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INDIAN SOCIETY OF PROFESSIONAL SOCIAL WORK

Contemporary society is witnessing progress, development and innovations in every sector with greater velocity. In this process the structure and functions of family and community have changed drastically and we are confronted with many challenges both at individual and the societal level. Social Work, a distinct practice based discipline under the Humanities has a major role to play in various sectors in the promotion of holistic health.

The Indian Society of Professional Social Work (ISPSW) is the oldest Association of Professional Social Workers in India that is geared towards empowering the society for social development through professional social work practice. ISPSW increased its reach worldwide through its website www.ispsw.wordpress.com.

The ISPSW focuses on uniting Professional Social Workers to debate, discuss and develop conceptual frameworks and implement feasible indigenous interventions of social work practice in India. The Society conducts Annual conferences, Seminars and Symposia on various social issues all over India. This is the 34th year of the conference and the theme is: Social Work and Sustainable Development. The society is able to generate funds by conducting regular Annual Conferences. The Best Paper Presentations are awarded in four categories; i.e. for Social Work Teachers, Researchers, Practitioners and Students.

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NATIONAL JOURNAL OF PROFESSIONAL SOCIAL WORK

CONTENT

EDITORIAL

The National Journal of Professional Social Work aims to bring together articles pertaining to Research and Practices in the field of Professional Social Work to enable young professionals to learn from empirical sources. Indigenous practices in the area of Social Work are the need of the hour to help the profession to grow and strengthen itself in our country. This illustrates the importance of this Journal in the dissemination of new knowledge which can be used by academicians, practitioners and students of Social Work. The AGBM of ISPSW, in its meeting held on 23-02-2018 had authorized the editor to edit the back volume articles of 2016 and 2017 and publish the same in 2018. It feels good to bring this idea to fruition.

This year the Editorial Board brought forth some guidelines and formats for the articles to be written and to a large extent the Board has seen to it that the authors adhered to them, but I fully agree that there needs to be an improvement in the same which the Editorial Board will implement from the forthcoming Volumes. This issue also saw the upgrading of the articles due to the review comments of the specially constituted Review Committee which comprised academician, practitioners and researchers from India and abroad. At this juncture I would like to thank them for their suggestions and response in a short time. I thank **Dr. Jotheeswaran A Thiyagarajan**, Technical Officer (Epidemiologist), Department of Ageing and Life Course, WHO, Geneva; **Dr. Janki Shankar**, Assoc. Professor, Faculty of Social Work, University of Calgary, Central and Northern Region, Edmonton, AB T6G0T2; **Dr. Rashmi Gangamma,** Assoc. Professor, 601 E. Genesee Street, Peck Hall, Dept of Marriage and Family Therapy, Syracuse, New York – 13202; **Dr. N. Janardhana,** Additional Professor, Department of Psychiatric Social Work, NIMHANS, Bengaluru; **Dr. Lakshmana G,** Assistant Professor, Dept. of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kalaburgi; **Dr. Manisha Kiran,** Head, Dept of PSW, RINPAS, Kanke, Ranchi; **Prof. P. Ilango,** Dean, Faculty of Arts, Bharthidasan University, Tiruchirappalli; **Dr. Sonia Pereira Deuri,** Prof. & Head, Dept of PSW, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur; **Dr. Sojan Antony,** Assistant Professor of Psychiatric Social Work, National Institute of Mental Health & Neuro Sciences Bengaluru; **Dr. Jahanara M Gajendragad,** Assoc. Prof., IBHAS, New Delhi; **Dr. Anish Cherian,** Assistant Professor of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru.

Any piece of academic writing based on field work is no doubt a challenge to edit, since the findings may or may not confirm to normally understood social constructs and many times is seen from the prism of students of Social Work. The reviewers have been gracious in their comments and observations. Their experience and technical finesse in making the observations have lifted the quality of the articles, undoubtedly. In addition, I'm aware that they are engaged in multiple responsibilities that demand their time and attention. I remain grateful.

It is any editor's fond hope the publication will contribute to the area of learning, both for learners and policy makers. While some of the discoveries of the researchers may not be new, they serve to reinforce already held perceptions of the discipline. Some others are responses to changing lifestyles and serve to draw attention to new ways of functioning and relating in technology-driven times. After all, it is research which translates practice into theory which in turn actually forms the base of any profession.

I acknowledge the work of the earlier Editorial Board headed by **Prof. K. Sekar** and assisted by **Dr. Bino Thomas** and the present Editorial Board headed by **Prof. D. Muralidhar** for their support in helping me to bring out this issue during the XXXVII National Annual Conference of ISPSW, at the Department of Psychiatric Social Work, NIMHANS, Bengaluru.

I am sure these articles will add to the insights in the field of Social Work and all of us will benefit from them.

Here's wishing all readers a fruitful time.

Dr. Rameela Shekhar
Editor (2018)

Prof.G.R.Banerjee Oration

A Tribute to Prof. G.R. Banerjee

Vimala Nadkarni
Immediate Past President (2016-2020)
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We cannot forget Prof. Banerjee's seminal contribution to the development of social work education especially in the specialisation of Medical and Psychiatric Social Work. She laid the grounding for indigenisation for Social Work Education, thanks to her deep passion for Indian culture and Sanskrit scholarship. Although she completed her Social Work degree in the west, she sought to modify and link concepts from the Bhagavadgita and Indian social reformers to analyse modern social work theory and practice in what she taught and practiced.

The fact that she turned towards Professional Social Work rather than continue a career in Sanskrit shows her great compassion and desire to serve the country by working for the upliftment of the poor and courage to shift to a line which was not supported by her friends. Her own educational pathway reflected her persistence as all her education was done privately, at Sahranpur, where she grew up, did not have very good educational opportunities for women. This reflected a very supportive family that did not decry female education but believed in women's empowerment through learning.

In this presentation I will thus discuss some of her very significant contributions as a pioneer of Social Work Education in India. The core social work concepts taught in most of our institutions have not changed much: we continue to use the same classification of Social Work Methods and almost the same course divisions in many of our programmes. However, there is a difference in the content of specialisation areas due to the changing social, economic, political and cultural scenario in our country and some transformation in our perspectives. We are giving more importance to people-centred, rights oriented and social development theories and practice. We are increasingly discussing the place of critical social work, radical social work, structural social work, feminist social work and social work with a human rights perspective. These are also related to the impact of globalisation and international social work: there are more exchanges between developed and developing countries and sharing of online courses. So the north is learning from the south and vice versa although the dominance of the west in our theories still continues as we as a professional community have not got organised sufficiently to develop a strong social work educational association focusing

on development of indigenous theory and quality of education. I will come back to this again later in my presentation.

Let us now reflect on the contributions of Miss Banerjee.

In a context where social work was synonymous with charity and Professional Social Work was just taking root, establishing the first specialisation in the Sir Dorabjee Tata School of Social Work (the precursor to TISS) in Mumbai was no mean achievement. Although Medical and Psychiatric Social Work was taught as separate units in the University of Chicago from where she graduated, she introduced the specialisation as a combined one which she believed could not be separated as there was a symbiotic relationship between physical and mental health like two sides of a coin. This amalgamation remains to this day in most of the colleges and departments in India although in the changing health context where public health and mental health are getting prominence and recognitions, there is a slow adoption of these shifts in perspective. This may also be because there are fewer posts in the municipal and government hospitals that cater to the poor and some in private hospitals where the role of the social worker is quite restricted either by the super-specialty in the institution or as defined by the administration. The changing scenario of health and health care with the re-emergence of old diseases and new disease pandemics requiring new knowledge and skills on the part of health social workers raises challenges for the development of a new social work which is more broad-based, people-centred, rights based and not necessarily in the way we were oriented in our specialisation courses.

Miss Banerjee did set the trend of demonstrating the role of health social work in medical and psychiatric units and specialised hospitals, in her era. This was also through the support of the 1946 Bhore committee report that recognised the need for training in these health social work areas. However, a degree in that specialisation was not an essential qualification for being designated as medical and psychiatric social work (MPSW) nor did it assure a status and salary equivalent to that of the other helping professionals.

In the 70s, senior social workers continued to lobby with the government for instituting MPSW as the required qualification in these specified posts. In Maharashtra and probably some other states, the status and salary continues to be less than that of other helping professionals working in the hospitals. This may reflect our failure to establish our role as essential in the hospitals although we have been able to make a niche in several specialised areas like psychiatric work, work with substance abusers, PLHIV/AIDS and many others including the newer ones of organ transplantation, stem cell and cancer research, ethics committees, surrogacy and so on.

Interestingly, when I was a student in the 70s, our MPSW specialisation subjects covered social aspects of illness and care using Leavell and Clark's three levels of prevention: primary, secondary and tertiary. The Indian version which took the form of the text created by Park, namely Preventive and Social Medicine, was popular even among social work students. Catering to the health context where communicable diseases were rampant in the poorer sections of society, understanding the social and environmental factors was critical besides being well taught in both medical and psychiatric sectors as the base for understanding health problems. The courses thus integrated the use of a variety of methods ranging from the individual to the community.

Field work is critical in Social Work Education and Training. Mumbai was, fortunately, blessed with an excellent public hospital system with large teaching hospitals and a network of smaller suburban hospitals that provided scope for fieldwork placements in the 60s and 70s. Miss Banerjee along with her two assistants Grace Mathew and Marie Lobo worked hard to pave the way for field work and creating job niches in the health settings. Through demonstration of the role of social work in the hospital setting, and posts being created because of the Bhore committee report, she met the challenge of working closely with each hospital's administration for fieldwork placement. She was so successful that this idea spread to other cities too.

Today social workers in hospitals may not be very forthcoming to supervise students for several reasons - heavy workloads; lack of adequate orientation in health social work; not wanting additional work, they fear being overwhelmed by any new initiatives by students. With the government reducing the budget for health and education, the municipal hospitals in Mumbai started charging for student placement "training" as part of their resource mobilisation drive; this led to fewer hospitals being used for fieldwork. Today health social workers are also asking for honorarium and greater recognition from the colleges, again a reflection of the changing ethics and practice of professional social work. With foreign universities seeking social work placements in India, social workers in NGOs are offering their services for an honorarium which benefits the organization.

The principle of field work placements established historically was that students contribute positively to the social work department by taking up cases, group work, and other activities. Thus social workers also get greater visibility through them and association with an academic institution. This is being disregarded today probably due to salaries and the changing market-oriented environment.

Miss Banerjee was again a pioneer in setting the trend of developing field action projects which became teaching-learning centres for social work students and demonstration of holistic practice. The Family Welfare Agency along with Kshithij (former Association of Friends of the Mentally Ill), a day care centre for PLMI, started in the 50s by her, continues till today in the chawls at Lower Parel. This was her initiative and a favoured fieldwork agency for many of us. The Child Guidance Clinic which was started in school in 1937 and later shifted to the Wadia Hospital for Children in Parel was developed by her as a Psychiatric Social Work placement agency with a social worker heading the team, again an out-of-the-box innovation!

Field action by departments of social work got institutionalised with the support of funds for extension work by the University Grants Commission. This was further encouraged when Prof. Armaity S. Desai became the Chairperson of the UGC in 1995. The UGC funds supported the salary of one social worker in extension work by social work departments and also by other disciplines as a contribution to bettering the life of the poor and marginalised.

Miss Banerjee was always a step ahead of her times. She believed in establishing agencies that would be governed independent of the department and faculty of the institute. She also worked on very controversial issues like the rehabilitation of sex workers at a time when they were usually kept in a reception home after being caught in a raid. Her analysis and suggested strategies would probably not be accepted today where sex workers have formed their own organisations and have become empowered enough to seek a better living environment for themselves and their children. The exploitation of brothel-based sex workers continues and prevention of human trafficking in women and girls is now an international issue.

As I did mention earlier, the conceptual contribution that Miss Banerjee made in indigenising social work was based on her Sanskrit scholarship which she constructively used to provide a cultural flavour and relevance to the modern social work concepts. Some of these concepts which evolved in her thinking and writing may be relevant even today, for example, Miss Banerjee's excellent rendition of the concept of dignity and worth and also her interpretation of "rights" which have become the focus internationally and which we in social work have embraced.

"Promoting dignity and worth of people(s)" is the second theme of the Global Agenda and the theme of the World Conference in Seoul. Miss Banerjee wrote about it in a

very succinct manner in several of her articles on social work in the 60s and 70s. These concepts have been defined in several of our traditional texts in the local languages also as our social work values are acknowledged as based on universal values that are embedded in spiritual teachings.

In her articles where she analyses the concepts of "dignity and worth of the individual", she links these concepts to the ideas of "right" and "dharma" in the practice of social work, taking examples of individual based work. She shows the movement in history from charity, focused mainly on material goods and for those who were assessed as "deserving poor". Thus their worth as individual human beings was not recognised.

This changed when the social scientists analysed that social problems were not due to the individual's capacity or lack of potential or his/her sole responsibility and that there were many societal, systemic and structural factors that led to poverty and allied problems. In several developed countries, social justice that "seeks to give each individual his due in terms of equal opportunity and growth" became the norm to help the poor. I quote Miss Banerjee who wrote: 'Thus the question of worthiness does not arise. The client has an unobligated right to these services because he has a need for them. He also has freedom to accept or reject these services or to make use of them in the way he thinks best. This is regarded to be consistent with the dignity of human personality and the highest democratic ideals" (cited in Banerjee, 1972:2).

The concept of social justice has become integrated into the international definition of Social Work along with ideas of "social cohesion, human rights, collective responsibility and respect for diversities" as the principles around which social work is organised (http://www.iassw-aiets.org/global-definition-of-social-work-review-of-the-global-definition/ accessed on February 13, 2016). I am sure that all of you here are familiar with The Global definition of Social Work.

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work, social science, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels.

