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Indian Social Work Education: A Generalist Core Competence Approach

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Abstract

This article is a critique of the current social work training methodology in India, which is specialisation-intensive and non-reflective of the training needs of practitioners. The paper draws attention to the growth of Social Work in the country in terms of the increasing numbers of schools of social work and Non-Governmental Organisations. These numbers have led to the demand for superior performance and accountability from social workers, which in turn is dependent on the quality of training offered to them. The paper employs an elaborate literature review, adopting a historical and international perspective, to expose the grey areas of the present system of social work education and training in India and bring out the relevance of the Generalist Core Competence approach in the country. It is argued that the Generalist Core Competence approach is capable of augmenting practice and assisting the social work profession to overcome its challenges.

Keywords

social work education, generalist practice, core competence

Introduction

The Social Work education scenario in India comprises mostly of professional social work schools and social work practitioners working in Non-Governmental Organisations (NGOs) and government offices. Today the number of social work schools in India is unofficially estimated to be over 300 (Nadkarni and Desai, 2012) whereas the number of active NGOs operating in the country at the end of 2009 was 3.3 million (Shukla, 2010).These numbers reveal the presence of significant manpower involved

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in the social work situation in India as educators, students, sponsors, managements, employees, volunteers and beneficiaries. This has led to the demand for increased performance and accountability from social work professionals and NGOs, which can be achieved only as a direct result of quality training. Amidst the non-uniformity rendered by the various training methods followed in numerous schools of social work and the diversity within different fields of practice, the need for offering qualitative social work training by setting common standards has long been felt.

Standards of training and practice can be framed only if social work schools and practitioners decide to come together. Ironically, the profession has seen very few efforts towards organisation. However, recent years have witnessed a drive for networking and associating, with governments increasingly demanding cooperation and partnership from the NGO sector; also, more and more schools of social work and professional social workers are being called upon to offer leadership in various aspects (Government of India, 2007, 2012). A National Network of Schools of Social Work (NNSSW) has become operational and active. It is in the wake of such a renewal that the need for questioning and reforming the present social work education syllabus and pedagogy assumes relevance. This article discusses the gaps in the social work education system in India and advocates a Generalist Core Competence approach.

Generalist Core Competence Approach

The American Council of Social Work Education (CSWE) in its Education Policy and Accreditation Standards (EPAS)defines social work competence and competency-based education as,

> "Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentionaland professional manner to promote human and community well-being" (CSWE, 2015).
>
> "Competency-based education is an outcomes approach to education. The emphasis is on *what comes out of* social work education, (e.g. what graduates know and can do) rather than *what goes into* the curriculum. With a competency-based approach, *you do not begin* preparing your syllabus by identifying content and readings. *You do begin* by identifying competencies and practice behaviours-then you select the content,

readings, class exercises, and assignments to support student attainment of those competencies and practice behaviours. Practice behaviours operationalise or measure the competency and become the basis for the design of your competency-based curriculum design" (CSWE,2009).

Within the competency-based education system, competence is an essential component for both generalist and specialised practice. While a generalist approach to social work education trains practitioners to apply the competencies to a range of social work situations; specialised practice adapts and extends the social work competencies for practice with a specific population, problem area, method of intervention, perspective or approach to practice (CSWE, 2008, 2015).The Generalist Core Competence approach refers to the acquisition of specific competencies, established as mandatory for competent practice across specialisations.

About the benefits of a core competence approach, a document prepared by the Ministry of Social Development (MSD), New Zealand, by reviewing materials from the United States (US),the United Kingdom (UK), Australia and Canada states thus (MSD, 2012):

"Proponents of a common core refer to the promotion of shared values, language and understanding across different parts of the workforce, thus improving practice...Proponents also recognize that a common core can:

- create opportunities for more flexible jobs, where appropriate, with workers able to work across different parts of the (workforce), knowing they have a core of skills, knowledge and understanding that they can bring with them to a new profession.
- make recruitment for certain roles easier for employers, creating a large pool of potential employees to choose from and providing employees themselves with many more career opportunities than they currently have.
- create opportunities for employers and education providers to rationalise and prioritise their education, training and development resources, e.g. focusing on filling any gaps in core skills and knowledge.
- create opportunities for education providers to rationalise the content of qualifications, stimulating more opportunities for articulation between qualifications or shared modules for different professions.

- provide a common basis for organisations to re-assess their organisational procedures, practices and cultures.
- encourage the application of best practices aimed at improving outcomes for (clients), by training strategies that progress from knowledge acquisition to building and demonstrating skills.
- encourage inclusion of community partners, whenever possible, in order to share responsibility for (client) safety, permanency, and wellbeing.
- ensure the workforce is equipped to intervene early, tackle inequalities and build the capacity of individuals, families and communities."

The need for a Generalist Approach in India

There are three reasons for the assumption that the Generalist Core Competence approach is best suited to social work education and training in India. Firstly, the present system gives inadequate emphasis to the development needs of the profession. Secondly, social work education has made omissions in incorporating indigenous practice realities, like the working conditions and training needs of practitioners. Thirdly, social work education in India has not reflected the wide changes that have been happening internationally in the areas of training and evaluation of social workers. These issues are discussed in the following sections (Josephand Alexander 2012, 2015).

Inadequate emphasis on professional development

Social work has made impressive headway in India in the last few decades (Gore, 2002). Nevertheless the discipline is still faced with a number of challenges in its efforts to acquire the status of a recognised profession. Desai's study (2002) shows that the ranking of the social work profession among social workers and the public was low. According to the study, two areas, among others, that need attention were: staff development and accreditation and licensing in social work education and practice (Desai, 2002). Mohan (2002)believes that the profession of being 'theoretically disconnected with its practice', lacking 'identity, purpose and mission' and attributes the cause to the social workers' 'complacence and narcissism'. The reports of the UGC Review Committees on Social Work Education

have repeatedly voiced issues of standardisation which still remains at bay (Bodhi and Tripura, 2013; UGC, 1980). Academicians recognise that after 75 years, unity has eluded Social Work in India and the profession 'continues its struggle to come to the forefront of the nation building processes' (Department of Social Work, 2012).

We see that many of the problems that were stated years ago have been echoed yet again, indicating that there has been little effort in addressing issues of standardisation and professional development. This disregard points at the failure of the pedagogy followed by social work schools to inculcate the right kind of professional values and skills required to boost professional development. A Generalist Core Competence model is a balanced approach which has the vitality to mould social work professionals who value professional development and are skilled in bringing about such development.

Non-incorporation of practice realities

The responsibility of Indian social work education to cater to the nation's development issues is made more challenging by the diversity rendered by cultural and regional differences. The model of social work education followed in the country should ideally adopt a social development orientation, incorporating the working conditions and training needs of practitioners.

The influence of the American School of Social Work in India was seen in the choice of post graduate courses and introduction of specialisations (Gore, 2002). Manysocial work educators have long voiced their discontent and declared that the American model was unsuited to the Indian social setting as it led to curative, case work and urban oriented interventions, with inadequate emphasis on broader development issues and this in turn resulted in limiting the scope of Social Work in India (Dobriyal, 2009; Pathak, 1975). Later, we see that even though Indian social work education did develop a model of its own, incorporating the development perspective, the dominance of American influence persists (Kulkarni, 1993).

Social Work is primarily a practice profession; hence the training needs and working condition of practitioners needs to be taken into account while designing a model of education. Social work schools differ widely

from each other with regard to admission policies, intake procedures, specialisations offered, syllabus, curricular demands, subjects covered, field strategies and priorities. Also, since a majority of social work jobs employ a graduate or post graduate, irrespective of qualification, specialisation or experience, these fresh appointees, including social work students, who have passed out from specialisation oriented post-graduate courses, find themselves working in multiple social work settings, with improper supervision and training. Low pay, heavy work load, high turn-over rates, competition from similar professions, poor motivation and lack of commitment are the other issues that severely affect the performance of social workers. These factors highlight the magnitude of responsibility upon social work educators and trainers; i.e. the two years of training offered by the various entry-level, specialisation-oriented post-graduate courses across the country should labour to equip diverse groups of students to professionally handle grave social issues in different social work fields.

In a resource scarce country like India, efficient and effective interventions are crucial and these affect the credibility of the profession. These practice realities do not find expression in education models of social work schools. The Generalist Core Competence approach adopts a social development perspective and is capable of training social workers who will be able to offer competent services in multiple settings and within the given conditions of social work practice in India.

Non- reflection of international developments

As mentioned earlier, the choice of the introduction of the two-year post-graduate courses with specialisation focus in Indian social work education was the direct result of American influence. However, whereas social work education in the US and in many developed countries underwent tremendous transformation in response to the prevailing social conditions, Indian social work education has failed to review the applicability of out-dated American models. A historical analysis of the factors that caused the shift in focus from specialised to generalist practice in the US, clarifies the drawbacks of a specialisation-intensive curriculum at the entry level and highlights the relevance of the proposition for the adoption of the Generalist Core Competence approach.

In the US, up until the 1960s, social work practice became increasingly defined by social work methods or by fields of practice (Hepworth et al.,

1997; Kirst and Ashman, 2009) whereas after that generalist practice was given its due recognition. Tracing the history of social work before the 1960s, it is clear that social work practice in the west began in the 1880s as a response to poverty (Ferguson, 1975). The Charity Organisation Society (COS), which was a pioneer in this regard, was concerned with the distribution of charitable funds to the poor. The activities of COS characterised the shift away from individual and volunteer philanthropy towards scientific charity (Sherr, 2008) and it was the forerunner of the social work method of case work. Hence, as the first social work school was established by the COS New York in 1898, it led to the birth of a cadre of 'casework' professionals who were employed by government and private organisations (Tannanbaum and Reisch, 2001) to solve the problems of the clients within the limits of the agency (Payne, 2006; Specht, 1990, cited in Reamer, 1995, Keith-Lucas, 1992, cited in Reamer, 1995). Thesesocial work schools also came under the influence of the psychoanalytic theories which fostered a clinical and curative model of social work education (Specht, 1990 cited in Reamer, 1995; Goldstein 2001). Thus social workers became deeply involved with the individual who was placed in various specialised agency settings, be it school, correctional setting, family welfare services, hospitals or community.

The need for unifying the profession was realised and efforts in this direction started in the beginning of the 1900s. The first schools of social work came together under the American Association of Schools of Social Work (AASSW) in 1917. These schools nevertheless continued to offer individualised case work oriented curative models of education and promote only post-graduate courses of a specialised nature. However, the demand created by the increasing number of jobs in the public social services, led to the growth of a number of undergraduate programmes in social work, which were refused recognition by the AASSW. This led to the clustering of such programmes under an independent body called the National Association of Schools of Social Administration (NASSA) in 1936. These undergraduate programmes were also concerned with training personnel for specific job positions (NASW, 1995; Stuart et al., 1993).

The Mildred Conference, which convened in 1928, was designed to be an effort to answer whether social work was a disparate group with technical skills or a unified profession with integrated knowledge and skills. In 1929,

the report of the conference was published as'Social Case Work: Generic and Specific'by the American Association of Social Workers (NASW, 1995). The report indicated that "social work is one singular profession with more similarities than differences among its specialties" (Brieland, 1977, cited in Cnaan and Dichter, 2007; Holosko 2003, cited in Cnaan and Dichter, 2007). The Hollis Taylor report (1951) on social work education in the United States was also the result of an effort to unite the AASSW and NASSA under the Council on Social Work Education (CSWE), which was subsequently formed in 1952. This report looked into whether social work possessed a systematic body of knowledge, skills, and values in the various areas of social work practice; and recommended a more generic orientation. In 1959, *Social Work Curriculum Study*, a 13-volume evaluation and recommendation for improved social work education was published in response to the Hollis Taylor Report (Cnaan and Dichter, 2007). Not only were these recommendations not given due attention by the CSWE, the post-graduate course was once again reaffirmed as the only legitimate qualification for professional practice. Undergraduate interests once again became under-represented (Stuart et al., 1993).

Despite receiving all the indications for change towards a more generic and development oriented practice, social work in the US still continued to let itself be confined by the limited interests of the agency and the individual. Because of this, the profession came under attack from various groups in the 1960s and 1970s and was criticisedfor abandoning its mission (Specht and Courtney 1994, cited in Reamer, 1995). The critical and structural approaches to social work was making way for a new practice regimen—one that focused viewing the individual as an integral part of the society, and sought to liberate the individual by labouring for social change (Martin, 2003; Sipporin, 1992, cited in Reamer, 1995). The need for redeeming the social worker out of the dictates and confines of the agency (Ferguson, 1975) and of the welfare state and the need for returning to the social development and social reform goals of social work was increasingly voiced (Martin 2003).

As a result of these criticisms and the large pool of social work job openings created by the 1962 Social Security Act, strong efforts towards developing undergraduate courses with a generic orientation began. By the late 1960s, CSWE finally took responsibility for the development and

accreditation of such courses which would be responsible for producing a cadre of generalist practitioners. Worthy of special mention are two documents which were produced under the leadership of Harold McPheeters: 'Manpower Utilization in Social Welfare' (Teare and McPheeters, 1970) and 'A Core of Competence for Baccalaureate Social Welfare' (McPheeters and Ryan, 1971). These documents not only contributed to the conceptualisation of generalist practice butalso harboured the seeds of a competency-based social work education in the US. The 'Core of Competence' publication defined core of competence to include three basic components: a) knowledge, b) skills, c) values and attitudes. It also describes the curricular implications of this core of competence. The need to surpass the traditional 'methods approach' and move to a full range of 'intervention methods and skills' was also recognised in this document. By 2004 that CSWE began the process of shifting to a competency-based approach to social work education (CSWE, 2008).

Core Competence Frameworks of different countries

Of the different models of social work education that have been adopted by the profession, the Core Competence approach seems to be the latest and the most popular. The core competencies have taken various forms in different parts of the world. In many developed countries like the US, the UK, Canada, Australia and New Zealand, a generalist Bachelors Degree in Social Work (BSW) is the qualifying degree for professional practice while specialised practice is pursued through the Masters Degree in Social Work (MSW) and other higher degrees. These countries have also stressed the importance of competence based social work education. International social work too calls for developing international competencies in students. Whereas in many developing countries like India, the entry level course for professional practice is the two year MSW degree, with the second year marked out for specialisation in a particular field of practice like community development, medical and psychiatry and child social work. The concept of competence based education seems to be new to these countries. In India, the UGC Model Curriculum Report 2001 recognised that the organising elements of the educational programmes for the profession irrespective of the curriculum frame chosen were: (1) the values

of the profession, (2) the skills and the methods developed for professional tasks, and (3) the major theories and concepts (UGC, 2001). These elements are similar to the competence components of knowledge, values and skills. However, the curriculum frame adopted by the UGC Model Curriculum placed the instructional content in four sets: the core domain, the supportive domain, interdisciplinary domain and elective content, without directly linking these to the organising elements. It is at this point that the UGC Model Curriculum deviates from a competence based approach. Also the report seems to give disproportionate weightage to electives/specialisations and no reference has been made to international trends in social work education.

