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Message from the Secretary ICANCL group

Dear ICANCL Members and Colleagues,

Despite hardships, the Indian Child Abuse Neglect & Child Labour(ICANCL) Group has steadily grown and achieved wide recognition within the country and from the International and Regional bodies over the past 20years (1996-2016). I take this opportunity to thank all our members of ICANCL Group for their commitment and hard work.

In developing countries, child rights, protection and sexual exploitation are intimately linked to poor socioeconomic conditions in a huge population base. Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are serious violations of UN Child Rights Convention (UN CRC) and fundamental rights of children worldwide. There is limited information available to pediatricians and allied health professionals on how they may protect these trafficked and vulnerable children? The ICANCL group successfully organized a national consultation to create awareness and sensitize the pediatricians and allied professionals how to provide medical and psychosocial services to these groups of vulnerable children at India International Centre Delhi on October13, 2016.

Every child has the right to optimal cognitive, social and emotional development. Early childhood has been recognized as the critical period for comprehensive development. Maximum development of brain occurs during the first 2 and subsequently the next 3 years and the potential lost during this period can be retrieved. The ICANCL group and partners organized a conference at All India Institute of Medical Sciences, November18, 2016 to address these issues. A detailed report of both the above meeting is enclosed in this newsletter.

We have also included a list of upcoming events, recent academic CANCL reports, updates and useful linkages for our members. The ICANCL group is a nationally registered society (registration Number S68745/2010) and more details can be had from our website www.icancl.com. Our membership is open to pediatricians and multidisciplinary professionals and anyone who is interested in protecting children. We request you to refer your colleagues to become ICANCL group members by filling the application form at the end of this bulletin.

Wishing you all a very HAPPY NEW YEAR 2017

Sincerely,

Dr Uma Agrawal
Secretary, Indian Child Abuse Neglect & Child labour (ICANCL) group (2014-2016)
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Message from the Chairperson ICANCL group

Dear Esteemed ICANCL Members & Friends,

On behalf of Indian Child Abuse Neglect Child Labour (ICANCL Group), it is indeed my privilege to introduce this PEDICON 2017 issue of CANCL News. The ICANCL group has completed 20 years since it was formed (1996-2016), at the 23rd Conference of the Indian Academy of Pediatrics (PEDICON), held at Mangalore in January 1996, under the IAP President ship of Dr RN Srivastava & Dr Swati Bhave Hon. Gen Secretary IAP. This current issue of CANCL news has an interesting article by our adviser Dr RN Srivastava, regarding brief history and significant activities of ICANCL group over the past two decades.

Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are major public health problems. Medical evaluation of CSEC and sex trafficking is an emerging area of research and practice and few healthcare settings have established screening practices, policies and protocols. The ICANCL group and partners jointly organized a National Consultation on **Child Trafficking and Commercial Sexual Exploitation of Children: Medical & Psychosocial Services for the Victims** at India International Center Annex, New Delhi, Thursday October 13, 2016. The consultation created awareness and sensitized the pediatricians and multidisciplinary professionals to prevent and respond to victims of "Child Trafficking and CSEC. The meeting addressed provision of direct medical care, anticipatory guidance, child protection systems and collaborative referrals to non medical colleagues for complex health needs and psychosocial services to victims of CSEC.

The comprehensive needs and care of children below age 6 years should receive maximum attention and investment, as early years are crucial towards achievement of full potential for children. The ICANCL group along with its partners has organized an expert group consultation to address **comprehensive early childhood care & development, focusing on preschool: child health care and learning** at AIIMS New Delhi November 18, 2016. The meeting was attended by senior Government officials from the Ministry of Women & Child Development, Ministry of Health & Family Welfare, and National Commission for Protection for Child Right (NCPCR), speakers from the Academic Universities, NGO, and Child Rights activists. The present edition of CANCL News also includes a brief report of our most recent national conference at Wayanad, Kerala (CANCL CON), focused on the theme **"How Medical Professional respond to Child Abuse & Neglect".**

Overall the 20th year was full of activities and several advocacy initiatives were taken up both at regional and national levels. We look forward to all our members to share their experiences and knowledge base. We request our members to send us their updated contact details. We look forward to your constructive feedback and suggestions.

Warm regards and sincere thanks for your support

Happy New Year 2017 Greetings to you and your families

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20 years of Indian CANCL Group

Dr. R.N. Srivastava
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IAP (1996) & Advisor
Indian CANCL Group
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Twenty years is seemingly a long period of existence for a relatively small society. However, despite facing substantial handicaps the Indian CANCL Group has steadily grown and achieved wide recognition within the country as well as from the International and Regional Bodies.

The CANCL (**C**hild **A**buse and **N**eglect and **C**hild **L**abour) Group was initiated in 1996 at the IAP Conference held at Mangalore on 4-7 January. Dr RN Srivastava was the IAP President, Dr YK Amdekar Past President, Dr A Parthasarthy President elect, Dr Swati Bhave, the IAP General Secretary and Dr Sanjeev Rai, the Organizing Secretary of the conference. The theme of the conference was "Children's Rights : Our Concern". In his Presidential Address Dr Srivastava mentioned that IAP had been doing outstanding work in promoting excellence in curative and preventive areas, particularly in developing various pediatric specialties and education. He emphasized on the need for pediatricians to take a comprehensive view of child care and try to tackle the socioeconomic issues that adversely impact health and development of children. At a plenary session on "comprehensive child care" the participants drew attention to various difficulties faced by underprivileged child population that comprised the large majority in our country. The problems of child labour and abuse of children were serious issues and IAP needed to advocate on them. There was wide support for these views.

A committee of IAP termed "Child Abuse and Child Neglect and Child Labour (CANCL) Committee" was constituted with the broad aims of addressing various problems of underprivileged and marginalised children. A small fee was charged from those becoming the members. Gradually the response grew and several senior IAP members from different parts of the country joined and took an active promotional role. Dr Indira Narayanan and thereafter Dr RN Salhan were the Chairpersons and Dr Kiran Aggarwal (Secretary) managed the activities of the CANCL Committee. The membership had reached 100 by 2003. The CANCL constitution was framed and approved at the General Body Meeting at IAP Pedicon 2003.

The preamble of the CANCL constitution includes statements that continue to remain relevant. It says "a majority of children in India face serious problems other than directly health related ones, the origins of which may be poverty, burgeoning population and deep entrenched, callous social attitudes towards children. Over a third of the child population in our country suffers from undernutrition, and lack of appropriate education and opportunities for optimal development. A large proportion is exploited in various forms, and several million (who should be in schools) contribute to the country's labour force. Governmental; (a) efforts for several years have been inadequate to tackle this serious and worsening situation". The chief objectives included to reach out to the neglected, deprived and abused children for their comprehensive needs including healthcare, education and development, rehabilitation and to protection; (b) to create social and community awareness of the problems of CAN in its various forms and child labour and; (c) to bring about attitudinal changes" .

Activities of CANCL Group during the first decade

During the initial period attempts were made to contact paediatricians interested in the problems of CAN and the difficulties facing the underprivileged children. Gradually the membership increased. Some of the activities of the CANCL Group during the first decade were as follows:

The first national conference of the CANCL Group was held at Rewa, MP, organized by Prof Harmesh Singh in January 1999. Subsequently, in February '99, at the conference of the International Society of Tropical Pediatrics held at Jaipur, the CANCL Group held several symposia on child abuse and exploitation, child soldiers (at which Dr Harendra De silva from SriLanka talked about the plight of such children), population and child health and child labour. The Pune members held a bicycle rally from Pune to Bangalore to join the Pedicon 2002, to draw attention to street children and working children.

One of our earliest meeting was on Child labour, held together with Inner Wheel (Rotarians) at which Swami Agnivesh

participated. He made a very emotional appeal to all for crusading against all forms child labour and putting these children into schools. Dr Narayanan supported his views, but recognised the difficulties in the face of grinding poverty of the child's family.

A detailed report submitted to the IAP President in 2003 (Chair Dr RN Salhan, Secy Dr KiranAggarwal, Advisors Dr Shanti Ghosh, Dr RN Srivastava, Dr Swati Bhave) mentions the Group's advocacy on child trafficking, children with disabilities and learning disorders, education for the girl child, AIDS orphans, health care strategies for street children and working children, children of sex workers, helping disabled children to get school admission and collaboration with ILO on International day against child labour (12th June). The Group participated in a large number of workshops, conferences and celebrations jointly with Govt departments and NGOs.

At a meeting of CANCL Group held on the occasion of the 30th IAP National Conference at Kolkata in 2003, Dr Kiran Aggarwal gave up the charge as Gen Secy. The members deeply appreciated the hard work done by her during the formative years of CANCL Group. Dr Rajeev Seth took over as the Secretary. Dr SR Banerjee was the Chairperson.

A CANCL Newsletter was started as a quarterly publication. The 1st and 2nd issues were released at IAP Pedicon 2002. The theme of the 2nd issue was "Girl child is asset to the nation" ! The newsletter has been regularly published thereafter. Dr Rajeev Seth was elected as the Chairperson in 2011.

Adoption of a village. The Delhi members adopted a village called Bhango in Dist. Mewat, Haryana. It comprised an impoverished and illiterate population of about 5,000 with very poor connectivity and non-existent infrastructure. Our team worked with the primary school providing assistance in teaching, meeting the health needs of children. They made regular visits over the next few years that resulted in substantial overall benefits to the village. We gained a close insight into the problems of a representative rural the community of our country, their attitudes and the difficulties of working at the ground level. A team lead by Dr Rajeev Seth has been working for several years to provide care and rehabilitation to abandoned and street children in parts of old Delhi. Our members in several States in the country have carried very notable work in the community, which has been regularly published in CANCL newsletter.

The subsequent decade

The CANCL Group was registered nationally as **Indian CANCL Group** with the Registrar General of Societies in 2010 (Reg No. S/68745/2010). The memorandum gives our constitution. It was decided to enlarge the scope of the CANCL committee and make it a CANCL Group and offer Associate membership to those outside the IAP who were working in the wide areas of child welfare (eg teachers, lawyers, social workers and experts in different fields). It continues to follow the rules of the IAP as those for a chapter/Group and submits its annual report to IAP. It participates in IAP annual conferences and hold symposia and expert talks on various CAN issues.

The ICANCL Group logo shows a boy and a girl jumping over barbed wire, which represents the shackles of abuse, neglect and child labour. The girl holds a book and the boy a ball, symbolozing education and childhood. Both girls and boys must be in school, and enjoy their childhood. The rising sun represents hope and future, perhaps assured by all those who care for children.

*ICANCL Group and **I**nternational **S**ociety for **P**revention of **C**hild **A**buse and **N**eglect (ISPCAN)*. Dr Rajeev Seth was elected as a regional representative on the council of the ISPCAN in 2012. He has regularly participated in its council meetings and its International and Regional conferences, and advised them on organizational matters.

9th Asia Pacific Conference on Child Abuse and Neglect. The ISPCAN council accepted the BID of ICANCL Group to hold this prestigious conference at new delhi in 2011. It was a major undertaking in view of the fact that such a conference had never been done in India. The Group had the support of the Ministry of W & CD, several leading NGOs and the National Law University Delhi. The conference was held most successfully on 6 -9 October, being inaugurated at Vigyan Bhawan (which by itself was singular recognition) by Hon Minister of Law and Justice, Shri Salman Khurshid in the presence of ISPCAN President and senior officials from the Ministry of Women & Child Development. There were 800 participants from 44 countries from all over the world. The speakers at the conference included leading experts on various subjects. Shri Kailash Satyarthi (subsequently a co-awardee of Nobel prize for peace) spoke about his experience with rescuing bonded child workers. A highlight was the ICANCL Group's contention that denial of health care and education to children represented a serious form of neglect. A *Delhi Declaration* was adopted by all the delegates. A book "Child Abuse and Neglect: Challenges and Opportunities" that included contributions by eminent experts was subsequently published.

Symposia. The Group has held a number of symposia on crucial childhood issues with wide representation from several agencies. Some of these include Right to Health, Child Trafficking, Care of the Preschool child and Child sex abuse. The reports have been published in the CANCL newsletter.

Advocacy and collaboration with NGOs.

ICANCL Group has closely worked with Govt agencies (NCPCR, NIPCD), Indian Medical Association, Delhi Medical Association, National Law University, Delhi and a number of NGOs including India Alliance for Chid Rights, ICCW, World Vision, PLAN, SAVE, HAQ, PRAYAS, BUDS, UDAYAN, ARPAN and many others. Our members have participated in their advocacy and policy meetings.

Our members have been carrying out working with child welfare activities in several parts of the country notably in Kolkata, Chhattisgarh, Udaipur, MP, Pune, Mumbai, Bengaluru, Kerala, Haryana and Delhi.

Recognition of ICANCL Group members. Dr Pukhraj Bapna (Chhattisagrh) is the recipient of Padmashri. Dr. Shabina Ahnad received the National Child Welfare award from President of India 2015. Dr Rajeev Seth, Dr RN Srivastava and Ms Pooja Taparia have been recognized by ISPCAN with its Distinguished Service Award.

Looking ahead

The problems of the impoverished, illiterate and marginalised population continue to plague us. Malnutrtion, lack of education and common diseases affect a majority of child population. Various forms of abuse and exploitation appear to be on the increase. The Govt has several schemes and programmes to help the children, and sufficient legal provisions exist, but limited resources have been provided and the implementation of the plans remains poor. ICANCL Group will make every effort to enlarge its membership from the medical profession (especially paediatricians), other professions and civil society. It will expand and strengthen its collaboration with NGOs and all others working for child welfare and aggressively advocate on behalf of children. We would expand our work in the underprivileged communities and inform and educate them about child rights and care of the child. ICANCL Group will closely work with similar organizations in South Asia.

Excerpts from the Presidential address given by Dr. RN Srivastava at 33rd Conference of IAP at Mangalore,on January 4,1996.

" We are now a fraternity of over 8,000 from all parts of the country and make a sizeable force. Our combined efforts can achieve a great deal for the children of our country."

"---the Academy must devote more time and efforts to tackle various other serious problems of children that affect the quality and the dignity of the child's life and prevent his optimal development.

The Academy has adopted "**Comprehensive Child Care**" as its motto. We need to be concerned with all aspects of the child's health and development, and not merely with the sick child and prevention of disease. Comprehensive Child Care entails, in addition, various aspects of child development, education, environmental aspects and prevention of child abuse and exploitation. Adverse socioeconomic factors, lack of education and overall awareness, large family size and poor rural development are the chief factors that lead to the poor quality of life for a majority of our children. In view of the large child population, the problems of underprivileged and handicapped children (using these terms in a wide sense) and child abuse and exploitation in various forms have assumed gigantic proportions.

In our country, Child Labor has recently emerged as a major issue, partly because of its economic and trade implications. The media have highlighted the plight of working children. One can only imagine what it feels to look at life through the eyes of a child who is hungry, deprived and abused. The Government is determined to eradicate child labor, and the Academy must add its might to all efforts being made by the Government and other agencies in that direction. I repeat, mere survival is not enough, and we must go beyond saving lives. We keep on saying "children are our future", but what is the future of our children? Whereas the society must rise against many injustices and evil practices, the Academy must be the advocate for children and act on their behalf.

There are many other developing countries which face similar problems of children. The 21st International Congress of Pediatrics was held at Cairo in September 95. In her Inauguration address, Mrs. Hosni Mobarak (wife of the President of Egypt) said, and I quote "increased survival with a low quality of life is not a desirable option". Talking about Comprehensive Child Care, she emphasized the educational, social and cultural aspects, besides the health needs, and called for an integrated approach taking into account all of these components.

A majority of children in our country, as in many other developing countries, face ill health and disease. Many are subjected to deprivation, neglect and exploitation. In this scenario, the Academy must play a wide role. It must speak and act. The problems are enormous, complex and almost intractable. We need to find appropriate ways to deal with each issue. I have alluded to the burgeoning population. Drastic maladies need drastic remedies. No child should come into this world as a bye product or as a side effect. But once he is here he deserves our best.

I conclude with a quote from the Declaration at the World Summit for Children held at New York in September 1990, **"Children of the world are innocent, vulnerable, and dependent. Their time should be one of joy and peace, of playing, learning and growing. Their future should be shaped in harmony and cooperation.**

I-CANCL Group Activities

December 2015-December 2016

Dr. Rajeev Seth (Chair) E-mail : icancl2015@gmail.com
Dr. Uma Agrawal (Secretary) E-mail : umaarp@yahoo.com

National Conference of the Indian Child Abuse Neglect Child Labour (ICANCL) group, Indian Academy of Pediatrics Wayanad, Kerala, December 11-13, 2015

The ICANCL group hosted a national conference at Wayanad, Kerala from Dec11-13, 2015 to sensitize pediatricians, doctors, nurses, and allied health professionals on how to identify, address, treat and manage child abuse and neglect with a multidisciplinary approach? The **theme of the CANCL-CON 2015 was "Medical Professionals Response to Child Abuse & Neglect".** Inaugural program was preceded by prayer song. Dr Madhusudanan, Organizing chairperson CANCL-CON 2015 welcomed the delegates. Dr Uma Agrawal, Secretary I CANCL Group read the Annual report, while Rajeev Seth, Chairman I CANCL Group delivered a brief Presidential address. Mr. Sreemathy Rosakuty Teacher Chairperson Vanitha Commission was the chief guest, along with Mrs. Glory Premjith, Member, Child Rights commission Kerala. After their presentation, CANCL News 2016 and Souvenir of CANCL-CON 2015 was released by them.Dr (Prof) RN Srivastava ,Adviser ICANCL Group delivered the key note address. At the end of function, Dr Sr Betty, Organizing secretary CANCL CON 2015 gave the vote of thanks. A total of 150 pediatricians and allied child health professionals, attended the conference. The conference raised the awareness of child abuse and neglect among the professionals. A workshop and symposium on basic understanding of Protection of Children from Sexual Offences Act (POCSO) Act and multidisciplinary child protection systems was organised by national expert faculty. It aimed to strengthen the capacity of medical professionals to respond child abuse and neglect. The ICANCL group pledged to exert every future effort in collectively implement the principles of protecting UN child rights, prevention and management of child abuse and neglect in all settings in India.

Pre-Conference Workshop for children and adolescents: A one day pr-conference workshop was held on December 11, 2015 for children. A multidisciplinary team comprising of child psychiatrist, clinical psychologist and psychiatric social worker from the Institute of Mental Health and Neurosciences (IMHANS), Kozhikode were the resource team for the workshop

Release of Booklet on Child Sexual Abuse (CSA) Prevention:

A booklet in Malayalam was released by experts from the Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala (an autonomous body under Govt. of Kerala), actively involved in child mental health. This booklet was prepared after discussion with a group of 50 school teachers. It was found to be very useful to empower teachers and parents on CSA prevention. We expect that parents and teachers will teach children to protect themselves from sexual abuse.

