

**A PILOT STUDY OF
REVIEW OF PRIMARY HEALTH CARE
AT MUTHALAMADA PANCHAYATH (Revenue Area)
OF PALAKKAD DISTRICT**

Report

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Brahmaputhran

Section - 1

Introduction

Health is the creative process - creative in the sense of overcoming the constraints - of ensuring the survival, growth and accomplishing well being. Health conceived as physical, mental and social well being by World Health Organisation (WHO) is true at the outcome level. For humans, this health process is considered as a bio-psycho-social process. Evolution of health care system in every parts of the world, though in different forms, can be an evidence of the social process of health.

Alma Ata Declaration of 1978 by WHO adopted Primary Health Care (PHC) Programme as a strategy for 'Health for All'. According to the Alma Ata declaration: "Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community".

India, being a signatory of this declaration, incorporated Primary Health Care Programme into its National Health Service. The National Health Policy (NHP) 2001 of Government of India also emphasis this approach. The main

objective of NHP-2001 is to "achieve an acceptable standard of good health amongst the general population of the country. The approach would be increase access to the decentralized public health system by establishing new infrastructure in the deficient areas, and by upgrading the infrastructure in the existing institutions primacy will be given to preventive and first line curative initiatives at the primary health level through increased sectoral share of allocations" (NHP 2001, section 3.)

Govt. of Kerala adopted the concept of Primary Health Care with the following pragmatic considerations: "As a practical measure to implement this objective, they have drawn up a 10 point programme. Of this, treatment and cure of disease is only one of the many aspects. (a) Total immunization of all children under five. (b) Supply of protected water to the entire population. (c) Sanitary method of removal of excreta and keeping the environment clean. (d) Maternal and Child Health Care (e) Implementation of the family welfare programme. (f) Supply of nutritious food, especially to children. (g) Giving of health education to all sectors of the population. (h) Making the people aware of the fact that health is not a gift but an active and positive goal to be striven for and for which the individual is primarily responsible. (i) To make transport and communications efficient so that everybody can avail of health care facilities". (Government of Kerala 1987 P.7).

In Kerala, though health parameters are comparatively better than other states several forms of inequalities in health exists. Muthalamada, one of the largest panchayat in Palakkad district shows less achievements in health and conditions for health. Muthalamada Panchayath is known for its economic and social backwardness with respect to Kerala average. Of the total area of 375 Sq. Km., 301 Sq. Km of the panchayath is forest area. 90% of people stay in the remaining revenue area. 1991 census shows a population of 33935. IRDP survey 1992 and Socio-Economic Survey 1998 of Government of Kerala showed that around 50% of the population in the area are below poverty line.

More communicable diseases and diarrhoea out breaks are reported from the area. A study on drinking water problems in the area (Shilaja and Sujith, 2000 under KRPLLD) shows that only 29% of people have own safe drinking water source. Most of the deprived sections depend on neighbour's well for drinking water. Public facilities for drinking water are less sufficient. Another recent study on health situations of elderly people in the area (Preetha K.K., 2001 under KRPLLD) revealed that the elderly people from poor households are more burdened with disease and the inadequacies of health security. Intimacy of family relations are becoming alien to older people, especially in poor households.

As elsewhere in Muthalamada also, a health system, in the sense as defined by WHO (2000) exists. Health system as defined by WHO comprises all the organizations, institutions and resources that are devoted to producing health action. Primary health care centre, a public institution of Govt. of Kerala, is the principal provider of PHC services in the area. The Primary Health Centre in the area is known for its non-availability of Medical Officers. The appointment of medical officers by the Health Department are seem to be routinely done. But this itself could not ensure the presence of medical officers at the centre. It is often said that doctors are not willing to work here. But many other staff members in the centre opine that the facilities of the health centre are poor and their attempts to improve the situation are failed by red-tapism of the government procedures. Recently a private practitioner in the area was willing to get provisional appointment in the health centre but was failed by the legislative procedures in public service commission (PSC) norms in the appointment of the government servants. Even attempt by the local MLA to get the procedures modified did not turn successful. This experience shows that not only the non-willingness of the doctors to work in the rural areas are affecting the health services in the area but there are legal procedures which cannot be easily sorted out even by the ongoing decentralization process in the State.

Whether regular presence of medical officers in the health centre will solve the health problems in the area is another question. 20% of the population in the area are schedule caste and schedule tribe people. As elsewhere they are the most vulnerable social section among the deprived sections in the area. The Primary Health Care Programme in the state does not seem to be tuned to the needs of the vulnerable sections of people. Apart from mass immunization programmes and fertility control measures implemented through Primary Health Centres no other Primary Health Care programme are seemed to be adequately covered among the deprived sections. A previous study by the author in the area under KRPLLD scheme shows that health promoting behaviours like seeking maternal and child health services are equally prevalent in both deprived and nondeprived sections, but hygienic practices are poor among the deprived. This is well in agreement with other studies in the area which showed that deprived sections in the area are also endowed with low accessibility to safe water and sanitation facilities. (Shilaja and Sujith, 2002).

The primary health centre of the State Health Service is not the only agency providing medical care in the area. Government Ayurvedic Hospital with in-patient facilities and one medical officer is there. There are two private clinics by modern medicine doctors in the area. One private hospital by Christian Missionaries is recently opened. Two or three Homeo practitioners and Ayurvedic practitioners are there. Few traditional healers are also there. Many people also consult doctors in near by towns - Kollengode, 5 to 10 kilometers away or Pollachi, 15 20 kilometers away. More severe and acute illnesses are taken to District Hospital at Palakkad or Medical College Hospital at Trichur or Private Hospitals in these towns.

