GOVERNMENT OF KERALA
KERALA STATE PLANNING BOARD

THIRTEENTH FIVE-YEAR PLAN
(2017-2022)

WORKING GROUP ON

SOCIAL PROTECTION AND WELFARE

REPORT

SOCIAL SERVICES DIVISION

KERALA STATE PLANNING BOARD
THIRUVANANTHAPURAM

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PREFACE

In Kerala, the process of a Five-Year Plan is an exercise in people's participation. At the end of September 2016, the Kerala State Planning Board began an effort to conduct the widest possible consultations before formulating the Plan. The Planning Board formed 43 Working Groups, with a total of more than 700 members – scholars, administrators, social and political activists and other experts. Although the Reports do not represent the official position of the Government of Kerala, their content will help in the formulation of the Thirteenth Five-Year Plan document.

This document is the report of the Working Group on Social Protection and Welfare. The Chairpersons of the Working Group were Dr K.M. Abraham IAS and Ms. T. Radhamony. The Member of the Planning Board who coordinated the activities of the Working Group was Dr Mridul Eapen. The concerned Chief of Division was Smt Shila Unnithan.

Member Secretary

FOREWORD

The report of the Working Group on Social Protection for the 13th Five-Year Plan is not a mere list of proposals and schemes that relate to social protection. It goes beyond giving suggestions on resource requirements for various measures.

In fact, for the first time, the Working Group has moved away from the conventional paradigm of assigning budgetary allocations to social protection schemes on the basis of residuary resources left over after all else is met. It marks a shift to an entitlement approach- where it tries to, pragmatically within the limits set by budgetary constraints, set the tone around what each person is entitled to whether it be under the Persons With Disabilities Act or the Juvenile Justice Act or any of the more recent and progressive legislations in the country.

This document will be the foundation on which Kerala; will move forward in the care of the elderly, persons with disabilities, women in difficult circumstances, probation services, running of our care institutions and our approach to emerging social concerns around multiple disabilities and dementia.

The Working Group has also proposed that spending on social protection should be subjected to social audit where beneficiaries, implementing agencies and institutions take part. This will have a definite positive effect on the quality of service delivery.

It is hoped that this work will be useful not only to the State Planning Board and implementing departments in Government and other agencies working in this field but also to academicians and researchers as well.

Sd/-
T. Radhamony
Co-Chair of the Working Group

Sd/-
Dr. K.M Abraham IAS
Additional Chief Secretary (Finance) &
Co-Chair of the Working Group

CONTENTS

LIST OF ABBREVIATIONS

AABY	AamAdmiBimaYojana
ARDSI	Alzheimer's and Related Disorders Society of India
ASD	Autism Spectrum Disorder
ASHA	Accredited Social Health Activist
BPBP	BetiBachao, BetiPadhao
CDC	Child Development Centre
CDPO	Child Development Project Officer
CHIS	Comprehensive Health Insurance Scheme
DDUGKY	DeenDayalUpadhyayaGrameenKaushalyaYojna
DEIC	District Early Intervention Centre
ICCONS	Institute for Cognitive & Communicative Disorders and Neuro Sciences
ICDS	Integrated Child Development Services
IGNDPS	Indira Gandhi National Disability Pension Scheme
IGNOAPS	Indira Gandhi National Old Age Pension Scheme
IGNWPS	Indira Gandhi National Widow Pension Scheme
JHI	Junior Health Inspector
JPHN	Junior Public Health Nurse
JSSK	JananiShishuSurakshaKarikram
JSY	JananiSurakshaYojana
KSHPWC	Kerala State Handicapped Persons' Welfare Corporation
KSSM	Kerala Social Security Mission
LHI	Lady Health Inspector
LHS	Lady Health Supervisor
LSGI	Local Self Government Institutions
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MMR	Mumps, Measles and Rubella
MWPSC	Maintenance & Welfare of Parents and Senior Citizens Act
NCD	Non Communicable Diseases
NHM	National Health Mission
NIPMR	National Institute for Physical Medicine and Rehabilitation
NISH	National Institute of Speech and Hearing
NPHCE	Natioanl Programme for Health Care of the Elderly
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OSCC	One Stop Crisis Centre
PMJDY	PradhanMantri Jan-DhanYojana
PwD	Person with Disability
RSBY	RastriyaSwasthyaBimaYojana
SCIP	Sruthitharangam Cochlear Implantation Project
SID	State Initiative on Disabilities
SJD	Social Justice Department
TPDS	Targeted Public Distribution System
UNCRPD	United Nation's Convention on the Rights of Persons with Disabilities

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EXECUTIVE SUMMARY

Social security is a sign of a humane society. It is a mechanism to ensure that the most vulnerable are protected and provided support to mainstream into society. There is a growing demand that the approach to social protection should progressively shift to a rights based framework. In countries where a vast majority of the population live below the poverty line and are unable to access services or benefit from a market economy, such protection is essential.

Moreover, the *Indian Constitution* through its Article 41 directs the State to provide public assistance to its citizens in case of unemployment, old age, sickness and disablement and in other cases of undeserved want within the limit of its economic capacity and development. Kerala has long been acclaimed as a welfare State which provides social protection and social assistance for the poor and the marginalized sections of society particularly the destitute, elderly, children, women, chronically ill and people with disabilities. However fragmentation of delivery of the various programs along with many other reasons reduces the efficiency and comprehensiveness of the programs in the state.

This working group report prepared through a systematic, consultative process is an effort in addressing the critical gaps in social protection sector in the state and to set a road map for more effective social protection during the 13th Five-Year Plan period.

Throughout their life all men and women are exposed to a wide and differing range of contingencies, although people's ability to address these adverse risks differs considerably. Therefore this document views that an ideal social security system should provide social protection from the cradle to grave. Hence the general approach of this document can be summed as *"Rights based Life-cycle approach"*.

It is acknowledged that multiple departments spanning over four ministries are involved in provision of social protection with multiple levels involved within each. Hence several of the social safety nets and programmes are being discussed in other Working Groups, in one sense showing the fragmented nature of the current system. Hence, of the whole host of social protection initiatives, this Working Group deals with the protection of the marginalised social groups with special focus on Elderly, Persons with Disabilities and Women in Difficult Circumstances among others.

Kerala is aging faster than the rest of India and the state also has the largest incidence of Non Communicable Diseases (NCDs). While this higher incidence of NCD is a general problem affecting all age groups, it disproportionately affects the old who are the most vulnerable group when it comes to health care. As specialised health care and other social protection services are warranted for this group, this working group proposes an exclusive Department in Government for Senior Citizens. It is to provide undivided attention for the effective planning, implementation, monitoring and evaluation of senior citizens' welfare programmes and matters incidental and related to it. The department along with the proposed state and district councils for senior citizens, state commission for senior citizens and vayojanasabhas at panchayat level

would enable effective and timely implementation of the social protection programs for the elderly which would include work opportunities for the more able among the older population. While doing so special attention should be given to social protection needs of the most vulnerable with in this elderly group like those who are above 80 years, older women and disabled elderly. This working group envisages and believes that Kerala state can become the first VayoSouhrudaSamsthanam (Age Friendly State) in India, setting a model for other states to follow. It is recommended that the minimum old age pension should be Rs.2500 per month (similarly for the disabled), and staggered with increasing age (severity of disability). Widows, those living alone or sick should get at least 20 percent more.

Services to persons with disability also form a focus area in this document. We believe that disability should no more be viewed merely from the welfare prism as now it is globally being recognised as a human rights and development issue. From being passive beneficiaries of doles, disabled have to be considered as citizens who can be equal partners and contributors to development. Rights based comprehensive life cycle approach of the document fits best to the section on services for Persons with disabilities. This includes prevention initiatives, early screening, early intervention through DEICs and other health and social sector Institutions, education support through special anganawadis, Buds Schools, Model Child Rehabilitation Centres, special schools, inclusive education, vocational training, Sheltered Workshops, Community Based Rehabilitation and assisted living projects among others. While schools are admitting students with disabilities, appropriate mechanisms have to be in place to make them inclusive. Teachers, in general need to be sensitised to the need of such students. That even in a literate state like Kerala, almost one third of the disabled are illiterate, in particular women; for every type of disability the proportion of women is higher. Needless to state this warrants urgent action. Individual Care Plan formulation and follow up shall be another major initiative. This requires convergence of Services, Resources and Institutions.

"Women in Difficult circumstances" was identified as another priority area of intervention by this working group. The problems of single women, widows, female headed households, survivors of gender based violence were discussed and priority strategies are enlisted in this document. The need for a comprehensive plan for prevention of violence, redressal and rehabilitation of survivors has been emphasised which includes strengthening of community based initiatives, including community surveillance systems for prevention of sex crimes, vulnerability mapping, activating the JagrathaSamitis, creating a gender consciousness starting from the school itself and prevention and protection programmes to be taken up by local self-governments. Rehabilitation programmes need to be revamped providing for a better life to survivors who continue n Nirbhaya Homes for long periods of time.

The section on institutional care in this document focuses on the need to improve the quality of service delivery through improving infrastructure, capacity building of caregivers and simplifying rules, procedures and processes. Conceptually social protection services should focus on non-institutionalisation and de-institutionalisation through community based services and family based alternative care. Having said this, institutional care will continue to be a reality for a residual group who are not amenable to non-institutional alternatives.

This document also tries to address emerging issues and areas like dementia care, psychosocial rehabilitation services for paraplegics, strengthening of palliative care services, among others.

In order to ensure effective, transparent and accountable implementation of the social safety net programmes mentioned in this document and otherwise, there must be an innovatively functioning and integrated monitoring system. Development literature suggests that a results framework for a social security program should focus on achieving three key outcomes for vulnerable populations and those at risk of becoming vulnerable. These are: (i) Increased Economic Security; (ii) Improved Human Capabilities; and (iii) Enhanced Resilience. This document also points to some examples of monitoring indicators for assessing the performance in implementation of the social security programmes at various levels.

To conclude, vulnerability arises from risks and insecurity caused by various factors. It is expected that social protection system as evolved by incorporating the recommendations in this document would help to significantly absorb the shocks and minimise adverse impacts due to such vulnerability. The need to think in terms of a minimum social protection floor, ensuring a basic income security and essential health care, netting in all in need has also been flagged off in this Report.

CHAPTER 1
OVERVIEW OF ELEVENTH AND TWELFTH FIVE-YEAR PLANS

Introduction

1. Kerala has several achievements to its credit in introducing social protection and welfare measures to address economic and social distress. Successive Five-Year Plans of the State as well as the Plans of the LSGIs have evolved social security strategies. The Social Justice Department (SJD) is the nodal agency implementing policies and programmes of social protection and welfare.

Review of 11th Five-Year Plan (2007-2012)

2. The 11th Five-Year Plan adopted two pronged development strategy to provide protection to the weaker section of the society like the persons with disabilities, senior citizens, deprived children and women, etc. They were: (i) Socio-economic empowerment of women and (ii) Protection of underserved segments and marginalized groups of the society. In view of this, the 11th Five-Year Plan emphasized to achieve the following objectives.
    1. Strengthening delivery of services and extending the reach of social security network to the neglected groups.
    2. Promoting skill development programmes for better livelihood and income generation in particular for women empowerment.
    3. Providing better facilities in the existing welfare institutions for effective service delivery.

3. In the 11th Plan, a total outlay of Rs.934.85crore was earmarked to the sector. Of which 70 percent outlay was utilized for implementing various programmes and schemes of social protection and welfare. During this period, Government had launched the Kerala Social Security Mission with a view to converge various social security measures/activities and facilitating wider coverage of the population who are in dire need of social provisioning. Cancer suraksha scheme for child patients, Hunger free city programme to provide subsidized meals to public at designated centres and Disability certification programme were the major initiatives.

4. About 5 percent of the total allocation of the sector in the 11th Plan period was allocated to the disability sector for the care and protection of physically and mentally challenged persons through institutional services. During this period, the NISH benefited 35073 disabled persons and the Kerala State Physically Handicapped Persons Welfare Corporation supported 10719 disable persons.

5. Further, the 11th Plan gave attention on skill development programmes for better livelihood and income generation for women. It also focused on gender auditing and budgeting of major development policies and programmes. For this, nearly 10 percent of the total outlay of 11th Plan in the social welfare sector was earmarked to women development

programmes. Gender awareness and finishing school schemes introduced in the 11th Plan helped to eradicate gender discrimination and improve the skill development activities for vocation of women. As a new initiation for addressing the psycho-social problems of the adolescent girls, counselling programme was started in 2008. The Snehasparsham scheme to address the problems of unwed mothers was one of the major initiations of the 11th Plan as it benefited 500 unwed mothers.

Review of 12th Five-Year Plan (2012-17)

6. To bridge the gap and to overcome the shortfalls and difficulties of the past, the 12th Five-Year Plan has given focus on
    1. Coverage and shortage of welfare institutions.
    2. Empowering women and preventing gender injustice.
    3. Strategy and effective policy instruments to address the problems of persons with disabilities.
    4. Implementation of State Old age policy to promote health, wellbeing and independence of the senior citizens.

7. The budget outlay of social security and welfare sector for 12th Plan was Rs.1869.62Crore. This is an increase of 124% over the 11th Plan outlay. As on 31st July, 2016 the expenditure wasRs.1651.75Crore which is 89% of the budgeted outlay. Review on the programmes and schemes for the socio-economic development of the vulnerable groups in the Twelfth Five-Year Plan are detailed below.

Services for Persons with Disabilities

8. For the empowerment of persons with disabilities, the 12th Plan has given attention to (i) Prevention of disability (ii) Early identification of disability (iii) Early intervention of disability (iv)Rehabilitation (v) Education and (vi) Employment generation. About 22 percent of the total allocation of the sector in the 12th Plan period was allocated for implementing various schemes for the welfare of persons with disabilities.

Review of Major Schemes for Persons with Disabilities

9. *Issuing disability certificate to differently abled.* According to the Persons with Disability Act, 1995 it is mandatory to provide disability certificate to all the disabled. From 2009 to March 2015, Kerala Social Security Mission distributed 283277 identity cards through disability certification camps.

10. *Aswasakiranam.* Kerala Social Security Mission provides monthly assistance to the caregivers of severe mentally challenged persons and bed ridden persons with severe physical disability and such assistance was given to 232216 caregivers up to 2015-16.

11. *State Initiatives on Disabilities (SID).* This is a special initiative of the Govt. for prevention, detection, early intervention, education, employment & rehabilitation of the persons with

disabilities. This initiative is implemented by Social Justice Department with the joint auspices of Education and Health Departments. The major achievements are

1. *MMR vaccination.* MMR Vaccination were started giving free of cost to new-borns from January 2014 onwards in Govt. Maternity Hospitals and about 3 lakh doses of vaccines supplied as against the target of 6 lakhs.
2. *Rubella vaccination.* Rubella Vaccination were administered to 5, 44,692 adolescent girls in schools. The MMR and Rubella vaccination programme would reduce the number of children born with various disabilities.
3. *Universal hearing screening.* To conduct hearing screening of new born babies, Oto Acoustic Emission Screeners were given to 5 Govt. Medical Colleges and 35 Govt. Hospitals. Since its commencement in the year 2014-15, the number of neonates screened was 178,523. The impact of the programme is that of the screened 20,514 babies were referred to further check-up and correction. If hearing problems are identified in the very early stage majority of cases can be rectified or can be corrected to a large extend.

National Institute of Speech and Hearing (NISH)

12. NISH is a premier institute in the area of disability declared as National University for Disability Studies & Rehabilitation Sciences for providing excellent environment for higher study opportunities for people with disabilities. In the 12th Plan (up to 2015-16), NISH was attended 28196 cases under the Audio clinics, 7126 cases under hearing and speech language disorders programme and 1935 cases under medical, psychology and allied services. The academic programmes conducted by NISH benefited 431 students during this period. Shortage of sufficient applicants in the academic programmes is the reason for shortfall in attaining the target of the courses.

Kerala State Handicapped Persons Welfare Corporation

13. The Corporation provides economic empowerment and rehabilitation to the persons with disabilities. During the 12th Plan, the Corporation supplied aids and appliances to 14216 differentially abled persons and distributed 500 motorized scooters (General category: 384, SC category: 116). Modern equipment's like powered bed, electronic wheelchair were distributed to 80 differentially abled persons and issued motorized tricycle subsidy @Rs.10000/- to 314 such persons. Also, the Corporation distributed loan to 544 disabled persons for self-employment from the National Handicapped Finance and Development Corporations. Of which 376 were male loaners and 168 female loaners.

Services for Older People

14. The programmes and schemes for senior citizens implemented through the Social Justice Department aim at their welfare and care by supporting old age homes, day care centres, mobile medicare units, etc. The Department also acts as the nodal agency for the effective implementation of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 in the State. Accordingly, maintenance tribunals are functioning for checking elder abuse and

redressing the petitions of senior citizens in all the districts with RDO's as the Presiding Officers and District Collectors as Appellate Tribunal authorities.

Review of Major Welfare Schemes for Senior Citizens

15. *Vayomithram programme.* Kerala Social Security Mission is implementing this programme in 5 Corporations and 29 Municipalities of the State giving welfare services to persons above 65 years. Free medicine, palliative home care, medical camps and helps desk facilities are the services. During the 12th Plan up to 2015-16, the programme assisted nearly 4 lakh older persons.

16. *Age friendly panchayat*. The age friendly panchayat implemented by SJD is a new initiative associated with State Old Age Policy, 2013. Converting all the panchayats in the State into age-friendly panchayat for ensuring good health, participation and assuring quality of life to the elders is the objective of the programme. Accordingly, the Manickal panchayat in Thiruvananthapuram district has been selected as the first integrated age-friendly panchayat.

17. *Vayo amrutham programme.* The Social Justice Department with the support of ISM department has implemented this new programme in 14 Old age homes for the treatment of inmates who are suffering from health problems like Diabetes mellitus, Asthma, Arthritis, etc. 674 inmates of the homes got benefited the benevolence of the Ayurvedic treatment, of which 372 were female.

Services for Women in Difficult Circumstances

18. The Social Justice Department and the statutory bodies - Kerala Women's Commission and Kerala State Women's Development Corporation are implementing plan schemes promoting social and economic empowerment of women. Their initiatives focus on the effective implementation of the provision of the Domestic Violence Act, Dowry Prohibition Act, Prevention of immoral trafficking act, etc.

Review of Major Schemes for Women Empowerment

19. *Indira Gandhi Matritva Sahyog Yojana*. This centrally sponsored scheme provides financial assistance to pregnant women of 19 years and above for the first two live births in Palakkad district. The scheme assisted 88527 beneficiaries till March, 2016.

20. *Snehasparsham.* This scheme implemented by KSSM aims to address the problem of unwed mothers.Monthly assistance of Rs.1000/- is given to all unwed mothers and benefited 6155 women till March, 2016.

21. *Women development programmes.* This is a major programme of Social Justice Department focusing on implementation of dowry prohibition, protection of women from domestic violence and sexual abuse, rehabilitation of victims including health care and compensation,

economic support to women headed families and women belonging to BPL families and assistance to low salaried women for self-improvement through capacitating. During 2015-16, educational assistance was given to 13540 women headed families.

22. *Nirbhaya programme.* Social Justice Department is the nodal agency of the Nirbhayaprogramme. It envisages setting up of 'Nirbhaya Homes' for sexually abused women to give skill development training for providing employment opportunities. 10 such homes were started in 9 districts sheltered 200 women. One Stop Crisis Cell were established in 14 District Hospitals and 7 Taluk hospitals providing all required services to women victims of sexual violence - emergency health care, psychological counselling, police assistance, legal aid and safe shelter service. Considering the increasing number of domestic violence cases, 12 shelter homes were also started in the state for catering the special needs of the women above 18 years of age and accompanying children. During 2015-16, these homes benefited 346 women.

23. *BetiBachaoBetiPadhao.* The new 100% centrally sponsored scheme implemented by the Department of Social Justice launched in Thrissur district on a pilot basis to address the issues of women in the longer term and to reverse the trend of declining child sex ratio. The GOI will provide financial assistance to the state to empower the girl child and enable her education.

Kerala Women's Commission

24. The Commission was established in 1996 to improve the status of women in Kerala and enquire into unfair practices against women and recommend remedial measures. The Commission implements gender awareness programmes and undertake legal workshops /seminars, Adalaths, DNA test, etc. During the 12th Plan, the Commission had conducted 371 legal workshops/seminars on various problems faced by women, 191 counseling/skill training programmes to panchayatJagrathasamathis on various laws related to women and other legal procedures, 480 Adalaths for early disposal of petitions and grievances, 31 DNA tests and 24 evaluation studies. Under gender awareness programme, the Commission undertook 69 pre-marital counseling in all the districts with the participation of women N.G.O's, and created orientation empowerment programmes in 1024 educational institutions. In between 2013 to 2014, the Commission received 13710 complaints and 7437 cases were disposed. The nature of complaints shows that domestic violence, harassment of women and family problems is on the increase.

Kerala State Women's Development Corporation

25. Self-employment schemes for women, flagship programme on gender awareness and finishing School are the major programs of the Corporation. The Corporation distributed over Rs.233 crore from National Corporations to 27169 women under self-employment loan scheme. The Corporation has so far been installed 49 She-toilet units across the state and 8 in major railway stations. As part of ensuring menstrual health and hygiene for adolescent girls and women, the Corporation launched supply of high quality sanitary pads

at affordable cost and installed vending machines and incinerators at 110 schools in Thiruvananthapuram district and 621 schools in Kozhikkode districts for safe disposal of used pads. Under the flagship programme on finishing schools, the Corporation launched Resource Enhancement Academy for Career Heights (REACH) at Thiruvananthapuram and Kannur with a view to bridge the gap between acquired skills and required skills by conducting training programmes including soft skill training communicative English training, IT training, etc. From 2010 onwards, 2100 students were trained, of which 1656 got placement in various organizations like Reliance, Asianet, SUT Hospital, etc.

CHAPTER 2
BACKGROUND

26. The Directive Principles of State Policy of the Constitution of India enjoin upon the State to undertake within its means a number of welfare measures for the poor and the vulnerable. Article 41 of the Indian Constitution directs the State to provide public assistance to its citizens in case of unemployment, old age, sickness and disablement and in other cases of undeserved want within the limit of its economic capacity and development. Social security, invalid and old age pensions figure as Items 23 and 24 of the 7th Schedule of the Constitution of India in the Concurrent List.

27. Social security is a sign of a humane society. It is a mechanism to ensure that the most vulnerable are protected and provided support to mainstream into society. In countries where a vast majority of the population live below the poverty line and are unable to access services or benefit from a market economy, such protection is essential. Social security benefits are a powerful tool to combat poverty and achieve the (now) Sustainable Development Goals. A further message is that the build-up of national social security systems early in the economic development process is a key investment in social and economic development. *Separate from the fact that social security is a human right, development literature indicates that social security programs are found to be effective if implemented well.* A 2014 study of the MGNREGS demonstrated "statistically significant poverty-reducing effects for the sub-sample of households belonging to scheduled castes and scheduled tribes during spring, which is the agricultural slack season". Several studies have also demonstrated the benefits of the mid-day meal programme in schools. It helps to increase school attendance, improve child nutrition and even enhance academic achievements of pupils.

