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EDITORIAL

ARTICLES

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EDITORIAL

Sebastin K V

The School of Social Work, Roshni Nilaya established in 1960 is a pioneer of social work education in south India, especially Karnataka. During the past half century, this institute has seen significant development. The School of Social Work, Roshni Nilaya has been nationally accredited with 'A' Grade by NAAC and the college has also been recognized as an institute with Potential for Excellence by the UGC. With its wide and varied experience in the field of social work for nearly six decades it is now appropriate to publish a peer-reviewed journal of social work. It is in this context, that the Adelaide Journal of Social Work has been brought out with the aim of providing an independent platform for educators, researchers and practitioners of social work to share their original, creative, critical experience and research and thereby contribute to the strengthening of the knowledge-base and practice of social work.

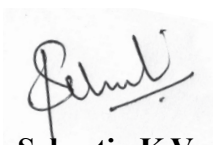
Adelaide De Cice, is the Foundress of the Society of the Daughters of the Heart of Mary, an International Religious Society which has established Roshni Nilaya. Adelaide was inspired by a deep desire to dedicate her life to God and service of the poor. True to the inspiration of Adelaide, the School of Social Work, Roshni Nilaya, aims to form a corps of competent social workers to offer skilled services

to the needy. This journal attempting as it does to enhance the knowledge base and practice of social work, very appropriately bears the name of "Adelaide".

This inaugural issue of the Journal of Social Work has a compilation of articles from senior academicians and professionals from India and overseas on a wide range of themes which are currently relevant and useful. This issue features two articles from two senior academicians from Australia, addressing the emerging paradigm of strengths based approach to social work practice, each focusing on some specific issues and concerns. While one article describes this approach in social work expanding on its assumptions and its core elements, the other stresses the importance of 'not discounting problems but offering possibilities, promises and hope'. Another article reports the outcome of an intervention-based study which was conducted to find out the impact of social work intervention on the coping strategies of care givers of persons suffering from schizophrenia. Social Work has a crucial role to play in the field of correctional administration and the criminal justice system. But, unfortunately in India, unlike many developed nations, the field of correctional administration and criminal justice system has not been given adequate attention by social work professionals. It is quite fitting and timely in this context, to have an article on the criminal justice system in India which, in the words of the author "purportedly provokes thinking on creating a niche for social work practice within the Criminal Justice System in India". One of the social work methods of intervention which, has almost totally been relegated to the background is the method of social action. Generally, social workers seem to be distancing themselves from so called 'social activists'. There is an interesting article on this subject which, based on the findings of an exploratory study involving social activists working in varied fields in India, advocates that "professional social workers need to give up the stereotypes regarding social activists and promote an inclusive and diversified approach to help the method of social action develop in a creative and dynamic fashion". Another article based on an in-depth case study of women survivors of domestic violence, their health problems, their experiences of health care services and health care providers.

Besides, there are interesting and insightful contributions from senior social work academicians addressing a wide range of currently relevant topics such as the effectiveness of governmental and non-governmental interventions in community development, spirituality as a pathway to wellbeing in old age, leisure – an empowerment perspective for women and the skewed sex ratio in Gujarat. A recent publication titled Community Work: Theories, Experiences and Challenges have been reviewed by a senior academician from Bangladesh.

The editorial board would like to thank all the authors for responding to our invitation to contribute to the inaugural issue of this journal. We welcome constructive feedback and suggestions from our readers for enhancing the quality of this journal.



Sebastin K V
Editor-in-Chief

Introduction to Strengths Based Approach in Social Work

* Venkat Pulla

Abstract

Social work and human services professions gain great outcomes when they work with inherent strengths of individuals, families groups and organisations. Whenever we assist people in their recovery and their empowerment our commitment to build on these inherent strengths goes a long way. This approach lets us refrain from using any damaging and labeling and stigmatized language. Descriptions ascribed pathology owned by persons groups and organisations that suggest acceptance of their condition as being hopeless or helpless to change are constructively challenged through this practice. We have a great opportunity here to foster hope from within and by constantly focusing and working with precedent successes, we could see change by asking small questions: what has worked for the clients before? What does not work for them? And what might work in the present situation? These three questions allow facilitators and clients to make important changes in the processes and goals of engagement that allows the desired changes to blossom. In this paper the author describes this approach in social work and expands on its assumptions and its core elements.

Key words: *Resilience, Strengths based practice, Strengths approach, Social Work*

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Introduction

In 2006, I launched the inaugural international conference on strengths based practice in India, the land of Gandhi (Pulla, V, 2006). The core values of Gandhian way of development have been being fair and respectful to all, focusing on strengths, assisting a self-directed transformation to bring forward changes that are meaningful and significant to people and to reflect on how they want their situation to be. Today in the western model of social work which to a large extent has pervaded the globe and has even returned to India with more formalized frameworks, the core values of Gandhi are quite evident. To call Strengths based practice a Gandhian mantra may sound a shade simplistic description. Nonetheless the core elements that he deployed in the context of communities and groups ensured social reforms and social change in the fabric of Indian society. Certainly Gandhi's work in India provided much to the critical frameworks in western social work such as anti-oppressive framework and the human rights engagement much in vogue in the western world today.

It is a tribute to Gandhi that he applied only positive thoughts and positive strategies across a wide range of social institutions including the governors of the British Raj that had India and several other countries as colonies in their grip.

Let us begin with ourselves as facilitators. It would be easier if we begin by accepting that everyone has strengths. As people we have experiences, abilities and knowledge that make us move on in life. If we are lucky, we also have a variety of people around us who act as a support network for us. A strengths based approach allows us to identify and build on our strengths so that we can reach our goals, and retain or regain independence in our daily lives. Why work in this way? As a practitioner I have seen that the approach improves self-care abilities, builds one's confidence and self-esteem of and allows our clients to carry out daily living activities quite independently. *'Strength based practice* in simple terms present approaches that promote resilience as opposed to dealing with deficits'. (Pulla 2006 p120). Strength based practices are gaining impetus globally in diverse fields of human services management, health care , education & training reminding that all environments have resources and that in every society individuals, and institutions are willing to assist each other to cause

human wellbeing. The principles of caring and caretaking, nurturing and ensuring that members of our society and our organisations in turn become resilient and hopeful is clearly within the scope of strengths approaches(Pulla, 2012). Community groups in Asia and the Pacific region have been dealing with self-reliance and indigenous development for several decades. Some of these self reliance experiences can be tweaked to reflect in strength based practice (Pulla, 2006).

The Strengths Approach

The main assumption with which we begin in strengths based approach is that people do have strengths and resources for their own empowerment. Traditional development models some of them are also pedagogical are premised on deficit based approaches, ignoring the strengths and experiences of the participants. In strengths based approach the focus is on the individual not on the content. Drawing on appreciative inquiry, strengths based methodologies do not ignore problems. Instead they shift the frame of reference while undertaking definition of issues. By focusing on what is working well, informed successful strategies are brought forward to support the adaptive growth of the individuals. This belief in inherent strengths focuses on identifying, mobilizing, and honouring the resources, assets, wisdom, and knowledge that every person, family, group, or community has and leads to a re-discovery of these resources. An opportunity therefore is offered to fathom their inner strengths. The Strengths Perspective recognises that for the most part of life, people face adversity, become resilient and resourceful and learn new strategies to overcome adversity. It would be pertinent to consider resilience in the context of strengths perspective 'as the opportunity and capacity of individuals to navigate their way to psychological, social, cultural, and physical resources that may pull together during crisis and provide them an opportunity and capacity individually and collectively to negotiate for life following adversity in appropriate and culturally meaningful ways' (Pulla, V, 2012). I suggest utilising client's personal strengths and in discovering resources in the environments to fulfil the client's needs and to enhance resilience. In fact the environment is conceptualises as 'the helping environment', in a strengths based practice (Early & GlenMaye, 2004, p. 113).

As a practitioner and facilitator of strengths approach, people told me that at times their negative experiences bring them down, at the same time I saw as the process work commences people recognise that even in their most adverse situation they have displayed their strengths.

The emphasis is certainly on 'getting up' to see opportunities to growth and development. It would be naïve to think that a strengths perspective allows social workers to casually taciturn the real pains and troubles that affect our clients and our societies. It is widely acknwedged that poverty, child sexual abuse, and violence towards elderly, torture and racism all these are 'real problems' and they exist. Certainly thinking on the above lines suggests that as facilitators we would not perhaps be aware of the upper limits of human capacity of our clients. How far would they grow? What changes would they show? What aspirations they have as individuals, groups, and as communities. These questions will determine our approach to go beyond the assessment, diagnosis, or profiling and presenting verdict on our client's lives. If we aim social work and human services to be professions that work with people to build their hopes, values, aspirations, and visions, then strengths approach obviously allows us all those possibilities through a collaborative pathway. For this to happen we need to be open to the idea that our clients do have the wisdom, knowledge, and experience that they bring with them and that in combination with the specialized skills and experience that the facilitator may have a valuable outcome can be created. This could not happen if the client or the end user voice is not heard and valued at all levels of management of change.

Some Common Myths about Strengths based practice

- It is just a glorified version of positive thinking.
- It's really about reframing people's perception to find good even in the worst situation.
- It basically re-labels weaknesses as strengths.
- It ignores the reality that serious symptoms and problems do exist and continue to persist.
- Strengths based practice assesses the inherent strengths of a client's people employees or family, and then builds on them.

Why Use It?

It is an empowering alternative to traditional human resource development methodologies that tend towards describing or diagnosing human motivation and human competencies functioning in terms of deficits and may offer un-related alternatives. Strengths approach avoids the use of stigmatising terminology, which people in need may have gotten used to and eventually accept, and feel helpless to change and contribute their future. It fosters hope within people by focusing on what is or has been historically successful for them in their personal, professional and or even career contexts, thereby exposing precedent successes as the groundwork for realistic expectations. It inventories the positive building blocks that already exist in the environment of the changer seeker which can serve as the foundation for future growth and change for him or her self and it reduces the power and authority barriers in number of situations such as employees and their managers or the clients and their therapists, the communities and the social worker by

- Promoting the client to the level of expert in regards to what has worked, what does not work, and what might work in their personal, professional and work group situation.
- Placing anyone in power or expertise in the role of facilitator, partner or guide.
- And lastly - it works. (Pulla, V, 2006)

Ecological and Strengths perspectives

The strengths perspective originated in response to criticism of the deficit-oriented psychotherapeutic model that dominated social work practice (Guo & Tsui, 2010; Saleebey, 1992). Different strengths based approaches to practice emerged in late 1980s as alternatives to the dominant models. The impetus for strengths based social work practice arrived at a time in US when helping professions were saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, abnormality, victimization, and disorder (Saleebey, 1996, p.296). The strengths perspective is rooted in ecosystem and empowerment theories with underpinnings of humanistic

philosophy. According to Johnson (1998), ecosystem theory provided a foundation for the integrated, generalist social work practice model and revived the core concept of 'person-in-environment' or 'how people and their environments fit' (Miley, O'Melia, & DuBois, 2004, p. 33). In fact, Weick and colleagues (1989), state that "the personal history and unique composite of personality characteristics of individuals interacts constantly with the political, economic, social, and natural forces in society (Weick, Rapp, Sullivan, & Kisthardt, 1989, p. 353). Because of their affinities, the combination of strengths based practices and new ecosystem approaches is increasingly being used in social work practice. Adoption of a reflective practice model that creates a strengths based social work practice model that promotes not only the strengths of service users but also the capacities of the social work profession, has also been advocated (Guo and Tsui, p. 234).

I see empowerment as an activity or a process when people work with their confidence, exiting skills, acquired skills and the resources available to them and most often they gain control over their problems and also their lives. Certainly personal empowerment and social empowerment are two interdependent but are also interactive phenomenon. Personal empowerment recognizes the client's uniqueness and it is analogous to self-determination; that is, clients provide direction to the process, take control of their lives, while client social empowerment provides him or her resources and opportunity to play an important role in his or her environment and in the shaping of that environment. While a part of this occurs while the clients are on their journey of coping and becoming resilient.

Empowerment theories identify and help individuals and communities to recognise barriers and dynamics that allow oppression to persist as well as circumstances and actions that promote change, human empowerment, and liberation. Considering that the Strengths Perspective is used to build on people's aspirations, strengths, resources, and resiliency and to engage in actions pursuing social justice and personal well-being (Robbins, Chatterjea and Canda ., 2006), it can be considered a theory of empowerment. The strengths perspective is committed to promoting social and economic justice considering that social work practice deals with transactions between person and environment in which the

dynamics of power and power are embedded. Client empowerment is central to a strengths based practice and the discovery of client's strengths nurtures that empowerment and emphasizes on positive qualities and development of attributes, including talents, knowledge, abilities, and aspirations to reclaim personal power in their lives (Cowger, 1994, Rapp & Goscha, 2006; Saleebey, 1997, Weick et al., 1989). The following table gives a classification of strengths based practices.

Table 1. Identified Strengths based practices Models	
Solution-focused therapy	(Berg & De Jong, 1996)
The individual placement and support model of supported employment	(Becker & Drake, 2003)
Positive youth development and resilience approaches	(Benard, 2004)
Asset-building model of community development (ABCD)	(Kretzmann & McKnight, 1993)

A number of writings that emerged from the Kansas School of Social Work, ((Chamberlain, 1991; Chamberlain & Rapp, 1991; Rapp, 1993; Saleebey, 1992; Weick et al., 1989) field studies in areas such as *people in poverty* (Jones & Bricker-Jenkins, 2002), *physical and sexual abuse* (Anderson, 2001, 2010), *older adults* (Fast & Chapin, 2002), *family violence* (Postmus, 2000), *secondary trauma* (Bell, 2003), *spirituality* (Canda & Furman, 2010), and *substance abuse* (Rapp, 2006) have contrbuted to the development of strengths approach in social work.

The strengths perspective is impacted by a variety of concepts and perspectives. According to Saleebey (2001a)

> "the ideas about healing, wholeness, and wellness that challenge the medical model; the empowerment and liberation movements within and outside of social work; the evolving resilience research and practice; the assets-based community building approaches; the power

of mind and health organization approaches to individual and community change; solution focused and narrative approaches to therapy; the research on hope, positive expectations and possibility; all of these extend links to, and embolden the strengths perspective" (p. 221).

It would be a misnomer to construe that the strengths perspective is some sort of only a positive reframing of a problem or being nice to clients, or sitting with them and compiling a list of strengths (Early & GlenMaye, 2004; Saleebey, 1996). It refers to a rather consistent process of identifying client strengths and resources and mobilizing resources that directly or indirectly improve the situation. With the purpose of clarifying what constitutes a strengths based practice, Rapp, Saleebey, and Sullivan (2005) identified six hallmarks that characterize strengths based practices:

1) It is goal oriented: Social workers invite clients to define goals for their lives. Client-set goal attainment is the indicator social workers can use for evaluation purposes.

2) Systematic assessment of strengths: Strengths based practice uses a systematic set of protocols for assessing and documenting strengths, with an emphasis on the present (although past resources and strategies can also be useful).

3) The environment is seen as rich in resources: the natural community is the main source of opportunities, supports, resources, and people. " a central notion is that the path to goal attainment is the matching of client desires, strengths, and environment resources" (Rapp et al., 2005, p. 82)

4) Explicit methods are used for using client and environmental strengths for goal attainment. For instance, in strengths case management, the strengths assessment is used to help clients set goals, elicit resources, set short-term goals and tasks, and guide role and responsibility assignments (Rapp & Goscha, 2006)

5) The relationship is hope-inducing: the relationship is clearly focused on increasing the hopefulness of the client through an empowering relationship.

6) The provision of meaningful choices is central and clients have the authority to choose: The social worker's role is to extend the list of choices, clarifying them, and supporting the clients to become confident and to take the authority to direct the process.

Does strengths perspective overlook the problems that the client brings?

The answer is No. However I do sit in the session with the client to encourage him or her to explore myriad possibilities and resources that might be there to reach that goal. I do not overlook the problems that clients bring. But as a practitioner I would not waste my time trying to understand the causes of the problem or labeling it. Through this perspective I acknowledge and take problems, needs, and challenges that are brought by the client into the scene. Often, these problems, situation, and challenges are where clients begin with what is most urgent and are compelled by their inner urges to talk about. However, as strengths based practitioner I would assist my clients to go beyond the challenges ahead and encourage them not to make those immediate problems as the priority or sole focus of intervention. Indeed, the strengths perspective believes in a resilient and self-righting capacity, opening the possibility for treating life as a great journey.

> "The strengths perspective does not deny the grip and thrall of addictions and how they can morally and physically sink the spirit and possibility of any individual. But it does deny the overweening reign of psychopathology as civic, moral, and medical categorical imperative. It does deny that most people are victims of abuse or of their own rampant appetites. It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might." (Saleebey, 1996, p. 297). In consequence, the strengths model allows us to see possibilities rather than problems, options rather than constraints, wellness rather than sickness, which, once seen, can be achieved.

Humanistic roots

Given its humanistic roots, at the core of the Strengths Perspective is the belief that humans have the capacity for growth and change (Early & GlenMaye, 2004). In addition, believing that people are capable of making their own choices and taking charge of their own lives promotes empowerment. It means that human beings have the potential to use their strengths and overcome adversity as well as to contribute to society (Cowger, 1994). It implies a belief that people are doing the best they can (Weick et al., 1989), as is reflected in the following underlying assumptions:

- Every individual and every environment have strengths and resources, i.e. Knowledge, talents, capacities, skills, and resources to mobilize in order to pursue their aspirations. (Saleebey, 2009)
- People who face adversity typically develop ideas, capacities, and strategies that eventually serve them well (Saleebey, 2009). In other words, every individual is resilient.
- All human beings have an innate capacity for health and self-righting, which is a drive, a life force (Weick, 1992), that heals and transforms
- Almost always, people know what is right for them. This requires a nonjudgmental attitude; instead, the principles of knowing what is best and doing what is best places the power of decision where it should be—with the person whose life is being lived
- A personal, friendly, empathic, and accepting relationship provides the atmosphere for healing, transformation, regeneration, and resilience.
- A positive orientation to the future is more useful for healing and helping than the preoccupation with the past.
- It is possible to find the seeds for health and self-righting, even in maladaptive responses or patterns of behavior, since individuals may be trying to satisfy some need for respect, connection, affection, or control.

How do we find Strengths in adversity?

The strengths perspective provides content and structure for the assessment of achievable alternatives, the mobilization of competencies to promote change, and the building of self-confidence to promote hope. According to Saleebey (2006), almost anything can be considered as strength under certain conditions (p. 82). Central to this finding is where they do emerge from? For instance, a person who is agreeable may be engaging and attractive to play a role in building relationships. Certainly if he or she is disposed to being always agreeable and does not have any boundaries to the others it could be due to their fear of losing them. Facilitation in those situations requires that the individual is made aware that he or she needs to work toward his or her own goals or aspirations as well.

A strengths based practice working tool is its assessment with no rigid boundaries. It is constantly updated through the partnership and collaboration between client and social worker or the organisations and the facilitator, thus a strengths based assessment is both, a process and a product. It is a process because through an assessment, strengths based facilitator help clients define their *situations*, evaluate, and give meaning to those factors that impact their *situations.* The assessment process helps clients to tell their stories, according to their unique socially constructed reality and thus, this process is multi-causal, interactive, and constantly changing (Cowger, 1994).

Exploratory Questions

Based on review of literature I have classified a number of questions that Strengths based practitioners would need to explore from the client's experiences in order to obtain the best outcomes for the clients. The following is not necessarily an exhaustive list of questions; nevertheless it assists an astute beginner and a seasoned practitioner who wishes to refresh himself with strength approach.

1. What have clients/ people learned and known about themselves, others, and their world? (Early & GlenMaye, 2004; Saleebey, 2006, 2009)
2. What are the personal qualities, traits, talents, and virtues that reside in people?

3. What personal qualities, traits, talents, and virtues do they display during crises and after trauma? (Early & GlenMaye, 2004; Saleebey, 1997; Weick et al)
4. As survivors how do they discover their inner strengths? How do they utilise the ones that they know, and also develop new ones?
5. What cultural and personal stories and lore has been a deep source of strength for them?
6. How dis those narratives, stories provide guidance, stability, heritage, belonging, or transformation?
7. How do they define their sense of pride? (Wolin and Wolin 1993)
8. Is pride described as 'survivor's pride' in overcoming the odds?(Trotman and Townson, 2013)
9. What are the personal and familial narratives of survival and redemption that can provide strategies, tools, symbols, and metaphors for rebound?
10. Is there a resilience factor? (Pulla, 2012, Pulla 2013)
11. How do they research and discover the community and its different resources, which are frequently overlooked during any presenting crisis?(Bhadra, Pulla,2013)
12. Family traditions, rituals, and the combination of the strengths of the nuclear and extended family members (Early & GlenMaye, 2004)
13. What Spiritual and world views do they provide with clues around essential holistic quality of being? (Pulla, 2014)
14. What are their personal hopes and dreams, which, with help, can be recovered and revitalised?

Indeed, a strengths based assessment should follow the above questions and guidelines. This is give preeminence to the client's understanding of the facts, which is central focus to the assessment as it draws on the rich texture of client's feelings and meanings about it. Cognitive, mental or intrapersonal assessments of the client are only relevant if they clarify the current situation or if they can help us identify strengths to use with the situation. Indeed, the process of empowerment begins by who defines the situation:

'Many alienated people have been named by others - labeled and diagnosed - in a kind of total discourse. The power to name oneself and one's situation and condition is the beginning of real empowerment' (Saleebey, 1996, p. 303)

Further beliefs

1. Believe the client:

   The belief that clients are trustworthy is central to the Strengths perspective. (Early & GlenMaye, 2004). Social workers need to re-view their attitude; that is they need to suspend their initial disbelief in clients Thus it takes courage and diligence on the part of social workers to regard professional work through this different lens (Saleebeyp. 297, 2009).

2. Discover what the client wants

   When we move the assessment toward personal and environmental strengths and from solutions to difficult situations the clients will further draw on their strengths. This is not as easy as it would seem, as the proposition is that client strengths are central to the helping relationship is simple enough and seems uncontroversial as an important component of practice. Yet much of the social work literature suggests otherwise (Cowger, 1994, p. 262). Following this, we need to make assessment of strengths multidimensional: both internal and external strengths are to be considered necessary to solve a situation. It is equally important to consider examination of power relationships in person-environment transactions.

3. Discover the client's uniqueness

   This principle requires that the assessment is individualised to the client's unique situation

4. Use the client's language

   By the above principle we mean that the product of the assessment should use a language that the client can understand and closer to his everyday language and culture. One can expect the client to have ownership when the assessment is open, transparent, and shared.

5. Avoid blame and blaming

Blaming anyone does not lead us anywhere. It is rather a bureaucratic route when something fails and can dissuade the client motivation to solve his or her situation and will increase his or her learned helplessness.

6. Avoid cause and effect thinking

   This binary thinking is too simplistic. It is important to consider that the cause-effect relationships do have several dimensions and complexities.

7. Avoid diagnosing

   In the language of the practitioner of strengths a diagnosis has no place and must be understood in the context of pathology, deviance, and deficits. We do not need that. I have tabulated a number of questions to identify strengths based on the format offered by Saleebey (2006, p 87). These questions are not presented as a protocol but are intended to direct social workers attention during conversations with the clients.

Table 2. Classification of Questions for finding strengths

Typology	Question
Survival questions	How have you managed to survive this far given all the challenges you have had to contend with?
Support questions	Who are the special people on whom you can depend?
Exemption questions	When things were going well in life, what was different?
Possibility questions	What are your special talents and abilities?
Esteem questions	When people say good things about you, what are they likely to say?
Perspective questions	What are your ideas about your current situation?
Change questions	What has worked in the past to bring a better life for you?

What makes change possible?

A strengths based practitioner attempts to understand a client in terms of strengths. This involves active listening of the client's stories and narratives, to discover the client's assets, abilities, and resources, as well as his or her concerns and challenges. All human beings are capable of creating meaning, within their culture and environment. For example the oppressed people typically have their stories buried under the stereotypes and may not have an inclination to narrate for example the atrocities committed on the scheduled caste people in India. While it is a social malaise in India and it is no exaggeration that not a single day passes without incidents of victimisation of these people. For every one that may be reported there could be tens and hundreds that do not get reported. In such caste ridden social fabric it is hardly possible for the victims to come out from their cocoons. They often remain there resigned to their fate. Therefore removing oppression and emancipating the visions and hopes of the oppressed involves a process of reconstruction, which ultimately is our role as social workers. Thus,

> 'it is a part of the work towards liberation to collaborate in the projection of peoples' stories, narratives, and myths outward to the institutions that have ignored or marginalized them'(Saleebey, 1996, p. 301)

Gandhi attempted this through many ways to bring reform in Indian society, through various voluntary schemes by his sheer power of his words and action in his time but what follows till today is a haphazard programme of interventions that do not carry the intent seriously and ethically.

When clients seek help, they are usually in a vulnerable position; they have relatively little power which is often associated with the reason why they seek help. The strengths perspective provides for a balanced power relationship between social workers and clients, by reinforcing client competence and thereby mitigating the significance of unequal power. To minimize the power imbalance between worker and client, it is important to conceive assessment as a joint activity in which the social worker inquires, listens, and assists the client in discovering, articulating, and clarifying whereas the client provides direction

to the content of the assessment. Saleebey includes expectancy, hope, and the placebo effect, as they are associated with positive expectations (the helper believes in the client's inner power to transform his/her reality). This expectation mobilizes hope and the possibility of a different future (Saleebey, 2001b). A personal, empathic, and accepting relationship provides the atmosphere for healing, transformation, regeneration, and resiliency in the clients.

Language matters

Language matters a great deal in social work. The kinds of words that we use preserve or annul the possibilities and promises of our clients. Certain words and concepts are central to the strengths perspective and these are depicted below.

Strengths perspective recognises people as being competent, resilient, and responsible and valued members of a group or a community. We need to believe in the restorative powers intrinsic to human beings and their bodies and that emotions have a profound impact on the overall health and wellness of individuals. Believing in the hardiness and wisdom of the human body implies the belief in the possibility of overcoming adversity inherent to all individuals. Central to this is our own journey as facilitators that resist all pathology focused paradigms to possibility focused paradigms. We require a deep inner transformation that allows us to to embrace a resilience framework.

Discussion

The process lets clients recognise and develop new strengths as they continue to gain power and growth. An emphasis on the individual and environmental strengths seem to act as a stimulus for further growth and development, leading individuals to contribute, not only to their personal goals and dreams, but also to the development and growth of their families and communities (Early & GlenMaye, 2004; C. A. Rapp & Goscha, 2006; Saleebey, 1996, 2006, 2009; Weick et al., 1989). Indeed, 'the interplay between being and becoming and between what a person is in totality and what may develop into greater fullness mark the essential dynamic of growth' (Weick et al., 1989, p. 352), which characterizes the helping process from a strengths perspective.

An empathetic, empowering relationship, characterised by the collaboration and partnership between two human beings, transforms the realities of both social workers and clients as participants in the process. One discovers, uses, and transforms her or his strengths in pursuit of her or his vision, dreams, and hopes, and, thus, becomes increasingly empowered to make his or her own choices, to lead his or her life, and to contribute. The other person is also transformed; her and his attitudes and expectations change regarding the person who is guiding the process, the person who facilitates the discovery of resources, the relationship between them, and the relationship with oneself. This process takes courage, commitment, and generosity. A strengths based practitioner is required to change his or her heart and mind. While the Strengths Perspective has reached most, if not all, areas of social work practice, an emphasis on deficit, disease, and dysfunction still persists in the field (Cowger, 1994,Rapp et al., 2005). However, As Blundo (2001) asserts, 'what is most problematic with the inclusion of strengths talk in social work conversations is that the insertion of strengths and empowerment language into a traditional frame gives a false sense of understanding to those learning and engaging in practice' (p. 301). Many social workers may not be ready to shift from a traditional social work practice to a strengths framework because it challenges our cultural and professional traditions; it questions our truths and hidden meanings. In fact:

> 'To learn the strengths perspective one must seriously challenge the basic foundations of practice knowledge, the 80 years of variations on

> a basic theme of disease and expertise as it is taught and practiced today. Anything less is a distortion of the meanings employed in a practice from a strengths/empowerment perspective." (Blundo, 2001, p. 301)

How can we expect to find the assets, the strengths, the protective factors among the damage if we only see the damage? We, as social workers, need to look beyond the client's damage and wounds. Sometimes we feel more 'competent' or 'empowered' when seeing the damage since we were trained to find it. To see beyond the damage it is necessary to fight against ourselves, our biases, our training, and even our own culture. We need to have positive expectations for our clients and truly believe in them.

I always ask this question: How can we find strengths in our clients if we cannot find strengths within ourselves? Affirming our inner strengths is challenging, because it requires personal exploration, which many of us may not be willing to do. Because many social workers have been trained in the damage model, this negative perspective is applied to their own selves and is considered much too painful to bear. However, the main tool of a social worker is his or herself. We do this all the time through our verbal and non-verbal communication, intuition, capacity for relationship, attitudes, life experience, and self-concept, among others. Without self-exploration, the most important tool of the social worker (self) may be misused and is potentially destructive. Moreover, the belief in a client's strengths and positive expectations cannot be faked. So, it is crucial to truly believe in a client and his or her potential. This can only be achieved by shifting our internal perspective and becoming aware of our own strengths and resilience. Any helper must develop a deep self-awareness to effectively promote this change.