Few voluntary health programmes are also in action in the area. Eye care programme by a private eye hospital in Madurai conducts Eye camps and

treatments are given free or at low cost. ' Knowledge, Water and Medical care for all' is a recently launched programme by another voluntary organisation in the area but coverage is not much. A Tribal Development Programme which intends to ensure drinking water facilities for 25 tribal settlements in the area (60% of the total tribal people) by 2003 by a World Bank aided project through Kerala Rural Drinking Water Supply and Sanitation Agency (KRWSA) of Government of Kerala is also in progress.

Inspite of all these government, private and non-governmental activities in the area few most striking features observed are that all these health activities do not cover the health needs of the deprived sections in the area. All health activities seem to be in non-co-ordinated manner and community involvement are found meager. If better co-ordinated with more community involvement the output with the same amount of health activities should have been better. Local panchayathiraj institutions can be the agency to tackle this incordination problems of the health care system in the area, if proper knowledge of the social process of health in the area is acquired.

In an area where 50% of the people are below poverty line market oriented private medical care is not-going to do health improvement in the area, especially of the deprived sections. Inefficiency of the public health care system also seem to be multiplied by the financial crisis of the State Government. So a review of primary health care in the area should suggest ways for improving the situation, especially of vulnerable sections. The present project proposed here was envisaged to look into the primary health care available in the area. This may lead to propose possible local actions that can contribute to the improvement of performance of the health care system in the area.

WHO (1992) proposes that primary health care review can be at seven levels - National, District, Health Centre, Community Health Workers,

Community Leaders and Household levels. " The main objectives of a review is to identify the strengths and weaknesses of a national programme in order to establish or adjusted priority and to make specific recommendations for future action" (WHO, 1992. P.3).

Aspects to be covered in a review of primary health care as outlined by WHO are:

"1. Health aspects

The health aspects involved an evaluation of the process, output and impact of the PHC programme from the health sector perspective, using various indicators that reflect the results in terms of health sector performance, health activities output with respective individual programme and the health impact.

2. Social aspects

The social aspects involve an evaluation of community involvement in health, including the influence of people at all levels in bringing about better health, the outcome in terms of community satisfaction and human resources development at the community level.

3. Intersectoral aspects

..... this includes an assessment of how the contributions of other sectors, such as agriculture and education, are affecting the health of the people". (WHO 1992, pp . 2-3)

In the proposed study review of Primary Health Care programme can be conducted at health centre, community health workers, community leaders and household levels as proposed by WHO (1992).

The review at **health centre level** shall be through structured questionnaire. This will include questions concerned with (1) demographic and other features of the catchment area - local health workers knowledge about the geographical and characteristics of the catchment area. (2) Organisations of health services - Are its activities co-ordinated and comprehensive ? . Are all the essential services being provided ? . Does the health centre meet the health needs of the area ? . How much attention is given to identifying and meeting the needs of the least healthy members of the local population. - Contributions of other sectors on health. - Level of community involvement. (3) Programme implementation - Are the national health policy document for their programmes available the health centre ? . Is there a written plan of work for the health care for the current year including a description of its activities and targets.

At the **community health workers** level, informations required will be obtained through a combination of observation and structured, but flexible dialogue with the workers. Separate questionnaires for junior public health care nurses, junior health inspectors (Grade I and II), health inspectors, lady health inspectors, health supervisors, lady health supervisors etc. can be used. The interview shall be concentrated on what they do, how well they perform, what is required to sustain and improve performance.

At the **community leaders** level. A choice will be usually be from among panchayat president, ward members, heads of local women's and youth organisations etc. Information shall be gathered through a combination directed discussions, a group interviews and observation of behaviour during the meetings as well as number of structured questions with limited number

of options for answers. The purpose of interview would be to determine what they perceive as priority health problems, what they do about these problems, and to what extent the community is supporting and contributing to primary health care and other health activities.

At the **Household** level. WHO (1992) opines that “ In PHC evaluations and other studies, household surveys are often the only reliable way to get crucial data for the population as a whole, such as indicators of health status, coverage of health services and essential PHC elements (e.g., immunisation, sanitation, water supply), use of health facilities” (p. 137). Informations from households shall be collected through structured questionnaire, posing questions to a well informed adult in the household during the house visit. Data will also be obtained from visual observation. Main types of issues considered at this level would be (1) social and economic determinants including intersectoral action and community involvement. This can help to identify the vulnerable or under served population in the areas of economic, educational or social development using indicators such as employment, literacy, agricultural productivity, wages or income level. (2) provision of health care - aspects to be considered as accessibility, acceptability, affordability, quality and utilisation of services as perceived at the household level. (3) health programme indicators - indicators related to essential components of primary health care will be considered - health education, immunisation, nutrition, maternal and child health and other programmes.

With these background of inadequacies of primary health care at Muthalamada and proposed ways of review of PHC by WHO, following objectives were formulated for this study.

Objectives of the study

Main objectives of the study proposed were :

1. To conduct a critical review of the concept of primary health care programme proposed by WHO, that is followed by Govt. of India and that is implemented by Govt. of Kerala.

2. To review the Primary Health Care programme implemented through primary health centre at Muthalamada.

3. To prepare an account of the health care practices in the area apart from the services provided by the primary health care centre.

4. To suggest measures to improve the performance of primary health care system in the area.

Hypotheses of the study

The first objective of the study is a critical evaluation of the concept of the primary health care programme uphold by WHO, Govt. of India and Govt. of Kerala. Underlying hypothesis of the exercise formulated was whether the proposed programme is capable of representing the health needs of the concerned people.

