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INTRODUCTION

REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

ACKNOWLEDGMENTS

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APPENDIX/ANNEXURE

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- Hunker, H.L. and A.J. Wright (1963), "Factors of Industrial Location in Ohio" Ohio State University, Nigeria.

CONTRIBUTIONS TO BOOKS

- Sharma T., Kwatra, G. (2008) Effectiveness of Social Advertising: A Study of Selected Campaigns, Corporate Social Responsibility, Edited by David Crowther & Nicholas Capaldi, Ashgate Research Companion to Corporate Social Responsibility, Chapter 15, pp 287-303.

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- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

CONFERENCE PAPERS

- Garg, Sambhav (2011): "Business Ethics" Paper presented at the Annual International Conference for the All India Management Association, New Delhi, India, 19–22 June.

UNPUBLISHED DISSERTATIONS AND THESES

- Kumar S. (2011): "Customer Value: A Comparative Study of Rural and Urban Customers," Thesis, Kurukshetra University, Kurukshetra.

ONLINE RESOURCES

- Always indicate the date that the source was accessed, as online resources are frequently updated or removed.

WEBSITES

- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Political Weekly, Viewed on January 01, 2012 http://epw.in/user/viewabstract.jsp

PROBLEMS OF PAIN AND PALLIATIVE CARE VOLUNTEERS IN KERALA

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ABSTRACT

Volunteers are the sole of the palliative care movement. Volunteers who have life experience with terminal ill patients, the desire to help others/ learn more about grief and loss, come to terms with their own morality usually come forward to become volunteer for palliative care service. The main objective of the study is to analyze the problems faced by the Pain and Palliative Care volunteers in rendering the services effectively to the patients in Kerala. The respondents of the study include Pain and Palliative care volunteers rendering Pain and Palliative care services in the State of Kerala. The volunteers have been selected from the data base maintained by the Pain and Palliative care units of the districts selected as sample for the purpose of the study. For selecting the Pain and Palliative care volunteers, the State of Kerala was first divided into three zones- south, central and north. From these zones, one district each representing south, central and north (Alappuzha, Ernakulam and Kozhikode) have been selected at random. There were in all 79 Pain and Palliative care units in the selected districts of Kerala (20 in Alappuzha, 22 in Ernakulam and 37 in Kozhikode) as on 31st Oct 2010. All the units which render home care services have been selected for the study. 12 units in Ernakulam, 11 units in Alappuzha and 32 units in Kozhikode are offering home care services. Thus, the total number of Pain and Palliative care units selected as sample has come to 55. There are in all 2653 Palliative care volunteers in 55 units. 20 % of Pain and Palliative care volunteers have been selected at random. The volunteers include both males and females (enrolled till 31st Oct 2010). Thus the total sample has come to 531 volunteers. The data collected were suitably classified and analyzed keeping in view the objectives of the study. For the purpose of analysis, statistical tools like averages, percentages, rank test and Pearson's Chi Square test were applied. The majority of the volunteers in Kerala were females. A few volunteers were providing palliative care without proper training. Only a few volunteers were providing their services without any break. Some volunteers did not get adequate support of doctor/nurses for providing required services to patients. Only a few volunteers always faced problems. The major problem of the volunteers was 'problems from other team members in the same locality/ different localities'. The major problem faced by them while dealing with the patients was that they were not able to reduce the stress of the patients. Power politics was the major problem faced by the volunteers while dealing with the team members which hindered smooth functioning of the unit. The first and foremost problems faced by male and female volunteers while dealing with the team members were lack of co-operation from the team members, partiality and lack of good volunteers who co-operate with patients and their family members .Membership in Other organizations and financial problems' was the major personal problem faced by volunteers. A few volunteers were providing palliative care services without proper training. Only a few volunteers were providing their services without any break. The major problem of the volunteers was problems from other team members in the same locality/ different localities. The major problem faced by them while dealing with the patients was that they were not able to reduce the stress of the patients.

KEYWORDS
Neighbourhood Network in Palliative Care, Chi square test, Kruskal-Wallis Test.