The concept of collective responsibility which is the other side of human rights is what Miss Banerjee would define as "dharma" or "doing right actions" for the overall benefit of society and for our fellow beings in our society. According to the eminent scholar late Prof. S. K. Ramachandra Rao (author, Sanskrit scholar and professor of psychology): "Dharma basically means 'to nourish', 'to uphold' and signifies whatever supports the universal order and also the individual life in society. Dharma is the basic value in life as well as in transactions – social, religious, secular and vocational. Dharma is the first of the three normal human purposes, the other two being the acquisition of wealth (artha) and the enjoyment of pleasures (kama). Dharma is characterised by certain common human values like truth, friendliness, absence of envy and rectitude in conduct" (http://www/deccanherald.com/content/23194/concept-dharma.html).

This is what Miss Banerjee reiterated in her 40 or so social work articles and four books that she published during her thirty years of dedicated social work. She contrasted the concept of dharma with that of human rights. She suggested that while human rights could ensure material comforts, they could not impose emotional or relational changes. Human rights are embedded in law in their implementation and so while we can assure that children provide material support by implementing the maintenance and guardianship act, we cannot force them to love them or show affection.

So from Miss Banerjee's perspective, if we follow the path of dharma, we will be acting on our social work value of acknowledging the inherent dignity and worth of human beings as following the path of rights will create better material conditions for people but not solve the non-material conditions like need for love, companionship and transcendence. Miss Banerjee advocated for the enablement of the individuals by the social worker to make them realise their inherent dignity and worth as human beings and thus to not allow any form of exploitation of themselves or their families.

The practice of dharma also applies to the response of the social systems to doing all that is right in upholding the integrity of society. It is the duty of the government to ensure that people have all the conditions essential for their survival and well-being. Due to the inability or disinclination of government to ensure that people have all the conditions essential for their survival and well-being, that they do not live below the poverty line, the concept of human rights has become more prominent in a democratic society. This concept is not accepted in countries where governance is by military or communist or dictatorship regimes. International conventions, treaties and laws are

getting countries to commit themselves to work for the development of people. The 2030 Sustainable Development Goals Agenda is again a move forward by the UN to reduce poverty, climate change and ensure prosperity for all.

Miss Banerjee wrote against the mechanisation of human beings in an industrial society where, according to her, (Banerjee,1966:4) "Certain sections of our society cease to seek in themselves the supreme purpose of living and to become instruments serving the economic machine their hands have made. They measure efficiency and success in terms of production of scientific gadgets and reward these in terms of money... such a man moulds himself as a marketable commodity..." The processes of globalisation have further aggravated this with the human being becoming more individualistic, market-oriented and self-interested.

The political and economic governance structures that are influenced by international trappings of the World Bank and International Monetory Fund have no mercy on people's lives. The poor continue to struggle for the basics of life while many in the middle class are being driven into the lower rungs. Lives are controlled by the international markets: when there is a crash in the stocks and shares market, as had happened a few months ago in China and after that in the US in 2008, people lose their life's savings, leading to depression and suicides. Farmers' suicides can also be laid at the door of international trading, climate changes and government indifference.

Miss Banerjee did not advocate "conformity to the group norm" as a means of adjusting to the reality of one's condition without seeking a better level of living. She suggested that "conformity to group norm should be with proper understanding of his (her) role as a human being and relationship to the group and duty towards the group. It should not be an abject surrender to the group".

She also practiced what she preached – that in order to be truly helpful to the client, the Social Worker should be involved with a high sense of duty towards his/her profession, clients and fellow beings. She included the traits of "unselfishness and self-denial" which are contentious concepts for social workers today although we do have many examples of our social workers who have taken up causes of the exploited by living and breathing with the people at great risks to their life and have "sacrificed" their own personal desires for a simple existence committed to empowerment of the poor and oppressed.

So although we all agree that in today's scenario where the market is King or Queen, and where Professional Social Workers also need to get a good salaried job with a good status and enough to lead a comfortable life, there is that niggling thought that we're not doing enough. Miss Banerjee was prescient and her plea to social workers was:

We, professional social workers, often profess social work more than we practice it. Constant emphasis on the rights of social workers have made us concerned about how much we can get but let our respect for the profession of social work make us also think now of our duties of a social worker and concentrate on how much we can do. The sense of duty will bring an attitude of humility and humanity which is indispensable for the practice of social work.

In today's context, we have shifted our focus on working for structural change rather than individual dependent changes as we believe in the human being's capacity to change but enabling change is possible only with radical societal change. So if we follow the Social Casework and problem-solving path only, we social workers cannot solve the problem of exploitation.

The influence of the freedom movement and reformers seemed to have had a strong influence on Miss Banerjee's perspective of viewing social problems and issues from a moralistic lens, a committed ethical base. She viewed social reform as the intervention for changing social conditions that caused social problems.

There is today more emphasis on a marketing model for service to society than a social change model. Social entrepreneurs are replacing social workers. Social workers prefer to be now called social entrepreneurs as this has more status and greater social sanction and funding support.

But will it really lead to structural change or a change to the conditions of poverty of the people? Will it stop bonded labour, drought and caste issues related to who is making and serving food in the anganwadis? The ideal combination would be to blend social entrepreneurship knowledge and business skills with the values and principles of social work for holistic development.

The concepts of "Maitri" or warmth and friendliness and "Karuna" meaning compassion were integral in the teachings of Patanjali, Lord Buddha, and Swami Vivekananda, which

Miss Banerjee linked to building the social work relationship. According to her, without genuine love for people and feelings for them, the social worker could not enter into a therapeutic relationship with his/her client (Baneree, 1970:20). Compassion conveyed the principle of empathy which was valued in the social work relationship.

Connected to the above is the concept of "Ahimsa" which is generally translated as non-violence which has a negative connotation. Miss Banerjee explained that the positive aspect refers to love and kindness. She quoted from Patanjali's Yogasutra where he refers to ahimsa as essential for practice by every human being. Buddha declared, "Not by hate is hate destroyed but by love is hate destroyed. This is the eternal law" (cited in Ibid, 1970:21). These concepts continue to be meaningful in our lives particularly when we are witnessing increasing global conflicts and influx of refugees and asylum seekers into the developed countries in Europe which are currently struggling with a lagging economy and austerity measures.

The other very popular and seemingly controversial concept is that of "controlled emotional involvement" which is supported by the practice of "nishkama karma" which literally means detachment in our actions. This she clarified was not akin to "indifference". It is not uncommon for our students to ask us how we can build a relationship without warmth or emotions. As a response to this I'd say that as long as we don't get carried away by our own personal self and the "misery" when the client reports to the social worker about his/her struggles against poverty or abuse or exploitation, we should be able to work satisfactorily. According to Miss Banerjee, controlling self-meant "the lower self that has greed, biases, judgmental attitudes, tendency to exploit others, desire for name and fame, etc.... (the) higher self (which) nurtures attitudes of acceptance and compassion for others" (Banerjee, 1970:22). Our philosophers asked for regulation of activity towards the attainment of moksha (liberation), "an inner blossoming, inner growth of and development" ---- thus spiritual growth which leads to "bliss".

Spirituality and Social Work are important areas for future development in Social Work Education. Seeing a close relationship with spirituality in the traditional texts, Miss Banerjee has emphasised in most of her articles the importance of mind over matter whether discussing rights and duties or increasing materialism in societies and marketization of human beings. This is an area which probably needs some attention in Indian Social Work Education. The irony is that while the world has recognised our

Indian practice of yoga for not only physical fitness but fitness of the mind, we have not included it in our courses. I am aware of a few colleges that start their classes with a session of yoga almost like an assembly! Similarly a few educational programmes follow the Gandhian concepts in their education of social workers.

Their relevance in our changing context today needs to be discoursed. We have many critiques of Mahatma Gandhi without probably sufficient deep studies on the relationship between Indian social work and Gandhian concepts. Just as we may mindlessly follow the yogasanas, we follow the practice of non-violent protests like dharnas, fasts and so on. But we also need to understand the deeper philosophy behind these actions and see how they can be integrated to create an alternative framework for Social Work Practice in India. We need yoga, we need spirituality and we need non-violence and more compassion and love for our fellow beings. Whether we can translate all these into an indigenous framework for Indian social work is a moot question.

It is fashionable for many of our social workers to criticise the use of western methods in social work; to reject casework and traditional forms of group work criticising them to be inapplicable and irrelevant in our social context. However we have adapted and adopted since the 70s the integrated methods approach and the integrated social work practice framework developed by Anne Minahan and Allen Pincus in 1973 which is based on systems theory. How applicable are they to the current scenario of Medical and Psychiatric Social Work in our country?

From my personal communication and observations with social workers in Mumbai and Pune, I find that we have not changed much in our roles and responsibilities in the hospital setting. Although I must admit that many of our social workers have been open to learning about the social aspects of new diseases like HIV/AIDS and new interventions associated with organ transplants or stem cell research or surrogacy. There are greater ethical issues today that we have to deal with and make our position clear with regard to supporting some of these highly expensive processes, for example, being co-opted to support surrogacy which is in conflict with our movement for adoption. We can argue, of course, that we can do both but we do need to research on the social and psychological impact of surrogacy on the woman carrying the baby and then giving it away besides the ethics of it.

In view of the changing economic scenario and the reluctance of the government to spend more on health, hospitals are being encouraged to privatise. Public hospitals are charging for everything now. So social workers have no choice but to spend much of their time on socio-economic assessment and mobilising donations for heavier workloads. Reduced budgets also lead to reluctance of the governments to fill in the vacancies of social workers.

MPSW continues in a narrow way more at the individual level in hospital and specialised settings while health social workers specialised in public health and mental health and in community health play a major role in preventive and promotive aspects of health care. Social workers join other health activists on ethical issues, on pressurising the government against raising essential drug prices, and so on. In TISS, MPSW doesn't exist as a specialisation but has expanded into Public Health Social Work and Mental Health Social Work.

I am ignorant about the changing health social work curriculum in other programmes across the country although many new social work colleges and departments in the country continue to prefer the MPSW specialisation. This is despite the fact that in this era of privatisation. Government posts are not being filled. Interestingly, quite recently an Association of Medical Social Workers has been formed to take up issues of salaries, status and so on. There may also be some discussion on improving the quality of practice.

It is possible for us to transform our practice even in restricted settings which have been classified as "secondary settings" for social work. This, I believe, is a transgression and lack of recognition and contribution of our role in these settings. Due to a lack of documentation and research, we have failed to prove the impact of our social work roles in dealing with the social, economic and psychological aspects of ill-health. In reality through the departments of Preventive and Social Medicine and Psychiatry (both adult and child), social workers who have understood and adequately demonstrated their role have been recognised and rewarded in different ways. They also have had the courage to demand equal status in their ethics and research committees as well as in governance. There are many examples of innovative practices introduced by social workers in these settings which also need to be written about and showcased. Adding to the articles and books contributed by Miss Banerjee and other social workers in health settings will merely serve to tell stories of cases handled but theorising and bringing out practice models which can be taught in the classroom is essential.

Social Workers in hospitals have to face many new challenges – HIV/AIDS, disasters whether natural or man-made; increasing aggression against the hospital system; deterioration of conditions in the hospitals and increasing poverty, with the government reducing subsidies for health and preferring to pander to the market through health insurance where people who can't afford a meal a day have to pay a premium for the insurance. Social Workers have to also learn new laws regarding child protection, domestic violence, the PWD Act, bioethics, the new Mental Health Act and so on that impinge on their work in these settings.

So I would like to conclude with Miss Banerjee's message to us which emerges constantly in her writings: "Marry Western science with Eastern morality". She also advocated social change and social action in the field of health. She foretold that: "Therapeutics of social medicine is not medical but social and political actions based on medical recommendations. The MPSW will now be able to work towards a synthesis of social work and social reform and bridge the gap that has long existed between the two. All this does imply opening up new vistas of social change and social action in the field of health for students undergoing training in MPSW." (Banerjee, 1967: 295)

Before I close I would like to highlight a few personal qualities of Prof. G.R. Banerjee.

Miss Banerjee, as she was popularly called, joined the social administration Diploma programme at the erstwhile Sir Dorabji Tata Graduate School of Social Work (the present Tata Institute of Social Sciences) in 1942 and devoted thirty years of her life thereafter to pioneering and developing Medical and Psychiatric Social Work in India. She retired in 1972 a year after I competed my postgraduation. Since we were only twelve students in our batch, she along with Dr. Grace Mathew and Marie Lobo (as assistants) were the only faculty during those years.

Miss Banerjee was born in Bhagalpur in Bihar but spent her childhood years in Sahranpur, UP, where her father was a doctor. She was a brilliant student having completed her matriculation, Bachelor's and Master's Degree as a private student. Interestingly, she received her D.Phil in Sanskrit while studying at TISS for her diploma in SSA. While studying at TISS she worked part-time in the Women's Rescue Home at Umerkhadi in Mumbai where she developed a deep interest in issues affecting prostitutes and worked for their rehabilitation. In her paper presented at a national seminar on people's role in

social defence in 1970, she has analysed the factors that lead women into prostitution. No doubt, some of them would not be accepted today as there is a reference to biological factors that lead to "overpromiscuity" among young girls. Also family stability and community support are viewed as important preventive factors. The entire perspective on women in prostitution has radically changed and one may probably not agree with her analysis but we must remember that the context was different and with HIV/AIDS and the sex worker being viewed as a vehicle for transmission of the infection, the medical and NGO community as well as the government has had to re-orient themselves about the issue.

On the recommendation of the Bhore Committee Report in 1946, the erstwhile Director of TISS Dr. Kumarappa identified Miss Banerjee as the ideal candidate to start Medical Social Work in the country. Armed with a scholarship, she completed her Master's degree in Medical Social Work at the Chicago University and returned in 1948, all ready to make a difference in the lives of patients attending hospitals.

She did make a wonderful difference to the field and we are reaping the benefits of her untiring efforts to this day.

