Study of Demand and Satisfaction of the Mauritius Health System

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THE INSTITUTE OF HEALTH SYSTEMS

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Objectives Of The Study

The terms of reference (TOR 11.1) envisaged an enquiry into the demand patterns, present complaints of patients, previous services rendered, the distance of patients from health centres and reasons for non-utilization of similar services provided at a lower level of the health system. An assessment of unmet health needs as perceived by the people was also sought for. In operationalising these as well as related aspects of the people's perceptions and expectations about the health system, we have taken up various questions in the exit surveys and the focus group discussions.

The exit survey addresses the following questions:

1. What services did patients expect to get in their AHC CHC or hospital and what did they actually get?
2. Did they feel they had waited long at the AHC/ CHC or hospital and how long did they actually wait? How long did they stay in the hospital and did they think their stay was long or short?
3. What was the distance from their home to the CHC/ AHC or hospital they visited?
4. Why do they not go to the nearby Health Centres before approaching hospitals?
5. What advice did the doctor give?
6. How did they rate the doctors, nurses, records section, drugs, medical equipment, surgical equipment, ward space & bedding, catering and sanitation? - Excellent Good Fair Average / Below Average?
7. Were they consulting several doctors in different health delivery facilities? If so, why?

The Focus Group Discussions conducted in Household groups and Local Health Committees (LHC) have addressed the following questions. Some overlap of questions addressed in focus groups and the exit surveys was inevitable. This was because in focus groups we expected a more free expression of views, emerging out of the security of anonymity and group strength. The question on community management was stressed in the Local Health Committees.

1. What good or bad things did the group find in the doctors, nurses, records section, casualty, drugs, medical equipment, surgical equipment, ward space & bedding, sanitation, visiting hours, ambulance service in the Public hospitals and health centres?

2. What good or bad things they felt in the above categories in the private clinics & nursing homes?

3. Did they find it necessary to go to hospitals before attending health centres?

4. What special health problems did the elderly feel needed attention? What suggestions did they have in this respect?

5. Did the elderly complain about drug regimen, diet advice and life style change?

6. What special attention was necessary for female health problems? What were women's suggestions in this regard?

7. What were people's views on local community involvement and raising of resources for running AHC/ CHC's?

8. What were people's views on linking up the working of AHCs and CHCs with the activities of women's groups and other voluntary groups?

9. Were people willing to pay a part of the expenditure on treatment in the public hospitals?

10. Was there interest in having a system of family practitioners?

11. In general, what improvements were desired in public hospitals and AHCs CHCs?

12. What improvements did people want in private health services?

Study Methodology And Sampling

The study has two components: 1) an exit survey, which was conducted separately for inpatients and out patients, and 2) the focus group discussions, which again were conducted separately for household groups and local health committees (LHC).

Exit Survey

The exit survey was conducted separately for inpatients and out patients. The sample for the in patient exit survey was obtained from the discharged cases of the last week of May 1995. This is the same sample used for the medical chart review study on ischaemic heart disease, myocardial infarction, renal failure, low birth weight babies, Cesarean sections, neonatal deaths and still births. Exit interviews for 155 discharged patients were conducted. Contrary to the usual practice of conducting exit surveys on patients as they get discharged from hospitals or leave the hospitals' health centres after the consultations, we have conducted the interviews in their houses. This meant a lot of travel, but responses in a household setting are expected to be much more free, and therefore reliable, than in a hospital setting, when patients have to comment on the hospital and related services itself.

The out patient sample was drawn from the OP cases in two hospitals, viz. Dr Jeetoo and Victoria, three area health centres, viz. Gumani, Bramsthan, Curepipe, and the Grand Sable CHC. These institutions represent the regions of Plain Wilhems, and the east and south east regions of Mauritius. Both well utilised and less utilised health centres have been represented in the sample. Equal representation has been given to boys and girls (under 15 years) and male and female adults. The targeted sample of 300 was divided equally among the 2 hospitals, 3 AHCs and 1 CHC. The OP sample was selected from OPs who attended the selected AHCs and CHCs for one week from June 24th to June 30th 1995 and in the two hospitals which had very high attendance from one day's patients during the week mentioned above. Out of the 300 targeted interviews, 218 were completed. The rest could not be finished due to the time constraint. The total number of cases for a day or week with respect to hospitals and health centres were first classified into two categories: those under 15 years of age, and those above 15 years of age. From each category 26 cases were selected, using systematic random sampling. The 'n' number was derived by dividing the total number of cases in each category by 26. Out of these 26 cases care was taken to include an equal number of males and females.

The investigators used in the study were selected from among the Medical Record Officers of the hospitals in Mauritius. They were given several sessions of in-house training followed by pilot interviews. The pilot interview forms were further looked into and various suggestions were made on them after which they started the enquiry. The exit surveys were conducted from mid-June to mid-July, 1995. Data entry was done in dbase or Fox Pro and analysis was done in Systat.

Focus Groups

Content Analysis of Focus Group Discussions

Organising and simplifying the complexity of qualitative data into some meaningful and manageable themes or categories is the basic purpose of content analysis (Patton M.Q. 1987). Most commonly, content analysis is used to study the frequency and the intensity with which certain items, symbols or themes appear in a document (Willamson, Karp and Darphin 1977). The content analyst also looks into the context in which a concept appears in the text (Fetterman D.M. 1989). In this case the discussion notes of focus groups among households and local health committees will serve as text.

The framework for content analysis is based on the construction of categories into which the data can be grouped. These categories should reflect the theoretical concepts on which the study is based and should bear close relation to the research problem. We have used the concept of Key Words In Context (KWIC) (Stewart W.D & Shamdasani P.M 1990 op. cit p.164) in developing categories. This concept takes into account the meaning of the key word in the context in which it is occurring.

The discussion notes were written up in a precoded manner following the same numbers of the aspects and issues which were provided in the discussion guide. In order to group the data as per the several aspects and issues, we experimented with Anthropac but later found that it was more convenient to do this under the Window-based word processing functions of Amipro. Several discussion notes which were entered as separate files were opened simultaneously and the relevant section of the discussion were grouped into separate files. Later print-outs of these grouped files were taken out and manually analysed for the various key words. The frequency of occurrence of various observations were calculated, as were their percentages. However, these percentages are only meant to be a measuring rod for the extent and depth of a certain perception or attitude among the groups. Also, as there are multiple responses which are not mutually exclusive, the total numbers of these responses will not add up to 32 or 21 nor will the

percentages total up to 100. Care has been taken to present the various shades of perceptions and attitudes in the people's own words with the minimum of editing. Verbatim quotations have also been used. The depth of emotions reflected in gestures have also been taken note of in the analysis and distinctly mentioned. All groups may not express themselves on every aspect and sub-aspect. This fact is also reflected in the percentages which we have calculated. Therefore, we have to be cautious in using these percentages as absolute values. They should always be weighed against the overall response level for each aspect.

Key Informant Interviews

We had also planned to conduct a set of key informant interviews of persons who were closely connected with the Health System of Mauritius. However, due to time constraints, we could cover only three of them, which are presented in Annexure 7.1.4. One was with Dr. J.C Mohit the Director, of the Mauritius Institute of Health. The second was with the Office Bearers of the Mauritius Medical Council, and the third was with Dr. N. C. Shah, Consultant - Advisor on Ayurveda to the Government of Mauritius.

Exit Survey

Characteristics Of In-patient Sample

Socio-economic

There were 59 males (38.06%) and 96 females (91.94%) in the sample of 155. The higher number of females was due to the large number of pregnant women whom we have represented in the sample. Irrespective of sex, only 2% of the respondents were in the 0-14 age group. The largest chunk of patients (39%) fell within the 25-44 age group. The percentage distribution of other age groups are given in Table .1. The oldest respondent was eighty-one

Table 1 In-patient respondents by age group

Age	No. of Persons	%
0-14	3	1.94
12-24	19	12.25
25-44	61	39.35
45-59	38	24.51
60+	34	21.96
Total	155	100.00

Education

In terms of education, nearly 17% of the respondents were illiterate or not educated, including children of pre-school years. About 37% had attended primary classes 10% had passed CPE. 19% had attended higher classes, but not passed S.C., while 3% had HSC and 3% had passed degrees or diplomas . Table .2

Table 2 Educational Status

Formal education	Number	%
None	26	16.77
Primary-attended	57	36.77
Primary-passed	16	10.32
Below SC	30	19.35
SC Passed	15	9.68
HSC & higher	8	5.16
Not mentioned	3	1.94

Occupation

The respondents are from a fairly wide range of occupations Table ..3 Due to the large number of pregnant women in the sample, the housewives make up a large percentage of the sample (37%). The broad range of the respondents' occupations is reassuring, in terms of generalisability of findings. It also speaks of the accessibility of the public hospitals. Evidently a large proportion of these respondents who had access to the public hospitals belong to occupations considered middle, lower middle or poorer classes.

Table 3 Occupation of respondents

Occupation	Number	%
Labourer, cleaner, servant, sewerage etc.	5	3.23
Factory worker, gonman DWC, customs clerk, messenger DBM, operator, painter, salesman, taxi driver, textile worker, vegetable vendor, knitter, carpenter, machine operator, driver, police, mason, sprayman, tailor, welder etc.	22	14.19
Co-ordinator, MCA, Industry supervisor, insurance sales, nursing officer, office clerk, preprimary teacher, bread maker, caretaker, priest, receptionist, supervisor, technical assistant, painter etc.	15	9.68
Bar keeper, manager, shopkeeper, planter, jeweler, civil servant etc.	2	1.29
House wife	58	37.42
Student	2	1.29
Disabled	1	0.65
Not mentioned	30	19.35
Elderly and retired	20	12.9
Total	155	100

Transport

A vast majority of respondents (i.e., 75%) used private cars or taxies to reach the hospitals Table [illegible].4). However, this result reflects not on the economic status of the respondents, but on the severity of health problems and the existence of community support. For example, 60% of patients could find a car (either own or a neighbour's) to reach the hospital. This finding has important implications about the overall health care system. It has also been found from chart review of myocardial infarction cases, for whom quick transportation to hospital is very important, that time to admission is comparable to that in most European countries. Although the ambulance system is not well developed the favourable time to admission is due to the geographical compactness of the country, the availability of private cars in almost every village, and good community support. Hence large investments in modern ambulance systems may be redundant in the specific circumstances of Mauritius.