The firmer question is how can I help someone discover hope in the future if I do not have hope in my own life? We need to discover our own hope and positive expectations for our own lives. Again, it is a challenging process of self-recovery, which involves a positive attitude towards one's life in general. Hope to me is clearly related to ones spirituality necessitating a reexamination of our belief system. What meaning do we hold of our life? What sense we make out

of our connection to the rest of the humankind? These questions may be daunting but are definitely rewarding and hence soul searching.

How can we provide opportunities for creating turning point effects if we do not believe in change? There is no possibility for creating any opportunity without a fundamental belief in change, first. A human being always has the possibility of change. Despite damaging experiences, what we learned about resilience shows that human beings have the capacity to construct new narratives for their lives. Benard (2004) insists in the importance of changing the life trajectories of children from risk to resilience, beginning with changing the beliefs of the adults in their environment.

How can we expect ordinary magic to happen if we do not believe in it? We must believe in the magic of resilience and we have to believe that the capacity for resilience is ordinary and universal at the same time. With these beliefs in place, it becomes obvious that everybody has the ability to bounce back from adversity; we can truly have positive expectations. If we believe these things, in the helping encounter, magic is likely to happen. Social workers are like alchemists because they have the possibility of changing lead into gold, by discovering the clients' strengths and resilience and encouraging this magical transformation by the power of the word and a deep relationship.Social workers interested in the strengths perspective need to engage in a personal process of analysis and transformation, recognizing that this will be a continuous process, recognizing signs of the traditional framework in their practice, becoming aware of themselves and their attitudes, biases, and limitations, and defining a new position for themselves in the helping relationship; that is, removing their "expert" hats and acknowledging the client's expertise, knowledge, and capabilities. When we have 'emptied our cups', we can have them ready to receive what the client brings, in an open, curious, encouraging, empathetic, and empowering way. As Blundo (2001) affirms:

> Challenging this cultural and linguistic tradition, as well as a process that has become synonymous with the social work profession, is a serious task that needs to be undertaken if social work is to embrace a belief in human resilience and strengths'(p. 304).

Strengths based practices challenge us, our professional traditions, our cultural influences, our beliefs and biases. As the client gains power and growth, the social worker grows as well. This process takes us away from our comfort zone, our habits, and hidden meanings in a process of discovery of our own strengths, resources, capabilities; our own resilience; our own hopes and capacity for transformation.

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Strengths- based Practice: "Not about discounting problems but offering possibilities, promises and Hope"

* Abraham Francis

A man is but the product of his thoughts what he thinks, he becomes.

Mahatma Gandhi (1869-1948)

Abstract

This paper seeks to explore, understand and discuss the strength-based perspectives in social work practice. A review of the literature has suggested that there has been a shift away from the mere focus on deficits to strengths based focus in the delivery of services to clients in the last few decades. The focus on strengths and empowerment has gained considerable prominence over the last couple of decades. Drawing on from the recent literature from the field, the author directs the attention of the readers to the relevance of adopting strengths based perspective in their practice by showcasing the various fields of application. The paper further reveals that strengths based approach to practice is not about discounting problems or denying issues, rather it is an attitude and a way of working with the clients/communities and groups to help them realise their goals. Hence, it is in this context, the paper discusses the applicability of such a method in our professional practice and answers some of the questions that may confront us as we embark on this journey. It is intended towards providing a brief overview of the concept, and its application in the various fields of practice as it offers a language of "possibilities, promises and hope" both for clients and practitioners in the field.

Key Words: *Strengths based, hope, transformation, mental health, social work*

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Introduction: What is strength based practice?

Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy as well as efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organisation and engaging in social and political action to impact social policy and economic development. The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical, and socio-economic conditions. It is in this context, this perspective has been discussed, drawing on the literature from the field and analyses its importance in the Indian context.

According to IFSW, "Social work addresses the barriers, inequities and injustices that exist in society. It responds to crises and emergencies as well as to everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments.

> Social work facilitates social development and social cohesion. Core to social work is supporting people to influence their social environments to achieve sustainable wellbeing. The profession is underpinned by theories of social work, social sciences, and indigenous knowledge. Principles of human rights, collective responsibility and social justice are fundamental to practice (IFSW, 2013).

Working from a strengths perspective requires a paradigm shift away from a deficit (problem focused) model of practice to one that aligns with possibility, promise and hope for the future. Drawing out clients capacities will foster "...a growing awareness in both the worker and client of the client's strengths relative to their goals rather than the client's deficiencies relative to their problem" (De Jong & Miller, 1995, p.731). Every person, family, group and community has strengths (Saleebey, 1997). Every person contains "…untapped and often unconscious resources" (Stalker, Levine &Coady, 1999, p.470). By analysing the problems through a strengths perspective, a path is created

towards the exploration of future possibilities for the client and his/her family (Saleebey, 1997).

To help client rediscover his/her strengths and abilities, social workers are encouraged to convey a positive and optimistic attitude and use an approach based on partnership and collaboration. This will increase the resources available to identify creative options and "…solutions developed collaboratively are more likely to be useful to the service user than those imposed by others…" (Healy, 2005, p.161).As a practice perspective (Sheafor, et al. 1996:51) the strengths approach takes a different look at the client, his problems and his environment, and it requires a different approach from social workers. This is also echoed when Miley, O'melia and Dubois (2004:81) stress that practitioners need to re-examine their orientation to practice, their views of client systems and the issues clients represent if the strength perspective is to be applied. According to them(2004:81), the practice of the strengths perspective will prompt social workers to examine three transitions from problems to challenges, from pathology to strengths and from a preoccupation with the past to an orientation to the future.

Saleebey (2001:1) states his view very clearly and forcefully:"The strengths perspective is a dramatic departure from conventional social work practice. Practicing from a strengths orientation means this - everything you do as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings, and society's domination." According to him, (2002:1) practice from a strengths perspective demands a different way of seeing clients, their environments, and their current situations. It is thus a practice perspective radically different from the problem-focused approach and it will take time for social work practitioners to change their mind set - moving from the known to the unknown. Saleebey (1999:16) points out that strengths-based approaches differ from pathology-based approaches in both their language and the principles that guide and direct practice.

It is worth re-establishing what strength based practice is, as well as reflecting on the contexts in which it is used and similar and/or compatible approaches and

theories. Dennis Saleebey (2009) has been involved in strength based practice from its (contemporary) inceptionand gives insight to this reflection in his introduction to *The Strengths Perspective in Social Work Practice*(5th edition). He reiterates that the strengths perspective is more than a framework, and more than has traditionally been required of social workers through ethical practice guidelines. The strengths based approach requires a particular, and sometimes challenging, way of thinking, speaking, and being. While he believes the central tenets of the strengths approach seem clear, he also warns that in practice it is hard work, and can never be seen simply as applying a formula to a given situation. A lexicon of key words and concepts has been identified by Saleebey as reflecting the core values of strength based practice. These include plasticity, empowerment, membership, resilience, healing and wholeness, as well as the importance of dialogue and collaboration as social workers and clients work together (pp. 10-14).

Witkin (2009) feels working from the strengths perspective can provide a number of benefits. He opines that there is an alternative language available under the strengths perspective –"… of promise, resilience, generativity, and transformation –" that allows a practitioner to "'talk back' to the dominant discourses of illness and pathology" that "still dominate social institutions and professions" (as cited in Saleebey, 2009, p. xiii). This is of particular importance in post-modern society where language is a key definer of social reality, and as Saleebey, (2009) points out, labelling in the problem focused approach is disempowering and stigmatising.

Key advocates of the strength based approach have been collecting, and publishing, case studies, evaluations, and peer reviewed work to extend the understanding of not only the approach itself, and its contribution, but also concrete examples of how the approach can be utilised in the field (for example Pulla, Chenoweth, Francis, and Bakaj, 2012). This attention to sharing knowledge has allowed the concept to become widely recognised over the last thirty years and it is increasingly becoming integrated into multiple disciplines, and client groups such as "the elderly, youth in trouble, people with addictions, people with chronic mental illness, communities, and schools" (Saleebey, 2009, p. 2).

Once again the author reiterates that strengths based practice is a way of practice with a belief that change is possible. It has also been summarized by Gottlieb as follows

> Strengths based care does not ignore or negate problems; neither does it turn a blind eye to weakness or deficits. Instead, it uses strengths to balance or overcome them. SBC, at its core, is about looking for what is working and capitalising and mobilising those areas within the person, and in the person's life, that are working. In SB, the conversation shifts from "What is wrong?" to "What is right?" and "What has happened or is happening?" to "What is working?" This change in thinking places the problem with in the context of what else is happening in a person's life that may directly or indirectly affect how the patient and family are responding to and coping with their challenges (2014, p. 24).

A Brief History of strengths based practice

Strengths based practice was first formalised as a concept and disseminated to academics and practitioners in the 1980's by Dennis Saleebey, Charles Rapp, and Anne Weick, at the University of Kansas, USA. However, the underlying philosophies of self-reliance and looking toward 'inner wealth' (within individuals, groups, and communities) came from the wisdom of Mahatma Gandhi, in India, and Pulla describes the core values of Gandhian visions of development as providing the fundamental context for community engagement practice in current times (Pulla, Chenoweth, Francis, & Bakaj,2012, p. 2). These core Gandhian values are "being fair and respectful to all, focusing on strengths, and assisting a self-directed transformation to bring forward changes that are meaningful and significant to people …" (Pulla et al., 2012, p. 2). Jackson, Gregory and Davis locate strength based language in the African psychotherapy of 'NTU' (NTU psychotherapy is a strength-based treatment model that accentuates the importance of culture and is steeped in African philosophy and spirituality.) ". . . the cosmic, universal force *from* which all life emanates . . . an awareness, and support and reinforcement of strength, competence, capacity, and resilience as opposed to pathology" (Jackson et al., as cited in Grothaus, McAuliffe & Craigen, 2012, p. 54) to explain the importance of culture and cultural

awareness in strength based practice. In mental health practice it was evident in the person centred approach of Carl Rogers who also stressed the importance of thequality of the client-therapist relationship (Saleebey, 2009, p. 5).

The KU School of Social Welfare continues be one of the leaders in research into the strengths model and are conducting wide scale evaluations to enhance evidence based practice knowledge. The KU School developed a fidelity scale in 2003 to assess social worker team's adherence to the Strengths Model, and thereafter analysed the data to assess whether strict adherence to the strength based model had a positive effect on client outcomes. The data collected so far shows a significant correlation between the two, and this evaluation process is ongoing (Goscha, 2012).Charlie Rapp and Rick Goscha, in their recent paper (2014), highlighting the significance of this approach in mental health field have stated that,

> …at the same time, a focus on strengths should never ignore that there are economic and social conditions that affect the wellbeing of those with a mental illness. Poverty, unemployment, discrimination, social exclusion, disparities in health care, etc., can be far more disabling for people than symptoms associated with a mental illness. The Strengths Model was never intended to serve as a comprehensive social, economic, and political agenda. Economic and social policy will continuously need to be evaluated to determine its effect on the wellbeing of those with disabilities. But we cannot wait for economic and social justice to occur before we help people use the power of their own strengths and existing strengths of the community to impact their life. This would be an equal injustice (Rapp &Goscha, 2014, p. 35).

While globalisation has, in some quarters, been considered deleterious to society, the strength based approach has seen collaboration, knowledge sharing, and support worldwide. This in no small part due to those who have driven the growth of strength based practice. This is particularly evident in the work of institutes such as the KU Institute of Social Welfare, The Brisbane Institute of strength based practice, NIMHNAS and the TATA Institute of India. The Brisbane Institute alone lists past or present partners from the following countries: United Kingdom, South Africa, Malaysia, USA, Bosnia and

Herzegovina, India, New Zealand, Pakistan, Netherlands, Thailand, Papua New Guinea, Slovenia, Singapore, Sri Lanka, Netherlands, Canada, Germany, Poland, Israel, Austria, Nigeria, Myanmar, China, Taiwan, and Peru. The partnerships include organisations, research and teaching institutes, hosts of conferences, and recipients of training and Venkat Pulla, speaking for the institute, states that "such interactions have produced great friendships, reinforcing conversations and journeying together through strengths approach to increase coping, build hope in all societies". (http://brisbaneinstituteofstrengths.cfsites.org/). The author of this paper has been instrumental in developing an international consortium on strengths based social work practice in mental health in Nepal in 2012.

Recent literature

Leading proponents of the strength based approach have sourced and published a growing body of literature that draws on a diverse range of projects from academics and practitioners alike, thus blending evaluation with personal experience, theory with practice, and successes with inevitable problems. Gaining insight with case studies not only provides valuable insight into methods of implementing strength based practices (across diverse cultural, disciplinary, and individual contexts) but also causes the reader to become invested in the process. It is hard not to become moved and excited by the journeys depicted in these papers. (Pulla, Chenoweth, Francis, & Bakaj, 2012). In addition there is a growing body of literature published in academic journals reflecting the growth of interest in strength based practice. The importance of these evaluative publications cannot be understated as they lay the foundation for future researchers and practitioners-not only to extend research, but also to tailor programs to suit the client base, and learn from the successes (and failures) of those who have gone before. This sharing of information is one of the biggest assets to the advancement and success in the implementation of the strength based approach into everyday practice.

As living conditions decline across the globe as a result of the global financial crisis, and we continue to grapple with unknown threats in the 'risk society', areas of specific concern emerge. The number of older people requiring support is growing exponentially, while unemployment is on the increase, leading to increased risk for many young people, particularly those from low socio

economic backgrounds. It is little surprise; therefore, that research is emerging under the strength based paradigm to address these areas. In their recent article Moloney, G& Francis (2014) highlights the importance of strengths based supervision in social work education and practice. In their article titled **'**Recognising the Blind Spot': An Edge for Growth and Transformation through Strengths Based Supervision, they reiterate the relevance of this concept.

> The "blind spot" may be regarded as a paradox for strengths. However, in this article the "blind spot" specifically refers not to typical deficits of supervisees, but to supervisees' unawareness of their strengths that, given the right circumstances, can be recognised, facilitated and developed. When this awareness occurs there is transformation within the supervisee as their strengths grow and develop. So rather than conceptualising "recognising of blind spots" as a *disabling or deficit concept*, this article sees it is an *enabling strategy* that can assist in identifying strengths and skills, and in the supervision of practitioners and their interventions with clients. (p.1)

Working with the Elderly

Nelson-Becker, Chapin, and Fast (2009) have examined how strengths based practice in care of the elderly can provide individualised care based on the persons needs and 'wants'. Many older people value their independence, and as residential care homes struggle to meet demand it seems logical to identify strengths inherent in the person, the family, and community to facilitate the client to maintain their independent living—or rather, 'customary interdependent community living' at home (p. 165). Using a case study of an elderly Mexican American lady, they have demonstrated that through strength based practice they have been able to break down barriers that often prevent older adults seeking or accepting the service options available. Through the process of building rapport and trust, a connection is maintained with the social worker who can then respond appropriately as the client's health improves, or deteriorates, allowing effective and responsive long term care to an individual in their own home. They also point out the harmony between strength based social work practice, based on the original model for helping "persons with severe and persistent mental illness are living in the community", and the concept of

successful aging, or aging well. Particularly important to involve the older person in the decision making process to avoid the feeling of mature dependence which is a crucial transition in late life (Motenko & Greenberg, 1995, as cited in Nelson-Becker et al., 2009). This will be a vital skill to have as the population ages, and, as the authors suggest, not only will successful strength based practice enrich the lives of the clients and their families, there is also the prospect of minimising the cost of long term aged care, and furthermore "can immeasurably enrich ongoing social transformation as we become a society that engages the resources of older adults …" (p. 178).Ponnuswami, Francis and Udhayakumar (2012) draw attention to a paradigm shift that is turning attention to the 'elderly as a resource', and state that with support of international bodies such as the United Nations, this perspective has been written into national policies. Older people not only have an extended history of using their own strengths which can be discovered and adapted to allow the client to improve their own life circumstances, they also possess a wealth of knowledge and strengths that can be used within communities.

A new approach to the de-institutionalisation of mental health care, child and youth care, and services for frail elderly clients has emerged in the Netherlands in the form of care farms. The shift in care also embraces the notions of socialisation and normalisation and are described as recovery-orientated, empowerment-orientated, and strength based (Hassink, Elings, Zweekhorst, Van den Nieuwenhuizen, & Smit, 2010). While the authors state limitations to their research, the potential for further evaluation and research is evident and of interest to strength based practitioners with a diversity of client bases.

Working with Youth

Zimmerman (2013) considers the role of resiliency theory as strength based practice suitable for use with vulnerable youth. Although resilience has long been identified as a key factor in healthy outcomes for 'at risk' youth, its recognition under the strength based paradigm has allowed the development of a conceptual framework that can provide scaffolding for both research into, and support of, young people. Using the idea of paying specific attention to promotive factors (those which enhance resilience) self-efficacy has been identified as a key factor in promoting healthy decision making in terms of healthy eating and

physical activity (Steele, Burns, & Whitaker, 2013 in Zimmerman, 2013) and appropriate appraisal of sex risk behaviour (Shneyderman & Schwartz, 2013, in Zimmerman, 2013). While some research may have been devoted to self-efficacy as a key strength, the underlying tenets of strength based practice are not ignored, with an emphasis on identifying and utilising existing strengths at the individual, group, and community level. Family is considered a particularly salient potential resource when working with vulnerable youth (Zimmerman, 2013). Zimmerman also states that "[a]lthough many researchers study resiliency by examining single risks and promotive factors, a burgeoning area of research focuses on the cumulative effects of multiple promotive factors across ecological domains (e.g., individual, family, community) to more accurately reflect the complex nature of influences on adolescent development (2013, p. 382).Anderson & Heyne (2012) provided an ecological extension to the leisure and well being model - which they call Flourishing Through Leisure. Primarily aimed at those with chronic illness or disability. Looks at strengths to be found in environment to create fulfilling leisure activities. The environment is thought of in terms of physical, social, and spiritual domains.

Gardner and Toope (2011) examine the role strength based practice has in overcoming barriers some youth face that can cause them to be marginalised by the current teaching methods. They propose that in the educational social justice perspective there are a number of interconnecting sets of practices, the main four being: "recognizing students-in-context, critically engaging strengths and positivity, nurturing democratic relations, and enacting creative and flexible pedagogies" (p. 86). In Canada there is a drive towards social justice in education that provides "equitable and inclusive learning opportunities for all students" (p. 88). They believe their findings support the perspective that strengths based work "… includes the premise of social change" (p. 88). Lopez and Louis (2009) define strength based education as "… a philosophical stance and daily practice that shapes how an individual engages the teaching and learning process" (as cited in Gardner & Toope, 2011, p. 89). Again, as seen in other areas where there is growing interest in formalising the use of strength based practice, the idea is not new. Early approaches to education from the 18th and 19th centuries "… highlighted student talents, skills and best qualities" (Lopez & Louis, 2009 as cited in Gardner & Toope, 2011, p. 89). Gardner and

Toope (2011) recognise the utility of strength based practice not only in education under the social justice umbrella, but also to allow effective and meaningful collaboration with other agencies involved with the students, such as social workers. The authors also emphasise the importance of challenging deficit-based discourses and policies, and retaining a dynamic and flexible approach at all times in recognition of shifting contexts, strengths, and resources within the educational context and recommend more research in this area.Lietz (2011) examined the procedural and theoretical adherence to family centred practice (FCP) - in order to assess the implementation of strength based practice. By examining the integrity of programs it is hoped to better understand the variable outcomes of strength based practice in child welfare, and FCP in particular.

Working with Inmates

The field of criminal justice is infused with problem-focused language, and labelling is inherent in the field. Clark (2009) expounds on the importance of introducing more strength based practice to promote growth in individuals. Clark reminds us of the underlying premise of deterrence theory that is the justification for punishment-that is, that punishment should deter the offender, and observers, from committing crime. However, punishment has been largely ineffective in achieving these aims, and may, in many cases actually increase criminal behaviour (Clark, 2009). This, he believes, is due to the fact that punishment does not motivate offenders to change. When it comes to compliance within the criminal justice system, Clark observes that "… deference is not change. Conformity is not transformation" (Clark, 2009, p. 126). Some researchers have noted that a confrontational approach, in its existing form, inhibits outcomes, but, within a strengths perspective, while confrontation may still exist, its format is changed to a style of 'self-confrontation' that "prompts mandated clients to 'see and accept an uncomfortable reality'" (Miller & Rollnick, as cited in Clark, 2009, p. 131). While the use of a strength based perspective in the criminal justice system may seem contradictory, it has been indicated that police and juvenile correctional facilities were among the first sectors to try the approach, as long ago as the 1800s (Clark, 2009; Oesterreich & McNie Flores, 2009). In addition the juvenile justice system was to be based on strengths based practice

(as advocated by Jane Addams-an early pioneer of youth development principles), however, the early vision of the system did not come to fruition (Clark, 2009, p. 143).

Oesterreich and McNie Flores (2009) advocate strongly for art education in correctional facilities as a strengths based practice, primarily because the arts "… engage the hand, eye and brain, expressing the identity of the whole person" and "crucially they encourage a natural self-discipline and autonomy, very different from an imposed synthetic cognitive version of education currently offered" (p. 147). As a strength based practice, visual arts appeals to young men in incarceration as many are already invested in art forms to some extent (as consumer or producer) and this form of expression can allow incarcerated youth to actively engage themselves in the "5 C's—connection, community, contribution, concentration, and completion" (Oesterreich & McNie Flores, 2009, p. 147). While there is not a large body of evidence to show a decrease in recidivism, it is evident that art education can "create the spaces for them to grow and change and see new possibilities in who they are and the strengths they already possess (p. 160).

Working with Groups

While much research has assessed the effectiveness of building relationships and recognising strengths within an individual, with strengths in families and communities accessed to aid the clients recovery, there has also been evaluation of the utility of using strength based practice in group settings. The aim of group work is "mutual aid and empowerment" (Lietz, 2008, p. 75) and should therefore fit nicely under the strength based perspective, however, Lietz (2008) notes that 'curriculum-driven groups with a pre-determined purpose' (thus removing the clients' ability to be in control of desired outcomes) remain common throughout social work, partly due to time constraints (p. 75). Lietz (2008) presents a case study where a single parents group were given the power to decide upon course content (using strengths), and found greater commitment and involvement by group members, with attendance remaining high throughout the course, an unusual event in itself. Social workers also noticed a growth in self-esteem in group members as they explained how they used their strengths in single parenting, and supported other group members to do the same.

Lietz (2008) further reported on the successful application of strength based practice in an institutionalised setting, with youth in a residential setting. This is a traditionally difficult setting that is prone to producing negative experiences, with some youth also finding it difficult to identify strengths within themselves. In this case study, however, the cultural diversity of the group provided an area of pride, and knowledge, unique to each individual within the group, and as Grothaus, McAuliffe and Craigen (2012) elucidated, cultural competence can enrich strength based practice.

Working with Communities

The AusAID funded Solomon Islands NGO Partnership Agreement (SINPA) is using strength based practice in the community development sector in the Solomon Islands, and is involved in development work in more than 100 communities within the Solomon Islands. Six non-government organisations are collaborating to provide an innovative approach to the provision of aid in a way that is relevant and appropriate for the circumstances of the communities involved (Willetts, Asker, Carrard, & Winterford, 2011). The role of those involved with SINPA is to "support and empower individuals, community based organisations and communities to take personal and social responsibility and respond appropriately to their own health and livelihood needs in their own culture" (p. 2). The independent authors of this paper found that the "investment of time and resources in the application of SBA in SINPA is of significant value" (p. 5). The underlying ethos of strength based practice was described by one Honiara staff member as not being new, but a "… part of culture and the old way of how people did things" (p. 5) thus describing its resonance with the communities in question. This paper was intended as a learning paper for partners and staff involved in SINPA, but its findings and future directions are informative for all practitioners, particularly those wishing to empower recipients of aid or 'hand-outs' to avoid disempowerment that can result from external intervention.

Acknowledging Culture

Grothaus, McAuliffe and Craigen (2012) consider cultural competence to be largely absent from both counselling practice in America and literature on

strength based practice. While cultural competence may not be at the forefront of American practice, case studies from a variety of other contexts show a strong cultural bias from the inception to completion of programs. Studies with youth in Nepal (Kaufman, 2012), social work practice in the Philippines (Ealdama, 2012), and *'Kwimenya' (*or knowing oneself) as a basis for self-discovery in post-colonial Africa (Mungai, 2012) have specifically emphasised culture as a primary foundation for their view or implementation of strength based practice, and many more authors show an implicit use of culture as strength (see Pulla, Chenoweth, Francis, & Bakaj, 2012).

The role of the social worker

In their recent article Rapp and Sullivan(2014) states that " The importance of recognizing and exploiting strengths in the natural environment is vitally important to social work, and is one clear area that distinguishes this disciple from others in the helping professions"(2014,p137).A social worker's role in assisting the client is underpinned by several practice principles. These include: adopting optimism, a language of hope and seeing the environment as full of resources; according deep respect for the family's frame of reference; demystifying the professional role and elevating client to the level of an 'expert' in a collaborative alliance; highlighting the family's strengths, resources and capabilities in the face of 'challenges' to facilitate their discovery of the power within themselves; avoiding 'victim mindsets' and engaging clients motivation for change through strengths; being flexible and open to negotiation as the client priorities change; and fostering links to communities and contexts where clients "…strengths can flourish" (De Jong & Miller, 1995, p.730; Saleebey, 2009).

Conclusion

It is also important to understand and establish the context of the intervention" (Healy, 2005, p.117). The strengths perspective emphasizes the personal and community assets of a client rather than their deficits and offers possibility, promise and hope for the future. The approach is flexible and can be applied to a wide range of interventions including disability, family and child support services. Benefits of the strengths perspective include: its recognition of the power of optimism for achieving quality of life for service users; it challenges

whether the worker alone holds 'expertise' (i.e. the client is seen as the expert on their own life); it is suitable for use across a range of social work domains; and it encourages a focus on the resources to be harnessed within service user's formal and informal networks which is in contrast to the individualistic orientation of task-centred practice (Healy, 2005; Saleebey, 2009). Working from a strengths perspective a great idea, but one needs to be aware of the principles and the key skills required to engage with clients without discounting the actual problems. One of the benefits of the strengths perspective is its application across fields of practice. A lot of work has been done in this area and has also extended this perspective across diverse populations. This has been documented in the earlier works of (Saleebey,1997,2002,2006,2009). This perspective can be used by practitioners in the areas of case management, clinical practice, community practice or any developmental activities. Of course, there could be differences in the way a service is provided and administered in different contexts but the essential strengths based elements of practice remain the same.The amalgamation of strength based practice into such a diversity of contexts illuminates its usefulness as not only a paradigm, or even as a set of tools, guidelines, or a framework for best practice (although it is all these things) but in social work it has become a way of thinking and being, and is thus compatible with many pre-existing methods of intervention; its application can only enhance efficacy and improved outcomes for clients. The very concept of strength based practice as identifying individual and group strengths, and using inherent resources available within a given context means that each experience, each client, and each community will be unique and provide individual challenges, and rewards. The growing body of literature, both of an evaluative nature, and that based on experience, provides insight into what has worked (and what has not), skills and techniques that can be tried in varying contexts, and the persistence and ingenuity practitioners have brought to strengths based practice. While there is still inconsistent application of the strength based approach, recent literature will help guide ensuing practice, and the development of tools to measure adherence to the core strengths, or fidelity, of strength based programs may help inform future program successes. The reflexive nature of strength based practice is evidenced by its adaptability and effectiveness across disciplines, client bases, and cultures.

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Social Work Intervention for Effective Coping Strategies of Care Givers of Schizophrenia

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Abstract

Schizophrenia is a complex syndrome that inevitably has a devastating effect on the lives of the persons affected and on members of family. This disorder can disrupt a person's Perception, thought, speech and mood; almost every aspect of daily functioning. This disorder makes a tremendous emotional toll on everyone involved. In addition to the emotional costs, the financial drain is considerable (Barlow Durand 2000). In the last few decades, research in the field of relationship of family and Schizophrenia is intense. Initially, the family was believed to be one of the causes of development of Schizophrenia, but due to lack of proper evidences, this idea has been discarded. On the other hand, families have been looked as contingency managers of therapy and different models have been developed for family Interventions. Unlike in the west where in many cases the expensive network of professionals act as a surrogate family, in our country family remains the single most important source of the care of the patients with chronic mental illnesses (Murthy, 1999).

Key Words: *Schizophrenia, Perception, Development, Mental illness, Interventions*

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Introduction

Families need information on management and Coping skills, medications which are being used and their side effects. In understanding the reasons and implications for non compliance with the prescriptions or following through with recommended treatment will go a long way in helping the care taker.

The recent developments of the management of Schizophrenia are best understood as having followed in the wake of stress vulnerability model and of the application of preventive principles to this disorder. These concepts have lead to complementarily of psycho social and biological interventions in Schizophrenia and have completely revolutionalised our view of the families and careers of the patents as resourceful units in the community.. Social Workers provide direct services to individuals, couples, families, and groups in the form of Counseling, crisis Intervention, and therapy, as well as advocacy, coordination of resources, and case management. (Canadien Association Of Social Workers 2005). Srinivasamurty R et al (1980) in his article 'Helping Chronic Schizophrenia; their families in the community' recommended for recognition of role of non medical Mental Health professions and welfare services. Social Workers who provide case work and group work services for patients and their members of family are very important. Strengthening the families in providing the care to the ill individual would be India's contributions to the world.

