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Professional Social Work: Revisiting the Past and Envisioning the Future in India

Y. Ronald*

Abstract

Unlike law, medicine and nursing, social work in India neither enjoys professional recognition nor has a professional council to regulate and popularize the profession. The reason for this is explained through the following analysis which reveals the contestations that exists between divergent camps dealing with social work. The author urges the social workers to shed their ideological differences and come to a mutual consensus to promote social work within the human rights and development paradigm. It is acknowledged that both micro and macro social work methods are relevant within the emerging paradigm. A four-point proposal that can build an acceptable consensus between the competing camps is proposed. This article is expected to help these young professionals and educators to identify the pertinent issues that are important for social work in India.

Keywords

social welfare, social work education, distance education, India

Founding of a 'Helping' Profession

Social work is closely related to social welfare. In England, dislocation of people due to the allocation of separate land for sheep farming resulted in poverty and impoverishment. This resulted in civil disturbances. The English Poor Laws were enacted during 1563 in order to assist the poor and clarify the role of the government and local authorities in the provision of aid (de Schweinitz, 1943). The 1601 version of the Poor Law became popular. The local authorities in the parishes (counties) determined the eligibility of those people who were to be supported under the poor laws (Titmuss, 1958). The poor laws became the cornerstone of modern social welfare planning and administration.

In 1800s, industrialization set in and became a major phenomenon that shook the world. This meant transformation of the predominant rural population into an urban milieu. This resulted in migration of people from the rural areas to urban industrial centers. These urban centers created

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problems related to living conditions, working conditions and even in the social structure which lead to the growth of private social welfare agencies.

The private social welfare agencies which developed in the mid 1800s attempted to meet the needs of people living in these urban areas (Zastrow, 1996). These agencies were primarily initiated by religious groups. Until 1900s the services (food and shelter, for instance) provided by them were very minimal. It existed primarily as projects of the clergy and wealthy philanthropists, who had no formal training and had little understanding of human behaviour. The focus of the groups were to meet the basic physical needs such as food, shelter and similar other requirements. They also attempted to cure emotional and personal differences with religious admonitions.

One of the foremost social welfare agencies in the early 1800s was the Society for the Prevention of Pauperism, founded by John Griscon in 1820 (Zastrow, 1996). The work undertaken by this agency involved investigating the habits and existing conditions of the poor and suggesting plans by which the poor could help themselves. By the end of 1800s, a large number of relief agencies were formed to help the unemployed, poor, physically and mentally disabled people and orphans. But most of the services provided by these agencies were poorly coordinated and often overlapping in several areas. It was in this context the Charity Organization Society (COS) caught the interest of everyone in 1877. COS provided direct services to the individuals and their families as well as coordinated the efforts of private agencies to meet as well as solve the pressing problems. The success of COS lay in its ability to find the needs of the client and in maintaining a central system to avoid duplication. They also used friendly visitors (volunteers) to work with the people.

Concurrent to the COS movement was the establishment of several settlement houses in the late 1800s. The Tonybee Hall became the first settlement house in London in 1884 (Woodroffe, 1971). The workers of these houses were daughters of ministers who in contrast to the friendly visitors (volunteers), lived in the same impoverished neighbourhood and used the missionary approach of teaching residents how to live a moral life and improve their living conditions (Barker, 1999).

The settlement houses used techniques which are now referred as social group work, social action and community organization. Settlement houses emphasized environmental reforms on one hand but on the other continued to teach the poor the prevailing middle class values of work, thrift and abstinence as a key to success. One prominent leader of this movement was Jane Adams.

In the late 1890s, COS found several problems in administering the aid efficiently. The relief funds received by COS had to reach the people effectively. But due to the lack of professional training, friendly volunteers could not effectively manage book keeping effectively. The friendly visitors had to be trained in book keeping skills and thus began the first training of its kind that took place in 1898. It was organized by the New York Charity Organization Society. By 1904, a one year certificate programme was offered by the New York School of Philanthropy (Zastrow, 1996). This became the first formal social work education programme in the whole world.

Gradually a number of schools for social work rose and social workers began to get employed in all kinds of professional settings such as schools, courts, child guidance clinics and urban neighbourhood centers. In 1917, Mary Richmond published *Social Diagnosis*, a text which presented for the first time the theory and methodology of social work (Mathew, 1992). It

was also during this time the concepts of Sigmund Freud became popular. The concepts of Freud was found to be appropriate to social work and thus the social workers switched their emphasis from “reform” to “therapy” for the next three decades (Ronald, 2013).

However, until the end of World War I, social work was never considered as a distinguished and definite profession. The depression of 1930s and the enactment of social security act in 1935 brought social work to the lime light (Younghusband, 1964). Since 1940s, social work has become a prominent field in the area of social welfare and development.

Emergence of Competing Camps in Social Work (1940-1970)

COS, in analyzing the causes of poverty, originally emphasized on a theory of personal failure, but later extended their analysis to include a lack of appropriate social policies that led to social problems. Meanwhile the writings of Sigmund Freud altered the direction of social work towards a more conformist field of practice and knowledge. The development of business-sponsored community chests, philanthropic foundations and the arrival of technology also influenced the social workers to focus their concerns on finding solutions to individual dysfunctions. This emphasis was heightened by the acceptance of the psychoanalytical theory (Ronald, 2013).

The next four decades, the profession of social work witnessed clear ideological and organizational disarray. The devastating polarization between clinical practitioners and the advocates of social policy and action, led to both sides identifying their own functions as that of the social workers. It was during this time in 1970, a variety of practice approaches namely, radical, structural, feminist, anti-racist emerged to challenge the existing social work practices as elite and hegemonic. These practices had differences in their analysis, but were quite united for the cause of social justice. They came under the umbrella of Anti-Oppressive Social Work (Ronald, 2013).

One of the approaches, namely, radical social work, was rooted in the Marxist theory. It introduced a class analysis of the role of the welfare state and the provision of social work services. Radical theorists identified the ‘individualization’ of client problems as a political ideology that could be challenged and replaced with an ideology that located problems within the capitalist social structure (Bailey and Blake, 1975).

Structural social work saw human relationships being influenced by power and privileges based on race, class, gender, sexual orientation or age embedded within the capitalist societies. Structural social work was a key development in the articulation of an anti-oppression stance, which was heavily influenced by the work of both Marx and Freire (Mullaly, 1993).

Feminist theorists began critiquing the structural approach, claiming that the theoretical analysis of the structural social workers and their resultant practices had not adequately integrated the issues of gender. Feminist social workers believed that the live experiences taken from women’s lives could be developed as a feminist analysis of practice (Langan and Day, 1992).

The anti racist social workers criticized both the structural and feminist social work theories for the lack of attention paid to the impact of racism, both at the institutional and interpersonal levels. Anti-racists place race analysis at the centre, thereby challenging the Euro-centric bias of social work. Thus during the last three decades, social workers have witnessed an unprecedented development of an anti-oppressive approach as an alternative to the traditional social work models of personal rehabilitation (Ronald, 2013). Anti oppressive social work

practices offers strong analytical perspectives for social workers. However it has found no place in the curriculum of most of the prominent schools dealing with social work.

Professionalizing Social Work

Right from the 1900s, social workers who worked in state institutions, such as in the prisons and the hospitals felt the need for a professional status for the social work done in these institutions. In the US, the National Conference of Charities and Corrections was established in 1915. Following that, the Association of Medical Social Workers was established in 1918 in the US. Later with the support from practitioners and social work educators, the National Association of Social Workers and the Council for Social Work Education was established. Thus the USA became a frontrunner in professional social work education and practice (Laavanya, 2013).

In the United Kingdom, various associations rose in the 1920s. Some of the prominent associations were the Association of Child Care Officers, the Association of Family Case Workers, and the Association of Psychiatric Social Workers. In 1962, these associations came under the banner of the Standing Conference of Organizations of Social Workers (SCOSW). Later, the SCOSW reemerged as the British Association of Social Workers in 1970. At present, the Health and Care Professions Council regulate social work education in the UK (Laavanya, 2013).

The Canadian Association of Social Workers (CASW) is the sole association in Canada with a national voice and an international reach. The association was established in 1926. Currently the CASW is a federated organization having partners in each province of the country. On the education front, the Council on Social Work Education founded in 1952 was given the responsibility of accreditation of social work education programmes in the country (Laavanya, 2013).

In Australia, the Australian Association of Social Workers was established as a professional representative body of social workers in 1947. On the education front, the Australian Council of Heads of Schools of Social Work (ACHSSW) and the Australian Association for Social Work and Welfare Education (AASWWE) provided the much needed leadership. In the international level, the International Federation of Social Workers (IFSW) established in 1956 in Munich and the International Association of Schools of Social Work (IASSW) provided an overall leadership to the professional associations and educational councils worldwide. These associations along with the local professional associations and social work education councils have tried to regulate both the social work profession and education as well (Laavanya, 2013). The International Federation of Social Workers and International Association of Schools of Social Work have identified four major areas of work for all the social workers across the globe. The areas are as follows:

- Tackling human rights violations
- Creating a just economic system
- Strengthening affirmative policies for aboriginal and historically excluded groups
- Building effective public systems for the well-being of the people

Thus from a pure clinical and service providing centered orientation, the social work profession is moving towards a human rights and development paradigm. The International

Federation of Social Workers and International Association of Schools of Social Work endorse such a stance.

Professional Social Work in India

Clifford Manshardt, an American missionary in Mumbai was the first person to articulate the importance of professional social work in India. He later became the Founder-Director of the Sir Dorabji Tata Graduate School of Social Work (later renamed as Tata Institute of Social Sciences). He recognized that the social conditions in India differ vastly from those of the West and therefore social work has to be context specific (Desai, 1985). But when the social work education programmes developed in India, the cultural, economic and social differences were not adequately taken in to consideration (Thomas, 1976).

The social work educators in India developed a curriculum which was largely copied from the West. In fact, all the specializations which evolved in the country were developed by the American social work educators who had no training what so ever about the Indian social economic issues (Mandal, 1989). Thus the curative model of social work based on the West was over emphasized, resulting in the limitation of social sciences content necessary for understanding the Indian socio-economic structures (Mandal, 1989). This ultimately led to the neglect of various social reforms (Pathak, 1975).

Nanavatty (1985:315) gives a clear picture of the fact in the following manner:

“Social work education in India began as an adaptation of the educational programme of USA, where social work services were meant to assist the people in their adjustment to an industrial, urban and metropolis dominated social milieu. In contrast, India has millions of people whose basic needs are unmet, rights infringed and mobility restricted. Hence social work had to primarily relate to social justice rather than promoting adjustments.”

Desai (1985:44) also reflects the same point:

“In a country where the majority of people are rural, where exploitation and injustice leave the majority in a state of poverty, social work has remained to a large extent peripheral to the root causes of the problems of a non-industrial and rural society.”

Unfortunately, the voice of the conscience keepers was not heeded by the curriculum developers. This resulted in the absence of a indigenous and context specific literature in social work. On the other hand, colleagues in the other sister subjects like sociology and anthropology developed concepts and ideas based on an Indian reality. These subjects have gained popularity and acceptance among the scientific community.

The social work educators have tried quite a number of times to promote social work and gain recognition akin to other practice professions like law, medicine and nursing. However due to the lack of support from their sister subjects and the infighting within the social work fraternity social work has not received its due recognition.

The first effort for professionalization of social work in India came in 1947 with the Indian Conference of Social Work (ICSW), which acted as a forum for the development of public opinion on social work and welfare. Later in the 1960s, two important associations came to the forefront, namely, the Association of/for Schools of Social Work in India (ASSWI) in 1960 and the Indian Association of Trained Social Workers (IATSW) in 1964. Since 1970s, an array of regional level associations such as Bombay Association of Trained Social Workers (BATSW), Maharashtra Association of Social Work Educators (MATSW), Karnataka Association of

Professional Social Workers (KAPSW), and Professional Social Workers Forum, Chennai (PSWFC) have emerged.

At the national level, the Indian Society of Professional Social Work (ISPSW), Associations of Schools of Social Work in India (ASSWI) and the National Association of Professional Social Workers in India (NAPSWI) emerged as the major players. Various legislative attempts have been made through the efforts of these professional associations at the regional and national levels. The National Council of Professional Social Work in India Bill (1993), the National Council of Professional Social Work in India Bill (2007), and the Maharashtra Social Work Council Bill are examples of some of the efforts taken by these associations at the legislative front.

However, due to the infighting between clinical social workers and social action / developmental social workers, a united face has never been shown by the social work associations. This has left the entire profession in deep slumber and inactivity. Therefore for the future efforts to be successful, as witnessed elsewhere, it is important for the both camps to come together. The proposal by Mizra Ahmad provided new directions in social work education (Laavanya, 2013). The five point proposal is as follows:

- Shifting from welfare to developmental and social rights orientation.
- Shifting focus from pathology to addressing the needs of development and promoting the empowerment of the vulnerable.
- Reducing the emphasis on micro level intervention strategies and more attention to be given to issues at the macro level.
- Reducing dependence on western models and evolving indigenous models of social work.
- Keeping constant watch on the changing social, economic and political realities at the local, national and international level so that professionals can respond to the changing needs of the clientele and the society in general.

Thirty four years have passed since Mizra Ahmad gave this suggestion. But the social work practitioners and social work educators are not keen in implementing the five-point proposal (Laavanya, 2013). One major reason for this was the lack of consensus among social work educators to the proposal. Most of the social workers from the clinical stream find the proposal of Mizra Ahmad to be biased towards macro practice. This is a compelling contention as the third point was for reducing the emphasis of micro interventions and the clinicians find it as a biased proposal which undermines the mental health challenges in the country.

To set the differences right, the national level associations of the schools of social work should have taken a lead. Due to the disintegration of the ASSWI, there is no clear national voice nor a mutual consensus making body of social work educators till today. In 2012, the School of Social Work in the Tata Institute of Social Sciences along with many other schools and departments of social work in India came together and floated the National Network of Schools of Social Work (NNSSW) for quality enhancement of social work education in India. The key objectives of the network were to suggest strategies for developing minimum standards in social work education, developing modalities for supporting new departments of social work, and formulation of the national council on professional social work bill. The social work educators who attended the national network consultation resolved to make social work emancipatory, participatory and liberating (Nadkarni and Desai, 2012). However one has to wait and see the impact of the consultation.

Conclusion

The divide between the clinical and developmental social workers is an area of concern for the majority of the social work educators and practitioners. The apprehension raised by developmental social workers holds true as the state control over professional council of social work would mean the death knell to those social workers involved in social action, and a direct confrontation with the state. For example, the people in power would not appreciate the use of demonstrations/ rallies to pressurize the state.

On the other hand, working with the state is absolutely necessary to make sure that the social welfare services reach the poor and the marginalized. In some of the agency settings, such as prisons and the hospitals, the role of a clinical / case worker is vital. Professional recognition of the qualification and services of the social worker within these systems is important for them to do their tasks successfully and without stress.

However, excessive stress on professionalism will create an elite and top-down approach. In the recent past, there has been a feeling that only students from the elite institutes are competent for professional social work. The rest of the students doing social work are looked down upon as being incompetent and unprofessional. This notion does not have any merit. In fact it further divides the social work fraternity.

Another major point of conflict is on the distant / correspondence form of education Bachelors in Social Work and Masters in Social Work programmes offered by some of the universities like Indira Gandhi National Open University. Most of the social workers who uphold professionalism are against the distance education programmes as they feel that these programmes lack academic rigour. But they fail to understand that distance education is a rigorous and equitable medium of education which promotes social inclusion (Saumya, 2013). Most of the middle and lower middle class aspirants tend to look at distance education as a feasible option to continue their studies. Anti-distance education stance will result in elitism. Social workers have to keep a vigil on this.