Review of the primary health care programme is based on the assumption that primary health centre in the area is bound to implement the PHC programme. So whether the level of performance of the PHC Centre in implementing the PHC programme is poor, especially for the care of vulnerable sections in the area was formulated that the hypothesis of the second objective.

The third objective of preparing an account of the health practice in the area other than PHC centre services is guided by the hypothesis that services of the primary health care by informal groups, non-governmental agencies, private agencies etc. are also rendering significant contribution to the primary health care in the area.

Fourth objective is guided by the hypothesis that community involvement in the PHC centre is poor at present and that better community involvement can improve the performance of PHC centre through local action.

The study proposed here is an evaluative study. No testing of specific hypothesis is intended. But any assessment of primary health care at household level presupposes the primary health care needs at households level. So whether primary health care needs of households are provided by the primary health care set-up in the area can be assessed. This would act as an underlying hypothesis guiding the study.

Method of study

Due to financial constraints the study proposed for one and half years duration was narrowed to a pilot study of 3 months. So the hypotheses testing by statistical methods are not attempted.

Complexities of the health process and abstract nature of concepts like health, suffering, well being, health action, health system, performance etc. make study of health systems problematic and calls for multiple methods. A participatory observation method is followed to get an account of health practices in the area. Some levels of perceptions and satisfactions are assessed through questionnaire

To familiarise the study area public contacts were established. Grama Panchayath officials were contacted and relevance of the study explained. Members of the voluntary organisations, anganvadi teachers and local leaders were contacted for personal discussions and to organise local group discussions. Focus group discussions were conducted at Chappakkad Anganvadi, Chulliyarmedu LP School and at Primary Health Centre, Muthalamada. Personal discussions were conducted with Nagaraj (Standing committee chairman for welfare, Muthalamada Grama Panchayath), Dr. Reetha (Medical Officer incharge of Muthalamada Primary Health Centre) and Vijayan (Health Inspector Muthalamada Primary Health Centre)

Data obtained from a previous study (Brahmaputhran, 2002) for measurement of the selected health promoting behaviours through a questionnaire survey at household level were re-analysed for this study.

The sample design adopted for this previous study mentioned was stratified random sampling of households. The universe consisted of all households in 1-12 wards of Muthalamada panchayath and strata used are deprived and nondeprived households. The overall sample size set was 60 households in each strata. List of households below poverty line as detected in socio-economic survey of Government of Kerala (1998) kept at Grama Panchayath Office served as the sampling frame for selection of deprived households. Sampling frame for nondeprived households were taken from list of households in Grama Panchayath excluding the below poverty line households. The households to be interviewed were selected from the households lists in each strata using systematic sampling with equal probability. A pilot study was conducted by visiting 10 households selected from these households surveyed for the previous study. (Questionnaire used for the pilot study is annexed.- Annexure No. 1)

First objective is approached through a conceptual analysis of literature regarding primary health care programme produced by WHO, Govt. of India and Govt. of Kerala and other critical thinkers of Primary Health Care.

Second objective of review of primary health care programme at Muthalamada is through a performance audit of the health centre and community health workers. Analysis of household level data collected for previous study (Brahmaputhran 2002) showing indicators of programme achievements compared at deprived and nondeprived households is analysed to test the hypothesis whether vulnerable sections in the area are served well by the primary health centre. Data collected through the questionnaire were used to construct a child care practice for each household in both deprived and non deprived sections.

Using the data obtained through interviews of PHC centre staff, community health workers, community leaders and households, third objective of understanding the health system in the area is achieved. Analysis of poor status of community involvement and identifying factors for it is done using the information obtained through previous study conducted in the area (Brahmaputhran 2002)

Section - 2

Findings of the Study

The Concept of Primary Health Care

The international conference on Primary Health Care held in Alma Ata in 1978 characterised the Primary Health Care programme as follows (W.H.O. 1978) "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

The contents of Primary Health Care is described by W.H.O document (W.H.O 1978) as follows

1. Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, bio-medical and health services research and public health experience;

2. Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. Includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors”.

This characterisation of Primary Health Care programme by W.H.O was elaborated in different ways by different authors.

Frits Muller views the acceptance of Primary Health Care strategy as a paradigm shift and determination of W.H.O in 1970's to lead the world health in an equitable way.

“Primary health care has been presented as an alternative paradigm in health. It is, but it was born differently from the paradigm changes described by Kuhn. This one was constructed and negotiated. The main motors were WHO and UNICEF. The former had to be expected, the latter played an unexpectedly important role in PHC all along.

Health was defined in Alma Ata as the capacity to live an economic and socially active life. That is quite different from a state of complete well-being. Health care had to be accessible for all, quite a contrast to the 70% of the world population which was outside the reach of healthcare at the time. It should be provided with support from the people themselves, this was also completely new. The first study on participation by WHO was done in 1975/1976, but was never published; moreover, it was part of development itself and therefore not isolated but inter-sectoral. Finally it was put into the context of reaching self-reliance and self-determination (WHO/UNICEF, 1978).