INTRODUCTION

Volunteers are the sole of the palliative care movement. Volunteers who have life experience with terminal ill patients, the desire to help others/ learn more about grief and loss, come to terms with their own morality usually come forward to become volunteer for palliative care service. Volunteering in palliative care offers the intellectual and emotional stimulation of having to deal with the meaning of life and death, and gives an opportunity to reflect on one's own values and priorities.

The IOM (1999)[1] stated that a shift is taking place from patient care in the hospital to family care in the home, which presents a special challenge for family or friend caregivers. Such caregivers need help with learning health care delivery skills, problem solving, and use of community-based services.

Steve Conway(2008)[2], in his study titled "Public health developments in palliative care services: the view from the UK" recommended for the encouragement of growth of community oriented work .Community development provided opportunities to increase access to services and address the inequality of the 'disadvantaged dying'.

SIGNIFICANCE OF THE STUDY

Palliative care is a team work where the doctors' help and nursing care constitute 30 % and 70 % of the help comes from volunteers, relatives and friends who provide psychological care, social care, financial care and spiritual care to the patients. Volunteers are primary care givers who originate normally from the same locality with local knowledge and good public contact through which they can make significant contributions in a team work by bridging the gap between the patient community and outside world. Volunteers empower and mobilize communities to prevent diseases, save lives, and diminish suffering. Palliative care is the continued supportive care and volunteers must have a deep commitment to their work on an ongoing basis. Palliative care volunteers must complement professional work by covering the basic and vital personal and psychosocial requirements of the patients and their families – providing well-being and assuring the best quality of life. Since they have to work in a team they are accountable to their programme's vision, mission, values, standards, principles, and norms. They must possess the skill to differentiate among the needs of their patients and their family members, team members and themselves.

For delivering proper palliative care , there should be a well integrated team with flexibility of leadership, good degree of trust, unselfishness , utilitarianism, respect in each other's skill and ability, high degree of mutual accountability, focus on the task etc. The network must be active so as to maintain continuity of care and improving the coverage. For this the crucial ingredient is the 'will and commitment' of the volunteers. Volunteering is a social wealth which is the core for the development and maintenance of democracy. Volunteers mobilize the community for the promotion of this wonderful movement. The multifaceted nature of palliative care entails that it is best delivered by a multidisciplinary team working in partnership with patients and their families. For the proper delivery of continuous complete home end-of-life care to patients, well integrated, responsible and accessible volunteers who have a thorough knowledge of the factors that foster or hinder recourse to care is a must.

In a developing country like India, there is absence of well trained doctors, nurses, volunteers, palliative care training policies etc. for delivering quality care. The number of active volunteers with unselfishness and utilitarianism is found to be negligible. Many of them who joined as volunteers in a unit do not or could not continue their service due to several problems. There is the need for strengthening the training strategies. An analysis of the problems of volunteers would help in identifying the exact reasons for their discontinuance/break of service and making suitable suggestions for their active participation in this movement.

Moreover, the review of earlier literature revealed that most of the studies in palliative care have been conducted in the field of medical science. No study has so far been conducted for analyzing the role and involvement of pain and palliative care units in the community development. In this context the present topic entitled "Problems of Pain and Palliative Care Volunteers in Kerala" assumes greater importance.

RESEARCH METHODOLOGY

SCOPE OF THE STUDY

The present study has been undertaken to analyze the problems faced by the Pain and Palliative Care volunteers in rendering the services effectively to the patients in Kerala. The study is confined to palliative care volunteers in the State of Kerala.

OBJECTIVE OF THE STUDY

The main objective of the study is to analyze the problems faced by the Pain and Palliative Care volunteers in rendering the services effectively to the patients in Kerala.

HYPOTHESES OF THE STUDY

H01 There is no association between age of the volunteers and sharing of emotions by the patients with the volunteers in Kerala.

H02 There is no association between occupation of volunteers and break in their palliative care services in Kerala.