The social workers who summarily reject distance education mode should in fact look at the models from Canada, Australia, New Zealand and elsewhere before making premature dismissal of distance education systems. Distance education programmes give opportunity to our own diploma and bachelors level social workers to complete masters degree and have career progression. We should encourage such career advancement options.

In this context, a dialogue between the two camps is necessary. The International Federation of Social Workers and the International Association of Schools of Social Work have developed documents that pave the way for seeing social work as a field of study and practice which is concerned about the human rights of the individuals, groups and communities. Social workers in both camps in India can come together to discuss these matters. Based on the current situation, we can decide to adopt the following resolution:

- To see social welfare services, social action, and social policy interventions as strategies within the developmental and human rights perspective for the holistic development of the individuals, groups as well as communities.
- To reduce the dependency on the pure biomedical models and develop indigenous and rural/ tribal community sensitive bio-psycho-social models of intervention.
- To appreciate both micro and macro social work methods as they are complementary to each other.

- To align with the regional and international professional associations and councils while developing a model curriculum and other professional and academic suggestions and regulations.

Agreeing on these points can bring both the camps together to deliberate on the other finer issues affecting both the social work education and profession. In a few years time, we will be celebrating 80 years of social work education in the country. We should therefore resolve the contentious issues quickly and move towards a golden age of social work in India.

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Medical Tourism and Medical Tourists: A Conceptual Analysis

Sindhu Joseph*
and
Robinet Jacob†

Abstract

Medical tourism based on transnational journeys for healthcare, cure and well-being is widely discussed in the literature. As an upcoming and fast developing phenomenon there are different views and perspectives on the concerns of medical tourists. This paper discusses the significance of medical tourism in the present global scenario and examines the practical difficulties faced by medical tourists from information search to after care. The concerns of the medical tourists such as the need for accreditation, patient risks, malpractices and legal issues, and after care issues are examined here in detail. This article establishes that the medical visa and medical attendant visa concerns are important in policy formulation in this area. The concerns discussed in this paper need to be addressed if it needs to be sustained in any economy.

Keywords

medical tourism, aftercare, India

Introduction

Media, practitioners, researchers and healthcare industry are optimistically viewing the new niche, medical tourism (MT). It has been noted that for the past few years, people seeking healthcare are inclined to travel from the advanced countries to developing countries such as India, Mexico and Thailand. It is a paradigm shift from the earlier pattern of medically motivated travel. This new trend has been referred to as MT which is emerging as a unique and readily identifiable form of tourism. According to Solomon (2011), MT is a boon for the desperate and needy who suffer from serious ailments and hindering situations. Medical tourists (MTs) travel mainly for cheaper and quicker treatment options which are equal to or better than that of their home country / destination (Horowitz and Rosensweig, 2007; MacReady, 2007). The main motivations for MT can be classified as better quality care, quicker access, cheaper cost, qualified doctors and staff and tourism options. However, the subsequent medical tourism survey (2013) found out that 80 per cent of the demand for MT is aroused solely by the cost effective factor.

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MT has grown on a greater pace and has become an important segment of the health care industry and is promoted by the stakeholders with its competitive advantages. All over the world, MT has found new niche and has become a prominent portfolio for many in the tourism industry and other related sectors directly and indirectly. It is more of a business opportunity for the stakeholders than ever before and so they seek to cash in on every available opportunity. MT includes primary, secondary and tertiary care and may include surgeries, transplants, health check-ups, psychiatry, fertility evaluations, curing lifestyle diseases and dental care.

Medical Tourism: Present Scenario

MT attains national industry status in more than 50 countries (Gahlinger, 2008). The average contribution of MT is accounted as \$45-95 billion to global Gross Domestic Product for six million patients (Medical Tourism Survey, 2013). The Medical Tourism Survey (2013) has found out that the prominent areas of MT are Latin America and Asia. The highly popular in demand and favoured destinations are India and Mexico. In 2006, out of 10 million tourists in Singapore, 410,000 (4%) were medical tourists and 89,000 were their accomplice (Voigt et al., 2010). The highest sought procedure is cosmetic treatments having 38 per cent of the total market. Average spending of a medical tourist is higher than that of a leisure tourist (Bennet et al., 2004) which is between \$7,475 and \$15,833 per medical travel trip (Medical Tourism Survey, 2013). World Travel and Tourism Council (2011) accounted the average spending of a medical tourist is US\$12,000 while a leisure tourist spends only US\$6,383 which means a medical tourist spends approximately twice as much money in the chosen country of its destination. Viewing this financial aspect, both the governments and stakeholders are increasingly interested in MT activity with policies, corporate tertiary care multi-specialty hospitals, MT networks and collaborations, and insurance portability concerns. Though there is a vacuum in the collection and dissemination of statistical information of MTs' volume, the UK provides some statistics which help to assume that the phenomenon is growing faster. The outbound MTs in UK estimated as 63,000 in 2010 while inbound MTs are 52,000 (Lunt et al., 2014) and outbound travel has been increasing tremendously for the past few years.

Medical Tourist's Muddles

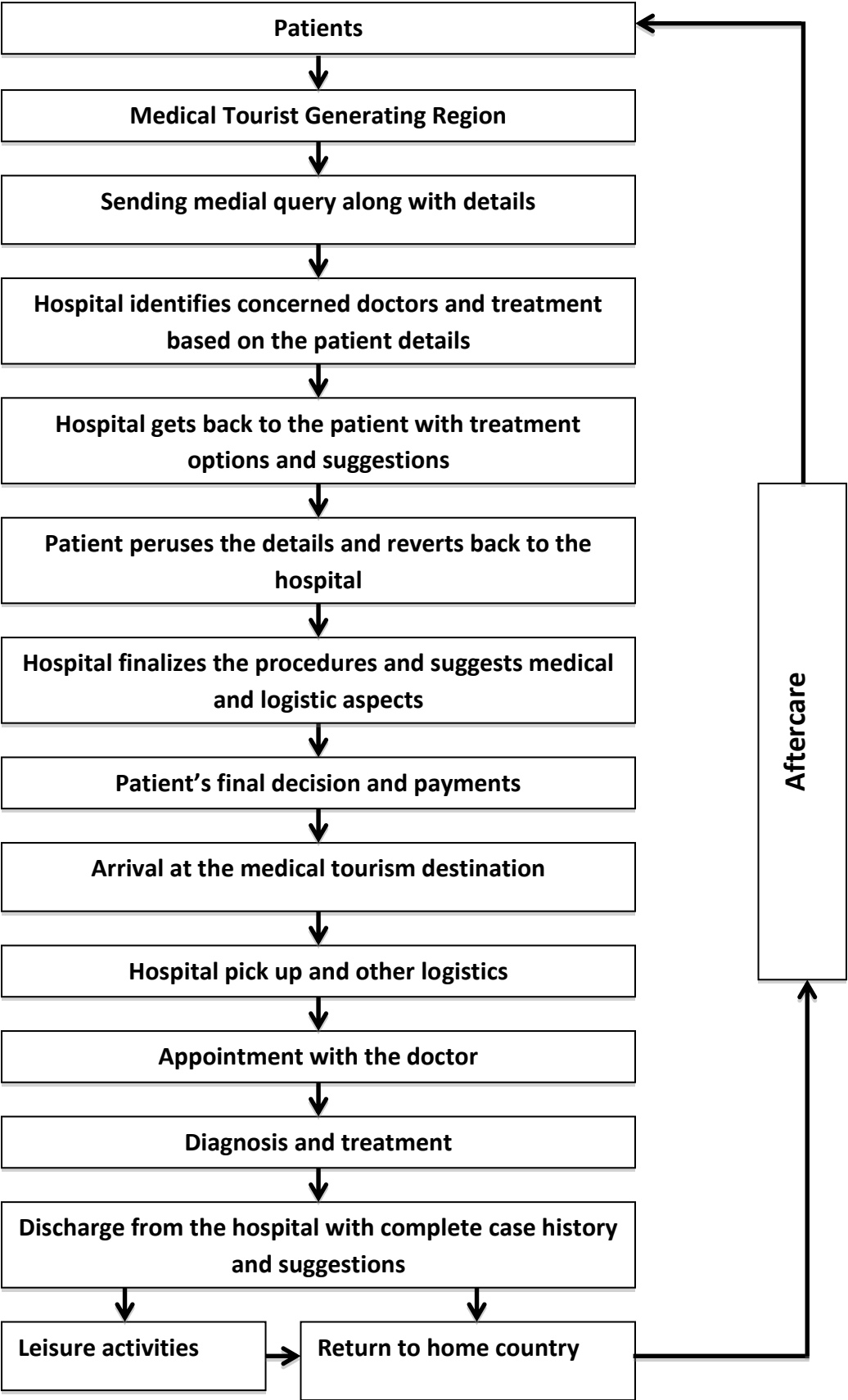
Now along with its fast development phase, the industry witnesses many arguments favouring and criticizing Medical Tourism (MT). Many are mere speculations based on little evidence and some are serious issues which must be debated but often ignored. The available literature on MT falls into both categories, yet these issues remain as it is because of the peculiar nature of this phenomenon. MT system itself is a bit muddled due to conceptual flaws and disintegrated activities. There are many challenges faced by the MTs themselves and many impacts directly or indirectly affecting the economic and social aspects of the country chosen as its destination.

Availability of Reliable Information and Treatment Concerns

There is a course of action for MT process, which starts from the tourist-generating region and ends at the destination region. The process is initiated by the search for information for a suitable treatment resort as shown in Figure 1. The current source of information for treatment options overseas is by word of mouth, referrals of doctors and most importantly websites. Being a bi-product of globalization and IT enabled industry; information on MT is mainly available

through websites. Current Google search for 'medical tourism' (as on 5 December 2014) gives 36,500,000 results. It is absolutely based on this information on which the decision for it and where to go for medical treatment is being made.

Figure 1: International Patient's Service Cycle



As MT is a highly profitable business activity, the websites are designed to impress like any other type of promotion. It is absolutely illogical to perceive that all patients have enough expertise to navigate and access the required information and then evaluate the quality and suitability and quite often are confused with the language and health systems which are not similar to theirs (Legido-Quigley et al., 2008). To make the appeal favourable to the patients, the websites will give guarantee for their services and competencies of healthcare which are not reliable as it is not regulated (Lunt et al., 2012) and are purely a marketing venture. Many research results show that the patients rely mostly on this information and are prone to be dissatisfied by some factor or the other as the entire system of MT is highly risky and consists of many interconnected components.

Many websites are functioning as 'ghost agencies.' Sometimes the search for 'contact us' on the website ends up in chaos. Many Medical Travel Facilitators (MTFs) are working without an office and it has become a mere business just like real estate or any other commercialized activity. Very often there is only one contact number and if it vanishes the condition of MTs will be a disaster.

A research conducted by Turner (2011) found out that a total of 25 medical tourism companies that were based in Canada are now defunct. Given that an estimated 18 MT companies and 7 regional, cross-border (MTFs) now operate in Canada, it appears that approximately half of all identifiable MT companies in Canada are no longer in business. Penney et al. (2011) studied 17 websites and found that Canadian MT broker websites varied widely in scope, content, professionalism and depth of information. Third party accreditation bodies of debatable regulatory value were regularly mentioned on the reviewed websites, and discussion of surgical risk was absent on 47 per cent of the websites reviewed, with limited discussion of risk on the remaining ones (Penney et al., 2011). Terminology describing brokers' roles was somewhat inconsistent across the websites (Penney et al., 2011). Mainly, brokers' roles in follow up care, their prices, and the speed for surgery were the most commonly included business dimensions on these reviewed websites (Penney et al., 2011).

Accreditation System

As there is no standard cost and quality for treatment, the only means for its reliability and authenticity is its international accreditation. Though it does not seem to be an important parameter for the developing nations, accreditation like JCI (Joint Commission International), QHA (Quality Healthcare Advice) has a direct influence on the decision making process of people from the advanced countries like the US and Canada. To them, due to the intangible characteristics, the slogans or promotional material has no value for them if it is not accredited. Due to the intangible nature of the MT product, accreditation is the one and only factor which gives them an assurance on the physical and mental risk that may come across. This makes the comparison and assessment easier for the common patient with regard to safety and quality and puts them at par with the advanced countries. It is perhaps absolutely true in the case of cosmetic, ophthalmic, dental and other less risky treatments, which are practised by doctors even without much expertise and qualification, and they may not disclose the potential problems that the patient may come across eventually.

On the contrary, Bies and Zacharia (2007) challenged that there are chances for errors even in accredited hospitals due to the heterogeneity in training and experiences of doctors. Sengupta (2011) observed that accreditation programmes will pave the way for a two-tier medical system where the private sector will have more interest as they have abundant resources and will target

the elite and foreign tourists. However, accreditation is the only one mechanism to ensure the quality of care in a totally unregulated global environment.

Medical Tourism and Patient Risks

MT is highly risky and vulnerable as it handles the life of those who are in a dilemma and extremely anxious especially due to the sudden overseas travel, unfamiliar environment and chronic conditions. Normally they will be confused with regard to the risk factors, complications that may arise even though the cost information is the only aspect provided with. Authors like Crooks et al. (2010), Riezman (2010) and Priya (2010) classified the MT risks into three types as patients' risk, travel risk and pre- and post- operative care risk. Long distance travel after the procedures is often prone to lung diseases and thrombosis and unattended leisure activities after surgery will have serious fatal repercussions like pulmonary embolism or blood clots (Steven, 2010). Comparatively less risky procedures such as cosmetic surgeries may have serious adverse effects due to the exposure of direct sunlight and environmental pollution. Cosmetic and dental procedures may also be problematic if it is not done properly and then the patients will eventually be forced to meet the doctors at the home country there by spending extra money (Turner, 2008). There may be unwillingness by the doctor at home to 'take over the case' (Riesman, 2010) and it will be worse if the case history and documentations are not clear and complete and this creates both an economic and an ethical burden on the physicians of their home countries, even to an extreme degree when some of the home country patients are fatally deprived of an organ transplant and the donor organ goes instead to a returning "transplant tourist." At times due to an emergency the need arises for a second transplant surgery (Steven, 2010). Riezman (2010) also discussed other diseases one might contract due to the unfamiliar food, air or water of the other countries. Outward-bound UK MTs are subsequently being treated by the National Health Service (NHS) for complications arising from poor care provided overseas (Birch et al., 2007; Jeevan and Armstrong, 2008). Furthermore, the outbreak of contagious diseases in the destination countries will be life threatening for tourists and is more aggressive for MTs in their post treatment period. Patients usually have no idea about the potential chance for infectious and non-infectious complications from MT, the trade-off between saving money on medical expenses and obtaining potentially life-prolonging medical care that the patient could otherwise not afford, and sacrificing potential legal remedies should medical negligence occur (Steven, 2010).

An observational study conducted from 2007 to 2009 on patients presenting complications of cosmetic tourism surgery to a tertiary referral plastic surgery practice identified 19 patients where operations performed in Europe or Asia (primarily breast augmentation procedures), 11 patients were reported to have received NHS treatment, at a cost of £120,841 (Miyagi et al., 2011). Similarly, Turner (2012) provided brief descriptions of 26 reported cases of mortality in individuals who travelled abroad and underwent cosmetic surgery or bariatric surgery at international medical facilities from 1993 to 2011. Of the 26 reported deaths 25 of the individuals were women. Eleven individuals died after receiving health care in Mexico, four died after receiving care in the Dominican Republic, two died after undergoing surgery in Hungary, and single deaths were reported to have occurred in Brazil, Colombia, Cyprus, India, Malaysia, Panama, Spain, the United Arab Emirates (Dubai), and the US. Identified surgical interventions included 13 liposuction procedures, four tummy tucks, three breast implants / breast lifts, three breast reductions, two face lifts, two injections of fat into buttocks or calves, two lap bands, one gastric bypass, one gastric reduction duodenal switch, one vaginal surgery

with the specific type of procedure unspecified, one facial surgery with the specific type of surgery unstated, one plastic surgery with the specific procedure unspecified, and one patient reported as having surgery done to her nose, chin, lips, and eyelids. Krishnan et al. (2010) observed that Indo-Asian patients with diagnosed renal failure seeking transplant abroad via commercial kidney transplants have poor clinical outcomes compared to the comparator groups of local transplantations (including high rates of infection and with over 30 per cent of cases resulting in patient death or graft loss). For the growing phenomenon of ‘fertility tourism’, a UK-based 11-year follow-up study of high order multiple pregnancy found that 26 per cent of mothers had their fertility treatment performed overseas (McKelvey et al., 2009). These complications present difficult issues that remain unresolved and merit further investigation and discussion to better establish the true economic benefit of MT for patients (MacReady, 2007).