Efficacy of Community-Based Intervention on Family Environment among Lambani families

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Abstract

Family environment plays a vital role in keeping the family intact in its well-being and quality of life of its members. Research was carried out to study the socio-demographic profile and family environment of Lambani families, to design and find out the feasibility of an intervention programme focusing on them. Following the need assessment using Focus Group Discussion (FGD) with 12 women, an intervention programme with five sessions was developed. The sessions focused on orientation about healthy family, stages of family development and problems in each stage, understanding and enhancing family communication, problem-solving skills and stress management techniques. The study adopted experimental research design- before and after without control group design. From seven thandas in Kalaburgi Taluk, one thanda was selected using random sampling and from the selected community all the families were included for the intervention (30 women from Lambani families). 37% of the respondents were educated upto 10th standard, 63% were illiterates and an equal percentage of respondents wereworking as coolies. 87% of the women earned below ₹ 5000/- and 43% were living in joint families. The mean age of the respondents was 33.97 (±10.45) years. There was a significant difference in the respondents, pre and post assessment (after one year), in the domains of cohesion, expressiveness, conflict resolution, acceptance and caring, active-recreational orientation, independence, organization, and control ($p<0.001$).

Keywords: Lambani, Family Environment, Community Study

INTRODUCTION

The Lambani community (also Banjara, Bangala, Banjori, Banjuri, Brinjari, Lamani, Lamadi, Labhani, Lambara, Lavani, Lemadi, Lumadale, Labhani Muka, Gohar-Herkeri, Goola, Gurmarti, Gormati, Kora, Sugali, Sukali, Tanda, Vanjari, Wanji) is a community in India spread primarily in Andhra Pradesh, Karnataka, Maharashtra, Madhya Pradesh, Rajasthan and a few other states. About half of them speak Lambadi, one of the Rajasthani dialects of Hindustani, while others are native speakers of Hindi, Telugu and other languages dominant in their respective areas of settlement. They are classified as Scheduled Castes in Karnataka. Karnataka has the second highest population of Lambanis (called Lamanis and Banjaras) in the country at an estimated 1.1 million, spread all over the state. Hundreds of Lambani thandas in Karnataka remain neglected (Nagaraj & Malshet, 2001). They live in exclusive settlements called 'Thanda', preserving their cultural and ethnic identity. Shunned and ostracized, Lambanis in the state continue to remain outside the mainstream of the society. In cities and towns, it is common to find them performing acrobatics on the streets while the menfolk have transformed into construction laborers. Nearly 30 per cent of the Lambani population lives on daily wages while the data about the remaining 70 per cent is in difficult situations of earning (Nagaraj & Malshet, 2001).

Jyothi (2013) reported that among Lambani families in Kalaburgi, the environment was not conducive and many families were having severe family issues related to cohesion, problem solving, faulty interaction patterns, health problems and health care practices (Prithviraj & Naik, 2012). Deepshikha & Bhanot (2011) in their study on adolescent girls in Lambani families stated that expressiveness and organization exhibited significantly adverse effects among adolescent girls. Cohesion also significantly affected them negatively. According to them, most of the environmental factors played a negative role in influencing the overall socio-emotional adjustment of the adolescent girls.

Researchers and Social Work students from the University situated in Kalaburgi, used to go for field work in the Lambani community. It was observed that there were many youngsters without jobs; children did not attend school and women had no freedom in the family. Women complained that husbands did not respond to their psychological needs in the family. They expressed lack of support, cooperation, emotional support and insensitivity to the family problems from other family members. These problems encouraged the researcher to look into the family environment in the community. Hence, this study was undertaken. It is believed that family environment can play a vital role in keeping the family intact, maintaining well-being and quality of life. The present study made an attempt to study the family environment among Lambanis families.

METHODS

The aim of the study was to assess the feasibility of an intervention programme on the family environment among Lambani families by studying the family environment among the Lambani women. It was hypothesized that there will be a positive change in the family environment after the intervention. Written informed consent of the participants was obtained to participate in the study.

Needs Assessment

A standardized script for conducting the Focus Group Discussions (FGDs) was developed after literature review and discussion with experienced Researchers. The script followed a semi-structured format using open-ended questions in a face-to-face conversational style. Although, the discussion script was flexible in nature, a few directions were given when the focus was lost and probes were used when necessary. The need assessment had been carried out amongst 12 women who participated in the FGDs. The FGDs were recorded, transcribed and similar themes and sub-themes were grouped. The needs identified emerged at the first level from the women and, second level, from the transcribed data. The Researcher then went back to the group and asked their opinion. Once a consensus was established with regard to the needs and training program areas, the researcher finalized the intervention program (See the Table 1).

Participants and Design

Kalaburgi is one among the 30 districts of Karnataka situated at the northern part of the state. It consists of nine blocks namely: Jewargi, Afsalpur, Aland, Chithapur, Chincholi, Sedem, Gulbarga, Shahabad and Kalagi. In all blocks, Lambanis reside. Gulbarga block has 7 thandas in the heart of the city. From seven thandas in Kalaburgi taluk, one thanda was selected using random sampling and from the selected community all the families who had family issues (the researcher knew them as part of field work training) were included for the intervention (30 Lambani families). Only women participated in the intervention phase. The main study adopted experimental research design - before and after without control group design.

Measures

To assess the socio-demographic details, a structured interview schedule was used. Family Environment scale by Harpreet Bhatia and N.K. Chadha (1993) was used to assess the family environment. This scale was developed in the year 1993 and has 69 items. It assesses eight areas in cohesion, expressiveness, conflict, acceptance and caring,

independence, active-recreational orientation, organization and control. The scale has good split-half reliability and both face and content validity. In the present study Cronbach's Alpha reliability was .943. It shows that it is highly reliable.Only married women, aged between 16- 45 years, and who were willing to participate in the study were included.

Assessment

Before the intervention, baseline assessments and after one year post assessments were conducted. Third parties who were trained for the study and not related to the study group, at different levels carried out the assessment. They were constantly monitored and discussions were held on doubts about the tools. Qualitative changes were also recorded and used in the research. The quantitative data analysis was done using the Software Statistical Package for the Social Sciences (SPSS, version 20.0) for Windows. Wilcoxon signed test was used to see the difference between pre and post intervention effect. Chi square test was used to see the differences between education and occupation, education and income per month.

Intervention Programme

Table 1: Intervention Programme

Identified need	Interventions	Number of sessions	Methodology
Chaotic family environment	Module 1: Orientation on healthy family	3	Lecture, discussion
Unable to move from one stage to another	Module 2: Stages of family development & problems in each stage	3	Lecture, Group discussion
Poor communication among family members leading to family problems	Module 3: Understanding and enhancing family communication	3	Lecture, Group discussion, demonstration, case study
Poor problem solving skills among family members	Module 4: Problem solving skills training	2	Lecture, Group discussion, demonstration
Stress due to various problems	Module 5: Stress management techniques	2	Lecture, Group discussion, case study

Module 1: Healthy family: A healthy family is one where roles, responsibilities, communication, handling problems are in the right direction. Basic processes involve the integration, maintenance and content. The module adopted Barnehill's (1979) healthy families' description.

Module 2: Stages of family development: According to Duvall the family has been divided into eight stages. The understanding of the development of the family will enhance the family member's knowledge in terms of the family's developmental stage, and roles that need to be performed. Through this the family environment could be enhanced.

Module 3: Understanding and enhancing family communication: Many of the problems of the family are related to its faulty, confusing or maladaptive communication patterns. It is well-accepted that behavior has communicative value and transmits several messages. The characteristics of family communications described by Lewis (1979:57-60) and Janzen and Harris, (1980,15) are used for the sessions.

Module 4: Enhancing cohesion, problem solving skills in the family: Problem solving is a skill that can be used when one is faced with a difficult situation. Situations requiring solutions can be connected to feeling confused, lonely, depressed, tense or inability to concentrate. Family members often find themselves confronted by difficult situations. A situation becomes a problem if the person has no effective coping response immediately available to handle it. Problem solving methods proposed by Lewis (1979:57-60) and Janzen and Harris, (1980,15) are used for the sessions.

Module 5: Stress management techniques:

Stress is a normal psychological and physical reaction to the ever increasing demands of life. Family members reported that they faced lot of stress and took it out on other family members. They wanted to handle the stressful situations in a healthy manner. In the sessions, what is stress, reactions to stress, impact of stress on various dimension of life, handling stress effectively were discussed (the training methodology used and the detailed intervention package is available with the author). Initial sessions averaged about 60 minutes with subsequent sessions averaging 55 minutes. The intervention was conducted in three groups.

RESULTS

37% of the respondents were educated up to 10th standard, whereas 63% were illiterates, 87% respondents' monthly family income was ₹ 5000, one respondent was a widow, 43% were living in joint families and 70% of them were multi-linguals who could speak Kannada, Hindi, Marathi and Lambani language. The mean age of the respondents was 33.97 (±10.45).

Table 2: Socio-demographical details of the respondents

Variable	Category/ Value label	N=30	% =100
Education	Illiterate	19	63.3
	Up to 10th Std	10	33.3
	PUC & Graduation	1	3.4
Occupation	Coolie	19	63.3
	Self-Employed	9	30.0
	Government Servant	2	6.7
Income per month (in ₹)	₹ 2000 - ₹ 5000	26	86.7
	₹ 5000 - ₹ 10000	3	10.0
	₹ 10000 - ₹ 15000	1	3.3
Marital status	Married	29	96.7
	Widow	1	3.3
Type of family	Joint	13	43.3
	Nuclear	17	56.7
Languages known	Kannada, Hindi, Marathi, Lambani	4	13.3
	Kannada, Hindi, Lambani	17	56.7
	Only Lambani	9	30.0

Table 3: Impact of Intervention programme on family environment

Domains	Value label/ category	Preassessment		Post assessment – after one year	
		N=30	%	N=30	%
Cohesion	High	0	0	0	0
	Average	6	20.0	29	96.7
	Low	24	80.0	1	3.3
Expressiveness	High	0	0	1	3.3
	Average	9	30.0	29	96.7
	Low	21	70.0	0	0
Conflict	Low conflict	0	0	0	0
	Average conflicts	2	6.7	24	80.0
	High conflicts	28	93.3	6	20.0
Acceptance and caring	High	0	0	0	0
	Average	4	13.3	29	96.7
	Low	26	86.7	1	3.3
Active- recreational orientation	High	0	0	4	13.3
	Average	9	30.0	25	83.4
	Low	21	70.0	1	3.3
Independence	High	0	0	0	0
	Average	0	0	27	90.0
	Low	30	100.0	3	10.0
Organization	High	0	0	13	43.3
	Average	8	26.7	16	53.4
	Low	22	73.3	1	3.3
Control	High	0	0	2	6.7
	Average	7	23.3	26	86.7
	Low	23	76.7	2	6.7

Table 4: Wilcoxon Signed Rank Test

	Ranks	N	Mean Rank	Sum of Ranks	Z	Level of Significance
Cohesion post- pre	Negative Ranks	0	.00	.00	-4.705[b]	000***
	Positive Ranks	29	15.00	435.00		
	Ties	1				
	Total	30				
Expressiveness post- pre	Negative Ranks	1	9.00	9.00	-4.511[b]	000***
	Positive Ranks	28	15.21	426.00		
	Ties	1				
	Total	30				
Conflict post- pre	Negative Ranks	0	.00	.00	-4.463[b]	000***
	Positive Ranks	26	13.50	351.00		
	Ties	4				
	Total	30				
Acceptance and caring post- pre	Negative Ranks	3	3.00	9.00	-4.600[b]	000***
	Positive Ranks	27	16.89	456.00		
	Ties	0				
	Total	30				
Active-recreational orientation post-pre	Negative Ranks	0	.00	.00	-4.784[b]	000***
	Positive Ranks	30	15.50	465.00		
	Ties	0				
	Total	30				
Independence post- pre	Negative Ranks	0	.00	.00	-4.787[b]	000***
	Positive Ranks	30	15.50	465.00		
	Ties	0				
	Total	30				
Organization post- pre	Negative Ranks	0	.00	.00	-4.751[b]	000***
	Positive Ranks	29	15.00	435.00		
	Ties	1				
	Total	30				
Control post- pre	Negative Ranks	1	3.00	3.00	-4.564[b]	000***
	Positive Ranks	27	14.93	403.00		
	Ties	2				
	Total	30				

b. Based on negative ranks

***Significant at 0.001 level

Table 3 and 4 describes the impact of the intervention programme on the family environment of the respondents. Asessment of the family environment has eight sub scales, which assess cohesion, expressiveness, conflict, acceptance and caring, active-recreational orientation, independence, organization and control. The impact of the intervention programme has been assessed using non-parametric test – Wilcoxon signed rank test.

Before the intervention about 80% of the respondents had a low level of cohesion and 20% had an average level of cohesion (Table 3). After the intervention about 96% had an average level of cohesion. As far as expressiveness is concerned, it was noted that before the intervention about 70% of the respondents had a low level of expressiveness and 30% had an average level of expressiveness. After the intervention about 97% had an average level of expressiveness and 3% had a high level of expressiveness. 93% of the respondents had a high level of conflict and 7% had an average level of conflict. After the intervention about 80% had an average level of conflict level and 20% a high level of conflict. On the domain of acceptance and caring, before the intervention about 87% of the respondents had a low level of acceptance and caring and 13% had an average level of acceptance and caring. After the intervention about 97% had an average level of acceptance and caring and 3% a low level of acceptance and caring.

