GOVERNMENT OF KERALA
KERALA STATE PLANNING BOARD

FOURTEENTH FIVE-YEAR PLAN
(2022-2027)

WORKING GROUP ON

CHILD DEVELOPMENT& NUTRITION

REPORT

SOCIAL SERVICES DIVISION
March 2022

FOREWORD

Kerala is the only State in India to formulate and implement Five-Year Plans. The Government of Kerala believes that the planning process is important for promoting economic growth and ensuring social justice in the State. A significant feature of the process of formulation of Plans in the State is its participatory and inclusive nature.

In September 2021, the State Planning Board initiated a programme of consultation and discussion for the formulation of the 14th Five-Year Plan. The State Planning Board constituted 44 Working Groups, with more than 1200 members in order to gain expert opinion on a range of socio-economic issues pertinent to this Plan. The members of the Working Groups represented a wide spectrum of society and include scholars, administrators, social and political activists and other experts. Members of the Working Groups contributed their specialised knowledge in different sectors, best practices in the field, issues of concern, and future strategies required in these sectors. The Report of each Working Group reflects the collective views of the members of the Group and the content of each Report will contribute to the formulation of the 14th Five-Year Plan. The Report has been finalised after several rounds of discussions and consultations held between September to December 2021.

This document is the Report of the Working Group on "Child Development & Nutrition". The Co-Chairpersons of Working Group were Smt. Rani George IAS, Principal Secretary, Women & Child Department, and Smt. Shoba Koshy, Former Chairperson, Kerala State Commission for Protection of Child Rights. Smt. Mini Sukumar, Member of the State Planning Board co-ordinated the activities of the Working Group. Dr. Bindu P. Verghese, Chief, Social Services Division was the Convenor of the Working Group and Ms. Dhanya S Nair, Deputy Director, Social Service Division was Co-convenor. The terms of reference of the Working Group and its members are in Appendix I of the Report. Member Secretary

Member Secretary

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REPORT SUMMARY

Kerala has a long-established preeminence among states in India in the matter of indicators pertaining to survival and development of children. This is, interalia, due to its success in matching global standards in its IMR and Child Sex Ratio (CSR), and ensuring near universal institutionalised delivery and school enrolment. These achievements, and many more, have been the outcome of policy initiatives and sustained investments over decades that supported the creation of infrastructure promoting public health, nutrition, and education.

However, some recent disturbing trends call for immediate response. They include the decline noted in CSR in certain districts, and the growing level of anemia in all cross sections of society, despite arrangements put in place to ensure both nutrition and supplementary nutrition for children in economically and socially vulnerable groups. Increase in obesity too is a serious issue. The drop in the rate of immunization and the increasing burden of morbidity and its social and economic consequences, even as efforts to reduce infant mortality succeed, are other aspects that need to be addressed.

In the field of education, there is concern about some children remaining outside the system from the preschool stage. Although dropouts from the schooling system may be negligible, the fact that they predominantly comprise children from socially and economically vulnerable groups, is a worrying trend. According to the recent SDG Report of NITI AAYOG, less than 25% of persons with disabilities in the state who are over 15 years have completed secondary education. This is a wakeup call for action.

Much needs to be done for basic child rights like protection and participation. Recently, disturbing trends have been noted in the state's hitherto favourable track record on issues like child marriage. The state's efforts in the matter of providing protection against mental, physical and sexual abuse against children, including abuse within the home, need improvement. Mental health issues, addictive behaviour and suicides among children have shown an increase, which call for a serious effort to address lifestyle and parenting issues. The adverse consequences of disasters, that repeatedly plagued the state in recent times, require better preparedness against climate change issues. The challenges posed by pandemics, and the influence of digital technology, the cyber world, and social media, that often rob children of their childhood, call for a fresh look at how to address child rights in an increasingly complex world.

There is need to review the space given to children to participate in matters that affect their life, be it at home, school or in their community. It is also required to assess to what extent facilities availed by children are "child friendly", and whether adequate child rights perspective is being factored into public systems, infrastructure, and policies where children too are stakeholders. The lack of adequate data on children availing services outside the government system is also seen as a handicap in effective policy formulation. There is an urgent need to streamline the efforts made by multiple stakeholders to improve implementation of various programmes, placing the child's "best interest" in focus. Children in socially and

economically vulnerable segments of the population need special support.

These issues were examined through five subgroups that addressed aspects relating to Survival, Development, Protection, Mental health and Effective governance of child rights. Their recommendations are summarized below:

1 Despite the availability of an elaborate network of grassroot workers in the Health and WCD departments, NFHS data shows a decline in complying with key ante and post-natal care requirements. It is necessary to review and streamline the efficacy of the existing arrangements and reduce duplication of efforts by the Health and ICDS grassroot machinery.

2 A single, comprehensive digitised database of all ante and postnatal services availed in both public and private facilities during the first 1000 days of a baby's life must be created. By digitally collecting data directly from the hospitals as is being done for notified diseases, and making it accessible to all stakeholders, the current overlaps can be avoided, and reliable data and effective and timely follow up can be ensured.

3 For improving the perinatal care given to mothers, (i) provision should be made for a "birth companion" for HRPs in all Government and major private hospitals conducting delivery, and Baby Friendly Hospitals upgraded to Mother and Baby Friendly Hospitals; (ii) focused efforts should be made to reduce MMR by developing protocols and clinical guidelines, through training and awareness creation, systematic reporting of maternal deaths and their audit; (iii) help identify and manage postpartum depression with the help of a standardized checklist, creating awareness and proper documentation; and (iv) reduce C-sections in the state from the abnormally high level of over 40%, through proper management of antenatal care, including nutrition and weight management of the mother, and by promoting ethical practices supporting natural delivery through effective audit by professional peer groups.

4 To improve the care given to newborn babies (i) improve the status of breastfeeding within an hour of birth. FOGSI and IAP must honour their joint commitment in this regard; (ii) ensure the availability of breast milk for all children by setting up LMUs in District Hospitals and CLMCs in Medical Colleges;(iii) set up SNCUs in the three pending districts, (iv) improve the infrastructure facilities in NICUs and decentralize them to all district and large maternity hospitals. (v) Set up Mother NICUs in Medical Colleges.

5 To reduce morbidity as also avoidable deaths (mostly within the first week after birth), in addition to items (iii) to (v) of para 4: (i) develop protocols for uniformity in handling children in SNCUs and NICUs/ MNICUs and to train mothers in handling SNCU graduates (ii) implement the National Programme, SAANS, in the state, and create community mobilization against pneumonia (iii) implement the India New Born Action Plan, including house visits by grass root workers at specified intervals, to monitor the baby's development and ensure timely corrective action.(iv) as part of antenatal care, ensure availability of periconceptional folic acid through anganwadis to prevent neurological defects in babies. Currently, this facility stands withdrawn due to

the verdict in a case filed by pharmacists. This needs to be challenged in High Court by explaining its serious implications, and supply resumed

6 To improve nutrition level of newborn babies (1) exclusive breastfeeding up to 6 months must be ensured through better awareness creation about its benefits;(ii) ensure better access to creche facilities for working mothers; (iii) focus on proper complementary feeding between 6 and 24 months, as less than 23% of children are being fed as per WHO's recommended pattern to avoid stunting, wasting etc.

7 To improve nutrition levels and curb anemia, (i) provide budgetary support for Government's ongoing Campaign 12 (ii) budgetary support also needed for increasing the nutritional value of the Food Basket for Supplementary Nutrition Programme (SNP) by adding fresh fruits, vegetables, proteins, micronutrients etc. (iii) Support also needed to increase the per head rate of the existing SNP food basket to offset the increase in input costs. (iv) Review the functioning of nutritional clinics and promote them with the help of LSGIs and through cross referrals from Adolescent Clubs Antenatal care clinics etc.

8 Promote a lifestyle change in society through an extensive Behaviour Change Campaign, with an extensive IEC component that creates better awareness of child rights as inalienable, bring about all-round impact on the care and nurturing of children, and promotes a life cycle approach to nutrition including appropriate eating practices and balanced diet, and in addressing issues of mental health.

9 To strengthen the effectiveness of the grassroot network of anganwadi and ASHA workers: (i) provide them regular training, including interactions online with medical professionals, to clarify their doubts (ii) close supervision over their functioning, (iii) prepare anganwadi/PHC level mapping of beneficiary families and implement plans with specified outcomes. There should be no compromise on home visits of targeted families (iv) ensure that their diverse responsibilities at the LSGI level do not hinder ICDS and health workers from their core duties to mothers and newborn babies (v) give budgetary support to develop an on line training portal and App based learning material for ICDS staff.

10 Give specific budgetary support to LSGIs for regular upkeep of all facilities in government schools, including playgrounds and toilets, for ensuring safe, clean, and hygienic surroundings.

11 Indicators need to be prepared, giving special attention to facilities for the gender and the disabled, for compulsory self-certification and publication of their facilities by all Government and aided schools to ensure a safe and child sensitive environment. Similar self-certification of facilities needs to be promoted for hostels and tuition centres also based on a checklist to be developed by the Departments of Education, WCD and Health.

12 School mapping and database maintenance of children up to secondary schools must be completed in a time bound manner by LSGIs (and regularly updated) for children in their jurisdiction, as specified under the RTE Act 2009.

13 Strengthen roles of PTAs, MPTAs, SMCs and SPCs by sensitizing them of their roles

and responsibilities through training, and monitor their performance for uniformity with a well-defined checklist. Space given to children for participating in these forums must be ensured by clearly specifying the terms of their engagement and for reflecting their opinion in decisions that affect their lives.

14 PTA must be reoriented to become a platform for nurturing students and optimizing their potential, by focusing on collaboration between parents and teachers rather than on fault finding. It can also be developed into a platform for sensitizing parents on addressing emerging challenges like addiction, cybercrimes, sex, gender etc. that impact children's behaviour. Teachers need to be given appropriate reorientation through training.

15 Review the existing number of school clubs at the secondary level. Ensure that every child can be member of a club and partake in extracurricular activities.

16 Given the large scale dropouts among children with disabilities and to ensure that they benefit from an education that accommodates their special needs and capabilities (i) put in place a system for getting these children "school ready" (ii) have a benchmark for the level of disabilities up to which they can benefit from inclusive education in a general class (iii) for ensuring effective inclusive education, every teacher providing inclusive education should mandatorily have at least a certification in special education (iv) Have a well-defined strategy for imparting life skills and appropriate education to children who need more individual attention (vi) develop yardsticks for measuring the learning proficiency of children with special needs at different stages, both in terms of academics and life skills (vii) update the curriculum to make their skills market compliant (viii) ensure optimum use of appropriate technology when imparting education to them(ix) in schools providing inclusive education, sensitise children about disabilities so as to foster mentoring and support rather than bullying tendencies.

17 Review infrastructure and facilities in MRS/SC/ST/Fisheries/Sports hostels and ensure that they are sensitive to child rights and the gender and culture of the children.

18 Undertake an infrastructure audit of all facilities in Government schools and prepare a time bound action plan with budgetary support to make them compliant during this Plan period with the provisions of the RTE Act, the KER1959, and the RPWD Act 2016. Ensure availability and access to facilities for physical fitness for all children.

19 The Department of Education should compile the list of all preschools, including anganwadis, functioning in the state in the Government, NGO and private sectors. Their functioning must be regulated under a framework which prescribes standards in terms of basic facilities to be provided, learning outcomes and safety.

20 Formulate the pedagogical framework for ECCE through consultations between WCD and Education Departments, giving due consideration to the care component, and in harmony with local culture, traditions, and folklore. It also needs to address the language barrier faced by tribal and migrant children to become "school ready". BRCs need to be empowered and supported to undertake this responsibility.

21 Infrastructure and facilities in all existing anganwadis and other preschools in the government sector must be reviewed to prepare a database of requirements, to make

them compliant with the defined standards (and ideally with their own buildings) during this Plan period. Building models must be designed keeping in mind local conditions.

22 Promote preschool education through the anganwadis, as was done for public education, involving all stakeholders and the local community. With support of the LSGIs, ensure that no child is deprived of preschool education.

23 Best practices in implementing the Midday Meal programme, including the role of MPTAS, creation of vegetable gardens, and providing clean dining spaces, must be shared, and encouraged. In private schools, nutrition and good eating habits must be encouraged through a partnership with them that seeks to curb junk food sale through canteens and tuck shops, and campaigns that promote a life cycle approach to healthy eating and balanced diets.

24 There must be ownership by the school for the School Health programme, currently managed by Peer Educators under the RKSK programme, with RBSK teams that visit from time to time. Early decision is needed on implementing the school component of the Ayushman Bharath programme, bring other health components like the WIFS, RBSK etc under this umbrella scheme and ensure effective, supervised implementation.

25 With schools reopening shortly, undertake a review of the School Health Programme, map different services to remove duplication, and identify gaps in availability of basic equipment for screening, First Aid etc. A guide may be prepared and supplied to schools on the basic services and referrals available and how they can be accessed. Also develop a holistic package covering child development and adolescent health, with focus on early detection and referral of COVID 19, to address issues connected with Long COVID

26 Tackle the increase in abuses against children: (i) declining CSR--monitor the data relating to PCPNDT ACT at the subdistrict level, focusing on all cases below 952. Ensure that the statutory bodies under PCPNDT Act are correctly constituted. Study incidence of long and continued low CSR in certain pockets. (ii) increase in child marriages—focus on sensitizing stakeholders, especially children, teachers and, parents. Closely monitor dropouts with the help of SMCs and LSGIs; special efforts need to be made to sensitise tribal communities about the illegality, and encourage them to break out of this practice. (iii) Increase in Child labour—create consolidated database on incidents of child labour lying scattered among various authorities for timely follow up, ensuring speedy punishment, and payment of compensation.

27 Promote safety of children by : (i) regulating day care, preschools and creches with prescribed standards under a regulatory framework (ii) developing safe spaces for children for physical activities in every panchayat and providing a playground for every school (III) Creating a community area in every panchayat where children can stay safe and not be left alone at home (iv) undertaking vulnerability mapping at ward level to identify families that need support, and to understand the nature of issues and support required.(v) reactivating VCPCs and Jagratha samitis to ensure proactive support to tackle vulnerabilities (vi) updating and circulating the Balasuraksha Protocol to ensure

effective, comprehensive action when a child's safety is compromised (vii) Improving the quality of the SCRB data wherein over 30% of information is not usable for want of clear details.

28 Ensure active involvement of parents in the upbringing of children: (i)-Promote the importance of parenting through Parenting clinics, Antenatal clinics, Adolescent clubs, NGOs etc.(ii) Make attendance of Parenting clinic a part of ante natal care for all parents-to-be, and develop standardised content/SOP for this interaction.(iii) Improve involvement of all parents in PTAS, MPTAs, SMCs, SPCs etc where they can play an active role to improve the school's facilities. (iv) Ensure presence of parents when counselling children in schools on discipline related issues. (v) Promote concepts like Effective parenting and Positive discipline for implementation in schools and at home.

29 Improve care of CNCPs and CCLs: (i) ensure that all rehabilitation is done only based on ICP. Prepare SOP for rehabilitation of children, and family counselling should be an integral part of it (ii) Review the KAVAL scheme and expand its coverage to all CCLs, with modifications if deemed necessary, Provide budgetary support for this initiative. The same approach to be followed for the pilot scheme KAVAL PLUS for CNCPs (iii) Budgetary support needs to be provided for (a) providing support facilities in homes for readying the children for rehabilitation (b) for setting up a Home for children over 18 years who wish to pursue higher studies (c) for a Rehabilitation centre for children with disabilities who cannot return home.

30 Budgetary support needed for providing a "child friendly" environment in institutions: (i) Create facilities for taking on line depositions and cross examination of CSA survivors in OSCs to avoid revictimization (ii) Ensure that the Special Courts set up for trial of POCSO cases are equipped to be '"Child friendly" (iv) Set up Special Juvenile Police Units in every district with appropriately trained personnel and facilities

31 To tackle issues of Mental Health: (i) Adopt a life course approach to mental health since 85% to 90% of brain development occurs in the first 1000 days (II) remove the stigma about Mental health by creating greater awareness about it and the support systems available (iii) With the involvement of local community and the LSGI, increase protective factors that promote positive action (eg. providing safe spaces for recreational activities) and reduce risks in the child's immediate environment (eg. providing a community centre for children to stay safe) (iv) Empower parents and teachers on how to tackle addictive behaviour

32 Involve children, including the Peer Educators in promoting mental health in schools. (vi) special attention must be given to support children with disabilities, those from economically and socially challenging backgrounds, and those with discipline and anger management issues, to help prevent any drop out.(vi) Post covid, since many children will experience some mental fatigue, make Mental Health a part of the School Health programme, and help overcome the stigma by terming it a Comprehensive Wellness programme for Physical and Mental health. This will also help to use the resources of multiple service providers more efficiently (vii) Based on screening, identify those who need support of the Psychological First Aid package developed by NIMHANS, and

train teachers to provide it, after giving them a brief clinical exposure.

33 Streamline the existing facilities for counselling in schools by avoiding duplication of efforts by WCD and Health, and integrating this facility into schools through greater ownership by the latter. Clearly define the roles and responsibilities of teachers and counselors in tackling issues of discipline and mental health. Utilise the services of counselors to provide support to children in hostels and Homes. CCLs and survivors of adverse childhood experiences may require medical support and long term, one- to-one therapy, which must be provided as part of rehabilitation. To enable counselors to function effectively, a mentoring/ hand holding support system must be made available to them to tackle difficult situations

34 Provide exclusive facilities in Medical colleges and De addiction centres for treating children with addictions and mental health challenges. Provide training in life skills by effectively implementing "Ullasaparavakal", the text prepared by SCERT for all classes, and training teachers to utilize it as part of the syllabus. Strengthen Adolescent Clubs/ Adolescent Health Clubs to play a major role in promoting mental health. Develop SOPs for their activities and hold special programmes for mothers and adolescent migrants. Consider using the support of duly accredited NGOs and experts to support these initiatives and mobilise the community.

35 Based on experience of handling children in repeated natural disasters and pandemics, and anticipating similar situations due to the impact of climate change; SOPs need to be prepared for them. Ideally, Government must formulate a Child Mental Health Policy that will spell out the strategies for tackling the rising incidence of mental health among children.

36 With a multiplicity of stakeholders providing services to children there is a need to review and streamline programmes and roles and to rationalize resources for optimum efficiency. To bring about this convergence, an Interdepartmental group of concerned departments must be set up to review, pool resources and ensure effective implementation

37 A consortium of key persons in Government and the concerned departments must be set up to address important policy issues and key areas of governance pertaining to children. A nodal officer should be designated in every department to ensure that a child perspective is included in every department's plans and programmes

38 Introduce the concept of Child Budget at the Planning Board and LSG levels and continue this exercise at the level of the State Budget. This will help bring greater focus to programmes relating to children

39 At the LSGI level, Child development should have a separate working Group and not be part of the Working Group on Social Justice. Forums must be provided for consultation with children in the plans of LSGIs upto the District level

40 The role of LSGIs in promoting child rights at the grassroot level is substantial but it is yet to be fully understood. Their involvement and support is crucial in ensuring the effective functioning of the grassroot network, in community mobilization, for conducting different programmes like immunization or for conducting Nutrition or

Parenting clinics. Their responsibilities towards improving various social indicators relating to women and children need to be better impressed on them with the help of KILA

41 KILA's Child Friendly Local Government Initiative (CFLG)sought to address this issue in select LSGLs. It is necessary to review the implementation of this initiative, and consider its implementation across the state, with course corrections as deemed necessary. During this Five Year Plan a beginning could be made to improve "child friendly" public spaces in the capital city of Thiruvananthapuram. This may be supported under the current plan period.

42 A special programme may be formulated for the especially vulnerable areas like SC/ ST colonies, fishing villages, layams, purambokes,, migrant settlements etc where access and infrastructure for basic care are both very poor. Under this programme,, minimum benchmarks of care and access may be set for achievement during the Plan period, with special budgetary support provided through the LSGIs and with their cooperation Hunger is an issue that children in these pockets face regularly on any day there is no school. Taking a leaf from the scheme implemented by the Education Department during lockdown, a special package may be formulated for such identified pockets so that no child goes hungry in the state.

43 The State needs to come up with an update on its State Child Policy2016 and the State Plan of Action, last formulated in 2012.

I SURVIVAL - THE FIRST 1000 DAYS AND BEYOND

1. INTRODUCTION

1.1 Kerala is considered a pioneer in India for initiating pro-poor polices and social protection programmes for children and women, especially in the most marginalised communities. The efforts that the state has made over the past few decades towards introducing progressive legislations and schemes, including various social security measures, and the special focus given to expanding the coverage of healthcare and nutrition, as well as in improving systems relating to provision of education, public health, clean and safe water, sanitation, and hygiene have helped in substantially improving its child survival indicators.

1.2 However, even as the recently published NFHS-5 data indicates that the state has the lowest infant and child mortality rate in the country, it also notes a simultaneous increase in the levels of malnutrition among children and mothers, despite the efforts made to reduce/eradicate it

1.3 The State has an obligation to ensure that all children have the opportunity to develop to their full capacity not only as a human right, but also for ensuring equitable prosperity and sustainable progress of society.

1.4 Globally, three areas are considered as the critical foundation for child development/ survival. They are. (1) stable, responsive, and nurturing caregiving with opportunities to learn, (2) a safe, supportive, physical environment, and (3)appropriate nutrition. These three aspects include many familiar best practices such as planned, safe, pregnancy and

childbirth, exclusive breast feeding, and appropriate complementary and responsive feeding.

1.5 This chapter addresses these issues pertaining to child survival in the state of Kerala, (commencing from antenatal care of mothers- to- be) and the multidimensional approach being adopted to foster the child's right to survival with a focus on the First 1000 days of life.

2. PREAMBLE

2.1 The "National Policy for Children 2013"(NPC 2013) envisages survival, health, nutrition, development, education, protection and participation of children not only as key priorities, but also as the undeniable right of every child. Based on the NPC 2013, Government of India (GOI) developed a National Plan of Action for Children in 2016 (NPAC 2016), which stands as the country's practical expression of commitment to national progress. This declaration is considered as a foundational investment in setting goals, strategies, and actions for the coming years.

2.2 Four priority areas were identified to develop strategies responsive to the specific situation of children in our country which include "survival, health and nutrition, education and development, protection and participation".

2.3 This document examines the issues to be addressed in Kerala, in relation to two priority areas, viz."Survival," and "Health and Nutrition", based on the available evidence, and puts forward recommendations for consideration towards improving child survival in the state during the next five year Plan period. It also briefly touches upon issues pertaining to Safe drinking water, sanitation and hygiene as they have a direct correlation with promoting good health for children.

3. ISSUES FOR DISCUSSION

- Situational analysis in relation to Survival, Health and Nutrition of children
- Preconception care and counselling package
- First thousand days approach (and beyond to the third year of the child.)
- Addressing preventable morbidity and mortality
- Importance of the grass root monitoring mechanism in protecting the child's right to survival
- Challenges in tackling high risk cases
- Other related issues
- Role of LSGIs

4. SITUATIONAL ANALYSIS

4.1 According to the NFHS 4 data, only 32.9% of the children in India receive the 'continuum of care' that new born babies are required to receive; however, for Kerala, that figure is 78.4%. While this comparison may present a rosy picture, there are reasons to worry. This is because included in this globally defined concept of 'continuum of care' are three critical parameters, viz.

- a minimum of 4 antenatal check ups (ANC4),
- institutional delivery, and

- the post -natal visit two days after delivery,

which appear to have been denied in some measure to one fifth of the target group. On closer scrutiny, this data raises some further areas of emerging concerns, the status of which, and the issues related to them, are discussed below:

4.2 Parameter number 1: Although 93.6% women were found to have received ante-natal care during the first trimester of their pregnancy according to NFHS 5, only 78.6% completed all the mandatory number of antenatal care visits. This is a substantial drop from the related figures of 95% and 90% respectively reflected in the NFHS 4 survey.

4.3 This sharp drop in antenatal visits is a cause for concern because there is a rapid increase in the number of prematurity cases, while birth asphyxia is emerging as a prime killer of newborns. Factors contributing to these cases are many, but they include antenatal factors like maternal conditions, hypertension, gestational diabetes, anemia, malnutrition, congenital anomalies, uterine causes, infertility treatment etc. Some of these factors can be modified through quality care during antenatal visits; if that happens, then mortality and complications during delivery can be avoided to an extent. This emphasises the importance of timely antenatal visits for check ups.

4.4 Parameter number 2: All births occurred in an institution attended by a trained attendant of which 65.9% occurred in private hospitals.

4.4.1 The fact that all deliveries in Kerala are done under proper medical care in an institution is a truly laudable achievement, and certainly one that has contributed to the reduction of IMR in the state. However, the fact that a majority of the deliveries are happening in private hospitals raises a few concerns because deliveries which happen in private facilities go out of the framework of the focussed, digitised monitoring that is provided to mothers and children who are delivered in government hospitals.

4.4.2 Normally patients who go to private hospitals are those who can afford those services, or those who have a high level of health seeking behaviour, whereby they would like to avail these services with the additional comforts that are available in a private sector facility, albeit at a price. These categories of people tend to follow the after care regimen for the mother and baby prescribed by the attending doctors, even without any prompting or follow up by the grassroot machinery.

4.4.3 However, there is now yet another segment of the population who are availing private facilities not because they can afford them, but because they get some measure of insurance coverage, and also because they cannot conveniently access the delivery facilities in government hospitals. Delivery facilities are presently available only in hospitals beyond the level of CHCs. This segment of the population is a concern because their health seeking behaviour is influenced by many factors, one of which is their financial situation.

4.4.4 Therefore, there is every chance of their defaulting on some of the prescribed visits, and the services provided during these visits, because these are all paid services in the private sector, which they may not be able to afford. This is a concern because the children in this vulnerable group can miss out on vaccination doses and the

benefits of early screening for disabilities that are being offered free of cost in the government facilities, which can have a very adverse impact on the quality of their life.

4.4.5 The Mother Child Protection (MCP) card which is provided to every parent, irrespective of whether they use the private or government facilities for their delivery, is a good tool to keep track of the progressive milestones of the baby and the follow up they are required to provide. However, the MCP card is not being used optimally (in those cases where it is put to use) and in the case of private hospitals, the latter are often using their own books or cards. So there is a multiplicity of documents now available with mothers and most of them are stated to have no clue about the contents of the detailed instructions available in the MCP card issued by the Government under the RCH programme which covers the care of babies beyond the 1000 days to address issues up to the 3rd year of the child. This is a situation that needs to be looked into and rationalised at the earliest by impressing on the grassroot network on the importance of following up on the instructions in the MCP card and impressing upon the mothers the need to understand and follow up on the instructions and also ensure timely visits to the doctor for follow up.

4.4.6 The only way to ensure regularity in visits is to do so with the help of the grassroot level workers through their regular follow up and prompting. Therefore, this follow up and its monitoring by the Department of Health needs to be expanded to include in the digitised monitoring framework those mothers and children who avail the services of private facilities but are vulnerable in terms of health seeking behaviour. Currently this digitised monitoring facility is provided only for mothers and babies who are linked to government facilities. The modalities of expanding this monitoring coverage need to be considered with the support of private hospitals, failing which at least by using the data available with the field staff of the Departments of Health and Women and Child Development (WCD).

4.4.7 At present the data is available with both the anganwadi workers as well as the ASHA workers through the MCP card as well as the booklet given by private hospitals, and through the latter and the Junior Public Health Nurse (JPHN), entered on the RCH portal. Similarly, through the anganwadis, the data is required to be entered in the portal of the National Nutrition Mission while it remains in physical form in the registers maintained by the anganwadi and Asha workers. In the ICDS system, the data is submitted in manual mode every month to the ICDS supervisor as a monthly progress report.

4.4.8 When this data is available in two branches of the grassroot system, there is scope for compiling this data and bringing it within the digitised monitoring framework. This needs to be examined to avoid multiplicity of work, improve accuracy, ensure more effective monitoring both by the WCD department and the NHM-department of Health, and also for obtaining an evidenced based understanding as to why, despite multiple levels of monitoring, children continue to remain anaemic or miss their vaccinations or the opportunity for screening them for disabilities. It

will also provide information on how many children actually benefit from these free services offered by the government.

4.4.9 There is also the option of obtaining this information directly from private hospitals. Today with every hospital digitizing its data, it would be useful to get the details of birth and other follow up care given to a child directly from the private hospitals, as is being done in the case of government hospitals. A dialogue with them needs to be opened to explore the possibility of obtaining this data.

4.4.10 The current challenges, if any, faced at the grass root level in terms of collecting data and uploading it, as well as in follow up reporting, also need to be reviewed. Given the ever increasing trends in anaemia and other nutrition related problems, their impact on the health of mothers and newborn babies, and the growing burden of disabilities caused by the increased number of preterm and low birth weight babies, there is an urgency to understand the reasons for this continued shortfall in the nutrition status of mothers and babies in order to take effective and urgent remedial action.

4.4.11 A related issue is the resultant increase in the out of pocket expenditure on health. Already Kerala is one of the states which has the second highest level of out of pocket expenditure on health as a percentage of the monthly income (17% according to the SGD Report 2021 of NITI AAYOG when the highest figure is 18%). Expenditure on maternity health, and on children if they contract health problems that are not attended to on time, could become a lifelong source of such out-of- pocket expenditure, especially in the case of the latter. Therefore, the issue of addressing the needs of this vulnerable group who currently use private facilities for their delivery, needs serious attention.

4.5 Parameter number 3: 94% of the mothers visited their doctor for a check up, while 93% is stated to have completed this visit on the second day itself.

4.5.1 It needs to be noted that since all deliveries happen in hospitals, and the mother and child continue in hospitals on the second day, particularly when cesarean section rates are high (going beyond the level of the NFHS 5 data to touch an average of 41% in the state, with higher percentage in the private sector), the high achievement in this last parameter relating to postnatal visits is rather misleading or skewed.

4.5.2 Government of India (GOI) has set a benchmark of six visits for institutional delivery and has set a target of 95% for achieving these visits by 2025 under the India New Born Action Plan (INAP) to reduce rates of mortality. Since the new parameter has been set keeping in mind the need to monitor various milestones of growth and development of the newborn in the first 42 days, of which the 14 th and 28th day visits are very important, the old norm of 2 postnatal visits which is still being followed in the state, needs to be discarded and the new parameters for assessing effective continuum of care adopted.

4.6 *Conclusion:* The key takeaways from an analysis of the state's data relating to 'continuum of care' is that while the requirement of institutional delivery has stabilised and become

a universal practice, the same cannot be said for the antenatal and postnatal visits which are critical for the care of the pregnant woman and the new born child to avoid complications at birth and mortality.

4.7 As a consequence of the efforts made by the state to reduce infant mortality, through delivery in institutions that are well equipped to handle any emergencies, the distance between the home and the government institutions, where such free delivery services are available, have also increased. This has also led to reduced capacity which in turn has encouraged people who were previously using government facilities, and who perhaps needed that support because of their vulnerable financial circumstances, to use private facilities close to their home.

4.8 The vulnerability of this segment results in their availing the paid after-care services in private hospitals not regularly, but only to the extent they are unavoidable. As a result, unless these mothers-to-be are prompted regularly, they are likely to miss the prescribed postnatal visits to the doctor and the immunisation as well as other time bound support that are required to be given to newborn babies in the first few years of the child's life. The grass root workers play a critical role in this process. Without their support, the health of the children from this vulnerable group is bound to be adversely affected due to the ignorance or negligence or financial circumstances of their parents.

4.9 Therefore, as stated previously, there is a need to find a way to ensure how best the mothers and children belonging to this vulnerable category who use private facilities can be brought under the umbrella of the monitoring system available to those who deliver in government facilities. This will help ensure their aftercare. Technology intervention can also be considered to support the manual follow up by the grass root machinery

4.10 This after care is critical in the case of children because the care given to them at this crucial stage of their lives will lay the foundation for the quality of life they will enjoy in the years ahead. This scenario also emphasises the critical role that this grassroot machinery has to play in ensuring the care and well being of pregnant mothers and newborn children as also in laying the foundation for their future quality of life. Unless their follow up is effectively done, the shortfalls noted between the two NFHS surveys cannot be bridged. This aspect needs to be impressed on the anganwadi workers, ASHA workers, the JPHN nurses and other grass root workers in the health sector.

5. PRECONCEPTION CARE AND COUNSELLING PACKAGE

5.1 The health of a baby is dependent on the health of the mother. In order to ensure this, ideally, it is necessary to focus on the health of a pregnant woman not just from the start of her pregnancy, but from her childhood and adolescence, especially the stage immediately prior to conception.This also emphasises the importance of Planned Parenthood. Such preconception care includes advice on a proper diet, hygiene and taking the right supplements to ensure a safe delivery and a healthy baby.

5.2 One of the important supplements that is recommended for the mother- to- be to take, from the time a pregnancy is planned through the pregnancy period, is

periconceptional folic acid which will help prevent crucial neurological problems like tubal defects. Previously, this supplement was being given to young mothers- to- be through the anganwadi workers as well as through the JPHNs during their home visits or when they come to the anganwadis or to the antenatal clinics. However, due to an order of the Hon'ble High Court of Kerala upholding a plea made by pharmacists in the state not to allow the dispensing of drugs included in national programmes except through them, (even though there is an exception for doing so under the Drugs and Cosmetics Act), the state government was compelled to withdraw the power to dispense this supplement from the anganwadis and the JPHNs etc to comply with the Court's directive.

5.3 Accordingly, these tablets are currently being given only at the PHCs where there is a pharmacist. When it is difficult to get pregnant mothers to come even to anganwadis and sub centres, to expect them to go to PHCs to collect these supplements seems an unlikely proposition Hence it is a matter of concern that many of the target group of women are not getting this crucial supplement which can help avoid complications during pregnancy and prevent disabilities among newborn babies. In the best interest of children, the order of the Hon'ble High Court should be appealed against without further delay, as has been done in the case of dispensing drugs relating to Non communicable diseases under the national programme during the Covid period and the previous mode of supply of folic acid restored .

5.4 TheAdolescent Clubs of the WCD Department, the Adolescent Health Clubs of the Health Department, the School Health Programme(SHP) etc can also play a very important role in sensitising late adolescents, especially young girls, about preconception care. They have the responsibility to ensure that from a very young age, the girl child is encouraged to follow a balanced diet, prevent anemia, learn the importance of menstrual hygiene and receive counselling on issues like HIV/ STI/ RTI etc. Counselling on substance abuse involving tobacco, drugs and alcohol is also important to impress on them the long term impact these substances have on health. They should also sensitise adolescents about the support that the Nutrition and Parenting Clinics, recently started by the WCD Department, can give them on important issues at critical stages of their lives.

5.5 All of these inputs ultimately contribute to the health of the pregnant mother and her baby. To what extent these clubs and programmes are able to reach out to eligible persons, especially adolescents, and encourage them to follow these healthy practices merits a review, and corrective action taken to plug the gaps identified, given the current levels of anemia noted among pregnant women.

6. THE FIRST THOUSAND DAYS AND BEYOND APPROACH

6.1 A thousand day approach is adopted the world over to ensure the health and care of pregnant mothers and babies. Now this period is being extended by another year using the continuum of care prescribed in the MCP card and included as part of the HBYC programme. There are four important components in the First Thousand Days approach which are discussed below in the context of the circumstances in Kerala.

6.2 ANTENATAL CARE: Four antenatal care visits to the doctor are recommended for a pregnant mother. During this period, the focus is required to be on

- treating anaemia
- giving the Td vaccine
- tracking adequate weight gain during pregnancy,
- closely monitoring and tracking high risk pregnancies, and
- initiating early admission of women with High Risk Pregnancies(HRP) close to Expected Date of Delivery (EDD) for close monitoring and follow up in the last stage of pregnancy.

6.3 Since each of these activities are of critical importance to ensure the health of the mother and the unborn child and for a safe delivery, failure to ensure that every pregnant woman completes all the four check ups and takes the nutritional supplements of IFA and Calcium, can have serious consequences for the health of the mother and child.

6.4 It has been scientifically established that children of anemic mothers are themselves prone to be anemic. Therefore, addressing anemia among pregnant mothers is a matter of priority. NFHS 5 data shows that although almost all (98%) mothers received Iron and Folic Acid (IFA) supplements during their last pregnancy, only 80% reportedly consumed the same for 100 days or more, and only 67% consumed it for the now recommended period of 180 days.

6.4.1 Among pregnant women, the age group of 20-34 where most pregnancies happen, had the lowest IFA consumption rate. This shortfall has an impact on the life of the new born baby. Hence it is necessary to identify the reasons for this shortfall and take corrective measures without delay.

6.4.2 The weight gain of mothers- to -be during pregnancy also needs to be systematically monitored because the present approach is to monitor this weight gain with the help of BMI based tracking, and if the weight at the start of the pregnancy is not known, to do it on the basis of the weight at the time of the first ANC visit. This underlies the importance of undertaking the first of the four visits without any delay.

6.4.3 High Risk pregnancies (HRP) need special attention. Such pregnancies are required to be escalated to the Taluka Hospital or the Medical College, as the case might be, and they require to be closely monitored to ensure that these mothers are admitted in the hospital well before the Expected date of delivery (EDD) to avoid any complication during delivery. Therefore, if the later ANC visits are defaulted, then the required monitoring, remedial action and early admission to hospital for HRP cases will not be possible, which in turn could adversely affect the survival of the mother and child.

6.4.4 As per NFHS-5 records, 97% of women had registered their pregnancy for the most recent live births, and 91% of these registered pregnant women acknowledged the receipt of a Mother and Child Protection Card (MCP card). Seven out of 10 of the surveyed women, who had a recent live birth (ie. within 5 years of the survey), had received advice from a community health worker on some aspect of pregnancy

and childbirth.

6.4.5 Despite being in this monitoring net, 36% of the women in the reproductive group were found to be anaemic and there was an 8 point increase in anemia among pregnant women, as against the data from the previous survey. It is necessary to analyse this data to understand which segments showed no progress despite the follow up and the possible reasons for it. This data also shows that tackling anaemia is an area that needs much closer attention of the anganwadi worker, the JPHN, the ASHA worker and other health workers, and their follow up needs to be strengthened.

6.4.6 It is also noted that the reduction in Maternal Mortality Rate (MMR) is not commensurate with the pace of reduction in Infant Mortality Rate (IMR). MMR has a definite impact on the survival and future development of the child and so it is necessary to look at this issue closely from the perspective of both the mother and the child. At present the state has an MMR of 43 and it compares favourably vis a vis the figures in many other states. Internationally the rate of MMR is very low in developed countries, with New Zealand having figures as low as 1.4, Australia 4.8, UK 6.5 and USA 17.4 In Kerala, the target was to reach 30, the country's SDG target for 2030, by 2020 itself, which could not be achieved.

6.4.7 When the state could achieve an IMR of 6, which compares with the best in the world, it is a matter for consideration as to why a similar achievement cannot be attempted in the case of MMR. This becomes relevant because, in COVID19 times, due to the inability to monitor pregnancies closely, there has been an increase in maternal deaths.

6.4.8 This trend needs to be corrected in the post COVID19 period. To improve the situation, it is important to look closely at the quality of care given during pregnancy, as well as the intrapartum and postpartum care given to pregnant women, and the need to develop SOPs and protocols to avoid maternal mortality both in government hospitals and in private hospitals, where majority of the deliveries occur.

6.4.9 According to the UNICEF, haemorrhage remains the leading cause of maternal mortality along with other causes like pre-existing medical conditions aggravated by pregnancy, hypertensive disorders during pregnancy, especially eclampsia, sepsis, embolism and complications due to unsafe abortion. As these complications can occur without warning at any time during pregnancy and childbirth, most of these complications are being prevented by skilled health personnel, who conduct the births in hospitals. In the Government sector, the delivery facility is now restricted only to the larger hospitals which have facilities like a blood bank, availability of an anaesthetist etc to address these contingencies.. NFHS5 data shows that almost all (99.8%) mothers in the state have received antenatal care for their last birth from a health professional, mainly doctors.

6.4.10 Therefore, ensuring the later antenatal visits, which in turn can lead to early admission of all HRPs in hospitals, is a key issue to be focussed on to prevent

maternal mortality. Standard protocols for treatment also need to be finalised to be uniformly implemented in all hospitals in the government or private sectors, with the support of professional associations of doctors like the Federation of Obstetrics and Gynecologists Society of India (FOGSI) and the Indian Academy of Paediatricians (IAP). A focussed approach to address this issue needs to be initiated during this Plan period to bring down the MMR following the strategies adopted to bring down the IMR which includes reporting of deaths using standardised formats, audit of such cases, as well as providing standardised protocols of treatment and clinical guidelines to be complied with in all cases of delivery in government and private hospitals, and training to be imparted to the gynecologists and supporting staff.

6.5 INTRAPARTUM CARE This is a key concern, in the case of women who have HRP, many of whom suffer from high BP or diabetes. In these cases, unlike normal pregnancies, the mother is not immediately returned to her room or ward after delivery, but kept near the labour room for close monitoring till her situation is deemed as stable. However, it is a universally acknowledged fact that doctors or nurses in a busy labour room will have no time to attend to such patients, thereby leaving her unattended unless some emergency occurs. As a result, there is no one to attend to any needs of the newly delivered mother, or even to flag any help she may require during this period.

6.5.1 Recognising the need to improve the quality of care to such mothers, hospitals in some of the other states, like Tamil Nadu for example, allow the facility of a "birth companion", a person who has experienced the process of birth, who can be by the side of the new mother to help her during this period of wait. Such an arrangement is not in vogue in the hospitals in Kerala today, but merits favourable consideration.

6.5.2 Similarly, as part of postpartum care, an issue that begs closer attention is the incidence of postpartum psychosis and depression, a condition that is not much documented at present. There are cases of postpartum psychosis and depression occurring after delivery; but it goes unrecognised because bystanders and caregivers may not be familiar with the symptoms.

6.5.3 As a result, in most cases, older female relatives take over the management of the child as the mother is unable to attend to the baby, or even feed the child. Consequently, the child is deprived of the care due to it, and the baby's feeding patterns are also disturbed. Therefore, there is a need to counsel the family on this condition, prepare a checklist of symptoms that need to be watched out for, and advise them how to tackle the situation effectively.

