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31/9/14

GOVERNMENT OF KERALA

Abstract

Social Justice Department - NIRBHAYA Policy - Minimum Standards of Care in Shelter Homes for survival of sexual violence - modified - Orders issued.

SOCIAL JUSTICE (B) DEPARTMENT

G.O.(Rt) No. 558/2014/SJD Dated, Thiruvananthapuram, 29.08.2014

Read: 1. G.O.(Rt) No.546/2012/SJD dated 18.12.2012.
2. Letter no. N/179/14 dated 12.08.2014 from the Director of Social Justice.

ORDER

As part of implementing Nirbhaya policy, Government have setup Nirbhaya Shelter Homes. As per the Government Order read as first paper above, Government have approved the Minimum Standards for Shelter Homes covering the Standard Operating Procedures (SOP) for conducting the Shelter Homes. Now, the Director of Social Justice, as per his letter read above, has submitted a revised Minimum Standards of Care prepared on the basis of the feedback from the staff and residents of the Nirbhaya Centres, Kerala Mahila Samakhya Society, various NGOs and civil society. These Standards of Care constitute a set of non-negotiable rules that should be integrated in any Shelter Home managed either by the Government or a NGO and the Director of Social Justice has requested to approve the revised Minimum Standards of Care for Shelter Homes.

(2) Government have examined the matter in detail and are pleased to approve the Minimum Standards of Care in Shelter Homes for survivors of sexual violence and trafficking, as appended to this order.

(3) The Government Order read above stands modified to this extent.

By order of the Governor,
Dr.K.M.Abraham
Additional Chief Secretary

To

The Director of Social Justice, Thiruvananthapuram.
The Principal Accountant General (Audit),Kerala, Thiruvananthapuram.
The Accountant General (A&E), Kerala, Thiruvananthapuram
The Accountant General (D.B.Cell), Kerala, Thiruvananthapuram.
Local Self Government Department.
Web & New Media (for publishing in the website).
Stock file/ O.C.

Forwarded/By order

Section Officer

Minimum Standards of Care in Shelter Homes For Survivors of Sexual Violence and Trafficking

Introduction

The Kerala State policy to combat sexual violence and the trafficking of women and children is based on five principles: prevention, protection, and prosecution, as well as rehabilitation and reintegration of the survivor into mainstream society. The policy takes a participatory approach - it requires the participation of survivors of sexual violence and members of civil society in formulating measures to address the issue in an effective manner.

Protection, rehabilitation, and reintegration measures are critical links to the overall process of transformation: a journey from a helpless victim to an empowered survivor. Shelter Homes play an important role in this journey. They constitute the locale within which the survivor is protected, empowered, and supported in exploring and implementing innovative optionsfor her rehabilitation and reintegration into society.

With the aim of empowering and capacitating survivors, the order on Minimum Standards of Care (December 2012) has been revised and strengthened. These revisions are based on the feedback from the staff and residents of the Nirbhaya Centre, Thiruvananthapuram, andother related Nongovernmental Organisations (NGOs) and civil society.

These Standards of Care constitute a set of non-negotiable rules that should be integrated in any Shelter Home managed by either the Government or a NGO. These standards can help to increase the safety, dignity and the well-being of each survivor. These standards are:

- Rights Based: All standards will ensure that the basic human rights of the survivor are upheld and respected. The following rights will be integral to the care process:
  - Right to development;
  - Right to care, safety and protection
  - Right to dignity of life
  - Right not to be re-traumatized or re-victimized
  - Right to informed choices, privacy and confidentiality
  - Right to self-determination and participation
- Individualized and Comprehensive Care: The care components should be comprehensive, but be able to address the needs of each individual through a continuum of care opportunities for persons of all ages.
- Equitable: The care program should ensure that services are accessible to all survivors, including persons who may be vulnerable, disabled, or challenged
- Gender & Child Responsive: The care program will recognize gender-based vulnerabilities and risks, will be developmentally appropriate and ensure that the recovery of the survivor is paramount. In addition, the program should be child-friendly and focused on the psychological recovery of the survivor, particularly when the survivor is below the age of 18.It should also be responsive to the needs of differently-abled children or adults.
- Accountable: All care programs will be subject to mandatory, external,and standardized care process audits. The Department of Social Justice will determine the timings of such audits.

The Standards of Care will be reviewed every two years for relevance, and revised as necessary, consistent with the lessons learnt from the experiences thus far.

Standards of Care For Nirbhaya Homes

A. Engagement, Participation, andInvolvement

Expected Outcome: A Survivor who resides in the Shelter Home (resident) views the Shelter Home (SH) as her home and feels nurtured and empowered. The views of such residents are taken into consideration in the day-to-day running of the SH and important decisions about their lives, unless it is contrary to their interests.

Standard 1.Resident's Right to Information

1. Residents should be provided with all information regarding the procedures, rules, and facilities of the SH within a week of their arrival. They should also be informed of their legal and civic rights.

2. The residentsshould be informed of the benefits to which they or their or children are entitled as per government orders, such as immediate relief and other rehabilitation packages including livelihood skills, livelihood options, and education.

3. The residents should also be informed and counselled about the routine medical tests and examinations they will be asked to undergo, including those for which they has to provide informed consent. The residentsmust also be informed that their consent is necessary for undergoing an HIV test, any surgical procedures etc., and that they would be informed of the reason for such tests or procedures, if they are found to be essential.