The Core Competence models of different countries are discussed below:

The US

In 2004, the Council on Social Work Education (CSWE) began the process of reviewing and revising the Educational Policy and Accreditation Standards (EPAS). It identified several principles to guide its work, one of which was to enhance programme flexibility by using a competency-based outcome approach to curriculum design; finally the competency-based education approach was adopted for the 2008 EPAS (CSWE, 2008). The EPAS (2015) outlines nine core competencies common to all social work practice (CSWE, 2015).The nine core competencies are:

1. Demonstrate ethical and professional behaviour
2. Engage diversity and difference in practice
3. Advance human rights and social, economic, and environmental justice and difference in practice
4. Engage in practice-informed research and research-informed practice
5. Engage in policy practice
6. Engage with individuals, families, groups, organisations, and communities
7. Assess Individuals, families, groups, organisations, and communities
8. Intervene with individuals, families, groups, organisations, and communities
9. Evaluate practice with individuals, families, groups, organisations, and communities

The UK

Social work training in Europe first began with a process of training for an occupation, which then developed through specialisation and degree level education to professionalisation and a scientific status (Hamburger et al., 2008). The Central Council for Education and Training in Social Work (CCETSW) was the earliest regulator of Social Work Education and Training in the UK, which comprises of England, Wales, Northern Ireland and Scotland. The functions of CCETSW were taken over by the General Social Care Council (GSCC) in 2001, which was replaced by the Health and Care Professions Council (HCPC)in England in 2012. Before the dissolution of the GSCC in England, all the social workers in UK were guided by the National Occupational Standards (NOS) which was framed and revised by the GSCC in 2003 and 2011 respectively (CCW, 2015).

CCETSW had defined the requirements for qualifying in social work in terms of knowledge, skills and values and recommended a single professional qualification with students achieving a general knowledge of all care settings and client groups. Students were encouraged to choose an elective-area which was not to be considered as 'specialisms' (DHSSPS, 1999). CCETSW laid down six core competencies, which was translated by the GSCC National Occupational Standards (NOS) as the six key roles of social workers:1) Prepare for, and work with individuals, families, carers, groups and communities to assess their needs and circumstances; 2) Plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups, communities and other professionals; 3) Support individuals to represent their needs, views and circumstances; 4) Manage risk to individuals, families, carers, groups, communities, self and colleagues; 5) Manage and be accountable, with supervision and support, for your own social work practice within your organisation; 6) Demonstrate professional competence in social work practice (WofScon, 2001; GSCC, 2011).

Since 2013, the Professional Capability Framework (PCF) is being used as a standard for evaluating the outcome of social work training in England, whereas the NOS continues to be used in Wales, Ireland and Scotland (Skills for Care, n.d.). The PCF was developed by the Social Work Review Board and is owned by The College of Social Work (TCSW) which holds the standards for the profession since 2009. The PCF has nine levels from

beginning social work training to the strategic social work level. Within each level, distinct capabilities have been identified that practitioners are expected to evidence. The capabilities under each level are organised under the following heads: professionalism, values and ethics, diversity, rights and justice, knowledge, critical reflection, intervention and skills, contexts and organisations, professional leadership (TCSW, 2015).The HCPC has also brought out Standards of Proficiency (SOP) for the social workers in England (HCPC, 2012).

Australia

The Australian Association of Social Workers (AASW) Practice Standards for Social Workers 2003 (revised 2013) stresses 'commitment to practice competence'. It defines such competence in terms of values of practice, components of practice and areas of practice (AASW, 2013).

- Values of practice: respect for persons, social justice, and professional integrity.
- Components of practice: values and ethics, professionalism, culturally responsive and inclusive practice, knowledge for practice, applying knowledge to practice, communication and interpersonal skills, information recording and sharing, professional development and supervision.
- Areas of practice: work with individuals, work with families, work with groups, work with communities, social policy practice, management, leadership and administration, education and training, research and evaluation.

New Zealand

The Social Workers Registration Board (SWRB) recognises core competencies that are essential for all social work practice in New Zealand (SWRB, 2014). These are:

1. Competence to practice social work with Mâori.
2. Competence to practice social work with different ethnic and cultural groups in New Zealand.

(For international students the first two competence are replaced by: competence to work respectfully and inclusively with diversity and cultural difference).

3. Competence to promote the principles of human rights and social justice.
4. Competence to promote social change.
5. Competence to promote empowerment and liberation of people.
6. Competence to utilise social work practice approaches.
7. Competence to utilise theories of human behaviour and social systems.
8. Competence to promote problem solving in human relationships.
9. Competence to ensure systems of accountability are in place for their work.
10. Adherence to professional social work ethics.

Canada

The Canadian Council of Social Work Regulators (CCSWR) developed the competency profile for the social work profession in Canada (CCSWR, 2012). This has been reflected in the "pyramid of competency", given below:

- Personal competencies: personal values and attitudes such as empathy, integrity, and respect for persons required for all types of work across fields of practice.
- General competencies: generic skills required for all types of work across fields of practice.
- Entry-level profession: specific competencies: minimal essential profession-specific competences that professionals must possess upon entering on the first day of professional practice regardless of their prior educational or professional preparation; and
- Advanced profession: specific competencies: competencies that professionals acquire as they engage in the profession and advanced study.

The Council also organised competencies into ten primary competency blocks:

1. Assessment of client needs: competencies required to determine the needs of the clients and assess their situations and eligibility for services.
2. Intervention planning: Competencies required to identify clients' goals and plan appropriate treatment and services.

3. Direct service delivery: Competencies required to provide services to address clients' needs.
4. Indirect service delivery: Competencies required to advocate for the improvement of policies and services to better meet the needs of the clients, as well as maintain documentation that supports the direct delivery of the services.
5. Evaluation: Competencies required to design and implement evaluations to assess the effectiveness of services and provide recommendations for their improvement.
6. Supervision: Competencies required to effectively manage and supervise staff and volunteers and to work effectively as a team member.
7. Management and administration: Competencies required to perform administrative and management tasks related to strategic planning, personnel practices, and project management.
8. Ethics and values: Competencies required for ethical and responsible service delivery.
9. Community building: Competencies required for effective communication and collaboration with community stakeholders and professionals in social work and other professional areas to address issues related to social work interventions and protect the best interests of the clients.
10. Professional development and contribution to the field: Competencies required to monitor and manage one's own professional development, attitudes and behaviour to promote and advance the social work practice locally, nationally, and/or internationally.

In addition to the abovementioned competency blocks, a number of topics have been identified: 1) Diversity and cultural responsiveness/ Indigenous ways of knowing/Cultural sensitivity/Cross-cultural communication; 2) Human rights and economic justice; and 3) Research-based practice.

Asia and Africa

There does not seem to be any literature on Core Competence in Asia and Africa (Chitereka, 2009). One particular research study in China sought

to examine the core competence of social work undergraduates in China; however, the core competencies examined and research tools used were borrowed from the US (Guo et al., 2014).

International competencies

According to Healy (cited in Merrill and Frost, 2011) international social work involves among other things 'cross-cultural knowledge', 'intergovernmental work', 'professional exchange' and a 'general world view'. Pettys et al. (2005, cited in Merrill and Frost, 2011)) suggests that social workers should have international and intercultural knowledge for the purpose of reducing ethnocentrism, developing cultural sensitivity, and preparing students to work in an interdependent world. A number of social workers across the globe feel that social work being a profession 'enmeshed in the global process of change' it calls for internationalisation of the profession, particularly in terms of competencies (Merrill and Frost 2011). The International Federation of Social Workers (IFSW) has laid standards for social workers, students and professionals across the globe (IFSW, 2012). A study from Hong Kong identifies five elements which contribute to international competency in Social Work: values, skills, knowledge, personal qualities and culture (Mok, 2013).

Conclusions

From the discussions made, we understand that the choice of introduction of a specialisation-intensive, case work oriented post-graduate social work course in India at the entry level was the direct result of American influence. The application of the American model of social work education to India was widely criticised. While in the US, this model was decried and vast changes were implemented to strengthen the generic base of the profession, in India the entry level MSW course is still specialisation oriented. We have also discussed how internationally, generalist training and the core competence approach has taken ground. The article further brings attention to various practice realities in India, which do not find expression in social work education. The present social work job scenario requires specialist social workers only in few situations and a majority of social workers get placed without due attention to their specialisation. Also, the highly stressful working conditions in the country calls for a different

approach to training which will adequately meet the skill requirements of social work students and practitioners. There is a need for the Generalist Core Competence approach, which has the potency of augmenting social work education and practice in India. The Generalist Core Competence approach is not only suited to a resource-scarce, culturally-diverse, practice-intensive and competitive environment like India, but also reflective of international developments and flexible to indigenous variations.

The competency or outcome based approach moves from practice to theory. Hence, the work for designing a competency-based approach for India has to start from the venues of Social Work practice in India.It is hoped that the current article stirs the minds of academicians and practitioners to question the present social work education system and contemplate the possibilities of adopting the Generalist Core Competence model as an effective alternative.

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Crop Diversification and Food Security in Kerala

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Abstract

The recent developments in agriculture in Kerala show crop diversification. The process of diversification is evident in different forms such as the cultivated area under food grain crops to non-food grain crops and one non-food grain crop to another non-food grain crop. During the early 1960s, the order of the first five preferred crops were rice, coconut, tapioca, rubber and pepper, in descending order of proportion to the total cropped area. But today the preferred crops are coconut, rubber, rice, pepper and arecanut. Rubber came in the second position. Coconut, rubber and pepper together constituted a major portion of the total cropped area. The main crops losing area were rice and tapioca. The crop diversification indices for all Kerala and districts revealed less diversification in the pre-1991 period compared to recent years. This has created an imbalance in the cropping system with serious economic and environmental consequences. Reduction in rice production, decline in the availability of livestock and its products, decline in food availability, and changes in the employment pattern in rural areas are some of the important economic consequences of crop diversification. Food security, particularly in the case of rice, is the vital issue for Kerala at present. This study shows that there will be an increasing demand for rice in Kerala in the coming years. This will enlarge the supply demand gap of rice in Kerala in future.

Keywords

Crop diversification, supply-demand gap, food security, Kerala

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Introduction

The agricultural scenario in Kerala continues to be the most important and single largest sector of the state's economy in terms of income and employment. In spite of the significant advances in industrial and service sectors, it continues to be the largest provider of employment and livelihood, both at state and district levels. The main agricultural systems comprising seasonal, annual, tree crops and plantation agriculture are prevalent throughout the state and cover the lowlands, midlands and parts of the highlands. Diversification of crops is the dominant feature of the state at the moment.

The concept of crop diversification has different meanings at different levels. Diversification means moving away from growing a single crop to a number of crops, a shift of resources from farm to non-farm activities, use of resources in a larger mix of diverse and complementary activities within agriculture, and a movement of resources from low value crops to high value crops (Sharma, 2007). In practice it is a relative concept and is used in terms of the degree of diversification. Crop diversification has been recognised as an effective strategy for achieving the objectives of food security, nutrition security, poverty alleviation, employment generation and income growth, judicious use of land and water resources, sustainable agricultural development and environmental improvement. No farm in India specialises in a single crop. A farm is treated as a diversified farm if no single product accounts for 50 percent or more of the total income. Several farmers adopted mixed cropping as a strategy of diversification. It is conditioned by the availability of inputs and growth in yield as well as prices (Deshpande, 2000).

One of the significant features of Kerala's agricultural scenario is the gradual shifting of areas from food crops like rice and tapioca to plantation crops like coconut, rubber and coffee (Karunakaran, 2013). The reduction in the area under food crops in Kerala from 40.43 percent in 1970-71 to 18.74 percent in 1992-93 and 16.52 percent in 2002-03 is a phenomenon that has happened very rarely in any state (Mani, 2009). The current trend reveals that Kerala is being converted into a non-food crop area. The main feature is the change in the cultivated area under food grain crops to non-food grain crops and from one non-food grain crop to another non-food grain crop. This creates an imbalance in the cropping system which affects

sustainable development and thus threatening food security, particularly rice securityand human progress. This paper therefore attempts to analysethe extent ofcrop diversification and the supply-demand gap of ricein Kerala during the pre-reform 1991 and post-reform 1991 periods. The projected demand for rice, which is very relevant following the introduction of the new economic policy in 1991, is also estimated.

Materials and methods

The study uses secondary data which was collected from publications of the Government of Kerala such as the*Economic Review, Statistics for Planning, Agricultural Statistics and Season and Crop Reports*. Different approaches tomeasure the extent of crop diversification are prevalent at present (Goswamiand Challa, 2004) and in this study the Herfindahl Index (HI) is employed. The Herfindahl Index (HI) is calculated by taking the sum of squares of acreage proportion of each crop to the total cropped area.

$$HI = \sum_{t=1}^{N} Pi^2$$

Where N is the total number of crops and P_i represents acreage proportion of the i^{th} crops to total cropped area. With the increase in diversification, the Herfindahl Index would decrease. The index takes a value of 1 when there is a complete specialisation and approaches 0 as N gets large (i.e., if diversification is perfect). Thus the HI is a measure of concentration; transformed by subtracting it from one, as follows:

Diversification Index (DI) = 1 – HI

Individual demand for rice for the state as a whole is worked out by multiplying the per capita consumption of rice by the population and aggregated by rural and urban. An attempt has been made to calculate the demand for rice in Kerala up to the year 2026 under different scenarios of growth in income (5-10%). The demand projections for rice were obtained by using the formulae developed by Sekhon et al (2008).

$$D_t = d_o * N_t (1+ y*e)^t$$

Where $D_t$is individual demand for rice in year t (2026), $d_o$isper capita demand for rice in the base year (2011), $N_t$is projected population in year t (2026), y is growth in per capita income (5-10%), and e is expenditure elasticity of demand for rice.

Analysis and discussion

In order to understand the extent of crop diversification in Kerala, a state level and district level analysis of the crop diversification areprovided. Firstly, the status of the land utilisation pattern in the state is examined. The data on the land utilisation pattern is shown in Table 1. It presents the land use classification during the pre-1991 and post-1991 periods in the state.

Table 1: Land use pattern in Kerala

Classification of Area	*Pre-1991 period*			*Post-1991 period*		
	1960-61 (%)	*1970-71 (%)*	*1980-81 (%)*	*1990-91 (%)*	*2000-01 (%)*	*2011-12 (%)*
Total geographical area	100.00	100.00	100.00	100.00	100.00	100.00
Forest	27.37	27.16	27.85	27.85	27.85	27.84
Land put to non-agricultural use	5.31	7.08	6.95	7.64	9.83	9.31
Barren and uncultivated land	3.91	1.85	2.21	1.49	0.75	0.46
Permanent pastures and grazing land	1.17	0.72	1.39	0.49	0.41	0.002
Land under miscellaneous tree crops	5.29	3.98	1.65	0.88	0.39	0.11
Cultivable waste	3.73	2.06	3.32	2.45	1.52	2.52
Fallow other than current fallow	1.61	0.59	0.69	0.67	0.88	1.17
Current fallow	1.74	0.62	1.13	1.13	2.01	1.98
Net area sown	49.87	56.34	56.09	57.81	56.78	56.11
Area sown more than once	11.02	19.59	18.15	19.89	20.98	12.56
Total cropped area	60.89	75.49	74.26	77.73	77.79	68.67

Area in 1000 hectare, percentage to Total Geographical Area.
Source: Computed from (i) Statistics for planning (various issues), Department of Economics and Statistics, Government of Kerala, Thiruvananthapuram. (ii) *Economic Review* (various issues), State Planning Board, Government of Kerala, Thiruvananthapuram.