SELECTION OF SAMPLE

The respondents of the study include volunteers rendering Pain and Palliative care services in the State of Kerala. The volunteers have been selected from the data base maintained by the Pain and Palliative care units of the districts selected as sample for the purpose of the study.

SELECTION OF PAIN AND PALLIATIVE CARE VOLUNTEERS

For selecting the Pain and Palliative care volunteers, the State of Kerala was first divided into three zones- south, central and north. From these zones, one district each representing south, central and north (Alappuzha, Ernakulam and Kozhikode) have been selected at random. There were in all 79 Pain and Palliative care units in the selected districts of Kerala (20 in Alappuzha, 22 in Ernakulam and 37 in Kozhikode) as on 31st Oct 2010. All the units which render home care services have been selected for the study. 12 units in Ernakulam, 11 units in Alappuzha and 32 units in Kozhikode are offering home care services. Thus, the total number of Pain and Palliative care units selected as sample has come to 55. Pain and Palliative care volunteers have been selected from the records of Pain and Palliative care units functioning in the three districts earmarked for the intensive study. There are in all 2653 Palliative care volunteers in 55 units. 20 % of Pain and Palliative care volunteers have been selected at random. The volunteers include both males and females (enrolled till 31st Oct 2010). Thus the total sample has come to 531 volunteers.

COLLECTION OF DATA

The data required for the study were collected from both primary and secondary sources. The Primary data were collected from the respondents based on structured questionnaire. The secondary data were collected from reports, books and journals published by the Consortium of Pain and Palliative care Units in Ernakulam District. Institute of Palliative Medicine and from various web sites.

TOOLS OF ANALYSIS

The data collected were suitably classified and analyzed keeping in view the objective of the study. For the purpose of analysis, statistical tools like percentages, rank test and Karl Pearson Chi Square test were used. For the rank data weighted average method was used to obtain the rank. Weighted mean is calculated and these means are ranked in order of magnitude from highest to lowest. To study the Problems of Pain and Palliative Care volunteers in Kerala the relevant questions were asked in five point scale and are scored in the order of magnitude from 5 to 1 for positive questions and 1 to 5 for negative questions. Overall score of each respondent was found out and which form the basis for comparison. To test the hypothesis that two attributes are associated or not we used the Chi-square test for independence.

PERIOD OF THE STUDY

The study covers a period of two years (1st May 2009 – 30th April 2011)

ANALYSIS

For the purpose of study 32.4% of the volunteers were selected from south, 8.85% were selected from central and 58.75% of them were selected from North zone of Kerala state, depending upon the size of the population (Table1). Most of the volunteers (79.1%) were in the age group of 20 to 59 years. 7.7% of them were in the age group of less than 20 years and 34.3% of them were in the age group of 20 to 40 years. It was also observed that 13.2% of them were in the age group of 60 years and above (Table 2).The majority of the volunteers (56.1%) in Kerala were females. It showed that females had an active participation in this movement in Kerala (Table 3).Palliative care service could be rendered without much education. It was observed that 47.1% of the volunteers in Kerala were having education up to SSLC and only 6.6% of them were either post graduates or professionals (Table 4). 16 % of the volunteers were unemployed and 14.1% of them were retired persons. Others constituted of 38.8%, including casual workers, agriculturists, technicians, bus conductors and students. It showed that palliative care service could be rendered by any individual irrespective of his/her employment provided he/she had a helping mentality (Table 5). During 1995-96 the percentage of enrolment of volunteers in Kerala was 1.3.The percentage was improved only from 2005 onwards. It was increased to 10.7% in 2005. From 2007 onwards, it showed an increasing trend till 2009. However, in 2009, the percentage showed a marginal decrease. The per cent of enrolment was the highest in the year 2008 which stood at 31.5 % (Table 6).