..... PHC was one of the many worldwide strategies that were born in that decade in the expectation that the world could be changed in a rational and equitable way. Worldwide strategies, global approaches were set”. (Frits Muller 1995. p.255)

Koos Van der Velden and Gilles R. de Wildet asserts that the adoption of Primary Health Care programme by W.H.O is a response to challenges of health inequalities existing in the developing countries: “Primary health care (PHC), as defined in the Alma Ata Declaration (WHO/UNICEF, 1978) was conceived as a response to the challenge in both South and North. It declared health as a human right, and, to advance towards the ambitious goal of health for all (HFA) by the year 2000, it proposed a radical and potentially revolutionary approach to meeting basic needs. PHC was conceived as a comprehensive strategy that would not only entail a people-centered approach to health services but would also address the social and political factors that influence health. Primary

health care would have to be an integral part of the social and economic system in society and the first contact of people with health care, which should be free and easily accessible. This health care should be close to where people live and work. Also, there should be a strong focus on promoting health. If health for all is to be achieved in the North by the year 2000, health promotion should be accorded equal importance with reduction of disease and its consequences (WHO, 1985). In short, effort, energy and resources should be deployed to:

- add life to years, by ensuring the full development, maintenance and use of people's integral or residual physical and mental capacity;
- add health to life, by reducing disease and disability;
- add years to life, by reducing premature deaths and thus increasing life expectancy".

(Koos Van der Velden 1995, p. 264)

The same authors also point out that Primary Health Care as a global strategy shifting from health to economics. "Since the Alma Ata Declaration, two approaches in PHC have developed in the South. These are the selective and the comprehensive approach and they have often been opposed. In the comprehensive approach, poverty and underdevelopment are seen as important causes of ill-health. In responding to these challenges, there is a strong emphasis on community diagnosis and solutions through community representatives and involvement of village health workers and other cadres. In the selective approach, health interventions, designed to resolve defined health problems, are selected on the basis of cost-effectiveness. The United Nations

Children's Fund (UNICEF) has played an important role in promoting selective primary health care. The World Bank has taken the emphasis on cost-effectiveness one step further. It sees keeping individuals and communities healthy as a means to promote economic development (World Bank, 1993). Werner (1993) turns the argument around. He proposes that one of the explicit purposes of economic policies should be the promotion of health". (Koos Van der Velden 1995, p. 265)

Imrana Qadeer is most eloquent critic of the way in which Primary Health Care is implemented in India. She has often tried to expose the politics of the acceptance of the concept of Primary Health Care. "A welfare state however, by its very nature, does not call into question the societal processes of creation and appropriation of wealth. It merely invests a certain proportion of the national surplus into welfare to harness its political legitimacy" (p.49). She has explained the background situation of this neglect of process of health as follows : " ----- World development over the 1960s and 1970s was characterised by two main features: the widening gap between countries, and the growing disparities within them. Alarmed by this situation, the World Bank's President (McNamara 1984) and the Willy Brandt Commission Report (Navarro 1984) gave a call to the 'enlightened of the world' to work for global solidarity and the mutual interests of the two 'blocks' of the world not capitalist or socialist but North and South. While the developed North was shown both the stick of a plausible 'break-down of the world order' and the carrot of expanded markets in the third world, the South was promised 'appropriate' aid and support for 'higher growth and greater productivity'. Neither of these documents made any mention of conflicts of interests between the two blocks nor the structural constraints that are at the root of the global inequity that they addressed. Thus, the interests of the powerful continued to guide the direction of development of the rest of the globe" (p.49). It is this political situation which compelled improvement of people's quality of life as an objective of PHC. " ----- --- An adhoc group of the Executive Board of the WHO on Promotion of National

Health Services warned that the resolution of the health crisis lay not only in the nature of the health care delivery system but also in addressing the wider existing social, economic and political structures which must be faced at once if destructive and costly reactions are to be averted (WHO 1975). This shift in focus provided the context for the Alma Ata Declaration of 1978. The declaration outlined a 'Health for All' strategy, in which PHC was not seen as elimination of disease by targeted technological means alone but as a complex of strategies that determined people's livelihood and quality of life. Intersectoral developmental linkages, equity, basic needs and people's participation were seen as the key instruments of PHC (WHO 1978)". (Imarana Qadeer 1999, p.49)

She has elaborately argued that in India Primary Health Care programme was accepted as a populist political strategy to hide the inequalities in health in India. "It was apparent by the 1970s that hi-tech medical care could not be made accessible to all, while the poor were rapidly getting disenchanted with inadequate/non-existent basic health care services. A series of schemes were introduced like feeding programmes, the Community Health Guide Scheme, the Multipurpose Workers Scheme, the integration of vertical programmes, and the Integrated Child Development Services. The most flaunted, however, was India's acceptance of the Primary Health Care Declaration of Alma Ata in 1978. It provided the government with the populist rhetoric it badly needed" (p.53).

" ----- Though India signed the Alma Ata Declaration in 1978 and pledged its implementation, the Sixth Five Year Plan made no mention of it. The programme of immunisation and later the child survival strategies were promoted, and Selective PHC silently became a part of health sector planning" (p.53). " ----- Within India's health sector, therefore, two trends are distinctly visible. One, original but frail, attempting to change the existing

balance, reach out to the majority, build basic infrastructure, and contextualise health within social and economic development (Government of India 1980). The other, more pragmatic, pushing Selective PHC and population control strategies in the name of Primary Health Care (ibid. 1994). The question that I propose to examine is does the World Bank's strategy tend to promote the latter?". (Imrana Qadeer 1999 p.53)

Marshall Marinker (1980) on describing the Primary Health Care as an organisational structure rather than an ideology narrated the history of General Practice in England. This interestingly reflects the contents of Primary Health Care in mid 19th century. "In England medicine was practiced by three influential professional groups: the physicians, the surgeons and the apothecaries. The surgeons and the apothecaries were both practitioners. They were not much concerned with scientia, that is to say with philosophical speculation. Scientia, in the sense of scrupulously careful observations, or of using the experimental method as a means of testing philosophical speculation, came later. The surgeons and apothecaries were concerned not with scientia but with arts, that is with technology, what Carlo Cipolla (1976) describes as artisan skills employed on the basis of empirical necessity. Of these two artisan groups, it was the surgeons who first exploited the possibility of applying intellectual techniques of enquiry, the new scientia, to the evaluation of their artisan skills. The structural situation of general practice made such a development more difficult. For all sorts of historical reasons, the general practitioner in the United Kingdom became increasingly banished from the hospital wards. The National Health Service Act of 1946 gave statutory expression to the fact that the specialist retained the hospital and the generalist retained the patient -----".

