GOVERNMENT OF KERALA
KERALA STATE PLANNING BOARD

THIRTEENTH FIVE-YEAR PLAN (2017-2022)

WORKING GROUP ON

CHILD DEVELOPMENT AND NUTRITION

REPORT

SOCIAL SERVICES DIVISION

KERALA STATE PLANNING BOARD
THIRUVANANTHAPURAM

MARCH 2017

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 AYUSH. The Chairpersons of the Working Group were Sri A Shajahan IAS and Dr MKC Nair. 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 Working Group on "Child Development and Nutrition" constituted by the Kerala State Planning Board under its Social Services Division has intended to identify the critical gaps in the holistic development of all children in the State and to set a road map to ensure a clean environment for them during the 13th Five Year Plan (2017-22) period. The working group has also mandated to review, evaluate, analyze existing programmes on child development and make recommendations. The composition of the working group is given in Annexure-1.

The working group in its first meeting held on 30/09/2016 broadly discussed the challenges in the sector and the major thrust areas on child rights. Apart from individual presentations by almost all working group members at the second meeting on 22nd October, 2016 the group was further divided into subtheme groups and a drafting committee set up for report writing. The composition of the drafting committee is given in Annexure-2. The working group met further on 6th December, 2016 and finalized the report.

We are grateful to the members of the working group for the effort they have put in for preparing the report more worthy. 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/-

Dr. M.K.C Nair

Vice Chancellor of KUHS & Co- Chair of the Working Group

Sd/-

A. Shajahan IAS

Secretary to Govt. & Co- Chair of the Working Group

CONTENTS

LIST OF ABBREVIATIONS

1.	ANC	Antenatal care
2.	ASD	Autism Spectrum Disorder
3.	ASHA	Accredited Social Health Activist
4.	AWW	Anganwadi worker
5.	BCC	Behaviour Change Communication
6.	CDC	Child Development Centre
7.	DLHS	District level house hold and facility survey
8.	EDSF	Energy Dense Special Food
9.	FYP	Five Year Plan
10.	GIS	Geographic Information System
11.	ICDS	Integrated Child Development Services
12.	IEC	Information education communication
13.	IFA	Iron folic acid
14.	IMNCI	Integrated Management of Neonatal and Childhood illness
15.	IMR	Infant mortality rate
16.	IMSAM	Introduced the Management of Sever Acute Malnutrition
17.	IYCF	Infant Young Child Feeding
18.	LD	Learning Disability
19.	MAM	Moderate Acute Malnutrition
20.	MCP	Mother and child protection
21.	MMR	Maternal mortality rate
22.	NNF	National Neonatology Forum
23.	ORC	Our Responsibility to Children
24.	PCOS	Poly Cystic Ovarian Syndrome
25.	PMDD	Pre Menstrual Dysphoric Disorder
26.	PMS	Pre Menstrual Syndrome

27.	PRI	Panchayati Raj Institutions
28.	RSOC	Rapid survey on children
29.	SAM	Severe Acute Malnutrition
30.	SOP	Standard Operating Procedure
31.	THR	Take Home Ration
32.	TORCH	Toxoplasmosis Other Infections, Rubella, Cytomegalo virus, Herpes
33.	ToT	Training of Trainers
34.	VHND	Village health nutrition day

CHAPTER 1
OVERVIEW OF ELEVENTH AND TWELFTH FIVE YEAR PLANS

Introduction

1. Kerala has made good reputation in addressing the rights of children and their development. As per 2011 census the children in the age group of 0 to 18 constitute less than 30% of the total population of Kerala. While those between the ages 0-6 years constitute only 10% of the population.

2. In Kerala, there are 32 Govt. welfare institutions, 1204 registered welfare institutions run by NGOs, 18 specialized adoption agencies, 5 recognized adoption placement agencies for inter-country adoption and 20 licensed adoption placement agencies for the care and protection of children. Child Protection Units, Child Welfare Committees, Special Juvenile Police Units, State Child Protection Society and District Child Protection Units and JJ Boards have already been established in the entire district to speed up implementation of the provisions contained in the JJ Act. Special courts have already been notified in the State to expedite the trial of cases registered under POCSO ACT, 2012. Childline service is now available in 15 cities, of which 12 in urban and 3 in rural.

3. All the above, a State Commissionerate was set up in the State in 2013 to examine and review the existing laws for the protection of child rights, inquire into cases of violation of child rights, look into factors inhibiting the enjoyment of those rights and suggest remedial measures etc. Also, there exists 37426 BalaSabhas, a neighbourhood network of children in LSGIs under Kudumbasree for ensuring children's participation in decision making processes.

Eleventh Five Year Plan (2007-2012)

4. The budgetary allocations for child rights have been delineated under the head of social security and welfare. The 11th plan focus of child rights sectors was to implement specific activities proposed in the State Plan of Action for the Child in Kerala-2004. About 5% of the budget allocation of Social security and welfare sector in the 11th plan goes to child rights activities and programmes.

5. Nutrition programme for adolescent girls, Integrate Child Protection Scheme and Development of AnganwadiCentres as Community Resource Centres were the schemes for which major budget allocation provided. Cancer Suraksha for child patients and Thalolamscheme for children below the age of 18 years who are suffering from life threatening diseases were the major child specific programmes implemented. Sruthitharangam project intended for cochlear implantation in children was one of the new initiatives of this plan period.

Twelfth Five Year Plan (2012-2017)

6. In 12th Plan, the approach was to address the key elements of child developments through extending the coverage of ICDS and by ensuring quality oriented services to the beneficiaries of care homes and orphanages. During this plan period, the percentage share of budget allocation under the social security and welfare sector for child specific programmes increased from 5% in 11th plan to 12%. Above all, the state plan allocation for the much needed ICPS scheme stands increased from Rs.6crore in 11th plan to Rs.36crore in 12th plan. In order to strengthen and universalize ICDS, Rs.38crore has been allocated to Anganwadi constructions. During this plan period, the KSSM has been provided budget allocation of Rs.139crore to provide social security to children through Thalolam, Snehapoorvam, Cancer suraksha and Cochlear implantation schemes.

Review of Major Schemes on Child Development and Protection

7. In Kerala, the schemes for the welfare, development and protection of children are mainly implemented by the Department of Social Justice, Health and Family Welfare Department and Kerala Social Security Mission. Review of various developmental programmes and schemes is listed below.

Integrated Child Protection Scheme

8. This centrally sponsored scheme provides preventive, statutory care and rehabilitation services to children who are in need of care and protection and children in conflict with law. State Child Protection Unit, State Child Protection Society, District Child Protection Society, Child Welfare Committee, Juvenile Justice Board, etc. are the major components under this scheme. The programmes related to various social legislations like Child Marriage Restraint Act, Kerala Beggary Prevention Act, programmes on Child Right Convention, adoption related laws, etc. are also being implemented under the scheme. During 2015-16, the various activities of ICPS benefited 8120 children.

Cancer Suraksha and Thalolam Schemes for Child Patients

9. These schemes of KSSM give free treatment through Government approved hospitals to children below 18 years who are suffering from cancer and life threatening diseases. During the 12th plan up to 2015-16, the cancer suraksha scheme benefited 15273children and the Thalolam scheme 32934 children.

Psycho Social Services for Adolescent Girls

10. This scheme of Social Justice Department provides counseling and guidance support to adolescent girls. The department has so far developed separate adolescent health clinics in 807 selected schools with the support of concerned PTAs and LSGIs.

New schemes of 12th Plan

Cochlear Implantation in Children

11. The project of KSSM provide cochlear implant to children in the age group of 0-5 years selected by regional and state level technical committees and to provide financial support for Auditory Verbal Habilitation (AVH) to operated children through empanelled hospitals. The project assisted 629 children till March, 2015-16.

Snehapoorvam

12. Kerala Social Security Mission provide financial assistance to children who lost both parents or either of them and the other alive parent is not in a position to look after the child due to financial crisis. The amount of assistance is as follows.
    1. Children below 5 years and class I to V @ Rs.300/pm
    2. For class VI to class X @ Rs.500/pm
    3. For class XI and class XII @Rs.750/pm

13. This programme benefited 109585 children till March, 2016.

Our Responsibility to Children inKerala

14. This is a project implemented by the Department of Social Justice offers psycho-social and emotional support to children to prevent social deviation with the support of other stakeholders like police, education, LSGD, health etc. The project was implemented in 36 selected schools in Trivandrum, Kozhikode, Ernakulam and Thrissur districts.

First 1000 Days Programme for Infants in Attappadi

15. This is a special programme by Social Justice Department for infants in Attappadi focusing on early initiation of breastfeeding, timely introduction of complementary foods at six months, hygienic complementary feeding practices and full immunization and vitamin A supplementation with de-worming, etc. So far the programme benefited 5528 children in Attappadi.

GIS Based Mother and Child Health Tracking System in Mananthawadi Block

16. This is a pilot programme run by Social Justice Department for tracking the health status of pregnant women and children in Mananthawadi block of Waynad district with the support of the JATAK and JANANI software applications. The health condition of 15128 children in Mananthawadi block is being monitored through this programme.

Model Anganwadis

17. Model Anganwadi is a concept of bringing the aged persons for sharing their experience with the children below six years, adolescent girls and mothers into a common centre. The centre shall have facilities for all the functions of the regular Anganwadi along with a separate reading room for the elderly. Out of the 115 model Anganwadis for which administrative sanction has been obtained 44 were completed. In addition to this administrative sanction has been obtained for constructing 700 regular Anganwadis under NABARD RIDF scheme, of which 193 were completed.

Nutrition

18. The Department of Social Justice and Health and Family Welfare are implementing various child centric policies and programmes which are vigorously attending the issues related to nutrition. The State Nutrition Bureau and Nutrition Research Centre are also conducting awareness programmes and advanced biochemical research studies, short term community nutrition research studies and survey to monitor the nutritional problems and development of people in the State.

19. The budget outlay of the Nutrition sector for 12th plan was Rs.377.82Crore. Out of this, Rs.127.05Crore was expended as on 31st July, 2016 which is 34% of the budget outlay. In order to provide nutritional security to all, the 12th plan has been visualized to establish an independent nutrition surveillance system in the state to monitor the status of nutrition. It also emphasized to the effective implementation of ICDS and related interventions and establishing Nutrition Rehabilitation Centres for identification and treatment of severely malnourished children.

Review of Major Programmes on Nutrition

20. *Integrated Child Development Services (ICDS).* ICDS is one of the flagship programmes of GOI, aims at early childhood development by providing an integrated package of services such as supplementary nutrition, immunization, health check-up, referral service, health and nutrition education and pre-school education to children less than 6 years along with pregnant and lactating mothers.

21. As on March, 2015, 258 ICDS projects and 33115 AWCs are operational across the state, covering 10.14lakh beneficiaries under supplementary nutrition programme and 4.44lakh children in the age group 3-6 years under pre-school education.

22. *Rajiv Gandhi Scheme for Empowerment of Adolescent Girls.* As a centrally sponsored scheme, launched in Kollam, Idukki, Malappuram and Palakkad districts, it aims at empowering the nutritional and health status of the adolescent girls in the age group of 11-18 years through 84 ICDS projects of the districts. Extending the scheme to the districts covering coastal and tribal areas of the State was the latest development. During the 12th plan up to 2015-16, the scheme assisted 5.13lakh beneficiaries.

23. *KisoriSakthiYojana*. This is a centrally sponsored scheme with the objective to improve the nutritional status of adolescent girls in the age group of 11 to 18 years by using the platform of ICDS. The activities proposed are vocational training to adolescent girls, health and nutrition day celebration including health clinic activities, monitoring and evaluation at different level, orientation, etc. During the 12th plan up to 2015-16, the scheme assisted 10.61 lakh adolescent girls.