15.63% of the volunteers in Kerala were providing palliative care services without proper training. This will affect the quality of service provided to the patients (Table 7). The services of the doctors were always available to 45% of the volunteers in Kerala 6.6 % did not get adequate support of a doctor which was one of the obstacles for providing required services to patients and 2.8% of them got the services of the doctors very rarely (Table 8). 69.7 % of the volunteers always got the services of the nurse which was very essential for the promotion and continuance of palliative care services. However, 3.6% did not get their services. Most of the volunteers in Kerala were getting adequate support of nurses (Table 9). 66.3% volunteers were able to infuse confidence, with whom patients shared their emotions, but 0.8% of them could not (Table 10).Patients always shared their emotions with 34.1% of the volunteers in the age group up to 20 years,70.2% of the volunteers in the age group of 21 to 30 years , 65.2% of the volunteers in the age group of 31 to 40 years , 70.6 % of the volunteers in the age group of 41 to 50 years, 75.3% of the volunteers in the age group of 51 to 60 years and 64.3% of the volunteers in the age group of 61 years and above . However with 0.7% of the volunteers in the age group of 31 to 40 years and 2 % of the volunteers in the age group of 41 to 50 years, patients neither did nor share their emotions (Table 11).

Chi square test (Table 11) revealed that there was significant association between age of the volunteers and sharing of emotions by the patients with the volunteers ($\chi 2$ =14.159 with 5 d.f. at 5% level).Therefore the null hypothesis **H01 stating that there is no association between age of the volunteers and sharing of emotions by the patients with the volunteers in Kerala is rejected.**

It was understood that 58.8 % of male volunteers and 72.1% of female volunteers could always share emotions of patients with them and 1.3% of male volunteers and 0.3% of female volunteers could not share emotions of patients with them (Table 12). Chi square test (Table 12) revealed that there was significant association between sex of the volunteers and sharing of emotions by patients ($\chi 2$ =13.260 with 2 d.f. at 1% level). Only 21.1 % of the volunteers in Kerala were providing their services without any break and 4.1% of them had always broken their services (Table 13). It was understood that 1.7 % of male volunteers and 6% of female volunteers always broke their services and 18% of male volunteers and 23.5% of female volunteers never broke their service (Table 14). Chi square test revealed that there was significant association between sex of the volunteers and break in the service of the volunteers ($\chi 2$ =49.735 with 3 d.f. at 1% level (Table 14). 5.9 % of volunteers who were unemployed and 6.7% of volunteers who were retired persons, 0.8% of volunteers who were in service field, 100% of volunteers who were professionals and 4.9% of volunteers who were engaged in other activities always broke their service. But 21.2% of volunteers who were unemployed, 2.7% of volunteers who were retired persons, 19.4% of volunteers who were businessmen, and 19.5% volunteers who were in service field and 29.1% of volunteers who were engaged in other activities did not break their services (Table 15).Chi square test revealed that there was significant association between occupation of volunteers and break in the service of the volunteers ($\chi 2$ =17.281 with 8 d.f. at 5% level) (Table 15). Therefore, the null hypothesis **H02 stating that there is no association between occupation of volunteers and break in their palliative care services in Kerala stands rejected.**

46.7% of the volunteers in Kerala always sought the help of their loved ones or professional agencies for either funds or amenities like water beds, wheel chairs, conveyances, clothes etc. for efficient discharge of their services. 47.08% sometimes asked help from such people. Only 2.64% of them did not seek any help

from their loved ones or professional agencies. This proved the fact that palliative care is a team work which could be rendered effectively only with public support (Table 16). 99.2 % of the volunteers in Kerala conducted team meeting for discussing their routine activities and their problems. But 0.8% of the volunteers did not conduct meeting (Table 17). 62.52 % of the volunteers in Kerala convened meeting regularly, 24.11 % conducted meeting frequently, 11.30 % held meeting occasionally and 1.32 % conducted meeting only once (Table 18).

Only 0.9 % of the volunteers in Kerala always faced problems. 62.9 % sometimes faced problems, 22.4 % very rarely faced problems and 12.8 % did not face any kind of problem (Table 19). The major problem faced by both male and female volunteers in Kerala was 'problems from other team members in the same locality/ different localities'. 'Problems from other members of the unit' was ranked as second by both of them (Table 20).