Some patients expressed regret that their isolation in hospital rooms meant that there was little opportunity for them to critically assess everyday life and illness outside the hospitals’ walls (Solomon, 2011). The relationship between tourist leisure and therapy was not without conflicts, for example, Spa doctors frequently mistrusted the commercial propensities of proprietors and doubted their commitment to medicalized therapy. They complained bitterly about the heavy meals frequently served in expensive spa hotels. Above all, they feared becoming mere tourist sites (Weisz, 2011). There is little comparable information with regard to the quality and safety of care provided by many of the destinations visited by UK MTs (Lunt et al., 2012). There is a need to address both the management of post-operative complications occurring after a patient leaves a foreign medical facility, and also the resulting financial costs associated with such care (MacReady, 2007).

Malpractices and Legal Issues

MT has become a complex phenomenon by its nature itself and there are chances that clinical errors and malpractices will be aggravated in an unregulated environment. There are many evidences of errors and mistakes occurring bat the hands of the healthcare people in advanced countries (Hurwitz and Sheikh, 2009). According to Riezman (2010), about 90,000 patients have died primarily due to the medical negligence and errors. Ben-Natan et al. (2009) pointed out that safety and appropriateness of treatment is a real problem for MT. However, there are many obstructions which make the foreign patients reluctant to complain against these issues in another country. Sometimes, it is mainly due to the weak legislation especially in developing countries which keep them away from litigation and eventually this makes the situation a real muddle where they cannot sue or succeeding in suing the culprits. Steven (2010) called attention to cases of surgical negligence without any exisiting meaningful legal recourse and the usage of medical devices which are not on par with the US. The FDA (Food and Drug Administration) or equal standards for safety are not available and it is worse when I these deficiencies are not informed to the patient. Currently, there are no reliable, or comprehensive sources for patients to learn about what legal recourse to take for malpractice committed in [foreign] jurisdictions (Steven, 2010). According to World Health Organization, the data collected in 2006 from 132 countries demonstrated that 31 countries (or 23.5%) have less than 100 per cent screening for at least one of the four common infection markers: HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), HCV (Hepatitis C Virus) and syphilis and many countries cannot provide complete information related to the screening process; even with testing of blood products, the testing process may often be incomplete or lack a quality assurance mechanism (Steven, 2010). Thus, patients risk becoming sicker through their travel to another

country, rather than gaining an improved state of health (Ben-Natan et al., 2009). Patients may be offered procedures and techniques in foreign countries that are illegal for the patients in their home countries (e. g., abortion and euthanasia) or illegal both in their home countries and the destination countries as well (Steven, 2010).

If something goes wrong with the medical treatment, it is extremely difficult to successfully sue the health care provider and obtain justice (Bookman and Bookman, 2007; Carrera and Bridges, 2006; Horowitz and Rosensweig (2007). Ormond (2011) observed that the usage of the terms ‘outsourcing’ and ‘off-shoring’ in relation to ‘medical tourism’, for example, implicitly assumes that control is in the possession of those entities ‘sending’ patient-consumers abroad and not those ‘attracting’ them.

According to Steven (2010), various forms of experimental, often scientifically invalidated treatments, including stem-cell therapy, that are allegedly marketed to desperate patients who can afford the tourism involved, have been the subject of ethical criticism and yet are a growing part of the medical tourism sector. The ethical issues with regard to these therapies include (1) providers making inaccurate medical claims in their direct-to-consumer promotional materials; (2) patients not receiving adequate and appropriate information and thus shouldering inordinate risks; (3) clinics contributing to public expectations that exceed what the field can reasonably achieve; (4) patients subjected to excess financial burden; (5) clinics not following international or national guidelines for the provision of stem cell-based treatments; and (6) inadequate patient informed consent, including patients suffering serious treatment side effects that allegedly were not disclosed in advance.

According to Marsek and Sharpe (2009), regulatory, administrative, public perception, continuity of care and liability issues are all restricting insurance companies from covering patients abroad. Concern is thus generally focused on the transnational regulation of private health-care to ensure (Western) patient consumer protection and future global industry growth. Another set of ethical concerns surrounds what has been labeled “transplant tourism,” those countries (identified in the past as China, Colombia, India, Pakistan, and the Philippines) offering organ transplants to international patients under circumstances in which the source and circumstances surrounding the procurement of donor organs has been criticized (Steven, 2010). Skeptics raise concerns about quality of care and patient safety, information disclosure to patients, legal redress when patients are harmed while receiving care at international hospitals, and harm to public health care systems in the destination nations (Turner, 2012). Reizman (2010) pointed out the malfunctions and risks associated with the medical tourism where people have been given inappropriate medicines or drugs, resulting in erroneous test results or abnormal reaction. In many countries, the doctors try to cheat the patients by suggesting to them to undergo a series of unwanted tests which are not at all related to the patient’s illness (Reizman, 2010). By doing so, they earn money and assure the patient a guaranteed successful outcome of their surgery (Reizman, 2010). Henderson (2004) suggests that there is the need for a strict control on advertising for such patients, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievance procedures. There is a lack of governmental safeguards ensuring the quality of healthcare generally and specifically the safety and effectiveness of certain procedures and also there is no international governmental body for accrediting hospitals, physicians or other health professionals (Steven, 2010).

Aftercare is the main factor, which can create favourable and sustainable image for the MT destination. In the absence of a governing mechanism for MT, a standard system of aftercare is neither endorsed nor monitored globally. A review of 100 internet websites under a search for “plastic surgery abroad” and covering services offered in Asia, Eastern Europe, and South America, it was found that there is a distinct lack of information for potential patients, particularly with regard to complications and aftercare (Steven, 2010). In the current situation, the MTs are sent back with aftercare advice and here effectiveness of communication with them and their home health care provider also matters. Thereafter various complications, side effects, and post-operative care usually become the responsibility of the patient’s home country's medical services following their few days of stay in a foreign hospital (Whittaker, 2008). In some cases, a schedule of follow up care is provided to foreign patients, but this would require further travel and many patients may not be prepared to follow through with the extra cost (Reddy et al., 2010; Whittaker, 2008). Further, providing only limited follow-up care and monitoring with no continuity of care if complications arise and revision surgery is required—the costs may not be covered by health insurance in the patient’s home country (Steven, 2010). Once they have returned to their home country, if the foreign patient experiences any problem with the medical care they had received, extensive legal protection may not be available within all the foreign countries. Although most post operation complications occur within the first few days after surgery (Marsek and Sharpe, 2009), if a complication should arise later on, it becomes very difficult for that person to seek immediate medical attention (Reddy et al., 2010). Foreign physicians may promise to provide follow-up care to medical tourists using telemedicine, but there are serious limitations in the consistency of law and regulations governing the practice of tele-medicine in foreign countries (Steven, 2010).

Cosmetic tourism has also been blamed for adding burden on local plastic surgeons for complications following private cosmetic surgery undertaken outside the patient’s country (Steven, 2010). Ben-Natan et al. (2009) suggested that appropriate follow-up care, adequate communication between providers and patients, provisions to assure the quality on long-term and provide for the cost of this care need to be considered before the patient decides in undergoing procedures in other countries.

M-Visa and MED-X Visa Concerns

Viewing the importance of MT, Indian Government issue two types of visa for MTs and accomplice namely Medical Visa (M-Visa) and Medical Attendant Visas (MED-X Visa) and if the validity period is less than 180 days, they are required to be registered. If any admitted patient and attendant is having a Medical and Medical Attendant visa of more than six months’ validity, it is mandatory to get himself / herself registered with FRRO (Foreigners Regional Registration Office), within 14 days of his / her first arrival, irrespective of the duration of his / her stay with the treating Consultants Certificate (separate certificate for both Patient and Attendant). If the patient and attendants are not having M-Visa and Med-X Visa (only having other types, e. g. Tourist VISA), they should be guided to FRRO with the treating Consultants Certificate for converting their visa type to Medical and Medical Attendant. If any patient and attendant need visa extension for treatment, they should report directly to the FRR Office with the treating Consultant’s Certificate (separately for both patient and attendant). Here the big paradox is that the medical tourists may not be in a position to do so due to health conditions. For obtaining M-Visa, many procedures and processes are involved which naturally require more money and time. For some countries, visa processing is delayed by more than two weeks and

most of the MTs are not in a position to wait so long and this wait time is the very factor, that forced them out of their country to seek treatment somewhere else. For obtaining M-Visa, medical report from recognized / specialized hospital / treatment center specifying the period of treatment with patient details, treating doctor's name and signature with hospital seal and nature of illness are mandatory. If any Pakistan national gets admitted, they should report directly to the FRR Office within 24 hours of their arrival and prior to 24 hours of their discharge with the treating Consultant's Certificate, apart from the online Form C submission. And we should also intimate the FRR Office over phone at the time of their arrival (before online submission of Form C. All these factors compel the MTs to take a tourist visa which is actually a serious offence. If everything is perfectly all right there will be no serious repercussions but in the case of death or other legal issues it becomes a serious matter But the government is not eager to look into this policy issue as yet and so the MTs, hospitals and MTs are conveniently neglecting this aspect.

Other Industry Level Concerns

A general lack of insurance portability hinders prospective patients from travelling abroad for health care (Bookman and Bookman, 2007; Porter et al., 2008; Steven, 2010). The industry positively views the changes that are happening in the medical insurance sector which may absolutely result in insurance portability in the coming years. George Eapen, Chief Executive Officer of Apollo Hospitals, India, said that "most western patients we get are covered by insurance or pay out of their own pocket. Canadian patients now get 75 per cent of their expenses reimbursed after treatment in Apollo Hospitals" (Mudur, 2014: 1).

A study of the problems and challenges faced by medical tourists in India by the Ministry of Tourism found that tourists find the overall cost of the treatment far more than what they had initially expected at the pre-procedure stage (Ministry of Tourism Report, 2011). Again, inadequate infrastructural services like roads and accommodation facilities, garbage and visual pollution and high noise levels are often big concerns for medical tourists. The congested rooms of hospital give a tough time to the medical tourists and accommodation of the accomplice is often ignored. A tourist in Kerala came from Washington D. C expressed her frustration to the author with the Indian toilet facilities and was anxious about his 4-year old daughter and his constant worry was "...if she gets sick?" Poor hygienic conditions, hygienic and ethnic food, Waiting time for procedures, overcrowding at the hospital, traffic problems, incidents of robbery, rape and harassment of tourists, cultural and language problems, political problems like demonstrations, strikes, and terrorism will give a very poor impression to the visitor and his experience and satisfaction will not be favourable.

Ben-Natan et al. (2009:4) identified the following challenges associated with MT.

- Cultural barriers and language, including medical jargon, may be problematic, even with the assistance of interpreters. Serious misunderstandings may occur on both the part of the patient and the provider.
- Quality of the hospital environment: Patients should carefully assess the quality and the standards that they expect and have been promised. This assessment should include the environment outside the hospital. In some countries the quality of the water and the air, as well as hygienic standards, may be quite different from patients' expectations and may compromise their convalescing situation.

- Selecting the best possible destination for the specific service(s) needed. It also remains a daunting task for patients considering medical care abroad to differentiate between desirable destinations from those that have incompetent practitioners working in unsafe facilities. Some help may be gained from medical tourism agents who have backgrounds in healthcare, and who are knowledgeable regarding the quality and outcomes of care achieved in different countries and by different medical institution abroad.

Conclusion

There should be a patient-focused approach which can ensure proper caring and after care of the patient without any legal problems. Cross cultural sensitivities must be handled with utmost care. Service quality of the hospitals and infrastructural services at the destination are to be improved for achieving a higher degree of patient satisfaction. Formulating and implementing medical tourism laws and policies with particular emphasis on accidents and risks and medical insurance should be a priority. There should be a conscious effort from policy makers and stakeholders of each destination to market and promote the unique and appropriate tourism products to each medical tourist so that they have a convenient and comfortable rest and relaxation after their initial treatment. Like tourist visa, medical visa formalities should be simplified and the government should consider E-visa or on arrival policies considering the very nature of the patient and should ensure fast track system in all the formalities concerned with medical tourists. There should be a proper mechanism to check the reliability of the websites. There should be a protocol for standards, quality and cost which will eventually lead to some sustainable development.

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Self Perceived Well-Being and Quality of life of People in a Water Scarce Village in India

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Abstract

Water is the elixir of life and forms an indispensable part of all natural and societal systems. It has been widely acknowledged that the health and socio economic development of a community depends on the availability, quality and management of its water resources. Water scarcity not only has a direct debilitating effect on health through a host of associated diseases; it also has an indirect but significant bearing on the perceived well-being of individuals. The foregoing study is steered towards the effect of water scarcity on the perceived health status and quality of life of a group of people in a rural village in Mewat. This study is based on an inductive approach, focus group discussions, participatory exercises and dialogue with key informants as primary modes of data collection. The data was sorted and analyzed through latent and manifest content analysis. This methodology resulted in appreciative inquiry and situated knowledge based on residents' subjective viewpoints. All the participants in the study setting, are perceived to have a poor quality of life due to financial constraints resulting from precarious livelihoods and poor health status, both being primarily attributed to water scarcity. It was revealed that the studied village had no freshwater source. The farming households practised rain fed agriculture, keeping them in debt and penury. The water for everyday requirements was obtained primarily by women and children from far off villages, taking a toll on their effort and productive time. In lieu of less water, open air defecation was practised, compromising on sanitation and personal hygiene. This resulted in drudgery, with serious repercussions like bouts of infectious diseases in women and children, fatigue, school absenteeism, physical abuse, domestic violence and migration. The respondents, mainly Meo Muslims, perceived that water paucity also hindered the performance of daily cleansing religious rituals. They reported water scarcity as the main reason for their physical, mental and social health problems and a major obstacle in their well-being and socio economic development. The secondary data also yielded information on a plethora of problems in terms of inadequacy of physical infrastructure and amenities, inaccessible health care facilities and meagre natural capital in the entire Mewat district,

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Haryana. The study concludes that water is an explicit component of health with clear implications on both the people's quality of life and psychosocial well-being.

Keywords

water, well-being, quality of life, Haryana

Introduction

The term 'well-being' is widely contested with distinct meanings to different people. In its broadest sense, well-being refers to "everything important to peoples' lives," ranging from basic elements required for human survival (food, water and shelter) to the highest level of achievement of personal goals and spiritual fulfilment (Maslow, 1954). Conventionally, it has been viewed as a physical need deprivation due to private consumption shortfalls (Schaffer, 1996). The contemporary participatory and qualitative approaches focus on a much broader conception of ill-being/ deprivation including, "physical, social, economic, political and psychological/ spiritual elements" (Chambers, 1995: vi). The holistic concept of the well-being of a person has been the core of the main work of some authors like Amartya Sen (1999:70) who argues that even though it is common to "use incomes and commodities as the material basis of our well-being...what use we can make respectively of a given level of income, depends crucially on a number of contingent circumstances, both personal and social." Hence, the concept of 'well-being' is firmly anchored in a particular social and personal context. In this sense, well-being should increasingly be understood as a multidimensional phenomenon ranging from income to the public provision of goods and services, access to common property resources and other intangible dimensions such as clean air, water, dignity, self-respect and autonomy (Razavi, 1999).