On the basis of the cropping pattern, in 1960-61 the order of the first five crops was rice, coconut, tapioca, rubber and pepper. Table 2 reveals

that currently the first five crops are coconut, rubber, rice, pepper and arecanut. Rubber movedinto second position by pushing rice to third. Coconut, rubber and pepper together constituted 54.54 percent of the total cropped area. The main crops losing area were rice and tapioca.

Table 2: Rank of principal crops in the Total Cropped Area (TCA) in Kerala

Principal crops	*Pre-1991 period*			*Post-1991 period*		
	1960-61	*1970-71*	*1980-81*	*1990-91*	*2000-01*	*2011-12*
Rice	1	1	1	2	3	3
Coconut	2	2	2	1	1	1
Arecanut	6	7	7	10	8	5
Rubber	4	4	4	3	2	2
Pepper	5	5	6	4	4	4
Cashewnut	6	6	5	6	7	9
Tapioca	3	3	3	5	5	7
Coffee	10	11	8	7	9	8
Tea	8	10	11	11	11	11
Cardamom	9	9	9	8	10	10
Ginger	11	12	12	12	12	12
Banana and other plantains	7	8	10	9	6	6
TCA (%)	100	100	100	100	100	100

Source: Computed from (i) Statistics for planning (various issues), Department of Economics and Statistics, Government of Kerala, Thiruvananthapuram. (ii) Economic Review (various issues), State Planning Board, Govt. of Kerala, Thiruvananthapuram.

At the all-India level there were changes in the cropping pattern and this led to diversification in Indian agriculture (Goswami and Challa, 2004). Table 2 clearly shows the shift from food crops, mainly rice and tapioca, in favour of tree crops such as rubber and coconut in Kerala, which is supported by the diversification index shown in Table 3.

The transformed values of the Herfindahl Index were lower in the pre-1991 period which implies less diversification. The higher values in the post-1991 period indicate more diversification. Considering the value of

Table 3: Crop diversification indices for Kerala

Districts	*Pre-1991 period*			*Post-1991 period*		
	1960-61	*1970-71*	*1980-81*	*1990-91*	*2000-01*	*2011-12*
Thiruvananthapuram	0.799	0.793	0.809	0.779	0.749	0.785
Kollam	0.844	0.817	0.833	0.819	0.805	0.848
Pathanamthitta	_	_	_	0.813	0.778	0.781
Kottayam	0.892	0.896	0.842	0.746	0.713	0.701
Alappuzha	0.739	0.736	0.764	0.727	0.736	0.763
Ernakulam	0.824	0.822	0.776	0.799	0.813	0.848
Idukki	_	_	0.876	0.831	0.898	0.918
Trissur	0.692	0.718	0.676	0.734	0.747	0.784
Palakkad	0.631	0.693	0.694	0.783	0.821	0.873
Malappuram	_	_	0.824	0.812	0.803	0.833
Kozhikode	0.828	0.806	0.857	0.667	0.673	0.699
Wayanad	_	_	_	0.808	0.835	0.870
Kannur	0.808	0.828	0.879	0.831	0.837	0.853
Kasaragod	_	_	_	0.834	0.801	0.813
State	0.821	0.833	0.852	0.867	0.858	0.863

crop diversification indices for Kerala, the relatively less diversification in the pre-1991 period compared to the post-1991 period could be attributed mainly to the farmers' preference for growing more commercial crops and less subsistence crops. Crop diversification indices for districts in Kerala also show a high value of diversification index.

The main objective of any developmental activity is to improve the consumption levels of the poor sections of the society (George, 1980) and it has been one of the objectives of planning in Kerala (Venkiteswaran, 1984). Among the food items, rice is the staple food and it is an important and sensitive item of the consumption basket. An analysis of the changes in food availability over time has special significance in Kerala.

The immediate result of crop diversification in Kerala in the last few years, particularly during the post-1991 period, was a reduction in rice

production (Karunakaran, 2014). In 2011-12, the annual production was down to 598.34 thousand tonnes from 1067.53 thousand tonnes in 1960-61. Table 4 shows that during 1960-61 to 2011-12, the decrease in the supply of rice was observed compared to the continuous increase in the demand for rice in Kerala. A comparison of the figures in Table 4 reveals that, during 1960-61, Kerala had a shortage of rice of about 40.12 per cent, increasing to 64.17 per cent in 1990-91 and 77.37 per cent in 2000-01. In 2011-12, the rice shortage in Kerala was 83.45 per cent.

Table 4: Supply demand gap and projected demand for rice in Kerala

Supply demand gap of rice					
Year		*Demand for rice*	*Supply of rice*	*Supply demand gap of rice*	
		(1000 tonnes)	*(1000 tonnes)*	*(1000 tonnes)*	*%*
	1960-61	1782.93	1067.53	-715.40	40.12
Pre-1991 period	1970-71	2248.86	1298.01	-950.85	42.28
	1980-81	2674.29	1271.96	-1402.34	52.44
	1990-91	3032.43	1086.58	-1945.85	64.17
Post-1991 period	2000-01	3319.82	751.33	-2568.49	77.37
	2011-12	3615.98	598.34	-3022.64	83.45
Projected Demand for Rice					
	Growth rate (In %)	*Rural (In'000 tonnes)*	*Urban (In'000 tonnes)*	*Total (In'000 tonnes)*	
	5	4673.28	1761.27	6434.55	
2026 AD	6	5190.75	1925.16	7115.91	
	7	5762.98	2103.63	7866.61	
	9	7095.05	2509.66	9604.71	
	10	7866.60	2739.95	10606.55	

In view of the increasing demand for rice in Kerala, it is felt that the conversion of paddy fields into gardens or orchards of rubber and coconut will accentuate the food problem of the state in the long run. Therefore

an attempt has been made to calculate the demand for rice in Kerala for the year 2026 under different scenarios of growth in income (5-10%). The projected population calculated by the Census Commission of the Government of India, was also used. The income elasticity calculated by Viswanathan and Meenakshi (2006) for the rural and urban populations in Kerala was used in the demand projections for rice. Here expenditure elasticity was used as a proxy of income elasticity. Theaverage monthly per capita consumption of rice for rural and urban areas in Kerala calculated by the NSSO 55^{th} round Report was employed for demand projections (Viswanathan and Meenakshi, 2006).

The results of the projected household demand for rice in Kerala are presented in Table 4 and the data presents the increasing demand for rice in Kerala in the coming years compared to the existing supply. This will enlarge the supply-demand gap of rice in Kerala in the coming years, indicating a threat to food security and revealing a further increase in rice production in a sustainable way (Government of India, 2005).

Conclusion

The analysis of the cropping system according to the land utilisation pattern shows that the area under tapioca and rice has declined continuously ever since the pre-economic reform year, 1991. The area under total food crops also declined rapidly. Rice and tapioca lost the area of cultivation during the period while rubber and coconut gained in area.

By calculation of the index of crop diversification, the extent of crop diversification can be noticed. The measure of diversification informs that there was less diversification in the pre-reform 1991 period and high diversification in the recent years. The diversification in the cropping pattern mainly towards rubber was also noticed in more recent years.

The substitution of rubber and coconut at the cost of rice and tapioca has far reaching implications for food and price policies. The continuous rise in the price of food grains and the food shortage affects the poor population adversely more than ever before.The conversion of rice lands into other farm lands has decreased the supply of rice in Kerala and widened the supply-demand gap of rice. The estimated projected demand for rice reveals that the demand will increase in the coming years in Kerala. The situation of rice production in the state can be augmented only if policy

prescriptions are launched by the government to make the farmers risk bearers. The yield of rice can be improved by adopting better technology involving adequate, efficient and effective types of inputs. In the paddy sector,strict enforcement of various laws relating to land use should be followed by the revenue authorities. Keeping in view the sustainability and ecological problems created by crops like rubber, there is a need to introduce legislative measures, if possible, to divert area from these crops to rice.

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Inclusive Education in India and Russia: A Comparative Analysis of Legal Frameworks

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Abstract

This article addresses the question of the comparative analysis of legal frameworks in the inclusive education system of India and Russia. The objective is to consider the issue of inclusive education. Despite the differences in mentality, special conditions and features, India and Russia have the same problem in this sphere. The main problem of the system of inclusive education in India and Russia is the lack of specially trained teachers and detailed developed legal frameworks. India and Russia have no all-Indian and all-Russian law about inclusive education. There were no significant differences of legal frameworks of inclusive education in India and Russia. There are significant differences in special conditions of transition to inclusive education in India and Russia. The lack of necessary conditions in schools and the lack of government policies and finances are the main barriers to inclusive education.

Keywords

inclusive education, people with disabilities, Russia, India

Introduction

India and Russia are countries with inclusive educational problems. Inclusive education gathers all students together in one class and social group and gives the opportunity to maximize the potential of all disabled

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learners. The importance of inclusive education is especially relevant in the context of India and Russia. In comparison with western countries, the systems of inclusive education in India and Russia are not properly developed. Most of the adults and children with disabilities do not have equal access to education in both India and Russia. In accordance with the new Russian law 'About Education' which came into force on 1 September 2013, disabled education was announced as one of the priorities of the educational policy. But, to what extent is the society ready for this innovation? Despite the validity of this law, privileges for disabled people who entered universities have been significantly reduced (Pavenkov et al., 2015; Rubtcova et al., 2015). The main cause of this was the public disaffection because priority was given to the disabled over healthy people in this relation.

Nine per cent of the population in Russia has some form of disability. This is 13 million people with special mental, intellectual or physical development needs, of varying degrees. (Kalabekov, 2010). These people should live in specially adapted conditions which often require considerable support in education.

In India the same situation obtains. India is a country with similar educational problems. In 2005, 2.2 per cent of the Indian population or 21,906,769 was disabled, but NGOs think that the figure would be closer to six per cent or 70 million (Thomas, 2005). Most of the adults and children with disabilities do not have access to education. Even if they have finished higher education, nobody helps these children to enter the mainstream community thereafter. In accordance with the Indian law of the Disabilities Act, which came into force in 1995, persons with disabilities have equal opportunities, protection of rights and full participation in the educational process. The Disabilities Act is a signal achievement for the system of Indian inclusive education. The preamble to the Disabilities Act clearly outlines its objective of promoting and ensuring equality and full participation of persons with disabilities. The Disability Act aims to protect and promote the economic and social rights of people with disabilities. (Mohitand Rungta, 2004). In India there is an increased number of special schools, which indicates that disabled children are capable of being integrated or included and could be admitted to mainstream schools (Bagga, 2010).

The development of the system of inclusive education in India and Russia from 1990

All phenomena have historical aspects. It is thus necessary to analyze the historical aspect of the development of inclusive education in India and Russia. A comparative study of the modern development of legal frameworks of the system of inclusive education in India and Russia is required. The system of education of persons with disabilities was created in the USSR in 1920. This system considers the disabilities of children as defects and children with disabilities have to be isolated from society. This exclusive ideology was dominant in the USSR. The system of social education in the USSR (1922-1926) is shown in Figure 1.

This system existed with some changes until the 1990s, when the USSR was destroyed. There are three stages of modern development of the system of inclusive education in India and Russia since 1990.

Figure 1: The system of social education in the USSR (1922-1926)

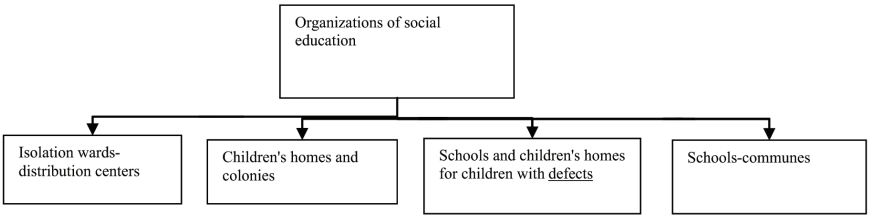


Table 1: Development of the system of inclusive education in India and Russia, since 1990

	India	*USSR / Russia*
1. The beginning of 1990	1992. Programme of Action (POA). The main achievement of this document is the idea that children with special needs must not study in a special school. A child with a disability who can be educated in the general school should not be in the special school (Hegarty	1990. Law about education. On the basic principles of social protection of disabled people in the USSR. This law consists of the whole system of rules that forms an institution of education and training of persons with disabilities.

	and Mithu, 2002).	
	1992. Rehabilitation Council of India (RCI) Act. An Act to provide for the constitution of the Rehabilitation Council of India for regulating the training of rehabilitation professionals and the maintenance of a Central Rehabilitation Register and for matters connected therewith or incidental thereto.	1992. The law about education (Government of Russia, 2012). The state provides the right to all citizens for education by creating a system of education. 1993. The Constitution of Russian Federation. 1. Everyone shall have the right to education. 2. Guarantees shall be provided for general access to and free pre-school, secondary and high vocational education in state or municipal educational establishments and at enterprises (Government of Russia, 1993) The guarantee of educational right of person.
2. 1995-2005	1995. The Persons with Disabilities Act (PWD Act). The main principles of this act are equal opportunities, protection of rights and full participation. The number of special schools should be increased to 3,000 by 2000. There were only 9,492 specially trained teachers. Of these 4,295 were trained to teach students with mental retardation, 1,079 were trained to teach students with visual disabilities, 4,011 were trained to teach students with hearing impairments, and	1995-1996. The decision of the Ministry of Education of Russia to include the curricula of pedagogical universities from 1 September 1996 courses such as the introduction in special (correctional) pedagogy and features the psychology of children with disabilities.

	107 were trained to teach students with locomotor disabilities in India (Sharma and Deppeler, 2005). A government study in 2004 revealed that only 0.51% of disabled students are in mainstream educational institutions at the school level (UNICEF India, the United Nations, 2012).	
	2005. The Ministry of Human Resource Development also drafted the Action Plan for Inclusion in Education of Children and Youth with Disabilities (IECYD) (Kalyanpur, 2008).	
3. 2005-2014	2009. Inclusive Education of the Disabled at the Secondary Stage (IEDSS). The objective of IEDSS is to enable the disabled children who have completed eight years of elementary education to continue their education at the secondary stage in an inclusive environment in regular schools (Government on India, 2009) 2009-2010. The Right to Education Act. This act put into effect in 2010.	2009. State educational standard—every school should create and execute the programme of inclusive education (correction work). 2012. Moscow law. About education of persons with disabilities (special education).

The first school of inclusive education Ark appeared in Russia, in Moscow in 1991. Since the autumn of 1992, Russia launched the project of the integration of persons with disabilities, resulting in the creation of 11 regions on site experimental education for disabled children. In 1995 the Ministry of Education of Russia made the decision to introduce into the curricula of pedagogical universities from 1 September 1996 courses such as "introduction in special (correctional) pedagogy" and "features psychology of children with disabilities." In 2009, the new educational standard was admitted. According to this standard, every school should create and execute the programme of inclusive education (correction work). The programme of inclusive education should be directed to the correction of deficiencies in the physical and (or) mental development of children with disabilities and to support special children in studying and understanding the basic educational programme of primary education (Ministry of Education, 2011).