CHAPTER 2
INTRODUCTION

24. UN Convention of the Rights of the Child states that for the purpose of the present convention, a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier. In order to achieve the same, focus has to be given to the four pillars (i) the right to survival, (ii) the right to protection, (iii) the right to development and (iv) the right to participation as envisaged in the UN convention. Accordingly, the Indian Parliament have brought in many acts to protect the childlike;
    1. Juvenile Justice (Care and Protection of Children) Act, 2015
    2. Protection of Children from Sexual Offences (POCSO) Act, 2012
    3. Right of Children to Free and Compulsory Education Act, 2009
    4. Prohibition of Child Marriage Act, 2006
    5. National Commission for Protection of Child Rights (NCPCR) Act, 2005
    6. Persons with Disability Act, 1995
    7. Pre-Conception & Pre-Natal Diagnostic Techniques (PNDT) Act, 1994
    8. Infant Milk Substitute Feeding Bottle and Infant (regulation of production, supply and distribution) Act, 1992
    9. Child Labour (Prohibition and Regulation) Act,1986
    10. Bonded Labour System (Abolition) Act, 1976
    11. MTP Act, 1971
    12. Hindu Adoption and Maintenance Act, 1956
    13. Immoral Traffic (Prevention) Act (ITPA), 1956
    14. Factories Act, 1948
    15. Children (Pledging of Labour) Act, 1933
    16. Guardians and Wards Act, 1890

25. Similarly, the Government of India, a signatory to the UN Child Rights Convention have formulated many national policies / programs/ schemes / projects for welfare of the child and adolescent like;
    1. Integrated Child Development Services (ICDS)
    2. RashtriyaBalSwasthyaKaryakram (RBSK)
    3. Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)
    4. BalikaSamriddhiYojana (BSY)
    5. KishoriSakthiYojana (KSY)
    6. Early childhood education for 3 – 6 age group children under the program of universalization of elementary education
    7. Central Adoption Resource Agency
    8. Rajiv Gandhi National crèche scheme for the children of working mothers
    9. Mid-day meal scheme
    10. Pilot Project to compact the trafficking of women and children for commercial sexual exploitation in destination area
    11. Program for Juvenile Justice
    12. Nutrition Program for Adolescent Girls (NPAG)

13. The Integrated Programme for Street Children by the Ministry of Social Justice and Empowerment, Government of India
14. The Elimination of Child Labour Programme implemented by the Ministry of Labour, Government of India
15. The National Programme for education of girls at elementary level is being implemented by the Department of Education

26. The National Policy for Children was adopted in 1974 and 2013, the thrust areas of the policy are;
    1. Reducing Infant Mortality Rate.
    2. Reducing Maternal Mortality Rate
    3. Reducing Malnutrition among children
    4. Achieving 100 percent civil registration of births
    5. Universalisation of early childhood care and development and quality education for all children;
    6. Achieving 100 percent access and retention in schools including pre-schools;
    7. Complete abolition of female foeticide, female infanticide and child marriage and ensuring the survival, development and protection of the girl child;
    8. Improving water and sanitation coverage both in rural and urban areas.
    9. Securing for children all legal and social protection from all kinds of abuse, exploitation and neglect.
    10. Complete abolition of child labour with the aim of progressively eliminating all forms of economic exploitation of children.
    11. Monitoring, review and Reform of policies, programmes and laws to ensure protection of children's interest and rights.
    12. Ensuring child participation and choice in matters and decision affecting their lives

27. The state of Kerala has always been in the forefront, when it comes to planning for the health of the people and successive Governments of Kerala have taken various initiatives put forth by the State Planning Board. A life cycle approach to child-adolescent development is a philosophy that help realize the four pillars of child rights across the age range of 0-18 years and includes all actions essential for preparing for future motherhood; joyful pregnancy and safe delivery; optimal growth, development, care, protection, education and community participation till 18 years of age. At a practical level, the essential components of this approach would include focussing on;
    1. Pregnant woman attending anganwadis& health facilities
    2. At-risk babies including low birth weight, for promoting early child development
    3. 0 – 3 year age group at anganwadis and crèches
    4. 3 – 6 year age group at anganwadis and preschools
    5. 6 – 10 year age group at primary schools
    6. The orphaned, marginalized and disadvantaged children
    7. Adolescent future parents – at schools or workplace
    8. Newlywed couples – at community facilities

28. The existing schemes of GoK are:
    1. Nirbahaya Programme
    2. Our Responsibility to Children (ORC)
    3. School counselling programme
    4. Snehapoorvam
    5. Thalolam
    6. Sruthitharangam

29. Hence the new strategies to be adopted would include;

    1. Survival : Achieving single digit IMR in Kerala
        1. Compulsory antenatal registration and four ANC visits
        2. Peri-conception folic acid supplementation for reducing Neural tube defects
        3. Resuscitation corners in all labor rooms
        4. Early and immediate initiation of breast feeding
        5. Baby Friendly Hospital Initiative (BFHI) programme to be revitalized
        6. Six months paid maternity leave for workers in the unorganized sector
        7. Ensure 100% immunization coverage
        8. Growth Monitoring to be done at well baby clinics
        9. Identify and manage severe acute malnutrition (SAM) among under fives
        10. Organize pediatric intensive care units at medical colleges / district hospitals

    2. Development: Reducing prevalence of low birth weight babies
        1. Prevent /reduce severe anaemia in pregnancy
        2. Neuro-developmental programs and early intervention for high risk babies
        3. Early detection and early intervention for developmental delay (0 – 3 yrs)
        4. Early detection and early intervention for Autism Spectrum Disorders (0 – 6 yrs)
        5. Establishing development friendly well baby clinic at all immunization clinic
        6. Early detection and Early intervention services at all taluk hospitals
        7. Skill training for health and ICDS functionaries
        8. Infrastructure development for anganwadicentres
        9. Promote Additional Skill Acquisition Programs in all schools
        10. SarvaShikshaAbhiyan to be streamlined with skill training for special educators

    3. Protection: Social safety net for children especially vulnerable ones
        1. A cadre of qualified professional baby mentors (Ayas) for crèches
        2. Strengthening Child Welfare Committees
        3. Revamp commissions for child rights, disability, SC/ST, women's,
        4. Empower panchayats to take up child protection activities
        5. Setting up of Child Development Referral Units (CDRUs) at all Taluk hospitals
        6. Setting up of District Early Intervention Centres (DEICs) at District hospitalsand Taluk hospitals
        7. Empower and equip adolescent girls/boys to protect themselves

8. Promote MMR vaccine for infants and Rubella vaccine for adolescent girls to reduce the burden of disability due to rubella infection in pregnant mother
9. Access to counselling services for school going and out of school children
10. Capacity building of local self-government to identify and support vulnerable children
11. Child friendly justice delivery mechanisms
12. Disability – protection at all ages

4. Participation: Ensure full participation by removing the potential barriers
    1. Special nutrition programs for 5 – 10 year age group
    2. Revitalize nutrition supplementation through ICDS and schools
    3. Supplementation programs for iron, iodine, micronutrients
    4. Set up crèches attached to working places (organized & unorganized)
    5. Skill development of preschool (school readiness)
    6. Strengthen preschool facility (regular preschool / anganwadi) attached to all Government schools in Kerala
    7. Skill development of primary school children-identification of LD
    8. Set up preschools attached to all Government schools in Kerala
    9. Improve access to school education in isolated far away regions
    10. Family life and life skill education for 10 – 18 age group
    11. Compulsory sports, games and recreational activities at school level
    12. School health programs to be streamlined

30. A proposal by sub-committees of State Planning Board should be a realistic, feasible down to earth, economical, and need based. It should take into account the strength and weakness of existing programs, the opportunities thrown up by national programs and assess the economic and socio-political barriers for innovative ideas. We should appreciate the fact that there are always better ways of implementing the existing programs and imaginative ways of adding new programs. The series of consultations at the State Planning Board should open-up opportunities for further refinement, if only we have the humility to consult the ultimate beneficiaries before launching any massive program.

CHAPTER 3
SURVIVAL- FIRST 1000 DAYS OF CHILD'S LIFE

Relevant Articles of UN Convention on the Rights of the Child

1. *Article 1*: Definition of a child: Children are defined as all people under 18 years of age
2. *Article 6*: Every child has the right to life.
3. *Article 7*: The child has the right to be registered, to have a name from birth and to be granted a nationality. In addition, the child has the right to know and be cared for his or her parents.
4. *Article 8*: The State has an obligation to protect and, if necessary, re-establish the basic aspects of the child's identity (name, nationality and family relations).
5. *Article 9*: The child has the right to live with his or her parents unless it is not deemed to be in his or her best interests; the child has the right to maintain contact with both parents if separated from one orboth.
6. *Article 23*: Children who are disabled, either mentally or physically, have a right to special care and education so they can lead full and independent lives.
7. *Article 24*: All children have a right to good health and good quality health care. All children should have clean water, nutritious food and a clean environment so they stay healthy.
8. *Article 25*: The child who has been placed in a care setting by the State for reasons of care, protection or treatment has the right to have all aspects of that placement reviewed and evaluated regularly.
9. *Article 27*: All children have the right to a decent standard of living. The Government should help families who cannot afford to provide a decent standard of living for their children.

Preamble

1. Researchers have identified the first 1,000 days of a child's life—from pregnancy through a child's 2ndbirthday—as a critical window of time that sets the stage for a person's intellectual development and lifelong health. It is a period of enormous potential, but also of enormous vulnerability.

Burden of Issues

1. Shortfall in Early Antenatal Registration (ANC). As per DLHS 4 Data only 77.2 per cent and as per RSOC it only 79.3 per cent are registered in the system in the first trimester.
2. Lack of adequate supply of MCP cards
3. Lack of VHND
4. Inadequate number of ANC Checkups (70.3 % coverage in full ANC coverage, DLHS4)

5. Prevalence of anaemia during pregnancy (34.6% have anemia & 2.4% have severeanaemia (DLHS 4) and among tribals only 38.8% are consuming 100 or above IFA tablets (RSOC 14).
6. Incidence of low birth babies (30% in general & 20 percent among ST population & 21.6 % in SC population RSOC 14)
7. IMR & MMR above state average in tribal areas
8. Shortfall in full immunization (83% coverage in general & 73.3% coverage among tribals).
9. Prevalence of Home Deliveries among tribes (78% RSCO 14)
10. Lack of initiation of breast feeding within one hour of delivery (66.6% RSOC 14) & fall in exclusive breast feeding (58.6% RSOC 14).
11. Faulty / unhealthy practices in new born care.
12. Prevalence of Malnutrition among the children below the age of 5 (24% wasting, 22.7% stunting, 10.9% underweight DLHS4)

Causes

1. Lack of awareness/knowledge with regard to the early ANC, registration, colostrum, exclusive breast feeding, new born care.
2. Lacunae in convergence with the line department.
3. Inadequate consumption/supply of IFA tablets and iron rich diets.
4. Inadequate gestational weight gain, high risk pregnancies, gestational malnutrition, early marriage and conception.
5. Low birth weight babies, lack of protein, energy, malnutrition, unhealthy/ faulty feeding practices, delay in deworming and detection of nutrition deficiencies, lack of vitamin A supplementation, and inadequate intake of food, micronutrient deficiencies & poverty.

Gap Analysis

1. Despite being covering the 1000'days population of the whole state, with a vast network of 33115 Anganwadis through various services, there is prevalence of Low birth weight babies (9%), anaemia, IMR, MMR, shortfall in full immunization, severely underweight, malnutrition, micronutrient malnutrition etc are high in certain districts of the state, particularly in the tribal population and among the pregnant women and children below two years. There is also a gap in ANC registration, breast feeding within one hour, exclusive breast feeding and in consumption of IFA tablets. Even though there is Take Home Rations provided to the pregnant and lactating as raw rations, many a time the ration meant for the beneficiaries are being shared by other members of the family. Lack of strong IEC towards creating awareness among the people on the importance of first 1000 days is also a major concern.