Shin and Johnson (1978) contend that well-being is an assessment of a person's quality of life according to his or her own chosen criteria. The World Health Organization (WHO, 1999:3) defines quality of life as:

"an individual's perception of their position in life in the context of the culture and value systems in which they live in relation to their goals, expectations, standards and concerns. It is a broad concept affected in a complex way by a person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment."

According to Felce and Perry (1995), well-being and quality of life stem from the degree of fitness between an individual's perception of their objective situation and their needs or aspirations. In the current development rhetoric and practice, virtually every realm of public policymaking and service delivery across nations is influenced by notions of well-being and quality of life.

Water, encompassing every aspect of our daily lives, forms an indispensable part of all natural and societal systems. History is replete with examples of how water is vital for human development. In view of its great versatility as a substance, it is unquestionably linked to sustenance of health, well-being and quality of life. The health and socio economic development of a community depend on the availability, quality and management of its water resources. Since water is the elixir of life and because safe water is a crucial component of health, the issue of water availability and access is a matter of survival for humanity. The UN estimates that by 2025, as many as 5.5 billion people, the two-thirds of the world's population, will face water shortage. The degradation of water quality may further worsen the imbalance

between water supply and demand, threatening the sustainability of life in an increasing number of regions (UNDP, 2001).

India is also facing a looming water crisis. The rural population in the country comprises more than 700 million people residing in about 1.42 million habitations spread over 15 diverse ecological regions (Khurana and Sen, n. d). It is true that providing drinking water to such a large population is an enormous challenge. The health burden of poor water quality is enormous. It is estimated that around 37.7 million Indians are affected by waterborne diseases annually, 1.5 million children are estimated to die of diarrhoea alone and 73 million working days are lost due to waterborne disease each year (Khurana and Sen, n. d). The resulting economic burden is estimated at \$600 million a year. It is expected that by around 2020, India will be a 'water stressed' state with per capita availability declining to 1600 cu m/person/year (Gupta et al., 2006).

Disparities in the availability of safe water constitute one of the primary underlying determinants of global health inequalities, recognition of which has inspired one of the Millennium Development Goals to halve the number of people without sustainable access to improved drinking water. Water scarcity has a direct debilitating effect on health through resultant food insecurity, a host of associated diseases and compromised hygiene and sanitation. According to the World Health Organisation, approximately 250 million individuals were diagnosed with a water-borne disease at the dawn of the twenty-first century. Of the 250 million, 75 per cent of these individuals lived in tropical rural or slum-like areas (UNICEF/WHO, 2000).

Scarcity of potable water has an implicit bearing on the perceived psychosocial well-being and quality of life of individuals. The foregoing study is steered towards exploring the multidimensional nexus between water and its varied manifestations on livelihood options, health, socio-cultural identity, religious rituals, daily routine and social relations, as perceived by the people in a water scarce rural community.

Study Locale and Methods

The study presents the case of Lafuri, a village in Mewat district of Haryana. Mewat is a district in the southern part of Haryana, contiguous to the National Capital Region of Delhi. The district has five Blocks (Tauru, Nuh, Punhana, Firozpur Jhirka and Nagina) spanning over 1, 499.46 sq. km and accommodating a total population of over one million (MDA, 2009). The Meo Muslims, account for 70.9 per cent of the total population and are numerically strong. They are listed under the OBC (Other Backward Classes) category being recognized as part of the backward class communities. The district is predominantly rural in its demography, having 88.6 per cent rural population, with just six towns and around 491 inhabited villages. The literacy rate recorded in district is 56.1 per cent, which is much below the national average and the female literacy rate is further low at 37.6 per cent. It also has a low sex ratio of 906 as against the national average of 927 (Census 2011).

The region also has very low geographical endowments as it falls under sub-tropical, semi arid zone with extreme climatic conditions, characterized by low and erratic rainfall as well as violent squalls and sporadic droughts (MDA, 2009). The land area in Mewat has uneven topography of plain and undulating patches dotted with hillocks and sandwiched between two parallel ranges of Aravalli hills. The lack of water resources, prevalence of sodic lands, sandy soil and brackish underground water have been widely reported in Mewat. The surface water is scarce and the groundwater recharge is also difficult due to topography (Gandhi and Kumar,

2009). The average level of ground water development in the district is 75 per cent and falls in critical category (Chauhan et al. 2007). The natural resource limitations are a major reason for economic uncertainty and distressed livelihood situation across the entire district.

This study is based on an inductive approach and utilized focus group discussions, participatory exercises and dialogue with key informants as primary modes of data collection. The field data was sorted and analyzed through latent and manifest content analysis. This methodology is based on an appreciative inquiry and situated knowledge based on residents' subjective viewpoints. It was assumed that this local grounded research would reflect on local idioms of stress and suffering associated with water scarcity along with the physical access constraints. Its chief goal was to identify expressions or elements that related water to important domains of health and psychosocial well-being. In order to encourage candour, participants were asked to deliberate on issues such as time required to collect water, queuing time at its source, quantity collected, seasonal variations, community assets, division of labour, obstacles to water access, opportunity costs of water collection, and measures taken to economize on water use not in terms of their own personal feelings but in relation to the feelings of the community in general. Secondary data was also used for a rigorous factual analysis.

Results and Discussion

Demographic Characteristics of the Selected Village and Saliency of Water

The village Lafuri is situated in the Punhana block of Mewat district. As per Census 2011, the village comprised of 468 households with predominantly Muslim population (97%). This is in line with the fact that in the state of Haryana, Mewat also has the largest concentration of Muslim population (IIHD, 2008). Since, religion and caste have an important bearing on the socio economic status of households, the high concentration of Meo-Muslims, minorities classified as OBCs, also indicates a higher level of denied opportunities for socio economic development. The Hindu households reportedly belonged to Scheduled Caste (SC) category and addressed their clan as *Valmiki* or *Harijan*. The Census 2011 data further revealed 33 per cent BPL households in Lafuri. Several families living in one room hutments in a dire state of penury were also observed during a transect walk through the village.

It was articulated in one of the discussions with the village elders and from the opinion of the leaders, that Islam as a religion ascribes the most sacred quality to water as a life-giving, sustaining, and purifying resource. Fazlun (2002) has also mentioned that the Qur'an and the *hadiths* contain a remarkable number of specific statements about water such as "water is the origin of all life on earth, the substance from which God created man" (Qur'an 25:54). He further stated that the Qur'an emphasizes water's centrality as: "We made from water every living thing"(Qur'an 21:30). Moreover, water has a specific religious significance for Muslims through *wudu* (ablution) and *ghusl* (bathing). The Muslims are expected to clean up with water through ablution at least five times a day. And, as the prophetic tradition prescribes, they are also expected to perform a ritual bath on Fridays in preparation for *SalatulJum'ah* (prayers). An old man affirmed:

"Without water, it is difficult to observe *Salat* or to fast in Ramadan, we are helpless, there is no water to drink, how can we wash regularly. "

Thus, unavailability of water hindered the performance of religious rituals in most Meo Muslim families across the village. Even in the *Masjid*, a small bucket of water was placed every morning as a service by neighbouring households in rotation.

The village also had around three per cent women-as the head of the families. These households reportedly belonged to widows who received a paltry monthly pension (Rs. 750) as maintenance by the State Government and were found to be surviving within finer margins, having low levels of education, fewer assets—less land, less livestock and fewer personal possessions. It was put forth in the discussions that labour opportunities within the village were much sought after by these women; however, water collection grabbed a significant portion of their productive time and effort, which could have possibly increased their finances through some other gainful employment.

Another three per cent households had disabled members with a pronounced physical deformity of limbs. Ignorance and lack of healthcare infrastructure were cited as the primary reasons that led to their health disability. In the absence of any freshwater source in the village, the water scarcity exacerbated the vulnerability of such households since water had to be procured from other villages, 3-5 kms away, making it extremely tedious for the family members.

Livelihood Patterns in Context of Water Scarcity

The livelihood profile of the community was ascertained from the *Sarpanch* during discussions. It was found that a great majority of households (96%) were engaged in farming and 85 per cent households also had members working as casual labourers. Although, land is a vital indicator of the economic status of people, these were primarily small and marginal farmers owning land ranging from 0.5 to 2 acres and practise drained agriculture. Most farmers were engaged in mono cropping of wheat. The coarse grains bajra and jowar were grown in kharif season as these crops required negligent to nil irrigation. Very few farmers diversified into vegetable crops like brinjals, tomatoes, onions and chillies due to lack of irrigation facilities. A considerable number of these peasants also worked as casual labourers for a major part of the year. There were two main reasons for this. One, their land was just enough to meet subsistence needs and not much yield was produced to be marketed to fetch income. Secondly, the rising cost of farm inputs, particularly water for irrigation, being not readily available (erratic rainfall and all underground water in Lafuri being brackish), pushed the farmers to look for alternate livelihoods.

To cope with freshwater deficit, saline water was used by some marginal farmers for irrigation. A farmer asserted,

“We are irrigating our fields with brackish water, I won’t lie, since I know it will make the land saline, but I don’t have money to invest in laying a pipeline, I can’t even think about it.”

As evident from this piece of narrative, the poor farmers admitted not having enough cash to lay pipelines for availing fresh water for irrigation from other locations. Thus, they expressed helplessness and resorted to using brackish water for irrigation. This could have a negative effect on the soil health since use of saline water enhances salinity and renders marginal soil as wasteland. Subsequently, this will deteriorate the land parcels and have a deleterious effect on the farm's livelihood for all the households in the near future.

The village also had 10 per cent households with migrant family members. These were mostly the cases of temporary migration in the absence of secured livelihoods and inability to farm due to lack of water. Some migrants apparently worked as rickshaw pullers in the urban centres at nearby Gurgaon, Faridabad and Palwal districts. It was also found that some families migrated to Punjab for a few months during the cotton harvesting season. The young boys

unanimously asserted discontent with farming and expressed the desire to abandon lands for right opportunities elsewhere. A commonly echoed sentiment by these youngsters was,

“Investing in land and agriculture is futile, demands more investment and there are fewer returns, it is of no benefit to us.”

The crisis situation due to water scarcity created deep-rooted desperation and pessimism among farming households. Although the previous generations could to some extent, combat the hostile environment and established themselves as cultivators due to their sheer will power. However, instead of farming, the youth preferred migration and seeking of work outside the village. Some have already begun learning to drive heavy commercial and construction vehicles like trucks, and earthmovers for mining activities, which are purportedly rampant in the Aravallis across Mewat. Although acquiring a skill enhances livelihood options and employability, but abandoning lands altogether may hamper food security in the long run.

Almost 75 per cent households in Lafuri also kept livestock. Sale of milk to private milk vendors was referred to as an important means of livelihood for these families. The lack of fodder and feed as well as potable water delimited their livestock holdings. The only pond in the village was initially used for bathing cattle but in view of its high salinity, it was gradually rendered unuseable /into disuse. The two handpumps in the village were also defunct since groundwater was also excessively saline. The upkeep of animals, being a primary responsibility of Meo women, apart from managing other household chores, to fetch water for animals further increased their drudgery. An old Meo woman highlighted the plight,

“There is not a drop of drinking water in the village, people and animals are all frustrated, how much can we fetch from the other village, they often object, we are dying of thirst.”

Her words signified the suffering and routine drudgery because of lack of potable water in the village. Dependence on their neighbouring villages was also not looked upon in good light and this reportedly resulted in bickering and conflicts on a daily basis.

Effect of Water Scarcity on People's Perceived Health and Well-Being

The study found a stark picture of water scarcity as a major source of stress in people's lives and more particularly for women. It was determined through community level discussions and informal observations that the main responsibility for water collection was held largely by women, although children, especially girls, also contributed as per the study community. The women were observed carrying water along their backs or over their veiled heads in earthenware pots whereas children more often carried water in plastic buckets or cans. They asserted that use of heavy vessels for carrying water together with the rugged terrain that characterizes the region makes water collection extremely tedious, physically demanding and an exhausting task. Along with bodily aches and pains, the negative feelings of anxiety and stress were widely reported by women across all groups. Most of the women asserted that they had no choice in this regard for water is needed for all household chores from washing to cooking and for the livestock, in fact for all tasks that they were responsible for at the home front.

The men folk also claimed that they helped ferry water on bicycles and motorcycles in their free time. Many laughed off at not having taken a bath for days together, this was done to save water for other important things. Some also admitted having to curb their thirst many times or drinking from contaminated sources, which perpetuated gastric problems and affected their physical health adversely. A few men admitted that they used saline water from the village hand pumps for ablutions and bathing, but it reportedly led to skin problems and eruptions.

It was further revealed that young children, particularly girls are also engaged in hauling water. For this, children often dropped out from school to help their mothers with this daily chore, so that fewer trips are made to other villages. The formal education of girls is already a culturally neglected domain in Mewat, and precarious water availability further fuelled it. The village had a functioning primary school (albeit, with only two teachers), where children were sent mostly for the lure of mid day meals. Girls were reportedly withdrawn as they attained puberty and were not allowed to pursue further studies. Almost all the women who took part in the discussions across the village, had never been to a formal school. Some claimed to have received '*Deenitaaleem*' though, at the *madarasas*. Frequent school absenteeism of young girls adversely affected their educational performance and achievements. Lack of access to water thus turned out to be an obstacle to their right to have access to formal education.

Lack of sanitary facilities and toilets was also observed in the studied village. When probed, people opined that they preferred open defecation since it saved water. Women found it as a source of extreme tension and shame. They revealed that they were forced to relieve themselves at dawn or late at night. Despite being aware of the government's Total Sanitation Campaign and provision for subsidized construction of toilets through Employment Guarantee Scheme, the Sarpanch remarked that the people did not show any sign of affirmation towards getting the household latrines constructed.

Apparently, the young girls and women also had to compromise on menstrual hygiene. Lack of hygiene and exposure to fecal contents on daily basis multiplied their risk to infections and consequent sickness. The health worker in the village revealed that diarrhea cases as well as vector borne diseases, particularly malaria and dengue, were widespread among children and adults alike. In the absence of effective health care infrastructure and lack of preventive measures, these diseases increased morbidity and mortality manifold.

The older women also were wary that young adolescent girls, while travelling without adult male accompaniment to other villages, located far away, run the risk of being abducted, molested, assaulted or raped. One of the women, during focus group discussions, commented on the helplessness of the women folk and young girls:

"Girls are in danger when they go to fetch water, if some thing wrong happens on the way, we won't be able to do anything for them, as no one will help."

Some young girls also shared being teased by boys of other villages, when they go for fetching water. Thus, they expressed living and working in constant fear. It is pertinent to mention that these girls and young women come from patriarchal families with little or no education and are not exposed to the world outside their village periphery. This is also evident from the fact that there was just one household with television in the entire village and media penetration was absolutely absent. In such a context, the negative and stressful social experiences instilled lack of self esteem and immense anxiety in them.

Impact on Social Relations

Focus on the group discussions showed that the lack of access to water sources strained the community ties often. Disputes with neighbours and within family were commonplace on account of water collection, ferrying, sharing and usage. One lady asserted, while indicating the double drudgery of work and domestic violence associated with water, that most women routinely faced:

"How can I work at home when I'm going to fetch water, only when I get water I'll be able to cook and serve, my husband doesn't understand this and hits me when I serve food late."

