Quality of life and people's participation in development-A REVIEW

Health and quality of life

Health is considered as an indicator of development. Quality of life is the broader dimension of health and it links health with development. Health is no more considered as absence of disease or infirmity. It is not a state, but a potentiality, the ability of an individual or social group to modify himself or herself or itself continually not only in order to function better in the present but also to prepare for the future. Last defines it as "In a general sense, that which makes life worth living, in a more quantitative sense an estimate of remaining life free of impairment, disability or handicap, is used in the expansion, quality adjusted life years, somewhere between there is an estimate of the utility of life, for instance in clinical decision analysis, the utility of life that is impaired by disabling degree of angina pectoris may be compared with that of life that may be shorter in duration but free of disabling pain as a result of applying therapeutic procedures".

In this broad sense, it encompasses the concept of development. According to the definition of WHO, quality of life is the condition of life resulting from the combination of the effects of complete range of factors such as those determine health, happiness, education, social and intellectual attainments, freedom of action, justice and freedom from oppression. It is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationship to salient features of the environment. This definition highlighted the view that quality of life referred to a subjective evaluation which included both positive and negative dimensions, and which is embedded in a cultural, social and environmental context. The new definition is consistent with the older definition of health as "a state of physical, mental and social well-being, not merely the absence of disease and infirmity.

Components of quality of life

Economic status

Income and economic status are important parameters in assessing quality of life. But, QOL could not be reduced to it alone as done in previous decades. Instead, it should be widened based on the newer definitions. Since a straight foreword cost and benefit analysis does not fully reflect the many dimensions and dynamics of either development or quality of life, we can use economic parameters only to a limited extent mainly to discuss quality of the environment, which reflects how well the development process has functioned. It is only one of the parameters of quality of life. (Nagchaudhuri). Various economic theories and development strategies have at various times expressed six different types of quality of life I) per capita income ii) growth of per

capita income iii Quality of life index iv) basic needs satisfaction v) levels of living and vi) Maslowian theory, the hierarchy of needs. (Sethi. J. D)

As per capita GNP fails to be a representative parameter if the underlying distribution is extremely skewed, Morris D. Morris introduced the PQLI. Instead of attempting to measure dispersion and distribution of income, PQLI attempts to quantify directly the so-called quality of life. It combines infant mortality, life expectancy at age one, and literacy at age 15 into a single composite index that represents a wider range of social conditions such as availability of nutrition and clear water, well-being of expectant mothers, healthy general environment, skill to participate effectively in society and to share the benefits of economic growth.

Human Development Index-Some of the indicators that measure the three components is now better defined. Educational attainment is measured by a combination of adult literacy and mean years of schooling The idea of diminishing returns to income is now better captured by giving a progressively lower weight to income beyond the poverty cut-off point, rather than the zero weight previously given.

Employment

Providing maximum employment opportunities is considered as a key measure in development and quality of life. People are given options and financial support for self-employment. New economic policies resulted in falling wages and cutting social services. Many people are driven to poverty in developing countries. Unemployment has increased. To cope with this situation, self-employment programmes should be developed through people's participation in developmental activities.

Development objectives should be to create a situation where there is no unemployment and opportunities exist for all to optimize expression of their inherent capabilities, including the creative ability. To bridge the gap- utilize resources more optimally, and towards more worthwhile social objectives. (Shimla BR) Hierarchies must be eradicated. To encourage creativity, greater support must be provided to handicrafts. Our educational system must lead to dignity of labour and respect for craftsmen. Restructuring of beaurocracy is desired. Education must be democratized so that there are adequate opportunities for not only just employment, but also creative employment that utilize optimally the individual's potential, for all. Facilities and lifestyles should be such that there is reasonable leisure for people to think and to express their creative urge in diverse areas. Restoring full employment should be as a high priority of economic policy. Economic growth contributes most to poverty reduction when it expands the employment, productivity and wages of poor people and when public resources are channeled to promoting human development. Key priorities include creating an enabling environment for small-scale agriculture, micro enterprises and the informal sector.

Right to organise is a basic factor of quality of life in case of employed people. This will raise the self-esteem of workers and help in developing work culture. But this is not often materialized in developing countries because many are employed in informal sector. In

developing countries a smaller part of the workforce tends to be unionized because fewer workers are in the formal sector.

Health

Health is another significant component of QOL. Adequate water supply and sanitation are parameters of development, which have bearing on health. Infant mortality is one of the components of Physical Quality of Life Index. (PQLI). Infant mortality is generally cited as good indicator of the availability of sanitation and clean water facilities because of the susceptibility of infants to water- borne diseases. There was wide gap in the health status of people in developed countries and in developing countries. Child mortality, maternal mortality, diarrhoeal diseases etc were very high and health care utilisation was very low in developing countries. But there have been considerable improvements in health care in the past three decades, and about 80% of the people in developing countries now have access to health services. Now there is wide acceptance to the notion that every one should have equal access to the best available medical and health care.

Housing

Housing is fundamental to the formation of individual capabilities and to family and community ties. Poor housing is often connected with poor sanitation that exposes people to infection. About 40% of the people in developing countries have access to proper sanitation, and ranges from 32%in South Asia to 68% in Latin America and the Caribbean. Democratization of education, protected water supply, adequate nutrition, basic sanitation and drainage, adequate toilet facilities and a guaranteed minimum health and medical care, are considered as achievable objectives in development.

Education

Education is getting acceptance recently as another important factor in assessing QOL. Before it was not given much importance. Many social scientists engaged in research on quality of life concentrate on six points of improvement in quality of life in which education is left out. 1) Food, 2) materials 3) energy) 4) environment 5) technology 6) control of population. Recently, this omission is realised and many people include it as one of the component of QOL. (Raman NSS) Hicks and Streeten (1979) cite six areas considered essential to basic needs as health, education, food, water supply and sanitation and housing. A relation is found between education of mothers and IMR. Development of the people in every society must invest in the education, health, nutrition and social well being of its people, so that they can play their full role in the country's economic, political and social life. Everyone should have equal access to education right from the beginning.

For decentralization, the remedy lies in education, accountability and designing appropriate structures and sequences of decision-making. The class and caste basis of the present-day education system must be destroyed. This can be done only by nationalization of

primary and secondary education, by abolition of private schools and colleges to which only the privileged may go. Right to information must be regarded as a fundamental right. (Development report (1994)

Gender

In all development activities gender is considered as a factor which determine the over all improvement of QOL of the communities. This is recent phenomena where as women had been excluded from productive activities historically. There had been a gender division of labour between men and women, which often was not advantageous to women. Women were unable to recognise it and were marginalised from the public domain by custom.

In traditional societies, man is the family's main provider and the woman has the total charge of bringing up children. In this society men are educated to make as much as they can of their talents and to achieve as much as they can. But women are not because they do not use their talents outside the domestic area. There are no laws forbidding women to hold certain jobs, custom will suffice, for example, by making parents reluctant to waste resources on educating daughters. (Julia Annas)

People's desires can be in large part formed by the circumstances and options that they perceive as being open to them. In societies in which the options open to them are fewer than those open to men, it has always been a common adaptive strategy for women to adjust their desires to what they can realistically expect. So examining the actual desires of women may lead us to the conclusion that women on the whole get what they want. But it is clear that desires, which owe their nature even in part to the agent's reduced circumstances, cannot adequately adjudicate questions of justice. This approach would lead us to conclude that it is women in the most traditional societies—those where in every area of living activity is divided by sex in the most marked and rigid way-who are most satisfied. A highly anemic, grossly malnourished and undernourished woman who carries all sorts of infections, still thinks she is 'normal', because that is the sort of life she had been for as long as she remembers. (Banerji D)

A creative commitment to gender equality will strengthen every area of action to reduce poverty. Gender equality means empowering women by ensuring equal rights and access to land, credit and job opportunities. Too often, women do not have a voice in decision-making in the household, in the community or in national and international arenas.

Political space has always been monopolized by men. Women are poorly represented in parliament and cabinet. But women are better represented in local government. Women's participation in various aspects of economic and community life has increased. The female economic activity rate is now nearly 70% of the male rate. Often constraining women's social and political participation is high fertility. But over the past 25 years fertility in developing countries has fallen by 40%. Though initially, family planning measures was target oriented without considering the reproductive health of women, the approach has changed in recent years. Reproductive tract infections and other related problems constitute the major health problem of women. But often

women are reluctant to open this subject, because of social stigma. Often, there is no sufficient space and privacy for women in hospitals and health centers.

In developing countries there are still 60% more women than men among illiterate adults. Female enrolment even at the primary level is 13% lower than male enrolment, and female wages are only three fourth of male wages. In industrial countries, unemployment is higher among women than men and women constitute three-fourths of the unpaid family workers. Now, organisations like UNDP also try to develop gender sensitive measures.

Gender disparity can be seen in proper perspective through the lens of gender related development index (GDI) and the gender empowerment measure (GEM). The GEM measures gender inequality in key areas of economic and political participation and decision-making. Human Development Report (1994) acknowledged that no single index could ever completely capture a complex concept like development. Hence disparity adjusted HDI was developed. This considered gender and disparity in distribution schooling, sufficiency rather than satiety, purchasing power parity etc. In industrial countries, gender discrimination shows up in the HDI mainly in employment and wages. In developing countries, the discrimination is not only in employment but also in education, nutritional support and health care. Disaggregated data or separate HDIs should be calculated for separate groups by region, by gender or by race.

Measuring quality of life

Measuring the complex phenomena of quality of life require an appropriate tool. The world Health Organization has attempted to develop an international quality of life assessment instrument, which allowed to an enquiry into the perception of individuals of their own position in life in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. This attempt is made in a context of broadening in focus in measurement of health, beyond traditional health indicators such as mortality and morbidity to include measures of the impact of disease and impairment of daily activities and behaviour, perceived health measures, disability/functional status measures.

Because there is no standard scale for health, a broad range of health indicators are commonly used, each representing a domain of the over all concept e.g.: - PQLI. Similarly, in WHO's work on quality of life, six broad domains have been identified which describe core aspects of quality of life cross-culturally; a physical domain (e.g. energy and fatigue), a psychological domain (e.g. positive feelings), Level of independence (e.g. mobility), social relationships (e.g. practical social support), Environment (e.g. the accessibility of health care), and personal beliefs/ spirituality (e.g. meaning in life). Under each of these domains different facets are drafted.

WHOQOL FACET DEFINITIONS

Domain I- physical domain
1 Pain and discomfort
2 Energy and fatigue

3 Sexual activities
4 sleep and rest
5 Sensory functions

Domain II-Psychological domain
6 Positive feelings
7 Thinking, learning, memory and concentration
8 Self-esteem
9 Bodily image and appearance
10 Negative feelings

Domain III-Level of independence
11 Mobility
12 Activities of daily living
13 Dependence on medicinal substances and medical aid
14 Dependence on non-medicinal substances (alcohol, tobacco, drugs.)
15 Communication capacities, Work capacities

DomainIV- social relationships
17 Personal relationships
18 Practical social supports
19 Activities as provider/ supporter

DomainV-Environment
20 Freedom, physical safety and security
21 home environments
22 Work satisfactions
23 Financial resources
24 Health and social care: accessibility and quality
25 Opportunities for acquiring new information and skills
26 Participation in and opportunities for recreation/ leisure activities
27 Physical environment (pollution/ noise/traffic/climate)

DomainVI- Spirituality/Religion/personal beliefs

In the very first level of understanding, the concept of quality of life, is connected with physiological well-being, which includes the perception of personal; health, adequate nutritious food, shelter and adaptation to the environment, including the perception of the environment by each individual and group not only as a resource but also as a source of aesthetic satisfaction. It has also certain derivative aspects such as self-esteem and social esteem. Quality of life is not an individual, but a social concept, which includes all participants of a society. It is a global concept implying a society that is highly participatory and is flexible and mobile, a society with uninhibited communication both within the society and the nation.

There are different indices developed, based on newer concepts of quality of life and development.

Richard J Estes (1984) has developed an index of social progress (ISP), which consists of 11 sub-indices containing a total of 44 social, physical and political components. Sub-indices include education, health, status of women, defense/fort, economics, demography, geography, political stability, political participation, cultural diversity, and welfare efforts.

Gonzalez has worked out a socio-economic development index (SEDI), the four constituents of which are, per capita GDP, diet consisting of kilocalories and proteins, health based on infant mortality and life expectation and education, the composite of literacy and proportion of population enrolled in higher education. The population wide measures tend to be less sensitive to individual differences as regards both the manner and degree to which a particular factor affects people's quality of life. There are measures, which have components to measure individual differences. E.g. Sickness Impact Profile developed by Marilyn Bergner has taken the following components. Sleep and rest, eating, work, home management, recreation and past times (independent categories) Ambulation, mobility, body care and movement (physical) social interaction, alertness behaviour, emotional behaviour, communication (psychosocial)

QOL index developed by Walter O Spitzer and colleagues included activity, daily living, health, support and outlook. In these measures, QOL is based on function, functions of the whole person as opposed to body parts and organ systems. In SIP categories of sleep and rest, and eating are necessary for biological function. The categories of work, home management and recreation and past times are central activities common in virtually all lives, though the relative importance they have in a particular life can be adjusted for by making the measure relative to what had been the individual's normal level of activity in each of these areas prior to sickness. The two broad groups of functions, physical and psychosocial are each broken down into several distinct components. For, each primary function, the SIP measures the impact of sickness by eliciting information concerning whether activities typical in the exercise of that function continue to be performed or have become limited. Even for primary functions, about which it is plausible to claim that they have a place in virtually any life, the different functions can have a different relative value or importance within different lives, and the SIP makes no attempt to measure those differences. The QOL addresses a person's level of activity in daily living, specifically measuring the presence of related behaviors in the relevant areas. In measuring health and outlook, the primary concern is with subjective feeling states of the person, though here too there is concern with relevant behaviour. The category of support addresses both the social behaviour of the individual and the availability of people in the individual's environment to provide such relationships. This category illustrates the important point that most primary functional capacities require both behavioral capacities in the individual and relevant resources in the individual's external environment.

Changing Concepts on quality of life and development.

In search of alternate strategies economists tried to create a measure that could indicate better than per capita GNP. It took the form of physical quality of life index. (PQLI). The purpose of the exercise was to identify those services, which could be provided to the weaker sections both as social defense and better share in the income. World bank funded PQLI programmes

only partially succeeded and in many cases it failed and faced the charge that it slowed down growth rate

Levels of living are defined in terms of satisfaction of human needs some of which are considered absolutely essential and are defined as subsistence needs. These are needs with which any society should strive to satisfy, such as the need for portable water, food, clothing and shelter. Modern societies also regard education and health care equally important. These six components together satisfy the primary needs. Others are societal needs and human requirements such as proper environment, security, leisure, entertainment etc. Indicators have to be worked out both for primary and secondary components. Where as it may be possible to have some statistical indicators for primary needs, it is possible to do so for the secondary needs. Even for primary components, not only is there a problem of weightage of components, but there is also problem of scope of each component.

A society which cannot provide some basic economic needs will always runs the risk of the political rights of its citizens being eroded or extinguished. Human freedom and the guarantee of human rights are also necessary conditions for any quality of life. A human being wants to enjoy self-respect, which is central to any axiom on quality of life. S/he also must enjoy the freedom of beliefs, association and expression. Individuals are part of the society and therefore their convictions and values are part of their quality of life. One's view of oneself is a part of self-respect but the views of others are part of social respect one cannot ignore. Society's cultural values are expressions of the quality of its people.

Many theories are put forward by different scientists on quality of life, each one based on a specific perspective. Preference satisfaction theories take a good life to consist in the satisfaction of people's desires or preferences. To be it plausible, they must allow for some correcting or laundering of a person's actual preferences. Other corrections of preferences have also been supported by proponents of the preference satisfaction theory that are compatible with its underlying idea that ultimately what is good for persons is that they should get what they most want or prefer. (Dan Brock)

According to hedonist theory, ultimate good for persons is to be the undergoing of certain kind of conscious experience. This is characterized by pleasure, happiness, or the satisfaction or enjoyment and accompanies the successful pursuit of our desires. Ideal theories of good life see good life as realization of specific, explicitly normative ideals. For e.g., being a self-determined autonomous agent. This theory acknowledge a plurality of component ideals that place constraints on and/or supplement the extent to which happiness and /or preference satisfaction serves a person's good.