28. AmartyaSen and Jean Dreze distinguish two aspects of social security —"protection" and "promotion." While the former denotes protection against a fall in living standards and living conditions through ill health, accidents etc the latter focuses on enhanced living conditions, helping the poor to overcome persistent capabilities deprivation. The unorganised workforce is characterised by scattered and fragmented areas of employment, seasonality of employment, lack of job security, lack of awareness and high unemployment levels. Social protection programmes in India can be broadly categorized as (i) targeted social security programmes for the poor, (ii) social security measures for unorganized/informal sector workers and (iii) social security measures for organized/formal sector workers. The important Acts/ Commissions/schemes are given below
    1. *The Right to Education (RTE) Act*, enacted in 2009 and enforced from 1.4.2010, gave a legislative framework for providing education. SSA addresses the educational needs of children in the age-group of 6-14 years by strengthening educational infrastructure and facilitating quality of education.
    2. *National Health Mission (NHM).* aims at reducing infant and maternal mortality rate, prevention of communicable and non-communicable diseases etc. JananiSurakshaYojana is being implemented with the objective of reducing maternal and neo- natal mortality.

3. So far as access to essential services is concerned, under a Scheme PM AwaasYojana financial assistance is provided to under-privileged section for construction/upgradation of dwelling units.
4. The Integrated Child Development Services (ICDS) is a nutrition and child development scheme with the objective of improving the nutritional and health status of children in the age group of 0-6 years to reduce the incidence of mortality, morbidity and malnutrition and enhance the capability of mother to look after the health and nutritional needs of the children.
5. The Mid Day Meal (MDM) Scheme covers elementary education (up to 8th class) and aims at providing hot, cooked mid-day meal with the stipulated, nutritive and calorific value
6. A Targeted Public Distribution System (TPDS) is in place to provide subsidized food grains to the disadvantaged populace.
7. Annapurna Scheme. 10 kg of food grains per person per month are supplied free of cost under the scheme to indigent senior citizen of 65 years age and above who are eligible for old age pension but are not getting it.
8. The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) aims at enhancing the livelihood security of people in rural areas by guaranteeing 100 days of wage employment in a financial year to a rural household.
9. Indira Gandhi National Old Age Pension Scheme (IGNOAPS). Under IGNOAPS all citizens living below poverty line (BPL) and above the age of 60 years are provided pension.
10. Indira Gandhi National Widow Pension Scheme (IGNWPS).Under IGNWPS pension is given to the widows aged between 45 and 59 years of age of BPL households.
11. Indira Gandhi National Disability Pension Scheme (IGNDPS). Under IGNDPS a BPL person aged between 18-59years of age and suffering from severe or multiple disability
12. RastriyaSwasthyaBimaYojana (RSBY) is a health insurance scheme providing for smart card based cashless cover of Rs.30, 000/- to a BPL family of 5 covering all pre-existing diseases, hospitalization expenses and transport cost.
13. AamAdmiBimaYojana (AABY). AABYprovides for death and disability insurance cover to rural landless households amounting to Rs.30,000/- in case of natural deaths, Rs.75,000/- in case of accidental death and total permanent disability and Rs.37,500/- in case of partial permanent disability. Under the scheme two children of the beneficiaries studying in 9th to 12th standards are given scholarships at the rate of Rs.300/- per quarter per child.

29. Throughout their life all men and women are exposed to a wide and differing range of contingencies, although people's ability to address these adverse risks differs considerably. Therefore an ideal social security system should provide social protection from the cradle to grave."Life-cycle analysis" allows policymakers to design social protection systems comprehensively and ensures synergies between individual programs to complement one another and together achieve desired benefits to individuals and households to promote pro-poor growth and reduce social exclusion. It also allows a people-centric approach to

formulating effective safety net programmes. This said, it must be kept in mind that such risks no longer can be viewed in a linear line ranging from birth to death. In the globalising and fast-changing world, life does not take a linear path, but individual vulnerability and lack of social security can occur at many times in the life of an individual. With the market ruling our lives, individuals become even more insecure with every incidence of risk starting a new life cycle of risks for the individual.

30. It is only in the last 15 years, in such a market led environment that the idea of a compulsory minimum level of non-contributory social protection has really gained momentum.

31. *Table 1 provides a bird's eye view of the different types of risks that an individual can face in life.* It also identifies national or state programmes that address such risks. The table also provides an analytical framework to understand the existing program that continues to exist and thus hinting the gaps in it.

Table 1 *Framework to Analyse Risk (Life cycle approach)*

Early years 0-4	
Risks and vulnerabilities (not exhaustive)	Government responses (not exhaustive)
1. Infant mortality 2. Low birth weight/ Premature baby 3. Congenital disability, disorders and deficiencies 4. Developmental Delay and failure to thrive 5. Neglect and discrimination of girls	1. JananiSurakshaYojana (JSY) : Govt. of India program implemented in the state thru Natioanl Health Mission 2. JananiShishuSurakshaKarikram : (for preganant mothers to prevent and neonates up to 1 month) Govt. of India program implemented in the state thru Natioanl Health Mission 3. RastriyaBalSurakshaKarikram (health care program for 30 conditions including disability and disorders for children up to 18 years): Govt. of India program implemented in the state thru National Health Mission 4. ArogyaKiranam: Health care program by Govt. of Kerala for disability, diseases and disorders other than that covered under RBSK 5. Thalolam: Govt. of Kerala program implemented thru KSSM, for diseases of children up to 18 years, causing catastrophic health expenditure 6. Integrated Child Development Services Scheme inter alia addresses issues of poor maternal care and early nutrition risks to the children 7. Indira Gandhi MatritvaSahyogYojana:The scheme attempts to partly compensate for wage loss to Pregnant & Lactating women both prior to and after delivery of the child.
Children years5-11	
Risks and vulnerabilities (not exhaustive)	Government responses

1. Risk of not attending school because of domestic or income-earning responsibilities or lack of household income to pay for school related costsor inability to benefit from schooling because of added burden of domestic responsibilities or income-earning responsibilities 2. Particular issues for girls: not prioritised for investment in education/ domestic responsibilities/ vulnerability to sexual exploitation when attending school 3. Insufficient food or poor diets increasing likelihood of illness 4. Dependency: risk from loss of parent/carer 5. Early disability	1. The BetiBachao, BetiPadhao (BBBP) addresses the issue of declining child sex ratio (CSR). This is implemented through a national campaign and focused multi-sector action in 100 selected districts with low CSR, covering all States and UTs. 1.It aims to prevent gender based sex selective elimination 2.Ensure survival & protection of the girl child 3.Ensure education of the girl child 2. Mid day meal programme 3. Universal immunisation programme 4. RastriyaBalSurakshaKariakram (see above) 5. ArogyaKiranam: (see above) 6. Thalolam: (see above) 7. Buds specialschools for intellectual disability: (by Local Self Government Institutions)
Adolescents 12-24 years	
Risks and vulnerabilities (not exhaustive)	Government responses
1. Impact of triple burden of work, unpaid care and schooling 2. Risks from early marriage and child-bearing 3. Lack of access to training/formal employment leading to entry into high risk employment categories 4. Increased risk of HIV and AIDS infection as individuals become sexually active 5. Increasing vulnerability of girls due to gender based violence 6. Disability 7. Catastrophic health	1. Sabla Scheme for Empowerment of Adolescent Girls: With the objective to improve the nutritional and health status of adolescent girls in the age group of 11-18 years and empower them by providing education in life-skills, health and nutrition. 2. Indira Gandhi MatritvaSahyogYojana (IGMSY) (see above) 3. Rashtriya Kishore SwasthKaryakram (Adoloscent and Reproductive health programme) 4. RastriyaBalSurakshaKarikram (see above): till 18 years 5. ArogyaKiranam: (see above): till 18 years 6. Thalolam (see above) : till 18 years 7. Cancer Suraksha Scheme : Thru KSSM 8. Aswasakiranam : Monthly assistance to care givers. Implemented through KSSM

expenseslike for Cancer pushing the family to poverty	
Young adults mid- 20s/30s	
Risks and vulnerabilities (not exhaustive)	Government responses
1. Lack of access to credit/ asset building opportunities 2. Lack of employment or further training/development: 3. Loss of employment/ reduced income earning potential for women through pregnancy and childcare 4. Reduced household income relating to HIV and AIDS prevalence, and other illnesses	1. Kudumbasree Mission 2. Aswasakiranam (see above) 3. PradhanMantriKaushalVikasYojana (PMKVY) is the flagship scheme of the Ministry of Skill Development & Entrepreneurship (MSDE). The objective of this Skill Certification Scheme is to enable a large number of Indian youth to take up industry-relevant skill training that will help them in securing a better livelihood. Individuals with prior learning experience or skills will also be assessed and certified under Recognition of Prior Learning (RPL) 4. DeenDayalUpadhyayaGrameenKaushalYojna: to engage rural youth especially BPL and SC/ST segment of population, in gainful employment through skill training programmes. 5. EMS BhavanaPathathi :Housing scheme by Govt of Kerala 6. Zero Landless Scheme : By Govt. of Kerala 7. Targeted schemes for marginalised ST and SC by Govt. India and Govt. of Kerala 8. Comprehensive Health Insurance Scheme (CHIS Plus) 9. RastriyaSwasthBhimaYojana
Middle adults	
Risks and vulnerabilities (not exhaustive)	Government responses
1. Risks of engagement in vulnerable employment 2. Loss of employment or employment insecurity through care for younger and older family members (particularly women) 3. Loss of partner's support through death, illness, abandonment leading to increased responsibility for dependents: 4. Acquired disability through hazardous employment or other practices	1. Kudumbasree mission 2. EMS BhavanaPathathi(see above) 3. Zero Landless Scheme (see above) 4. PradhanMantriSurakshaBimaYojana for accidental health insurance. 5. PradhanMantriJeevanJyotiBimaYojana (for life insurance) 6. PradhanMantriGraminAwaasYojana: 7. PradhanMantri Jan-DhanYojana (PMJDY) is National Mission for Financial Inclusion to ensure access to financial services, namely, Banking/ Savings & Deposit Accounts, Remittance, Credit, Insurance, Pension in an affordable manner. Overdraft facility upto Rs.5000/- is available in only one account per household, preferably lady

5. Social assistance programs (NSAP – agricultural labourers, social security 6. Emerging issue – 25lakhmigrant labourers. 7. Premature death of head of household	of the household. 8. PDS, ICDS, Mid-day Meals, Food Security. 9. Public Employment MGNEREGA 10. Excluded and vulnerable groups – program – elderly disabled, women in difficult circumstances, migrant labourers, and traditional sectors. 11. Comprehensive Health Insurance Scheme (CHIS Plus) 12. RastriyaSwasthBhimaYojana 13. 30-35% are covered in Kerala covering pensions
Elder Citizens	
1. Loss of income when work is lost due to age discrimination, frailty/illness etc.: 2. Work in informal sector throughout life means that there is no contributory pension provision: 3. Poor health in later life due to poor nutrition, multiple childbirth, poor working environment and lack of health care in earlier years 4. Continuing to work to support self and dependents in low-income earning and often physically disabling jobs 5. Discrimination against widows/ lack of inheritance rights for women; Widow's loss of access to late husband's family resources: 6. Increased childcare responsibilities where middle age adults have been lost to HIV and AIDS, leaving dependent children in the care of grandparents 7. Increased likelihood of age-related disability and chronic illness: (i) Indira Gandhi National Disability Pension Scheme 8. Welfare fund model for	1. Social Security Pension scheme for old age by State Govt. and LSGIs 2. Atal Pension Yojana is a government-backed pension scheme targeted at the unorganised sector. 3. Annapurna Scheme: This scheme aims to provide food security to meet the requirement of those senior citizens who, though eligible, have remained uncovered under the IGNOAPS. Under the, 10 kg of free rice is provided every month to each beneficiary. 4. Indira Gandhi National Old Age Pension Scheme; Indira Gandhi National Widow Pension Scheme 5. Between 18 and 59: Under National Family Benefit Scheme, Central Assistance of Rs. 20,000 is given in the form of lump sum family benefit for households below the poverty line on the death of the primary breadwinner due to natural or accidental causes 6. Comprehensive Health Insurance Scheme (CHIS Plus) 7. RastriyaSwasthBhimaYojana 8. Old age Homes and Schemes by SJD, Govt. of Kerala 9. Vayomithram Project :implemented thru KSSM (detailed in section 3.1)

	after 60 pensions plus social insurance, RSPY Group	
9.	Death of head of household	

*Adapted from table in ILO report2003, ILO.A Life Cycle Continuum Investment For Social Justice, Poverty Reduction And Sustainable Development.

32. There are two types of risk – individual or idiosyncratic risk and aggregate or covariate risk, Aggregate shocks affect large populations and can include natural disasters like floods, health epidemics. Covariate risks are those that deal with specific risks that occur at the individual level.

Selected Social Security Needs

33. Despite a strong social safety net, a considerable number of people still find it difficult to cope with the painful problems of exclusion, destitution, chronic or life threatening diseases, disabilities and sudden poverty. There are also outlier groups who are outside the social safety net. It is the responsibility of a civilized society to ensure that all marginalized groups have equal access to opportunities and capabilities and live a life of dignity. There is a need to strengthen the available services, improve their quality, and ensure a coordinated monitoring. Several of the projects are related to this dimension.

Analysis of Existing Systems

Are the Schemes Sufficient and Comprehensive?

34. Sufficiency of safety net programs depends on how well the poor are covered and on the adequacy of benefits. Are current levels of compensation paid by the programmes sufficient to achieve the outcomes? Do these programmes, if implemented well in an integrated manner, provide comprehensive support to a household so that it can contribute to poverty reduction in the receiving household, which can then gradually graduate from these programs? What percentage of a vulnerable household's income does a social safety program (including social assistance) provide? Is the quantum of support sufficient to meet the stated outcomes of the social safety net program?

35. It is important to ensure comprehensive coverage, identify the need for new interventions if there are critical gaps in coverage, avoiding duplications and overlaps. It is also important to ensure convergence with centrally sponsored programs in this process. To some extent, the table provides an analytical framework for doing so. Few identified gaps are noted below.
    1. Emerging Psycho-Social Issues (Dementia, Palliative care, and Paraplegic)
    2. *Poor migrants in Kerala.* Migrants are not protected under social security schemes in their own states and cannot seek benefits in Kerala because of their ineligibility to claim such benefits.

3. Houses for vulnerable people, particularly women and transgender, without any land
4. Support for women headed households; single women
5. People below the BPL who do not have ID cards (since they do not have addresses) and their access to benefits afforded by the system

36. Another key question is who is receiving these benefits. To be effective, social safety net transfers should be targeted towards those who most need it. There are anecdotal impressions that a significant portion of this support is reaching non-vulnerable segments of society.

Efficiency in Integration and Coordination of Social Safety Net Programs

37. At the national level, there is no policy for a comprehensive social assistance programme. Implementation of the social protection policy should be coordinated and within a clear policy framework or strategy. Kerala has long been acclaimed as a welfare State which provides social protection and social assistance for the poor and the marginalized sections of society particularly the destitute, elderly, children, women, chronically ill and people with disabilities. The State has a robust social safety net consisting of Ashraya and Buds school programme, social security initiatives of the Kerala Social Security Mission and community based palliative care programme of the Local Governments and Health department. The other major on-going initiatives in the area include (a) social assistance programmes including pension schemes for the aged, widows, disabled and agricultural labourers and national family benefit scheme, (b) assistance to meet medical expenses of chronically ill, (c) assistance to fully bed-ridden patients for caregiver support, (d) community based dementia care (e) psycho-social rehabilitation of the paraplegic, (f) community based pain and palliative care services and (g) MGNREGS. However, in Kerala also, social security is fragmented without an inter-sectoral institutional arrangement among all actors or a coordinated implementing strategy. For example, there are 33 Welfare Fund Boards, of which 16 are under the direct control of the Labour Department. They provide social security coverage to 47.23 lakh (69% of the total workers) workers in the unorganized sector in the last year. About 65% of the workers were from agriculture and allied sectors. The fragmentation of delivery of the various programs in Kerala reduces the efficiency and comprehensiveness of the programs. Multiple departments are involved in provision of social urban health spans four ministries and nutrition spans six, with multiple levels involved within each. Social registries, beneficiary registries, and monitoring and evaluation systems are found to be among the most commonly used tools to support the administration and management of social protection systems.

CHAPTER 3
SOCIAL SECURITY NEEDS: FOCUS AREAS

38. Several of the social safety nets and programmes are being discussed in other Working Groups, in one sense showing the fragmented nature of the current system. Of the whole host of social protection initiatives, this Working Group deals with the protection of the marginalised social groups, specifically older people, those with disabilities and women in difficult circumstances. The proposed focus areas, programmes, projects, and interventions are detailed below.

Services for Older People

Context

39. Kerala is aging faster than the rest of India. With 14% of the population already past 60 years, the population of senior citizens is expected to reach 20% by 2025 and 35% by 2050. Currently 48 lakh people of Kerala are 60 and above. 15% of them are 80 years of age and over. A good proportion of the elderly belongs to the poor sections of the community. Women outnumber men among the 60 plus and among them, majority are widows. In addition to widowhood, this category of the old suffers from 4 other disabilities – being women, being poor, being disease-prone and lacking care givers. NSS Survey 2015 on Morbidity indicates that 65% old are morbid. Most senior citizens are facing the problem of loneliness and a good number of them are victims of one or other form of abuse.

Demography of Aging

40. Kerala's demography is characterized by a steep fall in birth rate and an equally steep fall in death rate. This has added to the increase in the percentage of senior citizens in the population of the State. The age composition of Kerala's senior citizens is given below. (Percentages in brackets)

Table 2 *Age Composition of Senior Citizens, Kerala*

Age composition	Total	Men	Women
All ages	33406061	16027412	17378649
60-69	2416805 (7.23)	1114368 (7.14)	1272437 (7.32)
70-79	1234739 (3.7)	534879 (3.34)	699860 (4.03)
80+	541849 (1.62)	204348 (1.27)	337501 (1.94)

Source Census of India, 2011

41. It will be seen that the 80+ group formed 13 % of the 60+ in 2011. Currently it stands at 15% of senior citizens. This is the fastest growing group among the old. Expectation of life (in years) at birth for the periods 1970-74 and 2010-2014 is as follows (see table 3):

Table 3.*Expectation of life at birth during 1970-74 and 2010-14*

	1970 -74			2010-14		
	Total	Men	Women	Total	Men	Women
India	49.0	50.5	49.0	67.9	66.4	69.6
Kerala	62.0	60.8	63.3	74.9	72.0	77.8

Source Registrar General of India, Abridged Life Tables, 2016

42. It will be seen that Kerala had already a big edge over India in life expectancy at birth (62 years against 49 during 1970-74) and this was continued during 2010-14 (74.9 years against 67.9) though the edge became narrower.

43. One point to be noted in the matter of expectation of life is that at older ages, life expectancy is lower than some of the states in India. The following figures indicate this. Thus at age 60 while Kerala's life expectation was 20.0 years, that of Jammu and Kashmir was 21.1, Uttarakhand 20.5 and Punjab 20.3. At age 70 while Kerala's life expectancy was 12.9, that of Jammu and Kashmir was 14.3, Uttarakhand 14.5 and Punjab 13.5.

Table 4 *Expectation of life at later years*

	India	Kerala	Jammu & Kashmir	Utharakhand	Punjab
At 60	17.9	20.0	21.1	20.5	20.3
At 70	11.5	12. 9	14.3	14.5	13.5

Source Registrar General of India, Abridged Life Tables (2016)

44. This may appear a contradiction when contrasted against the fact that Kerala has the best health care system in India. But, as will be shown later, so many adverse factors conspire against advancing the years of life in later years in Kerala. The marital life of Kerala old is given below in table 5

Table 5 *Marital life of Kerala senior citizens*

	Total	Men	Women
Never married	2.6	1.8	3.3
Currently married	60.8	88.9	37.8
Widowed	35.7	8.8	57.0
Others	0.9	0.5	1 .9
Without partner	39.2	11.1	62.2

Source Census of India, 2011

45. The total figures for currently married is misleading because among the currently married which is 60.8% persons, men constitute 88.9% and women only 37.8% (in years).This means that for an overwhelming majority of men (88.9%) their wives are alive at older ages while for only 37.8% women, their husbands are living. Men marry wives several years younger and when they enter 60, their wives will be much younger (may be in their late fifties).Thus, at 80, while only 17% men are widowed, as many as 84.2% women are widowed (not shown in the Table).

46. The last row of the table shows persons without partners (husband/wife). This is real indication of loneliness in later years. It shows that while only 11.1% men are without partners, as many as 62.2% women are without a partner (never married/divorced/separated/widowed).

47. One feature about the living pattern is that in 58.9% cases, there was no old person present in the household. Households' having only one old person was 29.6%, those having 2 old persons was 11.0% and those having 3 or more old persons were 0.5%. The old living alone constituted 7.3% and those where both husband and wife were staying together constituted 11percent.

The Economic Scene

48. Main workers among the old (60 plus population) were 8.3%, Marginal workers 23.4% non-worker14.5; those seeking work were 5.2percent. .51% of the old in the rural areas were reported dependent on others (male 33.5percent, female 69.6percent) while in the urban areas, 51.2% were reported dependent(male 30 percent and female 71.8).Among economically dependent aged, 82% rural and 80% urban had to depend on children for their financial support. This means that by and large children were the main support for the old. There are the following types of economic support for senior citizens in Kerala:
    1. Pension for persons retired from government and statutory organizations.
    2. Pensions for BPL
        1. National Old age pension
        2. Agricultural workers pension.
        3. Widow's pension
        4. Disability pension
        5. Pension for unmarried women above age 50

49. Besides the first two which are old age pensions, the rest have a number of eligible older persons. In addition, there are over 40 welfare fund schemes for those who retire from unorganized sectors but a number of them are one time payments.

50. Item (a) above covers only around 15% of senior citizens and the rest (item b) cover around 25%, mostly those below poverty line. There is much anomaly in the payment of these pensions and complaints are widespread that not all deserving persons get it and a number of those who get it are undeserving. Recently the BPL pension amount in Kerala has been raised to Rs.1000 for those aged 60-79 years and Rs.1500 for the 80 plus. One point to be noted in this connection is that around 30% of the senior citizens are below poverty line and another 20 are in semi poor condition. Any plan has to take into account the plight of this category and should provide for it.

Social Situation

51. The traditional social security system provided by the joint family has almost eroded in Kerala. The emergent nuclear family has very poor arrangement for taking care of the old. This is accentuated by the fact that a large number of the able bodied and young have gone out for jobs (especially to Gulf Countries), leaving the old to fend for themselves. Also, many of the women who were traditionally the care givers in the family but are also working now combine outside work with care of the elderly.

