(1974)

DEMOCRATIC DECENTRALISATION AND PEOPLE'S PARTICIPATION IN HEALTH PROJECTS: A STUDY OF THREE PANCHAYATS IN KANNUR DISTRICT

Dissertation submitted to the Jawaharlal Nehru University in partial fulfillment of the requirement for the award of the Degree of

MASTER OF PHILOSOPHY

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19 July 2002

CERTIFICATE

This dissertation entitled **"Democratic Decentralisation and People's Participation in Health Projects: A Study of Three Panchayats in Kannur District"**, is submitted in partial fulfillment of the degree of **Master of Philosophy** of this University. This dissertation has not been submitted for any degree of this University or any other University and is my original work.

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Good ideas can get corrupted, distorted beyond recognition, and in the process destroyed. This has happened to many good ideas, which have been hijacked by the wrong people and then undermined in actual operation.

- Rajni Kothari

CONTENT

ACKNOWLEDGEMENTS

I am greatly indebted to my Teacher and Supervisor Prof. GHANSHYAM SHAH for his constant inspiration and help throughout the study. His scholarly suggestions at every stage have led to the improvement of my work.

My sincere acknowledgements are also due to Dr. K.R. Nayar for his support and inducement. I express my gratitude to Dr. Rama V. Baru, (Chairperson, CSMCH.) for rendering valuable help to carry out the study. I again acknowledge my indebtedness to all other faculty members. I am also grateful to Mrs. Muni Devi Rastogi (Documentation Officer) for providing helpful assistance.

I would also like to thank all the PHC Medical Officers, Staff, Panchayat Presidents, Panchayat Staff and Members and above all the people for their support and cooperation.

I am thankful to the following institutions ISS, New Delhi, NIEPA New Delhi, NIPFP New Delhi, AKG Centre for Research and Studies, Thiruvananthapuram and CDS Thiruvananthapuram for allowing me to use their library.

With gratitude and affection I acknowledge the help of all those who encouraged and inspired, shared ideas and materials, and engaged in discussion. I owe a special debt of gratitude to Mr. Vinoj Abraham and Cheri Jacob. K.

New Delhi,,
19.02.2002.

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LIST OF ABBREVIATIONS

BJP	-	Bharatiya Janata Party
CPI	-	Communist Party of India
CPI (M)	-	Communist Party Of India (Marxist)
DEC	-	Diethyl Carbomizine Citrate
DMO	-	District Medical Office
ESI	-	Employees State Insurance
ICMR	-	Indian Council of Medical Research
ICSSR	-	Indian Council of Social Science And Research
KPR	-	Kerala Panchayati Raj Act
LDF	-	Left Democratic Front
LSGIs	-	Local Self Government Institutions
NGOs	-	Non-Governmental Organisations
NFHS	-	National Family And Health Survey
OBC	-	Other Backward Caste
PHC	-	Primary Health Centre
PRIs	-	Panchayati Raj Institutions
SCs	-	Scheduled Castes
STs	-	Scheduled Tribes
SPB	-	State Planning Board
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations Childrens Fund
WHO	-	World Health Organisation
WTO	-	World Trade Organisation

LIST OF TABLES

LIST OF MAPS

CHAPTER I

CHAPTER I

INTRODUCTION

Health status of a community is closely related to the living conditions and livelihoods pursued by the people. Larger economic and political factors at societal level play an important role in determining status of health of a community. The involvement of the community is a crucial factor in the realisation of the goal of health for all. This involvement or community participation is possible through decentralisation of power and resources in all aspects of development. The 73rd and 74th amendment of the Indian Constitution has paved a strong constitutional base for the democratisation of power and resources to the people in order to plan and implement their needs.

Democratic Decentralisation

Centralised planning process can be criticised at various levels. An indifferent attitude towards regional issues, failures in achieving proclaimed goals, the complexity of religion, caste, size of the geographical area, the presence of different ethnic groups, linguistic diversity, regional disparity and the implicit requirements in growth with equity policies accentuated decentralisation as a key factor in development. In centralised planning, the people do not have any direct role in the national or sub-national government implemented programmes. They have no scope to intervene in accordance to their needs, objectives, strategies and resources. But democratic decentralisation, "implies people's right to initiate their own projects for local well-being and the power to

execute and operate then in an autonomous manner. It is thus wider than administrative decentralisation and the vital point of difference between the two lies in their purposiveness, the former laying stress on people's participation and the latter on efficiency".[1]

The arguments against centralised control and planning have mainly come from two schools. viz liberal interventionist and radical populist. Radical populists look at development from below. They focus on the people and they are concerned with political decentralisation and the empowerment of the people. And so they look political decentralisation for fundamental change. That is to say, they consider decentralisation and democratisation as together. Liberal interventionists argue for decentralisation as a means to improve government performance. They consider decentralisation as an administrative strategy and argue that decentralisation and participation is an instrument of development.[2] The common eclectic, a mixture of ideas drawn from the two schools, views decentralisation as "a public policy of the central government aiming to speed up development by meeting local needs more quickly through politically empowered local governments. It avoids red-tapism and corruption, makes administration efficient, quick, flexible, accountable and responsive, brings the government closer to the people, enables political and administrative penetration of national policies, improves link between demand and supply of public goods, and facilitates better mobilization of local

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[1] Narain, Iqbal (1963): ***Democratic Decentralisation: The Idea, The Image, and the Reality***. India Journal of Public Administration. Vol. 9, No.1, p.11

[2] Westergaurd, Kirsten (1983): ***Introduction to the Debate on Decentralisation and Participation***. Centre for Development Research, Copenhagen.

resources".[3] The proponents of decentralisation consider it as an essential tool for development. This is because decentralisation encourages and emphasizes the people's right to be involved in the planning and implementation of developmental programmes that are at variance with the nationally preferred ones. The report of the Working Group on District Planning says, "Decentralisation enables a better perception of the needs of local areas, makes better introduced decision making possible, gives their development and welfare, enables the felt need of the people to be taken into account, ensures effective participation of the people and build up self-reliance by mobilizing resources of the community in kind or money, making development self-sustaining, and enables better use of local resources and growth potentials of the local area for improving productivity and increasing production".[4]

Decentralisation may be presented and debated in the technical language of administrative efficiency or constitutional principles. But what has to be noted is that they reflect the conflict of interest between social groups, which feel that they have something to gain or lose in the restructuring of local institutions, in the delegation of power to them or in the redefinition of areas.[5] Usually decentralisation is considered as a process in which resources, functions and authority are transferred from the centre to the periphery, with decision-making

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[3] Gurukkal, Rajan (2000): ***Coalition of Conflicting Interest and the Politics of Decentralisation: A Theoretical Critique***. Paper presented at the International Conference on Democratic decentralisation, State Planning Board, Trivandrum.

[4] GOI. (1984): ***Report of the working Group on District Planning, Planning Commission***. New Delhi, p.22.

[5] Smith.B.C. (1985): ***Decentralisation –The Territorial Dimension of the State***. George Allen and Union, London.

largely vested with the people at the latter level.[6] Or we can say that it is 'the transfer of authority, or dispersal of power in public planning, management and decision making from the national level to sub-national levels, or more generally from higher to lower levels of governments like local self government institutions.[7] However, the issue of decentralisation is more complex in its concepts and practices. The terms **deconcentration, delegation, devolution, and privatisation are** understood differently with the generation of varied meanings in relation to decentralisation.

The **deconcentration** model involves the transfer of administrative power rather than political authority from centre to periphery. It is the least extensive form of decentralisation. Even with its limitations it improves efficiency within the managerial process. The **delegation** model involves the transfer of managerial responsibility for defined functions to organisations, which are outside the national or central government structure and are indirectly, controlled. The next model, **devolution,** is very often considered as the most important model. It is the ideal form of decentralisation. It strengthens sub-national levels of government to a great extent, with a defined set of functions. The purest form of devolution has different essential characteristics in relation to the set up of local self-government. Devolution ensures autonomous and independent bodies, legal and recognised geographic boundaries, institutional

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[6] Mills,Anne; Vaughan J; Patric, Smith; Duane; and Tabizadeh, Iraj (ed.) (1990): ***Health System Decentralisation Concepts, Issues and Country Experiences***. WHO, Geneva.

[7] Rondinelli, A Dennis (1983): "*Implementing Decentralisation Programme in Asia - A Comparative Analysis*", ***Public Administration and Development***, Vol.3, pp.181-207.

status and their own sources of revenue and budgets to perform their functions, public services to meet its needs as governmental organisations, and mechanisms of relationship and co-ordination among different levels of government.[8] But at the same time national intervention and necessary integration exists as it is. The most controversial and debatable model of decentralisation is **privatisation**. This involves the transfer of government functions to voluntary organisations or to private profit making enterprises. The controversy arises from the change of ownership between the public sector and the private sector. In decentralisation, the transfer of power is made within the public sector but in privatisation the transfer is to an individual or group having interests.[9]

Decentralisation and Panchayati Raj

In India, the concept of decentralisation of power began during the colonial rule itself. Lord Mayo's resolution of 1870 is considered as the first attempt to form local self-governments. Ripons resolution of 1882 and Royal Commission's report advocated decentralisation. But all these were only at the administrative level. Later, the Montegue-Chelmsford report and the Government of India Act, 1919 and 1935 introduced representative governance at local level.[10]

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[8] Cheema.G.S, and Rondinelli. (1983): ***Decentralisation in Developing Countries***. Sage. New Delhi.
[9] Collins.C and Green (1994): "Decentralisation and Primary Health Care: Some Negative Implications in Developing Countries". ***International Journal of Health Services***. 24 (3), pp.459-75.
[10] Jha S.N., Mathur P.C. (ed.) (1999): ***Decentralisation and Local Politics***, Sage, New Delhi.

If democracy in our country does not reach the grassroot level, where the real India lives, it neither could be true to its conception nor proper to its perception.[11] Even Gandhi endorses this perception. "Real Swaraj will come not by the acquisition of authority by a few but by the acquisition of the capacity by all to resist authority when it is abused".[12] To achieve the goals of democracy it should incorporate all sections of the people irrespective of social and economic conditions in the process of planning and in the implementation of developmental programmes.

The idea of democratic decentralisation is sought to be materialised through Panchayati Raj institutions, but these institution would be successful only if it is associated with local planning rather than working as an agency of the centralised development administration. This is because in a large country like India with a population running into millions, where power is concentrated with the national and state level governments, the role of the people is limited to their voting power. Panchayati Raj institutions did not succeed because of bureaucratic laxity, the lack of resoruces and the issues between the sub-national and national level governments (Ashoka Mehta Committee Report, 1978). Because of the poor social and economic conditions, the caste system, religious conflicts, the lack of basic amenities, etc., people could not realise the intended objectives of Panchayati Raj Institutions. Besides, the reluctant attitude of the officials to the elected members, the inadequate provision of

[11] Sharma, Sakunthala (1994): ***Grass Root Politics and Panchayati Raj***. Deep and Deep Publications, New Delhi.
[12] Gandhi, M.K. (1925): ***Young India***. 29.1.1925.

resources and the irregularities in the panchayat level election affected participatory planning. According to EMS Namboodiripad, "the basic reason for the alienation of the people from development planning is the class framework of development and the class bias of the development potentials".[13]

In India, parliamentary democracy or formal democracy is based on representation and not on participation. As has been said earlier this means that people's participation is limited to there voting power, that too once during every five years. Other than this exercise, they remain passive and helpless. In this context, democratic decentralisation provides power to the people and make people more active and responsible citizens. It implies that "people can be involved not merely in making demands but in taking decisions on how to improve their lives and their communities".[14]

Democratic decentralisation is possible through institutionalisation and peoples participation. In Panchayati Raj, power is expected to disperse among all voters, and they are supposed to participate in decision making and implementation.[15] Their level of participation may vary according to the various social, political and cultural factors. Even if all people participate in the decision-making and implementation process, it is limited in accordance with the power and resources of the local body. It is clear that decentralisation is

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[13] Namboodiripad, E.M.S. (1989): ***Panchayati Raj Bill and Decentralisation*** (Malayalam). Paper presented at Association of Panchayat Presidents, Thiruvananthapuram.

[14] Thomas Isaac, T.M. and Franke, W. Richard (2000): ***Local Democracy and Development - People's Campaign for Decentralised Planning in Kerala.*** Left Word Books, New Delhi. p. 7.

[15] Narayan, Jaya Prakash (1961): "Decentralised Democracy: Theory and Practice". ***International Journal of Public Administration***. Vol. VII, No. 3, July-Sept.

neither a substitute to centralised planning nor an exclusive bottom-up process of planning. There are many realms like defence, foreign policy, foreign trade, and industrialisation and key infrastructural development that can not be handled at the local level. So we can say it is a two-way process which begins at the top level as well as at the grassroot level simultaneously. They merge with each other at a point below which centralised planning becomes irrelevant and above which micro planning is meaningless.[16] But the outcome of any decentralised plan is determined by the role of the central/national government, the local power structure, people's participation and its nature, the availability of resources and the relationship between the national and local governments.[17]

To attain the goals of decentralisation, it should be combined with democratisation, so as to provide more equity and opportunities for mass participation. The integration of lower level plans into various upper levels, the institutional framework for local level planning, the local power structure, and financial autonomy are the major issues in decentralisation. In order to sort out these issues the Panchayati Raj system can be considered as an important strategy. The extension of democracy is possible through Panchayati Raj system and it should operate through a two-way system of political linkages

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[16] Thapliyal, B.K. (1990): "Decentralised Planning: Concepts, Scope and Methodology." ***Journal of Rural Development.*** Vol. 9, (6), p.996

[17] Harris, John (2000): ***The Dialectics of Decentralisation. A Note Based on Comparison of Some National Experiences. Paper presented in the International Conference on Decentralisation.*** 23-27 May, Trivandrum, State Planning Board, Kerala.

from bottom to top and vice-versa.[18] The question of national integrity and stability are the major fears in relation to the implementation of decentralisation. This fear of a possible counternationalism is baseless. When people get a share in decision making and implementation, it strengthens the relationship between the different regions within a nation. The proponents of decentralisation again argue that decentralised government is a semi-dependent organisation that provides more opportunity for people's participation and so it gets sufficient feed back from the people, which pave the way to development.[19]

World Bank and Decentralisation

The idea of Gramaswaraj, participatory planning and decentralisation are very old in the developmental discourse. But in 1980s, especially after the Structural Adjustment Policy (SAPs), all these concepts got wide spread attention. Because SAPs, implemented by World Bank, "emphasises on deregulation of central government activities, privatisation of state assets, curtailment of subsidies on some basic services".[20]

The World Development Report in 1999 says, "a government has not decentralised unless the country contains autonomous elected sub-national governments capable of taking binding decision in at least some policy

[18] Jha.S.N, Mathur P.C Op.Cit.
[19] S.S. Meenakshi Sundaram, (1999): "Decentralisation in Developing Countries" in Jha S.N., Mathur P.C. (ed.) ***Decentralisation and Local Politics***, Sage, New Delhi.
[20] Schurman, J, Frans (1997): "The Decentralisation Discourse: Post Fordist Paradigm or neo-liberal, Cut-de-sac?". ***European Journal of Development Research***. 9 (1) June, p. 153.

areas".[21] The proponents of democratic decentralisation do not agree with the World Bank's approach to decentralisation. They argue that the World Bank's model of decentralisation will not be of any positive benefit to the underprivileged and marginalised communities. They point out the example of the World Bank's advocacy for a basic package of essential health services instead of comprehensive health services.

There are some basic differences between the World Bank's 'decentralisation' and the preferred concept of 'democratic decentralisation'. This difference is very clear in the people's planning programme in Kerala. The World Bank's call for down sizing the role of governments is to execute its ultimate aim of privatisation and marketisation of the economy. Democratic decentralisation in Kerala tries to make the government's role more democratic and to strengthen the local self government institutions (LSGIs). Democratic decentralisation does not oppose the 'market', but it controls the market through LSGIs. The World Bank and its decentralisation programmes always induce the government to withdraw from its welfare programmes and give all responsibility to the common people. But in democratic decentralisation the burden of responsibility is not with the people. Here, the government devolves plan fund and administrative power to the LSGIs. For the World Bank, the concept of participation is limited to some individuals and NGOs. But

[21] World Bank (1999): ***World Development Report***, p.108

democratic decentralisation ensures participation from all sections of the community in the process of planning and implementation.[22]

Structural reforms that include the redistribution of power and opportunities, the availability and accessibility of basic requirements, and the removal of communal as well as regional issues are very important to achieve the goals of decentralisation. In addition to this, decentralisation has to be conceived as an exercise in providing rights to the people, "to those who have had no rights and entitlements or from whom these have been snatched away as a result of capitalist development and adoption of inappropriate technology and the penetration of urban interest as well as projects proposed by multinationals, the World Bank and other agencies". [23]

The concept of decentralisation became a political as well as a social necessity because of the failures of centralised planning and the challenges in the context of globalisation and liberalisation. To formulate a counter strategy against these challenges, the concept decentralisation which "has to be conceived as providing a total model of social, economic, political and cultural arrangement as a conception of organising civic life and as a philosophy that informs the functioning of the institutions, policies and programmes that impinge upon the lives of the people".[24]

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[22] State Planning Board (2000): ***People's Planning - A Study Book*** (Malayalam), State Planning Board, Thiruvananthapuram.
[23] Kothari, Rajni (1989), "Decentralisation: The Real Issue". ***Seminar***. August, p. 18.
[24] Ibid. p. 19.

Decentralisation in Health

Health, in its social context, cannot be achieved only through health services, which are separated from other developmental aspects of the community. Infact, the developmental and health issues of a community are not separate entities - they are complementary. Health planning in India has failed to distinguish between health and health services. More specifically, it has not considered 'social well-being' as the WHO has defined it.[25] Poverty, unemployment, and lack of basic requirements lead to health problems and it affects the development of the community. In order to check this to an extent, democratisation of a country and the involvement of democratic institutions is inevitable as they form the cornerstone of community participation.[26]

The Bhore Committee (1946) and the Srivastava Committee (1975) points out the importance of community participation in their study reports. The Health Survey and Development Committee (Bhore Committee) suggested that, in order to ensure the maximum benefit to the people, health services should be located as close to the people as possible.[27] With the broad principle 'people's health is in people's hand', on the basis of Srivastava Committee,[28] the Government of India implemented Community Health Works Scheme in 1997.

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[25] Banerjee, D. (1985): ***Health and Family Planning Services in India - An Epidemiological, Socio-cultural and Political Analysis and a Perspective***. Lok Paksh, New Delhi. p.368

[26] Ibid. p. 391.

[27] Government of India (1946): ***Health Survey and Development***. (Bhore Committee), Delhi, Manager of Publications.

[28] Government of India (1975): ***Group on Medical Education and Support Manpower*** (Shrivastava Committee). Ministry of Health and Family Planning, New Delhi.

(Later it became Community Health Volunteers Scheme/Health Guidance Scheme). However, due to lack of proper evaluation and appropriate political interventions, the scheme became a failure.

With the Alma-Ata declaration (1978) primary health care was seen as based on the people rather than a pre-determined system with equitable distribution, community participation, appropriate technology and inter-sectoral co-ordination as its defining principles. In the conference, WHO/UNICEF defined primary health care as "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". (WHO, Alma-Ata, 1978).[29]

Decentralisation in health helps to reduce inequality between different regions in both health status and the provision of services through the reallocation of central resources. Thus, it can eliminate centralised control over local and administrative matters.[30] Without a grassroot level attempt with more power to local self governments and community participation, we cannot improve public health, especially when it is a major governmental and social activity, multidisciplinary in nature and extending to all aspects of the society. Here the

[29] WHO, UNICEF (1978): ***Primary Health Care-Report of the International Conference on Primary Health Care***. Alma-Ata, USSR.pp34-35

[30] Mills,Anne; Vaughan J; Patric, Smith; Duane; Tabizadeh, Iraj (ed.) (1990), Op. Cit.

key word is 'health' and not 'medicine'.[31] Besides, public health gives its emphasises on social groups, privileges the role of the community in planning, implementation and utilisation of health services.[32] The participation of the people in health planning and implementation help to chalk out health programmes according to the felt need of the people. Their involvement is assumed to awaken health consciousness, and hence it empowers them to seek their rights for better health.