Good Practices

1. Implementation of first 1000 day's programme in Attapady of Palakkad District as a pilot programme is considered as a model intervention envisaged to improve the survival and overall development through prevention, early detection, early stimulation, interaction and rehabilitation of disability along with focus on Infant and Young Child Feeding Practices (IYCF), nutritional guidelines, Integrated Management of Neonatal and Childhood illness (IMNCI) etc. so as to bring down neonatal and infant child mortality rate. To improve the nutritional status situation of tribal children and addressing severe acute malnourishment (in Attapady), Government of Kerala with assistance of UNICEF had introduced the Management of Sever Acute Malnutrition (IMSAM) through Energy Dense Special Food (EDSF). Towards addressing micronutrient malnutrition among the children under three year a pilot project on fortifying the Take Home Ration (THR) with micronutrients has initiated in the Mananthavadytaluk of Wayanad district.

Suggestions

1. To reduce the state IMR to single digit, early intervention is indispensible.

Rationale

1. IMR in Kerala is remaining somewhat unchanged for the last few years

Objectives

1. To Reduce IMR into a single digit.
2. To Reduce number of SAM children

Strategies and Model for Implementation

1. Strengthening the IEC/BCC components at the community level targeting the beneficiaries.
2. Effective convergence with the line department, towards this strengthening the intersectoral platform including VHND, Monthly sectoral meeting & DMO level meeting.
3. Introduction of unique fortified ready to eat Take Home Ration to the pregnant and lactating so as to ensure the ration reaches the beneficiaries there by enhancing the nutritional status of the pregnant and lactating.
4. Digitalization of details of all beneficiaries under the Angawadi center for timely intervention and follow-up.
5. Appointment of the nutrition counsellors as envisaged in the ICDS Mission Document.
6. State wide scaling-up of Fortified ready to eat Take Home Rations for under three children.

7. Setting up of a fully equipped food testing lab exclusively for ICDS.

Agencies

1. Departments of Social Justice, Health,LSG's and Kudumbasree

Training

1. ToT to ICDS Supervisors

Research

1. Study of nutritional status of the anganwadigoing children.
2. Community level study on the service assessment of anganwadis in the state.
3. A study on the best cooking practices at anganwadi levels aiming to replicate it elsewhere in the state.

Outcome Indicators

1. Percentage of early ANC registration compared to the previous five year plan
2. Number of convergence meeting between the ICDS and line departments.
3. Percentage of pregnant mothers received 4 ANCs
4. Prevalence of anaemia among the pregnant women reduced to 10% from 34.6%
5. Percentage of consumption of IFA tablets among the tribals
6. Unique fortified ready to eat Take Home Rations introduced for Pregnant and lactating
7. Reduction of low birth weight babies
8. Reduction of IMR to a single digit
9. State wide availability of fortified ready to eat THR to children under 3 years of age.
10. Reduction in stunting, Wasting and underweight among the <5year children to below 5%.
11. All beneficiaries' details digitalized.
12. Nutritional counsellors in ICDS Projects.

Monitoring

1. Social Justice
2. Health and LSG's Departments.

CHAPTER 4
INFANT FEEDING, NUTRITION AND EARLY CHILD DEVELOPMENT

Relevant Articles of UN Convention on the Rights of the Child

1. *Article 6*: Every child has the right to life.
2. *Article 23*: Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives
3. *Article 24*: All children have a right to good health and good quality health care. All children should have clean water, nutritious food and a clean environment so they stay healthy.
4. *Article 27*: Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who cannot afford to provide this, particularly with regard to food, clothing and housing.

Preamble

1. Optimal nutrition is essential for the growth and wellbeing of the children and adolescence.Nutritional requirements varies in different age group. During first six months of infancy breast milk alone is enough for maintaining adequate nutritional requirement whereas after first six months infants' need for energy and nutrients will exceed, therefore appropriate complementary food are necessary to meet energy and nutritional requirement. Child's need for energy, protein, vitamins and mineral requirement increases with age. For adolescent girls iron requirement is high as there is chance of iron loss through menstrual bleeding.Unhealthy dietary habits such as excessive consumption of junk food are common in school going children and adolescents. Food-related problems for young children and adolescents include overweight, underweight, nutritional deficiencies, tooth decay etc. Overweight, obesity and their health consequences have been recognized as a major public health problem worldwide. A significant increase trend in the prevalence of overweight and obesity among children and adolescent has been documented over the last few decades. The most significant long term consequences of childhood and adolescent overweight and obesity are their persistence into adulthood with all the health risk. In Kerala obesity and under nutrition among children are two ends of the spectrum. Childhood obesity is being observed with change in life style of families. Nutritional problems varies in different age group, therefore adequate nutritional counseling should be provided in each age group.

Burden of Issues

1. According to the NFHS III report 21.1% of children less than 3 years are stunted, 16.1% wasted and 28.8% of them are under weight. 34.0% of women are overweight or obese.

2. Research studies from Kerala shows that high prevalence of overweight among children and adolescent group.
3. During the 12th plan period Nutrition Research Centre under Directorate of Health Services conducted a study among school children of age10-13yrs(total no 58052) in selected schools of all districts and found that 44.57% are under weight and 9.63% are overweight.
4. Anemia is a major health problem in Kerala especially among women and children. About 55.7% children of age 6 to 35 month and 33.1% of pregnant women are anemic.
5. Breast feeding is nearly universal in Kerala but still less than half of the children got breast feeding immediately after birth and only 43% on the first hour.
6. The prevalence of low birth weight babies are remaining high. According to NNMB report only 20% of 1-5 years children have normal serum vitamin A concentration (20mcg/dl)
7. Marginalized population groups share a greater burden of nutritional deprivation among children and adult. A tribal survey conducted by NNMB in Kerala shows a higher prevalence of underweight 43% and stunting 54%.

Causes

1. Poverty and lack of community sensitized health education
2. Unhealthy dietary practices such as excessive consumption and usage of junk food, oil, salt etc.
3. Excessive marketing of unhealthy foods such as junk food, milk substitutes
4. Chronic energy deficiency and micronutrient deficiency before and during pregnancy.
5. Low prevalence of exclusive breast feeding and inadequate weaning
6. Faulty Infant and child Feeding Practices

Gap Analysis

1. Marked rural-urban difference in prevalence of exclusive breast feeding up to 6 months.
2. High prevalence of malnutrition among tribal children
3. High MMR in tribal population due to anemia and related symptoms

Suggestions

1. To achieve and maintain the nutritional well-being of Children

Rationale

1. To achieve and maintain nutritional well-being of CHILDREN to enable them to contribute to nation building

Objectives

1. To promote optimal infant and young child feeding practices
2. To enhance and maintain nutritional well-being of children.
3. To prevent and control Diet-related non-communicable diseases in children.
4. To reduce the prevalence of LBW babies
5. To reduce anemia among "under 5 children"

Strategies and Models for Implementation

1. Strengthen inter and intra-sectoral linkages in the development and implementation of all nutrition – related activities in the state and GOI
2. Support efforts to improve food quality & safety
3. Promoting healthy eating & living
4. Assessment and monitoring of nutrition status
5. Ensuring nutrition and dietetics are practiced by trained professionals.
6. Pre-adolescent growth and nutritional screening
7. Micro nutritional screening and food supplementation for pregnant
8. Proper maternity care
9. Pre conception nutrition counseling
10. Food fortification with Vitamins and minerals
11. Universal fortification of at least one food staple with iron and other micronutrient for the general population (fortification of wheat, dhal and salt).
12. Promoting locally available plant food that are rich in iron and other micronutrient
13. Breastfeeding education to public through mass media
14. Code of Ethics for the Marketing of Infant Foods & Related Products – mass media advertisement.
15. Implementation of guidelines for the feeding of infants and young children.
16. Individual counseling and group nutrition education.
17. Development of nutrition modules& guidelines for pre-school children
18. Menus & recipes development for childcare centres in collaboration with Education Department
19. Nutrition education for pre-school children
20. Development of SOP for nutrition counselling services
21. Nutrition education for preventing & controlling obesity
22. Dissemination of nutrition information systematically to the various Government and non-government agencies
23. Develop comprehensive school programmes that integrate nutrition into curriculum and healthy nutrition into school food services.
24. Community kitchen in every settlement.
25. Nutrition Rehabilitation Centres for SAM

Agencies

1. Department of Health

2. Social justice department
3. Local Self Government
4. Education department
5. Information and Public Relations Department

Training

1. Training for base line health workers such as ASHA , AWW and JPHN for Infant and young child nutrition
2. Training of health professionals such as doctors, nurses,developmental therapist etc. for nutritional counseling

Research

1. A study on factors influencing food habits of adolescent school going children (Plus-2 students)
2. A systematic review of published data on harmful health effects of junk foods and preparation of a simple module for adolescents and young adults for positive behavioural change with regard to food habits.

Outcome Indicators

1. Prevalence of underweight and stunting among under 5 children
2. Prevalence of anaemia among adolescent girls
3. Number of base line health worker trained in nutritional counseling

Monitoring

1. Health, Social Justice, Local Self Government and Education departments

CHAPTER 5
EARLY DETECTION AND INTERVENTION OF DEVELOPMENTAL DELAY AND REHABILITATION

Relevant Articles of UN Convention on the Rights of the Child

1. *Article 23*: Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives
2. *Article 38*: Children under the age of 16 years should not take a direct part in any conflict and children who are affected by an armed conflict should have special protection and care.
3. *Article 39*: Children who have suffered in any way have a right to get help in a safe place, to help them recover.

Preamble

1. Newborns (0 – 28 days), infants (up to 1 year) and toddlers (1 – 3 years), form an important group where investment for fostering their growth, development and nutrition, will give long term dividends for the individuals, family, society and the state.

2. It can be observed that in our state even though infant mortality rate is low (12), the morbidity rate and prevalence of low birth weight among newborns are high. The low birth weight rate is high and is almost comparable to other states like Bihar, Uttar Pradesh, Madhya Pradesh. High risk babies are a group, which at birth have some risk factors, which may lead on to future developmental delay. Along with these congenital anomalies including heart diseases, chromosome anomalies are commonly seen among this group of children. Neuro-developmental disabilities like autism, attention deficit hyperactivity disorder (ADHD), intellectual disability, learning disability, hearing impairment, visual impairment are seen among children, who had some high risk factors at birth. The metabolic and other disorders, like diabetes mellitus, hypertension, heart diseases, which are seen in adults have their root during infancy itself. This origin has been established by Barker hypothesis

Burden of Issues

1. About 2-4% prevalence of developmental delay among children less than 2 years.
2. Lack of awareness among parents about the deviation in normal developmental milestone among young children
3. Delay in identification and early management of developmental delay among children less than 3 years which includes speech and language delay, visual impairment and hearing impairment.
4. High prevalence of neuro-developmental disability among children, which includes Autism, ADHD, Learning Disability and Epilepsy.

5. Our state has high prevalence of Low birth weight babies, which is an important cause for disability
6. High prevalence of Congenital Heart disease and other Genetic & Metabolic disorders.
7. Lack of comprehensive and multidisciplinary facility for early detection and intervention of developmental delay among children less than 3 years.
8. Lack of comprehensive and multidisciplinary facility for early detection and intervention of neuro-developmental disorders among children

Causes

1. The most important etiology of developmental delay and disability is low birth weight. The other causes would be Birth Asphyxia, Neonatal Hypoglycemia, Neonatal Jaundice, Congenital anomalies, Neonatal Hypothyroidism, other genetic and metabolic disorders, neonatal heart diseases, antenatal factors like TORCH infections during pregnancy, antenatal anxiety, other emotional trauma and antiepileptic drugs.