Unrestricted actual desire theory- holds that the quality of a person's life at a given time is measured by the degree to which the preferences which he or she has at that time fulfilled.
Griffin proposes what he calls an 'informed desire theory' which would make the quality of people's lives depend only on the fulfillment of those desires that they would have if they 'appreciated the true nature' of the objects of those desires. (Thomas Scanlon)

Harsanyi, bases his preference utilitarianism on what he calls the 'principle of preference autonomy' the principle that, in deciding what is good and what is bad for a given individual, the ultimate criterion can only be his own wants and his own preferences.

According to newer concepts, human poverty is more than income poverty. -It is the denial of choices and opportunities for living a tolerable life. It can also mean the denial of opportunities and choices most basic to human development-to lead a long, healthy, creative life and to enjoy a decent standard of living, freedom, dignity, self-esteem and respect of others. For policy makers, the poverty of choices and opportunities is often more relevant than the poverty of income, for it focuses on the causes of poverty and leads directly to strategies of empowerment and other actions to enhance opportunities for every one. The human poverty index combines basic dimensions of poverty and reveals interesting contrasts with income poverty. It uses indicators of the most basic dimensions of deprivation: a short life, lack of basic education and lack of access to public and private resources.

The index developed by Charles Humana include freedom of movement, the rights of assembly and free speech, the rights to ethnic and gender equality, the rule of law, and other democratic freedoms. Humana's index is thus more than a political freedom index, more than a human right index. (Development report 1997)

People's participation in development

The concept of development has been changed in recent years. People have become the center of development, instead of being the end. New concepts give stress to quality, sustainability and empowerment of people. The purpose of development is to create an enabling environment for people to enjoy long healthy, and creative life. This includes people's freedom to choose, and opportunities for being creative, productive, enjoying personal self-respect and human right, being active in social and political affair.

In earlier times, development meant production and distribution of commodity, expansion and use of human capabilities. At present, it encompasses these, but go beyond them. It analyses all issues in society, whether economic growth, trade, employment, political freedom, or cultural values from people's perspective.

Often development has led to the improvement of and well being of certain groups of people in a society while it did not spread to the well being of the entire society or nation. It has been demonstrated by many that the present patterns of population and capital growth are actually increasing the gap between the rich and the poor on worldwide basis, and that the ultimate result of a continued attempt to growth according to the present pattern will be a disastrous collapse.

Before, policies were made from top level for the people, where as now the programmes are people-centered. People are involved in decision-making, planning and each step in the development process. Everywhere the starting point is to empower women and men-and to ensure their participation in decisions that affect their lives and enable them to build their

strengths and assets. Such assets are not just economic. They are also social, political, environmental and personal-both for women and for men.

The real objective of development is to increase people's development choices. The aim should be the growth that is participatory-allowing for private initiative and broad-based people's involvement, distributed well benefiting all people, sustainable since raising future production may demand current sacrifices. Potential of the people and their choice are given maximum importance. Malcolm Slesser considered that a society's potential for changing the way it operates might be a surrogate for quality of life. He stresses the importance of increasing sustainability or quality of life and argues that one man's QOL can be another man's anathema, for e.g. Alcohol. PQL I form infant mortality rate, life expectancy, and literacy rate are to him, the value judgments of the officials who compounded it. To him, the availability, the potential to use the wilderness is the most important factor rather than actually using it. He argues that the level of economic development is never going to be a measure of quality of life. On the other hand, unfulfilled potential, the ability to change the manner in which life is run might be such a measure.

Successful NGO efforts recognize that the poor do not need charity or state subsidies. What they really need is access to equal opportunities and leveling of the playing field so that they can also compete in the market place on an equal footing. It is capacity building, not income transfers that can transform the lives of the poor.e.g. Aga Khan Rural Support Project, where the villagers themselves select the physical infrastructure project, whether a village road or an irrigation canal, then contribute free labour and manage the project themselves.

People must be the center of human development. Development by the people -Through appropriate structures of decision-making, people must participate fully in the planning and implementation of development strategies. These strategies should provide sufficient opportunities for income and employment growth, so that human capabilities are properly used and human creativity is given its fullest expression. Development increases human choices-with two caveats. First, enhancing the choices of one individual, or one section of society, should not restrict the choices of another. This calls for equity in human relationships. Second, improving the lives of the present generation should not mortgage the choices of future generations-that is the development process must be sustainable. Participation is a means to ensure the efficient provision and more equitable distribution of goods and services. If people are involved in decision-making, policies and projects tend to be more realistic, more pragmatic and more sustainable.

Decentralized planning: Kerala

Kerala achieved a better standard of life of people, when compared to other states of India. But there are many problems to be addressed which are specific to Kerala. And also some of these problems are determined by economic and social changes occurring all over world. The developmental activities taken place in Kerala followed a socialist approach. The land redistribution, public health service, free education and public distribution system have contributed to it. But at present, Kerala face problems in development because of crisis in agriculture and lack of industries. At the same time individuals are seeking job outside Kerala and

they earn money. New development in economy may result in the demise of public service systems. Mobilization of resources from individuals will be a prerequisite for development activities. People's participation and co-operation should be the basis of future development. Politically, this will initiate widening of the democratization process.

In this context, decentralized planning at Panchayat level is a step forward. In Kerala, people's planning movement was initiated following the Panchayat act 1994. A number of controversial and contrasting arguments are taking place in favour of and against people's participatory planning in Kerala. The project plans for the panchayat is made by people themselves and implemented through the local elected body. The assumption is that active participation of the population in such a planning system would empower ordinary people. But in the beginning people will be hesitant to internalize this new concept because of traditional value systems they follow. This is happening in a global context where the definition of development is rapidly changing on one hand and the gap between rich and poor, developed and underdeveloped is increasing. Much significance is given to individual differences and people's subjective evaluation about their own life. People's potential to change life is more important than economic achievement. But this potential can be developed only if there is an enabling environment. This depends on policy changes and people's political participation.

Development of tools to measure the complex phenomena of development in the new concept took place in other countries. This study is an attempt to study the perception and evaluation of their life. For this qualitative methods are used. None of the already developed tools are used for this. But the ideas of are accepted and put foreword to people to sense their preference. A quantitative analysis is done taking a sample from the community. It is interesting to see that many relevant factors are brought out by people are observed in the quantitative analysis also. People's potential in participating in local level development is tested by an action plan. It is seen that there are many hurdles and limitations in the present setting for expressing and experiencing the potential of people.

OBJECTIVES

1.To assess the quality of life of people residing in Vizhinjam panchayat.

1.1. To understand the health status of people from their perspective.

1.2. To assess the situation of health and health related aspects like education, employment, water & sanitation etc.

1.3 To understand the situation of health related aspects like education, employment, water & sanitation etc. from people's perspective.

1.4 To study the level of people's participation in developmental activities.

1.5 To understand the differences in each of these between gender and among communities and cultural groups.

2.To enhance people to involve in local level development and to improve their quality of life.

2.1. To develop an action plan with participation of the community.

2.2. To understand the limitations of people's participation in improving the quality of life in the present setting.

METHODOLOGY & SOURCE OF DATA

Participatory action research methodology was used for this project. In conventional research, the researcher formulates the questions and people are only study subjects. In action research people are motivated to ask questions by themselves and identify their problems. Usually there will be delay and gap between the outcome of research and its translation into policies. But in action research, people are motivated and they identify their own problems and try to find out solutions also. The significance of participatory research/action research includes, the following facts.

- The professionals should reflect critically on their concepts, values, behaviour and methods.
- They should learn through engagement and committed action.
- They have roles as conveners, catalysts and facilitators.
- The weak and the Marginalised can and should be empowered.
- The poor people can and should do much of their own investigation, analysis and planning.

It is done by using appropriate and flexible methods in a sequential manner, instead of a blue print-learning programme. Triangulation is done by changing the methods, by changing the sources of information and by changing the constitution of the learning team. The first two were tried in this study. Interactive participation and self-mobilization happened in this project. These principles were applied in this. The changing concepts of quality of life are considered here. The perception of people was considered to a greater extent. Both qualitative and quantitative methods are used for data collection.

Study design and sampling.

Since the study mainly followed the method of action research, no sample selection was done using conventional methods. A few (6) wards were selected in general representing different geographical and social background. The groups and members who participated in the study were selected during the progression of the project, based on the dynamics evolved. Community leaders selected the participants. For group discussions people were divided based on gender and age.

A plan of action was charted out before data collection. The sequence was as follows.

1. Making acquaintance with the community.
2. Collection of secondary data.
3. Selection of wards.
4. Primary data collection

4.1. Preparation of schedules.
4.2. Selection of appropriate methods.
4.3. Procedure of data collection.
4.4. Drawing inference.

5. Selection of groups for facilitating activities
6. Survey to collect more data of selected group.
7. Action by community

In between a small survey was done in Mullur ward and part of Mukkola towards the end of the project. 240 houses were selected using random sampling method. A schedule was prepared and quantitative analysis was done.

Making acquaintance with the community.

The research team members visited the Panchayat members, members of voluntary organizations, doctors, anganwadi workers and mahila samajoms. The purpose of the project was explained to them. Meetings were conducted with the key persons in mahila samajoms, NGO offices and parallel colleges. They were co-operative and agreed to participate in the project.

These people were interviewed to identify the problems in the Panchayat. Along with this, collection of secondary data was done from the different sources like Panchayat vikasana samity, rural development department, planning board, block office etc. The summary of the background information obtained as secondary data is given elsewhere. Participant observation was also done during this period. Local activists were identified from the community who agreed to take active participation in the study. They included men and women working in different community organisations. They arranged the focus group discussions.

Since the concept of quality of life includes subjective elements and varies from culture to culture, qualitative research method was the main method used to collect data. This was supplemented by secondary data collection and a small survey was conducted in one ward. The whole process was participatory. The qualitative methods used included

1. Key informant interview.
2. Participant observation.
3. Focus group discussions.
5. Key probs.
6. Ranking using charts.

The quantitative methods include
1.secondary source.
2. Survey

Selection of wards

The panchayat consists of 15 wards. Since the involvement of whole Panchayat was difficult, 6 wards were selected. The selection was based on the information obtained from the key informants, group discussions, and the report of the panchayat Vikasana samithy. A representation of the varied characteristic was ensured in the study. The three wards, Mullur, Kidarakkuzhy and Mukkola represented midland areas where Hindus are predominating. Three coastal wards were also selected, one Christian predominating area, kottapuram and two Muslim predominated area, Pullurkonam and township.

STUDY AREA BACKGROUND

All the background information about the Panchayat and the concerned district was collected from different sources like Vikasana Samity reports, health services, rural development report, blocks, planning board etc. and the survey conducted by the research team.

Thiruvananthapuram District

Thiruvananthapuram is the southernmost district of the state, is bounded on the north by Kollam district, on the east and south by Thirunulveli and Kanyakumary district of Tamilnadu, and on the west by the Lakshadweep Sea. The district has 4 taluks, 12 blocks, and 84 Panchayat. This includes highland, midland, and coastal plain.

According to 1991 census, total population is growing fast in the district. There is heavy rainfall and warm humidity. Comparing to the state, the growth in the productive sectors is less where as it is more in the service sector. As far as unemployment, measured in terms of registered employment seekers is concerned Thiruvananthapuram rank first among districts in Kerala .42% of the rural household in the district fall below the poverty line, as compared to about 32% at the state level. There is scarcity of potable water, environmental sanitation, deficient functioning of government hospitals, dispensaries, PHCs absence of sanitary latrines, lack of mosquito eradication programmes, absence of preventive activities for control of diseases, lack of medicines in PHCs, heavy cost of medical treatment, and privatization of health care facilities. There are 664 anganwadis in the district.

Nayyattinkara taluk

Neyyattinkara taluk is the southernmost taluk of Thiruvananthapuram district. It consists of midland and coastal plain. The soil in the coastal area is sandy loam. Red soil and brown loam exists in the midland. The cultivation include, paddy banana, tapioca etc. People are engaged in farming, fishing, animal husbandry, petty trades etc.

Athiyannur Block

Considering the agro-climatic zonal division, this comes under the red loam zone. 49.45% of the households area below poverty line, where as in the district, it is 42.24%.

Vizhinjam Panchayat

Vizhinjam is a village of historical importance, which was the capital of the chola dynasty. The western side is the seacoast. The costal areas of Vizhinjam are unique for its rocky shore. The land is filled with hills and slopes. The famous tourist center, 'Kovalam' and "Hawa beach" are located in this Panchayat. The total area is 12.62 sq KM. The wards are 1. Kovalam 2.Pullurkonam 3.Mathippuram 4.Town ship 5.Office ward 6.Pallithura 7.Townward 8.Kottapuram 9. Kadakkulam 10.Nellikunnu 11.Mullur 12.Kidarakkuzhi 13.Mukkola 14.Vanganoor 15.Paravilakom

Demographic characteristics-vizhinjam

Total population: 42402
Men: 21597
Women: 20805
Sex ratio: 1000:983 (1000:1036 Kerala)

Sex ratio in this Panchayat indicates that the number of women is less. This is different from the sex ratio of the population of Kerala, where it is 1000:1036 (1991 census) It is seen that the sex ratio of scheduled caste in this area is higher than the general population in this Panchayat.

Social structure

Hindus predominate in the midland area. In the coastal wards, Christians are predominating, except for two wards where Muslims are more. Population is mixed in all wards. People belonging to Dalit community are 3797 in number (9%)

Literacy status

The literacy status of the community is 64.04%. (Tvpm dist: 89.81) This shows that literacy is less than that (89.8%) Literacy rate is lower among women. In the coastal area, illiteracy is more. Children engage themselves in work related to fishing, during seasons, this being the reason for the dropouts. There are 3 high schools. But there are no vocational schools.

Occupation

Most of the people are unemployed. Employment rate is 30.19%. Out of this, women are only 12.5%. Some of them are employed part time only, and their number is increasing. Major occupational categories include fishing (35%), agricultural laborers (20.4%), farmers (7.5%). Others include animal husbandry, tourism related works etc. As the area is developing as a tourist center, economic as well as cultural transformation is taking place in the area.

Cultural Characteristics

The Panchayat is rich in its cultural tradition. Temples, Churches, Libraries etc function as cultural centers. The mural paintings, architecture, folk arts etc. represent traditional culture. Modern media such as print, T.V, and radio are enjoyed by majority of people. There are about a dozen social organizations based on youth, women and culture. T.S.S Society, N.S.S Karayogam, S.N.D.P Yogam, Tamil viswa brahma, Viswa Karma Mahasabha, Nadar Mahasamajam, Pulayar Mahasamajam etc are some of them.

Health Indicators

Birth rate :(Tvpm dist: 18.3, Kerala: 19.6)

The birth rate in vizhinjam Panchayat was found 7.2

Death rate Vizhinjam, 4.2 (Tvpm dist: 6, Kerala: 6)

Infant mortality rate (Tvpm dist; 17, Kerala: 17) In Vizhinjam Panchayat, it is high (38.8)The reason has to be explored.

Health care facilities

There is a community health center in the border of Vizhinjam and venganoor Panchayat. In Mukkola ward a mini PHC is functioning from 1996 onward. There are 22 private hospitals including modern medicine and other system. There is one midwife center in ward VII and one subcentre in ward IX. 22 anganwadis are working in the area. In Kovalam, there are a number of temporary clinics practicing traditional system and massage during season.

Nutrition

According to IRDP survey done in 1992 there were 3244 families below poverty line in the Panchayat. Ration shops are not functioning properly.

QUALITATIVE METHODS

Since the research include the participation of the study subjects and the topic of quality of life is a broader concern, a rigid pattern of data collection was not followed. A review of literature was done to understand the various methods to study quality of life and the appropriate concepts for the present study were selected. For example, the WHOQOL scale was reviewed. This included the following domains of study. i.e. physical domain, level of independence, social relationship, environment and spirituality. Under each domain different aspects were identified. For example, psychological domain included positive feelings (Thinking, learning, memory and concentration, self-esteem, bodily image and appearance) and negative feelings.

Similarly, certain areas were identified in this study to get a better idea of quality of life. For this, problems specific to our culture, gender related problems and so on were discussed with experts and also with groups from community. The evolved ideas were examined in the light of previous studies and the process was iterated.

The domains identified in this study are

Morbidity including perceived illness and disability.
Entertainments
Nutrition
Housing
Water supply and sanitation
Health care facilities and utilization
Mental health

Reproductive health
Occupational health
Work
Education
Social and political involvement

For each area a guideline was prepared, based on the concepts evolved through review of literature, discussion with others and the knowledge of the researcher. The guideline was used only to have a check. The process followed a flexible and participatory way so that newer ideas were also incorporated into it. Different and appropriate tools were used for gathering information. Focus group discussion was the main method applied. Others included participant observation, key informant interview, case histories, preference ranking and key probing.

