: 2/6/1984
(i) **The paragraphs of G.R.H. & FWD No. MIS-1084-917-B dated April 24, 1984 should be numbered as 1,2,3,4, and 5.**
(ii) **For the existing paragraph 4 the following paragraph should be substituted.**

The aforesaid staff (except that consisting of village health workers, anganwadi workers, helpers and trained dais) will be on deputation to Sewa-Rural and would be under its supervisory control and will be governed by the guidelines/conditions outlined in the Resolution passed by the village Panchayat, Bharuch No.119 dated 30-0683 letter No. DP/734/USAID/86 dated 22-02-1984.

It is further stipulated that those Government Servants who are not willing to work on deputation with Sewa-Rural can be transferred and absorbed in other equivalent posts in other areas of the district/ State. It is also further stipulated that in such a contingency the Sewa-Rural tenure basis for the period of present arrangement which is for 5 years with effect from the date of the aforesaid Government Resolution dated 24-04-1984 and such recruitment made by the Sewa-Rural will be on the condition that such recruited persons will not have any claim to get absorbed in Government service except through the Gujarat Public Service Commission for other regular procedure of recruitment.

It is also further stipulated that for such staff as recruited by Sewa-Rural, subject to above conditions, the Jilla Panchayat will give grant-in-aid for their remuneration for the duration of the project. It is also stipulated that voluntary village workers at the village-level, excepted above, are placed under the direct control of the Sewa-Rural and are, therefore, not on deputation like the other staff consisting of female and male multipurpose health workers

(iii) In paragraph 3 in line No.6 after the words 'and male multipurpose workers' the words 'and supervisors' should be added.

By order and in the name of the Government of Gujarat.

(sd/-) Deputy Secretary to the Government of Gujarat, Health & Family Welfare Department.

c. **(From the original in Gujarati)**
Entrusting Rural Health & Medical Services to a voluntary organisation, Sewa-Rural, Jhagadia, district Bharuch.

Resolution No. MIS-1084-2265/867-B, June 10, 1986.

References
(1) Health & Family Welfare Dept. Resolution No. MIS/1084/17/B, dated 24/4/84.
(2) Health & Family Welfare Dept. Resolution No. MIS/1084/917/B, dated 2-6-84.

Resolution

1) As mentioned in the reference 1& 2, Sewa-Rural, Jhagadia was entrusted the responsibility of providing health services to following 10 villages of Jhagadia taluka in Bharuch district as per the resolutions No. MIS-1084-917 dated 24- 4-84 and Corrigendum No. MIS-1084-917-B dated 2-6-1984.

   (1) Fulwadi (2) Bhimpor (3) Unita (4) Kharchi (5) Sardarpura (6) Ratanpur (7) Pora (8) Kharia (9) Khadoli (10) Simadhra

2. Entrusting 19 villages (as enlisted under) of Jhagadia Taluka of Bharuch District to Sewa-Rural, Jhagadia, for providing health and medical services was under consideration with the Government. After due considerations 19 villages (as enlisted under) of Jhagadia taluka of Bharuch district are entrusted to Sewa-Rural, Jhagadia, for providing health services.

   (1) Kharchi Bhilwado (2) Govali (3) Mulad (4) Naugama (5) Boridra (6) Amod (7) Bhrui (8) Maljipara (9) Malipipar (10) Damlai (11) Kunvarpara (12) Andharkachhla (13) Gundecha (14) Padwania (15) Amalzar (16) jajpor (17) Anadhra (18) Malpor (19) Dholakuva

The other conditions will be as per reference No.1 and 2 (Corrigendum). In the name of and by the order of Government of Gujarat.

(sd/-) Deputy Secretary Health & Family Welfare Department.

d. (From the original in Gujarati)
Entrusting management of Primary Health Centre to Sewa-Rural, Jhagadia

Resolution No. PHC/1087/8096/88 Gh. dated February 14, 1989.

References

1) Health & Family Welfare Dept. Resolution No. MIS/1084/17/B, dated 24/4/84.
2) Health & Family Welfare Dept. Resolution No. MIS/1084/2265/86/b/ Dated 10/6/86.
3) Health & Family Welfare Dept. Resolution No. BUS/1087/257/6-B/dated 15-7-87.
4) Health & Family Welfare Dept. Resolution No. BUD/1087/2571/B dated 13/1/88.
5) District Development Officer, Bharuch letter No. J.P./J.A/Development 2458-59 dated 5/11/88.

Introduction

As given in Reference No.1 dated 24/4/84, the order was given about providing health services of 30 villages by Sewa-Rural. As given in Reference No.2 this Dept. had given order dated 10/6/86, about health services of additional 19 villages to be provided by Sewa-Rural. As per above Reference No. 3 this dept., by order dated 15/7/87 has sanctioned necessary personnel and equipments, etc. for 30 Primary Health Centres in tribal area. As per above Reference No. 4 this dept., by order dated 13/1/88, has sanctioned 14 primary health centers in tribal area. Out of these fourteen, one primary health center has been sanctioned at Jhagadia. The organisation, Sewa-Rural, has proposed that Sewa-Rural be entrusted the management of the said PHC. As per Reference No. 5 District Development Officer, Bharuch, has sent a proposal to entrust the management of Primary Health Centre at Jhagadia to Sewa-Rural. The above proposals of Sewa-Rural and District Development Officer were under the consideration of Government.

Resolution

After due consideration the management of Primary Health Centre at Jhagadia is entrusted to Sewa-Rural under the following conditions:

1. At first stage the management of Primary Health Centre at Jhagadia is entrusted to Sewa-Rural under the following conditions.
2. Government will provide grant to the organisation to arrange Primary Health Centre from Dt. 1-4-89.
3. District Panchayat, Bharuch, will take over the management of this Primary Health Centre if the organisation either does not want to manage the Primary Health Centre or discontinue this activity.
4. The organisation can accept employees from District Panchayat on deputation. If the organisation want to recruit the employees by its own selection process the organisation will able to do it by following whenever possible, Recruitment Resolution of the concerned vacancy of either Government or District Panchayat.
5. When the organisation discontinued the activity in future Govt. will consider absorbing the employees, who were appointed by the organisation, provided they satisfy the necessary recruitment criteria like age limit, education qualification and experience at the time of their appointment.
6. When the organisation discontinues the activity, the employees appointed by the organisation, who do not fulfill the recruitment criteria will be absorbed by the organisation in their other activities after due consideration. If not then they will be relieved from the service and this matter is to be brought to the notice of such employees by the organisation.
7. When the organisation is required to have either District Health Officer in the selection committee and the appointment has to be given in his presence.
8. It is not possible to sanction the post of driver as it does not fall in to the pattern of Primary Health Centre. But if the organisation has the facility of vehicle, the organisation can create the post of driver for its use on its own cost.
9. These resolutions code passed following the approval of Department of General Administration, Panchayat and Rural Housing.

In the name of and by the order of the Governor.

(sd/-)Deputy Secretary, Health & Family Welfare Dept.

e. **(From the original in Gujarati)**
Entrusting Health & Medical Services to a Voluntary Organisation, Sewa-Rural, Jhagadia, Dist. Bharuch.

Resolution No. PRCH/1084/590/89 B. Dated April 13, 1989.

References

1. Health & Family Welfare Dept. Resolution No. MIS/1084/917/B, dated 24/4/84.
2. Health & Family Welfare Dept. Corrigendum No. MIS-1084/917/B Dated 2/6/84.
3. Health & Family Welfare Dept. Resolution No. MIS/1084/2265(86) B, dated 10/6/86.
4. District Development Officer Bharuch Letter No. J.P/J.A/Development 323 & 324 Dated 3/2/89.