" The apothecary, part artisan and part shopkeeper, was the precursor of the general practitioner in England. Only twenty years before the Medical Act of 1858, the following notice was displayed at the window of an apothecary's

shop in Manchester : *Surgeon and Apothecary. Prescriptions and family medicines accurately compounded. Teeth extracted at one shilling each. Women attended in labour, two shillings and sixpence each. Patent medicine and perfumery. Best london pickles. Fish sauces. Bear's grease. Soda water. Ginger beer. Lemonade, Congrave's matches and Warren's blackening*".

What Nizar Ahamed said (Nizar 2003) about definition of health W.H.O is also true about the concept of Primary Health Care discribed by W.H.O. His criticism about definition of health was that it did not tell us about what to do to achieve health described as physical, mental and social well being. Similarly the concept of Primary Health Care programme elaborated by W.H.O does not tell us how to operationalise it to accomplish physical, mental and social well being of people over earth.

Primary Health Care at Muthalamada

Muthalamada is one of the largest panchayaths in Palakkad district. Many of the geographical peculiarities make the area conducive to healthy living. Of the total area of 375 sq.km, 301 sq.km is forest area situated in the Parambikulam hills and 74 sq.km is revenue land belonging to Palakkad Gap region-both belonging to Western Ghats. With rich natural resources of water, fertile soil and vegetation the area is gifted by cultivation of large number food crops. This should have compensated the economic backwardness of the area in achieving basic needs of food, water and shelter for all households in the area. But people in the area seem to have not achieved the political acumen to utilize the locally available resources for the common good of all. This is evident by the deterioration of natural wealth in the area and well being of the people there. Resource maping report 1999 of the area reports land and soil degradation and changes in the land forms in the area due to degradation of forest that might have happened since early fourties. Drying up of perennial streams arising from Nellyampathy hills and draining to Gayathripuzha were

also reported. Extensive use of pesticide for paddy cultivation is common in the northern parts of the area. Hormonal spray for flowering of mango trees is also getting wide spread since five years in south-western part. As there are not many industrial units in the area, and land population ratio being low, industrial pollution and environmental pollution due to household waste are not yet serious problem.'

A previous study on the area (Brahmaputhran 2002) reported the cultural factors making rupture in the social fabric of the area as follows. "All economic activities - farming, manufacturing, exchange of goods, transport and banking in the area are low scale. So, even property owning sections earn less and economic class divisions are less hostile. Trade Union activities are also next to nil. But cultural divisions of people produce some undercurrents. Cultural divisions in the area are mainly religious, castist and linguistic. Though no serious conflicts prevail between groups, social relations are comparatively more intense among cultural sub groups. But in real emergencies like acute illness in a neighbouring household, households among all sub groups extent support. In practical life, schedule caste and schedule tribe people are largely alienated. Settled in colonies with least facilities for drinking water, sanitation, power supply and poor housing, they are often at distant places from main roads, with their physical accessibility to markets and public Institutions. The incidence of their children attending anganvadies or high schools is low and dropouts after primary/secondary level schooling are also more common among them. Many tribal youth/adults are found going as agricultural labourers in the forest border areas there by missing their chances of social skill achievement for main stream life through interactions with their peer groups. Schedule caste and schedule tribe peoples are less entertained even at grama panchayath office and village office from where many of their constitutional benefits are to be obtained. Schedule caste people are often marked as quarrelsome and tribal people as lazy fellows seeking benefits only. These versions are repeatedly heard in offices and from public minds. As else

where neglect of the deprived is prevalent here also- thus maximising the economic, social and cultural deprivation of the deprived. It is not surprising that men among the deprived sections are found more alcoholic here also. Cultural divisions of the people in the area at present are nodes of invisible ruptures in the social fabric of the area, negatively affecting the social well being of the deprived people”.

Empirical evidence of some aspects of primary health care in Muthalamada

a. Pilot Study.

Ten Households (five each) selected randomly from 42 households with children (0-5 years) identified for a previous study (Brahmaputhran 2002) were visited and number of users of local primary health centre for maternal and child healthcare were enquired using a questionnaire (Annexure 1). It was found that all the households from deprived sections and some of the households from non-deprived sections were using the services of local primary health centre for maternal and child healthcare. So the data on maternal and child health from this study is reanalysed to look for empirical evidence of service utilization of primary health center in the area.

b. Maternal and child care practice score in the area :

Data obtained for a previous study (Brahmaputhran 2002) on health promoting behaviors in the area is reanalysed here for assessing maternal and child care practices in the area. Many of the maternal and child healthcare programmed are being implemented through the primary health centre in the area. So a maternal and child care practice score in the area may be a measure of maternal and child health services of the local primary health centre.

In the 59 deprived households there are 23 children aged 0-5 years (boys 16, girls 7) and in the 46 nondeprived households there are 19 children aged 0-5 years (13 boys and 6 girls). In order to know the level of maternal and child care practices in the area, informations or following aspects of maternal and child care collected through the questionnaire (1. antenatal checkups undergone 2. post natal care 3. Immunisation of children 4. early seeking of treatment for illness 5. nutritional care of children) were reanalysed.