FOCUS GROUP DISCUSSIONS

Purpose: The purpose of using focus group was to facilitate people to think about and share their views on their quality of life on the areas identified by the research team. Since one of the objectives of the study was to enhance people in local developmental activities to improve their quality of life, the facilitator guided the discussions in that line.

Organization of focus groups: The focus group discussions were organized with the help of the local organizations. These organizations were Kerala Sasthra Sahitya Parishat, Mahila Swasth sangh, Programme for community development organization, local libraries, parallel colleges etc. The participants were homogenous groups including same sex and same age group .1-2 discussions were organized in each study area for each group. There were total 11 group discussions. 7 of them were that of women of age group between 19-50 years. 4 groups consisted of men under the age group between 20-55 years. There was a facilitator and two observers for each group.

The facilitator was either the project co-ordinator or the research assistant. The observers were the field assistants and the trained voluntary workers. The duration of the discussion was half an hour to one hour. The facilitator would introduce the topic to the group and the members were allowed to talk about their perception of quality of life. Each aspect was discussed in detail and they were asked to select the most important aspects according to their perception. Cards were distributed to the groups after dividing the large group into two smaller groups. In each card, one component of quality of life was written and those were distributed in the groups. They were asked to arrange the cards according to their perception of priority area related to quality of life. Pairing method was used to prioritize the areas.

It was noted that in all the groups of women, work was identified as the most important aspect of health and quality of life. In all the men's group, water and sanitation was selected as the major issue. In all the groups, the first five items included work, water and sanitation, education, morbidity, and health care facilities. People considered entertainment, mental health and reproductive health as of least importance.

RANKING BY GROUPS

ITEM	W 1	W 2	W 3	W 4	W 5	W 6	W 7	M 1	M 2	M 3	M 4
MORBIDITY	4	4	2	3	4	4	3	2	2	3	4
EMPLOYMENT	1	1	1	1	1	1	1	3	3	2	3
ENTERTAINMENT	0	1	0	2	0	0	0	1	2	0	0
NUTRITION	7	7	7	8	8	8	6	7	7	9	9
HOUSING	8	6	9	7	7	6	8	8	9	7	7
WATER&SANITATION	3	3	3	2	3	3	2	1	1	1	1
HEALTH FACILITIES	5	5	4	4	5	5	5	5	4	4	5
MENTAL HEALTH	1	2	1	0	1	2	1	0	1	2	1
REPRODUCTIVE HEALTH	2	0	2	1	2	1	2	2	0	1	2
OCCUPATONAL HEALTH	6	9	8	6	9	7	9	6	6	8	8
EDUCATION	2	2	5	5	2	2	4	4	5	5	2
SOCIAL PARTICIPATION	9	8	6	9	6	9	7	7	8	6	6

W=women; M=men

After this exercise discussions were started on each topic in detail. The observers took down all the discussions in notebooks. Tape recorder was used, when there was only one observer. For each topic a guideline was prepared by the investigator. The discussions were not guided initially, but the participants were allowed to talk freely. The observers intervened only when one person continued for long and others kept quiet. Each one was encouraged to speak. All the content was noted down. Descriptions and narratives were taken down as such. For example, regarding employment one woman said, " What is the use, even when the man has job. If we get the job, the income will be used for the family". Towards the end of the discussions a few leading questions were asked, if something relevant was omitted. This was analysed separately.

The whole notes would be reviewed by the research team. The relevant points were noted down after putting all the notes together. A content analysis was done later. Indexing was given on literary basis and interpretative basis. In literary analysis, a particular word or meaning relevant in the context is given an index. For example, during discussion regarding water and sanitation, many people told that impure water was coming out of public tap. Here, impure water from public tap was given an index. Any thing related to it and the repetitions the same index was given. In interpretative analysis the text was reviewed, using the guideline. The answers to the questions were marked using another index system. The discussion after the intervention of investigators was analysed separately. A separate analysis was done for men and women as well as for people in the midland and coastal area.

Triangulation with information collected through other methods was done before drawing conclusion. For any information, which needed verification or detailed study, further study was done using other methods.

Guideline used for each domain of quality of life, and the summary of data analysis is given below.

WATER AND SANITATION (Guideline)

- Availability of safe water.
- Availability of latrines.
- Reasons for non-availability of water.
- Awareness and attitude of people towards safe water and sanitation.
- Sources of water.
- Work related to water collection.(Gender)
- Health problems due to non-availability of water.
- Suggestion of people to improve water supply.
- Methods of waste disposal practiced by people.
- Perception of people regarding waste disposal.

All the groups had the opinion that lack of water supply is a major problem in the area. Though there is a water tank in Mukkola, the water is impure and has bad odor. In the men's groups people told that the problem is continuing because of lack of political will. There had been agitations from the side of people for the same. In general, people are aware about the need of safe water. They themselves reported that people take bath in the same unclean water where cows are bathed and clothes are washed. People think that rich people can afford supply of water through tankers, while poor people suffer more.

They complain that water from this Panchayat is given to other places. Even though people do not know the details of the health problems related to unclean water, they know that diarrhoeal diseases are the result of using unsafe water. People made the following suggestions for improving water supply. Inception of an overhead tank in Pullurkonam was one among them. They wanted pipelines in wards 8,6,10,12,5,1,13,3,11. In the group discussions of women, water problem was not the top priority. But they also raised the problem. Women alone are responsible for collecting water. They think that it is their role in the family. Sometimes they seek the help of their children to assist them.

Safe water supply is the major health issue in the Panchayat. Both people and the authorities are aware of the problem. Many projects were submitted by different groups to the Panchayat. They decided to follow up these.

Regarding latrines also, people told that there are many people who do not have latrines. In Kovalam area, there is overcrowding during season time. There is no proper waste management in the area and it is disposed in open space. There is no proper drainage for wastewater as well. There are areas were waste is dumped.

SANITATION

In the group discussions also lack of hygiene and poor sanitation was raised as an important issue by all sections. There was demand from people for more drainage channels. Projects were prepared and submitted to the Panchayat by the people. In Mullur ward people were demanding drainage to be constructed in the kalunkinida thottam road.

MORBIDITY

No probing was done. People were asked to list out the common illnesses/health problems they are having. The illnesses are listed out based on priority. Priority is determined according to the number of people who share the same. It is classified according to geographical area and gender.

(Guideline)

- Perceived illnesses/health problems
- Prioritization of health problems as perceived by people.

Distribution of illness according to people's perception

ILLNESS	COASTAL	MIDLAND
MEN	Injuries Rheumatic complaints Skin diseases Diarrhoeal diseases Breathlessness	Fever Rheumatic complaints Chicken pox Respiratory infections Asthma Paralysis
WOMEN	Skin diseases Diarrhoeal diseases Weakness Backache Joint pain Pain in limbs	Respiratory infection of children. Measles Back ache Joint pain Pain in limbs Asthma

Different groups prioritized different problems. According to men in the coastal area, the main illnesses are injuries, rheumatic complaints, skin diseases and diarrhoeal diseases. Women reported skin diseases, diarrhoeal diseases, weakness, backache, joint pain, pain in limbs. In the mid land area, men's complaints were fever, rheumatic complaints, chicken pox, respiratory infections, asthma and paralysis. Women in midland area reported respiratory infections, measles, backache, joint pain, pain in limbs and asthma. Chronic health problems are common. Paralysis of body and asthma were reported by many people. Diabetes, hypertension, filariasis and heart diseases were also reported.

In addition to this, Individuals had some complaints about the health care system. There was a death following chicken pox. People think that it happened because of negligence from the part of doctors. Some believe that polio occurs as a result of immunization. These reflect the communication gap between the healthcare providers and people. There was a child who is a

case of intersex and the family wants to convert it to a male, which reflects the lineage towards male children.

Women have not reported about reproductive health problem until they were specifically asked for it. The details are given elsewhere.

HEALTH CARE FACILITIES AND UTILISATION

(Guideline)

- Availability of health care services.
- Extent of utilisation.
- Problems faced.
- Perceived need.

In the group discussion, all group, (men, women, old age people, people from coastal area) told that the facilities in government hospitals are not sufficient. There is shortage of medicine. They have to go to private hospitals where the cost of health care is high. They were asked to list out the problems according to the degree of severity. The problems identified are

1. There are not enough medicines and other facilities in Govt. health centres.
2. The people who are working cannot attend the morning clinics.
3. There are no health programmes for the elderly.
4. There are no facilities for women to be examined in privacy in case of gynecological problems; hence they have to go to private hospitals, which is a costly affair.

NUTRITIONAL STATUS

(Guideline)

- Types of food consumed.
- Awareness about nutrition.
- Availability of food items.
- Attitudes and practices.

In the group discussion it was found that people in the coastal area do not take vegetables in their daily food. In other areas also green leafy vegetables are consumed less. Even though people are aware about the significance of nutritious food and there is not much scarcity of food

(e.g. green leafy vegetables) they are not consuming it. This shows that health education is needed to change the attitude and behaviour.

Even though discrimination against women is not much visible, there is subtle ways of doing it. For example one woman told, " My husband is in gulf. So we do not take non-vegetarian food. After all only, we women are here. So we are not bothered"

SOCIAL AND POLITICAL PARTICIPATION

1. Kinds of social and political participation existing in the society.
2. Extent of participation in decentralized planning.
3. People's opinion about participation.

Social and political participation is the main prerequisite in the improvement of people's participation in local planning. In the group discussions of men it has been discussed that even though majority of the men are involved in politics and other social activities, they do not have power. They are skeptical about their role in the ongoing planning activities. Some are anxious about the utilization of funds.

Women told that they were not much involved in politics. But some are active in mahila samajoms and Mahila Swast Sangh activities. Women in Mahila Swasth Sangh work voluntarily in many health programmes. They think that they should be provided some kind of remuneration. Women's participation is less in social activities. Women think that it is difficult for them to participate in social activities. It is a shame for the family. So husbands do not allow. They will ask, "Are you the only one responsible to change this world?"

In the groups, people told that all the programmes should be initiated and carried out by government only.

There are people who are not aware of gramasabha and local planning.

People think that partisan politics is a hindrance for local development.

The content of discussion in this area was similar in all groups like women, men, and people living in coastal area.

ENTERTAINMENTS

(Guideline)

Perception of people about their own entertainment

In this study the issue was discussed in the groups. It seemed that people are not giving much importance to this. The facilitators explained the concept to the group and the group members were asked to list out their entertainment. In the group of men, they told that reading magazines, watching television, playing games are their entertainment. Playing cards and taking alcohol were not mentioned by them voluntarily, but they agreed that these things also could be put in to the category of entertainment.

The list of entertainment given by women included stitching, weaving coconut leaves, making pickles, pappads, gardening, etc. They did not mention about watching television, reading going out etc. until these was specifically asked. On probing women told that they wish to go out more frequently with their husbands or friends that is not often materialized. They agreed that they do not allow their daughters to involve in games after adolescence. They never considered game and exercises like cycling as something contributing to the physical and mental health. After a brainstorming session they came up with positive ideas of entertainment

The gender difference in our culture is reflected here. Both men and women listed out the items of entertainment, which are culturally permitted for each gender. Even though they were involved in other types they did not want to open it For example, though women watch television, they did not accept it as an entertainment. They feel guilty, because they think that all the time they should be dedicated to household work or work outside to earn money for the 'family".

EDUCATION

(Guideline)

Perception of people about literacy status

Women's education.

Facilities available

Utilization of facilities.

In all groups, people had the opinion that people should have education. School dropouts during fishing season in the coastal area was another issue raised by all groups. In the focus group discussions of men the idea of starting a vocational higher secondary school come out. The subject can be computer, type writing, mechanical engineering, automobile engineering, fishing tailoring, garment making etc. There is another suggestion in the group discussions that health education and sanitation should be integrated with schools

EMPLOYMENT

(Guideline)

- Hours of work
- Nature of work
- Attitude towards working outside
- Reason for desiring work outside.(income generating)
- Reason for not desiring work outside
- Hours of domestic work
- Hours of rest
- Preference of domestic gadgets to reduce domestic workload
- Attitude towards domestic work
- Availability of work
- Perceived reason for unemployment
- Perception of relation between positive health and work
- Perception of relation between work and ill health
- Distribution of domestic work among family members
- Opinion about self employment
- Willingness and ability to initiate self employment
- Facilities in work place
- Unionization.

Most of the women participated in the groups were unemployed and they do not consider domestic work as work. They think that it is their duty and not work. Majority of women talked about the need for employment. Each one wanted to get a job. Women were talking very strongly about this. They wanted it because of two reasons.1. They thought that the income of their husbands was not sufficient enough to meet the needs of the family. 2. They felt that if they have their own income, it could be spent for the family, where as men waste their income for alcohol. Men also told that getting a job is an important aspect of quality of life. Majority of men told that they would prefer to send their wives outside family for work. But they were not much interested in favoring self-employment. Both men and women told that taking initiative for women's self help groups will give a bad reputation for women.

In the discussion about domestic work, many women told that they do not have much work. A few women told that they feel monotony, because they do not have much work. A woman was responding that she did not have much work, while her baby was sitting in her hand she was strained. She had to go out a number of times during the discussion, as the baby was crying. But she did not consider it as a work.

Then they were asked to list out their daily activities. These were cooking, washing, marketing, cleaning, serving husbands and other family members, cutting stone, fetching water looking after children, weaving coconut leaves etc. The time spent for each task was counted. A time budget was prepared by 4 groups of women about their work. The result showed that most of the women were working 15-18 hours a day. They were hesitant to come for the group meeting, because of their domestic duties.

TIME BUDGET-GROUP 1

Engagement-Work/Refreshing/Rest	Time in hours
Refreshing	3
Cooking	5
Marketing	1
Serving husband	3
Washing clothes	1
Fetching water	1
Caring children	4
Rest	5
Cleaning	1
Total	**24**

Time for work=16; Rest=5 Refreshing=3

TIME BUDGET-GROUP 2

Engagement-Work/Refreshing/Rest	Time in hours
Cleaning	1
Fetching water	1
Refreshing	3
Caring of children	4
Cooking	2
Serving husband & other family members	3
Work outside	2
Marketing	1
Attend hospital	1
Rest	6
Total	**24**

Time for work=15; Rest=6; Refreshing=3

TIME BUDGET-GROUP 3

Engagement-Work/Refreshing/Rest	Time in hours
Refreshing	3
Caring for children	5
Caring of husband and other family members	4
Cooking	5
Rest	5
Cleaning	2
Total	**24**

Time for work=16; Rest=5; Refreshing=3

TIME BUDGET-GROUP 4

Engagement-Work/Refreshing/Rest	**Time in hours**
Cooking	4
Fetching water	2
Cleaning	4
Caring of children	5
Serving husband & other family members	3
Refreshing	2
Rest	4
Total	**24**

Time for work=18; Rest=4; Refreshing=2

Both men and women did not have any idea of taking rest in between to refresh themselves in between work so that the quality of work also improved. They agreed with this point after intervention of investigators. Both men and women were not able to make opinion regarding use of gadgets to reduce domestic workload. They think that this question is not relevant in this context, because many of them do not have the purchasing power to afford these gadgets.

Women think that problem of unemployment is severe and it occurs because of lack of will power of governments to look after the welfare of people. The small-scale cottage industries are not functioning now. They are not aware of the reasons.

Men told that unemployment is increasing. They were not able to site any particular reason for this. Women told that work outside family would improve their health status, because it will give freedom from the monotony of housework. It will increase the income, adding to the nutritional status of all family members. Men were of the opinion that there was a positive relationship between work and health. But they could not explain the same.

Both men and women were generally unaware of work related illnesses. They responded only when leading questions were asked. Then they were able to find certain relation between work and illness. For example, everybody agreed that women working in stone cutting and coconut leaves weaving were suffering from backache.

Women and men told that domestic work was the primary duty of women. Some men share domestic work. But it should not be expected. Most of the people told that children should be spared from housework, because they had to study. The women are willing to do the double work, if they are employed. For employment they give that much value. They are willing to be involved in self-employment schemes but are not confident to take initiatives.