The major problem faced by the volunteers while dealing with the patients was that they were not able to reduce the stress of the patients. 'Possibility of creating a biased situation' was the second major problem faced by them (Table 21). 'Membership in Other organizations and financial problems' was the major personal problem of the volunteers in Kerala. 'Language barriers' was ranked as second. "Wrong attitude of the public" wais ranked as third problem (Table 22).

CONCLUSION

Most of the volunteers were in the age group of 20 to 59 years. The majority of the volunteers in Kerala were females**.** Only a few volunteers were post graduates or professionals. The percent of enrolment of volunteers was highest in the year 2008**.** A few volunteers were providing palliative care without proper training. Most of the volunteers always got the services of the nurse. Most of the volunteers were able to infuse confidence in patients. Only a few volunteers were providing their services without any break. A significant number of volunteers always sought the help of their loved ones or professional agencies for either funds or amenities like water beds, wheel chairs, conveyances, clothes etc. The majority of the volunteers conducted team meeting for discussing their routine activities and their problems. Only a few volunteers always faced problems. The major problem of the volunteers was problems from other team members in the same locality/ different localities. The major problem faced by them while dealing with the patients was that they were not able to reduce the stress of the patients. Power politics was the major problem faced by the volunteers while dealing with the team members which hindered smooth functioning of the unit. The first and foremost problems faced by male and female volunteers while dealing with the team members were lack of co-operation from the team members, partiality and lack of good volunteers who co-operate with patients and their family members .Membership in Other organizations and financial problems' was the major personal problem faced by volunteers.

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TABLES

TABLE 1: ZONE –WISE CLASSIFICATION OF PPC VOLUNTEERS

Zone	Frequency	Percent
South	172	32.40
Central	47	8.85
North	312	58.75
Total	531	100

Source: Primary data.

TABLE 2: AGE –WISE CLASSIFICATION OF PPC VOLUNTEERS

Age	Frequency	Percent
Less than 20 Years	41	7.7
20-40	182	34.3
40-60	238	44.8
60-80	67	12.6
80 Years and Above	3	.6
Total	531	100

Source: Primary data.

TABLE 3: SEX –WISE CLASSIFICATION OF PPC VOLUNTEERS

Sex	Frequency	Percent
Male	233	43.9
Female	298	56.1
Total	531	100

Source: Primary data.

TABLE 4: EDUCATION LEVEL OF THE PPC VOLUNTEERS

Education	Frequency	Percent
Up to SSLC	250	47.1
Pre-degree	118	22.2
Degree	128	24.1
PG	17	3.2
Professional	18	3.4
Total	531	100

Source: Primary data.

TABLE 5: OCCUPATION OF THE PPC VOLUNTEERS

Occupation	Frequency	Percent
Unemployed	85	16.0
Pensioner	75	14.1
Business	36	6.8
Service	128	24.1
Professional	1	.2
Others	206	38.8
Total	531	100

Source: Primary data.

TABLE 6: YEAR ENROLMENT OF THE PPC VOLUNTEERS

Year of Enrolment	Frequency	Percent
1995	7	1.3
1998	2	.4
1999	1	.2
2000	3	.6
2002	9	1.7
2003	14	2.6
2004	8	1.5
2005	57	10.7
2006	24	4.5
2007	83	15.6
2008	167	31.5
2009	156	29.4
Total	531	100

Source: Primary data.

TABLE 7: TRAINING PROGRAMMES ATTENDED BY THE PPC VOLUNTEERS

Type of Training	Frequency	Percent
Volunteers Training	382	71.94
Others	66	12.43
Nil	83	15.63
Total	531	100

Source: Primary data.

TABLE 8: AVAILABILITY OF DOCTORS

Availability of Doctors	Frequency	Percent
Always	239	45.0
Some times	225	42.4
Very rare	15	2.8
No	35	6.6
No opinion	17	3.2
Total	531	100

Source: Primary data.

TABLE 9: AVAILABILITY OF NURSES FOR THE SERVICE

Availability	Frequency	Percent
Always	370	69.7
Some times	125	23.5
Very rare	15	2.8
No	19	3.6
No opinion	2	.4
Total	531	100

Source: Primary data.