52. One feature of the old is that there are a large proportion of them who are illiterate. Illiteracy was reported as 16.72% among 60-69 age group, 24.39%, among 70-79 age group and 30.62% among 80 plus age group. This makes it difficult to retrain them and equip them for jobs after retirement. One advantage is that being in the unorganised sector, they do not retire but the general problems of aging will affect them also and eventually they will have to stop work at some point of time.

53. An emerging social problem is the generation gap – cultural and emotional gap - between generations – the old, their children and the grandchildren. The value system that traditionally bonded them together has now almost eroded and there is very little in common that would bind them together. A consequence of this phenomenon is the growing tendency among the young for abuse of the old. The worst form of this is abandonment of the old. Help Age India studies report that the abuse is increasing steadily over time and around 35% of the elders have suffered some form of abuse during their old age. Measures have to be evolved to save the senior citizens from being abused.

54. One result of all these disabilities for senior citizens (destitution, lack of carers, abuse, neglect, abandonment) is the rise of old age homes in Kerala. The state has the largest number of old age homes (around 600) in India but they are not run well. Most of them are managed on custodial lines and take care of only the food and lodging of residents. This has to be ended especially in view of the fact that their (residents') number is increasing and there is tendency for quality to deteriorate. It is important that the homes should be modernized and made resident-friendly as early as possible.

Health Scenario

55. Kerala is considered to have the best health care system in India. But Kerala is also known for its highest morbidity. The 71st Round of National Sample Survey on Morbidity(January – June 2015) shows that while a total of 89 persons out of 1000 persons surveyed reported ill during a 15 days period of survey all over India, the number reported from Kerala was 310 out of 1000. Among the 60+ this was 276 for India and 646 for Kerala. Kerala has the largest incidence of Non Communicable Diseases (NCDs) in India. The State is considered to be the diabetes capital of India. The Registrar General of India's Report on Medical Certification of Cause of Death 2013 shows that while in India only 3% people died due to diabetes during 2013, it was 10.2% for Kerala. The cases of hypertension and cardio vascular diseases are not different. These may be treated as the factors reducing life span

and affecting quality of life. While these are general problems affecting all age groups in Kerala, it disproportionately affects the old who are a more vulnerable group in matters of health.

Expectation of Life at Different Ages

56. Expectation of life at ages 60 and 70 for Kerala and s few selected States shows that the gains made by Kerala at birth and over the years has been showing a decline at later ages as we discussed earlier. .The only consolation for Kerala is that its statistics are better than all India average (17.9 years at age 60 and 11.5 years at age 70).

Disability

57. Old aged having any kind of disability constituted 29.5% (men 25.6percent and women 33.7percent) out of the total disabled population in the State.

58. The following types of disability were reported (the figures represent percentage of total for the whole state.): Seeing46.7; hearing36.5; Speech15.5; Movement33.0; mental retardation5.5; mental illness 20.9; others 23.2; multiple disability 29.8.Those unable to move from the house or who were immobile (confined to bed) constituted 8.4percent in rural and 7.0percent in urban areas (rural male 6.5percent, female 10.2percent; urban male 4.9percent and female 9.1percent). Among 80 plus, 34% rural and 27% urban reported immobility (NSS 71stRound).

Table 6 *Number of Ailments reported per 1000 in 2015 (during 15 days)*

	India	Kerala
Total	89	310
60+	276	646

Source NSS 71st Round

59. It may be pointed out that Kerala has the highest morbidity rate in India.

Proposals

60. Since the problem of aging is now being recognized as a major issue for governmental intervention we propose some institutional arrangements which need to be put in place for a focused plan of action for the older population. The suggestions dealt follow attempt to include essential features of age friendly measures.

Senior Citizens' Department

61. This Department will be in charge of all the dimensions of old age listed in this section. Additionally, it will take leadership in formulating the State Policy on Senior Citizens and in implementing and supervising the implementation of programmes for senior citizens. It will give directives to the concerned Departments and guide and coordinate senior citizens'

programmes prepared by them. In fact, all departments of the government have some role in matters relating to senior citizens and as such should be guided and assisted by the Department of Senior Citizens in playing their roles properly.

62. The Dept. of Senior Citizens will also ensure that the implementing Departments implement their senior citizen programmes promptly and achieve targets in qualitative and quantitative terms within the time schedule fixed. This Department will also have responsibility for ensuring the formation and effective working of the various institutions listed under item 27 of this document.

63. Then there is the vast field of NGOs which contribute substantially to the welfare of senior citizen in the State. Their effective supervision and regulation will itself demand a substantive part of the time of the new department. It may be pointed out that only an independent and full time department can devote undivided attention which is required for the effective planning, implementation, monitoring and evaluation of senior citizens' welfare/developmental programmes.

A State Commission for the protection and welfare of Senior Citizens

64. Currently there exist commissions for women, children, youth, disabled etc. A Commission on Senior Citizens is a telling need as
    1. Senior citizens form a sizeable proportion of the population of the state (currently 14%, soon rising to 20%).
    2. Their problems and needs are different from those of other segments of the population.
    3. Their span of life is rather limited, their waiting time and capacity to wait are limited and hence they should get immediate justice on their needs and problems.
    4. Unlike other categories of citizens, senior citizens are subject to considerable abuse and other forms of discrimination.

65. This Commission is indispensable for protecting senior citizens from abuse, neglect and abandonment, for hearing their petitions with empathy, for ensuring their rights and providing speedy justice for them.

66. In short, onlya Senior Citizens' Commission can do full justice to address the causes, concerns, problems and needs of senior citizens as it will additionally have the required judicial powers and can take up suomotu cases on behalf of senior citizens.

State Policy for Senior Citizens

67. Kerala's efforts at preparing a policy for its senior citizens started in 1997 when the Centre for Gerontological Studies (CGS) prepared a booklet *Challenges of Ageing Population in Kerala* and submitted it to the Government. In 2006, the State came out with a policy on senior citizens which were prepared by CGS. However, not much was done on it and in 2013 government announced a new policy which is relatively exhaustive and has touched most

major grounds. However, this policy also had the same fate as the two earlier policies. Old Age policy may be revised and implemented promptly. The new policy should have a Plan of Action which should clearly lay down a road map for its implementation and monitoring.

State Council and District Councils on Senior Citizens

68. The State Council should be a small body consisting of senior officials from related government departments and office bearers of the most representative senior citizens' organizations and an expert on aging from a renowned non-government organization. It should liaise with the State Department for Senior Citizens and with other related departments in matters concerned with the aged and aging issues. The Minister, Dept. of Senior Citizens, should be the Chairperson and the Director of this Department should be the Convener of the Council.

69. Similarly there should be District Councils with the Dt. Collector as Chairperson and Dt. Senior Citizens Department Officer as Convener. The Dt. Council should contain Dt. Officers of related Departments (LSGD, Health, Education, PWD, Police, etc.) and representatives from major senior citizens' organizations of the District.

Welfare Fund for Senior Citizens

70. There is need for a Special Fund (corpus) for senior citizens to meet the additional expenditure on health and social protection, among other things, that may come up from time to time and that are not provided for in the normal course.In many cases there will be need for meeting emergencies such as medical expenses of senior citizens in need of help, or for meeting rehabilitation needs of senior citizens in destitution. The Fund would enable government, also to meet special emergency situations relating to senior citizen as and when they arise. This Fund could be mobilized either by the government from its own resources and/or with the help of private collaborators.

Maintenance and Welfare of Parents and Senior Citizens (WPSC) Act 2007

71. This Act is sometimes hailed as the Magna Carta of senior citizens as it contains a number of provisions that will safeguard many of the vital interests of senior citizens. However, the Act suffers from two main lacunae, among others.
    1. The Act is implemented in a marginal manner. Currently an Regional Development Officer (RDO) is in charge of the Maintenance Tribunal in a District. Since he/she has other equally important responsibilities, he/she hardly gets time to do justice to this work. In the districts, this officer hears petitions from senior citizens only once a week. Hence, a large number of petitions are pending disposal before the Tribunal.
    2. A large number of people including the old are ignorant of this Act. In spite of all efforts of the government to give maximum publicity to the Act, studies have indicated that only around 30% of the stakeholders know about the Act and among them, only around 10% know the specific provisions and usefulness of the Act. As a result, only few applications are received by the Maintenance Tribunals.

72. Even so, only around three-fourth of the applications could be settled by the Tribunals in time, although a 90 days' time limit has been fixed by the Act for settlement. Hence a full time officer with adequate staff has to be appointed to handle the large number of cases being filed in the Maintenance Tribunal and dispose them within the prescribed period of 90 days.At the same time wide publicity has to be given to carry the message of the Act to all the stake holders involved. Besides the government machinery, Senior citizens' organizations and all other possible forums should be pressed into service for propagation of the Act.

Income Support - Social/Economic Security

1. The State currently has two pension schemes for economically backward sections - the National Old Age Pension Scheme and The Kerala Agricultural Workers' Pension Scheme. Recently the amount for all these pensions has been raised toRs.1,000/ per month. But this amount has been found to be too small for senior citizens as their expenditures on health care are very high in addition to meeting their subsistence.
2. The minimum Old Age Pension should be raised to Rs.2500 per month and staggered - 20% more at 70, 50% more at 80 and 100% more at 100. In particular, Widows, those living alone, those suffering from dementia and terminal diseases and those needing palliative care should get 20% more on each slab. The pension should be revised every 3 years or when salary and pension revision of State Government employees is effected and the increment in pension should be given automatically; the pensioner should not be required to put in any application for this.
3. For calculating eligibility for pension, the present rules take into account the total family income of the senior citizen (i.e. income of all earning members of the family) which should not exceed Rs.1 lakh. This is totally unjust because if a family is getting more than this amount, it will automatically deny pension to the senior citizen; in most cases, the senior citizen may not be gaining anything out of the family income. Therefore the total annual income of the senior citizen (not exceeding Rs.1 lakh) alone should be taken into account for deciding on his/her eligibility for pension.
4. The present rule of only one person in the family (husband or wife) being eligible for old age pension should be done away with and all 60 plus senior citizens in the family should be made eligible for pension.
5. An amount of 30% of the last pension received by the senior citizen should be give as family pension to the spouse of a deceased pensioner.
6. The Statutory Finance Commission should provide adequate relief to the state for enhancing the pension amount. The Government of India (GOI) should raise the amount of its National Pension Scheme appropriately or compensate the state for any additional expenditure involved in raising the Pension amount.
7. As GOI has already lowered its qualifying age limit from 65 to 60 for its old age pension, there is now no difference in age of eligibility in the National Old Age Pension Scheme and Kerala Agricultural Workers' Pension Scheme. Hence both schemes should be merged together and the amount of pension and the rules for award should be standardized and simplified.

8. Attempt should be made to rationalize and bring all non-statutory pension and welfare funds schemes under one authority.
9. The additional interest of 0.5% currently given on deposits of senior citizens by Banks should be raised to 1.0%.
10. All senior citizens below the income tax ceiling should be given free ration under PDS. Families taking care of the old also should be given free ration irrespective of their income status.
11. All needy 60 plus should be given at least one free nutritious meal every day. This could be done through ICDS or Kudumbasree or an agency to be created for this purpose. For those who are confined to their homes arrangements should be made to send their food to their homes.
12. The Aswaskiranam scheme, whereby caregivers attending on senior citizens who need terminal and full time care are provided financial support by the State should be extended to all needy individuals. This should cover those who attend on dementia and Parkinson cases. The amount of financial support should be equal to the minimum wage prescribed by the State.
13. A website should be created from where details of jobs available to older persons could be collected by those who have access to internet facility. Such jobs that could be done at home or that are convenient to them could be taken up by those who so desire.
14. Groups of old persons who want to travel on privately arranged tours of all sorts should be given conveyance facilities at reduced cost; as such tours will help the old in coming together.
15. Drinking water facilities and age friendly toilets also should be provided for use of senior citizens in the vicinity.
16. In hospitals, bus stations and other places of service visited by the old, there should be separate queues for them and a barrier free access.

Health Care

73. Health is a major concern of all senior citizens and should be taken up on a toppriority basis by the State. Indeed, *free health care should be recognized as a right of the senior citizen.*

1. All senior citizens belonging to BPL category and non-Income Taxpaying APL senior citizens should be covered by a free and comprehensive health insurance scheme without ceiling to cover treatment of old age diseases, including costly surgical interventions. The recent reform in the RashtriyaSwasthyaBimaYojana, viz expansion of coverage of the scheme to Rs.1 lakh and the removal of limitation in number of members in the family eligible for entitlement and an additional Rs.30,000 for treatment of senior citizens is a good move in this respect. But the existing restriction on family income should be done away with. Additional provision should be made for the health care of older women.
2. For those in the higher income groups, there should be a heavily subsided health insurance scheme having wide coverage both in diseases covered and eligible amount.
3. Currently Insurance Companies do not accept those who are over 80. Insurance companies should be instructed to extend coverage to all old irrespective of their age.

If this is not feasible, the state should provide health insurance to this category under a specially evolved scheme.

4. At present, the poor are not able to get the advantage of super specialty treatments as these are usually not covered under the free general medical insurance scheme. At the same time, the needy among the poor should have the advantage of the state-of-the-art in health care and hospital treatment. This can be achieved in two ways – one is to require the hospital to extend all available clinical and other facilities and services to them free of cost. The other is to cover such expenses from the Special Welfare Fund to be created (see later).
5. All government medical colleges and hospitals should have geriatric care facilities. Private medical colleges and hospitals should be required by appropriate rules/incentives to follow this pattern. AllPHCs, including the sub centres and CHCs should be re-oriented to take care of geriatric needs and there should be adequate number of trained staff and necessary equipment to take care of the health care needs of the rapidly increasing number of senior citizens in the State.
6. A mobile medical van should visit older patients at previously notified places at notified intervals and the doctor on duty should visit older patients in their homes who cannot come to the centre due to their illness.
7. Once in three months, the PHC nurse or trained ASHA worker should conduct special screening of the 80 plus and necessary free medical assistance should be provided to those who require special assistance as per their findings. For this, mobile geriatric medicare units should be commissioned which should also cover home-bound elderly.
8. The Vayomithram scheme (mainly providing free medicines through mobile clinics, Palliative care) has received much popularity and should be extended to cover all parts of the State in a time bound manner.
9. There should be arrangements in every Taluk Hospital for terminal care/palliative care, dementias, Parkinson's disease, etc. Additionally, there should be hospices/palliative care centres and terminal care centres at the District level.
10. For senior citizens with disability (hard of hearing, poor vision, orthopedic problems and other physical forms of disability, etc.), assistive devices should be made available free to BPL and to those who are outside of the Income Tax net.
11. Massive training programmes (short term and long term) in age care should be organized to cater to the needs of families which have problems in taking care of their old. Since the number of such cases is increasing (due to high morbidity rate and longer life expectancy), this has to be taken up on an urgent basis.
12. Currently, National Rural health Mission (NRHM) and National Urban Health Mission (NUHM) do not focus on older persons' health. Since this Mission operates as a grassroots programme and has wide coverage in the rural and urban areas, it should be appropriately modified to include geriatric care.
13. National Programme for the Health Care of the Elderly (NPHCE) seems to hold the key for the total health care of the elderly. But currently its scope is severely circumscribed. The scheme should be extended to all districts within a short time frame and its programmes should be expanded and made available to senior citizens with ease.

14. Courses in geriatrics at degree and PG level should be introduced in all medical colleges – government and private – in the state to cope with the acute shortage of geriatrically trained doctors. Similarly the Nursing Profession and Para Medical courses (including physiotherapy) should have facilities for training in geriatric care. The State should also ensure adequate supply of qualified geriatrically trained home nurses. In the teaching programme, medical colleges should give equal importance to geriatrics as for pediatrics since the number of the old will soon surpass the number of children.
15. Intensive short term courses in geriatrics and age care should be devised and offered in all Govt. Medical Colleges and Nursing Colleges in the State for training the large number of health professionals required in scientific age care. This is especially important in view of the fact that at present the facilities for this training in these institutions are almost nil. Training of all concerned in geriatrics within the next five years should be ensured.
16. To meet the huge demand for geriatrically trained staff, there is also need for in-house training and specially structured training programmes in geriatric care for those who are already in the profession but without any training in this field. Provision for their training should be made on a large scale. Private medical colleges/hospitals and nursing institutions should be inducted into this programme. Reputed NGOs could be encouraged to take up the work of training geriatric home nurses.
17. In view of the fact that the health problems of older women are in many respects different from the health problems of older men, special focus should be made on older women's health problems and special programmes should be devised to take care of their health concerns, problems and needs.
18. It is very important that the price of vital drugs (especially for cardiac and cancer treatment) and life supporting instruments (such as stents and mitral valves) should be made available at affordable prices by procuring them from manufacturers directly. The mushrooming of for-profit-hospitals on a large scale requires the state's attention on the need to regulate them. It is necessary to regulate their price structure and ensure that they reserve at least 10% beds and other services for poor patients.

Elder Abuse

1. Elder abuse has been reported to be on the increase in the State. Since most abuses occur within the four walls of the family and are perpetrated by close kin, both the abuser and the abused would prefer to keep these abuses off the limelight though for different reasons; hence they remain unmitigated.
2. There should be a law to punish the abusers on lines with Protection of Women from Domestic Violence Act 2005 and Protection of Children from Sexual Offences Act 2012.
3. The Panchayats and Social Justice Department (through the ICDS) should sponsor senior citizens clubs or VayojanaSabhas which could act vigil on such instances and settle matters amicably.
4. The VayojanaSabhas should act as JagrathaSamithis and should take up all cases of injustice to senior citizens, including abuse, and deal with them promptly and

seriously. These bodies could tackle such situations more diplomatically than any other body due to the fact that they are familiar with the culprit and victim more closely.

5. Sensitisation programmes should be organized, with the help of schools and NGOs on abuse situations and on how to eliminate them.
6. The Maintenance and Welfare of Parents and Senior Citizens' Act 2007needs to be strengthened and made more effective as outlined earlier.

Old Age Homes

1. In view of the unique demographic and socio economic set up in Kerala, the State has not only the largest number (over 600 with around 30,000 residents)of old age homes in India but the need for more old age homes is expected to increase in the future even though an old age home should be treated as the last resort of a senior citizen. Hence what government should do is to take steps to make the old age home a home away from home, with all its implications. However, the existing old age homes in Kerala are wanting in satisfying many of the needs and aspirations of the inmates.
2. At present, Old Age Homes (OAHs) are run on "custodial care" or at best on "welfare" lines. They do not treat the residents as having certain rights which the home management is bound to recognize and provide for. Many of them lack minimum infra-structure and facilities. They lack counseling and geriatric care facilities.
3. All existing OAHs, including those run by the State, should be revamped to include professional counseling and geriatric care facilities and should be required to provide transparency in their working. All new govt. OAHs should be Geriatric Homes rather than general old age homes. All new private OAHs also should have these facilities.
4. Minimum standards required for geriatric homes and OAHs should be laid down to ensure that the UN recognized rights of older persons to independence, care, participation, self-fulfilment and dignity are not violated.
5. It may be pointed out that the Centre for Gerontological Studies was commissioned by the Department of Social Justice to prepare a Manual on Old Age Homes and that the Centre has submitted its report in February 2015. It is hoped that the Government approves it and implements it in running the OAHs.
6. The OAHs of Kerala are under the control of the Board for Control of Orphanages and Other Charitable Institutions. This Board has also over 1500 other institutions to take care of. Consequently, the control and supervision exercised by the Board over OAHS is very weak and hence many of the homes are working on substandard lines.
7. To improve their standard and to enforce better discipline on them, a separate and independent Control Board for OAHs is warranted as also a new set of regulatory rules to modernize them on an urgent basis.
8. Many families who are keeping their old kin with them are in need of short stay homes where they could confidently and comfortably put their old kin during their absence from home. To begin with a short stay home could be established, one in every District, to be extended to Taluks according to need and demand. These homes could be pay and stay institutions.

Role of Kerala Social Security Mission

74. Vayomitram Programme should be extended throughout the state. Special programmes for Senior Citizens should be planned and implemented. The monthly allowance for care givers under the Aswasakiran Scheme should be enhanced and made equivalent to the minimum wages prescribed by the Government under the Minimum Wages Act.

The Persons with disability among the old aged

1. All building plans in the public sector and all new private houses including housing schemes should have elder-friendly layouts and fittings. Approval of building plans by the concerned authorities should be subject to this condition.
2. Also, all public places, buildings and utilities, toilets, parks, roads, bridges, banks, hospitals, places of worship, cinema theatres, shopping malls, multi-story buildings, footpaths, walkways, railways, bus shelters, waiting sheds, etc. And all places which are frequented by senior citizens should be made elder friendly and should have barrier free access to them. This may be taken as a special mission of the PWD in designing building and structures .The PWD should enforce the Central PWD Rules for the Disabled in the matter.
3. Seminars and workshops should be organized in every Panchayat for propagating the elder friendly buildings concept across all concerned.
4. Housing colonies and multi-story apartments should have common facilities center for social interaction of senior citizens (get-togethers, exercises including Yoga, cultural events, meetings, etc.). Apartment complexes should have provision for geriatric hospital facilities and walkways for senior citizens.

Role of the Police

1. The role of the Police is vital to the safety and security of senior citizens. Rule 20, Chapter V of the MWPSC Act, "Protection of Life and Property of Senior Citizens" and Rule 21 of Chapter VI of the MWPSC Rules 2009, stipulate the duties of the Police with regard to the protection of life and property of senior citizens. Based on this, the Director General of Police, Kerala, has issued a Letter (No.U1/164262010, Circular No. 16/2010dated 11/3/2010) to all Police Officers in Kerala listing very comprehensively their duties and responsibilities in the matter and asking them "for the Strict enforcement of Rules". Orders should be issued for the strict implementation of this circular in spirit and letter.
2. Both in urban and rural areas, the community police should keep an eye on the old staying alone or in couples-only, keep a register of such persons and frequently visit them and enquire about their needs and problems and monitor the extent to which they have been solved or mitigated. In this, they could enlist the help of the Residents' Associations if any and of the VayojanaSabha or Age Care Centre as appropriate.
3. Volunteers' Committees should be formed for each Police Station to ensure regular contact between the senior citizens, especially those living by themselves on the one

hand and the Police and the District Administration on the other. The old are soft targets for two kinds of anti-social elements - thieves and those selling wonder drugs, especially elixirs. Of these, the thieves can be dealt with by the Police directly. The Police, in cooperation with the State Health Department and Consumer Protection Council should check the claims of wonder drugs in the market and in the media and take necessary action on them. Police should do their part seriously in the implementation of the Maintenance Act (MWPSC Act 2007) as directed by the DGP.

