

School of Distance Education (University of Calicut)

Model Project for BA Political Science Programme

BA Political Science programme of Distance Education mode is recently modified adding project work for the final semester students. The framework of the project is different from regular BA political science programme and the features are noted below:

- Students can take any topic related to their core course.
- Viva-voce is exempted from the project.
- Students are entitled to limit the pages to 20-30 in number.
- Either qualitative / quantitative study can be selected.
- Group projects are not allowed.
- Font Size – 12 for content and 15-20 for Heading.
- Line space -1.5.
- Font Type – **Times New Roman**.
- Reference Format- Either MLA/ APA Style.
- Appreciated if submitted in printed version and also spiral binding is preferred.

A model project on the topic “*PEOPLE PARTICIPATION AND HEALTH SECURITY: A CASE STUDY OF PALLIATIVE CARE CENTERS IN VATAKARA THALUK*” is provided below which will be useful for the students. (Please note that this is just a model project and students can take topics of their choice related to their core course.)

**PEOPLE PARTICIPATION AND HEALTH SECURITY: A CASE
STUDY OF PALLIATIVE CARE CENTERS IN VATAKARA THALUK**

Project submitted to the University of Calicut

In partial fulfillment of the requirement for

the award of Degree

BACHELOR OF ARTS IN POLITICAL SCIENCE

By

Name

Register Number

POLITICAL SCIENCE

UNIVERSITY OF CALICUT

MONTH, YEAR

DECLARATION

I,..... do here by declare that this dissertation “**People participation and health security: A case study of palliative care centers in Vatakara thaluk**” which submitted in partial fulfillment of Bachelor of Arts in Political Science of the University of Calicut. I further declare that this project has not been previously submitted to this or other University for the award of any degree, diploma and fellowship on the similar titled or recognition.

University of Calicut

Name

Date

CONTENT

1. Abbreviations
 2. Introduction
 3. Data Analysis and Findings
 4. Conclusion
 5. Bibliography
 6. Appendix
-

ABBREVIATION

DPSP	:	Directive Principles of State Policy
GHSA	:	Global Health Security Agenda
HLEG	:	High Level Expert Group
ICMR	:	Indian Council of Medical Research
ICSSR	:	Indian Council of Social Science Research
IHR	:	International Health Regulation
ILO	:	International Labour Organization
MOHFEW	:	Ministry of Health & Family Welfare
NDC	:	Non Communicable Diseases
NGO	:	Non Governmental Organisation
NRHM	:	National Rural Health Mission
PHC	:	Public Health Care
PQLI	:	Physical Quality of Life Index
PVS	:	Performance of Veterinary Services
RSBY	:	Rashtriya Swasthya Bima Yojana
STD	:	Sexually Transmitted Diseases
UDHR	:	Universal Declaration of Health Security
UHC	:	Universal Health Coverage
UNO	:	United Nation Organisation
UNDP	:	United Nation Development Programme

UNICEF : United Nation Children's Emergency Fund

WHO : World Health Organization.

INTRODUCTION

Palliative care is a holistic care, which is specialized medical care for people with serious illness. Palliative care is a health care especially that is both a philosophy of care and an organized, highly structured system for delivering care to person with life treating or debilitating illness from diagnosis till death and then in to bereavement care for the family. Palliative care improves health care quality in three domains: the relief of physical and patient physician communication and decision making; and assurance of coordinated continuity of care across multiple health care setting, hospital, home hospice, and long term care.

Palliative care encompasses primary, secondary and tertiary care: patients of all ages and diagnoses: and all care setting. It therefore has relevance for most healthcare professionals. The concept of palliative care is relatively new to India, having been introduced only in mid 1980s. Since then, hospice and palliative care services have developed through the efforts of committed individuals, including Indian health professionals as well as volunteers, in collaboration with international organizations and individuals from other countries.

At the field of health care, palliative care provides holistic care for people with chronic illness are increasingly recognizing the wider need of older people and their families. Palliative care has focused on controlling pain and their families and being flexible about doing what is necessary to help people adapt and cope with their situation.

Since most of the patients prefer to be at home in the last phase of their life, it will be ideal if palliative care services are available to them in the community. Community based palliative care is the term commonly used to refer to palliative care services organized by the local community, with home based care as its corner stone .Community based palliative care services also has good participation from the members of the local community. Palliative care institution should be available to support these community based home care programme.

The better functioning of palliative care need the help of trained doctors, nurse and other health care workers and also trained volunteers in the community. The state, under Article 21 of the constitution in India, is duty bound to ensure the fundamental right to live with dignity. This policy aim at ensuring that palliative care services which are established and integrated in to routine health care within the state. Palliative care provides more effective symptom control, enhances patient and career satisfaction and can even have a positive impact on length of life.

Posing the problem

In India, the present medical and hospice system do not have the capacity to guarantee quality of life of the majority of people with life-limiting illnesses or for their care givers and

survivors, which focuses upon the identification and control of observable and predictable physical symptoms. The existing health care facilities are more attuned to caring for acute health problem and they plan only a limited role in the care of the chronically ill in the society. Patients with terminal illness need a multidisciplinary team and constant care. This has led to a mounting need for palliative care. The present study tries to understand the role of palliative care centers and the public involvement. This study has been conducted in Vatakara thaluk and it focuses on the role of palliative care centers to ensuring health security.