The Moscow law about education of persons with disabilities (special education) was put into full force in 2012. This law was an important step towards the development of inclusive education in Russia. It established three main ideas:

- First, the right of the person for early remedial help is ensured by this law.
- Second, the right of parents to choose the educational institution for the disabled child. Today there is a violation of human rights in this area. Schools refuse to accept these children, although the current law suggests the opposite.
- Third, the rights of children with disabilities to have technical means and receive distance education. These rights are clearly spelled out in the law.

The same ideas were enshrined in the Right of Education Bill which was adopted in 2009 in India by the Government of India and put into force in 2010. The right of the child to free and compulsory education became one of the most fundamental rights in India. From this time, the main principle of education in India as well as in Russia is free education. Free education means and includes providing elementary education to all children with no direct costs like fees/capitation fees,

or indirect costs like kind/services/fees for stationery, to be borne by the parents of the child. (Government of Andhra Pradesh, 2010).

The problems of modern system of inclusive education in Russia

In the context of the social and economic changes in the Russian Federation, the system of inclusive education has changed. However, at the same time this system reproduces Soviet stereotypes and educational standards. The latent purpose of inclusive education is to give education to people who are able to survive on an everyday basis. Educational perspectives are limited. However, the politics of special education for children with disabilities marginalise children and limit their social orientations and perspectives. The system of inclusive education in Russia has a number of problems:

1. Lack of educated teachers
2. Financial problems
3. The moral motivation of teachers to support students with disabilities is very weak. Such a problem is caused by the value orientation of modern teachers, who focus on talented children and reject some special children.

From another point of view, the main problem is the inaccessibility for children with disabilities to higher education and as a result inaccessibility to get normal or highly paid work places. Persons with disabilities cannot enter the universities after finishing special correctional schools or boarding schools for children with ICP (Elevated intracranial pressure). Such persons are directed to professional rehabilitation schools, but diplomas from such lyceums are not admitted by employers. As a result, they cannot get a normal job. Only children from fragile Xsyndrome-classes can continue education in a university by passing USE-exam (United state exam) and they can get a job. This is the main problem of the modern system of inclusive education in Russia.

The same problem is found in the system of education in India. The system of inclusive education is part of the general system of education in India, which is shown in Figure 2. Inclusive education in India exists only at the following level of education:

- Primaryspecialschools (6-11 years)
- Secondary and higher secondary special schools (11-15 years)

In India, special schools are private schools often located in urban areas. They date back to the 1800s (Byrd, 2010). The first special schools were founded by Catholic missionaries. The mission through education as well as social mission always was the main method of Christian mission in India. Now most of the special schools are founded by the Government of India. According to the study of Rao and Reddy (2004), various services are available in these centers, as shown on Table 2.

Table 2: Services available at special schools in India

Facilities/services	*% special schools*
Residential	26
Prevocational + vocational training	60
Home based	32
Early intervention	31
Sheltered workshops	13
Integrated services	17
Intellectual disabilities only	57
Multiple disabilities	23

Source: Rao and Reddy, 2004.

The number of special schools in India is extremely small (approximately 2500). Such schools cannot provide for all children and students with disabilities. Only 46% of children with disabilities attend schools, as shown Table 3.

Table 3: Condition and statistics of inclusive education in India

Estimated number of children attending school	192 million
Disabled population (including adults)	21.9 million (2001 census)
Literacy Rate	65.38% (45% for disabled)
Disabled Children	12 million

Children with Disabilities Attending School	46%
Special Education Law	Persons with Disabilities Act of 1995
Other important legislation	Rehabilitation of India Act of 1992: National Trust for Persons with Autism. Cerebral Palsy. Mental Retardation and Multiple Disabilities Act of 1999.
Types of Education Provided	Integrated and Special Schools
Name of Major Categories	Blindness, low-vision. leprosy-cured, hearing impairment, mental illness, loco-motor disability, intellectual disability
Number of Teacher Education Programmes for Special Education	37

The main problem of the development of the modern system of inclusive education in India is that the majority of people in the country are poor. A lot of disabled children live in very poor families. In countries like India, the social problem of poverty causes disability. Harriss-White (1996) noticed that this problem of poverty creates barriers to the participation of disabled children in the normal routines, especially regular school study.

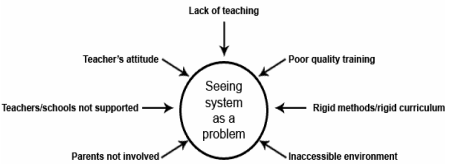
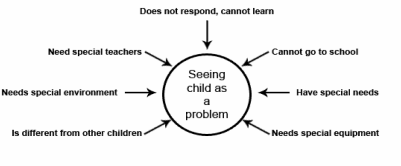
Special conditions and features of transition toinclusive education in India and Russia

It is important to stress the difference between the systems of inclusive education in India and Russia. From one point of view, this difference is caused by the special conditions and features of transition to inclusive education in these countries. India is a post-colonial country. The Indian system of education is under the powerful influence of the USA and the UK. The right of all students to be educated in mainstream schools has been strengthened further by specific legislation in the United States and Great Britain. In the US, legislation such as the Individuals with Disabilities Education Act (IDEA) has influenced significant progress for inclusive education (Duke, 2009). This Act was admitted in 1975. The Special Education Needs and Disability Act was put into effect in the UK in 2001. The

right of education bill, which was admitted in 2009 year by the Government of India, is continuation of this process.

The transition to inclusive education in Russia occurs in the situation of democratic norms, their first legislative design and deep economic crisis. Inclusive education is needed for the humane treatment of people with disabilities and recognising the fullness of their rights. Transition to inclusive education in Russia occurs in an atmosphere of permanent national conflicts (for instance, the situation in the Ukraine, 2014-2015). Inclusive education in Russia is faced with financial problems. The Russian tradition of charity was interrupted in 1917, and currently there is a very weak social movement. Supporting people with disabilities is not stimulated by sufficient financial subsidies. There was an unwritten taboo on discussing disability issues in the media sphere, but currently there are some changes in the Russian public consciousness.

Table 4: Special conditions and features of transition to inclusive education in India and Russia

Inclusive education in India	Inclusive education in Russia
System as a problem	«Child as a problem» (Rao, 2003)
	
The disadvantages of the system of education are considered as the problem for inclusive education. The main trend of development is transition of inclusive education from special schools to integrated education	Inclusive education in Russia considers the special child as a problem for the social system. Unfortunately, such an approach was saved from Soviet-Union epoch. The main trend of development is transition of inclusive education from correction of person with disability to inclusive education and adaptation.

Conclusion

In this paper we have analysed the comparative research of inclusive education in India and Russia. The common problems of the system of inclusive education in India and Russia are that the majority of people are poor, there is a lack of specially trained teachers and a helpful legal framework. India and Russia do not have all-Russian and all-Indian laws on inclusive education.

One of the most important findings of this study is the different consideration of the object of these problems. If Russian educational and government organisations consider the disabled child as a problem, Indians consider the system of inclusive education as the main problem. One of the aspects of the system is the quantity of specially trained teachers, which is small in India.

'Inclusive growth' is a priority for reform in Indian education. With the growth in the middle classes, Indian universities must prepare themselves for considerable changes in their student profiles.

These different views influence the specifics of transition of inclusive education in India and Russia. Rulers understand these problems and the situation is changing for the better. In 2009, the Russian president Dmitry AnatolyevichMedvedev said: "We need to create a normal system of education for children and young people with disabilities to learn among peers, including in ordinary secondary schools. This is necessary not only for them, but for all society" (Kyzmin, 2009).

India's 12th Five Year Plan offers a new perspective of development of the system of inclusive education. To counter education discrimination against people with disabilities, the Plan has to adopt the strategy of service delivery. "In the area of service delivery the challenges to be addressed include...improving participation and completion rates of students with disabilities at various stages of education (elementary, secondary and tertiary). Emphasis on the 12th Plan will be on educational development through: (i) Pre-Matric Scholarships for students with disabilities; (ii) Post-Matric Scholarships for students with disabilities; (iii) free coaching for students with disabilities; (iv) Special/ Residential school for students with severe and multiple disabilities, in districts not having Government special

schools; (v) Hostels for existing Government special schools not having hostels and augmentation of seats in existing hostels of Government special schools; (vi) Support for establishment/modernisation/capacity augmentation of Braille Presses; (vii) Scholarships for 'Top Class' education for students with disabilities studying in premier higher education institutes (like IITs, NITs and so on); (viii) Rajiv Gandhi National Fellowship for persons with disabilities; (ix) National Overseas Scholarship for persons with disabilities; (x) establishment of a college for deaf in each of the five regions of the country and (xi) establishment of a National Accessible Library." (Government of India, 2012/2017).

Thus, despite the differences in the special conditions and features, India and Russia have to solve the same problems in this matter and the two countries demonstrate similarities in the organisation of inclusive education.

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The Psychosocial Context of Youth Tobacco Use: Neglected or Forgotten?

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Abstract

Tobacco is a global epidemic killing six million people a year and this, according to theWorld Health Organisation (WHO, 2015), is expected to rise to eight million by 2030. It is not just this increasing death toll due to tobacco use that is crucial in calling it a public health priority. Tobacco is also the single most preventable cause of death among the five greatest risk factors for mortality including cardiovascular diseases and cancer. According to WHO, tobacco use is attributed as the cause of more than 70 per cent of deaths from lung, trachea and bronchus cancers (WHO, 2015). This indicates that a crucial proportion of our productive population die prematurely because of tobacco use which is totally preventable. Although several factors are responsible for tobacco use among youth, the psychosocial context of young people is primary in the initiation and sustenance of smoking, but is seldom targeted in preventive interventions. This article examines the psychosocial context of tobacco use by the younger generation in relation to smoking and how young tobacco users perceive the advertisements intended to curb and prevent tobacco use.

Keywords

youth tobacco use, tobacco initiation, anti-tobacco advertisement, Kerala

Introduction

Tobacco is a global epidemic killing six million people a year and this is expected to rise to eight million by 2030 according to the World Health Organisation (WHO, 2015). This makes tobacco prevention and control a public health priority all over the world, especially in India. In 2014, after

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studying a series of papers published in Lancet Oncology journals, *the Hindu* reported that tobacco use alone accounts for about 40 per cent of all cancers in India (Prasad, 2014). According to the Global Adult Tobacco (GAT) survey report of India in 2009-10 Kerala State, having the highest literacy in the country,has a smoking prevalence rate higher than the national average. The statistical data also shows that the prevalence of current smokers alone is 22.4 per cent with 35.4 per cent of males in the age group of 15 years and above as "current tobacco users" (IIPS & MHFW, 2010). This calls for a serious review of the tobacco prevention and control activities in order to facilitate the use of target specific strategies for preventing and controlling this grave public health challenge.

The psychosocial context of tobacco use

Like alcohol consumption, prevention of tobacco use is a difficult area to handle when it comes to operational activities. Although an array of factors, from pricing and accessibility to tobacco to media promotions, play their own roles in tobacco use by the younger generation, the psychosocial context of young people is apparently less recognised despite its key role in it. Tobacco use among youth is closely linked to many factors in the family and social life of young people. Initiation and maintenance of tobacco use is well supported by these factors which make preventive activities ineffective.

Globally, tobacco use has been found initiated at a younger age, ranging from 11 to 15 years of age (Caraballo et al., 2006; Narain et al., 2011; Swart et al., 2003). Starting tobacco use at an early age presents more risk since it is more likely to be continued for a longer time among the users. Initiation of tobacco use and its maintenance is closely related to some factors in the family environment of youth. Researchers have found that poor parental monitoring (Griffin et al., 2000; Scragg and Laugesen, 2007) is a key moderating factor in the initiation of tobacco use among adolescents. The smoking habits of parents or other adult family members hasalso been found to be associated with initiation of tobacco use by youth (Harakeh et al., 2004; Nofziger and Lee, 2006; Roberts et al., 2005; Scragg and Laugesen, 2007; Tercyak, 2003). According to Wang and colleagues, parental smoking was found associated with a 30 per cent increase in the likelihood of adolescents becoming current smokers and the number of friends who

smoked was associated with a 44 per cent increase (Wang et al., 1999, cited in Tercyak, 2003). High levels of family conflict was also found to contribute to tobacco use amongst youth (Biglan et al, 1995).

Peer influence was found to be another major influence in initiating and maintaining tobacco use amongst youth. Exposure to smoking peers and social acceptability of smoking in friendship circles influence the smoking decisions of youth. According to Chadda and Sengupta (2003), peer pressure is an important determinant in initiating tobacco use among adolescents where modeling and social approval play key roles. When one is distressed for any reason, an offered cigarette orbeediby a friend initiates the conforming process with a tobacco-using peergroup network (Patel, 1999 cited in Chadda and Sengupta, 2003). Corona and colleagues (2009) found exposure to smoking peers as the second stronger predictor factor of tobacco use. Taylor et al. (2004) found that adolescents with at least one significant smoking peer have a four times greater probability to smoke than others.

School related factors are also a major influencing factor of tobacco use. Corona et al. (2009) found academic failures as the strongest predictor risk factor for smoking initiation. According to Byrne and Mazanov (2003) smoking could be a coping strategy young people resort to, in dealing with stress related to academic achievement and social acceptability. Youth who experience difficulties in school may also be less engaged in or connected to their school than their peers, which may limit their exposure to school-level protective factors (Corona et al., 2009).

The existing literature also suggests that it is not just the social factors which are crucial in the initiation and maintenance of tobacco use. Psychological distress has been consistently reported to be associated with youth smoking (Brown et al., 1996; Covey and Tam, 1990; Patton et al., 1996). Escobedo et al. (1996) found depression as a strong predictor of smoking initiation. After conducting a qualitative study among low-income African American and European American adolescents, Scales et al. (2009) found the primary reasons for smoking initiation was for coping with stress, for social acceptance, and due to environmental influences. Family issues, boyfriend/girlfriend problems and school were reported as the common stressors.

Resorting to tobacco when facing a stress situation also shows that directly or indirectly young people learn to associate the use of tobacco with stress. Exposure to the positive feel effects of tobacco happen much before one initiates tobacco use. Although attached with statutory warnings, movies and advertisements foster positive attitudes, beliefs, and expectation regarding tobacco use right from childhood. These foster intentions to use and increase the likelihood of initiation. This is seen in diverse cultures and persists when other risk factors, such as socio- economic status or parental and peer smoking, are controlled (DiFranza et al., 2006).

After reviewing the studies on tobacco use among young people, it was found that the majority of these studies focused on school students. Fewer studies have been conducted among regular tobacco-using young people. The present study was conducted with the objective of gaining a better understanding of the psychosocial factors related to tobacco use among young people who are regular tobacco users. The study also attempted to understand how young people perceive anti-tobacco advertisements. The study was conducted among male tobacco consumers in the age group of 18-35 years in Kochi city. The researcher used accidental sampling for selecting the respondents. During the month of September 2014, those male tobacco consumers who visited tobacco vendors for buying tobacco were interviewed based on their availability and willingness to participate in the study. Interviews were conducted with sixty respondents using a structured interview schedule.