6.6 PERINATAL AND NEONATAL CARE

6.6.1 The Baby Friendly Hospital Initiative was implemented in a few hospitals in the state some years ago, and in those few hospitals where it was implemented, it is understood that there was improvement in the perinatal and neonatal care given to newborn babies. As part of the efforts to improve the quality of care in these hospitals, and recognising the importance of the mother in providing such care,

it is now proposed that these hospitals be upgraded to Mother and Baby Friendly Hospitals(MBFH) by strengthening certain key aspects such as providing a "Birth Companion" for the mother, initiating early breast feeding of the baby, and strengthening the immunisation dose at birth, which is only 73% at present, as per the NFHS 5 data

6.6.2 Since the components proposed for benchmarking MBFHs are very conducive to ensuring quality care to mothers and babies, all hospitals in the Government sector which provide facilities for delivery should be made part of this initiative. Private hospitals, where the majority of deliveries take place, should be especially encouraged to become part of this initiative. The Federation of Obstetrics and Gynaecologists Society of India (FOGSI) should be asked to promote this initiative in the best interests of both the mother and the new-born child.

6.6.3 Simultaneously, the reason why the percentage of babies who receive the first immunisation dose at birth is only 73% needs to be looked into since this data pertains only to deliveries in government institutions where it is given free of cost immediately after delivery. So, technically, no shortfall should have been registered. At the same time, it is understood that the zero dose is a paid service in private hospitals, as a result of which some parents may not be giving it to their children, though this dosage has to be given immediately after delivery and cannot be deferred. This assumption relating to babies born in private hospitals needs to be confirmed as this aspect is not being digitally monitored at present. This issue is also being flagged for consideration by the Health Department because there could be many reasons for this shortfall of 27% in government hospitals,, and they will need to be understood and corrective action taken.

6.6.4 In the case of families who deliver in private hospitals and are not in a position to pay, or are not sensitised adequately about the importance of timely immunisation, there is need for some strategy to ensure that all these babies get the zero dose, irrespective of the family's capacity to pay, since this dose cannot be delayed or deferred.

6.6.5 For this, it is important to find out from the private hospitals the numbers of those who are not availing this vaccine dose at birth, to assess the size of the problem and the financial implications involved, to work out a way of supporting the zero immunisation dose for the vulnerable group. This issue needs to be discussed with the Indian Association of Paediatricians(IAP). The possibility of having a nodal point for children's issues in all private hospitals with whom all interactions on such matters can be conveniently done is recommended, on the lines of nodal doctors available in private hospitals for other notified diseases like TB. This matter needs to be taken up with private hospitals for their support and cooperation. Such a public private partnership to ensure the good health of the child needs to be supported to reduce the shortfall, and increase coverage of immunisation.

6.6.6 Institutional births have been universal in Kerala since the NFHS-3 period, and the universality of these institutional births cuts across all backgrounds. The NFHS-5

Survey indicates that. assistance of a skilled provider was available for all births in the state during the last five years. Of the total births, 39% or two fifths of the births were delivered by caesarean section(C-S), and 28% of these are stated to have been emergency C-Ss. Of the total births that happened at a public facility (34%), 37.2% were C-S cases, while for the private hospitals it is 39.9%(66% of overall births happened in private facilities). These figures clearly indicate that the trend of having C-S births is almost the same in public as well as private facilities.

6.6.7 There is a need to understand the factors that contribute to such a large number of emergency C-S, which has an impact on the health of the mother and child, (including the difficulty in initiating breastfeeding one hour after birth), despite all the ante natal care facilities available in the state. It is also noted from the survey data that the patterns of this occurrence are similar in urban, rural and remote settings. One of the concerns in this regard is the lack of awareness among mother-to- be about the importance of weight management during pregnancy for their health as well as the health of the baby. It is understood that obesity and excessive weight gain also contributes to the increase in C-S rates. Given the increasing trend in obesity in the state, it needs to be examined whether obesity and excessive weight gain are indeed factors in the increase in C-S rates in all settings, so that corrective action is taken to address it through proper awareness campaigns.

6.6.8 According to the WHO, C-S rate should be in the range of 10 to 15%. The average rate in India is only 17.2% as per NFHS4 data, and Kerala has the highest rate of C-S, with 31.8% according to the NFHS4 report, which has further increased now to around 41% in the COVID19 period. The situation is inexplicable, given our health indicators and the convenience of access available for health services.

6.6.9 To address this issue comprehensively, an audit needs to be done with the help of the Federation of Obstetrics and Gynecology Society of India (FOGSI) in all delivery hospitals, regarding all the factors contributing to this increase, since the figures for C-S in Kerala are disproportionately high. Efforts have to be made to bring that figure down substantially. The audit needs to be done in both the private and public sector hospitals since the incidence is seen to be about equal in both categories of hospitals.

6.6.10 Early initiation of breastfeeding of the baby is an important aspect of care for the child. Although institutionalised delivery is universal (99.8% as per NFHS 5), only 66.7% of new-borns are put to the breast within the first hour of life, as against 64.3% in NFHS 4. When this gap is viewed against the reported increase in the rate of caesarean sections (C-S), over the years, there is concern because this trend deprives the infant of the highly nutritious first milk (colostrum) and the antibodies it contains.

6.6.11 According to Dr Suparna Ghosh – Jerath, Professor and Head Community Nutrition at Indian Institute of Public Health (IIPH – Delhi), Public Health Foundation of India (PHFI), early breastfeeding within the hour is found to also prevent hypothermia among neonates and reduce risk fir the mother from

postpartum hemorrhage which is one of the most leading causes of maternal mortality. Therefore, if this issue is not addressed, then a cost effective, key initiative to address neonatal, infant and maternal mortality and morbidity will be lost.

6.6.12 Recognising this the Federation of Obstetrics and Gynecology Society of India(FOGSI) and the Indian Academy of Paediatricians (IAP) had issued in 2020 a joint statement stating that early initiation of breastfeeding can be initiated and is feasible. They had also issued guidelines in this regard. To date, this does not appear to have been taken up by the government or private hospitals in the state. Therefore, this matter needs to be taken up very seriously with the FOGSI and the IAP to ensure implementation of these guidelines. There is also a need to study the reasons for the delay in initiating breastfeeding within the first hour and how best this gap can be bridged in the best interest of the child.

6.6.13 There are challenges in ensuring mother's milk in some scenarios, ie. where the mother does not have sufficient milk, or where the mother is no more, or in certain cases where the mother herself is a very young survivor of adverse childhood experience, and the baby is to be given up for adoption. Today the concept of Lactation Management Units(LMUs) has gained currency in many states. In Kerala, Comprehensive Lactation Management Centres (CLMCs) are available only in Kozhikkode Medical College and in two private facilities in Thrissur and Ernakulam.

6.6.14 There are many instances where the baby who is sick or preterm is unable to take a full feed and the mother is consequently faced with severe discomfort and related problems . There is also the danger of the milk flow stopping because the milk is not regularly used, as a result of which the sick or preterm baby will not have access to mother's milk when it is ready to do so.

6.6.15 Therefore, to ensure Mother's own Milk (MoM) to the extent possible, Pasteurised Donor Human Milk (PDHM) facility needs to be considered by establishing Comprehensive Lactation Management Centres where the milk can be stored. This report recommends piloting such CLMCs in all Medical Colleges and hospitals where there are NICUs. Smaller LMUs without pasteurization facility can be provided at hospitals at the district level and large maternity hospitals

6.6.16 An important component of the Mother and Baby friendly initiative is the promotion of the concept of the Zero separation between mother and child dyad and Zero alternate feeding for children who are preterm, or children who have critical health issues at birth. Kerala's singular achievement of an IMR figure of 4.4 as per the NFHS 5 is the consequence of focussed initiatives and investment made in perinatal and neonatal care.

6.6.17 Improved death reporting and auditing, along with formulating clinical guidelines and quality standards for improving and eneuring standardised antenatal, intrapartum, and neonatal interventions, investment in improving newborn care nurseries, setting up ICUs and Delivery points, and sustained training of obstetricians and newborn nursery care personnel resulted in achieving this single

digit figure.

6.6.18 However, this has also resulted in the survival of more sick and small babies who are born premature or who have congenital anomalies and congenital heart problems and who need special care.The main and immediate issues concerning preterm babies, are hypothermia, feeding difficulties, infections and other medical issues. Important components of their care include the presence of the mother, with whom bonding at this stage is important, as well as availability of breast milk, however little they may consume.

6.6.19 These babies are currently housed in ICUs where special care is given to them. In Kerala 18 Special Neonatal Care Units (SNCUs) have been established so far, which covers all the districts except Pathanamthitta, Kasaragode and Idukki. In Pathanamthitta and Kasaragode they are in the process of being established in the GH Adoor and the DH Kasaragode respectively, which need to be expedited. In Idukki, which covers even the remote high ranges, the plan is to create this facility in the proposed Medical College. Therefore, there are no prospects of an SNCU for Idukki district immediately. In these three districts this issue will continue to remain a serious concern till resolved. Hence it needs to be monitored closely for implementation at the earliest.

6.6.20 At present, in some cases, these sick and preterm babies need to be retained in hospitals for a month or more to stabilise their health. In such circumstances the mother is sent home. The mother's presence helps to promote skin to skin contact and bonding, provide emotional support, ensure better immunity and prevent sepsis through exclusive breastfeeding during this critical phase of the struggle for survival of these sick and small babies. This aspect is clearly stated in the national guidelines for Kangaroo mother care and family participatory care programmes.

6.6.21 Therefore, there has to be some provision to keep the mother with the baby in conditions that are conducive not only to the baby but also to the new mother who too needs care and support immediately after delivery. This aspect of joyful pregnancy and maternal care just does not exist at present. It is also necessary to have a protocol for handling the mother and child in a uniform manner in all circumstances so that appropriate care is assured even in busy hospitals where there may be an anxiety to send the mother home at the earliest to expedite the availability of beds.

6.6.22 SNCUs help to stabilise the baby in the short term before the child is placed in facilities that have the proper support system, including ventilators, the services of a neonatologist etc. At present, in the government sector, this facility, called the Mother Neonate Intensive Care Unit (MNICU), is available only in the Medical College at Kozhikkode. Here provision has been made to have the mother along with the baby in the hospital.

6.6.23 Similar MNICUs are an unavoidable necessity at present, given the increasing trend of having small and sick babies, and should be made available in all Medical College hospitals and hospitals providing tertiary care that have a large number

of deliveries. Space could be cited as a constraint but, this is a critical necessity and needs to be supported, both to avoid mortality of the baby and to improve the child's chances of survival with the support of the mother who can also be simultaneously sensitised about the care of the baby after the child is discharged.

6.6.24 Where the challenge for finding space is insurmountable, there should be space at least for MNCUs (Mother Neonatal Care Units) which will help keep mother and child together after the child is past the initial critical stage provision. In such cases also, the mother must be retained at the hospital and allowed to go home only with the baby. As mentioned previously, there has to be a protocol about the treatment of the baby and the role of the mother during the period the baby is in the MNICU, MNCU, or the SNCU, which will also address the requirements of zero separation between mother and child and some training to the mother on the care of the child after leaving the MNICU/MNCU/SNCU.

6.7 POSTNATAL CARE FOR MOTHERS

6.7.1 The major components of postnatal care are

- counselling of mothers on postpartum depression,
- the importance of exclusive breastfeeding for the first six months,
- strengthening the screening of newborns for visible and other forms of disability or congenital defects, and
- ensuring complementary feeding of the child as per WHO'S guidelines after 6 months

6.7.2 In the matter of postpartum depression, a checklist of the indicators of this condition has to be made available to the family, and the listed conditions explained to them as part of counselling before the mother leaves the hospital. At present it is very difficult to keep track of the mother's condition since very often, the baby is brought for checkups in such cases by older relatives and not by the mother who may be going through depression. Therefore, it is important during counselling to emphasise the importance of the mother's presence during postnatal visits so that it is ensured and the mother's condition is also monitored simultaneously.

6.7.3 NFHS 5 data shows that while 99.8% of the births were institutionalised, only 66.7% of the babies were breastfed within the first hour, and that this figure had further reduced to 55.5% in the matter of exclusive breastfeeding by 6 months. This means that even if more babies were initially breastfed after the first hour, the numbers reduced drastically within six months to cover only a little more than half the total number.

6.7.4 This is a serious issue in the context of the increasing number of preterm babies whose organ systems, including the immune system, are not fully developed and would therefore be prone to infections if anything other than mother's milk is given. Experts have pointed out that lack of breastfeeding has increased, and that the feeding of anything other than the mother's milk or initiation of other food items in the first six months can result in the early onset of malnutrition and deaths,

and that this vicious cycle of infection and malnutrition can ultimately lead to morbidity and mortality.

6.7.5 Therefore, this disturbing trend needs to be studied in depth to understand at what stage mothers are giving up breastfeeding, what causes them to do so, and to identify the preventable factors that can help curb this trend. The anganwadi and ASHA worker network can play a big role in this as they are required to follow up on all these cases. There is also an anachronistic practice in certain places of initially giving food other than breastmilk to the baby. Data also shows that 8% of children were given food other than breast milk in the first three days. While this is understandable in cases of maternal mortality or other situations where the mother is medically declared unfit to provide breast milk, this figure merits closer scrutiny to understand all the reasons for this phenomenon.

6.7.6 This aspect needs special attention given the growing cases of malnutrition and anaemia among children and the opinion of experts that when babies are fed within the first hour, there is every chance that the practice will be continued without any disruption. NFHS data shows that anaemia among children of six months to 59 months has increased to 39.4 from the previous figure of 35.7. Hence it is necessary to take all possible steps to prevent the early discontinuance of breastfeeding

6.7.7 Reduction in the rates of IMR and U5MR have resulted in the survival of more preterm babies. With the establishment of NICUs, even more preterm babies are likely to survive. According to Child Development Centre (CDC) Thiruvananthapuram there are greater chances for many preterm babies to become future candidates for Neurodevelopmental disabilities like Cerebral Palsy, Autism Spectrum Disorders, Learning Disability, Speech and Hearing Impairment, Visual impairment and Intellectual Disability etc than children born after full term. Even the late preterm babies are said to be At Risk for impending disabilities.

6.7.8 Hence, ideally, all preterm babies need to be enrolled for neurodevelopmental follow up for early identification, if any, of developmental delay. Early detection and early intervention of developmental delay ameliorates or prevents future disabilities, and this can help reduce the burden of disability. This effort will yield long term dividends in the form of improved quality of life for the children and their families..

6.7.9 Screening babies for visible forms of disabilities and defects is therefore the next major issue to be addressed during postnatal care. This facility is mandatorily provided free in all Government hospitals and also in the anganwadis with the support of the Rashtriya Bal Swasthya Karyakram (RBSK). Therefore, early detection of disabilities is a key aspect of postnatal care of children and an issue that again needs close follow up through the anganwadi and ASHA workers.

6.7.10 In private hospitals, screening for disabilities is an optional, paid service. Therefore, not every child catered to in a private facility may opt for such service. Given the long term implications to the quality of life of the child and to the family, as well as the financial implications involved for them as well as the state, it is essential to stress the importance of this screening exercise when counselling the parents-

to -be in all hospitals, both in private hospitals where it is a paid service (if it is available) as well as in Government hospitals, so that they understand the benefits of screening, early detection and early intervention.

6.7.11 Those who are not in a position to get the screening done in the hospital where delivery happens, should be advised to take it from the nearest nearby government delivery point which is convenient to them. Those identified as needing further probe after the screening, should be given further appropriate referral, including to the District Early Intervention Centres. (DEICs). There is a need for having a dialogue with private hospitals on this issue because they are best placed to give this sensitisation to the parents who avail their services. The IAP could be asked to facilitate this dialogue.

6.7.12 The anganwadi/ ASHA worker network is also in a position to find out if the screening has been done, either at the anganwadi itself or with any private facility. The importance of this exercise and the period within which they need to follow up is required to be impressed upon the grassroot network and ensured through close monitoring. A very extensive campaign also needs to be initiated to educate the public about the benefits of screening for disabilities, the facilities that are available for this purpose etc so that the public seek out such services voluntarily and only the vulnerable have to be focussed upon.

6.7.13 Where children are referred to DEICs from other hospitals, it is understood that their addresses are collected along with contact numbers for further follow up. It is also understood that sms messages are presently being sent to families for follow up, and their contact details made available up to the grassroot level. In all such cases, effective follow up must be ensured, and no child should be allowed to fall outside the care network for want of timely attention and advice. However such support is not currently available for children born in private hospitals since they are not part of the digitised monitoring system. This is a concern that needs to be addressed.

6.7.14 An important component of postnatal care is to ensure that vaccinations are given to the newborns on time. Vaccinations are considered the most cost-effective intervention to improve the overall health of children. According to the NFHS-5 report, only 77.8 % of children in the state, aged between 12-23 months have received all basic vaccinations.. Between the two NFHS surveys, it is noticed that there is a decrease in vaccination coverage for the three doses of the DPT containing vaccine(pentavalent), BCG, polio and Measles(MCV) vaccines with the three doses of DPT or penta vaccine showing the highest decline. This overall decline is another area of concern that needs closer attention.

6.7.15 An interesting aspect of the NFHS data is that the shortcomings in achievement of parameters reflect more of shortfalls/defaults and not total rejection of vaccines per se. In such cases there is hope of resolution of the problem to a great extent by close and focussed monitoring, and by stressing the importance of vaccines for the health of the child. There is a need to have community level mobilisation for ensuring

wider coverage for immunisation. That it is possible is evident from the experience of the Covid vaccination.

6.7.16 However, there are repeated instances of resistance to vaccines in certain pockets or families. Where vaccines are actively resisted, a different strategy needs to be adopted with support from LSGIs, the Health department and the community. Therefore, the data itself needs to be analyzed in greater depth to finalise separate strategies for different scenarios.

6.7.17 One difficulty in the matter of children's vaccination is that, unlike in the case of COVID 19 vaccines, there is no check at any point about whether a child has been vaccinated or not. Perhaps such a check could be done through preschools/ schools when they admit a child, by sharing the details of those not vaccinated to a designated authority in government for whatever follow up action is possible at that late stage. These challenges highlight the importance of field level tracking and follow up of every child. This is an area that requires serious attention because denying a child these basic services based on decisions to which he or she is not a party, and which can affect the quality of the child's entire life, is a denial of child rights.

6.7.18 Tracking and ensuring that children between the ages of 6 months and 36 months get the minimum meal diversity, minimum meal frequency and minimum acceptable diet is another important area of postnatal care of children. NFHS5 indicates only a very marginal improvement in exclusive breastfeeding up to six months as well as in the matter of children between 6 and 23 months (i.e. the first 1000 days) receiving an adequate diet, as compared to NFHS4. There is hardly any difference in the levels of children receiving an adequate diet with breastfeeding (23.6) and without breastfeeding (23.5) So it would appear that more than 50% of children do not receive an adequate diet, and approximately 76% of children do not receive a proper diet as well as breastfeed (as recommended by WHO), in order to avoid malnutrition or problems of anaemia.

6.7.19 Complementary feeding, which is required to commence at six months, therefore needs close attention. Very often solid food in the form of ragi gruel is introduced but, thereafter, no efforts are made to introduce the much needed vegetables, fruits, proteins and micronutrients into the diet. This needs to be ensured. The Key Infant and Young Child Feeding (IYCF) indicators recommended by WHO measures the adequacy of dietary diversity and meal frequency for breastfed and non-breastfed children. That only 23% of children < 2 years are fed according to all three recommended practices in addition to breastfeed is an alarming issue that needs to be addressed.

6.7.20 If we weigh this fact, viz. that approximately 77% of babies are not being given adequate nutrition despite initiating complementary feeding, and that the levels of stunting, and underweight cases have increased since the last survey, leading to rising trends of anaemia, malnutrition etc, we see the seriousness of the gap in childrearing practices in the state which needs to be urgently addressed. It

also highlights the fact that despite all the government schemes for nutrition and follow up, the results are not encouraging, calling for a proper study to identify the loopholes in the system.

6.7.21 It is therefore proposed that WCD address this issue immediately and come up with an effective strategy for this age group of 6 months to 36 months, ie till the child reaches the preschool stage, ie till the child is admitted in anganwadi/ preschool, so as to avoid neglecting this very crucial period in the life of a child that can lead to stunting, wasting. malnutrition, anemia etc among children. This assumes even more importance given the fact that the number of children who are SNCU graduates are increasing, and they need more care than the babies who have no problems at birth.

6.7.22 There is a need to bring about behaviour change among parents through greater awareness creation for which an effective communication strategy is needed. Field level mechanisms and interventions also need to give much closer attention to this aspect, and it needs to be closely monitored.

6.7.23 One of the emerging concerns faced during postnatal care is the introduction of ready to use, commercially manufactured food in the diet of the child. While this is often used for the convenience of parents, the disadvantages of using them in the long run vis a vis natural foods, and denying children the opportunity to be part of the family's routine daily diet needs to be highlighted and this trend discouraged. This practice is also a deterrent to following a balanced natural diet which can cause many problems like obesity and other NCD issues at a later date.This is yet another issue that needs to be part of the monitoring and counselling adopted to promote balanced diets in families.

7. ADDRESSING PREVENTABLE MORBIDITY AND MORTALITY

7.1 The state has approximately 5 lakh births in a year. U5MR is estimated to be 5.2 deaths per 1000 live births as per NFHS 5 data, which is lower than the figure of 7.1 at the time of the previous survey. A study by the Indian Academy of Paediatrics (2013) found that 75% of the infant deaths in Kerala occur in the neonatal period, of which 59% occurred during the first week. Prematurity accounted for 35% of deaths while congenital anomalies, especially congenital heart disease, accounted for 28% of IMR.

7.2 Given the achievements in improving IMR, it is necessary to focus attention on the infant deaths occurring in the neonatal period when 75% of these deaths occur, especially the 59% mortality that occurs in the first week. The establishment of SNCUs will help address this problem to some extent and it will certainly improve when more MNCUs/MNICUs are set up in the state. With these arrangements, despite an increase in the number of extreme prematurity cases, the rate of mortality at birth will continue to remain stable thanks to the focussed medical interventions at the time of birth and immediately thereafter. But, even as we focus on managing preterm delivery and related complications, it is now important to pay greater

attention to the preventable factors

7.3 The common causes of preventable morbidity and mortality normally include Acute Respiratory Infection(ARI) or pneumonia, fever, diarrhoea. anemia, and the onslaught of non communicable diseases. Though diarrhoea was the number one killer at one time, this has been addressed thanks to effective interventions. However, mortality due to Acute Respiratory Infection or pneumonia continues to remain high and remains a major killer.

7.4 Although many of the newborn babies are born with comorbidities , according to data under compilation by the Health Department, Kerala has approximately 25 deaths among the under 5 age group children who die of pneumonia every month, of which 25% are said to have no significant comorbidity but died solely due to delay in reaching the hospital or were detected late because they were not initially treated as per the standard/ required protocol.

7.5 All these children with no comorbidities can be saved if there is greater awareness in the community and the treating physicians about how to tackle such situations. No baby should die for want of information or delay in reaching the source of treatment, and for this, awareness is a key ingredient.

7.6 It is understood that there is a national programme Social Awareness and Action to neutralise Pneumonia Successfully (SAANS) which specifically targets children with pneumonia to provide them tertiary care at the level of the Medical College. This programme is yet to be implemented in the state because it would need some revamping in the Kerala context, in addition to some changes in the IMNIC protocol that is presently followed, the necessary training to be provided etc. One of the main elements of SAANS is the campaign to be done at the community level to create awareness about timely detection of such cases. Since delay in detection is one of the causes of mortality in cases of pneumonia, its early implementation needs to be considered in Kerala as part of the bid to reduce preventable mortality.

7.7 Birth asphyxia is a major killer of newborns and it is caused mainly due to prematurity and immature lungs. With the increase in the number of extreme premature births in recent years, this issue is a cause for worry. Birth asphyxia and prematurity can be addressed to some extent by quality antenatal care that will help modify some of the maternal factors. However, there are no solutions available as yet for correcting these anomalies in any of the present programmes. Congenital anomalies, especially congenital heart condition, are a major source of morbidity and mortality. Here, there is scope only for a preventive strategy whereby parents can be notified about the possibility of congenital anomalies through the two important anomaly scans at 10-12 weeks and 16-20 weeks. Consumption of Periconceptional folic acid is also to prevent serious defects at birth. However, due to the order of the Hon'ble High Court, which upheld a plea that no drug should be dispensed except through pharmacists, the supply of periconceptional folic acid has been rolled back to the PHC level. This move has resulted in many mothers- to- be not accessing this important supplement any more.

7.8 In all cases of premature babies, there is a need to have appropriate infrastructure and resources to support them, for which facilities in tertiary care hospitals need to be improved. At present even ventilators are available only in medical colleges. As part of an initiative to curb mortality of children and reduce their morbidity, there is a need to decentralise the facilities in Medical colleges at least to District level hospitals and other major hospitals that conduct a large number of deliveries. The Health Department needs to prepare a proposal for this purpose, which needs to be supported.

7.9 Other health conditions to be addressed as part of the initiative to reduce preventable morbidity and mortality among children are anaemia, obesity, hypertension and diabetes of mothers. All these are among the factors contributing to prematurity among new-borns and also the cause of various birth anomalies. They also cause complications at the time of delivery. Therefore, preventive steps have to be taken from the childhood of the mother to tackle these non-communicable diseases, as discussed previously in the segment pertaining to preconception care.

7.10 A detailed analysis of NFHS5 data indicates that although anaemia levels vary somewhat according to the characteristics of a child's background, anaemia among children is widespread in every group. Higher percentage of anaemia was noted among scheduled tribe children and children below two years (58%) Over 50% children aged between 6 and 23 months are anaemic and this is a matter of great concern as these age groups come under the first 1000 days of life. A 24-hour dietary recall conducted as a part of the survey indicated that only 51% of children under 2 years had consumed iron rich food prior to 24 hours of the survey. 32% responded that their children received some kind of iron supplementation, while only 30% received deworming medication in the previous six months.

7.11 NFHS5 data also showed that anaemia had increased among both adolescent boys and girls. Therefore, there is a need to address this issue seriously because anaemia among girls has an intergenerational effect with the child of an anaemic mother more likely to be underweight than the child of a mother without it. These conditions are preventable through appropriate, balanced diets and a proper lifestyle that parents need to introduce to children from their childhood.

7.12 The WCD department has initiated a campaign under the banner of "Campaign -12" to address the menace of anaemia. This programme envisages an intensive reduction of the incidence of anaemia (a minimum Hb of 12g) in all sectors of society. The department initiated the IFA supplementation programme with the limited budgetary provision available within the IEC pool.

7.13 The programme is said to have found wide reach and acceptability among the target population. The Department has also introduced Nutrition clinics that seek to provide expert advice to the public on how to reduce levels of anemia by following a balanced diet. These efforts need more support in terms of financial resources and technical support through the collective efforts of various departments like Health & FW, SC/ST Department, LSGD, Water resources, Agriculture etc.

7.14 Creating a mission mode action plan on a war footing is needed for addressing the anaemia situation in the state as this issue is not only reflected among the child population, but cuts across all categories of the population. A pool fund at LSGI level for awareness creation at the community level will provide a boost for all these initiatives.

7.15 Support is available to address most of these public health issues under various health and disease control programmes. Ensuring a Life-Cycle Strategy with a Family Participatory Approach, involving both parents and family members in newborn and child care at all ages, and eliminating gender related issues, is the key to tackling these problems in a preventive and promotive mode, for which the families must also be sensitised through regular follow up and monitoring.

7.16 During the last two years the implementation of various health related programmes were affected by the pandemic. Therefore, a special effort has to be made to monitor them and bring them back on track to the pre COVID19 level of implementation. In this connection implementation of programmes like the the IFA Supplementation programme for different age groups of children (ie. from 6 months to 59 months(SypIFA), 5 years to 10 years (pink tab) and for adolescents (IFA tab @ WIFS, the deworming programme and all school health programmes) need to be strengthened. Better coordination and convergence between the Departments of Health and WCD is needed to effectively implement these programmes successfully.

7.17 Since the approach to tackle these childhood illnesses requires a life cycle strategy, it is also necessary to look at the Supplementary Nutrition provided to children through the anganwadis with the support of the LSGIs. Supplementary Nutrition Programme (SNP) is one of the six services provided under the Integrated Child Development Scheme (ICDS). The scheme is primarily designed to bridge the gap between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI).

7.18 Even though it is implemented through 33,115 Anganwadi centres in the state with the support of LSGI, the coverage of the SNP beneficiaries is hardly 25-30% of the population As there is universal coverage for primary education in the state, the possibility of accessing all children through their education institutions and providing them adequate access to nutritious foods needs to be explored, if necessary through a public-private partnership model.

7.19 SNP is functional in all Anganwadi centres across the state but with slight differences in the menu, depending on the area. As LSGIs are the major contributors to the current SNP, at times it is reported that sufficient funds are not being earmarked for SNP, which results in compromising the very purpose of the programme. Moreover, increase in the market cost of food items makes it difficult to expand the food basket in SNP. Certain LSGIs across the state have already included eggs/milk in their SNP basket. LSGIs without adequate "own revenue" may not be able to follow this example.

7.20 Taking into consideration the current declining trends in nutrition among U5

children in the state, there is an urgent need to revise / expand the food basket provided through SNP. However, while such an expansion will certainly help increase the inclusion of nutritious food items in the menu, it will require a corresponding increase in the budgetary provisions to bring about this improvement to the food basket. Menu diversification with budgetary support from the government to LSGIs for providing the existing items and to add more nutrient foods including milk, egg etc across the state, is felt necessary for improving the nutrition levels among U5 children.

8. IMPORTANCE OF THE GRASSROOT MECHANISM IN PROMOTING THE RIGHT TO SURVIVAL

8.1 Three key players who comprise the grassroot mechanism that supports the medical interventions in promoting every child's right to survival are the network of anganwadi workers, the ASHA workers and the JPHN. There are also some other functionaries who also support the JPHN in grassroot activities in the health sector. Though they function under the WCD and Health Departments respectively, there are many areas where their responsibilities overlap. In brief, both of them have the base data of the target population, starting with the pregnant mother, whether they deliver in the private or government hospitals, and also about the baby through every stage of the child's early development.

8.2 The system laid down to support the care for the mother and child is extensive and technology induction has been done in their functioning to feed the data available in MCP cards or booklets given by private hospitals into the various national portals(RCH/NNM) and to maintain registers to ensure their follow up with patients in their neighbourhood. Yet, when comparing the data of NFHS4 and NFHS5 and the nature of the shortfalls, what is obvious is that the follow up system is not functioning optimally even though the MCP gives a unique ID to every mother child dyad. It also emphasises the need to ensure that every mother to be is a recipient of the MCP card and the shortfalls noted in the NFHS 5 survey are avoided

8.3 Antenatal visits of pregnant women are critical for ensuring the proper growth of the baby, and to prevent mortality and complications for the mother at the time of delivery. They provide opportunities to help modify various maternal conditions that lead to preterm deliveries and anomalies at birth caused by anaemia and the irregular consumption of supplements. The sharp fall in antenatal visits and also in the consumption of supplements are therefore a cause of worry, given the rising trend in cases of extreme prematurity, birth asphyxia, anomalies etc Similarly, many mothers develop complications during delivery, leading to mortality merely because these high risk cases were not admitted on time, or well before EDD, as advised by doctors.

8.4 There could be genuine challenges that these workers at the grassroot are facing in balancing their workload, problems with connectivity and data uploading , difficulty in managing work online, the inability to answer some health related

questions that members of the public ask them, and perhaps even a lack of proper understanding of their contribution to the quality of life in the state. The issue of balancing their workload needs special attention because during the COVID19 period, when children were not coming to school and physical visits were not encouraged, these workers and the ICDS machinery, including the supervisors, were entrusted with many additional items of work connected with the pandemic and otherwise, which, if continued, can compromise their core duties. This needs to be addressed by the concerned departments with the LSGIs.

8.5 In addition, there is perhaps a need for training and hand holding these workers not merely through online sessions that some of them may find difficult to assimilate, but also through the physical mode.There is also the social resistance to certain issues among certain individuals or pockets of the population in their jurisdiction, like immunisation for example, that can also be difficult to handle, for which they need community support with the help of the LSGIs.

8.6 It is necessary to examine these issues, review the functioning of these workers comprehensively, and understand the challenges they are facing to suggest how best the follow up that is expected from them can be strengthened and made effective. This needs to be done jointly by the departments of WCD and Health. There is also a need to have clarity regarding the quality parameters that must be checked at each level to ensure effective follow up, and how best it can be done jointly using the data derived through the various platforms. In brief, the focus should be shifted to monitoring outcomes, rather than on compliance alone, so that the implementation of these programmes becomes effective .

8.7 A very important issue that needs to be addressed in this connection is how best mothers and children in vulnerable segments of society, especially those who are currently not on the radar, can be brought into the framework of the monitoring system, even when some of them are availing services in the private sector. In this context, only the grassroot workers are at present in a position to do the follow up of these mothers and children as they have the basic data to follow up with all families, including those who are currently not being monitored through the digital monitoring framework. Hence their contribution is invaluable in ensuring improved quality in every aspect of child and maternal care.

8.8 For creating a comprehensive, digital database, which includes those who availed services in the private sector, the possibility of a private public partnership in the matter of data sharing, as well as in referring patients who are unable to pay to government facilities, needs to be explored. Since 65.9% of the population use private services, they can no longer be left out of the monitoring framework, especially when the data is available with workers at the grassroot level.

8.9 In recent years, thanks to the floods, the pandemic and other emergencies there has been disruption in the follow up for ensuring the provision of various services, and the impact of that is reflected in the declining figures of the NFHS 5 survey conducted in the midst of these problems. But with action now underway to

resume activities, there has to be a qualitative and quantitative improvement and follow up through the grass root mechanism if better health outcomes have to be achieved. It is also necessary to learn from the recent experiences of the impact on health caused by successive natural disasters as well as the pandemic, and chart out a strategy for emergency preparedness to tackle such situations in future.

8.10 Some of the key issues to be addressed to improve the quality of services are discussed below:

8.10.1 Data showed that 93.6% of the pregnant mothers registered their pregnancy in the first trimester, but only 78.6% completed the required number of visits. Once the mothers -to- be came for the first check up, they were in the radar of the anganwadi/ JPHN /ASHA worker network. So, there was every opportunity for follow-up, and to persuade them to complete all the four required antenatal check-ups explaining the significance of each visit. This system had worked in the past, as reflected in the figures of NFHS4 data. So why there is a subsequent decline needs to be examined.

8.10.2 Every Monday afternoon is designated the Antenatal Care Clinic day for the JPHN. Why the grass root network is unable to get the women to attend the nearest sub centre for this purpose is not clear. Besides, given the number of pregnancies happening in the state, there cannot be more than 8 to 10 persons to be attended to in a week. When this facility is available free and within easy reach, why pregnant women find it difficult to attend these clinics needs to be examined to identify the causes and take remedial action.

8.10.3 Post pregnancy visits by the ASHA worker are expected to happen on days 3, 7, 14, 21, 28 and 42. Of these, day 14 is very important for gauging whether the baby has regained birth weight. Similarly, day 28 is important for establishing contact and follow up for future monitoring. Day 42 is the date for follow up with the doctor as well as for immunisation of the baby. At present, during the period of COVID19, this follow up has been reduced only to enquiry by phone. However, that is not adequate, especially in cases of preterm babies, SNCU graduates, children with low birth weight etc, and the practice of physical visits needs to be resumed.

8.10.4 After the visit on the 42 nd day, because the visits by ASHA workers were prescribed only to ensure subsequent immunisation landmarks, GOI introduced a new initiative termed Home based Young Care (HBYC), a programme to fill the existing long gaps in visits, and to closely monitor the development of the child through various key milestones. Under this programme regular visits by ASHA workers have been prescribed at 3, 6, 9, 12 and 15 months, in addition to the last visit on the 42nd day, with special focus on health, nutrition, child development etc. As part of the effort to cover the age group 2 and beyond upto 3 years, further home visits have been prescribed during the 18th, 24th, 30th and 36th months also under the HBYC programme which have to be undertaken by the grassroot network.

8.10.5 The six postnatal visits are mandatory and it is also a key strategy for early identification and referral of sick newborn / infant, especially in the context of

increased prematurity and extreme low birth weight babies graduating out of the newborn care ICUs but dying in due course due to compromised care by caretakers who are ignorant about the difference between taking care of a normal newborn and this set of babies who fall in the high risk group. The 11 subsequent visits are important to ensure that the baby achieves its milestones on time and to take timely corrective action if any delays are noted.

8.10.6 Surprisingly this HBYC scheme, which will provide the crucial back up for preventing anaemia, nutritional diversity, help avoid shortfalls in immunisation, give focus to the nutrition given to children between the ages of 6 months and 36 months so as to avoid the stunting, wasting, underweight, and malnutrition problems, etc has not yet been implemented in Kerala, nor has these visits been made mandatory for the ASHA workers. There is an assumption that since Keralites have a high level of health seeking behaviour, people will approach the doctors even without follow up by the grassroot workers.

8.10.7 However, the high levels of anaemia prevailing in the state among people of all ages, including pregnant mothers, its adverse impact on babies, the complications at birth that this results in, the high level of preterm births and anomalies/ morbidities among children at birth, the significant number of avoidable deaths due to the child being brought too late to the correct centre for treatment, or the high levels of anaemia prevailing among all levels of the population, the stunting, wasting etc seen when the baby is checked in the 15th month…. by when it is too late to correct and catch up--- all of this presents a strong case for implementing this programme in the state with the 6 mandatory visits to be done physically at the homes of the newborns and mothers by the ASHA workers, as is being done in other states.

8.10.8 There cannot be a compromise on these physical visits, given the gaps already noted in service delivery, between NFHS 4 and 5. The best interests of the child cannot be compromised due to the neglect of parents as well as lack of support from the state, despite having a strong grassroot network that is capable of discharging this task effectively between the ASHA worker, the Anganwadi worker and the JPHN.

8.10.9 It is equally important to take into account the potential impact of the ever increasing burden of morbidity on the state, on society, the individual family and the child whose life is ahead of him or her, and the financial, psychological and social implications of the situation. The best preventive strategy is to ensure a system that closely monitors the child through the various stages of development. Any compromise in this respect would be against the best interests of the child.

8.10.10 Besides the number of visits, the quality of care offered to the pregnant woman during the antenatal visits also needs to be ensured in terms of the advice and counselling given on nutrition, self care, future aspects of newborn care, early initiation of breastmilk, importance of breast milk, contraception and spacing, timely consumption of supplements, and most importantly, on the need for first trimester(10 to 12 weeks) and second semester (16 to 20 weeks) scans to detect any

genetic anomalies.

8.10.11 Unless these aspects are carefully explained both to the pregnant woman and her husband using the MCP card containing all this information, they would not understand why these visits are important, and the significance of fixing these intervals for the care of the mother and the unborn child. This issue needs to be better impressed on the network of grassroot workers tasked with this responsibility and it calls for close monitoring of their work.

9. CHALLENGES IN TACKLING HIGH RISK CASES

9.1 While the management of the first 1000 days is a challenge even in normal situations, there are families who live in exceptionally vulnerable circumstances that need much greater support and care in every aspect of the ante and postnatal care discussed here, and to access the services in a timely manner. They are families who live in tribal and coastal areas, in SC colonies, in slums, in remote poramboke, in layams, in settlements etc.

9.2 It is necessary to have a separate action plan and a special mechanism to monitor the care of pregnant mothers and children in these areas to ensure that their survival and development needs are adequately addressed. This needs to be worked out jointly by the Departments of Health and WCD along with the respective LSGIs, and needs to be supported under Plan.

10. OTHER RELATED ISSUES

10.1 Maternity leave for mothers is currently allowed for a maximum period of 26 weeks for up to two children under the Maternity Benefits Act 1961. However, it is only for a maximum of 12 weeks in the case of more than 2 children. In order to support working mothers who may have to return to work early, there is a need for supporting systems like day care and creche facilities close to their workplace. At present, though standards exist for creches, they are not mandatory.

10.2 Therefore, this whole activity of providing day care and creche facilities is being managed in an unregulated sector. This needs to change because children are being entrusted to the care of these facilities at a very important and critical period of their development. Hence minimum standards of care and safety, and a regulatory mechanism to enforce them appear necessary.

10.3 According to the NFHS-5 survey, 92 percent of the last pregnancies in the five years preceding the survey had ended in live births, and that the remaining were terminated as foetal waste (abortion, miscarriage, or stillbirth). 5 percent miscarriage is the most reported type of foetal wastage. Of the reasons for abortion reported by women, 22 percent were due to complications in pregnancy, 18% each were due to unplanned pregnancy and health reasons. Of the abortions performed, half were from public facilities and another half were from private facilities.

10.4 The number of abortions performed due to reasons of unplanned pregnancy is a cause for concern because they affect the mental and physical health of women and they could almost all have been prevented if they had received proper guidance on

planned pregnancy. Similarly, the reasons for the complications that contributed to abortions are also worth looking into, to understand the reasons that lead to such situations, and what preventive action can be taken to avoid them to the extent possible. This issue also needs to be given some focus given the decreasing trend in the state of females in the child sex ratio at birth.

10.5 The importance of the role of the father or the father-to- be in antenatal and HNBC cannot be overstated. The NFHS-5 data, shows that 94 % of men with a child under three years responded that they were present during at least one ANC received by the child's mother, with no difference in this pattern in the urban and rural areas. Only 81 % of men reported that they received information from the health provider/ worker on what to do in case of pregnancy complications, but only 66% had information about pregnancy related complications and 68% on the importance of family planning or delaying the next child.

10.6 There is clearly a lack of uniformity in the dissemination of information by the grassroot workers. This needs to be standardised. It is also a matter of concern that the awareness has not translated uniformly into practical action in all aspects, since there is a drop in the number of antenatal checkups of pregnant women, in their taking the Iron and Folic Acid supplements, and also an increase in their levels of anemia vis a vis the number of husbands contacted, as reflected in the figures.

10.7 Hence the field level interventions, be it through the Anganwadi workers, ASHA workers or the Parent and Nutrition clinics need to be further improved in terms of effectiveness, uniformity, and coverage. The systems are in place to access a majority of the target group, but behaviour change needs greater efforts and the support of an effective communication campaign. Behavioural change communication (BCC) is a strategy that can support existing monitoring and other field level services with minimal investment, to bring about a change. Behavioural change communication usually refers to the use of different communication strategies to promote the sustained adoption of a desired health behaviour or behaviours that may lead to positive health outcomes.

10.8 In Kerala, despite near universal literacy, behavioural change, especially in matters relating to lifestyle, is not proving to be an easy task, given the competing factors that promote a consumerist lifestyle. Improvements in nutrition status of a human being are not possible without broad and widespread changes in everyday behaviours of the people. Most of the immediate and underlying causes of malnutrition are virtually influenced, either directly or indirectly, by the behaviours of individuals, household members and community. Evidence shows that people can change their behaviour to improve nutrition outcomes. Intensive BCC interventions among the community / household on the importance of child nutrition will definitely influence the patterns of purchase and consumption of nutrition rich food, thereby contributing to better nutritional outcomes.