2. The primordial preventive strategies would be optimal Adolescent Nutrition, prevention of Urinary tract infection, immunizing the adolescent girls with Rubella vaccine and preparation of the adolescent girl children and young adults for safe motherhood through family life education.

Gap Analysis

1. District Early Intervention Centres (DEIC) are not functioning well in most of the districts
2. Lack of sufficient research in the areas of neuro-developmental disability and adolescent heath
3. There is no triage and referral area at PHC and Taluk hospital level for effectively dealing with children having developmental delay and neurodevelopmental disability.

Good Practices

1. Newborn follow up programme for High Risk babies at SAT hospital, Medical College, Thiruvananthapuram, in partnership with CDC, Kerala
2. District Early Intervention Centres (DEIC), one each in 14 districts of Kerala for identification and management of childhood disabilities. DEIC at Kollam is functioning effectively with provision forearly detection of developmental delay using Trivandrum Developmental Screening chart (TDSC), 0–6 years and Language Evaluation Scale Trivandrum (LEST), 0–3 years.
3. Prevention of Childhood disability initiatives under various specialty units of CDC, Kerala- clinical, research, training and community extension activities.
4. Adolescent clinic at primary Health Centre, Pangappara, Thiruvananthapuram and General Hospital, Kozhikode, where comprehensive care and counselling services is being offered to adolescent population.

Suggestions

1. Reduction of childhood disability program and not just providing rehabilitation services alone.

Rationale

1. Early detection and intervention of developmental delay will improve the neuro-developmental status of children and reduce the burden of disability and improve the quality of life of children and parents
2. Early detection, intervention and rehabilitation of neuro-developmental disabilities like Autism, ADHD, Learning Disability, Epilepsy will improve the neuro-developmental status of children and reduce the burden of disability and improve the quality of life of children and parents
3. Newborn follow up programmes for high risk babies attached to all hospitals having antenanatal, intranatal and postnatal services can be a nodal point for early identification of delay or deviation of neurodevelopment of children as per provisions of PWD Act.
4. Improving adolescent health and preparing them for safe motherhood will have long-term dividends in terms of having healthy baby(Life-Cycle Approach)

Objectives

1. To provide early detection and intervention of developmental delay services to all children in the community through ICDS and Health services.
2. To provide early detection, intervention and rehabilitation services to all children having neuro-developmental disabilities like Autism, ADHD, Learning Disability, and Epilepsy through ICDS and Health services and educational departments.
3. To provide Newborn follow up services in all hospitals having antenanatal, intranatal and postnatal services.
4. To strengthen the early detection, intervention and rehabilitation facilities at District hospitals and Taluk hospitals of Kerala.
5. To establish adolescent care and counselling services at District hospitals and Taluk hospitals of Kerala.

Strategies and Models for Implementation

1. Establishing Newborn follow up clinics, at all hospitals having antenatal, 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 betheco-ordinator and other human resources like Developmental Therapist (PGDCCD), Nurse can run the clinic.

2. Strengthening District Early Intervention Centres(DEIC) in all districts of Kerala under NHM and establishing the proposed DEIC of Kerala Social Security Missionproviding advanced quality services for newborn follow-up programme with additional support of Developmental Therapist and Occupational Therapist.

3. Setting-up of Child Developmental referral units (CDRU) at all Taluk Hospitals (about 80) of Kerala in phased manner. This facility can be a triage and referral facility at Taluk level. Weekly once clinic for newborn follow-up programme and weekly once clinic for adolescent care and counsellingprogramme can be coordinated by the Pediatrician of the Taluk hospitals. Services of ENT Surgeon, Ophthalmologist, Gynecologist, Physiatrist, designated Nurse, Clinical Psychologist can be utilized.

4. Setting-up of Special Anganwadiesone each in all gramapanchayaths (around 950) of Kerala. At present, children with impending disability, developmental delay and other neuro-developmental disabilities, either attend other care facilities or will be attending the regular anganwadis of the state. It has been observed that the above children with special needs require services by therapist, who can deal with the various disabilities effectively.It may be noted that care and early education of normally developing children and children with special needs are different. Establishing special anganwadisfor the above beneficiaries will help them to grow and develop to their maximum potential. Providing transportation facilities by panchayath will help in maximum enrolment at the anganwadi. Developmental Therapist can play a key role in managing these special children along with AWW and helper of anganwadi.

5. Development friendly Immunization clinic: All the immunization clinic in hospitals can be used as a pivotal point for identification of developmental delay among children. Use of simple screening tools for identification of developmental delay in Personal social, Fine motor, Language and Gross motor domains, ADHD and Autism will help in the early detection process.

6. Setting up 'Autism – resource, training and treatment centre' in the state, which can act as an apex centre in Kerala, with adequate human resources and offering advanced training and treatment modalities available is US and other Western countries like ABA therapy, Sensory integration therapy, Picture Exchange Communicating System (PECS) therapy and other structured treatment packages that can be adopted in our state for the benefit of the children with ASD.

Agencies

1. Social Justice Department, Health Department, Educational Department, Local Self Government,Child Development Centre

Training

1. Training for ICDS functionaries in early detection and intervention of developmental delay in community for children less than 3 years.
2. Training for health functionaries including ASHA workers in early detection and intervention of developmental delay in the community for children less than 3 years.
3. Training for ICDS functionaries in early detection of neurodevelopmental disabilities in community for children.
4. Training for health functionaries including ASHA workers in early detection of neurodevelopmental disabilities among children in the community and appropriate referral.
5. Sensitization training for primary school teachers for identifying learning disabilities among children

Research

1. A study on prevalence of Autism Spectrum Disorder (ASD) among children less than 6 year in the community
2. A study on developing models for centre-cum-home based therapy for children with neuro-developmental disabilities like ADHD, ASD and LD
3. A study on efficacy of centre-cum-home based therapy for children having ADHD
4. A study on efficacy of centre-cum-home based therapy for children having ASD
5. A study on efficacy of centre-cum-home based therapy for children having LD

Outcome Indicators

1. Number of newborns screenedfor neuro-developmental delays or deviations in newborn follow-up clinic.
2. Number of newborns having neuro-developmental delay or deviation managed or referred to higher centres for treatment.
3. Number of DEIC strengthened for providing early detection, intervention and rehabilitation services to all children having neuro-developmental disabilities like Autism, ADHD, Learning Disability, and Epilepsy through ICDS and Health services and educationaldepartments.
4. Number of health care providers including ASHA workersreceived skill training in early detection of neuro-developmental disabilities among children in the community and appropriate referral.
5. Number of hospitals having newborn follow up clinic services
6. Number of special anganwadisestablished at Panchayat level

Monitoring

1. Social Justice Department, Health Department, Education Department, Local Self Government and Child Development Centre

CHAPTER 6
CARE - GROWTH MONITORING

Relevant Articles of UN Convention on the Rights of the Child

1. Article 3: All organizations concerned with children, for example, schools and the health service, should work towards what is best for each child.
2. Article 6: The child has an inherent right to life, and the State has an obligation to ensure to the maximum extent possible the survival and development of the child.
3. Article 5: The State has a duty to respect the rights and responsibilities of parents and the wider family or others involved in the upbringing of the child in a manner appropriate to the child's evolvingcapacities.
4. Article 7: All children have a right to a birth certificate.
5. Article 9: Children should not be separated from their parents unless it is for their own good. For instance, if a parent is hurting their child or not taking care of them properly.
6. Article 10: If parents decide to live apart, children have the right to stay in contact with both parents.

Preamble

1. ICDS addresses the nutritional needs of children, adolescent girls, pregnant women and lactating mothers. Efficient service delivery, effective monitoring & supervision and timely interventions at appropriate places are critical factors in the implementation of ICDS scheme for better outcomes. Setting up of a tool like Information and Communication Technology enabled Real Time Monitoring (ICT-RTM) in ICDS, will enables the system in improving service delivery and ensuring better supervision of ICDS Scheme by deploying a mobile solution driven by a customized ICDS-Common Application Software owned by the state.

Burden of Issues

1. Delayed detection of stunting, Wasting, underweight children under three years.
2. Delay in intervention to correct the stunting, wasting, underweight children.
3. Possibility of errors in identifying children with stunting, wasting, underweight under the age of three years.
4. Lack of timely data at higher levels.

Causes

1. Lack of identification of beneficiaries.
2. Manual data entry
3. Lapse in data collection
4. Lapse in data transferring

5. Lack of convergence with line department

Gap Analysis

1. Difference between the actual number of children in the age group of 0-6 and the actual growth monitoring reported from the field
2. Delay in receipt of data at higher level for timely intervention
3. Issue in data Storage for future reference, collation and difficulty in analysis.
4. Lack of proper documentation of the data.

Intervention- Good Practices:

1. A piloting of a GIS based real time growth monitoring system is implemented at the Attapady area of Palakkad district in collaboration with UNICEF &Riddi foundation.

Suggestions

1. Reduce incidence of MAM, SAM and IMR

Rationale

1. We cannot achieve reduction in the incidence of MAM, SAM and IMR without having a meaningful and practical growth monitoring services using available community health workers and anganwadi workers.

Objectives

1. 100% Coverage of Real time Growth Monitoring and early intervention. Supply of micronutrient fortified THR for children in the age group of 6 months -6 years to those who identified as underweight.

Strategies and Models for Implementation

1. Information and Communication Technology enabled Real Time Monitoring (ICT-RTM) developed and owned by the state agencies for real-time monitoring at Anganwadi level based on the mobile technology throughout the state.
2. Ensuring availability of sufficient devices at filed level and a monitoring cell at the state level with advanced technology.
3. Equipping the ICDS system (AW worker to state level officers) through training to handle the devices and technology involved in this system

Agencies

1. Social Justice, Health and LSG Department

Training

1. Training to ICDS Supervisors, AWWs,JPHN for proper growth monitoring and use of computer software.

Research

1. Effect of malnutrition on growth and development of children and outcome of intervention.

Outcome Indicators

1. Number of children identified with stunting, wasting and underweight
2. Participation of the community in the growth monitoring programme
3. Number of children changed from SAM to MAM.
4. Early detection of disabilities / diseases.

Monitoring

1. Social Justice Department, Health Department and through social audit.

CHAPTER 7
PRE-SCHOOL EDUCATION

Relevant Articles of UN Convention on the Rights of the Child

1. Article 3: All actions concerning the child must be based on his or her best interests.
2. Article 23: Children who have any kind of disability have the right to special care, education and support, as well as all the rights in the Convention, so that they can live full and independent lives.
3. Article 28: All children have the right to a primary education, which should be free. The Convention places a high value on education. Young people should be encouraged to reach the highest level of education of which they are capable.
4. Article 29: Children's education should develop each child's personality, talents and abilities to the fullest. It should also help them learn to live peacefully, protect the environment and respect other people. Children have a particular responsibility to respect the rights their parents, and education should aim to develop respect for the values and culture of their parents.

Preamble

1. Child Development encompasses the holistic development of all children upto 18 years of age. Early childhood is the most significant developmental period of life. A baby who is visually stimulated, continuously engaged in interactive activities, hugged, cooed to and comforted is more likely to fully develop cognitive, language, emotional and social skills, all of which are vital for success in school, in the community and subsequently in life. Yet, one fourth of children are missing out on programmes that can develop these skills in early childhood. Upto the age of 6 Early Childhood Care & Education programme addresses the holistic developmental needs of children viz. nutrition, health and cognitive development.

Burden of Issues

1. Absence of Universal preschool education in the state is a major issue. As per RSOC 14 26.2% of children in the age group 3-6 of children are not attending the preschools. Absence of scientifically prepared unique curriculum is also an issue which needs to be addressed. Absence of proper preschool environment.

Causes

1. Lack of awareness on importance of preschool education
2. Poor quality of preschool education
3. Lack of research and studies on preschool education procedures, lack of proper regulation of preschool institutions.