Expressiveness shows that before the intervention about 70% of the respondents had a low level of active recreational orientation and 30% had an average level. After the intervention about 13.3% had a high level of active recreational orientation, 83.4% had an average level of active recreational orientation and 3.3% had a low level of active recreational orientation. Independence domain shows that before the intervention all the respondents had a low level of independence. After the intervention about 90% had an average level and 10% had a low level of independence. Organization shows that before the intervention about 73% of therespondents had a low and 27% had an average level of organization in the family. After the intervention about 53.4%, 43.3% and 3.3% had average, high and low levels of organization respectively. The control domain shows that before the intervention about 77% of the respondents had a low level of control and 23% had an average level of control. After the intervention about 86.7% had an average level of control, 6.7% a high level of control and 6.7% had a low level of control. The Wilcoxon test shows that there was a significant difference ($p<0.001$) between pre and post interventions in all the domains. Hence, the alternative hypothesis that intervention enhances the family environment among Lambanis was accepted. The Chi-square test shows that there was no significant difference between occupation and education of the respondents and education and income of the respondents.

DISCUSSION

The women from Lambani families were not well educated, with mostly less than ten years of education. Majority of them were working as coolies and living in joint families and the income earned was minimal. This study shows that this community is backward in terms of education, occupation, had poor living conditions similar to the findings of Prithviraj&Naik (2012). Languages known by the respondents show that 70% of them are multi-lingual and can speak Kannada, Hindi, Marathi and Lambani languages. This shows that they have adapted to the local conditions.

The descriptive assessment (pre data, Table 3) showed that the family environment was not found to be healthy in any domain and indicated the need for intervention. The literature showed very few studies in this population and intervention is hardly done (Prithviraj & Naik, 2012; Jyothi, 2013; Anand, 2007; Naik, 2013). The modules had various aspects, which covered most of the problematic areas based on the needs of these women. The men were not liberal with their spouses and children were grossly neglected. Though the intervention was planned for females initially, the male counterparts were also included in the intervention in the later part of the sessions. There were discussions with male counterparts separately. This had led them to change their mindsets. There was a significant difference in eight domains of family environment ($p<0.001$) after one year of the intervention which shows that the intervention was very effective. This intervention gives hope that Lambani families can experience positive changes and thus they need to be helped.

CONCLUSION

The modules based on the needs expressed by the women in the Lambani community may be reused in other parts of the country or state. It is understood that, whatever may be the core characteristics of the community, by modifying the family environment we can make a lot of changes in families of such communities. Other interconnected issues like mental illness, child marriage, stress and superstitions are not dealt with. These issues need to be studied separately and appropriate interventions need to be made. The study on the effect of liberalisation, privatisation and globalisationf (LPG) on the Lambani community will give a picture of the changing lifestyle of the community. The results are encouraging for initiating community-based interventions among the disadvantaged families in general and Lambani families in particular.

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Application of the International Classification of Functioning to Persons with Schizophrenia in Rehabilitation- A Feasibility Study

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Abstract

Introduction: Classificatory systems have been central to medical as well as social sciences including Psychiatry. The International Classification Functioning is considered a holistic tool in that it codes a very wide range of variables under the construct of functionality. The ICF has been created with the idea that its use shall not be limited to physical disorders. Despite this, its use in the field of Mental Illness has been limited. This paper explores its use on persons with Schizophrenia in rehabilitation.

Methodology: A total of 30 persons with Schizophrenia (11 from a Half way Home, and 19 from a Day Care Center) were selected for the study and the WHODAS, the ICF checklist and the PANSS, apart from a Socio-Demographic Data schedule were administered to them.

Results: Of the 128 items on the ICF checklist, 45 items were coded for a majority of the respondents. Only 8 items were coded for 100% of the respondents. The mental functions domain on the ICF was found to be strongly positively correlated with the positive, negative and total scores on the PANSS.

Conclusion: The ICF needs to be used more often for persons with Mental Illnesses. ICF core sets have been developed for some physical illnesses. Similar work needs to be done for persons with Schizophrenia to gain a holistic understanding about their functionality and the lacunae therein.

Key words: International Classification of Functioning, ICF, Schizophrenia, Feasibility

INTRODUCTION

Classificatory systems have been central to medical sciences including Psychiatry. Classification is explained as, "A process by which the complexity of a phenomenon is reduced by arranging it into categories according to some established criteria for one or more purposes" (Jablensky & Kendell, 2002). Zimmerman and Spitzer (2005), list the three main purposes of classification as Communication, Control and Comprehension. While the ICD 10 and the DSM IV serve the purposes of Communication and Control, they do not serve the third purpose of classification, namely Comprehension (Dalal & Sivakumar, 2009). For example, a diagnosis of F20 is understood as a case of Schizophrenia (communication), calls for the use of anti-psychotic medication (control), but does not tell us much about the functionality of the patient (comprehension). The ultimate goal of any intervention is better functionality of the patient, and enough is not known about this aspect by merely a diagnosis of F20. As a result of these shortcomings, the WHO in 1980, came up with The International Classification of Impairment, Disability and Handicap (ICIDH). After multiple revisions of the ICIDH, the International Classification of Functioning (ICF) was launched in the year 2001.

The ICF incorporates three interrelated concepts. I) Functioning and Disability; II) Contextual Factors. Functioning and Disability further comprises two components: 1) Body Functions (includes mental functions) and Structures; and 2) Activity and Participation, while Contextual Factors include the individual's Environment and Personal Factors (WHO, 2001). According to Cieza and Stucki, (2005), the ICF presents and interprets relationships among the workings of the body, environment, and personal domains in two directions. According to them, patients with the same diagnosis as well as severity of illness may have the same ability to carry out assigned tasks when doing them in a controlled setting, but their performance might not be the same and may be significantly different in their natural environment. This may be due to certain individual factors and the characteristics of their environment. Disability is a complex phenomenon that is a result of many factors which are not isolated and cause specific types and levels of impairment. Schizophrenia remains a leading cause of disability even with advances in pharmacological and psychosocial management strategies and causes overall disability in areas of cognitive functioning, social skills and activities of daily living (ADL) (Strassnig, Signorile, Gonzalez, & Harvey, 2014).

While there have been a number of studies assessing disability in persons with Schizophrenia using disability assessment schedules such as IDEAS (Chaudhury, Deka, & Chetia, 2006; Kumar, Suresha, Thirthalli, Arunachala, & Gangadhar, 2015), Schedule for Assessment of Psychiatric Disability (Thara, Rajkumar, & Valecha, 1988), WHODAS II (McKibbin, Patterson, & Jeste, 2004), HRQOL, neuropsychological tests (Bowie et al., 2008) etc, the use of the ICF on persons with Schizophrenia has been rather limited. The ICF has been found to be covering the maximum sub-domains under the domain of Environmental Factors as compared to other measures of QOL (Cieza & Stucki, 2005) and allows for a comparison of the impact of different psychiatric illnesses on the functionality of patients and also gives an appropriate evaluation for the number of years lived with disability for patients with psychiatric disorders (Tenorio-Martinez, del Carmen Lara-Munoz, & Medina-Mora, 2009). Some of the main reasons for the lack of use of the ICF in the discipline of Psychiatry are its novelty, ascendancy of the medical model , the impact of medication on the ability to perform the assigned task, the notion that disability has to do only with physical problems or conditions, the complexity and inherent problems with the use of ICF and difficulty of access to ICF (Alvarezz, 2012)

The ICF takes into consideration the body functions, body structures, activity and participation domains as well as the environmental barriers and facilitators. In this context too, persons with Schizophrenia living in the community and those who have been institutionalized would differ in their ICF ratings. Similarly, persons with Schizophrenia receiving professional rehabilitation inputs would differ from those receiving none. The present study is an attempt to test the feasibility of the ICF checklist as a measure of functionality and disability by using it on persons with Schizophrenia in rehabilitation.

METHOD

Instruments used:

A) **Semi Structured Interview Schedule:** A semi structured interview schedule was used which collected information about personal, social, demographic, family, economic and illness profiles of the respondents.

B) **Positive and Negative Symptom Scale (PANSS):** This was used to create a symptom profile of the patient. PANSS is a tool which very specifically taps

positive, negative and general psychopathology symptoms of persons with Schizophrenia. PANSS ratings are based on the total information about the patient's symptoms, pertaining to a specific period, which is by and large the previous week. Information for the rating can be obtained from either the patient himself/herself, or from the hospital staff or from family members. The ratings provide summary scores on a 7-item positive scale, 7-item negative scale, 16-item general psychopathology. Each item in the scale is rated on a 7-point rating, a composite index which is derived from positive minus negative symptom score.

C) **International Classification of Functioning (ICF) Checklis**t (WHO, 2001) for the coding of the level of functioning of patients. The ICF checklist is a simple-to-use list of the most relevant ICF categories for clinical purposes. The checklist allows the clinician to recognize and qualify the patient's functioning profile in a simple and time-efficient way. ICF includes a list of items divided into the following domains. 1a. Body functions, 1b. Body structures, 2. Activity limitation and participation restriction, 3. Environmental factors. These domains describe the context in which individuals live. The uses of ICF are many and one such use is that the ICF can be used as an instrument in research to determine outcomes, quality of life as well as environmental factors. Similarly, it may be used as a clinical measure to assess needs, match treatments and interventions with specific problems, occupational evaluation, rehabilitation and outcome assessment. The ICF coding is simple: 0 = no impairment, 1 = mild impairment, 2 = moderate impairment, 3 = severe impairment, 4 = complete impairment, 8 = not specified, 9 = not applicable

Process:

The main aim of this particular study was to check the feasibility of the use of the ICF checklist on persons with Schizophrenia in rehabilitation. In all, a sample of 30 persons with Schizophrenia was selected for the study from 2 rehabilitation centers. 1) The Day-Care Center (DCC) (N1=19), Department of Psychiatric & Neurological Rehabilitation, NIMHANS, Bengaluru and 2) Half-way home (HWH), (N2=11), Family Fellowship Society, Bengaluru. The DCC has patients who reside in the city of Bengaluru and come to DPNR to be engaged in activities such as candle making,

crafts and mat making. The DCC is not a residential facility and the patients are here only from 9:30 am to 4:30 pm. The HWH on the other hand, is a residential care facility. Patients admitted here stay here from anywhere between one to six months, with family members visiting them from time to time. During the day time they are engaged in activities similar to those of patients at the DCC.

For the study, only patients with a diagnosis of Schizophrenia according to the ICD 10 were included. Patients with other Axis I diagnoses in addition to Schizophrenia were excluded from the study. Due permission was sought from the institutions from where the study sample was selected and ethical guidelines such as informed consent and confidentiality were duly followed.

Interviews were conducted with the patients during their admission/stay at the DCC/ HWH. Most of the information was collected from patients themselves with some inputs from the hospital staff.

RESULTS

Table 1: Personal, Social and Economic details of the Respondents.

#	Variable	Attribute	HWH (n1=11)		DCC (n2=19)				% Total N=30
			N	% (N=30)	N	% (N=30)	Mean	SD	
1	Sex	Male Female	6 5	20 16.66	11 8	36.66 26.66			56.66 43.32
2	Age	<or=40 yrs >40 yrs	2 9	6.66 30	8 11	26.66 36.66	42.83	9.01	33.32 66.66
3	Marital status	Married Single	1 10	3.33 33.33	1 18	3.33 60			6.66 93.33
4	Religion	Hindu Muslim Christian	8 0 3	26.66 0 10	15 1 3	50 3.33 10			76.66 3.33 20

5	Domicile	Karnataka Others	7 4	23.33 13.33	14 5	46.66 16.66			69.99 29.99
6	Qualification	<=SSLC >SSLC	0 11	0 36.66	7 12	23.33 40			23.33 76.66
7	Current Occupation	Working Non-work HH work	3 0 8	10 0 26.66	18 1 0	60 3.33 0			70 3.33 26.66
8	Primary Caregiver	Parent/s Sibling/s Spouse Self	3 7 0 1	10 23.33 0 3.33	7 10 1 1	23.33 33.33 3.33 3.33			33.33 56.66 3.33 6.66
9	Primary Caregiver's Occupation	Working Non-work HH work	8 3 0	26.66 10 0	13 5 1	43.33 16.66 3.33			69.99 26.66 3.33
10	Caregiver's income/pm	<=Rs 5000 >Rs 5000	1 10	3.33	9 10	30 33.33	6900	2826	33.33 66.66
11	Financial Problems	Present Absent	10 133.33	33.33 3.33	19 0	63.33 0			96.66 3.33
12	Primary support	Present Absent	1 10	3.33 33.33	18 1	60 3.33			63.33 36.66
13	Secondary support	Present Absent	1 10	3.33 33.33	0 19	0 63.33			3.33 96.66
14	Tertiary support	Present Absent	11 0	36.67 0	19 0	63.33 0			100 0

About 93.3% of the respondents were single (had never been married or divorced). Their illness was reported as the main reason for this. 96.6% of the respondents reported the presence of financial/economic problems. About 63% of respondents reported adequate primary social support. This is evident because 19 of the 30 respondents were living with families. All the respondents reported adequate tertiary social support from the DCC or the HWH.

Table 2: Illness profile of Respondents.

#	Variable	Attribute	HWH (n1=11)		DCC (n2=19)				% Total N=30
			N	% (N=30)	N	% (N=30)	Mean	SD	
1	Age at onset of illness	<= 20 yrs	4	13.33	8	26.66			39.99
		21-30 yrs	7	23.33	11	36.66			59.99
2	Type of onset	Abrupt	1	3.33	0	0			3.33
		Acute	8	26.66	15	50			76.66
		Insidious	2	6.66	4	13.33			17.33
3	Course of illness	Continuous	9	30	15	50			80
		Fluctuating	2	6.66	4	13.33			19.99
4	Family history	Present	2	6.66	3	10			16.66
		Absent	9	30	16	53.33			83.33
5	Other medical co-morbidity	None	9	30	18	60			90
		DM	1	3.33	0	0			3.33
		HTN	0	0	0	0			0
		Both	1	3.33	1	3.33			6.66
6	# of yrs admitted to rehab. org.	<=5 yrs	9	30	10	33.33	4.45	4.99	63.33
		>5 yrs	2	6.66	9	30			36.66

All the respondents had the onset of illness before 30 years of age. A majority of the respondents (76.66%) had an acute type of onset. A majority of them (80%) had a continuous course of illness. Among medical co-morbidities, approximately 90% had none, 3.3% had Diabetes Mellitus and 6.6% had Diabetes Mellitus along with Hypertension. About 63.33% of the respondents had been with the HWH or the DCC for a minimum of 5 years or less than that, while 36.67% had been with the HWH or the DCC for more than 5 years. The mean number of years spent at the rehabilitation unit was found to be 4.5 years with an SD of 4.99.