Findings

The mean age of the respondents was 25.85 years with more than half of the respondents falling in the 20-30 year age group. About 15 per cent of the respondents were below 20 years of age. More than half of the respondents (55%) were pursuing their education; while another 40 per cent were employed. Those who were employed had mostly received higher secondary education. About 67 per cent of the respondents were unmarried while more than one third (33.3%) of the respondents were married.

Psychosocial factors promoting the use of tobacco among the youth

About half of the respondents were found to be daily visitors to the tobacco vendors while more than one third of the respondents visited the

shop twice or three times in a week. The majority (66.7%) of the respondents smoked two cigarettes a day while nearly one-third of the respondents smoked three to eight cigarettes every day.

The majority of the respondents had at least one member in his family who smoked. More than one-third of the respondents had tobacco consuming fathers while 27 per cent of the respondents had siblings who smoke and another 22 per cent had relatives who smoked. Only 15 per cent of the respondents belong to the category that do not have tobacco consumers in their families.

When asked about the initiating factors into smoking, peer influence was found to be the prime factor which introduced about 98 per cent of the respondents to smoking. Stress closely followed on peer influence (97%) as the second influential factor in initiating tobacco use while influence of smoking relatives/family members (87%) was reported as the third influential factor. Familial problems (83%) also were reported as an important initiating factor by the respondents.

Regarding the trigger factors in everyday smoking, all the respondents reported everyday stress to be the most triggering factor which prompted them to smoke during the days on which they smoked in the previous month. Depressive feelings (98%) were reported as the second most important trigger factor while anxiety (88%) also prompted the majority to smoke regularly during the days they smoked in the previous month.

Regarding the immediate factors that led people to smoke, the majority (62 %) of the respondents reported that they always feel tempted to smoke when others around them smoked whereas 32 per cent often felt like smoking on seeing others smoke. Thus watching others smoke tempted almost 93 per cent of the respondents to smoke. In addition, 93 per cent of the respondents mostly smoke while they were in a group whereas only seven per cent of the respondents mostly smoked by themselves.

When asked about the factors which maintain tobacco use among the respondents, all the respondents reported peer influence as the primary factor in continuing the tobacco use. Stress (93%) was reported as the second most important maintaining factor followed by smoking being seen as a status symbol (70%). Familial problems (67%) and unforgettable past experiences (60%) were also reported as factors that maintained tobacco use among the respondents. About one-third of the respondents reported

that not being able to quit tobacco use itself led to further use while the majority (62%) did not find it to be a maintaining factor.

The majority of the respondents (63%) were frequently asked by family and peers to quit smoking whereas one-third of the respondents were at times asked to quit smoking and three per cent respondents were not asked to quit smoking at all. More than half of the respondents rarely tried to quit smoking while one-third of the respondents often tried to quit smoking. But the majority of the respondents (68%) were rarely influenced by others to quit smoking whereas 28 per cent were often influenced to quit smoking.

Perception of the youth towards anti-tobacco advertisements

Among the public places where anti-tobacco advertisements are noticed by the respondents, cinemas and theatres (97%) were reported by the respondents as the most frequent places whereas restaurants and educational institutions (90% each) were reported as the second most frequent places. About 35 per cent of respondents often saw anti-tobacco advertisements at hospitals while the majority did not notice such advertisements at hospitals.

The majority (80%) of the respondents often paid attention to the anti-tobacco advertisements, logos and boards while 17 per cent of respondents rarely give attention to such advertisements. While one-third of the respondents considered anti-tobacco advertisements as relevant and important, the majority (67%) rarely found them relevant and important. Half of the respondents often felt that the anti-tobacco advertisements threaten their freedom to consume tobacco whereas 40 per cent rarely felt threatened by anti-tobacco advertisements. A very small proportion(3%) of respondents always felt threatened by the anti-tobacco advertisements. On viewing anti-tobacco advertisements, fear was reported as the first feeling experienced by 47 per cent of the respondents while another 45 per cent reported feeling sarcasm. Nearly half of the respondents also felt annoyed on seeing anti-tobacco advertisements.

On enquiring about the influence of anti-tobacco advertisements, all the respondents reported having a desire to reduce their tobacco intake on viewing such advertisements. Among them, 60 per cent felt the need to reduce their intake of tobacco to some extent whereas 40 per cent very much felt the need to reduce their intake of tobacco. More than three-

fourths of the respondents (78%) felt that they needed to change to safer brands while 67 per cent of the respondents were reported to think about quitting tobacco use after viewing the anti-tobacco advertisements.

Discussion

The study was done among youth who were regular tobacco users in which more than half of them were students. The findings show that the presence of smoking family members and peers are critical factors in the tobacco use of young people, whether it is initiation or maintenance of the use. The results go well with the existing literature on tobacco use among youth (De Vries et al., 2003; O'Loughlin et al., 2009; WHO, 2009). According to De Vries et al. (2003), a longitudinal study on 15,705 adolescents from six European countries found that adolescent smoking was most strongly associated with friends' smoking and best friend's smoking, explaining 38 per cent of the variance in the total sample (De Vries et al., 2003).

Stress and depressive feelings were also identified as factors that play a key role in the initiation and sustenance of tobacco use among youth. Stress was reported as the highest trigger factor prompting them to smoke during the days they smoked. This was true in the case of both students and working men. This shows that young people are inclined to use tobacco as a ready-to-use coping mechanism in times of stress. This may be because of the learned images they have about their smoking family members or friends or celebrities whom they admire. Actors using smoking as either a stress reduction or depression escape strategy are more influential than the statutory warnings along with the film. Since tobacco is fast growing as a silent killer, this issue needs to be addressed for effective tobacco prevention and control. Policy level interventions are required for addressing this issue. On the other hand, family and school connections are important in serving as buffers against stressful situations. But familial issues and school related problems also make essential the need for supportive adults outside the home or help lines for reaching out to those young people in need.

It should also be noted that the majority of the respondents felt tempted to smoke when others around them smoked. Most of the respondents smoked while they were in a group. Proper implementation of the ban on

smoking in public places is one effective strategy to reduce such opportunities to tempt tobacco users, although this may not be a solution to smoking in peer groups. Smoking is a learned behaviour which is usually modelled in social situations. Therefore, for effective unlearning or for modelling positive behaviour, a peer-led educational strategy based on social learning and cognitive theories needs to be utilised. Experiments based on conceptual models built around these theories need to be tested to find out the efficacy of such models.

Together with this finding, it is to be noted that although the majority of the respondents were initiated into smoking by others, they were rarely influenced by others to quit smoking. This may be because the two sets of people were probably different. Peers influenced young people to smoke but usually elders will be the ones who will tell them to quit smoking. Hence a peer-based prevention and control strategy could be a better option to help young people. A randomised controlled trial experiment on a peer-led smoking prevention programme conducted in Romania found that the programme resulted in building negative beliefs and attitudes towards smoking and increased social self-efficacy levels among adolescents (Lotreanet al., 2010).

Being not able to quit tobacco was another important area practitioners and policy makers need to attend to. The Global Youth Tobacco Survey (GYTS) in India reported that out of 10,112 students surveyed, about two-thirds of the sample wanted to quit smoking (WHO, 2009). Although it is easy to initiate tobacco use, quitting requires external help and continued support for not relapsing into the habit. Stress management techniques, counselling services, telephonic or in person, are vital in helping young people to continue abstaining from tobacco. When an individual decides to quit the usage of tobacco it becomes the responsibility of the individual's family and friends to provide support and a favourable environment which would help in facilitating the process of quitting smoking or tobacco consumption.

The study also showed that anti-tobacco advertisements have prompted many young people to change to safer brands. This might be because of the clear depiction of the specific health risks of tobacco in such advertisements. Blake et al. (2010) reported that knowledge of the negative effects of tobacco and smoking status are associated with attitudes towards

tobacco control. Anti-tobacco advertisements need to be an aggressive part and parcel of wherever today's young people live, both in virtual and actual places. But the same type of advertisements may not attract both young and older people. Public private partnerships or Corporate Social Responsibility (CSR) initiatives for developing target specific, creative, informative and challenging advertisements also need to be undertaken, highlighting the specific health risks of tobacco use.

Conclusion

Globally, tobacco has become a pandemic requiring immediate and serious attention. Recognising tobacco as a public health priority and implementing target-specific preventive and control interventions are essential in this context. The increased tobacco use among youth is alarming as well as it points towards their psychosocial context which facilitates the use of tobacco. This calls for addressing the issue by utilising behavioural models of intervention as well as multipronged approaches in both the prevention and cessation of tobacco use among youth.

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Regulatory Framework in Healthcare Delivery: A Study of the Kerala Medical Travel Industry

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Abstract

Kerala has become a major international destination for healthcare.People from the South Asian Association for Regional Co-operation (SAARC) countries, Middle-East countries and the developed world look up to Kerala in their search of cheaper quality healthcare. There are many multi-speciality hospitals and medicities with accreditations and trained and experienced doctors. It can be observed that, in the last few years, billions of rupees have been invested in the healthcare sector of Kerala. Hospitals position themselves as centres of international healthcare. However, there is a regulatory vacuum in healthcare delivery and it has direct repercussions when it comes to international healthcare delivery. The absence of a regulatory framework leads to many unethical practices. This will force international patients to switch to other international competitors. This article describes the various ethical and legal concerns of Kerala medical travel from the perspectives of hospitals and intermediaries. This article evaluates the regulatory environment of Kerala and puts forward suggestions to address the issues by the industry players including public sector undertakings.

Keywords

medical travel, health care delivery, regulation, ethical issues

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Introduction

The earlier system of healthcare which was nationally bound and locally based has been changed to an international healthcare system where patients can go anywhere in the world to get appropriate treatment. The fast-growing trend of cross border travel looking for inexpensive and quality healthcare services while incorporating an extended holiday on discretion is termed medical travel or Medical Tourism (MT). Medical tourism is the catchphrase of the new globalised world which enhances the revenue portfolio of many direct and indirect sectors of the economy (RNCOS, 2011). More than 50 nations have identified MT as a national industry (Gahlinger, 2008; Rad et al., 2010). Kerala has been a hopeful destination for health seekers from abroad for decades and now witnesses a diverted trend of seeking curative care in the modern medical treatment system. It has become a good source of foreign exchange as well. It paved the way for a drastic development of the healthcare industry especially in catering to the needs of international patients. There are many corporate, super specialty and multi-speciality hospitals and medicities that have this international orientation. Qualitatively and quantitatively, healthcare facilities have been improved in Kerala over a decade (Destination Kerala, 2015). Currently Kerala has 22 hospitals accredited with the National Board of Accreditation for Hospitals (NABH) including public hospitals compared to 2005 when no accredited hospitals existed there (Destination Kerala, 2015). There are two Joint Commission International (JCI) accredited hospitals compared with no single hospital in 2005 (Destination Kerala, 2015). Kochi has become the hub of Kerala MT with its cultural, political and geographical advantages. Major cities like Calicut and Trivandrum are receiving a good number of patients from abroad. The high end technology, the talent pool and intellectual wealth of Kerala, its English speaking population, good connectivity, moderate climate and a wide variety of natural and cultural attractions have motivated many discerning patents to come to Kerala (Destination Kerala, 2015). The treatment cost in Kerala is 30-70 per cent less, including the expenses for air travel and accommodation, when compared to the cost in the international market (Destination Kerala, 2015). For example, a heart bypass

surgery costs USD 130,000 in the US but in Kerala it is USD 7,000 (Destination Kerala, 2015). Similarly, a knee replacement in the US costs around USD 40,000. Here it is 9,200 USD (Destination Kerala, 2015). Kerala is aiming to become the health tourism hub of India by 2020, by earning 15 per cent of the market share in the Indian medical travel industry from its current share of about seven per cent. To this end, hospitals and the Confederation of Indian Industries in collaboration with the state government have been conducting bi-annual International Kerala Health Tourism Conferences since 2005 (*Malayala Manorama*, 2015).

According to the Ministry of Tourism, as against an ordinary vacationer per capita expenditure of US$3,000 per visitor, the average medical traveller in India spends more than $7,000 per visit (Riesman, 2010). MT is identified as an opportunity and hence hospitals including general, dental and eye care specialties, spend huge amounts in healthcare and are adopting various promotional strategies to woo medical travellers. For this reason, there are chances for commercialization and malpractices. Above all, unlike other businesses, life is being handled in MT industry, which requires the utmost care as ignorance, negligence or malpractices will have serious repercussions. Being a knowledge specific industry, MT practice requires certain competencies. Sufficient knowledge within the medical care industry and know-how of marketing medical care and leisure are the prerequisites for operation within this niche market. Legal risks, medical risks and communication errors need to be addressed effectively.

MT has become a complex phenomenon by its very nature and there are chances of clinical errors and malpractices which will be aggravated in an unregulated environment. According to Riesman (2010), about 90,000 patients have died due to medical negligence. Yet there are several obstacles which make foreign patients reluctant to complain against the issues in another country. Sometimes it is the weak legislation, especially in developing nations, which keep them away from litigation. Steven (2010) called for responsiveness in the case of surgical negligence without meaningful legal recourse and using medical devices which are not on par with the US FDA (Food and Drug Administration) or equal standards for safety. Presently there are no dependable, complete sources for patients

to learn about the legal ways for malpractices committed in jurisdictions (Steven, 2010). In many countries, doctors try to deceive medical tourists by suggesting to them that they undertake a sequence of unwanted tests which are not related to the patient's illness (Riesman, 2010). The ethical issues include (1) falsified promotional claims; (2) provision of inadequate information (3) unreasonable claims of clinics; (4) excessive financial burden; (5) clinics which do not stick to international or national guidelines (stem cell-based treatments); and (6) inadequate patient informed consent, including concealing the side effects of treatments from the patients. Henderson (2004) suggests the necessity for firm controls on the promotional aspects, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievances procedures.

The healthcare providers in MT are suspected for commercialised services and inflated rates. 'Health' which is marketed through websites with 'tourism' and other sales promotion activities and are 'packaged' may create an image of suspicion. There is no uniformity in cost and quality across hospitals which are competing with each other. A wide gap exists in treatment costs between hospitals across the countries and across the world. For instance in India, a liver transplantation will cost more in Chennai than in Cochin (Destination Kerala, 2015). Again, there is an enormous difference in cost when treatment is offered to a foreign patient. Even though some might find the cost inflated, they will not question thisas the rates are still cheaper when compared to the expenses of the home nation. This finally makes the healthcare providers keep the rate high. Ability to pay determines access to care; the more customers are ready to pay, the more services they can purchase and in turn, limited economic resources buy limited care (Turner, 2011). MT often results in a way of widening the gap between the 'haves and have-not' (Tattara, 2010). In a study conducted among the vice presidents of hospitals in Bangkok, James (2012) found that costs are fluctuating even when the treatment is proceeding. While agreeing with the fact that individual cost of treatments will vary, there are hidden charges. "Add-ons" such as stays in luxury hotels and exclusive tourist resorts are determined by how much customers are prepared to

pay (Turner, 2011). Again, medical provision in Bangkok combined with the commercial operating notions of a five star hotel has led many first-world patients to select South East Asia as a medical-related destination (James, 2012). The demand for highly technologised medicine in a limited number of profitable specialities also creates distortions within the health care system. These include 'cherry picking', whereby corporate hospitals only provide the health services that are most profitable for their foreign patients (Chanda, 2002). Some doctors or owners may be motivated to favour services and treatments that are more profitable and may encourage the development of an inequitable two-tiered health system, where the elite, technologically sophisticated hospitals catering to wealthy foreign clients stand alongside poorly resourced public hospitals (Chanda, 2002). Pellegrino (1999) pointed out the dangers of the increasing commercialisation and commodification of health care as "physicians no longer look on patients as 'theirs' in the sense that they feel continuing responsibility for a given patient's welfare" (p. 253). In Israel, where MT is popular, waiting times of MTs are shorter than those of local people, especially in procedures like in vitro fertilisation (IVF) (Connell, 2011:205). Cohen (2008) observed that "each time a foreigner sees a Thai doctor at 'foreigner prices' he takes away an opportunity for a Thai person to see the same doctor at normal Thai fees. In other words, this programme, while presumably bringing foreign capital to our hospitals, is sucking medical care from our own people". This trend contrasts the Declaration of Alma Ata adopted at the International Conference on Primary Health Care in 1978 that has voiced the necessity for urgent action by the world community to guard and promote the health of all the people and make health available to individuals and families at a cost that they can afford. Since then the primary health care approach has been accepted by member nations of the World Health Organization as the key to attaining the goal of "Health for All" (Tattara, 2010).