Resolution

1. As given in above references No.1 & 3, by these dept. resolutions, SEWA – Rural, Jhagadia, was entrusted the responsibility of providing health services to 30 villages, as per attached list, for first stage of 5 years.
2. Sewa-Rural organisation having provided good services to the said villages, as given in the list, achieved SASAKAWA award for the best health performance. It was under consideration of Government following District Development Officer's proposal to enable Sewa-Rural to continue to provide health services for 10 more years. After due consideration the continuation of provision of health services by Sewa-Rural to 39 villages with an additional two more villages, is hereby sanctioned.

   The other conditions will be as per reference No.1 and 2 (Corrigendum). In the name of & by the order of Governor of Gujarat

(sd/-) Section Officer, Health & Family Welfare Dept.

Annexure 2

Minutes of the meeting held on 17-7-1992 at the conference room at the office of the Health Commissioner, Government of Gujarat, Gandhinagar, to discuss findings of the evaluation report and proposed innovative changes in SEWA Rural's PHC work

1. Shri K. S. Sugathan, IAS, Health Commissioner, presided over the meeting. List of participants is attached as Annexure.
2. Shri Sugathan referred to detailed proposals submitted by SEWA Rural (vide its letter dated 28th April 1992). He advised all participants to give their observations with specific reference to each point of the proposals.
3. Initiating the discussion, Shri Sugathan, Collector, Bharuch, A.D.H.O., Bharuch, and other senior officers of the Commissionerate expressed their satisfaction about the commendable work done by SEWA Rural in CHP (PHC) areas and they felt that through this experiment, Gujarat has developed and demonstrated a model, which can be considered for future NGO-GO collaboration.
4. During general discussions, all participants expressed that when any programme under PHC is entrusted to a voluntary organization, the scope for introducing innovations should be built into the system. This would be in the overall interest of the programme, as new ideas would emerge, which could be replicated elsewhere also. Shri Sugathan advised all officers concerned to keep this aspect in view, while implementing and evaluating such programme.
5. Thereafter specified changes suggested by SEWA Rural were taken up for consideration:

   a. **Programme Prioritization**

   Priorities suggested by SEWA Rural were accepted and were consistent with H.F.A. –2000 goals. In response to the point from Dr. Ghasura, Dr. Pankaj Shah of SEWA Rural clarified that "Young Women" would include newly married women and primis along with adolescent girls.

   So far as monitoring growth among children of age 3 to 6 is concerned, it was decided to continue quarterly weighing and health monitoring. Emphasis on care of children below the age of 2 was appreciated. Shri Sugathan advised SEWA Rural to furnish a detailed Note to the Government for re-determining AW priorities. Then the matter would be suitably taken up with the Government of India. He advised DDO/DHO to keep the programme priorities suggested by SEWA Rural in view, while monitoring and evaluating the performance of the SEWA Rural PHC.

   b. **Implementation Strategies**

   Suggestions made by SEWA Rural were appreciated. However, AW being a Government of India programme, it was not possible to change the nomenclature/designation of AW supervisor. But she can be carefully trained and assigned additional responsibilities of health supervision, etc. and the suggested integration can be achieved without affecting the critical needs of the AW programme. Similarly, health supervisors may be entrusted with combined responsibility.

   So far as integrated geographical distribution of work is concerned, the suggestions made by SEWA Rural were appreciated. But Shri Sugathan advised having one pair of male or female multipurpose workers for a population of 3000, instead of 4500. He advised male worker, which will be considered favourably. He also advised DDO to see if this could be done by suitably adjusting the total cadre strength of Bharuch district.

For supervisors, Shri Sugathan suggested that the responsibilities of two sub-centres be assigned to each supervisor. All concerned agreed to this.

c. **Personnel**
Already covered in (b) above and can be implemented accordingly.

d. **M.I.S. and Monitoring**
It was agreed that generally M.O. of the SEWA Rural PHC will attend the monthly meetings at the district level, so that experience of the SEWA rural PHC and other PHCs could be shared by all. So far as periodical returns are concerned, it was agreed that SEWA Rural submit quarterly such information as is required by the State Government to be sent to the Government of India and can be suitably changed keeping priorities and strategies and the HFA goal in mind. He advised that DHO and SEWA Rural could jointly work out the details, keeping this observation in view. Dr.Ghasura appreciated the need for reducing paper work and overlapping in M.I.S. He observed that the Government of India was also keen to simplify M.I.S. and now a set of M.I.S. recently finalised may solve this problem. He also advised DHO/SEWA Rural to work jointly on this issue.

So far as evaluation and monitoring is concerned, is was agreed that the SEWA Rural PHC is an innovative project and its performance will be reviewed accurately, at joint and separate meetings between DDO/DHO and SEWA Rural representatives. This would provide a proper forum to monitor the SEWA Rural PHC performance. This will be done keeping in view the long-term objective of HFA 2000.

e. **Finance**
Shri Sugathan mentioned that in the present financial structure, it was difficult to allow reallocation of grant across heads to SEWA Rural, though the suggestions is quite valid. He advised SEWA Rural to consider this issue further and submit a detailed Note to him, so that he could take up the matter with the Finance Department

So far as minus grant issue was concerned, the problem raised by SEWA Rural was well appreciated. Shri Sugathan requested the DDO to provide funds in such a situation from PLA account of the District Panchayat. The DDO agreed to consider the proposition favourably. The DHO Bharuch suggested that SEWA Rural representatives could meet him regularly to review the grant position and he would ensure that SEWA Rural did not face difficulties in this behalf.

So far as funds required for providing incentives to voluntary workers and additional cost of medicines are concerned, the requirement may not be large (Rs. 100,000 per year). But this was a critical input for greater success of the programme. Shri Sugathan advised SEWA Rural to submit a detailed proposal for allocation of additional funds for this purpose for further consideration of the State Government. He also advised Collector/DDO to see if this need could be met from the District Planning fund/tribal sub-plan funds and such other sources, available at the District level.

Concluding the discussion, Shri Sugathan once again mentioned the good work done by SEWA Rural and advised it to see, if it could consider to take up further responsibilities in the field. He also advised all concerned officers to keep the innovativeness of the project in view, while dealing with the various aspects of the project. This was a very important and

useful experience which the State Government would like to replicate elsewhere, using SEWA Rural experience and insight.

The meeting ended with a vote of thank to the Chairperson.