10.9 Therefore, a well thought out campaign backed by a multipronged strategy that comprehensively addresses the various behaviours that adversely affect the health of

the family, and which will help inculcate a balanced lifestyle and food habits needs to be implemented and duly supported under the current Plan.

10.10 Availability of clean, safe drinking water, sanitation and hygiene are issues that cut across all ages, including pregnant mothers and infants. It is essential that there is access to clean, potable water, hygienic conditions and proper sanitation near homes and in institutions like hospitals, creches and day care centres. Availability of hygienic, child friendly, girl friendly toilets in public places, in creches etc is also an issue that needs to be ensured. This is a responsibility that the LSGD should also be involved in.

10.11 A mapping of available facilities, that will also help create greater awareness among the public and ensure better access to them, needs to be done and gaps filled. This issue is of special importance in specially vulnerable areas where access to these facilities would be limited, if not nil.

11. ROLE OF LSGD AND OTHER DEPARTMENTS

11.1 Issues relating to antenatal and postnatal/ neonatal care of mothers and children are required to be primarily tackled at the grassroot level. Therefore, to ensure sustained, effective care, the support of LSGIs are necessary in many aspects. For example, the logistic and moral support of the LSGIs is crucial for the concerned departments to organise programmes/ or special days for marking the importance of certain key issues like balanced diet for proper nutrition, importance of immunisation, screening for disabilities etc. and to ensure community mobilisation.

11.2 Even more important is the role they play in deploying the ICDS machinery, including the ICDS supervisor, and the Health machinery, starting with ASHA workers, to ensure the health and wellbeing of mothers and children. Since these are transferred institutions under the jurisdiction of the LSGIs, there is a tendency to often use them for activities other than their core duties, sometimes flor a whole month at a time, leaving them no time to discharge the latter. This has grave consequences for the health and life of the target groups to be supported. The seriousness of this issue needs to be impressed on the elected representatives of the LSGIs since the adverse outcomes are not immediately measurable or visible except in cases of mortality.

11.3 While the power of the LSGIs to deploy the resources transferred to them is undisputed, it is equally important that the best interests of mothers and children are properly protected. GOI instructions about use of anganwadi staff reiterate that requirement regularly. With the devolution of powers and the transfer of the institutions to implement them to the LSGIs, they are as responsible for ensuring improvement in the care of mothers and children as the line departments of the state. So any additional tasks given by the LSGIs to the staff entrusted with that responsibility cannot be at the risk of compromising their core functions. Therefore, in addition to sensitising the LSGIs about these aspects, it is equally important for the Health, WCD and the LSG Departments to take up with them the need for balancing the workload of the grassroot mechanism for follow up and supervision,

and to explain the non negotiable responsibilities that these networks have to perform as also the implications to the LSGIs and the state if they do not do so. This is an issue that KILA also needs to take up as part of their training programmes for the elected representatives so that an arrangement that works to mutual satisfaction can be arrived at.

11.4 Although WCD is a key stakeholder in matters relating to women and children, there are other departments like the Health Department, the Tribal and SC Development department, the Fisheries Department, the Forest Department, the Labour department etc who also have a crucial role to play in ensuring that these services reach the targeted beneficiaries effectively. This requires better coordination at every level, and LSGIs need to play a lead role in this regard at the grassroot level.

12. GOOD PRACTICES

12.1 The comprehensive, digitised database available with NHM- HEALTH of children born in government facilities for monitoring the care given to mothers and babies.

13. RECOMMENDATIONS

13.1 Since there is a decline noted in several components of antenatal and postnatal care, such as non completion of all the antenatal check ups, in reducing anemia, and in providing all the prescribed supplements, vaccines etc, as reflected in the figures of NFHS4 and NFHS5, it is necessary to clearly identify the factors that negated the efforts to improve the quality of care despite all the systems that are in place. An effective strategy needs to be worked out by the WCD and Health Departments to tackle these shortfalls. Special effort must be made to understand the position in economically and socially disadvantaged areas.

13.2 There is a need to bring the large segment of persons who avail private facilities for maternal and child care services into the framework of the focussed, digitised monitoring system available with NHM, since that data is already available with the hospitals as well as the anganwadi and ASHA workers. This will help to ensure that the beneficiaries are alerted and services provided in a timely manner through effective monitoring. supported if possible, by alerts given through technological intervention, in addition to the existing manual system. WCD and NHM-Health Departments need to look into this issue. This is important because the number of persons using the private facilities are more than those availing government facilities and the majority cannot be left outside the digitised monitoring framework.

13.3 The reasons for the substantial shortfall noticed in the zero immunisation coverage, as reflected in the NFHS 5 data, is inexplicable as it pertains solely to the service given in government hospitals. It needs to be understood. The extent of shortfall in this regard that exists in private hospitals also needs to be understood to explore what further can be done to support certain vulnerable groups from defaulting, and for assessing the numbers involved and the financial implications thereof.

13.4 There is a need to support the upgradation of Baby Friendly Hospitals to Mother and Baby Friendly hospitals, by providing the facility of a “birth companion” in the

labour room for mothers who have HRPs, ensuring early initiation of breastfeeding within the hour, and strengthening the immunisation dose at birth. This initiative must be expanded to cover all government hospitals and major private hospitals where a large number of deliveries take place. The support of the private sector should be ensured with the help of FOGSI and the IAP who can be effective enablers in this initiative.

13.5 Focussed attention needs to be given to reducing maternal mortality rate (MMR) as was done for IMR, including the systematic reporting of deaths, audits and also development of protocols and clinical guidelines that will need to be enforced uniformly in both the government sector as well as the private sector, improved antenatal, perinatal and postnatal care, and sustained training of obstetricians. The state must atleast achieve the SDG target of 30 in the next five years.

13.6 Since postpartum depression is a mental health related issue about which very little information is currently available, there is a need to sensitise the new mother and her family about this issue, and provide them with a standardised checklist to identify the symptoms with directions on how to manage this condition. There is a need to document the incidence of this problem to understand its magnitude.

13.7 Given the alarming and unjustifiable increase of C-Sections in facilities both in the private and Government facilities, especially given the much lauded levels of the state's health indicators and access to health facilities, an audit should be done in these facilities and the care provided to initiate measures to reduce the current levels of C sections to the level of the current national average viz 17%. This needs to be done in collaboration with the FOGSI.

13.8 An initiative must be taken to reduce the current rate of deaths of children with morbidity, especially in the week after birth. To achieve this (i) SNCUs may be set up at the earliest in the three districts where they are not available. (ii) MNICUs must be set up in all Medical colleges as well as in large Maternity and Children's Hospitals (iii) the facilities in Medical Colleges must be decentralised to the district hospitals (iv) measures that address preventable factors that contribute to morbidity and mortality must be promoted through awareness creation and effective follow up.

13.9 While new-born baby screening is available as a free service in all government hospitals, private hospitals that provide this facility as a paid service, must be advised to counsel new parents on the importance of screening, so that those who are not able to get it done in the hospital where the delivery took place, can approach the nearest delivery points of their choice for early screening of newborn babies. The anganwadi/ JPHN and ASHA workers also need to be sensitised about promoting the importance of early screening, especially in the case of preterm babies and SNCU graduates. Paediatricians in private hospitals must also be involved in this exercise of referring patients who can't afford to pay for screening to the nearest delivery point. IAP may be asked to support this initiative for bringing all paediatricians into the loop.

13.10 Every hospital in the private sector that provides maternity and child care services must be asked to nominate a paediatrician as nodal officer for better coordination, as has been done for notified diseases like TB. This will make interfacing with them more convenient for all matters relating to children, including the collection of data for digitised monitoring.

13.11 To ensure that babies are provided with mother's milk to the extent possible, and to facilitate mothers who are unable to feed their babies, it is recommended that LMUs may be set up in all District Hospitals and CLMCs in Medical Colleges.

13.12 Since working mothers or mothers engaged in studies need the facilities of a safe and hygienic day care centre close to their place of work, it is recommended that standards may be fixed for day care centres and creches, and this facility monitored through a regulatory mechanism to ensure compliance of these standards.

13.13 Special focus must be given to socially and economically disadvantaged areas. The level of service delivery in these places need to be assessed so as to improve indicators of antenatal and postnatal care. Such disadvantaged areas include tribal areas, fishing villages, slums, SC colonies, poramboke etc. A Special action plan must be drawn up to reduce the gaps in service, improve the indicators for antenatal and postnatal care, and to reduce the mortality rates of mothers and infants from these areas.

13.14 It is necessary to focus on reducing the morbidity and mortality rates of newborn babies who die within a week of birth. For this purpose, there is a need to improve the infrastructural facilities in NICUs and also decentralise such facilities to the district hospitals and to large maternity hospitals. A protocol must be drawn up for the handling of children placed in SNCUs/ MNCUS and MNICUs and their mothers, which should include training for the mothers to provide the special care these babies require once they graduate from the SNCUs.

13.15 Since pneumonia is a major killer and the avoidable deaths due to it are primarily due to lack of awareness and delay, the national programme SAANS, that incorporates a significant component of community mobilisation and awareness should be implemented with suitable modifications to suit the state's requirements. Similarly the implementation of the HBYC programme, with home visits by the grassroot network to monitor timely achievement of developmental milestones and corrective action, where deemed necessary, merits urgent attention.

13.16 In between NFHS 4 and NFHS 5 shows the need to strengthen the effectiveness of the grassroot network and its supervision. The resultant impact on the health of mothers and children, particularly from the vulnerable groups, are substantial and often irreversible. Therefore, it is necessary to have an in-depth assessment of the system, to understand the challenges faced by the grassroots workers and supervisors, issues identified, and action taken to resolve them. In doing so it is necessary to explore how quality can be ensured instead of mere compliance in implementation and follow up. There must be a system to measure outcomes. Departments of WCD and Health should jointly address this issue.

13.17 The Antenatal care clinic run by the JPHN needs to be reviewed for its efficacy to understand the reasons for non-attendance by mothers -to- be despite the services being offered free and closest to their homes, so that shortcomings can be rectified.

13.18 Complementary feeding needs to be promoted and ensured through effective follow up by the grassroot team, focussing specially on this aspect during the ninth month visit, to avoid stunting, wasting etc. Where necessary, mothers and children who show signs of nutrition problems must be referred by the grassroot workers to Nutrition clinics.

13.19 There is a need to promote breastfeeding both at the institutional level at the time of delivery and initiating early feeding within the hour, and also at the community level once the mother is discharged. It is necessary to assess the reason why barely 55% of the population are providing exclusive breast feeding to their children up to six months. There has to be a conscious effort to promote breastfeeding, highlighting its tremendous benefits to the mother and child. This is another area where the support of the FOGSI and the IAP should be enlisted.

13.20 Tackling anaemia at all levels should become a priority issue as it impacts the health of adults and children in multiple ways. There is a need to support Campaign 12 to achieve its objectives. It is also necessary to support the mission mode action plan that seeks to address this issue cutting across various departments to promote a family based approach to adopting a balanced diet to reduce the present levels of anaemia.

13.21 Apart from the concerned department, the LSGI's role in reaching the campaign to each household is crucial. Towards this, LSGIs may earmark specific provisions in their budgets. Formation of an intersectoral cooperation committee / task force at Panchayath / Village Level to implement the programme would give it the necessary support.

13.22 Funds may be provided at the LSGI level to promote the Campaign 12 initiative and for them to take a lead in promoting proper nutrition and lifestyles, importance of the First 1000 days and beyond till the 36th month, etc as well as of immunisation, screening for disabilities, breastfeeding and complementary feeding, by celebrating special days, so as to create greater awareness through special talks and programmes involving the whole community.

13.23 There is a need to enhance the nutritional value of the Food basket for SNP by adding fruits, vegetables proteins, micronutrients etc. Since the price of foods have increased post-COVID 19, appropriate per head increase may be given to tackle this need as part of the mission mode effort to improve nutrition levels among children.

13.24 GIs may also encourage the planting of moringa, spinach and such other iron rich food sources so that they can be accessed locally and children can consume these nutritious foods from natural sources too. Similarly, nutritional gardens may be encouraged in anganwadis and cultivable open areas lying unused in the village jurisdiction by linking them to the Health clubs of schools and colleges.

13.25 Given the critical importance of making an effective change in the lifestyles of people and bringing about an all round impact on the care and nurturing given to children, activities for Behaviour Change Communication needs to be taken up, supported by a comprehensive IEC program covering child feeding practices to mothers/ families / communities on the significance of appropriate child feeding practices, the importance of balanced diets etc. This proposal merits support.

13.26 The entire ICDS team, including anganwadi workers, as well as the JPHNs, the ASHA Workers etc of the Health department are the real back bone of the programmes for antenatal and postnatal care of women and children who can make these initiatives a success. They make a critical contribution to the good health and quality of life of mothers and children, by helping to reduce mortality and morbidity through their timely action. Therefore, it is necessary to provide them the necessary training (capacity building) and handholding not just using the online medium which many are yet to assimilate, but physically, in person, so that their doubts and challenges can be understood and resolved.

13.27 In addition to regular monitoring and reviews, the possibility of interactions with paediatricians, and gynecologists in addition to doctors from the Community medicine department of Medical colleges can also be considered to boost the morale and confidence of the grassroot workers in dealing with the public. Budgetary provision may also be provided for developing / hosting online material/ learning portal for ICDS functionaries and development of APP based learning / information dissemination programme for the public. However, the training should not be limited only to the online mode. In-person training is also essential to provide them effective hand holding, especially on technical issues.

13.28 Micro Planning: A detailed plan may be prepared at the PHC/AWCs level to map families of pregnant women and children below 36 months as well as newly married women who are at the preconception stage, and identifying all those cases which are in the high risk category of undernutrition, in order to provide them special attention so as to prevent these families and children from slipping into the cycle of undernutrition. These plans must have quality indicators built into them to ensure minimum, measurable outcomes.

13.29 With the present status of undernourished children in the state, establishing NRCs in all districts should be considered in the next Five-Year Plan. Necessary fund allocation in budget provisions may also be provided to revamp/ establish/ strengthen NRCs in all districts.

13.30 As the nutrition sector falls under both Health and WCD Departments, specific action plans need to be charted out at every level to overcome pitfalls in implementation. Towards this, convergence activities between Health and WCD Departments in identifying, treating and preventing malnutrition need to be strengthened. There is also a need to strengthen monitoring at the field level focussing on quality and outcomes and not mere compliance.

13.31 The following parameters need to be achieved and monitored for compliance given

the importance of safe drinking water, hygiene and sanitation:

- Ensure child friendly and girl friendly toilets in hospitals, creches, day care centres and public places.
- Encourage hand washing with soap before mid-day meal in creches, and day care centres.
- Collect and test samples for water quality in households and public institutions regularly for taking remedial measures.
- Map the availability of child friendly and girl friendly toilets and drinking water facility in PHCs, creches etc.
- Identify all marketplaces, bus stands and other vehicle stands and mass congregation places for providing child/girl friendly public toilets.
- Serve Legal Notice to defaulting service providers.

13.32 The work balance of the grassroot mechanism in the health and ICDS sectors between their core activities and the other duties entrusted to them by the LSGIs has to be ensured to protect the best interests of children. Since these are institutions transferred to the LSGIs as part of decentralization of powers, this matter has to be ensured by the LSGIs who are now equally responsible for the status of various health indicators in their respective jurisdictions. The importance of this issue needs to be impressed on the elected representatives of LSGIs by the concerned departments and KILA, so that the core functions are discharged effectively by the Health and WCD personnel at the grassroot level, and effectively supervised by the former as well as the line departments.

13.33 The withdrawal of the facility to disburse periconceptional folic acid in anganwadis, through JPHNs etc and limit it only to PHCs where pharmacists are available, on the basis of the Hon'ble High Court's order upholding the plea of pharmacists needs to be appealed against to protect the best interests of both the children and mothers- to- be since this has limited the access to these supplements.

13.34 Given the importance of vaccination to improve the quality of life, and the need to ensure that all children are covered by it, it is recommended that a mandatory check of the status of vaccination be introduced at the time of admitting the child in preschool/ anganwadis and primary schools and the information shared with the designated local health authority and the LSGIs for further follow up to ensure some level of protection to the identified children.

14. STUDIES AND RESEARCH

- Detailed study on the SNP programme in ICDS and the way forward for improvement.
- A study on the usage pattern of SNP provided as Take-Home Ration and its impact on the nutritional status of the target group
- Reasons why persons from economically vulnerable segments go to private hospitals for antenatal, perinatal and postnatal care, availing services beyond their means and the impact of incurring such out of pocket expenses on their lives, especially for the care given to children.
- The challenges and efficacy of the grassroot network of anganwadi workers, ASHA

workers and the JPHN in supporting the right to survival of the child.

- The impact of the state's achievement in reducing IMR on overall service delivery of systems set up to protect the child's right to survive and achieve enhanced quality of life.
- A comparison of the level of compliance of ante and postnatal care of mothers and children in the private and public sectors, and the factors influencing them.
- Reasons for the decreasing levels in breastfeeding at all stages.
- Why feeding practices of babies fail to address the nutritional needs in all segments of society.
- Status of maternal and child care among the vulnerable people who live in socially and economically disadvantaged areas and the challenges in accessing services to improve them.
- Nature and extent of insurance coverage used to defray expenses on health for children in the first 1000 days of a child's life.
- Reasons for the ever increasing trends in caesarean sections in Kerala both in the private and government hospitals.
- Reasons for increase in anemia and decline in ante and postnatal care as reflected in NFHS 5 data despite the availability of a large grassroot network for monitoring and follow up.
- The extent of the role played by LSGIs, post devolution of powers to them, in improving maternal and child care through the machinery under them.

15. KEY INDICATORS

- All indicators of ante and postnatal care which showed a negative decline in the NFHS 5 survey, to be restored at least to NFHS4 levels.
- Availability of birth companions in all maternity hospitals or HRPs.
- Reduce MMR to achieve the figure of 30 from the present level of 43.
- Reduce the rate of C-Sections to the level of the national average of 17% by 2025 .
- Reduce mortality of babies in the first week by 10 %.
- Every District Hospital has SNCUs.
- MBHI initiative implemented in all Government Medical colleges and major maternity and children's hospitals as well as in major private hospitals having a large number of deliveries.
- LMUs are set up in all district health hospitals.
- All Medical colleges to have CLMCs
- Improve indicators in vulnerable areas by 10%.
- Improved SNP with uniform standard across the state.
- Achieve INAP targets for neonatal care
- Set up ventilators and other critical care units in all district hospitals and major maternity hospitals.
- 100%of houses, creches and public places have safe drinking water.
- Increase in number of water samples collected and tested from public institutions.
- Increase in percentage of samples certified as potable.

- Monitoring is done by the field network and the paediatricians (during hospital visits) with the support of the parents based on the MCP card.

II DEVELOPMENT

1. INTRODUCTION

1.1 Development is a key child right, because it influences the trajectory of any child's life, helps shape his or her unique personality and talent, and can help foster him or her to become a fully participating and contributing citizen. While the four basic child rights, viz. Survival, Development, Protection and Participation, intersect on many issues, the right to development covers, interalia, the physical, mental, moral, social, and cultural development of every child from birth.

1.2 Therefore, when addressing issues relating to development in the context of children, the factors that have been taken into account include the quality of education, the Early Childhood Care and Education (ECCE), the nutrition and health care provided to them, the life skills that children need to acquire in the course of development, and the extent to which they are inclusive and accessible to children hailing from vulnerable sections of society, as well as children with disabilities/challenges. It also considers what more can be done to achieve the goal of ensuring equal opportunity for every child to optimally realise his or her potential, irrespective of economic, social or geographical challenges.

2. EDUCATION

2.1 ISSUES TO BE DISCUSSED:

- Drop outs continue to persist, despite the high rate of enrolment in schools and overall rate of literacy among socially and economically disadvantaged populations, people with disabilities, Transgender children (TG) etc due to issues connected with inclusion.
- The need for more uniform, better equipped, and more child centric or gender and disabled sensitive infrastructure in schools. This includes the condition of the school building, the compound wall, classrooms, library, toilet and drinking water facilities, girl friendly toilets, and playgrounds, as well as availability of dining halls, waste disposal systems etc and barrier free access in all aspects.
- Shortcomings in the annual and routine maintenance and upkeep of school premises, toilets etc, resulting in lack of safety and well being of children.
- Need to further improve the implementation of services delivered through schools for promoting nutrition, health, and mental health of children by ensuring better coordination and integration between the school system, the LSGIs, and the different agencies responsible for these schemes.
- Adequacy of stakeholder participation through PTAs, Mother PTAs, SMCs and LSGIs, vis a vis the provisions of the RTE Act 2009.
- Lack of standardised protocols for engagement with students in participatory forums.
- Consequences of the failure to undertake school mapping by LSGIs, as envisaged

under the RTE Act 2009.

- Unique challenges faced by children from tribal areas.
- Challenges in integrating children with disabilities or challenges into the school system.
- Emerging issues in the wake of the pandemic and natural disasters.

2.2 PREAMBLE

Goal No 4 of the Global Sustainable Development Goals (SDG) 2030, to which India is committed, envisages that all boys and girls complete free, equitable, and quality education at the primary and secondary levels. SDG Goal numbers 1, 2, and 7 are also relevant here. They are in line with the spirit of the UN Convention on the Rights of the Child (UNCRC), to which India is a signatory, as also the objectives contained in the National Child Policy 2013. The National Education Policy (NEP) 2020 also recognizes education as the key to achieving full human potential, to achieve a just and equitable society, and to promote national development. The Right to (Free and Compulsory) Education Act 2009 provides the legal underpinning for achieving this objective.

2.3 OVERALL STATUS OF EDUCATION IN KERALA

2.3.1 NITI AAYOG rated Kerala as first among all the states in the country for achieving quality education as envisaged in the SDG Goal no 4. This has become possible due to the initiatives taken by the Kerala Government over the last few decades. A major initiative taken by the State Government over the past five years, to upgrade the infrastructure and provide state- -of -the- art facilities in select public schools, has given a boost to public education in the state.

2.3.2 However, despite this creditable performance, there are gaps that still need to be addressed. According to the data released by the NITI AAYOG in March 2021, the Adjusted Net Enrolment Ratio (ANER) for classes 1-8 is 92.07; the average dropout rate between classes 9 and 10 is 9.14; persons with disabilities over 15 years completing at least secondary level education is only 24.3%; 99.24% of schools have access to basic infrastructure;and, 94.53% of them have adequate numbers of trained teachers at the secondary level. It is also indicated that only 86.8% of the children in class VIII achieve the minimum proficiency level that they are expected to attain as per the nationally defined learning outcomes.

2.3.3 Dropout rate normally has a correlation with children from vulnerable backgrounds, including those hailing from tribal areas, SC colonies, coastal areas, and plantation areas, as well as children of migrant workers, street children, persons with disabilities, transgender (TG) children etc. As per the SC survey(KILA) 2010, 14.21% of the SC students belonging to 6-25 age group dropped out at primary, secondary, higher secondary, degree/diploma and PG level and 1.40% of SC children of the 6-14 age group never joined any schools.

2.3.4 Therefore, the reasons for this rate of dropout requires to be carefully identified and understood. The quality and adequacy of the infrastructure in schools also merits a review in terms of how conducive it is to create a safe, congenial environment for the students, and to what extent it is disabled and gender friendly.

2.4 STATUS OF SERVICES DELIVERED THROUGH SCHOOLS.

2.4.1 The school has always been a convenient point of delivery for several services targeting the needs of children. The nutritional needs of children have long been addressed through the mid- day meal programme implemented in government and aided schools, and programmes for supplementation of Iron and Folic Acid like WIFS (Weekly Iron Folic Acid Supplementation} and AMB (Anaemia Mukth Bharat), while health care needs are being addressed through the Rashtriya Bal Swasthya Karyakram (RBSK).

2.4.2 The School Health and Wellness programme component of the Ayushman Bharat initiative is yet to be implemented in the state. Measures to promote Mental Health are not part of the School Health Programme but are sought to be addressed through the counselling facilities extended through the counsellors of the Women and ChildDevelopment (WCD) Department and the Rashtriya Kaumariya Swasthya Karyakram (RKSK) programme of the Health Department.

2.4.3 Counselling facilities are yet to be extended to all schools; and where they are available, nowhere are they being fully utilized and integrated into the school system. With different agencies simultaneously providing health, nutrition and counselling services, there is concern about the quality of implementation of these various schemes, a felt need for greater partnership among the different agencies and for effective coordination with LSGIs.

2.4.4 The School Management Committee (SMC) is also mandated under Rule 3 (m) of the Kerala RTE Rules 2011 to monitor the implementation of the Mid-day meal programme. However, such. involvement is not uniform. Where the Parent Teacher Association (PTA), the Mother PTA (MPTA) or SMC are actively involved, schools have been able to ensure better quality in implementation of this programme.

2.5 STATUS OF STAKEHOLDER PARTICIPATION AND INFRASTRUCTURE

2.5.1 The school provides a convenient space for interaction between parents, children and teachers through the Parent Teacher Association (PTA), the Mother PTA (MPTA), the School Management Committee (SCM), and the School Protection Committee (SPC), besides the one-to-one interaction that teachers of individual classes have with parents and students. The effectiveness in the functioning of these forums vary significantly in different schools and this impacts the overall quality of the education imparted to the children, and in providing the latter with a safe and congenial space for learning.

2.5.2 The maintenance and upkeep of the infrastructure in Government run schools, for example, can be managed in most cases only with the support of the Local Self Government (LSG) institutions, since many schools may not be able to raise their own funds for maintenance and daily upkeep. Requirements for funding support would therefore have to be projected by the school in the Education Committee of the local LSG institution. Any infrastructure related requirement would also need to be based on the three-year School Development Plan (SDP) to be prepared by the School Management Committee, as specified under the RTE Act 2009.

2.5.3 However, though the school, parents, school leader and even the representative of the LSG institution are required to be part of the School Management Committee (SMC), this arrangement has not functioned optimally in many government run schools either due to lack of initiative on the part of school committees, or lack of budgetary support from the LSGI, or the inability of the SMCs to raise funds locally to meet their needs. In aided schools the situation varies according to the level of interest taken by the management in these issues as SMCs do not exist in many schools and PTAs play a very limited role.

2.5.4 Rule 4 of the Kerala RTE Rules 2011 does not provide for requirements relating to maintenance and upkeep to be included when preparing the School Development Plan (SDP). So, where SDPs are being prepared, their focus is on the creation or upgradation of facilities. While it is important to create new infrastructural facilities and also upgrade existing ones, it is equally important to ensure their maintenance and upkeep, which is not happening now in almost all cases. The daily maintenance of toilets. timely upkeep of water sources like wells, school premises, classrooms, and compound walls which are damaged, as well as the annual pruning of trees, removal of debris from school compounds etc fall in this category of activities.

2.5.5 These are issues that can be easily addressed with the support of the LSGIs. Effective coordination is needed to ensure it. Failure to do so has created safety hazards for children. Therefore, inadequacy in the upkeep and maintenance of the infrastructure, as well as in the quality of the infrastructure needs to be ensured uniformly in all schools with the support of the LSGIs. There is a need to undertake an infrastructure audit vis a vis the standards set by the from time to time in the KER 1959, the RTE 2009 and its Rules and the RPWD Act 2016. and make a time bound plan to rectify the shortcomings under this plan period.

2.6 STATUS OF INITIATIVES FOR PERSONALITY DEVELOPMENT OF STUDENTS

2.6.1 The school plays a very important role in moulding the character of its students, as well as in encouraging talents and qualities of leadership, through activities within and outside the school curriculum. Sports, arts and science related activities, as well as activity clubs covering a wide spectrum of other interests and social services, serve as forums for developing individual interests and talents, social commitment, empathy and leadership skills. While many children benefit from these facilities, there are some areas of concern.

2.6.2 There is a proliferation of clubs up to the high school level, though effort has been made to streamline them at the Higher Secondary level. A similar consolidation of activities appears necessary, since some clubs exist only on paper, those with active sponsors doing better than others.

2.6.3 While some students may be members of more than one club, and there are a large number of clubs, there is no provision to ensure that every child in a school is included in at least one of these clubs, as they ideally should be.

2.6.4 The purpose of these service clubs is to develop qualities of social commitment

and leadership, and a sense of altruism. They offer an empowering experience to their members. However, with varying levels of grace marks being given for participation in some of these activities, that aspect often clouds the very objectives for which these forums were conceived, and fosters unhealthy trends that need to be discouraged.

2.6.5 This issue needs serious attention in the light of the initiative and social commitment displayed by the younger generation when they, with an outpouring of empathy, rallied to support the initiatives undertaken during the natural disasters and the pandemic that engulfed the state in recent years. Currently, there are not enough student participatory structures in schools nor are their opinions or perspectives taken into consideration in the limited forums currently available to them.

2.6.6 Playgrounds and play activities too play a key role in personality development. There is a sad lack of playgrounds for encouraging children to undertake physical activities both in schools and outside it, in the community. Most schools do not even have facilities for non-competitive physical activities (like daily jogging on perimeter jogging paths, participatory perimeter cultivation/ gardening, etc).

2.6.7 Hence, there is need for focussed intervention during the 14th Plan to promote physical activities as an integral part of school curriculum, and ensure the availability of a playground in every school, or attached to it. Similarly, every panchayat must have a playground or public space where children can play or engage themselves safely in some physical activity. Better coordination between the LSGIs and the Department of Youth and Sports (Sports Council) could help open up opportunities to achieve this objective during the 14th plan period.

2.7 STATUS OF DROPOUTS, INCLUSION INITIATIVES

2.7.1 Despite the serious efforts made initially to ensure enrolment of children in schools, including celebratory events like the Pravesanolsavam, in which the local community is also involved, it is a fact that there are children who still remain outside the schooling system. Some children drop out from the schooling system subsequently, for a plethora of reasons, especially those from vulnerable sections of society. Access is often a problem, even at the preschool level, let alone in higher classes.

2.7.2 Under the provisions of Sec 9 of the RTE Act 2009, (as well as Rule 9 of the Kerala RTE Rules 2011), the LSGI is required to keep a record of every child eligible under the RTE Act, and undertake a school mapping exercise to assess their access to education, as defined under the Act. However, all LSGIs do not appear to have actively addressed this issue as yet. Rule 3(g) of the Kerala RTE Rules 2011 also mandates the SMC to address the dropout issue and take remedial action. Such efforts have also not been noticed in most cases.This in turn indicates that the functioning of the SMCs is not uniformly effective.

2.7.3 In the case of children from tribal areas, there is an issue about the language barrier they face when they start schooling. In anganwadis the medium of instruction is Malayalam, which is not the mother tongue of many students from tribal areas.

While a conscious effort is being made to bridge the language gap in the case of migrant children, by hiring persons who are familiar with their language to interface with the children, no such efforts appear to be forthcoming in the case of tribal children. The occasional efforts made to bridge the gap, like the "Teacher's aid" sponsored by KeSCPCR ,which was prepared by experts for those who teach children speaking the Irula language, have remained unimplemented. There have also been no special efforts to specifically recruit local persons or those who know the local language to address this issue.

2.7.4 The approach envisaged in the NEP 2020 is to ensure that children are taught in their local language, and to recruit people locally, because this initial barrier, which robs children of their self- confidence right at the start of their schooling, often culminates in them becoming dropouts at later stages .Hence this is an issue that calls for due condideration without further delay.

2.7.5 Another related issue is the strategy of overcoming access to education for children hailing from difficult terrain by providing hostel facilities. At present hostels are provided from a very young age for children hailing from such areas. However, here is a need to examine how "child right friendly" and culturally sensitive the arrangements in these hostels are, and whether the rights of these children are being hampered in any way by separating them from their families at a very tender age. The facilities in SC/ST hostels, Sports Hostels etc. and the extant policy of placing these children in institutions which are not in proximity to their homes, need a relook keeping in mind our present understanding of child rights.

2.7.6 In the case of tribal children, it is also necessary to ensure that the environment in their hostels is conducive to bring these children to the mainstream, without alienating them from their cultural roots. This appears necessary to motivate them to complete their education, and prevent drop outs.. The strategy of placing these children in hostels from a very young age at a time when all efforts are being made to deinstitutionalise children in need of care and protection and place them with families, also merits a review from the perspective of child rights.

2.7.7 Another group that tends to get isolated and therefore become liable to drop out pertains to children with disabilities. This is a heterogeneous category involving children with various physical and neuro developmental challenges/ disabilities.

2.7.8 The Government has introduced various measures to support children with any kind of disability (to the extent of 40% or more), including financial assistance to all students between classes one to eight who attend general schools, funding support for all girl children with disabilities, food security allowance to certain categories of children with disabilities, and a special package for children with neurodevelopmental disabilities. A direct intervention package is available to provide support to parents of intellectually challenged children.

2.7.9 Evaluation tools and supporting manuals (for ages 6 to11) are currently being prepared for early detection of developmental disabilities at the primary school level by trained teachers. This will help identify developmental disabilities which

were not identified during screening at the pr-eprimary level. While follow after screening is envisaged through the District Early Intervention Centres (DEIC) at the pre-primary level, subsequent follow up is envisaged through existing health facilities, based on the reference of DEICs.

2.7.10 Autism centres under the BRC provide long term support and therapy that children with autism require. BUDS schools under the Kudumbashree programme provide special education for children who cannot adjust in the general schooling system, and home based education is provided to those who are totally housebound, given the nature of their disability. Special schools are available for children with visual and hearing challenges as well as children with severe intellectual challenges. Support is also given in the form of assistive devices for those with physical disability, visual and hearing challenges.

2.7.11 The figures put out by the NITI AAYOG in March this year shows that in Kerala only less than 25% of persons with disability above the age of 15 years complete at least their secondary schooling. This is a matter of concern since the Government has introduced many measures to support children with different disabilities, as indicated previously..The reason why there is still such a serious drop out situation among children with disability despite all these interventions and support, needs to be urgently looked into. Issues for consideration in this context include the following:

- Why is there a delay in detecting developmental disabilities despite all the arrangements made for free screening from birth, and under the RBSK programme? Why are children escaping coverage till they reach regular schools?
- The Government has opted for inclusive education for children with disabilities. But, how equipped are the schools, teachers and mode of education to address their needs, especially those with developmental disabilities, each one of whom requires separate accommodation?
- Without every teacher being professionally qualified and having a reasonable understanding of the nature of disabilities that they have to handle, how is it possible to ensure effective communication between them and this special group of students, in addition to handling the regular demands of a classroom?
- In the inclusive approach adopted by the state, it is not clear how children with disabilities are currently being identified and their "school readiness" ensured.
- There is also concern whether the current method of assessing the level of intellectual disability helps ensure that a child is comfortable in a general class and his or her specific challenges are being appropriately accommodated to achieve expected learning outcomes. This issue is very important because the degree of disability and its nature can vary considerably even within each category of disability, and there are limits to the capability of more severe cases to cope in a general class.

2.7.12 It is necessary to address this issue at the earliest in the best interests of these children rather than lump them altogether in general schools. Maybe there has to be different strategies for addressing different levels of severity so that their learning needs and

the task of improving their socializing skills can both be addressed simultaneously.

2.7.13 Another area of concern is that there appears to be no viable method to assess the academic as well as basic social and life skills of children with developmental disabilities at entry point in the schooling system. Evaluation tools for use at the primary school level are still under preparation Therefore, for these children, to manage in a general environment which is not barrier free or disabled friendly, where there is no flexibility in the selection of subjects to suit their challenges, the limitations in the level of Special educator support available (in most cases more than one school shares a Special educator, and they have to simultaneously support all the children with different challenges), or to get appropriate accommodation for their specific needs in the general setting of a class as part of inclusive education, is definitely a daunting experience. This is a serious issue, and these aspects of the problem need attention.

2.7.14 There does not appear to be any effective yardstick available for measuring the learning proficiency of these children at every level, not merely in academic terms but also in terms of life skills and ability to cope in the real world. WHO recommends ten life skills that will equip any child with the right knowledge of life and the right attitude to face life successfully? Unless these life skills are ensured, there is the risk of children being promoted without acquiring any appropriate skills and eventually becoming a dropout, not just from school, but from an active, contributing role in society.

2.7.15 It is important to examine if some among this category of students, who would benefit from acquiring vocational skills, have access to training in vocations that have a market demand which in turn will enable them to become financially self-supporting. This would help boost their sense of self-esteem. Regular updating of the curriculum for vocational skills appears necessary. It is also necessary to examine the extent to which technology is being gainfully utilised to help them address their challenges effectively.

2.7.16 An allied area which raises concern relates to children who are attending Special schools run by NGOs or the BUDS schools run by LSGIs. Both these groups of schools are being funded through a special package supported by the Directorate of General Education. However their curriculum is decided by the SCERT. It is understood that a set of 8 books were developed by SCERT for the primary section around 5 years ago. Syllabuses for the pre-primary, prevocational and vocational classes are yet to be made available by them.

2.7.17 This issue is a matter of concern as children in these schools are continuing to use the same books even after the passage of 5 years. There is a need to get the curriculum for the remaining categories, especially for the pre vocational classes, prepared at the earliest so that the children who have been repeatedly learning from the same book can move forward.

2.7.18 The feeling of exclusion felt by a child with any kind of disability among his or her fellow students due to all the above issues (and more) needs to be remedied.

As a state that has done much to understand and support the challenges of the disabled, it is necessary to take the next steps forward to improve their integration into society as productive, contributing citizens. Solutions need to be found for the obstacles in their path so that no child is left behind, and that they do not become dropouts.

2.7.19 In the matter of dropouts, it would appear that the SMCs need to be sensitised to address this issue more seriously as per the mandate given to them under Rule 3 (l) of the Kerala RTE Rules 2011. The involvement of parents of differently abled children can also help improve the quality of services provided to disabled children in terms of early detection, providing better facilities in BUDS schools, ensuring inclusive education, and timely distribution of scholarships, stipends and other benefits.

2.8 EMERGING ISSUES IN THE WAKE OF THE PANDEMIC AND NATURAL DISASTERS

2.8.1 In recent years the state has witnessed several new challenges in the form of repeated natural disasters caused by climate change; it has also had to address pandemic issues like COVID 19, Nipah etc. This has affected many families, and caused serious displacement in the lives of children, due to loss of family members, important documents etc. COVID 19 resulted in total disruption of normal life, resulting in loss of precious years of childhood experiences that can never be made up.

2.8.2 While much effort is being made to address these issues without adversely affecting the children involved, from the perspective of the right to development, post COVID 19, there are a number of specific concerns that need to be addressed :

- The fresh enrolment of children of migrant workers is one such issue, as many of them had returned home with their families, whereby there was a disruption in their studies. Many of them would not have been able to access online facilities, and many others may have to face a change of school when the families return, due to their parents opting for new places of work.
- The system will have to be ready not only to address these issues but also to ensure that they are brought back to the schooling system and are not engaged in child labour due to their straitened economic circumstances.
- It is equally important to monitor this aspect in the case of children from tribal and coastal areas, where they may not have been able to avail online facilities optimally and will have to be given special support to keep up with the rest of the class.
- Over and above the challenge of ensuring that children from vulnerable socio economic backgrounds stay within the school system, it would also be necessary to equip teachers to face the challenges of getting children back into the groove of school discipline. There could be serious challenges to classroom discipline due to shorter attention span, restlessness etc after being away from the school routine for more than a year.
- This situation would need to be handled deftly without resorting to actions that

violate the statutory ban on physical punishment or mental harassment, as provided in section 17 of the RTE Act 2009. Sensitising the teachers to these challenges and preparing them for this new scenario is important because teachers too have apprehensions about coping with the new classroom requirements and discipline.

3. EARLY CHILDHOOD CARE AND EDUCATION (ECCE)

3.1 ISSUES FOR DISCUSSION

- Absence of a regulatory framework, as well as minimum standards for education, care
- infrastructure and safety relating to preschool education
- Declining attendance in the anganwadi system
- Inadequate and inappropriate infrastructural facilities in most anganwadis
- Possibility of rebranding the anganwadi system .
- Tackling the challenge of bringing the "left out" children into the fold of the ECCE
- Issues relating to anganwadi staff recruitment that affect standards

3.2 PREAMBLE

3.2.1 The legal provision pertaining to Early Childhood Care and Education (ECCE) is contained in Section 11 of the RTE ACT 2009. It mandates the appropriate Government to make necessary arrangements to provide free pre-schooling to children between the ages of 3 and 6 years to prepare them for joining the school system. There are no specific directions in the Kerala RTE Rules 2011 regarding the arrangements to be made in this regard, except the provision in Rule 7(4), which directs Government to consider providing pre-service and in-service training to teachers in anganwadis, as well as those in pre-primary schools attached to government, aided and unaided schools. The training in the latter cases was to be done at their cost.

3.2.2 The NEP 2020 has since given a clear picture regarding the expectations from pre-primary education. It calls for a uniform framework for implementing ECCE in a phased manner in all categories of preschools and anganwadis across the country by 2030, giving priority to economically and socially disadvantaged areas.

3.3 OVERALL STATUS OF ECCE IN KERALA

3.3.1 Preschool education in Kerala is provided through a large network of 33,115 Anganwadis, 1916 pre-primary schools supported by PTAs in Government and aided schools, 67 Government pre-primary schools, those run by local self govt institutions, SC/ST Development Department, Library Council, etc. Preschools are also run by aided and unaided schools as part of their school system, and as standalone institutions by individuals and institutions.

3.3.2 There is no actual account of the total number of pre-primary schools in the state catering to children between the ages of 3 and 6, because currently they operate in an unregulated sector, with no requirement of taking approval from any authority to commence operations.

3.3.3 SCERT has developed a curriculum and books for preschools, which includes a

teacher text and an activity book titled "KALIPPATTAM" for children in the 3+ and 4+ age groups. These are yet to be implemented. Therefore, no standards or guidelines exist regarding the basic infrastructure, pedagogical content, quality of services to be provided, or the minimum safety standards that must be adhered to. The qualifications of teachers are also not uniform.

3.3.4 In the absence of standards, the quality of infrastructure, teaching, care and education that preschool centres provide vary significantly, and children in many preschools are being exposed to situations that are not conducive to their healthy development. It is a scientifically acknowledged fact, and one recognized in the NEP 2020, that 85% of the cumulative brain development of any individual happens during the period between 3 and 6 years.

3.3.5 Therefore, lack of standards in preschools can deny children the stimulus that allows the synapses of the brain to develop in a healthy manner; on the contrary, they often create scenarios which have a toxic effect on children throughout their lives. An allied concern is that the school readiness of these children will also vary, whereby not only will they be denied the opportunity to flourish in the schooling system, but find it a traumatic experience to adjust to the new and often highly demanding requirements in the latter.