Managerial actions and regulatory support are essential for any destination to survive and it helps the tourists to keep themselves away from psychological and performance risks. Competition in the MT industry has caused innovations and cost effectiveness and this has also put the stress

on them to get accreditation. Aregulatory environment is the best option for developing sustainable medical tourism of which regulation of the behaviour of medical tourism intermediaries, hospitals and referring physicians in the home country are vital (Cohen, 2012). Government could necessitate these institutions to adhere to certain guidelines in terms of the facilities to which they refer patients, along the lines discussed above, perhaps by way of a licensing regime (Cohen, 2012). Hall (2008) observed that government helps shape the economic framework for the tourism industry although international economic factors relating to exchange rates, interest rates and investor confidence are increasingly important. The government could also make it a criminal or civil offense for the intermediaries to enable certain kinds of circumvention tourism (Cohen, 2012). In the case of malpractices, the government has to impose liability against intermediaries for medical negligence and errors. These types of regulation would be very easy to implement as against intermediaries incorporated or with assets within the patient's home country (Cohen, 2012).

One major instrument to regulate any industry is policy development. Tourism policy is a road map of tourism development, which lists thepriorities and action plan showing the direction the tourism industry needs to grow (Thomas, 2012). According to Richter (1989), tourism policy development and implementation is a function of political and administrative action, rather than economics or business. Policy conceptualisation is a holistic function of interactions and a process in negotiationwith all the parties directly or indirectly impacted from tourism development (Thomas, 2012). Therefore, tourism policy decisions must be collective and holistic andshould be made with the involvement of government agencies, non-government organisations and businesses (Airey and Chong, 2010).

Objectives of this study

1. To identify the unethical practices in international healthcare delivery of Kerala.
2. To identify the level of commercialisation of medical tourism services.

3. To analyse the level of regulation in the Kerala medical tourism industry with reference to modern medicine

Methodology

This is a qualitative study based on a descriptive research design. There are many stakeholders in the medical tourism industry such as hospitals, medical tourism companies and freelancing agents. The respondents in the study include the managers or Public Relation Officers (PROs) of hospitals and MT intermediaries such as higher officials of medical tourism companies/travel agencies and freelancing agents who collaborate with healthcare delivery for international patients (medical tourists).This study was undertaken in Kerala during January-May 2015. Seventeen hospitals in Kochi catering to medical tourists and 17 MT intermediaries from all over Keralawere interviewed using a semi-structured questionnaire. Data was collected and analysed using the Consensual Quality Research (CQR) method which is ideal for conducting in-depth studies of the inner experiences of individuals (Hill et al., 2005). In CQR, multiple researchers are involved to systematically analyse the data to arrive at a consensus on the representativeness of the results across cases (Hill et al., 1997). The five essential components of CQR are: the use of semi-structured open-ended questions in data collection, the participation of more than one judge in the data analysis process to have diverse perspectives, consensus of the judges to keep away from the biases of the research team members in arriving at the meaning of the data, minimisation of the effects of groupthink in the primary team of judges by the assessment of an auditor, and the enumeration of the domains, core ideas, and cross analyses in the data analysis (Hill et al., 2005). Hill et al. (2005) mentioned about 17 studies from the 27 studies using CQR, which used only one auditor and four studies used two external auditors. However, Hill et al., (2005) stated that the involvement of one external auditor is sufficient at the cross-analysis stage. The sophistication level of the team members must be determined by the topic (Hill et al., 2005). Further, Hill et al. (1997: 558) noted that the "results and conclusions of the data analysis need to be logical, account for all the data, answer the research questions and make sense to the outside reader".

In this research, along with the researcher, the research team for the analysis of the data was comprised of one judge and an external auditor. The judge had her masters in social work and the external auditor had a doctorate in clinical counselling psychology from De La Salle University, the Philippines. It is important to note that the auditor had used CQR methodology before. Before the research team began the data analysis, the researcher gave a description of the study to the primary research team members. In addition, the researcher provided them with copies of the research questions and interview protocol.

Data analysis using CQR involves three central steps. Domains (i.e. topics used to group or cluster data) are used to segment interview data. Core ideas (i.e. summaries of the data that capture the essence of what was said in fewer words and with greater clarity) are used to abstract the interview data within domains. For characterising the frequency of occurrence of the categories while allowing better description of the data, as Hill et al. (2005) suggested, 'general' include all or all but one of the cases. Typical would include more than half of the cases up to the cut-off for general (given that half does not seem typical). A variant would include at least two cases up to the cut-off for typical. With samples larger than 15, Hill et al. (2005) recommended adding a new category of 'rare', which would include 2–3 cases, to allow more differentiation among categories. Finally, as before, findings emerging from single cases should be placed into a miscellaneous category and not reported in the data analysis. Hill et al.'s (2005) recommendation is to fully and richly describe at least the general and typical categories and provide at least one example (using the core ideas or quotes) to illustrate each category in the text. Unless important for some reason, variant or rare data can be left in a table so that the results section is not cluttered with too much information.

Analysis

The study considered three aspects such as regulatory environment, legal and ethical issues related to medical tourism and cost difference of procedures. The results of the in-depth interview with the hospital authorities are shown in Table 1 and explained underneath.

Table 1: Regulatory environment (a)

Domain	*Subcategory*	*f*	*Exemplar Responses*
Industry Regulation	No	G	"There is no regulation. Mostly it's like real estate!"
Legal and Ethical Issues	No	G	"So far we have never felt any legal/ ethical issues"
Cost Difference	100-150%	T	"Normal x 2 is the average cost"
	30 to 40%	R	"Patients from SAARC patients are charged like patients or 25% extra as they are poorer than us"
	150-300%	R	For PET scan they charge, Rs. 60,000 instead of Rs. 20,000. Other hospitals charge Rs.40,000.
	No cost difference	R	We have published costs...no difference in costs

Note: n=17 and hence category and subcategory are considered as general (G) if applied to 15-17 cases, typical (T) if applied to 9-14 cases, variant (V) if applied to 4-8 cases and rare if applied to 2-3 cases.

The respondents are of the general opinion that there is no regulation at all. The following comments validate the finding.

"We use implants which are metal free...cost about 10,000 for one tooth. Since there is no standardisation, some doctors give inferior implants and charge lower and thereby give an opportunity to compare both. Then they will bargain thinking that we are adding up" (Dental Doctor, Kochi).

"People from the Gulf are highly demanding and difficult to fix the cost for them as they bargain to the core. So will keep a cost which is little higher than the actual cost" (Manager, Health check-up and Dental Clinic, Kochi).

There is a variant observation of the absence of strict legislation and policies against crime from the part of MTs. The following experience validates the finding:

"One Canadian couple has taken away my articulator that costs around Rs. 25,000. Soon, I had informed the local police, airport authority and I personally met the City Police Commissioner...my people went behind

them and shown them to the police...no use...nothing happened. Finally as a last resort, I called them and told them that I would report to the police. Next day, when I was not here, they came and gave it here (clinic) after taking all the costly parts. Will it happen in any other country?" (Dental Doctor, Cochin).

Another category which emerged from the data is unethical and legal issues related to medical tourism. It is a general observation that there are no issues at all. The following statement will manifest the finding.

"We insist on M-Visa for surgical patients. Other than that, nothing is felt so far."(Senior Manager, Allopathy Hospital, Kochi).

Another category which emerged from the interview is cost difference. There is a remarkable difference in cost in treatment between the local people and foreigners which varies from 25-150 per cent. This finding is validated in the following statements:

"There should be a standardised cost for each treatment in each category. There can be different standards of treatment, but the cost also will be uniform across the country for each treatment category. Here there is a huge cost difference in treatment as much as 100 per cent or more" (Dental Doctor, Kochi).

"Accreditation, standard protocols (like in Thailand), standardised prices and treatment are essential for this industry to survive and sustain" (Senior Manager, Eye Care Clinic, Kochi).

But there are few dental clinics that have published a cost chart which is the same for all regardless of whether the patient is local or foreign. One of the interviewees (Dental Doctor, Kochi) shared his feelings:

"We have the same cost for treatment both for locals and foreigners. This authenticity of my clinic leads most of the walk-in patients to us. They share their experience with others and that's why most of my patients are referrals" (Senior Manager, Eye Care Hospital, Kochi).

Medical tourism intermediaries

The study considered three aspects such as regulatory environment, legal and ethical issues related to medical tourism and cost difference of

procedures for the study. The results of the in-depth interview with the intermediaries are shown in Table 2 and explained underneath.

Table 2: Regulatory environment (b)

Domain	*Subcategory*	*f*	*Exemplar Responses*
Industry Regulation	No	G	"There is no regulation...all are working for profit."
Legal and Ethical Issues	Yes	G	"Patients are not reaching the correct doctor...instead they were the agents who get more commission"
	Unwanted tests	T	"We feel bad of these tests for MTs, but are forced to do"
Cost Difference	More than 300%	V	Normal x 3 is the average cost, 300 per cent increase.
	100-150%	T	A health check-up is charged Rs.12,500 which costs just Rs. 5,500.
	30-40%	R	They take just above normal rate, i.e., 30-40%

Notes: n=17 and hence category and subcategory are considered as general (g) if applied to 15-17 cases, typical (t) if applied to 9-14 cases, variant (v) if applied to 4-8 cases and rare if applied to2-3 cases.

The respondents are of the general opinion that there is no regulation at all. They all expressed the necessity of regulatory measures against malpractices and commercialisation of medical services. The following comments show the unregulated dimensions of the MT business in Kerala:

"There are hospitals that market treatment for non-curable diseases. In fact, for certain diseases, no medical treatment is available. It is so pathetic that some of them will become very complicated after arriving here. I had seen many deaths. The patients will realise that they are cheated after spending a lot of money here" (Medical Tourism Facilitator, Kozhikode).

"My patient aged 50 years was advised to do treadmill test (TMT) and the same day he was done the angiogram. The next day he was weak and in a couple of hours' time he died. It was due to the internal injury caused by the medical negligence while doing angiogram. He was very healthy. The

hospital was in a never mind attitude. We cannot work in this industry conscientiously" (Medical Tourism Facilitator Malappuram).

"Kerala is marketing where there are no treatment options. An official at the Oman embassy told me about this as 'we had many cases of death and complications related to this and we do not promote medical tourism in Kerala'" (Medical Tourism Facilitator, Kozhikode).

"One patient contacted us for a small child who is having some genetic problems. They had been even to the US. Somebody told them about Kerala and they contacted us. I spoke to a specialist and she had a perusal of medical records as well. The doctor is under the impression that there is no treatment. Still we asked them to come and undertake tests. Afterwards, we referred them to another hospital in Kochi where more facilities are available. Here the thing is that each time, each doctor tries out experimentation and they have to undertake same tests again and again" (Medical Tourism Facilitator, Kochi).

"When I took three Arab ladies to a doctor for orthopaedic problems the doctor prescribed same medicines to three of them and send us to the pharmacy. But I went to the medical shop and enquired about the medicine. One was for stomach upset and another was a vitamin syrup. Both the brands were very costly and a commission-based business of doctors!" (Medical Tourism Facilitator, Kochi).

"I know one Arab patient admitted in (hospital), Kozhikode. He is suffering from cancer in intestine which is in the advanced stage. He is there for the last five months and they have been telling it is curing. When I saw the tests and bills I really felt very bad. It is highly unethical" (Medical Tourism Facilitator, Malappuram).

"There is a case where the doctor advised not to have tablets for cholesterol after having a check-up using online ASCVD (Atherosclerotic Cardiovascular Disease) Risk Estimator" (Medical Tourism Facilitator, Thrissur).

"There are no regulatory measures to control the agents. One agent has taken one patient from Oman using his contacts. While he landed at Nedumbassery airport there was no agent, no vehicle, no translator. The

agent was not attending calls. He had taken 250 Rials in advance" (Medical Tourism Facilitator, Kothamangalam).

"I happen to hear the translation of an agent who wanted to translate about the pain which starts from head which then slowly spread to the whole body to the feet" like this. "I have a pain in my head and feet" (Medical Tourism Facilitator, Trivandrum).

A further category emerged from the interview is the cost difference. There is a lack of standardisation and regularisation of treatment costs. But there are few dental clinics that have published a cost chart which is the same for all regardless of local or foreign patients. However, there is a remarkable difference in costs in treatment between the local people and foreigners which varies from 100-150 per cent typically. This finding is evident in the following statement:

"Diagnosis is very costly. To test cancer, they will advise a Positron Emission Tomography (PET) scan which is available only in four hospitals. Doctors in Cochin prefer to give letter to a hospital where it costs Rs. 40,000 whereas in another hospital it is only Rs. 20,000. When I took them to the other hospital and submitted the report to the doctor he got angry" (Medical Tourism Facilitator, Thrissur).

"Check-up cost is very high for medical tourists like MRIs, scans etc., at least over 100 per cent" (Medical Tourism Facilitator, Trivandrum).

"The consultation fee for a foreign patient is Rs. 500 as against Rs. 150-200 for a domestic patient. But it can be justified by the excess time, effort and risk factor of a doctor. While a doctor sees a local patient in two minutes' time, a foreign patient will be checked up in detail sparing at least 10-20 minutes" (Medical Tourism Facilitator, Kozhikode).

However, it is a variant observation that there are hospitals that charge more than 300 per cent extra for the treatment when compared to for a local patient. The following remark manifests this:

"Charges are highly unethical, though the cost is still cheaper than in their country even after charging three-fold of the actual charges, it is real exploitation. It will affect the future business. Some patients know that it is cheating and some of them will bargain with the hospitals. Finally, it will result in bad reputation" (Medical Tourism Facilitator, Kozhikode).

It is observed that there are many allopathic hospitals that insist on unnecessary diagnostic tests. The following remarks clarify this.