Table 4 Modes of transportation to hospital

Transport	Number	%
Bus	29	18.71
Car	93	60
Taxi	23	14.84
Motor bike	3	1.94
By walk	2	1.29
Other	3	1.94
Not mentioned	2	1.29
Total	155	100

Disease Information Given By Doctors

It is important to recognise that the sample of inpatients was first selected on the basis of diagnosis for purposes of chart review. Hence the morbidity profile reported here is not in any manner representative of all hospital discharges. This information . . Table ~ .5) is furnished to reflect the extent to which persons knew the nature of their medical condition after discharge from hospital. This table is based on responses to questions 11 (what do you think was your problem?) and 12 (what was your problem in the opinion of the doctor?). Most (88%) of the respondents had some definitive information about the nature of their disease. There still is a gap of about 12% who did not have any definitive information about their disease. There appears to be some scope for improvement in this area if attending physicians were to explain the nature of problem to the patient more clearly.

Table 5 Disease information given by doctors

Disease information	No. of Persons	%
Normal Delivery / Uncomplicated abortion	24	15.48
Complications of pregnancy child birth and puerparium	26	16.77
Heart disease, high blood pressure, diabetes, stroke	58	37.42
Others including gastritis, acute respiratory infections, infective hepatitis, renal colic, chest pain &c.	26	16.77
"No problem"	2	1.29
Not mentioned	19	12.26
Total	155	100

Access to Doctor/Nurse

We asked in question 14 "Whom did you expect to see (in the hospital)" Naturally almost all (91%) expected to consult the doctor. About 82% (127) actually consulted a doctor It is possible that the rest were mainly cases of normal delivery attended by a nurse/midwife. Thus accessibility of doctors in hospital does not appear to be a big problem for in-patients.

Waiting Time

We asked three questions (Q16-18) to elicit patients' perceptions about waiting at the time of admission. A majority (70%) felt that they did not have to wait long for their consultations. However, 27% of in-patients perceived that they had to wait for long. When asked about the duration of their wait, 70% either did not remember or had waited for less than half an hour. Among those who remembered the duration of waiting, the median waiting time was 30 minutes. Eleven percent waited for more than one hour . Table 6.

Table 6 Perceived waiting time

	Nos.	%
Did not remember	54	34.84
Less than half hour	61	39.36
Half to one hour	23	14.84
One to two hours	10	6.45
More than two hours	7	4.5
Total	155	99.99

Reasons For Waiting

The main reason for waiting was that there were many people ahead of them in the queue. This reason was also mentioned in combination with other reasons, such as waiting for doctors, nurses, the record section, and for diagnostic reports Table 7. Note however that only 25% of respondents gave a reason for waiting. This is consistent with the 27% of people who felt they had to wait for long. As noted earlier, a majority of respondents did not have to wait for long at the time of hospital admission. This is an encouraging result.

Table 7 Reasons for waiting

Primary reasons	Number	%
There were a lot of people ahead of me in the queue or emergency cases.	21	13.5
The doctor / nurse was either late to arrive or was otherwise busy.	11	7.1
Long queue and doctor was either late or busy.	6	3.9
Had to wait for the diagnostic reports	1	0.7
Not applicable or not mentioned	116	74.8
Total	155	100
Contributory reasons		
Delay in receipt of records	3	1.9
Delay in receipt of diagnostic reports	4	2.6

Medical Attention

In order to get an idea about the quality of professional attention received in the hospital, we asked the respondents three questions (Q19-21). The first question was meant to focus respondents attention on his / her interactions with doctors and nurses. It was followed by "did he / she examine you?" and if yes, what did he / she examine. The last question was to check the validity of the answer to the second question. Eighty-five percent of the respondents reported that they were examined by their consulting doctor / nurse. Almost all of them were able to give reasonable description of the nature of examination. Forty six percent reported some laboratory investigations or X-rays, etc. Another 26% reported that no diagnostic tests were done. The other 27% either did not remember a diagnostic test or felt that the no testing was necessary in their case.

Length of Stay

Number of days stayed varied from 1 day to 32 days. The median length of stay was 5 days Table 1.8. In another study it was found that nearly 75% of the patients stayed between 1-5 days (*Health Systems Research Unit, Mauritius Institute of Health, Patient Satisfaction Survey in four regional Hospitals*, MIH, 1992, p.9.). The corresponding percentage in this study add up to 50%.

A small 9% of patients mentioned that their stay was short. A much larger 28% felt their stay was long. The rest of them did not feel the duration of their hospital stay was any thing to be taken note of.

Table 8 Length of stay

No. of Days	Number	%
1 - 3	34	21.9
4 - 5	44	28.4
6 - 7	23	14.8
8 - 10	33	21.3
>10 days	17	11
Not Mentioned	4	2.6
Total	155	100

Distance Travelled

Patients travelled from 0.8 km to 40 km to reach hospitals or health centres. The median distance travelled was 6 kms Table .9 This is not so high considering the specialized care most of these patients sought. Twenty-two percent have travelled 3 or less than 3 kilometers. Fifty-five percent have travelled less than 10 km. Thirteen percent have travelled more than 20 km.

Table 9 Distance Travelled For Hospitalization

Km	Number	%
<1 km	9	5.8
1.1 - 3	25	16.1
3.1 - 9.9	51	32.9
10 - 15	20	12.9
>15	30	19.4
Not Mentioned	20	12.9
Total	155	100

Bypassing /Non By-passing

It is commonly perceived by members of medical profession and public health officials that bypassing appropriate levels of health care facility for more sophisticated ones is an important cause for system inefficiency. To get an insight on this issue we asked a few questions (Q26-30) to check if the respondents considered going to local health facilities before going to the hospital for admission. Eighty five percent of patients had a health centres nearby, out of whom only 40% considered going there, while only 35% actually went prior to hospital admission. Note, however, that the sample consisted of persons discharged from the hospitals and was not population-based. Moreover, a large part of the sample consisted of persons who were admitted for emergent conditions like myocardial infarction, in which case going to a hospital with facilities for treatment of heart attack is the right thing to do. Hence the above numbers are not useful to form an opinion about the prevalence of bypassing. If we discount for the large number of emergency cases present in our sample, the above number of 35% prior consultation in local health centers is rather encouraging. Of significance, however, is the finding that seven women went to hospital for delivery but did not consult the health center prior to the due date Table 10 Another ten persons (6.5%) found the health center inadequate either in quality of care or in facilities. About 14% of respondents reported that the local health center was closed. Since 75% of the sample had used cars / taxies to reach the hospitals, considering the seriousness of their illness a comparative analysis of this category with those who used bus or walked has not brought about any significant results.

Table 10 Reasons for not consulting health center prior to hospitalisation

Reasons	No of respondents	%
Less satisfied with local facility, more satisfied with hospital, inadequate or no facilities at the local facility	10	6.5
No specialist treatment	7	4.5
Closed	22	14.2
Went For Delivery	7	4.5
Condition was serious, prior appointment or follow up care at hospital, sudden onset not anticipated earlier or referred by health center or hospital is nearer	36	23.2
Not applicable	59	38
Not mentioned	14	9

There are multiple responses to this question which are not mutually exclusive. Therefore, N will not add up to 155. However percentages are calculated in 155, the sample size, to express the magnitude of the reasons stated

Patient Satisfaction

Ninety six percent patients would visit the same hospital again, while 94% would suggest the hospital they have visited to friends and relatives. Eighty-seven percent of respondents rated the doctors as good or excellent. A similar 84% gave nurses a similar rating. Only 2.5% recorded doctors as average or above average. Approximately 3% said the same thing about nurses. Around 79% rated the drugs as good or excellent, while 4% found them only average or below average.

For medical equipment 71% gave a rating of good or excellent, while 4% gave only average or below average scores. 18% of respondents gave "no response" for this category. In the case of surgical equipment, 40% of respondents answered "no response." These "no response" replies are more due to lack of knowledge on these aspects. About 47% mentioned that the surgical instruments were good or excellent, while only 3% said they were average or below average.

On ward space, bedding, catering and sanitation the responses are more critical. Only 44% gave good or excellent rating for ward space, while 32% gave average or below average scores. Similarly only 41% gave good and excellent scores for bedding. 35% rated the bedding as average or below average. In catering, only 32% of respondents gave good or excellent ratings, while 22% felt the catering was average or below average. There were 23 patients (14.85%) who said that they did not take food from the hospital. It could be because of dissatisfaction with the food provided. A majority (51%) rated sanitation as average or below average, and only 36% rated it as good or excellent. Table 11

Table 11 Patient Satisfaction

Service	Excellent		Good		Fair		Average		Below average		Not Mentioned	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Doctors	68	43.9	68	43.9	11	7.1	2	1.3	2	1.3	4	2.6
Nurses	46	29.7	84	54.2	18	11.6	3	1.9	2	1.3	2	1.3
Drugs	29	18.7	94	60.7	17	11	4	2.6	3	1.9	8	5.2
Medical eqpt.	25	16.1	86	55.5	11	7.1	5	3.2	1	0.7	27	16.8
Surgical eqpt.	20	12.9	53	34.2	15	9.7	3	1.9	2	1.3	62	40
Ward space	10	6.5	58	37.4	32	20.7	23	14.8	27	17.4	5	3.2
Bedding	11	7.1	52	33.6	30	19.4	27	17.4	28	18.1	7	4.5
Catering*	7	4.5	43	27.7	32	20.7	18	11.6	16	10.3	39	20
Sanitation	7	4.5	49	31.6	15	9.7	23	14.8	56	36.1	5	3.2

*Among the 39 persons shown, 8 persons fall under the "not mentioned" category. Of the other 31 persons 4 got food from home, 1 was not allowed to take food, 23 did not take food in the hospital, 1 took only bread and tea, 1 was unable to eat, and 1 was vegetarian.