They told that there was discrimination against women in jobs. But they think that it is natural for the men to have more job opportunities. Usually men do not share the housework and it is considered as natural. Workingwomen face the problem of feeding their babies. There is no facility for caring babies in the workplace. Women are getting low wages compared to that of men. A few women are trained in tailoring. But they do not have sewing machines. Workingwomen do not have any facilities for feeding the babies. They do not have independent unions. Most of them are working in informal sector. Elderly women were talking about their health problems related to work. Working old women were suffering from fatigue and other illnesses like backache, body pain, post menopausal bleeding, blindness, giddiness etc. They felt that they could not do heavy work and should be shifted to light work.

Men had suggestions to improve the job opportunities. They told that co-operatives should be formed and market should be found out for the sale of the products. The people do not have much idea about the possibilities of generating employment opportunities in the Panchayat. Men working in fishing are facing many problems like lack of boats, nets and problem in trolling. Farmers are facing the problems of scarcity of water, floods, and increasing cost of production. Men suggested that women could be involved in pickle making, garment making, plastic, fancy items etc. Mushroom farming, procurement and distribution of dried coconuts and coir and coir products making are other areas to be intervened. There is possibility of developing electronic industry.

KEY INFORMANT INTERVIEW

This method was mainly used to identify the problem, select wards, to obtain a general picture of the community and to fill the gaps in the information obtained through other methods. The key informants were Govt. officials, community leaders, voluntary organization members, teachers, anganwadi workers, members of mahila Swasth sangh, doctors etc.

Selecting the study area.

Interviews were done with District Medical officer, District Immunization officer and Assistant Director of Health Services to find out an area where, there are more health problems. It was useful because of lack of data on this. All of them suggested Vizhinjam Panchayat based on the following facts.

- People in some parts of the Panchayat have poor quality of life, while tourism is developing in certain areas.
- There is wide gap between different groups of people in quality of life.

- There are outbreaks of diarrhoeal diseases, measles and chicken pox in this area.
- There are pockets where high fertility rate is existing
- School dropouts are higher in number.
- There are sexual health problems, because of tourism related trade.

Selecting the wards.

It was decided to take a few wards from coastal area and another few from midland area. The community leaders suggested the wards. For intervention the leaders suggested Mullur for the following reasons.

- This is a backward area in economy. But researchers and NGOs usually select the coastal wards and tourism ward for studies and activities.
- It is not easy to make rapport with people in the tourism area, because people are floating and do not build trust easily. It will take time to develop strategies to intervene here and by that time the project will be over.
- In the coastal area people are fed up with surveys, and they may become non-co-operative.

Water supply and sanitation

All the key informants in the community were of the opinion that there is lack of safe water supply for many years, in almost all areas of Panchayat. The problem is severe in the coastal area. During draught, water is distributed in tankers. Panchayat authorities are aware of the water problem in the area. They told that they have tried to reduce the problem in many ways like inception of public tap, purification of well water etc. In 1996-97 planning, most of the projects prepared were on safe water supply. They hope that it could be materialized, as soon as the funds are released.

Health.

Doctors and other health professionals in the health sector were interviewed. The information is as follows. Generally water born diseases and air born diseases are more in this area. The major illnesses are diarrhoeal diseases, viral fever, conjunctivitis, and rheumatic diseases as per the information from the health centers. There are reports of malaria also. Tuberculosis and leprosy are still present. 100 people are getting leprosy pension and 202 are getting T.B pension. It is reported that women are having more morbidity, since they are more among those who attend the clinic. Health problems of the old age are another area, which was identified as a problem, which need further study. There is a seasonal trend for some diseases like diarrhoeal diseases, chicken pox, measles, conjunctivitis etc.

The health problems pointed out by social leaders.

1. There are no health care facilities for the tourists.
2. Improvement of water supply and sanitation are prerequisite for improvement of health.
3. There are no facilities for the care of the occupational problems of fishermen. They demand an Aurvedic center and physiotherapy unit.
4. There is no control of pollution in the fish processing industries.
5. Food adulteration in hotels is not controlled.
6. Anganwadi buildings are not sufficient.
7. Service in anganwadis is poor.

Education

Literacy rate in this Panchayat is 64% where as that of state is 90%. The main reason is that children drop out during the fishing season. Dropouts are increasing now. There were 163 drop outs during the year 1996. Dropouts and failure rate are more among Dalits.

There is no govt. High school in the area. There is one govt. middle school and one private middle school. There are 8 Govt. L.P.School and one private L. P. School. In the govt. high school, Venganoor S.S.L.C.success rate has decreased drastically from 1991- 92(37%) to 1995-96(8.3%). This is in contrast to other schools. Pre primary schools and nurseries are less than what is needed. There are 10 parallel colleges. There is one balawadi.

HOUSING

There are 12733 buildings in the Panchayat. 4070 houses are in a bad shape and are to be reconstructed. 15 families are living in unauthorized land. There is a need of 1625 new houses according to IRDP survey –1992 .At present 1250 new houses are needed according to Panchayat development committee. Housing condition is poor among the fishermen community and Dalits.

One leader from the fishermen community told that they did not have space for cremation and also space for keeping their tools.

EMPLOYMENT

Key informants were interviewed for identifying the developmental areas where income-generating jobs can be created. Key informants were selected on the basis of their involvement in the community, living in the community for a long period and willingness to co-operate. There was suggestion to link tourism with hotel business. Traditional occupations should be rejuvenated. Mechanization should be brought, wherever necessary. Fish farming, prawn farming mussel-farming etc also can be developed. Poultry and vegetable cultivation can be done because, the major portion of the demand of the community is met by importing. Salt making, match box industry, hollow bricks making are other suggestions.

The employed people are only 30.2%. Only 10% of the employed are in the Govt.sector. Women's employment is lower than that of men. A few women are employed in fish marketing, vegetable marketing, coir making and other such small trades.171males and 105 women are working in cottage industry. 490 men and 194 women are working in other industries. Other available employment opportunities are provided by KSRTC depot, handloom co-operatives, milk cooperatives, saw mills, work shops' oil mills, boat making units, ice plants, furniture making units, press, theatres, power mills, fish marketing unit, fish processing and export unit, net making enterprises, weaving centers, hotels shops, etc. 300 families are involved in traditional trades like making baskets of palm leaves, coir etc. There is a Harijan co-operative society, which is not functioning well. People feel that co-operative society's functions are affected by party politics. Banks are not providing sufficient financial support.

There are about 200 people working in the gulf countries. 200 have returned from gulf. Even though there are a number of job opportunities related to tourism, people are over conscious of the cultural problems related to it. They demand for a tourism policy.

PARTICIPANT OBSERVATION

This was done in a planned manner as well as unplanned manner. The researchers kept diary in which they wrote the relevant observations every day. This was used to supplement and complement information obtained through other methods. Planned observations were done when

it was felt necessary. E.g.; During FGDs and interviews people told that sanitation in the market area is poor. There is sold waste accumulation and lack of proper drainage. The situation was verified by the research team by direct observation.

Water and sanitation

From participant observation it was found that many people were bathing and washing in unclean stagnant water. One of the main sources of water supply is Venganoor canal, a part of Neyyar irrigation project. There is another big source in Pozhuthil. 70% of people depend on well water. There are 78 public taps, but they are not working properly. Water is not consumable. Well water is not chlorinated. There are public taps, but these are not working properly. Those who depend on public taps often struggle and quarrel each other for water. Water will be available only once in a week. In Mukkola water tank is incepted, but people complaint that water has got bad odor and color, as it is not purified properly.

SANITATION

The researchers had visited all wards during the study period .It was observed that solid wastes are accumulated in the public places and the premises of houses in the coastal area. This is more in the market places. Drainage is improper in these areas. They are often filled and overflow during the rainy season.

HEALTH

It was observed during the house visit that there was lack of health care providers for the disabled and elderly. There are old women staying in the market plac e. They are not looked after by anybody.

SOCIAL AND POLITICAL PARTICIPATION.

The research team attended one gramasabha. It was conducted in the govt. primary school, Panavila. Ward member, Block member, Panchayat secretary, and village extension officer gave the leadership. There were about 160 participants. Women were more in this. People belonged to agricultural laborers, farmers, and fishermen. Representation from the upper class

and middle class were less. The group discussion was not effective. There were only two groups. No group was assigned to discuss about health, women's issues, and safe water. The leaders failed to communicate with people. People did not have much idea about people's planning. They were demanding and expecting every thing done by the authorities. The discussions were focused on income generating projects, which ended in dispute.

NUTRITION

It was found that a number of women are anemic. Children are malnourished in the coastal area.

EDUCATION

It was observed by the research team that many children are wandering without attending school. A few of the younger women who attended the discussions were illiterate themselves.

HOUSING

It was observed by he researchers that there are a few old women sleeping in the market place, as they have no residence. There are many houses, which are not suitable for living.

FREE LISTING

This method was used when more details of an identified problem was needed and also to get answers to specific questions E.g. to understand the nutritive value of the food they are taking, they were asked to list out all the food items they consume. Otherwise they speak only generally and we may miss some of the items. From the list they made, it was concluded that majority of people were taking nutritious food in the midland, where as in the coastal area there was lack of vegetables including leafy vegetables. But even in the midland the quantity and variety of food are not sufficient.

List of food items given by different groups.

Midland	Coastal
Breakfast	**Breakfast**
Pazhanji (rice with chili)	Pazhanji (rice with chili)
Dosai	Dosai
Uppuma	Idli
Peas	
Banana	
Roots/tapioca	
Shell fish	
Meals	**Meals**
Rice	Rice
Fish/	Fish/
Vegetables/	Fish/
Green leafy vegetable/	Fish/
Fish/	Fish/
Egg/	Fish/
Meat/	Vegetables(Once in 2 weeks)

KEY PROBING

This method is used when people are not ready to talk about certain things. This may be due to the sensitive nature of the topic or ignorance of people. Then the researchers probe through questions related to the key issue. This was used to get information in the areas like reproductive health, mental health and occupational health.

REPRODUCTIVE HEALTH

In none of the groups, people initiated the discussion about reproductive health. They started the discussion only when specific questions were asked and probing was done. Even though women were facing reproductive health problems, they were reluctant to talk about it openly. This was due to cultural values. Due to the same reason, they were suffering from those

problems silently with out demanding services. The nature and severity of the problem had to be further explored. For this key probing was used.

(Guideline)

Problems related to menstruation.

White discharge

Antenatal check up

Post-natal check up

Perception and practices of contraception.

Problems of old women

Perception about services and cost

To get more deep information about some aspects, hints were given to extract more facts. The questions started with those related to pregnancy and the health care utilisation. Women got interested in talking about these things. They told that the cost of reproductive health care is high in the private sector. They need more facilities in the government sector. Two women told that they had to sell their ornaments for getting services.

All women had antenatal check up during pregnancy. But only three of the 20 women in a group had postnatal check up. Regarding contraceptive practice, most of the women had undergone tubectomies. They had complaints of abdominal pain and backache. They think that it is the consequence of the surgery. They told that men are not willing to do vasectomies. For temporary methods women prefer to have oral contraceptive pills. The reason is that, for this they do not have to expose the private parts and they can do it by themselves. Others will not know about it. They are not aware of the side effects.

Women told that man are not ready to use condoms. They suggested that men should be educated on this.

Younger women have complaints of menstrual irregularities. They are worried of irregular bleeding and dysmenorrhoea. They were reluctant to talk about reproductive and sexual health in group. But they told that sex education is needed.

In the group discussions of men this area was not discussed because of lack of time.

Elder women had problems of postmenopausal bleeding, infection of genital tract, and perimenopausal syndrome. Even old women were shy to talk about sax. A 56-year-old woman told in her personal talk "I have been suffering from vaginal bleeding for the last 2 years. But I could not take treatment for it. I do not have daughters. How can I say these problems to my son? So I am suffering silently". This woman is not taking treatment just because of the attitude of the society towards such problems, which can result in serious consequence.

Even though women are facing reproductive health problems they are reluctant to talk about it openly. This is due to the cultural practices. Due to the same reason, they are suffering from those problems silently with out demanding services. The nature and severity of the problem have to be further explored.

Later women started talking about menstrual problems. Women of all age group had complaints of menstrual irregularities. A few complained about vaginal discharge. They were reluctant to talk about these in the group, but more women complained in their personal talks. After the group discussion women approached with the complaints of vaginal discharge and related problems.

MENTAL HEALTH

This is another area, which people do not react spontaneously. It is because of stigmatization and the sensitivity of the issue. Mental health problems include a varied number of illnesses related to mental health status. Usually these are not counted in health status assessments. People may or may not be aware of the problems. Key probing was done with following guideline.

(Guideline)

Alcoholism

Reasons for mental worries
Expression of mental worries
Sharing with others

People were asked to talk about stress and the ways of outlet. Alcoholism was the key issue with which discussion was started. Women talked about the alcoholism of men. The problem is more in the coastal area. Women complained about their husbands. They related wife beating with this. Women think that availability of alcohol is the problem. If we can ban alcohol, it would be a solution for the problem.

People did not talk directly about the mental health problems. But some of them hinted about features of depression and psychosomatic illnesses. For example some women told that they suffered from lack of sleep and appetite. They arrived at a conclusion that this might be due to mental worries. All these women had worries about the marriage of their girl children.

Then they were asked to list out the probable reasons for mental worries in their community. Having female children to get married, dowry problems were major problems identified and talked in groups. Even though women talked about problems about marriage and other family problems in their personal sharing, they were reluctant to open these issues in the group.

Widows told that they were having mental worries due to lack of security and other social problem.

Very few women talked about their worries with others. They thought that people would tease them.

Mental stress and related illnesses were invisible. The elicitation of these problems requires special techniques. However, it is clear that there are mental health problems like alcoholism, depression, anxiety etc.

In the men's group, there was no time to do key probing. In women's groups there was not much difference between coastal and midland area.

OCCUPATIONAL HEALTH.

As employment itself is a problem in the community, people do not give much attention to the occupational health problems. They are worried of getting employment. Hence, key probing was necessary.

(Guideline)

Particular diseases associated with occupation

Attitude towards preventive measures

Practices of preventive measures

The key given was hazards of chuhlas. Many women are using firewood as fuel and they do not have smokeless chuhlas. But they were not able to relate any associated conditions with it. But following this some other problems were raised by women. Different groups responded differently to the problems based on the occupations in which they are involved. Fishermen in the coastal area told that they need an ayuervedic hospital, since they are more prone to rheumatic complaints and accidents. Dust allergy, asthma, and joint pain were the complaints of both men and women working in the agricultural field.

Women who weave coconut leaves for long duration are suffering from backache and joint pain. Women doing housework for long hours are suffering from joint pain and pain in limbs. Regarding preventive measures they were asked about their perception. Example was given like people involved in stone cutting can wear mask and goggles. Majority responded that it is difficult to wear masks or change their posture during work. Rather they preferred to take some medicine, when problem occurred. After brainstorming and different arguments, they came to the conclusion that it will be good, if we take preventive measures.

QUANTITATIVE METHOD-SURVEY

The main method used was qualitative. The survey was done after the qualitative part to supplement to what was obtained by quantitative methods. This was done only in a small area consisting of two wards namely Mullur and Mukkola. The reasons for selecting this area were

1. This was the area selected for action after qualitative study. 2. There was more rapport with people in this area.

240 families were selected by random sampling method. (Each family constituted husband, wife and children or any of them) If there was more than two generations in a household, the third one was considered as another family. A schedule was prepared. The respondent was any person above the age of 18 in the family.