Gap Analysis

1. 26% per of the children are not getting preschool education. Lack of a unified preschool curriculum, absence of regulation on running of a preschool institution.

Intervention -Good practices

1. Welcoming new comers to Anganwadi centers by means of a grand celebration, which attracts children, parents and community. This has been organized by the state in the previous year, where close to 7900 new children joined the Anganwadi. A new pre-school curriculum has been introduced based on 30 new themes and activity charts in AWCs.

Suggestions

1. Achieve holistic development of children up to the age of 6

Rationale

1. Apart from first 1000 days, the most critical period for child development is preschool years and with ICDS, the largest community child development program in the world, it should be possible for India to achieve holistic development.

Objectives

1. Universal access to Pre schools
2. Regulation and setting up of quality standards to all ECCECentres.
3. Establishing AW cum crèche in semi urban and urban areas
4. Setting up of Quality Preschool centres
5. Monitoring and revision of pre school curriculum
6. Setting up of a regulated preschools and its curriculum

Strategies and Models for Implementation

1. A comprehensive legislation towards the ECCE, capacity building among the Anganwadi workers on new preschool curriculum, establishing Anganwadi-cum-crèches in semi urban areas and urban areas.
2. Grading and accreditation of preschool centers.
3. Setting up of state ECCE counsel. Community level IEC on the ECCE care at the Anganwadi centers.

Agencies

1. Social Justice Department, Education Department

Training

1. Training of ICDS Supervisors, anganwadi workers, helpers and Preschool teachers

Research

1. A study on the existing private preschool status and its efficiency.
2. A comparative study on the effectiveness of Anganwadi preschool education and private preschool education from the frame work of ECCE curriculum.

Outcome Indicators

1. Strong Legislation towards a quality ECCE,
2. Universal preschool education under the control of ICDS.

Monitoring

1. Social Justice and Education Departments.

CHAPTER 8
ADOLESCENT REPRODUCTIVE HEALTH

Relevant Articles of UN Convention on the Rights of the Child

1. Article 4: The State must do all it can to implement the rights contained in the Convention.
2. Article 6: Every child has the inherent right to life, and the State has an obligation to ensure the child's survival and development
3. Article 16: Children have the right to protection from interference with their privacy, family, home and correspondence, and to protection from libel or slander
4. Article 24: The child has a right to the highest standard of health and medical care attainable. States shall place special emphasis on the reduction of infant and child mortality and on the provision of primary and preventive health care and of public health education. They shall encourage international cooperation in this regard and strive to see that no child is deprived of access to effective health services.

Preamble

1. Adolescence is a transition stage in the life style, linking childhood to the adulthood during which physical, mental and social development takes place. Menstruation is a milestone and a sign of becoming a woman to every girls. During this phase of growth the girls first experience menstruation and related problems which is marked by feelings of anxiety and eagerness to know about this natural phenomenon. Reproductive health isan important area of concern in adolescent health. Reproductive health problems are unique, special and specific for the adolescent age. It is also a sensitive area due to the sociocultural taboo against discussion about sexuality and reproduction in the Indian society. Generally adolescents with reproductive morbidity symptoms will not seek treatment which may cause long term effect on women's reproductive health. Adolescence is one time in a woman's life when timely intervention will prepare her better for womanhood and motherhood as these girls are the future mothers.

2. Menstruation is a normal physiological phenomenon for females indicating her capability of procreation and abnormalities of menstruation are a major gynecological problem in adolescence. Majority of adolescent girls experience one or more problem during menstruation. The most common problem is dysmenorrhoea. Severe dysmenorrhea can affect the academic and social life of the girl. Severe forms like PMS and PMDD can negatively affect the quality of life .Another major problem is irregular periods especially oligomenorrhoea (infrequent periods) and amenorrhoea which may be a marker of PCOS when associated with features of hyperandrogenism and polycystic ovaries. This condition can later affect the reproductive capacity and also produce metabolic syndrome in future. Reproductive tract infections are common in adolescent girls, especially fungal infections and bacterial vaginosis which when not treated promptly can affect future reproductive health.

Burden of Issues

1. From the community studies conducted by CDC among 3443 adolescent girls in Thiruvananthapuram district during the year, 2011
2. About 22 % of the total girls had menstrual disorders, among them about 72% experienced dysmenorrhea.
3. Approximately 11.3% of girls were having oligomenorrhoea

Causes

1. Lack of awareness among adolescent girls and mothers about normalcy and abnormalcy in reproductive health (for eg. Normal and abnormal periods, normal and abnormal vaginal discharge)
2. Hesitancy to seek treatment due to prevailing sociocultural taboos
3. Lack of awareness or accessibility of health care facilities
4. Lack of privacy in the health care facilities
5. Superstitious beliefs and taboos related to menstruation

Gap Analysis

1. Lower level of awareness regarding sexual and reproductive health among adolescents and lack of proper dedicated facilities to deal with these problems in the State.
2. Lack of a proper health education programme in schools related to menstrual hygiene and other health problems. This leads to thedearth of knowledge on the same, which has got a negative influence on knowledge, attitude and practice of menstrual issues, food habits and available treatment in this area.
3. Menstruation is still regarded as something unclean or dirty among some places, which makes adolescents uncomfortable with their own bodies.

Intervention -Good practices

1. Model Child development centre in Kerala is the first model for comprehensive adolescent development services in the Government sector. A well-functioning adolescent clinic has been established at Primary Health Centre, Pangappara, Thiruvananthapuram in order to detect early, treat andmanage the different health problems of adolescentgirls and equip them for a better womanhood and motherhood. School adolescent health education programmes are going on to produce awareness on reproductive morbidity and management.

2. The Family Life Education (FLE) Module covers Life Skill Education, AIDS Awareness and ASRH with the focus not just on subject content but on social acceptability and appropriateness of language.

Suggestions

1. Target every adolescent girl for healthy reproductive development

Rationale

1. Adolescent girls with reproductive morbidity hesitate to seek treatment on their own. Unless the mothers are made aware of the consequences of reproductive morbidity health facilities will be inaccessible to the girls.
2. Adolescent girls have to be taken out of anxiety in prior to menstruation in order to exhibit the troubles and inconveniences related to menstruation

Objectives

1. To provide awareness on adolescent reproductive health
2. To promote and improve early detection and management of reproductive morbidity among adolescent girls
3. To educate mothers about the physiological changes that take place scientifically in order to reduce the existing superstitious beliefs and taboos and to train the adolescent girls with regard to reproductive health
4. To plan various strategies and models for implementation
5. To promote school adolescent health education programmes including their mothers for developing awareness
6. To develop mother child dyad model for improving health seeking behavior
7. To implement CDC model adolescent clinics should be in each district.
8. To promote early detection and management of RSH issues including life style modification for reproductive health

Strategies and Models for Implementation

1. CDC model child –mother dyad for effective adolescent reproductive health counseling, personal and menstrual hygiene, life style modification, early detection and management of reproductive health problems like dysmenorrhoea, irregular cycles, reproductive tract infections should be implemented in all districts
2. Mother community has to be educated about the physiological changes that take place scientifically in order to reduce the existing superstitious beliefs and taboos and to train the girl children with regard to reproductive health.
3. The educational institutions can tune the knowledge on the role of personal hygiene to the adolescent girls in order to highlight the infectious diseases with its consequences
4. The educational institutions can generate awareness on the significance of reproductive health to safeguard the reproductive health of the adolescents at the earlier stage
5. Early detection of reproductive morbidity can be picked up using self-administered questionnaire developed at CDC

Agencies

1. Department of health and family welfare
2. Social justice department
3. Local self -Government
4. Child Development Centre
5. Kudumbasree units

Training

1. Training for baseline health workers (ASHA, AWW, JPHN), school teachers and counsellors, Kudumbasree units on earlyidentification of adolescent reproductive health problems and counseling on hygiene and life style modification

Research

1. Factors influencing health seeking behavior of adolescent girls related to sexual and reproductive health
2. Evaluation of the effectiveness of the school health programmes and mother child dyad model for detecting reproductive morbidity
3. A comparative study between the rural and the urban adolescent girls regarding the menstrual hygiene practices

Outcome Indicators

1. Number of health workers trained in adolescent counselling and reproductive health
2. Number of health care facilities for detection and management of adolescent reproductive morbidity
3. Number of adolescent girls with reproductive morbidity
4. Number of mother community educated about the physiological changes that take place scientifically in order to reduce the existing superstitious beliefs and taboos and
5. Number of mothers educated to train the girls children with regard to reproductive health

Monitoring

1. Health and family welfare department
2. Social justice department

CHAPTER 9
CHILD ADOLESCENTS CARE AND PROTECTION IN KERALA

Relevant Articles of UN Convention on the Rights of the Child

1. Article 2: All rights in the Convention apply to all children without exception, and the State has an obligation to protect children from any and all forms of discrimination including that resulting from their parents or guardian's status.
2. Article 8: The State has an obligation to protect and, if necessary, re-establish the basic aspects of the child's identity (name, nationality and family relations).
3. Article 9: The child has the right to live with his or her parents unless it is not deemed to be in his or her best interests; the child has the right to maintain contact with both parents if separated from one or both.
4. Article 16: The child has the right to protection from interference with privacy, family, home and correspondence, and from libel or slander.
5. Article 17: The State has an obligation to ensure that the child has access to information and material from a diversity of media sources and to take measures to protect children from harmful materials.
6. Article 18: The State has an obligation to recognize and promote the principle that both parents and legal guardians have common responsibilities for the upbringing and development of the child; the State shall support parents or legal guardians in this task through the provision of appropriate assistance.
7. Article 19: All children should be protected from violence, abuse and neglect, and governments should protect them.
8. Article 20: The State has an obligation to provide special protection for children without families and to ensure that appropriate alternative family care or institutional placement is made available to them, taking into account the child's cultural background.
9. Article 22: Special protection is to be granted to children who are refugees or seeking refugee status, and the State has an obligation to co-operate with competent organizations providing such protection and assistance.
10. Article 26: The child has the right to benefit from social security.
11. Article 32: Children should not be allowed to do work that is dangerous or might make them ill, or stops them going to school.
12. Article 33: Children have a right to be protected from dangerous drugs, and from the business of making or selling them.
13. Article 34: Nobody can do anything to your body that you do not want them to do, and grown-ups should protect you.
14. Article 35: The State has an obligation to prevent any form of abduction of children or sale of or traffic in children.
15. Article 36: The child has the right to protection from all other forms of exploitation prejudicial to their welfare.
16. Article 37: No child should be punished in a way that humiliates or hurts them.
17. Article 40: Children accused of, or recognized as having committed an offence have the right to respect for their human rights and in particular to benefit from all aspects

of the due process of law, including legal or other assistance in preparing and presenting their defense. States have an obligation to promote alternative procedures and measures so as to ensure that recourse to judicial proceedings and institutional placements can be avoided wherever possible and appropriate.

Preamble

1. There are many programmes targeted to children in Kerala without proper convergence or coordination. Departments of Education, Social Justice, Health, etc. have well defined programmes for children without much proper monitoring. Hence the current status of these programmes is not available.

Burden of Issues

1. Drop outs in school
2. Pre-school for Tribal Children: It is noticed that in tribal areas, attendance of children in anganwadies has come down due to the language issue .In tribal communities children below six years are following their tribal language at home (mother tongue). But when they are coming to anganwadies they find it difficult to follow Malayalam.
3. Substance abuse is an emerging issue and it is very common among school children.
4. More acquittals in child sexual abuse cases
5. Unfriendly justice delivery systems
6. Child Sexual abuse victims are not getting victim compensation.
7. Family violence is also a major problem in Kerala. Children are the victims of family violence (e.g.Children of alcoholic parents, sexual abuse, victims of family violence etc).
8. Functioning of Juvenile Justice Institutions - are not functioning very effectively

Causes

1. Poor socio – economic background of the children: The marginalised children are facing lack of amenities or conducive environment at homes, no regular food, delay in getting entitlements, no electricity at times, no support systems, long travel, and no money to buy sanitary napkins.
2. Lack of proper infrastructure facilities in anganwadies and lack of adequate trained anganwadi workers
3. In Kerala, there are only three special courts for the disbursal of child abuse cases
4. Lack of flow of funds and improper functioning of JJ institutions

Gap Analysis

1. Even though there are children's homes in Kerala, they need special attention to improve the overall development of children.