1. Antenatal checkup of mothers: Antenatal care is essential for ensuring the well being of mother and the child. Level of antenatal checkups undergone by household with children aged 0-5 years is a measure of services provided by primary health center. Level of antenatal checkups undergone are given in Table1.

Table No. 1
LEVEL OF ANTENATAL CHECK UPS
AMONG HOUSEHOLDS WITH CHILDREN AGED 0-5 YEARS

*Percentage of households with children aged 0-5 years
showing level of antenatal care by study groups.*

Level of Antenatal Care	Deprived	Nondeprived
Total		
no specific measures traditional methods as advised by elders	30.43	0
visited doctor during illness	0	36.84
followed both doctor's advice and local knowledge	4.30	0
followed doctor's advice		2.30

correctly from the beginning	60.86	63.15	61.90
Total No. of households with children 0 - 5 years	23	19	
42			

(Source : Brahmaputhran 2002)

62 percentage of households in both sections had regular antenatal checkups by doctors. 30 percentage of deprived sections did not go for any specific antenatal care while 37 percentage among nondeprived consulted doctor only during illnesses.

2. Post natal care: Post natal care which is important for the health of mother and child is mainly provided by the primary health center in the area. Results of level of post natal care are given in Table No. 2.

Table No. 2

POST NATAL CARE OF HOUSEHOLDS WITH CHILDREN AGED 0-5 YEARS

Percentage of households with children aged 0-5 years

for levels of post natal care by study groups.

Levels of post netel care	Deprived	Nondeprived	Total
no special care done	86.95	0	47.61
traditional methods only	0	10.52	04.76
visited doctor during illness only 02.38	0	05.26	
followed doctor's instructions correctly	08.69	57.89	30.95

combined doctors instructions and Traditional method	04.34	26.31	14.28
Total No. of households with children 0 - 5 years	23	19	42

(Source : Brahmaputhran 2002)

Of the total 48 percentage of deliveries didn't have any specific post natal care. 14 percentage in both sections combined doctor's instructions and traditional methods. 58 percentage in nondeprived sections followed doctor's instructions only. Only 9 percentage in deprived sections had post natal care as advised by doctor. 87 percentage of deprived sections had no specific post natal care at all.

3. Immunisation of children: Immunisation of children is a well accepted health promoting activity provided by the local primary health center. Immunisation status of children aged 0-5 years in study groups are given in Table No. 3.

78 percentage of children have taken almost all vaccinations showing a better performance of the local primary health center in immunisation.

Table No. 3
IMMUNISATION STATUS OF CHILDREN AGED 0-5 YEARS

Percentage of households with children aged 0-5 years
for immunisation status by study groups.

Immunisation Status	Deprived	Nondeprived	Total
no immunisation done	17.39	10.52	14.28

some vaccinations taken	08.69	05.26	07.14
almost all vaccinations taken	65.21	15.78	42.85
all vaccinations available in govt.hospitals done	08.69	68.42	35.71
all preventive vaccinations done	0		0
0			
Total No. of households with children 0 - 5 years	23		19
42			

(Source : Brahmaputhran 2002)

4. Early seeking of treatment for illnesses in children :

Early seeking of medical treatment for illness especially in cases of children is a health promoting activity in a broader sense. It saves the child from complications, relieves anxiety of household members and provides more healthy days to the child. Modes of early seeking of medical treatment for illness of children are given in Table No. 4. As the first level contact point for treatment of illnesses of children local primary health center is well accepted especially by the deprived sections of people

TREATMENT OF ILLNESS OF CHILDREN AGED 0-5 YEARS

*Percentage of households with childrens aged 0-5 years
for treatment pattern by study groups.*

Treatment pattern	Deprived	Nondeprived	Total
will immediately take to doctor	78.26	84.21	80.51
will consult doctor if illness is not relieved	08.69	0	04.76
will consult doctor if not relieved by traditional methods	08.69	05.26	07.14
will treat according to nature of illness	04.34	05.26	04.76
only traditional methods are followed	0	05.26	02.38
Total No. of households with children 0 - 5 years	23	19	

42

(Source : Brahmaputhran 2002)

81 percentage of all households used to take the children immediately to doctor in cases of occurrence of illnesses. Only 2 percentage of households depend only on traditional methods.

5. Nutritional care of children aged 0-5 years:

Nutritional care in childhood period prevents a lot of illness and promotes mental and physical health in adolescence and later life. Nutritional education of mothers is an accepted function of primary health care by local primary health center. So measure of nutritional behaviour of households is an indicator of effectiveness of health education by local primary health center.

Table No. 5

NUTRITIONAL CARE OF CHILDREN AGED 0 - 5 YEARS

Percentage of households with children aged 0-5 years for pattern of nutritional care by study groups.

Levels of nutritional care	Deprived	Nondeprived	Total
usual home made foods given	78.23	31.57	57.14
special items like milk, eggs, green leaves are prepared for the child	17.37	15.78	
16.66			
available nutritious foods are brought specially for child	04.34	36.84	
19.04			
items chosen after consultation with doctor	0	15.78	07.14
any other new measures	0	0	0
Total No. of households with children 0 - 5 years	23	19	
42			

(Source : Brahmaputhran 2002)

78 percentage of households in deprived section give usual home made foods for children. In 37 percentage of nondeprived households nutritional foods are specially brought for child. 16 percentage of nondeprived used to consult doctors for choosing nutritional items for that children. All these show that nutritional awareness of households are poor in the area.