Folkman and Lazarus (1980) define *Coping* as cognitive and behavioral efforts to manage specific demands that are perceived to exceed an individual's resources. According to Folkman and Lazarus's stress-Coping model, when people are confronted by a stressful situation (e.g., a loved one displaying upsetting symptomatic behaviors), they evaluate it (e.g., "This situation is hopeless and I can't deal with it"), and then the outcome of this appraisal determines their emotional and behavioral responses to it (e.g., withdrawing from their loved one, using alcohol). Stress occurs when an individual's appraisal of a situation leads them to believe that the demands of it exceed their Coping resources. According to this model, stress may be reduced when people are able to improve their Coping skills. Research on the association between Coping styles and Burden in relatives of individuals with Schizophrenia has found that

use of Coping strategies that emphasize constructive action (i.e., problem-focused techniques) tend to experience less Burden and distress (Birchwood MJ, Cochrane R. 1990, Magliano L, Veltro F, Guarneri M, Marasco C. 1995). In contrast, Coping strategies such as resignation, denial, and avoidance have been associated with higher levels of Burden Magliano L, Veltro F, Guarneri M, Marasco C. 1995, Hinrichsen GA, Lieberman JA. 1999). In addition, reduction in avoidant Coping styles of Care Givers has been found to be associated with lower levels of Burden over time (Magliano L, Fadden G, Economou M, Held T, Xavier M, Guarneri M, et al 2000) .

Relatives who reported using more maladaptive Coping strategies had higher levels of distress and less hope than those who used fewer such Coping strategies. However, neither distress nor hope were related to relatives' reported use of adaptive Coping strategies, levels of criticism or over involvement, or their attitudes of blame for the illness on their family member. Hope and distress were only modestly correlated with each other, sharing about 15% of the variance. (Michelle S. Friedman-Yakoobian ET AL 2009.)

Coping is usually divided into two main dimensions: problem-focused and emotion-focused. The former includes strategies to manage or alter the problem, the latter refers to strategies regulating emotional responses to the problem (Billings and Moos 1981; Leventhal and Nerenz 1983). It has been repeatedly reported that Coping processes are influenced by available psychological, social, cultural and practical resources (Folkman and Lazarus 1980) and should be viewed within a social context (Pearlin and Schooler 1978; Thoits 1984).

Very few studies as yet have focused on the Coping strategies adopted by relatives of patients with Schizophrenia. Given the peculiarity of this mental disorder due to its clinical characteristics, the high family involvement it entails, and the social stigma it implies, studies specifically exploring family ways of Coping with it are of particular interest. (L. Magliano á G. Fadden et al. 1997)

Researchers have found that a family with a schizophrenic member is at a risk of network contraction and condensation, and are often dissatisfied with the social support obtained (Lipton FR, Cohen CI, Fischer E, Katz SE 1981 ;. Vaughn C, Leff P. 1976.)

Strengthening the family functioning would involve the development of informal supportive networks for the families and to expand the natural social networks. The patients and their families need support and comprehensive family intervention. The supportive model of multiple family group therapy is also a possible mode of intervention. (McFarlane W, Luckens E, Link B. 1995). Care giving is a chronic stressor and different Coping methods are used to handle such a situation. The use of Coping strategies such as avoidance, denial and resignation is linked to greater Burden (Budd et al., 1998; Hinrichsen & Lieberman, 1999; Scazufca & Kulpers, 1999, Sekharan et al, 2001). Utilization of social support and a sense of mastery over the situation are associated with lower level of Burden and distress (Noh & Tumer, 1987; Postasznik & Nelson, 1984). Greater use of problem solving Coping and less use of denial is a predictor of wellbeing in family Care Givers (Rammohan et al 2002).

Methodology

The aim of the study was to find out impact of Social Work Intervention on Coping strategies of Care Givers of persons with Schizophrenia

The study was quasi experimental in nature. Purposive sampling method was used to select seventy care givers of schizophrenia persons stayed with their relative who were admitted in hospital during November 2009 and April 2010. They were assessed for coping before and after social work intervention. Sample was drawn considering the following inclusion and exclusion criteria 1. Caregivers of Schizophrenia persons between the age of 15 to 60 , of any religion, caste, and economic background, who stayed with patient during admission to Manasa hospital (a private psychiatric hospital) were included. 2.Caregiver having found possible case of psychiatry,/ below the age of 15/above the age of 60 /not staying with the patient in hospital were excluded. The coping of caregivers was assessed before and after socialwork intervention.

Tools consisted of

1. A data sheet for recording demographic and selected variables of patient and caregiver,
2. Family Crisis Oriented Personal Evaluation Scales :

In the present research, Family Crisis Oriented Personal Evaluation Scales (F-COPEs)is also utilized in order to understand the Care Giver's behaviour to cope up with their stressful hardships. This instrument is also intended to substantiate the main objective of the study of exploring the Coping patterns among the Care Givers of persons with Schizophrenia . This instrument is developed by McCubbin, Olson, and Larsen (1981). According to them, this tool is created to identify problem -solving and behavioural strategies that families in difficult situations use. This instrument has its theoretical basis in the ABCX model of family in crisis. Consisting of thirty items, this tool focuses on family's behaviour at two levels: the internal level of handling difficulties among its members and the external level at which the family handles its difficulties in relation to its social environment. The alpha reliability (Cronbach's alpha) is computed for the entire scale. The overall alpha reliability for the first sample was 0.86, and for the second sample it was 0.87. The validity of the instrument was fairly impressive.

The instrument consists of 30 items with five response categories for rating each item. The response categories are 'strongly agree', 'moderately agree', 'neither agree nor disagree', 'moderately disagree', and 'strongly disagree' which are rated 1, 2,3, 4, and 5 respectively while reversing the scores for passivity items. Though a sum score can be obtained for the total scale, separate scores can also be obtained for each sub-scale by summing up the constituent.

3. Check list for evaluation of Social Work Intervention:

This check list contains 20 items. It helps to evaluate different methods of Social Work Intervention for the family members of schizophrenic. The planned Social Work Interventions are follows :–

Sl.No.	Method	Goal
1.	Case History	Psychosocial Diagnosis
2.	Counseling,	Catharsis, Empathy, Insight–focusing, problem solving, improve communication
3.	Group Work	Awareness, myths and misconceptions, sharing

4.	Home Visit / Visit to Work Place	Family/occupational adjustment
5.	Referrals and other extended services	Rehabilitation

After assessment social work intervention was applied. It was planned package based on social work intervention developed by Mathew Verghese, Anisha Shaw, G.S. Udaya Kumar, T. Murali, Isabel M. Paul in the manual on Family Intervention for Mental Health Professional in 2002 (NIMHANS).

Intervention package covered in minimum of 8 sessions to maximum of 12 included the following.

1. Two sessions for collecting information, building rapport, explaining about the study, and assessment.
2. One session was used to give brief psycho education.
3. Two sessions were used for counseling to allow individual to ventilate emotions, explore problems, etc.
4. Two sessions of group therapy.5.One session of counseling considering special needs in solving problem, improve communication, etc
6. Homevisit,Work place visit, marital counseling/,family counseling, referrals etc as per the need of the caregiver or patient.

Coping was assessed after intervention again after 3 months of their 1st admission...

Results

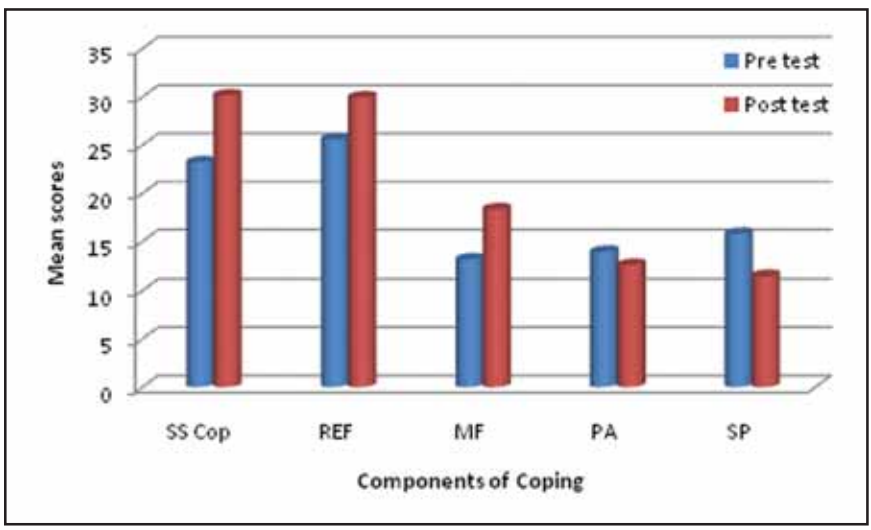
Table 1. **Distribution of the Care Giver sample by no. of years with Schizophrenic Person, type of family, domicile and previous treatment of the Person With Schizophrenia.**

Variable	Sub variable		Gender		Total
			Male	Female	
No of years with	<1 yr	Frequency	1	2	3
		%	2.3%	7.4%	4.3%

Schizophrenia Person	1-2 yrs	Frequency	1	0	1
		%	2.3%	.0%	1.4%
	2-4 yrs	Frequency	2	0	2
		%	4.7%	.0%	2.9%
	>4 yrs	Frequency	8	4	12
		%	18.6%	14.8%	17.1%
Type of family	since beginning	Frequency	31	21	52
		%	72.1%	77.8%	74.3%
	Nuclear	Frequency	36	24	60
		%	83.7%	88.9%	85.7%
	Joint	Frequency	2	0	2
		%	4.7%	.0%	2.9%
Domicile	Extended	Frequency	5	3	8
		%	11.6%	11.1%	11.4%
	Urban	Frequency	8	9	17
		%	18.6%	33.3%	24.3%
	Rural	Frequency	24	8	32
		%	55.8%	29.6%	45.7%
	Semi Urban	Frequency	11	10	21
			25.6%	37.0%	30.0%
Previous treatment of the person with Schizophrenia	Yes	Frequency	20	20	40
		%	54.1%	60.6%	57.1%
	No	Frequency	17	13	30
		%	45.9%	39.4%	42.9%

The above Table show that the majority of the Care Givers are above 41 years of age and majority of them are parents of the Persons with Schizophrenia. This has significant observation compared to the average age of the patients. Majority of the Care Givers try getting their relative treated, being with them from the beginning of the disorder. Thus the disorder results in enormous social and psychological anguish to the patient as well as to the Care Giver. . Majority of the Care Givers indicate that 57.1% of the patients have undergone previous treatment compared to 42.9% of them who have not undergone treatment. As majority of the Care Givers are parents most of them also live with the affected person since the beginning .This mainly shows that majority of the Care Givers are aware of the premorbid status of the affected person , the onset and development of the disorder and its chronicity. Thus there is more chance that most of them are also exposed to the challenges of care giving for longer period of time.

Diagram 1. Coping of Care Givers:



Mean pre and post test scores on various components of Coping of Care Givers

Table No. 2 Mean pre and post test scores on various components of Coping of Care Givers and results of paired samples t test

Variable	Session	Mean	S.D	Mean difference	t Value	P Value
Social support Coping	Pre test	23.21	8.163	6.95	7.848	.000
	Post test	30.16	3.425			
Refraining	Pre test	25.57	5.361	4.37	1.37	.000
	Post test	29.94	3.353			
Mobilizing Family	Pre test	13.13	3.336	5.20	13.151	.000
	Post test	18.33	1.657			
Personal Appraisal	Pre test	13.93	2.742	1.37	3.361	.001
	Post test	12.56	1.9383			
Spiritual support	Pre test	15.79	2.419	4.35	11.234	.000
	Post test	11.44	2.641			

In the pre test the selected sample had a mean social support Coping score of 23.21, which has been increased to 30.16 scores in the post test session. The increase in social support Coping was approximately by 7 units was found to be statistically significant. Paired sample t test revealed a significant difference between pre and post social support Coping scores with t value of 7.848 and significance level of .000.

Scores of Coping on refraining show that in the pretest, the sample had mean score of 25.7, and it had been increased to mean score of 29.94 in the post test session. The increase with approximate 4 units showed statistical significance with t value of 1.37 (P=.000).

The pre test selected sample showed a mean of 13.13 using mobilizing family Coping strategy, which has been increased to 18.33 in post test session. Thus,

the difference in increase was approximately 5 units. Paired sample t test revealed a significant difference between pre and post test mobilizing family Coping scores with t value of 13.151 and significance level of .000. This proves that the intervention given to Care Givers of persons with Schizophrenia helped in strengthening the Coping strategies of social support, mobilizing family and refraining.

Scores of personal appraisal Coping strategy showed that in the pretest sample had mean score of 13.93 which has been decreased to 12.56 in the post test session. Thus, difference in decrease was approximately one unit. Paired sample t test revealed a t value of 3.361 and significance level of .001.

The pre test selected sample showed a mean of 15.79 in spiritual support Coping pattern which has been decreased to 11.234. This difference with approximate 4 units showed statistical significance. Paired sample t test showed t value of 11.234 with significance level of.000. This proves that the intervention given to Care Givers has helped in altering the maladaptive Coping strategies like personal appraisal and faulty spiritual support. This difference in usage of different Coping strategies of Care Givers can be attributed to effective Social Work intervention by the researcher.

Thus the study proved effectiveness of Social Work intervention in strengthening appropriate Coping strategies of Care Givers of Schizophrenia persons.

Table 3. Mean scores on various components of Coping (Post-pre) of Care Givers by their age and results of One-way ANOVA

Variables	Age	N	Mean	S.D	F Value	P Value
Social support Coping	14-20	1	-12.00	.	5.505	.001
	21-27	7	4.86	4.45		
	28-34	13	4.46	6.60		
	35-41	13	3.54	8.27		
	41+	36	10.00	6.23		
	Total	70	6.94	7.40		

Refraining	14-20	1	-9.00	.	2.863	.030
	21-27	7	2.14	5.01		
	28-34	13	6.38	4.72		
	35-41	13	4.31	5.22		
	41+	36	4.47	4.69		
	Total	70	4.37	5.08		
Mobilizing Family	14-20	1	4.00	.	.339	.851
	21-27	7	5.57	2.64		
	28-34	13	4.31	4.77		
	35-41	13	5.23	3.49		
	41+	36	5.47	2.82		
	Total	70	5.20	3.31		
Personal Appraisal	14-20	1	3.00	.	.681	.607
	21-27	7	-0.43	2.99		
	28-34	13	1.92	2.99		
	35-41	13	1.85	3.24		
	41+	36	1.31	3.72		
	Total	70	1.37	3.41		
Spiritual Support	14-20	1	5.00	.	.477	.753
	21-27	7	4.86	3.80		
	28-34	13	4.15	2.76		
	35-41	13	5.31	2.72		
	41+	36	3.94	3.52		
	Total	70	4.34	3.23		

The highest change in the mean score of social support Coping is 10 among Care Givers who are above 41 years of age. The least change mean score is 3.54 which is found among Care Givers who are 35.41 years of age. In refraining the highest change in mean scores is 6.38 among the Care Givers who are 28-34 years of age. The least mean score is -9 among those Care Givers who are between 14-20 years of age. There was a significant influence of the age of Care Givers on change in specific Coping strategies like social support Coping and refraining where the F values showed significant differences. In the case of social support Coping F value of 5.505 (P = .001), it is found that those who were in the age group of above 41 years had high change in scores and those with 14-20 ages had least changes in scores. In the case of refraining, F value of 2.863 (P = 030), itbcan be seen that those who were in the age group of above 41 years had high change in scores and those with 28-34 ages had least changes in scores.

However in rest of the components F value of .339 (P = .851) for mobilizing family, F value of .681 (P = .607) for personal appraisal and F value of .477 (P = .753) for spiritual support Coping, no significant differences were observed for respondents in different age groups. In other words, the change in social support Coping is more among the Care Givers who belong to above 41 years of age group. In the same manner, the change in refraining is also more among the same group of Care Givers. The change in other Coping strategies is similar among Care Givers of different age group.

Discussion

Mental illnesses are widely prevalent all over the world and in India it is certainly not less than western countries. According to World Health Organisation (WHO 2001) in any country, including India, 1 to 2 percent of the general population suffers from severe mental illness like Schizophrenia. The Care Givers of Persons With Schizophrenia are exposed to high levels of Burden and distress. Psychiatric Social Workers render psycho social care and other services to the Persons With Scizophrenia and their families. Psychiatric Social Worker can teach family members of Schizophrenia the skills that will help them to become more effective care takers and cope more effectively with

the bizarre behavior of the ill family member. Psychiatric Social Workers can provide support for Persons With Scizophrenia' family members, teaching them skills for Coping with stress and for expanding their social network. Social Work Intervention is effective in addressing the Mental Health concerns of the Care Givers.

R Chandrashekaran et al (2002) in his study stated that though relatives used various Coping strategies, it is evident that resignation, which is basically an emotional reaction to the situation, has been employed more often than other strategies. It is also evident that the majority of relatives failed to maintain social contact. This is expected to have a significant influence on the well being of the individual. Most of the relatives did not attempt to use problem solving strategies. In contrast, Scazufca & Kuipers (1999) who reported that relatives used more problem focused strategies. Cultural beliefs may also play a significant role in shaping Coping strategies. An average Indian assumes a more fatalistic attitude towards life and future and accepts suffering with a sense of resignation (Verma 1982). Emotion focused strategy when employed are usually ineffective. This can increase the Burden on the family and the risk of high expressed emotions among the family members (Magliano et al 1999).

However the study shows that the Social Support Coping is used more by the Care Givers after intervention. The mean difference of 6.95 between post test and pre test showed significant variation. In the same way, Refraining is strengthened after intervention and the mean difference of 4.37 between post and pre test is significant. Mobilizing family as a Coping pattern is used more by Care Givers after intervention compared to before intervention. The mean difference is significant. The Personal Appraisal which is expected to be reduced after intervention had been reduced significantly. In the same way the study shows that the usage of spiritual support Coping which is high before pre test reduced significantly after intervention. Thus, the study proves that the Social Work Intervention has an effective impact in strengthening the effective Coping patterns among Care Givers of persons with Schizophrenia.

Mean Social Work Intervention scores of the Care Givers are 14.73 out of maximum of 20 scores. The study has effectively utilized Social Work Intervention than the expectation otherwise.

Families of people who have a mental illness are frequently confronted with the need to deal with problems requiring practical Coping skills. Yet many families report not knowing how to deal effectively with commonly reoccurring problems. On the whole it is found that the Social Work Intervention is effective in enhancing Perception, dealing Burden and strengthening Coping of Care Givers of Persons With Schizophrenia .

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Criminal Justice System in India: A Case for Social Work Intervention

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Abstract

Criminal Justice has encountered numerous challenges in the reformation of persons in conflict with law. In general, legislative majorities, rarely appreciate this priority. Criminal Justice Institutions (CJIs) also suffer from the bane further down the Criminal Justice System (CJS). In India, almost two-thirds of the detainees are 'under-trials' causing overcrowding, exacerbating prevailing conditions, clogging the system and demoralising those with the duty of running the prisons as well as reformation. The present paper is a concept paper compiled based on primary data generated from interviews with personnel working in criminal justice institutions (CJIs) as well as secondary data. It looks at the evolution of Criminology as a subject, traces the history of Criminal Justice Social Work, assesses the existing conditions as suggested by the NCRB, examines critically the existing practices and the gaps within, and finally comes up with recommendations to handle the complex problems and the impasse prevailing in the Criminal Justice System and Institutions in the Indian context. This purportedly provokes thinking on creating a niche for social work practice within the Criminal Justice System in India.

Key Words: *Criminal Justice, Conflict with Law, Criminology, Social Work*

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Introduction

The Criminal Justice System and Institutions have always thrown compelling challenges for reformation of persons in conflict with law. This is complicated with public opinion and legislative majorities, ignorant or slow to appreciate this priority, seeing the diversion of funds as better spent elsewhere. However, the problems facing our prisons seem especially great. While retributive punishment as a penal philosophy has been replaced with ideas of rehabilitationand welfare elsewhere, the custodial approach of our prison system hascontinuedand fed to the current system's obscurity.

Criminal Justice Institutions (CJIs) also suffer from the bane further down the CriminalJustice System (CJS). In the context of India, many detentions by the police are entirely unnecessary, and, further, delays in theprocessing of 'under-trials' create problems of overcrowding,only exacerbating the alreadydire prevailing conditions. Such systems and structures, demoralize those who have the duty of running the prisons, looking after the prisoners as well as their reformation. True, prison reform cannot be discussed and handled successfully in isolation of the system. Neither can this be taken as an excuse for notattending to systemic issues simmering for decades. A start has to be made somewhere; criticism of a prisonservice in which criminal justice, police and welfare policy ills all surface is not enough. The present paper is a concept paper compiled based on primary data generated from interviews with personnel working in criminal justice institutions (CJIs) as well as gleaned from secondary data sources.

The paper attempts to brief the reader with an inclination towards social work in criminal justice institutions (CJIs). The paper addresses the individual and the victim as 'she' endorsing the need to consider the special needs of victims being treated by a system that is designed and administered from the patriarchal psyche. Hence,this paper endeavours to sensitise the reader regarding the basic concept of 'crime', 'criminology' as a subject, trace the history of criminology, take a brief look at the criminal justice system in India, examine thesystemic constraints, highlights the gaps in services, and finally, recommends on areas for social work intervention with in the criminal justice system (CJS).

Crime: Concept

Crime**,** in common parlance, denotes 'an unlawful act harmful to an individual, a community or State' 'forbidden and punishable by the state' (Martin, 2003; OUP, 2009). The universality of morality is deemed base on the assumption that to be classified as a crime, the act of doing something bad (*actusreus*) must be usually accompanied by the intention to do something bad (*mensrea*).Although, the idea that commission of acts such as murder, rape, riot and theft, are prohibited universally on grounds of morality, crimes receive differential treatment, depending on how a criminal offence is defined by criminal law statutes of each country (Easton, 2010) and is redressed by way of a civil procedure based on the ethos of each country.

Based on this very logic of civilisation, crime has been perceived, over the centuries in varying shades of grey, ranging from being 'evil' and of 'evil origin' (as in Original Sin), that requires to be punished and extinguished; next as a deviance that needs to be corrected, by way of deterrence or psychological treatment; and much more recently, as a state precipitated on account of an interplay of a multiplicity of factors – psychological, sociopolitical, cultural, economic, and therefore requiring holistic and multidisciplinary treatment. The schools of thoughts too, have correspondingly undergone transition. Even in India the western thought and understanding has continued to influence the criminal justice systems and the institutions.

History of Crime

Christianity, that has shaped the thought, has regard sin as a crime; one may recall the mythological tale of Adam and Eve that germinates the theory of original sin. With the emergence of kingdoms and theocracies in the course of civilization, and a growing awareness of 'freedom of thought' and 'civil liberties', codes were designed presuming that crime may ignite war or conflict (Oppenheim, 1977). The first attempt was by the Sumerians who 'resented any encroachment by the King or an equal' (Kramer, 1971), followed by the Mesopotamians through the Code of Hamurabi and the Romans in their law concerning dominion (*pater familias*) – property and slaves. The Law Code of Manu (*manudharmasashtra),* perhaps as old as Christianity, deals with the relationships between social and ethnic groups,

men and women, the organization of the state and the judicial system, and all aspects of the law (Olivelle , 2010).

The comprehensive understanding of the complex social processes and modern sociological during the 19th century, induced fresh views on crime and criminality, thereby fostering the beginnings of criminology as a study of 'crime in society'. Nietzsche's assertion in "The Birth of Tragedy," linking crime and creativity, as well as Michel Foucault's 20th century classic "Discipline and Punish', were significant.

Dominant Schools of Thought

In the mid-18th century, criminology arose as social philosophers gave thought to crime and concepts of law. There were three main schools of thought - Classical, Positive, and Chicago - in criminological theory spanning the mid-18th century to the mid-twentieth century.

The Classical School originating in the 1750s was based on utilitarian philosophy and evolved with prisons developed as a form of punishment. Cesare Beccaria, author of *On Crimes and Punishments* (1763–64), Jeremy Bentham, and other classical school philosophers argued on human beings although 'hedonistic,' 'rationalistic' and capable of weighing the consequences of his act and also having a "free will" to choose how to act. Punishment therefore was perceived to 'deter people from crime', (Beccaria, 1764).

The Positivist School presumes that criminal behaviour is influenced by internal and external factors outside of the individual's control. Thus, scientific method was introduced and applied to study human behavior. Positivism can be broken up into three segments - biological, psychological and social positivism (David, 1972).

Cesare Lombroso an Italian Sociologist of the late 19th century suggested that physiological traits (as in phrenology) were indicative of criminal tendencies, (McLennan et al, 1980). Enrico Ferri, his disciple, believed that social as well as biological factors played a role, and held the view that criminals should not be held responsible when factors causing their criminality were beyond their control. Quetelet found that age, gender, poverty, education, and alcohol consumption were important factors related to crime (Beirne, 1987); Rawson suggested a link

between population density and crime rates, suggesting urbanisation creating an environment conducive for crime(Hayward, 2004); Émile Durkheim viewed crime as a consequence of uneven distribution of wealth and other differences among people.

The differential association (subculture) approach assumes that criminal subcultures that exist, force individuals to learn associatively to commit crime and crime rates may increase in those specific locations (Cullen & Agnew, 2002). The Chicago School popular in the 1920s, adopted a social ecology approach, postulating that urban neighborhoods with high levels of poverty experience breakdown in the social structure and institutions - family and schools, resulting in social disorganization, severely incapacitating the ability of these institutions to control behaviour and creates an environment ripe for deviant behaviour. Similar schools of thought were the social ecologists - who found that crime rates are associated with poverty, disorder, high numbers of abandoned buildings, and other signs of community deterioration (Bursik Jr., Robert J., 1988; Morenoff et al, 2001). This is a force that recriminalizes victims forcing them to evolve hard-core criminals; the same becomes a vicious cycle for families of criminals who are stigmatized by the general public.

Crime Statistics in India

The Code of Criminal Procedure (CrPC) of India classifies offences into two broad headings:

- Cognizable Offences - those for which a police officer can arrest a suspect without a court warrant
- Non-cognizable Offences - those for which a police officer cannot arrest a suspect without a court warrant

NCRB (2012) data seems to project 6.04 million cognizable crimes, with 2.38 million being crime under the Indian Penal Code (IPC), while 3.65 million has been reported under the category Special and Local Laws (SLL). The NCRB claims of a much more healthier picture with a reduction of an overall 3.4% over 2011. This is however, in any way a great consolation, if one went by the statistics five years ago, in 2007, when it was 5.63 million. The share of violent crimes in

total IPC crimes during 2012 was 11.5% as against 11.0% in 2011. The highest rate of violent crimes was reported from Assam (54.2) followed by Manipur (44.6), Kerala (42.7) and Delhi (34.7) as compared to 22.7 on an All-India average. Uttar Pradesh (33,824) reported the highest incidence of violent crimes accounting for 12.3% of total violent crimes in the country (2,75,165). Another menacing indicator of mental health is the indicator on 'violence against women'; the proportion of IPC crimes committed against women under total IPC crimes increased during last 5 years from 8.9% in the year 2008 to 9.4% during the year 2012. Andhra Pradesh has reported 40.5% (3,714) of Insult to the modesty of Women cases. Similarly, cases under Immoral Traffic (Prevention) Act increased by 5.2%. Human trafficking incidence was observed to increase by 1.1% between 2011 and 2012. Still far more disparaging is the crime against the tender-aged; a 15.3% increase in incidence of crime against children was reported in 2012 over 2011. All the more an indicator of criminalization is the involvement of children; the number of Juveniles in conflict with law under both IPC and SLL has increased by 11.2% and 42.3% respectively, during the year 2012 over 2011. The percentage of Juveniles apprehended under IPC was 66.6% in the age group of 16-18 years during 2012.

High-tech crimes too, abound. The incidence of Cyber Crimes (IT Act and IPC Sections together) has increased by 57.1% in 2012 as compared to 2011. Cyber Fraud accounted for 46.9%, while Cyber Forgery accounted for 43.1% (259 out of total 601) under IPC category for Cyber Crimes. For every one hour, 273 cases of rape were being reported in country, with 373 persons being arrested under different IPC sections in the year 2012. In other words, crime rate may have declined by a minor point, but it increasingly shows increase of violence against women and children, with man being the 'perpetrator.' It becomes important in understanding the dynamics and anticipate prevention strategies; here comes the relevance of criminology.

Criminal Justice Social Work in India

The induction of social work into the criminal justice system was a development that happened much later. In the 1930s, Dr Clifford Manshardt, a young American missionary, carried out a number of non-religious activities for the benefit of children and adults in Nagpada, a densely populated lower-class area in the heart of Mumbai,

through an institution called 'Neighbourhood House'. Manshardt, later held six-week courses for bright young people interested in social work in 1936, as the Sir Dorabji Tata Graduate School of Social Work which became the Tata Institute of Social Sciences (TISS) in the 1940s, and moved to in Deonar in the 1950s. In 1953, a separate Department of Criminology and Correctional Administration (CCA) was created, endorsing full recognition to the professional training requirements in this field. The department became TISS's Centre for Criminology and Justice, in 2006. Till the 1970s, most students of the CCA were candidates deputed from departments of 'prisons', 'social welfare,' as well as 'women and child development' across the country.

