Scientific Writing *and* Publishing *in* Social Work

Editors
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Abraham P.Francis
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NIRUTA Publications

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Scientific Writing and Publishing in Social Work
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Disclaimer

The contents of all the articles included in this volume do not necessarily reflect the views of the Editors. The authors of the articles are responsible for the opinions, criticisms and factual information presented. The contributors are also responsible for ensuring the proper adherence to the scientific rules of writing and copyright regulations. This publication has been brought out by the editors only with the sole aim of enriching the indigenous literature on professional social work and encouraging social work students, junior social work professionals and young faculty involved in social work education and research in order to enhance their career growth prospects. While the editors have tried their best to carefully review, format and make necessary corrections in the manuscripts, if there are still any lapses, the readers are requested to kindly condone the same.

Editors

Dedicated to

All the participants of the Three Day Residential Scientific Writing and Publication Workshop jointly organized by the Department of Social Work, Bharathidasan University, Tiruchirappalli, Tamil Nadu and the Department of Social Work and Human Services, James Cook University, Australia in January 2013 at KKID, Coimbatore.

Acknowledgement

It is with a great sense of hope, excitement and accomplishment that we would like to present this book to the readers, especially the social work students and researchers. There have been a number of people who have been instrumental in bringing this book project to fruition. We would like to first of all acknowledge the loving providence of God, who protected us and blessed us with some fantastic colleagues and friends to work on this project. Likewise, support and assistance have come from many corners for which we are indebted and grateful.

This book is the outcome of an intensive Three Day Residential Scientific Writing and Publication Workshop jointly organized by the Department of Social Work, Bharathidasan University, Tiruchirappalli, Tamil Nadu and the Department of Social Work and Human Services, James Cook University, Australia. The editors would like to gratefully acknowledge the support and encouragement of Dr.(Mrs).K.Meena, the then Vice-Chancellor of Bharathidasan University, Tiruchirappalli. Besides, this book would not have been possible without the help and assistance of the students and colleagues at James Cook University. Our colleagues, JCU colleagues Dr. Debra Miles, Peter Jones, Ines Zuchowski and BDU colleagues Dr.R.Mangaleswaran and N.Rajavel provided us with support and encouragement.

During the course of this project, we have been blessed to have come into contact with so manyresearch scholars and promising young and enthusiastic academics hailing from different social work institutions in India. Some have been able to contribute to this book, while others offered us words of appreciation, encouragement and moral support.

On the production side, we wish to thank Mr. M.H Ramesha, the Director of Niruta Publications,Bangalore and his efficient team for their professional support, comments, suggestions and commitment to seeing this work being published.

As you can imagine, this has been a long but passionate journey for our families too.We gratefully acknowledge their contribution and for their silent understanding and we believe that is the strength of our work!

We also would like to thank Anna Brackenridge for her support with proof reading this document.

Editors

Declaration

The idea of editing a book on "***ScientificWriting and Publishing in Social Work***" originated at the intensive Three Day Residential Scientific Writing and Publication Workshop jointly organized by the Department of Social Work, Bharathidasan University, Tiruchirappalli,Tamil Nadu and the Department of Social Work and Human Services, James Cook University, Australia during January, 2013 at KKID, Coimbatore, India. This book is largely a collection of research papers from participant social work researchers with additional contributions from Australian and Indian social work students, academics and practitioners. The views, ideas, arguments and data presented in these forthcoming chapters belong to the respective authors. The intention of the editors has been to provide an opportunity for beginning social work research scholars to show case their early publication endeavors.The editors are responsible for the overall design and structure of this book.

Preface

Ilango Ponnuswami[1]
Abraham Francis[2]
Nonie Harris[3]

The context

As a visiting scholar of The Cairns Institute, Professor Ilango Ponnuswami from Bharathidasan University, Tiruchirappalli, India had the opportunity in 2012 to work and collaborate with staff of Cairns Institute as well as social work academics of James Cook University(JCU) in North Queensland, Australia. These collaborations led to recognition that many of the challenges and dilemmas of scientific writing and publicationwere relevant to both the Indian and Australian contexts and that a meaningful cross-national collaboration would potentially enrich the learning experiences of students and staff in both locations. Subsequently the editors of this book, Professor Ponnuswami, and Dr Francis and Dr Harris from JCU, conducted a three day residential Scientific Writing and Publication Workshop (in January 2013), for social work faculty members and research scholars, at the Karl Kubel Institute of Development Education (KKID) in Coimbatore, Tamil Nadu. This book is a tangible outcome of this international, academic collaboration and, most importantly, is the result of the KKID participants' scientific writing endeavors begunat the 2013 workshop in Coimbatore.

This international collaboration directly aligns with James Cook University's Faculty of Arts Education and Social Sciences' (FAESS) Faculty Plan. The Plan specifically commits the Faculty to activities and endeavors that "increase links with other Universities in the tropics and encourage staff and student collaboration and exchange" (PC2.3). The international collaborative activity and publication outcome also align with the JCU's commitment to creating a brighter future for life in the tropics through a project that contributes to "the experience of new cultures,

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particularly … a new educational culture, [and] is also an opportunity for some creative thinking about how new knowledges are formed and generated" (McGinty, Koo and Saedi, 2010, p. 518).

Research and Writing in Social Work

As social work educators we, the editors, shared a common belief that the activities of research, writing and publication are fundamental to who we are as social work practitioners and that it is an incredible privilege to be involved in the process of creating knowledge – which is what the research and writing processes allow us to do. We recognize that social work practice is changing and that research is now an integral part of practice. The need for practitioners to be able to engage in researchis becoming more important both for clients, organizations and communities. We should assume that research and practice are not mutually exclusive and that as practitioners committed to social justice and human rights, we are also researchers (and writers and publishers) who embrace these same commitments.

The Australian Association of Social Workers states that: 'Research is key to the continued development of the theory and knowledge base of social work practice' (2008, p. 6). This professional practice standard emphasises the importance of the creation of an evidence base to inform our practice; that as social work practitioners we continue to monitor and evaluate what we do in a structured way; and that through these processes we are accountable for the quality and effectiveness of our practice. Practitioners also need to undertake research to determine the needs of clients, to test new ideas and to confirm practice wisdom. Research underlies the accomplishment of all of these expectations. However, as McMahon (2008) reminds us, undertaking research although important, is not sufficient- "doing research is a process of self-empowerment for the individual researcher but empowerment can begin and end with the individual unless the message gets published and broadcast to the wider context" (McMahon, 2008, p. 49). Giving written voice to our knowledge should be our priority.

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Contents

Section 1
Introduction to Scientific Writing and Publishing in Social Work

Scientific Writing and Publication in Social Work – Issues and Concerns

Ilango Ponnuswami[1]
Abraham.P.Francis[2]
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Introduction

As early as 2001, Alter and Adkins, in their interesting article in Journal of Social Work Education, referred to the declining ability of social work students to write proficiently as a 'writing crisis' and reported the outcome of 'Writing Counts' a writing assistance programme at a graduate school of social work. This is one of the most serious issues with which the social work profession in India, especially in the context of the 'not so good' status of the profession in the country even after its successful existence for over 75 years. The western academia's dictum of 'publish or perish' has somehow not yet fully caught up with the social work academic community in India. However, in recent times, owing to stiff competition for entry into faculty positions and thanks to the stricter guidelines of the apex higher educational body namely the University Grants Commission insisting on Academic Performance Indicators (API) scored on various parameters including publications, social work faculty members and aspirants have started showing interest in getting their research articles and books published. There has been a phenomenal increase in the number of ISSN classified journals and ISBN classified books during the last few years. Even though much remains to be desired with regard to the quality of publications, it is heartening to see the upsurge in interest to publish among social work faculty, doctoral and pre-doctoral (M.Phil) students and even MSW trainees.