Objectives

- I. To study the role of Palliative care centers in ensuring health security in Vatakara thaluk.
- II. To study the organizational structure and financial source of Palliative care centers with special reference to Vatakara thaluk.
- III. To understand the public involvement and people participation of Palliative care in Vatakara thaluk.

Hypotheses

- I. Palliative care played an important role in ensuring health security.
- II. Palliative care centers are lacking financial as well as organizational impairments.
- III. The people are highly involved in the development of palliative care system.

Methodology

The methodology applied in this particular study is both descriptive and analytical in nature. It looks in to the questions like the relevance of health security, the role of palliative care in the health security...etc. In addition to field work, quantitative method has also been widely used in the study. Both the primary and secondary data's are used for this study. Primary data's are collected through the prepared questionnaire and the secondary sources like newspapers, articles journals, books, internet etc.

Review of literature

Robert G T way cross, in his book (1999) Introducing Palliative care, developed from the authors training program that used in many countries around the world. This manual is designed from professionals working with the terminally ill. This book covers the physical, psychological and spiritual aspects of care.

Geoffrey Mitchell, in his book “palliative care; a patient centered approach” (2008), gives guidance on how to approach patients with life limiting illness. This book offers a look at the management of patients. It suggests various ways to care for the dying. It is useful for health care professionals working in palliative care.

Max S Walson, in his book Oxford handbook of palliative care (2009) this practical guide briefly covers the historical and epidemiological background of palliative care & growth of palliative medicines.

DATA ANALYSIS AND FINDINGS

The concept of security is related to the general well-being of the individual and overall welfare of the community. Generally, security can be defined as there is a freedom from danger safety and freedom from fear or anxiety, freedom from the prospect of being laid off, measures taken to guard against espionage or sabotage, crime, attack, or escape. These are some components of the standard definition of “security”. Human beings have a wide variety of needs which they want to satisfy. Security that is freedom from any kind of danger or risk is one of the well-accepted needs of people. The term security is defined as the “freedom from danger, risk, etc” [Webster 1996: 1200]. The UN Commission on human security endorses definition of human security as “the process of the vital core of all human lives in ways that enhance human freedom and human fulfillment.”[UNCHR 1998]

According to Kofi Annan, “human security, in its broad sense embraces far more than the absence of violent conflict. It encompasses human rights, good governance , access to education, health care and ensuring that each individual has opportunities and choice to fulfill his or her potential” [Annan 2000]. The security of people is related to their quality of life and, therefore, the threats to their security include a number of social and economic issues. Elements of human security include economic security, political security, access to food and health care, personal and community security, and environment security [UNDP 1994]. Here this study covers subject area, Health Security.

The economically smart countries are better insulated from disease enhancing trade and business. Healthier countries are more stable and prosperous they are more viable trading partners. Pandemic disease threats and ineffective responses can have devastating impact on public health and the global economy. Global Health Security strengthens Public Health System; CDS strengthens other global health programs like maternal and child health, flu prevention, and immunization through the cross cutting global health security activities including helping build better lab system; create faster and more accurate data sharing ; establish and improve emergency operations centers that can respond more quickly to all public health crises ; and support nationwide surveillance systems that enable real time disease tracking and reporting.

Traditional notion of security largely by the structure and dynamics of the cold war, were concerned mainly with a state’s of ability to counter external military threats from rival states. Under traditional security ideas, the only real security concern is for a state to maintain its survival, power, and political influence against external threats from rival state. After the end of

cold war and subsequent impact of a new phase of globalization, the rise of new type of security threats challenged the traditional perspective on security, with its focus of the survival of states. The new threats include dangers such as environmental pollution, transnational terrorism, massive pollution movement, and infectious diseases, such as HIV/AIDS. The new, non-traditional security threats pose dangers not only to the security of the state (national security), but also to the security of individuals and communities (human security). [Kim 2010:85]. 'Health is a state of a complete physical mental and social well-being and not merely the absence of disease or infinity'. Health and the provision of health care are an essential part of the quality of life because they directly affect one's daily activity and psychological as well as physical well-being. Health is defined as "positive state of physical, mental and social well-being, not merely absence of disease" and the goal for attainment of the level of health is set as to permit the people "to lead a socially and economically productive life" [Sanyal 1986: 97].

Health Security in India

As India seeks to become a global power there is perhaps nothing more important than the health and well-being of its citizen. This is ensured in part through an effective, comprehensive health system. Several seminars have been organized in order to try and find out some alternative healthcare system that can suitably be applied to a country where 80 percent of the population lives in rural areas. In 1976 a seminar was organized jointly by the Indian Council of Medical Research (ICMR) and the Indian Council of Social Science Research (ICSSR) where in several workers presented their work involving innovations in health delivery system [Damodaran 1979:70-72].

Today the most Indians seek health care in private facilities owing to many years of neglect. Lower-level public health care facilities often suffer from a variety of problem, including practice low demand for their use and shortage of supplies and staff. There are at least two health care programmes in India. The first is the National Rural Health mission (NRHM), which is the central government's attempt to improve delivery of services in public facilities as well as public health and preventive interventions, led by the ministry of Health and Family Welfare. The second is the Rashtriya Swasthya Bima Yojana [RSBY], which is the health insurance programme led by the ministry of Labour and Employment. In most states RSBY covers people "below poverty line "for a selected set of tertiary care services. NRHM launched 2006 has had some success in improving access to certain services, such as material health care (under the Janani Suraksha Yojana Program), NRHM has had on most other services. In contrast, there is early existence that RSBY has been for tertiary care, although it is not clear whether this program improves population health [Luthra 2012: 1-5].