TISS undertook a first-ever scoping study assisted by Commonwealth Human Rights Initiative (CHRI) of all such NGOs involved in criminal justice interventions; the study identified seven distinct areas in which the social work efforts could be focused:

- moral or spiritual guidance/instruction, such as conducting spiritual discourses, individual preaching, and counseling
- welfare of children of prisoners with regard to their shelter, health and education
- rehabilitation activities for women and youth
- health-related activities such as conducting health camps and health check-ups
- education of inmates, conducting literacy classes, coaching classes for Open University courses, and vocational training.
- legal guidance, referral services and legal aid
- generic support to prisoners such as organising lectures, celebrating festivals and attempting one-time activities

This was TISS investment in at influencing State policy to bring in reforms in CJI projects. TISS's intervetnions have inspired many other initiatives – Prayas (Mumbai), Sudhaar (Bhopal), Varhad (Amravati), Sahyadri (Solapur), Sahyog (Pune), etc.

Criminal Justice system in India: The Police Story

India inherited its criminal justice system from the British, under whose jurisdiction India was as a British Colony. For an academic discussion it is important to examine the underpinings of the Criminal Justice system from the historical point of view. The "Police Story" predates the evolution of the "police" as a permanent occupational group within a bureaucratic institution, providing the State a capability to respond to crime and disorder. This, development during the 19thcentury was a measured response to crime wave that swept Europe following the rapid social change and rapid urbanization that occurred post-industrial revolution. Prior to 1800, governments maintained order by a variety of means - local and national. One of the key historical debates concerns the effectiveness of these approaches and the degree of continuity between the pre-modern and modern police models. Around 1800 a small number of distinctively different types of police institution emerged. The French, under Napoleon, instituted the Gendarmerie, a state military police model, which evolved from the "Marechaussee," which had had a dual military and civil function, since the 16th century. This model was exported across Europe by Napoleon. The British set up the Royal Irish Constabulary to answer similar challenges to the Gendarmerie in France; this was close to the state military model, but distinctively styled as part of the civil power of the state and subordinated to the Magistracy (Neyroud, 2011). The Irish model was subsequently exported to Britain's colonies and turns out to be the basis of forces such as the Indian Police Service. The Metropolitan Police was consciously created as a local force with a uniform that was deliberately different from the military, and with a mission that focused on prevention of crime rather than the repression of disorder. This eventually evolved as the executive that had to enforce the judiciary's decisions, but distinctly outside the ambit of the Judiciary (Magistracy, in the context of British) (Neyroud, 2011) . Therein lays the inherent strength as well as the weakness of the Indian Criminal Justice system. The fact that the enforcement is outside the judiciary, makes it operate as watchdogs evaluating each other's actions and their outcomes.

The Indian Criminal Justice System and Systemic Problems

The Indian criminal justice system may be understood from two angles – one, from the dimension of being an entity with a legal structure; the second from the point of view of functionality.

From the legal structural point, the Indian criminal justice system is said to be governed overall by four laws:

(i) The Constitution of India

(ii) The Indian Penal Code

(iii) The Code of Criminal Procedure of India

(iv) The Indian Evidence Act

The legislative power is vested with the Union Parliament and the state legislatures and the law-makingfunctions are divided into the Union List, the State List and the Concurrent List, as mentioned in the Indian Constitution. TheUnion Parliament alone can make laws in domains mentioned under the Union list, the State legislatures alone can make lawsunder the State list, whereas both the Parliament and the State Legislatures are empowered to make lawson the subjects as per the Concurrent List.

The Constitution of India guarantees certain fundamental rights to all citizens. Under the Constitution,criminal jurisdiction belongs concurrently to the central government and the governments of all the states.

At the national level, two major criminal codes, the Indian Penal Code, 1861 and the Code of CriminalProcedure, 1973, deal with all substantive crimes and their punishments, and the criminal procedureto be followed by the criminal justice agencies, vis-à-vis the police, prosecution and judiciary duringthe process of investigation, prosecution and trial of an offence. These two criminal laws applicable throughout India, takea precedence over any state legislation. All major offences are defined in the Indian Penal Code apply to resident foreigners and citizens alike. Besides the Indian Penal Code, manyspecial laws have also been enacted to tackle new crimes.

For functional purposes the Indian criminal justice system has four subsystems:

(i) the Legislature - the Union Parliament and State Legislatures

(ii) Law enforcement - Police

(iii) Adjudication - Courts

(iv) Corrections - adult and juvenile correctional institutions, probation and other non-institutionaltreatment

Functionally, the legal system in India is adversarial. It is worth examining these in terms of their operations.

In the wake of a crime, the law enforcement is bound to act along two dimensions. First, it has upon itself the responsibility of using the power within its means to prevent the crime from happening in future (preventive role); secondly, in the event of a crime being committed it takes upon itself the responsibility of investigating a case with the purpose of gathering forensic evidence (investigative role). In its preventive role, the Executive has to initiate plans and strategies to prevention of crime in a local area, by way of organising the 'beats' teams. It within the constraints of inadequate police personnel that many States in India have attempted to introduce the progressive 'community policing'. In its second role, following a crime being committed, an investigation ensues, and the personprima facie accused ofa crime is remanded into Police custody for a period not exceeding14 days. During this period, in practice the Police,in order to piece together information regarding the crime, takes the "accused" on a hasty visit to the site and the path leading to the crime. But, one must understand that in the present way of operating the system, hardly any time is spent on gatheringthe 'vital' background history of the person, situation and dynamics behind the crime leading to its commission. Neither is there any attempt to consider of its impact on the "accused," her family, and the people around. Here functionally, and in the Indian context, the investigating officer goes overboard to obtain incriminating evidence that would implicate the accused, who is portrayed as an'antagonist'.

Interviews undertaken with police personnel shows that the Indian criminal justice system has discounted the importance of accommodating educated and competent. The subject observed that it would be ideal if both the remand and investigation be handled by a person above the rank of Sub-Inspector of Police, and preferably a woman. In India, especially with political crimes being a common occurrence, there has been an outcry for wresting investigations from the local Police force, and assigning it to the Central Bureau of Investigation (CBI), which is perceived to be a Central agency and outside the ambit of the state. For the same reasons, Judicial Enquiries are increasingly being demanded for. Hence, it would

beappropriate to dichotomise, and consider establishing a separate Investigative Agency on lines of the Scotland Yard, which would beoutside the purview of the Police force that is involved in enforcement. It would be the best space for engaging social work especially in recording the case history and circumstances that contribute to the sequence of events.

The second dimension of the Criminal Justice System is the Judiciary. This institution as per the Constitution has the onerous duty to examine and merit each case presented,on the basis of the evidence gathered by the Enforcement. Often, this is where perhaps the first time, the 'accused' gets to see for the first time the evidence against them; this is often concocted and stilted to the advantage of the plaintiff, and more than often in a language that either the plaintiff nor the 'accused' understands. Especially, if from disadvantaged background, this only infuriates the accused and extinguishes whatever confidence she has left with the Judiciary. It is not surprising that she responds in a manner disproportionate and by default forces the adjudicating Judge on account of the same for a conviction. The trail that ensues largely is perceived to follow a 'script' prefabricated. This is much more than what a victim can tolerate; for a rape victim male or female, the individual is taken through the same line of questioning many times over with little regard for their suffering. Often the plaintiff's representative presents and highlights the past history of the accused in a manner creating a precedence of conviction. There are numerous instances cited in the context of Article 376 following the Nirbhaya Case and the high profile harassment in connection with Tehelka'sTarunTejpal issue, where either party is portrayed having a history of promiscuity and provocative behaviour. This, if often reported to the public either by design or a 'slip of the tongue' with the intention of twisting the case. Often the trail enrages the accused, and there are instances where the person is forced to take revenge thereby committing a crime that becomes incriminating, and thereby living up to the self-fulfilling prophecy. This is where once again as cited in the earlier case where a social worker or criminologist could play a significant role.

The author and the experts and criminologists seem to suggest a new avenue for criminology and social work. Here the latter may play the Devil's Advocate to bringing in counter evidence and explanation as in the case of Judicial Enquiry. The Social Worker may compare reports from the Executive, educate the same to

the 'accused,' andbased on informed decision-making, recommend corrections or modification to the same. Beyond this, the Social Worker/ Criminologist may argue for a sentencethat commensurate with the magnitude of the crime and the intent (which becomes the prime pivot of determining a crime. This becomes a significant input into moderating the conviction which is generally weighed on the merit of the evidences presented.

The third dimension in the functional sphere is the correctional setting.Here the social worker many be engaged as a case manager. Post-conviction, as a practice, the 'accused' is handed over to the Police, who 'bundles up' the person convicted, and lodges him in a prison, which is administered and monitored by the Police. Ideally, there must be some sort of a parallel agency to send and receive the person into the correctional setting. The social worker must prepare, induct and orient the new entrant to the realities of the correctional setting whether it be the Prison or Juvenile setting. Subsequently, the social worker has to design a plan for programmatic intervention. Eventually, as the treatment progresses and depending on the assessment regarding the extent of reformation, the social worker may allow the person to go on parole. The social worker may also provide the family a feedback and also allow the convicted to visit their families on parole. In the case of probation, the necessary follow-up be undertaken by way of the social worker who is managing the case.

Reviewing the present functioning of the prison system based on the response of the stakeholders of the prison system, the author is left to conclude that there is much to be covered to ensure certain minimum standards of reformation service. There is a compulsion to establish a separate Prison Department, which has qualified personnel, trained in criminology and social work and having an inclination to work towards the reformation of the convicted. But unfortunately, at the this point in time there is no specific systemnor any training program for the enforcers who form the part of the correctional setting. Another, dilemma awaits those educated and motivated to enter into prison services. They come into the service with genuine intention and a clear motivation to serve and reform the inmates. However, unfortunately, they are 'systematically'demoralisedby the existing system, which is structured and administered by seniors who have been weaned on traditions and knowhow based on experience, and perhaps even too numbed to be sensitive.

Thesenew entrants are forced to undertake the 'job,' and do nothing further, forget alone innovate. This creates a sense of futility among the motivated new entrants. There are very rare cases, as in the historical case KiranBedi IPS (Tihar fame) or Alexander Jacob IPS (former IG Prisons, Kerala), whose zeal and dogged persistence won the hearts of the convicted and aided their reformation, and in the process beating the 'tried and tested' system.

The Acts: An Eye for Victims

There are numerous acts that are oriented on criminal justice and rehabilitation. Starting with the Borstal School Act of 1929, providing treatment to young offenders in a range of vocational courses - carpentry, wiremanship, and a host of other vocations, graduating into the Probation of Offenders Act, 1958 permitting release on probation (on admonition or on probation of good conductof offenders below 21 years , there have been innumerable enactments that have echoed concerns for the victim. Digressing from the earliest, this article examines only some enactments passed by the Parliament of recent origin designed to prevent victimization and provide relief to victims (Chockalingam, 2008):

A. The Protection of Women from Domestic Violence Act, 2005

The legislation provides for more effective protection to women from domestic violence and is wide enough to include physical, sexual, verbal and emotional abuse. Unique to the Act is the prohibition of denial to the victim "continued access to resources or facilitieswhich the aggrieved person (victim) is entitled to use or enjoy by virtue of the domestic relationship, including access to the shared household". Any violation of the protection order by the respondent invites an imprisonment for one year or a fine up to Rs.20,000 or both. The designated ProtectionOfficer who refuses to discharge his duties, is bound by the same penalty.

B. *The Maintenance and Welfare of Parents and Senior Citizens Act, 2007*

This is also an innovative law aiming to protect elders and prevent elder abuse and victimization, a growing problem in many countries, including India, hit by demographic aging. This law obligates children or adult legal heirs to maintain their parents, or senior citizens above the age of 60 years, who are unable tomaintain themselves out of their own earnings, in a manner to lead a normal life. In the

event of any neglect or refusal to maintain the senior citizen, the Tribunal can pass an order binding the children or legalheirs to make a monthly allowance for their maintenance.

C. *Prevention of Child Abuse and Victim Protection*

Empowering the child by the tool of eaduction is the road to prevention from abuse and victimization. Primary education for children has been made a fundamental right as perthe decision of the Supreme Court of India in Unnikrishnan 's Case (1993). The proposal also will have a positive impact oneradication of child labour. Following up on this a National Commission for Protection of Child Rights (NCPCR) was set up in March 2007 and its mandate is to ensure that all Laws, Policies,Programmes, and Administrative Mechanisms are in consonance with the Child Rights asenshrined in the Constitution of India and also the UNCHR that India ratified in 1992.

D. *Protection of Children from Sexual Offences Act, 2012*

This Act was passed in the Indian Parliament in May 2012 provides protection of any child (a person below the age-group of 18 and is gender neutral, and clearly defines all types of sexual abuses such as sexual harassment, penetrative or non-penetrative sexual abuse, and pornography as sexual offences. Anyone, who fails or suppresses information of the commission /apprehension of the offence shall be punishable with imprisonment for a term which may extend to one year with fine.

E.*Prevention of Caste-Based Victimization and Protection for Victims: The Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989*

This Act prevents atrocities against the members of the Scheduled Castes and Scheduled Tribes, as well as provides mandatory compensation to victims, besides several other reliefs depending on the nature of atrocity. The victims are entitled to receive monetary compensation ranging from Rs. 25,000 to 200,000 depending on the gravity of the offence.

In the wake of criticism on legislations 'soft' and bound to show leniency towards the young offender and also on insensitivity of the CJIs towards victims, the Indian

Criminal Justice System has geared up in tune with the changing times.Similarly, more efforts have been undertaken for scientific application of criminological and punishment theories to offenders, who can be corrected and 'reclaimed' without being imprisoned.

Social Work in Criminal Justice Institutions in India

India's criminal justice system is continues to be strained for the lack of resources. According to 2007 figures of the National Crime Records Bureau (NCRB), there are 3,76,396 inmates in India's 1,276 prisons. The following are the statistics on the Criminal Justice Institutions (CJIs) with the statistics of 2007 within parenthesis. Of the criminal justice institutions 127 (113) are Central Jails, 340 (309) are District Jails, 806 (769) are Sub-jails, 20 (16) are Women Jails, 46 (28) are Open Jails, 21 are Borstal Schools, 31 Special Jails and 3 Other Jails. The prisons are generally overcrowded. NCRB (2007) figures show that except in seven states and three union territories, the inmate population was much beyond the prisons' capacity. In 2012 the total number of inmates in Jails has been put at 3,85,169 against a capacity of 3,43,169. Of these 1.2% of total inmates, lodged in various jails during 2012 were mentally ill.The occupancy rates are at 112.2%, which is better compared to 115% in 2010. In Uttar Pradesh and Chhattisgarh, the number of inmates was twice the capacity of prisons in these states (NCRB, 2009). Except for special categories of prisoners, like high-profile terrorists or political prisoners, life in India's jails is hard. NCRB 2007 data quoted earlier shows that convicts comprise only 32% of the total number of inmates in Indian jails; 66.6% of them continue to be 'undertrials'- people who have not yet been proven guilty of 'alleged' crimes. In 2012 this is still static at 66.2%. In 2012, Chhattisgarh reported the highest overcrowding in prisons (252.6%) followed by Delhi (193.8%). A sad tale is that a total of 344 women convicts with their 382 children, and 1,226 women 'undertrials' with their 1,397 children were lodged in various prisons in the country at the end of 2012.

As in the case of victims discussed earlier, years spent in a CJI - deservedly or undeservedly - not only isolate the person from society, they impact him/her in other ways too. As the Kerala High Court observed, a prisoner is a person who not only loses personal possessions but also personal relationships, but totally "loses

his identity," and ends up being known by "a number." Loss of freedom, status, possessions, dignity and the autonomy of a personal life lead to psychological problems.

Unless they are from privileged backgrounds, people who are confined in CJIs suffer evenafter their release. They continue to be stigmatized even after leaving the system.Thetag of a criminal is heavy, persistent and very difficult to erase. Friends,colleagues and acquaintances in general prefer to stay away to avoid reverse stigmatisation. Past or potential employers wish to have nothing to do withthe person. In many cases, even families disown the so-called 'criminal' member. Withoutemotional and financial support to lead a productive, satisfying life there are good chancesthat a one-time offender is pushed into taking up criminal activities, associating with criminals s/he had been acquainted with while within the CJIs, or leading a life marked by addiction or destitution. All these tend to induce recriminalisation.

At best, State efforts at rehabilitation are restricted to providing training in income-generationactivities and advancing small business loans to prisoners after their release. Continuous andregular support to all released 'under-trials' is not formally recognised or offered by Stateagencies.

Impact of Crime, Vicitimisation and Social Work

Often crime pursues the vulnerable. Young boys, girls and women who have been forced out of their homes often take shelter at railway stations or bus stands. Being in unfamiliar surroundings, without knowing anyone, they are vulnerable to accepting help from pimps and drug-peddlers who first manifest as 'saviours' and eventually exploit them. Not daring to move out of the station premises, runaway children and women live a precarious life of beggary and sexual exploitation; many suffer physical and mental illnesses. There are numerous instances where shamefully the custodians of law too prey on their vulnerability; and in the process destroying whatever residual faith they have in the system. Thus, they live in peril, facing the threat of either being victimised by anti-social elements, or criminalised by the law.

Crime affects the victims and their families, as they result in significant financial loss to the victims, cause serious physical and psychological injuries to mild

disturbances. Studies by the observe that about a third of violent crimes resulted in victims having their day-to-day activities disrupted for a period of one day (31%), while in 27% of incidents, the disruption lasted for two to three days (Aucoin& Beauchamp, 2007). In 18% of cases, victims could not attend routine for more than two weeks. A majority of incidents caused emotional impact (78 %); one-fifth of the victims felt upset and expressed confusion due to their victimization. Apart from victimization, ill-treatment or the indifference on the part of personnel in the CJIs enrage the victims forcing them to take revenge, in otherwords, 'recriminalising' them.

Keeping in mind the above observations regarding victimization and the propensity of the vulnerable to recriminalisation, the following affirmative action may be considered within the context of the CJIs (Chockalingam, 2009):

1. Restitution to Victims: Assume a proactive role and resort to affirmative action to protect the rights of victims of crime and abuse of power by adopting the concept of restorative justice and awarded compensation or restitution or enhanced the amount of compensation to victims

2. Definitive guidelines for Victim Assistance: Award interim compensation, without awaiting the final verdict in a longwinding system if the Court is sufficiently satisfied with the prima facie culpability of the accused. In tandem with this a set of guidelines may be specified to assistrape victims, especially the vulnerable and the indigenous, who cannot afford legal, medical and psychologicalservices. Following are somerecommendations:

    (i) Sensitive treatment of Victims of Sexual Harrassment, Assault and Rape: Provide assistance of a Victim's Advocate wellacquaintedwith the CJS, capable of explaining to the victim the proceedings, and to assist her in the Police Station, in Court as well as to guide her as to how to avail of psychological counselling or medicalassistance from other agencies;

    (ii) legal assistance at the Police Station while she is being questioned; the same may be undertaken in-camera to avoid repeated *post-mortem* of the issue

(iii) the Police is duty-bound to inform the victim of her right to representation before anyquestions are asked of her, and the Police Report should state that the victim was so informed;

(iv) a list of Advocates willing to officiate in such cases should be maintained at the police station for victims requiring a lawyer; and Advocate shall be appointed by the Court, to ensure that victims are questioned without undue delay

(v) the Victim must be accompanied only by Women Police and subjected to medical examination by a female Gynaecologist in the presence of a female Social Worker, she is comfortable with.

(vi) In all rape trials, anonymity of the victims must be maintained; in-camera sessions may be held for the same purpose

(vii) In accordance with the Directive Principles (under Art. 38 (1) of theConstitution of India), Criminal Injuries Compensation Board must be set up to determine the financial loss incurred especially for those too traumatized to continue in employment;

(viii) Compensation for victims shall be awarded by the Court taking into account pain, suffering and shock as well as loss of earnings due to pregnancy and theexpenses of childbirth if this occurred as a result of the rape.

3. State Compensation must be for Victims of Abuse of Power "torepair the wrong done and give judicial redress for legal injury is a compulsion of judicial conscience".

Gaps and Recommendations

There is a dire necessity for demonstrating and advocating social work interventions in the Criminal Justice system. Some of the areas of potential for intervention may include (*Prayas*, 2006):

- police stations, especially in dealing with victims of crime, harassment and rape

- criminal courts
- prisons, to assist in reformation, rehabilitation and prevention of HIV
- institutions for women and minors, including shelters and centers for rehabilitation of persons coming out of or vulnerable to crime or prostitution
- families of persons in crime/prostitution, especially children to counter negative influences (expressed emotions) and prevent criminalization
- educate and improve access of citizens within the vicissitudes of the criminal justice system,on the legal rights enshrined inthe Constitution
- promote the use of correctional laws towards rehabilitation ofvulnerable groups especially women, youth and children
- increase awareness in government and society about issues related to the rehabilitation ofpersons affected by crime or prostitution towards law and policy change
- generate knowledge in the field of social work, criminology and corrections through theanalysis of field experiences

Programmatic Content

Specific programs may be designed for areas - custodial care, education, reformation and rehabilitation – ancilliary to the criminal justice system. The following programmatic interventions may be recommended based on the sub-settings within the correctional setting for social work (Prayas 2006):

- Prisons: work among youth - women and males (18 to 23 years)
- Police Stations: bringing about civil involvement in the prevention of crime
- Criminal Court: legal assistance and referral services to persons approaching the courts
- Protective Institutions for Women
- Contact-cum-Rehabilitation Unit
- Research and Documentation

- Policy and Advocacy: viz, the police, prison, law and judiciary, as well as the NHRC, NCW, SHRC and SCW

Conclusions

Criminal justice system is influenced by thoughts, while criminal justice system in India inherits its underpinnings from the British system of criminal justice. The crime rate in India continues to soar with globalization and rapid social changes sweeping the country; some of the worrisome trends are that women continue to be violated, children too have been dragged into committing crimes and cybercrimes too have soared. The jails are over-crowded boasting a 112% occupancy level, and almost two-thirds being 'under-trails' awaiting for their turn in justice in the clogged system of criminal justice. The criminal justice system continues to be disinclined to the demands of the changing social world, as a result of which little leeway being made in changing the strategies and programs towards reformation of individuals in the correctional setting. The treatment meted out by the system continues to offend the victim forcing recriminalisation of the victim and forcing the cancer of crime to grow. All this augurs well for social work in the criminal justice institutions (CJIs) as well as the system (CJS). Along with definitive roles specified in the article, the curriculum in schools and colleges need to include individual entitlements, legal literacy as well as life skills education as a proactive strategy for the effective prevention of crime. Here too criminal justice social work has a role to play.

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Social Activists' Responses to Globalization in India: Diversity in Perceptions and Strategies

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Abstract

This paper - as opposed to the general perception that views social activists as people marked by similar ideological, analytical and strategic orientations - argues that social activists have developed divergent perceptions and strategies to issues pertaining to globalization in India. Based on the findings of an exploratory study that involved social activists working in varied fields in India, the paper concludes that professional social workers need to give up the stereotypes regarding social activists of the day and promote an inclusive and diversified approach to help the method of social action to develop in a creative and dynamic fashion.

Key Words: *Activists, Globalization, Social Action, Social Work.*

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Introduction

Social activists, very often than not, are perceived as birds of similar feather. They are thought of as radicals with similar ideological orientations and fixed stages, principles and strategies in their use of the method of social action to bring about a just and humane society. Our study on the perceptions of social activists in India, on their ideology and effects of globalization and the possible responses of the activists to arrest and eliminate its ill-effects has thrown up certain findings which run contrary to the popular image of social action and activists. The study has revealed that the social activists in India have divergent ideological and tactical orientations. This, we believe, gives us some reason to reflect on the necessity to break the monolithic image of social action and the necessity for accommodating and appreciating diversity in its philosophy and approach.

General Perceptions of Social Action

Several definitions of social action have been provided by both Indian and foreign authors. Some of the scholars who have attempted to define social action are Richmond (1922), Maslin (1947), Baldwin (1966), Community Work Group (1973), Friedlander (1977) in the Western context; and Moorthy (1966), and Nanavati (1965) (all cited from Siddiqui 1984, p. 12ff) in the Indian context.

All the major elements of these definitions are reflected in Britto's (quoted in Siddiqui, 1984) comprehensive definition which runs as follows:

Social action is a conflictual process of varying intensity, initiated and conducted by the masses or by a group of elites, with or without the participation of the masses in the action, against the structures or institutions or policies or programmes or procedures of the government and/or relevant agencies/or power groups, to eradicate/control any mass socio-economic political problem with a view to bringing betterment to any section of the under-privileged at a level larger than that of a sociologically defined community (p. 50).

The attempts by scholars to define social action have led to stereotyping of the characteristics of social action and activists. They are thought of as highly informed and radical. This is true even of our understanding of social activists' perception and response to globalization. We are given to think that social

activists out-rightly oppose the idea and practices of neo-liberal globalization. However, our study has shown that this need not be true and that social activists are indeed more diverse in their views and practices than they are thought to be.

Defining Globalization

Different disciplines such as Sociology, Economics, History, Political Science, etc. employ different criteria for elaborating and defining the concept of globalization. Anthony Giddens' The Consequences of Modernity (1990) is one of the most important sociological works that attempts to construct a theory of globalization. He defines globalization as "the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa" (p. 64).

David Henderson (1999), an economist, views globalization as a model of fully internationally integrated markets meeting the two conditions of i) the free movement of goods, services, labor and capital, resulting in a single market of inputs and outputs, and ii) full national treatment for foreign investors as well as nationals working oversees, so that economically speaking there are no foreigners. For Desai and Said (2004) globalization is the growing reciprocal interdependence and integration of various economies around the globe.

David Held and his coauthors (1999) define it as "the widening, deepening and speeding up of world-wide interconnectedness in all aspects of contemporary social life, from the cultural to the criminal, the financial to the spiritual" (p. 2). For Richard O'Brian (1992), globalization essentially refers to a mixture of international, multinational, offshore and global activities and involves a general progression from the domestic to the global. Malcolm Waters (1995) finds globalization as a social process in which the constraints of geography on social and cultural arrangements recede and in which people become increasingly aware that they are receding. For him globalization merely implies greater connectedness and de-territorialisation. Scholte (1997) too understands globalization as a process of de-territorialisation and global relations as supra-territorial.

For some others globalization essentially means an intensification of multinational, international and transnational linkages in all spheres of human activity, including

trade and commerce, governance and non-government lobbying as a consequence of new communication technology of the contemporary period (Galligan et al, 2001). The International Federation of Social Workers (2002) has described globalization as 'the process by which all people and communities around the world come to experience an increasingly common economic, social and cultural environment' (p. 3).

The problem with the definitions presented so far is that while pointing rightly to the expansion of social and economic relations, they do not say much about the form and character of such relations. The capitalist and neoliberal character of globalization is therefore ignored. It is often either underestimated or supported.

There are some other writers who have inaugurated and justified neo-liberalism and have been profoundly critical of the welfare state. The writings of Robert Nozick (1974), Milton Friedman (1962), and Friedrich Von Hayek (1988) fall within this category. While these writings are helpful to understand the major 'justifications' for neo-liberal globalization, they do not do not take into consideration deeper forces shaping the form of the present phase of globalization.

Certain other versions of globalization describe it as a 'techno-economic, naturalistic, and inevitable force', which affects the political powers, policy autonomy and public policy role of the state. According to them, governments have been brought under the influence of global capital so much that its institutional allies have no choice but to pursue social and economic policies compatible to the claims of globalization and the requirements of international business classes (Yeates, 2001). This line of argument, however, fails to pay attention to the dynamics of advanced capitalism and the democratic spaces available to citizens and governments to shape alternative forms of globalization. It needs to be remembered here that it is the negative manifestations of the capitalist, neoliberal-globalization that movements for global justice resist and not globalization per se (Dasgupta & Kiely, 2006).

Globalization is often linked to capitalism and imperialism as it is often argued that it has close affinity with imperialism. Immanuel Wallerstein (2003), Samir

Amin (1991), David Harvey (2005), Ronald H. Chilcote (1981), and James Petras and Henry Velmeyer (2001) invoke such a stance in their own distinctive ways. Sklair (2002) believes that globalization exports "culture-ideology-consumerism".

Thus, it could be observed that many processes of globalization are closely linked to the economic and political interests of the advanced industrial world. This ideological dimension is described as 'globalism'. According to DaSilva (2001) 'globalism is apparently about the worldwide sweep of information technology, finance capital markets, trading of consumer goods and services and, of course, the militarisation of the globe for the safe conduct of those under the monopolar hegemony of the U S A. This order is heralded as the harbinger for world peace, just as the Romans once offered peace - on their own terms (pax romana)'.

Anand Telumbde (2003) provides a very comprehensive and analytical definition of the present-day globalization. It reads:

Globalization is a euphemism for the imperialist strategy of the capitalism in crisis. It is implemented through the programmes of the IMF and World Bank, viz. Microeconomic Stabilization and Structural Adjustment Programmes in the countries that needed assistance of these institutions to get over their financial crises which were invariably the results of the exploitative strategies of their imperialist patrons. In the unipolar world hegemonised by the USA, globalization has become a ruling creed, a veritable religion of the elites (p. 17).