Demographic characteristics

Total no. Of families		**240**
Number of people		835
Men		406
Fathers	185	
Sons	221	
Women		429
Mothers	235	
Daughters	194	
Sex ratio	**1000(men)**	**1056(women)**

Composition by Age (Men)

Age group	Number of men	percentage
<10	60	14.78
10-19	65	16
20-29	94	23.15
30-39	61	15.02
40-49	53	13.05
50-59	35	8.62
60-69	23	5.66
70-79	12	2.95
80-89	3	0.74
Total	**406**	**100**

Composition by Age (Women)

Age group	Number of women	Percentage
<10	62	14.45
10-19	72	16.78
20-29	97	22.6
30-39	58	13.51
40-49	55	12.82
50-59	36	8.39
60-69	34	7.93
70-79	11	2.56
80-89	4	0.93
Total	**429**	**100**

Composition by Religion (Number of households-235)

Religion	Number	Percentage
Christian	27	11.49
Hindu	204	86.80
Muslim	4	1.70
Total	**235**	**100**

Composition by caste (Hindu)

Caste	Number	percentage
Nair	63	30.88
Ezhava	23	11.27
Dalit	20	9.80
Nadar	54	26.47
OBC	44	21.57
Total	**204**	**100**

Composition by land ownership

(Total 240 families)

Land owned	No. Of families	Percentage
Nil	18	7.50
<_ 10 cent	123	51.25
11-20 .	54	22.50
21-50 ..	35	14.58
50-1 Acre	9	3.75
> 1 acre	1	0.42
Total	**240**	**100**

DISTRIBUTION OF WOMEN BY EDUCATION

(Total-235)

Education status	Number of women	Percentage
Illiterate	64	27.23
Primary school	72	30.64
Secondary school	20	8.51
S.S.L.C. passed	61	25.96
Pre-degree	11	4.68
Degree	6	2.55
Post-graduation	0	0
Professional	0	0
Technical	1	0.43
Total	**235**	**100**

DISTRIBUTION OF MEN BY EDUCATION

(Total-185)

Education status	Number of men	Percentage
Illiterate	31	16.76
Primary school	66	35.68
Secondary school	15	8.11
S.S.L.C passed	50	27.03
Pre-degree	12	6.49
Degree	4	2.16
Post-graduation	2	1.08
Professional	1	0.54
Technical	4	2.16
Total	**185**	**100**

DISTRIBUTION OF WOMEN BY OCCUPATION

(Total-235)

Occupation	Number	Percentage
Housewife	194	82.55
Agricultural labourer	16	6.80
Skilled labourer	9	3.83
Government employee	5	2.13
Private employee	4	1.7
Domestic servant	1	0.43
Street vendor	4	1.7
Petty shop vendor	2	0.85
Total	**235**	**100**

DISTRIBUTION OF WOMEN BY INCOME

INCOME (RS)	NUMBER	PERCENTAGE
Nil	175	74.47
<300&=300	33	14.04
301-600	17	7.23
601-1000	3	1.28
1001-2000	1	0.43
2001-4000	1	0.43
>4000	3	1.28
Total	235	100

DISTRIBUTION OF MEN BY OCCUPATION

(Total- 185)

Occupation	Number	Percentage
Nil	11	5.95
Agri: labourer	78	42.16
Skilled labourer	19	10.27
Unskilled labourer	8	4.32
Farmer	4	2.16
Fishermen	14	7.57
Petty shop owner	3	1.62
Business men	6	3.24
Govt. employee	16	8.65
Professional	2	1.08
Private employee	5	2.70
Technical worker	3	1.62
Retired	12	6.49
Gulf (Migrant)	4	2.16
Total	185	100

DISTRIBUTION OF MEN BY INCOME

INCOME (RS)	NUMBER	PERCENTAGE
Nil	9	4.06
<300&=300	18	9.78
301-600	29	15.68
601-1000	79	38.98
1001-2000	36	19.46
2001-4000	15	8.15
>4000	6	3.27
Total	235	100

HEALTH AND PEOPLE'S PERCEPTION

Health perceptions of people are inseparable from their surroundings, culture, way of life and other life concerns. Hence people's perception about their health and related life areas are considered here along with an objective analysis of the researcher. These areas include, morbidity including perceived illness and disability, water and sanitation, nutritional status, health care facilities and utilization and housing. Since health has given broader dimension than mere physical health, mental health and occupational health also was included in the discussions to understand people's perception about these. Specific health problems of women or reproductive health are also looked into. These problems are often underestimated due the reluctance of women themselves to talk about it. This study is an attempt to visualize health from a holistic perspective of life. Independent indicators have shown that Kerala has a better health status. The common indicators are as follows.

IMR-12 (Kerala); 72 (India)
Birth rate-18.2; 26.4 "
Death rate-6.4; 9 "
Sex ratio-1036; 927 "
Child mortality-4.6; 26.3 "
Perinatal mortality rate-17 (India44)
Neonatal mortality rate-10 (India-47)
Life expectancy-69 (men) 74 (women) [Kerala]
Population growth rate (1981-1991) Kerala 14.32 %. India-23.5%

All these numbers give a glorious picture. But how do individuals perceive about it in the totality of their life? Do numbers and percentages represent the 'individual'? There are regional, group and individual variations. People talked about their problems individually and in groups. A survey was also conducted in one area. These has brought out many relevant facts about health and related issues.

Sex ratio in favour of women and low infant mortality rate are two factors that raised the status of Kerala. But these two are different in Vizhinjam panchayat. (Vizhinjam1000: 983; Kerala

1000:1036) (IMR 38.8: Kerala 17) But the sex ratio of the sample selected from Mullur ward for survey is 1000:1056.

Morbidity

Epidemiologists may be more concerned about epidemics or endemic diseases in a particular community. But people themselves have some perceptions and knowledge about the illnesses in their community. Group discussions conducted among varied groups in the community showed that some of the illnesses consistently occur or make the people worried in the community. There are notable regional differences and gender differences in some cases. Diarrhoeal diseases and skin diseases are reported by both men and women in the coastal area, where as it is not reported by both men and women in the midland area. In the survey done in the midland area diarrhoeal diseases were not reported. Diarrhoeal diseases are seasonal. Skin problems may be related to fishing and related work.

Respiratory problems were reported from all groups like coastal men, women and midland men and women. According to health professionals also water born diseases, air born diseases, and rheumatic illnesses are highly prevalent in the area. As per the reports from health centers infectious diseases like tuberculosis, leprosy and malaria are present. All these are preventable illnesses. In the survey, it is observed that tuberculosis is 12 per 1000 for men and 2 per 1000 for women. 202 people are getting tuberculosis pension from the panchayat.

Only men from the coastal area reported injuries. These men were fishermen and were exposed to injuries during their work. There is demand from the public for an Ayurvedic center and a physiotherapy unit for fishermen in the area. Men from both areas reported diagnosed rheumatic diseases.

Women from both area reported symptoms of rheumatism. Women from both regions complained of vague symptoms like, joint pain, back ache and pain in limbs. According to health professionals, attendance in health centers is more for women. The percentage of reported morbidity in the survey is 9.85 for men and 11.55 for women. If the number of illnesses is considered, it is 15% for men and 24% for women. The average morbidity rate in Kerala is 206.39 per thousand according to the survey conducted by Kerala Sasthra Sahitya Parishat in 1987. The most prevalent illnesses reported in the survey for women include, rheumatic diseases, respiratory diseases, chest pain, headache, hypertension and backache. Major diseases for men include rheumatic diseases, respiratory diseases, chest pain and tuberculosis. Among disabling problems, loss of vision is the major problem for both sexes.

Percentage of asthma for women is 10 and for men it is 5. Occurrence of hypertension for men is 2% and for women is 7%. Diabetes for both men and women is 4%. The percentage for asthma, hypertension and diabetes are 11, 8, and 2.3 respectively in KSSP survey.

REPORTED MORBIDITY PATTERN OF WOMEN (Total-429) Morbidity defined as illness occurred at any time during the period from two weeks till the date of interview.

Number of illness per woman	Number of women
1	27
2	19
3	12
4	3
Total	**51**

Percentage of women reported illness=11.55

ILLNESS	NUMBER OF WOMEN
Heart disease	2
Rheumatic complaints	16
Total blindness	5
Loss of vision	12
Asthma	10
Chest pain	11
Acute respiratory disease	2
Chronic respiratory disease	6
Giddiness	3
Tuberculosis	1
Headache	10
Disability after polio	0
Hypertension	7
Backache	7
Mental illness	2
Hypotension	2
Paralysis	2
Skin disease	2
Epilepsy	1
Diabetes	4
Deafness	0
Goiter	1
Stomachache	3
Jaundice	2
Filariasis	0
General weakness	0
Allergy	1
Infertility	2
Acid peptic disease	1
Pain in limbs	1
Total incidents	**115**

REPORTED MORBIDITY PATTERN OF MEN (Total-406)

Number of illness per man	Number of men
1	23
2	12
3	5
Total	**40**

Percentage of men reported illness=9.85

ILLNESS	NUMBER OF MEN
Heart disease	2
Rheumatic complaints	6
Total blindness	3
Loss of vision	3
Asthma	5
Chest pain	5
Acute respiratory disease	4
Chronic respiratory disease	4
Giddiness	0
Tuberculosis	5
Headache	4
Disability after polio	1
Hypertension	2
Backache	3
Mental illness	0
Hypotension	0
Paralysis	1
Skin disease	4
Epilepsy	0
Diabetes	4
Deafness	1
Goiter	0
Stomachache	1
Jaundice	1
Filariasis	1
General weakness	1
Allergy	0
Infertility	0
Acid peptic disease	1
Pain in limbs	0
Total incidents	**62**

Data on morbidity pattern gathered from PHCs in Kerala also show similar pattern. The major communicable diseases include respiratory infection, diarrhoeal disorders, skin infections and gastro enteritis. And also it is seen that the infection rate is highest in the coastal villages.

The survey report shows that 32% of men have the habit of smoking. 17% regularly use alcohol and 10% have the habit of chewing tobacco.

DISTRIBUTION OF MEN BY HABIT (Adults=185)

Habit	Number of men	Percentage
Alcohol	32	17.30
Smoking	59	31.90
Chewing	20	10.80

(Not mutually exclusive)

People's perception and their concerns about illnesses were brought out through group discussions. This gave an opportunity to remove some misconcepts also. For example some people strongly believed that immunization against polio would produce polio. Such doubts were clarified during the sessions.

Health care facilities and utilisation

Health care facilities are available in both public sector and private sector. The utilisation can be illustrated from the number of deliveries taking place in hospitals and immunization coverage. The survey gives the following data.

PLACE OF DELIVERY

Place of delivery	No. of delivery	Percentage
Hospital	428	70.86
Home	176	29.14
Total	**604**	**100**

IMMUNISATION COVERAGE

Immunisation	No. of children	Percentage
Complete	405	67.05
Not complete	199	32.95
Total	**604**	**100**

There is fairly good coverage in these areas. But people are not much satisfied in the service of health care institutions. They have their own perception about the quality of care. There are a number of health clinics in the tourist area, which do not maintain quality. Many people are concerned about the increasing health care costs. In Kerala share of private hospitals is 93%. In this situation cost is an important issue.

People have demands like availability of medicines in the Govt. health centers, cost reduction in private sector, evening clinics for working people, health programmes for elderly people, special clinics for women witch provide privacy. There was also a demand from the public for improving sanitation in hotels and public place through public health intervention. People want to improve the functions of anganwadis also. Geriatric care is another area to be taken care of. Many older women specified this. There should be some policy level decision because it is a problem to be addressed statewide. Experts recommend facilities for geriatric care in health institutions considering the demographic transition.

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Water and sanitation

The linkage between water, sanitation and health is a well-established fact. According to health authorities Vizhinjam is an area where there are health problems due to lack of safe water supply and sanitation.

9th five year plan envisages 100 percent coverage of the state in regard to protected water supply. Rural water supply schemes in Kerala increased in 1990s. The coverage of rural population also increased. But in terms of quality of water supplied, the position is far from satisfactory, as in a number of cases; the coverage is measured as mere accessibility of piped water connections. Vizhinjam is a good example for this.

People themselves pointed out lack of safe water supply as one of the major health related problems in this area. If we just ask about health people will be talking about diseases. But since they were facilitated to talk about the health related problems as well, they were able to identify this as one of the main problems. In the ranking also it came first, consistently in the men's groups. In the women's groups it came second, first being employment. This gender difference also is important because it points out the perceived relevance of employment for women though scarcity of water also is very very important for them.

According to people's perception 70% of people are using well water. But during draught season there is difficulty for water. Survey in Mullur area showed that 65.4% people are using well water. But in the coastal area it is difficult to have wells. Here, the problem is severe. Hence a large number of people are using public tap. But the water available through the public tap is impure and have bad odour. People use unclean water from river for bathing and washing. The same water is used for washing cattle and so on. Only a small group of people could afford to pump set.

SOURCE OF DRINKING WATER

Source	No. of families	Percentage
Well	157	65.41
Public tap	75	31.25
Pipe supply	1	0.42
Pump set	7	2.92
Total	**240**	**100**

There is regional difference and class difference in the availability of water. In the coastal area the problem is severe. And also it is seen that rich people can afford safe water when it is sold through water tanks brought from other areas. Poorer people are suffering more. Women from lower social class have to spend much time and energy to fill water pots from the public tap for domestic use. Collection of water is considered as the duty of women. In the public taps water will be available only once in a week. So women have to fill the vessels for one week.

People are well aware of the health implications of lack of safe water supply. They have been pressurizing the authorities for safe water supply for long time. All the authorities also agree with this. People think that there is lack of political will. Any way now they hope that projects can be implemented through people's planning in the panchayat. A number of projects were prepared for this with people's participation.

Lack of environmental cleanliness is visible in certain areas. Kovalam, an international tourist center is located in this panchayat. But even in this area there is no proper drainage and solid waste disposal. There is accumulation of solid waste and collection of wastewater in different areas like market and tourist spots. In the survey 45% of families reported that they did not have any system for managing solid waste and 35% reported that they did not have a system for management of wastewater. But most of the people said that they burned the solid waste and used wastewater for kitchen garden. The survey was conducted in the midland area. But in coastal area there is too much congestion and little space for waste management. There should be some mechanism for waste disposal in this area envisaged by panchayat. The infection rate of communicable diseases was highest in the coastal area in Parishat survey also. The reasons were found to be overcrowding and poor environmental sanitation. Faecal contamination of drinking water and food was found responsible for spread of diarrhoeal diseases.

SOLID WASTE DISPOSAL

Method	No. of houses	Percentage
No management	107	44.58
Composting	1	0.42
Burning	132	55
Total	**240**	**100**

LIQUID WASTE DISPOSAL

Method	No. of houses	Percentage
Kitchen garden	152	63.33
Drainage	3	1.25
No management	85	35.42
Total	**240**	**100**

There are many houses without having sanitary latrines especially in the coastal area. In the tourist area also there are not sufficient public latrines. According to 1991 census, 51%of the

households in the state had sanitary latrine facilities. Here, in the coastal area many people do not have latrines. But in the midland 75% of people have latrines as shown in the survey.

AVAILABILITY OF LATRINE

Latrine	No. of houses	Percentage
Present	182	75.83
Absent	58	24.17
Total	**240**	**100**

From the survey it is seen that morbidity is higher in the families using water from tap (45%) than in families using well water (20%). There may or may not be some relation with the source of water supply and illness. This has to be further studied. The relation ship can be due to the economic status, which has linkage with source of water supply.

DISTRBUTION OF ILLNESS BY NATURE OF DRINKING WATER

Source	Disease present	Disease absent	Total
Public tap	34(45%)	41	75
Well	32(20%)	125	157
Total	**66**	**166**	**232**

DISTRIBUTION OF ILLNESS BY AVAILABILITY OF LATRINE

Latrine	Disease present	Disease absent	Total
Present	55 (30%)	127	182
Absent	32 (55%)	26	58
Total	**87**	**153**	**240**

A similar observation is seen in case of availability of latrines also. Morbidity is seen in 55% of houses with out latrines where as morbidity is present in 30% of houses with latrines. This difference may be also due to the difference in socio-economic status.

Housing

Physical environment has an important role in maintaining the health status of people. Housing condition is a determinant of health of the inhabitants. It also indicates the socio-economic status of the family. People did not initiate discussion on this in group meetings. But according to IRDP survey there has been need for 1625 new houses. About 4000 houses are badly constructed. Dalits and fishermen have prior need. There was scheme for fishermen and some houses were constructed. It was the result of the shift in approach to housing policy in the 1990s. High priority was given for economically weaker sections. Subsidies of housing schemes promoted housing for the poorer. Still there were women who had to sleep in open spaces for lack of houses.

Survey done in Mullur ward where Dalit population is more, showed that 7.5% families did not own land. About half of the families owned 10 cents of land or lesser than it. 89% of people had their own houses. But 34% were living in houses, which were not suitable for living.

OWNERSHIP OF HOUSES (Total=240)

House	No. of. families	Percentage
Owned	213	88.75
Rented	11	4.58
Govt. land	16	6.67
Total	**240**	**100**

HOUSING CONDITION

Type of house	No. of families	Percentage
Concrete	19	7.95
Non-concrete	140	58.34
Not livable	81	33.76
Total	**240**	**100**

Nutrition

Nutritional status is a very good indicator of health and quality of life. Though Kerala could reduce maternal mortality and infant mortality to a large extent, anaemia is highly prevalent among women. A study showed that anaemia among pregnant women in S.A.T. hospital, Thiruvananthapuram is 52.4%. There is high prevalence of low birth weight and perinatal mortality. These have to be studied in relation to the nutritional status of women. The calorie and protein intake of Keralite are found to be lower. (Panicker and Soman)

High infant mortality was observed in this panchayat. But a nutritional survey was beyond the scope of this study. The information gathered is not quantitative. This is helpful only in knowing the trend. Regarding quantity of food, women from low social class consume less than they need. Symptoms of aging are earlier among them. There is high prevalence of anaemia. In the midland, people are aware of nutrition and there is availability of different food items because they have land. But they do not have the habit of taking balanced diet. This necessitates some programmes for attitudinal and behaviour change.