Table 3: Frequency Distribution of PANSS Scores

#	Variable	Attribute	HWH (n1=11)		DCC (n2=19)		% Total N=30
			N	% (N=30)	N	% (N=30)	
1	Positive Symptoms	Absent	4	36.4	0	0	4 (13.3%)
		Minimal	5	45.5	15	78.9	20 (30%)
		Mild	0	0	4	21.1	4 (13.3%)
		Moderate	2	18.2	0	0	2 (6.7%)
2	Negative Symptoms	Absent	1	9.1	0	0	1 (3.3%)
		Minimal	2	18.2	0	0	2 (6.7%)
		Mild	8	72.7	12	63.2	20 (66.7%)
		Moderate	0	0	7	36.8	7 (23.3%)
3	General Psychopathology	Minimal	9	81.8	15	78.9	24 (80%)
		Mild	2	18.2	4	21.1	6 (20%)

Table 3 shows the frequency of respondents on the PANSS in both the groups of respondents. In the first group of respondents, (HWH), 36.4% of the respondents from within the group had no positive symptoms on the scale. 45.5% had the presence of minimal positive symptoms, 0.0% had mild symptoms, while 18.2% had moderate positive symptoms on the scale. Within the second group of respondents (DCC), 78.9% of the respondents had minimal positive symptoms and 21.1 % had mild positive symptoms. Overall, 13.3% had no positive symptoms, 30% had minimal, 13.3% had mild and 6.7% had moderate positive symptoms. In the negative symptoms domain, in the HWH group of respondents, 72.7% of respondents had mild negative symptoms while 18.2 had minimal level of negative symptoms. In the DCC group, 63.2% respondents had mild level of negative symptoms while 36.8 had moderate level of symptoms. Overall, 66.6% of the respondents had mild negative symptoms, 23.3% had moderate negative symptoms.

In the general psychopathology domain, in the HWH group of respondents, 81.8% of the respondents had minimal symptoms while 18.2 had mild level of symptoms. In the DCC group of respondents, 78.9% of the respondents had minimal symptoms and 21.1% had mild level of symptoms. Overall, 80% of respondents had minimal level of symptoms and 20% had mild level of symptoms.

Table 4: Number of items from the ICF Checklist that were applicable to at least one Respondent

No. of Items applicable		No. of Items not applicable		Total No. of items
Frequency	%	Frequency	%	
45	35.15	83	64.84	128

Coming to the results of the use of the ICF Checklist, it was found that out of a total of 128 items on the ICF Checklist, the Researcher was able to use 45 items on at least one respondent. This means that there were items on the checklist that were applicable to only a few of the respondents and not all. Most of these 45 items were applicable to a majority of respondents, however some items such as impairment in the blood pressure, or weight maintenance etc were found useful for very few respondents.

A detailed frequency analysis of the 45 items found applicable in this study is presented in the next 3 Tables.

Table 5a: Frequency distribution of items on the ICF Checklist that were found applicable on Body Part and Functions for persons with Schizophrenia

#	Domain	ICF code	Variable	No. of persons having a score (1,2 or 3)	%age (N=30)
1	Body Functions	b114	Orientation	21	70
2		b130	Energy & Drive functions	28	93.33
3		b134	Sleep	22	73.33
4		b140	Attention	28	93.33
5		b144	Memory	13	43.33
6		b152	Emotional functions	29	96.67
7		b156	Perceptual functions	5	16.67
8		b160	Thought Functions	18	60
9		b164	Higher level cognitive functions	28	93.33
10		b420	Blood pressure	2	6.67
11		b530	Weight Maintenance	8	26.67
12		b555	Endocrine glands	3	10
13		b640	Sexual functions	2	6.67

The ICF checklist is divided into 3 parts.

Part 1a deals with body-functions which includes the categories of mental functions, sensory functions and pain, voice and speech functions, functions of the cardiovascular, haematological, immunological and respiratory systems, functions of the digestive,

metabolic and endocrine systems, genitourinary and reproductive functions, sexual functions, of the neuro-musculoskeletal and movement related functions and functions of the skin and related structures. Out of all the above mentioned body functions, mainly, the mental functions could be applied to the respondents of this study. Some other functions that included endocrine system functions, digestive system functions etc were found applicable in very few respondents but have been coded. The applicability of the item was decided based on the researcher's interview with the respondents, their case files and accounts from the staff at the organization. Wherever possible and available, family members of the respondents were also interviewed to obtain enough and reliable information.

Table 5b: Frequency distribution of items on the ICF Checklist that were found applicable on activity limitations and participation restriction for persons with Schizophrenia

#	Domain	ICF code	Variable	No. of persons having a score(1,2 or 3)	%age (N=30)
14	Activity limitations and participation restriction	d210	Undertaking a single task	4	13.33
15		d220	Undertaking multiple tasks	19	63.33
16		d350	Conversation	26	86.67
17		d570	Looking after one's health	17	56.67
18		d620	Acquisition of goods & services	17	56.67
19		d630	Preparation of meals	4	13.33
20		d640	Doing housework	24	80
21		d660	Assisting others	6	20
22		d710	Basic interpersonal interactions	13	43.33
23		d720	Complex interpersonal interactions	19	63.33
24		d730	Relating with strangers	20	66.67
25		d740	Formal relationships	14	46.67
26		d750	Informal social relationships	19	63.33
27		d760	Family Relationships	22	73.33
28		d770	Intimate Relationships	2	6.67
29		d850	Remunerative employment	30	100
30		d870	Economic self sufficiency	29	96.67
31		d910	Community life	25	83.33
32		d920	Recreation & leisure	15	50

Part 1b deals with body structures. This part of the ICF essentially looks into the changes in the position, dimension, total absence, partial absence and other abnormalities in the body organs. Part 1b was found to be mostly inapplicable to the respondents. Part 2 deals with the activity limitations and participation restrictions domain. Here, the researcher found at least 18 items that were applicable to the present study.

Table 5c: Frequency distribution of items on the ICF checklist that were found applicable on Environmental Factors for persons with Schizophrenia

#	Domain	ICF code	Variable	No. of persons having a score(1,2 or 3)	%age (N=30)
33	Environmental Factors	e310	Immediate family	30	100
34		e320	Friends	12	40
35		e325	Acquaintances, peers, neighbours, colleagues & community members	19	63.33
36		e330	People in position of authority	20	66.67
37		e355	Health professionals	30	100
38		e410	Individual attitudes of immediate family members	27	90
39		e420	Individual attitudes of friends	11	36.67
40		e450	Individual attitudes of health professionals	30	100
41		e460	Societal attitudes	30	100
42		e570	Social security, systems services & policies	30	100
43		e580	Health systems services & policies	30	100
44		e585	Education & training services systems and policies	11	36.67
45		e590	Labour & employment services systems & policies	30	100

The final part of the ICF deals with the environmental factors. Here, the Researcher found that the domains on support and relationships, attitudes and services, systems and policies were found to be the most applicable, while those on products & technology and natural environment and human-made changes to the environment were not found applicable.

Tables 5 a, b and c show the frequency distribution of the number of respondents who had a positive score of impairment on any item. These Tables essentially show the applicability of the tool. For a majority of the items, the researcher found that more than 50% of the respondents responded with a positive code i.e., 1, 2 or 3, which shows the extent of impairment. For 7 items, the response was obtained from 100% of the respondents.

Table 6 shows the minimum, maximum and mean level of impairment on each item of the ICF checklist. The mean impairment comes high on the energy and drive functions, the emotional functions and the higher level cognitive functions. In the domain of activity limitation and participation restriction, the items looking after one's health, remunerative employment and economic self-sufficiency score the highest mean-wise.

Table 6: Mean scores of impairment of respondents on the ICF Checklist

#	ICF code	Variable	Min. score	Max. score	Impairment mean score	SD (N=30)
1	b114	Orientation	0	2	.83	.648
2	b130	Energy & Drive functions	0	3	1.70	.750
3	b134	Sleep	0	2	.97	.718
4	b140	Attention	0	2	1.30	.596
5	b144	Memory	0	2	.57	.728
6	b152	Emotional functions	0	3	1.63	.615
7	b156	Perceptual functions	0	2	.27	.640
8	b160	Thought Functions	0	2	.70	.651
9	b164	Higher level cognitive functions	0	3	1.90	.803
10	* b420	Blood pressure	-	-	-	-
11	*b530	Weight Maintenance	-	-	-	-
12	*b555	Endocrine glands	-	-	-	-
13	*b640	Sexual functions	-	-	-	-
14	d210	Undertaking a single task	0	2	.17	.461
15	d220	Undertaking multiple tasks	0	3	1.10	.960

16	d350	Conversation	3	1.70		1.29
17	d570	Looking after one's health	0	3	1.50	.820
18	d620	Acquisition of goods & services	0	3	.90 (N=29)	.93(N=29)
19	d630	Preparation of meals	-	-	-	-
20	d640	Doing housework	0	3	1.33	.884
21	d660	Assisting others	0	2	.27	.583
22	d710	Basic interpersonal interactions	0	3	.60	.814
23	d720	Complex interpersonal interactions	0	3	1.00	.910
24	d730	Relating with strangers	0	3	1.17	1.020
25	d740	Formal relationships	0	3	.77	.971
26	d750	Informal social relationships	0	3	1.03	.964
27	d760	Family Relationships	0	3	1.48 (N=25)	.82(N=25)
28	d770	Intimate Relationships	-	-	-	-
29	d850	Remunerative employment	2	4	3.07	.521
30	d870	Economic self sufficiency	0	4	3.67	.802
31	d910	Community life	0	3	1.43	.971
32	d920	Recreation & leisure	0	2	.63	.718

*The means and SD of these items have not been listed because the items got responses from very few respondents.

The means for the environmental factors have not been calculated, since there are two types of coding involved here - a barrier and a facilitator. A coding of 1 indicates a mild barrier, while a coding of +1 indicates a mild facilitator. Thus, higher the score on barrier, higher is the impairment on that particular item and higher the score of the facilitators for a respondent, lower is the impairment. Also, respondents have reported a barrier on some of the items and the same respondents have reported facilitators on other items. Therefore it becomes difficult to calculate the mean scores on these items. A simple frequency analysis of how many respondents felt there was a barrier and how many experienced a facilitator on each item has been presented in Table 7.

Table 7: Frequency analysis of the items under the domain of Environmental Factors of the ICF Checklist

#	Variable	Attribute	No. of respondents experiencing				Total %
			Barrier		Facilitator		
			N	% N=30	N	% N=30	
1	e310	Immediate family	13	43.33	17	56.67	100
2	e320	Friends	4	13.33	8	26.67	40
3	e325	Acquaintances, peers, neighbours, colleagues & community members	11	36.67	8	26.67	63.33
4	e330	People in position of authority	2	6.67	18	60	66.67
5	e355	Health professionals	0	00	30	100	100
6	e410	Individual attitudes of immediate family members	8	26.67	19	63.33	90
7	e420	Individual attitudes of friends	3	10	8	26.67	36.67
8	e450	Individual attitudes of health professionals	0	00	30	100	100
9	e460	Societal attitudes	30	100	0	00	100
10	e570	Social security, systems services & policies	30	100	0	00	100
11	e580	Health systems services & policies	5	16.67	25	83.33	100
12	e585	Education & training services systems and policies	9	30	2	6.67	36.67
13	e590	Labour & employment services systems & policies	30	100	0	00	100

The above Table shows that 13 items were found applicable to the respondents of this study and out of these, a majority of them have received a response, either in the form of a barrier or in the form of a facilitator. 7 items have been responded to by 100% of the respondents. 100% of the respondents have admitted to facing barriers in the context of societal attitudes, social security systems, services and policies, and labour and employment services systems and policies.

Table 8: Correlation between PANSS scores (Positive, Negative & Total) and the ICF domains

#	ICF Domains	Positive Symptom score	Negative symptom score	Total PANSS Score
1	Mental Functions	.754** (.000)	.635** (.000)	.798** (.000)
2	General tasks & demands	.468** (.009)	.316 (.089)	.495** (.005)
3	Communication	.359 (.051)	.262 (.163)	.384* (.036)
4	Self-Care	.647** (.000)	.520** (.003)	.660** (.000)
5	Domestic life	.203 (.281)	.355 (.054)	.367* (.046)
6	Interpersonal interactions & relationships	.483** (.007)	.543** (.002)	.637** (.000)
7	Major life areas	.362* (.049)	.396* (.030)	.463* (.010)
8	Community, social and civic life	.587** (.001)	.625** (.000)	.654** (.000)

*Correlation is significant at the 0.05 level (2 tailed) **significant at the 0.01 level (2 tailed)

The above Table shows the results of correlation between the positive, negative and total scores on the PANSS and the impairments in various domains in the ICF checklist. Karl Pearson's coefficient of correlation was used for this. The correlation comes out to be strongly positive in many of the domains.

The mental functions domain is strongly positively correlated with the positive (0.754), the negative (0.635) and the total scores (0.798) on PANSS. This means that higher the score of symptoms on the PANSS, higher is the impairment in the mental functions as reflected in the ICF checklist. Similarly, on the general tasks and demands domain, its correlation is strong with all the three scores on PANSS. In the domain of communication,

there is a positive correlation only with the total PANSS scores (0.384), and not with the positive and negative symptom scores individually. The domain of self-care is strongly positively correlated with all the three scores on the PANSS. In the domain of domestic life, there is a strong positive correlation with the total PANSS scores at 0.367. Similarly in the domain of interpersonal relationships and major life areas, there is a significant positive correlation with the positive, negative as well as the total PANSS scores.