While agreeing with the definition of Telumbde it is also important to take note of Amartya Sen's (2002) warning against the dangers of equating globalization with Western imperialism. He opines that 'to see globalization as merely Western imperialism of ideas and beliefs (as the rhetoric often suggests) would be a serious and costly error'. Sen links issues related to globalization to imperialism. However, he believes that it would be wrong 'to see globalization primarily as a feature of imperialism. It is much bigger- much greater- than that'.

Also, according to Keller (1997) either equating capitalism and democracy, or simply opposing them, are problematical as sometimes globalizing forces promote

democracy and sometimes inhibit it as in the domain of the Internet and the expansion of new realms of technologically – mediated communication information and politics.

From the discussion so far, it can be concluded that there are "multiple globalization processes". Globalization has business, economic, political, socio-cultural, legal, ideological and civil society dimensions among others. This in itself signifies something of a paradigm shift from the type of thinking that dominated the first phase of the globalization debate (Dasgupta & Kiely, 2006).

Methods

The research design used for the study was 'exploratory' in nature. The universe of this study consisted of all the social activists in India. However, as the number of social activists was too vast and spread out, the researchers decided to delimit the area with the help of inclusion and exclusion criteria.

It was decided to cover a cross-section of the population by multistage sampling techniques. This was done with the hope of getting representation of the population according to region and the area of involvement of social activists. The region-wise list of the social activists included in the sampling frame is given below.

Table 1. The Region-wise List of the Social Activists Included in the Sampling Frame

Region	Male activists	Female activists	Total
Southern region	843	221	1064 (165)
Northern region	641	215	856 (50)
North-eastern region	96	32	128 (25)
TOTAL	1580	468	2048 (240)

(The figures in the parentheses refer to the number of respondent considered for the study)

The respondents for the study were randomly selected from the sampling frame for collecting the data for the study. A mailed questionnaire method was used as the primary tool of data collection. The respondents to be included in the study were finalized based on the time taken to return the filled-in questionnaire.

Results

Data was gathered to find out the distribution of the respondents based on their area of involvement and training in Social Work in order to understand if they are evenly distributed across the fields and if at least a sizable number of them are trained in professional social work. The following result was obtained:

Table 2: Distribution of the Respondents based on their Area of Involvement and Training in Social Work

Area of Involvement	Training in Social Work		Total
	Yes	No	
Rural Development	08 (12.3%)	57 (87.7%)	65 (100.0%)
Urban Development	05 (25.0%)	15 (75.0%)	20 (100.0%)
Women and Child Rights	10 (23.8%)	32 (76.2%)	42 (100.0%)
Human Rights	06 (28.6%)	15 (71.4%)	21 (100.0%)
Media and Legislation	02 (25.0%)	06 (75.0%)	08 (100.0%)
Rural Development and Women Rights	00 (.0%)	08 (100.0%)	08 (100.0%)
Education and Environment	01 (3.1%)	31 (96.9%)	32 (100.0%)
Education, Health and Legislation	08 (33.3%)	16 (66.7%)	24 (100.0%)
Dalit Movement	00 (.0%)	08 (100.0%)	08 (100.0%)
Other Areas	00 (.0%)	12 (100.0%)	12 (100.0%)
Total	40 (16.7%)	200 (83.3%)	240 (100.0%)

(Figures in parentheses are percentages)

p=.016, Sig

Table 2 shows that of the 240 respondents only 40 (16.7%) are trained in professional social work (i.e. holding a BSW/ Diploma/MSW/MA in Social Work degree). Of these social work trained activists (n=40) 25 percent are involved in the area of women child rights, 20 percent in rural development, and another 20 percent in education, health and legislation. Their absence is quite conspicuous in the area of dalit movement and also their presence in the area of environment is very negligible (2.5%).

A large number of respondents (27.1%) are in the field of Rural Development. Comparatively a much lesser number of respondents (8.3%) are in the field of Urban Development. Quite a sizable number of people (17.5%) are also working for women and child rights. Relatively good number of respondents (13.3%) is found in the field of education and environment. There are relatively lesser number of respondents in the areas like human rights (8.8%) and other areas like media and legislation, rural development and women rights, and *Dalit* movement (8% each). Finally, 5% of the respondents belong to other fields like communal harmony and labor movement.

Probability value of the data is 0.016. Hence, it can be observed that the distribution of respondents between the variables, i.e. the area of work and training in social work, is significant.

Table 3: General Perception of the Respondents towards Globalization and their Reasons for it

General Perception	Reasons	Frequency & Percentage	Chi square value and p value
All of globalization is bad 40 (16.7)	Rich become richer and poor become poorer	14(35.0)	$X^2_{(4)}$=9.750, p=0.044, HS
	Increases the vulnerability of weaker sections	11(27.5)	
	Destroys our polity and economy	03(7.5)	

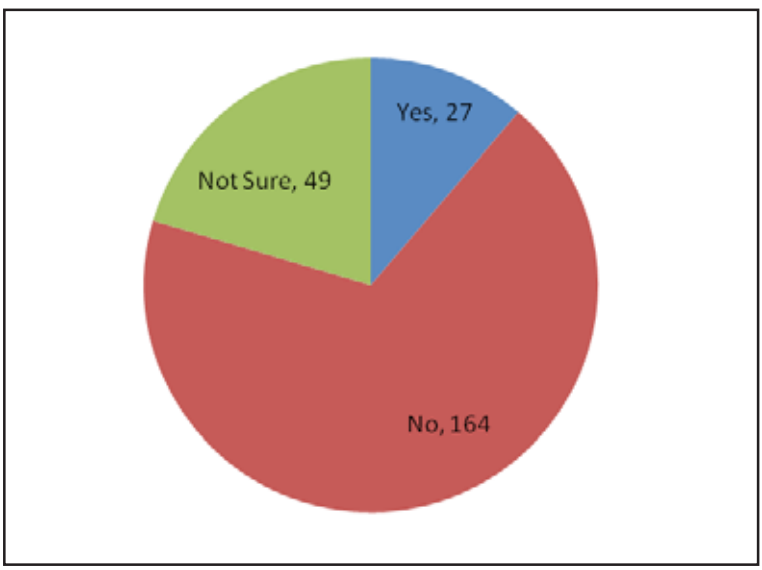
General Perception	Reasons	Frequency & Percentage	Chi square value and p value
	Globalization is led by aggressive transnational capitalism	06(15.0)	
	It is nothing but imperialism in another form	06(15.0)	
	Total	40(100.0)	
Only certain aspects of globalization are bad 191(79.6)	Only the rich grow richer	26(13.6)	$X^2_{(7)}$ =43.764, p=0.000, HS
	Harms the indigenous economic interests	25(13.1)	
	Displacement and environmental degradation	43(22.5)	
	Lack of protection to workers and environmental degradation	35(18.3)	
	Creates competition and stress	21(11.0)	
	Negative impact on agriculture and small-scale industries	23(12.0)	
	Wrong priorities and lack of preparedness	16(8.4)	
	No response	02(1.0)	
	Total	191(100.0)	
Nothing of globalization is bad 9(3.8)	It offers opportunities for development	05(55.6)	NA
	It is a process which inevitable and hence needs to be effectively used to one's advantage	04(44.4)	
	Total	09(100.0)	

(Figures in parentheses are percentages)
N=240, $X^2_{(2)}$ =237.025, p=0.000, HS

One of the aspects taken up for the study was the general perception of the respondents regarding the phenomenon of globalization and their reasons for it. As could be seen in table 3, majority of the respondents (79.6%) opined that only certain aspects of globalization are bad, while a small percentage of respondents (3.8%) have opined that nothing of globalization is bad.

Of those respondents who had opined that whole of globalization is bad (n=9) some (55.6%) feel that globalization offers many opportunities for development. The rest of the respondents (44.4%) feel that it is a process which needs to be effectively used to one's advantage. Here, as the number of subjects is very low chi-square test is not possible. This is quite revealing as the usual perception of people is that all the social activists hold the view that all of globalization is bad.

Figure 1: Opinion on if liberalization of economy has benefited All sections of Indian society



‘ $N=240,\ X^2_{(2)}=135.325,\ p=.000,\ HS$

As could be seen in figure 1, 11.3% of the respondents believe that it has benefited all the sections of Indian society in an equal manner. The respondents

who opined that liberalization of Indian society has benefitted all sections of India (n=27) were asked to provide reasons for their opinion. Most of the respondents said that liberalization of economy has created equality of opportunities (44.4%). 18.5% each of the respondents said that it has opened up newer opportunities for all and that it has made the economy more inclusive and competitive. Thus, the results of the study challenge the general perception that the social activists are the staunch opponents of the liberalization of economy.

Table 4: Impact of India's Attempt to Emulate American Model of Development

Response	Frequency	Percentage
Highly negative	121	50.4
Moderately negative	51	21.3
No great impact	33	13.7
Moderately positive	35	14.6
Highly positive	Nil	-
Total	240	100.0

$X^2_{(3)}$ = 85.933, p=.000, HS

Mean± S.D. = 1.925 ± 1.107

Percentage mean = 38.50

A question was asked to the respondents on the impact of India's attempt to emulate American model of development. As table 4 reveals, 13.7% said that there is no great impact, and the others (14.6%) said that it is moderately positive. This finding too shows that the social activists are divided on their opinion regarding the impact of imitating American model of development.

Table 5: The influence of globalization on the people the respondent has been working with

Response	Frequency	Percentage
Highly negative	73	30.4
Moderately negative	92	38.3
No perceptible influence	41	17.1
Moderately positive	34	14.2
Highly positive	Nil	-
Total	240	100.0

$X^2_{(3)} = 37.167,\ p = .000,\ HS$

The respondents, being social activists with a minimum of 10 years experience, would have seen the tangible impact of globalization on the people they have been working with. Hence, the researcher wanted to make use of this knowledge of the respondents to find out from them the influence of globalization on the people he has been working with.

As shown in table 5, most of the respondents (38.3%) felt that the influence of globalization has been moderately negative on the people they have been working with. Next large group of respondents (30.45) have opined that it is highly negative. 17.1% of the respondents have stated that they could not find any perceptible influence of globalization on the people they have been working with. Only 14.2% respondents have opined that the influence of globalization has been moderately working with. There was, however, no one who said that the influence of globalization has been highly positive.

Chi-square at 3 d.f. is 37.167. The probability value at 5% level of significance is 0.000. Therefore, it can be concluded that the difference between the responses of the respondents in this category is highly significant.

Table 6: Opinion on the influence of Liberalization, Privatization and Globalization (LPG) on Social Action in India

Responses	Frequency	Percentage
It has weakened social action	153	63.7
It has had no real impact	45	18.8
It has strengthened social action	40	16.7
No response	02	0.8
Total	240	100.0

$X^2_{(3)} = 210.633, p=.000, HS$

As could be seen in table 6, a few of the respondents (18.8%) have said that the general influence of liberalization, privatization and globalization has had no real impact on social action in India while some others (16.7%) have said that it has in fact strengthened social action. This too is a very interesting finding as it challenges the general thinking that social activists believe that LPG has weakened social action in India.

Table 7: Opinion on if social action can provide us with a meaningful alternative to today's globalization process and the ways in which it could be utilized to find the alternative

Response	The social action means to findalternative to today's globalization process	Frequency & Percentage	Chi square value and p value
Yes 150 (62.5)	Unity and networking among the activists at the national and international level	35 (23.3)	$X^2_{(7)}$ = 78.587, p=.000 HS
	Generation of awareness among the people	32 (21.3)	

	Reforming the education system	25 (16.7)	
	Revitalizing the civil space	11 (7.3)	
	Building people's movements	07 (4.7)	
	Lobbying and networking	04 (2.7)	
	Focusing on human rights and justice	01 (0.7)	
	No response	35 (23.3)	
	Total	150 (100.0)	
No 32 (13.3)	NA	NA	NA
Not Sure 58 (24.2)	NA	NA	NA

(Figures in parentheses are percentages)

N=240, $X^2_{(2)}$ = 96.100, p=.000, HS

Table 7 shows that 62.5 percent of the respondents believe that social action can provide us with a meaningful alternative to today's globalization process. 13.3 percent of the respondents believe that it cannot provide an alternative, while the remaining 24.2 percent have said that they are not sure if can provide a viable alternative to the present form of globalization. Chi-square at 2 d.f. is 96.100. The probability value at 5% level of significance is 0.000. Hence, it can be concluded that the difference between the responses in this category is highly significant.

Those who had opined that social action can provide a meaningful alternative (n=150) were asked to suggest suitable social action means for achieving suitable alternative. Some of the main means suggested are: unity and networking

among the activists at the national and international level (23.3%), generation of awareness among the people (21.3%), and reforming the education system (16.7%). Few of the respondents suggested revitalizing the civil space (7.3%), building people's movements (4.7%), combination of lobbying and networking (2.7%), and focusing on human rights and justice (0.7%). 23.3 percent of the respondents in this category have not suggested any means of social action.

Chi-square at 7 d.f. is 78.587. The probability value at 5% level of significance is 0.000. Hence, it can be concluded that the difference between the responses in this category is highly significant.

Implications of the findings

Acknowledging the importance of social action within the field of social work K.K. Jacob (1965) has stated that:

> …it is easy to see that social workers have to play an important role in social action. In fact they should be the central figures who should get the interested individuals and groups together and function as the prime movers in this primary movement for making the neighbourhood and the country at large, a better place in which to live and function (p. 64).

The findings of our study have two-fold implications. Firstly, it shows that social activists are not homogenous in their perceptions and strategies with respect to globalization. This implies that there is lack of appreciation of the deeper dynamics and impact of globalization by many of the social activists. This reality can lead to lack of depth and unity in the responses of social activists to the threats and opportunities of the processes of globalization.

Second implication of the findings of our study is that if social workers have to effectively engage with the field of social action, they have to shed the stereotypical perceptions regarding the activists and develop openness for accepting various hues among them. This could, in turn, prove beneficial to the development of social work profession which is striving to revive its various methods to face the challenges of the present era. This is because the diversity

in the philosophy and approach is much better than rigid ideological stand-points which might lead to the stagnation of the field of social action.

However, in appreciating the relative importance of both the implications discussed so far one thing has to be very clear to professional social workers who want to engage with the field of social action – i.e. what is non-negotiable in the process of understanding and responding to the challenges of globalization is the commitment to human rights and social justice, the twin-aims common to social work as well as social action.

Conclusion

Alston and McKinnon (2001) have argued that professional social work is concerned with human rights, social justice and support for marginalized people. It is commonly agreed today that it is social action, a widely accepted method of social work, which has the potential as well as the mandate to bring about such a transformation in society (Bhattacharjee, 1982). For this to happen, we need to give up the stereotypes that we cherish regarding social activists of the day and promote an inclusive and diversified approach to help the method of social action to develop in a creative and dynamic fashion.

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Experiences with the State's Health Care System- Voices of the Survivors of Domestic Violence in Gujarat

* Bhavna Mehta

Abstract

Domestic violence is the most common form of violence against women worldwide including India. The adverse impact of violence on women's health has been acknowledged as a crucial human rights and public health issue. It is declared as a 'Public Health Priority' by the 49th World Health Assembly of 1996 and the United Nations Population Fund in 1999. The World Health Organization recently declared that women who have been physically or sexually abused by their intimate partners report higher rates of number of important health problems (WHO, 2013). Being the first point of contact for victims of domestic violence, health care delivery system and health care providers are best place to identify and respond to the victims of violence.

The present paper based on doctoral work of the author would acquaint readers with the response of the health care delivery system to this critical issue in the state of Gujarat from the perspective of survivors of domestic violence seeking treatment at the public hospitals of the state. Based on the in depth case study of women survivors, the paper describes the health problems resulting from domestic violence that women present with, their perception of the quality of health care received and experiences with health care services and the health care providers while seeking care. Recognizing women's experiences as 'Good Experiences' or 'Bad Experiences' with health care system, at the end the paper elucidates needs of survivors of domestic violence when they approach health care system.

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Introduction

Domestic violence is the violence that occurs within the private sphere generally between individuals who are related through intimacy, blood or law. It can include any nature and type of violence taking place within the domestic place called home, household or family, violence between siblings, on child/children, elders of the family. In spite of its various forms, domestic violence is usually always used to describe gender specific crime/act perpetrated by men against women; more so by the husband and his family members on the wife. This is because police and hospital records have indicated that the majority of victims of domestic violence are women. Even experiences of women's organizations, voluntary organizations working with women reflect that women are abused, harassed, tortured, coerced by their own partners or husbands and marital family members within their own homes. Even the definition given by the United Nations General Assembly while formulating the CEDAW declaration in 1993 defines domestic violence as all such gender based violence and abuse taking place on women in adult marital relationship. Thus the term domestic violence has almost become a synonym for violence against women who are married or by their intimate partner taking place within the four walls of the home, within the family or in intimate relationship.

Of the various forms of violence against women, domestic violence is one of the most common forms of violence against women across the globe. Evidences from different countries across the world show that domestic violence exists in all societies. The latest report on prevalence of intimate partner violence developed by World Health Organization, the London School of Hygiene and Tropical Medicine and the South African Medical Research Council (2013) states that worldwide almost one third (30 percent) of all women who have been married or in intimate relationship have experienced physical and/or sexual violence by their partner, in some regions, 38 percent of women have experienced intimate partner violence and globally as many as 38 percent of all murders of women are committed by intimate partners.

India, being the patriarchal society having traditions, norms, customs, culture and practices that are discriminatory against women, is no exception; and has high incidences of domestic violence. A recent G20 survey ranked India as the worst

place to be a woman (Baldwin, 2012). An official statement released by Minister of State, Women & Child Development, Government of India in 2006 stated that around 70 percent of women in India are victims of domestic violence (BBC, 2006). Even a review of micro studies and national level data shows that 22 to as high as 70 percent of women surveyed in different parts of the country have experienced domestic violence (NFHS, 2007; UNDP, 2005; ICRW-INCLEN, 2000; Mehta, Desai and Desai, 2000; Subadra, 1999; Visaria, 1999; Jejeebhoy, 1998; Rao, 1997; Mahajan, 1990). Thus, government data as well as of other researches have identified home, domestic place, as a major site of violence against married women and indicate high prevalence of domestic violence in the country.

Domestic violence as a determinant of women's health

Domestic violence is one of the important sources of women's ill health. It is called 'hidden epidemic' because it is widely prevalent in the privacy of the home. A close examination of the widely accepted definition of violence against women given by the UN declaration on the Elimination of Violence Against Women (1993) and/or the latest legal definition of the domestic violence given in the Indian legislation (Protection of Women from Domestic Violence Act, 2005) indicate that both the definition accentuate the health, safety and well being of women. They recognize that violence of any form – threats, coercions, deprivation, physical sexual, verbal, emotional economic abuse, harm and affect women's physical, psychological sexual and reproductive health.

A growing body of research that has emerged in recent years across the world reveals that domestic violence is detrimental to women's health including their very survival (Dillion, Gina & et. al., 2013). The impact that domestic violence has on women's health can be immediate and/or long term, fatal and/or non-fatal, direct and/or indirect (Heise, Pitanguy and Germain, 1994). Apart from the direct health consequences, domestic violence also increases women's risk of future ill-health. Studies show that those women experiencing domestic violence experience ill-health more frequently than other women, with regard to physical functioning, psychological well being and the adoption of further risk behaviours. The conclusion of the multi country study undertaken by WHO (2005) states that the influence of violence/abuse can persist long after violence itself has

stopped. The more severe the abuse, the greater its impact on women's physical and mental health. Also, the impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative. And given the long term severe impact of violence on health, women who have suffered such violence are more likely to be long term users of health services. Thus, domestic violence is a pertinent health issue affecting large number of all those women of the world who live in agony, pain, stress and suffer in silence, within their own home in their marital relationship.

Domestic violence and health care – a syllogistic tie

There exists a natural tie between the domestic violence and health care. Due to the profound impact that domestic violence has on a large number of women's health and on their health care seeking behaviour, it is pertinent that health care delivery system of the country recognize and respond to it.

Health care providers can play a crucial role in addressing domestic violence. As the health care system is the only institution that interacts with almost every woman at some point in her life, health care providers are well placed to recognize women experiencing domestic violence and help them especially when women visit the health care institutions in trauma or with injuries (both physical and psychological). Health care providers in public health care delivery system have high level of public contact not only in numbers but also qualitative interactions. They assume significance, as they are the first point of contact for any victim of domestic violence. A woman with obvious fatal or non-fatal injuries is more likely to be taken first to a health care provider than to the police, social welfare or women's organizations. Health care providers are also in a position to identify women victims of violence as they may notice evidences of violence when women seek treatment for other conditions and refer victims of violence to other services or to the justice delivery system, provide empathy, support and document injuries which is critical to evidence gathering and securing justice for women. With the shown interest in life's experiences and positive response, health care providers can help change women's perceived acceptability of violence in their relationship and make it easier for them to access support services at an early stage.

As the goal of health care is improvement of the health status of the population, health development and empowerment of people, it is important that domestic violence become a part of the agenda of the health care system.

Survivors of domestic violence and health care system

Examining existing literature related to health care systems response to domestic violence in India, one find that until mid nineties, neither any of the earlier researches related to domestic violence nor researches related women's health had examined linkages with each other. Domestic violence was a 'missing agenda' in women's health research. And impact of domestic violence on women's health was hardly studied. (Subramanian et. al. 2007; Rao Athalye, 2004; Visaria, 2000; Mehta, Desai and Desai, 2000; Nair, Patel and Sadwani, 2000; Subadra, 1999; Jejeebhoy, 1998b; Khan and Townsend, Sinha and Lakhanpal, 1997; Rao, 1997; Ganatra, et al.1996; Sheshu & Bhosale, 1990). Barring few, no in depth studies could be found on health care system's response to the issue of domestic violence. (Ganatra, et.al. 2001; Purewal & Ganesh, 2000; Barge, et. al. 2000; Prasad, 1999; Jaswal, 2000).

Similarly experiences of victims/survivors of domestic violence who sought care from health care system had remained an unexplored area. Most of the studies focusing on women's experiences with health care system were in context of quality of care related to family planning services and family welfare programmes or rather of the maternal health and reproductive health services provided by public health facilities (NFHS, 2007, 1998-1999; Kapadia, Khanna & Mehta, 2005; Rameshan & Singh, 2005; Zamir, 2002; Mavalankar & Sharma, 1999; Townsend, Khan & Gupta, 1999; Roy & Verma, 1999; Gupte, et. al. 1999; Murthy, 1999; Joshi & Mirani, 1999; Subrahmanyam, 1997;CORT, 1995, 1996, 1997; Sumaraj, 1991). The review reveals that deficiency in health care system, exposure, experiences and expectations of women from the system make it difficult for them to seek care and help from it. In context of health care system's response to victims of domestic violence, Population Reports, 1999 stated that many women did not volunteer to give information unless they were asked directly about violence. Shame, fear of reprisals from husband or his family members or fear that they would be blamed for it was also one of the important reasons that women didn't 'speak up.'

Chatterjee (1990) has presented a model comprising four factors namely Need, Permission, Ability and Availability that determine utilization of health care services by women. Need refers to the extent of ill health among women, permission is the result of social factors which dictate whether women would seek health care. Ability is determined by the economic factors which enable women to meet the cost of health care and availability of services for women includes locations, timings, nature and quality of care. Even the Survivor theory given by Gondolf and Fisher (1988) explains "*Battered women are the active survivors and not the helpless victims."*The theory emphasize on the "System Failure" i.e. helping sources appear to have failed to respond effectively especially when woman had tried to seek its help or when violent husband or batterer had been elusive or unresponsive to the interventions designed to address such behavior.

Thus, women's perception of quality of care received by them from the health care system is an important determinant deciding their desire, willingness to seek help of system in relation to domestic violence experienced by them. Moreover, if any viable, effective and useful intervention programs have to be designed to help survivors of domestic violence seeking care from health care system, it is essential that it include women's perspective and participation.

Thus, a part of the doctoral study to understand health care system's response to domestic violence carried out in the state of Gujarat included women survivors (as users of the system) perspective of health care system's response to them.

Methodology

The study was conducted in five major teaching hospitals of the state of Gujarat using quantitative as well as qualitative approach to data collection and analysis. To supplement the quantitative data and to get deeper insight into the life situations and experiences with the health care system and give voices to numbers, 30 in-depth interviews of women survivors of domestic violence were collected following ethical and safety recommendation of WHO for research on domestic violence against women (WHO, 1999). These women for case study were identified on the basis of interviews carried out as part of quantitative

study of women users of public health care system of the state. Thus, women with either physical injuries or mental health problems seeking treatment and care from the public hospital of the state and who had reported it very clearly that domestic violence was a cause of their current health problem or who were the 'Suspect Cases' of domestic violence.

Voices of survivors – Response of health care system to domestic violence

Following are few excerpts of the voices of women survivors of domestic violence reflecting the variety of experiences that they had with the health care system. The title given to each voice reflects the response the woman survivor received from the health care system and providers. At the end experiences of women are categorized as good or bad; and positive or negative response to them.

A woman who was listened to-

> *"My parents died when I was very young. My uncle and aunt brought me up and got me married. My in-laws were poor and I had to live a dependent life. I worked as a cook at a hospital so that my children could study. Initially my husband used to beat me very badly. Whenever he would drink, it was as though the devil got inside of him. He would hit me so hard that I would get scars and bruises. But I never said anything to anyone. Now I am unable to work because I have to take care of him, clean up all his filth.*

When asked about the services and facilities provided at the hospital, she said,

> *"It is very good here. It is even better than the private hospitals. I feel good once I take medicine given from the hospital. After I met the social worker I felt very good. I felt as if I got my parents back. I feel very good with her. She takes good care of me".*

A woman who was supported –

> *"Once, five years ago, I was having severe headache. So I told my husband that I would not join him at work today. He got so annoyed that he threw a pressure cooker at me. I got hurt near my eye. It was bleeding. But I did not go to any doctor and just applied turmeric power and kept quiet about it."*

Three years ago she was admitted in the psychiatry ward of the hospital for almost three weeks. When she went back home her husband accused her of having an affair with the doctor of the hospital. He verbally abused her so badly that she attempted to commit suicide by consuming poison. She was brought back to the hospital and was admitted to the emergency ward.

When asked about the experiences, facilities and services at the hospital and the behaviour of health care providers, she said that the senior doctor was very good, *"She is my patient, and nothing should happen to her"*. The senior doctor and other doctors had called her husband and explained to him that it was due to his drinking habit that she had developed the problem. Apparently, as the health care providers had intervened in her domestic problem and explained to her husband, he has now changed his behaviour towards her and created less trouble for her.

A woman who was sympathized with-

> *"It was a pre-planned incident. Though I don't go out of the house anywhere he suspects me of having an extra-marital affair. We had a fight over it the previous night. On the next day around 12:00 in the afternoon he poured kerosene on me and set fire on me."*

When asked about the experiences with the services, facilities at the hospital and behaviour of health care providers, she said that nurses were nice and they did the dressing very carefully. She also said that while male doctors were good, she would prefer a female doctor checking her. She shared her problems and sufferings with the health care providers as they asked her. They were sympathetic towards her and tried to gain more information. They did not blame

her for the situation. Nonetheless no one had showed any willingness to help her nor did they guide her to any organization to seek help.

A woman who was attended to and asked-

> *"It is very nice here. It's like a home, much better than home. I get tea, milk and food. I get everything on time. It is better than private hospitals."*

She also said,

> *"They cleaned my body with a wet towel and sprinkled powder. They provide good care and services. All doctors are nice and give good treatment. They have provided me bed and a blanket to sleep. I felt good."*

She told health care providers about her problem and cause of injury, when they asked. Health care providers made her feel good, gave her enough time, allowed her to ask questions and listened to her with patience. They gave her respect and talked to her in the language, which she understood.

A woman who was cared for-

> *"When I was brought in, a resident doctor immediately took my case and told others to attend to me immediately. I was feeling very uneasy so they found me a bed just under the fan. They gave me medicines and treatment on time."*

When she told the doctor about her problems, they were sympathetic towards her and tried to gain more information about her problems. While they did not hold her responsible for the situation they did not even show any willingness to help her.

A woman who did not break her silence-

> *"Medicines are good; treatment given by doctors is also good. They come every hour for the check-up. The food that they give*

is also good. At the time of dressing, doctors talk nicely. Here the care they give is even better than that of private hospital".

She shared that health care providers had asked her about the true cause of injury, when she had approached them for contracture release operations. But she did not tell anyone her story as she felt that they would not be able to help her with it. Health care providers always made her feel good and gave enough of their time for her treatment. They tookinterest in her problems and allowed her to ask the questions and listened to her with patience. They gave her respect and talked to her in the language, which she could understand.

A woman who broke the silence and got help-

"*Earlier I was not able to tell my problems to anyone and kept brooding over it. When I spoke to the doctor, he asked me my problems very politely and patiently. Doctor called my husband and explained him, scolded him. He toldmy husband that hebeat me even when I was not at fault. Such behaviour could cause serious head injury."*

"While coming to this hospital we don't have to think about money because treatment is free of cost and above all it's very good."

A woman who felt neglected-

"I was sleeping, at the middle of the night around 2:30 am; I woke up suddenly as something hit me hard. I saw my husband with a knife in his hand. Before I could scream, he covered my mouth with one hand and began to stab me all over with the other. He sat on my stomach and hit me. He was very angry, as I had not been cooking food for ten days. I was doing so as he had taken away my five-year-old son from meandhad hidden him somewhere. I wanted to know where my son was. So in retaliation I stopped bringing anything home, stopped talking, cooking etc."