Importance of scientific writing

In science, writing is the most important means of communicating research findings. In most cases, scientists report the results of their research activities in scientific journals in a rather standard scientific paper format. In a recent article

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entitled Developing the Writing Skills of Social Work Students: Connecting Academic and Professional Expertise, Hughes, Wainwright & Ward (2011) discuss howacademic writing skills support effective professional communication and research skills allow for evidence-based practice. We can assume that research not only describes what we do in practice but that it also provides the evidence on which our practice is based. There is an "important relationship between research and practice effectiveness" (Trevithick, 2012, p. 57). This connection between research and practice (an evidence base) is fundamental to the practice of all professions, but it is particularly relevant to the social work profession: "Practitioner research is potentially the most useful and relevant source of new knowledge for social work and service innovations" (Harvey, Plummer, Pighills & Pain, 2013, p. 2). McMahon (2008) also reminds us that it is our 'job' to write about what we do. It is not enough to 'talk' about the practice-based research we have done. Writing about our social work practice and research contributes to a knowledge foundation, educates others and passes our knowledge on to our fellow practitioners. McMahon (2008) urges us to become 'published creators of knowledge" (p. 40) and thereby recognize the value of our knowledge and practice wisdom – of what we have learned. McMahon concludes his paper by emphasizing the following points relevant to our own deliberations:

> First, as researchers, the real task is to create knowledge relevant to our discipline. Second, doing research is a process of self-empowerment for the individual researcher but empowerment can begin and end with the individual unless the message gets published and broadcast to the wider context (p. 49)

Clear communication requires an array of skills and competencies, a number of which clearly relate to a set of skills that might be developed through academic writing, including the ability to:

- follow and develop an argument and evaluate the viewpoints of, and evidence presented by, others
- write accurately and clearly in styles adapted to the audience, purpose and context of the communication; and
- present conclusions verbally and on paper, in a structured form, appropriate to the audience for which these have been prepared (Quality Assurance Agency, 2008, p. 12–13).

Social work education is multidimensional (Tsang, 2006). Social work degrees are professional programmes which combine academic study with professional practice learning. Successful completion of the programme leads to both an academic award and a professional qualification. As such the curriculum has to be designed to reflect both academic concerns and the skills needed for future professional practice. It is important therefore that social work programmes are

able to help students to integrate their understanding of contextual, critical, explanatory and practical issues, and enable them to become accountable, reflective, critical and evaluative (Quality Assurance Agency, 2008).

Current realities

Ponnuswami and Francis (2012) expressed their concern about lack of originality and rampant plagiarism in the scientific social work publications blocking the progress of social work research in the country ultimately leading to lack of recognition of the profession. According to these authors, one of the major drawbacks is the lack of standard peer-reviewed publications in the field of social work in India. There are just a handful of good quality refereed social work journals. Most of the social work research studies are never published since there is a serious lack of 'publication culture' among the professionals. While some social work faculty and research scholars get their research papers published (at least for the sake of fulfilling requirements for their own career advancement), most of the practitioners in the field do not care much to write and publish even though their research works, if published, would make valuable contributions to the knowledge base of the profession and to the development of services for different client groups. This trend was also noted by Ramachandran in 1990 where the issues of research in India was more

> …the adhoc nature of research work, and the consequent limited career opportunities in research and has , on the one hand , resulted in a tremendous wastage of trained personnel and on the other, created a dearth of workers. Added to this is the fact that formal research training is not deemed as essential pre-requisite for research jobs advertise by potential employers (p.108)

This situation has not changed much since then but we can see a renewed interest in the profession to embrace the spirit of evidence based practice. It is in this context the exercise such as this creates an opportunity for students to engage in writing and publishing not only to just show case their own individual researches but the wider social impact it can create in the society. But we now see a renewed interest among practitioners, students and academic is social work to share their research ideas and publish their work which is indeed a positive direction and this book itself is an example of such a positive approach to building culturally appropriate evidences in social work practice and education.

In Australia, as in most other countries of the global north, there is a strong tradition of academics publishing in peer-reviewed journals, with many high quality journals for the academic researcher to submit to. However, there is not a strong tradition of practitioners engaging either in primary research activities or writing about or submitting the results of their research (if undertaken) to scholarly journals. The answer to why this might be so is complicated. It is generally the case that a social work degree is undertaken because of a passion for social justice and a belief in the possibility of contributing to positive societal change. Research and writing about research are seldom part of this original vision. Harvey et al (2013)

also argue that much of social work practice, which often requires the practitioner to rely on practice wisdom and thoughtful individualized interventions, does not easily lend itself to research based reflection and written transmission to others. Nevertheless, in recent years there has been a shift in the Australian social work landscape with "Growing support from within social work for the development of an evidence based for practice, together with recent interpretations and models of EBP [evidence based practice] congruent with social work, have increased the momentum for research capacity building" (Harvey et al, 2013, p. 4). There is now an emphasis, both in the practice and university sectors, on giving voice to social work knowledge.Ponnuswami and Francis (2012) commented that -

> A careful analysis of the present trends in social work research reveals that there are encouraging and healthy developments on the one side and almost seemingly insurmountable challenges facing social work researchers. What is needed in the present scenario is a serious and careful review of the strengths, weaknesses, opportunities and threats relating to social work research in the country (p.xxvi)

Purposes of social work writing

First and foremost, social workers need to be clear about the purposes of scientific writing and publication in social work. Most of the social work trainees think of scientific writing as a mere academic requirement which is rather too cumbersome and boring. They fail to see social work writing as the most powerful means of communication with serious implications for the profession, clientele, the professionals and even the society at large. A majority of social work faculty members view scientific writing again as an essential requirement for their performance appraisal or career progress. On the other hand, social work practitioners doing tremendous work with different client groups in different settings seldom realize the importance of scientific writing and documentation of the enormous amount of practice-based knowledge and practice wisdom gathered by them over a long period. As a result of these, a vast majority of undergraduate, post graduate, pre-doctoral and doctoral research studies undertaken by students never get permanently documented in the form of publications. Most of the dissertations, term papers and theses end up in the shelves of libraries gathering dust. Especially with the current trend of digitization of publications and the tendency on the part of students and researchers to depend on digitized form of information, this enormous resource just gets lost. While this is the case with student dissertations and theses, just to fulfill the ever growing demand among social work faculty members to get papers published in peer-reviewed journals, we find a mushrooming of several online journals which claim to be refereed ones but the quality of majority of these journals is questionable (in fact, many of them do not have impact factor ratings, are not indexed in appropriate databases and are not recognized when

one goes for faculty positions despite the fact these so called peer-reviewed journals have ISSN numbers and books have ISBN numbers). In the case of practitioners, there is hardly any scientific writing activity going on.

Falk and Ross (2001) reviewed nine purposes of social work writing—

PURPOSES OF WRITING	ASSIGNMENTS TO PRACTICE SOCIAL WORK WRITING	WRITING SKILL BEING ADDRESSED	OTHER SOCIAL WORK SKILLS ADDRESSED
TO UNDER STAND AND CARE FOR THE SELF	Reflective writing: personal journal free writing	Getting started, over coming barriers, writing freely	Self-knowledge
TO COMMUNICATE THE SELF TO OTHERS	Professional journal	Writing coherently, mechanics	Expressing the professional self
TO UNDERSTAND THE PERSPECTIVE OF OTHERS	Writing the voice of a client	Writing from a consistent point of view	Empathy, ability to envision a client's world view
TO DESCRIBE	Description of clients, agency, community, social work transactions	Making writing come to life, creating accurate, detailed representations	Observation skills, ability to recognize bias, communication of professional information
TO ANALYZE	Psychosocial assessment, process recording, term papers	Organization, using logical, progression of ideas	Critical thinking skills: drawing inferences from descriptive information
TO BE ACCOUNTABLE	Agency documentation: treatment plans, progress notes treatment summaries	Clarity, focus, consciousness of diverse perspectives and requirements of potential readers	Analytic reasoning skills: ability to formulate appropriate, specific time measurable goals and objectives
TO REACH AND PESUADE DIVERSE AUDIENCES	Proposals, testimony, letters to the editor, etc.	Adapting style and terminology to audience	Communication skills, including "cross-cultural" communication working with diversity

Section 2
Health Research

The Need of the Social Worker in Primary Health Care Centres

A.K.Praveenbabu*

Abstract

Primary health is essential health care based on practical, scientifically sound and socially acceptable methods. It includes technology made universally accessible to individuals and families in the community through their full participation. It involves a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self–determination. It forms an integral part— both of the country's health system, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact for individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Later this became the basis for the upcoming of government hospitals.