TABLE 10: SHARING OF EMOTIONS BY PATIENTS WITH VOLUNTEERS

Responses	Frequency	Percent
Always	352	66.3
Some times	149	28.1
Very rare	22	4.1
No	4	.8
No opinion	4	.8
Total	531	100

Source: Primary data.

TABLE 11: AGE OF THE VOLUNTEERS AND SHARING OF EMOTIONS BY PATIENTS (Chi Square Test)

Age		SHARING OF EMOTIONS BY PATIENTS					
		Always	Sometimes	Very Rare	No	No opinion	Total
up to 20	Count	14	19	8	0	0	41
	% within Age	34.1%	46.3%	19.5%	.0%	.0%	100%
21-30	Count	33	12	2	0	0	47
	% within Age	70.2%	25.5%	4.3%	.0%	.0%	100%
31-40	Count	88	36	10	1	0	135
	% within Age	65.2%	26.7%	7.4%	.7%	.0%	100%
41-50	Count	108	40	1	3	1	153
	% within Age	70.6%	26.1%	.7%	2.0%	.7%	100%
51-60	Count	64	21	0	0	0	85
	% within Age	75.3%	24.7%	.0%	.0%	.0%	100%
61 Years & above	Count	45	21	1	0	3	70
	% within Age	64.3%	30.0%	1.4%	.0%	4.3%	100%
Total	Count	352	149	22	4	4	531

TABLE 12: SEX OF THE VOLUNTEERS AND SHARING OF EMOTIONS BY PATIENTS (CHI SQUARE TEST)

Sex	SHARING OF EMOTIONS BY PATIENTS						
		Always	Sometimes	Very Rare	No	No opinion	Total
Male	Count	137	83	7	3	3	233
	% within sex	58.8%	35.6%	3.0%	1.3%	1.3%	100%
Female	Count	215	66	15	1	1	298
	% within sex	72.1%	22.1%	5.0%	.3%	.3%	100%
Total	Count	352	149	22	4	4	531
	% within sex	66.3%	28.1%	4.1%	.8%	.8%	100%

Source: Primary data.

χ^2 = 13.260with 2 degrees of freedom. Significant at 1% level

TABLE 13: BREAK IN THE SERVICE OF THE VOLUNTEERS

Duration of Break	Frequency	Percent
Always	22	4.1
Sometimes	294	55.4
Rarely	103	19.4
No	112	21.1
Total	531	100

Source: Primary data.

TABLE 14: SEX OF THE VOLUNTEERS AND BREAK IN THE SERVICE OF THE VOLUNTEERS (Chi Square Test)

Sex	BREAK IN THE SERVICE OF THE VOLUNTEERS						
		Always	Sometimes	Very Rare	No	No opinion	Total
Male	Count	4	166	21	42	233	4
	% within sex	1.7%	71.2%	9.0%	18.0%	100%	1.7%
Female	Count	18	128	82	70	298	18
	% within sex	6.0%	43.0%	27.5%	23.5%	100%	6.0%
Total	Count	22	294	103	112	531	22
	% within sex	4.1%	55.4%	19.4%	21.1%	100%	4.1%

Source: Primary data.

χ^2 = 49.735with 3 degrees of freedom. Significant at 1% level

TABLE 15: OCCUPATION OF THE VOLUNTEERS AND BREAK IN THE SERVICE OF THE VOLUNTEERS (Chi Square Test)