Pre- Conference Workshop for parents and teachers: A one day workshop on "Child Abuse & Neglect" was held for teachers and parents on December 12, 2016. A multidisciplinary team comprising of child psychiatrist, clinical psychologist and psychiatric social worker from the Institute of Mental Health and Neurosciences (IMHANS), Kozhikode were the resource faculty for the workshop

"IAP Kerala State started the Kerala ICANCL Group" during the CANCL-CON 2015 at Wayanad, Kerala. Declaration of New ICANCL Group Kerala was formally done by Dr KE

D Elizabeth, Professor & HOD, Pediatrics, Thiruvananthapuram & President IAP Kerala State. The following office bearers received Felicitations for their outstanding initiative: Dr Anandakesavan: I PP, IAP Kerala& Dr Shimmy Paulose: Secretary IAP Kerala. On the occasion, Dr Prof RN Srivastava stated "Kerala is the most progressive State in our country. I hope others will follow your example. Pediatricians on the whole have been wary of spending their time to address CANCL issues, but we cannot ignore them".

15th Asia Pacific Pediatric Association (APPA) and National Conference of Indian Academy of Pediatrics (PEDICON) at Hyderabad India from Jan 21-24, 2016

Indian Child Abuse Neglect & Child Labour group organized a 90 minutes sub-specialty symposium at APPA PEDICON Jan 23, 2016, 8-.30-10am, Hall 14, entitled:

"Child Abuse and Neglect in developing countries: Socio-economic dimensions".

Plenary session was chaired by Dr Professor SB Mathur, Hyderabad & Dr Bela Sachdeva, Senior Pediatrician, Abu Dhabi, United Arab Emirates **.** Dr Rajiv Tandon, Senior Technical Adviser, MNCH & Nutrition, PATH, India delivered the opening plenary presentation **"Socioeconomic dimensions and other factors in Child Abuse & Neglect in developing countries" .**Dr Shanti Raman, Community Pediatrician for Child Protection & Senior Lecturer University of New South Wales and University of Sydney, Australia **" Asia-Pacific perspectives on Child Maltreatment: What can Pediatricians do?"** Dr Prof Yogesh Sarin, Director Professor, MAMC, Delhi moderated the **Panel Discussion " Child Abuse & Neglect in developing countries.** The panel speakers included Dr Sandhya Khadse, Prof & Head, department of Pediatrics, BJMC, Pune **;**Dr Devendra Sareen, Professor of Pediatrics, Udaipur:Dr Achamma Joseph (Sister Dr Bettty), Kerala & Dr Uma Agrawal, Secretary ICANCL group. The symposium discussed how social, economic, and, educational issues impact child

care and relate to Child Abuse & Neglect (CAN). The significant **Recommendations** included " Global recommendations may not strictly apply to developing countries, where child care and protection systems are not well developed or do not reach." Moreover, in presence of socio-economic constraints and huge population sizes in developing countries, prevention of CAN is most important. Pediatricians can play an important role in prevention and response to CAN.

The 2nd biennial International Conference on Improving Standards of Care for Alternative Child & Youth Care: Systems, Policies and Practices", on 18th and 19th March 2016 at Amity University, Noida

The ICANCL group served as the technical partners at the above conference organized by Udayan Care, with special focus on South Asia. Dr Rajeev Seth chaired the session on development of care staff. Other ICANCL members, who participated included Dr RN Srivastava, Dr Uma Agrawal, Dr Yogesh Sarin and Dr Kiran Aggarwal.

The conference was attended by over 200 delegates from South Asian countries.The participants shared experiences, best practices, research and information on alternative child care, with special emphasis on the "**development of care staff"** at Children's homes. It also examined the gaps in legislative and policy environments of "**After Care"** settings in South Asian Regions. There were parallel sessions and capacity building workshops with caregivers on the first day and young adults on the second day.

The World Day Against Child Labour (12th of June is globally observed as world day against child labour)

Our ICANCL Member , Sudhir Sabat, State Convener, CACL along with the Labour Directorate, Save the Children and Campaign against Child Labour (CACL),Odisha jointly organized an event to commemorate the world day against child labour June 12th 2016 at the premises of the Labour Commissioner,Bhubaneswar. This was also in line with the SDG goal to eradicate child labour in any form which our government has also adopted. On this occasion **Shri Prafulla Kumar Mallik, Hon'ble Minister of Labour & ESI,Govt.of Odisha** graced the occasion. The event was followed by a puppet show and a drawing competition for children.

The Campaign against Child Labour (CACL), Odisha is a network of civil society organizations striving for the eradication of child labour system in Odisha since the nineties. In all districts of Odisha CACL district chapters are functioning. National & International days related to the issues of care & protection of children are observed by the CACL at District & State Level.

ICANCL group Community Outreach Program

Orphan & Vulnerable Children Program

Urban Slum Project

Dr Rajeev Seth, Dr Indira Taneja & Dr Uma Agrawal have been volunteering their professional services, along with our partner NGO BUDS at two different urban slum locations (Nizamudin railway station and Red Fort area-Mori gate, New Delhi) amongst the orphan and vulnerable children since 2003. The goal of the program is to reduce the vulnerability of children and youth living and working on the urban slums through a continuum of services that address their education, health, physical, psychological, life skills and vocational development. Families and other community members were also mobilized to address the needs of these children. The following strategic community activities have been conducted:

- Mobile health clinics, primary medical check-ups and immunization drives
- Day care facility and mid-day meals at drop- in centers
- Home repatriation for runaway children through Child Welfare Committee (CWC)
- Non formal and formal education programs
- Vocational Training programs to improve livelihood opportunities
- Annual Children's day events, cultural program, recreational activities and sports

Underserved Village Project

Despite the impressive economic strides India has made, education and access to basic health care coverage is abysmally low in rural communities. The ICANCL group, along with its NGO partner BUDS has recently adopted an under- served village Ghasera, also known as Gandhi Gram Ghasera, because of historic visit by Mahatma Gandhi to this village at the time of partition. The village is located near Nu, Mewat Haryana and has a population of over 25000. Dr Rajeev Seth, Dr Indra Taneja & Dr Uma Agrawal and their team have conducted weekly health camps in the two village anganwadi and evaluated the health needs of the community. They monitor the anganwadi's health, nutrition and pre-school education program. One of the major challenges is inadequate vaccination coverage, which leads to outbreak of vaccine-preventable diseases, poor child health and survival. The team have met Mr. Mani Ram Sharma IAS, Deputy Commissioner and Dr Rajora, District civil Surgeon, who have expressed government assistance and linked them to district health care workers, ASHA, ANM, Anganwadi and sanitation supervisors. In addition, the community team has networked with Mr. Wajid Hussain, Principal of Village Ghasera Primary and secondary school. The team will school start life skill and health education classes and health camps for the vulnerable children of this underserved village.

The ICANCL office bearers request our membership to submit their experiences of service in underserved communities, in order to learn and improve our services to children affected by abuse and neglect

Old Age Home and Children's Home

Our esteemed ICANCL member Dr. JC Sobti,Past Honorary General Secretary IMA Tel (9811175142) (email Id is drjagdishcsobti@yahoo.in & jagdishcsobti@yahoo.com) is managing an old age home project for 26 old residents, besides having 40 children, successfully rehabilitated & doing well without govt. grant. He recommends that each one CANCL member should take a project or activity to support vulnerable children.IN case some of our members want to volunteer his or her time with Dr Sobti, please do call and visit his project at the earliest

ICANCL Group North Zone Activity Report (2016)

Dr. Devender Sareen, Convener North Zone E-mail : drdevendersareen@gmail.com

1. Organized a drawing competition for destitute children with help of Suryaansh Sanstha and distributed prizes to the winners (Feb. 2016).
2. Celebrated Holi with the Institutional children of Udaipur along with distribution of sweets to them (Mar. 2016).
3. Delivered a lecture on child abuse and neglect organized for parents of children of urban slum areas (Apr. 2016).
4. Organized health camps including free health check –ups and medicine distributions in rural villages (May 2016).
5. A symposium was organized on prevention of child labour in collaboration with Rotary club of Udaipur (June 2016).
6. Health check-up of blind children of Udaipur (July 2016).
7. An awareness lecture for rural women of Udaipur for promotion of breast feeding and timely immunization of children (Aug 2016).
8. Organized a Bal-Mela for poor children of rural slum areas (Sept 2016).
9. Sensitization and awareness program for care-takers of under-privileged children (Oct 2016).
10. Healthy baby competition organized along with Rotary club of Udaipur and Rotary Panna on Bal-Divas (Nov 2016).
11. Organized a seminar on life skills for senior higher secondary school children on 3rd Dec (Dec 2016).

ICANCL Group Central Zone Activity Report (2016)

Dr. Pukhraj Bafna (Padmashri), Convener Central Zone: Email : dr_bafna@yahoo.co.in

1. Adoption of Children of a Tribal Village Chiklakasa for overall development of Children with help of IAP Rajnandgaon and Mahila Samuh under leadership of Dr. Pukhraj Bafna.
2. Adoption of a remote rural school at village Indamara for life skill development vaccination and monitoring growth chart by IAP Rajnandgaon under leadership of Dr. Pukhraj Bafna.
3. Adoption of 150 orphan children whose parents have been killed in naxalite movements of Bastar by the name of "Vatsalya" where all medical facilities including vaccination etc.
4. A workshop on " How to live with life" in Bilaspur Sindhu Samaj for Adolescents by Dr. Pukhraj Bafna in Month of October 2016.
5. A seminar at Neeraj School on " Health and Hygiene" for children and parenting session in month of July 2016 by Dr. Pukhraj Bafna.
6. An open health education camp for children at Rani Sagar Garden by IAP, Rajnandgaon.
7. A Seminar and Talk by Dr.Pukhraj Bafna at Yugantar Engineering College, Rajnandgaon on Life Skills in November 2016.
8. A Seminar on " Your Health -Our Concern"-With Interactive Session by Dr. Pukhraj Bafna at Baldeo prasad school Rajnandgaon during Science exhibition in December 2016.
9. A huge camp in a very remote tribal district Bhanupratpur, Kanker on Malnutrition management where mothers and children from 40 villages and Aangawadi/ health workers participated under leadership of Dr. Pukhraj Bafna.
10. A Guest lecture on " Health Emergencies in Schools" by Dr. Pukhraj Bafna at Chhattisgarh IAP State Conference at Bhilai in November 2016.
11. A Guest lecture on " Yoga in Adolescent Medicine" by Dr. Pukhraj Bafna in Adolescent Health Academy National Conference at Agra in September 2016.
12. Two lectures on a) Counseling Tips for Adolescents b) Teaching Spirituality to Adolescents delivered by Dr. Pukhraj Bafna at IMA meet Rajnandgaon in May-June 2016.

ICANCL Group West Zone Activity Report (2016)

Dr. Sandhya Khadse, Convener West Zone, Professor & HOD.Dept.Of Paediatrics.B.J.Medical College. PUNE. Email sandhyakhadse@yahoo.com

Meeting of city advisory board organised by child line pune was attended by dr. sandhya khadse. Lots of inputs were given on handling issues of child sexual abuse. A proposal put forward by child line for one stop center at BJMC, which is under consideration by govt of maharashtra,.Awareness and sensitisation programme for parents of hospitalised children regarding child abuse was conducted. cme on child abuse was conducted for the resident doctors and interns of BJGMC in sept. 2016.

Dr. Sandhya Khadse delivered a guest lecture at Footprints Academy Florida USA on 22nd june during summer camp for parents on child abuse. it was highly appreciated by all the participants. immunisation camp for street children was organised

at sassoon hospital in collaboration with public health dept. ICANCL group west zone have enrolled eight new life members for the year 2016. ICDS supervisors and aangan wadi workers were trained for recognising child sexual abuse and child neglect at manpada thane during one of their regular meetings in the month of August 2016.

ICANCL Group East Zone Activity Report (2016)

Dr. Sumita Basu, Convener East Zone E-mail : sumitabs@yahoo.com

East Zone activities were carried out throughout the year. Health camps for children residing in Khonjonpur which is a remote village in Birbhum district of West Bengal was done during which three children were found to have heart murmurs. Dr. Nurul Islam who is a trained Pediatric cardiologist performed their echocardiogram free of charge and they are now scheduled for surgery.

The mothers with young children were taught about benefits of breast feeding, immunization, safe drinking water, hand hygiene and proper nutrition.

The health statistics of these children have improved over the years as there has been a sustained effort to follow up these children with investigation as well as referral to appropriate place whenever necessary. My gratitude goes out to all the doctors who have come forward to help these children and also to the administration of the Ramakrishna Mission Hospital where I work for performing the investigations free of charge.

This is just a small part of my effort to improve the situation of the Santhal children residing in Birbhum which is far away from Kolkata and difficult for me to travel as often as I would like to. So the journey continues.

ICANCL Group South Zone Activity Report (2016)

Dr. Preeti Galagali, Convener South Zone E-mail : drpgalagali@gmail.com

1. Report from Collaborative Child Response Unit (CCRU) M.S.Ramaiah Medical College and Hospitals, Bangalore

   CCRU Team led by Dr Chandrika Rao, Professor of Pediatrics, examined 43 children (38 girls,5 boys) from 1st Jan to Dec 1, 2016. Each child was examined by a team of paediatrician, gynaecologist and psychiatry with nursing support. 37 were brought by the police and 6 children came with suspected abuse by parents or were referred for suspected abuse by other departments/ paediatricians.

   The other activities of CCRU were:
   1. Training of 97 nurses in Child abuse identification and initial response. 2. Training of 22 Post graduates of paediatrics and emergency medicine in SAFE kit. 3. Sensitisation of parents to child abuse on Nov 18, 2016. 4. Training of paediatric postgraduates by `Standardised patients~and retraining by OSCE. 5. Training of JSS Team of doctors and facilitated them to set up their unit. Covered by newspapers Hindu and Samuyukta Karnataka on 1 and 2 December 2016.

2. Report from Collaborative Child Response Unit (CCRU) KIMS Medical College and Hospitals, Bangalore

   CCRU Team led by Dr Srinivas, HOD, Pediatrics examined 31 cases of child physical and sexual abuse in 2016. All cases were brought by the police.Counselling and medical services were provided to all patients and their parents

3. Dr Preeti Galagali, South Zone Convener conducted the following activities in Karnataka

   • 1 April 2016: Interactive session for 50 counsellors of Samadhan Counselling Centre, Bangalore on Life Skills • 15 June 2016: Life skills session on Stress Management for 250 students of VVS PU College, Bangalore • 24 September 2016: 2 Sessions on Positive Parenting for 50 parents at Children's Academy, Dharwar • 12 November 2016: Family life education session for 100 girls of 6th, 7th & 8 th std of King's Convent, Bangalore • 26 November 2016: Chaired a session on adolescent sexuality at International Conference on Sexuality, Bangalore • 21 December 2016: Family life education sessions for 350 boys of 5th to 8th std of Silicon City Academy of Secondary Education, Bangalore

Children Day Celebration, November 14, 2016

The ICANCL group, IAP Delhi & Delhi Medical Association co-hosted this year's Children's Day along with local NGO partner along with our NGO partners Bal Umang Drishya Sanstha (BUDS) India on November 14, 2016 from 11-4pm at DMA auditorium, Daryaganj, New Delhi. The event benefited more than 250 orphan & vulnerable children from various slums of Delhi. The children got an opportunity to participate/ express themselves through a on the spot painting competition (focused on Beti Bachao Beti Padhao theme), quiz competition & performed an entertaining cultural program. Like previous years, the Children's Day participation was full of fun and raised self esteems of all children.

Dr Rakesh Gupta, President Delhi Medical Association & Dr Anurag Aggarwal, Secretary IAP Delhi were Guests of Honour. The following members attended the event Mrs. & Dr RN Srivastava, Dr Rajeev Seth, Dr Uma Agrawal, Mr RP Agrawal, Dr DN Virmani, Dr Indra Taneja, Dr Peeyush Jain & Mr. Aseem Pal. Members interacted with children, and gave special awards and warm winter clothes distribution ceremony at the end of program. All the children were given a welcome drink, snacks and sumptuous lunch at the end of the program. The IAP Delhi provided the meals and welcome drinks to all children.

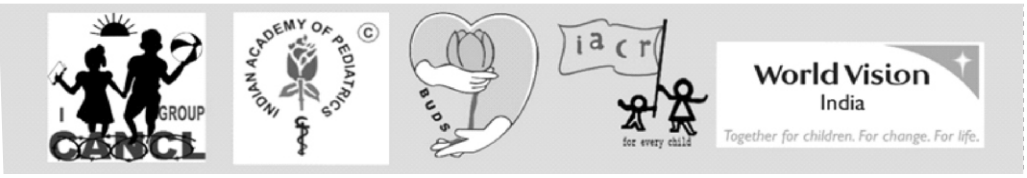
The event was a great opportunity to show our pediatric fraternity efforts, our support to child welfare and child rights to participation. Photographs of the chidrens day program are on back cover page.

National Consultation, 2016

Child Trafficking and Commercial Sexual Exploitation of Children : Medical & Psychosocial Services for the Victims

Dr. Rajeev Seth (Chair) E-mail : icancl2015@gmail.com
Dr. Uma Agrawal (Secretary) E-mail : umaarp@yahoo.com

October 13, 2016, India International Center Annex Lexture Hall 1, New Delhi



Executive Summary

Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are violations of the fundamental rights of children to be safe and are in contravention to the United Nations Convention on the Rights of the Child (UNCRC).[1] The exact numbers of victims of child trafficking and commercial sexual exploitation are unknown, although estimates range into millions. The interaction of poverty and gender-based violence in developing countries heightens the risk of sex trafficking and CSEC.

Medical evaluation in CSEC and sex trafficking is an emerging area of research and practice and few healthcare settings have established screening practices, policies and protocols[2]. There is limited information available to paediatricians and allied health professionals on how to protect trafficked and vulnerable children. Evaluations of CSEC victims may be challenging. Children are rarely forthcoming about their actual history and it requires patience and a secure environment to gain their trust. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country[3] .

A one day consultation on the issue of Child Trafficking and Commercial Sexual Exploitation of Children (CSEC): Medical and Psychosocial Services for Victims" was held on 13 October, 2016 at the India International Centre, Lodi Estate, New Delhi. The consultation aimed to help professionals, coming in contact with survivors/victims of child sexual abuse, get a better understanding of the issue of CSA and equip them with information to prevent and respond to victims of sexual abuse. Participants included paediatricians, physicians, mental health professionals, academicians, psychologist, nurses, medical social workers, child rights activists, allied NGO's, Government & International Agencies.