"In the emergency ward I was treated very badly. Many different doctors came and checked my wounds throughout the night. They

were curious to know what had happened. So when they came, they opened the bandage, checked the wound and asked the same question. Till morning they were taking stitches. When I requested them not to do more gently, they replied very rudely, and scolded me saying I did not understand the difficulties in taking the stitches. Whole night I lay on a stretcher. We too are live human beings. Only one doctor should do all the treatment. Ten different student doctors came and learnt how to take stitches."

"No! I will not come here again, at least not in the emergency where doctors are more interested in learning than treating the patient."

A woman who wanted to break the silence, but no one asked-

"After some months of marriage, I told him to get a job. I used an abusive word so he had slapped me. He had threatened me that he would kill me and also the unborn. He is very short tempered; he slaps me very often, holds me by the collar and hits me and beats me on my back."

"I want to tell about my problems but no one is asking so what can be done? Please let me go from here."

A woman who broke the silence, but no one responded-

When asked about her experiences with the health care providers, 'R' said that they did not give her family members adequate information related to anything like admission procedure, blood donation, visitors pass, etc. She felt that staff of the hospital did not have a time to explain them anything. It was difficult for her familyand herself to understand, treatment and medicine as they explained it only once. She felt that health care providers did not respond properly.

She also said that she felt embarrassed when male doctors examined her or did her dressings. She would have preferred a female doctor. 'R' had told about the incident and her problems to the doctor and the nurse who asked her when they

were examining her. However she did not expect anything from them as she felt that it was not realistic.

> *"They have no time even for their routine work, so it is totally out of question that they would do anything else"* she says.

A woman who was blamed for her situation-

> *"When I came to the hospital, I did not feel good as the doctor was constantly scolding me. For x-ray, blood-urine report they made us run from pillar to post. No one explained us properly".*

She also said that she was not informed about the type of treatment she was given, its cost, the time required for it, the rules and regulations of hospital or any other facilities that were available at the hospital.When 'L' and her father registered a police case, at that time doctor got angry with them and told them not to act out and make 'a mountain out of a mole hill.' After sometime the doctor calmed down and asked about her problems. He assured her that he would inform the police, if required.When 'L' shared with him the cause of her injuries, he held her responsible for it, as he felt that she should have listened to her husband. 'L' felt that health care providers did not want to understand her agonies and sufferings. No one showed any willingness to help her. 'L' also felt that if not much, health care providers at the hospital could at least talk nicely with patients and give them the required information.

A woman who was dissuaded from breaking the silence-

> *"My ear lobe was bleeding and I was in severe pain. Still they did not give me immediate treatment at the casualty. As the OPD hours were over, they asked me to come at 4.00 pm, when it opened again".*

A woman who was refused support-

> *"I told CMO that as I want to file a case please give me a written note. But he refused to give in writing and advised me not to do so. He felt that it was a small matter and if I filed a case against my brother-in-law and his wife, my family relations would be*

further strained. A lady doctor should be there at the hospital as she would listen and understand us. Male doctors do not even listen to women; they just say it's nothing."

A woman who wanted to go home-

"When I came to the hospital, I was kept unattended for an hour or so. I was crying all the time but no one came. The doctor came after an hour and began my treatment."

"Doctors are careless here and nurses talk very rudely with patients. Staff slaps women who come for delivery."

"They scold these women for screaming and abuse them saying they were not the only ones giving birth to a baby."

"I had not eaten anything since last night. So the next day at 12:30 in the noon when I asked the doctor what can I eat, he got angry with me and shouted at me saying should I now get you food too? He asked me to request the nurse to bring it for me. When I requested the sister she gave me food. I felt miserable then. Am I a beggar?"

"In the morning when I told the doctors that it is paining a lot. Doctor didn't like it. He shouted and asked the nurse to give me the medicine. Here no one takes care of me. All are careless."

What do these voices tell us?

Few of excerpts presented here show the different negative health outcomes of domestic violence that woman present with when they approach a health care facility for treatment. These survivors perception of the quality of care is influenced by the type of experiences they had with the health care services especially health care providers. The following table indicates what women in the study perceived as good and bad experiences.

Good Experience	Bad Experience
• When they received immediate attention and treatment for their problem.	• When they were left unattended /or had to wait for a long period to get treatment.
• When they are provided information on the hospital facilities like x-ray department, lab, admission procedures, visitors pass, course of treatment, medicines, dosage, etc.	• When they have to run from pillar to post to locate services and providers, they are not provided any information.
• When providers show involvement, attention, interest, patience and talk to them about their problem, allow them to ask questions.	• When providers are disinterested, refuse to listen to them or are dismissive of their problem.
• When providers intervene and talk to the perpetrator/spouse.	• When providers blame women for their situation, dissuade them from filing complaints, refuse support for filing complaint.
• Nice way to dressing wounds, bed and blanket provided, free food, free medicine, regular rounds to check on patients.	• Insensitive handling of injuries, dressing check-ups by male doctors, not offering food.

The case studies have also indicated that survivors of domestic violence have a great need for sharing their experiences, even if they do not report domestic violence as a cause of their health problem. All survivors currently seeking treatment from the psychiatry department were satisfied with the response of

the providers, because health care providers had talked to them about their problem, and even intervened by taking their husbands to task for inflicting violence on the women. Women who did not report or share their experiences of domestic violence with the health care provider did so either because they were not probed or because they could not visualize any role for the providersbeyond treatment and care giving. Thosewho did share their experiences of domestic violence felt relieved, especially when it led to intervention by the health care providers.

Women's experiences at the first contact with the health care providers at the time of entry into the hospital influenced their perception. Negative experiences were reported by women who were received at the casualty/emergency department. Negative experiences were mainly due to lack of information about the services and procedures of the hospital, and being left unattended for a long period of time. For most of these women the visit to hospital is their first visit. Without information or guidance on the facilities available (x-ray, pathology lab, etc) and the procedures for admission they feel lost in the hospital.

The responses of the health care providers varied – from listening sympathetically to intervening on the woman's behalf; from being disinterested in knowing the real cause of the injuries to out rightly refusing support in filing a complaint. The reluctance to intervene was observed in medico legal cases, where health care providers did not seem to probe for the real cause of the injuries. In fact there were instances where they had blamed the woman for her situation or had tried to dissuade the woman from filing a medico legal complaint for the sake of maintaining domestic harmony.

Regarding quality of care/services, the case studies showed that wherever women had positive interactions with the health care providers, i.e., where the latter had shown concern and sympathy, women had expressed satisfaction with the quality of care they received.The women seemed to be satisfied with 'free medicine', free 'food', 'bed and blanket', and the rounds of wards made by doctors and nurses showed low expectation of services.

Thus over all the case studies indicated the following needs of survivors of domestic violence when they approached a health care system:

1. Immediate attention when they arrive at the hospital.
2. Information about the procedures and facilities available to them.
3. Sympathetic and supportive behaviour from health care providers.
4. Sharing about their experiences of domestic violence and some mechanism for redressal.

Conclusion

The health problems resulting from domestic violence that women survivors present with vary from physical injuries to mental health problems. Women's perception of quality of care was influenced by the type of experience they had with the health care services and health care providers. Experiences were perceived as good, when providers showed interest and involvement and paid attention to them. Women liked it when health care providers talked to them about their problems patiently. Women survivors felt good when health care providers intervened in their problems and tried to help them in some way. Providing information on the infrastructure facilities and attending to their other requirements such as food, medicine, and bed were also found to be good experiences. Women perceived quality of care as poor when they had negative experiences such as not being attended to immediately, or being left unattended for a long period of time, not being given adequate information on the procedures and infrastructure facilities available to them. The responses of the health care providers varies – from listening sympathetically to intervening on the woman's behalf; from being disinterested in knowing the real cause of the injuries to out rightly refusing support in filing a complaint for the sake of maintaining domestic harmony. Women do not report or share their experiences of domestic violence with the health care providers either because they are not asked about it or because they do not see any role for the providers. However, they felt good when health care providers intervened. Lastly, when survivors of domestic violence approach the health care system they need: immediate attention by health care providers, information about the procedures and facilities available to them, sympathetic and supportive behaviour from providers, opportunity to share their experiences of domestic violence and some mechanism to resolve issues of their lives.

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Governmental and Non-Governmental Interventional Effectiveness in Community Development

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Abstract

The role and approach of Governmental and Non-Governmental Organizations in development has changed radically over the last fifteen to twenty years. They are accepted as significant contributors to the development process by governments and official agencies. In the early 1980s it was assumed that NGOs would have an impact because, of who they were and their relationship and closeness to the 'beneficiaries'. Community Development is a powerful approach to bring about a desirable positive change in the larger society by involving people. This study has been conducted in Mangalore, Karnataka to study the effectiveness of the organizations in developing the backward communities. Effectiveness as a measure of organizational success has for decades attracted scholarly attention across the social sciences. Among practitioners in the not-for-profit or governmental sector the issue of effectiveness has recently taken on additional urgency because of increasing demands for accountability, transparency and financial responsibility. As the domestic and international visibility of NGOs and Government programs increases, concerns about their impact as a core ingredient of legitimacy are likely to remain a central issue in the future.

Key Words: *Non-Governmental Organizations, Community Development, Relationship, Education, Health*

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Introduction

Community Development is a process that takes charge of the conditions and factors which has effect on the quality of life of its members. The term development often carries an assumption of growth and expansion. Governmental and Non-governmental agencies facilitate a positive change through collective action in economic, socio-cultural, and environmental aspects. Effectiveness of the intervention depends on responding to the felt needs of the people through a participative process.

While there is general agreement on the importance of effectiveness research, there is surprisingly little agreement on how to define and measure what constitutes effectiveness. This study aims at finding the effectiveness of both Government and Non Government programs in terms of positive changes brought in the areas of Education, Employment, Health, Water, Sanitation, and other basic needs.

Defining Effectiveness from Community Perspective

There are a number of different definitions of effectiveness. Effectiveness can also be the desired impact. For example, impact is 'improvements in the lives and livelihoods of beneficiaries' (OECD/DAC, 1997). The following definition by Blankenberg (1995) is particularly helpful because it is related to the key concepts surrounding impact assessment: 'Impact concerns long-term and sustainable changes introduced by a given intervention in the lives of beneficiaries. Impact can be related either to the specific objectives of an intervention or to unanticipated changes caused by an intervention; such unanticipated changes may also occur in the lives of people not belonging to the beneficiary group. Impact can be either positive or negative, the latter being equally important to be aware of.'(Blankenberg, 1995).Further, in this study the effectiveness also indicates the extent of reach, accessibility and utility of schemes and programs for by the communities. Therefore it is very important for us to analyze the roles, strengths, and limitations of the Government as well Non Government organizations.

The Role of Non Government & Government organizations

Governmental and the Non Governmental organization play a vital role in the development. This unsubstantiated assumption has increasingly come into

question; throughout the 1990s the issue of assessing NGO impact and the need for appropriate methodologies came to the fore. As the profile of NGOs has increased, so too has the need for them to assess the impact of their work. The rise in popularity of NGOs and the increase in funding channeled through them by governments have had consequences in terms of performance and accountability (Edwards and Hulme 1995). In addition, NGOs have become more critically aware of the need to assess their impact, both for organizational learning and strategy development and in order to inform an increasingly discerning public supporter base. This Policy Briefing Paper explores the current state of the debate on impact assessment of development interventions. It moves on to review the current state of practice and methodologies and concludes with a summary of critical issues and implications for NGOs.

Whereas the Government approach and programs are concerned, the projects are generally of large scale and wide reach. The effectiveness and impact of the projects might be limited in many cases due to poor implementation and accountability.

A Government is a complex of organizations created to look after the safety and welfare of the people. After the attainment of independence by India, the main objective of the State has been to usher in rapid socio economic development for raising the standard of living of the masses suffering from abject poverty, squalor, disease, hunger and ignorance. A large number of government and semi government organizations have been set up to accelerate the process of socio-economic development. The success of this infrastructure depends upon the competence, ethos, enthusiasm and interest of political elite and employees working in these institutions through good governance. (Goel 2007)

Relationship between NGOs and Governments

Parameters	Government programs/Projects	Non Government programs/ projects
Reach	Spread across State and National level	Limited and restricted to certain geographical area

Nature	Welfare focused	Charitable, Welfare & Right Based
Scale	Large scale	Usually small scale
Impact	Generally limited impact but some programs would have long term impacts	Both short term and long term impact can be seen
Funding	Government sponsored	Internal &external funding, receives foreign
Implementation	Usually directly through its existing machineries	Directly through appointed staff and sometimes in association with other NGOs and Government department involved

NGOs are more often distrustful and critical of governments and wary of forging close contacts. These sentiments are often reciprocated. Friendly coexistence between an NGO and government occurs when the NGO requires of the government little more than the freedom to get on with its chosen task, does not seek to influence wider areas of development planning and where its task is not actually hampered by government actions. A Government so happy with such relationship when it feels neither threatened nor challenged, and when the NGO's tasks are not incompatible with its own objectives.(Clark,1991)

Non-governmental organizations play a vital role in the shaping and implementation of participatory democracy. Their credibility lies in the responsible and constructive role they play in society. Formal and informal organizations, as well as grass-roots movements, should be recognized as partners. The nature of the independent role played by non-governmental organizations within a society calls for real participation; therefore, independence is a major attribute of non-governmental organizations and is the precondition of real participation.

One of the major challenges facing the world community as it seeks to replace unsustainable development patterns with environmentally sound and sustainable development is the need to activate a sense of common purpose on behalf of all sectors of society. The chances of forging such a sense of purpose will depend on the willingness of all sectors to participate in genuine social partnership and dialogue, while recognizing the independent roles, responsibilities and special capacities of each.

Non-governmental organizations, including those non-profit organizations representing groups, possess well-established and diverse experience, expertise and capacity in fields which will be of particular importance to the implementation and review of environmentally sound and socially responsible sustainable development. The community of non-governmental organizations, therefore, offers a global network that should be tapped, enabled and strengthened in support of efforts to achieve these common goals.

To ensure that the full potential contribution of non-governmental organizations is realized, the fullest possible communication and cooperation between international organizations, national and local governments and non-governmental organizations should be promoted. Non-governmental organizations will also need to foster cooperation and communication among themselves to reinforce their effectiveness as actors in the implementation of sustainable development.

Objectives of the Study

1. To study the profile of the respondents.
2. To assess the problems felt and faced by the respondents.
3. To identify the areas of intervention of government in developing the community development.
4. To find out the areas of intervention of NGOs among the community people.
5. To assess the effectiveness of the government and non government interventions in the target area.

Methodology

The Study was conducted in Madya Padav Community in Dakshina Kannada,using interview method. The research design of the study is descriptive. A sampling frame was prepared from the information gathered from the local schools and Family Service Agency on the number of household. Through simple random sampling the household were selected for the study. A sample size is 108 people belonging to the community which is undertaken for the study. The data collected was processed using SPSS (Statistical Package for Social Science) version 19. For the purpose of analysis and interpretation, data was organised into tables, charts and graphs based on the objectives of the study.

Results of the Study

Profile of the Respondents

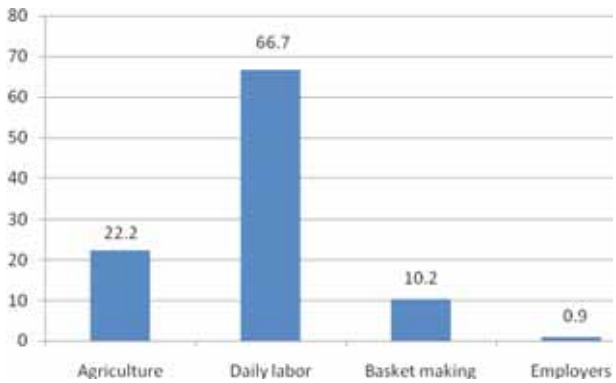
Total number of respondents of the study is 108. Among them, majority 82% Respondents are Female and 18% are Male. Either head of the family was interviewed for the study. A vast majority of the respondents 98 percent belong to the Hindu religion and only other religion is Christianity to which only a non significant (2%) of the respondents.

Table 1. Use of Ration Card in the family

Ration Card	Frequency	Percent
Yes	93	86.1
No	15	13.9
Total	108	100.0

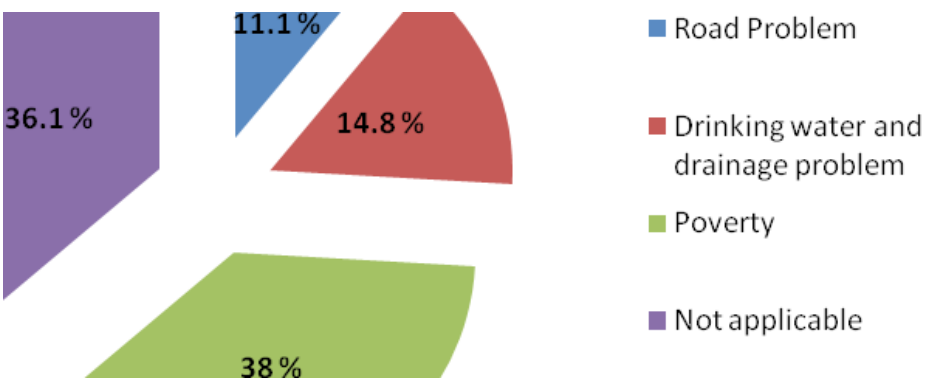
A large majority (86.1%) of the families do use Ration Card where as only 13 percent of the respondents are yet to avail the ration card facility. It can be ascertained that the PDS has been successfully implemented and it has been effective in terms of its reach and accessibility.

Diagram 1. The Major Livelihood activities of the People here



Majority (66.7%) said that daily wage as major sources of livelihood for the people in the locality a significant 22.2 percent said agriculture a one of the major sources of livelihoods and 10.2% said Basket making as another source of livelihood.

Diagram 2. Problems Faced by the People of the Area



A relative majority of (38%) of the respondents stated that poverty is one of the major problems faced by the people in their area. However a significant 36.1% felt that there are no problems as such. Marginal 14.8 percent and 11.1percent respondents felt that there is Drinking water cum drainage and Road problems respectively in their area. From the above finding it can be ascertained

that people in the area are met with basic needs. The presence of poverty is felt by on 38% percent of the respondents, which is significant, however considering availability of facilities in the area such as water, roads, electricity, education facilities etc, it can be assumed that there is a relative poverty.

Table 2. The Diseases that Family Members are Affected with

Diseases	Frequency	Percent
Malaria	12	11.1
Tuberculosis	1	.9
Fileria	1	.9
Rat fever	1	.9
Any other	10	9.3
No response	83	76.9
Total	108	100.0

With respect to the incidences of diseases' in the respondent's families a large majority (76.9 %) said that their family members are not affected with any of the diseases, however among those who got affected, a significant 11.1 percent stated that their family members being affected by Malaria. While analyzing table 19, 20 and 21, it can be ascertained that there has been prevalence of malaria in the community.

Table 3. School Dropouts in the Community

School dropouts	**Frequency**	**Percent**
Yes	57	52.8
No	50	46.3
3	1	.9
Total	108	100.0

A majority (52.8%) of the respondents stated that there have been drop outs from the schools. This is slightly contradictory to the findings of table No. 32 & 33, where a majority of the respondents have stated that there has been adequate number of teachers in the schools as well as the teaching has been made interesting.

This finding would lead to a further investigation into the issue of increase in school dropout rate.

Table 4. Provided with vocational guidance programme

Vocational Guidance	Frequency	Percent
Yes	43	39.8
No	65	60.2
Total	108	100.0

Majority (60.2%) of the respondents said that there has been no vocational guidance programs given or conducted, however rest of the respondents (39.8%) said that they have been provided with such programs

Table 5. The Awareness Programmes being conducted

Programmes	Frequency	Percent
HIV/AIDS	18	16.7
Malaria	28	25.9
Tuberculosis	3	2.8
Filaria	3	2.8
Rat fever	1	.9
Dengue	5	4.6
Cancer	1	.9
Any other	17	15.7
No	32	29.6
Total	108	100.0

With regard to conducting of community awareness programs, a relative majority 25.9 percent said that the awareness regarding to Malaria has been conducted and a significant 16.7 percent expressed that HIV/AIDS related awareness programs being conducted in the community, another 15.7 percent mentioned that there has been other awareness programs in the community.

Over all a vast majority 71.4 percent stated that there has been awareness programs in the community, however it cannot be ascertained that whether these programs are conducted by the Government or Non Government institutions.

Table 6. Medicines are distributed to prevent illness in the community

Medicines	Frequency	Percent
Prevention of Malaria	32	29.6
Fileria prevention	26	24.1
Tuberculosis	5	4.6
Any Other	14	13.0
No	31	28.7
Total	108	100.0

With regard to the preventive community health approach, a majority (72.3%) of the respondents said that there has been distribution of medicines in the community whereas 28.7 percent felt that there were no such activities.

Among those who agreed that medicines being distributed a majority 29.6 percent said that it was for prevention of Malaria and another 24.1 percent said that it was for fileria prevention. A very few (4.6%) said that it were for Tuberculosis.

From the above figures it is evident that there has been series of intervention by the government at the local level in order prevent and control communicable diseases.

Table 7. Health Related Programmes Organized in the Community

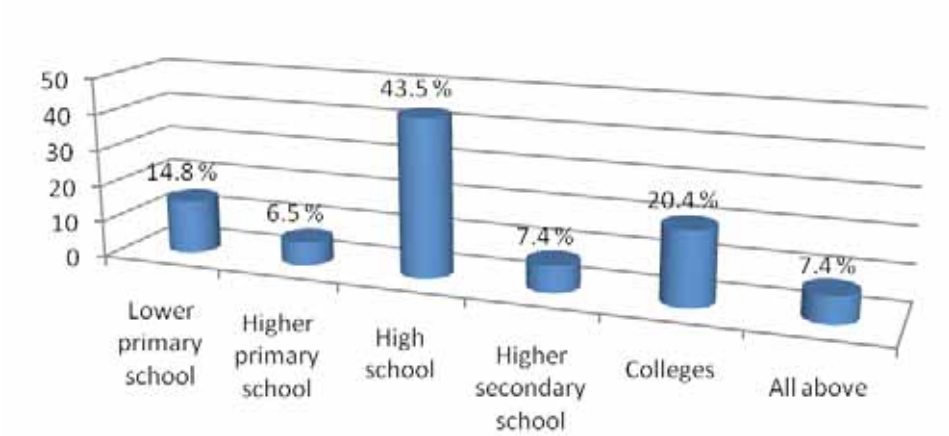
Health Camps	Health related programmes in the community				Total
	Once in three months	Once in six months	Once in a year	Any other	
General medical camp	3	3	23	1	30
Eye camp	2	3	32	0	37
Dental camp	2	0	8	0	10
Any other	2	1	24	4	31
Total	9	7	87	5	108

With regard to health camps conducted in the community, a majority (34%) said that of Eye Camps were conducted, 16 percent & 5.5 percent said that there were general medical camps and dental camps respectively. However a significant 28% stated Any other.

While frequency of health camps being conducted a vast majority (80%) stated that the camps are conducted once a year of which eye camps being highest at 36 percent.

Health camps usually being conducted at the community level by the Government or non government organisations for providing basic health care to the poor, however some private hospitals also get involved as a part of their CSR activities.

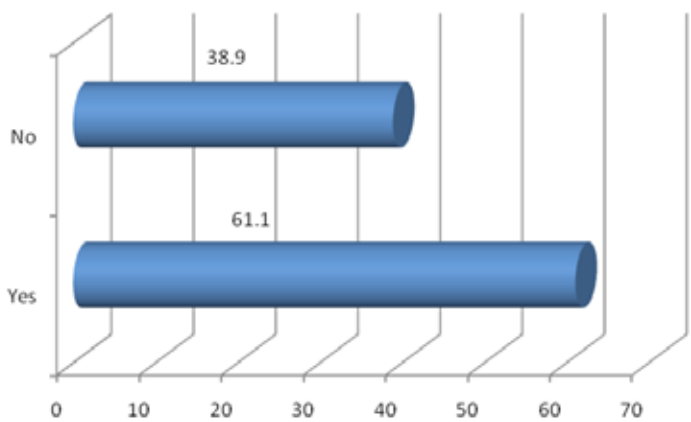
Diagram 3. The Educational Institutions Existed Within the Accessible Vicinity



With regard to access to educational institutes within the accessible radius or vicinity 100% of the respondents agreed that there is an easy access. A majority (43.5%) of them being are High Schools.

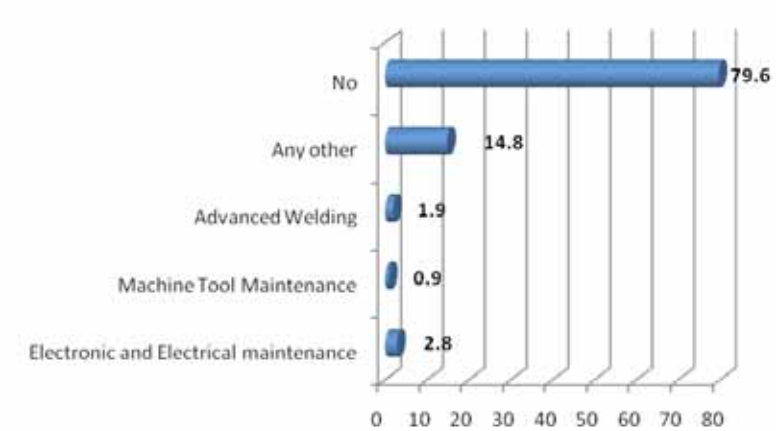
Diagram 4. NGOs Network with the School

The diagram below proves that while there are many non government agencies have their interventions among Children in schools, the current finding too indicate the same, however it also indicate that there is lot more need to be done



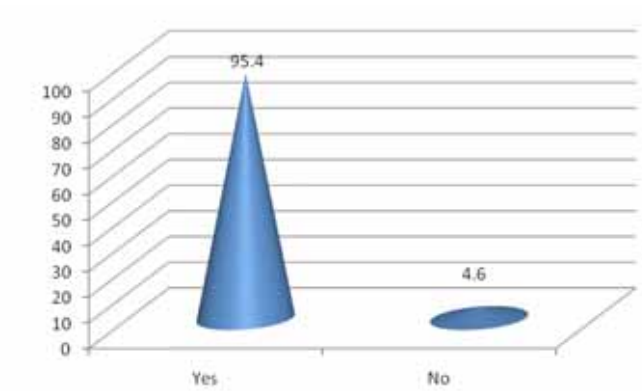
With regard to NGOs network with schools a majority 61.1 percent stated that there has been involvement of NGOs, however 38.9 percent opined that there is no such networking.

Diagram 5. Short Term Courses Given in Industrial Training



With regard to short term industrial training a large majority (79.6%) said that no such trainings provided, however 2.8 percent, 1.9 percent and 0.9 percent said that short term courses provided in the field of Electronic/electrical maintenance, Machine tool and advanced welding, respectively. 14.8 percent of the respondents said that there has been some other short term industrial trainings apart from those who listed above

Diagram 6. Regular Access to Transportation Facilities



With regard to regular access to the transportation facilities a large majority (95.4%) said that there adequate and regular transport facilities; however a 4. 6 percent of the respondents felt otherwise.

Availability of transport and communication facilities is a major factor in the development of the communities. This would help the children in taking up higher education and the youth to undertake employment at reasonable distances. This could also help women in their mobility.

Major Findings

Profile of the respondents

- A large majority (89%) of the respondents is females; also a relative majority (32%) of them is in the age group of 18-28 years. When put together two age groups (18-28 and 29-39) , which can be considered a productive adult age group, a large majority (50%) contribute to the total respondents and consist of 60 percent of total female respondents
- A vast majority of the respondents 98 percent belong to the Hindu religion and only other religion is Christianity to which only a non significant (2%) of the respondents
- Majorities (49%) of the respondent are educated up to primary level; a significant 20 percent of the population is illiterate. A very few (3.7%) of the respondents are educated up to and above Graduate level
- With regard to no. of persons unemployed in a family a majority of (34%) respondents stated that at least 2 members in their families are unemployed, where as 22 percent stated that at least one member in their families is unemployed. It can also be noted that a significant 40 percent respondents stated that there are no unemployed members in their families.
- While provision of vocational guidance is considered a majority of (60%) respondents stated that their family members have not received any vocational guidance where as 40% stated that they have received the vocational guidance.
- Of the total 37 (34%) respondents who have stated that two members in their family are unemployed, a majority 54% of them have not received any vocational guidance.

Basic Facilities Availability

- Vast majorities (93.5%) of the respondents have the electricity connection and 6.5 percent of them stated that they do not have the electricity facility.
- A significant 35 percent of the respondents have the aged members in their families of which a majority of 85 percent did not avail the old age pension benefit.
- Out of the total 108 respondents only 10 (9.2%) have differently able persons in their families of which 60% receive the pension and a significant 40% of them do not receive any pension meant for the handicapped.
- A large majority (86.1%) of the families do use Ration Card where as only 13. Percent of the respondents are yet to avail the ration card facility. Public Distribution System (PDS) is one of the effective programs in the district of Dakshina Kannada when compared to other parts of the country.

Addiction in the community

- A significant 38.9 percent respondents said that they have members in the their families who chew Gutka where as a majority 61.1 stated that their family members do not chew Gutka
- With regard to the consumption of alcohol a majority 70 percent of the respondents said that they do not have alcoholics in their families, where as 30 percent of them said that they have members in their family who are alcoholics.