It is important to note that the correlation is the strongest in the domains of mental functions, interpersonal relationships and community, social & civic life. This is reflective of the fact that persons with Schizophrenia face major difficulties in almost all the domains of life but more so in the above-mentioned domains. The correlation analysis brings out this fact clearly.

DISCUSSION

In the year 2010, one of the main contributors to Years Lost due to Disability (YLDs) were disorders in the category of mental, neurological and substance use. These disorders constituted 10.4% of global Disability Adjusted Life Years (DALYs), 2.3% of global Years of Life Lost (YLLs). Rates of treatment for this category of disorders are low, especially in Low and Middle Income Countries, where the documented gap in treatment is as high as 90%. Even in High Income Countries, where treatment rates are relatively elevated, treatment for mental, neurological, and substance use disorders is usually received several years post the onset of the illness (Wang et al., 2007). Modest estimates state that 40 million people in India are disabled, and this number may go as high up as 80-90 million if more broad and comprehensive definitions of both mental illness and mental retardation in particular would be used (The World Bank; 2007). Given that a sizeable percentage of the disabled in India and around the world consists of persons with mental illnesses, the importance of interventions that aim at improving the quality of life of this population cannot be stressed enough. Quality of Life, Disability and Functionality are concepts that are closely interrelated. Disability and functionality are complex phenomena that underline the interactions between a person's physical and mental health and her/his contextual factors. While there are many tools that measure disability, there is none that measures disability as well as functionality in as much depth as the International Classification of Functioning. There are measures which

focus on particular disorders or which focus only on disability. ICF can be used for any person with any kind of a disorder or with multiple disorders and focuses not just on impairments but also on the functionality. The ICF is perhaps the only tool that focuses on functionality also. This is reflected in at least two domains. The first one is the domain of Activity Limitation and Participation restriction where a performance qualifier as well as a capacity qualifier is asked for. The performance qualifier reflects the functionality in the current environment of the respondent while the capacity qualifier reflects the inherent capacity of the respondent in performing a particular task i.e if in the current environment the respondent is using any help from an external source or an assistive device, the capacity qualifier asks for the respondent's functionality in the absence of that particular support. The second domain which reflects the functionality part of the tool is the domain of environmental factors where along with a barrier; the respondent is also asked if a facilitator is present. This gives pointers to the areas/issues that need to be targeted.

The uses of ICF are many and one such use is that the ICF can be used as an instrument in research to determine outcomes, quality of life as well as environmental factors. Similarly, it may be used as a clinical measure to assess needs, match treatments and interventions with specific problems, occupational evaluation, rehabilitation and outcome assessment. This study was an attempt to demonstrate the use of the ICF on persons with Schizophrenia in rehabilitation and made use of the ICF checklist. It was found that while most items in the body structures domain are less likely to be applicable to persons with Schizophrenia, most other domains have been found very useful. It is also to be noted that being the comprehensive tool that the ICF is, it is much better suited to cases where there are multiple mental as well as medical disorders, as compared to a standard measure of disability or quality of life. It is therefore felt that the ICF is not a tool of importance just for medical professionals, but for other professionals such as social workers, occupational therapists etc. The ICF presents a huge scope for social workers working in the field of mental health or even disability in general, since the tool is so comprehensive that based on it a social worker can identify areas where action is needed, be it at the individual, group, community or even the political level. It is felt that there is a great scope for the use of the ICF in the field of mental health and it should be used more often.

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Knowledge and Preparedness of the Govt. School Teachers towards Mainstreaming the Children with Special Needs in Rural Rajasthan

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Abstract

In India approximately three out of hundred children have either physical or intellectual disabilities. At one end these children need special education and at the other end the non-availability of special educators and lack of training among the teachers for these children makes the situation more complex. This article is an attempt to research into the Government teachers' knowledge and preparedness towards mainstreaming the Children with Disability (Children With Special Needs- CWSN) in rural schools of Ajmer District of Rajasthan in India. The general education teachers working in these schools participated in the study. The primary data was collected with the help of a self-administered questionnaire. For this study 69 teachers were contacted and 57 teachers (28 Female and 29 Male) participated in the study. Results indicate that most of the teachers had low acceptance and less preparedness for the mainstreaming of children with special needs. Teachers need special teacher training and require total involvement of parents in the education of children with special needs.

Keywords: Children with Special Needs, Mainstreaming, Knowledge and Preparedness.

INTRODUCTION

Education for All (EFA) represents an international commitment to make sure that every child and adult receives fundamental education. EFA is based both on a human rights perspective and the importance of education for individual and national development. However, EFA has not given sufficient attention to marginalized groups of children till date, in particular those having 'special educational needs' or disabilities. Children with special needs are too far from basic education and the efforts taken by national and international authority are also minimal. It has become clear that, without targeted measures to help them overcome the barriers, the goals of EFA cannot be achieved for children with special needs (UNICEF, 2012). In the context of India, children with special needs have been marginalized due to the limited accessibility of resources (Singal, 2006).

The success of the inclusion of children with special needs in mainstream education largely depends on teachers' attitudes, knowledge and preparedness towards students with Special Educational Needs (SEN) and their knowledge on how to properly educate them (Dapudong 2014). But, at present as the children are included in mainstream, the attitude of people and teachers is observed to be changing. Over a period of time, the notion of inclusion has gained more momentum and a majority of classrooms now include students with diverse needs and abilities (Konza, 2008). When inclusion or mainstreaming was more sporadic and was beginning to gain momentum the teachers' attitudes towards students with diverse needs and abilities were not very positive (Siegel, 1992). Empirical data by Maxwell and Aloia (1981) showed that teachers possessed low academic expectations from students with special educational needs. They were also more concerned about their lack of knowledge and training for the inclusion of students with disabilities (Siegel &Jausovec, 1994).

UNESCO (2012) defines Inclusive Education as *a process of advocating and including the different needs of all learners through increasing participation in learning, cultures and society and it's also supporting to decreasing exclusion within and from education. Inclusive education is not a minor issue, but is central to the achievement of high-quality education for all learners and the development of more inclusive societies.*

Disability could be understood differently across different communities and cultures. The Convention on the Rights of Persons with Disabilities, article 1 (CRPD, United Nations, 2006) describes the children with disability as those who have long-term

physical, mental, intellectual, or sensory impairments, which creates barriers to interact with people and hinders them from enjoying full and effective participation in society on an equal basis. Due to lack of knowledge, specifically in people from rural areas and teachers from government schools considered physical disability was considered as the only type of disability.

Right to Education Act (2009) mandates every child (6-14 years) to receive free and quality education. However, children with disability are still deprived from education. In India approximately three out of hundred children have either physical or intellectual disabilities (Global Population Estimates, 2010). At one end these children need special education on par with the normal children and at the other end the non-availability of special educators for these children is a concern.

A billion people and above are estimated to be suffering with some kind of disability, or about 15% of the world's population (Shakespeare & Officer, 2011). This is higher than previous World Health Organization estimates, which date from the 1970s and suggested a figure of around 10% (World Report on Disability, 2011).

During the period of the present study, the Researchers were engaged in working with children with special needs in Ajmer District of Rajasthan state. It was observed by the researchers that parents of children with special needs had a lack of knowledge about the disability of their child. The parents themselves were illiterate; and lacked the knowledge of their involvement in the education of children with special needs. Many children with special needs were not enrolled in mainstream education and it was observed that CWSN have also dropped out from mainstream education. The Researchers observed that this phenomenon replicated itself in adjoining schools and villages. It is this observation which led the Researchers to study this situation empirically.

METHODS

The list of CWSN in Ajmer District was obtained from the District Medical Board. Based on the list, a survey of villages in Srinagar Block of Ajmer District was carried out as the organization where the Researcher worked engaged mostly in this block. The survey helped to identify CWSN enrolled in the mainstream schools. The survey

revealed that CWSN were available in the following nine villages, viz., Padampura, Magri, Magra, Hoshiyara, Brijpura, Chatri, Gagwana, Aararka and Babaicha. Each village has a government run school, wherein CWSN certified by District Board were admitted for availing education from these schools. An approval from the District Education Officer and Block Education Officer was sought to carry out the study. The criterion for selection of the sample was that they should be full time teachers engaged in teaching CWSN or should have had experience of teaching CWSN in the recent past (within the past five years). Screening of teachers was done; overall 69 teachers were found to be working in these villages. All 69 teachers were contacted to take part in the study. However, only 57 teachers (28 Female and 29 Male) could participate in the study. Twelve teachers could not take part in the study, due to their non-availability, some teachers were on leave, a few others were unable to spend time to participate and others refused to participate in the study. The teachers engaged in teaching the students are those who have had training in teaching general education only. A semi-structured questionnaire was prepared based on review of literature. It consisted of overall 59 items to elicit information on attitude, knowledge and preparedness of school teachers for teaching CWSN. Four experts, a Psychologist, a Professional Social Worker, a Special Educator and an Administrator working in field of special education were approached for content validation of the tool. The items were finalized based on the suggestions received from experts. The finalized semi-structured questionnaire was further subjected to a pilot study with five school teachers apart from the teachers who took part in this study. The primary data was edited, coded, entered into excel spreadsheet and tables were prepared. An informed consent was taken from teachers to participate in the research voluntarily. The pictures or photographs of teachers, classrooms and the CWSN were kept confidential. The information sought from the teachers was used only for research purpose. At the end of the study, the Researchers also provided training to the school teachers on how to deal effectively with CWSN. Special educators and experts in the field were invited to provide training to the school teachers. The main objective of the training was to empower teachers to effectively deal with teaching the CWSN.

Apart from this, 10 teachers were also interviewed to understand various issues related to mainstreaming or inclusive education of CWSN. The interviews were short interviews carried out to capture the knowledge and observations of the teachers related to teaching the CWSN.

RESULTS

Table 1: Preparedness of teachers for inclusive education of CWSN

		n (Total=57)	%
I can distinguish different disabilities among CWSN			
	Not Aware	1	1.8
	Moderately Aware	22	38.6
	Somewhat Aware	34	59.6
I have been adequately trained to meet the needs of CWSN			
	Yes	8	14.0
	No	49	86.0
I am able to identify the slow learner students			
	Yes	35	61.4
	No	22	38.6
I am able to identify learning disability among children			
	Yes	19	33.3
	No	38	66.7
I can identify children with intellectual disability			
	Yes	28	49.1
	No	29	50.9
I update myself with information related to inclusive education			
	Usually	1	1.8
	Sometimes	8	14.0
	Never	48	84.2
I feel inadequate for teaching CWSN			
	Yes	54	94.7
	No	3	5.3

Table 2: Attitude of teachers towards CWSN

		n (Total=57)	%
Difficulty faced to implement inclusive education			
	Non supportive behavior of Normal Children	16	28.1
	Physical environment of school	8	14.0
	Inadequate Special Educator	23	40.4
	Lack of Special Training	10	17.5
Opinion about: A general education teacher can teach CWSN			
	General Education teacher can teach CWSN	4	7.0
	Can teach after some training	15	26.3
	With the help of Special Educator	12	21.1
	General Education Teacher can never teach	26	45.6
Intellectual disability CWSN can get admission in a regular school			
	Yes, Intellectual disability can study with children without disability	28	49.1
	No, Intellectual disability cannot study with children without disability	29	50.9
Teachers need special training to handle CWSN			
	Yes	43	75.4
	No	14	24.6
CWSN increase the risk of safety of other students			
	Yes	33	57.9
	No	24	42.1
Schools need to spend more on financial resources to address the unique needs of CWSN			
	Yes	17	29.8
	No	40	70.2
The attention given to CWSN distracts teaching the other students			
	Yes	40	70.2
	No	17	29.8

The teacher should not be expected to make major adjustments to serve the CWSN			
	Yes	25	43.9
	No	32	56.1
CWSN gain self-esteem and confidence through mainstreaming			
	Yes	43	75.4
	No	14	24.6
All CWSN should receive passing grades regardless of performance			
	Yes	20	35.1
	No	37	64.9

The data pertaining to different types of disabilities and its prevalence was obtained from the District Medical Board engaged in certification of the disability. The records related to certification within the past five years were screened for Srinagar Block. It was found that 31.6% students had multiple disabilities, such as intellectual disability with cerebral palsy and mental retardation. It was also found that 29.8% students were found to have learning disability and 21.1% students had intellectual disability. Apart from that, 8.8% had cerebral palsy, 7% autism, 1.8% had hearing impairment as assessed by district disability certification board of Ajmer District. It is observed that almost all children with disability hail from marginalized and vulnerable families especially from an economically poor background. The CWSN were from villages with less ability to travel and or belonging to the below poverty line status. From the addresses of the CWSN it was found that they hailed from the marginalized section of the villages.

In all these nine schools, 21 children with special needs were enrolled as students. However, due to a lack of special educators most of the CWSN students had dropped out. It was found that the teachers and parents did not feel that education was of any use to these children. When teachers were found to be interested to provide special education to these children, they lacked training. Teachers reported that neither did they have special teaching equipment, nor was there any budget with the school to procure these materials (Table 1). Teachers also reported that the CWSN had to travel a long distance from home to school for which they did not have transport facilities. Parents were not willing to provide pick up and drop facilities to the children, as they were engaged in house work. Mothers had to travel far for procuring water for household work. When parents and teachers felt that the children were not benefitting, they stopped sending their children to schools.

Out of the 57 teachers, almost half, (50.9%) were males and 49.1% were females. It reflected a better gender balance in the education system in Ajmer block. Most of the teachers (61.4 %) were highly qualified, with either M.A and B.Ed/M.Ed degree (19.3%). Nearly half, 42.1% teachers had 1-5 years of experience and 15.8% respondents had between 6-10 years experience and most importantly 12.3% respondents had 26 to 30 years experience. The average teaching experience of the teachers was found to be 11.1 years. Nearly half, 49.1% teachers were working at assistant level and 29.8% at senior level.