In 1977, the Government of India launched a Rural Health Scheme, based on the principle of "placing people's health in people's hands". It is a three tier system of health care delivery in rural areas based on the recommendation of the Shrivastav Committee in 1975. The health planners in India have visualized the primary health centre(PHC) and its sub-centres as the proper infrastructureto provide health services to the rural population. This paper is an attempt to study the significance of thePHCsand how it has not been successful in recruiting social workers as part of this team despite social workers being recognisedan integral part of the healthcare systems.The Government has recommended the following staffing pattern in PHCs.

At present in each community development block; there are one or more PHCs and each blockhas a rural population of around 30,000. In the new set-up, each PHC will have the following staff. At the PHC level :1 x Medical officer, 1x Pharmacist, 1 x Nurse mid-wife, 1 x Health worker (female)/ANM, 1x Block Extension Educator, 1x Health assistant (male), 1 x Health assistant(female)LHV, U.D.C. 1, L.D.C., 1x Lab. Technician, 1x Driver(subject to availability of vehicle), 1x Class IV 4, Total 15.

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It is regrettable to note that the Government has not thought of recruiting a social worker /counselor. This analysis asks why social workers are not included in the hospitals multi-disciplinary team, considering they are very important to a hospital environment. The role of social worker /counselor is to act as a bridge between the staff, patients, and people. Social workers are the people who integrate all the activities of the hospital and serve as link between the patients, nurses, doctors and the other staff. In a way they are also great healers. Social workers have and provide specific skills such as counseling that provide tremendous benefit to hospitals.This analysis recommends the appointment of a social worker/ counselorbe madein government hospital staffing arrangements as soon as possible.

Keywords: primary Health Centre, Staffing, Alma-Ata, Integral Healer

Introduction:

Primary health is essential health care based on practical, scientifically sound and socially acceptable methods.It includes technology made universally accessible to individuals and families in the community through their full participation. It involves a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part— both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Later this became the basis for theupcoming of government hospitals.

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The Central Council of Health, at its first meeting held in January 1953 had recommended the establishment of primary health centres (PHC) in community development blocks to provide comprehensive health care to rural population. The

number of primary health centres established since then had increased from 725 during the First Five Plan to 5484 by the end of the Fifth Plan (1975-1980)-each PHC covering a population of 100,000 or more spread over some 100 villages in each community development block.

These centres were functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centres came under criticism as they were not able to provide adequate health coverage, partly because they were poorly staffed and equipped, and partly because they had to cover a large population of one lakh or more. The MudaliarCommittee in1962 had recommended that the existing PHCs should be strengthened and the population to be served by them to be scaled down to 40,000. In fact the Government of India appointed the Mudaliar Committee to review the progress made in medical relief and public health since the submission of the Bhore Committee's report to formulate guidelines and proposals for inclusion in the subsequent Five Year Plans. Mudaliar Committeethereafter went into the problems of public health in great depth and their recommendations were meant to serve as guidelines for the development health services, both curative and preventive. In India, as also all over the world, relief against sickness is made available to patients mostly through hospitals and dispensaries. Hospitals, in fact, are temporary homes for patients, and both the hospital authorities and the government have to create conducive conditions. It advised strict adherence to the recommendations of the Bhore Committee regarding implementation of the programme of PHCs.This was followed by theDeclaration of the Alma – Ata conference.

The Declaration of Alma-Ata Conference in 1978: 'setting the goal of Health for All by 2000 AD', ushered in a new philosophy of equity, and a new approach:the primary health care approach. The National Health Plan (1983).This approach proposes the reorganization of PHCswhich will see one PHC for every 30,000 rural population in the plains, and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage. As of the 30th sept.2005, 23236 PHCs have been established in the country.As a signatory to the Alma-Ata Declaration, theGovernment of India is committed to achieving the goal of health for all, throughprimary health care approach which seeks to provide universal comprehensive healthcare at a cost which is affordable.

In the establishment of the PHCs,theGovernment has recommended the following staffing patterns. At present in each community development block; there are one or more PHCs and each block has a rural population of around 30,000. In the new set-up, each PHC will have the following staff. At the PHC level : 1 x Medical officer, 1x Pharmacist, 1 x Nurse mid-wife, 1 x Health worker (female)/ANM , 1x Block Extension Educator, 1x Health assistant (male), 1 x Health assistant (female)

LHV, U.D.C. 1, L.D.C., 1x Lab. Technician, 1x Driver (subject to availability of vehicle), 1x Class IV 4, Total 15. This is what is called a multi-disciplinary team.

It is regrettable to note that the Government has not thought of recruiting a social worker /counsellor. This analysis asks why social workers are not included in the hospitals multi-disciplinary team, considering they are very important to a hospital environment. The role of social worker /counsellor is to act as a bridge between the staff, patients, and people. Social workers are the people who integrate all the activities of the hospital and serve as link between the patients, nurses, doctors and the other staff. In a way they are also great healers. Social workers have and provide specific skills such as counselling that provide tremendous benefit to hospitals.

The social workers role in a PHC is immense. The social workers help to educate the public about the physical illness in a manner that is understandable to them. They sensitize the voluntary agency personnel about the issues related to health problems and health services available in the District in order to enlist their active participation. They facilitate, coordinate and collaborate with District Health programmers along with welfare and development Departments in Governmental and non-governmental sectors for effective delivery of Health Services. They help and participate in the training programmes conducted for Health Workers and Voluntary Agency personnel as well as assist in the periodical monitoring of their services to the community.

Besides these factors, the social workers help to evaluate the community's perception about the PHCs and devise ways to improve the quality of services to meet the growing needs of their community. Apart from this they act as an agent of community education and community involvement in various health programmes in media/personnel for this work. In this they facilitate the quality of psycho social settings for well-being of the physically / mentally ill people. They also educate the attenders and caregivers of the patients about the nature of the disease and how to manage the symptoms. Not only that — the role of social workers is very significant in hospital settings as they are involved in educating the caregivers about the various treatment options available in the PHC/ Hospitals and rehabilitation services offered by the government and the financial assistance that could be acquired for welfare of the physically ill.In short the social worker is knowledgeable, understanding, empathetic and service-oriented and is of great help to each and everyone in the hospital environment.

Frequently doctors in hospitals are extremely busy and invariably may not be in a position to spend quality time with the patients due to their preoccupations with several issues. Similarly the nurses are often attending many patients due to which they are unable to talk freely with the patients. It is at these moments that the role

of the social worker as counsellor gains importance and looms large. They can communicate with the patients and their attendants and becomes fully knowledgeable about the patients and their illness and the background from which he hails.They can discuss in detail, the nature of the ailment to the doctor's and can remind nurses of the patient'sneeds. Consequently the social worker is not only helpful to the patients but also to the doctors and the nurses in attendance of the patients. Their role in hospitals is vast.

Conclusion:

As recommended by the Study Team on Social Welfare appointed by the C.O.P.P., counselling through a social worker should be introduced with proper machinery by the Central Welfare Board which is giving grants to voluntary agencies. This should be followed by licensing by the State Governments. But the question arises as to how the State Governments will be able to judge and select institutions which should be granted licenses. In the absence of proper standards and adequately qualified machinery to study various aspects of an applicant agency's work, the licensing law will not serve any useful purpose.Thereforethe State Governments should make use of the machinery for field counselling being set up by the central Social WelfareBoard and specialized knowledge of the agencies like the Indian Council for Child Welfare, the All India Women's Conference, Y.M.C.A., Y.W.C.A. the NationalAssociation for Blind, the Indian Red Cross Society, the BhartiyaGrameenMahilaSangha, etc.Suffice it to say that the social workers/ counsellors are the prime need in the current hour and their holistic involvement in all the activities and all the persons involved make them integrative healers.