The constitution of India not provides for the right to health as a fundamental right. The constitution makes imposed this duty on state to ensure social and economic justice. Part IV of the Indian constitution which is DPSP imposed duty on states. If we only see those provisions

then we find that some provision of them has directly or indirectly related with public health. The constitution directs the state to take measures to improve the condition of health care of the people. Thus the preamble to the constitution of India, inter alia seeks to secure for all the citizen justice –social and economic. It provides a frame work for the achievement of the objectives laid down in the preamble. The preamble has been amplified and elaborated in the Directive Principle of State Policy. The DPSP are only the directives of the state. These are non-justifiable. No person can claim for non-fulfilling these directives. But the Supreme Court has brought the right to health under the preview of article 21. The scope of this provision is very wide. It prescribes for the right to life and personal liberty. The concept of personal liberty comprehended many rights, related to indirectly to life or liberty of a person. And now a person can claim his right of health. Thus, the right to health, along with numerous other civil, political and economic rights, is afforded protection under the Indian Constitution. [Avanish 2007:68].

Article 38 of Indian constitution imposes liability on state that states will secure a social order for the promotion of welfare of the people but without public health we cannot achieve it. It means without public health welfare of the people is impossible. Article 39(e) related with workers to protect their health. Article 41 imposed duty on state to public assistant basically for those who are sick and disable. Article 42 makes provisions to protect the health of infant and mother by maternity benefit.

Article 47, makes improvement of public health a primary duty of state. Hence, the court should enforce this duty against a defaulting authority on pain penalty prescribed by law, regardless of the financial resources of such authority. [Vardichand 1980]

Public interest petition for maintenance of approved standards of drugs in general and for the banning of import, man structuring, sale and distribution of injurious drugs in maintainable .The healthy body is the very foundation of all human activities. Some other provisions relating to health fall in DPSP. The state shall in particular, direct its policy towards securing health of workers state organized village Panchayath and gave such powers and authority for to functions as unit of self-government. The DPSP has now been translated in to action through the 73 rd amendment Act 1992 were by part 11 of the constitution titled “The Panchyat” was inserted. The panchyat system has significant implication for the health sector. There will be discussed in relation to relevant article 243-234 a to 234 contained in part 11 [Govt: of India 2010].

Article 41 provides right to assistance in case of sickness and disablement. It deals with “the state shall within the limits of its economic capacity and development, makes effective provisions for securing the right to work, to education and public assistance in case of unemployment always sickness and disablement and in other case of undeserved want ”. Their implication in relation to health is obvious. [Govt of India 2010]

Palliative care

Palliative care is an approach to care, that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment, and treatment of pain and other problems- physical, psychological and spiritual. It ensure the most effective care for patients, palliative care being at the point of diagnosis, continues throughout treatment, and bereavement support offered to the family after the patient's death.

In India, currently there are approximately 908 palliative care services delivering palliative care through either through home care, outpatient basis and in patient service. More than 841 of these centers are in Kerala. Therefore, for the vast majority of Indians across the country, there is extremely limited access to quality palliative care services. In response to this essential public health need, the Ministry of Health and Family Welfare would initiate activities related to palliative care with a vision of facilitating access to affordable, safe and quality pain relief and palliative care to all those requiring it in the country.

The objectives include:

1. Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.
2. Refine the legal and regulatory systems and support implementation to ensure access and availability of Opioids for medical and scientific use while maintaining measure for preventing diversion and misuse
3. Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).
4. Promote behavior change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.
5. Encourage and facilitate delivery of quality palliative care services within the private health centers of the country.
6. Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the program.

The Ministry of Health and Family Welfare has recognized and acted on the increasing incidence of long term and chronic diseases through its comprehensive National program for

managing NCD plan since 2010. It now recognizes absolute necessity for starting Palliative Care activities to address the concerns regarding inadequacies in pain relief and palliative care facilities in the country. The activities are being planned and charted out with the explicit purpose of improving the quality of life of those with long term and life limiting illnesses after a detailed situational analysis. Target population for palliative care has been determined to be those with cancer, HIV/ AIDs and the elderly in India.

The range of specialist palliative care services broadly described as encompassing:

- Inpatient units (hospitals)
- Community-based services (home care).
- Day care services.
- Specialist palliative services in acute general hospitals.
- Indirect services (role in education, advocacy).
- Service linkages with other health care providers.[Miller 2000:40]

Palliative care is a distinct care approach which helps to people with life-limiting conditions to live life as well as possible for as long as possible. Specialist palliative care services are concerned solely with the delivery of palliative care. Generalist palliative care is often provided within other areas of health care, such as primary care. [Lacey, Quine 2002:68].

Palliative care has been declared by government of Kerala as part of primary health care-combined efforts by civil society organizations, local self-government and Government of Kerala have resulted in the best coverage of anywhere in low and middle countries of palliative care in Kerala. The service can be said to have originated in the state of Kerala with the establishment of a pain clinic in the Regional Cancer Center in Trivandrum, the capital of the state of Kerala in 1986. This is the one of the Indian regional cancer centers to have Palliative care a priority. The Kerala network has more than 60 units covering a population of greater than 12 million and is one of the largest networks in the world. In April 2008, Kerala became the first state in India to announce a palliative care policy.

Specialist palliative care services can support people with life-threatening illness through:

- Direct care for people requiring specialist palliative care interventions.
- Shared care arrangements with other health care providers.
- Consultation and advice to other services and healthcare teams providing end-of-life care.
- Education and training on palliative care and end of life issues.
- Undertaking and disseminating research about caring for the dying and their families/careers.