Nutritional deficiency is more in the coastal area. There is non-availability of certain food items like vegetables and green leafy vegetables. They have to buy everything. Anemia among women is more here. Children also show symptoms of nutritional deficiency.

Reproductive health

Though women in developing countries suffer from a number of reproductive health problems, these are often underestimated. The reason is the prevailing culture of silence in matters regarding reproduction and sexuality. Even in highly literate state like Kerala women do not have control over their sexuality and reproduction. Thus the Government programmes for family planning and maternal health programmes are being implemented without considering women's perspective. Now there is a centrally sponsored programme for reproductive health. HIV/AIDS prevention programmes also address these issues. Women's own evaluation of these issues is important in this context. Women in groups did not initiate discussion on this. Issues came out only when probing was done.

The major concern of women was regarding the increasing cost of care in the private sector as well as the cost required even when they attend public health centers/hospitals. Majority of them preferred to go to private hospitals. They want to improve the facilities and quality of care in Government hospital.

Almost all women go for antenatal check-up in this area. But only very few women go for post-natal check up. Deliveries are usually conducted in hospitals. The survey showed that 70.9% of deliveries had taken place in hospitals. Most of the home deliveries were reported by elderly women. Fertility pattern is that 85% of married women have 3 or less than 3 living children and 15% of women have more than 3 children.

FERTILITY PATTERN OF WOMEN (Total=235)

No.of deliveries	No. of women	No. of children	No. of women
0	19	0	19
1	40	1	47
2	73	2	78
3	47	3	56
4	29	4	20
5	14	5	6
6	5	6	4
7	5	7	3
8	2	8	2
9	0	9	0
10	1	10	0

The most common practice for contraception is tubectomy. This is not done as a choice of women. Hence all of them have fear about it. They complain that they have got abdominal pain and backache after surgery. Proper information and counseling should be given to women before undergoing surgery. There are misconcepts prevalent about vasectomy. Both women and men think that men may lose potency for sexuality, if they undergo vasectomy. Another false notion is that men cannot work after this. A real practical proble m is that people do not follow the advised

practice of condom use after a few months after vasectomy. Hence there is a high failure rate compared to tubectomy. For this also counseling services are needed.

For temporary contraception women find pills as a better choice. They like to avoid intra uterine devices, though it has got advantages like prolonged action. And also there are number of side effects for pills. Irrespective of this, women prefer pills because they can avoid hospital service and have control for themselves in the use. At the same time, if the achievements are examined it is seen that tubectomies and IUDs are more than pills and condoms. This indicates that women have conflicting situations when various family planning methods are imposed upon them. This also shows the need for active participation of women in decision-making in the use of contraceptives.

Condom is the safest method for temporary contraception. It has the additional function of preventing STDs as well. But most of the men do not prefer this. There should be educational programme for this.

Menstrual irregularities and dysmenorrhoea are other problems of women, especially for the younger groups. (Bang. R. A) Elderly women are suffering from perimeopausal syndrome, postmenopausal bleeding, and infection of genital tracts. But usually women suffer these problems silently. In a study conducted in rural India it was found that there is high prevalence of gynecological morbidity (92%).(Bang. R .A.)

White discharge is a common complaint for all women in this community also. A study in rural Kerala showed that the prevalence is 26. 8%. (Sheela Shenoy) But usually women do not talk it in groups, but they speak out individually. Usually there is over anxiety and misconcepts regarding this. Sometimes women mistake it for normal discharge. In case of infections, women interpret it as loss of body energy and melting of bones. They do not take proper treatment.

Mental health

Indicators of mental health like suicide rate shows that Kerala society is facing crisis in this area. Alcoholism, depression, domestic violence, sex abuse etc are high in Kerala society. But because of the stigma attached to this, people usually do not talk about this openly. Hence the problems were not brought out in group discussions. Hence, probing was done.

Women are suffering from alcoholism of their husbands. Usually it is related to domestic violence. But studies show that both are not related. The problem is more in the coastal area. Women show symptoms of psychosomatic illness. It is more among women who are deserted by their husbands. These are characterized by vague symptoms, multiple symptoms, which are unrelated, and there is no improvement by treatment. The reasons brought out by them include insecurity feeling, lack of economic safety, anxiety about daughter's marriage and dowry. To address these issues women help centres should be organized in panchayat level as recommended by committee on women's projects in people's planning.

It was observed that families are closed units. People do not share their problems with others. Majority responded that they do not have an intimate friend with whom they can share their personal problems. Women do not find time and space for entertainment for themselves. Even girl children are not allowed to involve in games after puberty. Even when there is television and radio in their houses women are reluctant to tell that they use it for entertainment. It may be because of the fact that they feel guilty, if they themselves find pleasure seeking which is not rewarded culturally.

Occupational health

People in our community are not much aware of this problem. Since lack of occupation itself is a problem, people do not give much importance to this. However, there has been a campaign by Kerala Sasthra Sahitya Parishat regarding the health hazards of smoke from domestic fuels. As an alternative Parishat has developed smokeless Chula and it has been distributed in the community. Since majority of women are housewives this is relevant in our community. But there was not much response from this community. They were not aware of the problem. But this has led to discussion and people identified certain problems. For example, women weaving coconut leaves are suffering from backache , joint pain and pain in limbs. This is due to sitting for prolonged hours in a particular posture. For taking preventive measures there should be education programmes, because it is very difficult to change behaviour suddenly. Agricultural laborers and stonecutters are more prone to asthmatic problems and respiratory infections. But wearing masks and protective goggles are not very attractive to them. Special training is needed to change the behaviour.

Shellfish poisoning

During the month of September there was an incidence of shellfish poisoning. 7 people including two children died after consuming shellfish, which is seasonal seafood commonly used by people. It was a sudden outbreak. More than 100 people were affected and hospitalized. Fear spreaded out in the community. The incidence happened as a result of a protozoal infection of the mussels. There was numbness of head, vomiting, giddiness etc. Those who were discharged from hospital were not completely cured. These people needed much support. There were volunteer's team and medical team working in the community for investigation and support to the community. We also joined with them. This was an opportunity to work with people and relate with community leaders.

There was much impact in the community after the incident. Many people who were involved in collecting shellfish lost their job. These people wanted to find alternative jobs. The poisoned people needed more care. They complained that the Govt. didn't give the support they offered during the time of the disaster.

Our team visited the houses and collected information. People developed irrational fear after the incident, so that they were not even taking fishes. Some people believed that somebody had put some poison into the sea purposefully.

There were a number of false beliefs prevailing in the area. Some were having symptoms even after months. These problems were psychosomatic. They demanded for medical camps. Medical college team arranged a camp in which a detailed examination of these patients was done. The team also participated in this and helped in developing better relation with community.

This intervention helped in knowing the cultural practices of the community. It was seen that poisoning was severe among those who had boiled the fish with tapioca and consumed without removing the gut and liver. People were affected by the incident in different manner. It was an unexpected shock to the community. Many families were affected economically, because they were living upon shellfish collection. The team members visited the houses and gave emotional support. Medical care was also given in some situations. This was an experience to the team members and helped in interacting with the community in a better way.

EMPLOYMENT, INCOME AND QUALITY OF LIFE

In all women's development activities income generation is an inevitable aspect. Income, economy and employment are closely linked with quality of life. Employment is not a mere engagement of people into productive activity, but it encompasses dignity of labour, recreation, worker's rights etc. It is advocated that there should be leisure time to think in order to utilize the maximum potential of people. There are different schemes for self-employment envisaged by policy makers. But creating an enabling environment is more important. People usually prefer to work in the formal sector because they have job security. But if there is enabling environment to choose jobs, people will be encouraged to find out their own jobs according to their interests and skills. In many places rights of the workers to unionise are not allowed to exercise. At the same time in some places workers do not take responsibilities and a work culture is undermined.

In the self-rating conducted in the study, employment was selected as the most significant factor related to their health and quality of life by women. Hence the topic was elaborated mainly in women's groups. This was consistent in all groups from different backgrounds. But unfortunately, the employment status of women in our state is low and the duty of women as housewives has not yet given the status of a productive work.

Work participation of women in Kerala is low. The sex ratio of is 345 women workers: 1000 male workers. The National ratio for the same is women 409: Men 1000. According to 1991 census percentage of workingwomen in Kerala is 5.85% where as that of men is 47.58%. According to economic review main workers in Kerala include 64.04 lakhs males and 18.96 lakhs females. There is a decline of 5% in Female Work Participation Rate in Kerala from 1981 to 1991. The reason is sharp reduction of land under paddy cultivation (31%) during this period. There has been a shift in cropping pattern from paddy to coconut and rubber.

Number of job seekers registered in employment exchanges of Kerala increased from 35.51 lakhs in 96-97 to 37.9 lakhs in 98-99. Women outnumber men who seek employment through employment exchanges. Total number of women job seekers in Kerala in 1999 was 20.77lakhs compared to 17.14 lakhs men. The spread of education and the difficulty to take up jobs freely due to various reasons may be the reason for the high incidence of unemployment among women. Among the districts in Kerala, Thiruvananthapuram ranks first with the highest number of job seekers. In 1999 the total number of job seekers in Thiruvananthapuram was 6.70 lakhs, of which women constituted 3.84 lakhs and men 2.87 lakhs.

There is disparity in the wages of women and men. Daily wage rate of unskilled workers in agriculture is Rs.103.72 for men and Rs. 69.35 for women. In construction sector the wage for men is Rs. 118-119 and for women it is Rs. 97-99 (Economic review-1999). There are some modern small-scale labour intensive industries with female employment, which is low paid. In some jobs women particularly are employed. This is because of the existing gender division of labour. Women's wages vary between 50-75% of men's wages due to sex stereotyping of occupations. Most of the women are in the unorganized sector or informal sector, where there is

no job security. Industries where more than 50% workers are women are cattle and goat breeding, beedi, wooden and cane boxes, cotton spinning, processing of edible nuts, embroidery, manufacturing of matches, weaving wool, cotton, khadi, coir. In 1981 7.7 percent women were employed in cottage industries. It has declined to 5.55 in 1991. Mechanization has affected women working in coir and other traditional work.

Most of the women are involved in household activities, which is productive, but unpaid. Even in this situation, there are female-headed households, where the women are earning for the family. This is much strenuous for the woman. Women's lower status in employment is the consequence of their traditional role in the family. In traditional societies, women working outside family were not respected. Women's childbearing capacity became a bondage to them. Even if women worked they were unmarried women. Unpaid domestic work had been the norm for long time for women. In the preindustrial period women worked in agrarian production as weavers, spinners, gardeners, washers and agricultural farmers. But their work in the field was always auxiliary to their work at home. Their economic role was viewed as supplementary for husband's earnings. During industrialisation, the demand for women's work increased. But it was characterized by low pay, lack of craft, weak unions and unskilled status. The division of labour existed in family when household was the unit of production was extended to capitalist economy. Women were denied access to socially reorganized skills. So they became reserve army, a source for cheap labour whenever needed.

In Vizhinjam panchayat only 30% of people are employed. Women employment is much lower i.e. 12.55%. Majority of the employed are working in the unorganized sector. The survey in Mullur ward showed that 17% of women are working in that area.

DISTRIBUTION OF WOMEN BY OCCUPATION

(Total-235)

Occupation	**Number**	**Percentage**
Housewife	194	82.55
Agricultural labourer	16	6.80
Skilled labourer	9	3.83
Government employee	5	2.13
Private employee	4	1.7
Domestic servant	1	0.43
Street vendor	4	1.7
Petty shop vendor	2	0.85
Total	**235**	**100**

They are working in agriculture and fishing. They included agricultural labourers (6.8%), skilled labourers (3.8%), Govt. employees (2.1%), Private employees (1.7%), Domestic servant (0.43%), street vendors (1.7%), Petty shop vendor (0.85%). Though majority of women were housewives they did not consider it as work because they were not earning anything from it. In the survey, 82.5% of women were housewives. Most of them desire to have some job for earning because they think that the income of their husbands is not sufficient. And also women do not

spend money unnecessarily like men so that all the money can be used for the family. They were ready to work, even if there is double work as a result of their domestic duties. The income distribution of women in the survey is as follows.

DISTRIBUTION OF WOMEN BY INCOME

INCOME (RS)	NUMBER	PERCENTAGE
Nil	175	74.47
<300&=300	33	14.04
301-600	17	7.23
601-1000	3	1.28
1001-2000	1	0.43
2001-4000	1	0.43
>4000	3	1.28
Total	**235**	**100**

74.47% of women do not have their own income. But only 4% of men respond that they do not have any income. Only 2.1 % of women have income of more than 1000 rupees per month, where as 31% of men have this in the sample selected for survey.

DISTRIBUTION OF MEN BY OCCUPATION

(Total- 185)

Occupation	Number	Percentage
Nil	11	5.95
Agri: labourer	78	42.16
Skilled labourer	19	10.27
Unskilled labourer	8	4.32
Farmer	4	2.16
Fishermen	14	7.57
Petty shop owner	3	1.62
Business men	6	3.24
Govt. employee	16	8.65
Professional	2	1.08
Private employee	5	2.70
Technical worker	3	1.62
Retired	12	6.49
Gulf (Migrant)	4	2.16
Total	**185**	**100**

DISTRIBUTION OF MEN BY INCOME

INCOME (RS)	NUMBER	PERCENTAGE
Nil	9	4.06
<300&=300	18	9.78
301-600	29	15.68
601-1000	79	38.98
1001-2000	36	19.46
2001-4000	15	8.15
>4000	6	3.27
Total	**235**	**100**

Majority of men are agricultural labourers. Other occupations involve skilled labourers (10.27%), unskilled labourers (4.32%), farmers (2.16%), fishing (7.57%), petty shop owners (1.62%), business men (3.24%), Govt. employee (8.65%), private employee (2.7%), Professionals (1.08%), technical (1.62%) Gulf migrants (2.16%), and retired (6.49%). About 6% of men were not working. Traditionally large numbers of women were working as agricultural labourers. But here women are lesser, probably due to reasons cited above. There is notable gender disparity in Govt. jobs.

Land ownership and ownership of houses also is an indicator of income and well-being. But in our family relations even if women own land or house the control may be in the hands of men. Hence through a survey the assessment of the real wealth of a family woman is difficult. Since the income of women show a low status, it can be assumed that there is minimum control for women in freely using the properties. The land ownership and house ownership are assets for the families. This gives a general situational picture of their wealth. More than 50% of people own less than 10 cents. 7.5% do not have land. In the ownership of houses also a similar number of people reported that they are living in Government property.

COMPOSITION BY LAND OWNERSHIP

(Total 240 families)

Land owned	No. Of families	Percentage
Nil	18	7.50
<_ 10 cent	123	51.25
11-20 .	54	22.50
21-50 ..	35	14.58
50-1 Acre	9	3.75
> 1 acre	1	0.42
Total	**240**	**100**

OWNERSHIP OF HOUSES (Total=240)

House	No. of. families	Percentage
Owned	213	88.75
Rented	11	4.58
Govt. land	16	6.67
Total	**240**	**100**

Though women are marginalised from economic realm, they desire to become part of it in a democratic system. Universal education in Kerala created a cultural environment in which women seek self-esteem through economic security. But because of the backwardness in economic development and traditional family values, the women have limited options in employment. The group discussions revealed that women have preference for permanent jobs. They were skeptical about self-employment.

The reasons were lack of job security and reluctance to take initiative. Some women told that it was the opinion about their husbands. This attitude is the reflection of the low status of women in society, which creates an insecurity feeling, and lack of confidence among women. But women do not have much scope in this situation to get permanent job in Govt. sector also. In the survey report where men's employment in govt. sector was 8.6%, women's employment was only 2%. As long as the sexual division of labour exists, women will be marginalized from dominant and wage earning sectors.