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Section 3
Child and Adolescent Research

Life Skills Education for Adolescents Living in Save Our Soul (SOS) Village - An Intervention Study

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V. Indiramma[2]
M.N. Vranda[3]

Abstract:

The numbers of institutions for children in need of care and protection have increased considerably over the years. Various psychosocial factors contribute to the institutionalization of children in residential care. The experience of growing up in an institution varies from child to child depending on the perception and kind of treatment they receive from care providers while in the institution. Numerous studies have reported positive and negative impact of long term institutionalisation on a child's well-being. Yet the fact remains that institutionalisation cannot be washed away. Institutionalised children are considered as highly deprived of a family environment required for their development in society. These children are left helpless, abandoned, neglected due to social, economic and personal reasons by the parents/caregivers. Early deprivation of parental care, love, affection, warmth, security, acceptance and discipline during childhood disrupts their normal socio-emotional development. So it becomes necessary to know whether institutionalised children who are devoid of family life with the emotional warmth grow up normally and acquire appropriate skills for pro social behaviour and how well they are able to cope with themselves and adjust to the demands of the society. The current study aims at imparting life skills training to the adolescents living in Save Our Soul (SOS) village of Bangalore City. The sample consisted of 2, randomly selected children residing in SOS Children's Village, a Non-Government Organisation which provides long term care and protection to orphaned and abandoned children in Bangalore City. The life skills assessment scale developed by Vranda, M, N,

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(2009) was used to assess the impact of life skills intervention on adolescents. The results of the study show that there was overall improvement in the life skills of adolescents in SOS village after the intervention.

Introduction:

Adolescence is a challenging transitional period for many young people due to going through physical, cognitive, emotional and social changes during this life stage. The beginning of adolescence is marked by puberty where changes in biological functions lead to an adult sized body and sexual maturation. It is also a period of "stress and strain" for many adolescents. Though, biological forces play a significant role in the physical changes that take place during the transition period from childhood to adulthood, a combination of biological, psychological and social forces influence an adolescent's development. In this transition period adolescents face problems in certain areas of life such as parent – child conflicts, risk taking behaviours and mood changes. If these issues are not resolved, the individual suffers role diffusion or have negative identity which results in mismatched abilities and desires, directionless and unpreparedness for the psychological challenges of adulthood (Berk, 2007).

It is known that there remains a significant gap between adolescents having accurate information and its translation into behaviour. Enhancement of skills is a key to facilitate this process of transforming information into healthy behaviour. Research studies show that various psychosocial factors and life skills deficits are the mediating factors resulting in behavioural, psychological and health related problems among adolescents (Keddie, 1992; Plotnick, 1992). These factors are far more severe among those children and adolescents who are under the care and protection of institutions (Vranda, 2009).

There are many factors which lead to poor life skills, low self-esteem and maladjustment among the children in institutions due to family deprivation. The study conducted on institutionalised children revealed that children raised in institutions differ from children brought up in families in every aspect of life. This is because of wide difference in family and institutional environment. The institution provides structured environment and strict routines to children. This kind of situation allows less variation in behaviour and activity and suppresses the freedom and individuality of the children and adolescents. The lack of privacy in the institutions compared to family setting has multiple ramifications on the child's development affecting his/her ability to adjust to the life situations. It is more so with the adolescents.

Absence of parents due to separation can lead to lack of parental role models in learning social skills such as cooperation, negotiation and compromising skills (Vranda, 2009). Jose (2008) in his study on few psychosocial aspects such as insecurity, self-esteem and adjustment problems among 252 adolescents in institutionalised and 252 adolescents from socially and economically poor families but who are in parental care found that institutionalised children significantly differed from those who are in parental care. Higher insecurity, lower self-esteem, emotional adjustment problems, unsatisfactory social, emotional and educational adjustment are common among institutionalised children (Hunshal and Goankar, 2008). Low achievement motivation, hopelessness, pessimistic attitude towards their life (Stanley and Ruth, 2000), risk taking behaviours and negative peer influences are found to be common among youth living either in group homes or institutions (Altshuler & Poertner, 2002).

Han and Choi (2006) examined loneliness and attribution styles in interpersonal relations of the two groups of institutionalized adolescents who live in welfare facilities and age-mates from middle class backgrounds. The results demonstrated that the institutionalised adolescents tend to show higher levels of loneliness than the home-reared group. In addition, the former group displays a non-self-serving cognitive style of attributing failures in social situations to more stable and global causes than the latter. A regression analysis showed that the institutionalised adolescents' attribution of failure to global reasons and the home-reared adolescents' attribution of success to unstable reasons can predict loneliness.

The literature review clearly indicates that institutionalised children have psychological problems and social skills deficits compared to those children who are brought up in family atmosphere. It is imperative that these children need to be equipped for independent living. Moreover, the children and adolescents living in institutions are often unprepared for independent living and fail to imbibe life skills for successful family and community living (Vranda, 2009). Jacquleen and Parthasarathy (2009) found in their study that child care personnel are more concerned and occupied with administrative needs than enhancing psychosocial competencies or skills or self-efficacy of these children. Enhancing these skills has been given the least priority.

Over the last decade there has been an increased interest among mental health professionals in the area of research in life skills. Life skills are defined as 'abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life' (WHO, 1993). Life skills are innumerable, with some being specific to certain risk situations and others being of a generic nature. Further, the life skills are summarized into five sets of ten generic

life skills, based on the various developmental theories and interventional studies from various sources. These skills include decision-making, problem solving, empathy, self-awareness, communication, interpersonal relationship, coping with emotions, coping with stress, creative thinking and critical thinking. Mallon (1996) reports that children and adolescents who are living in institutional care should be given basic age appropriate life skills training in order to help them to develop their self-esteem, self-sufficiency to deal with demands and challenges of life. Hence, the current study aims towards imparting life skills training to the adolescents living in SOS village of Bangalore.

Method and Materials

Sample:

The sample consisted of 20, randomly selected children of both genders, aged between 13 to 16 years, residing in Save Our Soul Village (SOS) - a Non-Government Organisation which provides long term care to orphaned and abandoned children in Bangalore City.

Instruments:

Socio Demographic Profile: was developed by the researchers for use in the present study which covered details of age, education, religion, class in which they are studying, duration of stay, and reasons for institutionalisation .

Life Skills Assessment Scale (Vranda, 2009): The psychosocial competencies and life skills among the adolescents were assessed using a 5-point Likert scale to measure life skills. The scale consisted of 115 items which assess the life skills of adolescents on ten domains such as decision making, problem solving, empathy, self-awareness, interpersonal relationship skills, communication skills, coping with stress, coping with emotions, creative thinking and critical thinking. The internal consistency co-efficient alpha for the overall scale was 0.94. The test-retest reliability co-efficient ranged from 0.70 to 0.95 and overall reliability co-efficient was 0.96 indicated high degree of temporal stability of the scale.

Procedure:

The researcher prepared the Life Skills Intervention package after reviewing existing modules and also based on the areas identified by the caregivers. The intervention package was given to experts working in the field of life skills for content validation. Based on the feedback from the experts the package was finalised. The main intervention study was conducted on 20 participants for the period of one week. The package consisted of various life skills building activities

using group activities, role play, brainstorming sessions, and discussions. The pre assessment (P0) was done before the Life Skills Intervention. Post-test (P1) was done after one week of intervention. Post-post assessment (P2) was done after one month of intervention to see the acquisition and retention of life skills over a period time among the participants.