The specific objectives of the consultation were: i) to create awareness and sensitise the paediatricians and allied professionals to prevent and respond to victims of "Child Trafficking and Commercial Sexual Exploitation of Children"; ii) to educate paediatricians and allied professional to improve provision of direct medical care, anticipatory guidance and collaborative referrals to non-medical colleagues for complex health needs and psychosocial services to victims of CSEC; iii) to provide useful information to paediatricians and allied health professionals regarding existing child protection systems available in the country.

Presentations at the consultation provided global and national perspectives on the status of Child Trafficking and Commercial Sexual Exploitation of Children that included legislative and policy initiatives. The term trauma informed approach and trauma informed care, while responding to children who have been sexually exploited, were introduced as was the importance of including mental health and emotional evaluations and interventions along with the medical treatment. Representatives from international agencies, government, advocates and representatives from civil society discussed the pros and cons of the draft Anti Child Trafficking Bill, community based child protection systems, child helpline and the importance of documentation for providing medical evidence in court.

Participants agreed on the need for a multi-disciplinary approach to interventions and for focussed initiatives to prevent trafficking and child sexual abuse by strengthening child protection mechanisms in the community. Attitudinal change was identified as a key factor for bringing about real changes in the lives of children at risk of sexual exploitation. Given the general lack of awareness while examining child victims of sexual abuse, it was agreed that medical curriculum must include modules to train doctors on key medico legal aspects that include comprehensive history taking, identifying psychosocial and mental health symptoms with a non-judgmental and open attitude. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country.

Report of Proceedings

The programme was anchored by Dr. Rajeev Seth,Chair ICANCL group. Dr. Seth welcomed participants to the consultation and expressed the hope that the day would bring about learning and clarity on the issue of Child Trafficking and Commercial Sexual Exploitation of Children and the role of the medical and health professionals in providing medical services to children traumatised by sustained abuse

Session 1: Overview of the problem of Child Trafficking and Commercial Sexual Exploitation in India

Speaker: Ms/ Enakshi Ganguly, Co- Director, HAQ Centre for Child Rights

Moderator/s: Dr. A.K. Shiv Kumar, Global Co- Chair, Know Violence in Childhood

In 2001, HAQ Centre for Child Rights undertook a comprehensive study on Child Trafficking in India for Terre de homes (Germany). The discussions and deliberations around the findings of the study led to the launch of the Campaign against Child Trafficking (CACT) on December12, 2001, in New Delhi. CACT currently has chapters in 12 states across the country. Fifteen years on, HAQ revisited the issue and released an updated version of the report in June 2016.

An audio visual presentation consolidating the findings of the study [4]gave the participants an overview of the situation of child trafficking in India. Painting a grim picture of the status of child trafficking in the country, the report highlighted the absence of data, the lack of sustained follow up after an initial uproar, including in instances that had received massive media coverage (Nithari, various search and rescue by NGOs). Adding to the confusion are the multiplicity of interventions and a seeming absence of synergy in multiple interventions introduced by the Government. An illustration of this is the lack of convergence between the Track Child programme of the Ministry of Women and Child Development and the Anti-Human Trafficking Units (ATHU) of the Ministry of Home affairs. Prior to the HAQ study, trafficking was thought to be synonymous with women and girls. The study expanded the group to include boys and men. The dissemination of the report provided an opportunity for deliberation on the issue among multiple NGOs and child rights activists, many of whom came together to form the Campaign against Child Trafficking. It was the sustained campaign by CACT that ensured attention to and the inclusion of Child Trafficking in the National Plan of Action, 2005. Internationally the Government of India ratified the UN Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography.

Revisiting the issue 15 years later, the report found that despite increased awareness on the issue, positive changes in legislation and the introduction of child protection schemes, the situation for children at risk remained, more or less, the same. Studies indicate that over 36 percent of children continue to be at risk of child trafficking. The, United Nations Office on Drugs and Crime (UNODC) report in 2013[5]came up with a report on trafficking rackets and gangs. Children were reported to being kidnapped for various purposes including begging, sex trafficking and for cheap child labour. Post disasters, children are at a higher risk of being trafficked as demonstrated after the Nepal earthquake in 2013. A large number of new-borns go missing from nursing homes. A perusal of the questions asked in Parliament indicated that while most of these related to the gravity of the situation, government responses were limited to government schemes, seldom addressing the human issue at hand.

With response to child trafficking becoming specialised (special Anti-Human Trafficking Units have been set up), the role of the local police has become minimised. There are serious discrepancies in data provided by various departments involved in responding to trafficking or collecting information. Rehabilitation efforts have failed to bring about desired change and the absence of cohesion and multiplicity of agencies make it difficult for victims to seek redressal.

Ms. Ganguly elaborated on the consequences of trafficking and the challenges in the rehabilitation of the survivors by citing the example of a girl, HAQ had come in contact with, following her rescue. The girl had been trafficked from NOIDA, taken to Dubai and was subsequently found and rescued in Jalpaiguri, West Bengal. To keep her quiet and submissive, she had been drugged and plied with alcohol. She had also been given hormonal injections to hasten the appearance of secondary sexual characteristics. . Rescued 3 years back, she is a recovering alcoholic, a drug addict, is unable to concentrate, and frequently demonstrates aggressive behaviour. The girl continues to seek justice, against the nine accused, in court. Three years down the line, the staff at HAQ are still struggling to discover what they should do to make her feel whole again. Unlike other violent crimes, trafficked individuals face sustained trauma with repeated sexual assaults. Torture, manipulation, abusive living conditions are part and parcel of a survivor's life.

Post-traumatic stress disorder, aggression, feelings of alienation and disruption of family life are common among the rescued. Violence need not necessarily end when the trafficking is over, it may continue in the family as parents may be unable to understand the changed behaviour pattern in their child.

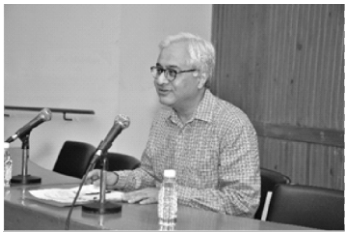
Although Standard Operation Procedures (SOP), to respond to the medico-legal needs of trafficked women and children, have been developed in India, these remain largely underutilised and unimplemented. The situation is further compounded for

children who fall in between many silos. Addressing their needs is divided between the Ministry of Women and Child Development, the Ministry of Labour and the Ministry of Home Affairs. The situation gets further complicated for children trafficked from or to another country.

Open session:

Key points that emerged from the open session following the presentation:

- The need to understand what constitutes 'protection' and bring about an attitudinal change among adults on the issue of child protection.
- The need for awareness of increased and emerging threats for children through online and digital platforms
- The absence or inadequacy of the interventions towards prevention of trafficking: Despite programmes like the Integrated Child Protection Scheme that provide for community protection systems at various levels, children continue to remain at risk owing to the limited reach of the scheme in the communities
- Limitations of rescue and rehabilitation: The follow up to prevent further trafficking is missing. Often rescuing children from brothels is like fishing in an aquarium – nothing changes for them.
- Need for policy changes to address the issue of rescue and rehabilitation
- Need for psychosocial interventions that are individualised since coping mechanisms among individuals vary.
- Trauma intensified by the delay in court procedures – victim unable to get closure owing to prolongedtrials. Special courts continue to be limited in numbers. How do we restore a sense of justice to the survivors?
- Challenges of medical examinations and the need to avoid value judgement while doing medical examinations –Need to include the procedures for such special examinations in the clinical curriculum
- Every practitioner must understand what protection means — every paediatrician must recognise abuse, every health worker must recognise symptoms of the possibilities of vulnerabilities.



Summing up the discussions, **Dr, Shiv Kumar** reemphasised the need to focus on prevention and the necessity to recognise and identify the social and societal factors that have to be addressed to prevent sexual exploitation that can be seen as an extreme form of modern slavery. Dr. Kumar recommended against categorising different forms of violence as these are interconnected and are drivers of social behaviour. The child who is bullied, faces violence and runs away. Trafficking, then, is a via media of perpetuating violence. Unless we create an environment that is protective, the issue of trafficking and CSEC will not be addressed. Dr. Kumar also drew attention to the emerging threats from the digital and online spaces and the proliferation of child pornography across virtual borders.

Session 2: Global Sex Trafficking and Commercial Sexual Exploitation of Children: Medical Services for Victims

Speaker: Ms. Jordan Greenbaum, MD,Paediatrician, Atlanta USA & Director of the Global Health and Wellbeing Initiative with the International Centre for Missing and Exploited Children.

Moderators: Dr Sunil Mehra, Founder and Director, MAMTA & Ms. Razia Ismail Convener IACR

Introducing the session, **Ms. Razia Ismail**, convener, India Alliance for Child Rights, recalled four points that had emerged in the previous session: the need to communicate; early detection; timely intervention; and no displacement. Within the continuum of "What we might look at – before, during and after", she wondered when it is that a child is brought in front of a health professional in instances of CSEC- and what is the 'before' in CSEC. Reminding the participants that safety for children was not merely the presence of a safe room, she stressed on the need for professionals to be watchful, and be alert to the possibility of abuse while examining children.

The key note address by Dr. Jordan Greenbaum, covered i) the scope of global human trafficking and risk factors involved; ii) familiarising the participants to a trauma informed approach to medical assessment and iii) recalling the steps of medical evaluation. Dr. Greenbaum, clarified, at the onset, that the use of the word "victim" in her presentation was solely from the medico-legal perspective and not applied to the social context.

Commercial Sexual Exploitation of Children (CSEC) occurs "when a person induces a minor to engage in a sex act in exchange for remuneration in the form of money, food, shelter or other valued entity." These include survival sex, trafficking a child for commercial sex act (on account of which anything of value is given to or received by any person), pornography, sex tourism, and the use of a child in sexually oriented business. It does not require force, coercion or violence.

Differentiating between human trafficking and the trafficking of a minor, Dr. Greenbaum explained that while trying traffickers for CSEC, demonstrating means of inducement is not necessary since children, unlike adults, are below the legal age of consent.

A summary of key presentation points by Dr. Greenbaum is given below: The complete PowerPoint presentation is attached.

Scope of global human trafficking and risk factors involved: The exact incidence and prevalence of trafficking is unknown and difficult to estimate owing to the criminal nature of the activity and its happening under the radar. The ILO estimates the number to be about 20 million[6].

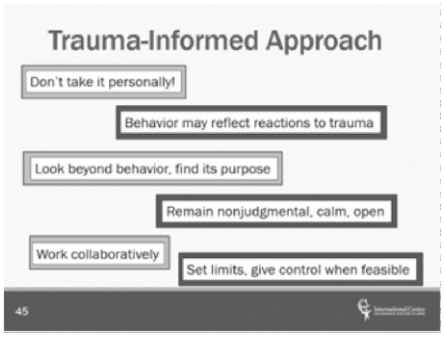
Disaggregated data on the identified victims of trafficking[7] indicate that out of all people identified as trafficked, women made up 49 percent while children comprised 33 percent (12 percent boys and 21 percent girls). 36 percent of total persons trafficked in South East Asian countries were children.

High risk groups vulnerable to being trafficked include those affected by poverty, girls left out of the education system owing to gender bias, street children, children from marginalised communities, sexual minorities, children affected by upheavals arising from natural disasters or community violence.

It is hard for children and even adult victims of trafficking to get medical care as very often the person is not in a situation where they can freely move. The health professional is approached only when the child is in an advanced stage of ill health.

Dr. Greenbaum listed the adverse health effects of CSEC. One study had indicated that approximately 50 percent of rescued children have an STI. The children face physical violence at the hands of traffickers and buyers - they are treated as objects rather than as human beings. Victims of CSEC may experience a variety of injuries (burns, bruising, broken bones, head injury) chronic pain, and malnutrition. In addition there is significant impact on the mental health of these victims with one study estimating up to75 percent of survivors suffered from symptoms of Post-Traumatic Stress Disorder (PTSD). Almost half of them had attempted suicide in the previous year. In India, a study pointed to the very high rates of HIV among young girls trafficked to Mumbai. Immature genital tracts make young girls more vulnerable to attacks by the human immunodeficiency virus and human papilloma virus, as does the fact that younger girls are more likely to be trafficked to multiple brothels as they are 'valued" more by clients. They also have lesser access to health care.

Recognising a victim of child trafficking could be extremely challenging. Most of them would not self-identify and would be reluctant to disclose any details owing to fear, shame and other factors. First impressions could give the medical professional possible indicators of trafficking. The youth may appear afraid of adults or be overly submissive, anxious. They may give false demographic information and provide an inconsistent history. They may show delayed presentation of illness since they would have been brought in only at a much later stage. . The child may not speak the local language indicating that they may have come from outside the community.



Dr. Greenbaum spoke of the paradigm shift while conducting medical examination of victims of sexual abuse from 'what's wrong with you to what has happened to you". She emphasised that having the right attitude was crucial while conducting medical evaluation of the child. She said that trauma affects behaviour, belief and attitudes. ***Trauma informed care*** is an approach to dealing with an adult or child who has experienced significant trauma. Central to the approach is the recognition that trauma affects the way a victim thinks, feels and acts, how they see the world. The health professionals need to acknowledge that the young person's actions may be influenced by what they have experienced. Talking to the child about trauma may trigger anxiety and fear related to the experience.

There is a need to minimize re-trauma, establish emotional and physical safety and encourage resilience. A human rights approach would ensure that the victim is treated with respect and empowered to make decisions. They must be informed of the actions that are being recommended including possible examinations and tests, and must realize they have the right to say NO.

It is essential for doctors to be non-judgemental while examining a victim of SEC, and avoid blaming them. When interpreters are required, they must be educated about human trafficking and employ a trauma-informed approach. Doctors must focus on the information they need and not try to ask questions only to satisfy their curiosity.

Before they begin the medical examinations, there are 4 actions to be taken: Provide the patient with explanations of what the exam and evaluation entails, ensure confidentiality and privacy of patient interactions, ensure physical and psychological safety of the patient and staff, and obtain permission by the patient/caregiver to proceed.

Mental Health Assessment is critically important and the doctor must assess the need for emergency psychiatric evaluation and help initiate referrals for full assessment and counselling. Drug testing is recommended in certain situations such as when the patient reports periods of memory loss within the past 72 hours, presents for medical care intoxicated, or reports taking substances within the past 72 hours. Again, informed consent for drug testing is necessary.

CASE 1:

16 year old female brought to your clinic by NGO staff. Patient with history of pelvic pain and vaginal discharge x 2 weeks. History of trafficking from Nepal at age 14; drugged at village event, kidnapped, sold to brothel. Illiterate, no education. History of sexual abuse by uncle. In brothel, had 10-20 clients per night; No health care. Not allowed out of brothel. Housed in single room with 9 other women/girls.

Case 2

13 year old homosexual male is brought in by police after being found in apartment of local man. Child ran away from home and parents called police.

Child tells you he has no friends, is ostracised for his sexuality, and feels alienated from his parents. He ran away and met a man on the street who offered to let him stay at his apartment. He had sex with the man, stayed with him for 4 days and then the man began bringing other men home to have sex with patient. Police were called when neighbor became suspicious of all the activity

Dr. Greenbaum presented two case studies to take the participants through possible interventions

Key points emerging from the discussions around the case studies were

Need to ensure that the medical examination includes documentation of any recent or remote injuries and if the child will allow it, documentation of these with photographs. If at all possible, victims need to be tested for HIV, Syphilis, hepatitis, N. gonorrhoea, C. trachomatis, T. vaginalis, other STIs that are common in the region and, potentially, diseases that are endemic in their home country. At all times, patient consent is essential. In many instances there are no signs of anogenital trauma and when injuries do occur, they heal quickly and completely, typically without any scarring. Therefore, a lack of trauma on exam does NOT rule out the possibility of sexual contact.

Having a chaperone during the exam, excluding the trafficker when speaking with the patient, monitoring for signs of distress during the history and physical exam, explaining all procedures to the child and asking the child if they have any questions about their body were some of the tips provided by Dr. Greenbaum. She was highly appreciative of the Standard Operating Procedures outlined by the Ministry of Health, Government of India.

In terms of common reports and referrals, Dr. Greenbaum mentioned the need to consider:

- Authorities, if not already involved
- Trauma-focused mental health assessment and therapy
- Referral to primary care resource if child lacks ongoing care
- Referral for medical specialty care if indicated (obstetrician for the pregnant patient, for example)
- Follow up of STI test results, and treatment if indicated (if child did not receive treatment during initial visit)
- Counsel on exploitation prevention, internet safety
- Crisis hotline (include Human trafficking hotline if available)
- Follow up with child if possible, to help facilitate services, provide support
- Resources for LGBTQ youth, as appropriate

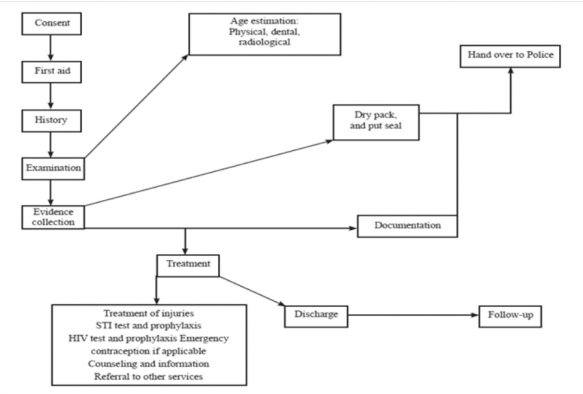


Fig 1. Comprehensive Medical Response to Sexual Violence

Concluding her presentation, Dr. Greenbaum summed up key points made during the presentation

- Trafficking victims experience many adverse health consequences
- Medical evaluation needs to be trauma-informed, sensitive
- Systematic evaluation with documentation is critical

Wrapping up the session, Dr Sunil Mehra, Director, MAMTA, highlighted the complexity of the issue and wondered how it would be possible to encapsulate what was needed within a fragile health system such as the one that exists in India. Dr. Mehra said that speaking from personal experience, the biggest problem for medical professionals was that they were trained to be prescriptive, not participatory. To have

any strategy for adolescents in this age group in different scenarios is difficult. Besides, ensuring confidentiality is a big problem in providing adolescent friendly health services. The problem is not the concern of doctors alone, there are many below and above who need to be worked on.

Dr. Mehra emphasised that if attitudes are right, much could be resolved. He was of the view that the focus needs to be on prevention and how we go about it. Referring to multiple articles every day in the newspapers on status of malnutrition, child marriage in our country, Dr. Mehra felt it was time we reflected on how we dealt with our children, gearing policy which protect. More importantly, there is a need to define protection. Can we say that the child is the index of the respect of the village and that every village respect its children? There is a need to invest abundantly in this subset so that children do not just survive but thrive. He wondered whether the Indian Association for Paediatrics (IAP) was geared to generate support from the private sector that has a significant role to play. Stressing on the need for more interventions at the societal level, Dr. Mehra expressed the opinion that denominators of social interventions are still not fully understood. Management is not about getting early detection, instead it is about identifying vulnerable groups, providing clinical care to prevent long term trauma.