Occupation	BREAK IN THE SERVICE OF THE VOLUNTEERS						
		Always	Sometimes	Very Rare	No	No opinion	Total
Unemployed	Count	5	47	15	18	85	5
	% within Occupation	5.9%	55.3%	17.6%	21.2%	100%	5.9%
Pensioner	Count	5	58	10	2	75	5
	% within Occupation	6.7%	77.3%	13.3%	2.7%	100%	6.7%
Business	Count	0	24	5	7	36	0
	% within Occupation	.0%	66.7%	13.9%	19.4%	100%	.0%
Service	Count	1	63	39	25	128	1
	% within Occupation	.8%	49.2%	30.5%	19.5%	100%	.8%
Professional	Count	1	0	0	0	1	1
	% within Occupation	100%	.0%	.0%	.0%	100%	100%
Others	Count	10	102	34	60	206	10
	% within Occupation	4.9%	49.5%	16.5%	29.1%	100%	4.9%
Total	Count	22	294	103	112	531	22
	% within Occupation	4.1%	55.4%	19.4%	21.1%	100%	4.1%

Source: Primary data.

χ^2 = 17.281 with 8 degrees of freedom. Significant at 5 % level

TABLE 16: DEPENDENCE OF VOLUNTEERS ON LOVED ONES OR PROFESSIONAL AGENCIES FOR HELP

Responses	Frequency	Percent
Always	248	46.70
Sometimes	250	47.08
Rarely	13	2.45
No	14	2.64
No opinion	6	1.13
Total	531	100

Source: Primary data.

TABLE 17: TEAM MEETING OF THE UNITS

Responses	Frequency	Percent
Yes	527	99.2
No	4	.8
Total	531	100

Source: Primary data.

TABLE 18: PERIODICITY OF TEAM MEETING

Periodicity of the meeting	Frequency	Percent
Regularly	332	62.52
Frequently	128	24.11
Occasionally	60	11.30
Only Once	7	1.32
No Opinion	4	.75
Total	531	100

Source: Primary data.

TABLE 19: CHANCES OF FACING PROBLEMS IN RENDERING SERVICES BY THE VOLUNTEERS

Responses	Frequency	Percent
Always	5	.9
Some times	334	62.9
Very rare	119	22.4
No	68	12.8
No opinion	5	.9
Total	531	100

Source: Primary data.

TABLE 20: SEX OF THE VOLUNTEERS AND NATURE OF PROBLEM FACED BY THE VOLUNTEERS

Sl. No	Nature of Problem	Male		Female	
		Mean	Rank	Mean	Rank
1	Lack of support from over-stretched service Staff	2.8696	6	4.4103	4
2	Problems from patients	2.5714	8	2.7419	10
3	Difficulty in reaching patients in rural areas	1.9024	12	2.9157	8
4	Travel potentially dangerous	4.7586	3	4.2656	5
5	Problems from other members of the unit	5.3333	2	6.9091	2
6	Problems from other team members in the same locality/ different localities	6.4615	1	7.5714	1
7	Personal problems	2.8333	7	2.8250	9
8	Problems from other local self government organisations	4.1818	4	3.4286	7
9	Problems from the family members of the patients	3.4000	5	3.7949	6
10	Lack of funds to provide service	2.1448	11	1.8478	12
11	Non availability of drugs	2.3580	10	2.2778	11
12	Fear in dealing with Patients	2.3846	9	4.5556	3

Source: Primary data.

TABLE 21: NATURE OF PROBLEM FACED BY THE VOLUNTEERS WHILE DEALING WITH PATIENTS

Sl. No	Nature of Problem	Mean	Rank
1	Unable to reduce the stress	7.1893	1
2	Lack of co-operation from the patient	2.3780	4
3	Ego clashes	2.3034	5
4	Unable to prevent long-term anxiety of the family	2.1688	6
5	Possibility of creating a biased situation	2.6990	2
6	Unable to find adaptive responses	2.6702	3
7	Not able to provide the required service	2.1485	7

Source: Primary data.

TABLE 22: PERSONAL PROBLEMS OF THE VOLUNTEERS

Sl.No	Nature of Problem	Mean	Rank
1	Resistance from family members	2.3934	4
2	Language barriers	2.8333	2
3	Cultural barriers	1.8358	5
4	Inadequate training	1.8125	6
5	Wrong attitude of the public	2.5180	3
6	Health problems	1.7554	7
7	Lack of time	1.6667	8
8	Membership in Other organizations and financial problems	5.6842	1

Source: Primary data.

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