Some other reasons mentioned for conflicts with neighbours over the issue of water were disrupting queues at the source, giving preference to friends to fetch water at the expense of others, fetching water in more containers at a particular time, and stealing or hoarding water. Some households, with better affordability, also reported purchasing water from private tankers and stored it in an underground or overground structures, built in the homestead. This water, although not always was found of acceptable quality, nevertheless, was scantily used for cooking and drinking purposes. It was observed that people had put locks on the water storage tanks for the fear of their purchased water getting stolen. This adversely affected both mutual trust and cohesion among community members and created an atmosphere of mistrust, stigma and conflict in the village. Some families even sold or traded this stored water with others in lieu of cash or kind, as and when needed.

The discussions also illuminated feelings of shame at the idea of appearing dirty in the eyes of others, failure to perform customary acts of hospitality and restraining from taking part in certain religious or communal events due to paucity of water.

Conclusion

The studied village located in the semi arid Mewat region, faced extreme temperatures, erratic rainfall and an acute water deficit. The village was also beset with low natural endowments, particularly, saline soils and brackish groundwater. It was further characterized by lack of food security and negligent economic opportunity for the inhabitants. Small landholdings, due to the lack of water resulted in low productivity which led to disguised unemployment. People were found relying on a combination of rain-fed agriculture, livestock rearing and other casual labour activities to sustain themselves. Sporadic droughts and dry spells were widely reported which further increased their vulnerability. The problems associated with water resources were paramount and significantly affected their individual and collective health and well-being. This was the key concern explored in the present study.

The study reiterates the importance of understanding community concerns and subjective well-being to be informed to concerned authorities for development interventions. Access to potable water having been recognized as a high priority need in the studied village community, strengthening water infrastructure, desalination of existent sources, revival of traditional harnessing structures, rainwater harvesting and adequate conservation and management practices in tandem with the socio cultural context, could be some of the measures to improve the water situation. The key message to emerge from this study is that water scarcity has both, direct and indirect implications on physical, psychological and social well-being. It is important to take into cognizance that the struggle for water is not only for access to a resource, but also for the quality of life and well-being of all human beings on which they have an indisputable right.

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Social Engagement and Meaningful Activities of Persons with Dementia: Some Best Practices in Kerala

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Abstract

This study was conducted to explore the practical techniques and strategies identified and developed by families for caring persons with dementia which will have a wider implications in families, institutional settings, developing training modules and practice guidelines in the field of quality dementia care. It is a qualitative study using the case study pattern / design. The ambit / sphere of this study are the families of the Kottayam district of Kerala having persons with dementia, who are taken care of within the families. Purposive sampling was employed selecting six families with good care practices as samples for the case study. These families were selected by consulting doctors and social workers working in association with ARDSI (Alzheimer's Related Disorders Society of India), of the Kottayam Chapter. Primary data for the study was collected from the family members (primary caregivers) of the persons with dementia and interview schedule was used for data collection. Even though the family caregivers in Kerala are not trained for providing care they have developed their own strategies and techniques to engage persons with dementia in activities that have some personal meaning and importance. All the good practices identified have already been proved effective by the families through years of practice, so these practices can be used in various different settings of dementia care for quality results.

Keywords

dementia, good practices, social engagement, Kerala

Introduction

Population ageing is a phenomenon occurring when the median age of a country or region rises due to rising life expectancy and/or declining birth rates. Initially this factor was common in the more economically developed countries, it has in the recent times started to affect the less economically developed countries especially in Asia, Latin America and Africa (UNHDR, 2005). This has encompassed almost every country with exception of 18 countries designated as "demographic outliers" by the UN (UNHDR, 2005). UN has predicted that the rate of

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population ageing in the 21st century will exceed that of the previous century. Given that variations in terms of the degree and the pace of these changes, the UN expects population that began ageing later, will have less time to adapt to the many implications of these changes (UNDP, 2005).

India's population too is undergoing a rapid demographic transition now, and there will be a sharp increase in the number of the aged in its population. It is only natural that this rapid demographic change is happening alongside the fast paced social restructuring that usually accompanies economic development. This makes the task of meeting the needs more challenging and an urgent one for the older people. According to the 2011 Census, the total number of older persons in India was approximately 103.8 million and is expected to cross 173 million by 2026 as the life expectancy at birth is projected to increase to 69.8 years for males by 2021-25 (from 61.6 years in 1996) and 72.3 years for females (from 62.2 years in 1996).

It is also a well recognized fact that the number of older adults who suffer from dementia has been increasing and will continue to do so over the coming years. Dementia is primarily (but not solely) an affliction of the elderly, and the prevalence increases dramatically with advancement of age and will finally include almost a third of the population almost over 85% (Mahandra, 1984). Alzheimer's disease and related dementias (ADRD) are a progressive, degenerative illness usually affecting the mental abilities, emotions, behaviour and physical functioning (Patterson et al., 1999).

Dementia can create an overwhelming burden for family caregivers, negatively affecting their physical and mental health (Burton et al., 2003). The number of persons with dementia double every five years and India will have one of the largest numbers of elders with this problem. It is estimated that over 3.7 million people were affected by dementia in the country in 2010. This is expected to double by 2030 (Shaji et al., 2010). In fact, nothing short of a three-fold rise in the number of people with Alzheimer's disease is expected to occur between 2000 and 2050 (Zimmerman et al., 2005). Since an extensive epidemiological study of dementia has not been done so far in Kerala, an exclusive prevalence data is not available. Regarding the financial liability, it is estimated that the cost of taking care of a person with dementia is about Rs. 43,000 annually; much of which is met by the families. The financial burden will only increase in the coming years. The challenge posed by dementia as a health and social issue is of a scale that can no longer be ignored. Despite the magnitude, there is gross ignorance, neglect and scarce services for people with dementia and their families (Shaji et al., 2010).

Dementia: History

The term "dementia" was probably coined in the first century A.D. For the next millennium it was generally quite ill-defined and often used (along with delirium) to refer to insanity in general (Lipowski, 1981; Mahandra, 1984). It is also likely that no real distinction was made between dementia and the changes in cognitive function associated with normal aging (Mahandra, 1984). Early in this century, the term "organic psycho syndrome" was used by Bleuler to refer to a set of behavioural manifestations of chronic diffuse cortical damage. The behavioural manifestations involved decrements in memory, judgment, perceptual discrimination and attention, emotional liability, and defective impulse control (Lipowski, 1981). This was essentially the classification adopted by the American Psychiatric Association (APA) in the early editions of its *Diagnostic and Statistical Manual of Mental Disorders*. Specifically, the DSM-II defined "organic brain syndrome" as a "basic mental condition characteristically resulting from

diffuse impairment of brain tissue function from whatever the cause,” and it manifested behaviourally as an impairment in orientation, memory, intellectual functions, judgment, and affect (Lipowski, 1981). In this classification, brain dysfunction resulted in a single behavioural syndrome, regardless of the etiology and site of neuropathology (Lipowski, 1981).

Medical Model of Dementia

Dementia as a clinical syndrome is characterized by global cognitive impairment, which represents a decline from previous level of functioning, and is associated with impairment in functional abilities and, in many cases, behavioural and psychiatric disturbances. Several formal definitions exist, such as that of the ICD-10:

‘a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capability, language, and judgment. Consciousness is not impaired. Impairments of cognitive function are commonly accompanied, occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. The syndrome occurs in Alzheimer’s disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.’

There are a number of conditions that cause the symptoms of dementia. Alzheimer’s disease (AD) accounts for around 60 per cent of all cases; other common causes in older people include cerebrovascular disease (vascular dementia [VaD]) and dementia with Lewy bodies (DLB) (accounting for 15–20% of cases each). In some cases of young onset, frontotemporal dementia (FTD) is also a common cause, second only to AD. Numerous other causes exist, including other degenerative diseases (for example, Huntington’s disease), prion diseases (Creutzfeldt-Jakob Disease (CJD)), HIV dementia and several toxic and metabolic disorders (for example, alcohol-related dementia). Dementia also develops among 30–70 per cent of those people with Parkinson’s disease, depending on duration and age (Aarsland et al., 2003). The distinction between Parkinson’s disease dementia (PDD) and DLB lies in the relationship between motor and cognitive impairment. If dementia precedes, or occurs within 12 months of, motor disorder, DLB is diagnosed (McKeith et al., 1996); otherwise the convention is to use the term PDD.

Symptoms, Presentation and Patterns of Illness

Alzheimer’s disease (AD) usually manifests itself with loss of memory, especially for learning new information, reflecting disturbances in the function of the anatomical sites (medial temporal lobe and the hippocampus), which are the primary focus of pathological change. Later in these illness the other higher cortical functions (for example language, praxis and executive function) become affected and behavioural and psychiatric disturbances are seen. These have been referred to in literature in a number of ways, including behavioural and psychological symptoms of dementia (BPSD), challenging behaviour, neuropsychiatric symptoms and, more recently, behaviour that challenges. Such symptoms commonly include depression, apathy, agitation, disinhibition, psychosis (delusions and hallucinations), wandering, aggression, incontinence and altered eating habits. These are important because they are the frequent symptoms, which are often difficult to manage and cause great distress to individuals and care takers. They are stronger predictors, more than cognitive impairment of both carer stress (Donaldson et al., 1997) and entry to institutional care (Bianchetti et al., 1995). Sometimes AD

can manifest itself initially as a behavioural disturbance, language disturbance or praxis but these may also be manifestations of other causes of dementia.

Frontotemporal dementia usually comes to the forefront with language disturbance and/or behavioural difficulties (either disinhibition or apathy), whilst DLB is characterized by recurrent visual hallucinations, fluctuating cognitive disturbance and motor features of parkinsonism. Associated features in DLB are falls, disturbances of consciousness, autonomic dysfunction and rapid eye movement (REM) sleep behaviour disorder (McKeith et al., 2005). Vascular dementia (VaD) can occur after an acute vascular event (for example, a stroke) or subacutely and insidiously with progressive attentional and executive/planning problems, gait disturbance and apraxia, reflecting 'subcortical' frontostriatal dysfunction due to vascular pathology. Focal neurological signs are common (and their presence is required in some diagnostic criteria) just as in the changes of brain imaging, including cortical infarcts, multiple lacunae and extensive white matter change. Behavioural challenges are also common in VaD, with depression and apathy most frequently seen as part of it (O'Brien et al., 2003).

Social Model of Dementia

While the clinical model of dementia presented above describes the changes occurring within the brain, the way that dementia affects a person in day-to-day life will vary from one individual to the other. For many years, people with dementia were written off as incapable, regarded as little more than 'vegetables' and often hidden from society at large. During the 1980s and 1990s, there was a move away from regarding people with dementia as incapable and excluding them from society, and towards a 'new culture of dementia care', which encouraged looking for the person behind the dementia (Gillard, 1984; Kitwood, 1997; Kitwood and Benson, 1995). People with dementia could now be treated as individuals with a unique identity and biography and cared for with greater understanding.

Building further on this work, others (notably Marshall, 2004) have advocated that dementia should be regarded as a disability and framed within a social model. The social model, as developed in relation to disability, where understanding disability is not as an intrinsic characteristic of the individual, but as an outcome produced by a social process of exclusion. Thus, disability is not something that exists purely at the level of individual psychology, but is a condition created by a combination of social and material factors including income and financial support, employment, housing, transport and the built environment (Barnes et al., 1999). From the perspective of the social model, people with dementia may have an impairment (perhaps of cognitive function) but based on their disability results they are often treated by, or excluded from, society. For people with dementia, this model carries some important implications, for example:

- The condition is not the 'fault' of the individual.
- The focus is on the skills and capacities the person retains rather than loses.
- The individual can be fully understood (by his or her history, likes/dislikes, and so on).
- The influence is recognized of an enabling or supportive environment.
- The key value is endorsed of appropriate communication.
- Opportunities should be taken for rehabilitation or re-enablement.
- The responsibility to reach out to people with dementia lies with people who do not (yet) have dementia (Gilliard et al., 2005).

Social Engagement and Involvement in Meaningful Activities

There is evidence that engagement in meaningful social activities is related to quality of life for individuals residing in long-term care facilities (Gonzalez-Salvador et al., 2000; Hagen et al., 2003). For example, participation in activities such as music, exercise, or cooking is associated with less depression, better cognition, mobility, and balance, and lower mortality rates (Kiely et al., 2000; Koh et al., 1994; Marsden et al., 2002; Mitchell and Kemp, 2000; Turner, 1993). Further, allowing the concerned person's choice in activity programming is associated with their involvement (Hedley et al., 1994). It is often a challenge, however, to involve persons with dementia in activities and for them to be able to inform the caregiver of their preferences. This challenge may be especially notable in residential care/assisted living (RC/AL) facilities, which have become a predominant provider of long-term care. RC/AL facilities are non-nursing home residential settings that provide or arrange supportive and health care services for individuals who require assistance with daily activities (Kane and Wilson, 1993). Traditionally, they differ from nursing homes in that they promote a more social model of care (e. g., resident autonomy and choice in a home-like environment). Further, this social model of care, to which activity involvement clearly relates, is important to enhance the quality of life of persons with dementia (Dobbs, 2004; Mitchell and Kemp, 2000; Zimmerman et al., 2005). Given the difference in the RC/AL philosophy compared to nursing homes, these residents may have, and their families may expect them to have, higher activity involvement than residents in nursing homes (after adjusting for functional, cognitive, and health status). Thus, it is useful to understand resident involvement in activities to both facility care well as to the resident involvement, both generally and separately, for each type of setting. A scrutiny of the findings related to activity involvement, assessment for and availability of activities, and what types of resident and facility characteristics are associated with activity involvement may provide useful suggestions to improve care.

Persons with dementia have the opportunity to maintain and enhance their sense of dignity and self-esteem by engaging in meaningful social interactions throughout the day, every day. Caregivers require training and support to understand how to help PwD (Person with dementia) achieve this goal. Both formal and informal activities provide the PwD and the caregiver a sense of security and enjoyment. Formal activities are those that are typically found on the community activity calendar (classes, parties, discussions); informal activities are everyday interactions (a chat with a friend, a walk down the hall, a soothing bath). Meaningful activities are carried out by the foundation of dementia care because they help residents maintain their functional abilities and can enhance their quality of life. Every event, encounter or exchange between residents and staff is a potential activity. For example, dining is a meaningful opportunity for socialization, enjoyment, satisfaction and self fulfilment. Access to personal space and opportunities for free time to relax are essential elements for enhancing quality of life. There are three care goals in this area according to Alzheimer's Association USA. 1) To offer many opportunities each day for providing a context with personal meaning, a sense of community, choices and fun. 2) To design interactions to do with — not to or for—the resident, and 3) To respect resident preferences, even if the resident prefers solitude.

Design and Methods

The major objective of this study was to identify good techniques and strategies developed by each family in taking care of persons with dementia based on different conditions of the family such as age of the person with dementia, behavioural patterns, nature of the disease, other age related physical problems, environmental factors, economic conditions, educational and vocational status of other members, including the total number of family members. One of the six specific objectives of this study was to explore the good practices to engage persons with dementia in activities that will have a personal meaning to them.

Each family has a unique system of caring for persons with dementia. So a case study method is employed for this study. The objectives of this study demands an in-depth study of each family and every minute technique and strategies developed by them are explored in this study. This is a qualitative study, regarding the good care giving techniques and strategies developed by families themselves which so far have not been scientifically studied and recorded properly. The area of this study are the families of Kottayam district having persons with dementia, who are cared for by the families themselves. The researcher employed purposive sampling. He had identified six families with good care practices as samples for a detailed case study by consulting doctors and social workers working in association with ARDSI (Alzheimer's Related Disorders Society of India), Kottayam Chapter. Primary data for the study was collected from the family members (primary caregivers) of the person with dementia and an interview schedule was used as the tool for data collection. Data analysis and interpretation was done using the methods of qualitative researches like acoustic recording and transcription. These interviews were recorded using the audio recorder. Based on the transcription, the case history of each patient was formulated and interpretations were made from it.