Statistical Analysis

Descriptive statistics such as mean and standard deviation were used to describe the data. Paired 't' test was computed to compare the mean difference in life skills before and after the life skills intervention programme.

Results

Table – 1: Socio-Demographic Details of Sample

Sl. No	Variables	N (20)
1	Age (years)	
	13-14	9 (45%)
	15-16	11 (55%)
2	Gender	
	Girls	7 (35%)
	Boys	13 (65%)
3	Religion	
	Hindu	18 (90%)
	Non-Hindu	02 (10%)
4	Education	
	8th Standard	9 (45%)
	9th Standard	4 (20%)
	10th Standard	7 (35%)
5	Duration of Stay in Institution	
	Less than 10 Years	5 (25%)
	10 years and above	15 (75%)
6	Reasons for Institutionalization	
	single parent	9 (45%)
	Loss of parents	6 (30%)
	Born out of wedlock	2 (10%)
	Abandoned in hospital	2 (10%)
	Poverty	1 (5%)

The socio-demographic profile (Table 1) revealed that 55% of the respondents were in the age group of 15-16 years. The age of the students ranged from 13-16 years. 65 % of the participants were boys and majority 90% belonged to Hindu religion. 45% of the participants were studying in 8th standard. The reasons for institutionalisation of children were due to single parent, loss of parents, born out of wedlock, abandonment and poverty.

Table – 2: Paired t-test for over all Life Skills

	Life Skills	**N**	**Mean**	**SD**	**t-value**
Pair 1	Life skills (P0)	20	374.85	43.994	4.787***
	Life skills (P1)	20	407.00	47.431	
Pair 2	Life skills (P1)	20	407.00	47.431	2.783*
	Life skills (P2)	20	392.00	38.975	
Pair 3	Life skills (P0)	20	374.85	43.994	3.159**
	Life skillf (P2)	20	392.00	38.975	

* $p<0.005$, ** $P<0.001$, *** $p<0.001$

Table – 2 shows, that there is a significant improvement in the mean scores in the form of acquisition and retention of life skills among the participants.

Table-3: Mean, SD, and t -value of Pre, Post and Post-Post Assessment

Domains of Life Skills Scale	Pair - 1			Pair - 2			Pair - 3		
	P0	P1	't'	P1	P2	't'	P0	P2	't'
Decission Making	31.3	32.5	2.86	32.5	33.3	0.78	31.3	33.3	2.66*
	(2.85)	(4.09)		(4.09)	(3.13)		(2.83)	(3.13)	
Problem Solving	42.8	48.2	4.80***	48.2	43.9	4.12***	42.8	43.9	1.201
	(6.42)	(6.24)		(6.24)	(4.65)		(6.48)	(4.64)	
Communication Skills	32.3	36.2	3.126**	36.1	34.0	2.03	32.3	34.0	1.473
	(3.94)	(4.85)		(4.85)	(4.11)		(3.93)	(4.11)	
Interpersonal	61.1	66.7	3.174**	66.7	63.8	1.99	61.1	63.8	1.541
Relationship Skills	(10.1)	(8.19)		(8.19)	(8.01)		(10.7)	(8.01)	
Empathy	40.0	43.7	3.13**	43.6	42.7	0.829	40.0	42.7	1.829
	(7.19)	(5.92)		(5.92)	(8.16)		(7.19)	(8.15)	
Self-awareness	32.5	36.3	2.616*	36.3	34.9	1.243	32.5	34.9	2.173*
	(6.20)	(5.91)		(5.91)	(4.93)		(6.20)	(4.93)	
Coping with Emotions	28.5	29.7	0.135	29.7	30.2	0.753	28.6	30.2	0.140
	(4.03)	(5.98)		(5.98)	(3.32)		(4.03)	(3.32)	
Coping with stress	28.5	30.4	0.066	30.40	30.05	0.635	28.5	30.05	0.161
	(4.03)	(3.36)		(3.36)	(3.17)		(5.35)	(3.17)	
Creative Thinking	46.2	48.7	0.114	48.7	47.05	0.294	46.2	48.7	0.612
	(7.72)	(6.48)		(6.48)	(6.83)		(7.72)	(6.48)	
Critical Thinking	31.7	34.7	3.388**	34.7	32.2	2.755**	31.7	32.2	0.547
	(3.94)	(4.34)		(4.34)	(3.92)		(3.94)	(3.92)	

* P<0.05; ** P < 0.01; *** P<0.001

Table 3 shows the paired 't' test before and after life skills intervention on all the domains of life skills scale. The results showed significant gain in the life skills of subjects immediately after the intervention after one week on the domains of problem solving (P<0.001), communication skills (P<0.01), interpersonal relationship skills (P<0.01), Empathy (P<0.05), self-awareness (P<0.05) and critical thinking skills (P<0.01). Further the gain in life skills between post assessment 1 and post – post assessment 2 significant on only two domains: communication skills (P<0.001), and critical thinking skills (P<0.01). However, the retention of life skills of the subjects after one month of intervention found on decision making (P<0.05) and self-awareness (P<0.05).

Issues & Challenges of Education in India

Mohana[1]
Ilango Ponnuswami[2]

"Education for all" declares that everyone has a right to education. Its aim is to give everyone a Chance to learn and benefit from basic education – not as an accident of circumstance, or as a Privilege, but as a RIGHT

Abstract:

This paper aims to review the Education system in India and to examine the Issues & Challenges in Education .A number of programmes have been initiated to achieve the goal of universalisation of elementary education in India. The present paper reviews the education system ,policies & programmes, literacy rate in india ,statewise literacy rate including male and female literacy level in the rural and urban india .Then the current attendance in school, Enrolment, Gender disparity dropouts, never attendance & Non Enrolment were analysed. The paper examined the physical attainments in terms of three basic principles of educational development consistent to the objectives of educational policy and planning namely access, equity and quality with the help of selected indicators of progress to the extent of the availability of data. This paper attempts to examine the actions taken and status achieved relating to school education in India. The challenges also looked into and remedies offered. Admitting that providing resources for educating the masses is the biggest challenge, the study emphasizes the need for better access through improved quality and providing incentives for enrolment and attendance. Besides creating environment for public awareness, training and human security, the appropriate strategy for education at school level also called for sustainable Development. The paper uses a review of published statistics and extant literature on Indian Education System, History, Provision, and Regulatory Mechanism, Literacy rate, Issues & Challenges in Education.

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Introduction

Education, as a discipline, is concerned with methods of teaching and learning in schools or school-like environments as opposed to various nonformal and informal means of socialization (e.g., rural development projects and education through parent-child relationships).Education can be thought of as the transmission of the values and accumulated knowledge of a society. In this sense, it is equivalent to what social scientists term socialization or enculturation. Education is designed to guide them in learning a culture, molding their behavior in the ways of adulthood, and directing them toward their eventual role in society. In the most primitive cultures, there is often little formal learning—little of what one would ordinarily call school or classes or teachers.

Instead, the entire environment and all activities are frequently viewed as school and classes, and many or all adults act as teachers. As societies grow more complex, however, the quantity of knowledge to be passed on from one generation to the next becomes more than any one person can know, and, hence, there must evolve more selective and efficient means of cultural transmission. The outcome is formal education—the school and the specialist called the teacher. Education has always been considered as the only key component of human development and greatest liberating force. Hence, traditionally, education has always held the most venerable position in our society. It is considered as fundamental to all round development of the individual both at material and spiritual levels. Education is intrinsically intertwined with the development process and constitutes the instrumentality of modernization of tradition (Raza, 1990).

The role of education in economic development has been noted by the researchers (Sodhi, 1985 & Singh, 1974). At the micro level the direct and indirect role of education through value-orientation in economic development has already been established (Bhagat, 1989). Education is also vital to sustain competitive markets and viable democracy. Researchers have shown that increasing the average primary schooling of the labour force by one year can increase output substantially. Even at the macro level, social benefits of elementary education are immense. Educated parents send their children to school; elementary education leads to perpetuation of benefits from one generation to another (Sinha, 2004, P. 628).