"Firstly, they will take patients to a physician who will insist on some tests. Then they will send to specialists, sometimes more than one. Each specialist will insist on a number of tests. Sometimes, we don't feel its logic, but are not able to question. For a small disease, they will ask to do all tests and scans. Most of the hospitals are having tie-ups with labs outside. Finally, when seeing the bill it's shocking. It happens to even a local patient, but when it comes to foreigners, it's more" (Medical Tourism Facilitator, Malappuram).

The triangulated findings of medical tourism hospitals and intermediaries revealed that there is no regulation in the industry. According to UNWTO (2004), in addition to the direct economic measurements such as volume and income generated, all managerial actions are related to the economical sustainability such as the lack of non-enforcement of policies. To achieve greater sustainability in the tourism industry the primary instruments of actions include the enforcement of laws and regulations as well as voluntary standards and initiatives (Bohdanowicz et al., 2005). No policies and regulations related to the MT industry are planned and implemented in the Kerala medical tourism industry. This study confirms the findings of Cherukara and Manalel (2008) that the government of Kerala is not involved in the promotion of MT except for some financial funding for holding events like the Bi-Annual Kerala Health Tourism Conference. Hosting events dedicated to raising awareness about physicians and best business practices will help reduce the incidence of malpractice in the future and earn the trust of foreign patients (Bookman and Bookman, 2007). The findings show that general observation of medical tourism intermediaries (Table.2) is that there are a lot of unethical practices taking place with regard to cost and treatment. Many unwanted tests are insisted upon for foreign patients with the intention of making money. Further, there is no proper mechanism to complain and sue against medical negligence and treatment errors due to the absence of an effective international legislation related to medical tourism.Ben-Natan et al. (2009) argued that safety and appropriateness of treatment is a real problem of MT. There are several

obstacles which make foreign patients reluctant to complain against the issues in another country (Steven, 2010). Sometimes, it is the weak legislation especially in developing nations which keep them away from litigation and eventually making the situation a real muddle without suing or succeeding in suing (Steven, 2010). Presently there are no dependable, complete sources for patients to learn about legal ways out for malpractice committed in [foreign] jurisdictions (Steven, 2010). Hence Henderson (2004) suggests the necessity for firm controls on promotional aspects, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievances procedures.

Medical Tourism Facilitators (MTFs) observed that there is a big difference between the perceived treatment cost and the actual cost. A big difference in costs from hospital to hospital and from local patients to foreign patients is observed. The average costs charged for procedures is about 150-300 per cent higher than that of the actual costs charged from local patients. The major market of Kerala is the Middle East and the Maldives (Cherukara and Manalel, 2008). Here it should be noted that Arab countries are at different stages of their development, ranging from the industrialising to the underdeveloped (Branine, 2011). The majority of the Arab nations have experienced depressed economic conditions especially from the 1980s to about 2004 due to fluctuation in oil and gas prices and political instability (Branine, 2011). The UAE, Jordan and Bahrain have also been severely affected by the 'credit crunch' recession (Branine, 2011). The global recession for the last few years has affected them again. Thus the backward pricing strategy and overpricing of stakeholders may keep the present budget category MTs away from Kerala. All the stakeholders have to believe and act by a philosophy that profits and money are byproducts which will come automatically from the quality service delivery.

Conclusion

The study throws light into the urgent need of managerial actions in the medical tourism industry in Kerala.Managerial actions in terms of regulatory support influence the MT destination choice (Smith

andForgione, 2008). The study reveals that there is a big difference in cost and a high degree of commercialisation in the industry. There are many unethical practices in terms of cost and treatment which is triggered by the absence of a regulatory framework. There is no significant effort made by the competent public authority to govern the industry with an effective policy framework, guidelines and legislation. It is high time to regulate the industry by preventing unauthorised entry of illegal investors to protect the interest of genuine stakeholders. In short, organised strategic synergy among all stakeholders aimed at improved quality embedded healthcare delivery with an overarching regulatory system is essential for the sustainability of medical tourism in Kerala.

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From the Field

Welfare Services Ernakulam, Ponnurunni, Kerala

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Introduction

Promoted by the Archdiocese of Ernakulam-Angamaly, Welfare Services Ernakulam (WSE) is a registered charitable organisation under the 'Travancore Cochin Literary Scientific and Charitable Societies Registration act, 1955'. It is also known as Sahrudaya. It has 50 years of experience in rural development and community mobilisation. It plays a very significant role in the development process and more than 100,000 families are directly linked with Sahrudaya. WSE operates mainly in the five civil districts of Kottayam, Alleppey, Ernakulam, Idukki and Thrissur in the state of Kerala. Its programmes and activities include community organisation and community development, sustainable environment, the use of non-conventional energy and watershed development activities. The patrons are His Beatitude George Cardinal Alencherry (Major Archbishop of the Syrian Catholic Church, Kerala) and Bishop Sebastian Adayanthrath (President – Welfare Services Ernakulam and Auxiliary Bishop of the Archdiocese).

WSE has an excellent and proven track record of functioning and collaborating with central and state governments, national and international donor agencies, institutions and NGOs for more than five decades. The programmes are managed by teams of volunteers, professionals and experts from different fields. The noble vision of WSE is the "formation of a just society based on human values." The mission is to promote activities, programmes and institutions with the objective of building up and enhancing the capacities of individuals in particular and communities at large such that they contribute positively and creatively to the establishment

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of a just and humane society. The total staff strength is 120 at the central, regional and field levels. The community SHG animators and community workers involve 347 and 20 people respectively. There are 280 village federations and 225 promoters in WSE.

Objectives

The programmes and activities of the organisation are centred on the following objectives:

- To facilitate the empowerment and integrated development of weaker and vulnerable groups in the society.
- To facilitate the infrastructure development of the poor and shelterless through habitat development.
- To facilitate the capacity building of the poor and the marginalised in the society for generating sustainable sources of income.
- To facilitate sustainable management of the natural resources, especially of land, water and bio-mass.
- To promote sustainable, eco-friendly and appropriate rural technologies amongst the poor.
- To promote and establish networking and resource sharing amongst the stakeholders and actors in development.
- To rehabilitate the victims of natural and man-made calamities and to rehabilitate the differentially abled.

Major Departments

- Human and Institution Development
- WESCO Credit
- Social Security Programmes (Micro Insurance)
- Livelihood Development (Micro Enterprises)
- Agriculture and Natural Resource Management
- Environment and Rural Technology Applications
- Family Development Programmes
- Habitat Development and Environmental Sanitation
- Community Health Programmes
- Community Based Rehabilitation Programmes
- Special Projects: CMDRR, Watershed Development and Jalanidhi
- Charity and Jeevakarunya Programmes
- Sneha Foundation
- Production Units: Sahrudaya Silk, Meat, Compost and Honey

- Institutions: Sneha, Naivedya, Soukysadan, Banana Village
- Research and Documentation
- Finance Department

Major Programmes

Human resource development programme

In order to fulfil the concept of social transformation, several capacity building programmes have been organised by WSE for functionaries, personnel and volunteers. These ensure the updating of personnel about changes in the sector and keeps them abreast with challenges, knowledge and skills.

WESCO credit

This is the financial intermediary division of WSE for extending financial services to the members of Sahrudaya self-help groups promoted by the organisation. It serves as the flagship programme of WSE for promoting stable institutions of the poor, particularly women, and enabling these institutions to provide a range of financial services, social security and livelihood services. The major activities of WESCO Credit are SHG formations, credit disbursement as loans for productive and domestic works, empowerment, skills development amongst women to facilitate self-enterprises. The five pillars of the SHG formation are knowledge, leadership, fellowship, value dissemination and economic empowerment. These operate as pulling factors even in the metropolitan cities.

Promotion of community based organisations

There are 55 Micro Credit Unions, 85 farmers groups, 212 children's clubs and 6598 SHGs. These evolved as the foundation stones of a social transformation process initiated by WSE. The organisation has a direct link with above one lakh families within its operational area.

Habitat development and sanitation programme

Over 28,000 low cost houses have been completed, and 16,000 families were supported for the renovation of their existing houses. Other activities under the department are the promotion of smokeless improved *Chula* (ovens) for the individual households and community *Chulas* as part of

energy conservation practices. As part of enhancing sanitation facilities available to poor people, the department had been able to construct more 22,000 sanitary latrines.

Entrepreneurship and livelihood development programme

More than 18,000 individuals have been trained and helped to start small scale ventures for income generation. These include petty shops, coir making units, garment making, bakery units, goat rearing, poultry, cement brick making, auto rickshaws, duck rearing, rice and flour mills and group farming. In addition, employment opportunities are provided to the local poor through a coir spooling unit, a silk cloth manufacturing unit and a rabbit processing unit. These units enable the families to receive a regular income of Rs.4,500-6,000 per month for each beneficiary. It has served as regular additional income to the families and thus manages their increasing requirements. This programme thus involves an orientation on the need of microenterprises, skills training in entrepreneurial activities, and the promotion of micro enterprises through departments, exhibitions and of marketing through networks.

Environment and rural technology applications

WSE gives precedence to addressing environmental issues and improving the environment through the collective efforts of individuals, families and institutions. The major activities promoted by the organisation are to encourage people and communities to make use of alternative sources of energy and to conserve biodiversity. Awareness creation programmes, sensitisation campaigns, publications and exhibitions, model creation, linkages and collaborations are part of this initiative. As a result, 28,500 biogas plants and 22,000 smokeless *chulahs* have been installed in rural areas. In addition, the distribution of solar power systems and the promotion of rainwater harvesting structures were also undertaken by WSE.

Community health and rehabilitation programme

WSE is active with community health programmes in 150 of the rural villages in its operational area. Both institutional and community based rehabilitation activities are carried out for the disabled, the aged and victims of natural and manmade calamities. Medical camps are periodically organised for the detection of disabilities, diabetes, cataracts and TB in collaboration with various medical institutions.

Family development programme

There are poor families who lack basic amenities and have poor access to resources. WSE extends support to 1,245 poor families through the 'Save A Family Plan' on a monthly basis for periods of 5-6 years as they are identified from the different regions served by the organisation. It aims to help poor families with direct assistance for leading a self-reliant life through a family-to-family support programme.

Educational support service

This is envisaged as supporting poor young people coming from economically limited families, enabling them to meet their higher education expenses through educational scholarships and financial advances.

Ecology and environment

Besides the promotion of sustainable agriculture practices, WSE has implemented solid waste management:

- Using terracotta-based vermi composting, watershed development programme, Palakkad (the strengthening of village watershed committees, the training of watershed development committee members, treatment of by the like construction of contour bunds, trenches, vegetable fencing, stone *kayyalas*, agronomic measure and livelihood development programmes).
- Environment management (environment education, sensitisation events, rallies, workshops and other action-oriented programmes with the participation of the community).
- *Harithajeevan* (a kaleidoscopic initiative to rejuvenate the ecosystem which includes Environment Sunday through parishes, resource team formation for this purpose, awareness classes, installation programmes of terracotta and competitions and awards).

Jalanidhi, watershed and NRM projects

The Jalanidhi drinking water and sanitation project supported by the Kerala government is facilitated by WSE in Kuttuppuram Grama Panchayath. WSE is the support organisation for the implementation of the World Bank-supported Jalanidhiproject which is coordinated at the state level by KRWSA (Kerala Rural Water Supply and Sanitation Agency).

Disaster management programme

In order to respond to the needs of the people during disasters and calamities, a department has been formed and is actively involved in disaster mitigation activities.

Social security programmes

The number of people seeking financial support to meet their expenses has increased and this has led to implementation of different life and mediclaim insurance programmes by the organisation. These insurance programmes provide the poor with insurance coverage against medical expenses and loss of life. These programmes have been implemented in past years and in the current year many have benefitted from these programmes. The main insurance policies are the Sahrudaya Arogya Suraksha Scheme, the JeevanMadhur Insurance Scheme and the VidyarthiSuraksha Insurance Scheme.

Jeevakarunyanidhi (charity programmes)

WSE gives prime importance to the most vulnerable sections of society as organised social work does not reach this specific group of people in our society. 'JeevaKarunyaNidhi' is designed to extend assistance to those who live in the most reduced circumstances. Funds are provided to people in this section of the society, enabling them to meet the adversities of life, and hundreds are supported through this programme.

Snehafoundation

Another programme implemented exclusively with the local fund is the Sneha Foundation. The programme was started in 2011 and so far more than 150 generous sponsors are contributing to the programme. The fund, mobilised through voluntary contributions of the sponsors, is utilised to support genuine beneficiaries enabling them to meet their exigencies.

Sahrudayafood and agri fests

WSE conducted the fests at seven places and approximately 60,000 people participated, with many farmers benefitting from it. The objectives were:

- To enhance the knowledge and interest of farmers and the community at large through the introduction of new concepts, innovations, farm equipment and machinery.

- To create a platform for small farmers and entrepreneurs to exhibit and sell their products and create understanding about market potential.
- To encourage organic and sustainable practices by the people and especially by farmers.
- To popularise and create awareness about the health benefits of organic farming, organic foods among the consumers and among various sections of the people, including the youth.
- To conscientise the public on food security and food safety aspects.

Other areas of intervention

- WSE undertakes the Asakiranam Cancer Care project with the support of the Caritas India. This project involves health surveys, awareness generation classes to village and schools, the setting up of medical camps, treatment and rehabilitation, counselling services, *santhwanam* palliative care and promotion of prevention methods (such as fostering organic and homestead farming, the fight against the fast food culture and environment education).
- The Kerala Labour Movement is another area of intervention where WSE is working among and with the organised and unorganised sector. Pallippuram has witnessed its effective involvement in organising labourers.
- The programme of *Gramotsavom* is an idea of creating parish-wise rural markets where products can be sold locally. This was successfully completed in 50 places before the valedictory celebrations of the golden jubilee and had the high appreciation from the people of the Ernakulam-Angamaly archdiocese.
- WSE has SahrudayaSparshan Melodies, a music group composed of persons with disabilities (15 member teams) and the stage programme includes *Ganamela*, a magic show and skits.
- The SahrudayaAgri Nursery and Poly House is a demonstration as well as a model for organic and homestead farming at the central office, Ponnurunni.
- There is a free housing arrangement at Pattimattomknown as *KarunyaVilla* inhabited by the homeless people in and around Ernakulam.
- *Prabhodhini* is a life skills development programme for adolescents. They are the children of the members of SHGs and animators of WSE.

- The Sneha mental health programme involves the distribution of free medicine and counselling to families and mentally affected children.
- WSE also provides the Sahrudaya Agro Award to innovative farmers for their contribution to the society.
- The programme of *Muttagramampaddhathi* facilitated awareness generation classes in 50 villages and 180 people joined this programme. The scale of collecting eggs is done by private partners and attracted people to take up this programme.
- The setting up of a family action team in each parish as an empowerment group to support poor families under the leadership of parish priests.
- Documentation and publishing are done accurately such that its operations have been recorded intact. The magazine *Jalakam*is the outcome of this department which has high impact on its followers and provides insights into the appraisal of activities of WSE.
- Live laboratories for students of social work.