The ICSSR/ICMR in its report pointed out that 95 to 98 percentage of all preventive, promotive as well as curative health care can be undertaken within the 100,000 population level in a decentralised people-based health system.[33] It again argues that "the present view is that the goal of 'Health For All' can only be reached through the fully democratic process; it must be a programme of health for the people, health of the people and health by the people. This new approach to health cannot be implemented in a centralised political system where a few experts take all the decisions on behalf of people and the bureaucrats implement them. It is therefore, necessary to abandon the existing centralised and top-down approach to the organisation of health services and create a new system of building from below with community based health services. This will be possible in a democratic, decentralised

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[31] Rifkin S. (ed) 1977: ***Editorial. Community Health in Asia: A Report on Two Workshops***. Christian conference of Asia, Singapore, pp.9-24.

[32] Navarro.V (1977) : ***Social Security and Medicine in the USSR, A Marxist Critique***. Letxington Books, p.65.

[33] ICSSR and ICMR (1981): ***Health for All: An Alternative Strategy***. Indian Institute of Education, Pune.

and participatory system of government in which the people in a community have the authority, resources and expertise to prepare and implement all plans for their welfare including health".[34] The community participation at various levels can seek out and solve health problems. Subsequently, the people can avoid the existing unhealthy conditions and poor health services. But without a social consciousness, having the involvement of the people in health related planning and implementation would be a meaningless exercise.[35]

The benefit of decentralisation and people's participation is influenced by different factors. Amongst these, the type of decentralisation, the nature of participation, and the social and political background of the community and the role of government are very important.[36] The experiences of various countries with decentralisation in health may not be considered as the optimum required experience. This is because those experiences could not incorporate the real character of decentralisation. The real character of decentralised planning can be ensured only if there are democratically elected independent legal bodies with adequate power, resources and support from the apex government to execute the people's felt need within the concerned geographical area with the active participation of the people in the decision making, planning and implementation.

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[34] ICMR/ICSSR. Op. Cit. pp17-18.

[35] Banerji.D(1989):"Contours of health Policy in Panchayati Raj." *I ASSI* Quartely 14(1-2)July-Dec, pp. 35-42.

[36] Nayar, K.R. (2001): "Politics of Decentralisation: Lesson from Kerala in Qadeer, Imrana; Sen, Kasturi, Nayar, K.R.(ed) ***Public Health and Poverty of Reforms***. Sage, New Delhi.

For instances, in Botswana, decentralisation experience in health started in 1965. But the regional health teams did not have any executive power to implement their programmes. Consequently, the decentralisation programme was limited to the supervision of national programmes.[37] In Senegal, the decentralisation in health was implemented with the privatisation of health care services. As part of the decentralisation programme, health service had been divided into five different levels. But the utilisation of health services was reduced due to the increased cost of health services.[38] The decentralisation in health in Nicaragua started in 1984 with the development of the district health system. But this experience only resulted in the privatisation of health services, on overall reduction in health spending and the promotion of user fees. Also, the health spending in Nicaragua declined by over 12 per cent from 1992 to 1996.[39]

All these negative impacts of decentralisation in health cannot be attributed to the principles of decentralisation. It may be due to the type of decentralisation, poor community participation, inadequate resources and also the political context of the state.

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[37] Mayann, T. Edward (1990): "Decentralisation of Health Services in Botswana" in Mills, Anne; Vaughan J; Patric, Smith; Duane and (ed.) ***Health System Decentralisation - Concepts, Issues and Country Experiences*** (ed.) WHO, Geneva, pp.45-54.

[38] N. Diaye, Jean, Michael (1990): "Decentralisation of Health Services in Senegal" in Mills, Anne; Vaughan J; Patric, Smith; Duane and (ed.)***Health System Decentralisation - Concepts, Issues and Country Experiences*** (ed.), WHO, Geneva, pp.106-113.

[39] Biru, Anne-Emanuelle, Zimmerman, Sarah; and Garfield Richard (2000): "To Decentralise or no to Decentralise, Is that the Question? Nicaraguan Health Policy Under Structural Adjustment in the 19990s". ***International Journal of Health Services***. Vol. 30, No. (1), pp. 111-128.

Decentralisation in Kerala

The first step towards decentralisation in Kerala was in 1957, (during the period of first communist led ministry). Though, the government recommended various measures towards the formation of institutions for devolution and decentralisation at different levels, they could not be implemented because of the dissolution of the ministry in 1959. In 1969, the Kerala Panchayat Act came in to being; but it functioned with very little power. Later, based on the 73rd and 74th constitutional amendments, the Government of Kerala initiated the Kerala Panchayat Act, 1994, with the three-tier Panchayati Raj system.

It has to be noted that the very low per capita income, the declining productivity of food crops, the low market price for cash crops and poor industrial growth resulted stagnation in Kerala's economy. However, universal primary education, public distribution system, the availability of basic requirements, political awareness and health consciousness has tried to sustain a desirable status. Despite this achievement, there exists a controversy in health sector in the case of the state's morbidity rate. This controversy is termed as 'Kerala Paradox'. This paradox may be due to more demanding health ideals and a social situation that is less willing to tolerate illness. When compared to developed countries, the morbidity rate in Kerala is

substantially lower.[40] The implementation of democratic decentralisation with people's plan could make changes in the social and economic field of Kerala; and this can have very a positive impact vis-à-vis health.

Statement of the Problem

The basic concept of decentralisation in Kerala is related to 'Gramasabha'. It can be seen as the first attempt to vest political power in the hands of the people. The process of decentralised planning in Kerala has been divided in to five phases. The concept of bottom-up planning gives that much more power and strength to the people and it legitimises the founding principles of democracy. People's plan has empowered local bodies to prepare and implement various plans for comprehensive local development through a transparent process. During the 9th plan 35-40% of the state plan fund had been devolved to all local self-governments to implementing panchayat's programmes.

When compared to all the other sectors in people's plan, the health sector needs more involvement from the community and health professionals. Moreover, in preparing and implementing the programmes, priorities should be related to local issues. In the field of health, all panchayats have implemented projects. Almost all programmes evolved in relation to preventive health care. However, the central health programmes have remained as they are.

[40] Ramachandran .V.K.(1997): "On Kerala's Development Achievements" in Drez and Jean (ed.) ***India's Development Selected Regional Perspectives***. Oxford University Press. New Delhi.

Sometimes, the people do not feel any importance or benefit out of the centrally controlled health programmes. Also, the health staffs were more concerned with their departmental programmes and so the local self-government institutions were not able to fully utilise the service of the health staff for local level planning. On the other hand, the panchayat is responsible for implementing the central programme. It became a conflict between the people' planning programmes and the centrally sponsored vertical programmes. The interconnection of the beneficiaries (people), their participation and its nature, the availability of resources and the involvement of health staff decide the process of planning and implementation. If any chain in the process is not involved properly, it will affect the planning, objectives and implementation of the project. So it is very important to ask questions like who prepared the projects, what is the nature of health projects, at what level people as well as officials participated in the planning and implementation, and to what extent the health projects were beneficial and what were the constraints in the planning and implementation of the health projects.

Objectives

1. To know the participation of the people in the planning and implementation of health projects.
2. To know the participation of the health staff and their views on the health projects.
3. To know the nature of participation of the people.
4. To understand the nature of health projects.

5. To know to what extent the health projects were beneficial under the people's plan.
6. To understand the constraints in the planning and implementation of the health projects.

Method of Data Collection

This study is based on primary and secondary data. The geographical area of this study is Kannur District, Kerala. The researcher focussed the study on three panchayats. (Kunhimangalam Grama Panchayat, Madayi Grama Panchayat and Pallikunnu Grama Panchayat). In selecting these three panchayats, the purposive sampling method was followed with a criteria that one should be a Congress (I) controlled panchayat and other two should be CPI (M) and Muslim League controlled panahcyats. This has done with a view to understand differences in extent and nature of participation under different political parties. The geo-physical conditions of the three panchayats are more or less same. To collect primary data, the researcher prepared two interview schedules, one for the field staff in the PHC including the Medical Officer and the second one for the grama sabha members. The researcher has also collected data from state and local self-government records and reports. The sample of gramasabha members from the three identified panchayats was selected on the basis of the random sampling method. From each grama panchayat, 40 people were interviewed. Besides, informal interviews were conducted with senior citizens and panchayat members. Source materials like Development reports, plan documents, and health projects were also used.

Health projects were selected on the basis of discussions with the health staff and the people.

Chapterisation

The entire study is divided into 6 chapters. The first chapter deals with the theoretical background, objectives and method of data collection. The second chapter deals with the Kerala Model, the Panchayati Raj in Kerala, decentralisation and its significance in Kerala and the people's planning programme. The third chapter deals with the profiles of the three panchayats and also the Kannur district. The fourth chapter is a descriptive account of health projects implemented in the three panchayats and the people's participation. The fifth chapter deals with the nature of people's participation in planning and implementation of people's planning programme. The last chapter is confined to conclusion and findings.

Limitation of the Study

This study deals only with the participation of the people and the health staff in direct health-related programmes. Due to time constraints, the researcher has not considered the participation of the people in other indirect health-related programmes like drinking water, sanitation, housing and agriculture.

CHAPTER II

CHAPTER II

KERALA MODEL AND NEW TRUST IN DEMOCRATIC DECENTRALISATION

The people's plan, bottom-up initiative, in Kerala is considered as a unique one. It is being implemented through Panchayati Raj Institutions,. They have been given political as well as financial autonomy with participation of the people in the planning and implementation of local level needs. The democratic decentralisation and people's planning programme became more relevant in the context of the existing controversy between Kerala's achievement (Kerala Model?) and its failures (Kerala 'paradox'?) taking into account various social and economic aspects.

When compared to the other states in India, and even to some of the developed nations, Kerala has always attracted attention with regard to its various social and economic conditions. It is even said that if Kerala with its exceptional outstanding achievements, is excluded India is mainly a homogeneous State in the development perspective.[1] The causes of Kerala's achievements in demographic conditions, public health, literacy, standard of life, and its failures in other socio-economic areas like suicide, environmental degradation, increasing morbidity rate, unemployment, poor economic growth and poor industrial growth are debatable.

[1] Dreze, Jean and Sen, Amartya (2002): ***India Development and Participation***. Oxford, New Delhi, p. 85.

The present state of Kerala was formed in 1956, integrating the erstwhile princely states of Travancore and Cochin with the Malabar district of the former Madras presidency. Agriculture is the main economic activity in the state. The small lush green state on the south-west corner of India lies between 8.19' and 12.47' north altitudes and 74.52' and 77.24' east longitudes. It is a narrow strip of land with a long coast of 580 kms with a width of ranging between 8 kms to 102 kms.

Kerala has a population of 31,838, 619 (Census 2001) and an area of 38,863 sq.km. (1.18per cent of total land area). It is a densely populated state, density per sq. km being as high 819, while the national average is 324. 74.03 per cent of in Kerala's population live in 1452 revenue villages which has been grouped into 991 grama panchayats, 152 development blocks and 14 districts. The state with an average of 90.92 per cent literacy, as against the national average of 65.38, at the top vis-à-vis the other states and Union territories.

Notwithstanding Kerala's relative economic backwardness (Per capita income at current price is estimated at Rs. 19,461 in 1999-2000), it could make remarkable achievements in health, education, literacy and demographic features. When we talk about Kerala's progress we should consider various multi-causal factors like the earlier social reform movements, the missionaries' work, the left movements, the trade union movements, the peasant movements, the state legislative measures which include land reform

and the abolition of tenancy, political consciousness, different cultural groups, public libraries, caste associations, women groups, youth organizations and farmers groups. Moreover, the tropical climate with plenty of rainfall provides favourable conditions, and geographical features and settlement patterns have their own role in the development process in Kerala.

Kerala's outstanding development in various fields has been revered by the term 'Kerala model'. It has a broader meaning with different characteristics. The Kerala model generally refers to the positive achievements of the people in the various human development indicators. The term 'Kerala model' implies a set of high material quality of life indicators coinciding with low per capita income, a set of wealth and resources redistribution programmes and high levels of political participation and activism among ordinary people along with a substantial number of dedicated leaders at all levels.[2]

Social reformers like Sree Narayana Guru, Ayyankali, Sahodaran Ayyappan, Vaikkam Abdul Khader Maulavi, Vagbhatanda and other social reformers contributed a lot in the development of the state. The Vaikam Satyagraha (1924-25) and The Guruvayoor Satyagraha (1931-32) were the pioneering movements that led to the eradication of untouchability in Kerala. The Temple Entry proclamation by Sri Chithira Tirunal Balarama Varma in 1936, allowed entry for all Hindus irrespective of their caste. All these movements were instrumental in modernizing the state, enfranchising social equality and

[2] Franke, W Richard and Chasin, H Barbara. (1996): ***"Is there Kerala Model sustainable? Lessons from the past"***. ISS, New Delhi.

exposing the people to new ideas in the realm of politics as well as social structure.[3] The works of the Christian missionaries' and the left movement were considered as further catalystic agents for social change in Kerala.

The Abolition of Tenancy Act, and the land reforms in 1963 with social and economic objectives helped to reduce the exploitative situation in the state.[4] The Kerala land reform could expand rice land ownership from 4 per cent to 28 per cent.[5] The Public library movement had a greater role in the social and political awareness of Kerala. In fact the Libraries in Kerala became centres for articulating people's anger against royal autocracy and bureaucratic misrule.[6] The people's science movement (KSSP) in the 1970s with the slogan "Science for Social Revolution", the People's Health Survey in 1987 (to initiate a health movement) and the mass literacy campaign paved the way for further social change in Kerala. Due to the planned literacy campaign programme, Kerala became the first totally literate state in India in 1991.

The census report of India 2001 throws light on Kerala's demographic achievements. Now Kerala has entered the third stage of demographic transition characterized by low death rate and birth rate. The decadal population growth in Kerala is 9.42 per cent while the national growth rate is 21.34 per cent. The state has retained sex ratio i.e. 1058 which is the highest

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[3] Pillai, K. Raman (1999): "Coalition Politics: The Kerala Experience" in Oommen M.A. (ed.) ***Rethinking Development - Kerala's Development Experience*** (Vol. 1), ISS, Concept Publishing Co., New Delhi, pp.100-110.

[4] Oomen M.A (1975): ***A study on land reform in Kerala***, Oxford & IBH, New Delhi

[5] Franke W, Richard (1995): ***Is there a Kerala Model?.*** Paper presented at the World Malayalee Convention. July 1-3, New Jersey

[6] R. Raman Nair (1994) : ***Role Public libraries in the National Movement in Kerala*** -Abstract Paper presented at the International Congress on Kerala Studies, vol. 3 Thiruvananthapuram, pp. 127-128.

in the country. The national average is only 933. When considering the literacy rate, Kerala ranks first, i.e. 87.86 per cent while the national average is 54.16 per cent.[7] It can also be seen that when compared to other states, the percentage of households subscribing to a daily newspaper is very high in Kerala. In rural Kerala 26 per cent households and in urban area 51 per cent households subscribe to a daily newspaper. However, in rural India it is only 4 per cent and in urban areas it is 25 per cent.[8] Kerala has also made notable achievements in health indicators. This is reflected in the low fertility rate, low birth rate, low death rate and high life expectancy. When compared to other states and developed countries, Kerala has a radically reduced fertility rate. In 1998, the fertility rate in Kerala was only 1.8, (just below China's 1.9). This has been achieved without any compulsion from the state machineries. The birth rate in Kerala has fallen to 18 per thousand by 1991 from 44 per thousand in 1950s.[9] According to the 1991 census, the life expectancy at birth in Kerala is 68.23 years for men and 73.62 years for women (The all India level is 62.8 years for men and 64.2 years for women).[10] The figures of vaccine preventable diseases shows a consistent decline in Kerala and this reduction is a reflection of the high immunization level attained by the state.[11]

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[7] Director of Census Operation, Kerala (2001): ***Provisional population totals – census of India 2001***. series 33, Kerala.

[8] Dreze, Jean and Sen, Amartya, op.cit.

[9] Ibid, pp. 138-139.

[10] GOK, State Planning Board (1999): ***Economic Review 1999***, *Kerala.*

[11] Rajmohan (1994): ***Vaccine Preventable Decease- Situation Analysis and programme implementation in Kerala,*** Paper presented in the International Conference on studies on Kerala vol. 5, Thiruvananthapurum.

Health Care System in Kerala

The public sector health care facilities in the government sector in the state consists of 276 hospitals in addition to 944 Primary Health Centres, 105 Community Health Centres and 5,094 subcentres. Under the cooperative centres there are 52 hospitals with 2507 beds and 992 doctors. The number of beds in the state for the three system of medicine is 360 per lakh of the population. Among these 154 are under the government sector. [12]

In Kerala, 74 per cent of the rural population live in a village with a primary health centre , 79 per cent live in a village with a subcentre and 87 per cent live in a village with either a PHC or a subcentre. The proportions who live in a village with other health facilities are 53 per cent for hospitals and 76 per cent for dispensaries or clinics.[13] In Kerala 61 per cent of households normally use the private medical sector when a household member gets sick. 38 per cent use the public medical sector. Only one per cent of the households normally use NGOs or trust hospitals or clinics for health care. Among the prevalence rate of public health disease in Kerala, acute respiratory infectious disease come first, i.e., 173.73. The prevalence rate of acute diarrhoeal diseases is 18.19 and that of tuberculosis which is 1.13.[14]

A study by the Central Statistical Organisation on 22 basic facilities in Indian villages shows that Kerala ranks first in 17 out of the 22 indicators. Most of

[12] GOK, State Planning Board (1999): ***Economic Review 1999***, *Kerala.*
[13] NFHS (2001) : ***NFHS-2. India 1998-1999 Kerala***, International Institute of Population Sciences.
[14] GOK, State Planning Board (2000): ***Economic Review****. 2000.*

the basic facilities are available in Kerala villages within a range of 2-5 kms. [15] 72 per cent of the households in Kerala have electricity and 85 per cent have toilet facilities. Though 74.03 per cent of population live in villages, they have telephone facilities and electronic media facilities.[16]

The public distribution system of food grains through fair priced ration shops distributed throughout Kerala assures minimum food materials at relatively cheap cost to the people.[17] This has helped the state to acquire a certain level of nutritional status for resisting poverty related diseases to some extent.

Apart from these factors, the people's political awareness and the strong civil society has played a unique role in Kerala's achievement. If a primary health centre is not working properly, there will be a massive demonstration or protest at the nearest collectorate or local self government institutions, demanding a redressal of the rights which the people know they were entitled to.[18] Regarding the social security and welfare programmes, the government of Kerala provides 12 pension schemes and 28 welfare schemes for the marginalized sections. It also gives a minimum level of help to the people in their daily life.

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[15] George K.M. (1993): ***Limits to Kerala Model of Development- An Analysis of Fiscal Crisis and its Implications***. Centre for Development Studies, Thiruvananthapuram.

[16] NFHS (2001) : ***NFHS-2. India 1998-1999 Kerala, International Institute of Population Sciences***.

[17] Wernel, David; David Santers; Janon, Westeon; Steve, Babb and Rodrignez (1997): ***The Politics of Primary health care and child survival questioning the solution series"***. Health Wright Publishers.

[18] Drez, Jean and Sen, Amarthya (1995) : ***India : Economic Development and Social Opportunity. Oxford University Press***, New Delhi.

Disturbing factors of the Kerala Model

Though the small state Kerala has achieved a good standard of living with comparatively very low birth and death rates, it faces numerous socio-economic challenges.

The relevance of the term 'Kerala Model' can be questioned especially in relation to the problems of marginalized groups. The Kerala model does not work with 'dalits' and 'adivasis' who have poor accessibility and availability of health and educational facilities and also employment opportunities. The existing stagnation in agricultural production and industry also affect their subsistence. Here the question is how far is it possible to sustain social achievements without economic growth? Judging from the performance of the Kerala economy, it is opined that the Kerala model is a no growth.[19] The growing consumerism, the decreasing agricultural and food production, the poor industrial growth, the stagnation in economy, and the declining state expenditure in the field of social development especially in health, and education put forward the question of sustainability of the Kerala Model. In this perspective, the achievements in human development in Kerala may be termed as 'Kerala's development experience' rather than as 'Kerala Model'.[20]

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[19]Tharamangalam, Joseph (1999): "The Social Roots of Kerala's Developmental Debacle" in M.A. Oomen (ed.). ***Rethinking Development***, Vol. 1. ISS, New Delhi, pp.184-185.