Reasons For Consulting Other Doctors/Health Facilities

34% of patients had consulted other doctors, clinics or nursing homes. A long list of reasons both singly and in combinations have been cited for consulting other doctors & health delivery institutions. Dissatisfaction with government health services is one of the prominent reasons cited, and long waiting time in hospitals and waiting time to meet specialists have also been pointed out. These three reasons figure in most of the other combinations as well. Table 12

Table 12 Reasons for consulting other doctors and health facilities

Reasons	Number	%
Long waiting time.	11	6.8
Not satisfied with treatment in government health centres/ hospitals, lack of personal attention, government doctor more interested in private practice	16	9.9
Both waiting and not satisfied with treatment in government hospital	4	2.5
Government health centre/ hospital too far	7	4.4
Non-availability of medicines in government health centres/hospitals	3	1.9
Others	3	1.9
Not mentioned	18	11.2
Not applicable	99	61.5
Total	161*	100.1

*Adds up to a little more than 155. as a few persons cited more than one reason.

Characteristics Of Out-Patient Sample

Socio-economic

Persons from different age groups are well represented in the outpatient sample Table .13. The sex composition is also fairly well balanced. The sample is 47.25% males and 52.75% females.

Table 13 Outpatient respondents by age group

Age	No. of Persons	%
0-14	98	45
15-24	18	8.3
25-44	52	23.9
45-59	25	11.47
60+	25	10.5
Total	218	99.17

Education

There were 29% (43) members of the sample who were illiterate or not educated. This figure includes children in pre-school. However, a large chunk of the sample (35%) had primary education, though they had not passed CPE. 12% had passed CPE, while the rest had higher levels of education. Thirteen percent had attended high school but had not passed SC, 6% had passed SC. 1% had passed HSC, while only another 1% held degrees or diplomas Table 14

Table 14 Educational Status

Formal Education	No.	%
None	64	41.29
Primary-Attended	76	49.03
Primary-Passed	27	17.42
Below SC	29	18.71
SC Passed	14	9.03
HSC & Higher	5	3.23
Not Mentioned	3	1.94

Occupation

Persons from almost all occupations listed in Table 3 earlier for the in-patient respondents are represented in the out-patient sample as well. There were more labourers, cleaners, sanitary workers (11%) and fewer (6%) factory workers, custom clerks, painters, salesmen and others shown with them in Appendix Table 7.1.3. Co-ordinators, industry supervisors and others made up 5%, and 2% were managers, civil servants, planters and others. Students constituted nearly 30%, housewives 10%, and retired persons 3.21% of the sample.

Transport

Unlike in the case of in-patient respondents, most out-patients have come to the hospital or health centre either by bus (30%) or by walking (48%). Only 15% used private cars or taxies. This is because the illnesses which the out-patients generally wanted to treat would not have been of the same severity as that of the in-patients.

Disease Information Given by Doctors

A majority of respondents (68%) were aware of the nature of their illness. They were either told by the doctor and/or the nature of problem was obvious. There are still a substantial proportion (26%) of the respondents who reported that doctors did not say anything to them about the nature of their illness Table 7.15

Table 15 Disease information given by doctors

Disease information	No. of Persons	%
Doctor either informed about the nature of disease or the nature of problem was obvious to the patient	141	64.7
Doctor said "No problem"	6	2.8
Doctor said nothing	57	26.2
Not mentioned	14	6.4
Total	218	100.1

Access to Doctor/Nurse

94% wanted to see the doctor, while a little above 1% wanted to see both a doctor and a nurse. 74% could see the doctor, 22% could see both doctor and nurse. There doesn't seem to be a serious problem of access to doctor or nurse.

Waiting Time

53% of out-patients had long waits, according to their own perception. At the same time, their perception of actual waiting time varied from 5 minutes to 3 hours. The median waiting time was 30 minutes. Fifteen percent of out-patients did not mention waiting time. Some among them would not have had to wait. 24% of patients had to wait for 15 minutes or less. However, 14.7% of them had to wait more than one hour : Table .16

Table 16 Perceived waiting time

	Nos.	%
Did not remember	33	15
Less than half hour	109	50
Half to one hour	44	20.2
One to two hours	23	10.6
More than two hours	9	4.1
Total	218	99.9

Reasons For Waiting

The reasons for waiting were as in . Table .7. The long queue was the primary reason given. The queue also figures in combinations with the perceived delay of the doctors and nurses, and time spent in the record section.

Table 17 Reasons for Waiting

Primary reasons	Number	%
There were a lot of people ahead of me in the queue or emergency cases.	72	33
The doctor / nurse was either late to arrive or was bury otherwise.	9	4.1
Long queue and doctor was either late or busy.	25	11.5
Had to wait for the diagnostic reports	1	0
Not applicable or not mentioned	111	50.9
Total	218	99.5
Contributory reasons		
Delay in receipt of records	11	
Delay in receipt of diagnostic reports	4	

Medical Attention

In 72% of the cases the doctor or nurse had examined the patients. All of them were able to give a reasonable description of the nature of examination. About 54% reported laboratory investigations

Distance Travelled

The out-patients had travelled from 0.025 to 25 km. The distances they travelled are presented in Table .18. The median distance travelled was 2 m. 35% had to travel 1 km or less. Another 18% had to travel only between 1 and 3 km. 8% had travelled between 5.1 and 10 km. while the remaining 10% had to travel from beyond 10 km.

Table 13 Distance travelled for hospitalisation

Kms.	Numbers	%
<1 Km.	77	35.3
1.1 - 3	40	18.4
3.1 - 9.9	42	19.3
10 - 15	18	8.3
>15	4	1.8
Not Mentioned	37	17
Total	218	100.1

Bypassing/Non-Bypassing

There were other hospitals or health centres nearby for 43% of respondents. But only 10% considered going there, while only 9% in fact went there. The reasons noted for not going to nearer health are given in Table .19. Respondents cited proximity to hospital services, satisfaction with the hospital services, and the seriousness of disease as the major reasons for bypassing. Expectation of better treatment was also an important factor.

Table 19 Reasons for not consulting health center before prior to hospitalisation

Reasons	No. of respondents	%
No specialist treatment	6	2.75
Appointment at hospital	9	4.13
Closed	4	1.83
Less satisfied	2	0.92
Less staff	3	1.38
Hospital is nearer	11	5.05
Serious	13	5.96
Satisfied with hospital treatment	16	7.34
Referred to the particular hospital	7	3.21
Not in a convenient place	1	0.46
Not applicable	135	61.93
Not mentioned	11	5.05
Total	218	100

Out of the 93 patients who were near health centres, twenty used them. Of those, 17 were females and 3 were males. Similarly, more patients who bypassed were males. This could be accounted for by the relatively higher mobility of males.

11 out of the 20 (55%) who used the nearest health centre or hospital travelled by bus or walked, while 9 (45%) patients used car or taxi. Among the bypassers, 50 out of 72 (69.44%) went by bus or walked, while 17 (23.61%) bypassers travelled by car or taxi. Out of the 32 patients in the sample who used a car or taxi, 27 had other hospitals or health centres nearby, but the majority, 17 out of 27 (62.96%) bypassed. It is interesting to note that 81% of those who travelled by bus or walked and had other hospitals or health facilities nearby also bypassed. In a similar study it was found that the usual mode of transport of bypassers was the car and that of non bypassers was bus.

Assessment of Services

As mentioned in the case of in-patient data, the responses on these items have to be taken with some caution. As in the case of in-patients, the respondents seem to have shown some hesitation in assessing the services. This is particularly evident in the case of doctors and nurses (Appendix Table 7.1. 20). In these the responses are heavily weighed towards the positive side. 78% rated doctors as good or excellent, while 84% rated nurses as either good or excellent. Another 14% considered doctors services as fair, while 11% regarded nurses in the same manner. With such a heavy salute on the positive side there were only a very small numbers who seem to have expressed their dissatisfaction. For 3.21%, the doctors services were just average, and for nurses the corresponding percentage was 1.38%. The two were rated as below average only by 2.75% and 1.83% respondents only. 66% only rated the drugs as good or excellent. For 20% it was evenly fair, for 3.67% it was average and for 1.38% below average. There are however 50% who considered the medical equipment as good or excellent. A number of "no responses" were naturally recorded for this question. On sanitation, the responses were more divided. Only 33% considered sanitation as good or excellent, and 22% thought it fair, while 24% found the sanitation average or below average.

Table 20 Patient satisfaction about different components of outpatient service

Service component	Excellent		Good		Fair		Average		Below average		Not mentioned	
	Nos.	%	Nos.	%	Nos.	%	Nos.	%	Nos.	%	Nos.	%
Doctors	47	21.6	124	56.9	31	14.2	7	3.2	6	2.8	3	1.4
Nurses	35	16.1	148	67.9	25	11.5	3	1.4	4	1.8	3	1.4
Drugs	29	13.3	115	52.8	44	20.2	8	3.7	3	1.4	19	8.7
Medical equipment	22	10.1	88	40.4	44	20.2	4	1.8	60	27.5	0	0
Sanitation	16	7.3	56	25.7	47	21.6	32	14.7	20	9.2	47	21.6

Patient Satisfaction

94% of respondents would visit the hospital again and would recommend it to a friend or relative. 15% of the out-patients have consulted other doctors or health providing facilities. There were various reasons for doing so which are mentioned in Table 21. One of the main reasons which came up was the dissatisfaction with government health services. It was also pointed out that government doctors were more interested in their private practice.

Table 21 Reasons for consulting more than one doctor

Reasons	Number	%
A. Long waiting time in Govt. Health centres/ hospitals in general	1	0.46
B. Long waiting time to consult specialists in government hospitals	1	0.46
D. Not satisfied with treatment in government health centres/ hospitals	7	3.21
I.Non- availability of medicines in government health centres/ hospitals	1	0.46
ADHJ	1	0.46
BD	1	0.46
BHJ	1	0.46
BJ	3	1.38
DI	1	0.46
HIJ	1	0.46
HJI	1	0.46
Not Mentioned	19	8.72
Not Applicable	180	82.57
TOTAL	218	100

Focus Group Discussions

Focus Group Discussions Among Household Groups

The main strands of the household groups' views and perceptions are presented here. All together, 32 focus group discussions were conducted among household groups. The percentages presented in this section are derived by dividing the respective group responses by the total number of household groups (32). However, since the diverse perceptions and views presented under a heading are not mutually exclusive, the total of percentages in a table will not add up to 100. This of course applies to the text mentioned in this section also. The perceptions on the public hospitals and health centres are presented first which is followed by other aspects.