Key discussion points at the open session:

- Prevention most important – number of trafficked children coming in contact with doctors is negligible.
- There is a need for medical syllabus to include sensitivity and communication skills.
- The traffickers may have their own doctors and these people may be difficult to influence as they had voluntarily decided to profit from the trade.
- Medical examinations need to include checking for the presence of warts, check whether the child has advanced sexual maturity – she may have been given hormonal injections
- Documentation of medical assessment is essential - as one participant put it - "If you didn't write it, you didn't do it"
- It is mandatory for doctors to report any instance of sexual abuse
- The trauma informed approach presented by Dr. Greenbaum is relevant as a framework for most systems including the police and the judiciary. The approach can be taken to every discipline.
- The detection of medical age may be affected by hormonal injections – however, it was suggested that teeth, bone age, bone density tests would not be affected
- Dilemmas of doctors around mandatory reporting especially in instances where young persons below 18 years have "consensually" entered into sexual activity.
- The doctor must limit their role to medical issues and not play a judge

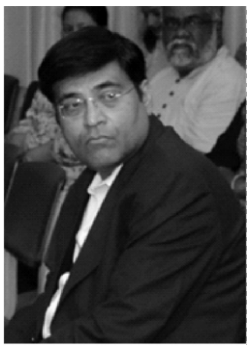
Session 3: Mental Health for Victims

Speaker: Dr Professor Rajesh Sagar, Child & Adolescent Psychiatrist, Department of Psychiatry, AIIMS

Moderators: DrD.N Virmani, Past President IAP Delhi &Dr. Kiran Modi, Udayan Care

Dr D.N. Virmani, Past President IAP, Delhi introduced the speaker for the session and mentioned that not many paediatricians have had training on physical examination of trauma victims. Thanking the organisers for the consultation, he highlighted the fact that child victims of sexual abuse were severely mentally traumatised. The scarcity of mental health professionals is a matter of concern given the need for intervention in many social cultural practices that lead to mental health disturbances.

Speaking on the issue of psychosocial context of child trafficking and child sexual abuse, Dr. Rajesh Sagar highlighted the proactive role of the medical professional in identifying the hidden, unidentified mental health problem. Stating that there is "No Health without Mental Health", he expressed concern that despite its importance especially in instances of continuous abuse such as those experienced by victims of CSA, the physical component gets more attention compared to the mental.



From the mental health perspective, coercion has a bearing on the mind and on mental health since it has to do with the use of power. This includes child marriage.

Although the situation of trafficking is alarming, it is not discussed much in India or given the consideration it deserves. The dearth of professionals in the field also does not help the situation.

Dr Sagar spoke of the push and pull factors that lead to trafficking. While poverty, inequality and disempowerment are factors that push people and children towards trafficking, the demand for trafficked individuals and the money involved act as a pull factors.

Reiterating the points made during the earlier sessions, he regretted the absence of curricular inputs

to develop communication skills. Children with psychiatric problems are more vulnerable to trafficking

Dr. Sagar advised doctors, observing multiple medical problems in the Paediatric setting, to always ask questions which may identify a mental health problem – to always ask these when they see an injury. He highlighted the risks faced by children in institutions. Speaking of anger management, he mentioned that there were a wide range of symptoms and these were not difficult to diagnose. Dr. Sagar emphasised the need to talk, to work on aggression issues which may be directed internally or outward. Symptoms of mental health may not be at the extreme criteria of disorder but children may demonstrate symptoms. Assessment in the mainstream must be handled in a multi –disciplinary manner with sensitivity. Each child has a different need and a needs assessment is required along with assuring the child of safety and confidentiality.

Dr. Sagar provided examples of Indian initiatives that he had personally been engaged in. Among these were 'Developing Guidelines for Prevention of Child Abuse' by the Delhi Commission for the Protection of Child Rights, the training of doctors and health professionals in accordance with the POCSO Act. The training included prevention and response to protection issues.

In the context of technology, Dr. Sagar spoke of the impact of cyber bullying, sexting, online abuse. He pointed out that the issue had far reaching implications needing intervention beyond that provided by health professionals.

A review of literature on child sexual abuse indicated some effective solutions. Therapies like Cognitive Behavioural Therapy have been found to be useful. Referring to the World Mental Health Day, Dr. Sagar reiterated that every child who has gone through a trauma needed, at the very least, a First Aid level of intervention. He listed the basic steps to reinstate psychological wellbeing - talk, instil hope, and communicate - can be beneficial for any person in distress. Training on this could be provided at the community level.

Dr. Sagar felt that it was important for professionals to develop skill sets to be able to help victims re-establish identify. The empowerment of the child is important and it is necessary to build a rapport before asking the child for information.

Concluding the session, Dr. Kiran Mody spoke of the risks and consequence, beginning from the time of recruitment, that children who were trafficked faced. Post rescue, their situation is devastating and it is essential to go beyond survival to getting them to thrive. There is a need to focus on attitudinal shift not only among doctors but among family, community. The *mantra* of protection must be on everyone's mind. In the absence of adequate number of professional counsellors, she suggested training of people who could be para counsellors.

Session 3: Government Initiatives & Draft Anti- Trafficking Bil

Special Guest: Ms Rupa Kapoor, Member, National Commission for Protection of Child Rights (NCPCR)

Speaker: Dr Professor Pravin Patkar, Fulbright Nehru Academic & Professional Excellence Fellow- 2015-16, Co-founder& Director, PRERNA, Mumbai

Moderators: Ms Tannistha Datta, Child Protection Specialist UNICEF & Dr Rajeev Seth, Chair ICANCL group

Introducing the session, Ms. Tannistha Datta, UNICEF provided some general comments on the Bill and brought to the participants' notice, the need to review the provisions of the current Bill in the context of existing legislations to identify overlapping elements. She spoke of the challenges in implementation of the draft legislation and of the heightened responsibility that this placed on the police.

While it was heartening to see Prevention highlighted, she felt that the issue needed to have been thought through in the context of the child protection systems established under the ICPS. Another area of concern was that rehabilitation seemed to be synonymous with institution based approach and there was a lack of focus on non- institutionalised services.

Ms. Datta wondered where the specialised focus on children was and said she had struggled to place children in the Bill. Owing to the confusing wording, it

was not clear whether the child needed to be presented to one agency or multiple agencies.

Ms. Datta maintained that law making should be based on experience of approaches and suggested that the current bill provided a good opportunity to deliberate more thoroughly on the issue.

Ms. Rupa Kapoor, member NCPCR, shared her initial experiences of working with sex workers and their children in Sonagachi in West Bengal. Describing the miserable condition that the young girls involved in sex work lived in, she also shared how many of them had told her that going back was not an option for them. Ms. Kapoor also spoke of the children of sex workers who seemed to be resigned and accepting of the fact of following in their mother's footsteps. The biggest aspect was the stigma attached to the victims of sex work especially if one did not have a rehabilitation package.

Expressing dismay at the levels of insensitivity displayed by the media and doctors that she had witnessed in inquiries that the NCPCR had taken suo motu cognizance of, Ms. Kapoor said that there needed to be an individualised approach to addressing rehabilitation needs of survivors of sexual abuse.

Ms. Kapoor shared her experiences of the Positive Deviance approach where solutions come from the involvement of the community. She gave the example of a study conducted in East Java where earlier no one talked of the children who went missing. Researchers visited the leaders and worked with them to conduct a mapping exercise, and set up a community watch dog group. After 3 years, they realised that they had saved hundreds of girls.

Ms. Kapoor spoke of the NCPCR initiative of piloting Child friendly villages where the Panchayat tracks its children. Committees are operational and benefit from all schemes available for them. In 50 villages in Andhra Pradesh, the entire focus is on child protection. A Manual is in place for capacity building of all stakeholders. In the same context she spoke of the Integrated Child Protection Scheme (ICPS), children in institutions and residential institutions.

She shared information about the "e button" project initiated by the Ministry of Women and Child Development after the Protection of Children from Sexual Offences (POCSO) Act, 2015 came into being. A web based programme, it shows 6 instances of abuse that the child could indicate on. On the draft Anti Trafficking Bill, the NCPCR had spoken of stringent punishment for perpetrators and had expressed its willingness t to be part of the anti-trafficking rehabilitation committee since rehabilitation is a key component. While concluding her presentation, Ms. Kapoor reemphasised the need for community based approaches

Professor Pravin Patkar, Director, PRERNA, expressed his happiness at seeing people from different disciplines coming together. Dr. Patkar shared that his competence to speak on the piece of legislation under discussion came from his work and teaching for over 20 years and protecting children and women from violence in the red light area of Kamatipura in Mumbai. Dr. Patkar and his wife who live and work in this area started a school that catered to children who were born and lived in dangerous situations. Very often these children would be drugged to prevent them from making a noise or go to sleep while their mothers were with their clients. They would be asked to close their eyes and be pushed under the bed. Older children would be sent out of the house. Professor Patkar and his wife established night care centres that ran educational programmes for these children and kept them safe. Professor Patkar participation in an Asian think tank group on Trafficking made him realise the need for advocacy to influence programmes for sex workers and their children.

Giving a background to the legislations already in place, Dr. Patkar pointed out that while the laws are good in India, what was lacking was action on these. He submitted that the earlier Immoral Trafficking Prevention Act, 1956 was a watershed in the development of legislation for preventing sex work. The Act spoke of organ trade, destination crimes and defined trafficking as an activity that procures people from exploitation and put them in an exploitative situation. In comparison, he expressed regret that the current draft 'Trafficking of Persons (Prevention, Protection and Rehabilitation) Bill, 2016', fell short on several measures.

Calling the earlier legislation, pro women and pro victim, he mentioned that in India, it was not a crime in India for an adult woman to voluntarily sell her body for money. He pointed out that the 1956 Act was one of the least used legislations and statistics showed that eleven times more booking was done under Bombay police act – behaving indecently in public

Dr. Patkar said that it was unclear to many activists as to why the new draft omnibus bill had been written in the first place. There was no court order, no demand for this new legislation. The lack of consultation had been an issue of concern for many in civil society. It was not clear how this would be implemented and how the government planned to bring multiple agencies together given that nodal departments for labour, beggary, destination crimes were all different. He wondered about the status of the existing Child Labour Act, Human Organ Act, and ITPA act once this legislation was passed– He wondered how India would recruit the huge police body that would look at prevention, protection prosecution. He expressed concern that in the new Act, pimping might become an unpunishable offence and brothel management unpunishable. He felt that the new thinking may have been influenced by international pressure groups as many western countries are legalising sex work and are

decriminalising brothels.

Giving the example of bonded labour which vanished when the economy started being more inclusive and the poor had more options and opportunities, he regretted that the entire exercise appeared to be a myopic approach of crime and punishment to what was essentially a complex socio economic cultural issue

Expressing disappointment that the government had not called for any consultations, Dr. Patkar opined that before finalising, it was necessary to remove discrepancies and align the Act to existing legislations and align definitions. Within the current social cultural economic situation, he questioned the prudence of following a decriminalising model in total. While the women must not be punished, there needs to be a provision to penalize sex buyers.

Suggesting that there is a need to learn from best practices, Dr. Patkar gave the example of Mumbai's special homes placed under joint management of the Government of Maharashtra and his NGO. Girls were not victimised, data was maintained through specially created software. Technology, victim registry systems, biometric systems, documentation were some of the suggestions that were put forward.

Following the session, the trailer of a film 'Sold' was shown to the participants. Based on true stories the film traces the travails of a girl who is trafficked

Session 5: Panel Discussion: Psychosocial Referrals, Resources, Innovative Programmes, Multi-disciplinary Interventions & Way Forward Recommendations

Panellists: Ms. Michelle Mendonca (Advocate), Samrat, Childline India Foundation (Child Protection systems), Dr. Indra Taneja, BUDS

Moderators: Mr Joseph Wesley World Vision India & Dr. Rajeev Seth

Mr. Joseph Wesley, World Vision, India provided an overview of World Vision's global presence and development work in India. Child protection is a cross cutting theme across all program work. This includes preventing child trafficking, working with street children, child labours, child slavery, combating female feticide. He shared the findings of a national level research conducted by World Vision in 119 districts across 19 states with 53550 children and 71400 caregivers. The study indicated that an average of 61.2percent adolescents knew of services to report abuse, the perception of parents /caregivers is that community is a safe place for children average of 57.7 percent parents felt this. A significant number of adolescents knew of services available. World Vision intends to continue with its programs on capacity building, parenting skills training, personal safety education for children, community based child protection systems and research and advocacy. Mr Wesley emphasised on the need for programs on parenting skills.

Mr. Samrat from Childline shared details about Child helpline, 1098, which is India's first 24 hours toll free emergency outreach phone number. Any child or concerned individual can ring this number to report instances of child abuse. The 1098 number is integrated into the Integrated Child Protection Scheme of the Ministry of Women and Child Development. Child line has more than 700 partners across India covered 402 districts. The main focus is to provide emergency support to children. They conduct open house programmes where children come to participate in the preventive mode, Childline India Foundation organises awareness activities for children and all stakeholders and collaborate with child rights groups, local organizations, panchayats and child care institutes.

Mr. Samrat spoke of the special programme for children on railway platforms in collaboration with the Indian Railways. Child help desks are available in 20 railway stations where you can take a child or seek assistance –awareness campaign and provide emotional support to missing children.

Intervention is undertaken with the support of the local/district administration. Childline links with para legal groups to advocate on behalf of children.

Michelle Mendonca focussed on the relevance of medical professionals in the legal system and their need to get involved. All trafficked children need to undergo verification of age and courts look towards the medical professionals to determine the age. She listed different age determination examinations that included dental examination, ossification method, and bone density. For proof of abuse, the physicians needed to identify the type of injuries. She reminded the group that as per current law it is not necessary for penetration to have happened. She stressed that rape is a legal conclusion and not a medical one and it was not the place of the medical professional conducting the examination to conclude definitely that rape had occurred. However, she cautioned that doctors stating that no injury had happened and therefore there was no rape may definitely influence the court. The identification of injuries and abuse testified by the doctors could contribute to the compensation given to the victim. Ms. Mendonca reiterated the importance of documentation of injuries as very essential and helpful and recommended that doctors look past the hostile first responses and avoid using legal language while documenting their findings. She suggested that

the doctors record their opinion and inference for conclusion, review their medical report a day before appearing in the court and deliver findings in a clear and concise manner.

Stressing on the importance of the role of doctors in the courtroom, Ms. Mendonca mentioned that doctors' opinion were testified and they were privileged witnesses. The court looks to them for linkages with different systems.

Mr. Wesley shared the grassroots experience of World Vision while working in the communities. They had identified gaps in terms of capacity and coordination in the implementation of the ICPS scheme. The child protection committees need to be made aware of the scope of establishing the monitoring of vulnerable children based on specific listed criteria in the scheme. The capacity of police also needs to be built. Handling cases at the grassroots level, continues to be huge challenge for the person despite the existence of good policies. World Vision had found a lack of awareness even at the district level. On the issue of responding to sexual abuse in the community, the family members were reluctant to report incidents. Even if they did, interference from the community or political parties may prevent them from pursuing the matter.

Professor Taneja, spoke of the role of the medical professionals in prevention. She emphasised on the need for paediatricians to be advocates for children and the need to be vigilant in identifying bruises and marks on the body. The location of the injury should give the doctor an indication of abuse. The child's body language may give a signal that something is wrong. While examining children, children who have been abused may react to touch. Unable to understand what has happened to them or name the proper body part, they may complain of stomach ache in cases of sexual abuse. Parents may try to avoid discussing the issue as they may not want to disrupt the family dynamics. There is a lack of parenting knowledge in India and the concept of sex education is completely absent in the country.

Ms. Rupa Kapoor, member NCPCR, invited to make observations, said that although the NCPCR was the nodal body for the protection of child rights, it needed the support of experts representing multiple disciplines. She said the extent of the instances of sex abuse was immense with 60 cases being reported daily in Delhi alone. The NCPCR and the State Commissions for Protection of Child Rights were trying to rope in volunteers to support them in their work. Ms. Kapoor recommended child friendly spaces in hospitals and that at least 2 doctors (of whom one should preferably be a female) be assigned to such cases. NCPCR is also in the process of trying to ensure that every school notebook has a page telling children about their rights and good and bad touch

The panel agreed that education and keeping children in schools was the key to preventing trafficking

Open session:

Questions, discussions and recommendations centred on the difficulty for children to understand they had been sexually abused and subsequently report that instance. Adults may come across instances of sexual abuse but are unaware of the redressal mechanisms. Most parents do not want their children to be provided with information or sex education. The access of children to incorrect information online is a matter of concern. Manuals for parents and parent training was advised by many experts at the meeting

Concern was expressed on the lack of adherence to required procedures by doctors owing mainly to the lack of awareness on these. Frequently samples were not properly sealed, or transferred on time. Evidence went missing due to improper storage facilities. IAP was requested to advocate for ensuring that senior doctors conduct medical examinations and that there be a one stop centre for children who have been abused.

Given the provision for crisis intervention centres and funds available in the ministry (NIrbhaya Scheme) participants suggested that lack of resources should not be an excuse for creating a separate room in hospitals for children to be comfortable in.

Participants recommended that there be more awareness created on the 1098 child helpline along the lines of the women's helpline.

An issue that needed more discussion was the prevention aspect given the innate vulnerability of children and the need for consciousness to question whether children are being targeted because of their vulnerability or due to the prevalence of paedophilia

Concluding the day's deliberations, Dr. Rajeev Seth spoke of the need for ongoing consultations on the subject of human and child trafficking and the need for inter –disciplinary coordination to ensure optimum care and rehabilitation for trafficked and abused children and to ensure that they recover from the sustained trauma they have experienced. On behalf of ICANCL, he thanked all the speakers, moderators, participants and expressed appreciation for the support provided by the other partner organizations.

Ms. Razia Ismail welcomed the suggestions at the consultation and while appreciating the extremely stimulating interactions during the day's proceedings, she also suggested constant engagement with the issue in order to make a difference in the lives of children who are trafficked. She requested participants to come together with a purpose and take the next step of sharing the current discussions outside of the current circle. Doctors, lawyers, police should all connect, and initiate a forum for continuous engagement on the issue.

Conclusions and Summary of Observations and Recommendations

The Consultation provided a platform for an inter-disciplinary conversation on the issue of Child Trafficking and Commercial Sexual Exploitation of Children. The participatory design of the programme ensured that the sessions were enriched by the contributions of many of the participants who themselves had significant experience in their field. A summary of observations and recommendations is provided below:

Attitudinal Change: All stakeholders must reflect on our attitudes towards children. This reflection must include how we implement policies and invest resources for children. The child must be seen as the index for respect of the village and every village must respect its children. The nation needs to invest abundantly and optimally on children's survival, protection, development and participation.