3.4 STATUS OF THE ANGANWADI SYSTEM.

3.4.1 Although the state has a vast anganwadi network, yet it is estimated that only around 25% of the children in the eligible age group attend anganwadis. A study conducted by KILA in 2017 (based on the ICDS Report, Thrissur, 2015) showed that in Thrissur district, out of the total number of children eligible to attend pre-school, only 42.5% attended anganwadis while 51.9% attended other centres offering pre-school education, and 5.6% attended neither.

3.4.2 There has been a progressive reduction in the trend of attendance in anganwadis over the years, despite a scientifically developed curriculum, nutrition support, and a mechanism to regularly monitor the children's development, as part of the ECCE offered through these centres.

3.4.3 The attendance in some of the anganwadis is so low that the possibility of using this network for creche facilities has also been considered. However, the requirements of a creche differ from the ECCE that is offered through the anganwadis, and it is not an optimum solution using the present establishment, since the anganwadi workers also undertake many other responsibilities, leaving them little time to take up fresh ones .It is perhaps time to discuss whether the extra assignments given to AWC staff by LSGIs and the WCD Department are affecting the services given to children in the anganwadi,s and how best the quality of care can be ensured.

3.4.4 A strategy is required for rebranding ECCE offered through the anganwadi system, on the lines of what was done for public education, to bring children back to this system. Mission mode actions appear necessary for AWC standardisation. More public involvement is also needed for developing model anganwadis. This initiative can be designed after the "Comprehensive Educational Rejuvenation Programme"

of the Navakerala mission. This is the appropriate time to address this issue as ECCE is expected to receive serious attention under the NEP 2020.

3.4.5 The areas that need attention in this rebranding exercise include:

- improving the infrastructure of anganwadis and providing them with their own ergonomically designed buildings which are child friendly. This continues to remain an aspiration despite efforts taken over the years to provide proper accommodation of their own to all anganwadis, with some rented buildings still not having even toilet facilities.
- training and upgrading the skills of teachers so that parents are comforted to know that their children are getting the best possible care and education.
- ensuring that the pedagogical framework not only reflects the best of national and international experiences and the best research that ECCE has to offer but also incorporates the culture and traditions of the local community.
- involving the local community, to create greater awareness about this initiative and to ensure sustained support for these centres.
- Most importantly, there has to be a regulatory framework to enforce the standards that will be created as part of this initiative. The unfettered freedom currently given for this activity in the state, which has resulted in the present mushrooming of pre-schools of uneven standards and safety, has to stop, as it goes against the best interest of every child.

3.4.6 It is a matter of concern that despite the availability of the large number of pre-schools and anganwadis, there are children still remaining outside the pre-school network. Their inclusion must be ensured. The LSGI and ICDS officials need to map all eligible children in their jurisdiction. The categories of children who stay outside the preschool network need to be identified, the reasons why they are staying away from schooling needs to be understood, and remedial action taken.

4. NUTRITION

4.1 ISSUES FOR DISCUSSION

- Need to promote nutrition literacy to tackle the rising incidence of undernutrition, overnutrition, malnutrition and micronutrient deficiency.
- Scope for further improving the mid day meal/ PM POSHAN programme.
- Addressing the nutrition needs of children outside the ambit of the Government/ Aided Schools.
- Addressing hunger issues among children in socially and economically disadvantaged areas.
- Scope for nutritional gardens in AWCs; perimeter fruit and vegetable gardening programmes in schools- to be integrated with their health clubs.
- Rejuvenating Nutrition Supplementation Programmes post COVID 19

4.2 PREAMBLE

4.2.1 Nutrition needs of children during the ages 3 to 6, ie., the preschool years are being addressed through the Supplementary Nutrition Programme(SNP) managed

through the anganwadis under the ICDS. In addition, children between 6 months to six years who are severely underweight are also provided micronutrient rich/ energy dense food as Take Home Rations (THR) under this programme. For children below 3 years and pregnant/ lactating mothers, THR in the form of ready to eat food/ premixes is also provided.

4.2.2 At the school level, nutritional needs up to the secondary level are being met through the Mid-day meal programme, or the Pradhan Mantri Poshan Shakthi Nirman Scheme (PM POSHAN), being implemented across the country in all government and aided schools. The NEP 2020 seeks to extend the PM Poshan to the Preparatory Class that is to serve as the bridge between pre-primary and primary schooling. It also proposes to extend breakfast to all classes up to the secondary level.

4.2.3 In addition to the above programmes, the state has also set up Nutrition clinics in 152 block panchayats and 6 corporations to educate people on the importance of balanced diets in ensuring the quality of life and to create nutritional literacy among the public.

4.3 CURRENT STATUS OF THE NUTRITION PROGRAMME IN KERALA

4.3.1 In Kerala, in addition to the support given to children at the preschool level through the ICDS, and at the school level up to secondary level through the Mid-day meal programme, or the Pradhan Mantri Poshan Shakthi Nirman scheme (PM POSHAN) being implemented in all government and aided schools, children are also being given an egg/banana (once a week) and milk (twice a week) under the SNP, as part of a state initiative. In 3217 schools across the state the LSGIs, with support of sponsors or the PTAs, are also providing breakfast. In all schools in Wayanad, breakfast is being provided to all the tribal students.

4.3.2 It is proposed to extend this scheme to schools in all the districts in the state. The Government is also poised to distribute fortified food grains (with iron, B12 and Folic Acid) from the third term of the current academic year. To ensure that children are served good quality pesticide free vegetables, kitchen gardens have been started in almost 70% of the schools. Some schools are even growing paddy on nearby Government land, taken on lease basis, with the support of the Department of Agriculture.

4.3.3 Other initiatives started to improve the quality of the mid day meal programme include:

- testing the food and water for quality and microbial content through government labs with the aim of testing these samples once every 6 months.
- tasting the food by members of the SMCs and MPTAs. and recording their comments in a prescribed tasting register. This initiative has been successful in only 50-60% of the schools so far, where the SMCs and MPTAs have demonstrated ownership for this effort.
- Ensuring safe drinking water facilities by regularly cleaning water tanks, disinfecting wells, providing water connections in schools that do not have their own source of

water, and supplying water purifiers. So far only 20% of schools have succeeded in procuring water purifiers either through CSR initiatives or sponsorships.

- Similarly, proper dining spaces have been created in only about 19% of the schools, again through similar modes of funding, despite many schools having land for providing such a facility.
- All these initiatives remain work in progress for want of financial resources.

4.3.4 Despite all these efforts, NFHS 5 and CNNS 2018 shows that in the under 5 category, 23.4% of the children are stunted,15.8% are wasted, and 19.7% are underweight. The data put out by the NITI AAYOG in its SDG Report of March 2021 shows that in the same category, 18.7% of children are underweight , 20.5% fall in the stunted category and 22.6% in the anaemic category. Anaemia among adolescents is stated to be 9.1 % in the SDG Report. In fact, anaemia could touch 30 to 40% if the benchmark is increased to Hb level of 12 G/dl, so as to also include mild anaemia.

4.3.5 Simultaneously, obesity is becoming a serious issue for even children under five. Problems of obesity have worsened in all categories of children during the COVID period when children were confined at home without any opportunity for play or exercise.

4.3.6 With overnutrition, undernutrition and malnutrition showing signs of simultaneous increase, there is a need to ensure a healthy, balanced diet. For this, corrective action needs to start with pregnant women and lactating mothers; it is important to educate parents and young adults about the need for proper dietary practices and its importance for the healthy development of children. They need to be made aware of the dangers of adhering totally to fast food culture, which has gained even greater prevalence during the COVID period with such food being cooked even in homes, inspired by culinary programmes available online.

4.3.7 A holistic, life cycle approach to nutrition and health interventions is necessary and needs to be promoted. The introduction of Nutrition clinics that function up to the block level is a welcome step taken by WCD to address this issue. It needs to be extended to the panchayat level with the support of the WCD.

4.3.8 Under-achievement in a child's current nutritional status can be due to ongoing sickness or hunger, or the result of more systemic and long term factors which need to be distinctly identified and referred either to the Nutrition clinic or appropriate health facility for remedial support. The anganwadi worker and the ASHA worker can also identify children with nutrition problems as part of the community surveillance done of mothers and children not meeting anthropometric norms, determine their history and make suitable referrals.Adolescents attending the Adolescent Clubs and young mothers to be attending anteNatal clinics, both of whom may have issues for clarification regarding nutrition, can be referred to these clinics.

4.3.9 Special attention needs to be given to children who were/are born as Very Low Birth Weight (VLBW)/ Low Birth Weight (LBW), or Sickle Cell Anaemia (SCA). While

there is significantly strong evidence linking LBW with poor maternal nutrition, significantly strong evidence exists linking LBW with enhanced risk of Metabolic Syndrome and Type II Diabetes for the child at a later age (Barker Hypothesis) Evidence also suggests that LBW, gender, and economic status are important predictors of stunting, wasting and underweight.

4.3.10 Children born with LBW are found to be 1.7 times more likely to be stunted, twice more likely to be underweight and 1.5 times more likely to be wasted. This emphasises the importance of strengthening the surveillance system through closer monitoring, and to have more targeted interventions over and above the universal approach, especially in the case of economically and socially vulnerable groups.

4.3.11 There is a need for a convergent action plan for pockets of vulnerability. In Kerala, they comprise the residents of tribal areas, the SC colonies, the fishermen's villages, the urban slums, the migrant settlements, colonies etc. Ethnographic studies and case reviews need to be taken up by the Departments of Health and WCD to identify pockets of vulnerable communities in order to provide them focussed care and attention.

4.3.12 These reviews can become the basis for local level decentralised approaches and convergent action plans between the two departments and LSGIs, to address the specific needs, with a well identified monitoring framework. Appropriate behaviour change communication will also need to be deployed to sustain these efforts through changed, positive, health seeking behaviour.

4.3.13 Nutrition clinics are held by turn on fixed days in different block panchayats with the help of nutrition experts. Their client base includes persons, including children who are either walk-in clients or those referred to them by anganwadi workers during their field visits. While the initiative to start Nutrition Clinics is a welcome move, like most services, this programme too has been impacted by COVID 19, with people unwilling to step out of their homes. It is understood that only 112 of the 158 clinics are currently functioning due to this reason. Special effort has to be made to get this important initiative back on track.

4.3.14 When doing so, it is important to review the following aspects of its functioning:

- How effective is the referral system?-- This can be assessed from the number of persons referred and the number of persons out of those referred who actually attend the clinic.
- There is a need to have some feedback mechanism as mentioned above to make it effective and accountable.
- Anganwadi workers can also be encouraged to refer members of the Adolescent Clubs to these clinics because diet related issues are not only important to adolescents, but is a matter of interest at that age.
- If walk- in public has to be attracted, then it is necessary to create visibility at the block panchayat, municipality and corporation levels so that the public know where and when this facility is available.
- With COVID 19 related activities preoccupying LSGIs, it is necessary to reconfirm

that there is a proper and visible accommodation available in panchayats to conduct these clinics. This aspect needs to be ensured.

- The credibility of the clinic also rests on the assurance that the services of an expert on nutrition will be available when it is held, and that it is not solely managed by in -house staff. Though persons with a background in nutrition had been mapped and identified for this purpose, perhaps this too has been affected by the restrictions during COVID. A remapping of expert resources needs to be done at the local level and communicated to persons at the grassroot level to ensure the presence of experts at these clinics.
- Keeping in mind possible constraints in financial resources, the possibility of tapping even the support of service organisations and voluntary organisations, who have expertise in nutrition related matters and may be willing to offer voluntary services, can be considered.

4.3.15 Nutrition needs of children between the ages 3 and 6 are primarily met through the SNP, for which LSGIs are the major contributors; the state also contributes to it. The beneficiaries of this programme are only those who attend anganwadis. Post COVID, the per head cost of the items in the food basket has gone up. At the same time, there is also a need to add more protein and micronutrient components to the food basket as has been done by some panchayats which have their "own" funds.

4.3.16 It will require additional budgetary resources to sustain and expand the coverage of the SNP, as detailed above.. Given the level of increase in anemia, this proposal merits consideration. But its impact needs to be assessed. A study of the impact of introducing these new components in the food basket needs to be studied in the panchayats which have already done so.

4.3.17 A related issue that needs serious attention is the nutritional and health needs of the large student population that attends preschools and private schools, and who are outside the reach of the above services, which are being provided only to children within the jurisdiction of anganwadis, or Government and aided schools.

4.3.18 Though the NEP 2020 plans to expand the scope of the mid-day meal scheme and the breakfast scheme to preschools and all Government and aided schools, this will only enhance the present coverage in Kerala marginally. Those studying in private institutions will continue to be outside the ambit of these services. Exposure to junk food, and absence of a balanced diet can cause in this large group not only obesity, incidence of fatty liver and other life style diseases from a very early age, but also the incidence of anaemia, as evident from the current available data---a disturbing trend that could be the harbinger of a serious public health problem.

4.3.19 There is a very urgent need to educate the general public about this looming threat through a well thought out public awareness campaign and also by addressing the private schools and parents of children attending these schools to help tackle this problem effectively through a public private partnership, in the best interest of children.

4.3.20 Another area of concern is about addressing the nutritional needs of children from

socially and economically vulnerable groups in times when they cannot reach their anganwadis/ schools where they can have access to food. During the COVID period, an excellent initiative was taken by the Education Department to reach the rations/ food to the homes of the beneficiaries. Food Security Allowance (FSA) was also given as a one time measure to all children in the state for 39 days during the summer vacation of 2020.

4.3.21 This initiative could be a model to resolve a long standing problem relating to certain categories of children like tribal children, especially children of nomadic tribes. They experience lack of food even in normal times when schools are on vacation. Efforts have been made in the past by the WCD department, in partnership with LSGIs and the Tribal development Department, to address this issue by planning special vacation programmes for the children in certain pockets, which included nutritional support. It is essential that pockets where such problems exist are identified and a system/ scheme put in place to ensure that such lack of food is comprehensively addressed.

4.3.22 Another group of children in vulnerable circumstances are the children of migrant workers. Schools and AWCs are perhaps the sole venues that can ensure multiple rights of all children, especially those from vulnerable backgrounds like children of migrant labourers. Their circumstances may be different but their needs are also similar in many aspects and need due attention

4.4 SCOPE FOR NUTRITIONAL GARDENS IN ANGANWADIS AND PERIMETER GARDENS IN SCHOOLS TO BE INTEGRATED WITH HEALTH CLUBS

4.4.1 As part of the initiative to provide children fresh, pesticide free vegetables, kitchen gardens are stated to be available in 70% of the schools. Similarly nutritional gardens are being cultivated in some of the anganwadis where there is scope to do so. There is an opportunity here for integrating these gardening activities with the activities of the School Health clubs of neighbourhood schools so that children not only gain an opportunity for physical activity and to learn a useful skill like gardening, but also acquire practical knowledge from early childhood about the composition of healthy, balanced foods and how they can be integrated into their daily diets. Such daily physical activities in bright daylight have a major role in ensuring freedom from depression, and increasing mental health and energy for study and co-curricular activities.

5. HEALTH CARE

5.1 ISSUES FOR DISCUSSION

- The efficacy and quality of School Health Programmes (SHP) to address important health issues among children
- The effectiveness of the anganwadi staff in managing Adolescent Clubs, and the functioning of the recently started Parenting clinics in terms of achieving their objectives.
- The challenges faced in providing counselling services and in imparting life skills.

- Importance of the role of LSGIs in improving the SHP.

5.2 PREAMBLE

5.2.1 Health care of children below six years of age as well as pregnant and lactating mothers is provided through:

- the ICDS, which addresses issues relating to immunisation, nutrition and health education, health check ups, and referral services: and,
- the Rashtriya Bal Swasthya Karyakram (RBSK) which, through their mobile units provide children in anganwadis biannual screening for early detection and management of the 4Ds viz. Diseases at birth, Deficiencies, Disorders, Developmental delays, including disabilities. Cases requiring further referrals are taken up with the District Early Intervention Centres (DEICs).
- Cases of nutritional deficiency are also referred to Nutrition clinics, or for medical intervention, as the case might be.
- The anganwadis follow up the implementation of the immunisation programme to ensure that children get their full complement of vaccine doses up to the age of six.
- For children above 6 years, health care is currently provided in schools under
    - The Rashtriya Bal Swasthya Karyakram (RBSK) through their mobile health units,
    - The Iron and Folic Acid distribution programme
    - The Deworming programme
    - The Rashtriya Kishori Swasthya Karyakram (RKSK) with focus on adolescent health.

The School Health and Wellness Programme under the National Programme titled Ayushman Bharath is yet to be implemented in the state pending a decision in this regard.

5.2.2 Cases screened by the RBSK and found in need of reference for further care and support, including cases of developmental disabilities referred to the DEICs, are handled through the services provided by the Health and Wellness Centres or the Adolescent Health Clinics.

5.2.3 Both Ayushman Bharat and RKSK focus on promotive and preventive aspects of health. These programmes are implemented through a collaborative effort between the Departments of Education and Health, coordinating with the National Health Mission.

5.3 OVERALL STATUS OF HEALTH CARE FOR CHILDREN OF 3 YEARS AND ABOVE

5.3.1 At the anganwadi level, the focus of healthcare is on monitoring the nutrition, development and timely immunisation of children. Following a life cycle approach, they are required to focus on care of pregnant and lactating mothers too. Nutrition supplements are provided through anganwadis to pregnant and lactating mothers as well as children. Health education is part of the package of services they offer. They are equipped with a digitised POSHAN tracker facility to monitor anaemia and the various milestones in the development of a child.

5.3.2 With the screening facilities available through the RBSK for early detection of disabilities, their further management through the DEICs, and the training given to the anganwadi staff for timely detection of developmental delays, with support of the Child Development Centre (CDC), there is a system in place to ensure that even children with challenges are given an early opportunity to have timely support to access resources to lead a fully productive life.

5.3.3 Adolescent Clubs hosted at the anganwadi level and Adolescent Friendly Clubs (ACs) hosted at the Primary Health centres provide platforms to discuss any issues that concern adolescents. Adolescent Health and Wellness Days (AHWD) provide opportunity for parents, teachers, adolescents and other social mentors to converge together in a 'mela mode' gathering. Recently, Parenting clinics have been started in all block panchayats and 6 corporations, taking into account the importance of parenting in ensuring the health and wellbeing of every child, and to promote a family centric(and not just mother centric), approach, in child care and upbringing.

5.3.4 Yet, despite these arrangements, the current scenario shows that nutrition and development related issues continue to persist, Anaemia and problems of obesity are not only prevalent, but are on the increase. According to NITI Aayog's SDG Report released in 2021, anaemia is stated to be prevalent in Kerala among 22.8% of pregnant women between the ages 15 to 49 and 9.1% of adolescents between 10 and 19 years. NFHS 5 data has also brought out the increase in the level of anemia among adolescent girls and boys. and it is a matter of concern.

5.3.5 The anaemia among girls has an intergenerational impact because there is a strong correlation between mothers with anaemia and babies with low birth weight. This is a particular matter of concern among the tribal community where the problems of infant mortality, underweight babies etc are a recurrent problem.

5.3.6 Currently, all these services have been impacted by measures taken to manage COVID, but they need to be resumed. When doing so, it would be useful to consider measures to ramp them up after reviewing the extent to which they have achieved their objectives, and what further needs to be done to do so.

5.3.7 Some issues for such consideration would include the following:

- Whether the Adolescent Clubs, hosted in anganwadis are able to attract their target group and achieve their objectives? At a time when issues like substance abuse, challenging lifestyles, need for better gender sensitivity, challenges in building relationships with the opposite sex, internet and social media addiction, anger management etc call for urgent attention among the adolescent age group, these clubs need to be able to attract and engage the young people in their jurisdiction.
- Whether the current modes of accessing them and the service delivery of these clubs are appropriate vis a vis their objectives need to be assessed. Perhaps they will benefit from additional external support through resources available locally such as the NSS, service organisations, voluntary organisations etc which can be tapped to facilitate creative activities, and attract youngsters to these meetings.

5.3.8 The effectiveness of the Adolescent Friendly Health Centres (AFHCs) set up by the

Health Department at the district and block levels also merit a review as to whether they have the capacity to fulfil their objectives with the human and technical resources (AH counsellor and supporting staff) available to them, as well as the problem of continuous attrition due to their unattractive working conditions. It is understood that the achievements of part time AFHCs, managed with pooled counsellors, are far below that of those managed by dedicated counsellors. Therefore there is a need to review the present arrangement, and consider corrective action, including the possibility of managing every AFHC with a dedicated AH counsellor.

5.3.9 Parent clinics have recently been started at the block level. They target joint participation of both the husband and wife, since the goal of home based care of children and a healthy lifestyle and diet can only be achieved if both parents are actively involved. So far, it has not been possible to inculcate a family centric or family participatory approach to issues connected with pregnant/ lactating mothers and the care of children, or attract fathers or father- to -be to these clinics. This responsibility continues to remain the sole responsibility of mothers. Strategies to create a demand in the community for these services are most important for their success.

5.3.10 Despite sustained attempts, several data gaps on the development aspects of children, including immunisation, continue to persist. For example the data available with the anganwadis and the health department do not match. There is a need to identify the reasons for this variation and to resolve it.

5.3.11 At the School level, the objective of the health programme is to address issues through screening, promotion, and by strengthening disease prevention among children. Traditionally, the School Health Programme included health check-ups, distribution of deworming tablets and Iron and Folic Acid tablets. These services were provided with the help of a Junior Public Health Nurse (JPHN) who was attached to the school and who monitored the development of all the children regularly, provided them First Aid etc.

5.3.12 The RBSK added a new dimension by screening the children for early detection and management of diseases, deficiencies, disorders and developmental diseases. This was done through their mobile units. With this, gradually, the JPHN/ School Health Nurse/School Health Nurse ((JPHN/SHN) was withdrawn and the screening responsibilities were limited to the annual checking of data that the mobile RBSK was expected to do, based on the measurements entered in every child's health card by the school. Wherever necessary, appropriate referrals were made.

5.3.13 The School Health Programme with the above components has been subsumed into the Ayushman Bharat initiative in other states, but not in Kerala. The implementation of this programme is primarily to be done through two teachers, selected and trained to act as Health and Wellness ambassadors and two students elected and trained to become Health and Wellness messengers. The teachers are to engage all the students for one hour every week in health promoting activity,

for which Tuesday has been earmarked. Resource kit and other training material is to be provided to them, and they can get support from the Medical Officer of the concerned PHC or the RBSK to resolve any doubts. The school component of the RKSK seeks to address the preventive and promotive aspects of adolescent health care.

5.3.14 However, the current status of the School Health Programme in the state merits a review. It no longer has the oversight of either a JPHN or any teacher from the school. It is primarily managed by children who have been trained to function as Peer Educators or Buddies under the RKSK programme for the purpose of helping, detecting, and providing referral service to needy children for further care and attention. Currently these students are entrusted with the responsibility of recording the height, weight etc of students, while the mobile unit of the RBSK decides on further appropriate course of action during their visit to the school.

5.3.15 To put it briefly, the whole School Health Programme is in a state of limbo, with only children being held responsible for its implementation. Under the circumstances, it is necessary that a decision is taken at the earliest to introduce the Ayushman Bharath initiative so that teachers can be brought in to take responsibility, as envisaged in that programme, and manage it with the support of two trained students. School health programme was not a priority in the last two years due to COVID when the schools were closed; however, with the reopening of the schools, it is necessary to stabilise the programme.

5.3.16 When reviewing the current School Health programme the following issues need to be considered:

- The approach to school health is now primarily focussed on preventive and promotive aspects, and it is being helmed by students. who are trained for this purpose. While involving children in this health-related activity and training them to play an active role, give First Aid etc are laudable, it is a matter of concern as to how trained and equipped these students are to undertake these new responsibilities and discharge them effectively.
- It is also not clear as to who monitors the effectiveness of the efforts they make. Some mentoring and support from the teacher community will need to be given to support the students and monitor their efforts on a regular basis.
- There is a definite overlap in some issues under the Ayushman Bharat and the RKSK, which need to be rationalised if the former is to be introduced. There is scope for having the same teachers and students as common functionaries for both programmes.
- The Peer Educator (PE) programme of the RKSK which trains students for Buddy Detection (for early detection of all minor adolescent health issues) Buddy Help (to provide as many persons as possible), and Buddy Referral (for making referral to higher functionaries or centres for expert assistance) has good potential for ensuring adolescent health at the grass root level through peer group mentoring and could be used for services related to health provided by other departments, including

measures to promote mental health. At any given time, it is understood that there are around 19,300 PEs active in the school system.

- Both the Health Department and the WCD focus on adolescent issues through their respective counsellors. Counselling is a very sensitive subject; therefore, no matter who addresses the issue, a uniform, comprehensive approach which includes the physiological, emotional, psychological and social dimensions of the subject needs to be adopted.
- Issues of counsellor burnout and frequent attrition, especially in the services provided by the NHM, are serious issues that need a detailed review for remedial action to make this service achieve its intended objectives.

5.3.17 The SCERT has effectively addressed the need to give age appropriate information and life skills to children through their laudable effort,"Ullasa paravakal"—"Health, Education and Life Skill Programme (HELP), a handbook for teachers and workbook for students of classes 1 to 12 . This activity based content was to be incorporated as part of the regular education provided to children. It is understood that till date it has not been possible to supply even a copy of this book to each student.

5.3.18 The activity-based approach to learning, and the digital resource developed, like the "flipped classroom" for example, which were novel approaches suggested as the mode of delivery for the contents of that book, have gained currency in the online education system prevalent during COVID period. Therefore, it is an opportune moment to promote these techniques to ensure effective delivery of the life skills proposed in this text book, so that they coexist within the exam oriented approach generally adopted in schools. For achieving this objective, it is necessary to train teachers and familiarise them with the new approach.This programme has to be closely monitored till it is fully embedded in the system.

5.3.19 Non availability of basic anthropometric equipment in schools to take the measurement of the height, weight and BMI of the students has been reported in schools. This defeats the very objective for which monitoring the development of children, especially for early detection at the primary level, was made a part of the programme. Therefore, when revitalising the programme, these aspects need to be reviewed and all necessary corrective steps taken.

5.3.20 Iron and Folic Acid tablets are being given on a weekly basis to both boys and girls to tackle anaemia. There is concern that these tablets, given on a weekly basis, exceed the upper tolerance limit of 45 mg for iron. Many children avoid taking them for a variety of reasons. This issue needs to be reviewed by an expert committee to ensure that the objective of the programme is fulfilled and wastage of resources is avoided.

5.3.21 This programme is also understood to be not functioning effectively, because children are not eating the supplements at school under supervision, as originally envisaged. Since the programme has a linkage with the eradication of anaemia, it is recommended that its implementation, including the technical issue of the dosage, may be looked into closely so as to put this programme back on track.

5.3.22 Counsellors have been provided in 1012 schools by the WCD department and they propose to extend this facility to another1012 schools. Although the counselling facility has been in existence for a number of years, there still appears to be a lack of clarity on the part of the school authorities and the counsellor on their respective roles.

5.3.23 While the role of the teacher as a mentor and guide is very important, there are certain issues that counsellors are well equipped to handle thanks to the specialised training that they have. A better understanding of the support that the teacher and counsellor can respectively provide would be in the best interest of the children. It needs to be spelt out by the Departments of Education and WCD jointly, to eliminate the present confusion.

5.3.24 Similarly, providing a space where any child can discuss his or her problems confidentially, and a secure place to store confidential records, are basic necessities for a counsellor that are yet to be provided in some schools. The recognition that the counsellor is also a part of the school system is yet to be fully accepted by many schools. A more cohesive approach on both sides is necessary to make this programme, which will be a crucial support system to address many critical issues post COVID-19, work effectively.

5.3.25 Counselling facilities are also provided by counsellors of the NHM through their Adolescent Friendly Health Centres (AFHC). There are 32 such centres which operate on a full-time basis at the district and block levels and 38 which do so on part time basis. There are also district level mental health facilities to offer specialised support, in addition to help lines like DISHA and CHILDLINE which offer free support.

5.3.26 Since the teachers in school form the base of a pyramid that provides a range of services through different agencies, it is essential that the nature and hierarchy of services and service providers are mapped locally, including referral services, so that there is no overlap or waste of resources and the referring teacher knows what to do in any eventuality. For this, the Departments of Education and WCD need to harmonise their efforts, and put in place a coordination mechanism that can monitor and address the issues that emerge periodically.

5.3.27 Since the School Health Programme involves various stakeholders and the school is the point of convergence, no programme which is promotive and preventive in nature can be effective without an effective partnership between the school, its LSGI, and the other connected stakeholders in the Departments of Health, Education, WCD etc. The role of the LSGI in ensuring the effectiveness of the School Health programme cannot be overstated. They can play an important role in bringing about effective convergence and better coordination by close monitoring.

5.3.28 Physical activity in schools is at a premium in many schools for want of a playground or for want of maintenance, although grounds are available. SCERT has developed a curriculum for physical fitness along with teacher text for classes 1 to 12, which includes a separate text titled “Healthy Kids” for classes 1 to 4. They have also

developed a "samagra yoga parisheelana padyakram" for classes 1 to 12. They need to be implemented.

5.3.29 In the context of COVID19, a holistic package should be designed to cover child development (well-being) and adolescent health with key focus on Long COVID. Long COVID is being increasingly identified as a key issue for both adults and children recovering from or exposed to COVID 19 in a family. Therefore, identification of Long COVID, its early detection and referral are key to reducing morbidity and cost of care for children and adolescents and merits attention.

5.3.30 Within the broad area of adolescent health, there is an urgent need for strengthening interventions in counselling for reproductive health and psychosocial support. Hence a linkage has to be built up between the Health and Education departments at the district and sub district levels for reviewing the programme implementation in the school setting and also to strengthen referral linkages

6. GOOD PRACTICES

Some good practices implemented in different parts of the states that are noteworthy and worthy of wider replication are listed below:

6.1 EDUCATION

6.1.1 Ensuring children's participation: The initiative taken during the COVID 19 period by the Director General Education (DGE) and the Department of Education to involve school leaders in decision making regarding the opening of schools, conduct of exams etc: This needs to be emulated in more activities so that children's opinions are also taken into account in matters that affect their lives

6.1.2 Collaboration with LSGIs. Over the last few years, some of the LSGIs in the state have begun to address a number of issues that help to promote child rights through the Child Friendly Local Government (CFLG) initiative supported by KILA. This is significant because it shows that where the Panchayat takes up children's issues seriously, they are able to find the resources and make a difference to the development of children in critical years of their lives. These good practices need to be shared and studied for replication in other areas. Some of the good practices include:

- Science labs and library facilities set up in the schools under Ramapuram Grama Panchayat.
- Child centric initiatives in the schools of Kaduthuruthy Grama Panchayat.
- Play and playground standardisation in the schools of Peravoor Grama Panchayat.
- Effective PTA and school meal programme of Kodaly, LP School, Mattathur Grama Panchayat, Vigyan Sagar (Mini ISRO) of Thrissur District Panchayat.
- The efforts made by Valapattanam Gram Panchayat to engage children before and during the COVID period through the children's library of the Panchayat.

6.2 ECCE

6.2.1 The Child Development Centre (CDC) has developed two skill certification programmes for training human resources in childcare centres, preschools, and

anganwadis that has been approved by the National Skills Qualification Framework (NSQF), Ministry of Skill Development and Entrepreneurship. They are:

- Child Health Assistant: Curriculum of the Course (Foundation Course, Antenatal & Perinatal Care, Essential Newborn care and Nutrition of Infants & Children, Growth & Development, Provide support with the daily activities & Basic needs of Child, Care of Special needs, First Aid & Common Ailments, Early Childhood Education, Women & Self Safety, Preparing Child for Social Interactions)
- Child Care Aide: Curriculum of the Course (Introduction to Childcare Aide programme, Introduction to development of the child, Health and safety in childcare-I, Health and safety in childcare-II, Care of the infant and new mother, Care of the toddler, Care of school going children, Internship). The above two courses are the first courses of its kind in India and also included in the National Qualification register of National Council for Vocational Education and Training (NCVET).

6.2.2 The courses are run by the Additional Skill Acquisition Programme (ASAP), a Government of Kerala Company. Child Health Assistant course is a full time one year course essentially meant for anganwadi workers and Child Care Aide is for Anganwadi helpers.

6.2.3 There is provision for Lateral entry known as Recognition of Prior Learning (RPL) where instead of attending the course for one full year, the candidates having prior experience need to attend only 40 hours of classroom teaching.

6.2.4 After meeting the required attendance, trainees have to appear for an examination. The successful candidates will be awarded the certificate of the courses.

6.2.5 Training document for Health and ICDS functionaries for identification of developmental delay, growth faltering among children, prepared by CDC in Malayalam language is available and contains details of developmental tools, early stimulation packages, early intervention programme for high risk babies, malnutrition in children- identification and management, growth deviation, immunization etc. The two publications are useful for health and ICDS functionaries in implementing community-based identification of development and growth abnormalities among children, appropriate Care of the infant and new mother management and referral.

6.2.6 A new training programme entitled NIRNAYAM developed by CDC for training ICDS, Health and NHM functionaries in early detection of developmental delays and intervention, referral and documentation is another very noteworthy initiative that will facilitate effective and early detection of disabilities. Possible integration with similar training programmes offered by the department of Health would be very useful.

6.3 NUTRITION

6.3.1 The distribution of Food Security Allowance in the form of grains and 9 essential food items during summer vacations to children in 2020, as a one time measure. This could serve as a model for addressing the hunger issues during vacations of

children in certain segments of the population, especially children of nomadic tribes, when they have no access to food.

6.4 HEALTH

6.4.1 Parenting clinics have been set up by WCD with the support of school counsellors in all 152 block panchayats and 6 corporations, to function every Saturday from 9.30 am to 1.30 pm. These clinics seek to guide parents, especially in cases of children at risk, to prevent violence against children, and increase awareness in parents and the general public of child rights. They give scientific guidance to parents on parenting, and counselling to parents and children on referral basis.

6.4.2 The 24/7 tele counselling and helpline facilities through DISHA, set up by the Department of Health- NHM, has rendered yeoman service through the NIPAH and COVID pandemics to support adolescents and youth who need advice, require mental health first aid, or state intentions of self-harm. These helplines are backed by dedicated AH counsellors and a pool of nearly 1200 psychological support experts via dedicated telephone numbers. There are also facilities for referral (via video conferencing, with prior booking), where further medical reference is found necessary.

7. RECOMMENDATIONS

7.1 EDUCATION

7.1.1 Review the Child Friendly Local Government (CFLG) Initiative of KILA undertaken in select LSGIs across the state and in the entire Thrissur District, and expand this initiative to all LSGIs in the state, to improve the 'child perspective' in local governance, and facilitate the LSGIs to prioritise spending in key areas. LSG Department and KILA should involve Departments of WCD, Health, Social Justice, LSG and KeSCPCR in this review.

7.1.2 Specific indicators for ensuring a safe and "child sensitive" school environment to be identified and laid down through joint consultation between KILA, Departments of Education, WCD, Social Justice, and Health, for compliance by all government and aided schools. Special attention should be given to ensure facilities sensitive to gender and the disabled. Every Government and aided school should be encouraged to self-certify and publish their status vis a vis these indicators.

7.1.3 Specific allocation should be made available under Plan to LSGIs for maintenance and regular upkeep of basic facilities, including toilets, to ensure the health and safety of children in schools. A system needs to be put in place to monitor the maintenance of basic facilities and ensure compliance, to ensure the safety and wellbeing of students.

7.1.4 LSGIs should ensure compliance of their responsibilities under the RTE Act 2009 in terms of maintaining a database of children up to the secondary level and undertaking a school mapping for this category of children for ensuring their right to access education as guaranteed under the Act.

7.1.5 Taking advantage of the rapport built up between parents and teachers during the

COVID period over the conduct of online classes, the role of PTAs , MPTAs, SMCs and SPCs need to be strengthened to ensure greater ownership on the part of these bodies in the functioning of the schools, as envisaged under the RTE Act 2009. The DGE needs to ensure this through specific sensitisation given to Headmasters, teachers and PTAs/ SMCs, on their roles and responsibilities. Their functioning needs to be monitored through a well-defined checklist to ensure some level of uniformity.

7.1.6 The present orientation of one- on- one interaction between parents and teachers in classroom level PTA meetings needs to change from a fault-finding exercise to a positive interaction where both parties collaborate to address the strengths and weaknesses of the child. Teachers need to be sensitised and trained in this regard.

7.1.7 The rules of engagement with children in various forums at school need to be clearly spelt out in the interest of clarity and transparency. Every child must be given an opportunity to be part of extracurricular activities organised through clubs and social service activities, to hone their social and leadership skills. This needs to be ensured by giving appropriate directions. Similarly, effort must be made to reflect the voice of children in issues that affect their lives, as was done by the DGE during the pandemic when taking decisions regarding the conduct of examinations, opening of schools etc.

7.1.8 DGE needs to undertake a review of the various school clubs to prevent their further proliferation, and encourage their effective functioning. While the concept of grace marks for such participation defeats the very purpose of these activities, the current system of giving different quantum of grace marks for different activities is even more pernicious as it creates unhealthy competition. This needs to be rationalised.

7.1.9 To improve the delivery of services undertaken through multiple agencies at the school level, and to ensure effective implementation of rights guaranteed under various legislations, a coordination mechanism is required to be set up, between various implementing agencies, and stakeholders like Education, WCD, LSGI, Health, Social Justice and SC/ST Development Departments, starting from the grass root level, where the LSGIs can play a pivotal role as the local authority under Section 32 of the RTE Act 2009 to redress grievances.

7.1.10 The incidence of large scale dropouts among persons with disability needs grave attention. Special focus must be given to making their education truly inclusive and beneficial by:

- insisting that every teacher secures at least a certification in special education so that they have a better understanding of the different challenges faced by the children they handle.
- having a blueprint for making the school environment disabled friendly and truly inclusive in a time bound and phased manner, in compliance with the provisions of the RPWD Act 2016.
- having a system to get children with challenges “school ready”.....by extending this concept which is highlighted in the NEP 2020 as applicable for all children.

- having a benchmark for deciding the level of disabilities up to which a child can be handled in a general classroom in a manner that is beneficial to the child and convenient for the teacher to impart education effectively. Also devise a strategy for the education of children who do not make the cut, so that they are imparted skills separately but are given scope for socialising with others.
- developing yardsticks for measuring at different stages the learning proficiency of children with different challenges so that gainful learning in terms of academics and life skills are ensured.
- ensuring that technology is optimally utilised while imparting education to children with challenges.
- ensuring that the vocational studies curriculum is updated to make their skills compliant with market demands.
- One of the factors that make children with disabilities drop out of the system is their inability to fit into the school environment. All children need to be given a general sensitisation about disabilities, and encouraged to become 'buddies' who can mentor and support them. This will help foster empathy and compassion and also help reduce in a positive way the bullying tendencies that are often reported.

7.1.11 Taking into account the difficulty that schools face in the maintenance and upkeep of their infrastructure and facilities, it is necessary to give some budgetary allocation to support this requirement, so that schools remain safe spaces for children. The Planning Board needs to consider this special requirement by providing support to the LSGs.

7.1.12 There is a need to undertake a review of the infrastructure and facilities in SC/ST, Fisheries and Sports hostels from the perspective of sensitivity to child rights, and the gender and culture of the children.

7.1.13 LSG institutions have a major role to play, including statutory responsibilities under the RTE Act 2009, in ensuring child rights as well as in promoting the physical and mental health of children, both in school and outside. KILA needs to sensitise them on these responsibilities to protect the best interests of children.

7.1.14 An infrastructure audit of all the facilities in schools needs to be undertaken, keeping in mind the provisions of the KER 1959, the RTE Act 2009,and the RPWD Act 2016. A phased programme must be drawn up to make schools "disabled and gender friendly" in a time bound manner during the next 5 years.

7.2 ECCE

7.2.1 For the implementation of ECCE in all preschools and anganwadis, it is necessary to prepare a comprehensive list of institutions providing preschool education in the Government, NGO, and private sectors. All departments engaged in this regard, viz. WCD, Education, Tribals, Forest and LSG Departments, should be involved in this effort, with the Department of Education taking the lead, being the nodal agency identified under the NEP 2020 to ensure uniform pedagogical content to all preschools, including anganwadis and *ashramshalas.*

7.2.2 Creating infrastructure of their own that will provide a rich and safe learning

environment for preschoolers in anganwadis has been a priority target in successive plans. With the focus being given to ECCE under NEP, it is necessary to review from this perspective all existing buildings in the anganwadi network and those run separately, like the ashramshalas, preschools attached to schools etc, to create a comprehensive database of requirements and allocations required to revamp them. This will help to prioritise requirements, keeping in mind the anticipated support likely to be forthcoming from the Central Government for socially and economically disadvantaged areas.

7.2.3 All preschools should be designed keeping in mind local conditions. It is necessary to keep ready some model designs, learning from the experience of successful models already implemented, so that at least one each can be implemented in every district within the first two years of the 14th plan, and the rest within the remaining Plan period. Such models should also include provision for the third and final bridge year of preschool which caters to children over 5 years.

7.2.4 Adequate allocation needs to be provided to ensure that all preschools in the government sector, including those outside the anganwadi system, are provided their own well designed buildings during the 14th Plan period. Where land is not forthcoming for an anganwadi building, the possibility of providing space within the nearby school complex needs to be considered not just for the regular preschool, but also for setting up the third year of preschool.

7.2.5 Minimum standards need to be specified with the help of experts for the anganwadis/ preschools in the matter of their infrastructure, the equipment/toys needed to facilitate learning, safety standards, number and qualification of persons who shall provide ECCE to the children, the continuous training to be provided to these persons through the Block Resource Centres etc .

7.2.6 The pedagogical framework for ECCE is to be prepared by the NCERT considering many factors, including the best national practices and local traditions, folklore, arts, etc. The SCERT should take up this issue right away so that they can provide their inputs in this exercise using the wealth of experience already gained in the state, so that the ECCE is developed in harmony with nature and traditions, local to the child's environment.

7.2.7 The SCERT should also address the issue of developing toys and other simple tools that will facilitate learning and stimulate the child's development. In preschools, the possibility of manufacturing these items locally, could also be considered, thereby creating a gainful employment opportunity.

7.2.8 Challenges in providing preschool education to children of tribals and migrants due to the language barrier has to be given special attention so that action can be taken to bring them to "school readiness" by the end of the bridge year. In this context the best international experiences of handling similar situations in multicultural, multilingual societies needs to be studied for appropriate incorporation.