Sahrudayaproduction units

In order to promote and demonstrate viable rural industries, the production units function under the society**.** These are:

- Sahrudaya Silk Production Unit: In the silk production unit 16 women are employed and 260 women are trained. Here they produce beautiful silk materials at very affordable prices.
- Sahrudaya Meat Production Unit: 2,800 families are involved in the decentralised rabbitry development programme. The unit produces nutritious, cholesterol free rabbit meat, which is good for heart patients.
- Sahrudaya Honey Processing Unit: Raw honey is processed and marketed through this unit. The unit has Agmark registration and provided employment to 50 women.
- SahrudayaVermi Composting Unit: solid waste management is a big problem today. Three large scale units are functioning for demonstrating and promoting income generating activities linked to waste management.

Sahrudaya institutions

- SoukyaSadan (a home for the aged). This is a centre which started in 1993. The old age home has received financial support from the Ministry of Social Justice and Empowerment since 1994. SoukyaSadan houses 50 aged people who are destitute and they are provided with personal

care and medical services. The main activities of the centre include a mobile medicare unit, day care facilities, dispensary, counseling and care for the inmates. The home also provides care to the elderly in the village named Chethicode.

- Naivedya Ayurvedic Hospital and Research Centre: The Ayurveda hospital is a Green Leaf certified centre of excellence in Ayurveda, where all treatments are carried out after scientific diagnosis and supervision. It has 20-bedded inpatient treatment facilities and offers different health care packages to suit the customer's demands and needs.
- Sneha Basic Facility Centres, Edakkunnu and PARUR: The basic facility, established with the support of SLF in the Netherlands, functions well and the centre is attended regularly by nearly 50 children with disabilities. Two therapists and other support staff are involved in providing services to CwDs. The services provided include physiotherapy, audio-therapy and speech therapies with the support of aids and equipment in a systematic way.
- Banana Village: The innovative Banana Village concept is located at Parambayam, Angamaly. The construction of the training centre in the village is completed. The reclamation of the land and the planting of different varieties of bananas, setting up a demonstration unit and an agriculture nursery are progressing.

Table 1: Major community structures promoted by WSE

Particulars	*Year of starting*	*Groups formed*	*No. of villages of people*	*Total coverage*
Formation of Self Help Groups	2001	6598	273	73,745 families
Micro-Credit Cooperatives	1990	55	31	5,625 families
Women's Welfare Centres	1965	247	247	12,350 women
SHGs of Persons with disabilities	2004	107	23	1,350 families
Farmers Clubs	2003	85	33	1,300 farmers
Care and Support Homes	1995	5		87 inmates
Production units	1991-92	5		61 people
Children's Groups	2003	212	43	2,100 children
Community Vigilance Groups	2006	10	2	70
BalaPanchayath	2007	2	2	30

Sahrudayabranches

The organisation has six regional offices to cater to the needs of the people and to ensure a decentralised process of development. They are:

- Sahrudaya Regional Office, Angamaly.
- Sahrudaya Regional Office, Kalady.
- Sahrudaya Regional Office, Vaikom.
- Sahrudaya Regional Office, Ponnurunni, Ernakulam.
- Sahrudaya Regional Office, Parur.
- Sahrudaya Regional Office, Cherthala.

Major achievements

- Facilitated the formation of 6,600 SHGs, 80 Credit Unions, 102 SHGs of persons with disabilities and 40 farm clubs in its 280 operational villages within five civil districts of Kerala State.
- Intervened in five civil districts of Kerala State bringing changes to the lives of 73,740 families directly through community platforms of self-help groups.
- Assisted 22,300 families for constructing cost effective and stable houses.
- 33,000 families have been supported for small scale economic activities and enhanced their livelihood opportunities.
- 1,500 poor families are now regularly supported under the Family Development Programme with a monthly assistance of Rs. 950 for a period of five years. During the past 50 years, more than 19,700 poor families were supported.
- More than 1,200 poor families are supported under the Family Development Programme.
- Constructed 32,000 biogas plants and 29,000 smokeless *chulas* as part of improving the environment and the promotion of alternative energy sources.
- Skills training has been imparted to 4,500 women in the coir sector.
- More than 6,000 families are being supported under the decentralised rabbitry programme.
- 1,000 poor children are being supported under the Educational Sponsorship programme.
- More than 18,000 families were imparted with entrepreneurship development training under various schemes.

- 400 persons with mental illness and more than 1,400 children with disabilities are supported under community based rehabilitation programmes.
- 6,000 poor women were provided with tailoring machines on a subsided rate.
- More than Rs. 1,800 million is distributed to 142,500 members of SHGs affiliated to Welfare Services Ernakulam.
- Constructed more than 9,000 Roof Water Harvesting Tanks for people, agencies and institutions affected by the scarcity of potable water.
- Solar power systems were distributed to more than 4,750 families as part of the propagation of non-conventional energy applications.
- Yearly 750 families are supported under a Charity Scheme for housing, treatment, marriage, education of children and livelihood development.
- Fifty destitute people are housed in the Old Age Home supported by the Ministry of Social Justice and Empowerment. 250 persons have so far been provided with shelter through this home.
- Insurance coverage is provided to more than 50,000 people yearly and more than 80,000 people received assistance and benefits in five years through various schemes.
- The Cardinalnagar Housing Project of WSE had been a model for the LakshamVeedu project of the Government of Kerala.
- PDDP evolution had its origin in the WSE self-employment programme.
- Collaborated with government to promote the DeenBandhu Model biogas plant in Kerala (as it is one of the programmes of the 20-point programmes of Indira Gandhi) in the Cochin Corporation.
- The initial impetus of decentralised household segregation of waste management of the Cochin Corporation and training was imparted by WSE

Ongoing Major Programmes

- Family Development Programme with Save A Family Plan India.
- Jalanidhi project at Kuttipuram supported by the World Bank.
- Integrated Agriculture Development under Western Ghat at Thatchanattukara.
- Cancer Care and Prevention programme supported by Caritas India.

- Family Farming Programme.
- Rehabilitation of persons with disabilities by CBM and SLF.
- Revised National Tuberculosis control programme by the Kerala Government.
- Parish markets where people can sell and buy quality products.
- Ayurveda treatment 24 hours and promotion of Naivedya hospital products such as dantadavanachoornam, chembarathithatli, kasthurimanjal, nellickapodi, thrifalachoornam, cheevackapodi, dahasamani, pramehadahasamani, vengakathal, mylanjipodi and multanimitti.
- Children's wing empowerment programmes.
- Discover ability: a job fair for mobile people with the support of the social justice department of Kerala State.

Conclusion

As a faith-based community agency, WSE is based purely on religious principles echoing a humanitarian ethos and social work values. The strength of WSE lies in the process of 'appreciative inquiry' built into its approach over the last few decades. This process is continued at more frequent intervals, which helps us to be sensitive and responsive to the needs of the community. The various programmes implemented by the organisation are its sincere efforts to translate its vision into reality. Taken together, these constitute powerful drivers that enable this organisation to create enduring values for all stakeholders, contributing meaningfully to its clarion call of empowering, sustaining, enabling and educating the society as whole.

WSE has had a remarkable impact on the human face of the community with its uniqueness, accountability to people, social entrepreneurship, pooling of resources, organisational structure, long term and short term cooperation and fund raising. The regular innovative dissemination of methods and appropriate interventions significantly maintained its credibility in the community. At the same time, WSE is on a trajectory to make it more relevant and meaningful in fast growing city life as well as adding more meaning to poor and vulnerable sections of society.

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Book Review

NGOs and Participatory Development in India.Baiju P.V.,2015, New Delhi, Concept Publishing Company Pvt.Ltd., ISBN-13:9789351251354. Paperback pp.x+134,Price: ₹450.

Participation as a concept has received wide acclaim in the context of grassroots development. The different strategies for stakeholder involvement in the planning, implementation as well as the evaluation stages of a project are of wider interest. The book under review caters to upgrading the knowledge and skill levels of development workers, NGOs and students of the social sciences. The book explores the concept of participation, participatory rural appraisal as a tool for participatory development and the response of NGOs to participatory practices.

The inspiration for the book is the research conducted by the author on the participatory practices in the development programmesof nine NGOs in the Wayanad district in Kerala, India. The book has seven chapters whichare progressive in nature. It concludes with lessons learnt from the field and possibilities for further studies.

Chapter one starts with the evolution of the voluntary sector in India. In this chapter, the author gives the rationale for selecting the area of research and the methodology of the research followed. The significance of the study is explained in terms of the effective practices employedin the participation and the philosophical basis of participatory approaches. The various participatory intervention models are introduced in this chapter, including participatory rural appraisal and the research questions. The study explored key areas like the means adopted by NGOs to get participation, training activities done for capacity building of the staff members, reliability of the participatory approaches, innovations done for ensuring participation, advantages and the challenges faced in using participatory methods. The profile of the NGOs and the beneficiaries are also described. The conceptual and operational definitions of the concepts like participatory approaches and NGOs are given. The design of the research follows a mixed methodology of quantitative and qualitative research methodologies.

Chapter two deals with NGOs. The author provides definitions of NGOs. The development oriented NGOs are divided into first generation(relief and welfare), second generation (community development), third generation (sustainable systems development), and fourth generation (people's movements) in terms of the strategies adopted by them. This will give the reader an opportunity to assess the evolution and adoption of different strategies by NGOs over a period of time.

The history of NGOs in India is highlighted in the book. In this section, the evolution of the voluntary sector as a necessity in the context of the shortcomings of governmental efforts in community development is elaborated upon. The categorisation of NGOs into five types according to the scale of operations and the location of head offices, and four types of funding mechanisms available for NGOs is an addition to the literature. Statistical details with regard to the number of NGOs and the volume of aid channelled to the Indian voluntary sector throw light on the importance of studying the relevance and effectiveness of their activities. The contribution of NGOs to development is also discussed with a people-centred development vision and viewing development as a people's movement rather than as a funded project. The evolution of NGOs in other parts of the world and the approach of NGOs in supplementing government efforts is underlined. The author is keen to address some of the criticisms ofNGOs which focus on technical deficiency, lack of accountabilityand the excessively politicised character of NGOs. Development NGOs in poor countries need to address concerns such as accountability, internal reform and mechanisms for regaining trust and confidence, developing quality ratings and preventing unhealthy competition between small NGOs. The chapter concludes on a positive note as the government of India has accepted the position of NGOs.

In Chapter three, the concept of participation and participatory approaches adopted by different players in the development sector are discussed. The initial sections of the chapter attempt to define and describe the concept of participation. The concept is introduced with the presentation of reviews from the literature which gives a common notion that participation needs to be considered as the process in which people are involved in the decision-making process, implementation of the programmes, sharing the benefits and in the overall evaluation. It is also

stressed that participation needs to be considered as a basic human right which is essential in social and economic development. The chapter goes on to discuss the typology of participation with regard to a range of varying intensities and types of community participation. The author relates the concept of participation to the process of development and introduces the concept of participatory development as the process by which populations, and especially their least considered members, influence the decisions that affect them. Participatory approaches in the changing paradigms of development strategies are discussed in the chapter which also gives their historical evolution. The idea of people-centred development needs to bedisseminated to all the people concerned. In particular, government functionaries in the developing nations must be targeted so that they develop a positive attitude towards people as well as to the strategy. The participatory nature of the community development Programmes initiated in 1952 is also elaborated upon. The Kerala's People's Plan campaign, women empowerment through Gramasabhas, transformation of the local ecosystem of Vasnditaluk in Gujarat, participatory natural resource management as happened in Hivare Village in Pune, and the MGNREG programme implemented in Andhra Pradesh are some of the cases where participatory approaches were adopted in India. The examples drawn from theinternational arena include the cases of Honduras, India, the Philippines, Poland, Brazil and Pakistan.These have elicited the participation at all levels of the programme by empowering the neighbourhood associations, underlining the acceptance of participatory approaches among the international community. But along with these cases, the role of NGOs in the success of the above-mentioned programmes should not be sidelined.

Chapter four discuss the concept and application of PRA(Participatory Rural Appraisal) as one of the widely recognised and established methodologies of the participatory development process. PRA is defined as 'a family of approaches and methods to enable people to share, enhance and analyse their knowledge of life and conditions to plan, act, to monitor and evaluate'. The key historical milestones which directly and indirectly contribute to a confluence PRA is presented in the chapter which helps the reader to understand the evolutionary line. Three foundations of PRA, the 11 principles in PRA and 20 important tools of PRA are also introduced. The field applications of PRA, especially in India, are elaborated upon in

the chapter which describes the use of PRA in stimulating community participation, conservation expeditions, art work and even in psychiatry. Several studies are cited which revolvearound the practice of PRA among NGOs and the Government. The findings show encouraging results so far as the feasibility and effectiveness of the participatory approach, methods and the tools used in the process are concerned.

Chapters five and six exclusively deliberate the findings of the research conducted by the author. In chapter five, the profile of the NGOs in the study and the beneficiaries are presented. The study covered eight NGOs and one GONGO (Government-owned NGO) and a very brief profile of the organisations is presented. The legal entity of the organisations and organisation-wise details regarding the type of building, geographical area of operation, details of the staff, target population, number of CBOs, field activities and sources of income are shown as tables. The profile of the beneficiaries like gender, age, marital status, religion, family size, education, family income, family status, duration of association with the organisation and position held and the present position in CBO is given. It is also noteworthy that the personnel from the NGO participate in the CBO programmes while the participation of other stakeholders, especially from the Panchayat Raj Institutions, is inadequate.

Chapter six explains the findings of the study with regard to the application of the PRA and the benefits gained. A diagrammatic sketch of the sources of triangulation is presented in the chapter which is very clear for the reader to get a bird's eye view of the process. Triangulation has happened through the sources of data and at the tools of data collection. The chapter sheds light on the rationale for the use of participatory practices, the stages of the project where PRA is applied, PRA workshops and trainings implemented by the NGOs, programmes where the PRA has been applied in NGOs and CBOs, people's participation in participatory programmes, tools of PRA used, results of participatory programmes, challenges in the application of participatory approaches and participatory approaches in organisations. The analysis presented in most of the tables represents the responses from the NGO as well as from the beneficiaries which gives the reader a chance to compare the benefactor-beneficiary perception differences. The problems faced in the field application of PRA is a useful guideline for a practitioner, particularly one who is naive in the area. The

analysis is also backed by a review of the available literature. The differences between NGO and GONGO is mentioned as the study included eight NGOs and one GONGO which used PRA as a part of the policy of Participatory Forest Management (PFM) of the national government. They differ mainly in their choice of the PRA tools and the stage of adoption.

The final chapter summarises the findings of the research and discusses learning in the field. The researcher discusses concerns in adopting participatory approaches and offers suggestions. A more professional approach in NGO governance with a special focus on ensuring the quality of staff members, the mobilisation of funds from local and corporate houses, technology assisted documentation in the NGO, involvement in research and advocacy, and expanding the coverage of target are some of the suggestions. The need to consider and adopt PRA as a useful methodology by NGOs in daily discourse and areas for further exploration are recommended.

The findings of the study will be useful for both the academic community and practitioners as they could explore the concept and practicality of participatory approaches further. As this research has taken the Wayanad District of Kerala state as the location of study, the adaptation of the findings with a different pattern of NGOs as well as the beneficiaries is going to be a challenge for the professionals. The detailed bibliography gives the reader a guide to seek more on the concepts mentioned. The book provides a good flow of the concepts and its interlinkages are well established.

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