Suggestions

1. Recognize adolescents as the best potential human resource for the next generation

Rationale

1. Panchayaths have a major role in implementation of the Right of Children to Free and Compulsory Act 2009 (RTE Act). So, it is very important to spread awareness among representatives of Local Self-Governments about their roles and responsibilities including in the preparation of the three years School Development Plan.
2. It is very important to Regulate / streamline pre-primary education /curriculum. Different nursery schools following different curriculum and some of them charge exorbitant fees also.
3. The vision of the National ECCE Policy is to promote inclusive, equitable and contextualized opportunities for promoting optimal development and active learning capacity of all children below 6 years of age. The Policy focus is on early preschool learning for every child below six years.
4. Right to family is one of the basic rights of each child. Family based rehabilitation of children in need of care and protection through Adoption, Foster care and Sponsorship are the best method to ensure overall development of a child. The Juvenile Justice Act 2015 and the Integrated Child Protection Scheme provide family based rehabilitation of children in need of care and protection through Adoption, Foster care and Sponsorship. Foster care and Sponsorship are the non-institutional services for the children whose parents are unable to care for their children due to poor economic background, death, illness, desertion etc. Institutionalization can be the last resort. Institutionalization can prevent through foster care, group foster care and sponsorship programmes. Children under foster care and sponsorship need regular supervision and monitoring to assess the progress of the child. In order to promote foster care and sponsorship programmes, it is essential to strengthen District Child Protection Unit and also the public have to be educated about foster care through awarenessprogrammes.
5. As per Protection of Children from Sexual offences Act 2012, Special Courts should be established in all districts for the speedy disbursal of child abuse cases. So there is an urgent need to set up child friendly Special Courts in all districts to protect the rights of child abuse victims.
6. Children of migrant labours need special attention with regard to health and education.
7. It is very important to take necessary measures to improve the present conditions of Children's homes in Kerala and also to set up uniform standards for child care as per JJ Act 2015.
8. It is important to implement Balasureksha Protocol in the State to protect the rights of children.

Objectives

1. To regulation of Pre-primary Education/Curriculum
2. To De-Institutionalization (Rehabilitation of Institutionalized children) Promotion of Foster care and Sponsorship Programme
3. To Protect children from Substance abuse
4. To effectively Rehabilitate victims of Child Sexual abuse
5. To develop and implement special package for the development of children of Migrant Labourers
6. To Strengthen JagrathaSamithi for Prevention of Child Marriage
7. To Improve the conditions of Govt.Children's home
8. To effectively Implement Balasureksha Protocol

Strategies and Models for Implementation

1. Panchayaths should have a phased plan for addressing the important issues relating to all transferred institutions like Government schools, SC/ST Pre-metric hostels, Fisheries Technical School, Anganwadis etc.
2. Organiseprogrammes at Panchayath level to identify drop-outs and take measures to readmit them in schools with the support of SSA (Special mission for implementation of RTE Act). Since children in plantation areas used to go for work, able to earn Rs.400/ per day as wages, leads to lack of attraction of the mid-day meal and lack of any career prospects at the end of their education.
3. There is a need for planning separate programmes at Panchayat level for tribal and fisher folk children to prevent drop outs in selected districts.
4. Improve the infrastructure facilities of Anganwadis, Training for Anganwadi workers, increase attendance in anganwadis, improve the quality of pre-primary education, and act as a community resource centre with the support of Local Self-Government.
5. Child Rights Commission already prepared a theme based handbook for anganwadi workers in Erula tribal language to impart pre-primary education in tribal language especially for AttappadiIrula tribal children. Commission already submitted this as a recommendation to the Government. This can be implemented in Attappadi by giving training to Anganwadi workers.
6. Promote Foster care and sponsorship programmes and also to frame guidelines on Foster care and Sponsorship programmes under ICPS Scheme. It is important to have separate programmes / budget for sponsorship at Panchayath level to support children who are in need of care and protection including differently abled children.
7. De-institutionalising children at Children's Home to be taken up as a mission by reintegrating a minimum of 5000 children (who are currently living in our institutions) into the mainstream of society within the next 5 years.
8. School level awareness programme should be organized for students, teachers, and parents to prevent substance abuse. De-addiction Centres are to be established in each district.

9. Separate rehabilitation programmes for children, who are residing in Nirbhaya homes to be worked out for Restoration, Legal support, Education, Mental Health, Skilled training, etc.
10. Setting up of one SOS model home for accommodating 100 children from Nirbhaya homes, if the child requires prolonged stay for enabling comfort stay, study and rehabilitation. The present Nirbhaya homes may continue to function as 'reception centres'.
11. There is an urgent need to plan a separate programme with the support of Local Self-Government to ensure the development and protect the rights of children of migrant labours.
12. Take necessary measures to strengthen JagrathaSamithis. Panchayath and school level awareness programmesin all districts to prevent child marriage.
13. Rejuvenate NHGs and Balasabas through awareness sessions making use of School Counsellors and students of Social Work, Psychology and Home Science Depts.
14. Improve the facilities of CH, OH and Shelter Homes with professionally qualified staff. Individual care Plan (ICP) for each child in CCIs should be prepared by Case Workers. Proper MIS should be established to collect and analyze data on Child Care and Protection and the SCPC should review it regularly.
15. As a preventive measure it is important to identify vulnerable children at Corporation/ Municipal/Panchayath levels and include them in child protection schemes through District Child Protection Units (DCPUs) to protect their rights and providing counselling to parents.
16. Strengthen functions of JJBs, CWCs and DCPUs with adequate staff and funds.
17. Make mandatory the meetings of DCPC and PCPC to monitor the activities.
18. Train SJPU especially women police to deal with children in need of care and protection.
19. Staff selection of DCPU should be done at state level with the help of subject experts and rank list be prepared to avoid delay in filling vacancies.

Agencies

1. Local Self Government, ICDS, Schools

Training

1. There is a need to prepare proper data base with regard to children in need of care and protection as well as to design need based training for all stakeholders.

Research

1. Evaluation of the effectiveness of ICPS
2. Study on substance abuse and smoking among adolescent children
3. Study on non-utilization of facilities of ICDS among tribal population

Monitoring

1. Social Justice Department and Education Department

Outcome Indicators

1. Number of drop outs in the school
2. Number of special courts in Kerala for disbursal of child abuse cases
3. Conviction rate on POCSO cases.
4. Number of children who are dependent on Institutions.

CHAPTER 10
ADOLESCENT MENTAL HEALTH-LIFE SKILL EDUCATION

Relevant Articles of UN Convention on the Rights of the Child

1. Article 5: The State has a duty to respect the rights and responsibilities of parents and the wider family or others involved in the upbringing of the child in a manner appropriate to the child's evolving capacities.
2. Article 13: The child has the right to obtain and make known information, and to express his or her own views, unless this would violate the rights of others.
3. Article 14: The child has the right to freedom of thought, conscience and religion, subject to appropriate parental guidance and national law.
4. Article 15: The child has the right to meet with others and to join or set up associations, unless doing so would violate the rights of others.
5. Article 28: All children have the right to education.
6. Article 29: The purpose of education is to develop every child's personality, talents and mental and physical abilities. Education should teach children to respect their parents, their own and other cultures. Education should prepare children to live responsibly and peacefully in a free society. Education should teach children to respect the natural environment.
7. Article 31: All children have the right to relax and play, and to join a wide range of activities.
8. Article 33: The child has a right to protection from illicit use of narcotic and psychotropic drugs and from being involved in their production and distribution.

Preamble

1. Mental health of children is an important area of concern to all involved in child development activities. Many of the major mental disorders have their beginning during childhood and adolescence. Emotional issues during childhood can predispose to development of unhealthy habits like substance abuse,antisocialbehaviour, sexual experimentations and self-injuriousbehaviours.

Burden of Issues

1. As per the National Mental Health Survey 2015-16, behavioural and mental disorders are present among 7.3% of children and adolescents in India with almost equal prevalence in males (7.1%) and females (7.5%). Prevalence of mental disorders were twice more prevalent in urban metros (13.5%) compared to rural areas (6.9%).The commonest problems were depressive episode and recurrent depressive disorder(2.6%),agoraphobia (2.3%),intellectual disability (1.7%),autism spectrum disorder (1.6%),phobias (1.3%) and psychotic disorder (1.3%).Prevalence of tobacco

use (7.6%),alcohol use (7.2%) and suicidal ideation (5.5%) was also high among 13-17 year olds.
2. Studies conducted in Kerala have shown that 38.6% of boys and 37.7% of girls have been subjected to some form of sexual abuse during their lifetime.

Causes

1. Various factors including genetic factors, poor family and social environment, faulty parenting and peer pressure contribute to the development of mental and behavioral problems among children and adolescents.

Gap Analysis

1. Despite the high prevalence of mental and behavioral disorders in children, a huge gap exists with regard to identification, management, prevention and rehabilitation of mental and behavioral disorders. The National Mental Health Survey indicates that there is a treatment gap of 28 to 83% for mental disorders and 86% for alcohol use disorders. Multiple factors including lack of awareness,lack of accessibility to care,superstitions and misconceptions regarding mental illness/treatment and lack of affordability are important factors behind this treatment gap.
2. Health promotion and illness prevention programmes like Life skills education have not become universally accessible to all children in the state.Lack of trained counsellors in all schools is another problem.Lack of effective parenting,combined with marital discord among parents, parental substance use and lack of communication with children are worsening the domestic situation in households.

Health Promotion and Illness Prevention

1. 'Ullaasaparavakal'- the life skills education module published by SCERT with inputs from doctors, mental health professionals,teachers,education experts and health workers-is a model intervention, which can be generalised to the whole state. This module has separate teacher's handbook and student's workbook for each standard from standard 1 to 12.Structured participatory, process oriented and experiential life skills education for 20 hours each year is proposed.

Parenting

1. Training for effective parenting is important and could be imparted at school level through class PTA meetings.A model available now is the 'parenting module' developed as part of ICPS-ORC project of Social Justice Department. Six parenting sessions covering topics like effective parenting,preventing substance abuse,anger control,learning methods, resilience and sexual-relationship issues in adolescents are discussed to parents with a provision for interaction and clearing of doubts.
2. Both the above mentioned programmes are now being tried in 100 selected schools in different parts of the state

Child Psychiatry Facilities

1. All the government Medical Colleges in the state have 'child psychiatry' clinics attached to them. For example in Govt Medical College Trivandrum child psychiatry clinic is functioning on every Saturday. Apart from this child behavioural problems are managed in psychiatry OPD also on all days from Monday to Saturday. The Child Development Centre in Medical College campus Trivandrum also caters to children with developmental problems.There is a behavioural pediatrics clinic attached to SATH Tvpm.
2. Kerala is the only state in India which has mental health programmes in all 14 districts. The district mental health programme (DMHP) Tvm is running a child mental health programme called 'thalir' which includes training of school counsellors in mental health problem management.

Suggestion

1. Develop child-adolescent mental health clinics at all major health facilities

Rationale

1. Child mental health enhancement is vital in developing a healthy generation of citizens who are empowered,socially committed and dedicated to the cause of developing our nation.