Kerala is the only state with a National Rural Health Mission project in Palliative care. The Kerala State Resource Center and coordinating Unit at Institute of Palliative Medicine is the

planning and coordinating agency for this project. The project is coordinated by the Director, Institute of Palliative medicine. The project started in 2008 has been working on the implementation of the palliative care policy of Government of Kerala. Kerala has now established itself as the for runner in the field of palliative care in India.

The present study was conducted at Vatakara Taluk, Kozhikode, district in Kerala. The topic of the study is ‘Health security and people’s participation: a case study of palliative care centers in Vatakara Thaluk’.

Case study: palliative care centers in Vatakara thaluk

For the study data was collected through field survey. The research data collected from both primary and secondary sources. The primary data collected through the simple random sampling method. The sampling consists of 50 sampling. The overall outlook of people participation and health security in palliative care assessed with the help of secondary data which are collected from published sources like, newspaper, books, articles, website etc. In Vatakara Thaluk five palliative care units were visited and interview was conducted with the workers, officers, nurses.

Vatakara Thaluk an overview

Table 3.1

Name of Thaluk	Vatakara
District	Kozhikode
Area	21.32 km ²
Village panchayath	55
Block	9
Palliative care centers	38
Total population	651.191(2011 census)
Male	312,749
Female	527,108

Gender-wise distribution of respondents

Table 3.2

Sl. No	Gender	No. respondents	Percentage
1	Male	30	60%
2	Female	20	40%
3	Total	50	100%

Age –wise distribution of respondent

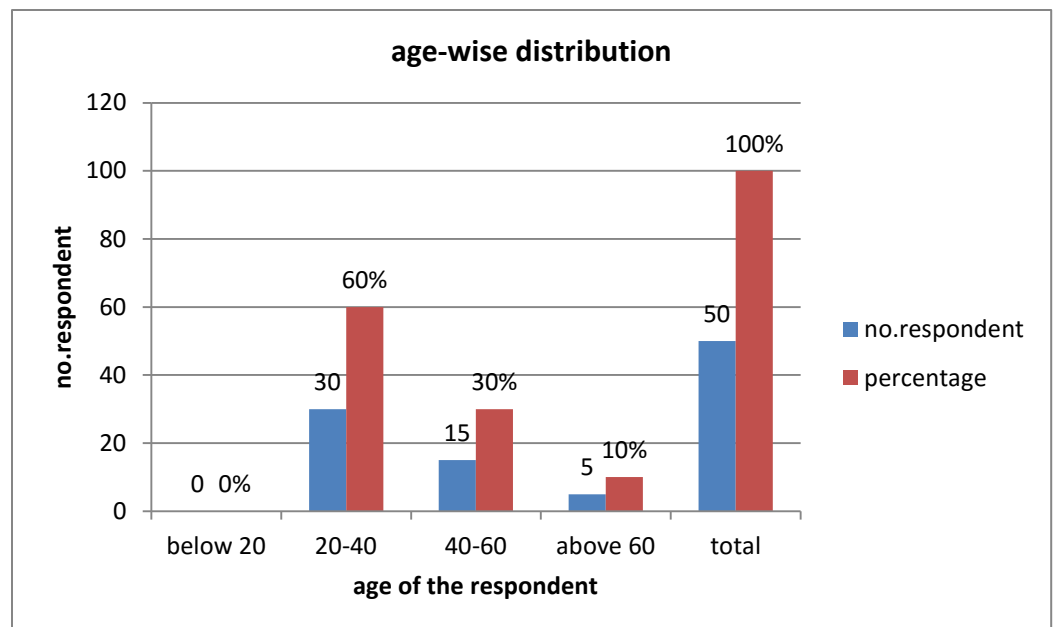
Table 3.3

Age	No. respondent	Percentage
Below-20	-	-
20-40	30	60%
40-60	15	30%
Above 60	5	10%
Total	50	100

Source: survey conducted by the researcher in palliative centers in Vatakara thaluk

The table shows, out of 50 workers interviewed 30 respondents or 60% of respondents come under 20-40 age group.15 or respondents are in 40-60 range and 5 workers are belongs to above 60.