Bonding of Generations/ ApnaGhar Programme

1. United Nations has put forward the concept of "Ageing in Place" by which is meant that an old person should preferably spend his/her last years in the place where he/she was born and where he/she spent his/her formative years. In the Indian context this would mean that the old should spend his/her last years in his/her home with his/her near and dear ones. Without doubt one could say that the old will be happier to spend his/her life with his/her children and with friends in his/her hometown (*Apna*G*har Programme*) if this is possible. However, due to changed social circumstances this may not be possible in all cases but all efforts should be made to promote this principle ("Aging in Place"). Concepts such as Continuing Care Retirement Community (CCRC) and "Life Communities" which are very popular in western countries need to be examined in this regard. These communities are characterized by the provision of elder friendly infra-structure and supporting services for all types of old – independent, needing partial assistance, or fully dependent.
2. It has to be pointed out that one of the reasons for the cleavage in the relationship between generations and possibly not-so-healthy relation between them is the burden that is imposed on the family in having to care for the old. Many families lack kin for care giving and the means of support for taking care of the health needs of their old members. In such circumstances, one way to make the old acceptable to the young and to encourage his/her stay in the family is by providing him/her a stable income and giving concessions on taxes on housing, electricity charges, water charges and the like to families keeping their old. Meeting the total health care needs of the old and providing paid care givers where ever necessary will be another way. Concession in income tax to the care givers of senior citizens would be yet another attraction for the young care giver.
3. One way to integrate the old with the younger generations is to observe and celebrate events like World Elders' Day (October 1) and Elder Abuse Awareness Day (June 15) at all levels – schools, local governments at ward levels, organizations and associations; in fact it should be a state event. Government should take initiative in this and ensure that its officials also observe these days seriously and join the festivities associated with these events. The message carried by these events will go some way in imbibing the need for love and respect for senior citizens.
4. The vast potential of the adolescents could be tapped through proper counseling on the one hand and providing a forum for them to serve the old on the other. The methodology used by Help Age India in mobilising school children could be adopted

for this purpose. It will provide a bond between generations and a dedicated core of young and dynamic volunteers for the cause of the elderly.

5. Opening day care centres for senior citizens and Vayojanasabhas, arranging programmes for the old (discussion groups, excursions, outing trips, cultural programmes etc) would strengthen their togetherness and solidarity besides keeping them active and meaningfully engaged in and around the home. An active and burden-free senior citizen will be more acceptable to the family than an inactive and burdensome elderly.

Public-Private Participation

1. Accepting the fact that it will not be able to take care of all the welfare programmes for the old and that the cooperation and participation of NGOs are vital for it, the State should assist NGOs to set up old age homes, Day Care Centres, geriatric homes, mobile geriatric clinics and other institutions that offer a variety of services to the old. In particular, the State should help NGOs with assistance for the purchase of land and construction of buildings and provide supplementary assistance for infrastructure and services.
2. Government should encourage NGOs which contribute to the betterment of older persons – whether in the form of skill improvement, generation of supplementary employment or guidance and counseling, etc. There should be continuous dialogue and communication with NGOs on ageing issues and on the services to be provided for the aged. The NGOs will be an effective agency for sensitization programmes relating to the Maintenance and Welfare of Parents and Senior Citizens Actand its programmes.
3. The State should fully support and supplement all the ventures of the NGOs in getting appropriate schemes from the GOI under the Integrated Programme for Older Persons (IPOP) and other financial assistance progrmmes (including essentially old age homes, day care centres and mobile medical units).Older persons should be encouraged to organize themselves to provide services to fellow senior citizens thereby making use of their professional knowledge, expertise and contacts. Initiatives taken by them in advocacy, mobilization of public opinion, rising of resources and community work should be supported by the State. Multi Service Community Age Care Centres mentioned elsewhere, could be run by NGOs on very good lines.
4. Trade unions, employers' organisations and professional bodies should be approached to organize sensitisation programmes for their members on ageing issues, especially on healthy and active aging, and to promote and organize services for superannuated workers.

Tribal and Coastal Old Persons

1. Due to their isolation from the mainstream social life, the tribal people do not get advantage of many of the government welfare schemes, in particular the old. Provision of the free meal programme mentioned earlier should be implemented here on a vigorous footing. The Tribal Panchayats have to be specially entrusted with the

special programmes on aging and TribalVayojanaSabhas should be constituted and empowered to oversee the programmes relating to the welfare of tribal senior citizens.

2. Kerala has a long coast line where most of the poor live on fishing. Their educational level is low and their income is seasonal and dependent on erratic fish landing. Poverty and poor health hit the old harder than other segments. In fact this segment of old is the most marginalized in the family for several reasons built around poverty and illiteracy and their peculiar value system. Free meal programme for older persons should be organized and, to the extent possible, this should be extended to two times a day during the lean period. The Coastal GramaPanchayats should have special cells to take care of their problems and needs. Mobile squads should be organized to take care of their emergency health problems.

Vulnerable Groups among Senior Citizens

75. The 80 Plus Category, is a special group among senior citizens for the following reasons
    1. They form a sizeable proportion among the old (currently around 15% and increasing nearly twice as fast as the other segments of senior citizens).
    2. Most of them have multiple diseases, especially non communicable diseases and need health care and home care (with care givers) more often than the rest of the old.
    3. Many of them lack proper mobility and are mostly confined to their homes. In Kerala where the migration of youngsters and out-of--home jobs for others leave the old at home almost alone, especially during day time, loneliness and consequent depression are fairly common among most of the 80 plus.
    4. Finally some of them will be in their terminal stage and as such under severe mental depression and, may be, under physical pain, or still worse, may be in a state of coma or unconsciousness. Palliative care/end-of-life care is needed for them.

76. Taking these factors into account proper measures have to be evolved for them. A higher rate of pension, visit to them in their houses frequently by a medical team, special geriatric care with a Mobile Medical Unit, special financial assistance to those taking care of them and palliative and dementia care and terminal care centres are a few measures to give relief to this category of senior citizens.

77. Older women constitute another category needing special attention and care. Women constitute the majority among the old and, among older women; widows constitute a very large number. Besides widowhood and old age, three other factors disadvantage them– the fact that they are women, may suffer from diseases of all kinds and the absence of care givers. Since women live longer than men and since the chances of morbidity are more among them (due to expansion of morbidity syndrome in old age), this category among the old is destined to suffer further handicaps.

78. As a partial remedy for these problems, the amount of old age pension should be higher for women(please see earlier), AswasKiran should be specifically extended to the needy among

them with more satisfying rewards to the carers, older women's sabhas should be encouraged and special attention (including periodic health check-up) should be provided by the medical profession. Special ration and other concessions should also be part of the programme.

79. *Other groups.* To this category will belong unmarried and childless old women, those who are staying alone or with spouse only, the disabled, total destitute, those without any living kin and dementia/palliative care/ terminally ill old. For obvious reasons they will require special focus in preparing old age.

Day Care/Day Centres

80. Day care/day centres should have programmes of training in skills, physical activity and the like so that those in need of skill development, partial employment and other forms of meaningful activity could benefit from them. In any case, these centres will give the Senior Citizen relief from boredom, isolation, idleness and purposelessness in life and would rejuvenate their life and make them happier and healthier. YOGA programmes could be organized in these Centres

Role of Grama Panchayats

1. The Grama Panchayat should be the kingpin of all old age programmes at the local level.
2. Each Grama Panchayat should have a Standing Committee on Senior Citizens; this Committee should be in charge of planning and implementing the old age programmes in the Grama Panchayat as well as in the implementation and supervision of State and Centrally Sponsored Schemes on aging.
3. The Grama Panchayat should constitute VayojanaSabhas (see later) at the Ward level and Vayojana Council at the Panchayat level. It should liaise with these bodies in preparing and implementing programmes for senior citizens.
4. The Grama Panchayat should prepare a comprehensive plan for spending the funds earmarked for senior citizens on the basis of felt needs expressed through survey of the elderly persons in the Grama Panchayat and implemented with the help of the VayojanaSabha/ Vayojana Council.
5. The Grama Panchayat should keep an updated register on 60 plus old, detailing the socio- economic and health profile of the elderly.
6. A Multi Service Senior Citizens' Centre, sponsored by the Grama Panchayat or the District Social Justice Office or a local NGO working for the elderly could act as the promoter of many senior citizens programmes. The Centre should be partly or wholly funded by the State. The Centre could effectively check elder abuse and resolve many other problems of the senior citizens and of their family care giver.

VayojanaSabhas

1. Like GramaSabhas, VayojanaSabhas should be constituted in all Panchayats, Muncipalities and Cities on a ward basis. These Sabhas are working very well in the VayosouhrudaPanchayats sponsored by CGS.
2. The Sabhas should also act as JagrathaSamithis for senior citizens where the problems of the old could be identified and discussedand solutions may be found promptly.
3. It should be the responsibility of the Sabhas to identify cases of elder abuse and to promptly and appropriately deal with them.
4. The Sabhas should have the power to formulate programmes on their problems and present them to local bodies for necessary action by them.

VayoSouhrudaKeralam (Age Friendly Kerala)

81. The Centre for Gerontological Studies (CGS), at Thiruvananthapuram is currently successfully implementing a programme called Vayosouhruda Grama Panchayats in 7 GramaPanchayats of Kerala (Manickal, Vembayam and Poovachal in Thiruvananthapuram District and Karimba, Peruvembu, Pudussery and Mundur in Palakkad District). Seeing its extreme usefulness, the Vellanadu Grama Panchayat in Thiruvananthapuram Dt. has come forward to adopt the Vayosouhruda model in the Panchayat with the help of the Centre for Gerontological Studies. This project could be extended to the whole state within a short time if the Government takes it up so that Kerala will become the first VayoSouhrudaSamsthanam (Age Friendly State) in India. The Centre for Gerontological Studies could join this endeavour and give all necessary assistance for it.

Allocation of Fund of Local Bodies

1. Of late, the fund for senior citizens, the disabled and women whichwas 5% of the total welfare budget of local bodies (Panchayats, Municipalities and City Corporations) hasbeen raisedto 10%. It is proposed that the amount to be used exclusively for welfare of senior citizens and others should be raised to 15% of the welfare budget given the fact that the growth rate of older age population is higher than that of the general population.
2. Government has stipulated the items that could be included in the budget on this account. This imposes limitation on the local bodies in spending money on items really needed by the senior citizens. Local bodies should be given discretion to utilize the amount on the felt needs of senior citizens rather than on items predetermined or prescribed from above.

Identity Cards

1. Currently many agencies and institutions issue Identity Cards to their employees which have limited validity within their circles. Multiplicity of Cards and carrying them will be difficult for a senior citizen. Hence, a uniform card which could be used for all purposes and in all offices should be devised for senior citizens. The Card should

contain basic information on the Individual. It will be desirable if this card contains some data on the health status of the individual.

Travel Concession

1. Currently concession is given to senior citizens in railways. Several Indian States give concessions in Buses also. Maharashtra, Delhi and Chandigarh give 50% concession in their transport buses to senior citizens while Punjab gives free travel to old women and in Tamilnadu travel is free for old women in metropolitan cities. It is totally free for all senior citizens in Pudusseri State.
2. Hence, 50% concession should be given to all senior citizens travelling in all buses – state owned and private. Government may subsidise private bus operators if necessary.

Aging Component in Educational Curriculum

1. Aging should be included in the educational curriculum at all levels.
2. At the school and college level, it should form part of the teaching curriculum.
3. At the university level, gerontology should be introduced in the social sciences and social work courses.
4. At the medical college level, Geriatrics should form an important subject in the curriculum at graduate, PG and higher levels.
5. Nursing institutions also should incorporate gerontology and age care in their curriculum.

Institute on Aging/Centre for Study of Aging and Senior Citizens

1. An Institute on Aging or Centre for Study of Aging and Senior Citizens should be established at the State level. This Institute should take up studies, research, training and extension work on aging on its own as well as for the government and the results should be made available to professionals, research scholars and the public besides the Government. The findings should be broadly publicized.
2. The Institute should have an E-library which should be open for private individuals, professionals and research scholars to work with on full time or part time basis. It should organize workshops, seminars, conferences and study/discussion groups on aging topics of current interest. It should open its doors for foreign collaboration and to institutes, organizations and universities in India and abroad.
3. A Reference Manual on aging with focus on Kerala aging should be brought out by the Institute and it should be made available to all concerned. It should be updated periodically.

At the State level

82. In view of the fact that the State is having one-seventh of its population already old, rising to one-sixth by the end of the13th Plan and progressively increasing to one-fifth by 2025,

and in view of the further fact that aging problems are rather complicated and require specialized attention and devotion, it is desirable to have the following arrangements to look after all matters on aging at the State level

1. A Cabinet Sub Committee on Aging.
2. A Standing Committee of the State Legislature on Senior Citizens
3. State Council on Aging (and District Councils on Aging)
4. A State Commission on Senior Citizens
5. A State Institute on Ageing
6. A full-time Department with Secretary for Senior Citizens in the Secretariat and a full time Director for Senior Citizens at the directorate level to deal exclusively with aging matters.

Programmes for the Younger Generation

83. Aging is a continuous process and it does not start at 60. Indeed many of the problems of aging will have an earlier history and could be traced to one's younger years. Hence, the younger generation should be educated and equipped toprepare for aging from an early age in life.
    1. Promotion of active and healthy aging habits should be effected through a well-designed Health Education Module. This module could serve as a handbook and reference manual for several agencies – the school, the media, trade unions, professional organizations, health camps, residents' associations and even family circles. It could be made available in all offices and institutions as well.
    2. Special measures should be devised for weaning away the younger generation from unhealthy habits in several areas of life, especially food habits and sedentary life habits. Elsewhere we have shown that though the state has a high expectation of life at birth compared to other states in India, in the matter of life expectancy in later years, especially after 60, Kerala's rank is lower than that of many states in India. This has to be explained in terms of the style of life of the Keralite which has added to his/her morbidity and consequent reduction in life span. Kerala is the home for many non-communicable diseases (NCDs) and NCDs have been a major villain in the cause of death in older ages. Hence a massive drive has to be carried out in impressing the Keralite on the need for a more sober life pattern involving regulation of food habits and life style.
    3. Habits of saving for financial security in old age should be promoted. The State as well as the Banking System should devise and provide instruments for encouraging savings for the rainy day.
    4. Pre-retirement counseling programmes should be organized on a large scale through a variety of organizations and institutions -the trade unions, employers' organizations, professional organizations of all sorts, management and training institutions, the media, and banking and investment institutions, etc. This will avoid many shocks in post-retirement life.
    5. On the job programmes also should be organized for those who are going to retire soon.

6. Residents' Associations, where available, also should be brought into the network in spreading the message of healthy aging among their members. Family counseling in the matter should be organized through ASHA, Anganwadi and Kudumbasree workers.
7. A value-based education respecting the aged and strengthening family ties should be introduced at the school level. Parent-Teacher Associations (PTA) also could be roped into this programme.
8. All conventional, folk and modern media should be garnered for communicating the message of healthy aging to the younger generations.

Services for Persons with Disabilities

84. Currently, around 15 per cent of the world's population or an estimated 1 billion people live with disabilities, making them the world's largest and one of most neglected minority spread across all countries and communities. Eighty percent of persons with disabilities live in developing countries, according to the UNDP. However, prevention and early detection programs are few and typically with limited impact in the developing countries; the treatment and corrective options are also limited in these countries. United Nation's Convention on the Rights of Persons with Disabilities (UNCRPD) urges its parties (signatory countries) to promote, protect, and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law. In October 1, 2007, India ratified the UNCRPD, much before any other significant country in the world.

85. People with Disabilities (PwD) often lack access to good quality basic and higher education. Studies on disability legislation show that only 45 countries have anti-discrimination and other disability-specific laws. Even in those countries that have such laws enforcement is weak and hence the benefit of such legislation does not reach the general population. As a consequence of these factors, PwD are often marginalized in society, and end up with a poor quality of life. Disability is a human rights and development issue and should not be merely viewed from a welfare prism.

Indian Scenario

86. According to the Indian Census 2011, a total of 26,810,557 persons are disabled, which implies that 2.21% of the total population of India is disabled. This figure is many magnitudes lower than the 15% reported for the world. This leads us to believe that in the Indian context, there is gross under reporting of the disabled population.

87. Though accurate studies have not been done, it is estimated that, in India, around 5 million people are speech and hearing impaired, around 10 million have autism spectrum disorders, and around 5 million have cerebral palsy and related multiple disorders. Then there are populations with other disabilities such as intellectual challenges, visual impairments, learning disabilities, orthopaedic challenges, genetically related syndromes, and degenerative conditions such as multiple sclerosis, and muscular dystrophy, ALS. These numbers point to

the critical need for concrete action to provide a range of services that would enable PwD to lead successful fulfilled lives.

88. The limited availability of services for PwD, across the spectrum ranging from prevention and early intervention to education and gainful employment to rehabilitation and integration into society, leads to marginalization of PwD in India and their inability to develop to their full potential. This is a huge loss to them and the nation. A recent Report (India Social Development Report, 2016, Disabilities: Rights Perspectives) reveals that 38percent of all male PwDs were illiterate while for females the rate was even higher at 55percent. Even in a near-total literate state like Kerala, 33.1percent of PwDs were illiterate. It is seen from the Report that for every category of disability, the proportion of females was higher. The PwDs do not get the early intervention, education or skill development opportunities as envisaged in the Right to Education Act of 2009. There is a cultural baggage due to the shame felt by the families in having a person with disability in the household and that prevents the family from seeking the appropriate help and support from outside agencies. Even for those who seek help, services are typically not available nearby in the communities where they live.

The Kerala State Scenario

89. A state wide census of persons with disabilities was conducted by the Kerala Social Security Mission in 2015. This survey was the first one done in the country and included 22 types of disabilities including those being listed in the upcoming Rights of Persons with Disabilities Bill.

Table 7 *Disability Census data for Kerala state (KSSM Disability survey 2016)*

Sl No	Disability	Number				% ge
		Male	Female	TG	Total	
1	Locomotor Disability	155836	104922	329	261087	32.89
2	Muscular Dystrophy	1359	913	8	2280	00.29
3	Chronic Neurological Disorders	2052	1575	6	3633	00.46
4	Multiple Sclerosis	282	232	1	515	00.06
5	Kyphosis	2044	2835	8	4887	00.62
6	Short Stature/ Dwarfism	2488	3577	14	6079	00.77
7	Blindness	11361	9094	22	20477	02.58
8	Low Vision	33907	27916	77	61900	07.80
9	Learning Disability	5257	2805	12	8074	01.02
10	Speech Language Disability	13152	9443	53	22648	02.85
11	Mental Retardation	38245	30546	143	68934	08.68
12	Mental Illness	48429	52423	131	100983	12.72
13	Autism	2179	950	6	3135	00.39
14	Hearing Impairment	28771	32093	61	60925	07.67
15	Leprosy Cured	679	494	2	1175	00.15
16	Haemophilia	1048	394	3	1445	00.18
17	Thalassemia	269	300		569	00.07
18	Sickle Cell Anaemia	461	544	1	1006	00.13
19	Cerebral Palsy	3781	2597	7	6385	00.80
20	Epilepsy	10839	8637	36	19512	02.46
21	Deaf Blindness	432	408	2	842	00.11
22	Multiple Disability	75982	61197	262	137446	17.31
	Total	438853	353895	1189	793937	100

Getting the "Right" Approach to Disability

90. Disability is a human rights and development issue and should no more be viewed merely from the welfare prism. From being passive beneficiaries of doles, disabled have to be considered as citizens who can be equal partners and contributors to development. Further while framing policy or schemes, it has to be borne in mind that Disabled are not a homogenous group and one size does not fit all (this is true even within the same disability also).

91. In this context in 2011, the Planning Board formulated a working group to look into the services required for disability and an expert committee was formed. . Action plans were listed and action was taken step by step. State Initiative on Disabilities (SID) was formed among others from this report in a mission mode with KSSM Director as the Project Director which has since taken up various projects listed below across the state.

State Initiative on Disabilities (SID)

92. "State Initiative on Disabilities (SID)"is an initiative for intervention in the disability sector of the State. The objective of this new state initiative is Prevention, Detection, Early Intervention, Education, Employment and Rehabilitation of persons with disabilities. Department of Social Justice is the nodal department and the initiative is implemented through Kerala Social Security Mission (KSSM). The activities of State Initiative on Disabilities are implemented with the involvement of Departments of Education, Social Justice & Health. At present State Initiative on Disabilities (SID) focus its activities in – Prevention, Early Screening/ Detection, Early Intervention and in the second phase for Education, Employment and Rehabilitation. The following are the ongoing activities of SID.

MMR and Rubella Vaccination for Disability Prevention

93. Prevention is always better than cure. This holds well with disabilities too. Mumps, Measles and Rubella are the three conditions where a child can become disabled, at birth. This situation can be avoided through MMR vaccination to all babies. For the first time the vaccines required for this purpose is provided by the Government through SID and administered through Department of Health.

94. Rubella virus causes serious disability conditions to the new born, if the pregnant mother is affected. In this context for disability prevention SID supports Rubella Vaccination of adolescent girls by providing sufficient quantity of vaccines. In the last two years 5, 44,692 adolescent girls studying in standards 9, 10, 11 & 12 were vaccinated. In the current year 500,000 doses of Rubella Vaccines will be supplied to vaccinate adolescent girls studying in standard 8 & 9. This activity is implemented as a joint venture of Departments of Education and Health & Family Welfare.

Establishing District Early Intervention Centre (DEICs)

95. For early identification and intervention of development delay and disabilities among children SID is establishing District Early Intervention Centres in all the 14 Districts of Kerala. The DEICs are established in the land allotted by the Department of Health & Family Welfare.

96. In the long run these DEICs will be elevated to the status of a Disability Hub, which provides all types of services in the disability sector at a single point in that District.

Universal Hearing/Congenital Anomaly Screening Programme

97. Hearing impairment is a disability which can be corrected if identified at an early stage. With the objective of early identification of hearing disability SID is conducting Hearing Screening for the babies at birth, using to Acoustic Emission Screeners provided by SIDto

40 Govt. Maternity Hospitals, which includes 05 Medical Colleges, where the number of delivery is 100 or more per month, as per the list provided by Director of Health Services.

98. The screening, monitoring and subsequent follow up of identified cases of hearing impairment is done by Junior Public Health Nurses of SID. A total of 1,95,470 newborns were screened till date out of which 21,875 babies were referred to ENT Department which is regularly monitored and progress is watched.

99. The Implementation and Monitoring Committee has decided to extend this facility to Govt. Maternity Hospitals having 50 or more births in a month and thereby taken steps to universalize this activity during the year itself.

Mobile Intervention Units

100. SID has initiated Mobile Intervention Units to provide services to the persons with disabilities at their doorsteps who are not able to reach DEICs and other centres. At present it is done as a pilot project in two Districts Malappuram and Kozhikode and based on the outcome it will be extend to all other Districts with suitable modifications. The pilot project is being implemented along with the Institute of Mental Health and Neuro Sciences, Calicut. About 600 children with development delay and disabilities are availing the benefit every month per District.

Support to Institutions for strengthening disability management

101. SID provides support for development of infrastructure, procurement of equipment and machineries required for different intervention and therapies related to disabilities to reputed institutions like Medical Colleges, National Institute of Physical Medicine and Rehabilitation, etc. as per the approval of Implementation Monitoring Committee and Empowered Committee based on the Government orders issued from time to time. SID supports institutions like National Institute of Physical Medicine and Rehabilitation, Irinjalakuda, Trissur and Govt Medical College, Kozhikode in setting up Audiology labs and Audio Verbal Therapy Centres.