[20] Parameswaran, M.P. (1999): "Kerala Model - Prospects and Problems" in M.A. Oomen . (ed.) ***Rethinking Development*** , Vol. 1 ISS, New Delhi, pp.210-219.

In Kerala, most medical needs, apart from immunization and sterilization, are met by private hospitals, private practitioners or the private practice-setups of government doctors.[21] The New Economic Policy ensuing from liberalization and privatization has resulted in a rise in the drug prices. Also, the changes in the prescription patterns and the overviews of technology by medical providers have made the health situation very problematic. The medical expenditure per morbid person per episode increased from Rs. 16.56 to Rs. 165.22 during the last decade, an increase of 898 per cent.[22] Therefore, public health is getting alienated from the people in Kerala. In fact, only about 30-40 per cent of the people (even from the lower income group) seek medical and health facilities from the government health care facilities in Kerala.[23]

The NFHS report (2001) observes that the utilization of health services is influenced by the standard of living of the household. That is, there is a direct relationship between the standard of living and the use of private sector health services. 77 per cent of households with a high standard of living generally use the private medical facilities for treatment, compared with 58 per cent of households with a medium standard of living and 42 per cent of households with a low standard of living. A study in 1997 which is identical to

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[21] Ramankutty V, (1999) : "Development of Kerala's Health Services -The need for Broadening the base of Policy making" in M.A. Oomen. (ed.). ***Rethinking Development*** , Vol. 2. ISS, New Delhi, pp.432-34.

[22] Kunhikannan, T.P and Aravindan, K.P. (2000): ***Changes in the Health Status of Kerala, 1987-1997.*** Discussion paper, No. 20, June. Kerala Research Programme on Local Level Development. Centre for Development Studies, Thiruvananthapuram, pp. 5-36.

[23] Ibid. pp. 5-36.

the KSSP survey done in 1987 reveals that only around the 28 per cent of acute illness cases get reported to the government hospitals for treatment. Rest of the cases go to private institutions (58 per cent), cooperative and other medical institutions (5 per cent). The major reasons for the non-utilization of government institutions, the study reveals, are the lack of availability of treatment facilities, the lack of medicines in the government institutions, the absence of doctors and the distance factor (private hospitals are nearer to the patients).[24]

The high demand for health care, the absence of government legislation regarding the settings up of hospitals, and the decreasing government expenditure give an impetus for the growth of the private health sector in Kerala. The National Sample Survey Organization in 1986-87 found that financial problem is the main reason for people not seeking treatment in Kerala. (14.66 per cent of the rural people who didn't take treatment as against 48.4 per cent in urban areas)[25]. Due to the poor intervention of the state on behalf of the marginalised people, the average density of beds in the private sector became twice than what is there in the government sector.[26] Ageing is another important health related issue, because chronic diseases amongst the aged need higher spending on health care.

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[24] Kunnikannan T.P., Aravindan K.P. op.cit., pp. 5-36.

[25] Sadanandan, Rajeev (2001) : "Government health services in Kerala. Who benefits?" ***Economic and Political Weekly***. Aug. 2001.

[26] Ramankutty V. (2000) : "Historical Analysis of the Development of health care facilities in Kerala state India". ***Health policy and planning***. 15(1), pp.103-109.

Another critical issue in the health sector is referred to as the 'low mortality high morbidity syndrome'[27]. According to census 2001, the infant mortality rate in India is 70, while in Kerala it is only 14. But the morbidity rate is far high in Kerala. The reported level of Asthma (4,806/100,000 population) in Kerala is twice the level reported for India as a whole (2468/100,000 population). The overall prevalence of TB in Kerala is 526/100,000 population. This about the same as in India as a whole (544/100,000 population) [28]

Though the land reform was a remarkable achievement in Kerala, the social and economic disparity in relation to the ownership of land is still existing, especially with reference to adivasis and dalits. In Kerala, most of the dalits and adivasis do not have any ownership of land. 77 per cent of the dalits are landless (compared to 63 percent at the all India level). The share of scheduled caste land holdings in Kerala was only 2.94 per cent in 1991 though their population was eleven per cent. Their average land holding was only 0.07 per cent, which was significantly worse than the national average of 0.49 hectares.[29]

The successive governments of Kerala have failed to redistribute land to the adivasis and dalits. 50 per cent of the land taken over by the government under the Kerala Private Forest Act, 1972 was meant to be distributed to the

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[27] Panicker PGK and Soman C.R. (1984): ***Health Status of Kerala: The Pradox of Economic Backwardness and Health Development.*** CDS, Trivandrum.
[28] NFHS, op.cit.
[29] ***Indian Express***, Thiruvananthapuram, 1999 August, 16.

adivasis. But it has not yet been completed. Besides, in the name of rehabilitation the land was encroached by corrupt and inefficient organizations and non-adivasis. [30] NFHS-2 survey found that 64 per cent of households do not own any agricultural land. Among people who have agricultural land, only 39 per cent have atleast some irrigated land.

The high density of population with limited cultivable land has posed the problem of food security and unemployment. Public distribution in Kerala is well appreciated, but it is made possible only through the food imports from neighboring states like Andhra Pradesh and Tamil Nadu. For the last two decades, agricultural production in Kerala has been declining at an annual rate of 1.09 per cent. The total area under food grain fell from 960,000 hectares in 1970-71 to 560,000 hectares in 1990-91[31]. The causes for this decline in agricultural production can be attributed to the fragmentation and subdivision of land (because of increased density of population), the increased cost of cultivation, and the fall in prices. With respect to the unemployment problem, Kerala ranks first. In 2000, 41.86 lakhs people have registered their name in the employment exchange. Among these 75 per cent people have completed tenth standard. Out of 41.86 lakhs 55.27 per cent of

[30] Sanjay Singh, Kumar (2001) ***The Dark Clouds and the Silver Lining : Adivasi Struggle in Kerala.*** Kerala Study Group, Delhi.
[31] Tharamangalam, Joseph (1999). Op. Cit. pp. 184-185.

the job seekers are women. [32] Owing to this unemployment crisis 307 people committed suicide in 1999. [33]

Amartya Sen and Jean Dreze have pointed out that the achievement of a state in its social field cannot be undermined on the basis of its suicide rate.[34] But it is a disturbing aspect when we look at from a social and economic angle. The increasing rate of suicide is indeed an important issue in Kerala. It is reported that the suicide rate in Kerala, is more than three times the all India average and more than that in the developed countries.[35] Statistics show that atleast one person tries to commit suicide in every 15 minutes. The Suicide rate in the last three years were 8961 (1997), 9306(1998) and 9778(1999).[36]

It has to be understood that it is not possible to make successful development in the long run unless the natural resources are maintained and utilised properly. Kerala has been subject to many vexing environmental degradation issues and the subsequent health problems for the last two decades - Industrial pollution, river pollution, salinity in drinking water, overt pollution in Sabarimala, the issue of spraying Eendosulfan in Kasargod.etc.. Further, the river systems in Kerala are being threatened by heavy discharges of industrial effluents. Though the government accepted the recommendations of the

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[32] ***Economic Review, 2000.*** Op.cit.
[33] ***National Crime Record Bureau***, Thiruvananthapuram, 2000.
[34] Dreze, Jean and Sen, Amartya, op.cit.
[35] Muralidharan. M.P. (1995): "Athmahathya Cheyyunna Keralam (Malayalam) – The Kerala that Commits Suicide" ***Mathrubhoomi Weekly***, Jan., 1995.
[36] ***National Crime Record Bureau***, op.cit.

expert committee, appropriate action has not being taken to remedy this problem. The incident of large-scale deaths of fish in the Periyar River was caused by the release of industrial effluents from FACT (Alwaye, Kerala) [37]

In the past few years, Kerala economy has weathered very difficult conditions. It is largely due to the fall in the prices of major agriculture commodities, poor industrial growth and also the declining gulf remittances. Kerala's per capita income declined from 93 per cent in 1970-71 to 90 per cent in 1980-81 and 73 per cent in 1987-88 and to 70 per cent by the 1990s. [38] In exports, Kerala has had a good record. But by 1990, its share of exports declined from 17 per cent in 1966-67 to less than five per cent. In addition to this, the increased bondage to WTO and other international organizations has accelerated the crisis.

All these challenges raise the question of the limitations of the Kerala model. It is sure that we cannot address all these issues through democratic decentralisation and Panchayati Raj Institutions, but we can use it as an instrument to seek some remedies to a great extent. This needs community participation in decision making, planning and implementation. In this context, decentralisation can be seen as a vital component as it is designed to promote socio- economic development characterized by equity and mass participation.

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[37] ***The Hindu***, 16-6-1998, Coimbatore.

[38] Tharamangalam, Joseph (2001). ***Kerala Model – what is the truth ?***– Interactive Kerala articles. html.

Panchayati Raj Institutions in Kerala

The Panchayati Raj Act 1994 is the result of various evolutionary processes in the area of democratic self-government in the state. After the 73rd Constitutional Amendment the Panchayati Raj Institutions have became more powerful.

Since October 2nd 1995 Kerala has a three tier Panchayati Raj system. It has, in the rural areas, 991 Gram Panchayats, 152 Block Panchayats, and 14 District Panchayats (Zilla Panchayat). In urban area, there are 55 municipalities and 5 municipal corporations. In Kerala an average grama Panchayat has a population of 25199. In 1991, the smallest Panchayat (Vattavada in Iduki district) had a population of 4588 while the most populous Panchayat (Munnar, Iduki district) had a population of 78,343. The smallest Panchayat in Kerala is Valapatanam (Kannur district) with an area of 2.04 sq. km and the largest one is Kumily in Idukki with an area of 795.28 sq.km. [39]

During the British period what is now known, as Kerala was comprised of the erstwhile princely states of Travancore and Cochin and the Malabar district of the former of Madras Presidency. The first Panchayat in the Malabar region was established under the Madras Local Board Act 1884. In 1920, the Madras Village Panchayat act was passed and Panchaayats were constituted in more villages. In 1930, the Madras Local Board Act was passed and all

[39] *Economic Review*, 1999. Op.cit.

Panchayats were brought under it. [40] In the Cochin area, the first Panchayat was established in 1914 under the Cochin Village Panchayat Act and in Travancore the first Panchayat was established under the Travancore village Panchayat Act 1925. Later, the Madras village Panchayat Act and the Travancore- Cochin Panchayat Act were enacted in the year 1950. These acts continued till the Kerala Panchayat Act of 1960.[41]

The first step in the direction decentralisation was the formation of Administrative Reform Committee, 1957, headed by the then chief minister EMS Namboodiripad. It recommended various measures for devolution and decentralisation in the state. The committee recommended the strengthening of Panchayats in the state as viable and basic units of administration, development and for the collection of land revenue. It also recommended the reconstitution of taluks and blocks. But it was not implemented due to the dissolution of the government in 1959. Following the first elected government, the Pattom Thanupillai Ministry enacted the Kerala Panchayat Act, 1960, the Kerala Municipalities Act, 1960 and the Kerala Municipal Corporation Act with the intention of constituting bringing Panchayati Raj institutions.

In 1964, the next government introduced the Kerala Panchayat Union Councils and Zilla Parishad Bill. It was also not passed due to the resignation of the ministry. In 1967, the new government again headed by EMS came into

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[40] Saju K.P(1990) : "Kerala's new Trust in Democratic Decentralization". ***Political Science Review*** 29(1- 4), June-Dec.

[41] SAHAY I (2000): ***Status of Panchayati Raj Institutions in Kerala. An appraisal 1995-2000***. Centre for Collective Learning and Action, SAHAYI.

power. The Kerala Panchayati Raj Bill was introduced with a two-tier system at the village Panchayat and district level. This bill also couldn't become law because the legislative assembly was dissolved and fresh elections were called for. The new government introduced the same bill but it was also dissolved before it could be enacted into law. The bill, Kerala District Administration Act 1974, was finally passed during the tenure of the A.K. Antony Ministry and it received the assent of the President in 1980.

The new left front government which came into power in 1980, issued a number of notification and rules as a prelude to implementation of the act. Initial attempts were made to implement it in 1980-81, but again it was stopped. In the year 1991, the District council came into power in all the 14 districts. When compared to other states, the zilla parishads district council in Kerala possessed more powers. As many as 18 departments related to 143 subjects were allotted to the District Council and a high power committee was set up to give suggestions for transferring more subjects. Special reservations were formulated for women scheduled castes and scheduled tribes. The District Collector was appointed as the secretary to the elected council. But the new United Democratic Front (UDF) government in 1991 withdrew some of the major subjects, which had been transferred to the district council. The whole programme received a jolt with the new legislation following to the 73rd and 74th Constitutional Amendments, wherein the district councils were formally disbanded.

Kerala Panchayati Raj Act, 1994

The 73rd and 74th Constitutional Amendments in 1993 ushered in a new era in the history of decentralisation and local self-government in India. The amendment gave constitutional status and institutional backing to all local self-government institutions and it also provided the framework for state legislation.

The Kerala Panchayati Raj Act came into force on 23rd April 1994. The draft of the act was drawn formulated when the United Democratic Front was in power. This Act envisages the three-tier structure of Grama Panchayat, Block Panchayat and District Panchayat. After the enactment, the act was amendmented three times in 1995, 1996 and 1999. The first two amendments were reformatory in nature and amounted to elaborations of the various sections in the act. The third one was on the basis of the Sen Committee report. It is considered to be a radical one, as it dealt with the peoples' right to knowledge/information, the constituting of the institution of Ombudsman for local self government institutions, for the resoloution of conflicts and the setting up of Appellate Tribunals for hearing appeals against the decisions of the Panchayat.

Under this act, the Gramasabha remains a consultative body. It does not have any administrative power. The Gramasabha can decide the list of beneficiaries and no authority can change or question that list. A Grama Panchayat with a population not exceeding 15,000 should have a minimum of

10 members and one additional member for every 4500 additional population subject to maximumof 20 members. Unlike in some states, in Kerala, the MLAs and MPs are not members of the Panchayat Council.

In the Block Panchayat, the minimum number is 10 and one additional member for every 25000 population, subject to a maximum of 20 members. The amendment act states that a district Panchayat having a population of 10 lakhs is entitled to have 15 members and one additional member for every one lakh population, subject to a maximum of 30 members. Also, all elected members are obligated to declare their assets and also that of their family members. If they fall, action can be initiated against them, culminating in their removal.

Elections to the local bodies for a five year term, the reservation of one third seats for women, the reservation for SC, ST in proportion to their population, the rotation of reservation seats of women and SC, ST during every five years, etc. are some of the characteristics of Kerala Panchayati Raj Act.

Many of the functions of the state department have been devolved to the Panchayats. These include 27 mandatory functions, 14 general functions and the distribution of power in 19 sectors. The Kerala Panchayati Raj Act prescribes three types of audit systems namely Local Fund Audit, Performance Audit and Social Audit. The first two-audit systems are customary, but the social audit is a creative assessment/ evaluation by the people. However, in practice, this social audit has not started.

People's Plan in Kerala

In Kerala the initiative for the implementation of decentralised planning started in 1970s with the delegation of district planning officers and the identification of district schemes. But due to various political reasons (coalition governments, the dissolution of governments and the lack of constitutional support till 1993) decentralised planning could not be realized effectively. It was after the constitutional amendment in 1993 that the concept of decentralized planning gained currency.

An effective and open political system is an essential factor for the realization of the goals of democracy. Here, the civil society has a specific role. It has to be noted that this space is not outside the purview of the state and political intervention.[42] Robert Putman (1993) has emphasized this importance of the civil society by refering to two regions in Italy, where civil society was strongest. In these regions, the government was most effective because of this existing space. In Kerala too, the civil society plays a vital role between the government and the people.

It is vital to mention here that the history of the people's plan for decentralized planning originated from an alternate movement, which started a discourse on the mismanagement of resources, corruption and inefficiency .[43] In this movement, the Kerala Shastra Sahitya Parishad (KSSP) played a major role. The organization became more influential after its successful struggle against

[42] Rawl, Vikas and Tharakan Michael, PK (2001) "Decentralisation and People's Campaign in Kerala". ***Social Scientist.*** vol. 29, No. 9-10 Sept.-Oct.

[43] Tornquist, Olle (2001) "Movement, politics & Development : The Case of Kerala". ***Social Scientist.*** vol. 29, No. 11-12, Nov. – Dec., pp.60-85.

a huge power plan in Silent Valley in 1978.[44] It launched a campaign on the developmental issues of Kerala focussing on decentralisation as a follow up. The campaign developed into a genuine bottom-up pressure, demanding genuine decentralisation and the strengthening of village level capabilities for self-reliant growth, based on the slogan- *Adhikarm Janangalkku (Power to the People)*. Apart from this, decentralized planning was inspired by the Kalliasseri experiment (Kalliasseri Grama Panchayat, Kannur District). The significant developments of the Kalliasseri experiment of decentralized planning were the socio-economic survey, the secondary data collection regarding various issues and health the survey.[45] By the early 1990s, the movement became increasingly clear, and identified the need of a more decentralized democratic polity for alternative development.

Concept and Methodology of People's Plan

The people's plan in Kerala intends to make use of the legacy of collective social intervention and the strength of mass movements to meet the contemporary crisis in development.[46] The people's plan campaign had a three point genesis: a synthesis of the critical review of the balance sheet of the Indian planning process, the challenges of the Kerala model development and the constitutionalisation of Panchayati Raj through the 73rd and 74th amendment.

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[44] Charvak (2000) : ***From Decentralisation of Planning to People's Planning : Experience of the Indian state of West Bengal and Kerala.*** Centre for Development Studies, Thiruvananthapuram.

[45] Issac, Thomas T.M. and Franke W. Richard. (2000) : ***Local Democracy and Development - People's Campaign for Decentralised Planning in Kerala.*** Left Word, New Delhi.

[46] GOK, State Planning Board (1996); ***Peoples Campaign for Ninth Plan - An Approach Paper.*** Thiruvananthapuram

People's plan originated from the proposal made by the State Planning Board to earmark a budgetary provision for planning and developmental activities at the three tier Panchayat as well as the two tier Nagarapalika system.

The concept of the people's plan has several core elements like Gramasabha, participation and the devolution of funds. It visualizes a process of decentralized planning. The planning process in peoples' plan is centred on local level self-government, starting from the grass roots including a high level of local autonomy in decision making with comparable levels of transparency and participation of ordinary people.[47]

Objectives of People's Planning Programme

The objectives of the Panchayati Raj Institutions in Kerala included the promotion of both economic development and social justice with special emphasises on planning. The People's plan (Ninth plan) was implemented on the basis of these objectives with the guiding principle that what can be done best at a particular level should be done at that level and not at the higher level. [48] People's Programmes implemented with more democratic traits and to thus enlarge the capacitation of the people to have their basic needs. It emphasises the importance to utilize the resources and possibilities at the local level and this increases the income and employment opportunities. The programme seeks to make sure that the fruits of development works reaches

[47] Varghese, Sheela and Rejimon PM (2001): "Peoples Campaign for Decentralized Planning: An Assessment" ***Economic and Political Weekly***. Vol. 39, No. 21, May.

[48] Issac, Thomas T.M. (2000) : ***Campaign for Democratic Decentralisation in Kerala: An Assessment from the Perspective of Expanded Deliberative Democracy***. Kerala State Planing Board, Thiruvananthapuram.

the people; to ensure the basic necessities of life like drinking water, health services, housing, educational facilities etc. Besides, it gives importance to the devolution of power to the people and substantial community empowerment. Above all, the peoples's planning programmes calls for the restructuring of the developmental agenda, its institutions and its organisation in such a way that they serve the rural folk in a better way.[49]

Participation

People's participation is the most important pre-requisite of development. It means that people are directly involved in the economic, social and political process that affect their life.[50] Decentralised planning is based on demand driven approach and therefore the activities and the planning focuses on the local needs expressed by the people. Here participation means direct involvement of the people, voluntary groups, official and non-officials experts, in decision making, preparation of projects, implementation, monitoring, evaluation and sharing the benefits.