Perceptions Of Government Hospitals And Health Centers

Doctors

Diverse views were expressed on the government doctors. Eight groups (25%) said that the doctors behaved politely while an equal number of groups (25%) said that some doctors behaved politely while others did not. Opinion was also divided on the explanation that doctors gave on diseases and medicines. One group (3.13%) said that some doctors informed their patients about the diseases, but this was not agreed upon by most other groups (53%). 18 groups (56%) said that most doctors did not explain how medicines were to be taken, what care was to be taken regarding diet, etc. Many groups (50%) were of the opinion that doctors did not give enough time to patients. There was again diversity of opinion on how clearly doctors explained things. Though four groups felt they could not understand, five groups said that they could understand. It was also pointed out that doctors were afraid to touch patients.

Nurses

Opinion was divided on the behaviour of the nurses as well. One group (3.13%) expressed the view that they were polite, but more groups (22%) said that they were not. Certain groups (6.25%) said that nurses gave sufficient time to patients, while most groups felt the opposite. In this connection some groups pointed out that doctors read newspapers, listened to radio and did other personal work during their office hours. However, there were groups (12.5%) which also expressed that the nurse's job was a delicate one.

Record Section

Some groups (15.6%) were happy with the record section. But this opinion was not shared by many other groups. It was pointed out that sometimes doctors did not keep appointments (25%). Long waiting time and queues (21.8%) were also mentioned. In addition, it was pointed out that sometimes files were getting lost (18.75%). There was a suggestion to computerise the record section (12.5%).

Casualty

It was expressed in 4 out of 32 groups (13%) that the number of doctors in the casualty was limited and that they had to examine many patients. Long waiting time was pointed out as a problem by 10 out of 32 groups (31%). Four groups (13%) said that preference was given to relatives and friends of doctors and nurses ("protectionism").

Drugs

There was apparent disenchantment about drugs. The mention of drugs made some participants laugh. Twelve out of 32 groups (37.5%) said that only Panadol, syrup "blare", syrup "Dilo lament" and MMT were available. Seven of the 32 groups (22%) said that not all medicines were available. There was also a distrust of the medicines supplied from public hospitals and health centres. 6 out of 32 groups said that they discarded medicines from public institutions so that they did not catch any unknown diseases, while another 7 groups (22%) said that they would discard those drugs if there was no response. 8 out of 32 groups (25%) said that at times they had to buy medicines from outside. In one group it was expressed that "for all pains Panadol" was prescribed. It was also pointed out that too much of Panadol gave gas trouble. In one group it was mentioned that the water used for making children's syrup was not sterilised, while in another it was pointed out that doctors were fond of prescribing antibiotics to children without thinking of consequences.

Medical Equipment

Many groups mentioned that the medical equipment, including dental equipment, was not in working order. Some groups (15.63%) pointed out that though equipment was there in AHCs CHCs, it was not working. A few groups (9.38%) said that the medical equipment was in good working order. The lack of sophisticated equipment like scanners was mentioned, and support for 100% Government financial aid for doing dialysis was voiced (6.25%).

Surgical Equipment

There seems to be some satisfaction on the surgical equipment. Some groups who expressed their views were confident that operation theatres were well equipped (12.5%), particularly the cardiac unit at S.S.R.N. (6.25%). However, not many groups expressed views on this, as they did not know.

Ward Space

19 out of 32 groups (59%) said that they disliked the practice of keeping two persons on one bed. Some groups (12.5%) were angry about it. They pointed out that even pregnant and newly delivered women were subjected to this practice. They were afraid that babies may get changed. In the humid summer months they found it more difficult to share bed (3.13%). They also pointed out that patients may fall down (3.13%). Also, 9 out of 32 groups (28.13%) mentioned they did not like to sleep on the floor with a mat. Opinion was also expressed that the bed sheets were not changed regularly (12.25%), though some felt they were (12.25%). There were demands for more beds in maternity wards (9.38%). To solve the problem of putting two persons on one bed it was suggested that wards be extended, have additional beds or even build new hospitals (15.63%).

Catering

Eight out of 32 groups (25%) pointed out that the food was not well cooked. They also said that half-cooked meat and vegetables were served, and fish with scales were found in food. Various other critical views about the catering were also expressed. At the same time there were also some groups (28.12%) which felt that hospital food was good for the sick. Opinion was also expressed on lack of taste and that the kitchen workers did not wear caps and overalls so that food could be cooked cleanly. 14 of the 32 groups (44%) favoured privatisation of catering. Three groups (9.38%) were against privatisation.

Sanitation

7 out of 32 groups (22%) felt that bathrooms and toilets were untidy. Some groups (6.25%) expressed that they were horrible, while some others (6.25%) expressed that they were cleaned only when there was supervision. Regarding the floors, opinion was equally divided with 6 groups (18.75%) saying they were cleaned only once and others saying they were acceptable. 23 groups (72%) were in favour of privatising sanitation.

Visiting Hours

Although some groups said that visiting hours should not be changed, many groups want the timing to be extended till 5:30 p.m. or 6:00 p.m. in the evening as well as having it in the morning between 6:00 and 7:00 a.m. They pointed out that in this way they would be able to visit patients without affecting their work schedule.

Ambulance Service

Some groups (12.5%) suggested that ambulances be attached to CHCs or AHCs. It was pointed out in one group that the condition of the ambulances were not good; they should not give shocks to pregnant women. Another group mentioned that only the driver and helper came to pick up the patients and that no doctor or nurse came along. 5 groups (15.63%) were not aware of the hospital ambulance service, while 4 groups (12.5%) contacted police emergency when they needed an ambulance

Perceptions of Private Health Sector

Doctors

On the face of it, the views on private practitioners were positive. Of the 32 groups, 14 (44%) said that they gave sufficient time to patients. Similarly ,14 groups (44%) said that they explained about diseases, while 20 groups mentioned (62.5%) that they explained about medicines, doses, care to be taken & side effects as well. Fifteen groups (47%) mentioned that they spoke politely while 10 groups (31%) said that their language was understandable. In two groups it was noticed that public hospital doctors behaved differently in private clinics, because they were paid large sums. Three groups, pointed out that: "private doctors have to behave well because we pay them." It was also expressed in a few groups that private doctors did not give sufficient time to their patients, and that they did not touch patients or inform them about diseases.

Nurses

5 groups (15.63%) mentioned that the nurses in private sector were polite, and one group stated that their language was understandable. 7 groups (22%) said that they gave sufficient time to their patients. Two groups were of the view that they did the job rather than listening to the radio or attending to personal work. At the same time it was pointed out by 2 groups (6.25%) that some nurses in private sector behaved roughly.

Record Section

Of the 32 groups, 9 (28%) mentioned that the doctors abide by appointments. The same number of groups also opined that the patients kept appointments as well. Six groups (19%) felt that the reception was good. 3 groups (9.38%) appreciated the quick service because of the absence of any queue. At the same time it was also pointed by 2 groups (6.25%) that doctors were not punctual.

Drugs

In drug availability and effectiveness of drugs, private hospitals were considered to be better. 14 groups (44%) mentioned that all drugs were available in the private nursing homes, while 11 of them (34%) considered the medicines effective. It is interesting to note that 9 groups (28%) mentioned that all medicines had to be bought, in contrast with the public sector. In addition, three groups (9.28%) pointed out that the medicines were costly, while 4 (13%) groups were of the view that because doctors had prescribed so many drugs, the cost had increased.

Medical Equipment

The general view in most groups was that all the medical equipment was available in clinics and nursing homes and was in working condition. Out of 32 groups, 12 (37.5%) were of the view that all equipment was available, while 16 groups (50%) felt that the equipment was in working order. 3 groups stated that the equipment was costly to use. 2 groups felt that private clinics nursing homes had all the latest equipment.

Surgical Equipment

7 groups (22%) felt that the private clinics and nursing homes had all the latest surgical equipment available and that they should be brought to public hospitals also. 3 groups (9.38%) mentioned that they were useful in various diagnoses. An equal number of groups expressed that they did not know anything about surgical equipment in private nursing homes & clinics, while 1 group pointed out that it was costly to use.

Ward Space and Bedding

The practice of putting two persons in one bed was not a problem since "we were paying" said 3 groups. Bed sheets and covers were changed frequently, according to 12 groups (38%). 9 groups (28%) also mentioned that there were sufficient beds set apart for women.

Catering

According to 7 groups (22%), catering in private nursing homes was good / tasty / balanced and included vegetable dishes also. Three groups (9.38%) rated it as very good. Another view was that the food was better than public hospitals because "payment was made for it."

Sanitation

According to 5 groups (16%) toilets, bathrooms, and floors were kept clean. 4 groups (13%) mentioned that in general cleaning was done properly. One group mentioned that cleaning was done thrice a day while another group mentioned that the toilets were dirty and slippery.

Bypassing/Non-Bypassing

A large number of groups, i.e. 11 out of 32 (34%), mentioned that they would go to a hospital if severely ill or injured. 3 more groups (9.38%) said that, "You have to go to AHC/ CHC since they ask for referral papers." Among the others, it was expressed in one group that they would go to hospital only when there was no doctor in CHC. 2 groups mentioned that they would do so when no treatment was available at CHC/ AHC, and one more group mentioned that the special clinics in CHCs AHCs on certain days in a week were forcing them to go to hospitals, while 4 groups stated that in certain cases they had to go to the hospital directly.

Problems of The Elderly

The elderly highlighted high blood pressure, diabetes, heart diseases, hypertension, asthma, respiratory infections, rheumatic pains and handicaps as their problems which needed special attention. These were mentioned by 9 groups (28%). Other suggestions of the elderly included special doctors to attend to them, an opinion voiced in 6 groups (19%). Preferences in consultations in public hospitals and health centres was mentioned in 5 groups (16%), a special day for elderly was suggested in 2 groups (6.25%), and a special unit for the care of elderly was mentioned in one group. They also wanted counseling on diet, life style and physical exercise.

Drug Compliance

The elderly claimed that they would continue with a drug regimen if asked to do so. This opinion was given in 11 out of 32 groups (34.38%) but was not elaborated on. In one group it was pointed out that drugs and diet advice was never given.

Diet Advice

Most of the elderly in 3 groups agreed that they would abide by diet advice. In one group all the elderly agreed to go by the diet advice. At the same time, elderly in two groups said that they would not accept the diet advice. Another group mentioned that they would follow such advice, depending on their means.