Health Status

- A majority of 51.9 percent of the respondents said that they approach private clinics for treatment of illnesses, however a significant 38.9 percent expressed that they go to the Government hospital in the event of illnesses in their families.
- With regard to health camps conducted in the community, a majority (34%) said that of Eye Camps were conducted, 16 percent & 5.5 percent

said that there were general medical camps and dental camps respectively. However a significant 28% stated any other.

- With regard to the preventive community health approach, a majority (72.3%) of the respondents said that there has been distribution of medicines in the community whereas 28.7 percent felt that there were no such activities.
- Among those who agreed that medicines being distributed a majority 29.6 percent said that it was for prevention of Malaria and another 24.1 percent said that it was for fileria prevention. A very few (4.6%) said that it were for Tuberculosis.
- With regard to conducting of community awareness programs, a relative majority 25.9 percent said that the awareness regarding to Malaria has been conducted and a significant 16.7 percent expressed that HIV/AIDS related awareness programs being conducted in the community, another 15.7 percent mentioned that there has been other awareness programs in the community. Overall a vast majority 71.4 percent stated that there have been awareness programs in the community.
- With respect to the incidences of diseases' in the respondent's families a large majority (76.9 %) said that their family members are not affected with any of the diseases, however among those who got affected, a significant 11.1 percent stated that their family members being affected by Malaria.
- A majority (66%) stated that the children are provided with Vitamin "A" Folic Acid with Iron; however a significant 38.9% stated that the children are not provided with the tablets.

Water and Sanitation

- A vast majority of (86%) said that there is regular supply of water, whereas 14 percent stated that there is no regular supply of water.
- With regard to drinking water facility majorities (46%) have access to drinking water through Tap water connection; the same population also felt that there is regular water supply.

- A majority (61.1%) of the respondents stated that there is drainage facility in the community, whereas 38.9% stated that there is no such facility.
- A vast majority (97.2%) of the respondents stated that they have toilets, whereas only 2.8 percent do not have the toilet facility.
- A vast majority (81.5%) of the respondents stated that bathroom facility is available in their houses where as a significant 18.5 percent stated that there are no bathrooms available.
- With regard to disposal of garbage a vast majority (78%) stated that there is no door to door garbage collection in there are where as 22 percent said that there is door to door collection of garbage.

Education

- A majority (54%) of the respondents stated that there are recreational facilities in the community. Among the leisure time activities a majority 25.5 percent stated that youth are involved in playing various games.
- A majority (84%) of the respondents said that the Children in the age group of 6-14 years do attend Schools, this indicate that there has been a healthy literacy rate in the community and also parents are paying attention towards their Child's education.
- With regard to access to educational institutes within the accessible radius or vicinity 100% of the respondents agreed that there is an easy access. A majority (43.5%) of them being are High Schools.
- A majority (80%) of the respondents stated that the schools have sufficient number of teachers.
- A majority (84.3%) of the respondents stated that teaching and learning has been made interesting for the Children in the schools
- A majority (52.8%) of the respondents stated that there have been drop outs from the schools,
- A majority (53.7%) of the respondents stated that no programs being conducted to bring the dropouts to the mainstream, whereas a significant 46.7 percent said that there are such programs being conducted.

- With regard to involvement of community in its functioning a majority (70.4%) said that the community being involved.
- A majority (70.4%) of the respondents opined that Schools seek support from the local people.
- This finding is in line with (Table 36,) the previous finding, it is very encouraging to see that there is community participation with regard to functioning of schools.
- A majority of 67.6 percent of the respondents stated that the SC/ST Children receive quality bags and note books from the Government. 26.9 percent said that the quality of the above said items are not good.
- With regard to NGOs network with schools a majority 61.1 percent stated that there has been involvement of NGOs, however 38.9 percent opined that there is no such networking.
- A large majority (88%) of the respondents said that the schools in the locality are attractive and have safe buildings, where as 12 percent opined otherwise.
- With regard to the involvement of parents by teachers in order to share their children's qualitative improvement a large majority 82.4 percent respondents stated that the teachers bring into notice of the parents about the improvements of their children
- A majority (72.2%) respondents felt that teachers do provide remedial measures for those who lagging behind in learning. This can be considered as a good sign as the teachers are being accommodative and cooperative in child's education. This would also help the children who are academically weak.
- A majority 87 percent stated that there is no mobile school in the locality. This seems to be irrelevant as (ref. table 31) as there are easily accessible educational institutes in the vicinity.

Livelihood and Employment

- A majority (66.7%) said that daily wage as major sources of livelihood for the people in the locality a significant 22.2 percent said agriculture a

one of the major sources of livelihoods and 10.2% said Basket making as another source of livelihood.

- A majority (60.2%) of the respondents said that there has been no vocational guidance programs given or conducted, however rest of the respondents (39.8%) said that they have been provided with such programs
- A large majority (76.9%) of the respondents said that there was no market linked/employment linked orientation programs and 23.1 percent said that there information related to employment available in the market is available or provided
- With regard to short term industrial training a large majority (79.6%) said that no such trainings provided, however 2.8 percent, 1.9 percent and 0.9 percent said that short term courses provided in the field of Electronic/ electrical maintenance, Machine tool and advanced welding, respectively. 14.8 percent of the respondents said that there has been some other short term industrial trainings apart from those who listed above,
- A large majority 90.7 percent of the respondents said that there is no Hi-tech training offered in the locality.
- A majority (66.7%) opined that there is no craftsman training being provided in the locality.
- Among those who opined (33.3%) that craftsman training provided in the locality, a majority (22.2%) were for the Tailoring.
- It is evident from the tables 48, 49, & 50 that there is need for skill training in the area which barely being addressed by the Government or Non Government agencies.
- A vast majority of (85.2%) said that there are no free trainings provided by the Government.
- A majority (76%) of the respondents stated that youth are not motivated to be economically productive.
- A majority (76.9%) of the respondents said that there are no steps taken by the youth to be employed.

Transportation & communication

- With regard to regular access to the transportation facilities a large majority (95.4%) said that there adequate and regular transport facilities; however a 4. 6 percent of the respondents felt otherwise.
- A majority (63.9%) of the respondents said that there are fixed line telecom services available and a significant 36.1 percent felt that there no such services available.
- Large majority (99.1%) respondents said that there is no internet facility available in their locality and an insignificant 0.9 percent said that such facility is available.
- A majority (67.6%) of the respondents said that there has been law and order situation in the locality however 32.4 percent felt that people do not observe law and order in their locality.

Problems faced by the community

- A relative majority of (38%) of the respondents stated that poverty is one of the major problems faced by the people in their area. However a significant 36.1% felt that there are no problems as such. A marginal 14.8 percent and 11.1percent respondent felt that there is Drinking water cum drainage and Road problems respectively in their area.
- Majority (58.3 %) respondents said that there reaction of police in controlling the communal problems or tensions are not adequate. However 41.7 percent of the respondents said that the police hold control during such situations.
- With regard to the marriage of the Children in the community a large majority (79.6%) stated that no marriages take place before the age of 18 years. However a significant 20.4 percent stated that the marriages takes place even before attaining 18 years of age

Conclusion

As we analyzed about Government and Non Governmental effectiveness in community development, it is very important that people are provided with

awareness of the schemes available for them. There is also need for an accountability from the community side by participating in the decision making process, this can be done by participating in Gram Sabhas or urban local self government.

Non Government agencies need to work in tandem with the Government agencies rather work as parallel institution. Whenever they worked together, the results have been encouraging. Most of the times private and government agencies have ended up in duplicating the same work, whereas the same resources would have yielded better results if they were used uniquely.

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Spirituality – A Pathway to Wellbeing in Old Age

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Abstract

This article focuses on spirituality and its influence on wellbeing among the old age. This paper presents a perspective on the development of knowledge in the spiritual dimension of aging. At present, the gerontological literature is drawing attention to the increasingly influential role of existential factors such as spirituality, religiosity and personal meaning in the wellbeing of older adults. Spirituality plays an ever-increasing role in the lives of older adults and in their pursuit of physical and psychological wellbeing. Since spirituality is viewed as basic human need it has the potential to promote the quality of life of elderly, whether ill or well. This article tries to explore the role of spirituality which influences the health status of elderly. It provides further evidence of universality of the concept of spirituality and applicability of its theory to the wellbeing of elders. Further, health problems in later life, role of spirituality in wellness, effect of spirituality on physical and psychological wellbeing of older adults have also been highlighted.

***Key Words**: Spirituality, Old Age, Wellness, Physical Health and Mental Health*

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Introduction

World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity. Further, WHO have also included the fourth dimension called spiritual well-being in its definition (Kapur, 1995). Hence, it is clear that spirituality plays a significant role in influencing the physical and mental health of an individual who practice it regularly. Optimism, quality of life, satisfaction with life and spiritual health were found to be positively and significantly related with subjective well being (Inang, 2002). An overview of spirituality and aging by Blazer (1991) stated that older adults frequently use both spirituality and religion as a coping and support mechanisms. Specifically for older adults, spirituality and religion are associated with a myriad of mental health and physical benefits. For example, spirituality has been described as a buffer against depression, a way to maintain meaning at the end of life, and a mechanism for preparation for death and dying (Blazer, 1991; Holt and Jenkins, 1992). Spirituality has been linked to positive physical health and inversely related to physical illnesses (Miller and Thoresen, 1999; Musick et al. 2000; Richards and Bergin, 1997). Additionally, the use of spiritually-based interventions with the spiritual client may further enhance the strength of the therapeutic relationship—a critical component in predicting positive outcomes for psychotherapy (Lambert & Bergin, 1994; Richards and Bergin, 1997). According to Gerber (2001) a system of medicine which denies or ignores [the spirit] will be incomplete, because it leaves out the most fundamental quality of human existence - the spiritual dimension.This article argues that spirituality is a core component for healthy and successful aging. This article first introduces the concept of spirituality and health. Second, the article briefly discusses the research relating to spiritual practice on health. Third, it sets the wider context of health problems relating to modern living. Fourth, the role of spirituality in wellness. Finally, the effect of spirituality on physical and psychological wellbeing of the older adults

Spirituality and Health

The word “spirituality” originated from a merging of the Latin word for breath, “spiritus,” with the concept of enthusiasm, from the Greek “enthousiasmos,” meaning “the God within.” Todd (2004) explains that the resulting word,

spirituality, "captures the dynamic process of divine inspiration" or "the breath of God within." Spirituality has salutary effects in the lives of older adults and in their pursuit of physical and psychological wellbeing. As one gets older, the role of spirituality becomes more prominent. Wang et al. (2008) proved that as spirituality increased, older adults tended to experience not only better physical health but also general mental health. Udermann (2000) concluded that there is strong scientific evidence that individuals who a) regularly participate in spiritual worship services or related activities and / or b) feel strongly that the presence of a higher being or power is a source of strength and comfort to them are healthier and possess greater healing capabilities than people who do not attend worship services and / or have a strong relationship with a higher being or power. Koenig (2008) examined nearly 3000 original studies since 1800 which looked that the relationship between religion/spirituality and the health of individuals and populations. It was concluded that the majority of studies report a positive relationship between religion / spirituality and well being including stress reduction, minimization of depressive symptoms, enhancement of quality of life, reduced alcohol and substance abuse, lower crime and delinquency, improve school grades, healthier lifestyles, reduced risky sexual behaviour, quicker recovery from illness and better physical health. Keonig (2008) also found that communities with a high percentage of religious involvement recovered more quickly from natural disasters and acts of terrorism. Alexander et al. (1991) performed a meta-analysis on the transcendental meditation literature. They examined 18 major studies with over 1200 participants who ranged in meditation experience from five weeks to five years. The researchers reported that many studies show that within three days of beginning to practice the spiritual meditation, "virtually all" participants were able to achieve a mystical state and, within this three days time period, individuals began to show psychological and physiological changes. Further, the research indicates that these mystical states occurred more often among spiritual meditation practitioners than among those who practice secular relaxation or meditation techniques. Correlations have also been reported between the clarity and frequency of mystical experiences and the levels of psychological and physiological changes (Alexander et al., 1991). By cultivating transcendence, spiritual meditation proponents claim that practitioners open themselves up to a

range of new spiritual experiences, such as a deeper connection to others and the universe around them. This new awareness, in turn, allows them to adapt better to stress, which, in turn, results in better psychological and physiological health (Alexander et al., 1991). Psychiatrists concern themselves with human mental suffering. Behind the consulting room door they reflect with their patients on questions of meaning and existence, issues that concern philosophy and religion as much as psychiatry. It is striking, therefore, that psychiatrists regard spirituality and religion as, at best, cultural noise to be respected but not addressed directly, or at worst pathological thinking that requires modification (Larson et al., 1993).

Research Relating to Spiritual practice on Health

At present the public has come to view spirituality and spiritual practices as ways of improving physical and psychological health and well-being. While not all clinicians and researchers share this view, an entire subspecialty of spiritually oriented counseling and psychotherapy has emerged, as well as lines of research that support it (Richards and Bergin, 1997; Sperry, 2002; Sperry and Shafranske, 2005). Research suggests that meditation may be useful in treating anxiety disorders (Carlson et al., 1998), heart disease and increasing immune functioning. The use of relaxation is often in conjunction with prayer, mindfulness, or other spiritual practices. Meditation represents one popular spiritual approach which has been integrated with many therapies (Koenig et al., 2001). According to Seccareccia and Brown (2009) modern palliative care defines four key domains fundamental to a patients' holistic care: physical, emotional, social, and spiritual. Regardless of the symptom being addressed, all four domains of care may need to be addressed to reduce suffering and encourage healing. Yet, despite the spiritual domain consistently being asserted as an integral part of palliative care, more is written on how to provide the physical, emotional, and social aspects of care than on how to provide spiritual care. Brown et al. (2009) argues yoga breathing is an important part of health and spiritual practices in Indo-Tibetan traditions. Considered fundamental for the development of physical well-being, meditation, awareness, and enlightenment, it is both a form of meditation in itself and a preparation for deep meditation.

Research study by Mayo (2009) on neurobiology supports the use of spiritual techniques as a beneficial treatment for anxiety. Psychotherapy, including mindfulness CBT and meditation, has been shown to change brain structure. The amygdale-the brain structure responsible for processing emotion and anxiety-demonstrates plasticity, and the purpose of therapy may be to allow the cortex to establish more effective and efficient synaptic links with the amygdale. Shafranske (2009) argues that spiritually oriented psychodynamic psychotherapy pays particular attention to the roles that religious and spiritual beliefs, practices, and experiences play in the psychological life of the client. Contemporary psychoanalytic theorists offer multiple approaches to understand the functions of religious experience. Spirituality provides a means to address existential issues and provide a context to form personal meaning. Psychotherapists address a client's spirituality by exploring the psychological meaning of such personal commitments and experiences and refrain from entering into discussion of faith claims. Addressing spirituality in the clinical encounter may lead to improved detection of depression and treatments that are more congruent with patient's beliefs and values (Wittink, 2009). Experimental research has examined the effects of meditation (Cahn and Polich, 2006) and many studies have found that meditation can induce a sense of deep inner peace and calm, creating a shift from sympathetic nervous system arousal to parasympathetic nervous system relaxation (Yehuda & McEwen, 2004). There is evidence that those who meditate on a regular basis experience less stress and more positive affect as well as enhanced immune functioning and lower cardiovascular reactivity, and more left-sided anterior activation (Grossman et al., 2004; Davidson et al., 2003; Ditto et al., 2006). Spiritually based meditation may have more powerful effects on health than non-spiritual-based meditation (Wachholtz and Pargament 2005). Spiritual needs are actually dimensions of spiritual well-being, and that these needs should be addressed by mental health professionals working with older adults (Blazer, 1991).

Health problems in Later Life

Aging is a universal phenomenon of increasing importance to both developed and developing countries as their older populations increase. Under its impact, long term care for the elderly has emerged as one of the most important issues

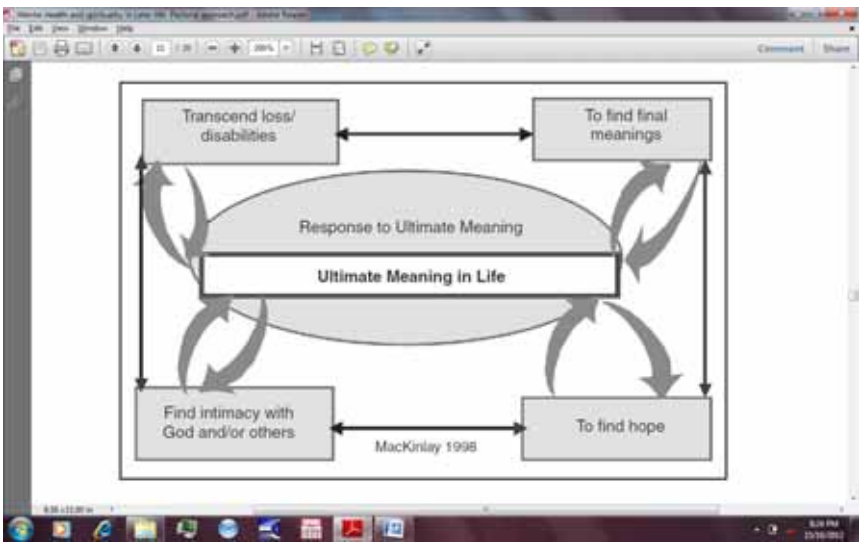
throughout the world in the twenty-first century. Regarding the health problems of the elderly of different socioeconomic status, it was found (Raju, 2002) that while the elderly poor largely describe their health problems, on the basis of easily identifiable symptoms, like chest pain, shortness of breath, prolonged cough, breathlessness/ asthma, eye problems, difficulty in movements, tiredness and teeth problems, the upper class elderly, in view of their greater knowledge of illnesses, mentioned blood pressure, heart attacks, and diabetes which are largely diagnosed through clinical examination. As age advances, due to deteriorating physiological conditions, the body becomes more prone to illness. The illness of the elderly are multiple and chronic in nature. In the later years of life, arthritis, rheumatism, heart problems and high blood pressure are the most prevalent chronic diseases affecting the people (Raju, 2002). The surgeon general's 1999 report on mental health devoted a whole chapter to older adults and mental health, addressing a wide range of issues including serious mental illness, "minor" depression, Alzheimer's disease, and substance abuse. The report concluded that mental illness among older adults "will become a major public health problem in the near future because of demographic changes" (U.S. Department of Health and Human Services, 1999). Jeste et al. (1999) have estimated that the number of elders with psychiatric disorders will reach approximately 15 million in 2030. Anxiety disorders are common in later life and may burden the public health system even stronger than depressive disorders (Schraub, 2000). Diagnostic criteria for anxiety disorders only work in young patients. The hierarchical rules of these criteria allow a diagnosis of anxiety disorder only in somatically healthy people. When anxiety disorders are diagnosed in the elderly, there is a relatively high probability of comorbid conditions being present (Beekman et al., 2000). Research has also found that the prevalence rate of minor depression in older adults is much higher than in other age groups (Wyman et al., 2010). Elderly people have a higher risk of committing suicide than any other age group worldwide (WHO, 2003). Despite this, suicide in elderly people receives relatively little attention, with public health measures, medical research, and media attention focusing on younger age groups (Uncapher et al., 2000).

Role of Spirituality in Wellness

Spirituality is emphasized as a "core component" of the retreats, which included activities such as meditation, prayer, yoga, relaxation, breathing exercises, visualization, physical exercise, communication skills, social support, and various discussion groups (Kennedy et al., 2002). Spirituality and Religion may directly and indirectly influence mental and physical well-being (Hodges, 2002; McCurdy, 2003; Miller and Thoresen, 2003; Seybold and Hill, 2001; Westgate, 1996). This relationship is apparent in much of the counseling research on wellness (Sweeney & Witmer, 1991). Wellness models by (Adams et al., 2000; Sweeney and Witmer, 1991) have included spirituality as a vital component of wellness. These wellness models emphasized the important link between spirituality, mental health, and physical health, as each play an equally vital role in the well-being of an individual. Spirituality and religiousness have generally reported positive correlations between internal characteristics and well-being including life satisfaction (Kelley and Miller 2007). Riley et al. (1998) examined spiritual well-being in different groups of patients with different types of spirituality. 216 participants with breast cancer, prostate cancer, spinal cord injury, post-polio or amputees were divided into three groups: a religious group, an existential group, and a non-spiritual/religious group. The results showed that the non-spiritual group demonstrated significantly less social, physical and emotional well-being than the other groups and reported lower quality of life. It was concluded that the lack of either religious or existential beliefs is correlated with a significantly lower quality of life following illnesses. Spirituality contributed significantly to mental well-being and functional health status and was inversely related to HIV symptoms (Sowell et al., 2002). Gurin et al. (1960) found church attendance to be positively related to such well-being measures as job and marital happiness, lack of distress and worry, positive self-concept, and general happiness.

Effect of Spirituality on Physical and Psychological wellbeing of Older Adults

Spirituality in Aging: Tasks



Source: MacKinlay et al. 2001

The spiritual dimension is an important as the physical and psychosocial dimensions of being human. Spirituality also plays a part in issues of suffering and pain; pain is not only physical, but may also be existential and spiritual (MacKinlay and Swinton, 2001). Bartlett et al. (2003) found that spirituality was an independent predictor of happiness and positive health perceptions. Cotton et al. (1999) examined the relationship among spirituality, quality of life, and psychological adjustment in 142 women with breast cancer. The results revealed a positive correlation between spiritual well-being and quality of life. In particular, spiritual well-being was related to specific adjustment styles such as positive thinking, faith, hope, optimism for the future, and finding meaning in life. Ellison (1994) provided a conceptual framework to help understand the mechanisms through which religious involvement and spirituality may influence mental health. He suggested that spirituality may (a) reduce the risk of a number of stressors (e.g., antisocial behavior); (b) provide a sense of meaning or coherence that counteracts stress and assists with coping; and (c) provide

a network of like-minded persons who can serve as social resources and promote the development of psychological resources, including self-esteem and a sense of personal worth. Kirby et al. (2004) reported that spiritual beliefs was a significant predictor of psychological well-being among 233 frail and non-frail elders in Britain and moderated the negative effect of frailty on psychological wellbeing. They suggested that spirituality was a resource in maintaining psychological well-being and that it was more significant for elders with greater levels of frailty. Seidlitz et al. (2002) found that individuals scoring at the low and high ends of spirituality reported relatively more positive (e.g., joviality, self-assurance) and less negative (e.g., hostility, sadness) emotions than those scoring near the middle of spirituality in a community sample. Participants described their faith in God and prayers as influencing their recovery. Spiritual meditation has been utilized to lower heart rate, blood pressure (O'Halloran et al., 1985; Wenneberg et al., 1997); metabolism (Elias et al., 2000; Titlebaum, 1998); galvanic skin response, respiration rate and alters EEG readings (Dillbeck, 1987); enhanced autonomic stability during stress (Alexander et al., 1991); and altered endocrine responses to stress (Infante et al. 1998). It has been suggested that spirituality can also affect pain tolerance. Among advanced oncology patients, religious beliefs correlate with general happiness and life satisfaction as well as with decreased reports of pain (showing increased tolerance) and less perceived pain (Yates et al., 1981). Studies on spiritual dimension of aging led to the development a model of spiritual tasks in aging by MacKinlay (2001). This model serves as a framework for pastoral care of people who experience mental illness, and in particular in the context of this paper, those who are depressed or have dementia. The model begins with an exploration of the person's sense of ultimate meaning in life, that is, what forms the core of existence and deepest meaning for the individual. Powell et al., (2003) labelled the evidence for the propositions ''Religion or spirituality slows the progression of cancer'' and ''Religion or spirituality improves recovery from acute illness'' as ''consistent failures''.

Relevance of Spirituality to International Social Work Practice

Interventions focusing on spiritual perspective need to be provided and considered to improve general wellbeing for spiritually oriented elderly. It is

essential for social work practitioners to learn about older adult's cultural backgrounds and values as an integral part of delivering client-centered services. Further, taking spiritual history of the client helps the social workers to understand the spiritual needs and allows the elders to voice their spiritual and existential concerns. Social works can use the responses form spirituality mini assessment protocol to determine how to provide support for progressive movement of older clients in terms of the refinement or adaptation of life themes in the face of current, adverse circumstances (Langer, 2008). Integrating of spirituality into social work curriculum is the better preparation for professional competence in caring for spiritual wellbeing. Scientific research studies on spirituality have to be undertaken by the social work educators to promote a high standard of spiritual based service to the society. In teaching research, social work educators should also include evidence that reveals the complexity of spirituality and its role in health and wellbeing. Finally, the inclusion of spirituality in social work training and practice offers many opportunities to the practitioner to develop an innovation and best practice that respectfully and completely responds to human diversity.

Conclusion:

This article seeks to convey the message that spirituality has a significant effect on the wellbeing of the old age. It has revealed the positive effects of spirituality on the physical and mental health of older adults. This article provides an important understanding of spirituality as a core component of elderly wellbeing. Further, spirituality is also been used as a low cost intervention in dealing with the geriatric problems. Salutary effects of spirituality on well-being have been found in the western literature and there is no much literature relating to spirituality and health with respect to Indian perspective and there exist a research gap in Indian nursing literature. Hence, attention should be given by Indian health care professionals to understand the real spiritual needs of the patients. Additionally, the use of spiritually-based interventions with the spiritual client may further enhance the strength of the therapeutic relationship. This article clearly depicts that spirituality is a most significant means for coping with the crises and problems of living and dying. In relation to physical health, spirituality has been linked to positive physical health and inversely related to

physical illnesses. It is important to emphasize that effective health care requires a team approach, and that spiritual care forms an important part of this approach, in both prevention and treatment. While this research has opened up many avenues for future research, it has also provided some valuable insights concerning the elderly.

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Leisure - An Empowerment Perspective for Women

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Abstract

This paper focuses on the Leisure from an empowerment Perspective for women. This is usually a sidelined issue, but access to leisure can be looked at even from a larger developmental perspective. It can bring about Gender Equity and women empowerment. This paper explains the different perspectives through which leisure can be considered for women empowerment. Leisure is viewed as social space in the lives of women, which helps them view their life as agents in their own lives, revisiting dominant stereotypes related to gender, ethnicity, culture, class and age and creatively constructing and reconstructing spaces of collective belonging and friendship. A body of research has also pointed out the benefits of leisure for health and well-being for women using several outcome variables, such as quality of life, life satisfaction and mental 'problems' that run from mere stress to psychological symptoms to psychiatric illnesses.

Key Words: *Leisure, Empowerment, Perspective, Gender Equity, Women Empowerment*

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Introduction

While leisure may appear to be a strange thing to worry about for an average Indian household, given their intense preoccupation with day-to-day life struggle, there is no doubt that some access to leisure enhances the quality of life not only of the leisured individual but also of his or her associates. Therefore, a concern with the access to leisure is legitimate even from a larger developmental perspective. In this paper, the author looks at one important but usually sidelined aspect of gender equity and female empowerment- Leisure. (Basu, 2006)Much of the research on empowerment is about women having the resources, technical, material and physical, to take decisions, to be physically mobile and to manipulate their larger environment. In turn, this empowerment is valorized because of all the good uses to which it is typically put according to the large and growing literature on female empowerment. The autonomous or empowered women is supposed to be good for society and for the family because her autonomy results in lower fertility, lower infant and child mortality, better household welfare, higher contributions to economic development, and other benefits. But there is much less concern with what autonomy and empowerment can do for women themselves, with the exception of the demographic outcomes like better health. However, a case can be made for thinking of access to leisure as an outcome of empowerment for women as well as a determinant of such empowerment. That is to say, that first of all, women deserve to get more out of equality and empowerment than better housekeeping and childrearing skills. In any case, as argued in another paper (Basu and Koolwal, 2004), becoming better wives and mothers may often reflect a greater sense of responsibility rather than a greater sense of authority or power. Empowerment that allows a woman to decide what to cook for dinner or whether to take a sick child to a hospital is desirable empowerment of course, but those activities are on the whole non-contested household activities because they lead to greater household welfare, so it is not clear that they require all that much freedom being exercised by the woman. In this sense, women's access to leisure may be better able to capture their autonomy.(Basu, 2006)

Access to leisure may also more accurately reflect gender equality than factors like employment. Not only are men and women in most societies, are

differentially enabled to access material resources, men are much more likely to be granted rights to the time and money to spend on themselves. Men are more likely to spend their money on tea and cigarettes than their women counterparts.

But tea and gossip are good for women too (even if cigarettes are not). They make life a little more interesting and fun. Leisure is also very important as a determinant of empowerment. That is, participation in leisure may empower women in direct and indirect ways, which in turn, also have important demographic implications. (Basu, 2006)

Theorizing Leisure

Leisure is of course not a clearly defined activity, to the extent that the statistics may understate women's access to leisure. At the same time, some attempt to separate out the "leisure" component of a day's activities becomes important as the nature of women's lives changes, precisely in response to calls for greater empowerment.