Disability Certification and Identity Card Distribution Camps

102. SID regularly organizes decentralized disability certification and identity cards distribution camps throughout the State. The camps are organized based on a well-defined procedure. Through this camp the assessment and certification of disability is done by a Medical Board constituted by Government. The eligible persons were issued with Disability Certificates and Identity cards, which can be used for availing various benefits and services. The applications for disability certification and identity cards are collected through ICDS O□ ces and a camp is organized for every 250 – 300 applications. In the year 2015-16, 174 camps were organized at panchayat level and 27,672 Medical Disability Certificates and 26,288 Identity Cards were issued.

Special Anganwadies

103. State Govt. has decided to establish special Anganwadies in each panchayat for providing better services, different therapies, parental awareness, etc to preschool children with disabilities, especially children with development delay. Before scaling up of this project SID piloted it in one District jointly with Department of Social Justice, Institute of Mental Health and Neuro Sciences and Govt. Medical College Calicut. In this pilot project one anganwady in each ICDS project is graduated as special anganwady by providing disabled friendly infrastructure, furniture and other equipment converged with therapy support and trainings. This needs to be expanded in phased manner to the entire state.

Project Autism

104. Autism Spectrum Disorder (ASD) is one of the major neuro development disorders and its prevalence is increasing enormously. It is high time to develop programs and strategies to provide quality services to the needy. The existing activities are to be strengthened and an organized strategy to deal with the large number of children with ASD in the rural, semi urban and urban population who are at risk is to be developed and put into action. With this objective SID launched Project Autism for early identification, early intervention, appropriate therapies, parental awareness, training programmes and preparation of a professional team to cater to the diversified needs of people with ASD.

105. Three vision sharing workshops were organized with parents, professionals and experts at three Districts and their suggestions were obtained. Accordingly following activities are planned.
    1. Establish Autism Centres at all Government Medical Colleges.
    2. Strengthen the existing Autism Centres of Education Department by training and providing necessary infrastructure.
    3. Training to Resource Teachers of Education Department.
    4. Sensitisation and Awareness programmes to parents and professionals.
    5. Awareness to Legal Guardianship programme.

Inclusion of Disability as a Paper in the B.Ed. and M.Ed. Curriculum

106. As a part of sensitization on the disability sector and to promote the rights of the persons with disabilities and related aspects, SID has taken efforts to include the subject 'Disability' as a paper in the curriculum of all important courses. So far the chapter on Disability has been included in the B.Ed. and M.Ed. curriculum of Kerala University. Efforts are on to include the same in the courses of all the Universities in the State of Kerala.

Sruthitharangam Cochlear Implantation Project (SCIP)

107. It is a program by Government of Kerala which provides Cochlear Implants for children belonging to lower socio-economic status in the age range of 1 to 5 years, with the objective of early intervention and speech and language development for children with profound

deafness. The project has tremendous response and project has been running for the past 3 years as a part of KSSM. Over 630 children have been implanted with CI. The children are selected from applicants who apply for government aid through this scheme and taken through a pre-implantation counselling and hearing aid trial protocol. Further the child is examined and certified for surgical candidacy by a Cochlear Implant Surgeon and further audiological candidacy by an Audiologist. Subsequently selected candidates are approved for implantation if they meet specific criteria as laid out by an overseeing technical committee. The cochlear implantation surgery, audiological and therapeutic management procedures are executed at ten empanelled centers across the geographical location of the state. Four centres are in the north zone, three in the central zone and three in the south zone of the state. Kerala Social Security Mission (KSSM) is the implementing Agency and NISH serves as the nodal agency for post implant rehabilitation measures.

108. It is planned to club the projects namely universal hearing screening and sruthitharangam for early intervention and better results. Consultative processes for the same are underway.

National Institute of Speech and Hearing (NISH)

109. National Institute of Speech & Hearing (NISH) was established as a society by the Government of Kerala vide G.O. (Ms) No. 7/97/SWD dated 11th March 1997. Set up with the primary objective of taking up activities necessary for the education and rehabilitation of the deaf and hard of hearing population of the State, it has made significant progress in implementing various programs and services for the benefit of people with communication disorders. Currently the various programs at NISH in the field of education, research and rehabilitation for persons with disabilities are categorized as follows:
    1. Early Intervention Programs (Auditory Oral and Auditory Verbal Training Programs)
    2. Audiology & Speech Language Pathology Clinical Programs
    3. Neuro Developmental Science Programs (Autism Spectrum Disorders)
    4. Medical, Psychology, Occupational Therapy and Physiotherapy services
    5. Academic programs
        1. Professional preparation Degree – BASLP
        2. Masters Level Program for preparing professionals - MASLP
        3. Professional preparation Diploma – Diploma in Early Childhood Special Education (DECSE),
        4. Training Interpreters and ISL Teachers - Diploma in ISL & Interpretation (DISLI)
        5. Higher Education for PwD (Undergraduate degree) – B.Sc. (CS), BFA, B.Com.
        6. Post graduate diploma in Auditory Verbal Therapy (PGDAVT)
        7. Center for Assistive Technology and Innovation (CATI)
        8. Extension Programs (Awareness Programs, Correspondence Programs)
        9. New Initiatives which includes NISH Interactive Disability Awareness Seminars (NIDAS), ASAP Program for Deaf Students, On the job training for Teachers of the Deaf, Special Education Training for the Deaf Educators in Higher Education (NISH Innovation Model-Special Education Training NIM-SET) etc.

110. In recognition to the services rendered to the deaf and hard of hearing, both in the clinical and academic fields, Government of India has announced in the annual budget speech of 2015 that NISH will be upgraded as a Central University. Accordingly, the proposal to establish National University for Rehabilitation and Disability Studies (NURDS) was, in principle, accepted by the Government of India. This has been a major milestone in the history of NISH as its mandate crosses the state boarders to cover the whole of India.

111. The mission of NURDS will be to address the problems faced by the disabled population in the country in getting proper early intervention, education, employment and inclusion by providing services and expertise in the core area of hearing and communication disorders. This will include among others
    1. Undergraduate programs with a wider variety of courses and programs to improve the chances of employment of young adults with disabilities.
    2. Preparation of high quality professionals such as audiologist and speech language pathologists, psychologists, counsellors, social workers, occupational therapists, psychiatrists etc.
    3. Research on more effective methods of screening and intervention, assistive technologies and integration programs.

National Institute for Physical Medicine and Rehabilitation

112. NIPMR provides comprehensive services consisting of diagnostics and therapy for disabilities. The institute mainly focuses on Cerebral Palsy and Communication Disorders. The objective of the institute is to provide services that will empower persons with disabilities to be rehabilitated into mainstream society and function in the best possible way. NIPMR has full-fledged departments for Physiotherapy, Speech Therapy, and Audiology testing. Multi-disciplinary assessment is conducted for customers at the in-take. A comprehensive evaluation is carried out, where goals are set according to functional level and achievement plan made by the trans-disciplinary rehabilitation team. A program for home based training and demonstrations are also being planned. In this new program, training is given to the primary care-givers for carrying out the skill training or therapy program through home management.

113. NIPMR also runs a Special transition school for children with Cerebral Palsy. Children with CP are prepared to be transitioned into main stream education. The institute was started on 15-08-2005 as Thressiama Memorial Hospital which was handed over with its assets to the Social Justice Department, Government of Kerala. In 2016, the institute was converted into an autonomous organization registered as a Charitable Society under the SJ department with the name of National Institute for Physical Medicine and Rehabilitation (NIPMR). Apart from the previous services, some other services including Social Work and Clinical Psychology have been started and some others are in the planning stage.

114. With CSR Funding from Petronet, NIPMR has launched Rehab on Wheels program. With the ambulance modified to house testing and assessment facilities, NIPMR conducts camps

for assessment of disabilities. Already 5 camps are over in two months and have been found to be effective as an outreach program.

115. NIPMR also is functioning as a consultative agency for the Local Self Government Agencies in the surrounding area to help them set up facilities that will serve children and adults with disabilities. It is being developed as a specialized Institute providing diagnostic and therapeutic services across the state. Academic courses, inpatient facilities etc. are also planned for future.

ICCONS (Institute for Cognitive and Communicative Disorders and Neuro Sciences)

116. ICCONS is the first of its kind of Institutions in the field of Cognitive Neurosciences in Asian Countries. The institute has a broad perspective of research and development in the field of cognition, communication, human robotics and navigation. The working philosophy and mandate of ICCONS includes:
    1. Unravelling the evolutionary, genetic and neurobiological mechanisms involved in basic cognative functions (e.g. intelligence, perception, attention, memory, learning, language, motor planning, execution) as well as robotic functions through multidisciplinary research.
    2. Through research and development, ICCONS aims at developing novel management, rehabilitation and remediation strategies for developmental and acquired disorders affecting all age groups, from infancy to elderly. The major disorders that come under this category include autism, developmental language disorders, learning disability, mental retardation, cerebral palsy, global developmental delay, hearing impairment, single and multiple congenital anomalies, acquired locomotors disabilities, aphasia and other stroke-related problems, dementia of Alzheimer's type, post-traumatic syndrome, and other neurodegenerative and neurometabolic disorders.
    3. Generation of suffcient manpower through regular academic programmes and long and short-term training programmes for the service of individuals affected with cognitive and communicative disorders.

117. Clinical, research and academic activities of the institution are achieved through a multidisciplinary team comprising of Neurologists, Neurosurgeons, Psychiatrists, Paediatricians, ENT Specialists, Physiatrists, Speech Language Pathologists, Clinical Psychologists, Clinical Linguists, Physiotherapists and Special Educators. The institute has well as established Department of Genetics (Molecular Genetics and Cytogenetic), Neurocardiology, and Neurochemistry (evaluation of the neurochemical, endocrinological, neurometabolic and biochemical factors underlying cognitive processing and its defects).

118. ICCONS provides clinical services to all kind of cognitive and communicative disorders across all age groups It is the first Neurocentre in India to obtain National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation.

CH Mohammed Koya State Institute for the Mentally Challenged

119. C.H. MuhammedKoya State Institute for the Mentally Challenged is in Trivandrum and working for the mentally challenged children. The specific objectives among others are
    1. To establish, maintain and regulate the affairs of the Institution for the health care, protection and rehabilitation of the socially, physically and mentally challenged children etc. Emphasis is on providing specialised training so that the children can become part of the main-stream of society.
    2. Individualized training based on periodic Educational and Psychological assessments.
    3. Provide professional guidance, parental counseling to help rehabilitate the mentally challenged. Assist parents in understanding their children at their homes through discussion and counselling
    4. To create or help public awareness towards recognizing the mentally challenged motivating the general public to help rehabilitating them.
    5. To organize or help to organize and co-ordinate training programmes and workshops in the realm of early detection of childhood disabilities especially in ICDS project areas.

120. The important activities of the centre are:
    1. Special school (Day care centre)
    2. Hostel for the Mentally Challenged Children Assessment Centre
    3. Early Intervention
    4. Vocational training Centre
    5. Parent Counselling and training
    6. Information and Documentation (Library) D.Eds.(M.R) Course
    7. Placement for Mentally Challenged adult. Clinic with Physiotherapy
    8. Susthithi (A Comprehensive rehabilitation Programme)

Insight Project:

121. Insight is a project under the Social Justice Department of Kerala, implemented by Kerala Federation of the Blind. The project was initiated in 2007 under Kerala State IT Mission, and was handed over to Social Justice Department in 2013.

122. Insight is a unique project which offers technology as a medium for assisting the Visually Challenged offering services to Visually Challenged individuals, Institutions and Organizations working for the Visually Challenged, and Parents/Teachers of Visually Challenged.

123. Insight currently focuses on Training, Technology Development, and Research on issues faced by Visually Challenged, especially related to education and employment.

124. Some of the major services under the project are
    1. Computer, Smart phone Training programmes.

2. Assistive Software & Operating System Installation in Computers/Smart phones. Online registration for PSC, UGC NET, RRB, Scholarships etc.
3. Telephonic/Email support on various technical issues.
4. Accessibility and performance Testing of Assistive software and Operating Systems. Technical consultancy for purchase of Smart phones, Laptops etc.
5. Preparation of ICT based lesson plans for Visually Challenged teachers.
6. Technical assistance to Visually Challenged students for their various academic needs. Consultancy services for Visually Challenged employees for increasing productivity.

Child Development Centre (CDC):

125. Child Development Centre at Medical College, Thiruvananthapuram is an autonomous centre established by the Government of Kerala with a mission to reduce childhood disability through novel scientific initiatives (dealt with in depth in the Working Group on Child Development and Nutrition).

The Kerala State Handicapped Persons' Welfare Corporation (KSHPWC)

126. KSHPWC is a Public Sector Undertaking under the State Government, established in the year 1979 in, Thiruvananthapuram. The main aims and objectives of the Corporation are to formulate, promote and implement various welfare schemes for the rehabilitation / improvement of the living conditions of the visually impaired, deaf and dumb, orthopeadically handicapped and mentally retarded persons and also to provide financial/technical assistance to the persons with disabilities, groups of such persons and organizations involved in activities on the rehabilitation and welfare of such persons. Over the years the Corporation has provided assistance to the differently abled persons in Kerala. It is proposed to strengthen the KSHPWC to
    1. Act as a renovator and innovator in the rehabilitation process of the differentially abled persons in Kerala.
    2. Providing quality aids and appliances to the differently abled persons for their better mobility to lead a normal life.
    3. Generate employment opportunities to the differently abled persons as far as possible.

First Priority Activities to be Taken up under the 13th Five-Year Plan

Rights Based Comprehensive Life Cycle Approach

127. Rights based comprehensive life cycle approach to disabilities shall be the key approach of State Initiative on Disabilities in the 13th Five-Year Plan. This includes Prevention initiatives- Primordial, Primary and secondary, Early Screening through Congenital Anomaly Screening, Early Intervention through DEICs/ Health Institutions and Social Institutions, Education support through Special Anganawadies, Buds Schools, Special / Regular Schools, Vocational Training and Rehabilitation through Assisted living projects. Apart from this Individual Care Plan formulation and follow up shall be another major initiative. This

requires convergence of services, Resources and Institutions wherein State Initiative on Disabilities shall be the support and coordinating agency. A workshop of Experts in this regard has already was done by SID and based on the recommendation of this workshop, strategic plan and action plan will be prepared.

Strengthening the Prevention of Disability

1. Creating awareness of planned healthy pregnancy
2. Mandatory MMR vaccination to all babies.
3. Mandatory Rubella vaccination for all adolescent girls in private and public schools if they have not taken the vaccination in early childhood to develop immunity against Rubella
4. Iron and folic acid supplements for all adolescent girls to prevent disabilities such as Spina Bifida

Early Screening, Detection and Intervention

1. Law to be passed and enforced for mandatory screening procedures for congenital anomalies to be done to all neonates before they leave the hospital either private or government
2. Implement a high risk register database accessible by all hospitals where screening is done and enter the details of the new born babies found to have disability
3. Implement a Social Worker force who will follow up on the high risk register so that the children are brought back for testing services and ultimately handed over to nearest Early Intervention Centers
4. Clinical and Rehabilitation intervention to all children with development delay and disabilities to be free of cost.
5. Strengthen the District Early Intervention Centres through adequate finance and human-power.

Inclusive Education with Appropriate Accommodation

1. Provide inclusive education for children with disabilities after they receive early intervention programs. Specific schools in a Panchayat block can be identified as a school that provides special services and children can be bussed there.
2. Appoint special education teachers in each cluster school where children with special needs are brought for inclusive education. Necessary training to update their skills and promote professional development exchange programmes.
3. Provide sensitization training for all general education teachers about special needs children in their classrooms.
4. Immediately implement a in-service training to all teachers of the deaf at NISH as proposed to the Minister of Education (on the same lines as was given to Vocational Higher Secondary Teachers from Schools for Deaf which was found to be very effective). The proposal has detailed plans and time lines.

5. Establish Assistive Technology centers in each district where AT required by students can be provided. Provide funding for the same.
6. Accessible text books/equipment to be provided to all needy children with special needs irrespective of their economic capacity.
7. Provide laptops with auditory software to students of standard 9 to 12.

Use of Technology for Education and Rehabilitation

75. Technology is the single biggest factor that enables PwD to function alongside everybody else. Technology has soared immensely and is becoming cheaper by the day
    1. Provide a nodal agency to bring in appropriate technology into the state by searching and finding out the current developments, assessing the suitability for Indian conditions, acquire technology and provide them to the students and the employees in a systematic manner. The Center for Assistive Technology and Innovation already established at NISH and the AT initiatives of KSCTE can be spearheading this initiative.
    2. Set up a fund with CSR and personal donations and use the same to make available Assistive Technologies
    3. Provide financial support for companies and Engineering Colleges to do research and bring out ideas. Provide seed funding for start up to manufacture Assistive Technologies

Employment of People with Disabilities

1. Appoint a Person with Disability (with at least a degree level education) in each Panchayat as the Disability Officer (from the same geographical area or nearby area) who will oversee implementation of the Disability services listed above from Prevention, Early Screening and Detection and Early Intervention, Inclusive Education, Employment and Rehabilitation. Use the LSGD funds for the same.
2. Take quick measures to report and fill the 3% reservation positions for PwDs in government organizations
    1. Provide tax breaks, funding to provide AT or accommodations for employing people with disabilities
    2. Develop more vocational programs for PwD under ASAP of Higher Education Department with special set of trainers and assistive technologies
    3. Disincentives like taxes or penalties (as exists in some countries) for not hiring people with disabilities should also be considered

Sheltered Workshops

76. Sheltered workshops are specially created environments in which people with disabilities can be employed. People with various disabilities, depending on their capacity, training and skills are employed. (In West Bengal, the Paschim Banga Rajya Prathibandhi Sammilini runs such workshops that are fully/partially managed by people with disabilities.)Food products, souvenirs, gift items, stationery, printing material, all these can be manufactured within

sheltered workshops. However, a common brand name has to be created and products manufactured in these workshops marketed under that name. They can be linked with Kudumbashree.

Increased Government Focus on Disability and Rehabilitation Services

1. Establish a Department of Empowerment of Persons with Disabilities (DEPwD) on the same lines established by GOI with a dedicated senior head of department who is passionate to implement the government policies
2. Transform all buildings and information sources of the government to be accessible to PwD in a fixed time frame across the state.
3. Establish an NGO accreditation and monitoring agency to provide regulations to operate services for PwD
4. Establish a single window for distribution of all assistance/equipment for PwDs.
5. Include a paper on disabilities in all the courses of all the Universities of Kerala.
6. Create a pool of sign language interpreters for deployment on demand.
7. All development agendas need to factor in disability. The PwD Act mandates that 3% reservation should be provided in all poverty alleviation schemes for the disabled
8. Equal Opportunities Cells need to be created in institutions of higher learning.

Special Focus Services for National Trust Disabilities

77. Persons falling under National Trust disabilities - Mental Retardation, Autism, Cerebral Palsy & Multiple Disabilities are basically those born with Intellectual Developmental Disorders. We can consider them as the most marginalized, amongst individuals born with disabilities.

78. Handling and extending care, imparting education/ life skill training for mainstreaming them, making them independent/contributive by extending possible rehabilitation & finding placement for them is not an easy task. To comprehend same one needs a lot of sensitivity and concern about this section of people.

79. Policy makers should give a thorough thought on the aspects of mainstreaming the intellectually disabled by having an understanding that their mainstream education is in making them independent in their daily living activities. Trying to mainstream them to that of a normal child is a futile attempt and leads nowhere.

80. The aspects which needs special attention and to be incorporated in the 13th Plan is as under which we sincerely feel would contribute to the betterment of the life of those born without the capacity to logically think, decide and act on their own.

Assisted Living Centers

81. The biggest hurdles and the challenges of the disabled is in the period of life after the demise of their parents. With our society's shift to Nuclear family system, the life of the

disabled especially persons with intellectual developmental disorders has become a matter of grave concern. Either they get dumped in an Institution or confined to the four walls of their home with restricted external interactions or they fade away after living a life of deprivation of basic human rights. To address this issue and to extend a dignified life to the Persons with Disabilities a school of thought had emerged as Assisted Living Centers where a mix of adult disabled would live together in a free atmosphere with certain amount of guidance and care. The13th Five-Year Plan should focus on effectively creating Preparatory Centers for such children focusing on making them independent and training them to develop with acceptable behavioural patterns so that they could blend well to the atmosphere of the Assisted Living Centers at a time when their parents are no more and none to care for them.

Creation of Human Power Resources for the Disability Sector

82. The biggest challenge the disability sector faces today is shortage of well-meaning and dedicated individuals for extending care to Persons with Disabilities. Our focus should be in creating such human power resources as caregivers by sensitizing and training individuals in our Society with a flair for social work, with special focus to those sections who are side tracked and marginalized from mainstream activities.
    1. Transgenders
    2. Widows & Singles
    3. Victims of various harassment and living in Govt. run rescue shelters.
    4. Self-motivated individuals

83. This again should be brought under a Regulatory Authority since it requires immense efforts and interactions on the Social / Psychological levels in preparing them to undertake this task and also calls for continuous training, sensitization & follow up with the involvement of peer group of involved individuals.

Review of Existing Welfare Measures

1. Extending ESI benefits to disabled, as dependent, even if they cross the age of 18 years. This will not only be a solace to the parents but it would also address the health issues of the disabled.
2. To bring in clarity on the disability pension scheme. It was observed in various Districts that certain Panchayats have restriction in disbursing pension for disabled below 18 years by referring to the stipulations of Indira Gandhi National Disability Pension Scheme.
3. To bring in uniformity of Scholarship being disbursed to disabled through Panchayats/Corporations and need to have a clear policy.

Second Priority Activities to be Taken up in the 13th Five-Year Plan

128. Training, Workshops, Research and New Initiatives. The involvement and support of general community is very much essential for mainstreaming of persons with disabilities. At

present this area is not getting much attention of the community and hence sufficient number of awareness campaigns, behavioural change communication programmes and advocacy programmes need to be organized. It is also essential to conduct training programmes for the Govt. Departments and Non Govt. agencies for ensuring equal opportunities, protection of the rights and full participation of persons with disabilities. SID proposed to organize State and District wide Seminars and Workshops and grass root level awareness programmes. It is also proposed to conduct research works and organize studies, to evolve new initiatives in this sector.

129. Congenital Anomaly Screening. Early identification of congenital anomalies and referring them for appropriate interventions can drastically reduce the gravity of disabilities. It is proposed to conduct screening for congenital anomalies among neonates by providing sufficient training to the JPHNs already working with SID for Universal Hearing Screening.

84. Categorization of Disabled - Identify the most vulnerable sections. An effort should be made to identify the most vulnerable groups among the disabled.
    1. Disabled persons who live in extreme poverty
    2. Severely disabled who live with a single parent
    3. Families having multiple members with severe disability

85. Situations like these put severe strain on the families, and it is essential that some measures are taken to offer a hand of support beyond the pensions. The first step is identification. Once the target groups are identified, potential donors or volunteers can be matched with the target group for offering support.