Results

Those cases with relevant and good visible practices are the ones given the priority care area for 'making these persons with dementia engage in some meaningful social activities' and only these are included in this article. So only five cases are being discussed here briefly. Specifically identifying only those social activities that have a personal meaning to the person with dementia (PwD) is an important task for the family which demands some skills from the caregivers. So the primary caregiver and his strategies are given focus in these case studies.

Case 1

Mrs. A is a 40-year-old housewife, who is the primary caregiver of her mother-in-law having dementia. Her husband is a shop keeper working in a vegetable shop. She has two children (girls), both school going students, studying in 9th standard and 6th standard. Only she will be there at home during the day time to take care of the patient, since her husband has to go for work and children have to go to school.

The grand mother is 73-years-old and she started showing symptoms of dementia at the age of 68. At the onset of the disease, she had a severe wandering tendency. She went out of the house and walked to distant places without any orientation. She woke up early in the morning between 3 and 4 am and went out, saying that she was going to church. She had a tendency to clean the premises of the house with the broom until the broom got damaged. Once she fried fish using kerosene instead of coconut oil. After that incident she was not allowed to cook. When she was asked to stop cooking and entering the kitchen, she became emotional and cried for hours. It might be because, she may have enjoyed cooking and she was famous for her skills in cooking. She became hyper active and destroyed a sewing machine and a chair. She took all the objects including the learning materials of children and hid it somewhere. All these behavioural problems led the family to consult a doctor and thus she was diagnosed as having Alzheimer's disease. Presently she is calm, speaks less, most of the time simply sits on a chair in the sit-out, occasionally walks along the bed room and sit-out. If we ask her a specific question she will respond, but it may not be the correct answer to the question.

This person with dementia (PwD), once busy with all the household chores and having frequent interaction with neighbours and relatives, the family realized and identified that it was difficult for her (PwD) now to be always confined inside the house. Hence, Exit seeking was a frequent tendency. The family members consciously gave several opportunities to her (PwD) to go outside the house with random monitoring. The grand children too have an important role to play in the monitoring. They take the PwD to the nearby house of their relatives; assist her (PwD) to walk along the road and nearby premises. The presence of children was found to be very useful in making the person engage in activities. The children make the grandmother (PwD) engage herself in games and they continually motivate her (PwD) to participate in it. It was noticed by the family members that their presence makes the person happy and comfortable. The positive impact on persons with dementia- both cognitive and affective, created by the presence of children opens doors for further studies and experiments.

Case 2

Mr. B is 67-year-old retired Indian Navy officer, who is the primary care provider for his wife who is at the primary stage of dementia. She is a retired primary school teacher of 65-years-old. She started showing symptoms two years back and was diagnosed with primary stage of dementia. She forgets the names of the close relatives while talking about them. Sometimes she forgets the recipe of the food items while preparing food. The wife and the husband are staying alone in a house. Their only son and his family stay abroad. The family hired a housemaid; she comes twice in a week and does the major household work. Other daily work such as cooking and cleaning are done by the husband and wife together. Being in the early stages of the disease, there were no serious difficulties and symptoms. Both the husband and wife have a good relationship; mutually understanding and supporting each other. While cooking, the PwD forgets the ingredients needed and confuses it with the recipe of some other items, which creates anxiety. So they prepared a hand written recipe book describing the preparation method and ingredients needed for all the items they cook and placed it openly in the kitchen. This has increased the courage and confidence of the PwD when she enters the kitchen.

The awareness among the other family members about the importance of making the PwD engaged in an important activity is a positive factor in providing quality care. The family where the husband consciously organized all the necessary facilities and made it available for the wife (PwD) to keep her engaged when she was diagnosed in the early stages of dementia, is a good modal. Both the husband and wife are mutually supportive and do all the household work together, including cooking. Cooking is a productive activity which provides satisfaction and ample opportunity to be engaged and to interact with other members (applicable only for early stages of dementia).

They watch TV programmes, especially spiritual programmes on religious channels, read news papers and religious magazines together. The moral support and presence of the husband in all the interested activities of the person having dementia is worth commendation. The PwD is noticed to be very comfortable in the husband's presence. The love and affection shown by the husband is the true motivation for the person with dementia to continue with her interested activities. In this family, the caregiver employs a supportive care giving strategy which has been found to be very effective in keeping the patient comfortable, confident, engaged and free from confusions due to mild cognitive impairment and memory lose.

Case 3

Mrs. X is a 42-years-old house wife, who is the primary caregiver for her father-in-law having dementia. She was a school teacher and now she has resigned from her job to take care of her father. Her husband is a journalist and has been working for a newsdaily for the past seven years. She has three children, one of them studying in the degree college another for, plus two and the third one is in the 9th standard. Now the family comprises of six members, father, mother, three children and the grandfather who is having dementia. The PwD is 66-years-old and he started showing symptoms of dementia at the age of 60. He is a botany degree holder and had worked as a lecturer for 30 years. After his retirement he was actively involved in social activities. He was the member of a resident association and was actively participating in many social services. He was also the member of a local public library. Reading was the happiest hobby for him. He loved to spend his free time with the children and he used to teach them also. Slowly he started showing symptoms of dementia. He started behaving like the children. He loved to spend all the time with the children and even tried to play cricket with his grand children. He developed a strong desire for chocolates. He suffered from loss of sleep and he seemed to be restless throughout the night. He forgot the alphabets and so began miss reading the newspaper. His manners deteriorated, and he often stuffed his mouth with food, often choking at the dining table. He insisted on eating food from his plate in a specific manner, often with his hands. The family decided to consult a doctor and he was diagnosed as having Alzheimer's disease. Towards the later stage, day to day activities became difficult. Over the months his short-term memory deteriorated. Severe gastrointestinal problems including diarrhoea led to dramatic weight loss. Depression was increasing. He spent most of his time on the bed. Mrs. X, the primary caregiver and the daughter in-law of the person with dementia, resigned her job to take care of the patient. Only she was at in the home during the day to take care of the patient.

The family gave strong support to the patient. All the members tried to be with the patient and make him comfortable. They started giving more attention to him. They also made some environmental changes in the home. Firstly, they shifted him to a room opposite to a garden which provided more light and air circulation. The family tried to give some physical activities to him to keep him occupied (PwD). In the evenings they would make him walk around the garden. The grand children would speak to him and help him speak about his interested topics. He likes to hear stories, so the children would play an important role in it. The caregiver would read the newspaper loudly for him. The family would go for a monthly outing with him. The usual places of the outing was the park and a school ground near the house. This was found to be an interesting activity that made him happy and energetic.

Case 4

Mrs. C is a 56-year-old house wife, who is the primary caregiver of a person with dementia who is 89-years-old. The patient is the mother in-law of Mrs. C. There are five members in that family—Mrs. C, her three girls and the patient. Her first daughter got married, the second one is studying, and staying in a hostel and the third daughter is going to school and stays with the mother. No information about her husband is available, because she did not want to discuss about him and got emotional when she was asked about him. So now she and her daughter together provide care to his mother.

The patient has been showing symptoms of dementia for the last two years. Sometimes she shows aggressive behaviour. She uses abusive words towards the caregiver, spits on her, and throws away food. She remembers several minute details of events of her younger years, but has little knowledge about the later years. She was a good singer, a person with a sense of humour and a spiritual orientation. She remembers old love songs, rhymes and devotional songs which she sings occasionally. She studied up to the 4th standard and has good general knowledge. Now she is very talkative, speaks very loudly, will respond to all questions which may be provocative and aggressive at times. The patient has seven children, two girls and five boys. Her husband died 10 years ago. Now she is staying with the wife/ the daughter -in law of her third son.

The PwD sings old songs and comic rhymes which she had sung in her younger days. When the children ask her for more songs, and motivates her she responds at times. The possibilities of art can be used effectively for engaging the patients. One who has an interest in art will have that interest at all her stages of life; even dementia seems to have minimum control over it. The opportunity provided by the family to the patient to interact and to be social is an important factor. In this family, the patient is in a room where there is a window which opens to a private road. She can see the neighbours passing through the road with whom she was friendly earlier. Whenever she sees someone, she calls them and talks to them (may be meaningless talk). Neighbours are ready to come close to the window and talk to her. This is an activity which she enjoys.

Case 5

Mrs. D is a 49-year-old school teacher who is the primary caregiver for her mother-in-law of 90 years. She is a qualified teacher (BA, BEd.) working in a nearby school. There are seven members in this family—father, mother (PwD), her husband and three children. Father is 92-years-old; he is still healthy and has no much physical problems. Husband is an officer working in the employment exchange. Two children are working in Bangalore and the younger daughter is studying in school. Thus two children are not available to the family but the other members are present.

The mother started showing symptoms of dementia at the age of 87. She has no formal education and was a house wife. She was diagnosed as having dementia at the age of 88. She has some past memories and her present behaviour has some link with her past. She wants to go out (exit seeking) for feeding hens, goats and pigs. Now these animals are not in the house. There is a busy road just in front of the house. So the family placed a spilt layered door facing the room towards the courtyard. The lower layer will be closed and it prevents her from going outside. But she can watch travellers and vehicles from the top portion of the door which is kept open. She was very religious and was very keen in observing all the important religious days and festivals.

Religious practices provide room for keeping the patient engaged. The PwD had a habit of reading the Holy Bible before the onset of the disease. So the Bible was placed beside the cot and she reads it occasionally, even though the caregiver doubts whether she understands any of the material she reads. The observation of important days and festivals provides the person with dementia an opportunity to interact with others and it makes her more social and engaged. Since

the PwD had a habit of observing all the important days, both religious and traditional festivals like Onam and Christmas; the family provides special attention to her so as to remind the PwD of those days by encouraging and facilitating her to observe these days. They celebrate it with the purpose of making the grandmother (PwD) happy and the family identifies it as a cheerful experience and a meaningful activity for their grandmother.

Conclusion

The personal meaning of activities is usually associated with the earlier experiences of life the person with dementia had in, his/her vocational history and educational background. One, who was very active and independent in their 'pre-dementia' stage /life, may find it difficult to adjust to the 'present' controlled life situations. A person with dementia is capable of finding meaning in the 'present' life situations and can also derive significance and importance in it if the caregiver recreates situations from their past history.

The family caregivers in Kerala are not trained for providing care; but they have developed their own strategies and techniques to provide maximum comfort to the patient. The findings of this study have a peculiarity that, all the good practices so far identified have already been proved effective by the families through their years of practice. A trial and error mechanism has already been applied by the families in each care giving strategy. The good, that has emerged and the relevance found in these specific situations should be used to find some universal applicability, therefore it would be worthy to study it universally.

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Development Programme

Community Radio for Change

Thomas Joseph Therakam*

The role of the community radio as a tool for developing / developmental communication has been widely discussed and debated all over India and abroad. Community radios are being looked upon as an alternative to the mainstream media because of its potential to address social issues at the grassroots level. Often the main stream media fails to reach the bottom line of the social strata and identify their core issues. This is where the community radio plays a key role; the role of a facilitator.

Radio Mattoli

Community Radio Mattoli (90.4 FM), the lone FM broadcasting radio station of Wayanad, located at Dwaraka, Mananthavady in Kerala is a community radio service initiated on 1 June 2009, and is licensed by the Union Ministry of Information and Broadcasting, New Delhi. Radio Mattoli functions as a socially responsible media with the prime objective of becoming a credible source of information that has direct and immediate relevance to the community living within its transmission zone. It provides farmers, tribals, dalits, women and children with an opportunity to speak out, and be heard. We have 17 hours of daily broadcasting from 6 am to 11 pm to cater to the information requirement of the people. Our radio signals cover 85 per cent of the Wayanad district, having a population of 816,558.

The programmes aired, open up possibilities for everyone especially the marginalized sections, to express themselves socially, economically, culturally and spiritually in order to become masters of their own destinies. We provide an avenue for the free flow of beneficial information aimed at bringing socio economic changes in the society. Radio Mattoli serves as a catalyst for integral development of individuals and societies, and operates as an avenue for the free flow of beneficial information aimed at bringing socio economic changes in the society.

The prime objectives of Radio Mattoli are:

- To provide a platform for the marginalized community to voice their concerns.

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- To act as a catalyst for integral development of individuals and society.
- To act as a harbinger of socio economic development of the community.
- To bring about a positive social change in the society.
- To enhance the knowledge 'spectrum' of the community.
- To cater to the information requirements of the community it serves.

What makes Radio Mattoli different from the other forms of media is its willingness to do the role of facilitator to make the authorities act on instances of public grievances. Radio Mattoli never shies away from taking responsibility as a media for social change. Radio Mattoli's interventions resulted in swift actions from authorities to address various issues.

Strategies as Development Communication Tool

Community Radio, one of the most dynamic tool for development communication has its own richness and importance as a versatile media. Radio Mattoli is the only FM broadcasting station in Wayanad. The prime objective behind setting up Radio Mattoli is to bring about a positive change in the socio, economic, cultural, educational development scenario of Wayanad district. The relevance of Radio Mattoli can be understood within the context of the findings by the Ministry of Panchayati Raj in 2006. The Ministry of Panchayati Raj named Wayanad as one of the country's 250 most backward districts. Since its inception in 2009, radio Mattoli has been donning the role of a harbinger of socio cultural and economic development of the society through its information rich programmes. Being a dynamic media, the Radio can reach the masses effectively. Its portability, and cost effectiveness make it an affordable source of information for all strata of the community. Radio Mattoli is not just a broadcasting station, but a true beacon of knowledge to the masses.

The needs of the local community which are often neglected by the mainstream media could be adequately addressed by this community radio through various participatory communication. Suggestions and contributions from the community add flavour to the content and enrich the radio programmes extensively. Radio Mattoli dedicates special slots during all religious festivals, to give equal representations to people from different faiths. Community participation towards programme making is immense here. Radio Mattoli has always been giving expression to people's thoughts/creativity by greatly encouraging the local community to be part of its programme making policies. This instills an emotional attachment, and a sense of ownership among the local community. Radio Mattoli has succeeded in winning the confidence and affection of the people in Wayanad as a credible media for social development. For the people of Wayanad, Radio Mattoli is a means to give expression to their voice 'in their own radio station.' This is the greatest recognition for us, which we value the most...!

We strongly believe that the true objective of a credible media is "To Convince, Not to Confuse." It takes great courage to use simple, crisp local language for presenting serious topics / issues in the broadcast media. For us, the proper understanding of the broadcast topic / issue by the listener is of prime concern; not the ultra sophisticated language being used. We can confidently assert that, it is this simplicity in the style of presenting the programmes that won us accolades from the public. People always opine that, this simplicity and warmth make them increasingly attached to Radio Mattoli. The feedback we receive from the public through letters and phone calls prove this fact. The expectation level of the Mattoli listeners is increasing each

day, and we are committed to meet it's a guide, friend, partner Radio Mattoli has always been with them; as one among them.

Radio Mattoli pays attention to the concerns / issues of the community. The main stream media often fails to recognize and address people's concerns at the grass root level. This is where Radio Mattoli becomes the cynosure of the common people.

Radio Mattoli functions as an alternative to main stream media. We always look deep into those areas which are often neglected by the main stream media. People of Wayanad depend upon Radio Mattoli for specific information/guidance that has a direct impact on their lives. The watchful eyes of Radio Mattoli never fail to capture the plight of the marginalized sections of the society. Radio Mattoli pays heed to the problems of the weak so as to provide possible solutions with its capacity as a media for social change.

Radio Mattoli truly understands that the prerequisite for bringing about a positive social change in the society, lies in the ability to understand the real pulse of the society. A society can find harmony only if its social chord is fine-tuned to perfection as far as social justice and social equality are concerned. Often, complaints of social inequality and injustice are mostly raised by the women folk in our country. Radio Mattoli takes note of this issue seriously. Ever since the inception in 2009, we have been constantly devising multi-pronged strategies to address this concern. We found that only if the marginalized sections in the society are instilled with confidence and assurance, then, they come out in the open to voice their concerns. To make them speak out, it is imperative to win their confidence. Participatory communication is the best strategy to win the confidence of people. By involving them in the communication processes, they get confidence to speak out and gain assurance that their voices are heard.