Defining Child Protection: There exists very little understanding of what protection entails for children. The concept of child protection needs to be understood and redefined within the Indian context. Community awareness on the issue must be increased through sustained advocacy and communication measures.

Increased attention to Prevention: Interventions on trafficking need to begin with prevention. Providing safety nets in the form of community monitoring and support systems, keeping children in school, ensuring access to incentives and schemes by children in especially difficult situations. Identification of risks involved and ensuring protection for children during upheavals - natural disasters or community based violence is essential. Existing systems outlined in schemes like the Integrated Child Protection Scheme need to be strengthened and made functional at the grassroots.

Trauma informed approach to assessments and interventions: Children who are trafficked and have been sexually abused have lived for a considerable period in situations of extreme stress and fear. This must be recognised and inform all decisions while providing professional assistance. A multi-disciplinary approach is required to address the needs of children.

No Health without Mental Health: Medical assessments and interventions should go beyond physical treatment of injuries to also include the mental health of victims of child sexual abuse. The psychosocial impact of prolonged bondage and subjugation needs to be acknowledged and addressed. Measures need to be taken to address the lack of trained professionals in this field.

Invest in capacity building of health professionals: The current curriculum of medical training for doctors and other allied health services does not cover examination or treatment protocols involved in instances of child sexual abuse. Doctors also need to update their communication skills. At least two doctors need to be identified and trained in each healthcare institution at every level to work with children who have been abused.

Ensure the implementation of existing policies, programmes and legislation: India has some strong legislation and good policies and programmes, however the challenge continues in the implementation of these. Concerted efforts must be made to involve various sectors to ensure that the benefits of these policies and programmes reach the most marginalised. Speedy trials and convictions will restore a sense of justice to the survivors of child sexual abuse

Annexure I

Concept Note

Child Trafficking and Commercial Sexual Exploitation of Children: Medical & Psychosocial Services for the Victims

Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are major public health problems (1). These are serious violations of UN Child Rights Convention (UN CRC) and fundamental rights of children worldwide (2).The exact numbers of victims of child trafficking and commercial sexual exploitation are unknown, although estimates range into millions.

In developing countries, child rights, protection and sexual exploitation are intimately linked to poor socioeconomic conditions in a huge population base[3]. The urban underprivileged, migrating population and rural communities are particularly affected. In large cities, there are serious problems of street children and child labourers. Children in difficult circumstances such as children affected by disasters, those in conflict zones, refugees, HIV/ AIDS are also at risk of commercial sexual exploitation(4). The interaction of poverty and gender-based violence in developing countries heightens the risk of sex trafficking and CSEC. Prevention efforts should work to improve economic opportunities and security for impoverished children, educate communities regarding the tactics and identities of traffickers, as well as promote structural interventions to reduce sex trafficking (5).

Medical evaluation of CSEC and sex trafficking is an emerging area of research and practice and few healthcare settings have established screening practices, policies and protocols ([6]. Victims of CSEC rarely self-identify, due to fear and shame as well as concerns about loss of income for oneself and/or family. Although some victims have no risk factors or obvious indicators, children at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with child protection systems or the Juvenile Justice Act, multiple STIs, pregnancy, or substance use or emotional abuse issues[7].

There is limited information available to paediatricians and allied health professionals on how they may protect these trafficked and vulnerable children? Evaluations of CSEC victims may be challenging. Children are rarely forthcoming about their actual history and it requires patience and a secure environment to gain their trust. A comprehensive history related to injuries/abuse, reproductive issues, substance use, and mental health symptoms have to be obtained with a non-judgmental and open attitude. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country (8).

Aims & Objectives

1. The main aim of the proposed one day consultation is to create awareness and sensitise the paediatricians and allied professionals to prevent and respond to victims of "Child Trafficking and Commercial sexual exploitation of children".
2. To educate paediatricians and allied professional to improve provision of direct medical care, anticipatory guidance and collaborative referrals to non-medical colleagues for complex health needs and psychosocial services to victims of CSEC.
3. The consultation also aims to provide useful information to paediatricians and allied health professionals regarding existing child protection systems available in the country.

Participants

Paediatricians, physicians, mental health professionals, academicians, psychologist, nurses, medical social workers, child rights activists, allied NGO's, Government & International Agencies, members of media

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138th session of WHO's Executive Board agrees on draft resolution on WHO global plan of action on interpersonal violence.

On 29 January 2016, in the context of the 138th session of WHO's Executive Board, governments agreed on a draft resolution on the *WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.*

Reference :

138th session of WHO's Executive Board agenda item *WHO global plan of action* http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_9-en.pdf
Global status report on violence prevention 2014

21st ISPCAN Congress on Child Abuse & Neglect, Calgary, Canada, August 27-31, 2016

ICANCL group members Dr Professor RN Srivastava, Dr Rajeev Seth & Dr Kiran Aggarwal participated at the 21st ISPCAN Congress on Child Abuse & Neglect, Calgary, Canada.

Dr Rajeev Seth presented the following presentations:

A key note presentation Aug 28 Pre -conference CIT forum "What Child Protection means in developing countries?

Master Class Presentation on Aug 28 on "Positive Parenting". I shall focus on role of parents in CAN prevention

Monday Aug 29-30 Poster Presentation " A Public Health Model for Rehabilitation for Street & Working Children, New Delhi India"

Monday Aug 29 1315 hours: Oral Presentation: Recognition and response to child sexual abuse (CSA) by the medical professionals in India

Comprehensive Early Childhood Care and Development Focus on Preschool Child: Health Care and Learning

All India Institute of Medical Sciences| *Friday, November 18, 2016*

Dr. Rajeev Seth (Chair) E-mail : icancl2015@gmail.com
Dr. Uma Agrawal (Secretary) E-mail : umaarp@yahoo.com

Executive Summary

Every child has the right to optimal cognitive, social and emotional development. Notably, early childhood is more than a preparatory stage assisting the child's transition to formal schooling; it has been recognized as the critical period for comprehensive development taking into account the child's social, emotional, cognitive and physical needs, so as to establish a solid and broad foundation for lifelong learning and wellbeing. If the child is not given adequate support and stimulation to aid this development, he or she is at risk of being prejudiced in reaching their full potential. It is therefore crucial for a society, and a nation, to invest in this period of a person's life – particularly for a country like India, where over 40% of the population is below the age of 20[1], and over 13% below the age of six[2]. Thus, Early Childhood Care and Education (ECCE) refers to an integrated approach combining nutrition, health and education for the holistic development of a child below the age of six/eight years.

The Constitution of India guarantees equality before the law to all citizens, and pledges special protections for children. In 1992, India ratified the UN Convention on the Rights of the Child (CRC), thereby committing to the obligations imposed by that instrument. The UN proposed a working definition of early childhood as the period below the age of 8 years[3], while in India, early childhood is referred to in the Constitution as being "below the age of six years"[4]. However, India still has a very long way to go in terms of caring for its young. Extensive research has highlighted particular risks to young children from malnutrition, disease, poverty, neglect, social exclusion and a range of adversities. The first phase of results of the National Family Health Survey 2015-16 (NFHS-4) indicate that more than half of the children in 10 out of 15 states are anaemic[5]. This data confirms that in India, the underprivileged preschool child is most neglected and vulnerable to various adverse elements that retard his/her optimal development. A large part of the blame for this can be placed on the poverty and illiteracy endemic to our country. Changing family structures have led to the dissolution of joint families, which often translated into a lack of adequate parental care, since both parents are forced to work to make ends meet. Uneducated parents often find themselves ill-equipped to provide the necessary stimulatory inputs and learning opportunities. Additionally, a lack of information also leads to poor nutritional and health care support, with even services that are freely available remaining unutilized.

The Government of India framed a National Early Childhood Care and Education Policy (NECCEP) in 2013 to reiterate the commitment to promote inclusive, equitable opportunities for promoting optimal development and active learning capacity for all children below age of 6 years. The revised National Plan of Action for Children (NPAC), 2016 is also due for release. However, significant gaps exist between policy and practice. The Indian government's flagship welfare program, under the banner of the Integrated Child Development Services (ICDS), is meant to provide food, preschool education, and primary healthcare to children less than 6 years of age and their mothers. These services are provided through *Anganwadi* centres established mainly in rural areas and staffed with frontline workers. However, the ICDS programme has not been particularly effective in reducing malnutrition, largely because of implementation problems and because the poorest states have received the least coverage and funding.

With this background, the Indian Child Abuse Neglect & Child Labour (ICANCL) group, Indian Academy of Pediatrics Delhi, Bal Umang Drishya Sanstha (BUDS) & Institute of Home Economics, Delhi University organized a one-day expert group consultation to bring together a convergence of stakeholders working on the issue of ECCE. The participants included doctors across specializations; academicians, nurses, medical social workers, child rights activists, others who have been working on the subject, including representatives of governmental ministries and Non-Government Organisations (NGOs) as well as students.

The report below is based on the discussions and dialogue held over course of the day. While it is impossible to summarize all the rich ideas that were shared at the forum, we have reproduced below some of the key outputs and learning that occurred.

Plenary Session I - Early Childhood Health Care

The session was chaired by Ms Mira Siva. The discussion for the day was opened by a presentation on child survival, early health care and learning by Dr. R. N. Srivastava. In India, children below the age of six constitute one-fifth of the total population.

While the priority in child care is to ensure survival, mortality continues to remain high in India, although it varies across states. The issue of neonatal and infant mortality has been studied extensively, and interventions can be made to reduce mortality. For instance, antenatally, a child can be given good nutrition through its mother. Neonatally, delivery has to be made as safe as possible, whether it is effected at home or in a medical institution; breastfeeding should be aggressively promoted; the rate of vaccination must be increased and enforced; and illness should be swiftly detected and treated. In regard to older children, safe water must be made available and accessible. Common illnesses such as pneumonia and diarrhea should be promptly identified and treated, and malnutrition controlled. Further, recurrent illnesses like diarrhea and cold reduce food intake and promote undernutrition and thereby retard growth; it is a vicious cycle. Undernutrition can also increase predisposition to infections and there is evidence that it may activate tuberculosis. Supplements of nutrients must be provided, and it is most important is to inform and educate the family and the community. Rural expenditure on health care is very small; little is spent in treatment until the time of hospitalization and common illnesses are ignored.

Dr. Srivastava reiterated that health care and education are the most important of children's rights, and thus must be made free and accessible to all children. The discussion on ECCE remains largely academic, and while there are some government programmes, information on best practices is not easily available. It is important that whatever is known be implemented. The responsibility for young children has to be taken by the local community, like the Panchayat, so that local best practices can be incorporated into the care of the child's health and his education.

Dr. Rajeev Seth then followed with a presentation on early brain and cognitive development and the need for multisensory stimulation. Without this, it can lead to impairment in a child's cognitive development. He further noted that survival alone is not enough, there has to be a comprehensive approach to ECD. In order to ensure this, the capacities of Anganwadi and ASHA workers have to be built up. Dr. Seth mentioned his work with the NGO Bal Umang Drishya Sanstha (BUDS) in some backward districts of Rajasthan, where he noted children have barely any nutrition, and are served the bare minimum in terms of food. There is no infrastructure for learning or play. Thus, again, the responsibility for this has to be taken by the local community, and everything cannot be left to the highest echelons of government.

Dr. Vandana Prasad then gave a presentation on the public health approach to the problems of malnutrition and anemia in preschool children. She mentioned that she had 25 years' work on malnutrition through different programmes, but pointed out that actual knowledge is gained by testing theoretical principles and it is a long process. Obesity is on the rise amongst children and at the same time malnutrition continues to be a huge problem in India. The biggest reason is the actual lack of access to food in many parts of the country, especially in tribal communities. There are proximal as well as distant determinants of malnutrition. The former is largely inadequate access to food, inadequate care, and nutrition. The care of children is left to their families and within the family to women, but these women are themselves malnourished, often working 18 hours of the day, and in no position to care alone for their children. There are policies to support working women in their child care functions but these need to be implemented, there is a need for an adult caregiver who has to know what to do with the child.

There are two approaches to the issue – malnutrition as a medical emergency and malnutrition as an outcome of socio-economic injustices. There is now a medical middle ground and convergence on the issue of stunting as a factor. She mentioned that there is a big difference in malnutrition in India vis-à-vis Arica. In India we have acute and chronic malnutrition but in Africa it is largely acute. Thus, in the Indian context, mere survival is not enough - it is not enough that a child has been kept alive but that he has to live with malnutrition all his life.

Like the previous speakers, Ms. Prasad also cautioned against relying solely on the government ensure the well-being of children: top down action doesn't yield satisfactory results, and there is a need to use local resources to ensure sustainability and we must build on good practices and existing knowledge. Women's empowerment will have to be at the forefront. Women must not be viewed through a utilitarian sense, as mothers, but in their own rights as persons who care about their children and want to support them. She mentioned some of the best practices employed by her organisation: The use of pictorial and low-text content to educate mothers as well as local health workers; and good quality food, referrals for health services and an overall umbrella of care including supervised feeding, nutrition, and rigorous growth monitoring which women themselves can understand and perform. It is necessary to ensure that a child is taken into the care system as soon as he or she starts to slip, and not wait till the child hits the malnutrition level. It is essential to have a continuum of care for every child, whatever their status. There is also a need to foster trust between the community and the health system, which is often very low. She ended by pointing out that the solutions are often simple rather than technical – good nutrition and disease prevention, and this yields visible results.

The session concluded with a presentation by **Dr. Tulika Seth,** who dealt largely with the effects of anemia on young children. Anemia is one of the most common afflictions plaguing children in the 0-6 age group, and can impact mental development, growth and physical capacity and reduce immunity. Traditional Indian diets are low in iron and we also have inhibitors like phytates that can

decrease the absorption of iron; in any event, Indian babies start off iron deficient due to maternal undernutrition. It is necessary to look at other interventions outside anemia programs to address the problem; thus, macronutrients are important. Apart from poverty, there is also a paucity of information and women are not aware of what is a good source of nutrition; thus, there is a need to educate and inform. Programs for prevention of anemia will not work for those who are already anemic – they need prompt referral and appropriate intervention for treatment. Compliance is very important to detect and cure anemia. It is also very important to ensure that adolescent girls are taken care of – this is to ensure that they do not pass on their deficiency to the next generation, especially as the problem of early marriage is so prevalent in India. Food fortification is controversial though countries like Pakistan have done it. However, it is important to understand whether those who need this fortification will be able to access it at all. We can learn from other countries but perhaps going the way of kitchen gardens and education will yield more results.

She revealed that there was soon to be a national program on prevention and treatment of sickle cell anemia and thalassemia.

The discussion following the sessions raised the very important question: how come we do not know more about the issue and do more about it? How do we communicate and who is supposed to be mobilized and enlisted for communication? Nutrition is a much-neglected area. There is fairly simple knowledge that is available and the cause and effect dynamic is fairly easy to disseminate but even the average doctor or average development worker is unaware of these facts. The information has to be disseminated at the local level, and the Anganwadi and ASHA workers have to be trained to impart this knowledge at that level. Simple things – the benefits of vaccination, good nutrition etc have to be made a part of the discourse at the village level.

There is also a need for a civil movement, for targeted advocacy at the government level, to ensure that the govt takes the necessary action. We are also lacking at the most basic levels – for instance there is no national policy on crèches. When we talk about the child we also focus on their physical growth but their mental growth is largely ignored; why is this so? The child's development includes this aspect as well.

There are large alliances to advocate with the government; it is strong and ongoing. There is an issue of a lack of political will and there is no getting away with that. It is an ongoing struggle. But there are policies on paper which are now beginning to take off. Maybe in five years there will a lot more of this on the ground and there is a need to push for more. Paediatrics should not be located exclusively in the wards of tertiary care hospitals; there is a need for preventive, promotive and then hospital care. Lastly, if women do not fight there will no improvement. There are many good ideas on paper but there are no resources and there is no environment in terms of encouragement and support for ASHA and *Anganwadi* workers. The *Anganwadis* are touted as a centre for nutrition and learning for children and this has to be enforced and demanded. Also, the definition of child abuse has to be reframed in the Indian context. Mental health of the child is indeed very important and this has to be incorporated in our programs for children.

The person who cares the most for the child is the mother, and if the mothers are not looked after the child will not be looked after. She has to be supported, the issue of maternity benefits and entitlements has to be kept in mind. South Asia has the maximum gender discrimination and gender violence and this has had a direct impact on programmes for the welfare of children. At the end of the day, the government has to be made to implement the SDG goals by increasing the budget allocation for health from the current dismal 1.2 per cent.

The first plenary session was chaired by Dr. Srivastava and **Dr Ranjana Mahna,** Director Institute of Home Economics, University of Delhi. Dr Srivastava in his opening remarks reiterated that the ECCE must not remain a solely academic discussion, and must be translated into action at the rural and village level and for the poorest of families.

In her opening address, **Dr. Venita Kaul of CECED, Ambedkar University** spoke on the issue, Meeting the Needs of the Young Child in India: Ensuring a Fair Start through ECCE. She lauded the effort put into organizing the conference, recognizing that it is very rare that academicians and educators working on ECCE are able to meet with doctors and other professionals, and advocated the need for a multisectoral approach to understand and address issues related to children. She mentioned that here is a very close linear relationship between what happens to a child in his or her early years and problems that the child faces later, even in adulthood, such as depression and alcoholism. There is also a relationship between problems at school such as hyperactivity and attention deficit and what are now being called executive functions. It is a lot to do with the toxic stress that the child is harboring. In terms of health, there is adequate research to show that malnutrition and learning have a lot of interdependence. It leads to low energy, low attention level and low learning outcomes. She mentioned that while remedies were being sought within the education paradigm, this was not enough. Nutrition supplementation may be needed to fill this gap, and there is also a research to show

that if nutrition is supplemented by early stimulation and early psychological interaction the effects would be better. She agreed that the first few years are critical and within the span of these early years these linkages have to be established so that the conceptual foundations of the child can be properly formed. The whole process of learning, education and development is a cumulative continuum and there is a therefore a need to provide the child with a wholesome environment from the beginning – health, education and protection. As mentioned by other speakers, she also mentioned that given that ECCE had been left out of the Right to Education Act 2009, there was a need for advocacy in this regards and for regulation in this field. She opined that there was also parental and community awareness has to be created, and doctors can play a pivotal role in imparting this awareness. In this regard, she mentioned the close connection between the methodology to be followed in preschool and giving them a sound foundation to develop those executive functions. Those imparting the education have to therefore be trained adequately. Also, the content of this education is largely market-driven: schools are delivering the kind of education that parents are demanding, and there is therefore a need to create informed demand in that sense. The National Curriculum Framework, as a very broad framework, is clearly inadequate in addressing the ECCE needs of today's children. There is therefore a need to change the perception of parents so as to address problems in terms of curriculum, as pre-school education in private schools is largely demand-driven. Doctors can be an effective tool for providing parents with the right kind of exposure and information. She concluded that the field has to be approached in a professional way rather than through a minimalistic approach and advocacy has to be jointly directed in that way.