86. Improving the quality of life of severely disabled, and bedridden individuals. Provide Assisted Living facilities using the models prepared by SID across the state. Local self-government and NGOs are to be involved in establishing and maintaining the facilities.

87. *Training for employed persons with disabilities.* Govt. is the largest employer of PwD, but it is seen that once the recruitment is over, there are no steps being taken to assess how they fit into the job, whether the workplace is accessible etc. It is estimated that there are more than 500 teachers with Visual Impairment who teach sighted students. The only training that these teachers have access to is the Vacation batches conducted by INSIGHT. However, many of them don't feel motivated to attend as it is not compulsory and because they do not get any leave benefits. These training programmes should be formalized and should be made mandatory.

88. *Special incentives to startups working in the domain of assistive technology.* Since assistive technology development is not a very lucrative business, we don't see many private players getting actively involved in this domain. Project ideas prototyped in Engineering Colleges and by other inventors, should be manufactured and made available to the end users. Special incentives including subsidies for products should be given to start-ups focusing on this area of work.

89. *Swavalambaban and Niramaya health insurance scheme for the disabled.* Deliberate efforts should be taken by the state to popularise these insurance schemes for the disabled with the a target to cover all the eligible beneficiaries of the scheme as specified under the PWD act (for Swavalamban) and National Trust act (for Niramaya)

90. *Creating an audit team.* By creating a monitoring mechanism at grass root level wherein members representing the Govt. Machinery, Elected Members and NGOs could form an Audit team. This would act as an oversight mechanism, which apart from monitoring, implementation and proper utilization of funds of schemes and checking various aspects like hygiene etc. in institutions housing children and women, should also look into aspects of abuse, including sexual abuse within these institutions. Abuses within these institutions are rampant, as the disabled are considered more vulnerable.

130. To encourage and bring in the much needed economic/financial independence of Persons with intellectual developmental disorders the Registration Fee and other duties & levies related to transfer of assets favouring the disabled shall be exempted. As per the Circular of IG (Registration)the written prior permission of the District Local Level Committees are mandated to effect any transactions on the assets of Persons with intellectual disabilities and which has created a monitoring mechanism too.

131. *Encourage and support voluntary student initiatives in community based disability management and palliative care.* Students especially of medical profession (including medical, nursing and paramedical) need to have a better and humane understanding of "what it means to be disabled" and learn to empathise better with the feelings and needs of the disabled. Supporting initiatives with this objective would enable to nurture a generation of better medical professionals who would be able to empathise with the disabled, understand their rights and differential ability and will be able to coordinate better with other stakeholders in the comprehensive community based rehabilitation of the PWDs. There are few such examples in the state in this regard like the "karunyam" community based palliative care initiative of medical students of Govt. TD Medical College Alappuzha. State Initiative on Disabilities (SID) shall support such initiatives with the above said futuristic objective.

132. Establishing New born follow up clinics at all hospitals having antenanatal, intranatal and postnatal services in a phased manner. This weekly once clinic can follow models like "CDC Model of Early Detection and Intervention Programme", for identifying developmental delay, incorporating NNF Guidelines for newborn follow up. The Pediatrician of the hospital can bethe co-ordinator and other human resources like Developmental Therapist (PGDCCD), Nurse can run the clinic.

Services for Women in Difficult Circumstances

Single Women

133. While conceptualising policies and programmes even for the weaker sections, certain sections get excluded either inadvertently or they are not visible to the policy makers. One

such broad segment is the category of single women subsuming a number of sub categories, (including female headed households) within which the case of widows needs special attention. A survey conducted in Alappuzha district revealed that there are over 59,526 widows in that district alone. This is a huge number whose problems have to be addressed. Being single can be by circumstances (widow, divorced/separated etc.) or by choice. Nevertheless, besides facing the social stigma attached to being single, they encounter a broad spectrum of specific problems ranging from access to employable skills, capital, market to rights awareness and leadership/training etc. If for some single women financial security is a major concern, for many their primary concern is simply physical security on aa day to day basis. The problems get compounded when the burden of motherhood befalls on single women. Rescuing single women from obscurity in the planning process implies not only a much needed shift in the mind set of policy makers but also corresponding institutional changes and budgetary support. The 'old' among the widows as we saw in the earlier section is a major category. A good practice seen in the Edavanakkad gramapanchayat is formation of Neighbourhood Groups (NHG) of the elderly which has proved to be very vibrant. The social networking the elders engage in through NHGs after long years of familial separation and social isolation is a source of great exhilaration for them. Expanding NHGs of the elders across the state should be a priority supported by adequate budgetary resources.

NIRBHAYA Programme

134. Violence is a powerful way to oppress and control women and is the clear manifestation of male dominance and patriarchal cultures in the society. It is a violation of the fundamental principles engrained in the Constitution. Needless to state survivors of gender based violence is a critical category of vulnerable women who seek support from the state for redressal and rehabilitation; what is required very urgently is the prevention of violence. The Nirbhaya policy aims at strong intervention against sexual violence and sex trafficking through four main areas of interventions viz.,1) Prevention,2) Protection, 3) Prosecution and 4) Rehabilitation and Reintegration of survivors into mainstream society. While the policy takes a participatory approach– it ensures a strong community surveillance mechanism for prevention of crimes, and ensures the co-operation of survivors of sexual violence and members of civil society in formulating measures for protection and rehabilitation in an effective manner, progress on prevention has been slow.

135. Protection, rehabilitation and reintegration measures are critical links to the overall process of transformation: a journey from a helpless victim to an empowered survivor. Shelter Homes were established as part of intervention for protection services. They provide a safe space to sexually violated women and children to recover from their physical & mental trauma, supporting and strengthening them emotionally while the system takes its time to bring the perpetrators of the crime to justice. Shelter Homes take care of all the day to day needs of residents, and also provide trauma care, counselling services, education and vocational training, legal assistance, life skill training etc. They prepare the residents for their successful reintegration back into mainstream society.

136. Under Nirbhaya, eleven shelter homes are presently functioning across Kerala. Shelter homes are run by NGOs. First Nirbhaya shelter home began functioning from 2013 at Poojappura, Thiruvananthapuram.Four service providers are presently involved in running shelter homes.They are Kerala MahilaSamakhya Society, Anweshi, and Cultural Academy for Peace and John Haw Service Society (Ashadeepam).Working fund is provided to the Service Providers as per the rates approved by State Government. With the aim of empowering and capacitating survivors, a Minimum Standards of Care is prescribed as per Order No. GO (Rt) 558/2014/SJD dated 29.8.2014.These standards of care constitute a set of non-negotiable rules that should be integrated in all shelter homes.

Observations of Gap Analysis of Nirbhaya Shelter Homes conducted by Nirbhaya Cell during Feb – March 2016

137. All Shelter Home managements have taken steps to meet the immediate physical and day to day needs of the residents. However, processes and activities in Home management , trauma care, development of life skills, vocational and occupational therapy which help in the transformation of a resident from being a victim to becoming a survivor, from a beneficiary to a participant which will help in reaching the goal of Nirbhaya, *i.e.* rehabilitation and reintegration of residents is completely missing.

Box 1 *NIRBHAYA some quick facts:*

- Around 64% of Homes in the state have more than the prescribed carrying capacity of 25 residents
- The residents' age group ranged from (a) below 5years (3%) (b) below 18 years (86%) .
- 16% of the residents were not gainfully engaged in any activities.
- 11% are not registered in open schools.
- Those residents who have special needs are not always given special food.
- More than 80% of Homes do not have the much needed services of a clinical psychologist for rendering trauma care and counselling.
- Lack of facilities for continuous vocational training for residents
- Other findings include lack of safety of campus, lack of adequate infrastructure including adequate toilets and separate library
- Gap in proper maintenance of records & documentation
- Urgent need for providing training to staff
- Improper financial management by few service providers
- Delay in timely disbursement of funds from Government
- Non-preparation of structured legally acceptable individual care plans for residents
- Non planning of suitable after care programs for residents

Recommendations for Nirbhaya Programme

1. One of the strongest recommendations we would like to make is to convert Nirbhaya Cell into an autonomous body with an Executive Director with financial and administrative delegation to head the same. Right now the Nirbhaya Cell has no

financial or administrative autonomy and this acts as a great barrier to functioning in a mission mode.

2. Establishing **One Centralized or three Regional Nirbhaya Shelter Complexes** instead of separate Shelter Homes in all districts.
3. SOS model smaller homes within the larger complex with
    1. Separate Homes for (a) rape victims below 18 years of age, (b) rape victims above 18 and (c) child marriage victims
    2. 24 hr. medical facility
    3. Trauma Care & Counselling Centre
    4. Vocational Training/ Educational support/Career guidance centre
    5. Centralised Library/ Centralised Prayer Halls
    6. Playground / indoor stadium/yoga centre
    7. Conference/ MeetingHall
    8. Marketing Support Centre
    9. Placement Cell

138. This system would be more effective instead of having district level Shelter Homes with meagre infrastructure facilities and minimal support systems. This will also be more facilitating for law enforcement agencies.

139. Establishing Model after care homes / transit homes for sex crime survivors. As rehabilitation and reintegration is one of the corner stones of the Nirbhaya Policy it is suggested that one Model After Care/ Transit Home can be set up for rehabilitation and reintegration of selected residents (about 10-15 nos.) of Nirbhaya Shelter Homes who have completed 18 years of age. Those who have been physically and psychologically healed can be shifted to this new Centre after detailed counseling and mental mapping, as a stepping stone to complete reintegration. A partnership with an identified industry/ company/ enterprise which can provide equipment and extensive Skill and Entrepreneurship Development training to the residents to produce the items required by the industry, as part of their Corporate Social Responsibility can be planned. The residents can earn an income while learning a new trade and keep themselves physically, mentally and emotionally engaged. This will help to make the victims emerge as survivors, with the required self-confidence to live with dignity in the mainstream society. The Home can be run by the residents themselves with the help of qualified and trained staff. A suitable NGO can be identified to supervise the management of the Home.

140. Strengthening community surveillance systems for prevention of sex crimes among general population-The need of the hour is prevention of sex crimes. Need for protection and rehabilitation of sex crimes comes in only after the crime is committed. Ensuring prevention can be done effectively only through strong community mobilization, community sensitization and effective community surveillance systems, in addition to the existing law & order systems.

141. Community mobilization and community sensitization can be done through Local Self Governing Bodies - through GramaSabhas, ward level campaigns- Residents Associations,

educational institutions, local level cultural, literary &sports organisations/ clubs etc, effective & regular media campaigns (audio/visual & print media).Community surveillance systems can be established through JagrataSamitis, Residents Associations, School Police Cadets (SPC), NSS/ NCC Volunteers in schools/ colleges, School Counsellors, Anganwadis – vulnerability study through Home Visits, Kudumbashree – CDS/ ADS etc. The crux of these systems should be effective implementation through regular monitoring, evaluation and follow up measures.

142. *Vulnerability mapping for sex crimes***.** The recorded sex crimes against women & girls are found to be on an increase in the State. Though all girls & women, irrespective of age, caste, creed or race, are vulnerable to such crimes and nobody or no place can be said to be 100% safe, it is observed that most often girls/ women from the following backgrounds / areas are found to be more vulnerable to sex crimes/ sex trafficking
    1. Belonging to economically & socially backward communities
    2. Living in unsafe houses
    3. Whose parents are out for work for very long periods and at odd hours
    4. Whose mother has remarried (incest rape is seen often)
    5. Broken families
    6. Alcoholic / delinquent parent/s.
    7. belonging to homes where the child feels neglected or lonely

143. It is proposed that an extensive ward level vulnerability mapping of houses/ families to identify vulnerable girls/ women can be taken up as a pilot programme. This can be done in collaboration with Kudumbashree officials/ workers and grass root level officials/ workers of Social Justice Dept. The data can be consolidated at ward level and panchayat level and compiled into useful information. This information can be disseminated to concerned local self-governing bodies, local police authorities, local level residents associations etc. for developing a local level community surveillance programme.

91. *District emergency response teams and short stay facilities for sex crime victims.* District level Emergency Response Teams consisting of One Social Counsellor, One Lawyer/ Para-legal Counsellor & one Field Worker can be constituted in each district to reach and assist victims of reported sex crimes within the shortest possible time (maximum 12 hrs.) to assist in trauma care for the victim & family, risk assessment of the victim , socio-economic assessment, legal aid, recommendation for immediate relief to the victim, referral service to One Stop Centre and short stay shelter. Exclusive Short stay facilities can also be arranged for the victim.

92. *E-portal for sex crime monitoring.* To have a centralized data on crimes against women & children & monitor the status of prosecution for effective and fast disposal of judicial cases, an e-portal may be established for monitoring every reported crime by linking all police stations, courts, shelter homes etc.

93. *Child friendly courts and video conferencing facility in courts.* To prevent children from being intimidated by Court proceedings, all courts should have separate child friendly court

rooms for hearing of cases of child victims, if physical presence of child is required. Also in order to prevent the victim of sex crimes from being threatened or intimidated by the perpetrator of the crime, as far as possible video conferencing facilities should be made available in courts so that the victim need not physically face the perpetrator.

94. *Exclusive / fast track courts for sex crimes against children (both girls and boys) and women* .At present there are 3 exclusive courts for women & children. However, at least one Exclusive/ Fast Track Court should be established in each district to ensure speedy justice.

95. *Prevention of sexual harassment in work places.* The SJD should be the Nodal agency to follow up on reports of Sexual Harassment in workplaces. A system of coordinating with various Govt. Depts./ Institutions/ private agencies etc. should be put in place by the SJD to ensure that such reported cases are dealt with immediately and strictly as per provisions of the Act. It is necessary to conduct an evaluation of this Act, in particular how many organisations have even put it in place.

96. *Safety in Public Places and Public Transport.* Public places and Public Transport can be made safer for children and women through
    1. Panic Buttons in easily accessible locations in public places & public transport systems especially near entrance, exits, toilets, ATM Counters, ladies seats in public transport etc.
    2. More Solar electrification on roads, streets & public places & high crime areas (based on crime mapping done by Kudumbashree)
    3. Increased CCTV camera surveillance in high crime areas linked to 24 hour police Monitoring Cell

97. *Prevention of sex abuse and sex crimes in care institutions/ orphanages/ educational institutions etc.* A general rise in sex abuse cases in Care Homes/ Institutions, Orphanages, Educational Institutions including Madrassas is being reported both among children, women & old age citizens. This is a cause for grave concern and certain mandatory systems have to be established to prevent such crimes. Stricter vigilance in the functioning of these institutions is essential.

144. Regular periodic (monthly / quarterly) health check-up, including Gynaecological check-up, if required, of residents of all Care Homes (Children's Homes, Juvenile Homes, Observation Homes, Old Age Homes etc.), Orphanages & residential educational Institutions, including Government & Private run institutions should be made mandatory using Government facilities. In case of residents of Old Age Homes, the health check-up can be linked to the Vayomithram Project of Kerala Social Security Mission by including a Lady Gynaecologist in the panel. School counsellors are to be imparted specialized training to identify sex abuse victims in schools. School Health programme should include gynaecological support also.

145. *Prevention and protection programmes for local self governments.* Projects aimed at prevention of sex crimes, human trafficking & protection for victims of sex crimes & human trafficking should be mandatorily included every year in the shelf of projects of Local Self

Governments. Finally it is strongly recommended that a high level Planning Board Committee meet on a quarterly basis to monitor, review and evaluate the successful implementation of the social protection and welfare policy of the state government.

Women Specific Programmes

146. The following special women –specific programmes are suggested

147. *CMs fellows in tribal and coastal areas.* Similar to the programme of Prime Minister's Fellows under Rural Development Department, it is suggested that GOK can initiate a programme called CM's Fellows to provide a catalytic support to the Social Justice as well as Tribal Development Department to identify the issues and problems of the tribal and coastal women as well as adolescent girls. Just as in the case of PM"s Fellows, the CM's Fellows will also focus on reduction of poverty and improving the lives of the population in backward and isolated regions. The Tata Institute of Social Sciences (TISS), as a knowledge partner of MoRD, facilitated the process of selection, recruitment, training, mentoring and monitoring the work of the PM's Fellows.

148. Kudumbashree in close collaboration with TISS has already trained a batch of women (and very few men) for a period of one year (Post graduate diploma in Development Praxis). Most of them are from BPL families and many from tribal families. They may be given preference while selecting the CM's Fellows. They will help the District Collectors in micro level integrated area development planning with special reference to areas dominated by tribes and fisher folks, in developing area specific specialised care programmes, improving programme delivery and interface with the tribal and coastal population. These Fellows will work with the departmental staff(LSGD, SJD, Tribal & Fisheries) in conducting capacity building programmes and help the poor tribal and coastal people to access their rights and entitlements, facilitate capacity building in Self -Help Groups (SHGs), design and implement innovative projects etc. These Fellows can form a good resource group for extension activities as well and can be paid a decent honorarium for their work.

149. *Annual preventive health care for women.* Regular health check-ups can help in early detection of problems, when the scope for treatment is better. Women need some special check-ups and screenings like pelvic examination, Papsmear test to rule out cervical cancer, clinical breast examination, mammogram, colon cancer screening, and bone density screening etc. Usually women never go for a routine medical check-up regularly unless they detect some diseases. Also women always get the last priority in the family in health screening as they always work for the betterment of the family ignoring their own ailments. So it is suggested that a programme for Health Screening for women be made mandatory to prevent diseases among women through a comprehensive health care insurance plan "Annual Preventive Health Care for Women".

Institutional Care

150. Institutional Care in the Government system offers residential facilities to the destitute and the abandoned and assumes total care of the residents. However, it has generally been characterised by depersonalisation, closed doors, rigid routines and lack of tender love & care. Institutional care functions on a one-size-fits-all approach to care and the individual needs are overlooked.

151. Government as well as NGOs and Voluntary Organisations provide institutional care to the weaker sections. There are 78 welfare institutions under the aegis of Social Justice Department (SJD) for the care, protection and rehabilitation of children, disabled, women and aged. Out of this, 33 institutions are for children, 20 for women, 12 for aged people and 13 for disabled. About 2800 persons had benefitted in 2015 through the network of these institutions. Apart from this, 88603 persons benefitted through 2185 registered welfare institutions run by NGOs and VOs. A significant number of residents of these homes have families and their separation could have been prevented if the right social protection system or community support was available to the vulnerable families. The focus therefore should be on non-institutionalisation and de-institutionalisation through community based services and family based alternative care. Having said this, institutional care will continue to be a reality for a residual group who are not amenable to non-institutional alternatives. Hence there is a need to improve the quality of service delivery through improving infrastructure, capacity building of caregivers and simplifying rules, procedures and processes.

152. Modernisation of Institutions. Most of the amount under this plan head is used for construction of infrastructure. Since the SJ Department has to rely on the PWD to get the construction of buildings done, there is inordinate delay as the PWD has to attend to works of several other departments. With a view to expediting construction work for the SJ department it is proposed to constitute an engineering section under the chairmanship of the Secretary, Social Justice Dept. exclusively for monitoring on a regular basis the progress of construction of infrastructure& annual maintenance of existing institutions under SJD and for removal of bottlenecks and coordinate with the PWD.

153. As stated earlier, there are over 70 institutions directly under the SJD. Many inmates continue to live for several years with no opportunities for rehabilitation and reintegration into mainstream society. They do not have the requisite skill nor will the support system for obtaining gainful employment that help them become self-reliant. It is also recommended that all institutions under SJD should develop necessary packages of rehabilitation and reintegration into the mainstream society. This implies imparting skills appropriate to each person and assisting in placements with decent salary Groups of 3 or 4 women can join together and start a small enterprise and they can move out of the institution to budget homes or rented rooms. There should be follow up and hand holding system for such women for at least a period of one year.

154. Most of the trades for the children in SJD institutions designed several years ago have not been suitably updated. It is recommended that training in modern trades using modern

machinery & equipment should be imparted to the inmates based on their aptitude. A few suggested trades (not a comprehensive list) are given below

1. Animation
2. Modern Carpentry for prefabricated furniture which can be assembled by
3. people who purchase it.
4. Hardware servicing
5. Mobile phone repair & servicing
6. Home –based caregivers (for elderly/ disabled/ paraplegia patients)
7. e-catering units
8. Industrial sewing units
9. Handicraft items
10. Costume jewellery making

155. All institutions under SJD should be aged friendly and disabled friendly in particular for women & children. In view of the recent allegations of abuse in old age homes, it is recommended that there should be different categories of old age homes

1. Homes exclusively for women and staffed by women
2. Homes exclusively for men staffed by men
3. Homes for couples
4. Paid Homes for affluent sections
5. Convalescent / respite homes for which funding can be given by Government to NGOs

98. Group homes or adult family homes for the differently abled girls/women. Group homes or adult family homes for the differently abled girls/women are another option suggested for persons needing specialized care. A group home provides housing and meals, and may provide other activities to residents, such as field trips, sports activities, transportation services to medical appointments, shopping and entertainment activities etc.. The person who is in charge of a residential home serving differently abled people encourages the residents to grow and explore their potential. Care plans should be made for residents, the staff, and family to create goals, and therapy, skills, activities, and employment. Residents should be made equal partners in the formulation of the plan. The residents can learn a range of skills from grooming to a variety of life-skill-based training for instance, shopping, cooking, money management, weight management, healthy eating etc. These specialized skills enable the residents to reach the highest level of personal independence in daily routines. The residents of such homes get the opportunity to enjoy a variety of supervised activities in the larger community like watching athletic events, making trips for dining, shopping for personal items, enjoying music concerts, arts, and food festivals, attending religious services at local churches, temples or mosques, visiting museums, Sightseeing etc..

99. The above mentioned assisted living facilities should provide full-time living arrangements in the least restrictive and most home-like setting. Facilities like individual apartments or rooms that a resident has alone or shares with another person are also suggested for the differently abled. It is also suggested that Accredited NGOs of the SJD or organisations like

PARIVAR (an organisation of the parents of mentally challenged) etc. can take a lead role in setting up such institution models. Suggested models are

1. Setting up of small villages by constructing cottages- in the model of SOS villages
2. Setting up of comfortable dormitories providing a safe, supportive environment of assisted living for adults with developmental disabilities and cognitive challenges, allowing them to live a whole new life independent from family, under 24-hour supervision.

Policy Recommendations

1. All Institutions under the Social Justice Dept. should be upgraded to international standards and residents should be rehabilitated through skill up gradation and reintegrated into mainstream society through gainful employment.
2. It should be made mandatory through legislative measures that 10-20% of all housing stocks should be earmarked for elderly & the disabled.