Gramasabha

The Gramasabha is the most important unit under the people's plan. The quorum for the gramsabha is 10 per cent of the village adults. Any failure to convene the gramasabha can be deemed to be a violation of the provision of the Kerala Panchayati Raj Act and calls for penal action including the loss of membership of the convenor in the case of two consecutive instances of non-

[49] State Planning Board (1996): ***People's Planning: Theory and Practice***. Thiruvananthapuram.
[50] United Nations Development Programme (1993): ***Human Development Report.*** Oxford University Press, New Delhi, pp.21-22.

compliance. The gramasabha has the full right to information in relation to planning, budgeting and implementation of developmental programmes. Besides, the gramasabha has the responsibility to select the beneficiaries of the programme, and also to evaluate the functioning of the local self-government institutions.

In the gramasabha, the people are supposed to organise around different subjects in groups according to their interest. In the subject group 'health', the people can discuss different health issues which include health infrastructure facilities, the service of primary health centres, health problems and its causes. Also, the people can talk on other health-related subjects like drinking water and sanitation. A trained volunteer facilitates each subject group in the gramasabha. The Panchayat will collect all reports from the different gramsabhas and then it will integrate it into a report. Based on the report, the Panchayat prepares health projects with the help of task force members.

Devolution of Fund

Without adequate resources no local self-government institution can make the decision, planning, and implementation of developmental programmes though people participate very active and large. In the people's planning programme, 35-40 per cent of the state plan funds has been devolved to the local self-governments to plan and implement their programmes. While preparing health projects at the panchayat level, the average plan fund allotted for a panchayat is between 6-7 lakh rupees (For a municipality it is 12-15 lakhs rupees). In addition to this the local self-government can mobilize funds from the state government, NGOs, public sector banks, cooperative banks and

such other financial organisations.[51] 75 per cent of the devolution is in terms of grant- in-aid and the rest is in terms of schemes sponsored by both central and State governments. Implementing the project should be in accordance to the development reports of the local government and it should be sanctioned from the expert committee.

Phases

The people's plan programme gets implemented through six phases. The local bodies are assigned to plan for themselves, identify the felt need of the people, analyse the developmental problems, assess the local resources and make feasible developmental changes. [52]

The first phase of the campaign focusses on the local development problems and the needs of the people. During this phase efforts are made to ensure maximum participation through the Gramasabha meeting. In the second phase, development reports are prepared on the basis of the history of the Panchayat, the reports of the gramasabha, the collection of secondary data, local development seminars and other available resources. Sectorwise task forces are constituted in the third phase of the campaign. The task forces are supposed to undertake a detailed review of the suggestion and draw project reports having the following components - introduction, objectives, beneficiaries, activities, organization, financial analysis, achievements and monitoring. In the fourth phase, after prioritisation, the prepared projects are incorporated into a planned document for the Panchayat. In the fifth phase,

[51] State Planning Board (1997): ***Project Evaluation - A Handbook***, Thiruvananthapuram.
[52] Issac, Thomas TM, K.N. Harilal (1997) "Planning for Empowerment : People's campaign for decentralized in Kerala". ***Economic and Political Weekly***, 4-11, Jan., pp.53-58.

the Panchayat level plans are integrated into the next higher levels, namely, the block and district levels. The sixth phase is plan appraisal. It means that the projects have to be examined for their technical soundness and rectified before the actual implementation.

To sum up it can be said that democratic decentralisation and people's planning programme in Kerala is an effort to address the problems of the 'Kerala Model' (Kerala Experiences) and also the challenges of the neo-liberal hegemony of the market forces. To sustain Kerala's achievements in the social and economic fields, and to make more progressive steps, the planning process needs more inputs from the people, especially from below. Empowered communities can infact resist the 'social exclusion' and 'marginalisation' embedded in the market forces. It is here that the trust in democratic decentralisation and people's participation gets more relevance.

CHAPTER III

CHAPTER III

PROFILE OF THE PANCHAYATS

As a part of the people's planning programme (Ninth Plan) all panchayats have implemented several projects pertaining to different aspects. Here, the focus is on health projects, which have been implemented in the panchayat. At the conceptual level these projects emphasis the participation of the people at the panchayat level for identifying their needs, formulation of the projects and then subsequent implementation. People's participation in the planning and implementation of the project is influenced by the various social and economic conditions of the participants in the panchayat. So it is very important to understand the comparative profile of the three panchayats.

The area of study is Kannur District, which is located in the northern part of Kerala. The District came into existence as an administrative unit on 1st January 1957, when the erstwhile Malabar District and Kasargod Taluk of Madras state presidency reconstituted into three revenue districts, viz; Kannur, Kozhikode and Palakkad.

Kannur District lies between latitude 11°40' to 12°48' North and latitudes 74°52' to 76°07' East. The district can be divided into three geographical regions, highland, midland and lowland. The total area of the district is 2966 Sq. Km. The district has three parliamentary constituencies (Kannur,

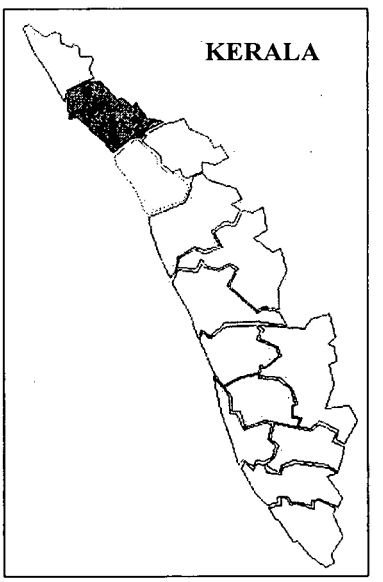
Vadakara, Kasargod) and ten state legislative constituencies. District has three Taluks, viz. Taliparamb, Kannur and Thalassery. There are six municipal towns and contonment in Kannur district. There are nine development blocks comprising of 81 gramapanchayats. Out of the three gramapanchayats in this study, two panchayats (Kunhimangalam and Madayi Gramapanchayats) come under the Payyannur block, and the third one, Pallikunnu Gramapanachayat comes under the Kannur block.

Kannur district got its place in the political map of Kerala on May 1928, when the fourth All Kerala Political Conference was held at Payyannur (in Kannur District) under the auspices of the Kerala Provincial Congress. The district was always in the forefront in civil disobedient movements. The notable event in the history of Kannur is related to the Salt Satyagraha. Infact, Payyannur was the main centre of Salt Satyagraha in Malabar.

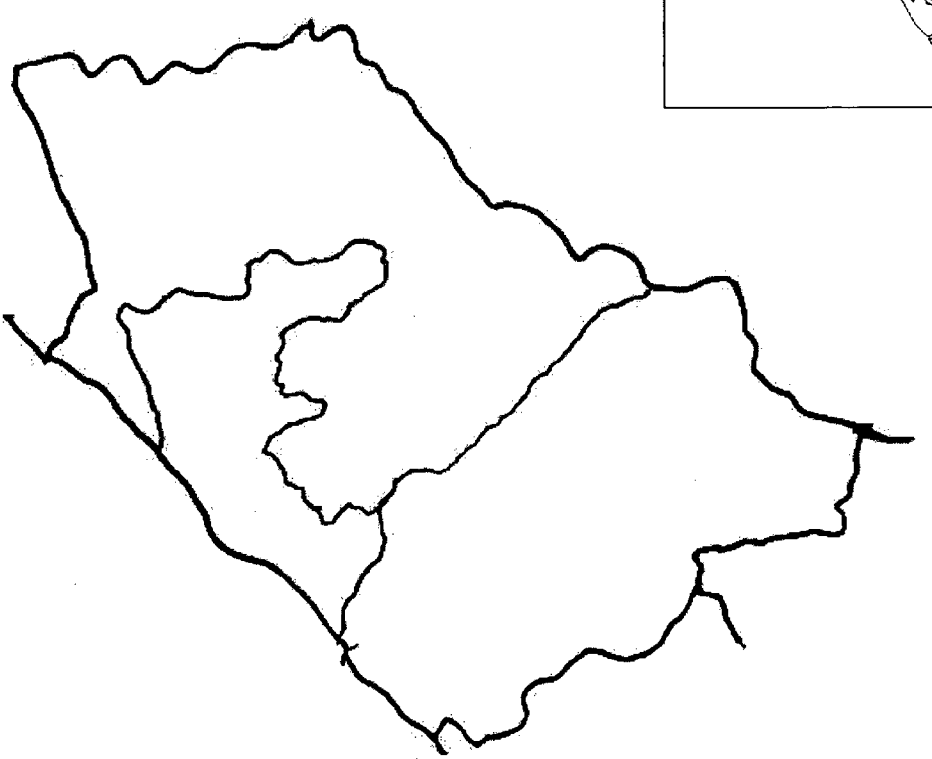
History of Traditional/Community Panchayats in Kannur

During the pre-British period, the traditional/community panchayats in Malabar, which included Kannur, were divided into *grammas* (inhabited by Nambuthiris), *tharas* (where the Nair community lived), *karas* (where the Ezhava community lived) and *cheri, muri*, etc. (where the lower castes such as cherumans and pulayas lived).[1]

[1] Menon K.P. and Padmanabha (1940); ***History of Kerala*** (Cochin State, 1940). P.374.



MAP OF KANNUR DISTRICT



Source: District Panchayat, Kannur.

The Grammas were an exclusive preserve of the Brahmin community. The 'thara' was constituted by a group of households and the senior most member amongst them was considered to be the chief. It was represented by a 'kootam', which had a high degree of authority. Even the Ministries of the kings were also accountable to the kootam. It is widely accepted by historians that the thara organization played an important role in the evolution of early administrative justice in Malabar.[2]

In the pyramidical structure of the Malabar village set up, the 'desavazhi' was in the second position. He was considered the chief of the village. The Desavahi was the most powerful person in the village with powers to control the civil, military and religious affairs of the people of the village. Higher up the hierarchy, one above the desavazhi, was the natuvazhi, who was the administrator of the 'nadu'. His status was interim to the king(Rajah) and the desavazhi. He was responsible for the collection of all taxes on behalf of the king, commanding the armed forced of the villages in his area and leading the army when ordered by the king. Nair community held all these positions, as they were the warlords in Malabar.

During the British period all these traditional/community panchayat institutions deteriorated. This was mainly because British officials were concerned only with the seizure of more territory. However, the British government appointed 'adikaris' (village head), who ruled over the 'amsams' (village). The adhikari

[2] Santha E.K. (1993): ***Local Self Government in Malabar (1800-1960)*** , ISS Occasional Paper Series-II.

was the village magistrate and he also had the responsibility for the collection of the taxes. The Adhikari's were more familiar with the land and the people of a particular region, their existence and assistance reduced the burden on the British. They were spread the effort of having to acquaint themselves with the local communities. However, in the first half of the 9th century, the Britishers were against the total delegation of the power to the natives. But Lord Rippon's act on local self government in 1882 reversed the entire situation. The Madras Towns Improvement Act of 1865 was a break as far as this new development was concerned and it can be considered as one of the earliest legislative measures n the direction of urban self government. Under the provision of this act, the municipalities at Calicut, Cannanore, Tellichery, Palghat and Fort Cochin were established in 1867[3].

The Madras Municipal Act of 1884 can also be regarded as a radical change as far as the previous acts on self-government was concerned. It was the direct outcome of the famous resolution of Lord Ripon. This act dealt with administrative areas, the constitution of local bodies, their functions, finances and powers. The recommendations of the Royal Commission on decentralization, 1909, was the next milestone. (It was amended in 1950 and later in 1980). Later, Montegu-Chelmsford Reforms in 1919 recommended the liberalization of local self-government in accordance with a number of principles. It decided that the Panchayat should be revived in the villages, local bodies should contain a large elective majority, the local government

[3] Menon, Sreedhara (1972), ***Gazetteer of India, Kerala, Cannanore*** (Trivandrum), p.583.

should be made broad based by suitably extending the franchise and also that the president of the local body should be a member of the public and should be elected rather than nominated.

In 1920, all panchayats were brought under the scope of Madras Local Boards Act, which governed the constitution and working of the village union. Pappinesseri panchayat was the first panchayat in Malabar under this act. According to this Act, the panchayats were under the control of the Malabar district board and the Inspector of Municipal councils and local boards.[4] Under this act, panchayats lost its power status. Instead, it became the part of a hierarchical structure. Later, the local board Act, 1920 was amended in 1946, and in 1950 a new Act, the Madras Village Panchayat Act came into existence. This Act continued till the enactment of the Kerala Panchayat Act of 1960.

Demographic Features

The population of Kannur district as per the 2001 census was 24,12,365 that is 7.58 per cent of total population of the state. Out of this 11,54,144 are males and 12,58,221 are females. The district is in the eighth position among the districts of Kerala in terms of the total population. Kannur ranks ninth in the state with regard to the density of population which is 813 persons per sq. km, the state average is 819. The sex ratio in the district is 1090, while the state average is 1058. The infant mortality rate in Kannur is 16, the birth rate

[4] Menon, Sreedhara (1962): ***Gazetteer of India, Kozikode*** (Trivandrum), p.610.

is 17.7 and the maternal mortality rate is 0.8. In terms of literacy, Kannur ranks fifth in the state (92.80). The population growth rate is 7.13 (5^{th} position). This is below the state figure of 9.42. According to the 1991 census the population of scheduled castes and tribes was 1,09,466. This is 4.86 per cent of the total population of the district. Here, 91,223 are scheduled castes and 18,243 are scheduled tribes.

Religion and Caste

The Hindu community in this district, as elsewhere in the country, is organized on the basis of castes and sub-castes. The castes are broadly categorized as Brahmin, Nair, Thiyya, Ambalavasi etc. The major scheduled caste is Cheruman and the prominent tribe is Kurichya. Other important scheduled castes are Pulaya, Nayadi, Valluvan, Malayan and Paniya.

The Muslim, known as Mappilas, forms the second largest community after the Hindus. The Majority of the Muslims here are Sunnis. The Christians form the third important community. They belong mainly to four denominations. The Syro Malabar Church, the Latin Catholic Church, the Church of South in India and the Orthodox Syrian Church.

Agriculture and industry

Majority of the population of the district is directly or indirectly dependent on agriculture for their livelihood. Kannur district has 16,835 hectares under irrigation, which is 3.24 per cent of the gross irrigated area in the state. In

terms of total area under irrigation, Kannur districts ranks last among the districts in the state. Well density per sq. km. is 160 in the coastal area, 90 in the midland and 48 in the highland area. It is estimated that there are 1.59 lakh wells in Kannur district. Only five per cent of the ground water potential is utilized at present for irrigation.

Kannur has had an industrial importance from very early days. The district is blessed with a variety of factors and they offer ample scope for the development of industries. Nevertheless, Kannur is an industrially backward district. There are only two major and five mini industrial estates in the district. Keltron complex and Western India Plywood (which is one of the biggest wood based industrial complexes in South East Asia). The district has 12 medium-scale industries, most of which are engaged either in cotton textile or plywood manufacturing.

Textiles, Beedi and Coir are the important traditional industries in the district. About one lakh people depend on the textile industries for their livelihood. The coir industry, which uses traditional technology, provides employment to about 11,000 workers. The Beedi industry is next to the handloom industry in terms of employment potential. It provides employment to about 50,000 people.[5]

[5] GOK, Department of Public Relations (1997): ***District Handbooks of Kerala, Kannur***. p. 31-40.

Health care system and problems

In the district, there exists a three–tier public health care system: including Taluk-District- General hospital. It is extended into 72 primary health centres, 408 subcentere, 14 community health centres and six government hospitals. Apart from these, 50 dispensaries, six hospitals and one medical college adhere to the Ayurvedic system of medicine. 33 dispensaries and one hospital are working under homeopathy medicine. Besides, there are 13 Employees State Insurance (E.S.I) dispensaries and one E.S.I. hospital functioning for the employees. The total number of beds in the government sector is 2125. In the cooperative sector there is one medical college and 9 hospitals working in the district. Also, there are 131 private health care institutions in the district.

A three per cent of annual increase has been recorded in the morbidity rate (prevalence of disease in a community) in 1997-98. The total number of patients (in OP and IP) in 1996-97 were 18,59,651. In 1997-98 the number increased to 1914515. In the year 1997-98, the total number leprosy patients were 381, it increased to 487 in 1998-99.[6] 57-leptospirosis cases were reported in 1999 April-November. Out of this, 9 people died. Only about 30 per cent of the people from the lower income group seek treatment from the government health care institutions.[7] Out of the 72 primary health centre, 11 primary health centres do not have electricity connection, and some primary

[6] Kannur District Planning Commission (2000): ***District Plan-Part-I. Kannur.*** 2000.
[7] Ibid.

health centres do not have room facility for keeping refrigerator and such other equipment. Out of the 408 sub-centres, 174 subscentres do not have own building. Among the 33-homeo dispensaries, 21 do not have their own building, 10 dispensaries have no electricity, 20 dispensaries do not have clean water, and 16 dispensaries do not have basic facilities. Further, there is no laboratory facility in the district homeo hospital.

KUNHIMANGALAM GRAMAPANCHAYAT

Initially, Kunhimangalam was a part of the Ezhimala kingdom. Later, it came under the control of the king, Kolathiri. The Cheruthazaham-Kunhimangalam, one of the panchayats in the Malabar district, was divided in 1962, and Kunhimangalam panchayat came into existence by joining the 7 wards in the Kunhimangalam area.

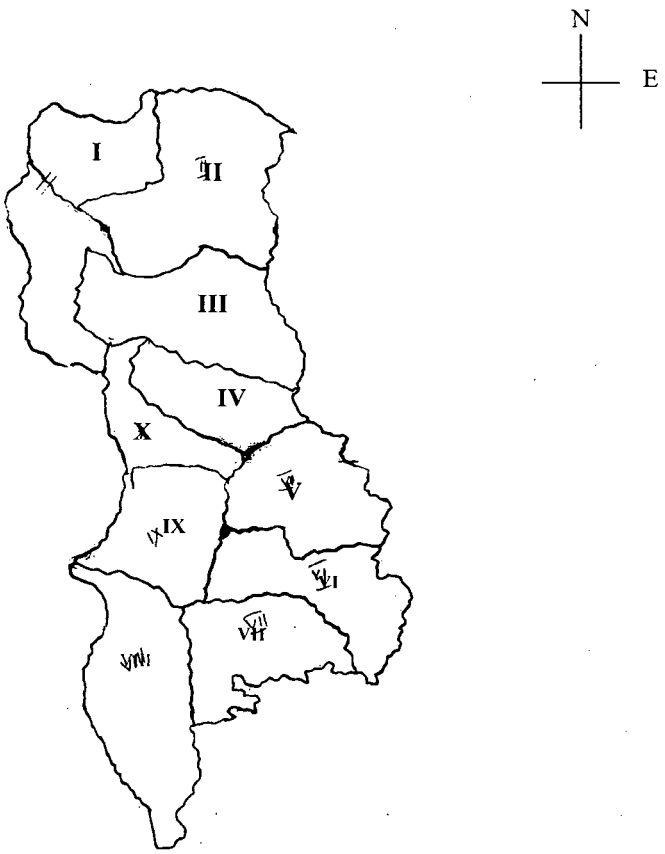
The historically famous temple entry proclamation of 1936, created resonances in this panchayat. During the period of freedom movement, several meetings and demonstrations were organized in Kunhimangalam. The People of Kunhimangalam also organized and conducted protest demonstrations against the Jalian Walabagh massacre. Communist party and farmers organizations were active in leading the movements against land tenancy and other exploitations associated with land ownership.[8]

[8] Kunhimangalam Gramapanachayat.(1996): ***Development Report***. pp. 1-20.

Details of the Panchayat

Name of the Gramapanchayat	-	Kunhimangalam Gramapanchayat
Area	-	15.44 km^2
Population (1991)	-	17279
Number of wards	-	10
Political control	-	CPI(M)
Native village	-	Kunhimangalam
Block panchayat	-	Payyannur
Taluk	-	Kannur
Legislative constituency	-	Payyanur
Loksabha constituency	-	Kasargod

KUNHIMANGALAM GRAMA PANCHAYAT



Source: Grama Panchayat, Kunhimangalam

Geographical features

Kunhimangalam Gramapanchayat comprises of highland, midland and low land. The lowland is comparatively narrow and it comprises of rivers and deltas. This is the region, which thrives in coconut and paddy cultivation. Though the panchayat is blessed with watercourses, the availability of drinking water is a problem in the panchayat. Households own most of the wells and ponds in the panchayat. There are only 13 public wells and 2 deep wells in the panchayat.