The session was concluded with comments from Dr. Mahna, who agreed on the need to dedicate both attention as well as resources to the issue.

Panel Discussion – Building Research and Sharing Practices: the CECED Experience

The following session was chaired by Dr. Kaul and the presentations were used to elaborate on the studies conducted by CEDED, which works extensively in the field of ECCE.

Dr. Aparajita B. Choudhary made a presentation on the findings from a three-state longitudinal study on the parameters and impact of ECCE in India, conducted by CECED. The study found that a good quality ECCE experience contributed to enhancing school readiness and that a combination of good quality training, mentoring and supervision enables teachers to work effectively with young children. School readiness levels make a significant difference in learning levels all the way, at least up to age 8, but she mentioned that school readiness levels of children are low across states and programme type. Further, major enrolments at preschool are in *Anganwadis* or in private preschools across states, while at age 4, there was a trend of migration to private schools. However, it was found that *Anganwadis* are often not associated with education.

Further, a good quality curriculum exhibits the following features:

- It features age and developmental appropriate activities which can be revised based on individual needs
- It focused on school readiness skills
- It provides opportunities for free play and guided activities with manipulated materials
- It provides a rich language environment which allows children to interact spontaneously with their teachers and peers.
- It teaches children concepts by doing things or participating in activities, not through rote memorization.
- All its programs aim to discipline children through positive guidance and have strong policies against corporal punishment.

The next presentation was made by her colleague from CECED, **Dr. Monimalika Dey,** who spoke about the CECED study "Early Childhood Development for the Poor: Impacting at Scale." She stated that the objective of the study had been to evaluate by randomized control trial (RCT) the impacts of two early stimulation interventions on child development and health, to investigate their scalability and the relative effectiveness of each mode of delivery, in comparison to an intervention solely based on nutritional education, and to identify the mechanisms whereby the interventions affect ECCE outcomes. She mentioned that to design the home visiting program on which the study was based, CECED had studied Sally Grantham-McGregor's intensive study which had followed children in Jamaica under it for 30 years. The program took into consideration principles of community psychology, child development, and activity based approach. She mentioned that while an adaptation of that methodology had been done in other countries like Bangladesh and Peru, it was in India that for the first time a group curriculum was also

developed and this takes into account Indians' socio-centric nature, and aims to deliver information to mothers with this in mind. The groups have been divided based on the ages of the babies and there is a facilitator for the interaction. She mentioned that while the study was started in January 2016 and CECED are just preparing to collect the midterm data, the pilot had shown significant gains in development outcome and it was also found that the gains amongst the boys were significantly higher than amongst the girls.

The final presentation of the session was made by **Dr. Sunita Singh,** who spoke on the validation process for Early Learning and Development Standards (ELDS) for India. Essentially, ELDS are statements of what children from birth to age eight should know and be able to do at various ages across their earliest years of development. Thus, they serve as a tool to track and promote healthy child growth and development. They also ensure good quality good quality ECCE by informing the design of an age-appropriate curriculum and care giving practices.

She mentioned that in regard to ELDS, one of the major challenges that children face is the transition from preschool to class 1. Thus, the objective of this study was to examine different settings and try to understand how ELDS can be established, so that these can inform policy as well as family interactions. She mentioned that ELDS had the following goals:

- To track the age and context specific developmental needs of children;
- To provide information which parents, educators, and policy makers can use to better understand developmentally appropriate needs of their children;
- To promote healthy child growth and development, good quality Early Childhood Care and Education for all children from birth to 8 years;
- To identify the areas which need improvement to ensure positive learning outcomes.

Thus, a core group had been set up consisting of experts in the field who would then work to develop ELDS in a manner that was age-appropriate and took account of development milestones.

Plenary Session II: Early Assessment and Interventions

The plenary session which followed was chaired by **Dr. Sheffali Gulati** of the Department of Paediatrics, AIIMS & Dr DN Virmani, past President IAP Delhi.

The first panelist, **Dr. Geeta Chopra,** spoke about her work on early screening and detection of disabilities. She mentioned that while World Health Organisation statistics revealed that childhood disability could be as high as 15%, most of these children are out of schools and therefore invisible. She also mentioned shocking statistics from a 2009 UNESCO Report, which found that 98% of children with disabilities in developing countries do not attend school. She quoted from a Harvard University study that toxic stress in the early years can damage developing brain architecture and lead to problems in learning and behavior, as well as increased susceptibility to physical and mental illness. Precipitants of toxic stress may include severe poverty, serious parental mental health impairments, child maltreatment, and/or exposure to violence, in the absence of stable, nurturing relationships with the adults in a child's life[6]. She advocated the need for early identification to commence timely interventions with family involvement, as this would be aimed at preventing delays, promoting emerging competencies and creating a more stimulating and protective environment. She stated that unfortunately many children with disabilities in developing countries, particularly those with "mild to moderate" disabilities, are not identified until they reach school age. She then shared details of the screening tools she has developed, which would be useful for identifying impairments and signs of major disabilities among children between 0-6 years. She also presented *A Training Module on Early detection of Disabilities and Inclusion* comprising of simply written and profusely illustrated guidebooks on Prevention, Early Detection of disabilities and Inclusion of Children with Disabilities in *Anganwadis,* Disability Screening Schedule, Posters etc, which has so far been used to train 119 grass-root workers, who have screened more than 13,000 children, finding more than 7% disability rate in the age group 0-6 years. (pl include this)

Prof. Gulati seconded Dr. Chopra's views, stating that a prevalence study by NIH in 5 districts in India, including a rural and a tribal area, had revealed that over one-eighth of the children were found to have one or more disabilities including learning, developmental and neuro motor disabilities, and almost a quarter of these had more than one disorder.

Dr. Arun Singh's presentation followed Dr. Chopra's. He spoke about the background of the Rashtriya Bal Swasthya Karyakram (RBSK) programme, which is a school health program launched by the government to conduct child health screening and early intervention services, so as to link these to care, support and treatment and provide a continuum of care from birth throughout childhood. He began by defining disability as not reaching one's genetic potential. While dealing with a child, we do not know his or her future, and the word disability therefore appears to all of us as something different from ourselves. There could be two children with the same medical problem, both with the same initial genetic potential (or lack thereof). Of them, one receives parental interaction and one doesn't and in five years one sees that the former has a higher

developmental index. This demonstrates a need for universalized care and attention for all children. The RBSK approach is to reach those who are untouched by other programmes, those who are completely excluded, and also to minimize out-of-pocket expenses on health care so as to make it genuinely free. It also provides comprehensive care, for which every child has to be screened twice a year by a dedicated screening team, upto the age of six. Defects at birth, developmental delay, deficiencies and diseases are the four red flags. The objective is to minimize or prevent disability rather than identify it. Intelligence and cognition are formed by the best utilization of the sensory organs and thus these organs have to be developed and disabilities in them picked up at the very earliest, so that the impact thereof can be minimized.

Government Schemes on Early Childhood

The following session was opened by **Ms. Roopa Kapoor,** member of the National Commission for the Protection of Child Rights (NCPCR) who shared her experiences in ECCE as a social worker as well as the work off the NCPCR on the subject. She expressed her opinion that ECCD would have to be addressed on a war footing, and advocated a positive deviance approach. Thus, solutions have to come from within the community; for instance, some communities have malnourished children but also healthy ones. Thus there is a difference in their backgrounds, as a result of which the child is a positive deviant, and this has most often been brought about by the parent who has taken care of the child in a way conducive to its well-being. She mentioned a rehabilitation program where the parent had to supplement the ICDS-given nutrition and care facilities; parents were taught about sanitization, cooking, and how to care or the child. The child's growth was monitored by young persons from within the community and it was noticed that there was a tremendous change in the children's health as well as their cognitive development. Thus there is a need for behavioural change within the community. She further agreed on the need to decrease the age of children and include younger ones into the RTE. She mentioned an NCPCR initiative as per which 15 states of India had been asked to select 30 villages each and to make them child-friendly. Thus, they need to ensure that these children are getting the benefit of government schemes and each child has to be accounted for in terms of health, education, schooling etc. She mentioned that ICDS centres work well as crèches in south India, and are able to provide comprehensive care to children, and this model should be replicated across the country.

The government viewpoint was presented by **Dr. Rajesh Kumar,** Joint Secretary in the Ministry of Women and Child Development. He highlighted that the stakes were very high when it came to ECCD, given that the number of children under discussion was enormous – ICDS has 8.5 crore children and UID has raised the number of children under 5 to 19.5 crores. He revealed that on 16-17 October 2016, the government had launched a comprehensive program to address micro-nutrient deficiency and were also trying to promote conventional plant breeding. He agreed on the need for more investment in the ECCD component of ICDS and conceded that while institutional deliveries were increasing, the stories from the field are very different from the schemes on paper. Supplementary nutrition, antenatal and postnatal care to be made directly available to mothers, by linking these subsidies and allowances with Aadhar cards and bank accounts. The government is also looking to use technology to make these more accessible and has signed an agreement with the Bill Gates Foundation for the same. New vaccines including rotavirus and pneumococcal were being rolled out. He concluded by mentioning that the government was keen to work with professionals in the field and stated that on December 7, 2016, a conference was being held with the directors of ECCD programmes in all the states so that when funds are given from next year onwards this deprived section receives it in the best way possible.

Plenary Session III: Rights-based Approach to Early Childhood Development and Investing in the Early Years

The following session was chaired by **Ms. Razia Ismail**, who mentioned the two imperatives: making sure that we are working from a rights-based perspective, which has evolved from a welfare approach. She mentioned that we have a National Policy for Children and it acts as a reminder to the government in the absence of a declared statement or policy on human rights. However, we also need to be mindful of policies are not explicitly stated as being for children, but affect them profoundly: the food policy being a case in point. In this, it is helpful to be mindful of the Sustainable Development Goals (SDGs), while the child-related goals are obvious, the non-child-specific goals also affect children. The government should bear this in mind now, when we are on the threshold of a new National Plan of Action for Children and that will set the tone for future policies and set a framework for actions.

The first panelist, **Dr. Ajay Khera,** spoke about the need to work towards the holistic development of the child, which is key to the commitments of the government regarding the SDGs and this is key for the achievement of these. While India has moved quite fast in terms of child survival, in terms of holistic development, it is not only survival that matters; the child's

potential has to be realized and this begs a lot more action. Social protection measures are necessary for this holistic development and this includes specific actions for the prevention of violence against children, as is universal health coverage which is a tool that has been adopted in the context of a strategic approach to the SDGs as well. This includes three dimensions: reaching every child i.e. horizontal extension, a challenge given there is a large chunk of population that is excluded even from primary health care. To achieve this, the government under the National Health Mission Programme has invested in infrastructure as well as programme management. Another approach has been to approach it under the Mother and Child Tracking System so that each pregnant woman and then her newborn are registered and given care, even home-based. This has a coverage so far of about 50% and they are closely and individually tracked, for instance for immunization, health checks etc. There is also a dedicated health worker in every village of the country and she is incentivized in terms of her performance. It is important also to provide a package of services, which will make drugs and diagnostics free and extend primary health care to the remotest parts of the country. This has to be linked with the referral support system for secondary and tertiary care. The third critical element is its depth, i.e. out-of-pocket expenditure to be minimized. If a person can't afford to go to the hospital, she won't go even if there is a promise of free services, due to the auxiliary expenditure like transport and medicines. Thus, these have to be minimized. For instance, transportation is being provided free of cost to pregnant women to facilitate institutional deliveries. He also mentioned some new initiatives such as Mission Indradhanush which is trying to expand immunization coverage, and the Indira Gandhi Matritva Sahyog Yojna where the private sector and public sector come together to screen pregnant women once a month.

The Guest of Honour **Ms. Rashmi Saxena Sahni,** Joint Secretary in the MWCD, stated that given its overwhelmingly young demographic, India is very well-placed to advantage of the digital revolution, and it is therefore important for us to invest in children as much as we can. She reiterated that children do have rights; they are entitled to a happy childhood and one that allows them to develop to their full potential, and the government is on track to come out with a NPAC which is a convergence document that lays down a structure for goals that we should achieve by 2021 and highlights the areas of concern, including marginalized children such as those of migrants. India has robust legislation in place in addition to constitutional guarantees, such as the Juvenile Justice (JJ) Act and the Protection of Children from Sexual Offences (POCSO) Act, which have been hailed as innovative and transformative in their nature. Unfortunately violence against children, which directly impacts their growth and affects them throughout their lives, is deeply ingrained in our society. Needless to say, it has grave implications for the nation in the longer term. The NPAC has an education focus and treats it as a means to counter the effects of poverty, violence and other problems that affect children. We also already have *Anganwadis* which is not merely a place for nutrition and school education but also to inculcate skills for social interaction. The NECCEP focuses on care and early learning and recognizes the dependence between health, psycho-social development and physical and emotional well-being. The National ECCE Curriculum has also been formulated and notified to the states. There is also an annual curriculum contextualization in each state so as to incorporate the local practices, folklore and cultural values in each system into the curriculum for that state. She agreed that family structures have changed greatly in the last few decades and this gap also has to be addressed by schools and *Anganwadis,* and concluded by reiterating that if we start looking after our children today it will pay dividends in terms of having a society that is not only educated but also innovative and can take the country forward.

Her speech was followed by a presentation by **Ms. Razia Ismail**, who spoke on the issue of "lost children". She began by agreeing that children are low-value in our general attitude, and do not have leverage in spite of being the most critical part of any population, and they can't even speak for themselves. She advised that a policy that reaches out to all has to take into account those who tend to be left out; a universal mandate has to be for everybody. The fact of being left out of basic services and the benefits of whatever the state and society are able to provide are what identify this lost or, indeed, last child, who is otherwise invisible. These children do not even get counted accurately. For instance, the children of what are called nomadic tribes are not even listed in the Census and their children are completely lost to the system. Thus they have no entitlements; any services that they are able to avail of is accidental rather than targeted. Their status has not been established. If we test a program on the basis of whether it reaches out to children like these, there is a denial of their exclusion, which is often termed as accidental. Who has forgotten these children? Are they asking for recognition? In the context of primary health care (PHC) we have no numbers on those who are left out; if they are migrating from place to place they cannot be admitted into ICDS as they do not have any proof of domicile. She mentioned that there was only one example of a migrating ICDS service, in J&K, which may even have become defunct. She stated that inclusion is the job of the state, and the Constitution itself envisages social justice. Mother and child health programs started years ago and ICDS is also decades old. Now there are *Anganwadis* everywhere but some people still get excluded from them because they do not qualify, for instance

as they do not have a fixed address. The NPAC has a 5-year timetable but without inbuilt and conscious accountability it could very well fail. She also mentioned the need for collaboration on the formulation of state plans, warning that at the Central level there had been no consultation with civil society and that this did not bode well in terms of inclusion. She repeated that while the SDGs are now influencing the programs and plans that are coming up, it is necessary to remember that all 17 goals affect children. These programs are an opportunity for us to ensure universal, pervasive and inclusive health care. Unfortunately, resource allocation is very low and there is no money to pay for professional services for children, but inclusion needs political will and not just capability. She also gave an alternate perspective to the talk of digitalization, mentioning that in putting health services under a scanner of technological advancement, there may have been a fading of human contact and its quality. She further mentioned that in order to ensure total inclusion, there should be a count of how many children there are, and there we may find some answers and realize that inside very not-so-high-risk district there are still high risk pockets. She concluded that the problem was one of governance, and that given that children are not in a position to raise their voices, we need to come together to look for these lost children and bring them into the mainstream.

Ms. Devika Singh, the founder of Mobile Crèches and a long-time child rights advocate, then took the floor, and began by reminding the gathering that India should not sight of its vision for social justice as enshrined in the Constitution. A rights-based approach begs the questions: what rights, who will deliver them, how will they be delivered? She stated that the problem was an urgent, and called for a reboot of the process so as to build the momentum all over again. In talking about equitable coverage and universal coverage, if we can account or the lost children we can move up the ladder and build on a sound foundation; that is what a human rights approach means. There is a need for investments for children and to have an absolute commitment that one will not allow the situation that exists today to persist. We need a crusade and not to just tinker with the system as it exists today.

The international and national communities are flagging the issue that early childhood development is critical to social, cultural, economic rights. When we have an environment where goals can be identified, we need to break the existing paradigms and set a new pace with a very firm commitment. India has signed numerous conventions and commitments and they are important as a starting point, and the rise in rights movements for women and children in India is heartening. However, so far India has used a welfare approach and does not yet have the rights-based approach other than on paper: neither in terms of programs nor budget. Ms. Singh made a very strong case for more determined legislation, which would give bite and structure to children's rights and bring together the knowledge, experience and data that we have so far gathered.

She agreed that early childhood is very complex and there is a set of rights attached to it, and that anything that points to the need for a comprehensive approach would necessarily have to look at the full set of rights. There is an intersectoral requirement – safety, protection, preschool learning, nutrition, health and so on – but we need a mandate with teeth, which has clear directions for enforcement and which makes people accountable. A welfare approach is also characterized by targeting and the moment we target interventions we exclude those considered lower in priority. This in itself is not a rights-based approach. We need training institutions to create accountable personnel who k now their job. What is to be given, how to give it, how much is to be spent on it – these are all issues that need to be resolved so we can move from paper to reality. Children's rights cannot be seen without looking at the rights of women and families. We have to look at overlapping rights and have legislation that addresses this intersectionality. It is a big challenge and we cannot rest on our laurels in terms of digitalization etc. We have to dialogue with people and bring them on board and we require convergence structures to equip people and build their capacities.

During the discussion that followed, participants were keen to understand the challenges faced by ASHA workers. Dr. Khera replied that while in the past the *Anganwadi* workers were expected to deliver all PHC services at the community level, it was found that they were already overburdened and that is how the ASHA posts were created. The objective was mainly to improve outreach systems so that coverage could also be improved. But he conceded that given the increase in the volumes of work, two workers in a village are simply not enough. There are many layers of care to be provided and there is a need for an integrated unit to address all these needs. He agreed that ECCE requires human time and effort to be invested in a child and there is therefore a need to reengineer the health system.