To ensure the engagement of the public in the various radio programmes, we constituted a panel of expert volunteers, accredited volunteers and student volunteers. Women, students, government employees, retired hands, and self employed people who represent different sections of the society constitute the panel of accredited and expert volunteers of Radio Mattoli. They contribute their services at different levels in the programme making of the radio. Besides, we encourage everyone in the society to come forward and participate in any of its aspect of community broadcasting for the social good of the people.

We employed multipronged strategies to ensure community engagement in the radio programme making aspects. The strategies are as follows:

'You Are the Right Person to Talk': Approach to Ensure Maximum Community Participation

Radio Mattoli programmes are exclusively meant for the empowerment of people. To empower them, their concerns and real issues have to be understood. We strongly believe that, to understand the real issues faced by them, the best solution is to make their own personal accounts. We follow the strategy 'You are the Right Person to Talk.' Each person will have different experiences—good or bad—to share. By attributing the prerogative 'You are the Right Person to Talk' to them, we strongly believe that they can confidently talk about their concerns/issues. The contents of the programmes are packaged carefully in simple language considering the socio cultural background of the people of Wayanad.

Dynamic Programme Formats to Ensure Community Participation:

The strength and uniqueness of Radio Mattoli programmes can be attributed to the active participation of community members in the different levels of radio programme making. To

facilitate community participation in the programmes, we device different programme formats such as:

- Radio skits
- Interviews
- Phone-in-programmes
- Panel discussions
- Awareness programmes on varied subjects

The logic behind this is simple. Different people have different talents and capabilities. To explore the real potential of people, and to ensure their participation we follow different formats of the programme. The idea is to provide ample opportunities to people to participate in the radio programme for social good. Radio skits provide platform for those who are good at presenting issues/topics dynamically. Interviews enable people to share their ideas or knowledge on any particular issue or topic. Panel discussions facilitate opinion sharing at a broader level. Awareness programmes for women bring in expert hands under one umbrella to participate in panel discussions, interviews, and phone-in programmes. In short, community engagement is at its best in the programme making aspects of Radio Mattoli.

Recognitions Received by Radio Mattoli

National Award for Sustainability 2013

Radio Mattoli is the recipient of the coveted National Award for Sustainability. Radio Mattoli Station Director received the prestigious award from then Minister for Information and Broadcasting, Manish Tewari at a function held in New Delhi in 2013.

Manthan Award South Asia and Asia Pacific 2012, Jury's Special Mention

Radio Mattoli achieved a golden feat by winning the Manthan Award South Asia and Asia Pacific 2012 Jury's Special Mention in Community Broadcasting category. We take great pride in this achievement, as there were a total of 470 entries from ten countries including India. This proves the calibre and immense potential of Radio Mattoli as a credible media for the development of communication.

Recognition by UNICEF

Radio Mattoli received a golden feather in its cap when a study published recently by the UNICEF ('The Abiding Voices: Sustainability of Community Radio in India' 2012) adjudged Radio Mattoli as one of the best community radio stations in India. This recognition stands as a testimony to the immense potential that the community radios possesses, as a powerful media for social change.

Social Intervention of Radio Mattoli

Radio Mattoli pays great attention to people's concerns and issues. What makes Radio Mattoli different from other media is its willingness to do the role of the facilitator to make the authorities act on instances of public grievances. Radio Mattoli's interventions resulted in swift actions from the concerned authorities to address various issues.

Emergency Veterinary Medical Camp

Radio Mattoli's timely intervention resulted in the conducting of emergency veterinary camps in places such as Thannikkal, Koyileri, Payyampally, and Arattuthara in Mananthavady Grama Panchayath where sporadic hoof disease among cattle had been reported. Radio Mattoli visited the dairy farmers in that locality to take stock of the situation, and immediately contacted the officials in the Department of Animal Husbandry, Kalpetta, and Dairy Development Department to inform the gravity of situation. Radio Mattoli aired a programme highlighting the plight of dairy farmers that evening. The very next day, a mobile unit consisting of a team of doctors and an ambulance was sent to the affected area, and the expert team took necessary preventive measures to check the further spread of the disease. The authorities also assured the people affected that compensatory measures would be taken to address the grievance of dairy farmers in that locality.

Benny Ulloppally, a dairy farmer in Koyileri who lost a cow to hoof disease told Mattoli that, unlike other main stream media who just make a report on the issue, Radio Mattoli took the initiative to call up the authorities and facilitated their intervention to tackle the issue.

Radio Mattoli is Pro Life

A lady in Kalpetta, who identified herself as Reshma was on the verge of committing suicide. But she gave up the intention after hearing the programme titled Thiricharivinte Vazhikal (Paths of Realization) She wrote, "The programme 'Thiricharivinte Vazhikal' by James Pilakavu was a wonderful one. This radio programme was an eye opener for me who had been thinking of committing suicide. The programme has indeed shown me the path of realization."

Ration Card to 350 Homeless Tribal People

Radio Mattoli received a complaint from a tribal lady, stating that she did not have a ration card, as she did not own a house. Radio Mattoli took up this issue and broad casted the letter she sent to our Janvaani programme. A copy of the same was sent to the authorities concerned with a request to correct the situation, which finally resulted in the issue of ration card not only to Leela, but also to all the other 350 homeless tribal people in the Gram Panchayath.

Media Visibility to Innovative Farmers

Radio Mattoli gave media visibility to Eldo Baby from Pozhuthana Grama Panchayath who earns around Rs. 0.5 millions from a meager 75 cents of land he owns. He specializes in cultivating mixed crops, and also in dairy farming. Radio Mattoli prepared a radio feature and broadcast an interview with him. This caught the attention of many people from different quarters, and it brought him the coveted "Best Farmer Award" of Thodupuzha Gandhiji Studies Centre 2010-2011. Today he is an expert resource person of M. S. Swaminathan Research Foundation, Puthoorvayal. Radio Mattoli introduced Eldo Baby's success story to the farming community which brought him wide acclamation.

Radio Mattoli was instrumental in highlighting the achievements of an enterprising student farmer known as Hashique, and a precision farmer Digaul Thomas in Wayanad. These Farmer success stories aired by Radio Mattoli inspired many people to turn to agriculture.

Allotment of Bus Service

Radio Mattoli's intervention resulted in the allotment of a state transport bus service (morning and evening schedule) from Thaloor to Mananthavady via Meenangadi. The people in Meenangadi were facing difficulties in reaching Mananthavadi due to lack of transport. They had

to change a minimum of three buses to reach Mananthavady. The children, aged and working women were the most affected. Their concerns were broadcast in 'Janavaani' (programme where concerns and issues of the public are broadcast), and this prompted the authorities to start a new bus service. It became operational from 25 January 2012.

Extension of Subsidy to Rubber Farmers

Rubber was not a traditional crop in Wayanad owing to the peculiar climatic conditions of the district. However the high price of rubber prompted certain farmers to plant rubber in their land on an experimental basis. The Rubber Board, citing low productivity of rubber in 12 villages, lifted the subsidy given to farmers belonging to that area and limited it to 37 villages that had been identified 'suitable' for rubber. Radio Mattoli on the request of the farmers intervened in the matter, and this prompted the Rubber Board authorities to conduct a detailed study, which made them extend the subsidy to six more villages in the district in 2009.

Conclusion

Radio Mattoli in its continuous journey of media excellence, which has achieved several milestones. Each milestone sets a new benchmarks for us to follow and be a responsible media for social change. We will always stand firm on pressing public issues and try our best to perform the role of a facilitator for the common people whenever they need our intervention. The role of this media wishes to be the reverberating voice of the voiceless. Championing the cause of socially deprived sections of the society has always been a prime concern for us and we are quite happy to acknowledge that our interventions have resulted in the redressal of many public grievances.

‘Know Your Neighbourhood’: An Innovative Programme in the Fieldwork Practicum of Social Work Education

Joseph M. K*

Abstract

Social Work Practicum enables the learner to develop professional skills through the process of action-reflection in a real life situation. As an essential component of fieldwork, Rajagiri School of Social Work has introduced an innovative practice titled as ‘Know Your Neighbourhood Programme’ where the students who are admitted to Master of Social Work (MSW) Programme are expected to undergo ten days of self-learning through observation, interviews, discussions about their own locality and its diverse resources, problems and prospects. The objective of the assignment is that students are motivated to acquire adequate information regarding various institutions and developmental programmes, in their own home village / town. They should also acquire sufficient information about various socio economic problems of the people of their neighbourhood. This process is envisaged as an opportunity to acquire better insights into the socio cultural realities of one’s own locality. This kind of self-learning at the beginning of MSW Programme will sensitize the students and facilitate them to better learning at subsequent levels of studies. The students may visit various governmental / non-governmental / private institutions and meet the concerned officials to understand the functioning as well as various services offered by these institutions. They also have to make a transect walk to understand the geographical features and natural resources of the place and to meet a few senior citizens to understand the history and traditions of the locality. Based on this study, a report of about 20 pages is to be submitted to their respective faculty facilitator and they have to share their experiences in the introductory sessions. An evaluation of the programme is carried out to understand its’ effectiveness. The programme has been found to be successful in facilitating self-learning as well as enhancing the social awareness of the MSW students.

Keywords

neighbourhood, social work practicum, self-learning, curriculum

Introduction

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The profession of social work is primarily devoted to addressing the diverse needs and problems of individuals, families, groups, organizations, and communities by helping them to restore or enhance their social functioning. As a practice-oriented profession, social work deals with a wide spectrum of social issues and concerns that range from struggles against unjust societal structures to attending to people's psychological problems. The definition of social work according to International Federation of Social Workers (IFSW) is "The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance their well-being. Employing theories of human behaviour and social systems, social work intervenes at those points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" (IFSW, 2012).

The mission of social work is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and communities they serve. Social work is an interrelated system of values, theory and practice. The framework of social work is based on humanitarian and democratic ideals, and its dominant values are respect for equality, worth, and dignity of all people. The social work profession draws on theories of human development and behaviour and social systems to analyze complex situations and to facilitate individual, organizational, social and cultural changes. The evidence based knowledge derived from practice evaluation and action research contributes to enrich the methodologies in social work. Social workers respond to problem situation by utilizing a variety of skills, techniques and activities which are based on the methods of social work. These interventions include counselling, clinical social work, family management and mobilizing resources for community organization and development (IFSW, 2012).

The discipline of social work is characterized by its constant innovation in field practice by addressing the expanding and deepening problems of the society. It has a 100 plus years of history in social work education, with the first social work class being offered in the summer of 1898 at Columbia University (NASW, 2014), it vouches that the social workers all over the world have made many innovative services in this field to address the societal needs and problems (NASW, 2014). Social work education was started in India in the year 1936 by the Sir Dorabji Tata Graduate School of Social Work (presently, Tata Institute of Social Sciences (TISS), Mumbai), as an adaptation of an educational programme of the United States of America, where social welfare services were meant "to assist the people in their adjustment to an industrial, urban and metropolis dominated social milieu" (UGC, 1978, cited in Lawani, 2002). The objectives of social work education aimed at providing sound professional education and creating opportunities for advanced studies and to enable the trainees to be efficient and good administrators in various social welfare organizations and to carry out independent social work research and social investigations for promoting social change and development (Lawani, 2002).

Fieldwork in Social Work Education

The social work education comprises of classroom training and learning from the actual fields of practice. While the classroom education provides theoretical knowledge and understanding of social work methods to the learners, fieldwork ensures the learning of social work training by the doing aspect. Dewey's idea of learning through doing has had a primary influence in the concept of fieldwork (Lawani, 2002). Fieldwork in social work education means any kind of

practical experiences in a social organization or agency, this experience has been deliberately arranged for the education of the students, who are undertaking these courses designed for social workers. It is an interactive process between a student and a social life situation. Fieldwork in social work is carried out in and through social welfare agencies and communities, where the student learns skills, test out knowledge according to an educational plan (Subhedar, 2001). Field practice is a process of learning the techniques, skills, strategies and use of methods of social work in fieldwork (Bhanti, 1996).

The distinguishing feature of social work education is the social work practicum which makes social work training a unique programme among various social science disciplines. The topmost priority is given to fieldwork in all prestigious universities which offer programmes in Social Work. Many western Schools of Social Work have metaphorically used the coinage that Field is the heart of social work education to highlight the importance of fieldwork training in social work education. "Field is the heart of social work education. These internships created the opportunity to experience social work practice in all of its various forms, and to apply the theoretical learning of the classroom to real agency situations with clients, programs, colleagues, and communities" (SFSU, 2014). Social work practicum forms the core of Social Work Training which plays a pivotal role and provides the experiential basis for the student's academic progress. According to the National Assessment and Accreditation Council (NAAC) guidelines for the assessment of Schools of Social Work for accreditation, Social Work Practicum, ideally, should form 50 per cent of the total academic training (TISS, 2003). An acceptable standard is one-third of the total training, i.e., a minimum of 30 days per semester (90 days) is to be stipulated for Fieldwork Practice. Social Work Practicum enables the learner to develop professional skills through the process of action-reflection in the real life situation.

Three Stages of Field Practicum

The field practicum could be envisaged as a process consisting of three stages: Exposure, Insertion and Immersion. The initial phase is that of exposing various settings and situations to the students. In field practicum proper, the student is inserted into the profession of Social Work, basically through an open community learning opportunity, with linkages with one or many of the existing systems or resources. Immersion phase is an expected stage of growth in the student's life, when the student absorbs the professional values and is able to take one's stand and get immersed in the field in which one is inserted with necessary competence (RCSS, 2009). Observational visits to social work agencies, social sensitization camp, concurrent social work practicum, block placement, summer placement, study tour, organization of annual conference / seminar, field survey and action research projects are the usual means employed to guide the students through the aforesaid stages of exposure, insertion and immersion of Fieldwork training (RCSS, 2009).

'Know Your Neighbourhood' Programme of Rajagiri School of Social Work

This is a pre-academic exposure programme, where the students are guided to learn from their own neighbourhood. As an essential component of field work, Rajagiri School of Social Work has introduced an innovative practice titled as 'Know Your Neighbourhood Programme' where the students who are admitted to the MSW programme are expected to undergo ten days of self-learning through observation, interviews, discussions about their own locality and its diverse resources, problems and prospects. The objective of the assignment is that students are motivated to acquire adequate information regarding various local institutions, development

programmes, local self government (LSG) in their own home village / town. They should also acquire sufficient information about various socio economic problems of the people of their neighbourhood (RCSS, 2009). This process is envisaged as an opportunity to acquire better insights into the socio-cultural realities of one's own locality. Such a self-learning at the beginning of MSW programme will sensitize the students and facilitate better learning at subsequent levels of studies (Sunirose, 2013).

Methodology of the Programme

The MSW students are expected to visit the various governmental / non-governmental / private institutions in their respective Panchayat / Municipality and meet the concerned officials to understand both the functioning of the institutions and various services offered by those institutions to people. The following instructions are given to the students to facilitate the learning process:

- Acquire a copy of the developmental report of the Panchayat / Municipality / Corporation.
- Visit a few self-help groups, local clubs, like youth clubs, or a farmers' association to understand their functioning.
- Do a transect walk to understand the geographical features and natural resources.
- Meet a few senior citizens to understand the local history and traditions of the village.
- Interview a few women, young people, children and a few elderly to understand the problems of the locality.
- Based on the work, prepare a report of about 20 pages and submit it to the irrespective faculty facilitator for evaluation.
- A formal presentation and sharing of personal experience in the class (RCSS, 2009).