Objectives:

1. To ensure universal health promotion and illness prevention strategies like LSE for all students in the state.
2. To ensure parenting training to all parents all over the state
3. To empower all school teachers in identifying and class room management of learning/behavioural problems

Strategies and Models for Implementation

1. Life Skills Education (LSE) as a universal health promotion and illness prevention strategy for all school students of Kerala. 'Ullaasaparavakal' the LSE module already developed by SCERT with the help of experts from the fields of psychiatry, paediatrics, community medicine and education can be effectively utilised for this purpose. 'Ullaasaparavakal' has separate LSE modules for standard 1 to 12. Separate teacher's hand book and student's work book are available. This training may be implemented in all schools of Kerala.
2. The syllabus of B.Ed.andD.Ed.may be modified to include sections on life skills education, identification and classroom management of child and adolescent

behavioural and learning problems, parenting training and counselling; in order to empower the next generation teachers to help the students better.

3. In service training should be provided to all school teachers on LSE, behavioural and learning disorders in students, parental training and counselling.For this purpose the training module developed for ICPS-ORC project of Social Justice Department may be utilized.
4. Class PTA meetings with the involvement of both male and female parents of each student to be held at regular intervals. A total of 6 class PTA's may be held every year. Each meeting can discuss a topic of relevance to parents. The topics may be
    1. Parenting methods
    2. Anger control and regulation of emotions
    3. Stress management in families
    4. Substance abuse
    5. Responsible use of media
    6. adolescent problems and healthy interpersonal relations
    7. How can a parent help a child to learn
    8. The parenting module developed for ICPS-ORC may be utilised for this training.

Mentoring of children: Three levels of mentoring may be tried-

1. Peer mentoring with students mentoring their own class mates with emotional/ behavioural/academic difficulties
2. Teacher mentoring: A group of not more than 4 students can be placed under direct supervision of a teacher
3. Social mentoring: In children from broken families/ poor socio economic background, respectable persons from society can be entrusted with the job of mentoring those children.
4. An assessment/ monitoring of the mentoring strategies should be done every month by the head of institution/ a teacher appointed for supervising the mentorship programme.
5. At least 10 teachers from each school should be given a hands on workshop model training in counselling
6. Parenting training can be undertaken at local level with the help of Kudumbasree.
7. Multiple intelligence assessment for all children of standard eight. Based on their dominant intelligence type they can be given career guidance counselling for the future. Along with that,the children can be allotted to various clubs functioning in the school based on the results of this assessment, as a result of which each child will have a chance to exhibit his talent, thus enhancing their self-esteem and preventing them from resorting to deviant behaviours.
8. Training on child rights, POCSO Act, behavioural management of children and avoiding corporal punishment for all principals/ head masters of schools.
9. Assessment of intelligence and learning ability for all students of standard six. Interventions to be given for all children with intellectual and learning disorders for a

period of two years. If still problems are persisting, disability certificate may be provided to them with consequent financial and academic assistance.

10. Training for staff of orphanages and juvenile homeson LSE, behavioural problems in students and counselling.
11. Special training for caretakers of homes in which children with special needs are placed.
12. Resilience training to inmates of orphanages and juvenile homes

Agencies

1. Department of education, health and family welfare and social justice should move in a coordinated manner to ensure that the activities are carried out well.
2. The co-operation of professional bodies like Indian Academy of Paediatrics,Indian Psychiatric Society and IMA to be ensured.
3. NGO's and media to be involved

Training

1. State level 'training of trainers' on LSE and parenting to be given to selected teachers from all districts,who will then co-ordinate district level and institution level training to the necessary number of teachers.
2. Training on 'behavioural problems and class room management' for all teachers in all streams of education-state syllabus,CBSE,ICSE,KV,Navodaya,international schools – belonging to both Government and private sector.
3. Mentoring training to teachers,social mentors,peer mentors
4. Training for staff of care homes,special homes,orphanages and rehabilitation centres on counselling and management of childrens' problems.

Research

1. An evaluation to assess the efficacy of the training and implementation fidelity of each of these programmes to be assessed periodically

Outcome Indicators

1. Number of students trained for Life skills
2. Behavioural problem reduction as evidenced by results of rating scales
3. Improvement in learning and positive mental health.
4. Competence among teachers to identify learning/behavioural problems in children

Monitoring

1. The departments of education,health and social justice to develop monitoring systems to periodically monitor the progress of the programmes.

CHAPTER 11
ADOLESCENT MENTAL HEALTH PREVENTION AND MANAGEMENT OF DISORDERS

Relevant Articles of UN Convention on the Rights of the Child

1. Article 23: Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.

Preamble

1. Kerala model of development had gained acceptance across the world. Due importance is given to the physical health of the children and adolescents in all our social groups. But developmental, behavioural and emotional aspects of the children are not getting enough concerns in our society. There are many reasons for this. Important ones among them are widespread lack of knowledge about child development and childhood mental disorders, limited number of professionals, lack of training in the field, poor financial assistance and relatively weak advocacy. The situation is relatively same across the world. Apart from this there are many other reasons for the underutilization of services like stigma, cultural traditions, cost, and reluctance on the part of parents or children to seek help, difficulty in getting to providers etc.

2. Child mental health is a state of achievement of expected developmental, cognitive, social, and emotional milestones. It will be achieved by developing attachments between the growing child and the primary care giver. Mentally healthy children and adolescents will have satisfying social relationships and effective coping skills. They enjoy a positive quality of life. They will function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology.

3. A child's mental illness or disorder is diagnosed when a pattern of signs and symptoms is identified that is associated with impairment of psychological and social functioning, and that meets criteria for disorder under an accepted system of classification such as the ICD-10 or DSM V. A mental disorder will disrupts daily functioning of the child in home, school, or community.

Burden of Issues

1. Community-based studies show that up to 20% of children and adolescents suffer from a disabling mental illness (Bird H,1996; Verhulst FC,1995; World Health Organization,2000). Of this 20% it is recognized that from 4-6% of children and adolescents are in need of a clinical intervention for an observed significant mental disorder (WHO, 2001). In Indian setting the prevalence of child psychiatric disorder is 12.8%(Srinath.S et al, 2005). Half of all life time cases of mental disorders start by age 14(Kessler RC, et.al, 2005).So early identification and intervention of mental health

problems among children and adolescents will help to improve the healthy and productive adult life.

Causes

1. The child mental illness can be due to the imbalances in the interaction of biological, psychological and social factors of the child and adolescents during their developmental period.

Gap Analysis

1. The lack of child and adolescent mental health professionals were very evident in developing countries. Child and adolescent mental health services in India and Kerala are very sparse and it is mainly city based. It is a costly affair and poor people are not able to afford it. The medical college psychiatry services are mainly adult based. CGSs are now emerging attached to Psychiatric departments in the medical colleges, but which are not sufficient enough to meet the demand. Child Development Center in the government medical college campus, Thiruvananthapuram is serving in the area of early identification and intervention ofneuro-developmental disorders among children and adolescents. There are no fully equipped CGSs in medical colleges with qualified mental health professionals under Paediatrics departments where children and adolescents attend for the service of physical health. Considering this gap in 2008, a Behavioural Paediatrics Unit was started with experts in child and adolescent mental health under department Paediatrics, SAT Hospital, Government Medical College Thiruvananthapuram. It is the first of its kind in the state. It is a four bedded unit which gives exclusive mental health service to child and adolescents. It runs separate OP service for behavioural disorders, developmental disorders, scholastic backwardness in children and adolescents. There is a wide gap in the need for child mental health service and the existing facility in the state.

Intervention -Good Practices

1. The problems of development, mental illness and emotional disorders will affect their behaviour and learning process and these can be identified in the school environment. So a school mental program addressing the mental health problems at the school level and providing possible service at school itself will be a good solution to the problem as envisaged by WHO. According to WHO, there are many advantages for school mental health program. Main advantage is that it will provide a better place for identification of mental health problems among children and adolescents since they spend majority of their wake period in school, their behaviour, emotions and learning problem can be observed by teachers. The provision of mental health service at school level can minimize the stigma attached to it and will become acceptable to parents. For early identification of developmental, behavioural and emotional disorders at school level, the selected school teachers can be trained. The trained teachers can do the identification and intervention at primary level. If not getting

improved, they can be referred to child mental health experts outside. For this networking of a panel of experts should be identified.

2. In this back ground, two best practice models can be mentioned namely UNARV (Adolescent school mental health program, which is running successfully since 8 years in JillaPanchayath, Thiruvananthapuram) and MAANASA (an innovative project for early identification and individualized intervention for scholastic backwardness among children of upper primary schools in South MaararikulamGramaPanchayath, Allappuzha. It is running successfully for the last 3 years). These two projects are funded by decentralized plan by respective LSGs.

Suggestions for New Activities

1. The UNARV and MAANASA can be disseminated at state level as components of child and adolescent school mental health model.

Rationale:

1. school mental health model can be an effective model forearly identificationand intervention for child and adolescent mental health problems in a resource poor setting as suggested by WHO. We lack specialized manpower and specialized centers for dealing with this problem.

Objective

1. To do early identification and intervention of child and adolescent mental health problems.
2. To train a selected group of teachers for identification and intervention at primary level at schools.
3. To develop a network of experts and refer those children who are not improved at primary level in the school.

Strategies and Models for Implementation

1. Training a selected group of teachers at each school level

Agencies

1. LSGs, education department, health department

Training

1. For selected group of teachers from each school

Research

1. Model research projects UNARV and MAANASA may be done as pilot research projects in selected districts.

Outcome Indicators

1. Suggested outcome indicators are learning skill improvement and behavioural improvement assessed by the feedback given by parents, teachers. It can be done by an independent agency also.

Monitoring

1. Can be done by the educational and health department

Appendix

1. Here summary of two best practice models namely UNARV and MAANASA for school mental health program are included.

UNARV

1. UNARV (Adolescent school mental health program) is successfully going program under theJillaPanchayath, Thiruvananthapuram since the last 8 years. About half of all life time cases of mental disorders start by age 14 years. First sign of mental illness or emotional distress can emerge in school environment. So schools are to be viewed as the potential resource for recognition of mental health problems, but an unexplored area. The aim of the UNARV was to evolve a district model for adolescent school mental health program, UNARV (awakening). In the UNARV, two teachers each from all government and aided high school and higher secondary schools under JillaPanchayath, Thiruvananthapuram, Kerala was given workshop based training. The training was given on adolescent development, behavioral and emotional disorders, and identification of children with problems, individual primary counseling and when to refer to child mental health expert. The non-responders were referred to UNARV clinic established in the office premise of JillaPanchayath, Thiruvananthapuram, which run on every Tuesdays from 2pm to evening. In the UNARV clinic, each referred child was evaluated and given psycho social interventions and pharmacological interventions by the child mental health expert. They were sent back to school after expert intervention, but reviewed monthly in the UNARV clinic. Primary counselors will continue the observation and intervention at school level. Behavioural and scholastic improvement were noticed by teachers and parents and reported to UNARV clinic. Five years data were analyzed. Totally 2432 students attended UNARV during the evaluation period. Most common problems for which students referred were physical fights (38.3%), pornography (21.8%), poor scholastic performance (20.7%), skipping classes (19.1%), alcohol abuse (19%), smoking (14.2%)

and love affair (8.5%). Common mental disorder was conduct disorder (36.4%). Usually students with these kinds of behavioral problem are thrown out or suspended from school. But UNARV made an end to this trend. UNARV forms a sustainable and alternative district model in a resource poor environment.