The current study revealed 86% of teachers had not received special training for further training CWSN students. While in a discussion with the teachers, it was observed that almost all teachers had no idea about the parameters to identify the slow learners. However, nearly half of the participants reported that they could identify Intellectual disability among children. More than half (56.1%) of them reported that they did not have knowledge about inclusive education. A significant group (8.2%) of teachers reported that they never took any serious efforts to update themselves about inclusive education and 94.7% of teachers felt that they had inadequate knowledge for teaching CWSN (Table 1). The result shows that 84.2% of the teachers had low acceptance and were less prepared for the mainstreaming of disabled. The main difficulty to implement inclusive education was reported to be the non-supportive behavior of the normal children. It was found that the normal children learnt the subjects taught and remembered them, however, when the CWSN required more attention, the normal children became restless and started making disturbing sounds. Apart from that, lack of special educators, lack of special training (40%) was another barrier to implement the inclusive education.

It is seen from Table No.1 that 86% of the teachers were not adequately trained to meet the needs of CWSN, 61.4% of teachers could identify the slow learner students, 33.3% could identify learning disability among children, 50.9% could not identify children with intellectual disability. A vast majority of teachers (84.2%) reported that they do not update themselves with information related to inclusive education. A vast majority (94.7%) reported that they feel inadequate for teaching CWSN.

While the teachers were asked the difficulties which they have faced to implement inclusive education for CWSN, 40.4% reported it as inadequate special educators and 28.1% reported non supportive behavior of normal children. Nearly half (45.6%) of the teachers are of the opinion that general education teachers can never teach CWSN,

26.3% are of the opinion that they can teach after some training. Half (50.9%) of the teachers are of the opinion that intellectual disability CWSN cannot study with children without disability. Three-fourth of the teachers (75.4%) are of the opinion that teachers need special training to handle CWSN, while more than half (57.9%) of the teachers are of the opinion that CWSN increase the risk to the safety of other students. A majority (70.2%) of the teachers felt that the attention given to CWSN distracts them from teaching the other students, nearly half (43.9%) of teachers are of the opinion that they should be expected to make major adjustments to serve the CWSN. More than half (64.9%) of the teachers are of the opinion that CWSN should not receive passing grades regardless of performance.

DISCUSSION

The success of the inclusion of CWSN in mainstream education largely depends on the attitude and knowledge of teachers on how to properly educate them (Dapudong, 2014).

The present study depicted that, 86% of the teachers were not adequately trained to meet the needs of CWSN, 61.4% of teachers could identify the slow learner students, 33.3% could identify learning disability among children, 50.9% could not identify children with intellectual disability. Preparation program in mainstreaming for regular teachers on attitudes, management styles and mainstreamed pupil behaviour is of utmost importance for mainstreaming the CWSN (Yona Leyser, 1988)

A vast majority of teachers (84.2%) reported that they do not update themselves with information related to inclusive education. A vast majority (94.7%) reported that they feel inadequate for teaching CWSN. The results of the study indicate that a lack of special training for these school teachers, their own inabilities to differentiate different abilities and their inabilities to accept the children with special needs have caused a great challenge towards mainstreaming the children with special needs in Srinagar Block. As Cook (2001) discussed, the attitude of teachers toward inclusion is largely based on training and confidence and the same were lacking in the teachers in Srinagar block.

The present study results also reveal the difficulties faced by teachers in implementing inclusive education for CWSN. 40.4% reported it as inadequate special educators and 28.1% reported non-supportive behavior of normal children. Nearly half (45.6%) of the

teachers are of the opinion that general education teachers can never teach CWSN, 26.3% are of the opinion that they can teach after some training. Limay and Sandhya (2016) discuss various factors that influence the accessibility of education for children with disabilities. They are: perceptions of parents of children with disabilities and their difficulties in helping their children with disabilities; the general attitude of society, government officials, school staff; infrastructure; inadequate levels of training of key stakeholders; invisibility of disability in community; poverty; lack of acceptance; lack of interest; gender discrimination; lack of awareness; poor physical access; availability of various support systems and government policies focusing on the education of children with disabilities in specific.

The results of the present study also depict that the teachers' educational qualification didn't help much for changing the attitude of teachers towards mainstreaming of children with special needs. This is an alarming observation about the general school education system itself. The observation that in every level of education such as elementary, middle, and high schools; teachers had different attitudes towards inclusive education (Hammond & Ingalls, 2003; Hastings & Oakford, 2003) was found to be less connected with the Ajmer experience. Even those CWSN who enrolled in schools have not benefited from the welfare schemes meant for person with disabilities, because of a lack of awareness about schemes and unavailability of disability certificates. Research has shown that the unpreparedness of teachers and parents' unwillingness were major factors hindering in mainstreaming the children with special needs in education in Srinagar block. Though peer support (Leatherman & Neimeyer 2005), is a key factor in influencing a teacher's attitude towards teaching students with special needs, a supportive environment among school teachers towards the CWSN wasn't seen mainly due to an attitude developed through the lack of awareness and skills.

The study showed that those who had more years of experience in teaching were found to be less adaptable to change and updates on the subject than those with less years of service. Female teachers were more sensitive than male teachers towards mainstreaming. Teachers need special training with utmost priority, because it will change the perception of teachers on mainstreaming the CWSN. These teachers believe that CWSN students increase risks for children without disability in inclusive classes. Almost 70% of teachers felt that attention given to students with disabilities distracts them from teaching the other students. However, the teachers agreed that through activities special students gain self-esteem and confidence, but at the same time they didn't agree that a CWSN

students need active participation with normal children.

The present study result is limited to a very small section of population in Ajmer District. As it is felt that a small number of teachers from one single block were selected for the present study, generalization of this result to a larger public cannot be suggested. However, it is considered here that the Researchers were able to unearth a very sensitive issue which requires the focus and attention of various stakeholders who promote the welfare of children with special needs.

CONCLUSION

Education is the most important tool which can change the life of children with special needs. Schools need to arrange for specialized training of teachers. Parents' involvement in the education of children with special needs have to be strengthened.

Special training programmes and the total involvement of parents could change the scenario towards inclusive education. Community support and parents' involvement bring positive changes in the teacher's attitude. There is an immediate need to improve human resource capacity and appointment of special educators in schools, which can be possible through effective education, training, and recruitment. The above recommendations would help to provide equal opportunities and enable inclusive education in every school that is committed to children with special needs to fulfill their potential.

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This work is not published anywhere and the authors take all responsibility towards the content of the article.

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Taking Primary Schools of India through the Decade of Education for Sustainable Development: Key Issues and Answers

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Abstract

The international journey of India towards quality education has witnessed a gradual amalgamation with the intent of parallel sustainable development, leading to national embracement of the idea of Education for Sustainable Development (ESD). As India takes a plunge into the new era of Sustainable Development Goals and promises to adhere to the goals of Decade of Education for Sustainable Development (DESD), it becomes significant to analyze how on one hand primary education schooling in India faces key quality issues and how on the other hand, the educational strategies proposed by DESD are being broken down on the field by civil society initiatives to provide realistic answers to these issues. The two objectives of the paper follow two methodological routes. Firstly, through a descriptive analysis and thematic review of literature, the paper begins by identifying key problems pertaining to the quality of education in India. Secondly, following purposive sampling method, a list of 100 innovative educational initiatives in India was made. Participant and non-participant observation was then used to narrow down 7 non-governmental interventions which translate strategies of DESD in reality. This descriptive and empirical analysis intends to give policy makers, education experts, school administrations, and social workers workable and effective ideas and models to achieve quality primary education on the field and make way for replicable social work interventions in the future.

Keywords: Primary Schools, Quality Education, Sustainable Development, and Field Strategies

INTRODUCTION

India stands at a cross-juncture of several interconnected international educational movements, as shown in Figure 1 (UNESCO, 2005).

In 2000, eight United Nations Millennium Development Goals (MDGs) were formulated to address different developmental issues. Two goals were dedicated solely towards providing universal and equitable education to children around the world, at the primary and secondary levels (Pigozzi, 2010).

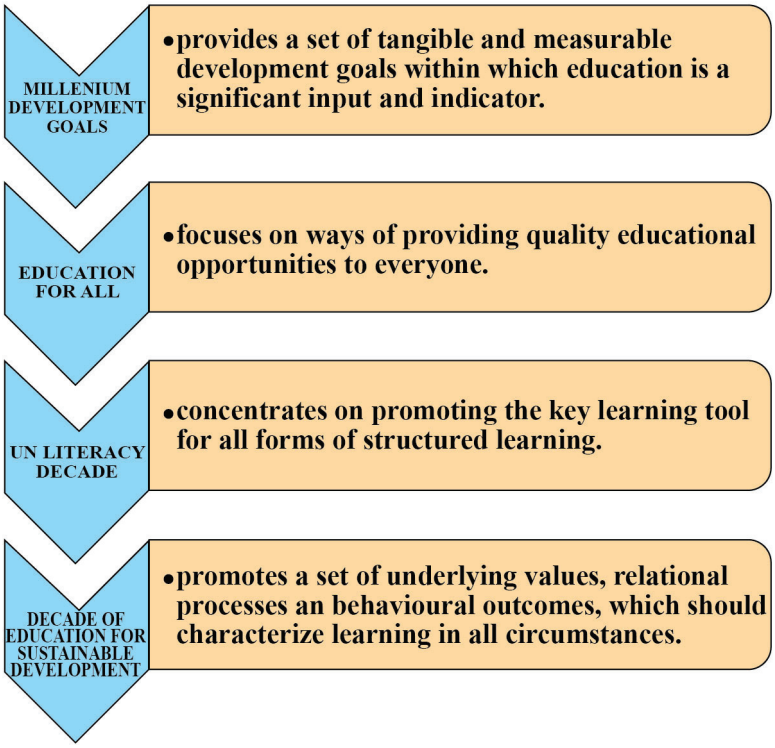

Figure 1: International Educational Movements

With an education specific agenda, the Education for All (EFA) campaign started in 1990 and culminated in Dakar, in 2000. This movement, with its six key goals, advocated for life long provision of learning opportunities, starting from early childhood to primary to secondary education – using formal as well as non-formal methodologies (Pigozzi, 2010).

The United Nations Literacy Decade (UNLD) gives an expansive view to traditional educational processes, by relating it to other aspects of mother-child health care, employment, gender equality, and income levels.

The Decade of Education for Sustainable Development (DESD) starting from 2005 to 2014, was proposed at the World Summit on Sustainable Development in Johannesburg, 2002 and also found acceptance and support at the United Nations General Assembly. It puts forward 7 key strategies which would synthesize the ethics, ideas, practices and values of sustainable development in an educational paradigm. By doing so, DESD aimed to address wider socio-economic, cultural and environmental challenges of the twenty-first century through effective attainment of quality education (Pigozzi, 2010).

This international journey of India towards quality education has witnessed gradual amalgamation with the intent of parallel sustainable development, leading to the evolution of the concept of Education for Sustainable Development (ESD).

RELEVANCE OF THE STUDY

Conventionally, ESD is viewed in the light of providing environmental education to students by modifying curriculum and training teachers in areas pertaining to resource conservation, bio-diversity, and climate change. However, the United Nations World Summit 2005, envisaged three 'pillars' of sustainability - economy, society and environment, along with their cultural context.

Especially with respect to young adults, ESD implies encouraging students to imbibe an identity of being a global, future facing citizen, wherein they learn to connect micro to macro and delineate upon how their actions of today would affect the current, emergent and future socio-economic situations (The Higher Education Academy, 2014). Educational opportunities which extend beyond the walls of a classroom and promote conscious critical thinking, decision making and teamwork so as to reflect upon urgent environmental needs are now a mandate for sustainable development (Bahuguna, n.d.).

Though India has taken a plunge into the era of Sustainable Development Goals, it needs to be understood that challenges for the developed vis-à-vis the developing world are starkly diverse. Especially in developing nations like India, where sustainability also implies dealing with realities of poverty, hunger, illiteracy, gender inequality, and unemployment; reaching these goals take up an entirely different meaning.

When talking about the goal of ESD, India faces multiple problems at the primary school level itself – the most glaring of them being the lack of quality of learning and

quality of teaching. Students in a majority of the government schools of the country lack core-learning competencies of reading, writing and arithmetic. In this bleak scenario, expecting children to grow into young adults who have an analytical mindset for critical thinking which facilitates problem-solving process for a sustainable future becomes a far-reaching goal. Within this context, the paper sets two goals following different methodologies as elaborated in Table 1.

Table 1: Objectives and Methodology of the Paper

OBJECTIVES	INDICATORS	METHODOLOGY
1. Situational Analysis of Primary Education in India	Identifying key issues and challenges, pertaining especially to the quality of primary school education in India.	Descriptive analysis through a thematic Review of Literature.
2. Taking Primary Schools of India through the Decade of Education for Sustainable Development	Identifying answers to these problems by highlighting a number of field interventions, which break down strategies of DESD and make way for replicable social work interventions in the future.	● Making a list of 100 innovative educational initiatives in India through purposive sampling method. ● Using participant and non-participant observation methods to narrow down 7 non-governmental interventions which translate strategies of DESD in reality.

Objective 1: Situational Analysis of Primary Education in India

Background

Primary schooling in India has been connected to the goal of Universal Elementary Education[1] for nearly seventy years. Till the 1960s, most endeavors were targeted towards a mere provision of schooling facilities. Only when the priority goal of access was successfully near attainment that other significant aspects of Universal Elementary Education, like universal enrolment and retention come into the focus of constitutionalists, policy makers and government planners (Mehta, 2002).

[1]Article 45 of the Indian Constitution elaborates upon the State's commitment to provide free and compulsory education to all children of the country, ageing 6-14 years.