A checklist for identifying the resources in the community is given to the students along with the guidelines for the assignments. The students are recommended to visit the maximum number of institutions / organizations within the stipulated time period. The following is a model checklist for the students.

1) Panchayat Office, 2) Village Office, 3) Krishibhavan, 4) Anganawadi of Integrated Child Development Services (ICDS) Project, 5) P. H. C / Hospitals, 6) Police Station, 7) Veterinary Hospital, 8) Co-operative societies (credit, producers co-operatives like dairy / fisheries), 9) Community Development Society (CDS) of Kudumbashree and Micro Enterprises units, 10) Children's associations, youth clubs and Senior citizen forums / MahilaSamajams, 11) Factories / Industries, Public and Private Firms / Small Scale industries), 12) public libraries / Continuing Education Centres, 13) Trade Unions, 14) Banking Institutions, 15) Special Schools / Schools / Colleges 16) NGOs / Orphanages, 17) Farmer's Forums and their farms, 18) Amusement Parks / Theaters, 19) Religious centres (Churches / Temples / Mosques), 20) Common Facilities (Beach, Railway Station, Bus Stands), and 21) Natural Resources—Springs, Rivers, Forest, etc.

Evaluation of the Programme

A study was conducted among the first year MSW students of the School of Social Work of Rajagri College of Social Sciences (RCSS) who have completed the assignment of 'Know your

Neighbourhood Programme ‘in the year 2012. The major objective of the study was to understand the various benefits obtained by the students and their evaluation about the effectiveness of the programme.

A structured questionnaire was used to collect the required data from the 30 first year MSW students deputed for this study. The analysis of the data and subsequent interpretations based on the objective of the study is presented in the following section. The socio economic profile of the students is analyzed in terms of variables such as age, gender, caste / communities, economic status, education, locality and major occupation of the head of the household (HOH).

The majority of the MSW students (66.7%) were females. The economic status of the family is determined by the official deceleration of the family as Above Poverty Line (APL) or Below Poverty Line (BPL) by the Government. Majority of the students (90%) belonged to the APL section and a most of them (73.3%) were from the rural background. Eighty per cent of the students had obtained their undergraduate degree in arts and social sciences subjects. The occupation of the HOH was found to be from five different sections (agriculture-20%, business-13%, private sector-23%, government sector-20% and the rest were Non Residential Indians (NRIs)). About 24 per cent of the heads of families were (NRI) and this indicates the migratory pattern of the people of Kerala who go in search of employment outside the country. All the students were from the state of Kerala and most of the students were from the central region of the State where their college was situated.

Participation of students in National Service Scheme (NSS) and in the activities of different students clubs in the college may often motivated them to opt for social work as their future profession. The following Table provides the data in this regard.

Table 1: Membership / Participation of Students in Associations at Degree Level

<i>Item</i>	<i>N</i>	<i>Yes</i>	<i>Per cent</i>
Membership in the NSS unit of the College	30	11	36.7
Membership in Clubs of the College	30	18	60.0
Membership in Local clubs	30	11	36.7
Participation in Rural camps	30	9	30.0

Only 36.7 per cent of the students were members in NSS during their undergraduate level but a good number of the students had worked in the nature clubs, tourism clubs and other similar associations during their degree level but only very few had participated in the rural camps organized by the NSS units of the respective colleges. Memberships in the local level clubs are also found to be very low among the students.

The students’ interaction with various institutions and resource systems of the community are presented in Table 2 to understand the effectiveness of the ‘Know Your Neighbourhood Programme’.

Table 2: Students Interaction with Agencies in the Locality

<i>No.</i>	<i>Agency</i>	<i>N</i>	<i>V-E*</i>	<i>%</i>	<i>V-KYNP#</i>	<i>%</i>	<i>%change</i>
1	Village Office	30	24	80	28	93.3	13.3
2	Panchayat Office	30	21	70	28	93.3	23.3
3	Public Health Centre (PHC)	30	17	56.7	21	70.0	13.3

4	Police Station	30	6	20	17	56.7	36.7
5	KrishiBhavan	30	10	33.3	21	70.0	36.7
6	Anganawadi (ICDS centre)	30	15	50	22	70.3	20.3
7	Cooperatives (PACS / DCS)	30	6	20	9	30.0	10.0
8	NHG of Kudumbashree / others	30	9	30	11	36.7	6.7
9	Local clubs (children, youth)	30	13	43.3	16	53.3	10.0
10	Local Trade Unions	30	1	3.3	3	10.0	6.7
11	Orphanages / Special school / NGO's	30	17	56.7	21	70.0	13.3

Legend: *V-E: Visited Earlier #V-KYNP: Visited as part of the Know Your Neighbourhood Programme (KYNP).

To understand the level of interaction of the students with various societal institutions and facilities, the students were asked about their visits to these areas. They were asked whether they had visited the centre earlier for any reason or had they visited these areas as part of the given field related assignment. The findings are:

- Majority of the students had contacted the village office and Panchayat office for their personal purposes earlier but the assignment had specifically helped more students to visit and understand the functioning of these offices (13.3% to 23.3% increase).
- Only 56.7 per cent of students had visited PHC earlier but as part of the assignment 70 per cent of the students had visited and interacted with the staff of the Public Health Centre (PHC).
- A few students (20%) had visited the Police station earlier, KYNP has helped about 36.7 per cent students to visit the police station and interact with the police officials.
- Majority (70%) of the students had visited KrishiBhavan, Anganawadi of Integrated Child Development Services (ICDS) and orphanages as part of the assignment.
- Students' interaction with cooperative institutions, neighbourhood groups and trade unions are found to be very low even in the context of the assignment.

Table 3 provides the details of the ranking given by the students regarding the major benefits of the pre-training assignment.

Table 3: Perception of students regarding the merits of the Programme (N=30)

<i>Statements about the Programme</i>	<i>Mean</i>	<i>S. D</i>	<i>Rank</i>
The visits have helped to improve the self confidence to interact with people	1.93	1.40	1
The visits have motivated self-learning	2.93	1.64	2
The visits have helped them to understand the working of the agencies	3.43	2.13	3
The visits have helped to understand the community resources	3.50	1.89	4
The visits have helped to follow the MSW classes effectively	4.27	2.21	5
The visits were useful in understanding social problems	4.63	1.77	6

The most important merit of the programme perceived by the students was that the programme has helped them to improve their self confidence to interact with the people. The methodology of the assignment was such that the students have to go independently and interact with the officials and collect the necessary information for their study. No letter of authorization was given from the college to the students so that students had to use their personal skills and competence to meet the concerned officials to collect the necessary information for the study. The second important merit reported by the students was that the visits have motivated self-learning. A major objective of the assignment was facilitating self-learning which was noticed to have been realized through the process of these assignments. The understanding of the functioning of the agencies, community resources were given subsequent priority by the students.

The feedbacks of the students regarding the given assignment are collected through open ended questions. Students' personal gains as well as their insights from the programme are summarized in Table 4.

Table 4: Students' feedback regarding the Programme
(N=30)

<i>Statements</i>	<i>Frequency</i>	<i>Per cent</i>
Improved the self-confidence of the student to interact with people	17	56.67
Programme has helped the student in self-learning	16	53.33
Obtained knowledge of local self government (LSG) and the Programme of Government for Development and Welfare	15	50.00
A positive perception regarding the government officials that they are approachable and helpful	10	33.33
The improvement in the communication skills of the students	9	30.00
Understand the community resources as well as problems of the village	8	26.67
The programme was a new learning experience and exposure	8	26.67

About 50 per cent of the students are of the opinion that the programme has helped to improve their self confidence and promoted self-learning and they could obtain knowledge about the working of the LSG institutions and the programmes of various government departments. A major insight for some students was their change in perception about government officials. Contrary to their assumptions the officials with whom they have interacted were found to be friendly and very helpful in providing the necessary information for the study. Improvement in communication skills was another merit observed by a few students. The learning method was a new experience for some of the students.

Conclusion

The initial phase of the fieldwork practicum of exposing the students to various settings and situations of the society in which they live and interact was introduced to them as a pre-academic exercise of 'Know Your Neighbourhood Programme.' It was a critical and conscious exposure of the students to the primary realities of their neighborhood and the local village. The students are now motivated to acquire adequate primary information regarding various societal institutions and programmes, through the process of self-learning. The evaluation of the programme reveals that it has helped the students in many ways like promoting their self-confidence, enhancing communication / interaction skills and facilitating self-learning.

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Book Review

Organisational Behaviour for Social Work. Gavin Bissell, 2012, Bristol, The Policy Press.
ISBN:978-1-84742-279-8 paperback pp.x+186, Price£21.99

Organizational behavioural knowledge is fast becoming essential for social work practices especially in care management services and consequently in the regulatory bodies in social work education and training for the past two decades. They are being specifically referred to skills in working in organizations which acts as an area of training and assessment. The book under review is a practice linked text catering to the needs of these social work students for knowledge in organizational behaviour.

The rationale of a book on organizational behaviour for social work and the contemporary significance of the study of organizational behaviour for social work students and practitioners are highlighted in the introductory session by the author, Gavin Bissell, who has rich experience in social work education as well as practice in organizational settings and also in inter organizational working. The different aspects of organizational behaviour are discussed in 12 chapters of the volume in a systematic manner with necessary linkages with various fields of social work. A practice-oriented methodology is followed with each chapter having a set of learning outcomes, explanation of the theories or models related to the topic discussed, application and linkages with social work practice and a set of exercises suitable for practice learning.

Chapter one provides an overview of theories and literature of organizational behaviour. The origin of organizational theory, types of organizational structures, relevance of scientific management approaches, effects of organizational context upon social work practice are briefly indicated to explain the organizational aspects of these welfare organizations. The organizational structure of welfare agencies does not easily map onto the mechanistic or organic structures found in the private sector since they are by nature simultaneously enabling and controlling. The second chapter deals with motivation reviews like the classical theories of motivation and explores the application of the same within the social work organizations. The findings of various studies about job satisfaction, job turnovers and career progress of social workers are cited to analyze the motivational factors of the social work profession. Religious and faith based motivation, aspiration to do meaningful and value based work, responsibility and personal growth are also discussed under motivation for social work practice. Kanter's (1977) approach towards motivation in terms of opportunities, organizational positions / power and social composition of the organization seems to be more helpful in analyzing "the social work career that moves beyond a series of salary-linked professional development milestones, to one which will result in more fulfilling work and improved staff retention and motivation" (p.36). The key learning outcome from the analysis of motivation is that the organization is a primary source of motivation (and de-motivation) for individual social workers, despite an emphasis upon intrinsic reward and vocationalism.

The third chapter looks at communication within the social work organizations, detailing the direction of communication, communication roles, obstacles to effective communication,

informal routes of communication such as grapevines and the importance of communication in the supervisory relationship of the social work profession. Even though communication in social work is primarily a matter of interpersonal skills, the structure and culture of the service delivery organization has a significant role in maintaining the effectiveness of communication between social workers and service users hence the organizational aspects of communication are to be standardized for effective service delivery. Models of organizational decision making such as planned and unplanned decisions, classical and administrative models, accountability models and seven models identified by Golensky (2011) suitable for social work practice and obstacles to good decision making are briefly explained in the fourth chapter to examine the impact of the organizations on social work decision making.

Team work is getting more importance among the skills and competence of social work practice. The social work team is becoming multi-professional as well as multicultural in the context of globalization where the up-skilling in teamwork is a challenge for social work practitioners. Chapter five investigates team roles in social work with some considerations given to the theories of primary groups and area teams. The teams in social services organizations have wider connotations i.e. “we have to speak of ‘open teams’ consisting of caseworkers consulting with service users and careers, and liaising with other professional workers in a wide range of partner organizations, rather than seeing teams as tightly knit working groups looking inwards to the organization and its business” (p.76-77). The learning outcome for the social worker is that area where life state organization of teams have been the norm in social work, but this is now being modified by interdisciplinary, inter-organizational out-ward-looking team involving service users. The impact of organizational culture upon the practice of social work is discussed in chapter six. The practice of service user involvement can facilitate openness and mutual care which results in enhancing the performance of the welfare organization.

Chapter seven elaborates on the recent idea of `The Learning Organization (TLO) with explanations of TLO model developed by Senge (1990). The TLO is made of five disciplines namely:

1) Personal mastery: personal goals; 2) Mental models: reflection and inquiry; 3) Shared vision: group commitment; 4) Team learning: collective thinking; and 5) Systems thinking: understanding interdependency and feedbacks.

The TLO model is a popular management strategy which is extensively used in social service organizations. In social work, there have been initiatives towards TLO emerging from the context of a fast moving and globalized environment where all organizations have to confront the prospect of continuous change and adaptation for effective service delivery based on the multifarious demands from the divergent fields of practice. The list of indicators of a learning organization given in the chapter is a good checklist for social workers to evaluate whether they are working in a learning organization or not. The pertinent question posited in chapter eight on leadership and management is whether a social work style of management possible. The theory of distributed management is more applicable in social work practice with core values of social work can be used to inform management practice. The application of the management strategies of management by objectives (MBO) and total quality management (TQM) in social work are discussed in detail in chapter nine.

The models of organizational power and control were examined in chapter ten. The traditional models of power outlined in organizational behaviour literature with rights-based and consumer empowerment models implicit in social work writings are briefly discussed to deliberate on who

really controls the social services. The author observes that right based approaches will not always offer service users power in public services even though there is a strong and popular argument that service users ought to control the social services. Chapter 11 looks at organizational change in social work agencies with emphasis on reorganization for social services and convergences with the voluntary sector. The various models of organizational change, change leadership, strategies of overcoming resistance to change are explained by drawing insights from contemporary management literature. Kotter and Schlesinger's (1979) eight step model for organizational change (identify crisis, form a guiding coalition or steering group, create a vision, communicate the vision, empower people to act on the vision, create short-term wins, consolidate, and institutionalize) are described with illustrations (p.145) and application of the same is explained with examples drawn from the field of social work practice. The organizational change in welfare organizations is often being influenced by local and national policy process. Chapter 12 provides a conclusion to the book, looking at policy and practice changes in social work organizations. The regulatory bodies of social work are currently undergoing organizational changes and this has an impact on the social workers and their social work practices.

The detailed bibliography and the good quality index provided are beneficial for the readers to go deeper into the concepts discussed in the volume. The learning outcomes and practice exercises provided in each chapter shall facilitate enjoyable reading of the text. The volume is written exclusively from the context of social work policies and practices in England hence the readers from other parts of the globe have to relate these concepts and models in their respective practice domain for a better appreciation of the same.

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INSERT THE MATTER FOR: GUIDELINES FOR CONTRIBUTORS

RAJAGIRI COLLEGE OF SOCIAL SCIENCES

COURSES OFFERED

- Doctorate (PhD) in Social Work, Management Studies and Social Sciences
- Master of Social Work (MSW)
- Master of Human Resource Management (MHRM)
- Master of Business Administration (MBA)
- Post Graduate Diploma in Management (PGDM)
- Master of Computer Applications (MCA)
- Bachelor of Social Work (BSW)
- Bachelor of Library and Information Sciences (BLISC)
- Post Graduate Diploma in Administration of Human Services (PGDAHS)
- Courses of Indira Gandhi National Open University (IGNOU) under convergence scheme

RESEARCH AND TRAINING DIVISIONS

- Research Institute
- Empanelled Training Institute (ETI) -NSS Middle Level Training Centre for functionaries of the Integrated Child Development Scheme (ICDS)

LIVE LABS OF FIELD ACTION

- Adoption Coordinating Agency
- Rajagiri Outreach Service Society
- Free Drug Cell
- Rajagiri Family Counselling Centre
- Childline-Rajagiri
- Aditya-Solar Shop
- Rajagiri Mediation Clinic