7.2.9 Since the pedagogical framework for ECCE will henceforth be the responsibility of the Department of Education, to be implemented with the care component

provided by the WCD Department, a joint coordination mechanism should be put in place at the earliest so that the implementation process is managed in an effective and smooth manner, and the anganwadis can continue to discharge their other important responsibilities.

7.2.10 The Department of Education has to empower the BRCs to take up the responsibility of training the ECCE providers, both in terms of skill upgradation as well as regular in service training, as envisaged in the NEP 2020. Action needs to be initiated for providing the BRCs necessary support, including budgetary support. The training modules developed by CDC for training anganwadi workers and helpers will be beneficial in ensuring proper training in the care component.

7.2.11 There has to be a regulatory framework for all preschools to enforce and monitor the prescribed standards. This needs to be created as part of implementing the NEP 2020, for which budgetary support would be necessary.

7.2.12 An initiative has to be taken by the Department of WCD (ICDS) along with the local LSGI to identify the children who are outside the preschool network, and a concerted effort made to ensure 100% coverage of children under the ECCE programme.

7.2.13 Along with this comprehensive initiative to implement the ECCE, the State must promote the preschool education offered through the Anganwadis through a people's mission, on the lines of the successful effort made previously to rejuvenate public education, involving all stakeholders like the LSGIs, WCD, Education, SC/ST development department etc as well as the local community. This is critical to ensure optimum utilisation of investment proposed to be made in this sector for ensuring the best care and education to children upto the age of six.

7.2.14 There is a need to ensure that henceforth, Anganwadi staff recruitment - standards given in (GO (Ms)366/2007 SWD dtd. 24.07.2007) are strictly adhered to. These standards include the following:

- Personnel should be selected from the locality.
- In the case of tribes, personnel should belong to the nearby hamlets.
- Provisions of the Inter State Migrant Workers Welfare Scheme, 2010 A should be taken into account.
- Persons with pre- primary training should be given priority.
- Talent and experience in child care activities must be given due importance. Appointment should be effected from the select list.

7.3 NUTRITION

7.3.1 A major IEC initiative is needed to promote nutrition literacy in the state and to inculcate healthy eating habits. The threat of junk food, and the rising incidence of anaemia, malnutrition and micronutrient deficiency on the one hand and obesity and the related threat of Non Communicable diseases on the other, needs to be effectively tackled through a family centric, life cycle approach which involves the entire family, and which commences from the pregnancy of the mother. The anganwadis, PTAs etc can also be leveraged to promote the concept of healthy

diets. through a comprehensive IEC package to back activities for bringing about a behaviour change. This proposal needs to be supported.

7.3.2 The functioning of the Nutrition clinics needs to be reviewed and strengthened with the support of LSGIs. Local resources available in terms of expertise in this field need to be identified and made available to the ICDS staff to ensure effective implementation.

7.3.3 Public awareness has to be created about these clinics to create a demand in the community through an effective campaign. SOPs need to be prepared and monitored regularly to ensure that the referral system works through an effective feedback and cross reference system, including in urban areas.

7.3.4 The best practices in implementing the midday meal programme need to be shared with other schools and LSGIs . This includes the advantages of involving MPTAs, growing one's own vegetables and providing children good dining space to eat their meals comfortably.

7.3.5 Where projects for improving the mid day meal infrastructure remain work- in-progress due to financial constraints, efforts need to be made with the support of the LSGIs to raise funds to ensure early completion.

7.3.6 Since a large segment of the child population is educated in private institutions, there is a need to address the issues pertaining to children in these schools with the help of these very institutions and the academic boards under which they function. A public- private partnership mode could be considered for effective implementation, by promoting health through canteens and tuck shops and curbing the sale of junk foods.

7.3.7 To find a solution to the hunger problem of tribal children, especially children of nomadic tribes, a special scheme may be formulated to address this issue during vacations, on the lines of the support given during 2020 summer vacations to all children. Adequate funding support may be given for this period. Support may be given to meet similar needs of children of migrant workers.

7.3.8 At present WCD Department, with the support of ICDS, run various clinics and clubs targeting young couples, parents and teenagers. However, given the enormity of the challenges to be addressed, the efficacy of these clinics/ clubs vis a vis their objectives may be examined, gaps identified, good models identified, SOPs prepared for their functioning and the possibility of strengthening them with the help of external resources considered.

7.3.9 A concerted effort needs to be made to have a nutritional garden in every school. The possibility of including it and any similar garden attached to a neighbouring anganwadi to the School Health Club needs to be considered to promote practical exposure to gardening and to instill in the children the idea of a healthy. balanced diet.

7.3.10 There is a need to increase the food basket for the Supplementary Nutrition Programme, to include proteins, micronutrients etc to improve the nutrition of the children in anganwadis in view of the increasing levels of anaemia. The per head

cost of food items for the food basket needs to be increased both for this reason and to accommodate the rising costs of food items.

7.4 HEALTH

7.4.1 With the thrust of implementation of the School Health Programme vested in select students, continuous monitoring and training is required to ensure effective implementation. The support of the SMCs, PTAs and the LSGIs in creating an environment suitable for appropriate, health promoting behaviour, be it in inculcating good habits, keeping the class rooms and surroundings clean, appropriate washroom culture, importance of physical activities, building healthy relationships, respect for genders other than one's own is crucial and needs to be ensured.

7.4.2 Screening and monitoring the development of children are both very important activities for providing early support to a child with any of the 4Ds, to achieve his or her full potential. So, all the challenges mentioned in para 7.1 (x) need to be urgently addressed as they will constitute a crucial support system.

7.4.3 An exercise may be undertaken by both the Departments to map the services provided by them, identify and rationalise overlapping services to ensure optimum utilisation of resources, and a guide may be prepared and given to schools regarding the basic services and referrals available, how they are to be accessed, and contact details, in case it is necessary to do so. This will help in more effective use of these services.

7.4.4 With more than a year's hiatus in the School Health Programme during the COVID19 period, it is necessary to put in place an effective system that addresses the needs of a child and is child friendly.

7.4.5 An early decision is required regarding the implementation of the Ayushman Bharath initiative, subsuming the existing schemes under it and strengthening the present situation in which the day to day implementation is left solely in the hands of the Peer Educators by ensuring greater ownership by the school.. In any case, there is a need to have some designated teachers supervising the efforts made by the Peer Educators.

7.4.6 It is also necessary to review the functioning of these schemes, especially the RBSK, WIFS etc to ensure their effective functioning in schools by sorting out the challenges to their smooth implementation.

7.4.7 The lack of equipment in schools for recording the measurements of children, as part of the screening and monitoring process mentioned in para 5.3.19, needs to be identified and corrective action taken.

7.4.8 Training in First Aid and availability of the equipment required must also be ensured in every school.

7.4.9 The tools prepared for effective screening of intellectual disabilities along with the preparation of the handbook and training modules for teachers needs to be implemented in the primary schools at the earliest.

7.4.10 The physical fitness of all children within the jurisdiction of an LSGI, especially

of children between the ages of 5 and 18 years needs to be ensured. The following activities are suggested for this:

- Engage each child in the family in daily exercise activity.
- Sensitise and include every child in the school, for sports and similar activities.
- Special attention has to be given to ensure the inclusion of girls in these activities.
- Improve and maintain playgrounds in schools with coaches.
- Improve and maintain parks and public spaces, preferably with space for sporting activities and gymnastic facilities.

7.4.11 To ensure the effective imparting of age-appropriate life skills, budgetary support must be given to ensure that a copy of Ullasaparavakal is printed and supplied to every child along with all other textbooks. Teachers need to be trained and given appropriate hand holding to enable them to impart its contents as part of the curriculum. Its implementation needs to be closely monitored.

7.4.12 A holistic package should be designed to cover child development (wellbeing) and adolescent health with key focus on early detection and referral of COVID 19, to address issues connected with Long COVID which is being increasingly identified as a key issue for both adults and children recovering from or exposed to COVID in a family.

8. STUDIES AND RESEARCH TO BE UNDERTAKEN

- The pattern of dropouts in the state and factors influencing this phenomenon among children from vulnerable segments.
- The reasons for the low figures in respect of children with disabilities completing secondary education.
- The performance of SMCs in terms of their mandate.
- Evaluate the conditions in all Sports Hostels, and hostels attached to Fisheries schools to assess whether they are child friendly and are gender and child rights sensitive.
- Review the existing standards for school buildings and related facilities as per KER III and the relevant provisions in the RTE Act 2009 and RPWD Act 2016, to derive a model which reflects the minimum standards that should be maintained in a school.
- Prepare SOPs for all services offered to children by the WCD and Health departments and standardise them to bring about greater transparency and convenience in implementation and greater acceptance by the beneficiaries.
- SCERT to undertake:
    - a study of the status of anganwadis in terms of their facilities and the quality of ECCE offered through them, to identify their strengths and gaps in service vis a vis the best international experiences in preschool.
    - study of the best practices adopted for pre-schooling, including those in multicultural, multilingual societies.
    - assess the existing strategy to increase access to education for SC/ ST children by placing them in hostels away from home, the conditions in their hostels,

and whether they are “child rights”, “gender”and “culturally” compliant and appropriate.

9. INDICATORS

- Decrease in the number of dropouts.
- 50% increase in the number of children with disabilities who complete secondary level.
- 100% coverage of food during vacations to children of nomadic tribes and those hailing from vulnerable populations.
- Reduce the number of children with anaemia by 50%.
- Reduce the number of children with obesity by 25%
- 100% coverage of ECCE in all pre primary schools through a regulatory framework.
- One model anganwadi by the first year of Plan in every district.
- Skills of all Anganwadi teachers upgraded through training.
- Every school to have facility for physical activity..
- Every school to have a ready reckoner of services and referrals available for the health of their children under the SHP, and the contact numbers for these facilities.
- Every school child will have the option to be part of a school club.
- Every LSGI will maintain and regularly update the database of children covered under the RTE Act 2009.

SOPs will be prepared for all services offered to children through clubs/ clinics set up by the WCD and Health Departments

III EFFECTIVE GOVERNANCE FOR CHILD RIGHTS – IMPROVING SAFETY AND PROTECTION OF CHILD RIGHTS

1. INTRODUCTION

1.1 The unique distinction between human rights and child rights is that while both recognise and protect the dignity of all human beings, the latter takes into account the child’s fragility and age appropriate requirements such as the right to development and the right to protection during childhood, which is a very vulnerable period in every human being’s life. Just as the child is dependent on adults, especially the caregivers, for day-to-day survival and enjoyment of basic rights, he or she is also dependent on the state and its machinery to protect these basic rights, viz. the right to survival, development, protection and participation, to which all Governments who ratified the UNCRC committed themselves.

1.2 The child’s enjoyment of these rights is dependent on the system of which he or she is a part and the extent to which that system understands, recognises, and supports these rights. If they are not factored into the system with which the child has to interface, there is bound to be denial, if not, violation of the child’s rights. It is therefore necessary that these rights are reflected in all matters that affect the child’s life, and give him or her the opportunity to grow and develop to become a contributing citizen in the community.

1.3 To create an environment that facilitates this outcome, it is important that greater

awareness is created about child rights in the system as well as among parents and caregivers, and thereby help foster a child right perspective that becomes an integral part of all major decisions that affect the lives of children. It is also important to ensure that these rights are enforced by the system through regular monitoring.

1.4 In Kerala, the state has been successful in protecting the rights of the child to survival and development to levels compared with the best in the world if we go by important social indicators. Today, the state has near universal institutional deliveries with a doctor in attendance, and an IMR of 6, which compares with the best in developed countries. Protective measures like immunisation, early screening for birth defects and developmental deficiencies are being freely provided through the Government systems through specially targeted health programmes.

1.5 Nutrition is supported through supplementary nutrition schemes. While there is provision for preschool education through the anganwadis, the government has been promoting public school education where nutritional needs, physical and mental health needs are all being addressed through the School Health Programme. Kerala has near universal enrolment of students in the primary section and a very low dropout rate, which was only 0.11% in 2019-20.

1.6 Despite these impressive achievements, problems remain. The immunisation measures are not fully utilised by certain pockets of the population despite the fact that it is free in government facilities, a situation caused by parental neglect or their personal choices which are imposed on the infant. There is a growing trend of anaemia which persists from childhood, despite many initiatives to tackle it…… again a matter of lifestyle choices of the family which the child imbibes from childhood.

1.7 Simultaneously, there are also concerns about the increasing cases of obesity, fatty liver, PCOD among adolescent girls and a host of other lifestyle problems that are precursors to Non communicable Disease (NCD) in later years. In schools, children face the lack of facilities for physical activities and exercise, and there is a significant loss of safe public spaces, which reflects the lack of a child perspective in the development and planning process. Abuse of child rights, in the form of child marriage, decreasing child sex ratio at birth etc continue to cause concern.

1.8 This is significant because they are the by-products of societal attitudes to gender issues which continue to influence decisions in the family setting that go against the best interests of children, and which are yet to evolve, despite near universal literacy even among women. Even more tragically child sexual abuse is increasing rapidly, that too mostly at the hands of persons known to the child, with no respite even in COVID 19 times. The child is not safe in his or her own home.

1.9 Weighed down by the weight of expectations from parents, growing peer pressure, and lack of communication at home, children are resorting to violent behaviour, showing tendency to self-harm and getting out of touch with the environment around them by escaping into the digital world, or the world of substance abuse, often with very tragic outcomes.

1.10 The COVID19 period has disrupted life for everyone, but none more than children

because they lost two valuable years of childhood, and this has definitely affected their physical, psychological, emotional and social development. The loss of two years of regular schooling has also disrupted the entitlements which they were receiving through schools, although a laudable effort was made by the State to reach food rations and supplements to their homes. Post COVID19, as efforts are being made to resume normal life as we know it, there is an opportunity to assess the situation as steps are being taken to move forward.

1.11 There is an opportunity now for the multiple agencies that cater to children's entitlements to come together and explore how programmes can be better implemented through convergence, better coordination, and monitoring and pooling of resources, rather than operate in silos. It is also an opportunity to bring a "child rights" perspective into governance, to shift decision making on issues that affect the lives of children from a purely protective angle to one that allows space for participation.

1.12 Two examples which may not appear significant in the larger scheme of things but are critical to the lives of children are the oft repeated instances of inadequate budgetary allocations made in LSGIs for giving scholarships for the disabled, resulting in non-distribution or delay in distribution of their annual entitlements; yet another is the taking over of the playground within the school premises for new construction, while public spaces that were previously available to children for recreational purposes, are put to other uses.

1.13 A child rights perspective in governance will require the child's voice to be reflected in matters that directly or indirectly affect their lives. It will recognise the right of the child to be consulted, and allow space for participation, an aspect that has not been given due accommodation so far in decision making. It will give children the opportunity to be more socially responsible, and become contributing members of their community, as was reflected in their contributions during the disasters that engulfed the state in the last few years.

2. ISSUES FOR DISCUSSION

2.1 Coordination and convergence between different departments and agencies
2.2 Improving Child safety and protection
2.3 Increasing the participation of children
2.4 Greater awareness among parents of Child Rights
2.5 Importance of the role of LSGIs in protecting Child Rights
2.6 Child Rights in the Post Covid scenario.

3. COORDINATION AND CONVERGENCE BETWEEN DIFFERENT DEPARTMENTS AND AGENCIES

3.1 Decisions and actions of a number of departments and agencies affect children. The most prominent among them are the Women and Child Development Department, the Education Department, the Health Department, and the Local Self Government Department that directly provide services for the development and/ or safety of children.

3.2 However, there are also departments like the Police, the SC and ST Development Department, the Fisheries Department, the Forest and Environment Department, the Sports Department, the Excise Department, the Transport Department, the Labour and Employment Department and the Social Justice and Empowerment Department that address children's issues as part of dealing with matters connected with their sectors as a whole.

3.3 Decisions taken by Departments like Finance, Planning, IT, or PWD or even the Agriculture and Animal Husbandry Departments too affect the lives of children. Then there are Departments like Tourism which provide services for which children too are important consumers. This is only an indicative list; but what it underlines is the fact that the work of almost every department and agency can affect the lives of children directly or indirectly.

3.4 Departments that provide services and entitlements directly to children, do so based on felt needs that are assessed from their respective perspectives. However, these services could have similar or overlapping elements and could be targeting the same outcomes.

3.5 Counselling is one such service that WCD, Health and Education departments are involved in, which readily comes to mind. Similarly, there are areas where the services run parallel, but the expected outcome is the same. The School Health Programme and initiatives relating to Mental Health and disabilities are areas where the common focus is on physical and mental health, and where there is scope to share some of the resources for mutual benefit.

3.6 Therefore, convergence in some of these schemes as well as pooling of resources, both in terms of manpower and finances, can make them more effective. Better coordination between the departments, and monitoring at various levels, will certainly improve the quality of their implementation. In post COVID 19 times, when resources have to be effectively utilised and focussed on priority areas, there is scope for closer coordination, as well as convergence of some of these schemes and their consolidation under an umbrella programme. E.g., all School Health and Mental Health programmes can be consolidated under a comprehensive programme titled the Comprehensive School Health and Wellness programme.

3.7 Such an exercise merits consideration because physical health and mental health go hand in hand and a comprehensive child development perspective, which offers multi sectoral responses, is the need of the hour. To improve delivery of these entitlements, elements like consultation of children through Children's grama sabhas, School Management Committees etc and social audit of the programmes should also be introduced as an integral part of every programme from the stage of design to delivery.

3.8 Formation of a state level consortium for child rights governance that involves all major departments engaged in this sector would help bring a child perspective into governance through its functioning. This consortium should meet at least biannually. Each department in the consortium should designate one officer as the nodal point, to respond to any matter concerning children vis a vis that department;

the department should also map and monitor all child centric programs under its jurisdiction.

3.9 There is also a need for an interdepartmental coordination committee to monitor programmes for children. The programmes thus monitored should include not just those that directly affect children, but also those that can have an indirect impact. Agencies and Departments should gauge both the positive and negative effects that all new programmes and policies have on children prior to their implementation.

3.10 Theme wise discussion forums, {for example issues relating to children from SC and ST community, or children with disabilities, children from coastal areas etc. could become subjects for discussion for deciding further course of action}. Theme wise discussion forums can also be formed to discuss unique challenges that children face, like disability due to endosulfan, increased risk of child marriages etc.. This could be a key step in bringing a child perspective into governance.

3.11 Another allied step would be to introduce the concept of child budget at the state and panchayat levels. The state has made a beginning last year with the Finance Department identifying those elements in which the amount was directly utilised for implementing any schemes for children, or to support such schemes. This effort needs to be continued and followed up. In fact, just like the gender budget, every department could be asked to directly indicate in the Child Budget any activity that was taken up which benefited children wholly or partially (however small the project might be), and the amount allocated and utilised for that purpose.

3.12 This can be consolidated by the Finance Department and presented as the Child Budget. Such an exercise will give the state an opportunity to assess the extent of funds that are being used directly for children's entitlements per se as compared to funding support services. This effort will help pave the way for more budgetary allocations to directly address some of the felt needs of children.

3.13 Planning Board can also adopt the same approach for the Plan budget. This will give a truly comprehensive picture and provide opportunities for every department to think about more activities that will reflect the needs of children, not just in terms of protection but also in terms of their development and participation. For example, it was the support offered by the Agriculture department that resulted in 70% of government schools having their own vegetable gardens that provide vegetables for their midday meals and also encourage them to learn gardening . Thus, although the Agriculture department does not necessarily feature in the traditional list of departments that provide services to children, they have provided an invaluable addition to the quality of life of children by bringing a child rights perspective into their plans. So, with the introduction of a Child Budget at the state level, a major step would have been taken to encourage every department in government to think proactively for the best interests of children.

3.14 A similar approach can be taken at the LSG level since they are a key player in the provision of services for children at the grass root level. An advantage of introducing a budget for LSGIs is that it will give each panchayat, municipality or corporation an idea of what percentage of funds are going into each activity, and plan their

budget accordingly. This break up will also inspire other panchayats, through a mutual sharing of information on their activities, to initiate crucial activities in priority areas that have not been taken up by them so far.

3.15 There must already be standing instructions for reporting expenditure for the gender budget. Similar instructions need to be issued for the Child Budget also, particularly about how to report in the case of expenditure incurred on a project, where the child is only a part beneficiary.

4. CHILD SAFETY AND PROTECTION

4.1 Creating safe spaces for children, both physically and socially, can help change attitudes, perceptions and actions that prevent violence against them. Some measures for providing safe social spaces would include:

- a community activity centre in each panchayat where children can be safe after school till parents return so that they are never left alone, especially in vulnerable families and neighbourhoods. These centres could also provide education support and avenues to promote different skills.
- Provide a playground or exercise facilities in every panchayat that children and adults can use for physical activities.
- Ensure the upkeep of grounds within school complexes so that boys and girls can conveniently use it.
- Strengthen School Protection Groups. This would involve ensuring regular meetings of this committee and providing some support to follow up on decisions taken, and to implement items of work that are critical for the school from the point of view of safety
- Ensure the basic upkeep of school facilities like toilets and grounds and the availability of water, girl friendly toilets etc.

4.2 It is imperative that Child Protection Committees (CPC) that seek to protect child rights at the village and district levels, and the Jagratha Samithis that address women and children's issues at the ward level are all activated and encouraged to function regularly. They can play a very crucial role at the grass root level, in preventing the very many abuses that are being reported today, and in mobilising community support by creating awareness about such issues locally. Kudumbasree and neighbourhood groups, Residents Welfare Associations, socio religious groups, etc are among the many groups that can be mobilised for locally supporting the responsibility of identifying pockets of vulnerability and children who need support.

4.3 Another area of concern where local interventions would be effective is the issue of improving public service areas like bus stops, health facilities, public toilets, parks and other public areas for leisure, or even the streets to make them more safe for children. The needs of women and children must be factored in when providing new facilities. Simultaneously, there should be focus on ensuring that existing facilities are made safer. One key issue that begs to be addressed is the need for proper lighting on the streets, near bus stops where children have to wait for long

periods, as well as all other public facilities. Clearing the undergrowth, paving and covering open holes, removing garbage from the proximity of public spaces etc are simple steps that can bring about major differences to the landscape while enhancing security for children.

4.4 A related issue is the need to make facilities in schools and public spaces disabled friendly to improve access. Today children with disabilities face barriers in social interaction due to these barriers. Even matters like reaching their class rooms, using the general toilets, accessing transport, drinking water units, mid-day meal areas, etc prove to be a challenge which needs to be addressed at the earliest.

4.5 Another issue is the inappropriate design of classroom furniture or the slippery tiles used as flooring, the inadequate lighting and ventilation….. all of which are areas that need attention when designing such facilities for children, including those with disabilities. Accommodation of special requirements, be it for children, for persons with disability or for the elderly are basic concerns that need to be displayed by civil societies and it will contribute substantially to the safety of children. Therefore, these concerns have to be factored into planning and designing of public spaces by local self-governments, and measures taken to improve existing ones.

4.6 An important issue that needs attention is the question of making the justice delivery system child friendly, as required under legal statutes. This would include, police stations, Special Courts and even the institutions where children in need of care and protection are housed.

4.7 While Special Courts have been set up, there is much to be done to make them more child friendly. This needs to be done to protect the interests of the child who is at the centre of this whole exercise, and that aspect cannot be ignored or given lower priority when setting up this infrastructure. The Special Courts need to be made "child friendly", because without that element, the basic objective of creating this special system to render speedy justice to children will not be achieved. Providing video facilities that will enable the CSA survivor to give statements and participate in the legal proceedings without fear of victimisation is a feature that must be available in every Special Court. Similarly, since these courts will be frequented by children, there must be provision for basic amenities that they need while waiting for their case to be called, without having to face the accused.

4.8 In the case with police stations, while some effort has been made to train police personnel and create child friendly police stations, much remains to be done. Setting up Special Juvenile Police Units in every district is a requirement under the JJ Act 2015. While the responsibilities have been set up by designating these responsibilities on existing personnel, the state is yet to set up the units with the required training and facilities as required under the JJ Act. These are all cases of work -in- progress which need to be addressed to improve the quality of protection that the State makes available for child rights..

5. INCREASING THE PARTICIPATION OF CHILDREN

5.1 One of the four basic child rights is the right to participation. Space for participation

of children in decision making has been created through the inclusion of children's nominees in the School Management Committees, School Protection Committees, the Bala Sabhas, the Children's Grama Sabhas etc in addition to membership in the school level clubs and service organisations. However, the difficulty is that in many places these committees and forums remain on paper and even where they function, the need to listen to the voice of children in matters that affect their lives is not taken seriously.

5.2 A major departure from that approach is the effort made by the Director of General Education to involve children in the decision-making process about closing and reopening schools during the COVID19 period as children were the most affected party in this exercise. This should inspire more forums to involve children more actively in the functioning of various forums in which they too have been included as a participant.

5.3 At the panchayat and district levels, at the planning stage, children should be consulted on the plans prepared for their areas, and their opinions factored into the process, as was done by WCD when the State's Child Policy, for example, was formulated.

5.4 A first step could be made at the panchayat level when finalising the budget for the next year, to get the perspective of children as to whether the funds earmarked for development are being allocated for areas that they consider as priority and whether their interests are also being served. This could become the start of a process that encourages children to become more responsible and contributing citizens within their own communities.

5.5 The State's Child Policy was formulated in 2016 while the last SPAC was formulated in 2004. Without a time bound plan of action, the focus that is given to achieve measurable targets have also dimmed. This situation needs to be rectified. There is a need to develop a State Plan of Action with specific time bound targets based on the State's Child Policy to give greater focus and urgency to activities in the child sector.

6. CREATING GREATER AWARENESS AMONG PARENTS ABOUT CHILD RIGHTS

6.1 Parents are the main caregivers for any child and as such they need to be sensitised about all aspects of child rights. That child rights are legal entitlements on par with basic rights that every citizen mandatorily enjoys, and that they are not discretionary in nature, to be made applicable at the convenience of parents, is an issue that is not understood by most parents

6.2 This proprietorial attitude can lead to situations of exploitation where the parents may find themselves held legally accountable, as in the case of violent punishments, child marriages, child labour, etc, to mention a few situations. Child sex abuse that happens within the family is the worst case scenario caused by the abuse of power and position within the home to exploit the defenceless.

6.3 These issues need to be better articulated with parents to bring about a change

in parental behaviour in society. Family strengthening strategies like mandatory premarital counselling need to be introduced at the earliest. This will help to instil the role that both parents have to play in the upbringing of a child.

6.4 Counselling facilities need to be introduced for parents about how to tackle various issues at defined stages of a child's development because parents are faced with the challenges of dealing with issues of discipline, addictive behaviour, be it drugs, alcohol or risky behaviour online, questions about gender and sexuality, problems of peer pressure both online and in real life, which call for an understanding of the complexities involved and support systems available to tackle them.

6.5 Age appropriate sex education must be given to children, particularly in these times when they are exposed to such issues from multiple sources. Parents have to be encouraged and assisted so that they do not fight shy of these issues and learn to articulate and discuss these issues with their children. One such issue us the topic of sex. There is a genuine parental dilemma about discussing and explaining sex to their children in an age appropriate manner. These are issues where inputs can be provided to them through forums like the PTA or Parenting clinics, which can play an active role in educating parents with the help of experts on how to tackle such situations.

6.6 The importance of keeping communication channels open and to have family time together, which are age-old practices that kept families together, also need to be reiterated in the changed context of present times. The WCD department's Parenting clinics seek to create greater awareness about the possibilities of Effective Parenting in order to help parents manage situations better and guide children effectively. This initiative needs to be supported. At the same time parents must also be encouraged to participate in forums in schools like the PTA, SMC and SPC where they can effectively contribute to the wellbeing and all-round development of their children. The possibility of using the PTA mechanism to actively sensitise parents about such issues, and how to tackle them optimally, merits serious consideration, as PTAs are a convenient platform available for addressing such issues.

7. IMPORTANCE OF THE ROLE OF LSGIs IN PROTECTING CHILD RIGHTS

7.1 LSGIs are key stakeholders in promoting child rights because they are responsible for the state of the community of which the child's home and school and all other areas that the child interfaces with form a part. In communities respectful of the varied needs of its members and their rights, child rights too are bound to be respected. Therefore, as part of the training given to elected representatives of LSGIs,, it is essential in the first place that they are sensitised about child rights as well as the potential they have to support their communities to achieve better well-being. This training is currently being provided by KILA.

7.2 After the devolution of powers to the LSGIs, a number of institutions at the grassroot level have been transferred to them along with the related manpower and financial resources to manage local governance. Included among them are the entire

ICDS network of anganwadis, their staff as well as the ICDS supervisor, the Health centres, including sub centres of the health department, and their staff and doctors. However, though these members of the staff come under the administrative control of the LSGI, they continue to be responsible in their respective jurisdictions to the line departments for the programmes and activities being implemented by those departments.

7.3 Therefore, there is a need for the LSGLs and the line departments to work in harmony, and with a fine understanding of each other's priorities and responsibilities, to find a balance between the two, which is to mutual satisfaction. It also requires a proper appreciation of the nature of the responsibilities of the grassroot workers and their supervisors so that any additional work that may be entrusted to them by the LSGIs which they have to mandatorily obey, does not compromise their core duties and responsibilities to the public they serve.

7.4 This relationship is yet to stabilise for a number of reasons:

- The LSGIs opine that there is need for better compliance of their instructions by some of the field staff vis a vis the directions they receive from their superiors in the line departments.
- At the same time the common grievances of the field and supervisory staff are that they are often given specific responsibilities by the LSGIs on the same day that they have been called for review to an higher office of their department, or when given a task to be completed either on the same day or within a fixed time frame. In their bid to please both parties, it is the quality of the job itself that gets compromised, and results in avoidable stress.
- The State's commitment to improve various parameters of social development is implemented through certain time bound initiatives with measurable indicators, in furtherance of which they set out specific responsibilities to the field staff. After the devolution of powers to LSGIs, the quality of the implementation and the responsibility of achieving these goals is vested not only with the state departments but also with every LSGI, for the area in its jurisdiction This aspect of their role in implementing these initiatives and achieving the desired outcomes needs to be clearly impressed on the elected representatives of the LSGIs to bring about a more harmonious working environment and effective outcomes. Since KILA provides the training to the elected representatives, they will need to ensure this.
- The due importance to be given to child rights and the care to be given to the needs of mother-to-be and baby to ensure their well being are very important responsibilities of the grassroot functionaries of the WCD and health departments as well as that of the LSGIs. It is the follow up and time bound care given to them that ensures a safe delivery and helps avoid morbidity and mortality of both mothers and children, help prevent anaemia, malnutrition etc and thereby help prevent various birth defects and disabilities. Therefore it is important that when LSGIs deploy members of the staff for various other duties, that they ensure that their core, time bound responsibilities are not disturbed or diluted.
- Since these persons, including the supervisors, are discharging their responsibilities

on behalf of the LSGIs also, it is important that they are given proper logistic support , including a proper seating arrangement to conduct various programmes, conduct clinics, and also any other tasks assigned to them.This basic support is crucial for the proper discharge of their responsibilities.

- To avoid situations that result in conflict, it is necessary for the line departments to come to some understanding with the LSGIs about their mutual responsibilities so that persons posted under the LSGIs,but discharging responsibilities assigned to them by both the LSGIs and line departments, are not placed in difficulties on a regular basis. The fact that it is the LSGIs that have the power to deploy the staff as per their requirement has to be recognised and accepted by the line departments as much as the LSGIs need to understand that compromising the core, time bound functions of these functionaries will eventually compromise the best interests of the public to whom they are accountable.
- Bringing child rights as a priority in the local governance through the smooth functioning of this system which has inherent scope for certain contradictions unless there is better coordination between the key stakeholders, is very important for protecting the rights of children.

7.5 LSGIs also offer scope for promoting the children's right to participation in matters affecting their lives. One option for doing so is to hold consultations with children on the plans of LSGIs as children are as much stakeholders of what happens in their neighbourhoods as adults. There is a need to activate Special grama sabhas at the local level, and meetings held twice a year, so that the participatory process can become a reality.

7.6 It is also necessary to stop viewing children and their needs from a purely protective aspect and recognise them as individuals who have a stake in what happens around them Keeping this aspect in mind, there is a need to remove children from the Social Justice Working Group in which they are currently placed and have a separate Working Group for them, as in the case of gender, so that issues concerning their development and participation can become the main focus.

7.7 The initiative that the Child Resource Centre of KILA undertook to introduce the concept of Child Friendly Local Governance (CFLG) in select panchayats and municipalities across the state and in Thrissur district panchayat as a whole, was a step in the right direction because it sought to bring these issues into focus, supported by documentation which identified key areas of concern along with measurable indicators for gauging improvement.

7.8 There is a need to review the lessons learnt from this pilot project, review the parameters and focus areas based on the outcomes achieved, and expand the project, with modifications if needed, across all LSGIs in the state during this plan period. In this context, as part of the 14th Plan, the State could consider taking up a project in the capital city of Thiruvananthapuram, for which initiatives are already afoot to make it a smart city, into a "child friendly" city too, by incorporating appropriate elements reflecting the needs of children, identified in consultation with them and the concerned departments. This will certainly give a fillip to the efforts to include

a child's perspective in governance in the state.

7.9 Panchayats have a major role to play in supporting the school environment and in keeping it a safe and enriching space for children to gain an education. They also have a role in ensuring that children enjoy good health by creating safe spaces, including playgrounds for children to play. LSGIs can help mobilise communities in matters relating to immunisation, in promoting nutrition, in keeping neighbourhoods clean, in identifying vulnerable families and supporting them and even in ensuring that children stay within the school system without becoming drop outs, to name a few areas where they can play a very important role. There are caps on the funding available to support initiatives in all these areas. Therefore, there is also a need to prioritise to ensure timely and systematic action.

7.10 An area where priority is needed is in the distribution of scholarships for the disabled for which adequate allocations are often not made adequately. This situation definitely needs to be corrected as these are among the most vulnerable persons in society, for whom this small support goes a long way.

7.11 The other issue is in the matter of providing Supplementary Nutrition because some LSGIs which do not have their own resources are unable to provide food items which meet the nutritional requirements, resulting in lack of uniformity in the implementation of this programme. In this matter, such panchayats need to be provided special support.

7.12 It is important that the Panchayat, through its approach to these issues, communicates the right message, of giving importance to child rights. The logistic support they give in hosting nutrition clinics or parenting clinics are in themselves an important signal to the community about the importance of child rights for its well-being. LSGIs need to be sensitised about these aspects.

8. CHILD RIGHTS IN THE POST COVID 19 SCENARIO

8.1 Over 3000 children in the state have lost one/more than one parent due to the pandemic. Urgent measures need to be taken for their well-being. Studies on the status of such children need to be undertaken so that their exact psycho-social and financial standing is mapped. A comprehensive policy needs to be formulated to address the issues of these children. The COVID19 pandemic has left a lasting effect on all children, specifically in their social abilities and accessibility to education, nutrition. and health care

8.2 Many programmes which came to a halt during the lockdown have to be restarted, and that will require a lot of mobilisation at the grassroot level. In the matter of education there is need for a comprehensive curriculum to reintegrate children who have lost out on education during the last two years. This curriculum should also include inputs that can help children enhance their social capabilities.

8.3 With repeated and successive experiences of managing natural disasters in the form of floods and also the pandemic which has impacted the very quality of childhood of children in the state, it is essential that an effort is made to study the very effective responses that were made by the state machinery in very many spheres of activity

in responding to these crises. Climate change and its consequences are a reality that has to be recognised and for which the state has to be prepared for. Therefore, it is also necessary to critically identify the areas where preventive action can be taken, and also where the responses could be improved, in order to develop a plan for effective emergency response during such situations . This plan should help to reduce the stress and anxiety levels and the sense of alienation that children may face in such situations and also identify opportunities for them to participate and make meaningful contributions to such endeavours.

9. GOOD PRACTICES

9.1 CFLG initiative with the support of KILA that gives focus to child rights in local governance

9.2 Parenting Clinics, an initiative of WCD that seeks to promote the concept of effective parenting in the community

9.3 Child Budget, the effort initiated by the Finance Department to identify funds used for the benefit of children in the state

10. RECOMMENDATIONS

10.1 The following recommendations are being made to ensure effective governance of child rights:

10.1.1 To ensure more effective implementation of existing schemes and to optimise resources, the possibility of better coordination between departments , convergence of schemes with overlapping elements and consolidation of schemes having similar outcomes needs to be considered by an inter departmental group of the concerned departments, which will also be responsible for monitoring the implementation of the schemes, pooling of resources, review, and timely course correction, wherever needed.

10.1.2 A State level consortium involving key persons in Government, and comprising the major departments connected with child rights governance should be set up to address important policy issues relating to child rights as well as key areas of concern in child rights governance.

10.1.3 An officer should be designated in every department to respond to issues relating to children in matters concerning that department.

10.1.4 The concept of Child Budget, which was initiated by the Finance department, should be expanded to all the departments by requiring them to identify the efforts that they have made to include the "child rights perspective" in their activities, and to indicate the funds utilised for this purpose so that they are included in this budget.

10.1.5 The Planning Board also needs to prepare a Child Budget as proposed above, on the lines of the Gender Budget which is being done presently.

10.1.6 Child Budget should also be introduced in LSGIs so that there is clarity about where the funds are being utilised for children and the quantum of funds thus utilised. Necessary instructions may be issued to initiate the process, and key personnel sensitised through training.

10.1.7 Child development should become the subject of a separate Working Group at the LSGI level, as has been done for gender, so that children are treated not just as beneficiaries of social justice, but as stakeholders in their own right, and focus can be given to their development, participation and empowerment.

10.1.8 Forums for consultation with children need to be set up and those available activated, at the state, district, local and school levels. At the local level, the children's grama sabha must be convened twice a year with the support of the ICDS network, and participation of children ensured when issues like the Annual Plan of the LSGI, the budget etc are presented. The Adolescent Clubs of the area, members of school clubs etc can also be encouraged to actively participate in these discussions.

10.1.9 The Child Friendly Local Governance Initiative which has been implemented in select LSGIs, needs to be reviewed to assess how its implementation has impacted key aspects of child rights, and expanded across the states with due course corrections, where deemed necessary, also taking into consideration the new demands of the post covid scenario. This effort needs to be supported.

10.1.10 The possibility of implementing a project for the Child Friendly capital city of Thiruvananthapuram merits consideration in the 14th Plan as that will give a fillip to the efforts to implement development plans with a child rights perspective. Proposals for this can be formulated with the support of children with whom discussions can be held before plans are formulated.

10.1.11 LSGIs need to address the issue of creating safe public spaces and making existing public spaces safer for children. Pilot projects should be taken up in major cities, municipalities and panchayats for undertaking better maintenance of areas frequented by children and improved lighting in places around bus stops and public facilities used by them.

10.1.12 An initiative to provide a playground and a community centre in their jurisdiction during the plan period should be taken up .

10.1.13 Coordination of activities between LSGIs and line departments also needs to be ensured so that the staff are not placed in a dilemma about the proper discharge of their responsibilities and the quality of care given is never compromised. KILA can play a major role in facilitating this coordination between LSGIs and the various departments so that there is a proper understanding of each other's responsibilities and powers

10.1.14 Mandatory pre marriage counselling needs to be introduced to help bring about behavioural changes within the family structure, including the role and responsibilities of the male partner as husband and as father. Counselling at different, defined stages of the child's development also needs to be introduced to enable them to tackle complex situations that parents are called upon to address.

10.1.15 Age-appropriate sex education is necessary to be imparted to children. Parents have to be encouraged to shed their hesitation and discuss sex with their children in an age appropriate manner to correct the children's understanding of it, often incompletely or incorrectly, gained from multiple channels of information to which that they have access.

10.1.16 Facilities created or are in the process of being created in the justice delivery system should be made child friendly as envisaged in the relevant provisions of the JJ Act 2015 and the POCSO Act 2009

10.1.17 The state must formulate a State Plan of Action for Children based on the State's Child Policy to give a focussed approach to children's development and child rights.

10.1.18 The state must review its responses to the emergencies it has faced in recent years in addressing the needs of children during such crises and draw up a plan of action for effective response in future in such situations, which will also include opportunities for children's participation and contribution where such inputs are feasible.

11. STUDIES AND RESEARCH TO BE UNDERTAKEN

11.1 The impact of COVID on the lives of children with special focus on their physical, social and psychological development.

12. INDICATORS

12.1 A consortium to address key issues concerning child rights including all key departments is set up to meet at least twice a year

12.2 An interdepartmental coordination committee is constituted to monitor services and programmes for children.

12.3 Child Budget becomes part of the budgetary exercise at the state level for Plan and non-plan activities

12.4 Child Budget is a part of the budgetary process of LSGIs

12.5 Consultation with children is held annually at the district and LSGI levels as part of the planning process.

12.6 All Special Courts are set up with uniform 'child friendly' facilities.

12.7 Number of joint interdepartmental meetings for reviewing, coordinating and monitoring programmes.

12.8 % of allocation to the child budget.

12.9 Capital city of Thiruvananthapuram to be made a "child friendly" city under the CFLG initiative.

IV MENTAL HEALTH AND WELL BEING OF CHILDREN

1. INTRODUCTION

1.1 The World Health Organisation (WHO) defines mental health as " a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" Well-being itself is broadly defined as a state of being healthy,happy and comfortable.

1.2 Therefore, mental health is a positive state of mind and body in which the person feels safe, comfortable and able to cope with the challenges of life, while feeling connected with the people and community around. The level of a person's mental health is influenced by the conditions of the environment in which he or she is born and grows up. It is also influenced by the fundamental attributes of the individual, the ability to realise one's potential and make a meaningful contribution to society.

1.3 For children, the foundation of mental health is in the availability of a stable,

loving, caring and secure home, in a community that is safe and supporting, where family, teachers, peers, school and community provide the safety net as well opportunities to realise his or her full potential in academics, physical health and other capabilities, and where avenues are available to acquire life skills to cope with the challenges of life, thereby creating a sense of belonging to that community, and a desire to contribute to it. Therefore, mental health can be achieved through an approach that seeks to address the risk and protective factors in different stages of life, so as to reduce the impact of the risk factors and enhance the protective factors.

2. ISSUES FOR DISCUSSION:

- The current scenario
- Challenges within the family
- Situation at school
- Response of children
- Challenges in addressing mental health issues of children

2.1 THE CURRENT SCENARIO

2.1.1 Kerala has the highest rate of literacy, near universal enrolment in school at the primary level and a minimal rate of drop out as compared to other states in India. It has social indicators which are among the best in the country, in some cases comparable with the best in the world, and a health system and facilities that are accessible.