Figure 3.1



Educational qualification- distribution of respondents

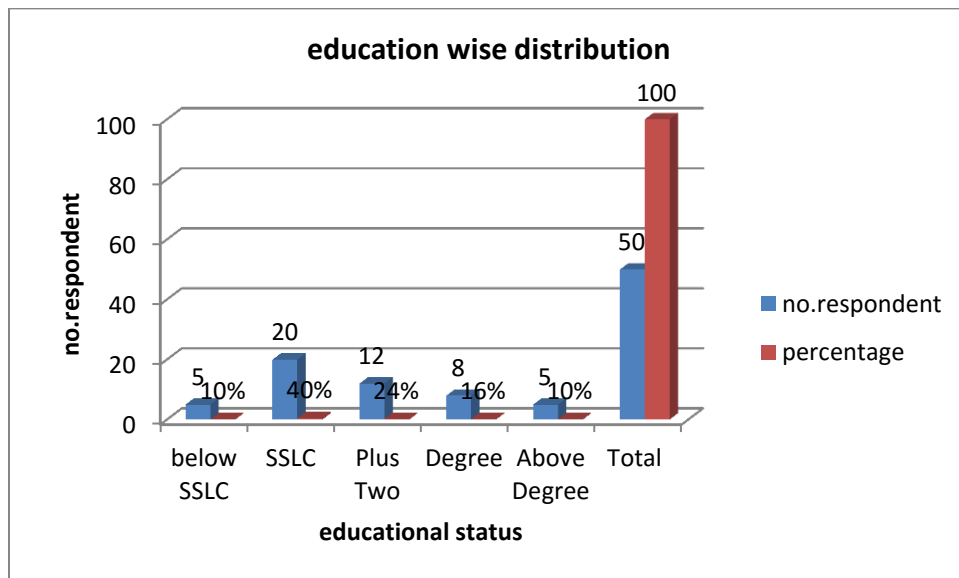
Table 3.4

Educational Qualification	No. respondents	Percentage
Below SSLC	5	10%
SSLC	20	40%
Plus Two	12	24%
Degree	8	16%
Above Degree	5	10%
Total	50	100

Source: survey conducted by the researcher in palliative centers in Vatakara thaluk

The above table shows the educational qualification status of the workers in palliative care. It shows the workers are educated. 50 workers were interviewed 20 were SSLC qualified and 5 were comes under below SSLC. 12 workers are plus two qualified and 8 have degree qualification. Out of 50, 5 have education above degree. When we analysis the table we can find out that the most of the workers in palliative care centers are educated and literate.

Figure 3.2



Income-wise distribution of workers

Table 3.5

Income(monthly)	No. respondents	Percentage
Below 1000	-	-
1000-5000	3	6 %
5000-10000	34	68%
Above 10000	13	26%
Total	50	100

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table describes the income wise distribution of interviewed workers in palliative care. None of the respondent is earning below income 1000 / month. The majority of the workers or 60 % of the interviewed respondents comes under the income range of 5000-10000. Only 26% of the respondent can get above 10000.

Nature of respondent's membership

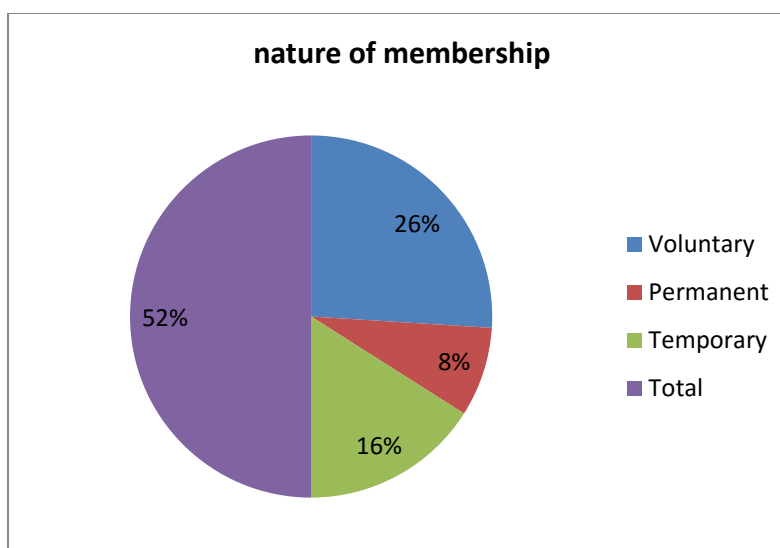
Table 3.6

Nature of membership	No. respondent.	Percentage (%)
Voluntary	26	52%
Permanent	8	16%
Temporary	16	32%
Total	50	100

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table describes the nature of membership of the respondent. Majority of the respondent's membership were voluntary. Out of 50 samples 16 were temporary workers and remain 8 have permanent membership.