Hours of work and working environment are also important. Some of the women said that they do not have much work in the family. But when the time budget was prepared it was seen that most of the women were working 15-18 hours a day. This includes cooking, washing, cleaning, marketing etc. Some women feel monotony in the work. A study conducted by ILO estimated that the value of unpaid household work itself constitute 25-39% of the total Gross National Product (GNP) of developing countries. This substantial contribution to economic growth comes out of a number of domestic work such as gathering of wood, fetching water, washing, cooking etc. And also even for the same work, women are not paid equal wage when they work outside the family. (Shamim A)

Both men and women have internalized the gender division of labour. They think that domestic work is the duty of women. Even if men do not share household work it is considered as natural. More opportunities available for men for job were also considered natural. All these show that though women desire to have employment, they do not want to change the stereotypical role in society. But employment opportunities for women will be created, only if there is a change in the stereotypical roles. This is conflicting to woman's self-identity and challenging to the system. It seems that gender training also is needed for women along with creation of job opportunities.

Working women shared their problems. Some women were working as agricultural labourers; some work in fish marketing, vegetable selling, coir making and such small trades. Women vendors are facing problems in transportation. Monitoring committee on women, planning board suggested provision of lightweight fuel-efficient vehicles to women vendors. There are

women in cottage industry also. Some women make baskets of palm leaves. Workingwomen do not have facilities to feed their babies. Those women, who had undergone skill training like sewing, do not have money for initial investment. They noticed disparity in wages of men and women.

Some suggestions came out of the discussions. This was about forming co-operative for self-employment. Women should undergo trainings for skill development and market should be found out. There was opinion to rejuvenate the traditional occupations like Coir and coir products making, poultry, vegetable cultivation, fish, mussel, prawn farming and mushroom farming were also suggested. It is interesting to note that though it is a tourist area, women do not venture into any tourism related work.

It will be better to look into the various development programmes going on in the country. The programmes are sponsored by the social welfare department, department of industries and the department of rural development. Development of Women and Children in Rural Areas (DWCRA), Composite Programme for Women and Pre-school children (CPWP), Integrated Rural Development Programme (IRDP), Training of Rural Youth for Self-employment (TRYSEM) are some of the programmes. Problems of women's development schemes are lack of sufficient funds, organizational problems like selection of participants, lack of supportive services like supply of water, sanitation, crèche-cum day care centres in the unorganized sector etc. Many of units of these programmes are found not viable. A study showed that only 50% of units are viable in case of DWCRA. The sustainability of these programmes are in question due to lack of enabling environment and infrastructure. In some areas there is lack of training and skill development. The production units have difficulty in finding market. Even after encouragement from all these programmes there are only 5.42% women entrepreneurs. Women's development should involve access to productive resources, equal remuneration, skill formation and empowerment. There should be special protection for women those who are marginalised due to mechanization in traditional work.

People are not aware of occupational illnesses and their preventive measures. Any way elderly women talked about the impact of prolonged work upon their health. They complained of fatigue, back ache, body pain, giddiness etc.

People are not concerned about the need for refreshment and rest in between working hours. Women are unable to distinguish between their work and entertainment. It is true that many work in which women involved are refreshing the mind also. Caring of baby is a very god example. Women made a list of entertainments when they were asked to do so. Those included stitching, weaving coconut leaves, making pickles, pappads, gardening etc. But the problem is that they do not reflect it as entertainments and do not feel the need for it. Even those who watch television for entertainment are considering it as an activity for information gathering. This happens because people do not think that entertainment is needed for improving the quality of work as well as quality of life. On probing women agreed that they like to go for outing with their husbands, which often do not materialize. In the survey women did not respond to the question regarding entertainment. But about half of men responded to the question. 45.85% from the sample considered watching television/listening to radio as their entertainment. 2.7% of them engage in sports and games for entertainment.

PERCEIVED ENTERTAINMENT OF MEN (185)

Perceived Entertainment	No. of men	Percentage
Sports & games	5	2.7
Television/Radio	85	45.95

EDUCATION

Education has been considered as a tool for emancipation from the time of modernity. Recently, this is included as a component of quality of life in development concepts. Educational status is one of the components of the composite index of Physical Quality of Life Index (PQLI). If literacy status alone has been considered before, now more qualitative assessment is done. Adult literacy and mean year of education etc are taken into account in development measures. It is seen that education brings out optimum creativity from a person. But at the same time content and method of education has much bearing on changing a person's life positively. Relationship between mother's education and infant mortality is a well-established factor. Educational status has got many implications on health.

There has been criticism regarding the inappropriateness of elite education as the only choice to marginalised groups like low socio-economic class, Dalit, fishermen, tribal etc. There is strong relationship between economic development and education. There is lack of social accessibility in case of Dalit. The existing hierarchy is reproduced through education. In the Indian situation it is seen that there is relatively high degree of dropouts among Dalit pupils as they proceed in school. There is gender difference within these groups also. Though these students get incentives it is insufficient and they do not get it in time. The percentage of dropouts among female children considerably exceeds that among males.

In India the reason for dropouts and low level of literacy relate to poverty and the need for work by children. Hence, vocational component in education has been suggested by educational experts. The preliminary report By Dr. Ashok Mitra (1997) recommends as follows.

'Secondary stage comprising standards 9, 10, 11, 12 may be broken down into two components, academics and vocational. A school may select the vocational subjects based on the facilities already available to the neighborhood. Since the vocational course for higher secondary school has not measured up to the expectation, the system may be completely restructured with maximum emphasis on practical work and field experience. The physical facilities in school will have to be supplemented by those available in work places in the neighborhood or in collaborating institutions. Programmes with a practical and vocational content may be introduced under the management of private or voluntary agencies including local self-government institutions. "

There are many projects aimed at non-formal education of illiterate adults and working children. There is criticism regarding Govt. run non-formal centres. These institutions continue to allow the working children and bonded children in the same exploitative system while giving them an education, which falls for short of minimum. There is lack of quality and spirit of innovation of alternative system, which had been diluted by the system. Thus it became ritualistic and mechanical. In fact mainstream system can be enriched and strengthened by incorporating many of the features of these alternatives. Plurality should be respected when alternatives are developed. This can effectively address the various issues of culturally different communities rather than by a monolithic system. Non-formal education should be need based, relevant to local institutions and responsive to local concerns. More autonomy and flexibility is needed so that

there can be freedom from unnecessary bureaucratic interventions in appropriate utilization of resources, innovation and experiments. Curriculum should be developed suitable to the culture of the community. Usually the education system as secondary socialization stands at odds with and criticizes the local culture and tradition that are transmitted through primary socialization.

Kerala is renowned for its achievement in literacy status along with other achievements as in health. Literacy level of both males and females was higher in Kerala even at the beginning of this century. This further improved in the second half of this century particularly in female literacy. Kerala has got the highest effective literacy rate in the country according to 1991 census i.e.89.91% where as Indian average is 52.21%. Female literacy rate in Kerala is 86.17 where as in India it is only 39.39%. Infant mortality rate, which is supposed to have a negative correlation with female literacy, also is considerably low in Kerala. But still there are regional differences and group differences. For example, female literacy among scheduled tribes is low (41%). In Kudumbi community 85% of women are illiterate. In certain areas low literacy exists among fishermen and Muslim community

Enrolment of girls and boys in primary and secondary schools does not show significant gender difference in Kerala. But women's enrolment in professional colleges and vocational higher secondary schools is lesser than that of boys. The proportion of women to men teachers in professio nal colleges is less when number of female teachers in schools is higher. The National sample survey results for 1986-87 indicate that of the female literate population of Kerala, 59% had not gone beyond primary level, 25% had acquired middle school level education and only 16% had qualified for matriculation and above.

Educational institutions reflect and reinforce the gender difference existing in society through different ways. Organisation of different schools for boys and girls, recapturing of dichotomy of masculine and feminine role difference in subjects and extracurricular activities are examples for it. These perpetuate gender power relations in subtle ways thereby reinforcing socializing values and norms. Even though female literacy is high in Kerala, experts are of opinion that percentage of girl students not achieving minimum levels of learning is high. So there is recommendation from the monitoring and evaluation committee on women, State planning board as follows.' There should be special programmes for girl students. Anganwadi and preschool curriculum should be gender sensitive and also Anganwadi teachers are to be retrained with a gender component. With regard to physical training and sports, special training for women at all levels with emphasis on special diet is required. The content of education training include stereotyped programmes. Special vocational schools for girls should be developed and girls should be encouraged in non-conventional areas.'

The perception and experiences of people in Vizhinjam should be analysed in this context. Secondary data shows that the literacy rate in the panchayat is 64.04% whereas it is 90% for Thiruvananthapuram district. This may be due to the low literacy and school dropouts in the coastal area. But there is not much difference in the literacy level of the Dalit community and general population.

In the group discussions, people's perception about the literacy was brought out through brainstorming. People are oriented towards conventional education. They think that all people

should be educated. They are not thinking of alternative systems based on cultural specificity. They are worried bout the drop out children in the coastal area during fishing season. They are aware of the fact that the literacy status is low in this panchayat owing to the school dropouts in the fishermen community. People do not think that the literacy level of Dalit is lower. But dropouts are more among them. In the women's groups they had the opinion that women's literacy level is lower. They are forced to stop education earlier than men because of social norms.

The survey conducted in Mullur ward also showed that educational status is lower for women. Illiteracy among women is 27.23% where as that for men are 16.76%. Though graduates were equal in numbers, there were no post graduate and professional women in the sample. The percentage of women completed primary school education is 30.64 and that of men is 35.68. Percentage of men passed S.S.L.C is 27.03 and that of women is 25.96. Graduated were almost equal in both genders (Men=2.16% Women=2.55%). There were no postgraduates and professionals in the sample of women. All these show that women's educational status of women is lower than that of men.

DISTRIBUTION OF WOMEN BY EDUCATION

(Total-235)

Education status	Number of women	Percentage
Illiterate	64	27.23
Primary school	72	30.64
Secondary school	20	8.51
S.S.L.C. passed	61	25.96
Pre-degree	11	4.68
Degree	6	2.55
Post-graduation	0	0
Professional	0	0
Technical	1	0.43
Total	**235**	**100**

DISTRIBUTION OF MEN BY EDUCATION

(Total-185)

Education status	Number of men	Percentage
Illiterate	31	16.76
Primary school	66	35.68
Secondary school	15	8.11
S.S.L.C passed	50	27.03
Pre-degree	12	6.49
Degree	4	2.16
Post-graduation	2	1.08
Professional	1	0.54
Technical	4	2.16
Total	**185**	**100**

In the focus group discussions people suggested that vocational higher secondary schools should be started for the benefit of drop out children. Though people did not have much understanding about culture specific alternative education, they were aware of the need for vocational education, which will be useful for school drop outs during fishing season. They do not have much idea about the way in which this can be worked out.

There were certain similar areas in people's perception and expert's visions. 1. There is low level of literacy in the panchayat compared to other areas of the district. 2. Women's educational status ids lower than that of men. 3. The need for vocational higher secondary schools for school dropouts considering the life style of people.

In the discussion about action plan there were two suggestions. 1. To advocate with authorities for a vocational higher secondary school in the area. 2. To rejuvenate the non-formal education programmes.

Social and political participation

People's literacy is functional only when they participate in social and political process. It is very difficult to measure social and political participation in a quantitative manner. In the present context of decentralized planning, people's participation in gramasabha is a good indicator of social participation. Initially people were skeptical about people's planning campaign. But there has been gradual involvement over a period of time. There was good participation in the gramasabha. The participation was mainly from the category of women and from lower social class in this village. But in general women's participation in gramasabha is less (36%) The reasons for not participating include inadequate awareness (51%), engagement in public activities (24%), burden of household duties (17.4%) discouragement from men (12.5%)

But this alone cannot be taken as a measure. Real involvement occurs only when people become aware of the need of the society and plan for real beneficiaries. At present most of the people are concerned about the benefit of their own family. The culture of corruption still exists. But there is more opportunity for people to exercise their rights.

The older institutions are hierarchical, patriarchal and fundamentalist. Hence for many people, social activities were confined to caste-based organizations. The progressive organizations included political parties and cultural organizations associated with libraries. But these organizations also follow the traditional values. So there is minimum participation of women in these organizations. There is a clear gender division in social and political activity. There is more physical presence of women in public meetings. But men are more active in power politics and decision making in public bodies. But women are active in some organizations like mahila samajoms and Mahila Swasth sangh, which are related to certain beneficiary programmes. For the last two – three decades there has been some women centered Government sponsored programmes. Women have been participating in these, but the actual benefit is not much because of the prevailing gender roles and values.

In the elected bodies like parliament and assembly, there is only minimum representation of women. But now in panchayat and corporation there are 33% of women representatives after reservation. This has facilitated the process of politicization of women. But it is said that these women are having triple burden like income earning activities, public office activities and domestic activities. And also 10% budget of the panchayat is earmarked for women's projects. This also provides an opportunity for women to enter into the public domain. Now 34% of district councilors are women. There are 4153 women grama panchayat members, 595 women block panchayat members and 116 women district panchayat members. There are some efforts to change the stereotyped works of women like garment making, pickle making, food processing etc. But still there is predominance of the sexual division of labour.

But all these become meaningful it there is transformation of the rigid rules of social control over women.

In the group discussions, women told that they couldn't take initiatives in public action for two reasons. 1. They had to look after their household duties and responsibilities. 2. Women think that their reputation will be lost, if they become socially active.

In the survey women could not respond to the question about participation in social activities. Hence it was difficult to make a quantitative assessment. About 10% of men responded that they participate in social and political activities.

INVOLVEMENT IN SOCIAL ORGANISATIONS (185)

Involvement	No. of men	Percentage
Involved	19	10.27
Not involved	166	89.72
Total	**185**	**100**

People's participation in local level development will be fulfilled when there is functional literacy, democratization of education, and elimination of gender discrimination from education.

PLAN OF ACTION (September 1997to May 1998)

Planning of second phase.

Participatory research programme is fruitful only if it leads to an action plan chartered with the involvement of concerned people. The information gathered during the first phase was evaluated and presented to the people involved in the project. A meeting was called for planning the future programme. In this meeting local leaders and research team members participated.

Considering the opinion of the evaluation committee and the suggestions made by the local leaders, it was decided to concentrate on a focused area and topic. In the discussion, it was suggested that one ward should be selected for future activities so that more attention can be given to the area. The activities will be based on the problems identified by local people. Local authorities and leaders will be involved in the programmes. Regarding the selection of the ward, the criterion used was that the beneficiaries should include people from the underprivileged group.

The suggestions were the coastal ward and the wards where there are more people from the dalit group. Since there are other NGOs working in the coastal area, it was decided to take a ward where number of dalits and other backward communities are more. And also people in the coastal area are subjected to many surveys. Hence, there was reluctance from the community to be subjected to research.

It was decided to select Mullur ward where, there were more people belonging to dalit community. Even though there were other wards where number of Harijans was more, the common feeling was that this was an area where an intervention was needed.

It was also decided to focus the work in one community i.e. women. The reasons are 1. Women are more underprivileged. 2. Women involved more in all stages of the project.

Mullur is a sloppy area bounded by the ward Kidrakkuzhy, Nellikunnu and seacoast. The climate is favorable for paddy cultivations. Since there is shortage of water, at present the major cultivation include banana, tapioca and coconut. There are 461 households in the ward. 183 houses are below poverty line. Total number of dalits in the ward is 525. Number of men are 259 and Women are 256. There are two laksham veedu colonies occupied by dalits viz, Valan-vila and Kuzhivilakom. Water problem is more in Valan-vila colony. There is no electrification in laksham veedu colonies.

During the month of September there was an incident of shellfish poisoning. In addition to the project activities the team members associated with the medical team who visited the area for research and care services. As a result there was an opportunity to integrate the work with local organizations. Relationship with local leaders was improved.

A seminar was conducted in which panchayat members and other local leaders participated. The topic was on people's participation in local development with special emphasis

to women. Following this, a meeting was convened including the Panchayat member to plan the future activities. The general opinion was that activities could be organized centering the local women's organizations. It was decided to conduct another meeting in which local women's organizations would be participating.

A meeting was conducted in which leaders of the following organizations participated
Harijan mahila samajom
Janatha mahila samajom
Kasthurba Vikasana Kendram

In this meeting panchayat member, Angan wadi workers and other social activists also participated. The objective of the meeting was to identify the felt need of the community and to enhance the organizations to actively involve in developmental activities in future. The significance of people's participation in local planning was explained to the participants and they were asked to respond to it. It was observed that people were expecting some thing to be done by the authorities. They still considered themselves as the receivers of developmental activities. All of them agreed to the fact that they needed some developmental activities. But they did not have any idea of sustainable development. They were demanding services from other organisations. They wanted medical care services also. They were unaware of the available developmental schemes. Meeting came to a conclusion with a decision of conducting independent group discussions in all the organisations.