Demographic features

The population of Kunhimangalam gramapanchayat, as per the 1991 census was 17,279. The density of population in the panchayat was 1119. 5.7 percentage of the population belongs to scheduled castes and scheduled tribes. The literacy rate in the panchayat is 89.62. According to the 1996 social survey the total population of the panchayat is 18866. The infant mortality rate in the panchayat is 12.4, the death rate is 4.4, the birth rate is 9 and the maternal mortality rate is 12.4.

Major communities

The Hindus constitute the largest community (around 80 per cent) in the panchayat. Thiyya (around 70 per cent of Hindu religion) (ezhava) community, comes under other backward caste list, is the major subcaste in the panchayat. The Muslim community is the second largest (around 18 per

cent) and Christian community follows them. (Around 2 per cent). In 1991, the total number of persons belonging to scheduled castes in the panchayat were 991. However, the number of persons belonging to scheduled tribe were only 3.

Occupation

Kunhimangalam is an agriculturally predominant area. Paddy and coconut form the bulk of the agricultural production in the panchayat. Majority of the population is dependent on agriculture and other related activities. Around 50 persons work in the Beedi industry.(This is under the cooperative sector.) 50-70 persons work in the toddy industry. Very few are employed in the government sector. A considerable number of people work in the Gulf countries. (Around 3 per cent of the total population)

Health care

A rural dispensary was opened in 1973. It was upgraded into primary health centre in 1988. There are two subcentres under this primary health centre. There is one homeo clinic and one allopathy clinic working in the private sector. Majority of the people in the panchayat utilizes private health care institutions, which are outside the panchayat. The Panchayat constructed a 15 bed hospital in 1995, but due to lack of infrastructural facilities and health personnel, the government is yet to open it for the public.

Major political parties

CPI (M), CPI, Congress, and Muslim League are the major political parties in the panchayat. The CPI (M) has been ruling the panchayat since 1964. There are 10 wards in the panchayat and now all seats are monopolized by the Communist Party of India (Marxist).

People's Participation in Gramasabha

In the year 1996-97, 845 persons participated from the general category(663 male and 182 female) and 59 from the scheduled castes participated in gramasabha meeting. In the year 1998-99 it was decreased by 737(498 male and 246 female) and 42 respectively. In 1999-2000, 785 (512 male and 273 female) persons participated from general category and 99 from scheduled castes participated in the gramasabha.[9]

MADAYI GRAMAPANCHAYAT

The Madayi Panchayat is known by many names such as 'Marahi' 'Marahi 'Matayelii', Hilmaravi etc. These names are recorded in Sangam literature,' Tuftul Mujahideel' and 'Logeans Manual'. However, it is in the context of the partientarity of the terrain that, the name madayi is gained currency. The geographical area that has been formed as a result of the displacement of water is known as ' Madu'. It is believed that this particular geographical area was a part of the sea. Madayi is called so, as it was a place, which was

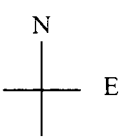
[9] District Planning Commission (2000): ***District Plan - Part I.***

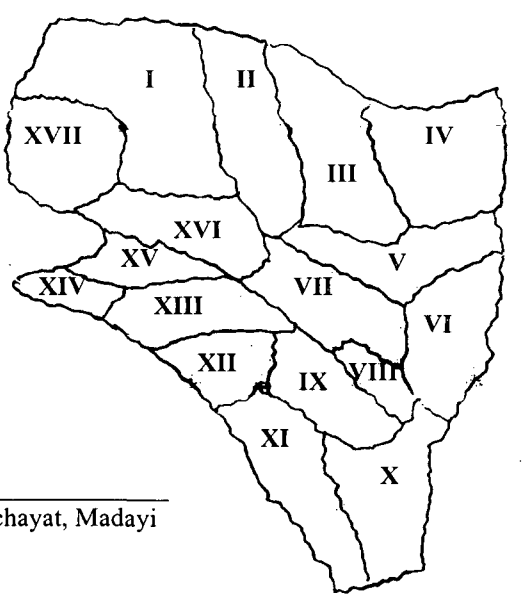
formed as a result of displacement of seawater. In 1124 'Malik Ibin Denar' and his family who came from Arabia with the help of Kolathiri king laid the foundation of Madayi palli.[10]

Details of the panchayat

Name of the Gramapanchayat	-	Madayi Gramapanchayat
Area	-	16.71 km^2
Population (1991)	-	33488
Number of wards	-	17
Political control	-	Muslim League
Native village	-	Madayi
Block panchayat	-	Payyannur
Taluk	-	Kannur
Legislative constituency	-	Payyannur
Loksabha constituency	-	Kasargod

MAP OF MADAYI GRAMA PANCHAYAT





Source: Grama Panchayat, Madayi

[10] Madayi Gramapanchayat (1996): ***Development Report.*** pp. 16-21.

Geographical features

Majority of the land in Madayi comprises of plains. On the basis of geographical conditions, the land area is divided into six regions. They are riverbanks with marshy land, paddy fields, hillsides, land fields with red stone, white lands and forest areas.

Demographic features

Madayi Gramapanchayat is a densely populated panchayat. According to the 1991 census it had a total population about 33,488. Density per sq. km is as 2004. Out of this, 17411 are females and 16077 are males. 8.9 per cent of the total population belong to SC and ST. The literacy rate in this panchayat is 88.08.

Major Communities

The Muslim community forms the largest community (around 65 per cent) in the panchayat. The Hindus form the second largest community. Thiyya (ezhava) (around 70 per cent) are the major subcaste with in the Hindus. The Christians form the third community (around 3 per cent) in the panchayat. In 1991, the total number of people belonging to scheduled castes were 2988, while the number of people belonging to schedules tribes were only eight.

Occupation

Agriculture is the main occupation in the panchayat. The sea and rivers bound the Panchayat. Fishing and related work is the other important occupation in the panchayat. Among the industry, cottage industries are predominant. About 200 families depend on the coir industry. When compared to Kunhimangalam Gramapanchayat and Pallikkunnu Gramapanchayat, considerable number of people from Madayi Gramapanchayat work in gulf countries.(around 10 per cent of the total population.)

Health care

There is one primary health centre, two private hospitals and one private homeo clinic in this panchayat. Under the primary health centre there are seven subcentres. But, six sub-centres do not have their own building. Majority of the people in the panchayat is seeking medical facilities from private hospitals. Very few people depend on district government hospitals and community health centres.

Major political parties

Muslim league, Congress (I), CPI (M), CPI and BJP are the major political parties in the panchayat. However, BJP has never opened account in panchayat election. Infact it is the Muslim league, which has a strong, base in Madayi panchayat.

Party position in Madayi Gramapanchayat in 2001

Muslim League	- 10
Congress (I)	- 4
CPI (M)	-3
Total	= 17

Peoples Participation in Gramasabha

In the year 1996-97, 1015 (927 male and 88 female) people participated from the general category and 15 from scheduled castes participated in the gramasabha. In the year 1998-99, this number increased to 1149(804 male and 345 female) and 301 respectively. In year 1999-2000, participation from the general category further increased to 1235 (813 male and 422 female), but the participation from the scheduled category decreased to 81.[11]

PALLIKUNNU GRAMAPANCHAYAT

The history of Pallikunnu gramapanchayat is closely related to the history of Kannur City. Archeological evidence attached to the various place names point to the existence of a Buddhist presence in ancient times. Historians point out that the tantric form Buddhism was popular in these areas during those times. The religious reformation under the spiritual guidance of Sankaracharya in the 9th century A.D., restored the brahminical dominance in this area, this in fact degraded the existing social relationships and the earlier caste based varna system was rigidly reinstated. It has to be noted that this area was famed for remarkable achievements in literature and art. This was primarily the result of the patronage extended by the Chirakal

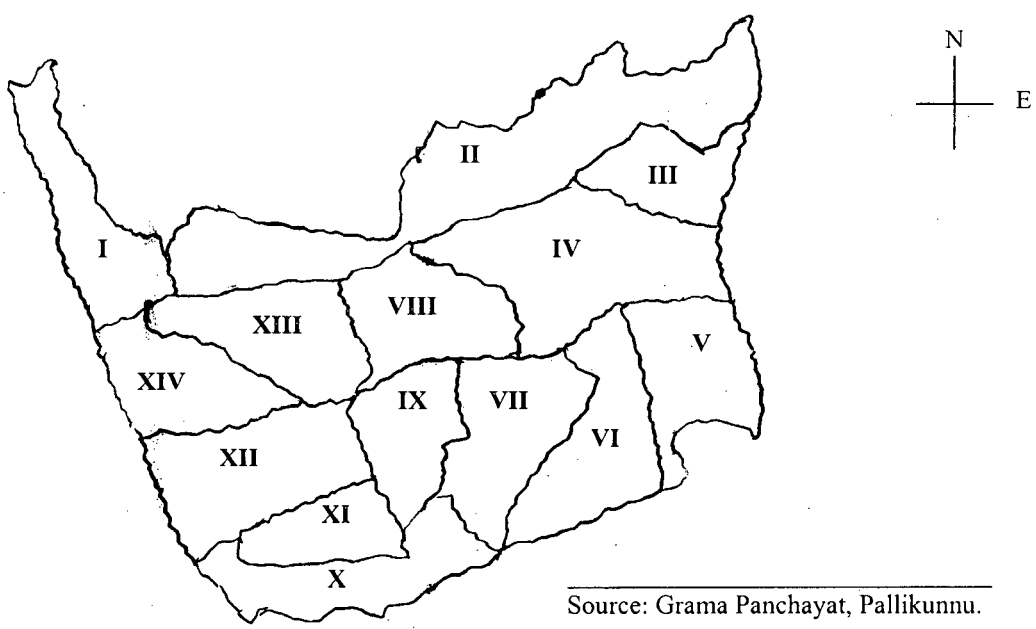
[11] District Planning Committee (2000): ***District Plan- Part-I, Kannur*** p. 11.

Kingdom of Kolathiri. During the first half of the twentieth century, the waves of the National movement had their resonance in Pallikunnu. During this period, movements for social and political reform were quite vibrant.[12]

Details of the panchayat

Name of the Gramapanchayat	-	Pallikunnu Gramapanchayat
Area	-	6.9 km^2
Population (1991)	-	25057
Number of wards	-	14
Political control	-	Congress (I)
Native village	-	Pallikunnu
Block panchayat	-	Kannur
Taluk	-	Kannur
Legislative constituency	-	Kannur
Loksabha constituency	-	Kannur

PALLIKUNNU GRAMA PANCHAYAT



Source: Grama Panchayat, Pallikunnu.

[12] Pallikkunnu Grama Panchayat (1996): ***Development Report***. pp. 1-20.

Demographic features

According to 1991 census, the total population of the panchayat was 25057. 4.2 per cent of the total population belonged to the scheduled castes and scheduled tribe. The density of the population in the panchayat is very high i.e., 3631. The literacy rate in the panchayat is 97.47.

Major communities

The Hindus form the first largest community (around 85 per cent) in the Pallikunnu panchayat. Thiyya community, a subcaste within Hindu religion, has a very strong base in the panchayat (around 75 per cent). The Muslim community (around 11 percent) and the Christian community (around 4 per cent) are second and third in terms of numerical dominance. In 1991 the total number of scheduled castes in the panchayat were 1036 and tribes were eight.

Health care

The Primary Health Centre in the panchayat was established in the year 1998. Apart from this, a homeo dispensary is also functional in the panchayat. There are no government hospitals. A very few villagers visit this centre. (PHC). Among these, the majorities are from the socially and economically backward communities.(The PHC is situated near to the sea shore, so most of the health seekers are from the fishing community.) Instead, they utilize the district hospital, which is only 4 km away from the panchayat. Also, there are allopathic, homeopathic and Ayurvedic health care institutions in the panchayat.

Major political parties

Congress (I), CPI (M), Muslim League and CPI are the major political parties in the panchayat. The BJP and CPI do not have much support in the panchayat.

Party position in the panchayat

Congress (I)	- 9
Muslim League	- 2
CPI (M)	- 3
Total	= 14

Peoples Participation in Gramasabha

In the 1996-97, 838(737 male and 101femalw) people participated from the general category and 22 from the scheduled castes participated in the gramasabha. In the year 1998-99, this number decreased into 814(620 male and 194 female), but the participation from the scheduled caste category increased to 52. In 1999-2000, the participation again decreased into 705.

The social and economic status attained by the three panchayats is more or less same. When compared to other two panchayats Pallikkunnu Gramapanchayat has a proximity to a growing urban centre. Regarding the factor religion, except Madayi Gramapanchayat, the dominating religion is Hindu religion. But in all these three panchayats, the dominating caste is Other Backward Caste (OBC). The next chapter of the study deals with the planning and implementation of health projects in the context of different

CHAPTER IV

CHAPTER IV

HEALTH PROJECTS AND PEOPLE'S PARTICIAPATION

Health is a state of being that is subject to wide individual, social, economic, political and cultural interaction. The possibility of such an interaction and its positive outcome is influenced by the combined deliberative attempts by the people, the local level elected representatives and the bureaucracy. The involvement of these three groups has always been regarded as an integral part of the process of social development.

Speaking specifically about Kerala, one of the vistas through which issue of community health has been addressed is the movement popularly known as the "People's Plan". Constitutional support, the Panchayati raj Act, the concept of democratic decentralisation and mass participation in planning and implementation have all been instrumental in giving an impetus to this movement in Kerala. This movement seeks to redress different social and economic issues including public health. This chapter deals with the participation of the people, and health staff in the planning and implementation of health projects in the three different panchayats. It also looks at the nature of health projects, which have been implemented in the three panchayats.

In relation to the people's plan, the State Planning Board and the Department of Local Self Government has issued detailed guidelines for the formation and implementation of local plans by the Panchayati Raj Institutions comprising Grama Panchayats, Block Panchayats and District Panchayats, functioning under the Kerala Panchayati Raj Act 1994. (Municipalities and Corporation included parallelly). The Government and the State Planning Board stipulated that atleast 40 percent of the fund should be spent in the productive sector, namely agriculture, animal husbandry, minor irrigation, fisheries, manufacturing etc., In the infrastructural sector [Buildings, roads, bridges etc] the maximum fund is not to exceed 30 percent. The remaining 30 percent of the plan fund should be spent in the service sector, which includes public health and drinking water, education, social welfare, etc.

The Gramasabha and people's participation is the most important units in the people's plan. On the basis of the instruction of the apex bodies, all panchayats in the state implement their own plans through different types of projects. The process of preparation and implementation of the Project is based on the discussion and participation of the voters in Gramasabha. And the issue, which is to be dealt with through the project, is expected to be relevant and in tune the development report of the Panchayat. All projects in the Panchayat are prepared and implemented jointly by the people, and the experts in the concerned fields. These include government servants too.

Project in people's plan

The project is the smallest unit of the developmental process. It should be formulated in such a way that there is feasibility regarding its analysis, planning and execution.[1] Every project has certain objectives, an area and a time period.

The projects in the people's plan are related to three sectors –namely the productive sector the infrastructural sector and the service sector. The time period of a project varies from six months to more than one year. Some projects focus on specific sections of the society: SC, ST, Women etc. while some others are meant for all sections.

A project usually has eight factors (sections) - preface, objectives, beneficiaries, activities and technical analysis, organization, financial aspects, achievements and monitoring. The need and relevance of a project is explained in the preface of the project. Available statistics can be used for this purpose. The objectives of the project should be enumerated properly. The beneficiaries of the project and the selection of beneficiaries should be mentioned in the project. The time bound activity of the project is another important factor, and those activities should anticipate the outcome. All the activities in a project are related to different agencies and each agency has a

[1] Kerala State Planning Board (1997*): **Project Vilayiruthal Kaipusthakam (Malayalam)***. [Hand book for project evaluation], Thiruvananthapuram, p. 20.

specific role. This should be described under the section 'organization'. The financial aspect deals with the total fund for the implementation of the project. The last part of the project deals with its monitoring. A separate agency can be formed for this purpose. Grama Sabha members can also be included as members of the monitoring committee.

Generally, in health projects, all persons are considered as the beneficiaries of its programmes. However, special consideration definitely needs to be given to the persons who are poor and also to those living in remote areas. At the organizational level it should be ensured those health experts, health staff and the people are involved in the preparation and implementation of the project. The medical officer is the implementing officer of the project. While preparing health projects at the panchayat level, the average plan fund allotted for a panchayat is 6-7 lakhs rupees (for municipalities it is 12-15 lakh rupees).[2] Apart from the plan fund, the panchayat may also get funds from the state government, public sector banks, cooperative banks, other financial institutions and also some contributions from the beneficiaries.

In this study, the researcher has selected three panchayats. Interviews were conducted with 120 persons, (40 persons from three different panchayat) who were selected randomly. In selecting these panchayats, the purposive sampling method was adopted with the criteria that one panchayat should be

[2] ***Kerala State Planning Board***. Op.cit.p141

a Congress(I) controlled panchayat and the other two are CPI(M) and Muslim League Panchayat respectively. Other than the grama sabha members, 18 health staffs from three primary health centres in the respective panchayats were also interviewed. Within this sample group, there were three medical officers, two health inspectors, two junior health inspectors, and 11 junior public health nurses.

In addition to this, six health projects, which have been implemented in the three panchayats were also considered. These projects were divided into two categories, namely DEC (Diethyl Carbomaizine Citrate) projects and non-DEC projects. The DEC projects were implemented in all panchayats to tackle the problem of lymphatic filariasis. The non-DEC projects in this study are 'Medical Camp for all people in the panchayat' (Kunhimangalam Grama Panchayat), 'Blindness Eradication Camp' (Madayi Grama Panchayat) and 'Hepatitis –B immunization camp for children below one year' (Pallikunnu Grama Panchayat).

DEC Projects

As part of the national level filariasis control programme, all panchayats in Kannur District undertook a mass distribution of DEC tablets for the treatment of the Lymphatic filaria disease. Lymphatic filariasis is a crucial public health problem affecting over 120 million people worldwide. India is the largest endemic country and accounts for 40 percent of the global burden of the

disease. About 450 million people in India are exposed to the risk of infection and 40 million are already infected. [3]

Kerala is regarded to be the high-risk state in India with respect to lymphatic filariasis. The principle control strategy of the national level programme is based on an annual single dose treatment of all eligible prospective individuals of the high risk community. The distribution of the tablets depends on age of the beneficiaries. An individual who is above 18 years is prescribed a doze of six tablets at a time. One tablet weighs 50 mg. Infants, pregnant ladies, old infirm persons, chronic patients with heart, lungs and kidney diseases are excluded from this treatment. The implementation of this programme was made possible through decentralization: the people's plan and its plan fund. DEC tablets were distributed through the District Medical Office.

Kunhimangalam Grama Panchayat implemented DEC distribution project along with an awareness programme against the insensitive usage of plastic bags. This was executed under the title "Filariasis Eradication and Awareness for Elimination of Plastic Bags". Similarly Madayi Grama Panchayat implemented the project with the title "Comprehensive Filariasis Resistance Programme". Meanwhile, Pallikunnu Grama Panchayat implemented the

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[3]. UNDP/WB/WHO(-2002): ***Drug delivery strategies for Lymphatic Filariasis elimination in India- Report of a Multi Centre Study.***

project with the title "Filariasis Resistance Treatment- DEC Tablets Distribution".

In two of the panchayats, the projects were prepared by the concerned medical officer, but in the third panchayat (Madayi Grama Panchayat), the project was prepared by a panchayat member, who was interviewed in the course of the study. He revealed that he had not prepared any health projects. Here it is possible that the project might have been prepared by a health staff or any other person who then attributed the authorship to the panchayat member.

In all these three projects, the preface explains the problem of filariasis and the importance of the distribution of DEC tablets. All the projects aimed to eradicate filariasis within five years. But the preface of the three projects does not give any statistics on the prevalence rate of such a problem in the panchayats.

The beneficiaries of these projects are infact the people in the Panchayat. Madayi Grama Panchayat gave special importance to SC and ST person, but the project does not say anything about the desirability of SC or ST people in relation to this project. It is felt that all projects get sanctioned easily if importance is given to weaker sections like SCs, STs and Women. Perhaps it was this notion that made the author of the project to specifically foreground SCs and STs. What has to be understood is that even though this project is

implemented through the peoples' plan machinery and fund, it is a national programme and so it gets special sanction even if it does not give importance to SCs and STs.