Life-Style Changes

3 groups (9.38%) said that they would accept life-style changes if necessary. In one group the elderly said they would accept changes if they were practical.

Women's Health Problems

One of the major suggestions from women was to have female doctors attending to female health problems, particularly when pregnant. This view was expressed by 11 out of 32 groups (34%). They said that not all female problems could be told to men. In 4 groups they held the view that not sufficient attention was paid to women's diseases. Breast cancer was cited as an example. In 7 groups (22%) women wanted to have special attention or a special section in the casualty wards. Provision for a full time gynaecologist was the demand of women in 2 groups. Special doctors for females and separate female section in CHC were also suggested.

Community Involvement and Community Resource Raising

A large number (14 out of 32 groups, 44%) felt that the community should get involved in the management of CHCs & AHCs, but did not mention community resource raising. It was said in one group: "Community should be like guards to ensure smooth running of the service." At the same time, 5 groups (15.63%) were against involvement in management. In 4 groups (12.5%) it was expressed that the community should be involved in management and resource raising.

Linking Up Health Centres With Women's Groups And Other Voluntary Organisations

All together, 4 groups (12.5%) expressed interest in this idea. Of these, 3 groups explained that they felt doctors and the staffs would become more responsive. 10 groups (31%) felt that women would benefit a lot if health centres were linked to women's groups.

Willingness to Pay

There was a diversity of opinion attached with strong emotions on this score. 11 out of 32 groups (34%) were not willing to even pay part of the cost. 9 groups (28.13%) gave an outright refusal, while others justified their response by saying that they belonged to low income group or that the poor would be hurt. It was also mentioned that this could hit the elderly hard. At the same time, 6 groups (19%) were willing to pay, depending on their income. Another 3 were agreeable if there was reform in the system. 2 groups felt that the rich should contribute towards their treatment. 4 groups (12.5%) voiced concern that even if payment was introduced, the services were not going to improve.

Family Practitioners

On the whole this idea was acceptable to many groups. 8 groups (25%) expressed willingness to have it but they did not elaborate. 3 groups (9.38%) felt that they could get better follow-ups under such a system, while 3 more groups (9.38%) said that it would be particularly useful to the elderly and the handicapped. 7 groups (22%) expected home visits for the handicapped and the aged.

Suggestions for the Government Health Services

There were a wide variety of suggestions to improve the services. One of the prominent suggestions was to increase the number of doctors and staff. It was mentioned by 8 groups (25%). All together 10 responses (31.13%) dealt with improving the behaviour of doctors, nurses & other staff towards patients. One suggestion was to have training courses for this purpose. Equipment was another area of concern. 19 responses (59%) dealt with that. 6 of these were in favor of providing all equipment including scanners, and dialysis machines like Echography to hospitals; four groups wanted CHCs/ AHCs to be better equipped, 3 groups were in favor of training persons to operate them properly, 2 groups were for familiarising doctors and nurses with the working of equipment, and 3 for increasing the number of such equipment.

A desire for provision of all necessary drugs, in sufficient quantity, was articulated by 6 groups (19%). The need for health education on public health was brought out by 4 groups. Regular talks, films, etc. were suggested. Improvement of the water system was suggested by another group. Delays were frowned upon. As members of one group said "the practice of a leg broken today and a prop provided the day after should be stopped." It was suggested that there be a permanent doctor in casualty. Having a burns unit in every hospital was suggested by another group. Round the clock service of specialists was also demanded. More doctors have been asked for in CHCs and AHCs by 3 groups. Dental units in CHCs is another demand. 2 groups suggested that dispensaries (CHCs) should be opened until night.

Another important suggestion was to build more wards corresponding to area population. Proper cleaning of toilets was again suggested by 3 groups. The need for better midwifery services was brought up by one group. One group wanted Family Planning services in CHC. Developing a better system of filing and reducing the time taken to obtain blood and X-ray results were also brought up by one group each.

Suggestions About Private Health Sector

Costs in the private health sector were discussed in 9 groups (28%). Two groups suggested lowering charges, while these two as well as another group wanted cost reduction, particularly in surgery. Two other groups wanted a system of tariffs for the services of private clinics and nursing homes. Two groups suggested that drugs issued by private clinics and nursing homes should be controlled by the Government. 4 groups (13%) once again voiced the need to stop the private practice of Government doctors. 6 groups (19%) however, did not feel the need to have any changes in the functioning of the private sector.

Focus Group Discussions In Local Health Committees

A Note On Local Health Committees

In April 1986, the Minister of Health of Mauritius launched the movement for Community Health Development. He exhorted the communities to undertake self-help schemes for the construction of their local health centers and promised that the government would then provide the necessary services (Health Systems Research Unit, Mauritius Institute of Health, 1992. pp.1-2). The communities organized themselves into Local Health Committees (LHC), comprising leaders from different local organizations, with the chairman acting as the Community Health Leader. The committees organized fund raising activities, mobilized community resources and acquired a piece of land to set up the health center. People contributed cash, building materials and voluntary labor. By the end of 1989, 50 CHCs were operational, each covering 5000 population (Ibid. p.1).

The National Trust Fund for Community Health Act was enacted by Parliament on 19th August, 1986, with a view to enhancing community health. The following were the objects of the Trust Fund:

- To set up CHCs in Mauritius.
- To support the maintenance of centres.
- To promote and support primary health care.
- To give such assistance as the fund may determine to the Ministry of Health for improving the centres.
- To mobilize fund for (1) to (4) locally & overseas.
- To advise the Minister of Health on running the centres. (Ibid.p.1)

The administration and control of the Trust Fund was vested in a Board of Trustees known as the Community Health Board, which comprised all community health leaders and a chairman appointed by the Minister of Health. In pursuance of section 12 of the Trust Fund Act of 1986, 47 Committees were organized. The main tasks of these were to:

- Identify a convenient site for construction of health centres.
- Plan, manage, and implement the centre project.
- Raise funds for the project.
- Look for volunteers for labor and construction materials.
- Plan for holding 'health weeks' and 'health days'.
- Liaise with MCH and Trust for the implementation of project and health activities.
- Consolidate the holding of public health care in localities and modify community behaviour related to infant feeding practice, dietary habits and life style.
- Motivate members of community for the utilization of public health care services so as to reduce attendance at out-patients departments in hospitals.
- Maintain the centres.
- Develop good working relations and co-operation between the staff and community.
- Promote community financing.
- Informing and Assisting Ministry of Health & Trust Fund with local health problems and proper provision of primary care at peripheral level (Ibid p.2).

The views of the Local Health Committees (L.H.C.) were elicited in focus groups to compare the perceptions of the household groups, as the L.H.C. members had a better idea of Mauritius health system, because of their association with the functioning of the health centres. The perceptions and the views of the L.H.Cs are presented below. Since the views presented in each table are not mutually exclusive, the percentages given in each table and stated under various heads in the text will not add up to a hundred. Focus group discussions were conducted in 21 LHCs. Percentages of group views are therefore calculated

in 21 groups only to project the magnitude of a certain perception or attitude among the groups. The responses of LHC groups on the different services in the private sector were not analyzed since it was their view on the Government health services which needed consideration. In addition we had ample information on the private health sector from the household groups.

Perception of the Government Health Services

Doctors

As in the case of the household focus groups, most of the Local Health Centre groups also felt that the doctors were in a hurry and did not give sufficient time to patients. 12 out of 21 Local Health Committee groups (32.65%) were of this opinion. 5 out of 21 groups (23.81%) said there were few doctors who behaved well. Also five groups (23.52%) said that doctors did not explain patients about their diseases or how drugs were to be taken. 7 groups however (33.33%), pointed out that the number of doctors was low compared to the heavy work load. Further, 11 groups (52.38%) said that doctors were arrogant and rude.

Nurses

Nurses were rated somewhat better by the Local Health Committee groups. 9 of 21 groups (43%) mentioned that their services were satisfactory, while in 8 groups (38.17%) it was mentioned that nurses were overloaded with work and that therefore they couldn't give sufficient time to patients. At the same time, there were 5 groups (24%) who said that only some nurses behaved politely, while others did not. 4 groups (19.05%) pointed out that all patients were not satisfied.

Record Section

As in the case of household groups, the problem of long waiting time was been mentioned by 9 of the 21 groups (43%). However, 6 groups (28.57%) said that the patients were well received. The complaint of doctors not keeping appointments and that of case sheets getting lost were voiced by 4 (19%) and 2 (9.52%) groups respectively.

Causality

"Treatment" in casualty was considered good by three groups (14.29%), although they felt there was a heavy rush. 2 groups (9.52%) said that they patients were received well and priority was given to emergency cases. At the same time, 4 groups (19%) pointed out the need to have doctors in casualty on Sundays, public holidays and odd hours.

Drugs

There was dissatisfaction about the availability of medicines and their quality. This was expressed prominently in the household groups as well. It was pointed out by nine groups (43%) that "not all medicines were available," while 8 groups (38%) mentioned that at times they had to buy medicines from outside. 7 groups (33%) were not happy with the quality of medicines supplied. In connection to this, it must be noted that 6 groups (28.57%) said that people discarded drugs obtained from Government health delivery institutions. 4 groups (19%) were concerned that doctors mostly prescribed only panadol, "lament" and M.M.T. This was stated in household groups as well.

Medical Equipment

10 groups (48%) pointed out that not all equipment was in good condition, while 4 groups (19%) said that all equipment was in working order. The non-availability of certain equipment and the lack of modern equipment was pointed out by 4 groups (19%).

Surgical Equipment

As in household groups, a large number of groups (43%) were satisfied and confident in the surgical equipment. At the same time, a smaller number of groups was concerned about the lack of modern equipment, poor working condition of equipment and the need for trained personnel to operate them.

Ward Space

The same issues raised in household groups came up here also. 13 of the 21 groups (62%) spoke strongly against the practice of keeping two persons in one bed. 7 groups (33.33%) disliked the idea of sleeping down on a mat as a solution. 11 groups (52%) said that the bed covers were unclean and not changed regularly.