List of participants in the meeting held on 17-7-1992

1.	Shri K. S. Sugathan	Commissioner, Health and Medical Services & Medical Education (Health), Gandhinagar.
2.	Dr. N. D. Ghasura,	Addl. Director of Health Services, Gandhinagar.
3.	Dr. N. K. Bellany	Joint Director of health services (NCH EPI)
4.	Dr. M. H. Shah	Addl. Director (VS)
5.	Dr. J. H. Shukla	Dy. Director (RHS)
6.	Dr. R. N. Shah	Asst. Director (N)
7.	Dr. K. G. Patel	Asst. Director (FW)
8.	Shri Agarwal	Collector, Bharuch
9.	Shri Rajiv Gupta	D.D.O., Bharuch
10.	Dr. Vashishtha	A.D.H.O., Bharuch
11.	Dr. Anilbhai Desai	SEWA Rural
12.	Dr. Smt. Lata Desai	-do-
13.	Dr. Pankaj Shah	-do-
14.	Shri Anandpurwala	-do-

Annexure 3

Minutes of the Meeting held at SEWA Rural, Jhagadia, on Wednesday, 8-1-1997

The Health Commissioner; Mrs. Sudhaben Anchalia and the Additional Director of Medical Services, Dr. K.C. Mehta, visited SEWA Rural on 7-8 January 1997, and observed all health activities of the organisation. They were highly appreciative of the quality of the work undertaken by the organisation with many innovations in the PHC and ICDS activities, as well as the hospital at Jhagadia. At the beginning of the visit, Dr. Pankaj Shah of SEWA Rural made a presentation of the innovations introduced by SEWA Rural over the years. At the end of the visit, a meeting was held to review and resolve some of the issues that have emerged over a period of time regarding the working relationship of the organisation with the Government health department. The following persons attended the meeting, which was chaired by the Health Commissioner:

1.	Dr. K. C. Mehta	Additional Director of Medical Services (Rural Health), Government of Gujarat.
2.	Dr. Yavalkar	Regional Deputy Director of Health, Vadodara.
3.	Dr. K. N. Patel	Dep. Director of Health (i/c Bharuch District)
4.	Dr. Jain	CDHO, Bharuch.
5.	Dr. Chopra	District Leprosy Officer, Bharuch.
6.	Shri Kanubhai Shah	Programme Coordinator, District Blindness Control Society, Bharuch.
7.	Dr. Lata Desai	SEWA Rural.
8.	Shri DA Anandpura	,,
9.	Dr. Anil Desai	,,
10.	Dr. Pankaj Shah	,,
11.	Shri Bankim Sheth	,,
12.	Dr. Manjusha Sridhar	,,
13.	Dr. Uday Gajiwala	,,
14.	Dr. S. Sridhar	,,

The meeting was significant in that it was being held against the backdrop of major changes in the approach of the Government Health Services in recent times, including the target-free approach, which envisages greater emphasis on quality assurance and client satisfaction, and serious efforts by the Government to involve genuine voluntary organisations in various aspects of healthcare of the public, both rural and urban. At a previous meeting held under the chairmanship of the then Health Commissioner, Shri K.S. Sugathan, on 17-7-1992, at Gandhinagar, many principles had been laid out to guide the collaboration. The relationship between SEWA Rural and the Government represents the longest lasting and most comprehensive NGO-GO collaboration in this field, and each major decision in this process is likely to play a vital role in the determination of the nature of similar future collaborations.

The following issues were discussed and resolved at the meeting:

The process of monitoring the work of the PHC given to SEWA Rural: It was pointed out by members of SEWA Rural, through illustrative examples that on many occasions, the letter and spirit of the agreement of the organisation with the State Government as regards the method of monitoring the work of the PHC (as decided at the meeting referred to above) was at times overlooked by the district health authorities, particularly the importance of this innovative experiment was not being

sufficiently appreciated, and the organisation's representatives at various meetings at the district HQ were being unwarrantedly embarrassed, causing avoidable pain to the organisation, to the point where at times, the organisation seriously considered the possibility of handing the PHC back to the Government; that, going simply by figures, the district authorities were expecting the organisation to fulfil impossibly high targets, etc.

After considerable discussion on these issues, it was reiterated and concluded that, since the PHC work of SEWA Rural has its own distinct identity, character and role, it cannot be equated with other PHCs, and must be recognized and dealt with independently. Accordingly, the monitoring of the work of SEWA Rural PHC would no longer be done on a routine basis at district level meetings at Bharuch, but by a separate committee consisting of the Regional Deputy Director (Dr. Yavalkar), the Deputy Director in charge of the district (Dr. K.N. Patel), and the CDHO, along with appropriate members of SEWA Rural. This committee will conduct quarterly reviews of the work in the spirit of an exchange and sharing of ideas, rather than merely monitoring. Any action in this regard deemed necessary may be taken in consultation with appropriate State level officials.

1. Negative balance of grants due to SEWA Rural PHC: It was pointed out by members of SEWA Rural that the deficit in the current balance on the PHC account had lately shot up to around Rs. 5 lakhs, representing around half the year's budget of the PHC. This was despite regularly submitted financial reports clearly showing the gross deficit, and was in contrast with other PHCs of the district, which had got grants delayed by not more than a month. Also, for three years previous to this, there had been a constant negative balance of around Rs. 1 lakh. The Health Commissioner directed the CDHO to ensure that the backlog was made up, if necessary, using funds from different heads under his command at the earliest. She requested Dr. Yavalkar to pursue the matter, and pointed out that SEWA Rural, being a voluntary organisation, should not be starved of grants, and definitely not out of proportion to the other PHCs.

2. Better utilisation of the kits supplied to FRUs of Bharuch district: In the course of their stay, the Health Commissioner and the Additional Director of Medical Services also visited the CHC at Jhagadia, and took stock of the obstetric work there. It became clear that, the CHC, though it had been recognised as a FRU, was virtually non-functional as regards obstetric work (in the absence of gynecologist and related necessities), and the supplied equipment meant for use at a FRU was consequently lying unutilised. The Health Commissioner directed that SEWA Rural's hospital, which was already having all the necessary infrastructure and facilities, and handling a large part of the load of hospital deliveries in the area, be given the responsibility of a FRU and the said equipment be transferred from the CHC to this hospital.

3. With regard to the question of hospital charges being levied on affording patients by the hospital run by SEWA Rural, it was pointed out that norms exist even for Government- run CHCs and other hospitals to charge affording patients, and that, SEWA Rural is also giving free treatment to all non-affording patients, just as in CHCs. There is also the recent precedent of Moat Ophelia in Vadodara District where a trust hospital has been granted CHC status and permitted to levy charges on affording patients. In addition, being a grant-in-aid hospital, any income from patients at SEWA Rural's hospital was being adjusted against the Government grant, thus obviating any possibility of the trust making profits from patient's fees.

4. Utilization of facilities at CHC, Haggadic by SEWA Rural: The Health Commissioner also pointed out that in view of the vast unutilized space and infrastructure at the CHC, SEWA Rural be permitted to utilize the same for the purpose of ophthalmic and general medical camps which it conducted or was involved with from time to time, or the residential and other facilities be

available to SEWA Rural for the purpose of conducting health related training programmes; that no further procedures be considered necessary for such arrangements to be made as and when requested by SEWA Rural.

5. The supply of additional medicines required from time to time by PHC, Haggadic: The members of SEWA Rural brought to the notice of the Commissioner the difficulties that were being faced in getting supply of medicines over and above the routinely granted amount. After discussing the matter for a while, the Health Commissioner pointed out that, in view of the obvious need of such medicines at SEWA Rural due to a dominant curative role played by its field workers, and since it was possible to arrange for such supplies from stocks and funds already available for the purpose with the district health authorities, and since there could be no doubt about the integrity of the organisation (here, in terms of the possibility of abusing supplies), the district health authorities be directed not to deny SEWA Rural such supplies henceforth.

6. The opening of a government-managed anganwadi (ICDS centre) at Jhagadia village: An anganwadi had been set up in Jhagadia village in the project area given to SEWA Rural, by the block-level ICDS authorities recently, without the knowledge or concurrence of SEWA Rural. This was brought to the notice of all present. Dr. Mehta pointed out that this should never have happened in the first place. He directed Dr. Yavalkar to talk to the district programme officer (ICDS), Dr. Bagga, in this regard and resolve the issue.

7. Laparoscope: With regard to the question of old laparoscope requiring heavy expenditure on maintenance, Dr. K. N. Patel promised to follow up the matter and explore the possibility of replacements.