2.1.2 Yet, it is also the state with the fifth highest suicide rate (24.3), higher than the national average of 10.2, according to NCRB data for 2019. Kollam city in the state recorded the highest suicide rate in the country as per NCRB data for 2020, with 44 suicides per lakh of the population. Family problems are cited as the main cause of these suicides, accounting for almost 43% of the total cases. Recently the Minister for Social Justice stated that 12.8% of the total population in the state have mental health issues which require medical attention, of which only15% seek such treatment.

2.1.3 As far as children are concerned, the rate of suicide was 229 , 203 and 215 in the years 2017 to 2019 . During 2020, the year of the COVID 19 lockdown, the SCRB recorded 324 deaths of children by suicide; upto April 2021, the number of suicides were 53. Children in the 15 to 18 age group were the main victims of this trend in 2020, and a majority of them were girls.

2.1.4 A study conducted by a committee headed by former DGP R. Sreelekha on the suicides that occurred between January and June 2020, when there was a spate of suicides, pointed out that fifty of the 158 children who committed suicide were good at studies, one had even got the President's award, another was a class leader and yet another was a Student Police Cadet. 48% were students of government schools while 30% were from Government aided schools

2.1.5 The report mentioned the inadequate systems within the family to manage the situation--- this when in most of the cases (74%) studied by the Committee, the

children were with both their biological parents, 9% with single parent families, and they were all together as a family during the lockdown period

2.1.6 A study done by DISHA, the teleHelp line managed by NHM- Department of Health, of the suicides that happened in the first half of 2020, cited family conflicts, confused love affairs, fear of failure in examinations, and issues over mobile phones and two wheelers, as among the major reasons for these suicides.

2.1.7 What emerges from the above scenario is that the stability, care and love that should be forthcoming from families is not available in many families, driving both adults and children to take the ultimate step. In some cases the immediate reason for taking the drastic step was very flimsy, like an argument over a mobile phone, or imagined, like the fear of facing failed aspirations of the family in the examinations.

2.1.8 Clearly even among children who achieve success in various parameters, there is a lack of coping mechanisms. Therefore, there is a serious issue of mental health to be addressed in the state of which these suicides are but the tip of the iceberg, an outward manifestation of a deep rooted malaise that needs to be addressed urgently. It also gives a glimpse of the real problems and issues to be tackled in the matter of mental health, many of which have got amplified in the context of the uncertainties during the COVID19 period

2.2 CHALLENGES WITHIN THE FAMILY

2.2.1 In Kerala, as elsewhere, the family as a unit is faced with a number of challenges, reflecting the fast paced changes happening in the external environment. However, there has not been any effort in most homes to respond to these changes with a change in the pattern of responsibilities, even after women started to work outside the home environment, which is a major departure from the earlier situation. In many homes, even today, parenting is considered the sole responsibility of the mother.

2.2.2 The Sreelekha Committee report had pointed out the failure of the family to function as an entity. This pattern of parenting is clearly visible from the fact that in most cases, both parents do not attend school PTAs together, and that fathers rarely ever attend them. The mother who is left to manage the home in all respects, is often the victim of domestic violence, (as is reflected from the rising number of cases of domestic violence that is reported), and an alcoholic husband.

2.2.3 It is also to be noted that during the lockdown when rate of crimes in general reduced by 17%, the rate of Child sexual abuse decreased only by 1.5%, and most of the perpetrators of this crime were family members, relatives and neighbours, clearly indicating the mother's inability to protect her child in many situations even in her home, and that too during lockdown periods. Therefore, in most vulnerable families, children are faced with difficult situations, caught between a patriarchal father, indifferent to his parenting responsibilities, and a mother struggling to keep the family afloat.

2.2.4 The other issue that children face in many homes is the lack of communication within the family, clearly visible from the fact that most suicides happened at a time

when the family members were all together. Even though many parents worked from home or were available at home, there was no improvement in the levels of communication between members of the home in many families.

2.2.5 The Sreelekha Committee Report clearly mentions that in many of the suicide cases, the parents had no clue about the state of their child's mental health which prompted him or her to take such a step. Due to this lack of communication, parents are often clueless about the experiences that a child is going through, including instances of bullying, or the pressures of managing his or her social image with peer groups within the constraints of family circumstances. This in turn often leads those to make decisions that lead to even riskier behaviour.

2.2.6 The family is the primary ecosystem that conditions the behaviour of a child and, ideally, it should be the nurturing ground for developing the right values, and providing the right role models for children to emulate. However, this is not forthcoming in many homes today and the situation is worse in homes where the parents are alcoholics, or drug addicts who themselves indulge in antisocial behaviour. Therefore, it is important to understand the family background of the children very carefully before deciding on appropriate interventions. The one-size -fits- all approach will not be effective in such cases. Active involvement of the parents will need to be ensured in all such cases, which could prove a challenge.

2.2.7 There is also the burden of unreasonable expectations from the family who force upon children their choices of the courses to study, professions etc ignoring the inherent aptitude or interests that these children may possess; or being compelled to take up courses of study that they are not in a position to do justice. The resultant anxiety and fear of examinations are what drives some of them to take the drastic step of ending their lives, as reflected in these suicides. The lack of a bonding between parents and children in many homes has resulted in a situation where, in vulnerable families, there is a serious communication gap and lack of support from the family to address these issues.

2.2.8 Lack of gender sensitivity in the domestic setting is yet another major challenge that children face. The inherent preference for the male child, gender stereotyping in the upbringing of boys and girls, be it in their responsibilities, their upbringing or in providing them opportunities for development, continues to be a major issue that keeps the girl child suppressed right from birth and to lose her self-worth from early childhood. This bias also results in even activities outside the home, freedom to interact with friends etc all being defined by and limited by gender related restrictions and perceptions in the case of girls.

2.2.9 Consequently, there is a tendency for girls, especially those from vulnerable communities and homes, being unable to even express themselves or articulate the problems they are faced with. Similarly, children who have issues connected with their sexuality also face lack of acceptance and a sense of exclusion and rejection that can result in them running away from home, becoming drop outs, and facing serious situations of abuse. Therefore, there is a need to address the attitudes to gender in families so that rights of the girl child and those with issues relating to

their sexuality are not compromised in the domestic setting.

2.2.10 Weighed down by all these factors, and the lack of opportunities that allow for positive interactions, children slip into depression, a problem the symptoms of which are not easily discernible to the untrained. Today depression is projected as the single largest contributor to the global burden of disease. The impact of this problem among adults and children alike was noted in the increased number of suicides that occurred during the COVID19 period and the number of calls that flooded the helplines with thoughts of self harm, prompted by a sense of alienation, oppressive conditions at home and lack of outlets for positive experiences.

2.2.11 This situation needs to be addressed with a multipronged approach including improved mental health literacy of communities, youth and teachers, enhancing case identification as well as the capacity of caregivers and teachers to identify children with possible depression, and addressing it with the help of the available referral facilities. The successful efforts made by the District Resource Centre under the ORC project of the WCD department or under the UNARVU project of the of the Mental Health Authority in Thiruvananthapuram district, where care was taken to create a setup that helps avoid the inevitable stigma, once the public becomes aware of the problem, are good models for consideration.

2.3 SITUATION IN PRE-SCHOOLS/ SCHOOLS

2.3.1 Mental health of a child is an issue that needs to be addressed from birth, following the 1000 day approach advocated by the WHO. The trauma that children undergo from birth has a lasting impact on their mental health. Hence it is important to address the mental health of children following a life course approach commencing with the health of the mother. The preschool period and the experiences of children in Day care centres/ Creches and Pre-primary school are also important because this is the stage when maximum development of the brain occurs. So, it is important to ensure that children are not exposed to environments and experience that will have a toxic effect on their brain development. Therefore, it is necessary to have standards for care and protection for children in Day care centres/ creches/ Pre-Schools and regulate them.

2.3.2 In schools children have an opportunity for education, for learning social and life skills, and the opportunity to develop their talents through various co-curricular activities. For many, especially girls, the school is perhaps the sole avenue for physical activity as their movements outside are restricted for a number of reasons, particularly for reasons of safety.

2.3.3 However, in many cases, even schools are not a safe, enriching environment conducive for learning. While some schools have been upgraded substantially, and others improved, there are many schools where basic requirements are wanting or badly maintained, rendering them unsafe and leading to situations where there has been loss of life or limb, and girls facing the discomfort of not having even proper toilet facilities. Despite training and sensitisation, there are teachers who still resort to out-dated, legally banned methods of punishment and discipline.

2.3.4 With schools focussing only on academic outcomes, children are reeling under the burden of education and struggling to cope because there is no other outlet available to relieve this relentless stress. In many schools there is lack of a ground to play, as required under RTE norms, (often due to using such space for construction of new buildings), or facilities for exercise. As a result, children have no avenue for physical activities or for getting a break from continuously sitting in class.

2.3.5 All government schools have opportunity for co-curricular activities through various clubs or service organisations like the SPC, NSS, Junior Red Cross, Scouts and Guides, etc but there is no provision to ensure that all children are included at least in one co-curricular activity. As a result the marginalised are often left without access to these opportunities. This, and many other reasons leading to the feeling of lack of inclusion, result in children dropping out of school and becoming victims of further abuse and antisocial behaviour.

2.3.6 There are forums available in school for interaction between parents and teachers and also some forums like the School Management Committee (SMC), wherein the children's representative is also included, to capture the voice of children in matters that affect their lives.

2.3.7 Yet, in many schools, these forums either do not function, or function in a manner that is not in consonance with the objective for which it was created. PTAs are rarely attended by fathers, or parents of children with behavioural issues. Class PTA meetings with parents are usually focussed only on fault finding and not on a solution based, fostering and positive approach.

2.3.8 In schools where there is a non-inclusive approach, there is an air of distrust and discomfort between teachers, parents and students. However, there are also many schools and individual teachers who buck these trends and are able to make a positive impact on their students, despite all odds. There is a need to consider fixing a minimum attendance of the PTA meetings in a term for every parent, which is not negotiable, so that the interests of the child are addressed effectively.

2.4 RESPONSE OF CHILDREN

2.4.1 Today, children face more stress than ever before due to many reasons, some of which have already been mentioned. There is tremendous peer pressure from the real world as well as the digital world of social media, temptations to risky behaviour like drugs or addictive substances, and the thrills offered by the internet and OTT platforms to escape the monotony of their lives.

2.4.2 This interface with the external environment, if not done with care and guidance, without an understanding of the risks involved, can result in addictive behaviour that can lead to many behavioural problems, which can cause disruptions to the lives of the child, and the family. It can also result in the child getting exposed to content that is not age appropriate, which he or she is not yet old enough to process with maturity. This in turn can result in an information overload that can lead to actions caused by poor judgement which bring them into conflict with their families, school authorities and even the law. In many cases due to lack of awareness

of the pitfalls of careless online activities, children fall victim to grooming, cyber bullying etc leading them to situations that they cannot extricate themselves from.

2.4.3 Children who hail from homes which are stable and caring and which provide the support that the child needs, are able to overcome the challenges that such a complex situation presents. However, in other cases it leads to conflicts within the home, secretive behaviour, emotional attachments that often cause havoc in their lives, and dependence on drugs to overcome their inner conflicts, which in turn leads to more serious problems and excessive screen use.---- all of which leads to poor social and health outcomes, and serious problems both within and outside the family.

2.4.4 Anger and violence related issues are yet other problems connected with the young that call for attention These are manifested in sudden outbursts which have serious implications, as recent incidents in the state involving children have clearly shown. Therefore, there is a need to provide support for anger management and to have a dialogue with them about violence as well as coping mechanisms and life skills that will help them address these issues.

2.5 CHALLENGES IN ADDRESSING ISSUE OF MENTAL HEALTH AMONG CHILDREN

2.5.1 The key issues that need to be currently addressed in the context of the mental health of children are excessive use of screen time, problems of substance abuse, emotional issues like problems of anger management, anxiety, depression and suicide. There are also conflicts arising from gender stereotyping that lead to serious mental health issues among girls, and children conflicted about their sexuality.

2.5.2 All children who are dropouts from the schooling system, children staying in hostels away from their families, and children placed in institutions because they need care and protection or faced adverse childhood experiences, or were found to be in conflict with law, children with physical and intellectual disabilities and children with mental health issues— they all have their own unique set of challenges.

2.5.3 The main challenges that are likely to be faced when addressing their issues are:

- The child's behaviour and mental health are by- products of the environment in which he or she lives. Unless these are tackled there cannot be sustained progress.
- While modifying a child's behaviour can be attempted, it is not easy to change the adult behaviour and lifestyle which dominates the environment of which the child is a part. This will be a greater challenge in cases where the family members are themselves engaged in anti-social behaviour.
- Systems have been set in place to address issues connected with the management and safety of the school through the School Management Committee (SMC) and the School Protection Committee(SPC). Children too have been given representation in these committees. But in many places these committees do not do justification to their mandate or function effectively. They also do not give adequate space for children to articulate their opinions.
- Interaction between teachers, the school management and the parents is to

be ensured through the PTA (Parent Teacher Association) and MPTA (Mother Parent Teacher Association). They do not function uniformly in all schools. Not all parents attend the PTA meetings,, especially the fathers. As a result there is a lack of ownership for what happens to the child at school. There is a need to ensure their attendance and expose them to awareness programmes on various issues that affect a child's mental health from time to time. But ensuring their presence will be a challenge that needs to be addressed.

- Availability of a playground (mandated under the RTE Act 2009), activity room, a PT/ Arts teacher are factors that will encourage activities other than academic ones and which can create positive reinforcement in the mental wellbeing of a child. However, where such facilities are not available (or available but the focus is on academic results), children are deprived of all physical or co-curricular activities. This has a serious impact on their physical and mental health.
- There are many programmes implemented by different departments like the WCD, Education, Police, Health, and Excise for tackling issues contributing to mental health. The multiplicity of programmes takes up time and efforts of the teachers and children.
- A Comprehensive Health and Wellness programme that will address all these issues, along with life skill sessions, would be more beneficial in achieving the objectives through sustained follow up using shared resources. For this there has to be coordination between the various departments, and convergence where that is possible. This has proved to be a challenge to achieve.

2.5.4 Some initiatives that have made an impact among children where they were introduced are:

- Our Responsibility to Children (ORC) which is currently running in 500 schools in the state. It focuses on mental health of children It seeks to adopt a "solution" based approach to facilitate the development of both physical health and positive mental health with the support of parents, teachers and different agencies of government.
- Counselling centre at Varapuzha Police Station, an outreach programme of Rajagiri outreach, Rajagiri college of Social Sciences in collaboration with Kerala Police and Kerala Excise Department. This project provides guidance and counselling to children identified as substance users by the Police and Excise departments, with the help of the experts in the Rajagiri Outreach in a space created by the Police station in the sylvan surroundings of a beautiful garden developed by them in their backyard.
- CHIRI which addressed the distress faced by children during the pandemic with special focus on suicide prevention
- KAVAL and KAVAL PLUS programmes that support children in conflict with law and children in need of care and protection after they are de- institutionalised, with the support of NGOs, and
- The UNARVU project implemented in 78 High schools and 55 Higher Secondary schools with the support of the District Panchayat, Thiruvananthapuram from 2007 to 2016. There is a need to extend such support services with the help of the

Panchayat or identified voluntary agencies to more schools and needy areas.

2.5.5 There are a number of NGOs doing salutary work at the community level and in schools, among teachers and in engaging parents and sensitising them on key issues. There must be a system to tap their expertise and resources to address mental health and wellbeing issues in needy areas.

2.5.6 Positive discipline is a concept that needs to be introduced in schools in place of the archaic, traditional measures for imposing discipline that adversely affects the mental health of children. However, that will require a dialogue with and support of parents since positive discipline cannot be a standalone method followed only at school, but would need to be supported at home too to be truly effective, ideally from a very young age. There is a lot of preparation and planning to be done to get oriented to this approach and teachers need to be sensitised before it can be introduced. This process is yet to begin.

2.5.7 Today, parenting is a responsibility that calls for awareness of the developments in technology, as well as its possible misuse and the adverse impact it can have on the whole family, especially on the lives of children;

- parents need to know about some key issues like substance abuse and its impact on brain development, about the long term impact of adverse childhood experiences which can result in risky behaviour and life style disorders later in life, about issues relating to sex and gender which need to be explained to children so that they have a proper, age appropriate understanding about these subjects. They also need to know about the legal entitlements in relation to child rights.
- Parents should also know how to handhold, mentor and support their children through this complex maze, for which they need the necessary awareness, training, and communication skills. Unfortunately most parents take on their parenting responsibilities with no planning or understanding of the commitments required. This is especially true in the case of most men, as they do not change their habits or lifestyle even after becoming a parent, which adversely affects both the child and family life.
- Among some social and religious groups, there is already a system of mandatory counselling which couples have to go through prior to their marriage ceremony. However, this does not include any component about developing good parenting skills. The possibility of including the latter in existing counselling arrangements, and also expanding this concept universally, merits consideration.

2.5.8 Counselling facility is available through the WCD department in 1012 schools and it is proposed to be expanded to an equal number shortly. But, this system has yet to be accepted as part of the existing school system.

2.5.9 With teachers being trained to deal with various issues that hamper mental health, they are best placed to give Psychological First Aid PFA) to children in need, especially since they are present in school at all times. Counsellors, on the other hand, are available only part time, though they may have more professional training for the task. There is a lack of clarity in the roles and responsibilities of teachers and counsellors, which needs early resolution to help support children

with mental health effectively.

2.5.10 Counselling support is yet to be made available in many schools. Whether they too will be provided this facility through counsellors or by any other means (eg. like empowering select teachers) needs to be decided. Then there is the issue of the private schools following the State Board, and schools following other patterns of education like the CBSE, ISC etc. These schools may have counsellors but they have a mandate that is understood to be very different from that given to counsellors in government and aided schools as their sole focus is on imparting lessons in general life skills and not address any problems that an individual child may face. The avenues available to children in these institutions to seek redressal for mental health issues are therefore only through their families which can be a matter of concern, particularly in the case of families which are themselves not functioning properly.

2.5.11 Further training is also required to be given to counsellors already working in schools and Adolescent Friendly Health Centres (AFHC) because they receive very limited induction training. A training similar to that which was provided to counsellors of ORC, which included a clinical exposure, needs to be considered to enable them to have a better understanding of the problems that they would be handling.

2.5.12 There is also a need to consider providing mentoring, hand holding support for the counsellors in every district, many of whom are very young and with limited life experience, to guide them when faced with challenging situations . Recently an initiative titled "Venda" was introduced by the WCD department under which training was given to counsellors to identify children who are using drugs, and to plan their rehabilitation and IEC focusing on prevention. Regular training and updating of their skills and availability of a platform to share their experiences would benefit them to address issues with greater confidence.

2.5.13 Life skills are proposed to be taught in an age appropriate manner with the help of the content for classes 1 to 12 called "Ullasa paravakal" and the associated teacher text developed by SCERT, as part of the curriculum. However, though it was prepared a couple of years ago, it is yet to be printed and implemented.

2.5.14 There are many activity based clubs and service organisations for children like the SPC, NSS, Junior Red Cross, Scouts and Guides in which children are encouraged to participate and contribute to society while fostering leadership skills and their capabilities.

2.5.15 While these clubs have been very successful in encouraging children to become more socially committed, have a better understanding of many issues that impact us all, and build connections with the external environment, there are some issues that still need to be addressed to make them more effective. Most important is the fact that while some children are allowed to be part of more than one club, there is no mandate that all children need to be part of any one of these clubs or organisations. This enhances the sense of exclusion of the left out children.

2.5.16 Children with various disabilities are encouraged to come to general schools as part of the inclusive approach to teaching them. But, the ecosystem in schools is not yet fully geared to address their needs. They are faced with challenges to manage their

daily affairs, in addition to the challenges of acquiring education in a system that does not accommodates their needs. This is particularly true in respect of children with intellectual disabilities. Many of them are therefore compelled to drop out for want of a supporting environment. These children, including the dropouts, have mental health and well being issues that emanate from their inability to integrate into the system and the daily stress that they are consequently exposed to. These issues need to be addressed.

2.5.17 Children with various intellectual disabilities (ID) and mental health problems are often not screened early and given the requisite support, resulting in them developing chronic conditions. The screening facilities for disabilities, though available from a very young age, are not yet comprehensive. A large part of the population which does not avail government facilities are outside the network of these free facilities. Therefore detection in many of their cases happens later. How their cases will be included in the early detection initiative is a challenge that is yet to be addressed. Tools for screening children in primary schools are still under preparation. Therefore, children with ID problems are not getting the treatment due to them on time because of the delay in detecting their condition. This certainly affects their quality of life and well-being.

2.5.18 For children with severe substance as well as other severe addictions or persons with chronic mental conditions, the line of treatment will require medical consultation and in some cases a period of institutionalisation. Today they are taken to the IP/OP of addiction centres or general psychiatric facilities respectively and housed in these facilities along with adults, by separating them through makeshift arrangements that are not optimal. There is need to provide separate facilities for children with addiction and severe mental health issues when they need medical intervention as the present arrangements are inadequate, and sadly, their numbers are increasing

2.5.19 Special Gram sabhas for children, Bala sabhas etc are avenues open to children to participate in decision making , to reach out and connect to the external world. They are unfortunately held only in a few village panchayats but need to be ensured across the state.

2.5.20 Very often children feel the constant stress caused by interfacing with systems outside the home environment that are not child friendly. These include hostels, courts, police stations and such other places. A conscious effort has to be made to make these institutions more “child friendly”. While this requirement is spelt out in the various legal enactments relating to children, adequate attention has not been paid to comply with the spirit of the law in mist of the institutions set up to address the needs of children.

2.5.21 Though there is great emphasis laid on how important the child is to the future of the country, interestingly, their perspective is hardly ever reflected or their interests protected in decisions taken and facilities provided. An example is the loss of safe public spaces where children could play in the past. While much is said about inculcating healthy habits, including physical exercise, in children from their early years, and it is included as part of their syllabus in many contexts, it is a sad reality

that no effort is being made to provide them access or opportunity to engage in such activity both at school and outside. This has a serious and lasting impact both on their physical and mental health. This situation calls for urgent remedial action on priority basis as a proactive measure to address the mental health needs of children.

2.5.22 Yet another area where a child perspective needs to be developed relates to disaster management. In recent years, Kerala has witnessed repeated instances of natural calamities, pandemics etc which have disrupted life in the state. They have proved to be a life altering experiences for some children who suffered the destruction of their homes or the loss of their loved ones. In the case of an experience like the COVID 19 lockdown, all children lost part of their precious childhood, and the opportunity to learn, play and interact with each other and develop socialising skills…an opportunity that can never be replaced. With climate change a reality that we need to accept, the possibility of further experiences of natural calamities cannot be ruled out and it is necessary to be prepared to address such situations, keeping in mind the best interests of children.

2.5.23 The Disaster Management Act 2006 requires provisions to be made for "widows and orphans" but there is no other specific direction in it about addressing the needs of children. However, given Kerala's experience in handling successive disasters in the past few years, it should be possible to develop a Protocol to address the needs of children in camps, in homes, and to address the aftermath, including preventive measures..

2.5.24 Special efforts have to be made to address the mental health of children who have faced the trauma caused by these situations. This is particularly relevant in the post covid scenario, where the mental health of all children have been affected due to the long periods of isolation at home, disruption of their routines at school, the experience of having to handle new methods of learning, giving exams etc (especially in senior classes), and in the worst case scenario, having suffered personal tragedies through the loss of immediate family members. Therefore addressing their mental health issues needs to be given due priority.

2.5.25 The community has a major role to play in supporting the mental health of its members, including children, and in encouraging them to feel a part of it. In this, the LSGIs have to take the lead as they represent the common will of the people in the community. While support is forthcoming from them on many issues, they face limitations of resources, some more than others, to provide better amenities in their jurisdiction.

2.5.26 There is a cap on the extent of budgetary provisions (5%) that can be allotted for children, which itself is to be shared with persons with disability and transgenders as they are all clubbed together in the Social Justice working group at the LSG Ievel. Much of these funds go towards scholarships for the disabled. Therefore, the spending on development issues connected with children come from other working groups when the latter provide for their overall activities. LSGIs which have their own source of funds ie.'revenue from own sources', have more flexibility

in spending. However such flexibility or resources will not be forthcoming in the socially and economically backward areas where there is no scope for generating their own resources but the requirements for support are greater. Hence such LSGIs need to be supported for implementing such specific activities.

2.5.27 Even in LSGIs where funds are available, it is seen that there is no continuity in the initiatives taken for children because they are mostly dependent on the personal inclinations of those in power. Therefore, good initiatives started by one set of people get discontinued when another set of people come to power. For example, many initiatives were taken up in a number of panchayats to handhold children and keep them engaged during the COVID19 period. However their continuance post covid is doubtful due to funding constraints and lack if priirity given to them.

2.5.28 Two very good initiatives taken up in the past to promote mental health and well being of children with the help of expert support were implemented in Thiruvananthapuram and Alappuzha. The successful UNARVU initiative in Thiruvananthapuram has since been discontinued for want of funding support while in Alappuzha, it is still continuing. There is a need to ensure that such good initiatives, especially those which succeeded in mobilising the community on challenging issues like mental health, are sustained.

2.5.29 A related issue is the lack of importance given to routine issues of maintenance and upkeep of schools. This issue has a serious impact on the lives of children and their mental health. However, it is not considered a priority in almost all panchayats. Post the devolution of powers to the local self-government institutions, this responsibility of maintenance and upkeep of schools is vested in them, a responsibility the importance of which they are not adequately conscious. This needs to change as children are the greatest investment that one can make in the future and there is a need to have a child perspective and provision for their welfare through such activities when an LSGI draws up its annual plan of activities.

2.6 GOOD PRACTICES

2.6.1 Our Responsibility to Children (ORC) which focuses on promoting physical, and positive mental health among children with the joint involvement of parents, teachers and and different agencies of government

2.6.2 CHIRI- addressing the distress in children during the pandemic with special focus on suicide prevention

2.6.3 Parenting Clinics- to promote the concept of effective parenting in the community

2.6.4 KAVAL and KAVAL PLUS to provide psychosocial support to CCLs and CNCPs post deinstitutionalisation

2.6.5 Special Police Cadets (SPC)-Model lIfe skill training programme

2.6.6 UNARVU project which focussed on improving the mental health of children in select High Schools and Higher Secondary schools with the support of the district panchayat, Thiruvananthapuram between 2007 and 2016.

2.6.7 DISHA, the helpline of NHM- Department of Health that was started during the problem with the NIPAH virus but which continues during the pandemic and

thereafter to provide free online counselling, backed by the support of over 1200 experts.

2.6.8 Counselling centre at Varapuzha Police Station, an outreach programme of Rajagiri Outreach, Rajagiri college of Social Sciences, in collaboration with Kerala Police and Kerala Excise Department to provide guidance and counselling to children identified as substance users by them, with the help of the experts in the Rajagiri Outreach.

3. RECOMMENDATIONS

3.1 Keeping these aspects in mind the following recommendations are being made:

3.2 Adopt a life course approach to mental health, keeping in mind that almost 85 to 90% of brain development occurs during the first 1000 days. Therefore, mental health related issues of pregnant and lactating mothers, issues of post natal depression etc need to be given attention, and further action ensured through counselling and follows up visits for early identification of the problem and appropriate support.

3.3 Importance should be given to early screening for disabilities after birth which is now being given in all government facilities. Awareness should be created about the importance of screening so that parents are advised of this requirement in private hospitals too. In anganwadis this should be done systematically with the support of RBSK.

3.4 Minimum standards of care must be implemented through a regulatory framework for day care centres, creches and pre-schools to avoid a stressful environment for children that will have a lasting impact on their mental health.

3.5 The school is an important space where the mental health and well-being of children can be addressed effectively. Therefore, age appropriate life skills must be imparted to children to cope with the challenges of life in a positive way. Ullasaparavakal, the content developed by SCERT must be introduced to children at the earliest. This initiative must be supported with adequate budgetary support for printing the content along with other text books, and teachers guided about how it has to be imparted along with the regular curriculum. Its implementation should be closely monitored.

3.6 The life skill approach to mental health should include:

- physical fitness programmes for girls and boys which includes martial arts training, cycling, yoga and swimming
- programmes against alcoholism/ drug abuse and cyber crime for adolescent boys and girls,
- Strengthening adolescent clubs
- Making special efforts to enroll “single” children and “single parent” children in adolescent clubs.

3.7 Organising special programmes for mothers of adolescents, life skill programmes for adolescent migrants and anger management sessions for all adolescents.

3.8 The school environment must be kept safe and secure for promoting mental health. This issue, of ensuring the upkeep of basic facilities like ensuring clean toilets

with water facilities, clean drinking water, maintenance and upkeep of the school grounds and class rooms etc which are a cause of daily stress in schools, must receive priority with the LSGIs for which separate budgetary support may be given to the LSGD, given its importance in promoting mental well-being of children.

3.9 Physical activity and sports, which are major contributors to the promotion of mental health, must be made mandatory in all schools. For this, every school must be given access to a ground. This could be ensured by the panchayat with the help of the Department of Sports. Facilities for exercise must be provided within every school, wherever possible, and the concept of giving a "power break" or two for children during long class sessions must be made a mandatory requirement

3.10 The concept of "Positive Discipline" must be made part of the school's efforts at imposing discipline, without the aggressive behaviour that often affects the mental health of children. For this, teachers may be given necessary training, and decisions taken at the institutional level, to create an environment that will promote positive discipline with the participation of parents and children.

3.11 To facilitate this process, all individuals and institutions who are involved with children should be provided with checklists to identify the risk and protective factors that can impact the wellbeing of children at different stages. Clear instructions should also be given on the measures to be taken at the individual and institutional levels respectively. The Department of Education must help prepare this list with the help of experts and circulate it to all schools to ensure uniformity in implementation.

3.12 The role of the family in ensuring mental health cannot be overstated. At present the school's interaction with parents is done on an individual basis through the class PTA and collectively through the regular PTA as well as the MPTA. There is a need to review the interaction in the class PTA to make them more positive and nurturing than a fault finding exercise.

3.13 Efforts should be made to create awareness among parents on important challenges faced by children and how to tackle them, at least once every quarter. Presence of representatives of all families of children needs to be ensured in PTA meetings, especially the ones which include awareness sessions on critical issues connected with parenting.

3.14 In cases where a child is in need of counselling for behavioural issues, the school must ensure that the parents are mandatorily part of the change process and counselling, as is being done under the ORC project in 500 schools.

3.15 In schools where counselling services have been provided, the ambiguity prevailing in the roles and responsibilities of teachers and counsellors need to be discussed and resolved by the Departments of Education and WCD. In schools where no counselling facilities have been provided, the possibility of empowering teachers who have the aptitude, with suitable training, needs to be considered.

3.16 Since many of the counsellors and teachers may need handholding to address complex issues and to prevent burn out, the possibility of having a mentoring system where expert support can be accessed needs to be considered. Creating a platform

for sharing experiences at periodic intervals which will benefit all counsellors also needs to be considered.

3.17 Children can play a major role in promoting mental health among fellow students, especially those who feel a sense of "exclusion" in the school environment. The possibility of using the Peer Educator (PE) or "buddy system" of the Department of Health, which has more than 19000 children in their fold and who have been trained to address health issues for purposes of promotion and referral may be considered.

3.18 Different departments are running different schemes for creating awareness as part of preventive activities and to promote mental health. The possibility of having one single Comprehensive Health and Wellness programme for Physical and Mental health needs to be considered, as it will contribute to better efficacy and sustainability of these initiatives, achieved through a pooling of technical and financial resources. The coordination between different departments is also envisaged in the Ayushman Bharat School Health Programme, though it is yet to be implemented in the state.

3.19 Special attention has to be given to the mental health needs of children with disabilities, both physical and mental, and to reduce their day to day stress levels. Action plans have to be made to improve access by creating facilities that are barrier free in all aspects. In the case of children with ID, early screening and support for accommodations of their individual requirements need to be provided to help them feel inclusive in the general schools

3.20 Children from economically and socially disadvantaged families face numerous challenges in integrating with the mainstream of activities in school and in hostels, resulting in them dropping out from the school system. There has to be a special effort made to retain them within the schooling system by addressing the factors that affect their well-being in schools. Use of peer support for addressing such issues merits serious consideration.

3.21 The functioning of SMCs. and SPCs in schools needs to be revitalised and the space given to children to participate in them needs to be supported so that their voices too are reflected in decisions that affect their lives.

3.22 There are many opportunities for children to improve their leadership skills through membership in school clubs and service organisations like the SPC and the NSS or the Health Club, Science Club etc. where they can participate in and contribute to community- level activities. This must be encouraged and it must be ensured that every child is a member of one such club or service organisation in school so that everyone gets an equal chance to develop their capabilities.

3.23 In a bid to improve parenting skills in the community, the WCD department has introduced Parenting clinics at the block level. This needs to be extended to the village level with support from the LSGIs. SOPs must be prepared for ensuring uniformity in the functioning of these clinics, SOPs need to be also prepared for the functioning of all counselling facilities in schools as well as the Adolescent Friendly Health centres as well as the Adolescent Clubs to ensure standardisation in the quality of services offered through them, which are very good avenues for

promoting life skills and mental well-being of children

3.24 With the experience gained in handling disasters over the last few years, there is need to have a SOP and emergency response plan for handling the needs of children in disaster situations, with special focus on children who have suffered loss of parent/ parents or loss of home and belongings and who will need to be displaced from earlier circumstances either temporarily or permanently, depending on the nature of the loss. The plan should provide opportunities for children to participate and contribute in some appropriate activities. This Plan needs to be prepared and shared with all competent authorities who are responsible for rehabilitation activities.

3.25 The mental health needs of children in hostels and institutions need special attention. This needs to be addressed either through the counsellor system available in Government or using the services of volunteers. An example of this is the work being done in the Boys Home in Thiruvananthapuram with the help of the NSS volunteers of Trivandrum Medical College under the supervision of the Department of Psychiatry. Similar support can be obtained through volunteers from NGOs with expertise or colleges where there is experience in handling counselling activities.

3.26 Where children have gone through the trauma of adverse childhood experiences, their rehabilitation and reintegration will take time, for which suitable hand holding must be provided with the help of experts based on an individual care plan both within the institution and thereafter.

3.27 In cases where children are found to have mental health disorders requiring medical support, there must be facilities in the Homes for detailed assessment and follow up, including individual therapy sessions which will help them acknowledge their emotions, give insight into their actions and motivate them for change. Provision for skill development training will also need to be provided to enable the process of reintegration into the community. SOPs must be developed for providing such services.

3.28 In this COVID19 period, all children have been affected by the loss of opportunity to normal physical, psychological and social development that can have a long lasting effect. Many will be suffering from the effects of excessive use of screen time, lack of exercise, obesity, abuse, tendency to drop out etc This is an opportune moment, in the post COVID19 period, to consider making mental health a part of the regular School Health Programme and giving an image makeover to the mental health initiatives as wellness programmes, as envisaged in Ayushman Bharat.

3.29 Regular mental health screening can be introduced among all students to identify the level of the children's vulnerabilities. Cases which show tendencies for suicide and other high risk behaviour can then be given additional support without the fear of stigma. Health department,NHM and WCD department need to jointly work this out

3.30 In crisis situations, children with pronounced vulnerabilities may need additional support. They should be provided Psychological First Aid (PFA). Modules developed

by NIMHANS can be used for such interventions through the existing staff in schools and Child Care Homes.

3.31 There is a need to train all school personnel including teachers on PFA This will help educate them to recognise early signs of mental health challenges and help promote mental health literacy. Such training should include a clinical exposure with the help of the Medical Colleges and the State Mental Health Authorities,, as was given under the ORC project

3.32 Since early detection and speedy access to care are two of the most important aspects of a good mental health programme, and there are many good initiatives by voluntary organisations who are working in the field of mental health at the grassroot level and in schools, the possibility of accessing the support of these organisations run by qualified professionals for buttressing the efforts being made to promote mental health, both in schools and at the community level, especially in vulnerable communities, needs to be considered

3.33 In cases where children are in need of medical help, since there are no separate facilities OP/ IP in any medical college or Mental Health facilities for treatment of severe cases of mental health as well as substance or other addictions, and given the difficulties being faced in treating children along with adults creating temporary separations using makeshift adjustments, there is a need to provide separate facilities for children at least in major medical centres for treatment of both these mental health issues . Support for this proposal through the budget is recommended.

3.34 Community support is one of the key elements of support needed for reducing mental health challenges, by reducing risk factors and promoting protective factors. This is important even in rehabilitating persons with mental health back into the community without stigma. This emphasises the role that LSGIs can play in creating an environment that promotes mental health, reduces the risk factors, and promotes mental health literacy in the community. .

3.35 Every LSGI must be sensitised about the need to prioritise mental health promoting initiatives when drawing up their plans for development, especially in creating safe spaces for children to play, interact and participate in activities that creates a sense of well being. Activating the Jagratha Samithi and the VCPCs is also necessary because they can help substantially in promoting mental health at the grass root level by taking action to remove or resolve issues that increase vulnerabilities in their respective areas.

3.36 Given the extent of loss of lives that the state has suffered due to suicides and mental health issues in recent years, as well as the increasing trend in this regard, it is proposed that the State should come up with a Child Mental Health Policy that will include rights as well as protection of a child starting from conception, clearly articulating the issues, the priorities and the strategies for achieving good mental health and well being among children.

4. STUDIES AND RESEARCH TO BE TAKEN UP

4.1 Regular survey - baseline and every 2-3yrs using appropriate tools(eg like 'National

Adolescent School-based Health Survey') on internationally accepted standards on child mental health including Wellbeing of children (Student wellbeing questionnaires/WHO Wellbeing tool) sedentary life.

5. INDICATORS

- Number of Parenting clinics held and the number of parents who attended the clinic together.
- Number of life skill education programmes conducted by LSG and other agencies
- Number of adolescent children attending fitness programmes organised by LSG and other agencies
- Number of mental health camps organised for children and teachers
- Number of children reported as users of drugs, alcohol or smoking
- Resource mapping done for all districts, including list of voluntary agencies with professional expertise functioning in each
- Regular assessment of ACE –adverse childhood experience using structured tool(Adverse Childhood Experience (ACE) Questionnaire) in different group of children –community, schools, child care institutions, Nirbhaya (Women and Children)homes, Hostels etc
- Reported incidence of bullying, fights, cases registered under the JJ Act, school drop outs, suicidal attempts, substance abuseetc
- Annual monitoring using Child friendly checklist/indicators for families, child care homes, schools and LSGIs
- Solution focused (FRaMES) auditing and strengthening of all programmes related to children-

a Future oriented questions- What are the expectations from our project/programme? What are the changes that you would like to see in this programme? What are future goals?

b Resource activating questions- What are the resources available? What are the strengths? Who are the important persons who can help?

c Miracle questions- If all problems get settled or if our goal is achieved, how it will look like?

d Exception questions/success stories- How did you manage things earlier? Mention exceptional situations where you succeeded or managed things effectively in the past.Other successful models in this field-regional/national/international?

e Scaling questions- How do you rate effectiveness of this programme in a 0-10scale? What shall you do to improve the score by at least one point?

V PROTECTION

1. INTRODUCTION

1.1 Protection with reference to child rights has two dimensions. The first one relates to the principle or ideal, a basic human right, that entitles every child to protection from abuse, exploitation, violence, and neglect. The second dimension relates to the framework or the safety net that is created by the state, other agencies connected with children, and the community at large, to protect the child during childhood.

These stakeholders have a responsibility to facilitate the child to realise his or her rights and prevent situations of violation or abuse through effective risk assessment of the vulnerability of childhood, and its management. But, where the system fails, it is also incumbent on them to ensure that justice is speedily rendered and that the child is effectively rehabilitated.

1.2 When a child gets exposed to harm of any kind, it can affect his or her physical, mental, and psychological health, adversely affect the enjoyment of other basic rights, and have a long term effect on the child's development and future life. Therefore, this exercise reviews the status of both dimensions of this right in Kerala, from the time the child is conceived right through adolescence, addressing some key areas of concern; it also seeks to identify what measures need to be initiated in the state to better children's access to the right to protection.

2. STATUS OF PROTECTION IN KERALA

2.1 Over the years Kerala has done much to promote the rights of children, be it in terms of their health or education. Its indicators in these areas have earned it a position of preeminence among other Indian states. However, despite sustained efforts, the situation in respect of protection issues needs to be improved in many respects. According to the SCRB data for 2020, 3941 cases of crimes against children were registered in the state, which constituted a marginal decrease from the 4754 cases registered in 2019.

2.2 Even when there was an approximately 17% drop in the overall number of cases registered in this category during the covid period, it is a matter of concern that the reduction in the number of cases registered under the POCSO Act 2012 was only 1.5% (from 1262 to 1243), while the number of murder cases rose from 25 to 29, and child marriage cases showed a marginal increase from 7 to 8.

2.3 When these figures are viewed in the context of the fact that for a major part of that period, people enjoyed limited outdoor movement due to covid restrictions, and that not all cases of violation of rights get reported, they give cause for concern. They also lend credence to the argument that much of the lack of protection, violence, abuse, exploitation, and neglect happens at the hands of the very people responsible for providing the safety net for children to enjoy their rights and proper development.

3. CHILD SEX RATIO

3.1 ISSUES FOR DISCUSSION:

- Pattern of Child Sex Ratio (CSR) in the state.
- Reasons for the decline in CSR.
- Efficacy of the legal provisions and statutory structures.

3.2 **PREAMBLE**

3.2.1 The World Health Organisation (WHO) estimates that the natural sex ratio at birth is about 952 females to every 1000 males. By that yardstick, and in comparison with the CSR in other states in the country, the figures in Kerala have traditionally been favourable. In 2011 the CSR for the state was 964, which was an increase

from 960 reflected in the census of 2001.

3.2.2 However, even when the figures met the WHO benchmark, or there was an overall increase, in certain contiguous pockets within some districts, the figures were much lower than the state average as well as the desired benchmark. The census figures of 2011 pertaining to some pockets in Thrissur district, which had the lowest figures for CSR, or of certain parts of Kottayam district which had a high CSR, are examples of this phenomenon.

3.2.3 Looking at trends post 2011, the data gleaned from the Annual Report of the Civil Registration System (for births in a year) shows a declining trend in the state post 2011, with figures at 965 in 2017, 963 in 2018 and 960 in 2019. The SDG Report issued in March 2021 shows the sex ratio at birth to be 957, while the National Family Health Survey(NFHS5), released this year also shows a decline of this figure in 2019 to 951.

3.2.4 While the NFHS figures may not be as accurate as the census data, this steady decline in the CSR is indeed a matter of concern, especially since the central monitoring done by the WCD ministry has also recently informed that decline in child sex ratio is currently noted in 7 districts of the state. There is therefore a need to understand the reasons for this decline.