Plenary Session IV: Equity and Quality in ECCE

The session was chaired by **Dr. Adarsh Sharma,** who began by flagging a few recurrent themes:
- holistic development can only take place if we have a multidisciplinary approach - health is not a separate issue and is linked to all other aspects of thee child' well-being - ECCE is every child's right and it comes not from medical or scientific evidence but from popular belief and observation - a child deprived of the necessary ECCE interventions will be put at a disadvantage and if we do not catch that window of opportunity it is missed forever - we have failed to translate our knowledge and experience into action and there is nothing to excuse that

She then handed the floor to **Dr. Rekha Sen,** whose presentation made a case for distance education on the subject of ECCE. She mentioned some of the pertinent questions: even when you do bring in regulation of those responsible for ECCE, how do you train those who are already in service? She mentioned that the National Council for Teacher Education (NCTE) doesn't have norms for training those who are already in the field. She explained how the program headed by her, which has been

running since 1995 at the Indira Gandhi National Open University, was attempting to bridge this training gap. She stated that her objective was to show who are the people who take these courses, why do we need to lobby for it and debate on whether we even need these programs. The objective of the IGNOU's ECCE program is to help professionals who work with children develop their knowledge, skills and education and its innovation is that education and child health and nutrition have been spoken of together.

Ms. Shruti Mishra of Plan India, although unable to come, had sent in a presentation which was presented at the Conference. It was revealed that given that ECCE has been a neglected component of ICDS, Plan India had tried to understand how they could contribute to enriching it. When it comes to quality there is curriculum, pedagogy, creating a learning environment and other aspects to this issue. Each state has different developmental needs and needs different inputs and this has to be incorporated into all our programme is workers and health providers who translate the curriculum into practice and they need suitable training for this. Ultimately, mothers have to be equipped to care for their children, as well as other family members and the community so that they can all support the child and help in its optimum development.

The methods of early childhood should be followed into primary classes but this is discounted by the NCTE because since 2014 they have disassociated teacher training for preschool from classes 1 and 2 which completely disrupts continuity. This is a regressive step in terms of teacher training. This also sets us back in terms of building an appropriate cadre of workers. There needs to be a structure even for innovation and contextualization has to be based on that.

During the discussion, the participants enquired as to whether parent education was included in ICDS. The panelists replied that it was, under the moniker "parental counseling", in which ECCE includes not just the mother but also the father and other family members. There is an ECCE day on which all these issues are discussed at the village level and each *Anganwadi* is supposed to organize it once in a month. The need for support services in the extra-familial context (day care) was reiterated.

Closing and Recommendations

This session was moderated by Dr Rajeev Seth, Dr. Srivastav and Dr Geeta Chopra. The speakers and experts present agreed on the following recommendations:

To the Government:

- Comprehensive ECCE is possible if it includes the medical, health, developmental needs, education and early stimulation of the young child during infancy and preschool years. The approach has to be holistic.
- As for health, the facts are well-known and it is distressing that those who cannot afford treatment should be provided free medical assistance. This has to be addressed on an urgent basis.
- The government is trying to reduce out-of-pocket expense on health care, and while this is necessary (how and why?), it is necessary to make a push for the right to health for all children to be made a part of the government's obligations
- Budget for children is also being reduced. This is very worrisome as studies are indicating that for every Rs.1 spent on ECCE, there is a return of Rs. 25. Investing in early years is the foundation of any strong nation.
- Much information is available and this must be translated into practice. The *Anganwadi* centres must be transformed into genuine one-stop centres providing comprehensive health care and learning for children. Also, the centres have to be made inclusive across socio-economic strata as well as with respect to disabilities and other disadvantages
- Strengthen the ECCE profession by working on the curriculum, training of early educators, access to quality preschools, and childhood free from violence and abuse
- The government must come out with a policy to regulate play schools centres that provide ECCE.
- There is an opportunity at the Delhi level to look at a Delhi-centric mapping, assessment and outreach and this is practically feasible. We can look at gap areas and concerns that need to be addressed .
- There is a felt need for training across the board – from Anganwadi and ASHA workers to government doctors as well as those in policy-making positions, so as to ensure that they understand the parameters of good ECCE.

To the medical community:

- Paediatricians tend to worry more about physical health rather than overall early stimulation and this is missing from the paediatrics curriculum, and this needs to be addressed. To start, the IAP can form an advisory group to encourage paediatricians to provide anticipatory guidance to parents
- IAP can also have an advocacy document on right to health and learning for early childhood
- The IAP must also take the initiative to identify some innovators from other sectors and make first connections so as to foster convergence

To civil society:

- More components of ECCE must be included in academic discourse
- There is a case to be made for the need to look for intersectionality across issues, or instance to find connections between government policy which may even inadvertently lead to the exclusion of certain categories of persons, and tie these in with broad-based advocacy on ECCE.

Acknowledgement and Thanks to Hansa Vijayaraghavan for consolidating the above report.

National Workshop on Early Childhood Care and Education (ECCE) (excerpts)

Dr. Rajeev Seth Chair, ICANCL group Email sethrajeev@gmail.com

The Ministry of Women & Child Development, Government of India organized a National Workshop on Early Childhood Care and Education (ECCE) on December2, 2016 at Vigyan Bhawan, Hall, New Delhi. The Ministry recognized that early childhood Development spanning from birth to six years is a period of most rapid growth and development of the entire human life span. It is during this period the foundation of cognitive, physical and socio-economic development, language and personality are laid. Workshop discussed the status and challenges of ECCE implementation and to facilitate cross learning of innovations across States/UTs. Status of ECCE implementation based on 8 States assessment of ICDS, along with DFID and Deloitte. Discussion on State level difficulties in ECCE implementation, possible solutions, and support sought from Centre were brought up.

Dr Rajeev Seth, Chair ICANCL group was invited to chair an expert group multidisciplinary professional group symposium. Panelist included Dr Prof Venita Kaul, Professor and Director of School of Education Studies the Ambedkar University, Delhi, Razia Ismail, Convener India Alliance for Child Rights, Dr Geeta Chopra, Associate Professor, Human Development and Childhood Studies, at the University of Delhi, Dr Rekha Sharma Sen, Associate Professor, Faculty of Child Development, School Of Continuing Education, Indira Gandhi National Open University, New Delhi & Ms Mridula Bajaj, Executive Director Mobile Crèches and Child Development Specialist. The expert group concluded that Comprehensive ECCE is possible if it includes the medical, health, developmental needs, education and early stimulation of the young child during infancy and preschool years. There is an urgent need for Government to invest in this field for maximum returns, and provision of basic child rights. Active engagement with medical professionals, academic, multidisciplinary experts in early child development, civil society, NGO's, Child rights activist and training/ capacity building of frontline line anganwadi workers is urgently needed.

National Conference of Indian Academy of Paediatrics (PEDICON 2017)

January 18-22, 2017, Gayatri Vihar Palace Ground, Bengaluru

ICANCL Symposium Friday, January 20, 2017 at Hall 10 from 9-10.30 am

Prevention of Violence against Children: Focus on the Girl Child

Chair: Dr RN Srivastava, Dr Satish V Agrawal & Dr Amul Rastogi

Violence against the girl child: What do we know about the effects on health and wellbeing? Dr Prof Shanti Raman,IPA

Systematic Review of the Epidemiology and Response to Child Sexual Violence in India Dr Ms Ameeta Kalokhe, Public Health Foundation of India

What works in preventing violence against girls? Ms Ramya Subramanian, Know Violence in Childhood

Questions

Panel discussion with practising clinicians and academics using case studies

Moderator: Dr Rajeev Seth

Panel members: Dr Sangeeta Saksena, Dr Prof Sandhya Khadse, Dr Prof Chandrika Rao, Dr Prof Devendra Sareen

Day & Date:	**Saturday, January 21st 2017**
Session	What is New?
Time:	0900 – 1000 hours
Topic:	**Symposium on Child trafficking and sexual exploitation**
Chairpersons:	Dr. Renu Agrawal & Dr. Avinash Mishra
Moderator:	Dr. Dr. Rajeev Seth
Speakers:	Dr. Shanti Raman, Dr. Shaibya Saldanha Dr Prof Jagadeesh narayanareddy Dr. Prof Sandhya S. Khadse, Dr. D. S. Rawat

Day & Date:	**Saturday, January 21st 2017**
Session	Panel Discussion
Time:	1300 – 1400 hours
Topic:	**Child Sexual Abuse**
Moderator:	Dr. Rajeev Seth
Speakers:	Dr. Sujata Jali Dr. JP Kapoor Dr. Geetha Patil Dr. Dinesh Laroia

Predictors of Violence in Children & Adolescents

Dr. Sandhya Khadse, Dr. Aarti Kinikar, Dr. Chhaya Valvi, Dr. Rajesh Kulkarni, Dr. Naresh Sonkawade
Email : sandhyakhadse@yahoo.com

Young Adolescents indulging in Violence is a major public health issue. Juvenile Delinquency refers to antisocial behavior. Development of violent and antisocial behavior is the feature of antisocial behavior diversity with increasing age. Maturity reduces the frequency of aggressive act. Peer influence has now found to be correlated with a harmful behavior. The quality of parent child relationship seemed to be most strongly associated with aggression behavior in adolescents. Parental monitoring has a protective effect on many adolescent risk behaviors in middle class populations and poor urban environment. Authoritative parenting generally leads to be best outcomes for teens.

Prevalence: The Prevalence ranges from 1.6 – 9.5% across different countries. The US homicide rate in the age group of 15 – 24 years is 18 times higher than for UK & 73 times higher than Austria.

Etiology: Numerous theories have been put forward for violent behavior in young people. They are three major risk areas.

a) Child Centered b) Family Centered c) Contextual

Child Factors

- Learning Disability - Genetic Factors - Psychiatric Disorder like ADHD

Poor impulse control and educational difficulties are implicated in this risk. Depression in adolescence can manifest itself as anger, which in turn is correlated with aggression. Anxiety and post traumatic stress disorders show raised rates in violent young offenders Autistic spectrum disorders are being increasingly recognized as important etiological factors. The reason proposed for offending and aggressions in autistic person are 1) their social naivety may allow them to be led into criminal acts by others. 2) Aggression arises because of disruption of normal routine. 3) Antisocial behavior may stem from a lack of understanding or sudden impulse. 4) Child usually reflect some obsessions

Family Centered factors Include poor parenting ability, Family History of Criminality and exposures to domestic violence. Primitive, harsh and inconsistent parenting styles are associated with conduct disorders in children.

Contextual factors Include substance abuse, peer group influence, media and opportunity for criminal activity. Violence depicted on media makes the person more aggressive. Constant influence on the young mind leads to aggressive impulsive behavior. That is why television viewing by young children should have some restrictions and monitoring and supervision is important. As far as the prognosis is concerned earlier the age of onset of behavioral disturbances are more it is likely that the antisocial behavior will persist into adulthood. If juvenile delinquent are rehabilitated with employment and helped in establishing a stable work record and dear previous criminal behavior can be erased.

Interventions: Most of the therapeutic modalities for management of violence in young adolescents require multidisciplinary heath settings where there are skilled professionals like psychiatrist, clinical psychologist, social workers, counselors working in conjunction with the family and young adolescent.

Young adolescent: Parent management training, family therapies, social skills training and anger management training are some of the techniques and modalities which are used by therapists.

The primary issue for pediatricians is to treat any diagnosable behavior disorder like ADHD and identifying early signs of emergence of behavior disorders. Moral science and Human values have to be taught with an important along with other subjects not only in school but also in colleges and they should form part of curriculum with weightage on scores deciding the result.

There is a need to design structured streamlined programmers for prevention of antisocial behaviors with a strong political and administrative will so that it can be delivered through community workers at grass root level. As good parenting enhances a Childs potential parents also require some training and teaching in identifying a high-risk behaviors and difficult adolescent.

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Prevention of Violence Against Children

Dr. Abhishek Ojha, Manasvin Sareen, Dr. Shruti Priyadarshini, Dr. Devendra Sareen
Email drdevendrasareen@gmail.com

There are two distinct types of violence experienced by children (defined by the United Nations as anyone aged 0-18 years)

A. Child maltreatment by parents and caregivers in children aged 0-14

B. Violence occurring in community settings among adolescents aged 15-18 years

These different types of violence can be prevented by addressing the underlying causes and risk factors specific to each type.

A.) Child maltreatment by parents and caregivers can be prevented by:

- reducing unintended pregnancies;
- reducing harmful levels of alcohol and illicit drug use during pregnancy;
- reducing harmful levels of alcohol and illicit drug use by new parents;
- improving access to high quality pre- and post-natal services;
- providing home visitation services by professional nurses and social workers to families where children are at high-risk of maltreatment;
- providing training for parents on child development, non-violent discipline and problem-solving skills.

B.) Violence involving children in community settings can be prevented through:

- pre-school enrichment programmes to give young children an educational head start;
- life skills training;
- assisting high-risk adolescents to complete schooling;
- reducing alcohol availability through the enactment and enforcement of liquor licensing laws, taxation and pricing;
- restricting access to firearms.

Improving the efficiency of pre-hospital and emergency medical care will reduce the risk of death, the time for recovery and the level of long-term impairment due to violence.

All violence against children and especially child maltreatment occurring in the first decade of life is both a problem in itself and a major risk factor for other forms of violence and health problems through a person's life. Child physical abuse, sexual abuse and other childhood adversities have been linked to excessive smoking, eating disorders, and high-risk sexual behaviour,which in turn are associated with some of the leading causes of death including cancers and cardiovascular disorders.

WHO supports countries to collect data and information related to violence against children, develop national violence prevention policies and programmes, and create systems for the provision of appropriate medico-legal and emergency trauma care.

The six strategies to prevent and respond to violence are:

1. Supporting parents, care givers and families-Educating families, caregivers and parents on their child's early development increases the likelihood that they will use positive disciplining methods. This reduces the risk of violence within the home.
2. Helping children and adolescents manage risks and challenges- Giving children and adolescents the skills to cope and manage risks and challenges without the use of violence and to seek appropriate support when violence does occur is crucial for reducing violence in schools and communities.
3. Changing attitudes and social norms that encourage violence and discrimination- Changing the attitudes and social norms that hide violence in plain sight is the surest way to prevent violence from occurring in the first place.
4. Promoting and providing support services for children- Encouraging children to seek quality professional support and report incidents of violence helps them to better cope with and resolve experiences of violence.
5. Implementing laws and policies that protect children- Implementing and enforcing laws and policies that protect children sends a strong message to society that violence is unacceptable and will be punished.
6. Carrying out data collection and research- Knowing about violence where it occurs, in what forms, and which age groups and communities of children are most affected is essential to planning and designing intervention strategies, and setting numerical and time-bound targets to monitor progress and end violence.

Gurukool Enrichment and Skill Development Center

Deepak Bhatnagar, (Member ICANCL, Gurgaon) E-mail : deepas1949@gmail.com
Jyotsna Gurukool Enrichment and Skill Development Center E-mail : jyotsna.amit@gmail.com

As I enter the rented basement which serves as classrooms, my heart leaps with joy to hear cheerful voices of a hundred little children ,but beautifully orchestrated , which is music to my ears: all saying in unison " Good Morning Sir" . In these trying times , when one is depressed with a wave of pessimism , these bright eyed kids give so much hope and reason to make me cheerful .They are so eager to learn new things about the world around them . If they are given them a few small sums in Arithmetic , within minutes I am swarmed with note books -they are eager to show that they have done the sum correctly .It is so encouraging to see their enthusiasm to learn more every morning . One feels so grateful to this learning environment created by a young lady, named Jyotsna, , and there is no doubt that may of these children will become responsible citizens , having learnt , not only the basics taught in school but have imbibed news skills in handwork , which could pave the way to earn a respectable livelihood.

The school , initially named , 'Gurukool' is an initiative of Jyotsna who had an urge to bring these children into the mainstream of society . With its humble beginnings in 2007 from the staircase of her house to under a tree in a park, this informal school for the less-fortunate children has flourished, now operating out of rented premises with more than 100 kids.Recognizing the need to make the children self-sufficient; over the years the Center has also added vocational training facilities like computers, Art and Craft and stitching classes.

With an enlarged canvas of combining teaching with basic skills in arts & crafts, , the center is now called , "Gurukool Enrichment and Skill Development Center". It has now been registered as a non-profit learning organization for providing education and holistic skill development. It is committed towards physical, social, emotional and intellectual development of a child in most crucial years of growth. We are a dedicated team of social entrepreneurs, educators and volunteers committed to providing each and every child the opportunity to fully realize their potential and to ensure personal and professional growth.

.These are all children "of a lesser God " - who had never gone to a school . Thanks to Gurukool centre , they will not be forced to follow their parent's vocation , but will imbibe new skills and learn simple communication and maths so that they could join formal schools later and contribute more meaningfully to society .As you may see from the pictures of their handwork in color arrange or ICANCL activities each child is given a uniform , books , stationary and a healthy clean environment to study and mix with each other .They are a happy lot getting a good environment to be together with other children and learning new things .

ICANCL readers who would like to encourage the children , or would like to participate in the school , may kindly contact Jyotsna Founder, Gurukool Enrichment and Skill Development Center, F-37, Sushant Lok III, Sector 57, (near Rail Vihar) Gurgaon . Tel. +91-9810515082. Please see photo inside cover page 3.

Honours & Award

ISPCAN Distinguished Service Award 2016.

Dr. Prof. R.N. Srivastava (Dr RNS) The Distinguished Service Award recognizes Dr. R.N.S. for his pioneering work as founder, first chairperson and subsequently adviser to the Indian Child Abuse Neglect & Child Labour (ICANCL) group..Dr RNS received this award at the ISPCAN Congress at Calgary, Canada in August 2016. Dr RNS is most grateful to the ICANCL members for their untiring efforts and support in advancing it's aims and objects and making great team efforts.

Kerala Sate Best Doctor Award Private Sector 2015

Dr Achamma Joseph Organizing secretary CANCL CON 2015 has been awarded the Kerala Sate Best Doctor Award Private Sector for the year 2015

Donation Thanks

Dr Bela Sachdeva, Senior Consultant Pediatrician, Abu Dhabi and ICANCL Member donated Rs 50000/- to ICANCL corpus to support its aims and objectives. On behalf of all ICANCL Members, we wish to thank Dr Bela Sachdeva for her sincere and generous gesture of support.

Yamini, student of class One at Ridgewood Elementary School, Northville, Michigan has sent Rs 5000/- from her savings for sweets for our vulnerable children program in Delhi.

Recent Legislations & CANCL links

Rights of Persons with disabilities bill 2016

http://www.narendramodi.in/rights-of-persons-with-disabilities-bill-2016-passed-by-parliament-533533

The Lok Sabha today passed "The Rights of Persons with Disabilities Bill - 2016". The Bill will replace the existing PwD Act, 1995, which was enacted 21 years back. The Rajya Sabha has already passed the Bill on 14.12.2016.