8. Auditing of PHC accounts: Dr. Pankaj Shah pointed out that for years, the SEWA Rural PHC accounts had not been formally audited by Government auditors, despite repeated reminders. Dr. Yavalkar reassured him that this was not a lapse, and that in the process of random selection of PHCs for auditing, it must have so happened that SEWA Rural's PHC had never so far got selected.

   The Health Commissioner again reiterated the importance and uniqueness of the project, and requested Dr. Mehta to take up the responsibility of its ongoing monitoring. Taking charge, Dr. Mehta directed the concerned Health Department officials in the district and region to ensure that full cooperation was available to SEWA Rural from the department in all aspects, and that he should be promptly informed in case of any problems arising. He also pointed out that it was the responsibility of the CDHO to inform officials of other departments in Bharuch district and Jhagadia Taluka, such as revenue, of the uniqueness and importance of the project, and the quality of work done by the organisation, when it came to the question of such officials making unreasonable demands on SEWA Rural in the matter of targets, etc.

In her concluding remarks, the Health Commissioner said that most of these were minor issues and technicalities, which should not be allowed to come in the way of the smooth functioning of the project. The Government's image was at stake, and it should be seen to be playing the role of a facilitator for such an important project, rather than that of an irritant, especially at a time when the Government of India was looking forward to and inviting close collaborations with more and more voluntary organisations. While such flexibility given to the organisation undoubtedly created a precedent, she said, future dealing with other organisations can be on a case-by-case basis, depending on the integrity and the track record of the organisation, rather than by blind precedent. She once again appealed to all concerned to ensure that the working relations remained smooth and facilitatory.

Annexure 4

Participatory Review and Documentation of Community Health Programme of SEWA Rural by UNNATI

Terms of reference (ToR) for the assignment

SEWA Rural invited UNNATI and Vadodara Medical College (BMC) to jointly undertake the above assignment. This ToR primarily focuses responsibility of UNNATI and other terms and conditions.

While UNNATI will work in coordination with the BMC, its primary responsibility will be to facilitate the study design and methodology and carry out the field investigation with regard to programme coverage, effectiveness, outcomes, level of community participation. At the PHC level, UNNATI would look into the PHC management systems, motivation level of the staff and their individual and team contributions. Vadodara Medical College will look into the technical aspects of the health programme.

The study process would include methods and techniques, which are participatory in nature like community-level meetings, semi-structured discussions with the staff and survey methods.

This assignment will be completed between January and August 1999. The key steps and time person involvement are as follows:

Date	Place	Event	No of persons days involved
January 4-5	Jhagadia	Planning meeting	2
February 1	Vadodara	Planning meeting	1
February 9	Ahmedabad	Discussion on the questionnaire	1
February 15-17	Ahmedabad	Developing questionnaire for community workers	2
March 1	Vadodara	Discussion on community-level questionnaire	1
March 2	Ahmedabad	Developing the community-level questionnaire	1
March 5	Ahmedabad	Translation of questionnaire and finalization	2
March 10	Jhagadia	Community-level meeting and meeting with health workers	2
March 11-12	Jhagadia	Community-level meeting and meeting with health workers, looking at secondary data	8
March 19	Jhagadia	Interviews and meeting with community workers	1
March 20	Jhagadia	Interviews and meeting with community-level workers	1
April 13	Vadodara	Meeting to discuss study of control area for FRU	1

Date	Place	Event	No of persons days involved
May 25-26	Jhagadia	Attend annual review meeting of SR	6
May 27-28	Jhagadia	Meeting with staff of PHC in control area and meeting with community.	4
June (dates to be fixed)		Interview, discussions with outside stakeholders	3
June		Analysis of secondary data, records	2
June		Analysis of primary data	3
July		Preparation of draft report	4
July		Discussion on report	1
August		Finalization of report	2

Overall management of the exercise

From SR, Dr. Shoba Shah will coordinate with UNNATI. SR will organise the field level activities. From UNNATI Ms. Alice Morris will coordinate the assignment. Any fixing or change of date will be done in mutual consultation.

Expenses with regard to the assignment

All expenses with regard to the assignment will be borne by SR. SR will take care of local hospitality and field and data collection related expenses directly. UNNATI will be paid an honorarium of Rs 1500 per person day and all other actual expenses incurred while conducting the exercise. In total there are 48 person days of involvement in this assignment. Any change of methodology and nature of assignment, which may have bearing on the involvement, should be finalised in mutual consultation.

Ownership of the Product

SR is the statutory owner of the product. UNNATI and Vadodara Medical College may use this product for writing articles, or using in training programmes with due acknowledgment to SR.

Annexure 5

A. Basic Information of the Survey

Sr. No.		PHC managed by SEWA - Rural	PHCs managed by Govt. (Dist. Panchayat, Bharuch)
1.	Name of PHC	Jhagadia	Avidha, Umalla, Panetha, Dharoli and Moriyana
2.	Villages Randomly Selected	15	16
3.	Total Population	10,911	16,266
4.	Sample Households Surveyed	542	597
5.	Mothers Surveyed (who delivered in last year) (Form 1)	70	97
6.	Pregnant Mother Surveyed (Form 2)	45	55
7.	Children Surveyed (between 1 and 2 yrs of age) (Form 3)	66	81
8.	Eligible Couples Surveyed (Form 4)	289	268

B. Socio-economic and Cultural Status

	SEWA Rural	Control Area (Govt. PHCs)
Tribal (%)	56.4	66
Income Less than 10,000 per annum (%)	22.7	37.6
Literacy male (%)	64	62
Literacy female (%)	36	38

Annexure 6

Evaluation Survey Questionnaire

COMMUNITY KAP QUESTIONNAIRE

Section A: General Information

1. Village Falia: House No: Form No:

2. Head of the Household:

3. Religion:

4. Details of members of the Household:

Sr. No.	Name	Relation with head of the household	Age	Sex	Education	Present Occupation
1.						
2.						
3.						
4.						
5.						
6.						
7.						

5. Monthly income of the household from all sources:

6. Was there a birth in your family in the last one year? Yes/No

7. If yes, then fill Part-I

8. Is anyone in your family pregnant? Yes/No

9. If Yes, then fill Part-II

10. If there is a child in the age group 12-23 months, kindly fill Part-III

11. If there is a couple in the reproductive age, kindly fill Part-IV

12. Was there a death in your family in the last one year? Yes/No

13. If yes, give details

Sr. No.	Name	Age	Sex	Reason for Death
1.				
2.				
3.				