Catering

Unsatisfactory quality of food came up as one of the common complaints between household groups and Local Health Committee groups. 7 out of 21 groups (33%) were not satisfied with the quality of food. Lack of variety in vegetarian food was been pointed out by 6 groups (29%). The difference between Household groups and Local Health Committee groups was that privatization was not supported as strongly in LHC groups. There were 8 groups (38%) who supported, while 6 groups (29%) were not in favour. The latter felt that it would shoot up the cost of hospital food.

Sanitation

Three groups said that it was not even 1% good. Four groups (19.05%) supported privatization, while no contrary views was expressed.

Bypassing/ Non-Bypassing

The responses were similar to those in the household groups. Five of the 21 groups (24%) would go to hospital in the case of injuries and emergencies. Four groups (19.04%) would go to hospitals at odd hours, Sundays or public holidays. Three groups (14.3%) pointed out that doctors were not available at Community Health Centres/AHCs at all times.

Drug Compliance, Compliance To Diet And Life Style Changes By Elderly

Elderly in 11 groups (52%) claimed that they would adhere to the drug regimen. Elderly in one group said that patients were not properly informed about the drug doses, while the aged in another group said that they were not getting their drugs regularly from the NCD clinics. Elderly in 5 groups (24%) said that they followed the diet prescriptions, while in one group they admitted that dieting was very rare. In seven groups (33%) the elderly agreed that life style changes were needed. However, in 8 groups (38%) they felt that changing life style was difficult due to old habits. In four groups (19.04%) it was pointed out that the CHCs should help the elderly in dieting and changing life style.

Women's Health Problems

In six groups (28.57%) women stressed the need for health education in female health problems, the importance of breast feeding, and family planning. In 5 groups (23.58%) the women voiced the need for lady doctors and female nursing officers so that they felt free to express themselves

Community Involvement In Management And Resource Raising For Health Centres

Fifteen groups (71%) stated that they wanted to be involved without making it clear whether they would be involved in resource raising also. Five groups (25%) spoke about raising funds from the Community Health Trust Fund, and not on their own. Three groups (14%) said that resources must come from Government.

Involvement of Women's Groups and Voluntary Organizations In The Functioning of Health Centres

Five groups (23.8%) felt that it was a good and helpful idea, but did not elaborate on it. One group mentioned that it would make CHCs more responsive, but wanted support services to activate the organizations.

Willingness to pay

Four groups (19.04%) said that a medical scheme would be good, but did not dwell more on it. One group was agreeable to an insurance scheme. However, 3 groups (14.29%) were totally against any kind of payment, while one group could not agree on payment.

Family Practitioners

In four groups (19.04%) it was expressed that this system would benefit bed-ridden patients. However, it was implicit in this view that home visits would be part of the system. As was pointed out in household groups, the system of family practitioners would be beneficial to the elderly who needed regular medical attention. The possibility of having home visits under the scheme was mentioned as well.

Suggestions for Improvement of Government Health Services

Although there was no particular suggestion which was put forward by a large number of groups, several were worth mentioning. Below is a list of these suggestions.

- More Health personnel, More clinic sessions
- More specialist clinics
- More Drugs
- Ambulance service attached to CHCs & AHCs.
- AHCs/CHCs to be open in odd hours also.
- Opening a Public Relations Department in hospitals
- Setting up a commission for suggesting improvements in public hospitals.
- Female patients to be attended by female nursing officers & doctors.

Suggestions on Private Health Sector

It has been plainly pointed by 5 groups (24%) that fees should be controlled. The demand to bring down the charges had come up in household groups also, but in L.H.Cs the desire for fee control was more openly stated. In tune with the household groups, three LHC groups have also said that the private practice of public hospital doctors should be discontinued.

Conclusion

Both in-patients as well as out-patients were not facing any serious problems regarding access to doctor / nurse. Most of the out-patients had reached the hospital or health centre either by bus or by walking. A large number of in-patients used car or taxi to reach hospital, as they were suffering from more serious diseases. The average distance travelled by in-patients was 6 km. This distance is considered reasonable for the in-patient category. The corresponding figure for out -patients was 2 km which again appears reasonable. This is consistent with our observation that in Mauritius, the barrier to entry is minimal. The problem is the quality of services.

Doctors (or Nurses when patients wanted to see them) were quite accessible to the in-patients as well as out-patients. The average waiting time for both in-patients and out-patients was 30 minutes. Delay in reporting on the part of doctors, nurses and in retrieval of records or handling by the records and reception service were the main reasons for long waiting time in ambulatory care. Along with these reasons, the in-patient respondents added that delay in getting the diagnostic reports was common.

The average length of stay for in-patients was 5 days. Twenty eight percent of patients considered their stay in the hospital long.

Forty-three percent of out-patients had other health centres or hospitals near by. Of these out-patients, only 9 % visited the nearby health centres or hospitals. Of the out-patients who did not bypass, more among females. This could be attributed to the relative immobility of women. Analysis of this variable by the mode of transport used to reach hospitals and health centres did not yield very significant results. Satisfaction with the hospital services, closeness to it and the seriousness of diseases patients were suffering from were offered as the reasons for bypassing.

Relatively more forthright and critical responses were available to some extent in the case of ward space, bedding, catering and sanitation. There were more responses in the average and below average categories for these aspects of the service as compared to Doctors, Nurses & Drugs. A probable lack of information has prevented the respondents from commenting freely about medical, surgical equipment.

This lacuna in information on assessment of services has been more than overcome in the focus groups discussions. Inspired by group strength and supported by anonymity, the participants of focus group strongly expressed their views on various aspects of the health services. The perceptions and views of the focus group participants on Government Health Services, the Private Health Sector and on other related aspects are mentioned below.

Perceptions Of Government Health Services

In several groups, both among households as well as in local health committees, it has been emphasized that the doctors and nurses in Government hospitals and health centres did not give sufficient time to the patients. Nor did they did explain about diseases, how to take medicines, and other cares and precautions. It was also voiced that while some doctors and nurses behaved well with patients, some did not. These have been attributed in part to the large crowd of patients which doctors and nurses have to handle.

Delay in the records section was mentioned by both the household groups as well as the local health committees. The suggestion to computerise records and to improve the filing system needs to be looked into.

The need to increase the number of doctors in casualty and to have doctors available in casualty on Sundays, public holidays and odd hours has been emphasized as well.

There was a general feeling among people that the right drugs were not prescribed, and that certain drugs like Panadol were routinely prescribed, irrespective of the illnesses patients had. There was a tendency among some patients to discard drugs obtained from public hospitals on the pretext that they were ineffective. This points to the need for health education as well as improvement in prescription practices

It was pointed out in some groups that the medical equipment, including dental equipment, was not always in proper working condition. People also wanted more sophisticated and modern equipment. There was, however, a general satisfaction with surgical equipment.

There was near-total disapproval of the practice of putting two persons on one bed. The groups suggested increasing the number of beds to solve this problem.

There was also dissatisfaction on the quality of food served in public hospitals and about the standards of cleanliness. A large number of groups suggested privatisation of these services. There was also a suggestion to extend visiting hours to the morning and also one hour later in the evening.

Perceptions Of Private Health Sector

The views on the various categories of services provided in the private sector have been generally positive. At the same time, various household groups pointed out that the services are good because they pay for them. They did make a contrast between the quality services offered at the Government and private institutions, but opinion on the private sector also took a more critical turn in Household as well as Local Health Community groups when we asked what suggestions did they have for improving the private clinics and nursing homes. These are mentioned later.

Bypassing /Non-Bypassing

Coming back to Government health services, in household groups and Local Health Committees it was mentioned that patients bypass a lower level health delivery institution depending on the seriousness of illness or accident or injury. They also bypassed health centres on Sundays, public holidays and odd hours. A suggestion was made to have doctors in CHCs throughout the day.

Problems of Elderly

The elderly said that high blood pressure, diabetes, heart diseases, hypertension, asthma, respiratory infections, and rheumatic pains were the diseases which needed special attention. Suggestions such as special doctors to attend to them, a special unit and a special day for them in health centres and hospitals were made.

Women's Health Problems

The need to have female doctors attending to women's problems was expressed by several groups. A full time Gynaecologist in hospitals was another suggestion. Some Local health committee groups brought up the need to have health education for women about their health problems.

Community Involvement in Management and Fund Raising for Health Centres

There was an agreement among most groups in Household as well as Local Health Committees to get involved in the management of the health centres. However, only a small number of groups showed interest in raising funds for the health centres.

Participation of Women's Groups And Voluntary Organisations in Management of Health Centres

It was also agreed upon that involving women's groups and voluntary organisations in the working of health centres would make them more responsive.

Willingness To Pay

There were more shades of opinion on the question of users charges than from the household groups. While most groups expressed that they were not willing to pay or that services won't improve even if they paid, there were some other groups who said they would pay depending on their means or if the services really improved. Among the Local Health Committee, some groups would welcome a "Medical Scheme", one group an insurance scheme, while some others like a large number of Household groups would not pay.

Family Practitioners

In household groups as well as local health committees, the idea of family practitioners was welcomed as it would help in better follow up treatment, particularly for the elderly. There was also the expectation that home visits would be part of the scheme.

Suggestions for the Government Health Services

When asked specifically what suggestions they had to improve the Government Health Services and the Private Health Sector, the groups and the local health committees gave a number of them. The prominent among them are presented below.

- More Doctors, Nurses & Staff.
- Better behaviour from Doctors, Nurses & Staff. Training to them for that purpose
- More clinic sessions & specialist clinics.
- Better filing system.
- Supply of all drugs in sufficient quantity.
- Providing all equipment including scanners, dialysis apparatus, & Echography to all hospitals and training the personnel to operate them.
- Permanent doctor in casualty.
- A burns unit in every hospital.
- Providing more wards corresponding to area population.
- Better sanitation.
- Female patients to be attended by female Nursing Officers & Doctors
- C.H.Cs/ A.H.Cs to be better equipped.
- Ambulance service attached to C.H.Cs.
- Dental Units in CHCs.
- More Doctors in CHCs/ AHCs.
- CHCs to be open till night.
- FP services in CHCs.

Suggestions on Private Health Sector

- Bring down the charges in general.
- Introduce a system of tariffs on charges.
- Reduce the charges on surgeries.
- Stop private practice of Government doctors.
- Government control of the issue of drugs.