Need and Importance of Education

On the need for education, I wish to quote our Father of the Nation, Mahatma Gandhi, who once said that

"Education not only moulds the new generation, but reflects a society's fundamental assumptions about itself and the individuals which compose it".

The famous philosopher Einstein while discussing the need for education has projected the following fundamentals:

1. To educate the individual as a free individual; to understand and use critical thinking skills.
2. To educate the individual as a part of society – virtually all our knowledge, our clothes, our food is produced by others in our society, thus, we owe Society and have responsibility to contribute back to Society.
3. Through education, knowledge must continually be renewed by ceaseless effort, if it is not to be lost. It resembles a statute of marble which stands in the desert and is continually threatened with burial by the shifting sand. The hands of service must ever be at work, in order that the marble continue to lastingly shine in the sun.(Dr K C Chakrabarty,2011)

While discussing the importance of education, Dr.K.C.Chakrabarty,Deputy Governor of the Reserve Bank of India, state that schools have become the most important means of transforming wealth of knowledge and skills from one generation to another. However, the role of institutions becomes more challenging in the modern world with innovations and technological development.

Education provides children with life skills that will enable them to prosper later in life. It equips children with the skills to maintain a healthy and productive existence, to grow into resourceful and socially active adults, and to make cultural and political contributions to their communities. Education also transmits more abstract qualities such as critical thinking skills, healthy living, resilience, and self-confidence. An educated adult population is vital for strong economic development. It also lays the foundations for greater overall economic productivity, and the full use of new technologies for development. A system of compulsory schooling helps fight child labour.

Education in India

The school education in India has a long history. The concept of the provision of elementary education to all children has its root in the beginning of Indian civilization. In the Vedic Aryan times education for children was not provided by the state but was more in the form of a religious practice. Education began with Upanayana ceremony (hinduism.iskcon.org/practice/602.htm), the practice of taking the pupil to the teacher or guru for education.(L.N.Bhagat,1989)

During pre-independence period the British build up an elementary education system for training natives for administrative work under the empire. A tremendous progress made with the transfer of elementary education to Indian control under the Dyarchy

(1921-37) when the value-education was stressed, universal participation in education for all attempted and expenditure allocation increased.

The post independence period saw a very strong demand by the people for free and compulsory universal elementary education for national development. Free and compulsory education for all children up to the age of fourteen years is the Constitutional commitment in India (Article 45). At the time of the adoption of the Constitution in 1950, the aim was to achieve the goal of *Universalisation of Elementary Education* (UEE) within the next ten years i.e. by 1960. Keeping in view the educational facilities available in the country at that time, the goal was far too ambitious to achieve within a short span of ten years. To facilitate the achievement of UEE goal, the National Council of Educational Research & Training (NCERT), the National Institute of Educational Planning & Administration (NIEPA) and many other institutes were set up in 1960's as resource, research and training centers.

In order to give access to elementary education for all children up to 14 years of age and for universal participation till they complete the elementary stage of educational programs, the National Policy on Education (NPE) in 1968, the NPE in 1986, the Program of Action (POA) elaborated in the NPE of 1986 and the updated form of the NPE in 1992 gave an unqualified priority to the Universalization of Elementary Education (UEE) program.

At the time of Independence in the year 1947, India inherited a system of education which was not only quantitatively small but also characterized by the persistence of large intra- and inter-regional as well as structural imbalances. Only 14 percent of population was literate, and one child out of three had been enrolled in the primary school. The need for a literate population and universal education for all in the age group of 6- 14 was recognized as a crucial input for nation building and was given due consideration in successive five year plans.

The NPE, 1968 stressed on the elimination of disparities in the educational system and on the improvement in the quality of the school. The emphasis was more on retention rather than merely on enrollment. Between 1950 to 1968, there was substantial increase in the number of primary schools, but records shows that in 1967-68 the retention rate came down to 35%. This shows that the policy statement did not get translated into a detailed strategy of implementation. As a result, problems of access, quality, quantity, utility and financial outlay, have accumulated over the years, to reach massive proportions.

The Fifth All India Educational Survey-1986 mentions that, the disparity in enrollment still persisted between the states at the primary level. To tackle these problems, the Govt. of India formulated a new education policy in 1986. In this policy, along with the universal access, enrollment and universal retention of children up to 14 years of age, a substantial improvement in the quality of education, was emphasized. This policy gave the highest priority to solving the problem of children dropping out of the school. This is evident from the emphasis given on non-formal education in the policy.

At the same time it was decided that the various parameters of implementation of New Policy must be reviewed after every five years. This would ascertain the progress of implementation of the policy and focus on the emerging trends in the area of education.

The NPE, 1986 which was modified in 1992 as a 'Program of Action (POA) made certain modifications in the earlier policy. The POA, 1992 emphasized three aspects: universal access and enrollment; universal retention of children up to age 14 years; and a substantial improvement in the quality of education to enable all children to achieve essential levels of learning at the primary education levels.(Sangeetha Shirname (2007): "Education for All" in India: Historical development, especially in the light of gender equality and impact on the present day situation) http://dise.in/Downloads/Use%20of%20Dise%20Data/Sangeeta%20Shirname.pdf.

Literacy in India

India is the largest democracy with remarkable diversity among its population of 1.2 billion which makes up about 17% of the world's population. The 15th official census in India was calculated in the year 2011. In a country like India, literacy is the main foundation for social and economic growth. When the British rule ended in India in the year 1947 the literacy rate was just 12%. Over the years, India has changed socially, economically, and globally.

After the 2011 census, literacy rate India 2011 was found to be 74.04%. Compared to the adult literacy rate here the youth literacy rate is about 9% higher. Though this seems like a very great accomplishment, it is still a matter of concern that still so many people in India cannot even read and write. The numbers of children who do not get education especially in the rural areas are still high. Though the government has made a law that every child under the age of 14 should get free education, the problem of illiteracy is still at large.

Table 1:
Total Literacy rate for Male and Female in India

Total Literates	Male Literates	Female Literates	Total Literacy Rate	Male Literacy Rate	Female Literacy Rate
77,84,54,120	44,42,03,76233,	42,50,358	74.04	82.14	65.46

source: Family Welfare Statistics in India - 2011 & CensusIndia.gov

Table 2:
Male and Female literacy rates and the overall literacy rates in Indian States and Union Territories

S.No	State/Union Territories	Literacy Rate-Male	Literacy Rate-Female	Literacy Rate
1	Andaman & Nicbar Islands#	90.1%	81.8%	86.3%
2	Andhra Pradesh	75.6%	59.7%	67.7%
3	Arunachal Pradesh	73.7%	59.6%	67.0%
4	Assam	78.8%	67.3%	73.2%
5	Bihar	73.5%	53.3%	63.8%
6	Chandigarh	90.5%	81.4%	86.4%
7	Chattisgarh	81.5%	60.6%	71.0%
8	Dadra & Nagar Haveli#	86.5%	65.9%	77.7%
9	Daman & Diu#	91.5%	79.6%	87.1%
10	Goa	92.8%	81.8%	87.4%
11	Gujarat	87.2%	70.7%	79.3%
12	Haryana	85.4%	66.8%	76.6%
13	Himachal Pradesh	90.8%	76.6%	83.8%
14	Jammu & Kashmir	78.3%	58.0%	68.7%
15	Jharkhand	78.5%	56.2%	67.6%
16	Karnataka	82.8%	68.1%	75.6%
17	Kerala	96.0%	92.0%	93.9%
18	Lakshadweep#	96.1%	88.2%	92.3%
19	Madhya Pradesh	80.5%	60.0%	70.6%
20	Maharashtra	89.8%	75.5%	82.9%
21	Manipur	86.5%	73.2%	79.8%
22	Meghalaya	77.2%	73.8%	75.5%
23	Mizoram	93.7%	89.4%	91.6%
24	Nagaland	83.3%	76.7%	80.1%
25	NCT of Delhi#	91.0%	80.9%	86.3%
26	Orissa	82.4%	64.4%	73.5%
27	Puducherry#	92.1%	81.2%	86.5%
28	Punjab	81.5%	71.3%	76.7%
29	Rajasthan	80.5%	52.7%	67.1%
30	Sikkim	87.3%	76.4%	82.2%
31	Tamil Nadu	86.8%	73.9%	80.3%
32	Tripura	92.2%	83.1%	87.8%
33	Uttar Pradesh	79.2%	59.3%	69.7%
34	Uttarkhand	88.3%	70.7%	79.6%
35	West Bengal	82.7%	71.2%	77.1%