As for what constitutes leisure, it is a somewhat ambiguous concept – lawn mowing may be a leisure activity for the energetic homeowner, while it is a day's work for the professional gardener. Very broadly one can think of leisure as made up of activities that are undertaken because they afford pleasure or happiness in themselves, not because they lead to some other kind of good; that is, not for their instrumental value. For example, child care does not count, even if it is inherently pleasurable, because it does achieve a greater purpose, that of child welfare. By contrast, more creative forms of leisure (art or music, for example) may have instrumental value in addition to being intrinsically pleasure giving, yet if they are done with this larger instrumental purpose they would not count as leisure. In any case, women have traditionally not had the kind of access to leisure that produces good artists and musicians, so this may be a moot point. For the bulk of women in country like India, leisure as an indicator of empowerment and welfare is probably best described in terms of very simple things such as a chance to rest, to socialize, to be entertained by the mass media and may be defined broadly as: the ability to be somewhat "unproductively free".

Women, Leisure And Empowerment

In view of these findings many studies pertaining to leisure suggest that, now-a –days, women's leisure is no different than man's leisure. In fact, it acts as an inalienable factor and a resource which contributes not only to women's overall well being and development, but also with its inherent aspect of freedom of choice, it helps to rejuvenate their energies and spirits. According to Borg and Clark (2007), an opportunity to enjoy one's leisure gives women space in which they could experiment with different lifestyles as well as opportunities for identity development. Green (1998) also seems to endorse this argument while stating that, access to leisure may also more accurately reflect gender equality and also a crucial site of gendered identity construction.

Wearing (1998), has visualized leisure as a personal space which could be physical and metaphorical, which exists with women through whatever persons, objects, activities or thoughts one chooses. A space of resistance; a space for being and becoming. Leisure is also viewed as social space in the lives of women, which helps them view their life as agents in their own lives, revisiting dominant stereotypes related to gender, ethnicity, culture, class and age and creatively constructing and reconstructing spaces of collective belonging and friendship (Green, 1998).

Not only does female empowerment increase the possibilities for leisure, leisure in turn increases female empowerment in several ways. As Shaw (2001) explained, leisure, especially collective leisure, can become a site of resistance to traditional power relations, both deliberately as well as unintentionally (Green, 1998). Women can both acquire as well as exercise power and resistance as individuals by undertaking leisure activities that are not socially or culturally legitimate (sports, for example). Alternatively they can do so as a group – group activity usually being easier to organize when traditional structures of authority are being challenged. In addition, whether operating as individuals or as groups, women practicing leisure can exert a ripple effect – their behaviour can cause others to rethink and energize other individuals or groups to follow their example. In turn, the sense of control that such "political" forms of leisure give can increase the overall sense of control women feel with other aspects of life; again an empowering effect.

In the 1990s there was a clear shift in feminist thinking from looking at the relationship between women' s lives and women' s leisure as negative and linked to their oppressed status within a patriarchal structure, to focusing upon the ways in which leisure participation can function as resistance to traditional gender relations. As Shaw (1994) argues, this is not to claim that all or even most of women' s leisure can be seen in this light, rather , that not all leisure is oppressed, constrained or constraining; it is the context and the meanings which determine whether it can be perceived as resistance. Understanding the meanings and events which comprise the fabric of day-today living allows us to interrogate the importance of leisure in lives of women, which are oriented around relationships and changing familial and domestic roles; roles and relationships which are central to identity formation. In the case of young mothers overwhelmed by the ethic of care, the need to prioritize some time for ' pampering' themselves, or engage in 'self-care' , is conceptualized as a way of bringing balance into their lives and could also be seen as a way of maintaining a sense of self or personal identity through leisure (Bialeschki and Michener , 1994).

Despite underlining the importance of choice, and closely negotiated leisure spaces for women as a source of identity and self-esteem, feminists among others, have neglected the relationship between enjoyment, relaxation and leisure, and identity . Given that women' s leisure is shaped by their relationships with others, in addition to an awareness of and concern for others' feelings and wishes, (Freysinger,1995), women only events which facilitate autonomy and freedom from caring responsibilities provide a crucial forum for self empowerment and autonomy .

Construction Of Gender Identities Through Leisure Friendship

According to a research, on leisure as affiliation or community (for women), among the different ways, there is also a mention of maintenance of friendships and interaction with others, (Freysinger, 1995) especially with other women, gives them the specific opportunities for resistance to gender stereotyped roles and images. This friendship provides a forum for women

to re-construct gendered identities, especially those elements which challenge socially acceptable 'womanly' behavior, which can be an empowering aspect.

The emphasis here upon the shared sense of belonging which women experience in talk as friendship characterized as 'mirroring' and 'discourses of 'blend and mesh' (Coates, 1996), is balanced by resistant discourses, i.e. those which challenge dominant (androcentric) discourses and offer alternative ways of being a woman. Women drawing upon feminist discourses, for example those which cite socialization rather than biology as the mechanism through which women learn to undervalue themselves, often use a joking style and laughter to acknowledge the discrepancy between feminist ideas and what is commonly accepted as the ' real' world. Within one conversation women may be simultaneously resisting gender stereotypes and acknowledging the power of dominant discourses which construct masculinities and femininities.

What is clear , is that women' s talk is a powerful medium in the process of friendship, the construction of personal identities and the maintenance of gender divisions. It is also a key aspect of leisure activities, arguably of the most satisfying and sustaining kind. American research on the life satisfaction and leisure of older retired women (Riddick and Stewart, 1994), suggests that: 'leisure activity participation emerged as the strongest contributor to the life satisfaction of older females' (Riddick and Stewart, 1994). Conducted in the early 1990s, O'Neill' s (1993) study documents the experience of women from a broad diversity of economic and social circumstances who differ in age, household position and levels of health. What they share is the experience of leisure with other women as an empowering source of identity and personal growth. In common with findings from American research, O'Neill found a significant group of older women using relaxation and leisure activities to bolster their self-esteem and self-image. Rather than being discomforted by the loss of youthful looks, for many women ageing brings with it a freedom to be themselves and re-construct their identities as women. Interestingly , in the above extract it is memories of the shared

community of other women which provide the key context for this empowerment.

The choice of women' s humour as an example of spaces for re-working gender identities via resistance to stereotyped gender roles, is linked to the previous discussion about the importance of women' s friendships as a site for leisure and relaxation. Adopting analyses of friendship and humour as part of a theoretical framework or 'lens' through which to understand the potential of women only leisure activities as a site of empowerment and resistance to gender role stereotyping, leads us to link 'talk', relationality and shared humour as significant aspects of women' s leisure. As suggested above, theorizations of humour as a social process are limited, but humour as interpersonal, emotion management (Francis, 1994) and bonding (Yoels and Clair , 1995) illuminates its centrality as a focus for sharing common concerns, differences and problems within a 'safe' context. Francis (1994) argues that shared laughter and humour generate positive sentiments among 'insiders', which bonds the group and reduces external threats, often at the expense of excluded 'others'.

Having outlined the potential of women' s friendships, as possible sites of power and resistance, it is important to avoid an essentialism which equates women' s friendships as nurturing and supportive. The majority of studies of women' s leisure have cited social networks, friendships and family-based pursuits as key sites of women' s leisure, but few have analyzed in detail the actual process through which those relationships are constructed and maintained. Paradoxically , analyses of 'women' s talk', which is commonplace, and often dismissed as ' gossip' or ' tittle tattle' , may provide us with the key to both its focus at the heart of women' s leisure experiences and its role in the construction and maintenance of gender identities which sustain gender relations. Talk with other women which is one of the most commonly chosen leisure activities across differences of age, social class and ethnicity, provides women with a series of arenas in which to explore and review the many facets of changing, multiple identities.

Leisure and Health

Leisure is also good for women's health. A body of research has pointed out the benefits of leisure for health and well-being using several outcome variables, such as quality of life, life satisfaction and mental 'problems' that run from mere stress to psychological symptoms to psychiatric illnesses (Ponde and Santana,2000). As these role conflicts can bring subsequent stress and strain in women, the importance of leisure for health and well being using several outcome variables, such as quality of life, life satisfaction (Ponde and Santana, 2000), leisure can be used as a protective factor for the women, to come out of the stress which is triggered by the role overload. Some leisure activities, especially those that are physical, are directly good for an individual's health. Now there is a wide body of literature (Anderson, Schnohr, Schroll and Hein, 2000) on the health benefits for women of any form of physical leisure – benefits related to cardiovascular disease, stress, osteoporosis, cognitive functioning, Alzheimer's disease, asthma, many kinds of cancer.

Caltabiano, (1995) found that differing kinds of leisure activity had different health effects and that any buffering of stresses' influences on health depended on the level of participation. For some kinds of leisure activities minimal levels of participation were sufficient to enhance health status, whereas for other kinds of leisure activity high levels of participation were required to effect the buffering. Wheeler and Frank (1988) investigated the relationships between a large number of potential coping sources and health. In the case of leisure, the finding meant that people whose leisure participation was high or who were satisfied with their leisure were less vulnerable to the adverse effects of life stress than those who were less active in and satisfied with their leisure.

Two main sources of health benefits associated with leisure have been identified; perceived social support derived from leisure and various stable qualities of people's leisure experiences. By participating in most leisure activities, social support is likely to be established and maintained and this support could buffer the impacts of life events. As well, dispositions associated with the experience of leisure itself, such as perceived freedom, intrinsic motivation and the absence of boredom, could contribute to people's resilience to life stressors. If people are

capable of experiencing freedom and are intrinsically motivated in their leisure time, they may possess general dispositions that allow them to live healthier lives.

Conclusion

There is no doubt that some access to leisure enhances the quality of life not only of the leisured individual but also of his or her associates. Therefore, a concern with the access to leisure is legitimate even from a larger developmental perspective. Given that women seem to be worse off in their access to leisure than men in most situations and often more for ideological and cultural rather than practical reasons, it makes sense to think about the problems of ensuring more leisure for them. Leisure can also mean empowerment for women. Women's talk, an essential ingredient of women' s friendships, accomplishes more than meets the eye; it includes discourses of belonging and similarity which enable women to 'mirror' traditional aspects of femininity such as caring and vulnerability , whilst at the same time allowing for contradictory or counter discourses of difference. The latter, often taking the form of joking or humour , challenge one-dimensional images of womanhood; constructing instead, feminine subjectivities. Hence an attempt has been made in this paper to think of leisure as an empowering aspect for women. These findings call for a need for empowering women further to undertake leisure activities of their interest and manage more time for their intrinsically motivated leisure.

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Skewed Sex Ratio in Gujarat: A Matter of Concern

* S.D. Mishra

Abstract

Mainly two types of family arrangement can be seen in the world a Male dominated and Female dominated. As a matter of fact these two arrangements are neither exclusively supplementary to each other nor contrary to each other. The family arrangement of any region is dependent on socio economic condition and religious customs of the people dwelling in the respective area. Effects of all these factors on the entire country have proved to be more effective in the eastern countries than in western countries. Generally sex ratio is determined against number of females per 1000 males. Comparison of males and females of all age groups has shown less percentage of female, per 1000 males. The deficit of women in India's population has been documented ever since the first decennial enumeration of people was conducted in the British-occupied parts of India in the late nineteenth Century. Over the span of more than 100 years, the deficit of women has progressively increased as evident from the sex ratio of the population; the number of women per 1000 men more or less steadily declined from 972 in 1901 to 940 in 2011.. Along with rise in population size, there is evidence of masculinity in sex ratio in general as well as in child sex ratio in particular. The present article tries to elaborate gender composition in India and Gujarat and Child Sex Ratio in particular. National and State level analysis has been discussed and Regional diversity within and across in India is tried to figure out. Author also tried to understand the worsening conditions of the girl child and map out the adverse child sex ratio in India and Gujarat as well.

Key words: *Sex Ratio, Adverse Child Sex Ratio, India and Gujarat.*

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Introduction

India is a country of striking male and female diversity wherein male outnumbers females. Declining or change in Sex Ratio and Child Sex Ratio largely effect the socio-economic and cultural patterns of modern Indian society. Since the first census of British India in 1872 there have been discussion concerning the issues of female deficit. In Economic Times 2011 the Madhu Kishwar described "the sick culture of preferring sons". She argued that the increasing number of abortions following sex determination tests that showed the foetus to be female is the single most important reason for the consistently declining child sex ratio (CSR) in India. The national sex ratio (females per 1,000 males) of the child population in the 0-6 age group registered a 13-point decline from 927 in 2001 to 914 in 2011 (EPW 2011).

Amartya Sen set off a debate in development economics when he estimated that there are 100 million of missing women in the world, referring to the magnitude of female survival disadvantage due to unequal treatment in the intra household allocation of survival related commodities. It is important to analyse the processes by which they went missing, irrespective of the debate whether the excess death due to unequal access to the intra household resources and sex selective abortion should be treated ethically equivalent.

Ansley Coale (1991) also drew attention to unusually high sex ratios at birth and high female mortality rates relative to males, especially in the early years of life and for daughters with elder sisters. To give a rough approximation of the numerical impact of excessive female mortality, he also estimated the ratio of males to females in selected populations that would exist in the absence of discriminatory treatment of females, and thus the total number of 'missing' females. For the populations of China, India, Pakistan, Bangladesh, Nepal, West Asia, and Egypt, he calculated the total number of missing females to be about 60 million. Given this, it is perhaps more apt a problem of missing girls than missing females. Thus, the most serious contemporary concern is the elevated female death rates due to gender discrimination, which offsets the natural lower mortality of females. Coale has argued that the high masculinity ratio in many Asian countries is traceable to this single cause. Moreover, the high female death rates occur mainly in the first five years of life.

Croll (2002) raises the controversial question of why millions of girls do not appear to be surviving to adulthood in contemporary Asia. Thus, there is an urgent need to focus attention on daughter-discrimination, family planning, girlhood, children differentiated by their gendered value, their birth order and sibling configuration particularly in South Asia.

Purpose and Essence of the Study

Sex ratio is defined as the number of females per 1000 males in the population and is an important social indicator to measure the extent of prevailing equity between males and females in a society at a given point of time. It may be noted that the sex ratio is expected to be almost at parity in nature. According to experts sex differential in mortality, sex selective outmigration, skewed sex ratio at birth are the major contributory factors that influence changes in sex ratio. In India, sex ratio is skewed in favour of males and has continued to rise and expand in various forms. This has drawn wide attention of policy makers and planners to reverse the trend to bring it back to parity.

The present study is primarily based on secondary data from decennial Census of India Reports, Government of India covering sex ratio and juvenile sex ratio in India compared to other countries, state wise trend, regional variation and issues and challenges with reference to Child sex ratio. Further author tried to map out the adverse child sex ratio in India and Gujarat state.

Data Speaks: Status of Sex Ratio in India and Gujarat

India is one of the few countries in the world where males outnumber females. The sex ratio of Indian population in the century has shown a secular-declining trend except some marginal increases in the censuses of 1991, 2001 and 2011. Changes in sex ratio largely reflect the underlying socio-economic and cultural patterns of a society in different ways. It is an important social indicator to measure the prevailing equity between males and females in a society at a given point of time. There have been discussions concerning the issue of female deficit ever since the first census of British India in 1872. In fact, one scholar considers the female deficit of about 5 million and speculates the reasons behind this, based on the findings of 1881 census (Saraswathi, 1888).

(A) Sex Ratio

The sex ratio at birth is slightly favourable to boys. This means that more boys are born as compared to girls. This is a natural phenomenon. The sex ratio at birth is usually between 940-950 girls per 1000 boys. The child sex ratio is calculated as number of girls per 1000 boys in the 0-6 years age group.

Tabel 1. Number of females per 1000 males for all age group since 1961 till 2011

Sr. N	Year	Gujarat	India
1	1961	940	941
2	1971‘	934	930
3	1981	942	933
4	1991	934	927
5	2001	921	933
6	2011	918	940

Source: Primary Census Abstract, 2011

From the above data it can be analysed that since 1971 to 1991 the sex ration of all the age group compared to India is higher than the corresponding ratio of India. But figures are quiet disappointing looking to the data of 2001 and 2011. Gujarat sex ratio is considerably lower than India.

(B) Child Sex Ratio

The overall sex ratio — the number of females per 1,000 males — is falling across the world. While the global sex ratio was 986 females per 1,000 males in 2010, it reduced to 984 in 2011..India’s child sex ratio dipped tremendously — the worst since the country’s independence but the overall sex ratio of the country has increased only marginally – from 933 (2001) to 940 (2011). However, according to the Registrar General of India’s (RGI) records, some big countries across the globe have reported a sharp decline in the number of women. China is a case in point. The country’s sex ratio in 2001 was 944, and

it fell to 926 in 2011. Bhutan's sex ratio saw a major drop: from 919 in 2001 to 897 in 2011. America's sex ratio also fell from 1,029 in 2001 to 1,025 in 2011.Indonesia's overall sex ratio fell from 1, 004 (2001) to 988 (2011), while Nigeria's sex ratio stood at 987 in 2011 as against 1, 016 in 2001. Union health ministry officials said, "India's child sex ratio (0-6 years) has declined from 927 in 2001 to 914 in 2011. As per Census 2011, the urban child sex ratio is 902 as compared to 919 in rural areas. However, while some countries have seen a dip in sex ratio, some countries have also recorded an increase in their overall sex ratio."According to RGI's records, some countries also saw an increase in the sex ratio. For instance, in Bangladesh, the sex ratio was 958 in 2001, which increased to 978 in 2011. Japan's sex ratio improved from 1, 041 (2001) to 1055 (2011), Russia's improved from 1, 140 (2001) to 1, 167 (2011) and Pakistan's from 938 (2001) to 943 (2011). Brazil too saw an increase – from 1, 025 (2001) to 1, 042 (2011). While Sri Lanka's sex ratio stood at 1,034 in 2011 as compared to 1, 010 in 2001. Nepal's sex ratio also improved from 1, 005 females per 1, 000 males in 2001 to 1,014 in 2011, and Myanmar's was 1,011 (2001) as against 1,048 (2011).

Table 2 . Comparison of Gujarat Child Sex Ratio and India

Sr. No	Year	Gujarat	India
1	1961(*)	971	962
2	1971(*)	969	979
3	1981@	947	962
4	1991@	928	945
5	2001@	883	927
6	2011@	890	914

(*) 0-4 years age group (@) 0-6 years age group

Source: Primary Census Abstract, 2011

It can be seen that chid sex ratio in Gujarat is lower compared to India. On the base of research studies and literature it can be view that in Gujarat particularly during last four decades there must be an expectation of male child stronger in comparison to that of female child among married couples.

Table 3. Distribution of Trends in Juvenile Sex- Ratio (0-6) of India, Gujarat

Sr No.	Area limit	1991	2001	2011	Decade change 1991- 2001	Decade change 2001-2011
1.	India	945	927	914	-18	-13
2.	Gujarat	928	883	890	-45	7

Source: Primary Census Abstract, 2011

Declining trend in the juvenile sex ratio of India is seen as decadal change resulted 18 less than the year 1991's juvenile sex ratio of 945 in year 2001. Even the downfall was witnessed in Gujarat's decadal of 1991-2001 by the slip down of 45 in 2001 from 928 of 2001, but little improvement took place in the Gujarat's decadal period of 2001-2011's juvenile sex ratio in in the particular period with the ratio's movement to 886 which was 883 in 2001.

Table 4. Regional Comparison of Child Sex Ratio and Literacy Rate

Sr No.	Year	Child Sex Ratio			Literacy Rate		
		Rural	Urban	Total	Rural	Urban	Total
1	1961(*)	978	948	971	24.09	48.77	30.45
2	1971(*)	963	950	869	28.33	54.90	35.78
3	1981@	953	933	947	36.20	60.31	43.70
4	1991@	936	909	928	53.09	76.59	61.29
5	2001@	905	827	878	61.29	81.24	69.14
6	2011@	914	852	890	**73.00**	**87.58**	**79.31**

(*) 0-4 years age group (@) 0-6 years age group

Source: Primary Census Abstract, 2011

It is observed from the above Table that compared to rural areas urban areas considerable lower sex ratio. Looking to literacy level it is found that in urban areas is comparatively higher than rural areas. According to it transpires that more the literacy rate in the area there is more expectation of male child in that area. Thus there is a negative correlation coefficient between literacy rate and child sex ratio. Expecting of male child found more in urban area compared to rural areas.

Table 5. Juvenile Sex ratio of Best and Worst Performing Five Districts of Gujarat in 1991, 2001 and 2011

1991		2001		2011	
Best Performing District	**Worst Performing District**	**Best Performing District**	**Worst Performing District**	**Best Performing District**	**Worst Performing District**
Dahod (1001)	Gandhinagar (888)	Dangs (974)	Mahesana (801)	Dang (964)	Surat (835)
Dang (999)	Anand (896)	Dahod (967)	Gandhinagar (816)	Tapi (953)	Mahesana (842)
Narmada (985)	Ahmedabad (896)	Tapi (951)	Ahmedabad (835)	Dahod (948)	Gandhinagar (847)
Valsad (976)	Mahesana (899)	Narmada (945)	Anand (849)	Narmada (941)	Ahmedabad (857)
Tapi (975)	Kheda (900)	Panchmahals (935)	Rajkot (854)	Panchmahals (932)	Rajkot (862)

The data has also thrown up a shocker — the ratio has turned negative in Gujarat's tribal districts, where it was exceptionally high thus far. Surat, which is partially a tribal district, registered the worst decline of 24 points, from 859 to 835, compared to 2001 census.

Interestingly, Mehsana — the district with the worst child sex ratio of 801 in 2001 — has shown the maximum improvement of 41 points and stands at 842.

Surat, which has a majority tribal population, recorded the greatest decline — 24 points — as CSR slipped from 859 to 834. This was followed by tribal-dominated Dahod, where the CSR has slipped from 967 to 948, an alarming decline of 19 points. Dang, another largely tribal district logged a decline of 10 points, with its CSR going from 974 in 2001 to 964 in 2011. The districts which had shamed the state with highly skewed sex ratios in 2001 showed improvement. Mehsana is followed by Anand, which improved its child sex ratio by 35 points, Gandhinagar by 31 points, Patan (25), Sabarkantha (24), Ahmedabad (22) and Kheda (20).

Urban areas of the state improved their sex ratios more than rural areas. However sex ratios in rural areas are considerably higher than urban areas.

Table 6. State/Union Territory which improved Child Sex Ratio between 2001 and 2011- A Progress Report

State	2001	2011	Improvement
Punjab	798	846	48
Chandigarh	845	880	35
Haryana	819	834	15
Himachal	896	909	13
Arunachal	964	972	12
A & N Islands	957	968	11
Gujarat	883	890	7
Mizoram	964	970	6
Goa	938	942	4
Kerala	960	964	4

Source : Times of India, 2013

While the country's child sex ratio in the 0-6 age group dropped by eight points in the past decade, Gujarat's numbers improved by seven points — from 883

girls for every 1,000 boys to 890 girls in 2001 to 890 in 2011. This has been revealed by the final data of the Census 2011 But it is still not time to uncork the champagne.

Gujarat only 's child marginally sex ratio improved in the past decade even as other states have taken bigger strides towards saving their daughters. An increase of just seven points shows that the state has a long way to go before it can claim to have won the war against female feticide. The Gujarat government should crack down on clinics that unabashedly continue with sex determination Some other states are doing a much better job of saving their daughters. Like Punjab, this posted an impressive improvement of 48 points after being one of the worst states adecade ago. The figures show that of the 35 states and Union Territories (UT), only 13 have shown improvement in their child sex ratio, while 22 registered a decline. The all-India child sex ratio went down from 927 to 919 points during the period.

Way Ahead: Role of Professional Social Worker

Present article clearly pointed that discrimination against daughters as being the mirror image of son preference. The studies also support the idea that the existence of a strong son preference is indicative of greater discrimination against daughters. The Juvenile Sex Ratio (number of female children per 1000 male children in the age group of 0-6 years) attempts to bring out the recent changes in our society in its attitudes and outlook towards the girl child. It is a broad indicator, which reveals the ground realities that exist in fabric of the society. Moreover, the Juvenile Sex Ratio is a powerful index to examine the social response on female children. Present sex composition of child population determines the future vital events such as marriage rate, labour force, age structure, birth and deaths, migration, and replacement etc. Therefore deficit in girl child population, leads to serious demographic imbalance and adverse social consequences. However, in recent decades, the drastic decline in Juvenile Sex Ratio is an issue of grave concern in Gujarat. Therefore, efforts are needed to solve the issue thereby create equal regard and affection for the girl child. Otherwise, the child population will become skewed leading to a host of several societal problems.

Role of Social worker here is to take up the field action project on sex ratio and under beneath carry out a series of activities such as awareness about girls education, success stories of couple having a girl child, awareness and action program on girl child rights to create awareness among different stakeholders and community at large. Professional Social worker should involve social institution for the prevention of female foeticide or sex selection. Religious leader would be great help for the society to create awareness on declining child sex ration.

The analysis highlights that increasing trend of child sex ratio is gradually surfacing as a national crisis need to tackle with greater physical and fiscal resources to minimize the potential social loss owing to 'demographic consequence of marriage squeeze' which the country is bound to experience in coming days (siddhanta)

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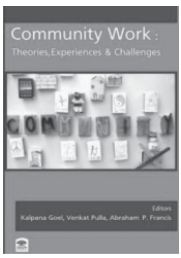
Community Work: Theories, Experiences & Challenges



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The book 'Community Work: Theories, Experiences & Challenges' edited by K. Goel, V. Pulla and A. P. Francis published by NIRUTA Publications, Bangalore in 2014 is a new book that is in the horizon. This book has presented contextually driven chapters from across three continents, Asia, Africa and Australia. The authors have done immense justice to the concepts as teachers of social work in Australia. The book presents applied and theoretical knowledge of community development and the reviewer believes is an addition to the literature for the students, academics, NGO and GO workers. Starting with fundamental definitions of community as expressions of 'we feeling', the authors see communities as rapidly globalizing. As all of us are aware that communities are becoming technology-reliant and virtual with limited face to face interaction for its members in the industrially developed countries and will soon sweep through the developing nations too.

The authors have shown the effectiveness of community development approach in addressing the needs and problems of ever changing communities their continuous research in their continents and explained as to how community development method can bring about a positive change in any community. Kalpana Goel delves at length on how community-based organizations can assist development of inclusive society utilizing the principles of community development. Goel finds CD strategic while working with immigrants' community. Abraham Francis in his article applies safety net groups as a tool to address the mental health.. Bala Raju Nikku presents ways through which social workers could be fully equipped in dealing with rapid changes in a globalized

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world. James Mugisha et al refer to extended families break into nuclear families in Ugandan society in particular and Africa in general. Narayan Gopal Krishnan discusses in his article as to how to effectively handle the negative effects of globalization in different communities. Fredrik Velander and Andreia talk about a culturally secure community development practice that seems to be befitting while working with indigenous communities. Heather Percey and Peter Orpin in their article explore theoretical insights embedded in community development practice through the study of ground theory and examine the possibility of effective practice of community development in a rural setting. Ndungi Wa Mungai in his article as the approach deals with the goals of people both collective and individuals goals. Bharath Bhushan Mamidi and Radha R. Chada put emphasis on utilizing community organization method as well as different pieces of social work knowledge and skills to organize the street vendors so that they themselves can establish their rights. Subhasis Bhadra and Venkat Pulla demonstrate the efficacy of community development in disaster management. . Abraham Francis, Venkat Pulla and Kalpana Goel in their paper address strength-based community development practices assists to address the problems of mental health. Joy Penman in her paper discusses the importance of health education to strengthen community capacity at the locality. In the last chapter, Abraham Francis and Venkat Pulla explain and analyze the challenges of globalization and uncertainties that throw the modern communities into situations of helplessness.

As an academic from Bangladesh, I see this book being very useful particularly for the students and scholars of applied social sciences across SAARC countries, and the book will equally be demanding in the pacific region. A novel idea has been developed by Anne Riggs and Venkat Pulla reflecting on arts and the practice of social work aiming at presenting some of the common concerns relating to development options both for individual and communities. On the whole, I congratulate all authors for their chosen themes and for the analysis in each chapter of the book which, I'm sure, will be a very useful literature for those who teach and practice community development across the nations. The price of the book is very affordable at 350.00 Indian rupees for this region.

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The Adelaide Journal of Social Work is an annual publication of School of Social Work, Roshni Nilaya, Mangalore, providing an independent forum for researchers and practitioners in social work. It encourages original, creative, critical and empirical research and promotes fine–tuning of the existing theory in social work. It helps the reader to be updated with the theoretical and empirical developments in the field. The Journal invites contributions from academicians, practitioners', research scholars, policy makers on various relevant areas keeping with the general objective. It also solicits case studies and personal experiments as well as critical book reviews of recent social work publications.

Guidelines for the contributors:

* Articles should be of original nature and should not have been sent or accepted for publication elsewhere.
* An abstract of 250 words to be sent in case of articles.
* The manuscript length should be of 3000-5000 words including figures and tables typed in 1.15 space with 12 font Times New Roman on 8.5" X 11" – A4 size papers.
* The manuscript should not contain foot notes. References should be cited at the end of manuscript. The list should mention only those sources cited in the text of the manuscript.
* Each table/figure/graph should have brief and self explanatory title. Also, mention the source and explanation, if any, at the bottom of the table/figure/graph.
* In the case of articles, precise conclusion to be given.
* Prospective article is subject to blind review by a panel of eminent referees.
* Cover page should contain title of the paper, name, present designation, postal address, mobile/telephone number and email ID of the author with brief resume.
* A hard copy of the manuscript should be sent to the editor with a stamp size photo. Further, soft copy along with the abstract is to be mailed to adelaidejsw@gmail.com or in compact disc in MS word.

The manuscript should be sent to:

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