Some of the concerns raised by the Key Informants also need to be attended. The contemporary challenges posed to the health services by the problems related to demographic, epidemiological and industrial transitions which Dr. J.C Mohit has highlighted needs to be dealt with. Already, measures are being taken in some of those areas. The Mauritius Medical Council's interest in bringing about a rating system for nursing homes to increase their standing could be explored. So also could their interest in evolving an insurance system. Since patients seem to be using Ayurveda as an alternative system of medicine for rheumatism, arthritis, and digestive, respiratory and dermatological diseases, it needs to be promoted further.

A Methodological Note

Focus groups form an important part of the methods used in this evaluation study of demand and satisfaction of the health services. Both the extensive use of the method and the depth and richness of data generated by it makes it necessary to include this methodological note on focus groups.

Krippendorf (1980) distinguishes between two types of data: emic and etic. Emic data arise in natural or indigenous form, and are only minimally imposed by the researcher's view of the setting. Etic data on the other hand represent the researcher's imposed view of the situation. However, little research can be called completely etic or emic. Focus groups (along with a few other techniques such as unstructured individual depth interviews) provide data that are closer to the emic side of the continuum because they allow individuals to respond in their own words, using their own categorisation and perceived associations. They are not completely without structure however, because the researcher does raise certain questions for discussion. Survey research (with structured questionnaires particularly) and experimentation tend to produce data that are closer to the etic side of the continuum, because the response categories used by respondents have been generally prescribed by the researcher (Krippendorf F.K 1980 in Stewart W.David & Shamdasani N. Prem 1990 p.13.).

This method is not an accurate way to measure precisely the amount of some behaviour in a population. But focus groups are excellent for getting an indication of how pervasive an idea, value or behaviour is likely to be in a population, and for understanding how deeply feelings run about products, issues or public figures (Russel H. Bernard, 1988 p.267).

Focus group studies are not just convenient ways to accumulate the individual knowledge of the groups' members. They also give rise synergistically to insights and solutions that would not come about without them (Brown et. al 1989, in Patton 1990, p40). The focus group interview was developed in recognition of the fact that many of the consumer decisions that people make are made in a social context, often growing out of discussions with other people. Thus market researchers used focus group interviews in the 1950s as a way of simulating the consumer group process of decision making in order to gather more accurate information about consumer preferences. The participants are typically a relatively homogeneous group of people who are asked to reflect on questions asked by interviewers. Participants hear each others' responses and make additional comments beyond their original responses as they hear what others have to say. It is neither necessary for the group to reach a consensus nor for it to disagree. The object is to get high quality data in a social context where people can consider their own views in the context of others (Patton 1987, p.135).

Among the more common uses of the focus groups are the following :

- Obtaining general background information about a topic of interest.
- Generating hypotheses that can be tested with quantitative methods.
- Stimulating new ideas and concepts.
- Diagnosing the potential for problems with a new programme, service or product.
- Generating impressions of products, programmes, services, institutes or other objects of interest.
- Learning how respondents talk about the phenomenon of interest, so as to facilitate the design of questionnaires and other survey instrument for qualitative research. (Stewart W.David and Shamdasani N. Prem, 1990, p.15).
- Interpreting previously obtained quantitative results.

Focus groups have the following advantage :

- They provide data from a group of people much more quickly and at less cost, compared to interviewing individuals separately.
- They allow researchers to interact directly with respondents, and thereby to provide an opportunity for classification of responses, for following up questions and for probing of responses. It also allows respondents to qualify their responses and give contingent answers to questions.
- They provide large and rich amounts of data. Researchers obtain deeper levels of meaning, make important connections and identify subtle nuances.
- They allow respondents to react and build upon responses of other members.
- They are useful for getting information from children or illiterate or less educated people. (Stewart W. David and Shamdasani.N. Prem 1990 p.16.)

In addition, Patton (1987 p.135) points out that focus groups also provide some quality control on data collection, in that participants tend to provide checks and balances on each other which weed out false or extreme views. The group dynamics typically contribute to focusing on the most important topics and issues in the program, and it is fairly easy to assess the extent to which there is a relatively consistent, shared view of the program among participants.

The following are the limitations of focus groups:

- Both the small number of respondents and the convenient nature of most focus groups' recruiting practices limit generalisation.
- The responses from members are not independent of one another. Results may be biased by dominant or opinionated members.
- The live and immediate nature of the interaction may lead a researcher or decision maker to place greater faith in the findings than warranted.
- The moderator may bias results knowingly or unknowingly.

Focus group sampling is not always convenience sampling, as the following section on sampling will show. The need to control the group from being led by dominant or opinionated members has been noted, and in order to prevent this, persons of authority are generally not included in groups. In addition, the facilitators were briefed to encourage the group's silent or less talkative members to express themselves and then build up on those views by asking more and more members to talk about that. They were also told not to express their own views, or encourage only those views which they support. A note on conducting the discussion was given to all facilitators and reporters for this purpose. In addition, they were also given in-house and in-the-field training before starting the discussions.

Sampling in Focus Groups

In quantitative research, one's sample should be representative of some larger population to which one hopes to generalise the research findings. In qualitative inquiry, of which focus groups are a part, sampling is driven by the desire *to illuminate the questions under study and to increase the scope or range of data exposed to uncover multiple realities.* Quantitative sampling concerns itself with representativeness and qualitative sampling with information richness (Patton,1990 in Kuzel J Anton,in Crabtree & Miller Ed.1992 p.33). The two methods differ in that quantitative inquiry usually starts with theory that is closed and needs to be proven or disproved while qualitative inquiry generally begins with theory or understanding that is to be modified and confirmed in the context of the study. (Kuzel 1992 in Crabtree and Miller 1992 p.33). The non-probabilistic nature of sampling underscores the distinction made earlier between the goals and resulting sampling strategies of qualitative vis a vis quantitative inquiry.

The sampling strategy we have adopted combines aspects of maximum variation sampling and snowball sampling. Both are part of Patton's typology on sampling in qualitative methods

Maximum variation sampling occurs when one seeks to obtain the broadest range of information and perspectives on the subject of study. By looking for this broad range of perspectives, the investigator is purposefully challenging his or her own preconceived (developing) understanding of the phenomenon. This perspective also mitigates against the tendency to make the "messiness" of reality appear unduly "neat and tidy". This is in contrast to studying a homogenous group and seeking to understand a particular group of individuals particularly well, with some appreciation of course of the unarticulated diversity yet to be explored (Ibid pp.38-39). Patton (1990 p.182) points out that maximum variation sampling "documents unique or diverse variations that have emerged in adapting to different conditions", and "identifies important common patterns that cut across variations "(Ibid p.39).

In snowball sampling, one identifies in whatever way one can, a few members of the phenomenal group one wishes to study. They are used to identify others, and they in turn others. Unless the group is very large, one soon comes to a point at which efforts to net additional members cannot be justified in terms of the additional outlay of energy and resources; this may be thought of as a point of redundancy (Lincoln & Guba, 1985,p233 in Ibid p.40). Although rules are not hard and fast, experience has shown that 6-8 data sources or sampling units will often suffice for a homogenous sample, while 12-20 commonly are needed when looking for disconfirming evidence or trying to achieve maximum variation (Lincoln & Guba,1985, Marshall & Rossman 1989, Mc Cracken 1988, Patton, 1990 in ibid 1992 p.41)

In tune with the maximum variation sampling we have tried to gather the views of diverse sections of the population, particularly those of women and elderly, though they are not the only people represented in the focus groups. Although our groups are not homogenous in terms of age group of participants, they are homogenous in that they are served by the same health care delivery system and would therefore have some common concerns. On the one hand we could perceive this homogeneity cutting across the other heterogeneous aspects while on the other hand the views of different sections were also getting articulated. Heterogeneity therefore has not come in the way of expressing the views of particular sections. In addition there are a few women-only groups which discussed women's issues at greater length. Women's representation in other groups was also quite high.

We have also drawn from the technique of snowball sampling in identifying households. We started our focal work by getting the maps of Enumeration Areas from the Central Statistical Office. Certain Enumeration Subdivisions were selected giving weightage to class and community composition of the sub divisions and geographical representation. Most of the Sub-divisions chosen had mixed populations. Care was taken not to select localities predominantly populated by the affluent

The original idea was to fix the index households in the enumeration sub-divisions and then to select the 2 houses nearest to it to form the focus group. But we found it difficult to get participation from such pre-selected houses. Therefore, we changed the strategy and made it more flexible. We kept the enumeration subdivisions as it was and solicited participation from different clusters of houses at different points on the same lane or on different lanes. Care was also taken in these groups to insure sufficient representation of females and the aged. Contact was established through youth clubs, neighbourhood women groups, church groups on Sundays and so on. Thus, by using the snowballing technique, where one household whom we contacted using the above mentioned groups put us in touch with other co-operating households and they themselves even organised a suitable venue. The members of this focus group again put us in touch with other houses in the locality who formed the next group.

Special care was taken to ensure that the venue was not the house of persons of authority or those in the health department, so that group members would not be afraid to speak out Occasionally we also had to break the prescribed upper limit of 12, suggested by Scrimshaw & Hurtado (1987 p 15) because of the enthusiasm of people to participate. The number of participants in some of our focus groups, both in the household groups as well as among the local health committees (LHC), had gone up to 14. The average

number of participants in the household groups was 9, while in the LHC's it was only 8. However, Scrimshaw's position is not very rigid on the size of groups. She says that in Indian and African settings, people from the neighbourhood may also join in, and that they need not be turned away; instead it should be treated as a natural group. Indeed, in the end, the responses revealed that by relaxing on some of the rigidities of the method, we have only gained in terms of information. We have conducted 32 household-based focus groups, and 21 group discussions in local health committees. According to Patton, 12-20 focus groups are sufficient to get the diverse views necessary for maximum variation sampling (Patton 1990 in Kuzel 1992 op.cit.p.41).

Another set of focus group discussions was conducted in the local health committees. The intention in holding these discussions was to get to know the views of persons who are more closely associated with the community health centres and thus be exposed to the problems of the Mauritius health sector. Views were also elicited on community funding of health centres. On the whole, 21 local health committee groups were involved. According to the Community Organisers of the National Trust Fund for Community Health (hereafter referee to as Trust Fund), 11 of these were fully active LHCs, and 10 were moderately active. However, this classification is rather arbitrary, and not based any clearly defined criteria. Both the household group discussions and the LHC group discussions were conducted in widely spread-out places in Mauritius, as shown in .2.