Figure 3.3



Financial sources of palliative care

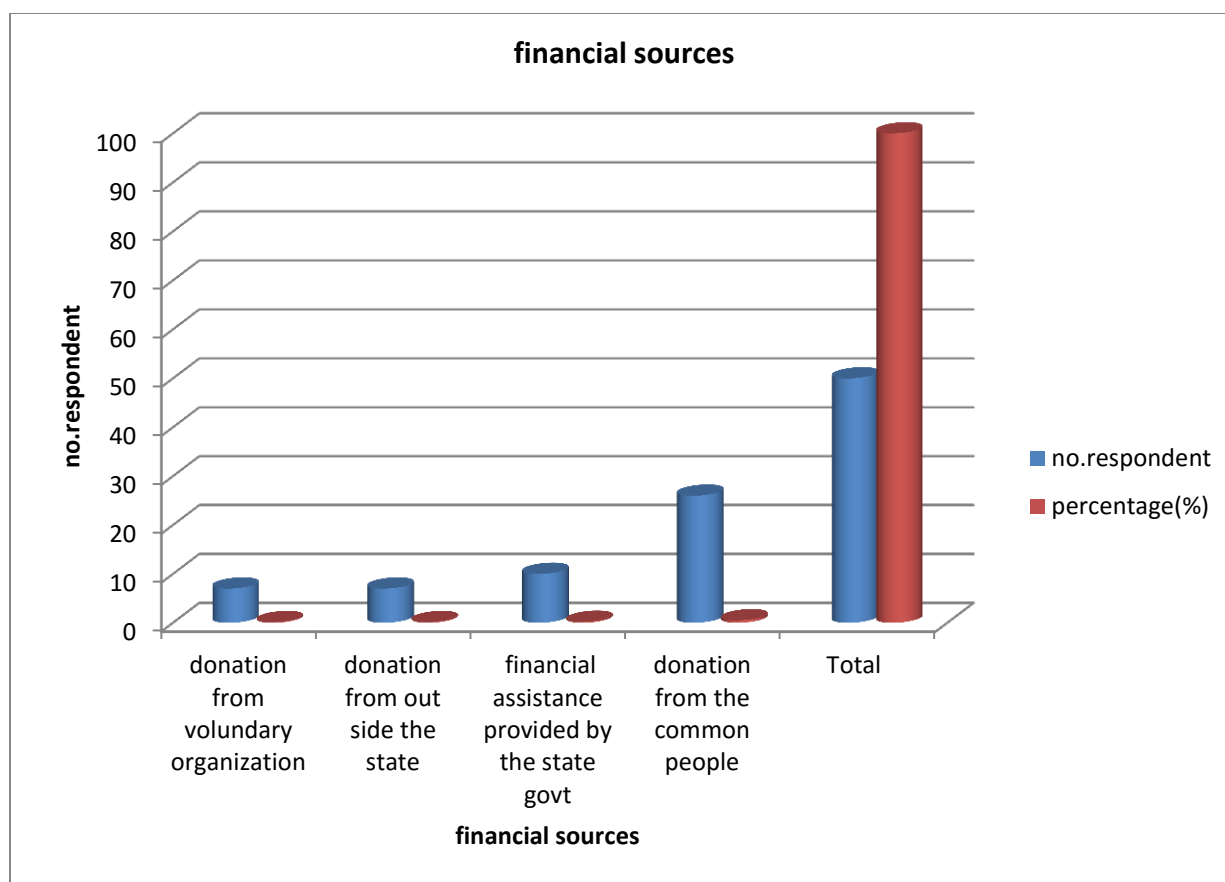
Table 3.7

Financial sources	No. Respondents	Percentage
Donation from voluntary organization	7	14%
Donation from outside the state	7	14%
Financial assistance provided by the state govt	10	20%
Donation from the common people	26	52%
Total	50	100%

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table shows the major financial sources of palliative care. The majority or 52 % of respondents were of the opinion that the major financial source of the palliative care is the donation from the common people. It shows active participation of the people in palliative care for ensuring health security or to protect unhealthy people. Out of 50, 10 were to the opinion that state Government to provide the financial assistance to palliative care. 7 were to support voluntary organization as the major financial source and remaining 7 were the opinion that the donation from outside the state.

Figure 3.4



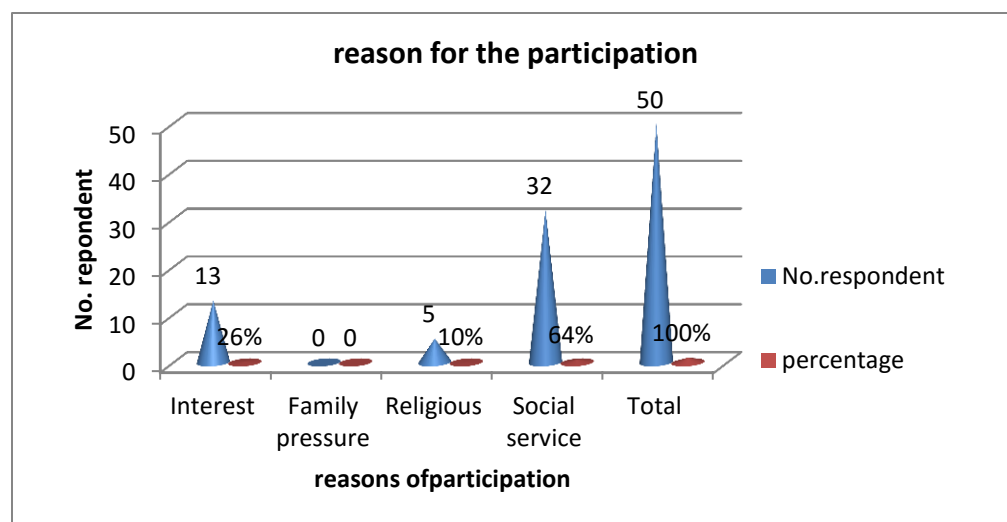
Reason for the participation of respondents

Table 3.8

Reasons	No. Respondents	Percentage
Interest	13	26%
Family pressure	-	-
Religious	5	10%
Social service	32	64%
Total	50	100%

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

Figure 3.5



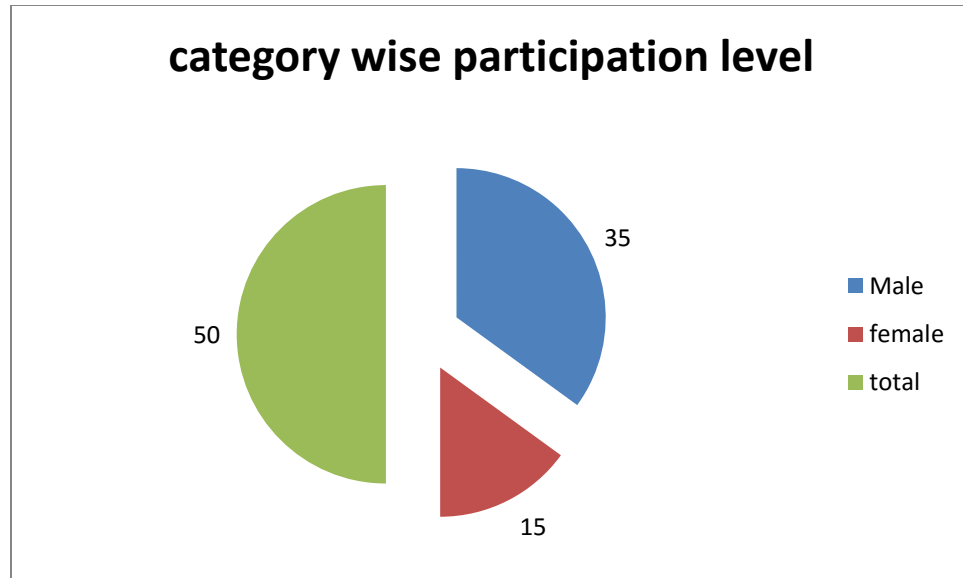
The figure shows the major reason for the participation of palliative care workers. Out of 50 respondents, 32 (64%) were to respond the main reason for their participation is the interest of social services. 26% of respondent comes under the reason their own interest and 10% of participate religious interest also. when we analysis the table we can clearly understood that the majority of the workers are working the interest of social services.