Probation Services – Non-Institutional Treatment and Rehabilitation of Offenders

Context

1. Probation is a universally accepted, effectively tried out, widely practiced non-institutional method to be used by Judiciary at their discretion to treat and rehabilitate a good variety of selected offenders, especially young offenders, without sending them to prison .Probation or non-custodial sanctions are not to let the offender off the hook; it is a conditional suspension of the sentence because it is considered more suitable for certain types of offences and offenders who are found to be amenable to correction and rehabilitation. If a probationer violates any condition he or she will be re-incarcerated.
2. Independent research shows that probation is as effective as and considerably cheaper than imprisonment if wisely and effectively administered. There are significant cost savings to the public. While it costs Rs.200 per person per day for incarceration, probation costs are only Rs.20 per day.[1]Probation helps to reduce overcrowding of prisons. Additionally, there is some evidence that almost 90 percent of those who are released on probation have been successfully mainstreamed back into society as productive and dignified human beings.[2]From the community point of view, probation can help to reduce recidivism, including incidence of sexual offences, and reduce crime rates.[3]From the offender's point of view, it is a "gift" or an opportunity to learn from his or her past mistakes and become a productive citizen, without the stigma of being an offender or having to be incarcerated with hardened criminals.

[1]"Probation - ArthavumVyapthiyum" Information and Public Relations Department, Govt. of Kerala (2005)
[2]See above.
[3]The probation program will also help and support the Nirbhaya program by aiming to reduce sexual offences through treatment of such offenders.

Table 8 *Percentage Eligible for Probation*

Under Trial Prisoners in 47 Jails in Kerala	Total
Prisoners	4119
Grave Offence	752
Potential Eligibility for Probation	3367

Source Response to a RTI Request in May 2013

Box 2 *A Brainstorming Workshop of Probation Officers, academics, and NGOs, conducted by DSJ in June 2014, suggest the following constraints:*

1. The lack of a vision or a clear mission for the Probation system
2. Weak awareness of the benefits of effective probation by many stakeholders and the public
3. The lack of an updated Probation of Offender's Act, given that the 1958 Central Government Act and the subsequent 1960 State rules are based on outdated concepts of control and incarceration.
4. Weak inter-departmental synergy between key actors such as judicial officers, probation officers, prison administrators, advocates, and the police.
5. Weak capacity and morale of Probation Officers to maintain excellence in work due to lack of any supervisory structure (the system envisaged in the Rules was disbanded when the probation system was handed over the then Social Welfare Department (now renamed Social Justice Department (SJD)).
6. Weak demand by offenders themselves due to lack of resources and knowledge, thereby resulting in the weakest of society continuing to languish in jails without access to justice.
7. Box 2: Constraints of effective probation system in Kerala.

100. Recommendations of the National Correctional Conference on Probation and Allied Measures October 1971, The model prison manual 2003 (BPRD, MHA, GOI), the Mallimath Committee report on criminal justice reforms, and the Draft National Policy on Criminal Justice Administration have made various suggestions and recommendations relating to strengthening alternative mechanisms of crime control such as Probation, community services and rehabilitation. Table 1 presents the current status of under trial prisoners in Kerala and indicates the immense need for, and potential of, an effective probation system. However, today the system is beset with a host of issues and there are several institutional, organizational, and human limitations that need to be addressed (Box 2).

Proposals

101. The broad goal of the proposal is to rejuvenate and modernize the probation services, staff and system in Kerala. Specifically, it aims for better and regular identification of offenders eligible for probation, to undertake comprehensive investigation reports to ascertain whether they are amenable to correction, to provide necessary psychological treatment when necessary, and to ensure effective supervision to enhance the likelihood that the probationers will be reintegrated back into society.

Components

102. .The project is divided into the following key elements as described below.

103. *Capacity development of probation system.* This component aims to develop capable probation and justice institutions that are well structured, financed, trained and equipped to handle matters of probation. This will consist of three sub-components related to capacity development of the different actors in the system
    1. *Capacity development of magistra.*: Given the key role that judicial officers play under the current legal system, it is important to build and strengthen their capacity as well as enhance their understanding of their roles and responsibilities in this regard.This component will engage the Honorable High Court of Kerala and the State Judicial Academy to implement relevant capacity development programs in this area.
    2. *Strengthening the organizational structure for probation offices***.** There is currently no managerial structure to strategize, supervise, and monitor the functioning of the probation system. This will require the establishment of a supervisory structure, as per Section 3 and 5 of the 1960 PO rules, namely, the appointment of the Chief Probation Superintendent and the Regional Probation Officer. In addition, the state and district advisory committees should also be established as per the present rules.
    3. *Capacity development of probation officers and associated staff.* This component will finance the development of training modules for staff of probation offices to meet the objectives of the project including better social investigation and report writing, supervision and rehabilitation, and monitoring and evaluation. Part-time services of a legal counselor and a clinical psychologist will be necessary and the project will finance the attachment of such technical experts to each district probation office. (Starting in Phase 1)The last phase of the project will ensure the appointment of Honorary Probation Officers in each district probation office, proportionate to the increased demand for probation services, and arrange for their training.

104. *Infrastructure and facilities for probation systems.* Achieving the objectives of the Probation of Offenders Act will require minimum infrastructure and facilities. Some of the offices have required facilities. Others do not. The following is proposed under the component
    1. *Strengthened probation offices.* Under this component, a brief and rapid assessment will be undertaken to evaluate current facilities, to understand the gaps and needs in this area, and make recommendations on measures for strengthening.
    2. *Probation homes.* As recommended by the Kerala Probation of Offenders Rules of 1960, probation homes are essential for the effective rehabilitation of probationers who have no fixed place of abode. This sub-component will finance a study to assess good practices in this regard in Maharashtra and other states, and to make suggestions for the suitable program to establish such homes in Kerala. The establishment of homes will begin after the recommendations of study are received, and it is expected that NGOs will be contracted to establish one Home in each region during each phase.

3. *Reorganization and strengthening of borstal schools*: The Borstal School Act requires the establishment of Borstal schools to ensure special treatment for adolescent offenders aged 18-21.At present, there are no properly functioning schools as per the spirit and intention of the Act. This subcomponent will finance a study to investigate how such schools are functioning in other states such as Tamil Nadu, understand the costs and benefits of the system, and make recommendations for the implementation of the provisions of the Borstal School Act.

Enhancing Accountability Of, and Demand for, Probation-related Functionaries and Stakeholders

105. Enhancing the accountability for the smooth and effective functioning of the Probation System is essential to ensure effectiveness of the probation system. This is, however, a challenging task given the multiple actors and respective roles that each actor has to play. A range of activities is planned in this component to enhance accountability and increase the demand for a well-functioning system.
    1. *Establishing an accountability framework*. The roles of the multiple actors (the judiciary, executive, and the legislative branch, the police, prison, probation service, and other social service agencies) should be clearly defined, and each should have a common understanding of the vision, mission, and approaches of the probation system. To achieve this objective, this component will finance a high-level Roundtable workshop to discuss the objectives and principles of the Nervazhi project and to develop an understanding of the accountability framework consistent with current laws and to establish a set of responsibilities and standards that will be applicable to all.
    2. *Sensitization programmes for stakeholders*. Development literature suggests that demand for a well-functioning probation system can be created through sensitization programmes for different stakeholders to apprise them of the benefits and to convince them that probation is a balanced approach of sanctions with equitable welfare considerations. Such stakeholders include the community and public, elected representatives, justice institutions, NGOs, government departments, media personnel, and offenders. This component will finance a consultant to develop and implement Information, Education, and Communication (IEC) programs, targeted to the above groups on the rationale, advantages, and efficiency of the probation system. Such programs will use a variety of media such as radio, television, posters/bulletins, and newspapers to get to the widest range of people.
    3. *Computerized MIS systems and using modern technology*. There is no existing monitoring and evaluation mechanism to understand the results of the probation system and without a clear understanding of the results, accountability can only be vague. This component will help to establish an effective mechanism to guide, supervise and monitoring the results of probation at the district and state levels. During the pilot, a probation framework will be developed and a pilot MIS established.

Strengthening the Regulatory Framework for Probation in Kerala

106. The legal and regulatory framework for the Probation system is still based on a 1958 Probation of Offenders Act, Kerala Borstal School Act, 1961, and the Kerala PO Rules 1960.As of now, there is also no state policy for probation clarifying the Government's approach to probation. This legal and regulatory framework is based on the previous approach of control, where probation was controlled by the Prison Department. In 1975, the responsibility was shifted to the Social Welfare Department to inter alia handle and manage the probation system because it was felt that probation was not only an approach of non-institutional correction and control, but also one of welfare and care activities.[4]However, the regulatory and policy framework for this institutional arrangement was not updated, and there are significant gaps between the conceptual and the functional frameworks. It is therefore imperative to close this gap and modernize the regulatory framework. While the ability to revise the 1958 Act is limited, this component proposes a review of the current 1960 Rules and the framing of a modern probation policy for the state. This component will finance the following.
    1. Understanding Best Practices: A comprehensive literature review will be undertaken to identify good practices, understand what has worked and what has not, and propose recommendations for the way forward.
    2. Review Committee: A Policy Technical Committee will be established to review and recommend changes to modernize the system related to Probation.The recommendations of this Committee will feed into the formulation of a Policy on Probation for the State as well as set into motion the revision of the Kerala Probation of Offenders Rules, 1960. It may also recommend to the Central Government on changes required to the 1958 Probation Act. It is proposed that the Technical Committee would be established by DSJ comprising of Director of Social Justice (Committee Convener), Secretary, Law department, ADGP (Prison), DGP (Home), Advocate General, Registrar (General), Honorable High Court of Kerala, and Secretary, KELSA.The Secretary of SJ will act as Chairman of the Committee.

Emerging Issues

State Initiative on Dementia care

Context

107. In 2015, the number of people affected by dementia is estimated to be over 1.9 lakh. Despite this magnitude, there is gross ignorance, neglect and scarce services for people with dementia (Dementia India Report 2010). Caring for a person with Alzheimer's can be very difficult and with a total lack of personnel who have been trained to care for those with dementia, the quality of life is very poor for the patients as well as the care-givers/family members. Nearly 50 per cent of those with Alzheimer's disease have associated psychiatric problems that can grossly interfere with their family's life and environment. The break-up

[4]Kerala Gazette No: 37, dated September 23, 1975

of the nuclear family set-up and consequently, diminishing family support for those with dementia are major problems in the State affecting the care of those with dementia. Overseas migration of young adults in the family, dual employment of both son/daughter and their spouses, a drastic change in modern work environments with the young adults in the family spending more time at workplaces than at homes all exacerbate the care of the elderly, especially those with Alzheimer's. The increasing burden of care on the spouse who is also likely to be old and with various physical ailments is another problem that families face. Yet, there is little awareness of this mind crippling illness.

108. A wide-range of studies and literature observe that caregivers lack access to information or advice on how to ably respond to the disease and related social and emotional challenges. Exclusive reliance on specialists (psychiatrists and neurologists) and secondary services to identify and manage patients with dementia is unrealistic considering the lack of resources and manpower in the state. Having a large elderly proportion and dementia prevalence, Kerala needs to make dementia a public health and social welfare priority. Since the care and support of those with Alzheimer's is a specific problem and not to be tackled along with general geriatric care, we need a special health strategy for the care of the elderly with dementia, especially as the number of those requiring this care is growing fast. For this, it is necessary to put all systems in place to handle the increasing requirements of care and support facilities for those suffering from dementia. Maximal utilization of locally available resources and personnel including training and integration with existing infrastructure in identifying, assessing, managing and supporting people with dementia and their families is needed.

109. The Social Justice Department in association with Alzheimer's and Related Disorders Society of India (ARDSI) has already taken initiative to develop a sustainable initiative to effectively meet the challenges thrown up by dementia in the state. Unlike other States, Kerala is well-placed to establish a care model for the population with dementia. The recently held state Consultative Meeting on Dementia in Thiruvananthapuram discussed the importance of creating dementia awareness among the public, capacity building of social and health care professionals, setting up of community memory clinics and promoting dementia friendly institutions.

Proposals

110. Making Kerala the First Dementia Friendly State by

110. *Information, education and communication*: Effective Information, Education and Communication (IEC) materials are an important component of the comprehensive dementia awareness campaign. The materials should be clear, relevant, communicate specific messages, easily remembered and should tap into interests of the local population. Prototype IEC material on Dementia should be developed to sensitize community about the disease and its various aspects.

111. *Capacity building and enabling –training health and social care professionals*. Considering the higher prevalence of Dementia in Kerala due to the increase in the percentage of the elderly population and the associated conditions, it is essential that the health and social care staff including the doctors are equipped with adequate technical and personal skills for dealing the dementia cases in a systematic manner. Dementia training programmes for the Health staff can be organized as separate programme, and also in the various ongoing training programmes of the Health Services department it can be included as a component.

112. *In-service education*: The dementia training can be incorporated with the RCH training of the Health Service department. It is intended to develop clinical skill, communication skill and managerial skill connected to their respective job responsibilities.) Since all these trainings are long duration trainings extending few weeks, it may be possible to allocate at least few theory and practical sessions on Dementia care. So that we can cover the target groups like JPHNs (-Two weeks), JHIs, HIs & HSs (One week training.), LHIs & LHS s; (18 Working days), Medical Officers: (Two weeks training), Staff Nurses (Two weeks training.), Pharmacists: (Two weeks training).Theory classes and practical based field level training on dementia care can be very well incorporated as part of this package. JPHNs can again train the multipurpose health workers and ASHA workers. The multipurpose health workers and ASHA workers in their annual household survey can make an assessment of the patients requiring dementia care in their respective field areas and provide advice and referral services.

113. Considering the huge demand of dementia care requirements in the primary health care level, one-day Dementia training can be provided for more number of doctors and other paramedical staff (especially staff nurse and pharmacists) on a batch basis at district level so that adequate dementia service can be provided at the primary level. The training will cover basic understanding on dementia especially major warning signs, basic caring tips, and preliminary dementia screening protocols. Dementia manual will be given to them. These Trained people will give training to the other Staff like JPHNs, JHIs, HIs & HSs, LHIs & LHS s; multipurpose workers and ASHA workers and these people will extend the dementia awareness at the grass root level in the community. So that dementia awareness and in response to that dementia screening will be taken place in the community.

114. *Dementia training for CDPOs/supervisors under ICDS*. Two hundred and fifty eight CDPOs working in ICDS will receive one-day dementia training in five regions. The trained personnel will train the Anganwadi workers to extend the dementia awareness and preliminary identification in the community, and provide adequate support to the families with the available resources.

115. *Training for personnel of government old age care institutions.* At present, SJD manages 22 old age care institutions, each with an average capacity of 50 inmates. Although these institutions do not entertain persons with dementia, most of the old age homes have got a good number of persons with dementia, but often unrecognized. Superintendents/matrons/staff Nurses of the Old age homes will receive a one-day Dementia training (together in one batch) and, others such a scaring staff and multi-purpose workers will receive two day training at two

regions. The training will cover basic understanding of dementia, behaviour issues caring strategies, dementia environment, minimum standards of care to be given to the persons with dementia, caregivers' issues and its management, etc.

116. *Training to the vayomitram coordinators and nurses.* Vayomithram is a Kerala initiative for elderly care run by Kerala Social Security Mission.At present Vayomithram has got 44 units across Kerala and it is mainly conducting medical camps for the persons above 65 in the community. Each unit has got a Social Worker coordinating the entire function, medical doctor, staff nurse and pharmacy assistant. These professionals can be trained in dementia care so that they can extend dementia awareness in the community, identify dementia cases and provide adequate dementia advice and information. Two-day dementia training can be given to these professionals on basic understanding of dementia, preliminary screening measures, and adequate information for providing advice and support to the affected families. These people will identify dementia friendly doctors and institutions under their area. They can also identify facilities, which have got potential to be geared up as Dementia friendly facility both under Govt. and non-Govt. set ups. They can follow dementia guidelines for memory clinic for all the information with regards to memory clinic. Apart from this they can also conduct basic dementia assessment as part of their medical camps and dementia advice. They can work in tie up with district mental health programs for the initial screening and memory clinic at the govt. medical colleges/district/general hospital for detailed work up.

117. *Caregivers training through kudumbashree mission.* Recent estimates and current socio economic background of the state suggest that demand for paid care givers will far outstrip supply over the next decade. So training of caring personnel should be considered as a prime pillar for dementia care. In order to address this issue, training should be conducted in association with Kudumbashree Mission. A batch of 10 candidates with right attitude towards caring can be trained in dementia care. This one-week training will include both theory and practicum in a very simple manner. Through the placement cell of the Kudumbashree Mission, these trained carers can be placed at houses or institutions where dementia care is required.

118. *Training for community nurses in the LSGIs.* As part of the State Palliative Care policy, local self government institutions have appointed Community Nurses for palliative care. Currently around 1000 community nurses work under LSGIs. Most of them will come across the person with dementia in their field, but often are helpless without any knowledge or skills to handle them. Two-day Training program on dementia can be given to these Community nurses so that they can spread awareness on dementia in the community, identify dementia cases and refer them for diagnosis, and provide adequate information and advice on caring and availing other services needed to them. They will be given training on basic understanding of dementia, Caring strategies, caring advanced cases of dementia, preliminary identification measures, etc.

119. *Community memory/dementia clinic.* As the population of older adults in the state grows, it is necessary that the state be prepared to meet the needs of this population, through the

continued development of memory clinics. Memory clinics are equipped to diagnose elders with dementia and also educate and provide families with the supportive guidance required to manage those with dementia. In the absence of memory clinics, dementia is diagnosed but not explained properly, resulting in untold distress to the care giver. But in India only less than 10% of the dementia cases are diagnosed and given adequate support. Based on our experience, what is critical to the development of a memory clinic are dedicated offices and treatment rooms, standardized assessment methods, a clinical team with clearly defined roles, standardized diagnostic procedures, and regular consensus conferences. It is likely that most of the resources needed to develop a memory clinic are already present in our health and social care settings. They may be able to allocate offices and treatment rooms for this purpose, and existing staff may be able to fill the roles of the clinical team through a training program that promotes capacity building. The immediate requirement of the memory clinic is availability of a Neurologist / Psychiatrist / Geriatrician supported by the psychologist/social worker. The memory clinic could function twice in a month at every medical college.PG students can do the initial work with the patients, before referring them to the medical officers in charge of the clinic.

120. Regular monthly or bimonthly memory clinic can also operate in every district through either district or General Hospitals depending on the availability of a neurologist/Psychiatrist/geriatrician. In the absence of social worker, the trained Vayomithram coordinator can work in the memory clinic team. District mental health program should play a major role to support the district memory clinic. The memory screening programs can be conducted in the community by the community medicine department of the medical colleges, after the initial screening, the patients can be referred to district or medical college run memory clinic for detailed workup if needed.

121. In all cases follow-up support like information and advice to the family can be provided either though the state dementia helpline or Support Group meeting or the Vayomithram Coordinators.

122. *Community intervention and care facilities for dementia persons.* Old age homes are mushrooming in Kerala. As noted earlier, there are 14 old age homes and 7 MahilaMandirams in the state under the social justice department, each with average intake of 50 inmates. Apart from these, Local Government institutions also operate homes for the aged. Neither the environment nor staffs of the old age homes is dementia friendly, although most old age homes could have 5-10 residents with dementia, whose illness is mostly undiagnosed and unrecognized. Keeping this in mind the old age homes have to be equipped with dementia friendly environment and dementia trained staff. Adequate facility for caring persons with dementia should be established in each Home, including at least two more additional dementia trained carers. The existing carers should also be trained in dementia care. In this case additional costs need to be incurred only for appointing additional caring staff or multipurpose workers. Exclusively dementia day care centers/Respite care/Fulltime care centers accommodating 20 people with dementia can also be planned in unused buildings owned by social justice/health/LSG departments. In this case, entire new staffs have to be

appointed and equipment and materials purchased. A public private partnership model can be considered, to minimize the cost burden of the government.

123. *State dementia helpline.* The State Dementia Helpline can provide confidential information and support to anyone who needs information or wants to share their concerns on dementia or related issues. It can offer guidance for people with dementia, their families, carers, and professionals.

Psycho social Rehabilitation of the Paraplegic

Context

124. There are patients who develop significant paralysis and who need psycho-social and medical support to improve general condition and to get back to mainstream society. A paraplegic care centre has been established with the technical support of Palium India. This in-patient rehabilitation service centre takes care of 4 patients every month during which time their physical condition will be optimized, psycho-social issues assessed and addressed; they are provided training in some activity aimed at earning capacity. The unit functions in a rented building and has regular service of doctors, nurses, physiatrist, psysiotherapist and social workers, and also of visiting consultants. There is a need to identify physical, psycho-spiritual and social issues of people with spinal injury or stroke and to rehabilitate them physically, psycho-spiritually and socially, as useful members of the community.

125. In Kerala, a large number of people, mostly young individuals, live with spinal injury. The most common causes are falls from trees, falls from construction sites and road traffic accidents; other diseases like spinal tumours accounting for only a small number of incidents. All three categories of injuries happen most often to young men in their ages of twenty to thirty. The consequence, almost invariably, is paralysis from the waist down (paraplegia).

126. The consequences of this injury on the person and the family are unimaginably catastrophic. The vast majority of them are earning members; sometimes the only earning member in the family. Many have been married for a short while, and have one or two children. The injury, very often results in an initial course of treatment. The injury being unexpected, usually the patient will be taken in an ambulance to the nearest hospital, understandably many being on the corporate sector, this results in huge cost of investigations, including imaging scans, and usually a surgical procedure to fix the spine. The economic impact of such treatment very often destroys families completely, and by the time the patient gets back home, the family is in a debt trap already.

127. Physically, at this point, the patient would come home with several medical problems including bladder dysfunction, which necessitates an indwelling catheter in the bladder. This is not usually the best option; intermittent self-catheterisation of bladder is what suits the patient best. Unfortunately, despite all the expensive treatment, the necessary health education is almost invariably not given to the patient and family. If the patient has not

acquired a pressure sore in the hospital, they may do so in the first few weeks of care at home. In the absence of adequate physiotherapy at home, possible recovery of muscles in the partially injured area becomes less likely. Even in the uninjured upper half of the body, muscles slowly waste away. Sometimes, lack of exercise causes the patient to put on weight; some of the medicines prescribed at this stage may also cause weight gain. This weight gain further hinders proper care, adding to the problems.

128. Emotionally, understandably, the patient and family are devastated and a good number of patients go into clinical depression. In the usual setting in our country, this goes undetected, often resulting in suicidal tendencies for the patient and often for the spouse.

129. The patient is socially isolated. In the first month of care, the patient may get a lot of visitors but gradually, this stops and the patient is physically isolated. Once the spouse or other members of the family go for work, the patient would be left all alone from morning till late evening. As the patient is physically ill and emotionally and socially vulnerable, often there is associated irritability which causes difficulties with social relations within the family. Though not common in our country, a patient may be abandoned by a spouse. Even if this does not happen, almost invariably the patient feels himself to be a burden on the family.

130. The consequences on the next generation are also huge, though less recognised. In addition to the fact that the financial implication often changes the lifestyle of the family, very commonly it affects the nutritional status of children adversely. It is very common to find children being forced to drop out of school. The emotional stress of the parents reflects on the children, unfortunately resulting in possible behavioural disorders.