The focus group facilitators and discussion recorders were selected from the Medical Records Officers, Trust Fund, and certain other staff of the health department. They were given both in-house and in-the-field training in the technique of conducting focus groups and recording the discussion as outlined by S. Scrimshaw (1987).

A note was prepared in this regard and copies were given to all facilitators .3
The facilitators and recorders started carrying out the discussions only after conducting pilot discussions. The Trust Fund staff was not used to conduct the discussions of the LHCs with which they were working. The focus group discussions were conducted from the beginning of July for about three weeks.

Coverage Of Focus Groups

Table 1 Geographical distribution of focus group discussions among household groups

Clusters	Location	District	No. of discussions
Phoenix	Cite Palmerstone; Nehru Road; Ramputh Lane	Plaine Wilhems	4
Rose Hill	Gandhi Avenue; M.A. Jinnah Avenue; Stanley; Camp Levieux	Plaine Wilhems	4
Chemin Grenier / Tyack	Lorquet Lane; Lotus Lane; Newton Lane	Savanne	8
Port Louis	Cassis	Port Louis	8
Bramsthan	No. 67G; Kalimaye Road; Royal Road; No. 68	Flacq	4
Petit Raffray	Pave Road; Near Social Welfare Centre	R. Du Rempart	2
Rivier des Anguilles	Rue Prudence	Savanne	2
		Total	32

Table 2 List of local health committees selected for focus group discussions

S.No	Local Health Committees	District	Activity Status
1	Camp Itchier CHC	Flacq	Active
2	Mare La Chapeaux CHC	Flacq	Moderately active
3	Mare d'Albert CHC	Grand Port	Active
4	Nouvelle France CHC	Grand Port	Moderately active
5	Melrose CHC	Moka	Active
6	Pellegrin CHC	Flacq	Active
7	Amaury CHC	R. Du Rempart	Moderately active
8	Saint Julien d'Hotman CHC	Flacq	Moderately active
9	Le Hochet CHC	Pamplemouses	Moderately active
10	St. Croix CHC	P. Louis	Active
11	Villebague CHC	Pamplemouses	Moderately active
12	Esperance Quartier Militaire CHC	Moka	Active
13	Medine Camp des Masque CHC	Flacq	Moderately active
14	Frand Bois CHC	Savanne	Active
15	Chamouny CHC	Savanne	Moderately active
16	Tyack AHC	Savanne	Active
17	Plaine Lauzun CHC	P. Louis	Moderately active
18	Beau Bassin AHC	Plaine Wilhems	Active
19	Yves Cantin AHC	Black River	Active
20	Riviere des Creoles CHC	G. Port	Moderately active
21	Cite la Cure CHC	P. Louis	Active

Note Given To Facilitators And Recorders

II.3 A Note on Conducting Focus Group Discussions

- It should be an open conversation in which each participant speaks, asks questions to other participant responds to questions.
- Facilitator will only guide the discussion so that all subjects get covered.
- The first discussions take a long time.
- Location of Focus Group discussion should be neutral. (Certainly not Hospital AHC CHC)
- Invitations to focus groups should be made ahead of time if required.

Discussion Facilitator

- Should be thorough with the objectives of the study.
- Uses the discussions guide which has open ended questions, to keep the session focused.
- Facilitator should not convey the impression of an expert.
- Formulate appropriate questions on the basis of the discussion guide to encourage a discussion. Take care to react neutral to the different views that are expressed by participants.
- Emphasize that there are no right or wrong answers.
- Gestures and non-verbal communication should not suggest agreement / disagreement with participants.
- Facilitator should avoid expression personal opinion.
- Observe participants and be aware of the extent of their involvement and reactions.
- Encourage all to participate, do not allow a few to monopolise the discussion.
- Keep track of the points to be covered.
- Guide the meeting away from Question-Answer, Interviewer - Interviewee session to a group discussion where all participate.
- Take a sincere interest in the participants and in learning about them.
- Be flexible and open to suggestions / interruptions.
- Subtly control the time allotted for each question.
- Conversation should move quickly over issues expressed by other groups and move on to views received afresh.
- Observe the participant's non-verbal communication.

Discussion Recorder

- Is present primarily as observer and documenter.
- Record the discussion along with group dynamics.
- Document the interest level, anxiety, boredom expressed by the group.
- Document the interruptions and distractions that occur during meeting.
- What makes them laugh, what seems to make them reluctant to answer, how the discussion ends
- What is the majority view? The other views. Record points in their own words
- Intervening on points missed by facilitator.
- Intervening to collect a participant's view not expressed / heard properly.

Focus Group Session

- Facilitator / recorder should come to the place of discussion before the time of the discussion. At this time learn names of participants.
- Sit in a circle, everyone face to face.

Opening a meeting

- Make introductions. Explain the project and roles to facilitator and recorder
- Ask their names.
- Say that the meeting is not an educational lecture but to get views of participants to improve the health system.
- Say that the views of all are important. All should participate and feel free to express themselves
- Only rule being that the speaker should address the subject of the focus group discussion and that one person will speak at a time.
- Ask a question to each participant not related to the topic so that all start talking.

Focus Group Meeting Techniques

- Specialists, experts, people of authority should not be there in the group.
- More eye contact should be used to open out the reluctant participant.
- Less eye contact with dominant participant to prevent him from monopolising the discussion.

Ending

- Explain that the meeting is about to end. Ask if anyone has anything more to add.
- The relevant comments among these can be explored.
- If there are no more fresh comments thank the participants and reaffirm that their ideas will be used in planning.

Key Informant Interviews

[No interview guide was used for these interviews, so as to give maximum freedom to the interviewees to express their views on the health system. These interviews were conducted by the researcher himself, who intervened only to keep the conversation focused.]

Interview 1

Dr. J.C. Mohit, Director, Mauritius Institute of Health.

(Dr. Mohit is a former Chief Medical Officer and was also the first Chairman of the National Trust Fund for Community Health.) Interviewed on 13th July, 1995 at 11a.m

He pointed out that in urban areas people had several places to go for treatment and transport was also not a problem. In contrast in rural areas buses were not too frequent and therefore patients had to travel longer distances.

On the Local Health Committees, he mentioned from his rich experience as the first chairman of Trust Fund that in 1986 when the Community Health Movement started there was abundant enthusiasm and co-operation from the people which took the form of contributions in money and labour for building up CHCs. This led to setting up around 50 CHCs in Mauritius and 4-5 in Rodrigues. However, "now the style of co-operation needed is different" and this was not forthcoming. The community had to take more interest in the day to day functioning of CHCs now.

In general, people knew that the health service was not free, as they were indirectly paying for it through taxes. They were seeing the service as a right and therefore had various expectations from it.

He further highlighted that the society of Mauritius had changed, and that the Health services had to take that into account. He pointed out that the society had undergone a *demographic transition, an epidemiological transition, and an industrial transition.*

As part of the demographic transition, families were opting for less children. Two or 3 children were becoming the norm. Every child was precious. Proper care should be given to them from conception onwards.

Similarly, the aged needed special treatment. Connected to this, he mentioned the epidemiological transition. He said the practice had to tune itself to the changes in disease pattern, i.e. the emergence of heart diseases, hypertension, diabetes, etc., as major diseases affecting people. Health education for the aged, for example, has become necessary to prevent heart disease. And for that, staff training is needed.

Thirdly, he mentioned the particular problems caused by industrial transition, which has not only led to occupational health problems, but had also given rise to certain social problems with implications for health. With females going for work, there was no one at home. The care for children even under the age of 2 was left to the creches. The pattern of living was changing. Even the food. Sexual behaviour was undergoing changes, with less monogamy, more premarital sex and teenage pregnancies. The health services should face up to all these changes.

In day to day operations he had the following suggestions:

- Instead of giving too many appointments at the same time, they should be distributed. This would reduce over-crowding and waiting time.
- Distribution of medicines could be made at each out-patient clinic rather than at another counter
- Referral services should be made available near the work site. A.N.C. should also be provided in or near to the work site. If F.P. services can be practiced at the work site, why can't A.N.C.?
- Better standards of cleanliness should be maintained in hospitals. The hotel services, i.e. sanitation and catering, should be privatised.

Interview 2

Dr. Baboo Ramdawar, Chairman Mauritius Medical Council (MMC), Dr. D. Heeraman Registrar, (MMC) and Dr. Hruhangi, Secretary, Mauritius Dental Council (MDC).

This was a group interview in which the functionaries of M.M.C. and MDC expressed views on the Mauritius Health system and gave suggestions for its improvement. Since there was no distinct differences in the opinion among the three office bearers, their views are presented in common.

They suggested that the emergency cases should not be asked to queue up. There should be patient education on the referral system. Residents of each region should be given a differently coloured health booklet. Health education through TV and other media was suggested.

For doctors, both in Government and Private practice, they suggested continuing education. Proper co-ordination should be brought about between the Health Ministry Staff and the hospital staff.

They would welcome some sort of rating system for nursing homes because that would increase their own standing. In Dental Council some effort was made to formalise fees for certain services. On fees they said that some reasonable rates should be agreed upon between patients and doctors. At the same time, they mentioned that the same clinic which charges should also have cheaper wings for the poor. They suggested an insurance system parallel to public hospitals. They said it had existed before.

Interview 3

Dr. N.C. Shah, Consultant Advisor on Ayurveda, Ministry of Health Mauritius: Interviewed On 16th July, 1995 at 12 p.m.

Dr. Shah mentioned that the Ayurveda clinics at Long Mountain and S.S.R.N. hospitals were attracting patients with rheumatism, arthritis, diabetes, digestive, respiratory and dermatological diseases. The potentiality of Ayurveda to deal with these problems was increasingly becoming known to the community. To cope with this, the facilities in the Ayurvedic clinics were being updated with modern equipment designed to perform the complete *panch karma* therapy. Simultaneously, a medical plant garden was being nurtured. Dr. Shah has also plans to undertake a survey of the medicinal plants of Mauritius. The following table gives diseases-wise classification of attendances at the Ayurvedic out-patient clinics at Long Mountain and S.S.R.N. hospital in 1993.

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