3.2.5 One of the main factors assumed to be the reason for the healthy CSR trend in Kerala is its high level of literacy and access to quality health care. Viewed from that perspective, there is no reason for the figures to show a decline. There is a school of thought that this decline in CSR is a natural phenomenon that happens from time to time. If that be so, it should not be a regular, recurring pattern only in certain pockets, but should be scattered across the state.

3.2.6 The recent spate of dowry deaths and the increasing trend of child marriages in the state give reason to speculate whether socio economic aspects play an overriding role in this declining trend, and whether it is a pointer to a larger malaise in the state relating to erosion in the status of women despite efforts being made to better it.

3.2.7 So far, given the fact that the overall CSR figures are at an acceptable level, the woman's right to make reproductive choices, was given due respect, and adequate efforts have not been made to understand the low or declining trend in CSR in certain pockets.

3.2.8 There is a widespread undercurrent of acceptance of the alleged practice to abort the second or third child if the earlier child or children are of the female gender. This too is passed off as part of the right of the woman to make reproductive choices. But inherent in that decision are the social and cultural perspectives that view a girl child as a burden on the family; that needs to be corrected.

3.2.9 If on the other hand, the high rate of abortion in these pockets is due to continuous, "accidental" pregnancies, then that too needs to be understood and efforts made to create awareness about addressing this issue, which has a detrimental effect on the health of women. Whatever be the reason, the time has come to undertake an in-depth study of the recurring rates of decline or low figures of CSR that occur

continually in certain pockets, and take remedial action.

3.2.10 Inherent in the above issue is the question of how the sex of the child could be known to the parents when it is legally prohibited to reveal the gender of the child after a scan. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection (PCPNDT) Act 1994 expressly prohibits any communication between the qualified person conducting the technique, and the client. It calls for proper documentation to be maintained and reports to be sent from these registered centres to the appropriate authorities for scrutiny.

3.2.11 The constitution of Advisory Committees and Appropriate Authorities at the state and district levels to monitor the status of this activity is also prescribed. The statute requires at least one representative from a women's organisation to be included in the constitution of both these entities. It needs to be checked if this provision has been strictly adhered to when constituting these authorities and committees at every level.

3.2.12 While the responsibilities of these statutory entities are well defined, the close co-relation between their responsibilities and the child sex ratio at birth cannot be denied. Ensuring a healthy child sex ratio at birth could be one of the key indicators to help assess the proper functioning of the scan centres in a given area. It is understood that these committees and authorities currently base their monitoring on district level figures. But the major variations are often seen at the sub district level. So there is a need for these entities to study the disaggregated data in each district.

3.2.13 The ICDS could also play a key role in highlighting this issue locally, by monitoring these trends. Whenever declining trends are noted based on data readily available with the LSGIs (where every birth is registered), this needs to be brought to the attention of the concerned Advisory Committees for closer scrutiny of the functioning of the scanning activities in their watch. It is necessary that these agencies, viz. the Advisory Committees, the ICDS and the LSGIs work in tandem to protect the rights of the unborn child.

4. CHILD MARRIAGE

4.1 ISSUES FOR DISCUSSION:

- Status of child marriages in Kerala
- Reasons for the increasing trends
- Issues relating to child marriages among tribals
- The connect between child marriages and dropouts from schools

4.2 PREAMBLE:

4.2.1 Compared to many other states, Kerals's record for child marriages is comparatively favourable. The level of literacy and social development has been traditionally accepted as the key factors that contributed to this situation. However, over the years, there have been pockets in the state where child marriages continue to be prevalent despite efforts to create awareness and enforce the provisions of the Prevention of Child Marriage (PCMA) Act 2006.

4.3 STATUS OF CHILD MARRIAGES

4.3.1 The Census Report of 2011 showed that there is an increase in the number of child marriages vis a vis the figures of 2001. As per Census data 2011, there were 23,183 married girls below the age of 15 years in the State. In 1992– 93, the percentage of child marriage in Kerala was 37.9 per cent, which came down to 15.6 per cent in 2005-06.

4.3.2 But unexpectedly, this rose to 25.5% per cent in the year 2011–12 as compared to the data of 2001. Some important aspects inherent in this trend were that child marriages rose by 43.3% in the Christian community, 40. 3 % in the Hindu community and 26.5% in others while increase in the Muslim community was only 6%.

4.3.3 However, in terms of actual numbers, the highest figures continued to be in the muslim community. Another interesting trend was that the prevalence of child marriages is not limited to the northern part of the state, contrary to popular belief, as the southern part of the state too showed similar trends in the last census.

4.3.4 Despite efforts made by the state government in the last decade, a recent survey report published by the Kerala Government's Economic and Statistics Department for 2019 showed that 20,995 of the mothers who delivered babies that year were between the ages 15 and 19. Of these, some had their second or third baby by the age of 19, clearly indicating the prevalence of child marriages.

4.3.5 A surprising aspect of these figures was that the majority of these cases, ie.15,248, occurred in the urban areas. A religion wise break up shows that 11,725 were Muslims, 3132 were Hindus and 367 were Christians; only 57 of them were illiterate while 16,139 had passed the 10th class.

4.3.6 Therefore illiteracy was not the prime factor for these child marriages. Between 2020 and August 2021, according to the Woman and Child Development (WCD) department, 86 child marriages took place, of which 45 occurred in the current year as against 41 in the previous year. Last year, and this year up to September, 8 cases each of child marriage have been registered.

4.4 REASONS FOR THE INCREASING TREND

4.4.1 Despite the high level of literacy and social indicators of development, the trend in child marriages continues to register an increase in the state. A number of social and economic factors appear to influence this trend. They include the deep rooted patriarchal mindset which continues to see the girl child as a burden that the family must relieve themselves of at the earliest opportunity.

4.4.2 As a result, marriages are arranged even before the girl completes her education or reaches the legally permissible age for marriage. There appears to be a tendency to allow the girl to complete the tenth class, because most child marriages occur during the higher secondary phase.

4.4.3 The fact that in some communities there is a higher premium for younger girls, coupled with the fact that many boys discontinue their education early to obtain jobs abroad at a relatively younger age and look for a bride immediately thereafter,

deny the girls the opportunity to acquire a skill or a qualification that will help them at a later date.

4.4.4 Poverty and economic constraints also contribute to this situation. Some of these child marriages happen because there is waiver of dowry or even lesser demand for dowry when the bride is very young. The widespread acceptance of such practices that parents believe are in the best interests of their child adds to the problem.

4.4.5 Often there is full support from the community and the immediate community leaders in places where this practice is prevalent. This social support system makes it very difficult to break the hold of this pernicious practice; marriages are held surreptitiously and every effort is made to evade detection.

4.4.6 However, what adds complexity to the situation is the fact that increasingly such marriages occur even in affluent homes. Here, factors that influence this trend are the fear of parents that children will form "undesirable" attachments that will affect their social standing, the children themselves wanting to enter into matrimony influenced by the alluring images of brides that they see constantly in the visual and print media, the influence of the flourishing marriage industry in the pre covid era, which helped marriage become a spectacle where the bride and the groom are the stars for a day, the lack of safety for women, as seen from increasing reports of violence against them as well as the problems arising from increased cyber and social media interactions— all these issues compel parents to worry about the safety of their daughters and conclude that a marriage will protect them from such dangers.

4.4.7 There are many factors that hinder the implementation of the PCMA Act 2006. A prime factor is the sensitivity of the issues involved since the main perpetrators of this violation of child rights are the very people closest to the child, viz, the parents and guardians who are convinced that they are doing it in the best interest of the child.

4.4.8 An intervention becomes effective only when it happens before a wedding takes place; but given the clandestine circumstances in which these weddings are conducted, sometimes with false documentation, it is important that the authorities are tipped off in time to enable them to prevent the event.

4.4.9 The Government has focussed on this preventive aspect by sensitising children in schools to alert them when they know of an impending child marriage. This year, under the scheme Ponvakku, it has offered Rs.2500. to any member of the public who provides such an alert. When such cases come to notice, the effort is to counsel and encourage a postponement rather than file a case against the parents as that will affect the care and protection of all the children in that family.

4.4.10 Efforts to strengthen the implementation of the Act through better coordination among the stakeholders ….from the judiciary, the District Magistrate and the police, to the child protection and the ICDS network at the grassroot level….., and through measures taken to improve the database in anganwadis and LSGIs regarding the age of children in their jurisdiction, as well as the use of technology to alert everyone concerned (since time is of the essence), have proved effective when

implemented in some districts like Malappuram. Other key players like religious leaders, who conduct the weddings and the wedding halls who provide venues for the weddings have all been roped into this exercise.

4.4.11 Yet, so deeply entrenched is the problem that ways are found to circumvent these efforts by conducting clandestine ceremonies, or even getting them conducted in other states. The latter is an issue even with the children of migrant labour in the state. This calls for constant vigil because the state is also a witness to the devastating impact of the failure of such marriages on the young women and children of such broken marriages, many of whom are the victims of the grossest violation of human and child rights.

4.4.12 Many women enter into second marriages after the breakup of the first one and they and their children fall prey to untold miseries…. a pattern that has come to light repeatedly. They are forced to face these undesirable situations for want of appropriate education or skills to manage their lives independently because of early marriages. Hence it is critical that the efforts made to stop this practice are sustained and strengthened.

4.4.13 In all cases of child marriage, the core issue is that the people concerned, be they the girl or the boy (even some bridegrooms are very young), are not mentally or physically mature enough or prepared to handle the responsibilities that come with a marriage. This is causing the break-up of marriages in many cases, resulting in many adverse consequences that follow both for the young mother and children.

4.4.14 The social cost involved is an issue that needs to be taken seriously. There is a need to study the various aspects of this matter and sensitise the general public, the student community, and all religious and community leaders .A special effort has to be made in the case of tribal.

4.5 ISSUES RELATING TO CHILD MARRIAGES AMONG TRIBALS

4.5.1 The practice of child marriage continues to enjoy wide acceptance among tribal communities despite the prohibition under law.. According to the figures available with the WCD, 27 child marriages are said to have occurred only in Wayanad last year, and the figure has risen to 36 in the current year. Idukki too had 2 cases in 2020 and 3 cases in the current year.

4.5.2 The cohabitation practice among the tribals, the imposition of charges under the POCSO Act on the man or boy involved, the fact that they have to languish in jails for following what they believe is part of their cultural practices, and also for want of resources to secure bail, are among the many issues that have been under debate for a while.

4.5.3 There is a school of thought that advocates that people who hail from a tribal background should be allowed to continue their cultural practices unhindered. However, this is not an argument that is acceptable in the best interest of the young boy or girl involved or in the interest of the future health and wellbeing of the community.

4.5.4 Cultural practices are not cast in stone. They evolve with the changes in the

environment around them. In the case of tribal their food habits have undergone a change due to the changes in the land owning and cultivation patterns, and attempts are being made to bring their children to the mainstream through education.

4.5.5 Therefore, to advocate child marriage alone as a practice that needs to be sustained does not seem justifiable, especially when we consider the impact it has on the health of the young girls who have to embrace motherhood well before they are physically in a position to so, the poor state of their health (as many are anaemic), the incidence of infant mortality, and birth of underweight babies that continue to be a constant source of worry. There is a serious intergenerational impact of child marriages on the tribal community itself that needs to be effectively communicated to them to tackle this problem effectively.

4.6 THE CONNECT BETWEEN CHILD MARRIAGES AND DROPOUTS FROM SCHOOL

4.6.1 Every child, bride or groom, involved in a child marriage is likely to be a drop out from school, no matter which community or economic or social class of society he or she hails from. Therefore, along with the campaign for sensitisation, an effort to address the drop out issue in schools upto the higher secondary needs to be initiated with the support of all stakeholders so that all children upto the age of 18 are retained in schools, and acquire some skills to cope with the challenges ahead, before they enter into matrimony. The drop out issue needs focussed attention in the post covid period when it is expected to increase due to various reasons, especially the financial conditions in economically vulnerable families.

5. CHILD LABOUR

5.1 ISSUES FOR DISCUSSION:

- Status of child labour in Kerala
- Pattern of child labour
- Challenges in addressing this issue

5.2 PREAMBLE

5.2.1 Kerala's reasonably good record in the matter of child labour has been achieved through sustained efforts over the years to promote access to universal education and nutrition for children, besides conducting sustained drives against child begging. However, the census of 2011 showed that the number of children in the age group of 5 to 14 years engaged in work was 45,400, which constituted a 74% increase from the data of 2001.

5.2.2 A survey undertaken by the Ministry of Human Resource Development showed that there were 33,200 children in the age group 6 to 13 years not attending schools in 2014 as against only 15,800 in 2009. Given the co-relation between out of school children and child labour, this raises the concern that this problem continues to exist in the state in certain pockets.

5.3 STATUS OF CHILD LABOUR IN KERALA

5.3.1 Under the *Saranyabalam* scheme launched in 2016 by the WCD, to rid the state

of child labour and child begging, 279 children were identified by 2020 and sent to safer places. Majority of these children were from other states, a pattern that has existed for years.

5.3.2 However, while most of the child labour in the past came from Tamil Nadu, Karnataka and Andhra Pradesh, today they comprise children from Jharkhand, Assam, Arunachal Pradesh etc. Children from the state involved in child labour are limited in number, and mostly from economically and socially vulnerable sections like the fishing and tribal communities or the SC colonies and "layams," where there is also a higher level of drop outs from schools.

5.4 PATTERN OF CHILD LABOUR IN THE STATE

5.4.1 Studies undertaken in different parts of the state in the last decade have shown that child labour exists primarily within homes, in different cottage industries, the plywood industry in the backroom of shops, restaurants, dhabas and, catering services, in the construction and plantation sectors and for begging, especially near religious places.

5.4.2 The main difficulty is that they are engaged in work that is largely" invisible" to the public. Most of them are migrants, very often brought here through agents from extremely economically and socially deprived homes. Their migrant status makes them very vulnerable and exposes them to long hours of labour and work in the most exploitative situations which are violative of all child rights. Almost all of them have had no exposure to education.

5.4.3 In contrast most children hailing from Kerala attend schools and the dropout rate is very minimal. (0.11% in 2019-20). But where the drop out happens, there is incidence of child labour.

5.4.4 In the case of tribal children, boys are being hired to work in cardamom, betel nut and palm fields as well as in the ginger fields of Kodagu, adjoining Wayanad district. Some are engaged to play drums during the festival season So there is a pattern of seasonal dropouts in schools, which is not conducive to their receiving a sound education.

5.4.5 In the fishing community also children drop out and find work in places like bakeries, in catering facilities etc. Given the increase in substance use in the state, there is concern that these children could also be gainfully engaged to work as carriers and sellers of these addictive substances to children.

5.4.6 With the reduced financial conditions in socially and economically challenged families during the Covid period, there is a greater tendency for young persons, especially adolescents to seek employment . The fact that schools were shut down during this period has helped them to seek employment without this fact coming to notice.

5.4.7 A rapid survey conducted by Campaign against Child Labour, a consortium of NGOs, among 818 children found that there is an increase in the engagement of child labour following the Covid 19 pandemic, that children were working over 8 hours a day and 94% of them were working due to the economic conditions in the

families.

5.5 CHALLENGES IN ADDRESSING THE PROBLEM OF CHILD LABOUR

5.5.1 According to the pattern of child labour in the state, the majority of the cases involve children from very economically deprived homes in other states where the parents are active collaborators with relatives working in the state or agents to supply these children.

5.5.2 Secondly these children are engaged in sectors that do not come to public notice easily. It is also difficult to check the situation within homes when they are employed as domestic labour, as the employer are not sensitive to the plight of these children. When they are not hailing from the same state, there is even lesser sensitivity and ownership for them. Most of these children have never been to school in their home states, or in Kerala. Therefore there is no way to monitor their whereabouts.

5.5.3 Where children of the state are concerned, the problem is mainly in the coastal and tribal areas as well as in the tea plantation areas, where more often than not, it is economic necessity that triggers such a situation. Therefore, the possibility of child labour increasing post Covid is very likely, also causing higher levels of drop outs.

5.5.4 According to the Prohibition of Child Labour (Prohibition and Regulation) Act 1986, employment of children below 14 is completely prohibited except when working in a family enterprise, non hazardous work or as an artist. But children between 14 and 18 years can work in all but a few identified non hazardous industries subject to certain conditions regarding the total number of hours of employment and breaks to be given in between.

5.5.5 However, since such employment is mostly hard to detect there is difficulty in monitoring violations of the conditions prescribed for employing adolescents. Further, the fact that the children themselves are not in any position to complain gives rise to the possibility of child labour becoming a serious threat to child rights in economically vulnerable pockets of Kerala in the post COVID19 scenario.

5.5.6 This situation will be further aided by the adolescents themselves being resistant to go back to the rigours of school life after a taste of independence while earning for themselves, and employers being ready to employ children who can be paid less than the regular workers, with lesser chances of causing any challenges to the conditions of work.

5.5.7 Since different agencies, like the Labour department, the WCD department, the Child Welfare Committees (CWCs), the Education Department, the Local Self Government Institutions (LSGIs) and the District Magistrate all have a role to play in effectively checking cases of child labour, drop outs, and the number of children remaining out of school, as well as for ensuring that approvals are taken in cases where exemptions have been given with certain stipulations under the law to employ children, there is need for greater collaboration between them to ensure effective implementation of the provisions of the law.

6. PROTECTION ISSUES IN CRECHES AND PRESCHOOLS

6.1 ISSUES FOR DISCUSSION

- Lack of standards and regulatory structure
- Importance of ensuring safety

6.2 PREAMBLE

6.2.1 There are more than 35,000 preschool centres in Kerala which include around 33, 000 anganwadis run by the state. Details of the number of creches are not readily available . The Kerala State Council for Child Welfare runs 220 creches. There is also provision to set up creches under the Factories Act 1948, Mines Act 1952, Plantation Act, 1951, Inter-State Migrant Workers Act, 1980, Building and other Construction Workers' (Regulation of Employment and conditions of service) Act 1996, NREGA 2005, the Maternity Benefit Act 1961 and the Kerala Shop and Establishments Act.1960.

6.2.2 Majority of the creches/ Day care centres are managed by the private sector. Last year WCD department decided to start 15 anganwadis cum creches on a pilot basis in the state for children between the ages of 6 months and six years. Anganwadi staff, helpers and creche workers were to take on this responsibility.

6.2.3 No regulations or standards have been laid down for running preschools, and no approval is necessary from any authority to start one. This has resulted in the mushrooming of such centres across the state with services of a very uneven nature, often compromising the safety and development of the children placed in such centres.

6.2.4 In the case of creches, the broad guidelines call for adequacy of accommodation which is easily accessible by the women employees, and which is well ventilated, adequately lit, clean and hygienic, managed by women trained in the care of children and infants, and offered free of cost. More detailed standards and avenues to monitor them have been laid down in the National Creche Scheme announced in 2017.

6.2.5 However, there is no direction to mandatorily extend these standards or to enforce them in creches outside the purview of the scheme. There is a proposal in the pipeline in Kerala to bring about a legislation to prescribe standards for preschools and creches and to have a regulatory mechanism to enforce it.

6.3 LACK OF STANDARDS AND REGULATORY STRUCTURE

6.3.1 Although the ICDS programme offers facilities like free food, preschool education, primary health care, immunisation, health check-ups and referral facilities, and their education and care components have been drawn up with the help of experts, these services are available only to 25% of the total eligible children in the state between 3 and 6 years because rest of them do not attend anganwadis.

6.3.2 The infrastructure of the anganwadis also varies substantially with some having been developed as model anganwadis with their own infrastructure while some are housed in less than optimum conditions in rented buildings, some even without toilet facilities or proper ventilation and upkeep.

6.3.3 In preschools outside the anganwadi network the situation is not uniform. Different preschool centres follow different pedagogical content. The care component in

terms of health, nutrition etc are also not part of their services. As a result, the outcomes are very uneven even though all children have to join formal schooling at the age of 5 or 6 where uniform standards are applicable.

6.3.4 This situation poses serious challenges to the future wellbeing of children once they join the schooling system. In the case of creches too, though standards have been spelt out, there is no check on whether they follow any basic, acceptable standards of care for want of a regulatory framework.

6.4 IMPORTANCE OF ENSURING SAFETY

6.4.1 One of the factors that prompted the drafting of legislation in the state to regulate creches/ day care centres and preschools was the occurrence of abuses and avoidable deaths in some preschools in the state. The lack of safety standards resulted in children suffering fatal accidents. Abuses, including physical and sexual offences, were reported when unqualified persons or persons of doubtful backgrounds were employed in such centres.

6.4.2 It is a scientifically acknowledged fact that 0 to 6/ 8 years is very crucial for the brain development of a child, for the identification of any developmental delays, and for ensuring proper care and nutrition; failure to do so will have life long implications.

6.4.3 Educating parents about the relevance of these issues to their child's future is equally important so that the choice of preschool education for their children is prompted by the right considerations. Therefore, addressing this issue in the case of creches/ Day care centres and preschools is a matter that requires high priority.

7. SAFETY ISSUES IN PUBLIC SPACES FOR CHILDREN

7.1 ISSUES FOR DISCUSSION

- Inadequate recognition of child rights in matters involving children.
- Lack of protection in transport facilities
- Creating "child friendly" public spaces
- Special challenges in vulnerable communities

7.1.1 There are a number of public spaces that a child frequents in the course of his or her childhood. They include schools, tuition and study centres where education is imparted, centres for training in art forms and sports, for religious education, for physical exercise, hostels where they are compelled to reside when away from home etc, to name a few. There are transport facilities that children have to use to reach centres of learning. All these situations are opportunities for children to take fledgling steps to learn appropriate social behaviour which will be the foundation for their behaviour as adults. This calls for the community at large to factor their needs into the systems in which children interact, and also to mentor them with appropriate behaviour.

7.1.2 Standards have been laid down under the Right to (free and compulsory) Education (RTE) Act 2009, and systems have been prescribed to ensure that children have a safe space in schools to develop appropriate social skills as part of their education. The Juvenile Justice (care and protection)(JJ) Act 2015 lays down the minimum

standards for care and protection of children who live in Homes registered under that statute. Conditions for registration require that these minimum standards are complied with to protect the best interests of the children. However, these are yet to be effectively enforced and ensured in all such Homes.

7.1.3 Hostels are another category of residential facilities where children stay away from home, for availing training in matters ranging from tuitions , sports, and arts to religious training. Hostels for SC/ ST children and children from fishing communities, hostels attached to schools for children with special needs, sports hostels, and centres for education in the arts, some of which are run by Government, also fall in the category of residential facilities that are not required to be registered under the JJ Act 2015.. So currently there are no minimum standards prescribed for the facilities they offer and legal statutes are invoked only when violations of child rights occur.

7.1.4 Hence the concept of child rights are often not incorporated into the systems in these hostels. Many of them are neither child friendly or gender sensitive nor do they address the needs of children with disabilities, leading to cases of abuse coming to light from time to time.This raises the issue whether there is a need to lay down minimum standards for all such facilities so that there is greater transparency and accountability, and the spirit of child rights is incorporated in their functioning.

7.1.5 The lack of safe public spaces and the inability of the community to provide a safety net for children through appropriate accommodations of their needs or through appropriate behaviour of the adults with whom they interact and the sad consequences of it on their lives have been apparent in the incidents of child right violations that occur regularly, and which continue to show a rising trend, as reflected in the data published by the State Crime Records Bureau (SCRB). This needs to be addressed keeping in mind the best interests of children.

7.2 INADEQUATE RECOGNITION OF CHILD RIGHTS

7.2.1 Although standards defining systems and infrastructure are laid down in the RTE Act 2009 and the Kerala Education Rules (KER), these requirements are not uniformly adhered to in all schools. There are many schools which do not meet the basic infrastructure requirements and yet others where the maintenance and upkeep are not satisfactory. Most schools are yet to comply with the requirements under the RPWD Act 2016. Gender sensitive arrangements are also not available in many schools due to poor upkeep of toilets and other facilities.

7.2.2 Similarly, in the matter of imposing discipline, the RTE Act requires that no child should be put through physical punishments and mental harassment. However, discipline still continues to be enforced following age-old methods in many schools, even as world over new measures like Positive Discipline are being attempted.

7.2.3 Children's space for participation in decisions that affect their lives or in extra curricular activities are very limited ; however, even these are not allowed to be exercised in many schools. The concept of child rights is yet to gain wider acceptance within the school system.

7.2.4 While the RTE Act clearly lays down provisions for ensuring the protection of child rights in schools, there are no such stipulations when children engage in studies and training outside the school system in places like tuition centres. The same is the situation in residential facilities provided to children for various purposes.

7.2.5 This raises the issue whether there is a need to lay down minimum standards for all facilities interfacing with children, be they hostels or other training centres. There could be a framework in which the management of these facilities could self-certify themselves against certain basic standards which are laid down by the government as desirable, and make public the extent of their compliance with these standards, so that there is greater transparency and accountability in these systems. This will help the spirit of child rights to be better incorporated in their functioning.

7.2.6 The concern today is that while there is much effort being made to promote child rights in some spheres of interaction with children, there are a large number of children outside such safety nets, where the idea of child rights has not made any impact.

7.2.7 This dichotomy in approach has led to a false understanding that child rights is a concept that only needs to be selectively applied at one's convenience and based on one's interpretation of what constitutes " child rights". In fact some violations get the seal of approval of parents under the false belief that such practices are in the best interest of the child, or are acceptable because it has the sanction of tradition, however traumatic that may be to the child.

7.2.8 The outcome of this ambivalent approach to child rights is visible in many aspects of life involving children. One such common example is the practice of caning in tuition centres. Caning a child, while frowned upon by law in school, is still considered acceptable in a tuition centre if the child does not secure marks as per expectations.

7.2.9 Similarly, there are regular reports of numerous practices where children are involved in religious rituals and practices by parents for the family's or a sponsor's welfare, sometimes with very tragic consequences. Negligence of parents in the matter of immunisation due for children is yet another example.

7.2.10 It is clear that there is a lack of clarity among parents, teachers and other stakeholders on what constitutes child rights and that they are inalienable. There is a need to mainstream the concept of child rights and make it a part and parcel of all interactions with children if we wish to create a child friendly society.

7.2.11 Another area where violation of child rights happens in the public eye relates to various transport arrangements made for children. The ill treatment meted out to children in public transport systems when they avail the concessions provided for travelling to and from school is perhaps the most public and daily display of child rights violation. There are numerous cases of injury suffered by children when they are allowed to board the bus only when the bus is about to leave or have to remain standing with their heavy bags even when empty seats are available merely because they are recipients of this fee concession from the government.

7.2.12 Childhood is a time when children have to be groomed into behaviour that allows them to fit into civil society. Such harassment and indignities that children suffer repeatedly in public transport systems, with the public turning a blind eye to them, is an issue that needs to be acknowledged as inappropriate behaviour that needs to be corrected with the support and cooperation of the public for which greater awareness of this issue needs to be created.

7.2.13 Even in private transport facilities, be it organised by schools or through pooling arrangements, there are numerous incidents of abuse when schools or parents fail to exercise due caution. These are issues that call for a serious public debate, and greater awareness created about the unhappy consequences of such poor models of social behaviour for the affected child, and the community at large.

7.3 CREATING CHILD FRIENDLY PUBLIC SPACES

7.3.1 A growing area of concern is the ever diminishing availability of safe public spaces for children. The space available for children to undertake any physical activity has reduced substantially over the years. For example, in many schools, where grounds once existed, such free spaces have been used for setting up new buildings. Therefore there is no ground available in such schools for any physical activity, even though this is a mandatory requirement under the RTE Act.

7.3.2 Similarly the lack of proper compound walls, well-tended grounds, functioning toilets, or waste disposal systems, annual pruning of trees and clearance of wild undergrowth and debris have all made schools less safe for children. Though children have been statutorily empowered to reflect their opinions through the SMCs on matters that affect their lives, in reality this is not happening.

7.3.3 The same is the case with spaces outside the school environment. Public spaces available in cities, towns and villages, where once children could congregate and play freely, are now substantially reduced because they are either not being maintained or used for setting up tiled parks, or putting up statues. While this trend affects boys substantially, it has spelt the end of all physical activity for girls, resulting in many adverse health consequences.

7.3.4 There is provision to involve children in decision making at the LSGI level through platforms like the children's Gram Sabhas. Yet, very few LSGIs make the effort to do so. It is clear that the needs of children are rarely being factored in when designing or maintaining different public spaces and services, be it at school or elsewhere, and that the voice of children and their needs are not being given consideration. This needs to change.

7.4 SPECIAL CHALLENGES IN VULNERABLE COMMUNITIES

7.4.1 In Kerala, there are some pockets which are traditionally considered as particularly challenging for children to enjoy their basic rights due to the fragility of the social and economic conditions of which they are a part. Normally, tribal and coastal areas come to mind in this context.

7.4.2 However, there are a number of other pockets where the conditions and challenges are similar, if not worse, because their plight is not even as well recognised as those

of the two above categories; nor is their plight as well as documented as that of the others.

7.4.3 In this category fall the 24,200 odd SC colonies scattered across the state, fishermen's villages, slums in cities, layams in plantation, persons living in isolated , scattered shelters in poramboke or on the banks of canals, backwaters etc away from regular human settlements, and also the migrant families, like those from Sri Lanka who settled down in remote places like Gavi, Kulathupuzha and Athirappally.

7.4.4 Like the tribals, their ability to access services is fraught with difficulties, because of many factors, especially the difficult terrain in which they reside, where even to reach the village office or go to school are a challenge. Some communities like the Sri Lankan migrants do not still have nativity and community certificates which denies them and their children many benefits due to them. Residents of such geographical spaces also find a place in the list of violations and vulnerabilities that children face, be they drop out issues, CSA, addictive behaviour, malnourishment etc to name a few.

7.4.5 Theirs is an intergenerational issue as the same plight continues unabated generation after generation…almost as if they do not exist in this landscape. This situation needs to change and it is time that some focus is given to their problems, and efforts are made to extend the safety net to them too.

8. PROTECTION OF CHILD RIGHTS WITHIN THE DOMESTIC ENVIRONMENT

8.1 ISSUES FOR DISCUSSION

- Factors that challenge child rights within the home
- Importance of proper parenting

8.2 PREAMBLE

8.2.1 The most important space for a child during childhood is with his or her family. It is one of the cardinal principles underlying child rights.Every effort is made to ensure that a child is given the opportunity to live with a family even when there are situations that deprive the child of this experience. Adoption, foster care, sponsorship etc are all such opportunities promoted by the Government. Similarly, much emphasis is being placed on efforts to rehabilitate children who are survivors of some form of abuse or exploitation or neglect.

8.2.2 An unfortunate corollary to this issue is that very often the roots of such violations are within the home itself. Data shows that much of the sexual abuse occurs at the hands of someone familiar with the child, be it a close relative, neighbour or at school.

8.2.3 Today suicides, addictive behaviour and many other mental health issues plague children from a very young age which also have their roots in behaviour that remains unaddressed from childhood till it is too late.

8.2.4 This highlights the importance of parenting in these times of constant flux, increased use of technology in our daily lives, information overload, peer pressure, the influence of social media and the demands placed on children to fulfil their family's expectations.

8.3 FACTORS THAT CHALLENGE CHILD RIGHTS WITHIN THE HOME

8.3.1 The many factors that challenge child rights within the home include the following:

- vast changes in the traditional understanding of the structure of a home . Single parent homes, homes constituted through remarriage of one or both the partners, (both with their own set of children from previous relationships) are no longer the exception. Each of these circumstances have their own set of challenges.
- homes which are more in line with the traditional understanding of a family also face their own set of internal pressures. as well as the external demands of a society which is rapidly changing, and having to cope with the demands of work and physical absences, especially if both are working.
- the mindset that looks at responsibilities at home through gender stereotypes.
- the lack of a family centric approach to home based care of children and reluctance of fathers to share the responsibilities of raising a child; and,
- domestic violence and alcoholism. Increasing trend of parental conflicts and divorce rate also affect the child's right to a safe home

All or any of these issues can have a serious impact in the upbringing of children.

8.4 IMPORTANCE OF GOOD PARENTING

8.4.1 An understanding of good parenting techniques is important because:

- Parents can be called upon to address a complex set of issues at various stages of childhood, such as excess screen use, substance abuse, and addictive behaviour, emotional issues like anger management, anxiety, depression and suicide.
- Parents need to know about the nature of support to be given to children and the support systems and statutes available to help them and the children to successfully handle challenges. E.g. online safety or domestic violence.
- Parents can gain a better understanding of child rights that will help them to avoid unreasonable expectations that are in conflict with the unique talents of the child. It will also help parents to understand that the child may be one's own but that he or she also enjoys all the rights granted to an individual citizen, which are to be realised with the support of their family; and where parents are found responsible for any violation or neglect that the child suffers, that they can be held accountable.
- Parents will gain confidence to discuss with sensitivity subjects relating to adolescence such as reproductive health, which are necessary but normally avoided in families. It will help them to handle discussions on issues relating to gender and sexuality, including subjects like homosexuality, TG etc so that children get the right perspective on such issues.
- Exposure to good parenting techniques will also provide parents an opportunity to understand the importance of maintaining a good communication channel with their children.

8.4.2 Parenting demands time, effort and commitment. Therefore, it is necessary to be ready and prepared to take on this serious responsibility for the life of another. Today, very little thought is being given to this aspect or the need for planned parenthood to raise children who will become assets to society. The concept of

planned parenthood therefore needs to be promoted.

8.4.3 The traditional approach to parenting has become anachronistic to the extent that one can no longer cope with parenting demands only with the help of the instinctive responses that one is assumed to develop on becoming a parent. Therefore, the WCD department's initiative to provide Parenting clinics at the block level with possibility of expansion to the panchayat level is a step in the right direction.

8.4.4 The concept of good parenting, the importance of being equipped to handle parenting challenges and the support available through parenting clinics needs to be promoted to create greater public awareness about these issues and their role in empowering children and the families

9. CHILD SEX ABUSE AND ITS CONSEQUENCES

9.1 ISSUES FOR DISCUSSION

- Trends in Child Sex Abuse (CSA)
- Challenges in addressing this issue

9.2 PREAMBLE

9.2.1 Child sex abuses occur in different settings such as child marriage, in trafficking, when the child is placed in employment, or within the child's own home from family members, relatives, and friends of the family. A new dimension to this problem is online sex abuse.

9.2.2 Even during COVID 19 times, when the state was under lockdown, the rate of sex abuse against children through child marriages, through offences committed against children by persons close to them, and through online abuse did not let up. With increased online activity of children, and lack of awareness of safety measures, it is widely felt that this lock in period has been a fertile opportunity for sex predators to groom impressionable children and there is likely to be a further spurt in these cases in the immediate future.

9.2.3 There is already a concern that India is emerging as one of the main centres for child sex abuse material in the world. Though details are not readily available about the extent of the problem in Kerala, there is a need to flag the potential of this abuse to affect the children of this state, given their level of online activity and more often than not their own ignorance and that of their parents to this potential threat.

9.2.4 Although the stringent provisions of the POCSO ACT 2012 seek to provide protection to children from sexual offences, its implementation is yet to stabilise and to serve as a deterrent against such heinous acts against children.

9.3 TRENDS IN CHILD SEX ABUSE

9.3.1 A comparison of the trend of POCSO cases filed since 2013 reveals the rapid increase in cases registered under the POCSO ACT 2012. In 2013 the number of cases registered was 1002; it more than doubled by 2016 to reach 2093 and by 2020, despite the lock in periods due to the COVID19 pandemic, the figure was 3030, a very small dip from the figure for 2019, which was 3616.

9.3.2 An analysis of the figures of 2020, the year of the pandemic, shows that 47% of the

children affected belonged to the category of 15 to 19 years, 32% were in the 10 to 14 age group, 13% in the 5 to 9 age group and 2% in the 0 to 4 age group. The classification of offenders is not clear in about 38 % of the cases, because the details were not clearly recorded in 17% of the cases and in another 17% the relationship was not established though the accused were known to the child. Only in 4% of the cases were the accused unknown to the child.

9.3.3 Of the balance 62% cases where the status was clearly indicated, 12% were immediate family members, 8% were relatives, 17% were neighbours, 2% were teachers and 1% were drivers of buses, autos etc. 16% in this category were lovers and 6% were stated to have been friends.

9.4 CHALLENGES IN ADDRESSING CSA

9.4.1 The problems in tackling CSA are many:

- All offences do not get reported. CSA is by its very nature a clandestine activity and the child, a minor, may not always be able to comprehend or explain what happened.
- Given the stigma, and when family members are involved, most families tend to not report such occurrences. Therefore, hardly any cases will be reported from affluent sections of the population. Cases of incest also go unreported till someone outside the family circle comes to know and is inclined to report.
- Delays in securing justice, the lack of privacy and the repeated victimisation that the survivor has to undergo adds to the problem.
- Where children hail from vulnerable homes, they are also made to stay separately till their statements are recorded. The delay in finalising these cases results in survivors of CSA being further punished through physical isolation from their families in Homes for long spells.
- Impact of adverse childhood experiences on their mental and physical health is normally long term and calls for a long period of treatment and hand holding. In order to reduce the impact on this adverse experience on their cognitive, emotional, physical and social development, it is necessary to give them psychosocial support and mentoring till they are fully reintegrated into society. This is a major challenge given the numbers involved. The arduous aspect of the challenge is to fully reintegrate them in a society that stigmatises such survivors.
- Since the greatest threat to the child in matters of CSA comes from the child's own circle of family and acquaintances, addressing this violation, which mostly occurs within the four walls of the child's home, is challenging. It underscores the importance of reaching out to parents and providing them timely support in vulnerable situations.
- Therefore, it becomes crucial to strengthen neighbourhood groups that can help identify and provide timely support to vulnerable families. Parenting clinics can be an important support if they are expanded to the panchayat level.
- The high percentage of cases involving neighbours shows the need for providing safe spaces for vulnerable families, where children can be left without harm when

there is no one else at home.

- The loss of data in 34% of the cases available with SCRB due to details not being captured properly, is also a matter of concern that needs to be addressed because the numbers involved are significant, constituting over one third of the total cases .

10. MENTAL HEALTH AND WELLBEING OF CHILDREN

10.1 ISSUES FOR DISCUSSION:

- Factors that adversely impact mental health and well-being of children
- Challenges in managing mental health and well being

10.2 PREAMBLE

10.2.1 Today, lack of mental health and wellbeing is among the fastest growing threats to child rights across the world. From the time of birth, children are exposed to factors within the home and outside their homes that affect their emotional, social, and psychological well-being.

10.2.2 As a result they are unable to function in a productive manner, cope with the stresses of life, realise their full potential, and contribute to society. In extreme cases it even leads to self-harm suicide or harm to others. Therefore managing mental health and promoting well-being are among the biggest challenges that societies face today.

10.3 FACTORS THAT ADVERSELY IMPACT MENTAL HEALTH AND WELL BEING OF CHILDREN

10.3.1 Well-being is about having a positive approach to life and feeling good. It involves the presence of positive emotions, absence of negative emotions, a feeling of satisfaction and fulfilment leading to positive functioning.

10.3.2 In the case of children, risk factors include a negative home environment, exposure to continuous pressure from unreasonable expectations, physical, sexual, emotional and psychological violence, peer pressure in the real and digital worlds, stress caused at school, excessive screen use which affects speech and brain development, substance abuse, and adverse childhood experiences in early childhood that can lead to risky behaviour and lifestyle disorders.

10.3.3 While continuous lack of well-being affects mental health, it can also be affected by biological factors such as genes or brain chemistry or family history of mental health problems.

10.4 CHALLENGES IN MANAGING MENTAL HEALTH AND WELL BEING

10.4.1 In order to maintain wellbeing and mental health, it is important to adopt a life course approach whereby efforts are made to reduce the impact of risk factors and increase the protective factors. It is necessary that children are provided a safety net at home, in the institutions which they attend, and in the spaces in which they interact.

10.4.2 Therefore, it is important for parents and teachers to equip themselves to guide and mentor the child, protect them from adverse childhood experiences, limit screen use, be alert to any addictive behaviour, encourage children to embrace a positive

and physically active life and to optimise his or her full potential. Where the child's mental health is affected, it is also important to secure professional help and avoid fear of stigma to do so.

10.4.3 Schools play a very important part in tackling mental health and well-being by channelising their energies into positive activities, physical exercise and providing opportunities to develop their latent potential. Lack of co-curricular activities has a very negative impact on mental health and well-being. Teachers and counsellors can provide an effective support system if they can rationalise the current overlap and ambiguities in their roles and responsibilities.

10.4.4 Where there is a medical component to the mental health problem, or to addictive behaviour of any kind, then medical support is required. Today, there is the District Mental Health Programme that offers support as also Psychiatry departments in Medical colleges in addition to the three exclusive mental health facilities in the state.

10.4.5 However, whether it is for treatment for mental health or for addictive behaviour, there are no exclusive facilities for the treatment of children in cases where medical intervention is required, which is very essential since the approach to their management is not the same as for adults. There is a need to assess the extent to which facilities are available to tackle medical aspects relating to mental health and addiction issues among children in Kerala, and to provide the infrastructural support needed to manage them in psychiatry departments of medical colleges and in addiction centres.

10.4.6 Creation of awareness about mental health and well-being is very necessary since levels of self-harming behaviour and suicides reported among children today indicate a deeper level of malaise that needs urgent attention.

10.4.7 There are efforts being made through the ORC, the CHIRI initiative, initiatives of the Psychiatry Department of the Trivandrum Medical College or their collaboration with KILA and the Alappuzha District Panchayat, as well as helplines like DISHA, and CHILDLINE, to name a few.

10.4.8 Efforts are also being made by a number of committed voluntary agencies who work among children at the school and community levels to promote wellness by addressing risky behaviour, promoting life skills, supporting rehabilitation etc. SCERT has developed a Handbook titled Ullasaparavakal to provide age appropriate life skills to students from classes 1 to 12 . The police and excise departments also have programmes, in addition to the WCD department, to address issues that negatively impact mental health.

10.4.9 It is also necessary to look at efforts being made by Government departments to promote well-being, and prevent risky behaviour, so as to avoid duplication of efforts and to optimise resources through systematic coordination instead of working in silos.

10.4.10 There is also a need to explore the extent of support that children in schools other than Government and Aided schools currently receive. This last issue is a matter of concern as there is a large segment of the child population who study in these

schools .