14. At present is anyone in your family undergoing long term treatment? Yes/No

15. If yes, then answer Part-V

16. Do you know the following health care providers?

Health Worker	Anganwadi Worker	Dais

17. Do the HWs visit your village? Yes/No

18. What services do they provide?
    (1)
    (2)
    (3)
    (4)

19. Do they hold meetings in your village? Yes/No

20. Do you attend the meeting? Yes/No

21. Have the meeting helped you to handle illness?

22. What work does the Anganwadi worker do?

23. Do you send your children to Anganwadi? Yes/No

24. If Yes, then why?

25. If No, then why?

26. What work does the dai do in your village?
    (1)
    (2)
    (3)

27. What do you do at first if anyone in your house has fever/falls ill?

Home remedies	Traditional healer	Contact HW	Mobile
Go to private	Go to SR hospital	Go to Bharuch	any other

28. If not cured then what do you do?

29. If any member of the house has diarrhea what action would you take?
    (1)
    (2)
    (3)

30. Has anybody in the family been referred by HW to SR Hospital in the last three months? Yes/No

31. If Yes then
For What?
Did the HW come with you?
What was the result? Cured/not cured/referred to higher level/died

32. Did any epidemic take place in your village in recent past? Yes/No

33. If Yes, what and what was done?

34. What has been the impact of SR's work in your village?

Nothing	Treatment of sickness	Health Education
Children get food	Vocational Training	Savings
Others		

35. What help have you rendered in the work of SR?

Given place/food	Work in anganwadi	Helped in immunisation
Helped in Gram Shibir in health education		Others (give details)

36. What else should SR do in your village?

Section B:

Part I

For Mothers with Children below one year

1. Name of the Mother:
2. Order of last pregnancy (please tick)
   One Two Three Four Five
3. Number of living children .....
4. Was the pregnancy registered by the FHW?
5. In which trimester was it registered? .....
6. Did you receive TT during pregnancy? Yes/No
7. If Yes, no of doses.....
8. Where did you get vaccinated?
9. How many tablets of Iron – FA tablets did you received?
10. How many have you consumed?
11. How many ANC check-ups were done during the pregnancy? .....
12. What was done during the ANC check-ups?
    Abdominal examination — Height and Weight taken
    Urine examination — Blood Pressure
    Blood examination — TT Injection given
    Advice on diet — Recognition of danger signs
    Delivery pack received
13. Who conducted the delivery?
    TD Un TD Doctor Relatives
14. Delivery was at:
    Home Sub-centre/PHC SR Hospital Private nursing home
    Govt. dispensary Any other
15. How soon did you start breast feeding?
    <than one hour 1st day 2nd day 3rd day another
16. Does she attend ICDS Anganwadi? Yes/No
17. If Yes, then
    How long during pregnancy? .....
    How long during lactation? .....
18. If No, why?
19. How many visits did the health workers make to your house after delivery?
20. Was the birth weight taken or not?

Part II

To be filled by pregnant women

1. Name of the pregnant women:

2. Order of Pregnancy (please tick): First Second Third Fourth

3. Number of living children .....

4. Did the HW come to your house? Yes/No

5. Months
When did she come first? 1 2 3 4 5 6 7
When did she last come? 1 2 3 4 5 6 7

6. Has the pregnancy been registered by the FHW? Yes/No

7. If Yes, then in which trimester was it registered?

8. How many times has Iron – FA tablets been given: 0 1 2 3
Do you take the tablets Yes/ No

9. If No, why?

10. How many injections of TT have you received? 0 / 1 / 2 / 3 / booster

11. Where did you get vaccinated?

12. How many AN checkups were done during the pregnancy? .....

13. What was done during the AN checkups?

Abdominal examination	Height and Weight taken
Urine examination	Blood Pressure
Blood examination	TT Injection given
Advice on diet	Recognition of danger signs

14. When you see which symptoms would seek health care?

(1)

(2)

(3)

(4)

15. Have you received the Delivery pack? Yes/ No

16. Where are you planning to have your delivery?
Home Sub-centre SR Hospital Private Any other

17. Do you attend the anganwadi? Yes/No

18. If No, why?

Part III

For Children between 12 and 23 months

1. Name of the mother:
2. Do you have a immunization card?
   available not available
3. What is the status of the vaccination?
   Complete Partial Not vaccinated
4. If not vaccinated or incomplete then give the reasons
5. Where was the vaccinations given?
   Out reach Sub-centre Hospital Private
6. Was primary vaccination completed within one year? Yes/No
7. Was vitamin-A solution given with measles vaccination? Yes/No/Other time
8. How many doses were given?
9. Has the child suffered ARI in the last one month? Yes/No
10. If Yes, then where and from whom did seek for treatment?
11. Did the child suffer from diarrhea in the last one month? Yes/No
12. If Yes, where and from whom did you seek treatment?
13. If your child is ill, when would seek medical care? (open)
    (1)
    (2)
    (3)
    (4)
14. Does your child attend anganwadi? Yes/No
15. If No, then why?

Part IV

For couples in the reproductive age

1. Name of the Couple:
2. No. of living children:
3. No. of pregnancies:
4. Sex of the living children:
5. Do you know about Family Planning (FP) methods? Yes/No
6. If using FP method whether Permanent of Temporary? .....
7. If Yes, then which method? .....
8. Since how long are you using this method? .....
9. On whose advice have you being using FP methods?
10. What is the source of the FP Methods?
11. Do you receive follow up services?
12. If No, then why?

Part V

For those undergoing long term treatment

1. Name of the Patient:

2. What is the disease?
   Tuberculosis
   Leprosy
   Heart related
   Any other (please specify)

3. Who did the diagnoses?

4. How was it diagnosed?

5. Where are you receiving treatment from?

6. Do you pay for the treatment? Yes/No

7. If Yes, how much do spent during a week?

8. Who pays for your treatment?

9. Do you takes the drugs regularly? Yes/No

10. If No, what is the reason? (some details)

11. If Yes, then where do you get the drugs from?

12. Do you pay for the medicines? Yes/No

13. If Yes, then how much per week?

14. Do you think the treatment is benefiting you? Why?

1. How is your PHC different from Government PHC?

Government PHC	SR PHC

2. What are the key factors/contributions towards developing this difference?

3. In what way has your PHC made difference to the lives of the local poor people's health?

4. What kinds of standards have you set over the years and how do you continue to manage these standards?

5. What system have you developed to link up at various levels? (Grass roots to PHC and to Government level)

6. If you were not in SEWA Rural (with Dr. Desai and referral service) would you have been able to run a Government PHC so efficiently? If Yes/No, what are the crucial factors.

SUPERVISOR

1. Name

   Sex: Age:

2. Qualification (Last degree)

3. *How many years have you worked in SR?*

4. How long have you held the post of supervisor?

5. Which sub-centre are you in charge of?

7. Besides sub-centre what additional responsibilities do you hold?

8. What different roles do you play?

I	Role at sub-centre	Details of role	Time spent/
II	Role at SR		

9. What kinds of inputs have you received to upgrade your skill?

10. What specific contribution have you made in making the PHC effective and efficient? Elaborate.

11. What kinds of health issues has the PHC not been able to address and why?

12. Do you face any difficulties while doing your work?
    - Community
    - Sub-centre
    - PHC

13. What are the coordination mechanisms with the sub-centre and PHC?

14. What difficulties do you face in the coordination?

15. As compared to the Government run PHC'S, in what way do you play different roles?

16. How far are your problems addressed? What are the organisational mechanisms?

HEALTH WORKER

1. Name
   Age : Sex:

2. Post currently held

3. Qualification (last degree)

4. Name of sub-centre to which you are attached

5. No. of years you have worked at the current post

6. Where do you stay:
   - In sub-centre quarters:
   - In the village:
   - Outside the village:

7. If at the sub-centre, then:
   1. Do you find it difficult to stay at the sub-centre?
   2. If yes, what are the problems you face ? (Kindly elaborate)

8. Has SR tried to solve these problems and how?

9. Daily work schedule

Work PHC	Details	How many villages
Sub-centre		
Village		

10. What inputs have you received from SR to develop/upgrade your skill?
    - training
    - equipments
    - others

11. What problems and difficulties do you face in your work?
    1) at PHC
    2) at the sub-centre
    3) during house visit (community)

12. Have you discussed these problems with SR?

13. If yes, what steps have been taken by SR to solve these problems?

14. What are the innovations you have made at work? Has the village benefited from this? If yes, give details.

15. What is the nature of your linkage with PHC/SR Hospital? Give details.
    - Referral
    - Drug and equipment
    - Maintaining records
    - Any other

16. Do you think that the villages have benefited from SR activities? If yes, give details.

17. Apart from health service what other activities can help improve the living standards of the village?

18. At the community level do you conduct training?

19. If yes, what do the trainings cover?

20. How regularly do you hold village meeting?

21. What do you discuss in meeting?

DAIS

1. Name

   Age : Sex : Village :

2. Qualification

3. For how many years are you doing dais work ?

4. How did you enter into this work

   a. Traditional occupation

   b. Developed as a hobby

5. Whether trained Yes / No, If Yes, then from where?

6. Have you received any training?

   (Who gave the professional training)

Sr.	Year	Name of the training	By whom
1			
2			
3			
4			

7. Do you hold a card?

   Yes No NA

8. How did you benefit from the training?

9. How do you compare SEWA Rural training, give details.

   SEWA Rural :

   Others :

10. Do you feel that your legitimacy among the community has changed after training?

11. What are the main roles you play?
    - Community
    - Health worker level
    - PHC/Hospital level

12. What significant contribution have you made to the health services ?

13.