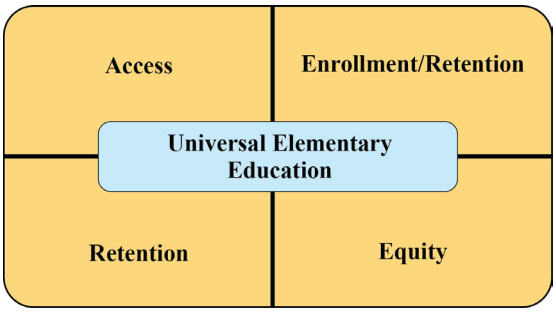

Figure 2: The evolving concept Universal Elementary Education in India

The National Policy on Education 1986 proposed an improved educational system at the national level, which would impart primary schooling within 1 km walking distance (NCERT, 1998). As a paradigm shift took place, policy makers started taking into account issues of quality, outreach and empowerment of local education providers through the introduction of innovative government schemes like Non-Formal Education Scheme, Operation Blackboard, Mid-day Meal Scheme, and District Primary Education Program.

The commencement of the Sarva Shiksha Abhiyaan further defined the parameters of Universal Elementary Education with its goals of (i) all children going to schools; (ii) bringing social and gender parity in elementary education (iii) retention increment (iv) upholding and prioritizing satisfactory quality in education (GoI, 2014).

Primary education in India has shown tremendous growth due to three major reasons. These include an increased persistent support from the Centre to improve infrastructure and service provision of primary education; empowerment of local self-governance mechanisms for planning and implementation; and increased demand for primary education, enhancing the role of non-state actors (Govinda, & Bandhyopadhyay, 2008).

These accelerated efforts culminated into enactment of 'The Right of Children to Free and Compulsory Education Act, 2009' (RTE), whereby attainment of Universal Elementary Education for all children between the age of 6-14 years comes as a fundamental right guaranteed by the Indian Constitution (MHRD, 2009). RTE is undoubtedly a landmark act in the field of public education, but does provision of schooling facilities automatically result in learning achievements required in the framework of 'Right to Development?'[2]

[2]The United Nation Convention on Rights of a Child, ratified in 1992 by India, talks about Survival, Development, Protection and Participation Rights of a Child.

The United Nations Convention on the Rights of Child (UNCRC) points out in its Article 29 that children's education should be a medium of discovering each child's interests, inclinations and abilities to the optimum level. It should help each child to imbibe values of peace and human rights, which would help one to develop respect for one's own culture as well as of others (Kingdon, 2016.).

The concept of Universal Elementary Education has evolved in government policies and programs, as shown in Figure 2, but whether the same has been translated on the field still remains questionable.

Methodology for Objective 1:

This review is descriptive and analytical in nature. It has been conceptualized primarily with the help of secondary sources, including books, journal articles, research reports/ publications and newspaper articles. The reviewer has accessed internet academic data bases, mostly using the following key words either singly or in combination: primary education in India, educational policies, quality of learning and teaching. The reviewer has also accessed libraries of Delhi University (Department of Social Work), Indian Institute of Technology, Delhi (IIT) and National University of Educational Planning and Administration (NUEPA).

Findings and Discussions

Quality and quantity cannot be substitutes for each other, in any sector, and especially in the education sector. However, the assessment of educational achievements in primary classes has unfortunately been tilted towards a supply of school, physical and ancillary facilities in terms of more schools, more teachers, more students and more instructional materials as shown in Table 2.

Table 2: Increase in schooling facilities in India

Assessment Parameters	2000-01	2004-05	2010-11	2013-14
Number of elementary schools	845,007	1,042,251	1,362,324	1,448,712
Enrollment in elementary schools (in millions)	156.6	182.0	197.4	198.9
Number of teachers in elementary schools (in millions)	3.22	3.75	6.40	7.72

Source: The Statistics of School Education, NUEPA (National University of Education Planning and Administration) and MHRD, Government of India.

This concentrated focus on quantification of education has left the question of quality in education unanswered. When *Quality of Education* in the government schools of India is analyzed through two important parameters of *Quality of Learning* and *Quality of Teaching,* several harsh realities are brought in the limelight.

Quality of Learning

In India, a majority of students who attend government schools are from the economically weaker section of society. This unfortunately justifies low level of teacher input, dismal quality of teaching and consequent low learning levels of children in the government schools (UNICEF, n.d.).

National Achievement Survey is periodically conducted by NCERT[3] to check the learning levels of students in each state. In 2012-13, the result of the survey for Class III students revealed that from a scale of 0 to 500, the average learning score was 257 at a pan-national level. As per this average, children of 15 states including Haryana, Bihar, Jammu & Kashmir, and Chattisgarh scored considerably low in learning levels (NCERT, 2012).

The Annual Status of Education Report of 2014 shows that though enrollment in primary classes of rural government schools sustainably goes beyond 95%, the learning levels of children remain low (Pratham, 2014). Table 3 clearly shows, that around half of the students in Class V do not have Class II language and arithmetic competencies, which raises serious questions on the quality of education imparted in government schools of the country.

Table 3: National learning achievements of students in rural government schools of India (2014)

Primary Classes	% Children who can read Class II Text	% of Children who can do Class II Subtraction
Class III	23.6	25.3
Class V	48.1	50.5

Source: Annual Status of Education Report 2014

[3]The National Council of Educational Research and Training provides expert guidance and support to the central and state governments on matters pertaining to school education, research and development.

A research study done with slum children of Delhi showed that even when children attend school regularly for several consecutive years, they still are not able to gain learning levels of even primary school level, making parents feel cheated and even preferring not sending their children to school as no beneficial teaching takes place there (Aggarwal & Chugh, 2003). Hence even if a government school student says that he is a "4th Pass", we have full reason to doubt if he has competencies of a similar level.

The no detention policy of the RTE Act poses another serious issue of quality of learning. The RTE Act, under Section 16, does not allow failing a child in any subject till he/she is in elementary school. Hence a child, irrespective of his/her learning level, can go on to the completion of Class 8. A qualitative study done on implementation of RTE revealed that teachers feel since children will invariably graduate to the next class, regardless of their performance, they do not focus on whether the children are learning the required skills in a particular standard (Ojha, 2013). Hence learning shortfalls and deficits keep building-up over the years. With these setbacks, the risk of a majority of Indian children lacking even basic skills to become productive future citizens of the country remains high (Banerji, & Walton, 2011).

Quality of Teaching

The quality of education and the learning that is inculcated therein is intrinsically related to the Quality of Teachers that are recruited.

Primarily, it is the pedagogy and content of teaching that takes place in a classroom, which is directly related to the quality of education that is imparted. However, a paper analyzing the National Curriculum Framework of 2005 explained that pedagogical issues in teaching have risen due to a binary problem of a curriculum which is completely unrelated to the local life of students on one hand and unimaginative teaching methods on the other (Batra, 2005). With little or no focus on comprehension and improvement of learning abilities, government school teachers tend to follow the traditional rote methods of teaching.

Moreover as mentioned before, there has been a steady decrease in pupil-teacher ratio as portrayed in Table 4, which implies that there is greater teacher availability for government school students of the country.

Table 4: Decreasing PTR trends in India

Pupil-Teacher Ratio	2006-07	2010-11	2013-14
All Schools	34	30	26
Primary Schools	36	32	25

Source: District Information System for Education, NUEPA

But again the data on teacher availability does not provide a real picture. In India, majority of the times, teachers who are employed at government schools are presumed to be coming from economically weaker sections, having a poor socio-educational background, with minimum teaching experience and training, and limited or no access to books, research resources, science and technology (Govinda, & Bandhyopadhyay, 2008). Coupled with this are problems of teacher absenteeism and teachers being more involved in administrative and disciplinary work (UNICEF, 2005).

Rampant presence of single teacher schools and para-teachers also raise serious issues of quality. While the former leads to over-dependence of functioning of the entire school on one person, the latter leads to employment of low qualified and low paid contract teachers who further dilute quality. Hence, when we talk about quality of teaching, it also includes a number of other significant parameters i.e. whether the teachers are adequately qualified, trained, motivated and most importantly, besides just being 'available' in school, whether teachers have adequate space, time and willingness to actively engage in vibrant teaching-learning processes which would result in improved learning outcomes?

Objective 2:

Taking Primary Schools of India through the Decade of Education for Sustainable Development

Background

This goal of ESD found its realistic and committed world-wide implementations with the recent heralding of the Decade of Education for Sustainable Development (2005-2014). DESD promoted quality education in a manner that it helps young minds to connect the very concept of development with key issues of economic viability, peace, human rights and environmental sustainability (UNICEF, 2005). The recent Aichi-

Nagoya Declaration on Education for Sustainable Development held in Japan in 2014 urged all developed and developing nations to collaborate and move the ESD agenda forward globally post-2015.

National Initiatives

Despite the challenges in delivering quality education that have been analyzed in the paper, it cannot be overlooked that integration of ESD in the education system of India is also taking place at the national level. For on-ground implementation of DESD and realizing the importance of creating environmental awareness and education as a potential instrument of social change, the Government has expanded the curriculum and learning scope of environment education in schools, colleges and universities (Alexander, 2012; Alka, 2014). Paryavaran Mitra (Friends Of The Environment), National Nature Camping Programme and National Green Corps are a few such government supported initiatives which have been taken up to sensitize and empower children of the country towards more sustainable futures. Institutes like Centre for Environment Education (CEE), Mahatma Gandhi Institute of Education for Peace and Sustainable Development (MGIEP), The Energy Research Institute (TERI), Wildlife Institute of India (WII) have been set up in the country to conduct research and capacity building that fosters new educational approaches towards peaceful and sustainable world (Alka, 2014; Sarabhai, n.d.).

DESD stressed particularly on building partnerships amongst international, national, regional and non-governmental (NGO) partners to achieve its objectives. A list of such civil society initiatives that have been fostered in India has been made below.

Methodology for Objective 2

India has been an active member in the national enhancement of the global educational movement. A list of such 100 recent governmental and non-governmental initiatives, specifically in the field of education, was made by the method of purposive sampling. This list was collated with the help of NGO portals, personal field visits, fellow social workers working in areas of education, and knowledge base of educational experts. The list was made comprehensive in the sense that it covered initiatives in all areas pertaining to education, be it awareness creation, educational inclusion methods, schooling the underprivileged, teacher training, curriculum enhancement, funding of other educational projects etc.

A decision was made to narrow down on only non-governmental initiatives, that too mostly in the areas of primary education. A second filter was put by including a majority of only those initiatives which could be empirically verified either by the Researcher herself or by fellow social workers in the field. Method of participant observation to observe, analyze and relate the workings of the NGO's to larger DESD strategies was used. The purpose of creating this list has not been to point out the 'best' initiatives in the field of education, but to highlight the work of few which are making a difference on field.

Findings and Discussion

DESD listed down seven strategies to implement its goals, the translation of each on the field has been dealt with below in Table 5.

Table 5: Micro Perspectives of Macro DESD Strategies

DESD Strategies	Field Examples	Work being done
Vision-building and advocacy.	M.V. Foundation	With a strong ideology of child rights, M.V. Foundation does exemplary work in **public mobilization and awareness generation** about issues of child labour and significance of child school access as well as retention. It makes use of strong forums like public hearings, panchayats, marches and rallies to send out the message of right to education.
Consultation and ownership	Aarohan	Aarohan is an NGO in South Delhi which fits the perfect example of self social sensitization and **taking ownership of the problem** instead of passing on the baggage. It has been started by a few women who took it upon themselves to teach the street children in their vicinity. It focuses on providing early childhood education, bridge courses, and remedial help to bring the child on the street to school or vice-versa.
Partnership and networks	Pratham Education Foundation	Pratham works across many states in India. In its Haryana chapter, it portrays a significant example of how p**artnerships with government schools** can lead to a marked difference in the learning levels of the same children who were earlier deprived of quality education. It provides training to 160 local rural women to act as supplementary teachers in 80 government public schools to help children learn basic reading and writing in key languages (English and Hindi) and numeracy skills in arithmetic so as to bring them to their age-appropriate learning level.

Capacity-building and training	Meljol	With thought-provoking strategies of financial and social socialization processes, Meljol aims to imbibe concepts of **self-exploration, responsible citizenship, resource management** in children through child friendly activities, songs, poems, books to inculcate critical and reflective thinking in the makers of tomorrow.
Research and innovation	Education Innovation Fund for India (EIFI)	EIFI is an innovative forum which **financially supports, encourages and nurtures** the most promising projects in the field of education within India. It encourages young minds to think out of the box and come up with ideas to foster education service delivery.
Use of Information and Communication Technologies (ICTs)	Azim Premji Foundation	This organization has tried to bring ICT to schools by developing their **Digital Learning Resources** which contain over hundred CDs in regional languages for classes 1 to 8. These CDs contain child-friendly and interactive material, which encourage self-learning. In collaboration with National Knowledge Commission, Azim Premji Foundation has started a **National Teacher's Portal** for the purpose of knowledge sharing, dialogue and collaborative change in education.
Monitoring and evaluation.	The Annual Status of Education Report (ASER)	ASER is a perfect example of how with low cost and use of local resources significant information pertaining to enrollment and learning levels of children in basic language and math can be collected and used for policy making. With its pan-India survey and use of simple scientific techniques it **breaks down concepts of monitoring and evaluation** to their simplest levels.

CONCLUSION

The above list gives policy makers, education experts, school administrations, and social workers hope and encouragement of workable and effective ideas and models, which can be replicated, on the field, either in totality or in specific aspects.

It cannot be denied that the challenges and issues are multifold in nature, but so are the answers and solutions.

Targeted towards overcoming these obstacles, the list focuses on bottom-up micro strategies that would help to not just understand DESD within the boundaries of the decade, but much beyond it. They make India's commitment to the global goal of ESD look achievable at the national level, if done with conscientisation and collaboration.

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