Category of public participation

Table 3.9

Category	No. respondents	Percentage (%)
Male	35	70%
Female	15	30%
Total	50	100%

Source: survey conducted by researcher in palliative centers in Vatakara thaluk



The above figure shows the category wise participation of the people. The majority that is 70% of respondent argue that the male participation in palliative care is very high. The 30 % of respondent have another opinion that is the female participation is very high in palliative care. When we analysis the table we can clearly understand that, the male participation in palliative care is very high rather than female participation.

Selection of the office-holders in palliative care

Table 3.10

Selection	No. Respondents	Percentage
Nomination	9	18%
Education	12	24%
Experience	29	58%
Total	50	100%

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table describes the selection of the office holders in palliative care centers. Out of 50 samples 9 were appointed by the recommendation or based on nominations. 12 were respond they were appointed on the basis of their educational qualifications. The majority of interviewed persons that is 29 (58%) were selected on the basis of their experience in specials field.

Opinion about the political influence in palliative care

Table 3.11

Political influence	No. respondents	Percentage (%)
Yes	23	46%
No	27	64%
Total	50	100 %

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table shows the political influence in palliative care centers. Out of 50 respondents 23 (46 %) were to agree that, there is a political influence in palliative care centers and 27(64%) were disagree, they argue there is no any kind of political influences in palliative care centers.

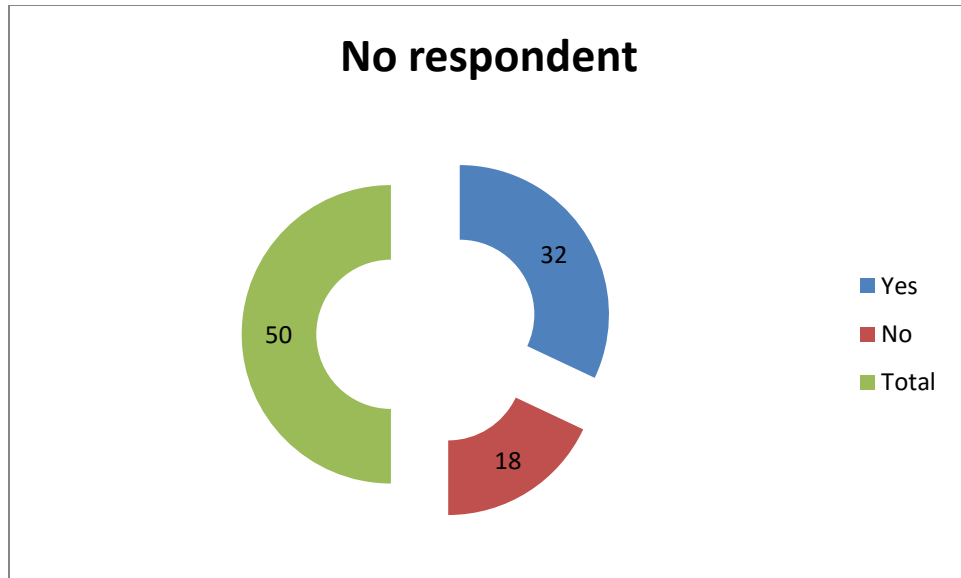
Assistance from panchayath

Table-3.12

Panchayath assistant	No respondents	Percentage
Yes	32	64%
No	18	36%
Total	50	100%

Source: survey conducted by researcher in palliative centers in vatakara thaluk

Figure 3.7



The above figure shows the opinion about the panchayath assistance on palliative care centers for their better functioning. Out of 50 samples 32 of respondents argue that palliative care centers can get some financial assistant from panchayath for their better functioning. And remaining 18 were argue that they cannot get any kind of assistance from the part of panchayaths.

Participation level of retired civil servants

Table –3.13

Participation level	No. Respondents	Percentage
Active	26	52%
Moderate	16	32%
Less	8	16%
Total	50%	100%

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The above table shows the participation level of the retired civil servants in palliative care. The majority of the respondents that consist of 52% argue that the retired civil servants are actively participate in palliative care centres. 32 % of respondents agreed the participation of retired civil servants in palliative care but it is medium level. 8 were argue there is a less level participation of retired civil servants in palliative care.

Time period for holding position in palliative care centers.