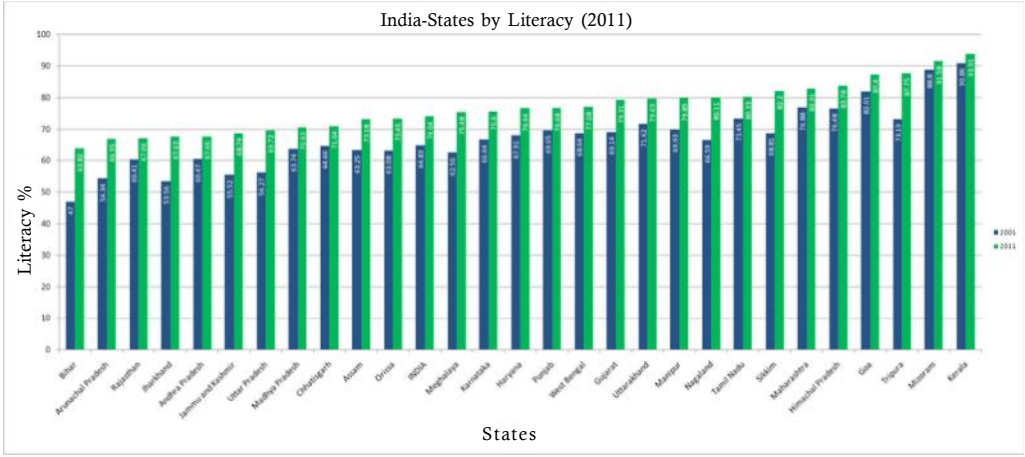
Union Territories

Source: Family Welfare Statistics in India - 2011 & CensusIndia.gov

Table 3:
State Wise Literacy Rate

	Persons (%)	Males (%)	Females (%)
State with Highest Literacy Rate	Kerala (90.9)	Kerala (94.2)	Kerala (87.7)
State with Lowest Literacy Rate	Bihar (4.0)	Bihar (59.7)	Bihar (33.1)
UT with Highest Literacy Rate	Lakshadweep (86.7)	Lakshadweep (92.5)	Lakshadweep (80.5)
UT with Lowest Literacy Rate	Dadra & Nagar Haveli (57.6)	Dadra & Nagar Haveli (71.2)	Dadra & Nagar Haveli (40.2)
District with Highest Literacy Rate	Aizwal, Mizoram (96.5)	Mahe, Pondicherry (97.6)	Aizwal Mizoram (96.3)
District with Lowest Literacy Rate	Dantewada Chhattisgarh (30.17)	Dantewada Chhattisgarh (39.75)	Shrawasti UP (18.

Source: Family Welfare Statistics in India - 2011 & CensusIndia.gov



Source: *Selected Educational Statistics:* Ministry of Human Resource Development, New Delhi, India

Now, if we consider female literacy rate in India, then it is lower than the male literacy rate as many parents do not allow their female children to go to schools. They get married off at a young age instead. Though child marriage has been lowered to very low levels, it still happens. Many families, especially in rural areas believe that having a male child is better than having a baby girl. So the male child gets all the benefits. Today, the female literacy levels according to the Literacy Rate 2011 census are 65.46% where the male literacy rate is over 80%. The literacy rate in India has always been a matter of concern.

Here are some facts about different states literacy rate, Kerala is the only state in India to have 100% literacy rate. It is followed by Goa, Tripura, Mizoram, Himachal Pradesh, and Maharashtra, Sikkim. The lowest literacy rate in India is seen in the state of Bihar. We also need to think why is the literacy rate is low here in India compared to other developed countries. Basically the population in India is very high. Being the 7th largest country its population stands 2nd in the world after China. There are over 1 billion people in India. The number of schools and educational centers especially in rural areas is less. Even today many people are below the poverty line. Also people aren't aware that children should get free education according to the law. (*Main article: Indian states ranking by literacy rate*, Census of India 2011 & National Family Health Survey 2011.)

Issues & Challenges of Education

Current Enrolment & Attendance Status

General school education is divided into primary, middle or upper primary, secondary and Higher secondary levels. In most states these terms refer to Classes I V, VI VIII, IX X and XI XII respectively, but the number of years corresponding to primary, middle, secondary and higher secondary levels is not uniform in all the states. So class wise grouping is more appropriate for studying current enrolment/ attendance rates. Age specific current attendances in education are studied with age groups formed according to the official ages for each class group. In most of the official educational statistics, enrolment ratios are taken as important indicators which give an idea of the proportion of a population enrolled in educational institutions. Gross enrolment ratio,age specific enrolment ratio and net enrolment ratio are taken as three principal indicators.

As per administrative statistics of the Ministry of Human Resource Development of the Government of India, the Gross Enrolment Ratio (GER) for Grade I V in India has already overshot the 100 percent mark for both girls and boys. GER for Grade I V unlike NER (Net Enrolment Ratio) tends to exceed 100%

Domestic Violence, Human Rights and Mental Health of Women - An Agenda for Social Work in India

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Abstract

Domestic violence violates women's human rights. It not only impacts on women's physical and mental health but also deters women from attaining a healthy life. The present paper establishes triangular relationships among domestic violence, human rights and the mental health of women in the larger context of what profession social work stands for. Reviewing the efforts of social work professionals working in the field of mental health, human rights and/or women's issues in India, this paper advocates the need to recognize this inseparable nexus existing amongst the three and make social work interventions accordingly.

Introduction

Women's rights are human rights and domestic violence (DV) is a human right issue. This was recognized and accepted by the world community almost two decades ago, forty five years after the adoption of the Universal Declaration of Human Rights (UDHR).

Every year, violence in the home especially violence by husband or intimate-partner affects the lives of millions of women globally. It is a universal phenomenon and one of the most common forms of violence against women worldwide. While it differs in its scope from one society to the other, it exists everywhere. Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way – most often by someone she knows, including by her husband or another male family member; one woman in four has been abused during pregnancy (UNFPA website). The WHO (2005), Multi-country study on women's health and DV in 10 mainly developing countries found that, among women aged 15-49 between 15 percent women in Japan and 71 percent women in Ethiopia reported physical and/or sexual violence by an intimate partner at some point of time in their lives. Thus, it is acknowledged now that violence against women (VAW) is a violation of women's human rights.

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India with the presence of myriad customs, traditions and cultures based on strong patriarchal, discriminatory values and practices, is no exception but a glaring example of a society having high incidences of DV. A review of micro studies shows that 22 to 79 percent of women surveyed in different parts of the country have experienced DV. According to National Family Health Survey (2007), nearly 37 percent of Indian married women between 15-49 years of age have experienced DV.

VAW be it in any form, affects all aspects of women's health including their survival. It is also a risk factor for their ill health (WHO, 2002). The adverse impact of violence on women's health has been acknowledged worldwide in various international covenants, conventions, conferences and declarations (notable among them CEDAW 1992, World Conference on human Rights, 1993, Fourth World Conference on Women, 1995, Beijing + 5 Conference, 2000).