At the organizational level, all DEC projects speak about the formation of a committee, in which the concerned medical officer is the convenor. All projects mentioned the participation of volunteers; one volunteer for 25 homes. But it does not say anything about their selection procedure.

When one looks at the financial aspects, Madayi Grama Panchayat was expected to spend Rs. 29,500 (plan fund- Rs. 29,000 + voluntary contribution -Rs. 500), the Kunhimangalam Grama Panchayat was to allot Rs. 10,400 (plan fund only) and the Pallikunnu Grama Panchayat was to spend Rs. 17,645 (own fund). Madayi Grama Panchayat allocated Rs. 1,500 for committee formation. This included fund for notice and snacks. In Pallikunnu Grama Panchayat this was only Rs. 200. Madayi Grama Panchayat allocated Rs. 5,500 for the training programme and study materials of the volunteers. But in the other two panchayats (Kunhimangalam Grama Panchayat and Pallikunnu Grama Panchayat) no fund was allocated for the same. In Madayi Grama Panchayat 's project, it was expected to select 230 volunteer workers and allocated Rs. 11, 500 for incentives (Rs. 50 per volunteer). One volunteer was supposed to distribute DEC tablets to 25 households. In Kunhimangalam Grama Panchayat, the number of volunteers was 140. It allocated Rs. 7,000

for this purpose. In Pallikunnu Grama Panchayat, it was Rs. 12,950 for 259 volunteers. Madayi Grama Panchayat allocated Rs. 2,000 for supervising the programme and transport charge on the DEC tablets distribution day, while Kunhimangalam Grama Panchayat allocated only Rs. 500 (The total area of Madayi Grama Panchayat is 16.7 sq.km and the total area of Kunhimangalam Grama Panchayat is 15.44 sq.km). However, Pallikunnu Grama Panchayat did not allocate any amount for the same. The Monitoring of these projects were done by a Panchayat level committee and a ward level committee.

In all the three projects, DEC tablets were made available from the District Medical Office free of cost. But all other expenditure was met through the plan fund or the panchayats' own fund. Informal interviews were conducted with the volunteer workers, who were Balawadi workers and degree level students. Volunteer workers told that some persons showed hesitation to accept the medicine (DEC tablets) and also that they did not even know as to how many persons really took the medicine. This was despite the fact that the volunteer workers were trained about the quantity and usage of the medicine from the medical officers and health inspectors.

In this study, interviews were conducted with 120 persons, (40 from three different panchayat) Out of these, 100 persons got DEC tablets. Among these 100 persons, only 15 respondents actually took the tablets. Among these, seven persons developed side effects like fever headache and vomiting. One

panchayat member said, "I got DEC tablets, but I did not swallow it, because I do not give importance to these tablets". One high school teacher said, "Actually the project DEC was decided and prepared by the health staff. Common people do not know anything about it. We think they are right, and so we did not oppose the programme. But I have not swallowed the tablets." One medical representative from Pallikunnu Grama Panchayat said "In this area there is no filaria case, and so I have not swallowed the tablets." One Beedi worker from the same panchayat said " I swallowed DEC tablets, and the next day I had headache, fever and vomiting." On the other hand, the Pallikunnu Grama Panchayat medical officer claimed that she evaluated the project DEC, and found out that 70 percent of people had swallowed the medicine. But she could not say as to how she obtained this data and as to how many people got side effects.

Non-DEC projects

The non-DEC projects in this study are the 'Blindness Eradication Camp' (Madayi Grama Panchayat), the 'Medical Camp for all people in the panchayat' (Kunhimangalam Grama Panchayat) and the 'Hepatitis B immunization camp for children below one year' (Pallikunnu Grama Panchayat).

1. Blindness Eradication Camp

This project in the Madayi Grama Panchayat was implemented in the year 2000-2001. The preface of the project speaks about the problem of eye disease and blindness. The project maintains that due to the lack of proper government health facilities, the people are compelled to go to private hospitals where they are exploited. The following were the objectives of this project.

1. To achieve possible the blindness eradication in the panchayat.
2. To control the increasing treatment cost
3. To give treatment to marginalized people like fishermen farmers, and SCs.
4. To ensure that every individual in the panchayat is healthy.

All the persons who reside in the panchayat were the beneficiaries of this project. The Project was expected to form a committee in which the panchayat President is the Chairman. All health workers and voluntary workers were the members of the committee. It was supposed to conduct three camps in the panchayat. It was also expected to form ward-level committees. The project was expected to involve district team who was working with the blindness eradication programme at the government level in the district. The project discusses the distribution of medicine in the camp and also the distribution of spectacles after the camp. It also speaks about

free operation facility for needy people free of cost. The total time period of the project was four months.

The panchayat was expected to spend a total of Rs. 65, 100 for this project. From this total amount, Rs. 60,100 was from the plan fund and Rs. 5000 was beneficiary contribution. For committee formation, notice, banner, pamphlets, posters, mike announcement, TA for camp members and other materials, the panchayat allocated Rs. 21,100. For medicines the panchayat allocated Rs. 18,000. For spectacles it was Rs. 14,000 and for operations it was Rs. 12,000. The project does not tell much about the monitoring committee and its convenor. It only mentioned that technical expert from block level panchayat and Grama panchayat will be in the monitoring committee.

One of the objectives of the project was to ensure the health of all individuals in the panchayat. But the project does not say that this would be done through this project. Also, the project does not give any justification for spending Rs. 21,000 for committees, banners, mike announcement and such other activities. It was decided to conduct three camps in the panchayat, but there were only two camps. There were a total of 543 participants in the camp. Out of these, 114 persons got spectacles and 12 persons were selected for operation. But nobody has utilized this facility. The health staffs of the PHC (Madayi Grama Panchayat) were not able to say as to why those people have not utilized the facility. All the health staff from Madayi PHC said

that it was an important and successful programme, because people participated in the camp and they got benefits out of this project.

2. Medical camp

The Kunhimangalam Grama Panchayat implemented this project for all people in the panchayat. This project gave importance to people who live in Harijan colonies. The objectives of the project were (a) try to find out different types of health problems among the people. (b) Provide free medicine and treatment (c) create awareness among the public about epidemics and (d) try to avoid long journey for awaiting the service of private specialist doctors' service.

This project was to have involved specialist doctors atleast once in 6 months. It was decided to conduct four camps in the panchayat in a year. A committee was to be formed in which the President is the Chairman and the Medical Officer is the Convenor. All ward members and health staff were to be the committee members. It was decided to spend Rs. 47,000 for the project (plan fund-. Rs. 40,500 + voluntary organization–Rs. 5000 + donations- Rs. 1500). Out of this total amount Rs. 47,000 Rs. 30,000 was allocated for medicine, Rs. 12,000 for doctors, Rs. 4,000 for publicity and Rs. 1,000 for TA for doctors. The monitoring of this project was expected to be done by a committee in which the medical officer was the convenor.

3. Hepatitis B. Immunization Camp for Children below One Year

This project was implemented in Pallikunnu Grama Panchayat in 2000-2001. The preface of the project speaks about the problem of hepatitis B in the state. It states that the cost of hepatitis B vaccine in the private market is costly and so all people in the panchayat cannot afford it. The objective of the project is to save all infants in the panchayat from the problem of hepatitis B. Awareness programmes against the disease, conducting discussion and classes in all wards of the panchayat, and organizing immunization camp in the panchayat where the activities of the project. The prospective beneficiaries of the project were around 360 children (bellow 1 year). It was decided to give three-dose vaccine to these children.

The total fund allocated for the project was Rs. 66,920. For publicity and other stationery items Rs. 2120 was allocated. Rs. 64800 was allocated covering the cost of medicines, and other expenses. Out of the total fund, Rs. 44, 247 as from the plan fund, Rs. 10,000 from the state fund and Rs. 12,673 were from the panchayat fund. It does not mention the details regarding the purchase of medicines. Monitoring of the project was to be done by a five-member committee including the medical officer and panchayat members. This project still exists and Rs. 14193 was spent by 2001 March. Project was expected to give vaccination for 360 children. But only 120 children were given the vaccine.

An analysis of this prevalent situation reveals the social and economic status of the gramasabha members, their participation and involvement in the people's plan and also the involvement of health staff in the programme. Besides, the study tries to analyze the views of the people as well as that of the health personnel about decentralised plan in general and the implementation of health projects in particular in their panchayat.

TABLE IV. 1 Position of the respondents by village panchayats

Position	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Voter	36 90%	35 87.5%	39 97.5%	110 91.7%
Ward member	-	2 5%	1 2.5%	3 2.5%
Taskforce member	4 10%	3 7.5%	-	7 5.8%
Total	40 100%	40 100%	40 100%	120 100%

Among the 120 respondents 110 persons were gramasabha members (voters), three people were ward members and seven were task force members. There was no panchayat member or Task Force Member from the Pallikkunnu Grama Panchayat.

The majority of the respondents i.e. 51 (42.5%) come in the age group 31-45, and there are only 12 (10%) respondent in the age group 60 and above. The second largest section comes in the age group (18-30), i.e. 37, and the next

one was 46-59, in which there were 20 respondents. In Kunhimangalam panchayat 23 (57.5%), out of 40, come in the age group 18-30, but in Madayi Grama Panchayat and Pallikunnu Grama Panchayat it was six and eight respectively. In Madayi Grama Panchayat 22 (55%) respondents came in the age group 31-45, in Kunhimangalam Grama Panchayat it was 11 and in Pallikunnu Grama Panchayat it was 18.

TABLE IV. 2 Respondents by Sex and Village Panchayats

Sex	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Male	29	21	23	73
	72.5%	52.5%	57.5%	60.8%
Female	11	19	17	47
	27.5%	47.5%	42.5%	39.2%
Total	40	40	40	120
	100%	100%	100%	100%

Out of the 120 gramsabha members 73 respondents. (60.8%) were male and the remaining 47 were female. In all the three panchayats, the percentage of male population is higher than female. In Madayi Grama Panchayat the percentage of male population is 52.5% i.e., 21. In Kunhimangalam Grama Panchayat and Pallikunnu Grama Panchayat it is 72.5 percentage (29) and 57.5 percentage (23) respectively.

TABLE IV. 3 Religion of Respondents by village panchayat

Religion	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Hindu	37 92.5%	21 52.5%	36 90%	94 78.3%
Islam	1 2.5%	18 45%	3 7.5%	22 18.3%
Christian	2 5%	1 2.5%	1 2.5%	4 3.3%
Total	40 100%	40 100%	40 100%	120 100%

Out of the 120 respondents, 94 (78.3%) respondents were Hindu. The second largest group were Muslim i.e. 22 (18.3%). There were only four people who were Christians. Except in Madayi Grama Panchayat, the other two panchayats had more than 90 percent Hindus. In Madayi Grama Panchayat 21 (12.5%) were Hindus and 18 (45.1%) were Muslim. Among the 18 health staff in the study, 14 respondents were Hindus, three Christians and one Muslim.

TABLE IV. 4 Caste of Respondents by Village Panchayat

Caste	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Forward caste	9 22.5%	5 12.5%	7 17.5%	21 17.5%
OBC	26 65%	33 82.5%	30 75%	89 74.2%
SC	5 12.5%	2 5%	3 7.5%	10 8.3%
Total	40 100%	40 100%	40 100%	120 100%

Eighty-nine (74.2%) people in the study were in the OBC category, (Other Backward Caste), 21 (17.5%) from forward castes and 10 (8.3%) from scheduled castes. In Madayi Grama Panchayat 33 people, out of a total of forty respondents, were OBC. Here the Muslims population is comparatively high and so the OBC in this panchayat is high. Among the health staff four respondents from FC and 10 were from OBC, including two medical officers, and four were SC.

The Educational Qualification of ten respondents (8.3%) in the sample was lower primary. Twenty-four (20%) respondents had Upper Primary School qualification.

The educational qualification of 41 (34.2%) respondents in this study was high school. 18 respondents (15%) had completed their plus 2/ pre-degree. 11 respondents had completed their degree (9.2%). Thirteen respondents (10.8%) had completed professional qualification including polytechnic and B. Ed., and three (2.5%) respondents had completed their Post Graduation. Among the health staff, the educational qualification of the medical officers was MBBS, and all other health staff had completed their SSLC and training course.

TABLE IV. 5 Occupation of Respondents by Village Panchayat

Occupation	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Government servant	7 17.5%	8 20%	4 10%	19 15.8%
Coolie	10 25%	7 17.5%	7 17.5%	24 20%
Private	10 25%	9 22.5%	11 27.5%	30 25%
Dependents	13 32.5%	16 37.5%	18 45%	47 39.2%
Total	40 100%	40 100%	40 100%	120 100%

Forty seven 44(39.2%) persons included in the study did not have any specific occupation. Among this 47, the majority of the respondents were housewives and the remaining were dependents including the aged and students. Thirty (25%) respondents were working in the private sector, 24 (20%) respondents were coolie workers, and 19 (15.8%) were government servants.

TABLE IV. 6 Land area of Respondents and Village Panchayats

Land area*	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Nil	3 7.5%	1 2.5%	1 2.5%	5 4.2%
1-10cent	5 12.5%	20 50%	18 45%	43 35.8%
11-20	10 25%	4 10%	13 32.5%	27 22.5%
21-40	11 27.5%	7 17.5%	6 15%	24 20%
41-50	3 7.5%	3 7.5%	2 5%	8 6.7%
Above 50	8 20%	5 12.5%	-	13 10.8
Total	40 100%	40 100%	40 100%	120 100%

* 100 cents = 1 acre = 43560 sq.ft.

Population density and fragmentation of land is another fact to be kept in mind. The majority of the respondents owned land between 1-10 cents , i.e. 43 (35.8%). Only 13 people (10.8%) owned land above 50 cents. Among them, eight people were from Kunhimangalam Grama Panchayat and five were from Madayi Grama Panchayat. There were no respondents from Pallikunnu Grama Panchayat with land above 50 cents. It is very clear that fragmentation and daily transaction of land is very high in Pallikunnu Grama Panchayat and so a huge majority of the people do not have more than 50 cents of land in this urban panchayat. 27(22.5%) of the respondents had land between 11-20 cents and eight (6.7%) respondents owned land between 41-50 cents.

45 respondents (39.2%) came under on annual household income below Rs. 10,000. 55 Respondents (45.8%) came under an annual house hold income of Rs. 10,000-25,000. There were 13 respondents (10.8%) percentage who were under an annual household income of Rs. 25,000-50,000. Four (3.3%) respondents had an annual house hold income between Rs. 50,000-75,000. And there was only one (0.8%) respondent with an annual income of above Rs. 75,000.

Forty eight respondents in this sample said that they came to know about peoples plan through ward members, 29 respondents came to know about the movement through different media like Television, Radio, and Newspapers. Three respondents got connected with this movement through political party influence. 40(33.3%) respondents were connected through all

political party influence. 40(33.3%) respondents were connected through all these three factors. (Media, political party and ward members). Out of the 120 respondents, only 17 (14.2%) were from various political parties. From them, 10 persons were from CPI(M), four from Congress I, and three from the Muslim League, 25 respondents from were members of non-political organizations like youth clubs, Mahila organizations, NGOs etc. The rest (78) were not affiliated with any political or non-political organization.

TABLE IV. 7 Nature of Participation of Respondents by Village Panchayat

Nature of participation	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Not participate	20 50%	23 57.5%	24 60%	67 55.8%
Site quietly	8 20%	5 12.5%	8 20%	21 17.5%
Ask doubt	2 5%	1 2.5%	1 2.5%	4 3.3%
Give instruction	6 15%	7 17.5%	2 5%	15 12.5%
Active	4 10%	4 10%	5 12.5%	13 10.8%
Total	40 100%	40 100%	40 100%	120 100%

The participation of the people in the gramsabha is a crucial factor which decides the effectiveness of planning and implementation of the grassroot level programme. Out of the 120 respondents, 53 respondents participated in their concerned gramsabha in the three panchayats. Nature of participation is another very important factor that influences developmental issues. People

can participate very actively or they can be passive. Among 53 participants, 21 respondents participated in the gramsabha meeting without offering any comments or question. Fifteen respondents participated by giving their instruction in the formation of different programmes, and policies. The participation of four respondents were limited to the asking of some doubts. Thirteen persons participated in the gramsabha very actively. Here the notable factor is that among the 13, four participants were taskforce members. (Among this four, 3 are government servants) and three were ward members. Among these 53, 20 participants were from Kunhimangalam Grama Panchayat, 17 from Madayi Grama Panchayat and 16 from Pallikkunnu Grama Panchayat.

TABLE IV. 8 Participants of Respondents in Health Meeting by Village Panchayat

Participation in Health meeting	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Yes	3 7.5%	4 10%	4 10%	11 9.2%
No	37 92.5%	36 90%	36 90%	109 90.8%
No	40 100%	40 100%	40 100%	120 100%

A total of 53 respondents participated in the people's planning programme. when it came to the public health arena, the number of participants were only 11. Three from Kunhimangalam Grama Panchayat, and four each from Madayi Grama Panchayat and Pallikkunnu Grama Panchayat.

No medical officer had participated in the gramsabha meetings. However, they participated in the project planning and sectoral committee meetings. It has to be noted that the medical officers are considered as the implementing officers in relation to health projects under the people's plan planning programme. Only five health staff participated in the programme, that too only on a couple of occasions. They remarked that the gramsabhas were mainly convened on Sundays and so they could not attend the meeting as they resided in some other panchayats.

Among the participants, one junior health inspector participated in the programme very actively. He worked as a task force member and he prepared one health project on public health awareness programme. One health inspector explained that he participated in the gramasabha, but he was not asked any question and he did not get any chance to speak. Some of the health staff were very new to the department and panchayat, and so they did not get any opportunity.

In case of training, only four respondents(out of 18 health staff)d attended the class. Two people attend the block level class and two (doctors) attended the district level class. The health staff and the people themselves identified the health problems or issues. Most of the time, identification took place as part of the house visit of health staff. There was no special committee or group to identify health problems and issues under the people's programme.

The participation of the people in people's plan depends on different social, economic and political factors. Political factors like party politics party politics local level party rivalry have a major role in this. One medical representative, who is a CPI (M) sympathizer in Pallikkunnu Grama Panchayat. (Congress I panchayat) said, "In this panchayat I do not like to participate in people's plan, because we do not have any voice before the ward members. So I do not like to participate in any group meeting in the peoples plan". Another respondent from Kunhimangalam Grama Panchayat said, "Due to too much party politics, I was not able to cooperate with this movement. I was a CPI (M) member, before this people's planing programme. I participated in the gramsabha, but my opinion was not considered and I have been isolated. So I did not participate after the first one or two meetings". One respondent from Kunhimangalam Grama Panchayat said, "Democracy exists only on paper. Most of the projects were preplanned or planned by officials and political party members."

One housewife in Madayi Grama Panchayat said "Most of the people in our panchayat are going to private hospitals and the PHC is working only for the immunization programme. So hardly five or four people participated in the public health meeting, and so it does not get proper attention". 14 health staff told that most of the people were not interested in the subject health. The subsequent lack of adequate participation was the reason for the failure or poor performance of the projects. Besides, health centre do not have

minimum infrastructural facilities like laboratory, X-ray units, etc. Moreover, there is only one doctor, in the PHC. He is always busy with conferences and departmental programmes like the pulse polio immunization camp. One panchayat (Kunhimangalam Grama Panchayat) had built one hospital five years back, but yet it is not opened for the public. Apart from this, an adequate fund for the health project is another issue. Because of these reasons the people are not concerned with or interested in public health projects and meetings in relation to people's planning programme.

Nobody has discussed any public health issue with the panchayat before the formal meetings or even after the meeting. Only six health staff (out of the 18 health staff) discussed their opinions with people outside the formal meetings of the gramasabha. But most of the time it was with Balawadi workers and mothers. Elected representative at local level are responsible for formality the programme in the panchayat. After the implementation of panchayti raj system elected representatives got more power than the officials. One junior health inspector, who was a taskforce member, told that the panchayat was not interested in talks outside the meeting. This also affected the programme. A study on the interpersonal relationship between official and elected representatives reveal that officials were not ready to accept the power and

superiority of panchayat members specially of who come under reservation quota like SCs, STs and women.[4]

To a question, to gramsabha members, whether their participation is necessary in public health programmes 57(47.5%) respondents said 'Yes', 41 said 'No' and 22 respondents said 'Do not know'. All panchayat members, task force members and party members included in this 57, who replied positively regarding the importance of participation in public health programme. Among these, 31 respondents (42.46% of the total male respondents) were male and 26 (55.31%) were female. Regarding their caste 46 respondents (51.68% of the total respondents from OBC) were from OBC, five were (50%) from SCs and six (28.57%) were from forward caste.