Table No. 6 gives a summary of maternal and child care practice score obtained for deprived and non-deprived sections in the area after reanalysing the data from table 1 to 5 above. This shows ante natal care services and

treatment of children during illnesses are widely used from primary health centre. Use of immunisation is above average. Poor nutritional care score can be an indicator of poor nutritional awareness services.

Table No. 6
MATERNAL AND CHILD (0 - 5 YEARS) CARE PRACTICE SCORE.
(Score Range 1-5)

Items	Deprived n = 23	Nondeprived n = 19
Level of ante natal care	3.5	4.2
Level post natal care	1.2	3.2
Immunisation status	2.6	2.9
Treatment of illness of children	4.5	4.5
Nutritional care of children	1.3	2.9

(Source : Reanalysis of data from Brahmaputhran 2002)

Social participation household heads :

In the previous study mentioned social participation of household heads were measured by scoring method. This is reanalysed here to look for social health in the area.

Social health of individuals is usually defined as "that dimension of an individual's well being that concerns how he gets along with other people, how other people react to him and how he interacts with social institutions and societal moves" (Page 122 Ian McDowell 1996). Level of social participation in

this sense is an indicator of the social well being of household members and are health promoting behaviours. Measures of social participation considered in this study are 1. level of participation in social gatherings and functions 2. Social activities other than occupation 3. level of participation in Grama Sabha meetings 4. level of social support received during difficulties in family 5. level of participation in trade union activities.

1. Level of participation in social functions/gatherings : Participation of household members in social functions like marriage, death ceremonies or other gatherings is a clear indication of social integration of the household members and hence a health activity.

2. Area of social activities other than occupation : All most all adults are forced to involve in an occupation for livelihood of their families. Involvement in social activities other than this is a social necessity rather than a personal preference indicating social concern and can be health promoting to him and his household.

3. Level of Participation in Grama Sabha: Regular active participation in Grama Sabha is an indication of awareness of citizenship and concern for a better social life. It is also the occasion where local solutions for local health problems are sorted out and rules of allocation of health resources are formulated. So this is important for the health action by households.

4. Levels of social support received by households: Many of the problems arising in households require help from others. Level of such supports received during difficulties in the family is an indication of the integration of

the household members with society and hence is an indication of health behaviour.

5. Level of participation in tradeunion activities: As most adult members are involved in any one of the occupations and trade union activities being prevalent in Kerala, level of participation in tradeunion activities should be an indication of social integration of the adult members in the households. Also many of health welfare measures are channalised through trade unions. Hence level of involvement in trade union is important for healthy living.

Scores obtained for various forms of social participations are given in table 7. The table shows that levels of social activities other than the occupation, social support during difficulties and trade union activities are very poor in both sections. All these show a poor social participation in the area which indirectly indicate poor social health in the area.

Table No. 7
Social Participation Index Score

forms of Social Participation	Average score obtained (score range 1- 5)		
	Deprived n = 59	Nondeprived n = 46	Total n
=105			
level of participation in social gatherings and functions	3.6	3.8	3.7
social activities other than occupation	1.4	1.6	1.5

level of participation in Grama Sabha	3.4	3.5	3.5
Level of social support received during difficulties in family	1.7	3.5	2.7
level of participation in trade union activities.	1.2	1.7	1.5
Average score	2.3	2.8	2.6

(Source : Reanalysis of data from Brahmaputhran 2002)

Section 3 Discussion

Muthalamada is one of the largest Panchayaths in Kerala. No health indicators like infant morality rate, life expectancy etc. specific to Muthalamada are available. So in terms of conventional health indicators the area can be considered as having an average health status of Kerala. Does this mean that Muthalamada have no health problems today or the performance of local health system is good ?.

It is well known that the indicators of health which are sensitive to large population need not be a good indicator of health of a population like 50,000. And also the indicators like infant mortality rate and life expectancy need not indicate all the attributes of health. The sufferings endured by groups of people in a locality may not be captured by infant mortality rate and life expectancy

unless there is war like situations. So also absence of signs of social unrest is not an indicator of healthy living. Similar is the state of health in Muthalamada. Physical indicators of health remaining satisfactory social suffering as indicated by poor social participation is persisting. Is this argument a strategy for winning the argument, that is, shifting the premises of the subject health ?. No, because attributes of health here considered are creative process of ensuring survival, growth and well being in an area.

Giving these attributes of ensuring survival, growth and accomplishing well being to health is like conceiving health as a process and health system as a social sub system. In these terms of health Muthalamada is not yet a place of healthy living. The suffering experienced by each household in accomplishing life is every where. Every moments of or most of the moments of life, let it be for the rich or poor, have become a struggle with the fellow beings. Earning a livelihood by a worker or a businessman has become a competition by which suffering is the often experience. No households in the area caring of their children and older ones are without burdened by financial constraints. Learning by every children at school has never become an experience of joy. Seeking medical treatment is an experience of suffering due to subjugation by medical rationality or exploitation rather than being cared. Neither for the poor nor for the rich home is a place of joyful togetherness or bliss of loneliness. Social life, as elsewhere, have made most of the moments of life for most people in Muthalamada a source of suffering.

Depending on the logic of practice expressed by the agents in the social process of health in Muthalamada they can be identified as follows. (1) Govt. with the declared goal of welfare of people or improving the health status of people. But most often its rationality is directed by objectives of other powerful agencies in the field. For example, the programme of fertility control is dictated by the international agencies. (2) Profit seeking private firms doing the service with the logic of profit operating from neighbouring urban areas. So their

services are available only to the health needs from which profit is ensured. (3) Charitable Organisations with the egalitarian objective of improving health for all but with the logic of dominant biomedical model and selective in approach. (4) Health Care providers positioned in all the above three practices at different levels like doctors, paramedical, administrators etc. are mainly keen on keeping their status of power and maximising their interests. (5) Households which are truly struggling with the logic of well being of all its members. But their selflessness do not reach beyond their households. Practice of none of these agents are tuned with the definition of health accepted here as human action accomplishing well being. So the local health system is a site of conflicting interests resulting from intersections of power exerted by different agents with different interests.