Role play	Self-assessment			PHC assessment		
	H	M	L	H	M	L
• Motivator/educator						
• As a delivery support						
• As a link person						
• As a model community health person (Practices what is preached)						
• Any other						

Give a case of success/failure/important case.

Annexure 7

Evaluation Report
prepared by

Department of Preventive & Social Medicine
Government Medical College, Vadodara

Background and Objective of the Evaluation

SEWA Rural (SR) in Jhagadia was given the responsibility of providing the complete services for Primary Health Centre (PHC) in Jhagadia for a period of over 10 years. In order to expand their activities, SR Jhagadia then decided to hand the PHC back to the Government. SR is a well appreciated Non Government Organization (NGO) in Government, academic institutions and the voluntary sector. This can be explained by the staff members of SR being committed and that the working environment is congenial and open. Constructive and positive feedback and supervision is readily available from the senior staff members for problem solving in the NGO set-up. Given this background it is hypothesized that the services provided, utilised and perceived by people of the area served by the SR PHC are likely to be of higher quality than in the nearby PHC areas.

However, to test the hypothesis, an evaluation by an independent team was considered appropriate. Thus UNNATI was assigned to carry out an independent evaluation looking into the social aspects whereas the technical aspects was studied by the Department of Preventive & Social Medicine, Medical College, Vadodara.

Methodology

Approximately 500 households from 15 villages each from SR project area and control area were to be studied. The demography details, including population covered, number of households, pregnant women, eligible couples and children are given in Annexure 5a. The socio-economic details such as per capita income, caste and literacy levels are provided in Annexure 5b. To ensure comparability, the selection of villages was based on the population and the distance of the villages from the PHC areas. It would have been ideal to compare all activities of the PHC over the year in all the villages. However, because of the paucity of time, a survey covering a cross-section of the community served was done to compare and evaluate access to key services such as MCH services and Family Welfare programme. These indicators are used to highlight the overall performances.

Results and Discussion

It is important to note that all the observations and comparisons between SR-served areas and the other areas were statistically significantly more advantageous to the community in the SR-served areas.

Antenatal Care (ANC)

All women served by the SR PHC received full ANC as against 79 per cent in the other areas. However, early registration is the most useful tool to detect problems and take necessary corrective actions. In this regard, the performance of SR PHC was greater. There were 70 per cent more registrations in the first three months of pregnancy in the SR PHC area as shown by the ratio 1:7. Similarly, TT injection was given to all women in the SR PHC area while as many as 25 of the women (36 per cent) did not get the TT injection in other areas, despite 10 of them accessing ANC. Iron tablets were adequately received (more than 90 tablets) by 2/3 of the women served by the SR PHC area while only 14 per cent of the women in the other areas received the tablets. It was observed that 34 per cent

of the women in the other areas did not receive any iron tablets at all as against only 3 per cent in the area served by the SR PHC (see Table 1).

The quality of care is further highlighted by the fact that almost all women (65/70) in the SR PHC area had their blood hemoglobin tested as part of ANC as against only 1/3 of the women in the other areas. Blood pressure check-up was done on 67 per cent of the women who received ANC while only 29 per cent of the women in the other areas had the blood pressure check-up. This suggests not only better coverage but also better quality of ANC.

SR PHC area also provided better nutrition education and information related to high-risk pregnancy compared to other areas.

Intranatal care

Home delivery was the choice for the majority of women in all areas. However, the proportion of hospital deliveries was three times more in the SR-served area than in the other areas. This difference is likely to be due to more awareness and better utilization of the services rather than higher risk pregnancies leading to hospital delivery.

Delivery was conducted by trained dais in 88.6 per cent of the cases in the SR-served areas as against 73.2 per cent in the other areas. This is 15 percentage points higher for the SR PHC area compared to the other areas (see Table 2).

Postnatal care (PNC)

A very high proportion of the women (81.4 per cent) received PNC in the SR-served area compared to 33 per cent in the other areas, suggesting that 2.5 times more women receive PNC in the area served by SR compared to other areas (see Table 3).

Newborn Care

The birth weight is a result of the quality of health services received during pregnancy and it is an important indicator. Almost all newborn babies (93 per cent) were weighed soon after birth in the SR-served area compared to only 26 per cent in the other areas. Another important area in newborn care is the time of initiating breast-feeding. It is recommended that breast-feeding be initiated at the earliest possible. The proportion of women who initiated breast-feeding within one hour of birth was as high as 43 per cent in the SR-served area compared to only 10 per cent in other areas. This is a 4 times higher rate for the SR-served area (see Table 4).

Vaccination

Vaccination is a priority programme in the Government and it is targeted to achieve 100 per cent coverage. However, the vaccination was complete in 94 per cent of cases in SR PHC area compared to 74 per cent in the other areas. Vaccination was also available to 80 per cent of mothers in the SR-served area while, in the other areas, it was only given to 52 per cent of the mothers (see Table 5).

Summary

Summarizing the findings, it should be highlighted that the health services provided, utilized and perceived are of a higher quality in the SEWA Rural PHC area compared to other areas.

Further three sub-centres served SR PHC were visited by a doctor and staff members on 11 March 2000 followed by a visit to sub-centres in other areas for observing the antenatal care, vaccination and family planning services provided. These observations are summarized in table 6a-b and table 7a-c.

Survey Findings

Table 1 Antenatal Care

	SEWA Rural	Control Area (Govt. PHCs)
Total No.	70	97
ANC Registration(%)	100	79
TT Injection Received (%)	99	64
Iron Tablet (%)		
>=90 (received)	67	14
>=90 (consumed)	57	9
Not received	3	34
ANC checkup >=3 (%)	56	17.5

Table 2 Intranatal Care

	SEWA Rural	Control Area (Govt. PHCs)
Delivery Conducted by Trained Persons (%)	88.6	73.2
Delivery Place (%)		
• Home	66	88.7
• Hospital	34	11.3
Choice of delivery (%)		
• Hospital	52	16
• Home	48	84

Table 3 Postnatal Care

	SEWA Rural	Control Area (Govt. PHCs)
Total No.	70	97
PNC Visit by Female Health Worker (%)	81	33
>=3 (%)	44	11.3

Table 4 Newborn Care

	SEWA Rural	Control Area (Govt. PHCs)
Breast Feeding (%)		
Initiation within a day	57	43
Initiated in within 1 hour	28.9	10
Birth weight taken (%)	93	26.8

Table 5 Vaccination

	SEWA Rural	Control Area (Govt. PHCs)
Total No.	66	81
Vaccination Card Available (%)	80	52
Vaccination Received (%)	94	74