11. CARE OF CHILDREN IN NEED OF CARE AND PROTECTION (CNCPs) AND CHILDREN IN CONFLICT WITH LAW (CCL)

11.1 ISSUES FOR DISCUSSION

- Effectiveness of the rehabilitation process during institutionalisation
- Challenges to effective post rehabilitation and reintegration
- Tackling rehabilitation of children with Special needs
- Need to reduce the repeated re-victimisation of CSA survivors
- The way forward in providing care and protection

11.2 PREAMBLE

11.2.1 Children in need of care and protection (CNCP) are placed in institutions as a last resort. Today the focus is to rehabilitate children who are without a family of their own through adoption, foster care, and sponsorship. That approach is being followed even in cases of children who have been orphaned as a result of covid and other natural calamities.

11.2.2 Children are placed in hostels only when the family environment is either not considered safe or suitable for the present health and emotional condition of a child, especially those who have suffered adverse childhood experiences like CSA.

11.2.3 Similarly, children who are in conflict with law are also placed in Homes in cases where it is not considered desirable to keep them with the family till they are provided the necessary psycho-social support and are considered ready for rehabilitation into society.

11.3 EFFECTIVENESS OF THE REHABILITATION PROCESS DURING INSTITUTIONALISATION

11.3.1 The JJ Act 2015 and its Model Rules have prescribed detailed standards for the rehabilitation of both CNCPs and CCLs. However, there is a need for SOPs for evaluation and follow up support till these children are fully integrated into society. An Individual Care Plan (ICP) is required for every child who is a CCL or a CNCP, and it needs to be closely monitored till the child is fully integrated.

11.3.2 This is very important, especially in the case of children who have suffered adverse childhood experiences if their rehabilitation has to be handled in a systematic manner. Unfortunately, available information shows that ICPs are not being prepared for all children, and decisions regarding rehabilitation in such cases are therefore not being taken by those responsible for their care and protection on the basis of their respective ICPs, as envisaged in the JJ Act and Rules. This is a serious gap that needs to be urgently addressed.

11.3.3 In the case of **CCLs, a study undertaken in Thiruvanathapuram** in 2018 of 150 boys showed that 63% had conduct disorders, 53% had a at least one substance dependence, 37.5% had ADHD features, 8% had internalising disorders and 9% had features of bipolar disorders.

11.3.4 For reintegrating them into society, regular follow up support, provision for skill development, training in some job that will help them become financially

self-reliant, and individual therapy sessions, are necessary.

11.3.5 There is a need to provide these facilities in homes for CCLs to ensure their effective rehabilitation. This is a gap that needs to be addressed. In these cases too rehabilitation needs to be done on the basis of ICP which has to be ensured in all cases.

11.4 CHALLENGES TO EFFECTIVE REINTEGRATION AND REHABILITATION

11.4.1 In the case of both CNCP and CCL, the main stumbling block in rehabilitation is the stigma involved. In the case of these children, especially in the case of CCLs and survivors of CSA, there is a tendency to stigmatise the child and the whole family, resulting in families becoming more vulnerable and at times having to move away from their place of residence to be able to rebuild their lives.

11.4.2 In this endeavour they need local support to establish themselves once again. Currently there is no provision for this. Attempts to ostracise the family socially, and efforts of unscrupulous elements to take advantage of the survivor have, in a number of cases, derailed the rehabilitation process and rendered nought the efforts made to reintegrate the child in society.

11.4.3 Even in the case of CCLs, a supporting environment is needed to give them an opportunity to find their bearings and rehabilitate themselves. WCD department, CWCs, the KeSCPCR, and the LSGIs all need to address this issue from their different perspectives, to ensure that effective follow up is provided even after the child is deinstitutionalized. The ICP's implementation also needs to be closely monitored even after rehabilitation to ensure its efficacy, as envisaged in the JJ Act 2015.

11.4.4 The *KAVAL* project initiated by the WCD department addresses this issue by providing the much needed psychosocial support to CCLs. It would be useful to review the implementation of this initiative to examine how many CCLs are fully integrated. Where there was no success or only partial success, the reasons need to be identified for corrective action.

11.4.5 A similar handholding mechanism for CNCPs has been initiated in 7 districts through the *KAVAL PLUS* project. Both these good initiatives need to be supported to cover all the districts, for which appropriate budgetary support needs to be provided.

11.4.6 There is also a need to involve the family in the rehabilitation process. They too need appropriate hand holding and support to understand where their safety net failed, how they can provide support to their children in future, and help them rebuild their life. If this is not done, the child goes back into the same environment in which the violation occurred, with hardly any chance of making a fresh beginning.

11.4.7 Today, this engagement with the parents is very limited or none at all for a number of reasons. In some cases it is financial constraints to attend such sessions, while in others it could be due to job or family constraints or the distance factor.

11.4.8 However, the requirement of such counselling sessions is critical to the success of the rehabilitation process and needs to be standardised and ensured, providing support to the families, where necessary, to facilitate their attendance at these

sessions.

11.4.9 A recent study conducted in 2019 by the Mahila Samakhya in respect of children who passed through their home in Wayanad highlights the problems if that gap is not effectively addressed. Therefore any scheme to involve the parents in the rehabilitation process merits attention.

11.5 TACKLING REHABILITATION ISSUES OF CHILDREN WITH SPECIAL NEEDS

11.5.1 Existing facilities: WCD department, through the Nirbhaya cell, has set up homes in all districts except Pathanamthitta for CSA survivors.A separate Home has also been set up in Ernakulam district for survivors above 16 years of age who are not interested in pursuing higher studies or who are dropouts. Here they are given an opportunity for skill development aimed at securing livelihood, based on scientific assessment of their interests and capabilities.

11.5.2 There is also a Model Home for approximately 150 girls which seeks to provides the required support services. Two SOS Model Homes have been started in Thiruvananthapuram to cater to CSA survivors below the age of 12 hailing from the four southern districts upto Alappuzha with the objective of providing them a homely environment.

11.5.3 A separate home is functioning in Thrissur which caters to the special needs of CSAs with behavioural problems, both major and minor. Here they are provided specialised care with the help of psychiatrists and psychologists and supporting systems.

11.5.4 Proposals on the anvil: Among CSA survivors, there are children in varying stages of pregnancy. Whether they need MTP, or complete full term and go through the delivery process, specialised care is proposed to be given through an Integrated Care Centre which is proposed to be set up shortly. Another Home, based on the SOS Village model, is proposed to be set up in Palakkad during the current year for children hailing from the northern districts.

11.5.5 There are CSA survivors who cannot be rehabilitated within the fold of their families for varying reasons. In these cases, where they are interested in pursuing studies, they need to be provided the support of an After Care Home after they turn eighteen, and assisted to obtain a placement based on their qualifications and skills, so that they become financially independent. There are also survivors with disabilities, who cannot be rehabilitated within any home and who require special arrangements to support their special needs.

11.5.6 At present there are no arrangements in place for them. This is an important gap that needs to be addressed. For the latter, a facility where they can be accommodated and where they can remain active and productive based on appropriate skill training, needs to be considered. WCD department needs to formulate proposals to address these gaps which will need to be supported with appropriate budgetary allocation.

11.6 NEED TO REDUCE THE REPEATED RE VICTIMISATION OF CSA SURVIVORS

11.6.1 One of the main challenges in the case of CNCPs who have suffered abuse, especially child sex abuse, is the revictimisation that the survivors have to undergo both in the process of getting redress and justice for the wrong done to them, and subsequently when rehabilitation is undertaken.

11.6.2 Though there are clear directions about protecting the identity of the child and respecting his or her privacy, the systems available today are not geared to ensure this, and the child has to undergo the trauma of having to repeatedly face the accused at close quarters.

11.6.3 This unhappy situation can be redressed by (1) ensuring that appropriate infrastructural support is provided in Special Courts and reception centres where the formalities can be completed while safeguarding their rights, and (2) by sensitising the persons interacting with these children regarding the provisions of the guidelines issued for professionals handling such cases, and monitoring their implementation effectively.

11.6.4 In Kerala, infrastructure has been created for 14 One Stop Crisis centres for management of all the formalities once a CSA survivor comes into the system. They are yet to become fully operational. If video conferencing facilities are provided in these centres, then recording the section 164 statement of the survivor using video facilities can be done in the OSC itself, as has been done in some states.

11.6.5 Even for trial, if similar video conferencing facilities are provided in the Special Courts, as has been done in Delhi, the child could participate in the judicial proceedings and give testimony from this facility itself. This would not only help the child to better cooperate with the judicial process but also help remove the trauma of coming face to face with the accused, and being threatened or offered inducements to recant the charges.

11.6.6 Even the support person could be accommodated with the child in the same "child friendly" room in the OSC when the statements and testimony are recorded. This measure would certainly help eradicate the repeated victimisation that a survivor presently undergoes and speed up the recording of statements. Therefore these proposals are worthy of support.

11.7 THE WAY FORWARD IN PROVIDING CARE AND PROTECTION

11.7.1 In consonance with the basic principles of child rights, it is in the best interest of children to be with their families .Till 2017, there were around 51,000 odd children under institutional care in the state. With the institutions providing child care being required to register themselves under the JJ Act 2015, the numbers almost halved, and with COVID 19, when institutions were required to send children to their homes, the number is now understood to be approximately 5000. Therefore, going forward, this is a very good opportunity to ensure that children are not placed unnecessarily in institutions.

11.7.2 More focus and support must be given to support Sponsorship and Foster care and to smoothen any wrinkles in the management of these programmes. Financial support must also be given through budget support to ensure that the pace of

Sponsorship is maintained.

11.7.3 This does not in any way mean that institutionalisation can be totally wiped out. There will always be some children, including children with disabilities, who cannot be given a placement in a home setting for various reasons. There are also short term requirements for institutionalising children who are CSA survivors. These requirements will continue and each case will need to be decided on individual merits.

11.7.4 However, there are a large number of cases where children are placed in institutions merely because of lack of easy access to education. In such cases, facilities like the Gotrasarathy project need to be provided by the LSGIs. This issue needs to be given some priority by the LSGIs, especially those in remote areas, tribal belts etc, and they need to be given appropriate budgetary support.

11.7.5 Where children are institutionalised because families have difficulty in keeping them safe when they are out working, the possibility of having a Day care centre or a Community Activity centre where they can be safe at the village level need to be considered.

12. ENSURING CHILD FRIENDLY JUSTICE DELIVERY SYSTEMS

12.1 ISSUES FOR DISCUSSION

- Need for child friendly infrastructure in Special Courts and Family Courts.
- Improving the case settlement process and payment of victim compensation.
- Plight of children in legal proceedings where they are a collateral party.
- "Child friendly" approach in the police system.

12.2 PREAMBLE

12.2.1 Every child who is compelled to interface with the law either directly, due to their own actions or experiences, or indirectly, because their parents are involved, has to interact with the judicial system. This interaction should ideally happen in an environment that is "child friendly". However, that is hardly the situation today.

12.2.2 In cases attracting the provisions of the POCSO Act, the need to protect the rights and dignity of the child, throughout the entire enquiry and judicial proceedings, have been specifically emphasised, be it in the police station, the hospital, or the court. But the infrastructure and resources currently available do not fully comply with that requirement.

12.2.3 With 14 new Special Courts being set up, there is an opportunity to rectify the situation with the support of the Courts. Child friendly infrastructure needs to be ensured in all these 14 Special Courts for which they will need to be provided budgetary support.

12.3 NEED FOR CHILD FRIENDLY INFRASTRUCTURE IN SPECIAL COURTS AND FAMILY COURTS

12.3.1 Children are required to attend Family Courts in the context of custodial issues relating to divorce or when accompanying their parents in matters connected with domestic violence. Handing over custody of a child to the divorced partner happens in the premises of Family Courts in many cases. Simikarly, during the divorce

proceedings, children, including babes- in -arms, have to wait endlessly with their parents till their case is called.

12.3.2 There are no infrastructural arrangements to support breastfeeding mothers, nor are there any facilities to keep their children engaged during this long wait. It is understood that some courts in the country have woken up to this need and have addressed this issue. This gap needs to be bridged in Kerala with the support of the Courts.

12.3.3 Children are victims of collateral damage in cases involving divorce of their parents or in cases connected with domestic violence. Yet there is no space currently available to redress the violations that they suffer of their rights as a result of being a silent but integral part of these proceedings. There is a need to look into this aspect of the problem to explore how the adverse impact that children suffer from this experience can be alleviated, since it creates a life long, negative effect on the children.

12.4 THE CASE SETTLEMENT PROCESS AND THE PAYMENT OF VICTIM COMPENSATION

12.4.1 Initially, Special Courts were set up only in 3 districts to exclusively handle POCSO cases. In the remaining districts, when these cases were handled in Sessions Courts that were merely designated for the purpose, delays were noted because of the workload involved.

12.4.2 Now that Special Courts have been set up in all the 14 districts, there is an improvement in the speed of disposal of cases, although some cases of 2013 and 2014 continue to show pendency. There is a need to address this issue by reviewing the causes for such delay and taking remedial action.

12.4.3 The related issue is the lack of child friendly infrastructure (which has been referred to previously) and which needs budgetary support. The delays in recording the Section 164 statement of the child are yet another area of concern.

12.4.4 It is necessary to ensure that timelines stipulated for these activities are scrupulously maintained to protect the best interests of the child by providing a suitable supporting environment for the child to cooperate with the proceedings without fear and hesitation.

12.4.5 Survivors of CSA are eligible for compensation under the Victim Compensation Scheme, implemented with reimbursement support from the Central government, as well as under the *Aswasanidhi* scheme of the State government. The first scheme is managed by the Legal Service Society and the other by the Nirbhaya cell of WCD, both funded through budgetary provisions.

12.4.6 Support under the Victim Compensation Scheme is given based on applications received from the survivor and there is also a provision to give interim compensation in certain circumstances. However, this scheme is yet to stabilise.

12.4.7 In 2020, only 182 applications were received through the Courts in all by the DLSAs for compensation (120 for interim and 52 for final) while 31 were received directly by the DLSAs (15 for final and 16 for interim relief). These figures are far lesser than the number of cases settled by the Courts during the same period. In all,

225 beneficiaries received relief under the Victim Compensation Scheme. At the same time 108 applications were received by the DCPOs under the Aswasanidhi scheme of which 87 were settled. Compensation given also ranged from Rs10, 000 to Rs. 500,000.

12.4.8 While the amount of compensation varies according to the elements of each case, there is a need to review the scheme's implementation to see whether the minimum compensation being given is in accordance with the amended provisions of the Victim Compensation Scheme.

12.4.9 A related issue is about the utilisation of the compensation given to the children. At present no stipulations are made on the utilisation of these funds. Therefore it is understood that these funds are often used by the families for their own needs rather than for rehabilitating the survivors.

12.4.10 This defeats the very purpose for which the scheme has been set up. There is a need to look into the pattern of utilisation of the compensation given to victims, and examine if some arrangements can be put in place to help the survivor in managing these funds for their rehabilitation so that the objectives of the scheme are achieved.

12.5 PLIGHT OF CHILDREN IN LEGAL PROCEEDINGS WHERE THEY ARE A COLLATERAL PARTY

12.5.1 There has been a widespread discussion, and even modifications made in the legislation to redress grievances that male partners have regarding the implementation and provisions of the DV Act 2005. However, very little concern has been expressed about the effect it has on children of such families who continue to suffer silent collateral damage, mentally and at times physically, due to the violence that precedes action under the Act, and thereafter when implementing directions given by the Court under the Act, (which are often not acceptable to the male partner, and at times his family) resulting in all manner of actions that threaten the safety and well-being of both the aggrieved spouse and the children. This situation, that violates the rights of children for sustained periods, needs to be documented and the possibility of providing relief, including counselling support to children, needs to be considered.

12.5.2 The same is the situation in the case of many divorces happening today. There too, children suffer collateral damage which is not being taken into consideration during the proceedings which is currently focussed only on the husband and wife.

12.5.3 Where children are involved, besides the trauma of the separation, they face the additional trauma of being induced to support one or the other parent. Unless the parents themselves decide to keep children out of the proceedings, they will, willy-nilly, be dragged into the proceedings.

12.5.4 Therefore the impact that such situations have on children where they are nothing but collateral participants needs to be studied in depth and understood, to consider how best the impact of the divorce proceedings can be reduced for the children

12.6 "CHILD FRIENDLY" APPROACH IN THE POLICE SYSTEM

12.6.1 Another aspect of the justice delivery system that children are required to interface

with relates to the police and police stations. Section107 of JJ Act 2015, Rule 86 of the JJ Rules 2016, and Sections 19 and 24 of the POCSO Act 2012 lay down very specific provisions about the handling of children through the police system, including the need to avoid wearing uniforms when looking at cases of CSA, to make children comfortable when taking their statements, to ensure that inquiries under the POCSO Act are completed in a time bound manner, and investigations completed speedily.

12.6.2 There are also clear provisions about having Special Juvenile Police Units (SJPU) which are manned by persons who are trained to manage children's issues in a child friendly manner. While efforts are being made to comply with these provisions, these are yet fragmented, and much needs to be done, be it in the matter of registering a complaint, investigating it, or filing the case in court speedily.

12.6.3 There are still reports about the police not registering cases reported to them citing numerous reasons. The lack of uniformity in the approach from case to case and from individual to individual in the system (despite training and sensitisation programmes being provided regularly), and difficulties in getting speedy response from the forensic labs where the capacity to respond is challenged by the increase in the number of cases, are all issues that still need to be resolved.

13. EFFECTIVENESS OF PROTECTION MECHANISMS AT THE GRASSROOT LEVEL

13.1 ISSUES FOR DISCUSSION

Status of :

- DCPCs and VCPCs
- Jagratha Samithi
- Child Protection Committees in schools
- The GramSabhas/ BalaSabhas

13.2 PREAMBLE:

13.2.1 DCPCs and VCPCs have been provided under the ICPS scheme by Government order to promote and protect the rights of children at the grassroot level with the support of identified stakeholders. These forums are important to help redress issues taking into account the local context and also as a convergence point for all the stakeholders involved in providing safety and protection to children through the respective services and systems that they offer.

13.2.2 Unfortunately, these committees are yet to function optimally. Last year, the KeSCPCR took the initiative to hold training and sensitisation sessions in selected panchayats to promote child rights literacy and the importance of the role that these committees play in promoting it.

13.2.3 In this context it needs to be mentioned that currently at the district level, there is the DCPC involving the people's representatives as well as the JJ Committee involving the judiciary, that are both addressing protection issues of children. This causes an overlap, though both of them are critical pillars in the JJ system. So it is important to have some clarity in their roles to ensure their effective functioning.

13.2.4 Jagratha Samithis are required to be set up to address complaints, challenges, and vulnerabilities faced by residents at the ward level of every Panchayat, and to protect the rights of women and children. They function under the LSGIs. VCPCs are also envisaged to function under the LSGIs but they are yet to take off. There is some overlap in the functioning of both these entities, resulting in their non-functioning or less than optimum functioning, especially in the case of VCPCs. This is an issue that needs to be addressed

13.2.5 Currently, there is some level of ownership displayed by the panchayats for the Jagratha Samithis.How this can be leveraged to provide better support to children and families at the ward level needs to be given greater attention.

13.2.6 Child Protection Committees (CPCs) are similar committees at the school level that help the school in addressing the many challenges to children's safety when in school or its neighbourhood. It comprises all stakeholders involved in this exercise, including school authorities, parents, children, the ward member, police, excise officers, and representatives of vendors and auto drivers in the neighbourhood. The issues addressed by it include physical threat to safety, threats posed by substance abuse, (especially tobacco and drugs), and through internet related activity.

13.2.7 In this context, members of the Committee have a major role to play in ensuring safety in the school premises, and in sensitising the students, PTAs /SMCs, and the local governments to support decisions taken by them. At present these committees are not functioning in many schools. Therefore, this needs to be reactivated with the support of the Education department and the LSGIs.

13.2.8 Children's right to participation and to have their voices heard in matters concerning their rights is an issue that is accepted in principle but needs to be translated into concrete action. To this end, platforms like the Bala Sabha, Children's GramaSabha have been created.

13.2.9 However, they are not functioning uniformly in all panchayats. They need to be activated and children's opinions heard in matters relating to their protection as well as in all other matters that affect their lives. To this end, LSGIs need to be directed to activate these forums.

14. GOOD PRACTICES

14.1 *KAVAL* and *KAVAL PLUS* projects of the WCD department which seek to provide psychosocial support to CCLs and CNCP during the period of reintegration after deinstitutionalisation.

14.2 Parenting Clinics, another WCD department initiative, which seek to provide support to parents in handling parenting issues with the help of trained counsellors.

14.3 Our Responsibility to Children(ORC), an initiative under the WCD department, that seeks to identify and scientifically address deviancies and vulnerabilities of children and integrate such children in the social mainstream by enhancing life skills, by promoting mentoring and good parenting, by nurturing strengths and addressing risks.

14.4 Saranabalyam, an initiative of the WCD department to identify cases of child

labour in the state and rehabilitate children involved in such situations.

15. RECOMMENDATIONS

15.1 CHILD SEX RATIO

15.1.1 A study should be done of the recurrent reduction in child sex ratios in certain contiguous pockets of the state to understand the reasons, and for taking corrective action.

15.1.2 The functioning of the Advisory Committees and the Appropriate Authorities constituted under the PCPNDT Act 1994 needs to be reviewed to assess their compliance with its provisions in terms of their constitution which calls for mandatory representation of women, as well as the objectives of the statute.

15.1.3 Since decline in child sex ratio is noted at the sub district level, the Advisory Committees under the PCPNDT Act 1994 should be directed to look into the sub district data in all cases where there is a decline below 952, instead of focussing only on district level data.

15.1.4 In places where there is a decline in the child sex ratio, the ICDS workers need to be directed to look into the matter, based on data from their own sources as well as the data on births from the LSGIs, and draw the attention of the Advisory Committee to such decline.

15.2 REGARDING CHILD MARRIAGE

15.2.1 An effective campaign against child marriages needs to be launched across the state sensitising both boys and girls in schools, as well as parents and all other stakeholders. The social and economic cost to society and the individuals and also its impact on the next generation needs to be made part of this campaign besides the violations to child rights and its consequences.

15.2.2 LSGIs need to be directed to update their databases on births so that this information is readily available if applications are to be submitted for obtaining injunctions from courts against child marriages at short notice.

15.2.3 Given the direct corelation between the drop out phenomenon in schools and the incidence of child marriage, monitoring of dropouts and bringing them back into the system should be given due importance, giving special attention to children from vulnerable sections of society, including migrant children. LSG, Education and WCD Departments need to work together for effective results.

15.2.4 Since parents are mainly responsible for the violation of child rights in cases of child marriage, and they do so due to financial concerns and worry over their children's future, LSGIs can play a part in supporting parents to conduct weddings after reaching the legal age by helping with arrangements that will reduce their financial burden.

15.2.5 In order to contain the problem of child marriages among tribals and the debate about protecting tribal customs, a campaign needs to be undertaken that focuses on the many adverse outcomes of child marriage on the future of the tribal community as a whole in the changed circumstances of their lives, their health and the health of children born to them.

15.2.6 Since the accused men are often incarcerated for some spells in prisons, even that could be used as an opportunity for counselling them and creating awareness about the legal provisions, either through the prison support system or the counselling facilities of the WCD department, or a combination of both.

15.3 REGARDING CHILD LABOUR

15.3.1 An initiative like the Saranabalyam project needs to be continued and follow up action taken to rehabilitate the children.

15.3.2 Stern action should be taken against persons responsible for violation of labour laws relating to children. Since information on this issue is scattered across various implementing agencies, an effort must be made to consolidate it to create a single database that will facilitate follow up action, which includes enforcing the provision for compensating these children by the employer for such violation. A study on this issue could be undertaken by KeSCPCR to understand the gravity of the issue and report to the Government.

15.3.3 In the post COVID19 scenario, when an increase in child labour is anticipated due to straitened financial circumstances of socially and economically vulnerable families, and inadequate monitoring of labour laws pertaining to children over 14 years of age, there is need to take special efforts to monitor drop outs in vulnerable areas and provide relief to support such families and deter employers from employing children illegally. The Labour, WCD, LSG, and Education departments need to take coordinated action in the matter.

15.4 SAFETY IN CRECHES AND PRESCHOOLS

15.4.1 In order to ensure a safe, "child friendly" environment for children in creches and preschools, it is necessary to prescribe standards and regulate the functioning of these facilities. Functioning of Day care centres also to be regulated as part of creches.

15.5 SAFETY IN PUBLIC SPACE

15.5.1 The standards stipulated in the RTE Act 2009 should be strictly enforced by the Department of Education with the support of the LSGIs to remove the shortcomings in infrastructure that affect the safety and well being of children.

15.5.2 The existing infrastructure and facilities in hostels/ residential facilities run by the Government for children may be reviewed, from the perspective of child rights, gender and the disabled. Gaps need to be identified and rectified.

15.5.3 To protect child rights, minimum standards may be stipulated for tuition centres, hostels and other training centres for children for mandatory self certification by these facilities, and for ensuring transparency about their systems and facilities.

15.5.4 With a view to ensure adequate protection to children with disabilities and also to overcome the currently high rate of dropouts, time bound action is needed to make the physical facilities in schools compliant with the provisions of the RPWD Act 2016 Schools need to prepare a plan of action to do this in a phased manner with the support of the LSGIs for which necessary funds need to be given.

15.5.5 When creating public services that are also accessed by children, it is necessary

that their requirements are also factored in when designing the infrastructure and systems. Therefore, it is recommended that all such facilities and services must be assessed from the point of view of their sensitivity to cater to the needs of the child, gender and the disabled. Such an assessment should be made a part of the process of approvals. A similar assessment may be made of existing services and corrective steps taken to make them more "child friendly".

15.5.6 At present, due to lack of child right literacy among the public, parents and other stakeholders believe that all decisions taken by them on behalf of the child are in the child's best interest, though that may not necessarily be so in all cases .

15.5.7 To prevent and rectify such discretionary application of child rights leading to violation of these rights , and to place a proper understanding of these rights in the public and private spheres, it is necessary that a well designed, sustained and effective campaign that communicates the fact that child rights are inalienable entitlements, needs to be undertaken.

15.5.8 Resident Welfare Associations and other local bodies can play a major role in protecting child rights. Efforts must be made to sensitise them on all aspects of child rights and make them partners in promoting child friendly systems, including as possible venues for Parenting and Nutrition clinics.

15.5.9 A major problem faced by children is the lack of safe spaces to interact and engage in physical activities. LSGIs need to take an audit of the availability of grounds for children, including girl children, to engage in recreational activities, and to consciously create one play ground with such facilities in every panchayat during this plan period.

15.5.10 Given the increasing number of cases where neighbours have been involved in cases of CSA, there is a need for creating a community centre in every panchayat which provides a safe space for parents to leave their children so that they are not alone when the parents/ guardians are not home. This centre could be made a focal point for children to also take up various activities. A model centre should be tried out in every district and then upscaled, giving priority to economically and socially disadvantaged areas.

15.5.11 An attempt was made in the past to do a vulnerability mapping of children to improve the support and protection that can be given to them. There has been no further progress thereafter. This is an initiative that needs to be pursued as it will give a boost to efforts to undertake proactive, preventive measures at the grassroot level.

15.6 PROTECTION OF CHILD RIGHTS WITHIN THE DOMESTIC ENVIRONMENT

15.6.1 To promote the importance of parenting as a key tool for raising children, an IEC initiative may be taken up to create public awareness about its importance, among parents as well as the young.

15.6.2 In communities or groups where counselling is already prescribed as a mandatory requirement before conducting the religious ceremony for consecrating the

marriage, the possibility of including parenting as part of their existing course must be explored. Another option is to link a session in parenting at any Parent clinic or approved counselling centre as a mandatory requirement prior to obtaining the marriage certificate from the competent government authority.

15.6.3 Where children have committed petty offences that bring them before the JJB, they are charged fines / given counselling etc in some of the cases. Parents too are required to participate in counselling in some cases.The possibility of prescribing counselling for parents in all cases where counselling is involved, as a part of the order of the JJB, needs to be considered, as the parents too share a responsibility to society for such lapses, and need to take corrective action beyond the payment of a mere penalty to avoid recurrence of such offences.

15.6.4 To tackle incidents of violence and abuse against children in a uniform, systematic and time bound manner, there is a need to put in place a protocol. Such a protocol had been drawn up in 2014 but it does not appear to have been used thereafter. The protocol developed for this purpose in 2014 needs to be updated and put into effect in all cases so that there is comprehensive, systematic and time bound action.

15.7 REGARDING CHILD SEX ABUSE

15.7.1 Given the nature of child sex abuse and those primarily responsible for it, there is need to promote local support groups like the VCPC and the Jagratha Samithis that can initiate preventive action and also provide effective support .

15.7.2 A common facility for working mothers from vulnerable backgrounds needs to be considered for care of children when they are out work, at the Panchayath level to prevent the increasing incidence of CSA from relatives and neighbours.

15.7.3 Although SCRB data relating to POCSO cases are collated and reported to the Government, by KeSCPCR annually, it is seen that in a significant number of cases crucial details about the accused are not available. This needs to be taken up with the police department and action initiated to avoid such loss of data.

15.8 MENTAL HEALTH

15.8.1 Necessary support may be given to create appropriate infrastructural facilities in medical colleges and de addiction centres for the treatment of children with chronic mental health problems and addictions that require medical intervention.

15.8.2 To promote protective factors that can counter risk factors, it is necessary to ensure physical and co curricular activities in schools. This includes the revival/ creation of a playground in every school or attached to a school, as required under the RTE Act 2009.

15.8.3 There is a need to review the activities currently being undertaken by different departments in government to tackle mental health and related issues, and explore the possibility of better coordination and pooling of resources. The possibility of using the resources of professionally managed NGOs with proven expertise in tackling mental health issues could also be used to support government initiatives.

15.8.4 Implement *Ullasaparavakal* in schools from the next academic year by providing necessary funds to print it and supplying it along with other text books.

15.8.5 Create greater awareness about mental issues to help remove the stigma around it and also to popularise the support systems available.

15.8.6 In matters relating to mental health and addiction issues in schools, there is a need to ensure that parents are made a part of the counselling process.

15.8.7 Teachers and parents need to be educated about Positive Discipline and Effective Parenting so that they are able to guide their children better.

15.9 CARE OF CHILDREN IN INSTITUTIONS

15.9.1 Contrary to current practice, it needs to be ensured that rehabilitation of all CCLs and CNCPs are done only on the basis of Individual Care Plans. This needs to be regularly monitored as it is a statutory requirement and the key to systematic rehabilitation of the child.

15.9.2 As the authority in whom the statutory responsibility of ensuring the effective implementation of the JJ Act is vested, KeSCPCR should undertake the quarterly review of this issue and furnish the status and corrective action initiated in its annual report to the Government. This data could also be placed before the JJ Committee of the High Court for review and necessary follow up and action.

15.9.3 Rehabilitation of all CCLs and CNCP who are institutionalised needs to be done effectively to ensure their early rehabilitation. To do so, SOPs must be prepared to ensure that standard procedures are followed in each category of cases.

15.9.4 Existing best practices for providing such support, as available in the Boys home in Thiruvananthapuram, where a mentoring and life skills programme has been initiated with the support of the NSS unit of the Government Medical College Thiruvananthapuram, may be considered for replication in other centres.

15.9.5 There is a need to involve LSGIs in the process of rehabilitation to provide local support to survivors or CCLs and their families to avoid the stigmatisation many of them face.

15.9.6 Where families of survivors do not have a home of their own, the possibility of providing such support must be considered at the request of the WCD department, by including them in the LIFE programme, as a special component, to avoid long term institutionalisation.

15.9.7 Family counselling prior to the release of children from institutions must be made mandatory as required under the JJ Act 2015. To facilitate them to attend these sessions, where necessary, financial support for travel and stay must be considered as part of a scheme, for which necessary budgetary support may be provided.

15.9.8 For ensuring effective psychosocial support to CCLs, the KAVAL project must be continued and necessary budgetary support provided.

15.9.9 Since effective reintegration of CCLs can be ensured only if they have economic independence, it needs to be ensured that every child is given necessary skills according to his or her aptitude and the market requirements. In this context, besides the traditional training avenues, newer possibilities can also be explored with the help of the NGOs.

15.9.10 *Kaval Plus* project, currently under implementation on pilot basis in seven districts

for CNCP, needs to be extended to all the districts. For this budgetary support may be provided.

15.9.11 There must be regular review of the efficacy of the Kaval and Kaval Plus projects so that timely feedback and corrective action is taken.

15.9.12 To provide continued support to survivors who wish to continue their education after 18 years of age, and who cannot be rehabilitated in a home setting, an After Care Home needs to be established where they can be supported till the completion of their education that will enable them to be financially independent. The WCD department may prepare a scheme for providing this facility, which needs to be supported.

15.9.13 To rehabilitate survivors with severe disabilities who cannot be placed in a home setting, there is a need to provide a facility where they can be housed for their lifetime after giving training appropriate to their capabilities so that they can remain productive during their lifetime.

15.9.14 To avoid repeated victimization of survivors, the newly set up One Stop Centres could be made the focal point in each district, for recording the Section164 statement of the child as well as for giving evidence during the trial proceedings. This will also help to reduce the current level of delay in recording this statement.

15.9.15 For implementing the above suggestion, necessary facilities need to be set up in One Stop Centres as well as in the Special Courts. A proposal may be made to provide this facility in conjunction with the Police department and the Courts, which needs support through the Budget.

15.9.16 To continue the efforts at deinstitutionalizing children in need of care and protection, through Foster care, Sponsorship etc, adequate resources may be made available in the budget to support the Sponsorship programme.

15.10 ENSURING CHILD FRIENDLY JUSTICE DELIVERY SYSTEMS

15.10.1 Keeping in mind the difficulties faced by children who have to wait for long spells in court premises, there is a need to provide " child friendly" arrangements for both young mothers and children to alleviate the stress and tedium of the whole process.

15.10.2 Where it is not possible to provide such facilities in the courts for want of space, it is proposed that the transfer of custody could be arranged in the district's new One Stop Centres.

15.10.3 Given the low figures of applications for securing compensation under the Victim Compensation scheme, action needs to be taken to ensure that all victims are advised of this facility as well as the support available under the Aswasanidhi scheme with the help of the CWCs/ DCPOs, so that no eligible beneficiaries are denied this support.

15.10.4 Courts need to be sensitised about the amended provisions of the Compensation scheme so that their recommendations are in consonance with these revised provisions.

15.10.5 At present there are no stipulations regarding the utilisation of the amount given

under the Victim Compensation Scheme to ensure that the funds are used for actual rehabilitation of the victim herself. A study may be made of the utilisation of funds given to survivors over the last few years, and if the facts substantiate the above concern, then the possibility of managing at least a part of the funds for rehabilitating the survivor, for earning a livelihood, needs to be considered.

15.11 CHILD FRIENDLY APPROACH IN POLICE STATIONS

15.11.1 The gap between the expectations under specific provisions in the JJ Act 2015 and the POCSO Act 2012 for creating a child friendly approach in the police system when handling matters relating to children, and the current ground reality needs to be bridged through greater levels of sensitisation, and by empowering SJPUs.

15.12 PLIGHT OF CHILDREN WHO ARE PART OF LEGAL PROCEEDINGS AS A COLLATERAL PARTY

15.12.1 In matters relating to divorce proceedings and also in cases of domestic violence, although children are an integral part of the proceedings, no space is available to address the suffering and trauma that they have to undergo. There is a need to examine how best the interests of these children can be protected and whether children in these situations should be given counselling and support so that their basic rights and well being are protected.

15.13 EFFECTIVENESS OF PROTECTION MECHANISMS AT THE GRASS ROOT LEVEL

15.13.1 Though many mechanisms have been provided at the grassroot level to protect the interests of children, none of them are functioning effectively or regularly. Their functioning needs to be strengthened. These protective mechanisms include the VCPCs/ DCPCs, the Jagratha Samithis and the School Protection Committees. The Bala Sabhas and Grama Sabhas are platforms available where the children themselves can participate and lend voice to matters concerning their lives. They are not unfortunately being held regularly. This needs to be revived across the state. The Departments of LSGI, Education and WCD need to take action to get these committees activated and regular meetings held.

15.13.2 Protection of children and their rights is a responsibility that needs to be shared by all the stakeholder departments to ensure that the child has a secure safety net to enjoy his or her rights during childhood. Hence close coordination among them has to be ensured in implementing these laws to protect the best interests of the child.

15.14 GENERAL

15.14.1 Every statute dealing with children requires the Government to create awareness about its provisions among the public. Even KeSCPCR is tasked with this responsibility. There is a need to undertake this proactive measure to educate the public on the provisions of the statutes, its objectives, and mode of its implementation. Necessary action must be taken during the Plan period to

disseminate this information and thus create awareness about the various statutes that seek to protect the rights of children.

16. STUDIES/ RESEARCH TO BE UNDERTAKEN

16.1.1 Reasons for recurrent decline in child sex ratio in certain contiguous pockets in the state.

16.1.2 Impact of child marriages on tribal communities.

16.1.3 Status of hostels set up by the Government for SC/ST children, children from the fishing community, and for sports and arts education in the state, viewed from the perspective of child rights, gender and disability laws.

16.1.4 Effectiveness of the rehabilitation process of CCLs and CNCPs since 2012.

16.1.5 Impact of legal proceedings and their outcomes on children as collateral parties to issues connected with divorce and domestic violence in their families.

16.1.6 The status of children who live in SC colonies, fishing villages, slums, layams of Plantations, in poramboke, and in refugee settlement colonies, to understand their conditions from the perspective of basic child rights.

17. KEY INDICATORS

- No sub district to have a child sex ratio below 952
- Reduce the number of child marriages in the state by 50%
- Reduce the number of dropouts in tribal and coastal areas by 50%
- All creches and preschools to be registered under a regulatory mechanism.
- Minimum standards of care for hostels, tuition centres and sports, arts and religious training centres issued and mandatory self-certification implemented.
- Every panchayat must have a playground that provides space for children's physical activities.
- Network of Parenting clinics expanded to cover every panchayat .
- Provide a community activity centre in every panchayat as a safe space for children.
- Every institutionalised CNCP and CCL rehabilitated only on the basis of an ICP.
- All OSCs and Special courts provided video conferencing and recording facilities.
- All Special Courts have arrangements that are "child friendly,"as statutorily mandated

PROCEEDINGS OF THE MEMBER SECRETARY

STATE PLANNING BOARD

(Present: Sri. Teeka Ram Meena IAS)

Sub: - Formulation of Fourteenth Five Year Plan (2022-27) – Constitution of Working Group on **Child Development and Nutrition** – Revised Orders -reg.

Ref: 1. Order No. 448/2021/SS (CD&N)/SPB dated 10.09.2021
2. Guidelines on Working Groups

ORDER No. 448/2021/SS (CD & N)/ SPB Dated: 22/10/2021

As part of the formulation of Fourteenth Five Year Plan, Working Group on **Child Development and Nutrition** was constituted vide order referred. In the first meeting of the Working Group, it was decided to co-opt the following members.

1. Dr. Babu George, Director, Child Development Centre, Medical College
2. Dr. Anilkumar T.V, Prof. & Head, Department of Psychiatry, MCH, Tvpm
3. Dr. Amar Fettle, State Nodal Officer for Adolescent Health, National Health Mission, Tvpm
4. Dr. Preetha P.P, Additional Director of Health Services
5. Smt. Meena Kuruvila, Project Director, Rajagiri College of Social Sciences, Kalamassery

In this circumstance, revised orders are hereby issued by including above members in the Working Group on Child Development and Nutrition. The Working Group shall also take into consideration the guidelines read 2nd above in fulfilling the tasks outlined in the ToR for the Group.

Co - Chairpersons

1. Smt. Rani George IAS, Principal Secretary, Women & Child Department
2. Smt. Shoba Koshy, Former Chairperson, Kerala State Commission for Protection of Child Rights

Members

1. Smt. T.V.Anupama, IAS, Director , Women and Child Development
2. Shri. Jeevan Babu IAS, Director, Directorate of General Education
3. Smt. Anitha Damodaran, Secretary, Kerala State Commission for the Protection of Child Rights
4. Smt. Sivanya S.N, Joint Director, ICDS, Social Justice Department
5. Adv. Sreela Menon, Nirbhaya Cell Coordinator
6. Dr. K E Elizabeth, Child Nutritionist, UNICEF Consultant & Retired Professor SAT Hospital, Thiruvananthapuram
7. Shri. Shiju Khan, General Secretary, Kerala State Council for Child Protection,Thycaud, Thiruvananthapuram
8. Adv. Majida Abdul Majeed, Prosecutor, POCSO Fast track Special Court, Ponnani
9. Smt. Remadevi. L, Assistant Project Director, Kerala MahilaSamakhya Society,Department of General Education
10. Dr. Aswathy. P, ICDS Supervisor, ICDS Project Office, Alangad
11. Shri. K. T. Radhakrishnan, Former President, KSSP
12. Smt. K.K.Prasannakumari, General Secretary, Anganwadi Workers & Helpers Association
13. Dr. Peter. M. Raj , Associate Professor, KILA
14. Dr. Babu George, Director, Child Development Centre, Medical College

15. Dr. Anilkumar T.V, Prof. & Head, Department of Psychiatry, MCH, Tvpm
16. Dr. Amar Fettle, State Nodal Officer for Adolescent Health, National Health Mission, Tvpm
17. Dr. Preetha P.P, Additional Director of Health Services
18. Smt. Meena Kuruvila, Project Director, Rajagiri College of Social Sciences, Kalamassery

Convener

Dr. Bindu. P.Verghese, Chief, Social Services Division, State Planning Board

Co- Convener

Smt. Dhanya.S.Nair, Deputy Director, Social Services Division, State Planning Board

Terms of Reference

1. To develop strategies for improving the quality of infant and early childhood care through modernising infrastructure, capacity building and teaching-learning material.
2. To suggest measures for effective coordination across the Women and Child Department and Local Self Governments.
3. To develop strategies to promote awareness on child rights, measures to protect children from abuse, violence and neglect, and effective enforcement of POCSO Act.

Terms of Reference (General)

1. The non-official members (and invitees) of the Working Group will be entitled to travelling allowances as per existing government norms. The Class I Officers of GoI will be entitled to travelling allowances as per rules if reimbursement is not allowed from Departments.
2. The expenditure towards TA, DA and Honorarium will be met from the following Head of Account of the State Planning Board "3451-00-101-93"- Preparation of Plans and Conduct of Surveys and Studies.

The order read as 1st above stands modified to this extent.

Sd/-
Member Secretary

To

The Members concerned

Copy to

PS to VC
PA to MS
CA to Member (Smt. Mini Sukumar)
Sr. A.O, SPB
The Accountant General, Kerala
Finance Officer, SPB
Publication Officer, SPB
Sub Treasury, Vellayambalam
Accounts Section
File/Stock File

Forwarded by Order
Sd/-
Chief (Social Services Division)