The salient features of the Bill are:

Disability has been defined based on an evolving and dynamic concept. The types of disabilities have been increased from existing 7 to 21 and the Central Government will have the power to add more types of disabilities. The 21 disabilities are given below: Blindness, Low-vision, Leprosy Cured persons, Hearing Impairment (deaf and hard of hearing), Locomotor Disability, Dwarfism, Intellectual Disability, Mental Illness, Autism Spectrum Disorder, Cerebral Palsy, Muscular Dystrophy, Chronic Neurological conditions, Specific Learning Disabilities, Multiple Sclerosis, Speech and Language disability, Thalassemia, Hemophilia, Sickle Cell disease, Multiple Disabilities including deafblindness, Acid Attack victim, Parkinson's disease

iii. Speech and Language Disability and Specific Learning Disability have been added for the first time. Acid Attack Victims have been included. Dwarfism, muscular dystrophy have has been indicated as separate class of specified disability. The New categories of disabilities also included three blood disorders, Thalassemia, Hemophilia and Sickle Cell disease.

iv. In addition, the Government has been authorized to notify any other category of specified disability.

v. Responsibility has been cast upon the appropriate governments to take effective measures to ensure that the persons with disabilities enjoy their rights equally with others.

vi. Additional benefits such as reservation in higher education, government jobs, reservation in allocation of land, poverty alleviation schemes etc. have been provided for persons with benchmark disabilities and those with high support needs.

vii. Every child with benchmark disability between the age group of 6 and 18 years shall have the right to free education.

viii. Government funded educational institutions as well as the government recognized institutions will have to provide inclusive education to the children with disabilities.

1. For strengthening the Prime Minister's Accessible India Campaign, stress has been given to ensure accessibility in public buildings (both Government and private) in a prescribed time-frame.
2. Reservation in vacancies in government establishments has been increased from 3% to 4% for certain persons or class of persons with benchmark disability.
3. The Bill provides for grant of guardianship by District Court under which there will be joint decision making between the guardian and the persons with disabilities.

xii. Broad based Central & State Advisory Boards on Disability are to be set up to serve as apex policy making bodies at the Central and State level.

xiii. Office of Chief Commissioner of Persons with Disabilities has been strengthened who will now be assisted by 2 Commissioners and an Advisory Committee comprising of not more than 11 members drawn from experts in various disabilities.

xiv. Similarly, the office of State Commissioners of Disabilities has been strengthened who will be assisted by an Advisory Committee comprising of not more than 5 members drawn from experts in various disabilities.

1. The Chief Commissioner for Persons with Disabilities and the State Commissioners will act as regulatory bodies and Grievance Redressal agencies and also monitor implementation of the Act.

xvi. District level committees will be constituted by the State Governments to address local concerns of PwDs. Details of their constitution and the functions of such committees would be prescribed by the State Governments in the rules.

xvii. Creation of National and State Fund will be created to provide financial support to the persons with disabilities. The existing National Fund for Persons with Disabilities and the Trust Fund for Empowerment of Persons with Disabilities will be subsumed with the National Fund.

xviii. The Bill provides for penalties for offences committed against persons with disabilities and also violation of the provisions of the new law.

xix. Special Courts will be designated in each district to handle cases concerning violation of rights of PwDs.

3. The New Act will bring our law in line with the United National Convention on the Rights of Persons with Disabilities (UNCRPD), to which India is a signatory. This will fulfill the obligations on the part of India in terms of UNCRD. Further, the new law will not only enhance the Rights and Entitlements of Divyangjan but also provide effective mechanism for ensuring their empowerment and true inclusion into the Society in a satisfactory manner.

Child Labour Bill (2016)

(Excerpts from http://in.reuters.com/article/india-children-labour

Parliament of India on Tuesday July 26, 2016 approved a law that would allow children to work for family businesses. A week after the bill was passed by the Rajya Sabha; the Lok Sabha approved the measure that brings a raft of changes to a three-decade-old child labour prohibition law. The bill now goes for the President's assent before becoming law.

The U.N. Children's Agency (UNICEF) as well as many others have raised alarm over two particular amendments - permitting children to work for their families and reducing the number of banned professions for adolescents. A 2015 report by the International Labour Organization (ILO) put the number of child workers in India ages 5 to 17 at 5.7 million, out of 168 million globally. More than half of India's child workers are employed in agriculture and more than a quarter in manufacturing - embroidering clothes, weaving carpets or making match sticks. Children also work in restaurants, shops and hotels and as domestic workers.

The new legislation extends a ban on child labour under 14 to all sectors. Previously, only 18 hazardous occupations and 65 processes such as mining, gem cutting and cement manufacturing were outlawed. It also stiffens penalties for those employing children, doubling jail terms to two years and increasing fines to 50,000 rupees ($740) from 20,000 rupees ($300).

While child rights groups have welcomed such changes, there has been concern over other amendments proposed by Prime Minister Narendra Modi's government. For example, children will be allowed to work in family businesses, outside of school hours and during holidays, and in entertainment and sports if it does not affect their education. Also, children 15 to 18 will be permitted to work, except in mines and industries where they would be exposed to inflammable substances and hazardous processes. The government says the exemptions aim to strike a balance between education and India's economic reality, in which parents rely on children to help with farming or artisanal work to fight poverty or pass on a family trade."The purpose of this very act is that we should be able to practically implement it," Labour and Employment Minister Bandaru Dattatreya told parliament. "That's why we are giving some exemptions."

UNICEF had urged India to exclude family work from the proposed law and include an "exhaustive list" of hazardous occupations."To strengthen the Bill and provide a protective legal framework for children, UNICEF India strongly recommends the removal of 'children helping in family enterprises'," it said in a statement on Monday."This will protect children from being exploited in invisible forms of work, from trafficking and from boys and girls dropping out of school due to long hours of work," it said.

Juvenile Justice Rules 2016

http://www.wcd.nic.in/acts/juvenile-justice-care-and-protection-children-model-rules-2016-0

Model Guidelines for Foster Care

http://cara.nic.in/writereaddata/uploadedfile/NTESCL_635913297457227598_FInal%20Edited_guidelines.pdf

Draft Trafficking in Persons (Prevention, Protection and Rehabilitation) Bill, 2016.

The Ministry of Women and Child Development, GOI, has come up with the **Draft Trafficking in Persons (Prevention, Protection and Rehabilitation) Bill, 2016.** The Ministry has put up the draft Bill in public domain for seeking recommendations on the Bill. We request you to share your own feedback on the Bill with the Ministry of Women and Child Development or on the MyGov Portal.

Sustainable Developmental Goals - United Nations

http://www.un.org/sustainabledevelopment/sustainable-development-goals/

Global Launch of UNICEF's The State of the World's Children 2016 report

Downloadthe full report: www.unicef.org/SOWC2016 Discuss online using: #ForEvery Child mailing address is: UNICEF 3 UN Plaza New York , NY 10017 outreach@unicef.org

Beti Bachao Beti Padhao http://wcd.nic.in/BBBPScheme/main.htm

The Beti Bachao Beti Padhao (BBBP) Programme was launched by the Hon'ble Prime Minister on 22nd January, 2015 at Panipat, Haryana to address the declining Child Sex Ratio (CSR) and related issues of dis-empowerment of women through a life cycle continuum.The BBBP programme is a tri-ministerial, convergent initiative of Ministries of Women and Child Development, Health & Family Welfare and Human Resource Development. The key elements include a nation-wide awareness and advocacy campaign targeted at changing mindsets, strict enforcement of Pre Conception and Pre Natal Diagnostic Techniques (PC&PNDT) Act and a well-received focused community outreach through local innovative interventions in 100+61 districts.As you would agree that the societal mindset towards daughters is deep rooted, and such a grave issue cannot be combated by Government efforts alone. All stakeholders need to join hands to address this problem by creating awareness, highlighting the negative socioeconomic consequences of sex-selective abortions and reinforcing progressive social practices.While medical fraternity has a critical role to play in ensuring that law is abided in letter and spirit, it also has the ability to influence mindsets and counsel people to not indulge in the heinous practice of gender-biased sex selective elimination.In this context, we request you to advocate the message of Beti Bachao, Beti Padhao by integration of this issue in your existing trainings and other programmes, inclusion of BBBP logo in doctor's prescription, displaying simple messages on "What can I do" at your clinic and hospital premises.

CANCL SCAN

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Child abuse and neglect could generally be defined as the behavior or the lack of it of the individuals, who are responsible with the care, health and protection of the child, primarily the parents, causing physical, psychological, sexual or social harm, and endangering the health and safety of the child. It is a violation of the basic human rights of a child and it is the outcome of a set of inter-related familial, social, psychological and economic factors. The problem of child abuse and human rights violations is one of the most critical matters on the International Human Rights agenda .

Disentangling the mental health impact of childhood abuse and neglect *Child Abuse & Neglect*, Volume 63, Pages 106-119 Charlotte A.M. Cecil, Essi Viding, Pasco Fearon, Danya Glaser, Eamon J. McCrory

The above study aimed to systematically characterize the unique, shared and cumulative effects of maltreatment types on psychiatric symptoms, a community sample of high-risk youth (n = 204, M = 18.85) was studied. A range of potentially confounding variables, including socio-demographic variables, neighbourhood deprivation and levels of community violence exposure were analysed. Outcome measures included multi-informant reports of internalizing difficulties, as well as data on externalizing problems and trauma-related symptoms. It was found that (i) consistent with previous studies, maltreatment types were highly interrelated and frequently co-occurred; (ii) symptom severity linearly increased with the number of maltreatment types experienced (more so for self-report vs informant ratings); and (iii) while most forms of maltreatment were significantly associated with mental health outcomes when examined individually, few unique effects were observed when modelling maltreatment types simultaneously, pointing to an important role of shared variance in driving maltreatment effects on mental health. Emotional abuse emerged as the main independent predictor of psychiatric symptomatology – over and above other maltreatment types – and this effect was comparable for males and females (i.e. no significant interaction with sex). Findings contribute to a better understanding of heterogeneity in individual responses to maltreatment

Relationship between child abuse exposure and reported contact with child protection organizations: Results from the Canadian Community Health Survey. Afifi, T. O., et al. Child Abuse & Neglect (2015), http://dx.doi.org/10.1016/j.chiabu.2015.05.001

Across Canada, child protection organizations become involved with families when a child is or may be in need of protection another study to examine the prevalence of a broad range of child abuse experiences (physical abuse, sexual abuse, and exposure to IPV) and investigate how such experiences and socio-demographic variables are related to contact with child protection organizations in Canada using a representative general population sample. Data were drawn from the 2012 Canadian Community Health Survey: Mental Health collected from the 10 provinces using a multistage stratified cluster design (n = 23,395; household response rate = 79.8%; aged 18 years and older). Physical abuse only (16.8%) was the most prevalent child abuse experience reported with the exposure to specific combinations of two or more types of child abuse ranging from 0.4% to 3.7%. Only 7.6% of the adult population with a history of child abuse reported having had contact with child protection organizations. Experiencing all three types of child abuse was associated with the greatest odds of contact with child protection organizations (AOR = 15.8; 95% CI = 10.1 to 24.6). Physical abuse only was associated with one of the lowest odds of contact with child protection organizations. Preventing child abuse is widely acknowledged as an important, but challenging public health goal. Strategies to increase reporting of child abuse may help to protect children and to connect families with necessary services. One obvious priority would be physical abuse.

Pilot study of a program delivered within the regular service system in Germany: Effect of a short-term attachment-based intervention on maternal sensitivity in mothers at risk for child abuse and neglect. *Child Abuse & Neglect*, Volume 42, Issue null, Pages 163-173. Melanie Pillhofer, Gottfried Spangler, Ina Bovenschen, Anne K. Kuenster, Sandra Gabler, Barbara Fallon, Joerg M. Fegert, Ute Ziegenhain

This above pilot study in Germany examined the effectiveness of a short-term attachment-based intervention population at risk for child abuse and neglect. The intervention used home visits and video feedback to promote maternal sensitivity, and was implemented by trained staff within the health care and youth welfare systems. Mothers in the control group **(**n = 33) received standard services only, while those in the intervention group (n = 63) additionally the Ulm Model intervention. The outcomes measured were maternal sensitivity, as assessed by the CARE-Index at pre-intervention, after the last session, and at about 6 and 12 months of age; and infant socio-emotional development, as assessed by the ET6-6 development test at about 6 and 12 months of age. The moderating effects on treatment outcomes of two variables were examined: risk for child abuse (moderate vs. high) and type of maternal attachment representation (secure vs. insecure). Among participants at moderate risk for child abuse, no differences were found between the intervention group and control group in either maternal sensitivity or infant development. Among those considered high risk, mothers in the intervention group showed a significant increase in

maternal sensitivity from pre- to post-intervention; however, no group differences were seen at follow-up. There were some indications that infants of mothers in the intervention group showed better emotional development. The variable of maternal attachment representation was not a significant moderator for the intervention effect, but post hoc analysis indicated that the mean sensitivity of secure mothers was significant higher at the 6-month follow-up.

Intergenerational transmission of child abuse and neglect: Real or detection bias?
Cathy Spatz Widom, Sally J. Czaja, Kimberly A. DuMont. *Science* 27 Mar 2015:Vol. 347, Issue 6229, pp. 1480-1485

The literature has been contradictory regarding whether parents who were abused as children have a greater tendency to abuse their own children. A prospective 30-year follow-up study interviewed individuals with documented histories of childhood abuse and neglect and matched comparisons and a subset of their children. The study assessed maltreatment based on child protective service (CPS) agency records and reports by parents, nonparents, and offspring. The extent of the intergenerational transmission of abuse and neglect depended in large part on the source of the information used. Individuals with histories of childhood abuse and neglect have higher rates of being reported to CPS for child maltreatment but do not self-report more physical and sexual abuse than matched comparisons. Offspring of parents with histories of childhood abuse and neglect are more likely to report sexual abuse and neglect and that CPS was concerned about them at some point in their lives. The strongest evidence for the intergenerational transmission of maltreatment indicates that offspring are at risk for childhood neglect and sexual abuse, but detection or surveillance bias may account for the greater likelihood of CPS reports

Tashjian, Sarah M., et al. "Delay in disclosure of non-parental child sexual abuse in the context of emotional and physical maltreatment: A pilot study." *Child Abuse & Neglect* 58 (2016): 149-159.

The present pilot study sought to identify predictors of delays in child sexual abuse (CSA) disclosure, specifically whether emotional and physical abuse by a parental figure contributes to predicting delays over and above other important victim factors. Alleged CSA victims (N = 79), whose parental figures were not the purported sexual abuse perpetrators, were interviewed and their case files reviewed, across two waves of a longitudinal study. Regression analyses indicated that experiencing both emotional and physical abuse by a parental figure was uniquely predictive of longer delays in disclosure of CSA perpetrated by someone other than a parental figure. Victim–CSA perpetrator relationship type and sexual abuse duration also significantly predicted CSA disclosure delay, whereas victim age at the time of the police report, victim gender, and victims' feelings of complicity were not significant unique predictors. Child abuse victims' expectations of lack of parental support may underlie these findings. Parent–child relationships are likely crucial to timely disclosure of CSA, even when a parent is not the CSA perpetrator.

Child Abuse and Neglect and Subclinical Cardiovascular Disease Among Midlife Women. Thurston, Rebecca C. PhD; Chang, Yuefang PhD; Barinas-Mitchell, Emma PhD; von Känel, Roland MD; Jennings, J. Richard PhD; Santoro, Nanette MD; Landsittel, Doug P. PhD; Matthews, Karen A. PhD. http://journals.lww.com/psychosomaticmedicine/Abstract/publishahead/Child_Abuse

A childhood history of abuse or neglect may be associated with elevated adult cardiovascular disease (CVD) risk. We hypothesized that midlife women with a history of childhood abuse or neglect would have increased subclinical CVD beyond standard CVD risk factors. We tested moderation of associations by sleep, hot flashes, and race/ethnicity.two hundred ninety-five midlife women completed the Child Trauma Questionnaire, physiologic hot flash and actigraphic sleep monitoring, blood draw, and carotid ultrasound (intima media thickness [IMT]; plaque). Relations between abuse/neglect and outcomes were tested in linear regression models adjusting for demographic, psychosocial, and CVD risk factors. Interactions with sleep, hot flashes, and race/ethnicity were tested.Forty-five percent of women reported a history of child abuse or neglect. Women with any child abuse or neglect had higher IMT [b(SE) = .039 (.011), p = .001] and carotid plaque [odds ratio (95% [CI] = 1.95 [1.15-3.33]); p = .014] than nonabused/neglected women. Furthermore, physical abuse, emotional abuse, and emotional neglect were associated with higher subclinical CVD. Sexual abuse was associated with higher IMT among nonwhite women. Interactions with sleep time and sleep hot flashes (p values < .05) indicated that higher subclinical CVD with an abuse/neglect history was observed primarily among women sleeping less than 6 hours/night or with sleep hot flashes.

Conclusions: A history of child abuse or neglect is associated with higher subclinical CVD in women, particularly when paired with short sleep or hot flashes. Findings underscore the importance of childhood adversity in midlife women's CVD risk.

Child Online Safety in India event

New Delhi, India Habitat Centre – Silver Oak room, 22nd September 2016

Dr. Rajeev Seth, Chair ICANCL group participated at the above official launch of the Unicef report on child online protection in India and attended session on the key partnerships and mechanisms required to secure safe digital spaces for children in India. The main findings of the Child Online Protection in India assessment were presented. The Key technical experts presented response to and prevention of child online abuse and exploitation in India. Examples of promising practices from India and other countries to prevent or tackle online abuse and exploitation of children were also shared.

Membership Form

Indian Child Abuse Neglect and Child Labour Group

Nationally Registered under Society Registration Act XXI of 1860
Society Registration No. S/68745/2010

1. Name _____
   (In BLOCK letters)
2. Age _____ Sex _____ Nationality _____
3. Present Designation _____
4. Office/Institutional Address _____

   _____
5. Residential Address _____

   _____

   Telephone: Office _____ Residence _____ Fax _____

   E-mail _____
6. IAP Membership No. _____
7. Qualifications _____
8. Details of work (if any) in field of child abuse, neglect, and child labour

   _____
9. Areas of interest in field of child abuse, neglect and child labour

   _____
10. List of publications (including original work, brief reports, chapters in books)

    (If needed oppend separate sheets _____

    _____

Place:

Date: [Signature of Applicant]

Completed application form along with Cheque/Bank Draft in favour of Indian Child Abuse, Neglect & Child Labour (ICANCL) group, payable at Delhi, should be sent to the Chairperson: Dr. Rajeev Seth, E 10, Green Park Main, New Delhi-110016, India. Life membership ₹1000 for Indian National, for non resident Indians it is ₹ 6000/ $100; larger contributions are greatly appreciated. All donations are exempt for income tax under section 80G(5)(VI) of the income tax act, 1961.

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