Table 3.14

Position	No. Respondents	Percentage
1-3 year	5	10%
1-4 year	8	16%
1-5 year	3	6%
No. such a criteria	34	68%
Total	50	100

Source: survey conducted by researcher in palliative centers in Vatakara thaluk

The table shows the office position of the respondents. Out of 50 samples the majority that is 68% of respondent respond there is no such a criteria for hold their position. The remaining 16 were temporary members so they have a fixed time for hold their position. 5 were to come under 1-3 year, 8 were 1-4 year and 3 were can hold 1-5 year. The volunteers in palliative care centers are economically not very rich many of the respondents are middle income families and they are led simple life of living. Most of them are come under the age group of 40-60.

Palliative care centers have an essential role to protect the human beings. Many palliative care centers in Vatakara Thaluk played an important role to ensure health security. The 50 samples strongly agreed that palliative care services ensure the health security and there is a high level participation of common people. Volunteers are primary care givers who originate normally from the same locality with local knowledge and good public contact through which they can make significant contributions. Most of the selected samples agree that the common people have an essential role for the better functioning of the palliative care centers and the major financial source of palliative care is the donation of the common people it also shows the high participation level of common people.

Conclusion

Palliative care is a prerequisite for a complete medical care. It provides the best care to the patients and their families. Palliative care has become an emerging need of the day as the existing health care facilities play only a limited role in the care of the chronically ill in the society. There are lot of progress in palliative care in Kerala.

The recent declaration by the World Health Assembly asking all members states to integrate palliative care with routine health care comes as a major tool in advocacy and hope full will boost the current efforts. Though palliative care services have been in existence in India for

many years, there has been steady progress in the past few years. India has moved from Group 2 countries making capacity-building activities. Although India ranks at the bottom of the Quality of Death Index in overall score. Kerala, an Indian state, is cited as a 'beacon of hope' for providing palliative care services. Constituting only 3% of India's population, Kerala provides two-thirds of India's palliative care services. The state has a formal palliative care policy in place and its government provides funding for community-based care programs. It was also one of the first of India's states to relax narcotics regulations to permit use of morphine by palliative care providers. Recognizing the need of palliative care as primary healthcare and the importance of homecare services, the neighborhood network in palliative care was commenced as a community-run system that operated through local micro-donations. The volunteers identify those in their community who need care and supplement the work of healthcare professionals linked to the state's 230 local palliative care units covering a population of 12 million. National Rural Health Mission has also initiated the development and expansion of community-owned palliative care services in collaboration with the state government of Kerala.

Here by testing hypothesis, we can conclude that, Health security is a major concern for welfare state. Palliative care plays as an essential role in ensuring health security in India. The participation of people in palliative care is very high and they provide more financial assistance to palliative care centers for their better functioning. The study proves that the hypothesis one and three is proved and second one is partially proved.

Palliative care centers in Vatakara taluk plays an essential role to ensuring good health for the people. The main financial source of most the palliative centers is donation from the common people, it shows the high level of people participation in the palliative care centers in Vatakara most of them are working as an NGO. For the better function of palliative care centers the Government must be provide more fund. The level of permanent members in palliative care is very low for the development of the centers there must be appointed more workers to palliative care centers.

BIBLIOGRAPHY

(Either APA/ MLA style can be used, here APA style is used: please note that this is a model of reference style given and the students should include all the books they used in the study)

Books

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APPENDIX

The survey conducted by, student of, Calicut University as a part of the research project to be submitted to the University of Calicut in partial fulfillment of the requirement for the award of Degree of Masters of Arts in Political Science.

Question for volunteers

1 .Name:

2. Age :

Below 20

☐

20 -40

☐

40-60

☐

Above 60

☐

3. Sex :

Male

☐

Female

☐

4. Qualification:

Below SSLC

☐

SSLC

☐

+2

☐

Degree

☐

Above degree

☐

5. Income status:

Below 1000

☐

1000-5000

☐

5000-10000

☐

Above 10000

☐

6. What is the nature of membership of volunteers?

Voluntary

☐

Permanent ☐

Temporary ☐

7. What is the major financial source of palliative care?

Donation from the voluntary organizations ☐

Donation from outside the state ☐

Financial assistance provided by the state govt ☐

Donation from the common people ☐

8. What is the major reason for the participation in the palliative care?

Personal interest ☐

Family pressure ☐

Religious interest ☐

Social services ☐

9. What is your opinion about the working of palliative care?

Very good

Good

Bad

10. How long volunteer is working in palliative care centers?

1-5 year ☐

5-10 year ☐

Above 10 year ☐

11. Do you get any financial assistance from the panchayath ?

Yes ☐

No ☐

12. Participation level of retired civil servants ?

Active ☐

Moderate ☐

Less ☐

13. How long the office holders hold their position?

1-2 year ☐

2-4 year ☐

4-6year ☐

No such a criteria ☐

14. Public participation belongs to which category?

Male ☐

Female ☐

15 .How the office holders of palliative care are selected?

Nominations ☐

The basis on education ☐

On the basis of Experiences ☐

16. If any political influence on palliative care?

Yes ☐

No ☐

17. Do you think the palliative care centers to ensure health security?

Yes ☐

No ☐

18. What is the economic status of people seeking assistance?

Rich ☐

Middle ☐

Poor ☐

19. Which type of people that normally seek assistance of palliative care centers?

Govt officials ☐

Business persons ☐

Common people ☐

20. What is the age?

20-40 ☐

40-60 ☐

Above 60 ☐

21. Your suggestion for improving the working of palliative care centers?

Provide more fund ☐

More governmental support ☐

People initiative for proving health security ☐

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