Observation at Sub-centres

Table 6a Vaccination

Question	SEWA RURAL		CONTROL AREA	
	Done correctly (%)	Incorrect/ Not done (%)	Done correctly (%)	Incorrect/ Not done (%)
Confirmation of the dose of vaccine to be given	3 (100)	0	0	3
Use of sterilized needles	3	0	3 (100)	0
Correct dose of vaccine given	3	0	1 (33.3)	2 (66.6)
Correct technique used	3	0	1	2
Explanation about side effects of vaccine given	1 (33.3)	2 (66.6)	0	3
Explaining why particular vaccine given	3	0	0	3
Entering vaccination date on vaccination card and record	3	0	1	2
Informing mother of next vaccination date	3	0	0	3

Table 6b Antenatal Check-up and Care

Question	SEWA RURAL		CONTROL AREA	
	Done correctly (%)	Incorrect/ Not done (%)	Done correctly (%)	Incorrect/ Not done (%)
Clinical examination of anemia	3 (100)	-	2 (66.6)	1
Blood pressure check-up	2 (66.6)	1	1 (33.3)	2
Urine examination	0	3	1	2
Per-abdomen examination	3	0	0	3 (100)
Advise regarding TT injection	3	0	2	0
Confirming intake of Iron Folic Acid tablets	3	0	2	1
Advice regarding complication	2	1	0	3
Delivery advice	3	0	0	3
Advice regarding regular ANC check-ups	3	0	2	1
Next date of visit told	1 (33.3)	2	2	1
Details/history of previous pregnancy taken	2	1	2	1

Response of Health Workers and Supervisors

Table 7a Antenatal Care

Question	Health Worker (SR)			Supervisor (SR)		
	Correct Response (%)	Incorrect/ Response (%)	No Response (%)	Correct Response (%)	Incorrect/ Response (%)	No Response (%)
How do you identify a pregnant woman?	14 (100)	0 (0)	0	5 (83.3)	0	1 (16.7)
How many home visits did you make to?	12 (85.6)	2 (14.4)	0	5	0	1
pregnant women? What are the components of ANC?	12	2	0	5	0	1

Table 7b Family Planning

Question	Health Worker (SR)			Supervisor (SR)		
	Correct Response (%)	Incorrect/ Response (%)	No Response (%)	Correct Response (%)	Incorrect/ Response (%)	No Response (%)
How do you identify eligible couples?	13 (92.2)	0	1 (7.1)	5 (83.3)	0	1 (16.7)
What are the methods of family planning?	13	0	1	5	0	1

Table 7c Immunization

Question	Health Worker (SR)			Supervisor (SR)		
	Correct Response (%)	Incorrect/ Response (%)	No Response (%)	Correct Response (%)	Incorrect/ Response (%)	No Response (%)
What is immunization schedule?	10 (71.4)	1 (7.1)	3 (21.5)	5 (83.3)	0	1 (16.7)
Precautions to be taken during immunization	13 (92.9)	0 (0)	1 (7.1)	5	0	1
Side-effects and complications of vaccination	11 (78.6)	1	2 (14.3)	5	0	1
How is cold chain maintained?	10	1	3	5	0	1
Precaution to be observed for vaccination at field side	11	0	3	5	0	1

Annexure 8

List of Interventions

- Emphasis on availability of curative care for minor ailments at village level, 1982-83
- Fixing convenient time and place for service delivery, 1984-85
- Strengthening of dais, 1984-85
- Use of delivery pack, 1987
- Performance-based incentive to dais, 1989-90
- Care of unmarried pregnancy, 1987-88
- Special care of high-risk mother, 1989-90
- Adolescent girls' health and development, 1989-90
- HB estimation - filter paper method, 1990-91
- Vitamin A supplementation in postnatal period, 1990-91
- Postcard system for follow-up of family planning, high-risk pregnancy, TB patients, etc., 1990-91
- Postnatal care within one week, 1990-91
- Sub-centres as a team unit, for planning, monitoring, and supervision tasks, 1992
- MIS system to good duplication in records
- Common supervisors - integration on ICDS and PHC staff, 1992
- Decentralization process - involvement of workers in target setting, monitoring, etc., 1993-94
- Programme for newly married couple, 1993-94
- Deworming and malaria prophylaxis during pregnancy, 1993-94
- Payment for delivery pack, 1993-94
- Management of ARI by AWW, 1993-94
- Quality care of pregnant mother - 3 ANC check-ups < 16 weeks, 24-28 weeks, after 36 weeks, 1994-95
- Blood donation camp at villages, 1994-95
- HB estimation $CUSO_4$ method, 1994-95
- Infertility programme, 1994-95
- RTI treatment at sub-centre level by FHW, 1994-95
- Special package for newborn care, 1996-97

Annexure 9

List of Health Education Material Developed

Poster	Pamphlet Hard Board Cloths
Roller Board	
Calendar	Safe delivery newborn care, newborn care
Laminated Hardboard Poster	STD, habits
Hard Board Poster	Infertility, sickle cell anemia
Paper Poster	Reproductive system
Roller Board	Safe delivery
Cloth Poster	Safe delivery Diarrhea Newborn care Malaria AIDS TB Infertility
Slides	Antenatal care - AIDS Process of delivery Winning of breast-feeding
Pamphlet	Antenatal care TB Infertility Sickle cell anemia
Video	Kali kem mari (maternal death) Janetana jatan Jakaro Pani pahela pal (sickle cell anemia) Pacho theleo andhakar Seven ** Dai mela Protection against mosquitoes CBR programme

Annexure 10

List of Field Studies

1. Feasibility of Measles Vaccine. (1985-86)
2. Social factors in epidemiology of measles diseases. (1985-86)
3. Study of long-term sequel of children suffered from measles diseases in comparison to the immunized and non-immunized children with measles vaccine. (1985-86)
4. Feasibility of Nutrition Education for infant care through Primary Health Care approach. (1986-87)
5. Impact of Nutrition Education on knowledge, attitude and practice skills of mothers and on-growth status of infants. (1986-87)
6. Feasibility study of the use of pre-sterilized delivery pack by traditional birth attendants conducting home deliveries. (1986-87)
7. Impact of pre-sterilized delivery pack used for conduction of home deliveries on morbidity and mortality of mother and child during postnatal period. (1986-87)
8. To evolve a scoring system or establish major and minor criteria to arrive at more accurate diagnosis of childhood tuberculosis. (1986-87)
9. Comparison of children's health status belonging to planned and unplanned families. (1986-87)
10. Knowledge, attitude, practice and belief status about various terminal and non-terminal methods among the target couples in the rural tribal area. (1986-87)
11. Role of voluntary organizations in implementation of strategy of Health for All: Suggestions by SEWA Rural. (1987)
12. Women's Health in Rural Gujarat: SEWA Rural's Experience. (1989)
13. Involvement of Voluntary Organizations in the Implementation of ICDS Programme: A Case Study of SEWA Rural. (1990)
14. Study on Women Accepting CuT. (1990)
15. Factors Affecting Compliance with Iron Folic Acid Supplementation during Pregnancy in Rural Gujarat. (1991)
16. Field Study on Extend and Mode of Use of the Delivery Pack in Management of Home Deliveries by Traditional Birth Attendants. (1991)
17. SEWA Rural Team, Evaluation of the Actual Use of the Monetary Help During Pregnancy. (1991)
18. SEWA Rural Team, Traditional Practices in Neonatal Care. (1991)
19. SEWA Rural Team, the KAP Survey for Spacing Methods among Eligible Couples of SEWA Rural Project Area. (1991)
20. Aseptic Delivery Pack: An Innovation Developed and Tested by SEWA Rural. (1992)
21. Malaria Control by Active Participation of Rural Community through Vector Control: Initial Experiences at SEWA Rural. (1994)
22. Prevalence of Clinically Detectable Gynecological Morbidity in India: Results of Four Community-based Studies. (1995)
23. Anemia: An Experiment. (1995)
24. Dr. Sudhakar Rao and SEWA Rural Team, Assessing Qualitative Indicators Among Cu-T Acceptors in SEWA Rural Project Area. (1995)
25. SEWA Rural Research Team, Community-based Workers as an Alternative to Female Health Worker in a Primary Health Centre Set-up: An Experiment by SEWA Rural, Jhagadia. (1995)
26. The Comprehensive Health Care Approach at SEWA Rural: The Scope for Primary Health Care as Part of Social Security for the Unorganized Sector. (1996)
27. SEWA Rural Team, Towards a Target-free Population Programme, An Innovation in Primary Health Care: SEWA Rural Experiences. (1996)
28. Infertility Study in Community Health Project Area of SEWA Rural, Jhagadia.
29. SEWA Rural Team Enhancing the Roles and Responsibilities of Men in Women's Health Programmes. (1998)
30. Women's Health Programme in the Context of Primary Healthcare - SEWA Rural Experience. (1999)