Health is a basic human right. And as large numbers of women are affected by violence against them world over, VAW is now recognized as a crucial human rights as well as public health issue due to the associated health risks of this violence. The 49th World Health Assembly of 1996 and the United Nations Population Fund in 1999 declared VAW as a 'Public Health Priority'. This stems from a belief that for women's holistic health, all the factors impinging on their health must be addressed by health system especially when large numbers of women are affected by violence and are of ill health.

Understanding Domestic Violence

DV is the violence that occurs within the private sphere, generally between individuals who are related through intimacy, blood or law. It can include any nature and type of violence taking place within the domestic place called home, household or family. It can be violence against women and girls of the family, violence between siblings, on child/children, elders of the family. But, DV is usually used to describe the act of violence committed by men against women in intimate relationships or by husband and his family members on the wife.

This is because police and hospital records globally have indicated that the majority of victims of DV are women. Even experiences of women's organizations, voluntary organizations working with women reflect that women are abused, harassed, tortured, coerced by their own partners or husbands, and marital family members within their own homes. (UNFPA, 2003).

The British Council (1999) defines DV based on the concept of gender violence given by the United Nations General Assembly while formulating the CEDAW

declaration in 1993. It defines DV as all such gender based violence and abuse taking place on women in adult marital relationships.

In India until recently, the laws, public discourse and media had equated DV with dowry violence (Violence on woman by her husband or in laws due to their demand/ expectation of gifts, money, goods or property from woman's family before, during or any time after marriage). It was only in 2005 that the newly enacted legislation of the country titled Protection of Women from Domestic Violence Act, 2005 considered physical, psychological and sexual abuse confronted by women daily in her marital relationships for any reason or without reason as DV.

Thus, now the term DV has almost become a synonym for violence against married women or violence by intimate partner taking place within the four walls of the home, within the family.

Perspectives on Domestic Violence

The issue of DV has been viewed and understood from different perspectives. A few of the common perspectives that have dominated different societies' views and their responses to DV historically include the traditional perspective, the socio-legal perspective and the feminist perspective.

The traditional perspective views DV as a justifiable act, a 'rightful act' on the part of the husband. It is considered as a private affair, an intra-familial issue that is a sanctioned and an accepted evil of the society.

The socio-legal perspective views DV as a social problem affecting the quality of life of many women, children and families. It accepts that DV has serious social, economic consequences at individual, familial and societal levels. While also a crime perpetrated against women by men/husbands and their family members.

Feminists view violence as a means used by men to control women. Its roots are seen in the unequal balance of power between men and women found highly in patriarchal family and society set ups. Feminists believe that violence is not a private, family matter but a social one (Personal is Political). They believe in understanding violence from the experiences of women's own frame of reference and view women who have experienced violence as "survivors" who have many adaptive capacities and strengths.

Domestic Violence - A Human Right Issue

Though it was only after the World Conference on Human Rights, 1993 that VAW especially DV was recognized formally as a human right violation, the right to life and bodily integrity are the core fundamental rights that existed under Universal Declaration of Human Rights since 1948. DV, considered as 'private

affair' was not recognized earlier as human rights violations because traditionally it was believed that international human rights laws do not apply to 'private harm'. Similarly, international legal institutions then had restrictive interpretations of the State responsibilities. As per this view, human rights norms governed the conduct of the States, and States were responsible for the violations they perpetrated however, DV occurring in private spheres called homes was seen as outside the peripheral of the State's responsibilities.

Over time, the notion of state responsibility under international law has been expanded in number of ways. It is now recognized that human rights laws apply to 'private conduct' such as DV. As Radhika Coomaraswamy, United Nations Special Rapporteur on VAW explains, there are three ways in which DV can be understood as human rights violations: due diligence, equal protection and torture.

First, as articulated by the Committee on the Elimination of Discrimination Against Women in General Recommendation 19, States are not only obligated to refrain from committing violations themselves, but are also responsible for otherwise "private" acts if they fail to fulfill their duty to prevent and punish such acts. This responsibility is reflected, as well, in the Declaration on the Elimination of Violence against Women and the Vienna Declaration and Program of Action from the 1993 World Conference on Human Rights. Consequently, when the State fails to ensure that its criminal and civil laws adequately protect women and consistently hold abusers accountable, or that its agents—such as police and prosecutors—implement the laws that protect victims of DV, it has not acted with due diligence to prevent, investigate and punish violations of women's rights.

Second, States are required under international law to provide all citizens with equal protection of the law. If a State fails to provide individuals who are harmed by an intimate partner with the same protections it provides to those harmed by strangers, it has failed to live up to this obligation. When law enforcement officers respond quickly to reports of stranger violence but fail to respond to reports of intimate partner violence, when forensic medical classifications allow accurate evaluations of the severity of injuries inflicted by strangers but consistently fail to reflect the seriousness of the kinds of injuries inflicted in an abusive relationship over time, when judges impose lower sentences on those who assault strangers than those who assault their intimate partners—battered women have been denied equal protection.

Third, advocates and scholars increasingly recognize that DV is a form of torture. Under international human rights law, torture is severe mental or physical pain or suffering that is intentionally inflicted either by a State actor or with the consent or acquiescence of a State actor for an unlawful purpose. According to

Coomaraswamy, the dynamics of DV closely resemble the defining elements of torture: "(a) it causes severe physical and or mental pain; it is (b) intentionally inflicted, (c) for specified purposes and (d) with some form of official involvement, whether active or passive." (Coomaraswamy, 2000). The similarities between these violations are striking particularly because DV and torture are often perpetrated for the same unlawful purpose—namely, to establish and maintain power and control over another.

Thus, the human rights perspective considers VAW as an act against the fundamental notion of humanity, eroding women's sense of being human, viewing women's rights as human rights and VAW as a violation of women's human rights. Moreover, it believes that the State and its agencies (social, political, legal, health, etc.) have an obligation to protect, support and help women victims of violence. Failure of the State and its agencies to carry out any obligations (action or omission) that violates women's human rights against violence is also seen as the one inflicting further VAW. This perspective strongly believes that it is the responsibility of the State to ensure that victims of DV are afforded the same legal protections that are available to all victims of any other type of violence.

In India, the specially enacted legislation on DV, titled Protection of Women from Domestic Violence Act, 2005 defines DV not only from the human rights perspective but also recognizes that any act by family members which harm women either physically or mentally be considered as an act of DV.

Understanding Women's Holistic Health as a Right

Health has evolved over the centuries as a concept of individual concern (absence of disease) to wellbeing of individuals and society determining social development (Bajpai, 1998) to a powerful tool for women's empowerment (Batliwala, 1993) or as relative to the aspirations of individual or groups thus defined in relation to the users' perspective. It has also evolved from being a welfare concern to a fundamental human right encompassing the whole quality of life and a worldwide social goal. It is not mainly an issue of doctors, social service and hospitals but an issue of social justice.

In this context, women's health must be defined holistically so that it encompasses all the determinants affecting their health. A holistic view of women's health recognizes that biological, psychological, social-cultural, economic, violence and life style issues affect women differently than men, and that women require specialized services and care. The holistic approach strives to address all aspects of women's health and all sources of ill-health across their entire life cycle. It

About the Book

Scientific Writing and Publishing in Social Work

Scientific Writing and Publishing in Social Work is an edited book arising from an intensive Three Day Residential Scientific Writing and Publication Workshop jointly organized by the Department of Social Work, Bharathidasan University, Tiruchirappalli, Tamil Nadu and the Department of Social Work and Human Service, James Cook University, Australia during January 2013 at KKID, Coimbatore. This book is largely a collection of research papers from participant social work researchers with additional contributions from Australian and Indian social work students, academics and practitioners. This book offers a cross national cultural perspective in writing about social work research. It is an outcome of a productive collaborative research partnership which focused on mentoring students at the beginning of their research careers.

The values of social justice and human rights connect the writings of these research scholars as they explore with a new lens, a range of social issues such as child abuse, women's issues, prisoners' rehabilitation, adolescents' resilience, mental health, domestic violence, life skills education, disability, addiction and, more generally, frameworks for research and practice.

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