If health is conceived as life without sufferings none other than the agency of people is capable of accomplishing health. This is because health is the out come of various interactions by human beings internalise with the idea of some form of well being. So the agency of health lies not in isolate human beings but in multitudes of human being at every moments. But when does a human being become an agency of 'people' for accomplishing health ?. People is not a mere collection of human beings. It is a group of human beings identified or internalised with certain legitimate rules of behaviour for accomplishing a project of common good. So the agency of people for accomplishing health is a group of human beings well informed about realising a well thought out conception of health. Details of this conception, identification and conditions of formation of this agency of people have to be well understood by the people for the better performance of the health system in an area.

The World Health Report (2000) also emphatically state the central role of people in a health system. "The World Health Report (2000) of World Health Organisation (WHO) (2000) *"Health systems : improving performance"* defines a health system to include all the activities whose primary

purpose is to promote, restore or maintain health. (p.5) 'Formal health services, including the professional delivery of personal medical attention, are clearly within these boundaries. So are actions by traditional healers, and all use of medication, whether prescribed by a provider or not. So is home care of the sick, which is how somewhere between 70% and 90% of all sickness is managed. Such traditional public health activities as health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement, are also part of the system. Beyond the boundaries of this definition are those activities whose primary purpose is something other than health - education, for example - even if these activities have a secondary, health - enhancing benefit. Hence, the general education system is outside the boundaries, but specifically health - related education is included. So are actions intended chiefly to improve health indirectly by influencing how non - health systems function - for example, actions to increase girls' school enrollment or change the curriculum to make students better future caregivers and consumers of health care'. (p.5). The world health report 2000 also recognizes the central role of people in the health system but not only as recipients of health services. "At the center of service delivery is the patient, in the case of clinical interventions, or the affected population, in the case of non-personal public health service. People are also consumers, because they behave in ways that influence their health, including their choices about seeking and utilizing health care'.(p.50). The basic tenants of ethical provider-patient relations usually include 'respect for persons'. People's choice about seeking care depends on this, thus making "responsiveness" of the system an intrinsic value and objective for it. 'People also play the role of contributors to financing the system. Millions of poor people pay for all of the services they receive at the time they are ill. In health systems with fairer contribution arrangements, people who are not sick contribute most to financing the health system, through taxes for health insurance contribution, so that the contributed may or may not be the patient or the consumer. Finally, as

citizens - particularly as officials whose job it is to represent citizens and protect their interests-people participate in the system as stewards'.(p.51).In order for the system to perform well, people have to play all these roles in order for the potential benefits for each the patient and populations at the center. 'People act as providers, consumers, contributors and stewards of the health system during their adult working lives. In contrast, they can assume the roles of patients at any time from before birth right up to death'. (p.51)

The central role of people identified by W.H.O (2000) in health system is not easily achievable. The agency of Govt. always being influenced by elite groups in the system all its investments made are only capable of reinforcing the hierarchical relation between elites and people. By this, majority of people are made recipients rather than actors in system. Private firms driven by the logic of profit will be alien to people's well being. Households' concern have not yet outgrown into concern of all people's well being. Voluntary organisations also have no conceptions of their own in accomplishing people's well being. The existing primary health care practise arising all these agencies can never accomplish health for all in the area as their premises of action are antagonistic.

If this central role of people in a health system is accepted and poor social participation identified in the area is true the problem in the local health system in Muthalamada is that it has not identified the problems of health in the area and the agency involved in solving the problem. No health education is taking place in the area to help the people in regaining the central role of people in health system as proposed in WHO Report (2000). If the central role of people have to be regained in order to improve the health system performance investment of resources like knowledge and things should be more on people rather than on professionals, thus reinforcing the hierarchy of health care providers over people. People should be made to recognise the role of people's health praxis in improving the health system performance. Because it is

through their interaction with fellow beings with the intentionality of health that a health system is constituted (Nizar Ahamed 2003). So informed action by people alone can accomplish the well being of all the people in the area.

Section 4

Conclusions and Recommendations

The concept of health as curing the bodily ailments and control of population growth is the principle guiding the present primary health care system in the area. This approach keeps away many issues of health in the local area - both positive and negative aspects-for consideration as health activities. The fact that local planners, medical professionals and other health care providers are holding this approach make them fail to comprehend the sufferings happening in the area. The existing primary health care practice can seldom accomplish well being of all people in the area.

A detailed plan of the idea of people's health praxis in which people themselves recognise their central role in local health system has to be worked out. For this, fundamental issues giving rise to suffering in human interactions have to be understood by each agents involved in the interactions giving rise to health system or any social system. As a beginning some fifty people including both formal health care providers and health activists should be trained in people's health praxis for preparing a detailed plan of action. Five members from each neighborhood group should also be equipped for people's health praxis. This should result in a local health system in which each human agent is aware of the genesis, reproduction and conditions of overcoming suffering taking place in the area.

In an area like Muthalamada where most people are oppressed economically, socially and culturally for long years, people's recognition of their central role in constituting health system may take years of time. This also

needs continuous effort of training individuals from deprived sections of people in the area by experts committed to people's health praxis.

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