Annexure 11

Publications

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- *"Health in One World"* p. 42, Proceedings of International Symposium - The CHP Background Paper, June 1989.
- SEWA Rural Research Team - *Beliefs and Behaviour regarding Diet during Pregnancy in a Rural Area in Gujarat, Western India.* in Gittlesohn, J., et al (eds.), *Listening to Women Talk about their Health*, Har-Anand Publications, Delhi, pp 95-115, 1994.
- Desai, Lata, Shah, Pankaj & Sridhar, S., *Integrated Interventions for Child Survival - A Case Study.* The Indian Journal of Pediatrics, 61:1-9, 1994.
- *Prevalence of Clinically Detectable Gynecological Morbidity in India: Results of Four Community-based Studies,* BCC, CINI, SEWA Rural and Streehitakarini, 1995
- SEWA Rural Team, *Voluntary Effort in Community Health, People's Health in People's Hands: A Model for Panchayati Raj,* FRCH, Bombay, pp. 209-234, 1993.
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- SEWA Rural Team, *Infant Mortality Rate - Gujarat 2010 Challenges and Opportunity*, pp. 373-377, presented at seminar in State Planning Commission, Government of Gujarat, Sardar Patel Institute of Economics & Social Research, Thaltej, Ahmedabad.
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- *The Comprehensive Health Care Approach at SEWA Rural, The Scope for Primary Health Care as Part f Social security for the unorganised sector,* 1996.
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- *Unitary Concept for prevention and treatment of respiratory diseases syndrome.* The Lancet, pp. 126-128, July 21, 1973.
- *"International Helaminthiasis in children below 12 years"*, Dissertation – B.J. Medical College, Gujarat University, Ahmedabad, 1969.
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- *Experience in Reduction of Infant Mortality Rate*, paper in "Anvesak" published by Sardar Patel Institute of Economic and Social Research, Ahmedabad, 2002.

Annexure 12

List of Participants Trained at SEWA Rural (1990-2000)

Category	No. of Organisations	No. of Participants
Dai	55	1348
Anganwadi Worker	6	162
Health Worker	63	1061
Coordinator (Trainer)	99	460
Students from various Academic Institutions	75	600

Annexure 13

Expenditure on Community Health Project

RECURRING EXPENSES												
YEAR	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	TOTAL
ICDS	5,263,036	414,978	327,967	343,721	472,175	412,588	431,155	385,526	450,434	495,507	432,397	9,429,484
PHC	862,520	855,442	929,686	1,030,231	1,026,806	1,077,731	1,224,233	1,259,024	1,467,262	1,468,979	1,431,559	12,633,473
FORD	299,916	459,429	630,571	906,256	966,169	1,018,040	1,166,597	1,228,464	906,121	1,146,955	1,084,347	9,812,865
TOTAL (A)	6,425,472	1,729,849	1,888,224	2,280,208	2,465,150	2,508,359	2,821,985	2,873,014	2,823,817	3,111,441	2,948,303	31,875,822
NON-RECURRING EXPENSES												
ICDS												0
PHC												0
FORD	243,104	103,559	489,782	199,418	56,269	529,690	428,927	25,163	24,700	130,200	118,435	2,349,247
TOTAL (B)	243,104	103,559	489,782	199,418	56,269	529,690	428,927	25,163	24,700	130,200	118,435	2,349,247
TOTAL (A+B)	**6,668,576**	**1,833,408**	**2,378,006**	**2,479,626**	**2,521,419**	**3,038,049**	**3,250,912**	**2,898,177**	**2,848,517**	**3,241,641**	**3,066,738**	**34,225,069**

Annexure 14

Health Facilities Available to the Project Population

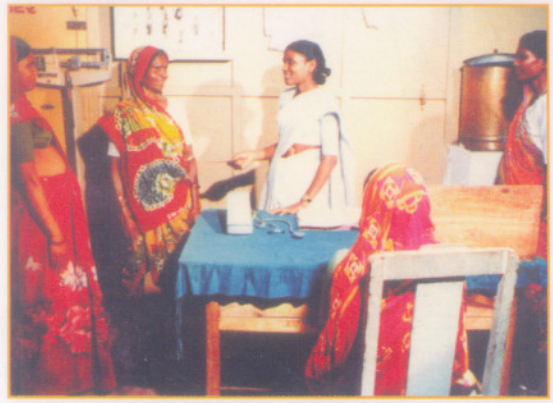
Jhagadia is one of the Talukas (blocks) of Bharuch District. Health services in rural areas are provided by Primary Health Centres (PHCs) and referral-level hospitals, under the administrative control of the District Panchayat. In addition, some private health facilities are also available.

When SEWA Rural began its work in 1982, there were two PHCs in the entire block: one at Umalla, about 20 km from Jhagadia, and the other at Moriyana, 35 km away. At present, there are six PHCs, at Avidha, Dharoli, Panetha, and Jhagadia in addition to the earlier two. The PHC at Jhagadia, which is under the administrative control of SEWA Rural, is the largest, covering a population of 45,000. The others serve populations of between 20,000 and 35,000.

The curative services commonly availed by the people of the project area include:

- The Kasturba Hospital at SEWA Rural, Jhagadia, a 70-bed general hospital functioning since 1980.
- The Government CHC at Jhagadia, a 30 bed general hospital functioning since 1985.
- The recently upgraded PHC at Umalla.
- The Civil Hospital, Rajpipla (45 km from Jhagadia), a 30-bed general hospital.
- Vijay Prasuti Gruh, Rajpipla, a private trust hospital offering mainly obstetric services.
- The Municipal Hospital and Jayaben Modi (Trust) Hospital, both general hospitals, at Ankleshwar, and (District) Civil Hospital and Sevashram (Trust) Hospital, Bharuch, both around 20 km away.
- An Ayurvedic hospital at Netrang, 30 km from Jhagadia.
- Around 10 private clinics run by qualified doctors in the project area, and in adjacent areas and a number of such others in Netrang, Ankleshwar and Bharuch.
- An unspecified number of local healers at every village.

It must be mentioned that for the entire district east of Ankleshwar and Bharuch, the only modern indoor facilities available are at Rajpipla and Jhagadia.



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