Group discussions.

Various group discussions were conducted with different groups. Initial discussions were exclusively for women. They were given awareness on different programmes and projects for women, funding agencies, project preparation, social change, women's emancipation etc.
Group discussions were organised in which local authorities and leaders also participated.
The first meeting was held by Janatha mahila samajom. The members of the organization and the women from the community participated in the meeting.

The women suggested two priority areas to start an intervention programme. As revealed in FGDs women were more towards employment programmes. But unlike in the FGDs women took some initiative in self-employment programmes. Their interest was to find out some income generating jobs. The second one was a literacy programme for school dropouts. They themselves identified it as one of the major problems in the area. A brainstorming was conducted for the planning and implementation of self-employment schemes. The team members facilitated the programme.

The initial task was to select a trade, which is feasible, and profit making. Women came out with a few suggestions. They put forward a suggestion of coir producing unit. A plan of action was charted out by the whole group. The first step was to mobilize necessary resources. They told that they could find out a building. And also marketing is not very difficult. Even though they have this much idea they did not know how to start with. The panchayat member was also present in the meeting. The activities to be done by the leaders of the samajoms, by the panchayat member and by the researchers were assigned and it was written in a chart paper.

The activities were to contact the agencies having schemes to help the project. It was decided to contact women's development corporation, dist. industrial office, social welfare department, grama panchayat, block panchayat, and district panchayat members. Information regarding building, resource, and loan were to be collected. It was decided to involve the block panchayat members also in the working group.

The follow up meeting was conducted after two weeks. It was found that the members were not able to finish the tasks assigned to them. The reasons attributed were

1. They felt that they would not be able to fulfill the objective.
2. There was a workshop organised by the socio economic unit. They wanted to attend that, since it was on employment. What they expected in the workshop was to get some financial help, which was not fulfilled.
3. They had to look after their household duties.
4. They were not confident enough to travel to the city and meet authorities.

The registration of their organization got cancelled since they did not renew it. Hence they were asked to do it before the next meeting. It was decided that the research team would also help them to organize the project. But the initiative should come from them. It was also decided that we need not confine to the area of employment only. Other activities also should go along with this. They were more interested in medical camps, which is again a welfare activity and is not sustainable. The researchers told that we would have a detailed discussion on the need; advantages of medical camp and will arrange planned ones, which will be useful to the community as well as to the researchers. Later medical camps were conducted along with other programmes. In these women's health problem alone was cared. And necessary referral services and follow up were also done. Based on their demand health awareness programme were also conducted.

A similar meeting was organized in the harijan mahila samajom also. They suggested that mushroom farming would be a feasible economic productive unit. It can be done by individual women or as a group. They themselves found out places where training is given for it.
The problems faced by them include

1. It is difficult to find out money for training by the poor women.
2. Women cannot come foreword for these kinds of activities because people make scandals about them. Then their husbands also oppose them.
3. Difficult to find out suitable building.

Regardless these constraints, a programme plan was charted out and it was written in a chart. There was discussion about other activities also. As there were illiterate young girls and boys, there was a suggestion to start a literacy programme for the illiterate youth. But women told that if we start such a programme these girls might not attend because it is a shame for them to make others know that they are illiterate. Hence it was decided to start awareness programme on all topics and introduce literacy along with it.

Interactive session

An interactive session was organised in which authorities from State Planning Board, Panchayat authorities, Government officials and representatives from different women's organisations participated. Women put foreword their ideas of self-employment schemes according to their background. The suggestion came out from women and experts include the following. 1. 300 women are involved in cottage industries like basket making. Rejuvenate it. 2. Develop existing opportunities in hotel business and tourism for women. 3. Use already existing opportunities in agriculture and fishing and try to improve the business. 4. Form an industrial estate of women. 5. Making of pickles, curry powder, other food items and garments. 6. Form co-operatives and find markets. 7. Make handicraft items for tourists in Kovalam 8. Laundry service for tourists 9. Procure dried coconut and make coir and coir products. 10. Start fish processing and transporting centre. 11. Develop business related to fishing like boat unit, net making, ice plants etc. 12. Chicken farming, prawn farming. 13. Salt making soap making. 14. Match box industry. 15. Candle making. 16. Chapel making. 17. Hollow bricks making. 18. Milk storage and distribution. 19. Fancy items for tourists. 20. Goldsmith 21. Form co-operative for building construction. 22. Run Maveli stores, fertilizer depots, notebook-distributing centres.

From this long list it can be seen that women do not have lack of ideas. There are so many other factors that prevent them from taking initiatives. Other related aspects were also discussed. Women said that more roads are needed in some areas. There was discussion on energy also. Somebody suggested that wave energy project could be started. Biogas production and use of social forestry for household fuel was also discussed. Organising weekly market by women to sell their product was another suggestion came from women. Experts suggested starting units of DWCRA, TRYSEM and IRDP. It was brought out that there are 2% female-headed households there is no women co-operative. Women's low wage and situation of unpaid work were also debated. Women suggested that co-operatives should be freed from party politics. There was deliberation on resource mobilization and about various schemes for loans. This discussion was a stimulant for rural women. This led them to conduct training programmes by themselves on women's development, with the help of other agencies.

They were interested in environmental activities also. They have arranged field visit for planning board officials in different parts of the village where more activities are needed. The officers offered their support to them. Women agreed to take initiative in cleaning a well in the area.

Informal discussions

A number of informal talks were done with the Mahila samajom leaders for motivation. They were motivated to conduct meetings, prepare projects for Panchayat planning, net- working with Govt & Non-Government organisations, organizing seminars and cultural programmes.

Programmes organised by women.

They have organised another seminar in October. . The objective of the seminar was to impart awareness to women in the community, about the programmes of Women's Development Corporation and other special programmes for women. A campaign for the seminar was done by women along with the team members. About one hundred women participated in the seminar. Chairperson of State Women's Development Corporation, Panchayat President, members and other leaders participated in the seminar.

Following these regular meetings were conducted in the mahila samajoms. Ideas evolved through these meetings. In between women started attending various training programmes and workshops organized in other areas outside the village with the intention of women's development.

Impact of the programme is reflected in the community activities initiated by the Mahila samajoms in the following months.

1. The mahila samajoms got activated. They started meeting regularly. They took steps to register the organisations, which had not been registered or renewed the registration.
2. Women started attending the workshops conducted by different agencies like socio-economic units.
3. They organized seminars and workshops by themselves. Different topics like women and law, women and media, women and health, women and culture etc were discussed in these.
4. They have prepared projects to submit to women's Development Corporation. The corporation gave them funds to organize an awareness programme.
5. They contacted various development agencies themselves though they were hesitant to come to the city in the initial phases.
6. They involved in gramasabha more than before and became aware of the ongoing projects.
7. They prepared projects by themselves to submit to the Panchayat.
8. They started literacy project for women and children for which Saksharatha Mission gave technical support.
9. A theatre workshop was conducted in the area and the participants presented a drama in the end of the workshop.
10. Girls took initiative to organise cultural programmes in school in which women's issues were highlighted.
11. A cultural programme was organized mainly for children. The initiative was taken by the women.
12. Some of the women volunteered to take part in a documentary videograph showing issues on reproductive health. They were able to articulate the problems.
13. Women stated that they had become more confident and empowered after participating in these programmes.
14. They initiated co-operatives and started self-employment units under women's scheme in people's planning.
15. Women from Mahila Swasth sangh formed a health action club and they are working for the sexual health project in Township area.

16. One of the active members of the Samajom stood for panchayat election.

Women co-operatives

There is one garment making unit initiated by Priyadarshini mahila Samajom. They found market by themselves in the neighboring areas. They also sell other products of panchayat projects. A part of the profit is saved for the society. The workers are members of society itself. They also earn from the work. Women have become more confident and their self-esteem is raised though there is not much economic benefit as they have expected. They are planning to start a school for giving training in garment making. Now they are facing difficulty to get a building for it.

Problems faced.

Women are doing this work in addition to the heavy duties and responsibilities in their own houses. They cannot dedicate much time for this.

The skill of the workers is poor.

There is lack of organizational skill.

Women cannot contribute for the initial investment.

There is not much co-operation among women.

Food making unit

This was initiated by Janatha Mahila Samajom. They make different bakery items and sell it in the neighbouring shops. They have started a banking service also along with it. Women can take loan from it. They are trying to integrate it with Kudumba Shree project. The members are earning some money also. They have savings in bank. The merit of this unit is that there is co-operation among women. Another advantage is that women can do the work along with their household activities. Women are concerned about the profit. According to them the shopkeepers to whom they sell the products, are making more money. Based on this center, they are doing charity work for the poor.

Literacy programme.

Literacy programme was initiated by the women's organizations as per the ideas evolved in the group discussions. The beneficiaries are school drop out children and adults. Majority of them are women. The age group ranges from 5-55 years. The programme was approved by the State literacy mission. The institution gives technical support to them. The activities were highlighted in the media as example of continuing literacy programmes. Though it was started in two centers only one among them is functioning now. The center is used for conducting other awareness programmes also.

Other Women programmes of the panchayat.

Programmes for women in the panchayat, which was benefited to the women in this area, include loan for fish vending women, loan for small-scale work (Rs. 500 for each), machine for embroidery, loan for coir rats, loan for stone crushing.

Lessons Learned

Though women were much enthusiastic about starting co-operatives for self-employment, they have realized many things during the process. They realized that the gender roles of women within the family are to be addressed for the success of participation in development. The initial investment is a problem for many women. Co-operation can be built among women only through a social process. This is needed for any joint ventures. Economic activity alone is not worth. That is why they initiated literacy programme and other service activities. There is a group of health volunteers working for women. But there is no link between these women and the women who took initiative in employment activities. These are limitations of women in the present society. They do not have much space and time for exchange of ideas and visions.

SUMMARY

This project is an exploration to give new definition to quality of life from people's perspective. People were allowed to talk freely about their perception about development, their desires and expectations and scope for participation in local development.

The different inter-related aspects of QOL are identified through review of literature and discussion with experts. Twelve areas were identified like morbidity, employment, entertainment, health care utilisation, nutrition, reproductive health, mental health, housing, water and sanitation, education, social and political participation and occupational health.

Participatory research methods are used. More than one method is used for data collection. Triangulation is done before coming to conclusion.

The key points obtained from people are documented as follows.
The most relevant factor related to health, and quality of life is opportunity for employment according to women. But men gave preference to availability of safe water and sanitation. Gender difference in perception itself is notable.

Employment status of women is only 12%. Women consider employment as a very important concern in their life. But they usually do not take initiative for self-employment. Women are not involved in tourism related work except for a few fruit vendors and sweepers.

There is shortage of safe water supply. Majority of people use well water, which is not available always. The public tap water is not pure. Only rich people can afford water when it is sold during drought. The problem is severe in the coastal area.

There is solid waste and wastewater accumulation in the beach area where tourists are coming. There is no proper management system for waste.

In the coastal area seasonal diarrhoeal diseases occur. There is malnutrition in the coastal area.

Though there are government health centers people are not satisfied with it. There is lack of facilities. In the private hospitals cost is too high for poor people.

The quantity of food taken by women is less. There are no variety items also. In the coastal area vegetables and green leafy vegetables are scarce.

Women do not have opportunity to have information on reproductive health matters and they do not have choice for contraception. Majority of them have undergone tubectomy and fear that this has affected their health. They are suffering from backache and abdominal pain.

There are about 7% of people who do not own land. 34% of houses are not suitable for living.

Many women are suffering from somatisation disorder. This is the result of their worries in the life situations. They are worried of economic security and the dowry to be given to their daughters. The problem is more when husbands desert them

Regarding occupational health there is poor knowledge in the community. Even when they become aware of it, it is very difficult to change the attitude and behaviour.

There is gender disparity in the attitude towards entertainments. People in general do not have the idea about the refreshing role of entertainment, which increase productivity. But men could identify certain activities they consider as entertainment, where as women could not. Women cannot often distinguish between work and entertainment.

School dropouts are more related to fishing. People raised the need for nonformal education and vocational education for these children.

In social and political participation also there is gender disparity. Even in case of men, they do not have much orientation about participation in planning. There is an opportunity for women to take part in development after 33% reservation in panchayat body and earmarking of 10% of budget for women projects in the panchayat. But this is a process and takes time for fulfillment.

Considering the vastness of area and issues an action plan was charted out focusing on one area and group. Thus Mullur ward was selected. The group was women. The issue mainly concerned was employment. For this mahila samajoms were activated and facilitated to initiate self-employment programmes.

Some other activities were evolved during the process. Women took initiative for literacy programmes, cultural activities and training programmes.

Women became more confident and participation in panchayat planning improved.

One of the active women stood for election and few others formed a group to intervene in a sexual health project. The project catalysed the developmental activities in the area.

CONCLUSION

This study, which considered people's perception about life, revealed that there are similarities between people's perception about their life and opinion of experts. But it also brought out insights into areas, which were invisible to experts. For example, this study illustrated the perception of women about the determining role of employment in their life and reflexivity of their self. This sort of action research methodology evoked new thoughts among the participants. For example, people who were not aware of occupational health problems cited many problems after brainstorming.

Though there is opportunity for people to participate actively in development in the context of people's planning in panchayat, the prevailing culture of top to bottom planning prevents them from active involvement. There are many cultural factors like gender based role models, institutionalized hierarchy, system of corruption, individuation, isolated family traditions and so on. Since democracy is not practiced in personal and family life it is not reflected in the public realm also. Practice of democracy is a two way process. There should be active involvement from people's side and creation of enabling environment from policy makers' side. Decentralized planning is a step from the policy makers. This project attempted to facilitate people for involvement from their side. The process is initiated. But there are many constraints.

Limitations.

There were inbuilt problems within the project. Since standardized method for qualitative research is difficult, there has been criticism from the academic experts. A survey serving the purpose of comparison between communities was not possible due to resource and time limits. The factor of domestic violence, which is an important determining factor in the quality of life of women, was omitted in the study.

There were some external factors also which limited the achievements of the project. Though the employment was identified as one of the main areas to be intervened, the present status of women in the society itself is a constraint to it. Lack of sufficient resources is another problem. There are different programmes implemented through different agencies. These are fragmented and there is no co-ordination among them. Integration of these projects is beyond the power of people.

Similarly, lack of safe water supply and sanitation is identified by all groups of people. There have been many attempts from people to improve the situation even before the project. People submitted many projects to the panchayat after facilitation through the project. But authorities did not take these seriously. The leaders are well aware of the problems. But there is no implementation, probably due to lack of political will.

Though the people in the coastal are more in need of action, the team could not concentrate in this area. The reason is that there are many organizations working in the area.

People are fed up with studies and half hazard development activities. Hence people themselves suggested another area.

Though literacy programmes got rejuvenated after the project, it could not make a qualitative leap. Nonformal education will be successful only if it can make some alternative model specific and appropriate to the culture. No perspective is developed by the organizations who conduct the programme.

RECOMMENDATIONS

1. Programmes should be implemented for safe water supply and sanitation. Though there have been efforts from people, it has not materialized. There should be initiative from authorities.

2. People are aware of the occupational hazards of fishing. Authorities should consider an accident care unit, ayuervedic unit and physiotherapy unit demanded by the people.

3. Schemes to provide housing for landless people should be developed.

4. Since there was an incident of shellfish poisoning a team should be trained for disaster management in the panchayat level.

5. A vocational higher secondary school should be started to address the problem of drop out among children in the fishermen community.

6. Nonformal education should be modified according to the need of the community. The content and spirit should be culture specific.

7. To make the women's development programme effective, there should be integration of different projects envisaged under different schemes. The co-ordination should take place in the higher level like district panchayat or block panchayat.

8. Women's development programmes will be effective only if these are empowered through active involvement in women's movement. There should be support system for divorced women and women subjected to domestic violence.

9. Health care institutions will be equipped to provide women friendly care in reproductive health matters. Health care providers will be given gender orientation. Counseling services should be given in health centres to address the issues of reproductive health and mental health.

10. Practical sessions should be included in nutrition awareness programmes arranged by Anganwadi.

11. Projects should be developed for involvement of women in games and cultural activities in panchayat level.

12. Training in occupational health should be arranged for employees and employers. Projects can be implemented through panchayat.