131. These individuals and their families need support. It is the responsibility of any cultured society to lend a hand to people who have disabilities. Low cost interventions can change many lives dramatically, thus improving the health of not only that person and the family, but of the society as a whole.

132. Much of the suffering of the patient and the family is avoidable. The palliative care community in Kerala has embraced care of the paralysed among its responsibilities. Palliative care is treatment aimed at quality of life of patients with life-limiting disorders and their families. It assesses problems that threaten quantity or quality of life and intervene by addressing physical, psychological, social and spiritual issues.

133. Non-governmental organizations engaged in palliative care as well as the government's healthcare system have joined hands with the Department of Social Justice, following declaration of Kerala's Palliative Care Policy in 2008, to take care of these people. Precise statistics are not available; but there have been claims in northern Kerala that 60% of these people receive some sort of care at home. Unfortunately, this care is often limited to a monthly visit by a nurse to the patient's home and change of a urinary catheter at home. This, in itself, becomes a huge financial and physical boon for the patient, though it touches only the fringe of the problem.

Proposals

134. The lives of these patients and their families can be dramatically changed by the following aspects of care
    1. *Physical*. The mainstay of care lies in empowerment of the family in caring for the person. The few days of physiotherapy which some patients might have received during initial hospitalisation become pointless when no such care is available at home, but most patients have willing family members eager to help. By empowering them to perform basic physiotherapy pressure sores can be strengthened, recovering muscles can be further improved and the uninjured part of the body can be strengthened. In addition, the patients can be mobilised. We find that many of these patients are needlessly bed-bound, and can be mobilised with a wheelchair. Providing a wheelchair alone is not enough; it is important to empower the person to be as independent as possible. The patient is taught to use the uninjured part of the body, to move independently from the bed to a wheelchair. Similarly, patients with some strength left in their low limbs can be taught to exercise themselves on parallel bars which can be installed within a home at negligible cost.
    2. *Psycho-spiritual support*: In addition to treating clinical depression, the patients need help to get out of the self-pity to which they are plunged and to become independent as much as possible. They need someone to listen to them and sometimes to facilitate initiation of an open communication between the patient and the spouse and sometimes between the remaining family members. The person may also be asking himself, "What is the meaning of my life?" Here again, some skilled counselling can result in dramatic changes.
    3. *Social support*: Essential social support can also be provided by empowering the person to earn for himself, when the upper half of the body is healthy and once the patient is mobilised on a wheelchair. Many patients have learned a variety of skills including painting, screen printing, jewellery making etc.

Palliative Care

135. Estimates show that 0.4% of the total population of the state qualify for palliative care Thanks to the LSGI programs in palliative care, there is a basic home care network for the incurably ill, bedridden and dying patients in the state. There is also good community participation and volunteer support in these programs. NRHM and Government Health Services also play a role in delivery of services. There is a lot of overlap between the needs of the elderly and palliative care population. In fact, more than 70% of the palliative care patient population are above the age of 60. There is no system of accreditation of services/ personnel, quality control and refresher training.

136. *Medical and social support for old people and differently abled*. Various schemes by different departments (Social Justice, Health, Education and LSGI) are available. All are patchy and work in isolation with each other. There is a lot of confusion among stakeholders on which all schemes are available, who all qualify and how to access. There is no proper system to coordinate services and guide beneficiaries. There are huge gaps in accredited skilled

manpower in caring sector at the grassroots level. None of the so called home nurses today are trained, monitored or supervised. There is lack of coordination between services available for each of the above sectors.

Proposals

1. Social Justice Department to form an agency/ mission to take a lead role in coordinating existing services by various departments, developing new services wherever necessary and in ensuring monitoring and quality control.
2. A proper accredited training program for carers at grass root level to be developed. Two options are available
    1. To evaluate, modify and accredit the existing three month course for community nurses run by training centres in palliative care
    2. To make use of the one year nationally accredited Certificate Program offered by Government of India through Composite Regional Centres. The new CRC in Kozhikode can run this course. The second option looks better in view of acceptability in other states also.
3. Helpdesks to be established in all districts to act as single window guidance cells for all the three target groups.
4. Orientation programs to be developed for stakeholders.

CHAPTER 4
MONITORING AND EVALUATION OF SAFETY NET PROGRAM

137. The need to ensure transparency and accountability in the implementation of safety net programmes cannot be stressed enough. For this, there is need for an innovative administrative system and an integrated monitoring system at the state level. Given the highly decentralized functioning in the state, the involvement of local government in such monitoring will be most effective in enhancing transparency and accountability. Development literature suggests that a results framework for a social security program should focus on achieving three key outcomes for vulnerable populations and those at risk of becoming vulnerable. There are three broad outcomes for which an effective social safety net should aim. These are: (i) Increased Economic Security; (ii) Improved Human Capabilities; and (iii) Enhanced Resilience. Input, output, and outcome indicators should be associated with this framework.

138. *Typing programs***.** Thus, each social security program must be typed based on which of the above results it intends to contribute to. Thus, a pension program for widows, which contributes to the first, may be typed as Type 1. One that contributes to all results may be typed separately as Type 4. Or it may be contributed by percentage. That is, for example, the MGNEGRA contributes to say 50% of the first dimension, and 25% to each of the other two. Such codification must be carefully done after all the programs are fully listed. There may be need for a more complex system of typology.

139. As is, monitoring is fragmented across departments, focused on inputs and outputs, and it is a great challenge to understand if the wide range of existing interventions is supporting the desired outcomes. Box 3 provides an illustrative sample of key performance indicators associated with each of the above 3 desired outcomes. It is based on the assumption that the Planning Board wishes to have a unified monitoring system, which is implemented at the department levels, and then aggregated at various levels.

140. Each department must identify the dimensions to which the program/s will contribute, and select a few key performance indicators (from an agreed list) to assess its contribution. It can then measure progress in achieving these indicators, and to better understand the results of its interventions. This will allow aggregation of results from a project to a program to a sector/department and to state levels. See Box 3 for examples of key indicators (including process and output indicators) for few of the expected outcomes. It is to be noted that these indicators are not exhaustive and specific output indicators needs to be formulated for each of the targeted strategies to achieve the desired outcomes.

Box 3 *Examples of key indicators (including process and output indicators) for few of the expected outcomes*

1. *Key Performance Indicators* (A comprehensive List to be discussed at workshop and agreed for all dimensions – only a sample suggested for discussion and to show possibilities of assessing outcome. The list will need to ensure that it is precise and not too long, but yet at the same time cover all programs)
    1. *Improved Protection for Vulnerable Groups*
        1. % of beneficiaries of each vulnerable group(orphans, the elderly, single women with children, widows, people living with HIV, people with disabilities, patients of TB and other chronic illnesses, etc.) who receive income, in-kind, psychosocial support, or adequate social care
        2. Number of scholarships for primary/secondary school children focusing especially on children vulnerable to child labour such as ST/SC/Coastal Areas/TG
        3. Number of Beneficiaries of MGNEGRA programme by gender, vulnerable variables, and average wage
        4. % of poor elderly, chronically ill and disabled people benefitting from social assistance as part of total number of the group
        5. Number of men and women benefitted by work injury as a % of total number in the group
        6. Increased access to information on available social security schemes through one stop centre or help desk
    1. *Increased Economic Security*
        1. Increased wages or income disaggregated by gender through decent livelihood support
        2. Men, women, TGs receiving pension by type increased from xx% in 2017 to 100% by 2022
        3. Others including right to shelter, and so on
    2. *Improved Human Capabilities*
        1. % of beneficiaries where social assistance contributed to increased food consumption and improved health as assessed say by reduced number of visits by household members to PHC;
        2. Challenged/Vulnerable children participating in education increased to 100 percent in the State by 2022;
        3. Patients receiving palliative care increased to 100 percent in state (aggregating from Panchayat and district levels) by 2022 (baseline for 2017: 70%)
        4. Stunting of children reduced at the state level from xx% in 2012 to xx percent in 2022
        5. Maternal mortality rate reduced from 42 per 1000 in 2016 to 12 in 2022 (?)
        6. Reduce by one-half the prevalence of underweight among children and adults by xxxx

7. Reduce by one-half the prevalence of anemia among women and children by xxx
8. Reduce by half the low birth weight cases by xxx
9. Eliminate iodine deficiency and vitamin A deficiency and disorders by xxx
10. Universal Access to treatment for malnourished women and sick children by xxx
11. Reduce by half the prevalence for post-partum obesity and adult obesity by xxx
12. Increase the per capita consumption of fruits and vegetables by 25 percent by xxx
13. Reduce by 2/3 the prevalence of underweight and anemia in SC and ST population by xxx
14. Halt the increase in prevalence of diabetes and cardiovascular diseases by xxx

3. Enhanced Resilience to Risks:

1. % of beneficiaries who borrowed less (in amount) than the previous year
2. Savings increased by xx% from previous year
3. Increased awareness of their basic human rights

2. *Indicative list of higher-level Outputs* (Must be collected by each Department and aggregated by panchayat, block, district, and state levels):
    1. % of government budget allocated for social protection net program for the state and by district during a particular reference period (by type) (*this will require each program or project to be codified by type* – this could be around desired results)
    2. Total average cash transferred through social assistance during a particular reference period (this refers only to all social assistance schemes) to beneficiary in a particular location (district) and during a particular reference period
    3. Percentage of targeted groups among beneficiaries of all social safety net programs (by gender, community (SC/ST/Coastal areas/BPL). Elderly, challenged, chronically ill, prisoners and so on)
    4. State-level capacity development training programs in this area including number of workshops, number of people trained against the target etc.

CHAPTER 5
SOCIAL AUDIT OF SOCIAL PROTECTION PROGRAMMES

141. There has been a growing demand that the approach to social sector programmes and schemes should progressively shift to a rights based framework. Rights based initiatives, including the Right to Information which empower people to make informed decisions, are now increasingly getting embedded within the realm of social protection as well.

142. The enactment of the MGNREGA established legal guarantee to the right to work. The mandatory provision of Social Audit within this enactment established the right of ordinary people to engage themselves in the planning, implementation and monitoring of the works undertaken under MGNREGS. It also established the right of workers and the local community to engage in public hearings to openly discuss the merits and demerits of programme implementation. The MGNREGS mandates that an independent mechanism outside the implementing agency be established for conducting social audit. Under MGNREGS Social audit is carried out by Village Social Auditors who comprise of workers or their children. The independent social audit agency builds the capacity of the Village Social Auditors. Village Social Auditors conduct verification of files and work sites, interact with the workers and officials of the implementing agency, organise exclusive gramasabha meeting for social audit and facilitate open discussion regarding the implementation of MGNREGS. Social audit in the context of MGNREGA strives to make both the panchayats and the implementing agency accountable to the people for their responsibilities, thereby paving the way for transparency, accountability, grievance redressal and people's participation in the implementation of the scheme. It is an empowering process whereby beneficiaries jointly monitor the scheme and involve in the task of verification.

143. The Governor's address to the legislative assembly in June 2016, underlined the need for social audit in all sectors including social welfare and public works. Further, in his budget speech for 2016-17, the Finance Minister, reiterated the need for social audit of the local government system and declared that an independent professional social audit system would be put in place.

144. In 2014-15, the Social Justice Department initiated a Social Audit of the ICDS scheme with technical support of the Kerala Centre of the Tata Institute of Social Sciences (TISS), Mumbai for developing a methodology for the social audit of ICDS and capacity development. A Manual for Social Audit has also been developed. A team of 40 CDPOs and Supervisors from across the state has been trained in Social Audit, to facilitate further scaling up. If Social Audit is extended to social protection programmes it will help to enhance access, transparency, accountability, grievance redressal and community participation in programme implementation.

CHAPTER 6
WAY FORWARD

145. Vulnerability arises from risks and insecurity caused by various factors. Social protection system helps to absorb the shocks and minimise adverse impacts. It helps the poor not to resort to negative coping strategies like selling livelihood assets, reducing consumption, migration, spending from savings, pulling children out of schools etc. in the face of crisis. It covers both deprivation and contingencies and prevents, reduces or eliminates economic and social vulnerabilities to deprivation. It plays a key role in strengthening resilience of the poor."Social security system contribute not only for human security, dignity, equity, and social justice, but also provides a foundation for political inclusion, empowerment and the development of democracy" (Juan Somavia, ILO).

146. The framework of a Rights Based Social Protection Floor for the State will consist of the following key elements, namely, (i) protective measures for the formal sector(ii) promote measures like (a) improved earnings in the informal sector, (b) social assistance pensions, (c) public employment like MGNREGS, (d) food security: PDS, ICDS and Mid-Day Meal Programme and (iii) protection of the excluded social groups like people with disabilities, older people, victims of abuse, transgender, migrant labourers etc. The Social Protection Floor should lay down clear-cut entitlements backed by legislation.

147. In Kerala, the local governments can formulate their own social protection floor consisting of the following six dimensions of social protection (a) primary education, nutritional status and health of children (b) employment and livelihood security with the MGNREGS in the central place (c) social pensions for the elderly, widows, persons with disabilities and agricultural labourers (d) health protection (e) food security and (f) housing, water and sanitation.

ANNEXURE 1

Composition of the Working Group on Social Protection and Welfare

Sl No	Name	Status in the Working Group	Designation
1	Dr K.M. Abraham IAS	Co-Chairperson	Addl. Chief Secretary to GoK, Finance Department.
2	Ms T. Radhamony	Co-Chairperson	President, Kerala Working Women's Association
3	Sri. Balakiran IAS	Member	Secretary to GOK, Social Justice Dept.
4	Sri. A. V. Jose	Member	Visiting Fellow, Centre for Development Studies
5	Ms K.B. Valsalakumari	Member	Former Executive Director, Kudumbasree, GoK
6	Sri. S. Padmakumar	Member	Secretary, Kerala State Social Welfare Board
7	Dr D. Narayana	Member	Director, GIFT
8	Dr Samuel N Mathew	Member	Executive Director, NISH
9	Sri. V. N. Jithendran	Member	Former Director, Social Justice Department, GoK
10	Sri. MuralidharanVishwanath	Member	Secretary, National Platform for the Rights of the Disabled, New Delhi
11	Ms Sonia George	Member	Secretary, SEWA, Thiruvananthapuram
12	Sri. James Mathew	Member	INSIGHT Project Co-ordinator
13	Dr Suresh Kumar	Member	Technical Advisor, Institute of Palliative Medicine, Kozhikode
14	Dr Mathews Numpeli	Member	Medical Officer, PHC, Ayavana
15	Dr P.K.B. Nayar	Member	Chairman, Centre for Gerontological Studies, Kochulloor, TVPM
16	Sri. Venugopalan Nair	Member	State Co-ordinator, National Trust
17	Sri. V.S. Venu	Member	Managing Director(i/c), Kerala State Handicapped Persons Welfare Corporation
18	Dr MuhammedAsheel	Member	Executive Director, KSSM
19	Sri. AmaravilaRamakrishnan Nair	Member	Secretary, Senior Citizens Friend's Welfare Association, TVPM
20	Ms Sreerenjini	Member	Programme Co-ordinator, KSSM
21	Dr MiniNair	Member	State Co-ordinator, Nirbhaya Cell, Social Justice Dept.
22	Ms ShilaUnnithan	Convenor	Chief, Social Services Division, State Planning Board
23	Sri. M. Thomas	Co- Convenor	Deputy Director, Social Services Division, State Planning Board

ANNEXURE 2

Composition of the Drafting Committee

Sl. No.	Name	Designation
1	Sri. V. N. Jithendran (Chairperson)	Former Director, Social Justice Department, GoK
2	Dr MuhammedAsheel (Co- Chairperson)	Executive Director, KSSM
3	Dr P.K.B. Nayar	Chairman, Centre for Gerontological Studies, Kochulloor, TVPM
4	Sri. Venugopalan Nair	State Co-ordinator, National Trust
5	Ms K.B. Valsalakumari	Former Executive Director, Kudumbasree, GoK

ANNEXURE 3

PROCEEDINGS OF THE MEMBER SECRETARY STATE PLANNING BOARD

(Present: Sri. V.S.Senthil IAS)

Sub: Formulation of Thirteenth Five-Year Plan (2017-22) – Constitution of Working Group on **Social Protection and Welfare** -Orders issued.

Ref: Note No. 260/2016/PCD/SPB Dtd: 6/09/2016 of the Chief, PCD, State Planning Board

No.298/2016/SS (W12)/SPB Dated: 19/09/2016

As part of the formulation of Thirteenth Five-Year Plan, it is decided to constitute 14 Working Groups under Social Services Division. Accordingly, the Working Group on **Social Protection and Welfare**is hereby constituted with the following Co-Chairpersons and Members.

Co-Chairpersons

1. Dr. K.M. Abraham IAS, Addl. Chief Secretary to Government, Finance Department, Govt. Secretariat.
2. Ms. T. Radhamony, Member of the Executive Committee, KSSP and President, Kerala Working Women's Association, Near Co-Bank Towers, Vikas Bhavan P.O., Thiruvananthapuram.

Members

1. Ms. T.N. Seema, ex- Rajya Sabha MP, State President, AIDWA, Thiruvananthapuram
2. Sri. Balakiran IAS, Director, Social Justice Department, Thiruvananthapuram
3. Sri. A.V. Jose, Visiting Fellow of CDS,TC 5/53/2, Ulloor-Akkulam Lake Road, Thiruvananthapuram -695017
4. Ms. K. B. Valsalakumari, Former Executive Director, Kudumbashree, SKNRA 134,Sree Krishna Nagar, Jagathy, Thiruvananthapuram – 695014
5. Sri.S. Padmakumar, Secretary, Kerala State Social Welfare BoardSasthamangalam, Thiruvananthapuram - 695010
6. Dr. D. Narayana, Director, GIFT, Thiruvananthapuram
7. Dr. Samuel N. Mathew, Executive Director, NISH, Akkulam P.O., Thiruvananthapuram
8. Sri. V.N. Jithendran, Former Director, Social Justice Dept., Swasti, Udayagiri, Thiruvananthapuram 695587
9. Sri. Muralidharan Vishwanath, Secretary, National Platform for the Rights of the Disabled, 36, Pandit Ravishankar Shukla Lane, New Delhi -110001
10. Ms. Sonia George, Secretary, SEWA, Thiruvananthapuram

11. Sri. James Mathew, Insight Project Co-ordinator, Federation of the Blind,Netaji Nagar, Plamood, Thiruvananthapuram- 695033
12. Dr. Suresh Kumar, Institute of Palliative Medicine, Kozhikode
13. Dr. Mathews Numpeli, Medical Officer , Primary Health Centre (PHC), Ayavana, Ernakulam
14. Dr. P. K. B. Nair, Chairman, Centre for Gerontological Studies, Kochulloor, Thiruvananthapuram- 695011
15. Sri. Amaravila Ramakrishnan Nair, Secretary, Senior Citizens Friends' Welfare Association, Thiruvananthapuram
16. Ms.S. Sreerenjini, Programme Co-ordinator, Kerala Social Security Mission, Poojapura, Thiruvananthapuram
17. Dr. Mini S. Nair, Nirbhaya, Social Justice Department

Convener

Smt. Shila Unnithan, Chief, SS Division, State Planning Board

Co-convener

Sri. M. Thomas, Deputy Director, SS Division, State Planning Board

Terms of Reference

1. To review the development of the sector with emphasis as to progress, achievements, presentstatus and problems under its jurisdiction during the 11th and 12th Five-Year Plan periods.
2. To evaluate achievements with regard to the plan projects launched in the sector, both by the State Government and by the Central Government in the State during these plan periods.
3. To list the different sources of data in each sector and provide a critical evaluation of these data sources, including measures for improvement.
4. To identify and formulate a set of output and outcome indicators (preferably measurable) for each sector and base the analysis of the previous plans on these indicators.
5. To outline special problems pertaining to, inter alia (a) evolving a strategy which recognises social security as an instrument for the provision of State-level social protection (b) to ensure inclusive development for all socially vulnerable sections through appropriate policies pertaining to institutions and homes.
6. To suggest, in particular, a set of projects which can be undertaken during the 13th Plan period in the sector. In particular explore the possibilities of a comprehensive social security system and its financial implications.
7. The Co-Chairpersons are authorised to modify terms of reference with approval of State Planning Board and are also authorised to invite, on behalf of the Working Group, experts to advise the Group on its subject matter. These invitees are eligible for T.A and D.A asappropriate.

8. The working group will submit its draft report by 1st December, 2016 to the State Planning Board.

The non-official members of the Working Group will be entitled to Travelling Allowances and Daily Allowances as applicable to Class I Officers of the Government of Kerala. The Class I Officers of Government of India will be entitled to travelling allowances and Daily Allowances as per rules if reimbursement is not allowed from departments.

Sd/-
V.S. Senthil IAS
Member Secretary

To

The person concerned
The Sub Treasury Officer, Vellayambalam
Copy to:

The Accountant General, Kerala (A&E) with C/L
All Divisions, State Planning Board
P.S. to Vice Chairman, State Planning Board
C.A. to Members
P.A. to Member Secretary
C.A. to Sr. Administrative Officer
Computer Section, Accounts Sections
Stock File

Forwarded/By Order
Sd/-
Chief, Social Services Division
State Planning Board

PROCEEDINGS OF THE MEMBER SECRETARY
STATE PLANNING BOARD

(Present: Sri. V.S.Senthil IAS)

Sub: Formulation of Thirteenth Five-Year Plan (2017-22) – Constitution of Working Group on **Social Protection and Welfare** –Orders issued.

Ref: - 1. Note No. 260/2016/PCD/SPB Dtd: 6/09/2016 of the Chief, PCD, State Planning Board

2. This Division order of even No. dated 19/9/2016

No.298/2016/SS (W12)/SPB Dated: 14/10/2016

As part of the formulation of Thirteenth Five-Year Plan, the Working Group on **Social Protection and Welfare** was constituted vide order referred 2nd above. In the first meeting of the Working Group held on 26/9/2016, it was decided to include the State Co-ordinator, National Trust, Managing Director, Kerala State Handicapped Persons Welfare Corporation and the Executive Director, Kerala Social Security Mission in the Working Group as Members. In the circumstances, the following persons are hereby included in the Working Group of Social Protection and Welfare.

Members

1. Sri. Venugopalan Nair, State Co-ordinator, National Trust
2. Sri. V.S. Venu, Managing Director(i/c), Kerala State Handicapped Persons, Welfare Corporation, Thiruvananthapuram
3. Dr. Muhammed Asheel, Executive Director, Kerala Social Security Mission, Thiruvananthapuram

Sd/- V.S. Senthil IAS
Member Secretary

To

1. The person concerned
2. The Sub Treasury Officer, Vellayambalam

Copy to:

The Accountant General, Kerala (A&E) with C/L
All Divisions, State Planning Board
P.S. to Vice Chairman, State Planning Board
C.A. to Members
P.A. to Member Secretary
C.A. to Sr. Administrative Officer

Finance Officer, P.P.O, Publication Officer,
Computer Section, Accounts Sections
Stock File

Forwarded/By Order
Sd/-
Chief, Social Services Division
State Planning Board