MANASA

1. A model for early identification and individualized intervention of children with poor scholastic performance among upper primary school students. Learning is not a unitary process involving teacher and student. It depends on the relationship and interplay of familial, psychological, educational, social and economic atmosphere in and around the child. In a normally developing child having normal vision and hearing with adequate psycho social stimulation and school exposure, the basic learning skills including reading writing and basic arithmetic will be attained by the end of 4th standard. Scholastically backward children are backward in relation to the average attainment of scholastic skills for that age and grade. Poor scholastic performance (scholastic backwardness) is only a symptom. Analysis of the symptom will help in understanding the problem and designing an early intervention strategy. Aim of the present study was to find out children with poor scholastic performance in the upper primary schools and do early individualized intervention for students and psycho social intervention for respective families. Early identification and individualized educational and psycho social interventions were carried out by trained resource teachers who were appointed in each upper primary school as part of MANASA project under the South Mararikulamgramapanchayath. Out of total 629 students in the four upper primary schools, 147 had poor scholastic performance (23.7%). Among these 147 students, reading skill grading showed that, 68 were mild, 60 were moderate and 19 were severe type with poor scholastic performance. Common psycho social problems (family psycho pathology) observed were domestic violence, alcoholism, quarrelsome events, and abandoned family (single parent family). Family psycho pathologies were noticed among 48.7% of the children with scholastic backwardness. After one year of individualized educational and psychosocial interventions, 54.88% of students improved in their reading and writing skills and moved to higher grade. Outcome indicator is the attainment of learning skill and improvement to higher level of learning skill demonstrated in the outcome assessment.

1. Articles 43 to 54: Governments are responsible for carrying out the CRC and ensuring that all children can enjoy their rights.

Preamble

1. An appropriate infrastructure and child friendly environment is essential for the effective delivery of ICDS services. Anganwadi centers must be housed in pucca buildings with baby friendly toilets, safe drinking water and sanitation, electricity connection and should have clean surroundings. And Anganwadi's should have LPG connection and sufficient storage space.

Burden of Issues

1. Inadequate infrastructural facilities in Anganwadi centers: As per the annual survey report of ICDS, 33% of Anganwadi centers are functioning in rented buildings and most of them are in kucha buildings. About 84% of Anganwadi centers do not have baby friendly toilets, 42% of Anganwadi centers are not electrified, 9.35% of Anganwadi's have no LPG connection and 28% have no drinking water facilitiesof its own.

Causes

1. Lack of land availability
2. Ineffective convergence with LSGD.
3. Lack of community intervention.
4. Delay in completion of infrastructure projects initiated.
5. Lack of adequate fund earmarking from LSGD for infrastructure development in anganwadies.

Gap Analysis

1. Out of 33115 anganwadi centers, 22536 centers have own building and 1803 is functioning in public buildings and rest of 8776 are functioning in rented buildings. 42% have no electricity facility, 9% are still using fire wood/ kerosene, 87% have no baby friendly toilets, 28% don't have drinking water facilities and 47 % have no compound walls. Of the 33115 anganwadi centers 512 are in "D" Grade, 3979 are in "C" Grade, 15904 in "B" grade and only 12718 are in "A" Grade (38%)

Intervention -Good Practices

1. Model anganwadieswith a unit cost of 23.75 Lakhs is being constructed in each 140 Legislative Constituencies of the State with the support of concerned MLAs. This anganwadi centers envisages as the meeting place of 3G (3 Generations, viz. Preschool children, Adolescent and Women and Aged). 506 anganwadies were constructed with NABARD/RIDF fund. Grading of anganwadi centers was developed on the basis of infrastructure facilities and quality of delivery of services.

Suggestions

1. Provide all infrastructure facilities to anganwadies

Rationale

1. ICDS has the largest network across the country and hence the best option to reach out to the disadvantaged

Objectives

1. Create 100% own buildings/pucca rented buildings with all modern facilities compete with advanced countries.

Strategies and Models for Implementation

1. (i) Incorporating BALA (Building as Learning AID) concept while constructing Anganwady centers (ii) setting up on clear norms on creating infrastructure facilities.(iii) Installation of solar panels for electricity, where electrification is not possible. (iv)preparing a unique plan for Anganwadi center construction here after, and (v)converting all Anganwady centers to "A" Grade in the 13th Plan period.

Agencies

1. LSGs, Social Justice Dept., Suchitwa mission,PWD

Training

1. Awareness to PRI membersregarding need for infrastructure and duties of LSGs in this.
2. Special training for engineers of PWD and LSG's regarding childfriendly construction.
3. Research:
4. A study on the availability of the existing infrastructure facilities in Anganwadi Centers.

Outcome Indicators

1. 100% Anganwadies with own/pucca rented buildings.
2. All Anganwadies with electrification, baby friendly toilets, safe drinking water, compound wall with adequate play materials for children. Number of new Anganwadi buildings constructed by LSGD.
3. 100 % Anganwadi in "A" grade.

Monitoring

1. Social Justice and Local Self Government Departments

REFERENCES

Bhattathiri M M and Kumari S (2015) A cross sectional study conducted on the Infant and Young Child Feeding Practices among mothers in a selected Rural area of Kollam,Kerala.International journal of Health Science and Research 6(1):26-30.

Bird H (1996). Epidemiology of childhood disorders in a cross-cultural context. Journal of Child Psychology and Psychiatry and Allied Disciplines, 37:35-49.

DLHS – 4. District Level Household and Facility Survey (DLHS-4), 2012-13: International Institute for Population Sciences; 2014.

Global burden of disease study 2013: A systematic analysis: Lancet 2015 August 22;386

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Co morbidity Survey replication. *Archives of General Psychiatry*, 62(6), 593-602.

MKC Nair, DS Chacko,Darwin MR etal (2011). Menstrual Disorders and Menstrual Hygiene practices in Higher secondary school girls. Indian Pediatr79(1), S 74-78.

MKC Nair, Harikumaran Nair GS, Mini AO, Indulekha S, Letha S, Russell PS (2013). Development and validation of language evaluation scale Trivandrum for children aged 0-3 years--LEST (0-3). Indian Pediatr.50(5), 463-7.Epub 2012 Nov 5.

MKCNair, GS HarikumaranNair, BabuGeorge, N Suma, C Neethu, ML Leena, Paul SwamidhasSudhakar Russell (2013). Development and Validation of Trivandrum Development Screening Chart for Children Aged 0-6 years [TDSC (0-6)]. Indian J Pediatr.80 Suppl 2, S248-S255.

Nair AB, Devika J (2014). Self reported sexual abuse among a group of adolescents attending life skills education workshops in Kerala- Academic Medical Jounal of India. 16, 2(1),3-6

National Mental Health Survey Of India 2015-16; Ministry of Health and Family Welfare Govt of India.

Nelson V,Aslam AN and Simon S (2015) Gap between Awareness and Practices of Breastfeeding among mothers attending a pediatric clinic in rural hospital along the costal belt of South Kerala.*International Journal of Allied Medical Sciences and Clinical Research 3* (3) :264-270.

NFHS-III. Indian National Family Health Survey (NFHS-3), 2005-06: International Institute for Population Sciences; 2007.

Srinath.S, Girimaji SC, Gururaj G et al, (2005).Epidemiological study of child and adolescent psychiatric disorders in urban and rural areas of Bangalore, India. Indian J Med Res. 122, 67-79.

Verhulst FC (1995). A review of community studies. In: Verhulst FC, Koot HM, eds. The Epidemiology of Child and Adolescent Psychopathology. Oxford, Oxford University Press.

World Health Organization (2000). World health report. Geneva: World Health Organization.

World Health Organization (2001). World Health Report: Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

ANNEXURE 1

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 **Child Development and Nutrition** -Orders issued.

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

No. 298/2016/SS (W13)/SPB Dated:19/09/2016

As part of the formulation of Thirteenth Five Year Plan, it is decided to constitute14 Working Groups under Social Services Division. Accordingly, the Working Group on**Child Development and Nutrition** is hereby constituted with the following Co-Chairpersons and Members.

Co-Chairpersons

1. Sri. A. Shajahan IAS, Secretary, Social Justice Department
2. Dr. M.K.C Nair, Vice Chancellor, Kerala University of Health Sciences, Medical College P.O., Thrissur

Members

1. Sri. P. Balakiran IAS, Director, Social Justice Department, Thiruvananthapuram- 695011
2. Fr. Joye James, Childline Nodal Director, Loyola College of Social Sciences, Sreekariyam PO, Thiruvananthapuram -695017
3. Dr. Babu George, Director, Child Development Centre, Medical College, Thiruvananthapuram- 695011
4. Dr. Jayaprakash R., SAT Hospital, Medical College, Thiruvananthapuram
5. Adv. J. Sandhya, Member, Kerala State Commission for the Protection of Child Rights, Vanross Jn., Thiruvananthapuram-695034
6. Ms. Seema Bhaskaran, National Mission Manager, National Rural Livelihood Mission, (MoRD), Attappady, Palakkad
7. Sri. Sinildas, Director, VKM Special School, Malappuram.
8. Dr. K. P. Asha, Community Medicine Department, Medical College, Thiruvananthapuram-695011
9. Ms. Meena Kuruvila, Coordinator, Adoption Coordinating Agency, Rajagiri College of Social Sciences, Ernakulam
10. Dr. Peter. M. Raj, Associate Professor, Child Resource Centre, KILA, Mulamkunnathu Kavu,Thrissur
11. Dr. Arun B. Nair, Asst. Professor, Psychiatry, Medical College, Thiruvananthapuram-695011
12. Dr. Baspin, Clinical Psychologist, Neuro Linguistic Programme Trainer forChildren, Study Skill Guidance Centre, Thrissur.
13. Dr. Thara, State Programmer, Iodine Deficiency Disorder Control Cell, Medical College, Thiruvananthapuram- 695011
14. Dr. K.T, Sreelatha, State Nutrition Officer, Nutrition Research Centre, Health DepartmentThiruvananthapuram -695011

15. Sri. V.S. Venu, State Project Director, ICDS, Social Justice Department, Thiruvananthapuram- 695011

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, present status 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.

   To list the different sources of data in each sector and provide a critical evaluation of these data sources, including measures for improvement.
3. 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.
4. To outline special problems pertaining to, inter alia, (a) eradication of malnutrition among children and other sections of society and create awareness regarding 'proper' nutrition; (b) promote a healthy environment for the growth and development of all children which would require a major change in the existing social norms and practices starting from homes to schools; (c) stopping child abuse of all kinds; (d) measures for eliminating child labour and providing homes and security for street children.
5. To suggest, in particular, a set of projects which can be undertaken during the 13th Plan period in the sector.
6. 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 TA and DA as appropriate.
7. The working group will submit its draft report by 1st December, 2016 to the State Planning Board.
8. 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
Finance Officer, P.P.O, Publication 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 **Child Development and Nutrition** –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 (W13)/SPB Dated:17/10/2016

As part of the formulation of Thirteenth Five Year Plan, the Working Group on**Child Development and Nutrition**was constituted vide order referred 2nd above. Dr. Mridul Eapen, Member, State Planning Board desires to include Dr. Sobha Koshy, Chairperson, Kerala State Commission for protection of Child Rights in the Working Group as Member. In the circumstances, Dr. Sobha Koshy is hereby included as Member in the Working Group of **Child Development and Nutrition**.

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

ANNEXURE 2

COMPOSITION OF THE DRAFTING COMMITTEE

1.	Dr. Babu George	–	Chairperson
2.	Dr. Arun B. Nair	–	Member
3.	Ms. Deepa Martin	–	Member
4.	Dr. Jayaprakash	–	Member
5.	Fr. Joye James	–	Member
6.	Adv. Sandya	–	Member
7.	Dr. SreelathaKumari	–	Member

The Working Group on **'Child Development and Nutrition'** has received support from the following members of staff of State Planning Board at its different stages.

1. Smt Shila Unnithan, Chief, SS Division, State Planning Board
2. Sri M. Thomas, Deputy Director, SS Division, State Planning Board
3. Smt. Geetha, Personal Assistant, Perspective Planning Division, State Planning Board
4. Sri. Deepak Johnson, Technical Assistant, VC's Office, State Planning Board
5. Sri Vijayasuryan CK, Technical Assistant, VC's Office, State Planning Board
6. Sri Harshan TEE PEE, Special Private Secretary, VC's Office, State Planning Board