On an average, 50 percent of OBC and SCs persons in the sample consider that their participation is necessary in public health programme. On the other hand, majority of the respondents (15) from FC do not consider their participation as an essential one. Either it may be due to their unwillingness to participate in the gramasabha or they think that they will not get any benefit out of their participation.

Among the 57 respondents, 22 respondents total annual house hold income was below (46.8% of the total respondents with an annual household income below Rs.10, 000) Rs.10, 000. Twenty seven (49.09%) respondents annual

[4] Kumari, Leela (2001): "Interpersonal Relationship between officials and women elected representatives in present panchayati raj system." ***ISDA Journal*** 11(1) Jan- Mar pp. 29-37.

household income was between Rs.10,001-25,000.Five respondents (38.46%) annual house hold income was Rs.25,0001-50,000. Two respondents(50%) annual household income was Rs.50,001-75,000. And there was one respondent, who is a panchayat member,(100%) with an annual household income above Rs.75,000.

Among 41 respondents, who said that their participation in public health programme was not important, 27 respondents(36.98% of the total male respondents) were male, and 14(29.78%) were female. Regarding their caste 29 respondents (32.58%) were from OBC, one from FC.

Regarding the participation of health staffs every one regarded their participatiotn as necessary and important. They told that they had good contact with the people and so they knew their problems and that they could present it in the gramasabha. Two health staff told that they wanted to participate only as an advisory group but now they were working as slaves of the panchayat. One Medical Officer (Kunhimangalam Grama Panchayat) "Personally I do not think it is (our participation) necessary, because it is another burden for us". Adequate redeployment of employees was not done at the local level and so the workload of bureaucracy has been increased after the implementation of the people's planning programme. Another Medical Officer (Madayi Grama Panchayat) said "People's planning is a community programme. If we involve in this we can understand their problem and we can utilize the resources properly".

In people's planning programme ,some projects are prepared for a specific group of beneficiaries and some other projects are for all the people in the panchayat. The beneficiaries of a particular project are selected by the gramasabha on the basis of certain criteria/marking system but the final list is approved by the panchayat. In the health sector almost all projects do not have a specific beneficiary group. Hence, people do not participate in Public Health meeting and they try to participate in other sectors especially in the productive sector where individual benefits schemes are high when compared to other sectors. Out of the 120 respondents only 18 persons participated in the beneficiary selection group. Among 120 respondents six persons participated in project preparation, five in project implementation and three in monitoring.

To a question regarding the feasibility of preparation and implementation of health projects, except two Medical Officers, the entire health staff told that if there was coordinated and systematic teamwork they can prepare and implement health projects with maximum result. Finance is the important factor in the preparation and implementation of the project. One medical officer (Madayi Grama Panchayat) said, "If people get a proper idea about the need of the public health programme and there is enough fund with staff, their preparation and implementation is feasible". But one medical officer (Pallikunnu Grama Panchayat), told that it was not feasible because the people will not make house visits, and they would not take responsibility. So

they could not prepare and implement health projects. Another Medical Officer (Kunhimangalam Grama Panchayat) supported this argument. One junior health inspector, who is very active in people's planning programme said, "Preparation and implementation of health projects under the peoples plan is feasible because people prepare and implement their project on the basis of their interest and need". Here it is very clear that some of the officials are not interested in local level people oriented health programmes.

Table IV.9 Monitoring of Health Projects in three Panchayats

Monitoring has taken place	Panchayat			Total
	Kunhimangalam	Madayi	Pallikunnu	
Yes	12 30%	8 20%	6 15%	26 21.7%
No	7 17.5%	7 17.5%	12 30%	26 21.7%
Do not know	21 52.5%	25 62.5%	22 55%	68 56.7%
Total	40 100%	40 100%	40 100%	120 100%

Majority of the respondents are not aware of monitoring, even if it has taken place. To the question whether monitoring has taken place or not, 26 respondents said 'Yes' (Twelve from Kunhimangalam Grama Panchayat, eight from Madayi Grama Panchayat , six from Pallikunnu Grama Panchayat) and 26 said 'No' and remaining 68 respondents said 'Do not know'. One CPI (M) member (Kunhimangalam Grama Panchayat) said, "The monitoring committee visits and checks all places and programmes. But sometimes it does not take place". One high school teacher, who was a taskforce member

said, "Monitoring committee was influenced by people who are outside the committee (in relation to a particular road project). But this is not in the all projects. However in the personnel benefit scheme monitoring has taken place". Most of the health staff was not even aware about the projects, which have been implemented in the panchayat. And they told that this was because they were new to the PHC and the panchayat. Out of 120 people, 20 people got health benefit through peoples' plan. (Five from Kunhimangalam Grama Panchayat, eight from Madayi Grama Panchayat , seven from Pallikunnu Grama Panchayat). Sometimes the benefit is to their close relatives within the family. In the DEC projects 100 people, out of 120, got tablets but only 15 swallowed it.

To a question whether public health improved in the panchayat or not only 36 respondents replied positively. Then percentage breakup was more or less same in all the three panchayats. (Twelve from Kunhimangalam Grama Panchayat, 14 from Madayi Grama Panchayat , 10 from Pallikunnu Grama Panchayat) and 19 respondents said 'No' and 65 respondents said 'Do not know'. One teacher (Kunhimangalam Grama Panchayat) said, "Before the people's planning programme people were not well aware about the PHC. People's plan could make a better relationship between the PHC and the people." One Panchayat member CPI(M) , (Madayi Grama Panchayat), who is in the opposition wing said, "Free medical camps and other awareness classes could make some positive changes. Blindness eradication project was a notable health project in our panchayat." Another respondent from Kunhimangalam Grama Panchayat said "Through medical camps and such

other programmes, the people's attitude towards the PHC has changed." One health staff commented "It is not easy to say anything about improvement, but we could convey ideas about health issues and rights, that is the success" .

One health inspector said that basic facilities and services had been improved due to the people's plan programme. One medical officer said that people's awareness regarding public health had increased and it could make some changes. Most of the health staff did not say any thing about the necessary changes in the peoples plan programme with special reference to health. This may be due to their lack of interest or poor involvement in the people's planning programme. One health inspector told that there should be some initiative for more peoples participation, and health projects should be related to people's need.

One health staff said ,"Possibilities and limitations of the people's plan mainly depend upon the people's spirit. Through health programmes under the people' plan, we can evaluate our performance. This is a good possibility". One Medical officer (Pallikunnu Grama Panchayat) told that they did not know whether fund is utilized properly or not, and they did not have enough time to check those things. This was pointed out as the limitation. One medical officer told that the result or deficiency of decentralized plan depends upon the nature of the panchayat, participation of the people and the availability of fund.

Most of the health staff ranking below the designation of medical officer told that the shift from centralized planning to decentralized planning was effective

when it was related to peoples plan. Now, the changes are notable, because atleast some people know what is happening in the panchayat. A decentralized plan gives more chances to solve their problems at the panchayat level itself. If there is any public health issue in the panchayat, the people can question it in the gramasabha and the local government is responsible and accountable to it.

Regarding the present and previous (before PRIs) working systems of the PHC, the entire health staff had the same opinion against the panchayat. Now they are supposed to go to panchayat for different needs. In the past they did not have any connection with the panchayat. They said, "Now we are accountable to the panchayat and the DMO". One Medical Officer told that regarding daily expenditure, they were waiting for panchayat's decision. Earlier, the DMO office without much delay did it. One Medical Officer (Pallikunnu Grama Panchayat) said, "Right now our head ache has increased. Now we should go to the panchayat and must explain everything. But they do not know anything about the minimum quantity of the required medicine and other problems of the PHC." All Medical Officers told that part time workers are not getting their salary timely, because their salary is sanctioned by the panchayat. Earlier, it was sanctioned by DMO along with the regular staff's salary.

Majority of the respondents was not satisfied with the people's participation in preparation and implementation of health programmes. Seventeen respondents told that the preparation and participation of the project were

satisfactory. Fifty-two respondents told that in the primary health centres basic infrastructure improved because of people's plan programme. Seven people did not agree with this, and 61 people were not able to say anything about it. To the question whether the basic health service of PHC improved, 45 respondents said 'Yes' nine respondents said 'No' and 60 persons said, 'Do not know". One respondent told that Health service system in the panchayat had improved after the implementation of people's plan, because now the field staff, doctors and panchayat members were working together and some good projects had been implemented. One Beedi worker from Pallikunnu Grama Panchayat said, "Now we can go to the PHC, we get good service. Now we do not need to pay money in the private hospital."

Conclusion

If community participation in the decision-making, preparation of plans and its implementation is active and the entire politico-economic pyramid is inverted, we can say that people's power has become a reality. Decentralization of power through Panchayati Raj Institutions (PRIs) has already proved that the people can take initiatives to formulate policies and implement various programmes at local levels. The analysis of people's participation, local level health projects, the involvement of health staff and their views give an idea about the prospects and problems of the people's plan programme in Kerala.

Differences in political control in the three panchayats do not make any differences in the planning and implementation of health projects. But it is undoubtedly clear that the people's planning programme could address

different local issues including public health. Though the participation of the people in public health was low, the movement created a sense of confidence among the people.

When compared to the centralized planning process, decentralized planning and its effect is remarkable. The integration of a local level project into the state as well as national level plan may help us to solve the problem in a better way. But here the implementation of the DEC projects is just an integration of national level programme into the local level. It gives more possibilities to implement centralized programme in the name of decentralization. Above all, the fund for the implementation of DEC projects were not given by the Central or State Government. All panchayats spent their plan fund or own fund for these projects. And the health personnel and other machinaries for the preparation and implementation of the project were from a democratically decentralized set up, which is supposed to handle local issues. This is a challenge and contradiction to what usually goes on in the name of decentralization. When people lose their power, the panchayat becomes an agency for regulatory functions and the concept of 'bottom–up planning' gets to evolve a myth or illusion.

Though there are problems like poor participation, misappropriation of the programme, issues regarding fund allocations, the three panchayats could make progress in public health arena to an extent. That is the possible outcome.

CHAPTER V

CHAPTER V

NATURE OF PARTICIPATION

Democratic decentralisation seeks to ensure the participation of the people in the planning and implementation process. In lieu of this purpose, local democracy and decentralisation of power represents one vital means of participation in the longer democratic system, which is relatively accessible to all sections of the community.[1]

According to the UNDP, "participation means that people are closely involved in economic, social, cultural and political process that affect their lives".[2] This definition implies that people participate in those economic, social cultural and political processes that have the potential to bring about favorable changes in their lives. People's participation is a collective effort, which involves mobilization, conscientisation, organisation and empowerment.[3] Hence we may say that, though people are disadvantaged, the powerless could be empowered through participation and they could share the fruits of development, along side those who have already achieved power.[4] This is because "participation is an active process by which beneficiaries influence the decision and execution of a development project with a view to enhancing

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[1] Drez, Jean and Zen, Amartya (2002): ***India – Development and Participation***. Oxford University Press, New Delhi, p. 359

[2] UNDP (1993): ***Human Development Report*** . Oxford University Press. New Delhi, pp.21-22 .

[3] Prasad, RR. (2002): "Participation and Empowerment – Rhetoric and Realities." ***Kurukshetra.*** vol. 50, No. 7 May. p. 103

[4] Mayo and Craig (1995): "Community Participation and Empowerment: The Human Face or Structural Adjustment or Tools for Democratic Transition?" in Mayo and Craig (ed.). ***Community Empowerment – A Reader in Participation and Development.*** Zed Books. London. p.5

their well-being in terms of income, personal growth, self-reliance, or other values they cherish".[5] This is what Karl Max implies when he endorses universal political participation as the means and end of the manifestation of human freedom.[6]

Participation is a qualitative process and it is closely related to the empowerment of the people. In development literature participation has been explained in different ways. Midgley distinguishes participation as 'authentic participation' and 'pseudo participation '. In 'authentic participation', local people democratically control project-decision making. In 'pseudo participation', the project is carried out by outsiders.[7] Whatever be the different explanations for participation, it is commonly accepted that there are social, economic, political and cultural obstacles in this process. Religious belief, caste, economic conditions, political changes and traditional beliefs can all be seen as possible impediments. All these obstacles arise from the question of redistribution of power, which enables people to participate in the planning and implementation of developmental programmes.

Apart from the social, economic, political and cultural obstacles, individual motive knowledge, personal values and attitudes have an influential role in the shaping process of participation. In the Weberian analysis rational

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[5] Paul. S. (1986): "Community Participation in Development Project; The World Bank Experience." ***World Bank Discussion Papers*-6.**

[6] Marx's Critique of Hegal, Philosophy of Right as Cited in ***Women and Politics – A Study in Political Participation.*** (1993). Rama Chandran, M, Lakshmi K. Book links Corporation, Hyderabad. p.23

[7] Midgley (1986): ***Community Participation, Social Development and the State***. Methuen, London.

acceptance of the values of a group or movement (value-rational), resentment of or enthusiasm for an idea, organisation or individual (emotional-affection), the acceptance of the behavioral norms of a social group to which the individual belongs (traditional) and personal advantage (purposive-rational) influence participation in developmental programmes.[8]

The next question pertains to the involvement of the participants in the process of participation. The out come of the participation is decided by the nature of the participation. The nature of participation should be understood with respect to the social economic and political condition of the participants. Participants' awareness, educational background, occupation, personal experience, political affiliation and social consciousness influence the nature of their participation.

This chapter analyses the nature of participation and also the participants' social, economic and political condition in relation to planning and implementation of the projects in three panchayats. In doing so, the researcher has considered four different natures of participation, which includes four categories viz., "Sit Quietly", "Ask Doubt", "Give Instruction" and "Active Participation". "Sit quietly" implies, the participants are mere listeners and they do not talk about anything in the gramasabha meeting. "Ask doubt" points to the people, who are intervening in planning and decision making by

[8] Rama Chandran M, Lakshmi K (1993): ***Women and Politics a Study in Political Participation***. Book Links Corporation, Hyderabad.

asking doubts related to planning, budgeting, method and the implementation of the projects. "Give instruction" refers to those people who participate in gramasabha by making instructions for the better planning and the implementation of the programmes. The last one is "active participation". This means that the participant overtly expresses his/her ideas, and comments with the understanding that they can influence the decision by demanding explanations about planning. They even question the decision and can sometimes influence the majority opinion. In addition to this, active participants help the officials and panchayat members to organize the meetings and other related activities.

In order to understand how social and economic conditions influence the nature of participation, the researcher has analysed nine variables (sex, age, religion, caste, educational qualification, occupation, ownership of land, annual house hold income and respondents position in the gramasabha) and its relation to the nature of participation.

Table V.1 Respondents by Sex and Nature of Participation

Sex	**Nature of Participation**				**Total**
	Sit quietly	Ask doubt	Give instruction	Active	
Male	13 34.2%	3 7.8%	11 28.94%	11 28.94%	38 71.7%
Female	8 53.3%	1 6.66%	4 26.6%	2 13.33%	15 28.3%
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

Out of 53 participants, (Total 120 respondents from three panchayats), 15 (28.3% of the total participants) were female and the remaining 38 (71.7%) were male. Here the percentage of male participation is higher than the women. The variable sex has a major role in determining one's participation in political activities. Different studies show that men participate more than women who are found to be more conservative. Women are generally preoccupied with home and family may be the one reason for their poor participation. Though there are active women participants in various social and political spheres their number is very marginal. It may be due to their submissiveness to the general culture which always emphasis morality.

Among 15 women participants four each from Kunhimangalam Grama Panchayat and Pallikunnu Grama Panchayat and seven were from Madayi Grama Panchayat. All these seven female participants from Madayi Grama Panchayat, six participants were from Muslim community. It has been noted that Muslim women's participation in people's planning programme is high from their dominating areas, Malappuram district is an example for this. In Madayi Grama Panchayat, the existing matriarchal system and migration of Muslim male population to gulf countries created high social mobility among the Muslim women. It may be a reason for their participation in the people's planning programme in their panchayat. Out of 15 women participants, there were only two (13.33% of the total women participants) active participants. Eight women (53.3% of the women participants) were sitting in the gramasabha without asking any questions or expressing their views. When it

comes to male participants there were only 13 (34.2% of the total male participants) participants sitting quietly in the gramasabha. Percentage of active participation was also high among male participants.

Table V.2 Respondents by Age and Nature of Participation

Age group	Type of participation				Total
	Sit quietly	Ask doubt	Give instructions	Active	
18-30	8 53.33%	1 6.66%	4 26.66%	2 13.33%	15 28.3%
31-45	7 28%	2 8%	8 32%	8 32%	25 47.16%
46-59	2 40%	-	1 20%	2 40%	5 9.43%
Above 60	4 50%	1 12.5%	2 25%	1 12.5%	8 15%
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

Age is another important factor, which determines one's participation in social activities. Among the 53 participants 25 (47.16%) respondents were from the age group 31-45, and there were only eight (15.9%) respondents from the age group above 60. During the old age, people are not much able to confront with a situation and they are normally become passive. Among 13 active participants, there was only one active participant from the age group above 60. Four respondents from this age group were sitting quietly in the gramasabha. From the age group 31-45 there were eight active participants. (32% of the respondents from the age group 31-45). From the age group 18-30, there were only two active participants. Most of the respondents in this

age group were students. It is generally said that youth were not attracted to people's planning programme

Table V.3 Respondents by Religion and Nature of Participation.

Religion	Type of Participation				Total
	Sit quietly	Ask doubt	Give instructions	Active	
Hindu	16 36.36%	4 9.09%	13 29.54%	11 25%	44 83%
Islam	5 55.55%	-	2 22.22%	2 22.22%	9 17%
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

Religion, caste, ethnicity all these variables have perceptible importance on participation. In this study, out of 53 participants 44(46.8%) were from Hindu religion and the remaining nine (40.9% of the total respondents from Muslims) were from Islam religion. Here the dominating religious group is Hindu, which may be the reason for their higher participation.

Though there are religious based pressure groups are existing, religion and caste do not have much influence on local level political and social activities in Kerala. It may be due to the earlier social reform movements and the contribution of left movements and cultural aspects. Among 44 participants from Hindu religion, 11 people (25%) participated very actively and from nine Muslim participants two (22.22%) participated very actively. The reason for the poor performance of the participants from Muslim community may be due to their social and educational background and religious reasons. Out of 53 participants, 21 participants (39.62%) were sitting quietly. There were only

four respondents from Christian religion, and nobody has participated in people's planning programme.

Table V.4: Respondents by Caste and Nature of Participation

Caste	Type of participation				Total
	Sit quietly	Ask doubt	Give instructions	Active	
Forward caste	1 14.28%	1 14.28%	2 28.57%	3 42.85%	7 13.2%
OBC	18 41.86%	3 6.81%	13 30.23%	9 20.93%	43 81.13%
SC	2 66.6%	-	-	1 33.3%	3 5.66%
Total	21 39.62%	4 7.5%	15 28.3%	13 24.32%	53 100%

When compared to the participation of the respondents from OBC, percentage of participation of the respondents from FC was low. Out of 53 participants (from 120 respondents), 43 participants (48.31% of the total respondents from OBC category) were from OBC. Three participants (30%) were from SC, and 7 respondents (33.33%) were from FC.

But, when it comes to nature of participation performance of respondents from FC was better than the performance of OBC and SC respondents. Among 13 active participants in the sample three respondents (42.85%) were from FC, nine (20.93%) from OBC and one (33.33%) from SC. The percentage of participants who were sitting quietly from OBC and SC category was very high. The reason for poor performance may be because of their educational backwardness, poor social consciousness and financial background.

Table V.5 Respondents by Educational Qualification and Nature of Participation.

Educational Qualification	Type of participation				Total
	Sit quietly	Ask doubt	Give instructions	Active	
Lower Primary	2 66.66%	-	1 33.33%	-	3
Upper Primary	6 75%	1 12.5%	-	1 12.5%	8
High School	5 29.4%	1 5.88%	6 35.29%	5 29.4%	17
Pre-Degree/+2	4 36.36%	1 9.09%	3 27.27%	3 27.27%	11
Degree	3 42.85%	-	3 42.85%	1 14.28%	7
Post Graduation	-	1 50%	-	1 50%	2
Professional	1 20%	-	2 40%	2 40%	5
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

The variables education and occupation also play influential role in participation. Out of 53 participants, three participants (30% of the total respondents with the qualification LP School) educational qualification was LP. Eight participant (33.33%) had completed their UP School. There were 17 people who completed high school class. Eleven participants (61.1%) completed their +2 or pre-degree. Seven participants completed (63.63%) completed there degree. Two participants completed (66.66%) their post graduation. Five participants (38.46%) had professional qualification. It is very clear that percentage of participation and educational qualification has a direct relationship.

Regarding the nature of participation, there was no active participant from below lower primary qualification. Table shows that out of 17 participants who have completed their high school standard, there were 5 (29.4%) active participants. There were 3 (27.27%) active participants with the qualification plus two/ pre-degree. There was only one (14.28%) active participant with the qualification Graduation. Percentage of participants with the qualification Post Graduation was 50. The number of active participates from professionally qualified respondents were two (40%). The percentage of participants who "sit quietly" was high among respondents with the educational qualification LP School (66.66%) and UP School (75%). And from eight upper primary school qualified respondents there was only one (12.5%) active participant. So it again proves that people's participation and its nature is influence by education of the participants.

Table V.6 Respondents by Occupation and Nature of Participation.

Occupation	**Type of participation**				**Total**
	Sit quietly	Ask doubt	Give instructions	Active	
Government Servant	1 7.69%	1 7.69%	5 38.46%	6 46.15%	13 24.52%
Coolie	5 62.5%	-	2 25%	1 12.5%	8 15.09%
Private	3 21.42%	3 21.42%	5 35.71%	3 21.44%	14 26.4%
Dependents	12 66.66%	-	3 16.66%	3 16.66%	18 33.96%
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

Out of 53 participants, 13 (68.42% of the total government servant in the sample) participants were from the category 'government servant.' Number of participants from the coolie workers was eight. (33.33% of the coolie workers is the sample). There were 14 participant (46.6% of the total respondents from the category private) from the category 'private'. 18 participants (40.9% of the total respondents who do not have any job, which includes students, housewife, old age people) were from the category 'dependents'.

Out of 13 active participants six (46.15%) participants were government servants. This includes three task force members and the panchayat member. When it comes to coolie workers, there was only one (12.5%) active participant. From the category private, which includes two panchayat members, three participants (21.42%) participated very actively. From the category dependents, which include one task force member, three respondents participated (16.6%) very actively. 62.5% of participants from coolie workers and 66.66 per cent of participants were sitting quietly.

Table V.7: Respondents by Land Area and Nature of Participation

Land area*	Type of participation				
	Sit quietly	Ask doubt	Give instructions	Active	**Total**
Nil	1 100%	-	-	-	1
1-10 cent	10 52.63%	1 5.26%	3 15.78%	5 26.31%	19
11-20	5 35.71%	2 14.28%	4 28.57%	3 21.42%	14
21-40	2 25%	1 12.5%	1 12.5%	4 50%	8
41-50	-	-	3 75%	1 25%	4
Above 50	3 42.85%	-	4 75%	-	7
Total	21 39.62%	4 7.54%	15 28.3%	13 24.3%	53 100%

* 100 cents = 1 acre = 43560 sq. ft.

Ownership of land has greater influence upon the people's economic and social status, and it can decide their participation in social and political aspects of development. There is a positive correlation between people's participation and their ownership of land.

Out of 53 participants in the sample, 19 participants (44.18%) of the total respondents with land 1-10cents), had owned land between 1-10cents. 14 participants (51.85%) had owned land between 11-20 cents. There were eight participants (33.33%) with land between 21-40cents. Four participants (50%) had owned land between 41-50cent. And there were seven participants

(53.8%) with land above 50cent. One participant (20% of the total respondents with no land) had no land.

Here, the nature of participation and ownership of land also related each other. There was only one participant from the category 'nil' (no land) who was sitting quietly in the gramasabha. More active participants are also based on the ownership of land. There were four active participants, who owned land between 21-40 cents. Though from the group above 50 cents, there was no active participants, there were four participants who gave instructions in the gramasabha meeting.

Table V.8: Respondents by Annual Household Income and Nature of Participation

Annual income	Type of participation				
	Sit quietly	Ask doubt	Give instructions	Any other	Total
Below Rs. 10,000	12 63.15%	-	5 26.3%	2 10.5%	19
Rs. 1001-25,000	7 33.33%	3 14.28%	6 28.57%	5 23.8%	21
Rs. 25001-50,000	2 20%	1 10%	3 30%	4 40%	10
Rs. 50001-75,000	-	-	1 50%	1 50%	2
Above Rs. 75,000	-	-	-	1 100%	1
Total	21 39.62%	4 7.54%	15 28.3%	13 24.32%	53 100%

Among 53 participants, 19 participants (40.42% of the total respondents with an annual house hold income below Rs. 10,000) were from the annual household income group below Rs. 10,000. 21 participants were (32.18%)

from an annual household income group Rs. 10,000-25,000. There were 10 participants (76.92%) from the annual household income group. Two participants (50%) were from the income group Rs. 50,000-75,000. And there was only one respondent with an annual household income with above Rs. 75,000, who also participated in people's planning programme. Data show that the percentage of participation is increased according to the increased of an annual householder income. But from the annual household income group Rs. 50,000 –75,000, the percentage of participation was reduced to 50 per cent. It shows that after a particular point (income level) people do not participate in the programme. This may be because of their understanding that, they will not get any personal benefit from their participation.

Regarding the nature of participation percentage of active participants is also increasing according to the house hold income of the people. Out of 19 participants from the income group below Rs. 10,000, twelve participants (63.15%) were sitting quietly in the gramasabha. But when it comes to other income groups it is decreasing. In the third section of the nature of participation i.e., 'give instruction', percentage of participation has a direct positive relationship with participants annual household income. People from low-income group are not participating actively and they participate only for the namesake, besides people from high social and economic status dominate them.

Table V.9: Respondents by their Positions in Gramasabha and Nature of Participation

Position of the respondent	Type of participation				
	Sit quietly	Ask doubt	Give instructions	Active	Total
Voter	21 46.66%	4 8.88%	14 31.11%	6 13.33%	45
Ward Member	-	-	-	3 100%	3
Task force Member	-	-	1 20%	4 80%	5
Total	21 39.62%	4 7.54%	15 28.3%	13 24.3%	53 100%

Out of 120 respondents, three participants (25%) were ward members and seven (5,8%) members were task force members. All three-ward members participated in the people's planning programme and among seven task force members five people participated (71.42%). Out of 110 gramasabha members 45 members participated (40.9%) in the people's planning programme. It is very clear that task force members and elected ward members political affiliation prompted them to participate in the people's planning programme.

Among thirteen active participants there were only six active participants (13.33% of the 45 participants) from gramasabha members. 46.66 per cent of participants, from the category voter/gramasabha members were sitting quietly in the gramasabha meeting. When it comes to ward members/panchayat members they participated very actively. And among task force members 80 per cent participated very actively. It is very sure that their active participation is due to their responsibility by the rule. More over,

when people are interested with political organisation they will invest more time in participation and development activities.

Conclusion

It is very clear that the nature of participation from 'passive to active' has a direct relationship with the socio-economic conditions of the participants. Even if people participate in large numbers, the result of the participation would be meaningful only if the people participate actively with full involvement in decision-making, planning and implementation. So we can say that the nature of participation has an equal role with the other determining factors of democratic decentralisation like devolution, participation of the people and availability of resources.

When the diversity and unevenness of social, economic, cultural and political factors influence the nature of participation, it must get adequate importance in the theory and practice of democratic decentralisation and people's participation. The participants social and political consciousness is the two most important elements in the composition of participation and its nature. These two elements are controlled and determined by quality of life of the participants. That quality is determined by social and economic transformation aimed at progress. Unless and until such a transformation happens in the community, people's participation will become a meaningless concept in the process of development.

CHAPTER VI

CHAPTER VI

CONCLUSION

Democratic decentralization and people's participation are widely recognised as key factors in the process of community development. Democratic decentralization, it is assumed, protects the freedom of the people by dispersing power in the community, and that freedom is sustained through people's participation in decision-making processes related to their needs. And people get involve in planning, and implementation of the programmes. But people's participation is always influenced by different social, economic and political factors. Religion, caste, belief system, economic status, occupation and political affiliation and the role of the national government have influential role among the people in relation to their participation in development programmes.

Democratic decentralization and people's participation are a complementary rather than alternative movement. They stand for a political structure in which democracy is extended to local level in real and large measures. Grass root level attempts with adequate power to the local self governments and people's participation, it is hoped, can accelerate the organized effort of the society to protect, promote and restore the people's needs including public health. Strengthening local self-government institutions through administrative and financial devolution can fulfill such an organized effort.

In order to sustain the achieved social, economic, and demographic status of the Kerala State, to address development issues and to strengthen democratic process, the Government of Kerala and the State Planning Board launched 9th Plan People's Plan-"Power to People" in 1996. The programme ensured people's participation to decide their needs and priorities in various sectors including public health. When public health emphasizes the role of the community in planning, implementation and utilisation of health services, the concept of 'People's Health in People's hand becomes more relevant and important.

Then Gramasabha is the most important and basic unit in people's planning programme, where the people and government officials participate to plan and the implement local level needs of the people, which are not resolved by the centralized 'top down' planning system. The participation of the people in Gramasabha and the nature of participation are crucial factors, which determine the effectiveness of planning and implementation of local level programmes.

Different factors like bureaucracy, political interference, gender, religion, caste, income, occupation, and resources influence the participation of the people and its nature in the planning and implementation of different projects. From a total of 120 respondents, 53 respondents (44.16 % of the total respondents in the sample.) participated in people's planning programme. And among them, only thirteen persons (24.52 % of the total respondents)

participated very actively. The number of participants in public health is very limited, i.e. only eleven (9.16%of the total respondents). 21 respondents (39.66 % of the total participants) who attended in the Gramasabha had a very passive role.

Regarding the participation of the health staff, no Medical Officer had participated in the gramasabha meeting, though they are considered as the project implementing officers. Among the other health staff, only five health staff (Total 18 health staff including the three Medical Officers) participated. (That too with an attendance average of two.). One medical officer of the PHC opined that the participation of the health staff in Gramasabha was a additional job and hence a burden. Regarding the training for health staff as part of the people's planning programme, only four respondents received training.

All of the health staff felt that the shift from centralized planning to decentralized planning with Panchayati Raj system is effective when it is related to people's plan. According to them in people's plan programme, people can participate and utilize the available resources positively on the basis of their need. And so they would get better health services, and could avoid regional inequalities in the provision of health care facilities. The entire health staff, except two Medical Officers, told that the preparation and implementation of health projects with greater involvement of the people was feasible, if they are provided better training and the much needed fund. But

health staff were not fully convinced about the importance of health programmes under decentralized planning. And there was no special committee or group to identify the health problems and issues in the Panchayat.

Majority of the health staff and respondents were not aware about the monitoring aspect of the health projects. Usually in monitoring, all projects are carried out by panchayat members and health staff, including people from the gramsabha. But most of the monitoring committees felt that they have too much work at hand, and so systematic monitoring is not feasible. The health staffs are also very busy with the centralized planning programme, Some times they are new to the panchayat, and so they do not have a clear idea about the health projects already implemented in the panchayats.

Through the people's planning programme, all primary health centers got basic infrastructural facilities to an extent and 20 respondents (16.66 % of the total respondents) got health benefit. Along with this, people's awareness regarding public health had increased and it could make positive changes. If we go by the opinion of health staff, we can say that there is an improvement in public health in the panchayat after the implementation of health projects under the people's planning programme.

DEC (Diethyl Carbomizine Citrate) projects against lymphatic filariasis were implemented in the three panchayats as part of the national/central level

health programme. It was implemented with the help of the decentralized plan fund and its machinaries. Fund for the implementation of these projects was allocated from the plan fund or from the own fund of the panchayat. The panchayat procured only tablets from the DMO office, and all other expense was met by the local self-government institutions. Before the implementation of the DEC project, no study was conducted in terms of the distribution and morbidity of problem of the lymphatic filariasis.

Majority of the respondents had not utilized the tablets given to them, as they were suspicious about its benefits. Moreover, the financial aspects of the same project (DEC) in the three panchayats had major differences. However, the result of the project was more or less same in all three panchayats. Out of 120 respondents, 100 respondents got DEC tablets. But only 15 respondents swallowed the tablets. After swallowing the tablets seven people developed side effects like fever, headache and vomiting.

Instead of an integration of local level projects into the state and national level, the national level programmes have been integrated at the regional level. So the implementation of projects like DEC can be seen as a challenge to the idea of decentralisation. This project itself proves that it is the modified version of departmental stereotyped scheme. It not only undermines the principle of decentralisation but also helps to implement centralized programme in the name of decentralization. Though non-DEC projects like blindness eradication camps, free medical camps, and hepatitis B

immunization camps could help the people, there are some technical and financial problems.

Most of the direct health related projects were implemented for all the people in the panchayats. But in certain other sectors, especially in the agricultural and housing programmes, people get more personal benefits. So they were not interested to participate in the health sector. The people feel that they do not get any benefit from the PHC except the immunization programme. And because of the non-availability of doctors' service, the lack of health infrastructure facilities like X-ray, the laboratory etc, the people are forced to go to private care institutions and so the slogan "people's health in people's hand" does not create any inspiration among the people. Lack of adequate data in the health sector at the panchayat level, the lack of more expertise, the non-availability of fund, the poor quality of services, the lack of poor training of the health staff, the inadequate number of health staff to handle national/departmental and panchayat level health programmes and above all the poor participation of the people are the major problems in health related planning and implementation. When compared to other sectors, the health sector does not get adequate fund to implement health projects. All these factors have created constraints to people's participation in health.

To improve public health programme we need more involvement from the community and health staff. And there should be enough fund and political support. It is important to note that under the people's planning programmes

the power and functions of the people's representatives in the panchayat have increased. But the people and their representatives are not able to resist the implementation of central health programmes like the distribution of DEC tablets by using the decentralized plan fund.

Political consciousness of the people is an essential tool to maintain good developmental programmes at all levels. The intervention of political parties and the commitment of their members have helped a lot in improving the decentralized planning in Kerala. But at the same time, the people are also displeased due to the favouritism of the ruling political party to their hard core members. Hence some people were not interested in participating in the planning and implementation of the peoples' planning programme.

Regarding the participation of the people in the decision-making, planning and implementation of the programmes, there was no difference in the three panchayats in terms of its political control. There were no policy level changes in the implementation of the health projects in the three panchayats. (Implementation of DEC project is an example for this.) But in participation, 50 per cent of the respondents in sample participated in the CPI (M) controlled panchayat. In the Muslim League controlled panchayat and the Congress (I) controlled panchayat the percentage of participation was 42.5 and 40 respectively.

Though there are active women participants in various social and political spheres, their number is limited. The percentage of women's participation in the people's planning programme, in three panchayats, is lower than that of men. And regarding the nature of participation, the percentage of active women participant was only 13.33.(2 out of 15) But among males, it was 28.94 per cent (11 out of38) . There was no big difference between the percentage of active Hindu participants (25%) and active Muslim participants.(22%). But when it comes to caste the percentage of active participants from OBC was only 20.93 and from the forward caste it was 42.85. The ownership of land also influenced the nature of participation of the respondents in the gramsabha. People who have more land participated very actively than the people who have less land. Political parties' membership also facilitated better participation for task force members and panchayat members. Among thirteen active participants, three respondents were panchayat members, and four respondents were task force members. The percentage of active participants from the higher income group was high. And percentage of active participants from government sector was also high. The minimum number of participants (eight) was from the unorganized sector. And among these only one participated actively.

Democratic decentralisation and people's participation have already created more awareness among the people about their rights and duties in decision making, planning and implementation of local level projects. Peoples planning

and implementation of local level programmes could realize, ofcourse with shortcomings, the people's need to an extent. Thus it is visible that decentralization and people's planning programme could legitimize the principles of democracy in the three panchayats to a good extent ahead. However it needs necessary follow-ups and corrective efforts to make such efforts better and more effective in its reach and outlook.

The existing guidelines and methods are not enough to ensure the participation of the people from all sections of the society in terms of number and quality. This is because participation and its nature mainly depend upon the participant's social and economic conditions. So there must be a change in people's life with respect to their social and economic conditions. Centralised governance has a major role in causing such a change. Due to this, the idea of democratic decentralisation is seen to depend more and more on the centralised system for the smooth functioning. As of now, this over dependence, is the major limitation of the decentralised planning system. However, even with this limitation, it gives more power and rights to the people within the institutionalised set up of democratic decentralisation; and here in lies its scope and strength.

APPENDIX

INTERVIEW SCHEDULE - I

[Questions addressed to the people of Khunhimangalam, Madayi and Pallikunnu Grama Panchayats in Kannur District].

Name of the Panchayat:

1. Name
2. Sex
3. Age
4. Religion and caste
5. Education
6. Occupation
7. Land Area
8. Type of House : Hut / Tiles Thatched/Terraced
9. Annual Household Income
11. The Position of the Respondent

    Voter/Ward member/Task Force / Other
12. How do you get connected with peoples planning programme?
13. Are you a member of any political organization ? Yes / No.
14. Are you a member of any organization other a political organization ? Yes/No.

    If yes specify.
15. Do you participate in the group meeting of Public Health in Gramsabha?
16. How do you participate in group meeting of Gramsabha?

    Sit Quietly/Ask Doubts/Give Instruction/Active.
17. Do you participate in Gramsabha in which beneficiaries are selected?
18. Did you involve any of the project related to Health? Yes /No.

If yes, a) In which project?

b) How were you involved?

19. Did you involve any of the health project implementation committee? Yes/No.

If yes a) What was the project?

b) How were you involved

20. Did you involve any of the health project monitoring committee ? Yes /No.

If yes a) What was the project ?

b) How were you involved?

21. Do you think that monitoring of the project implementation has taken place? How?

22. Have you got any benefits from health projects under People's Planning? Yes/No.
If Yes, Particulars.

23. Do you think public health programme in your panchayat is improved because of people's planning programme? How?

24. Do you think people's participation in preparation and implementation of the health projects were satisfactory or not?

25. Do you think your participation in health projects in necessary or not? Why?

26. What is your opinion about the success or failure of objectives of health projects in general in your Panchayat?

27. Do you think that the basic infrastructure of the health centre has improved after the implementation of people's planning programme?

28. Do you think health services of the health centre has increased after the implementation of people's participation?

INTERVIEW SCHEDULE - II

[Questions addressed to the Staff of Kunhimangalam, Madayi and Pallikunnu Primary Health Centres in Kannur District].

Name of the PHC:

1. Name
2. Sex
3. Age
4. Designation
5. Religion and Caste
6. Education
7. Do you participate in people's planning programme? How do you participate? What do you do?
8. Have you got any kind of training/workshop experience under the people's planning programme?

   If yes, particulars.
9. Who identified the health problems and issues in your Panchayat? How?
10. Have you discussed your opinion with people outside the meetings?
11. Did you discuss your suggestion with the Panchayat, before the formal meetings?
12. Do you think your participation (in health programmes) in people's planning is necessary or not? Why?
13. Have you evaluated the health projects, which are implemented completely?
14. Which is the most important health project implemented in your panchayat? Why do you think it is important?
15. Do you think that basic infrastructure of the health center has improved after the implementation of the people's planning programme? Give details?

16. Do you think that public health programme in your Panchayat improved after the implementation of the people's planning?

17. What are the reasons behind the success or failure of objectives of health programmes in general in your Panchayat?

18. How far the preparation and implementation of health projects under people's planning is feasible?

19. How do you perceive the possibilities and the limitations of health programmes in people's plan?

20. How do you see the shift from centralised planning to decentralised planning being effective as a result of people's plan?

21. What is the difference between the present and past working system of health center in your Panchayat, after the implementation of people's planning?

22. What kinds of changes are necessary in people's planning programme with special reference to health?

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