4. A user-friendly handbook should be prepared for the residents summarizing all their rights and duties as well as the facilities available in the SH. Key matters outlined in this document should be included in the handbook or posters.

Standard 2.Resident's Right to Education

5. General education upto the age of 14 years shall be compulsory for all children. The SH should take all measures in a timely manner to mainstream residents in normal schools, on priority basis. Where necessary, Special Orders or other necessary instructions should be collected from the competent authorities, in a time bound manner, to facilitate a resident to continue her studies at the school or college level without disruption. Children should participate in preparing their education plans.

6. The Government should meet all expenses relating to education, whether in a public or a private school, in a manner that will ensure no break in the resident's education. Exemption may be obtained from payment of fees for public examinations. Special tuitions may be given to children who show an aptitude for higher studies. In special cases needing extra security, where the resident cannot go out of the SH, arrangements must be made to conduct the tests within the SH.

7. The SH shall provide for educational training opportunities to all children according to their age, aptitude and ability, both within the institution or outside. Residents who have no formal education (and above the age of 14) should be helped to obtain education through the Open School, the Saksharatha program or any other Adult Education program. A range of educational opportunities should be considered,

including mainstreaming them into inclusive schools, bridge school, open schooling, non- formal education and learning and input from special educators, where needed.

8. Residents who have attained basic literacy, and have an aptitude for higher education, should be helped to enrol in non-formal education programs including the Open School/ regular school/university for completing their education. All residents must be instructed in physical exercise and drill. Gardening is also compulsory, if there is space for this purpose. Games must also be arranged if a ground is available.

9. Every SH should also arrange to provide gainful vocational training, either externally in institutions like the ITIs or within the SH itself. Residents, who are not in the formal or informal education system, should be admitted to livelihood training as soon as possible after admission to SH. To the extent possible, all livelihood training should be relevant and linked to the existing job markets. Such training should lead to job placement after the stay in the SH. Instructors can be provided for the vocational training being imparted in-house.

Standard 3.Resident's Right to Legal Aid/Assistance

10. The SH should have a part time professional legal advisor (who is duly sensitized) to provide legal aid/assistance to the residents, including residents with special needs. Existing legal aid/assistance structures should be fully utilised; there should be tie-up with KELSA/DELSA for free legal aid. In case of non-availability of a Government legal aid cell, the services of a private advocate may be utilized.The legal advisor should provide assistance to the residents to prepare for their trials (through mock trial or any other role play/discussion). Psychological counselling should also be provided to the resident to cope with the stress of dealing with the legal process.

11. Legal assistance shall be provided unconditionally, i.e., it shall not be conditional upon the resident/resident's willingness to serve as a witness. The resident should be provided all assistance if she is a witness in a case and, if need be, provided additional protection, as part of survivor witness protection. Care must be taken to get the full consent of the resident for her to become a witness.

12. The Handbook for SH residents should provide all information about the legal rights and the legal facilities available to the resident, including the provisions of the laws under which these are available. A directory of women lawyers handling criminal cases, who can provide pro bono services, could also be compiled to assist in the legal proceedings.

13. Arrangements should be made with the police and other enforcement agencies to recover all properties of the residents from the place of exploitation.

Standard 4. Participation of Residents in SH Management

14. The residents should be directly involved in the day-to-day management of the SH. All residents should be part of the General Body in charge of running the SH. A three member Leadership Committee should be chosen on democratic lines from the different age groups, which will support the management of the SH. Allocation of

responsibilities should be assigned only after a psychological screening of the residents is complete, to ensure proper discharge of responsibility.

15. The Leadership Committee will appoint other sub-committees such as Kitchen subcommittee, Garden subcommittee, Sanitation subcommittee, Nutrition subcommittee etc. to handle specific responsibilities. The Leadership Committee and the sub-committees should be reconstituted every two months, taking into account the interests and capability of each resident. Every resident in the SH should be given a chance to be an active committee/sub committee member.

16. All proceedings of the committee meetings, staff meetings, and general body meetings should be documented. Effort must be made to identify residents with an aptitude for doing documentation work, analytical skills etc., to assist with the preparation of reports, and maintain documentation of relevant and useful information.

Standard 5. Rights of Residents to Good Nutrition

17. Residents should be provided with a nutritious diet, consistent with standards set by the Government in this regard (Annex I). Care should be taken to cater to the special needs of residents such as accompanying children, those who are HIV positive, lactating mothers and those requiring special diets due to health reasons; a special diet should be prepared for them. Residents shall be provided four meals a day, including breakfast. Special meals shall be provided on Holidays and festival days.The Nutrition sub committee should assist in the preparation of the weekly diet charts for the SH in consultation with the Home Manager and/or Warden, and the Committee leaders.

Standard 6. Participation of Residents in Provision of Care

18. Under the guidance of the staff, a Resident Mentoring Committee (RMC) should be established to support and enhance the provision of care to the residents. The RMC must consist of senior residents, selected from the available pool. A transparent process of selection, based on clear criteria, must be established for the selection of RMC members.

19. These senior residents (or Peer Counsellors), should possess the necessary skills and mental aptitude to provide additional care to the junior residents, and to contribute to the overall social and emotional welfare of the SH. Health education and literacy classes can be used as a means for identifying suitable persons for the committees handling care issues, and to reinforce their abilities to deliver results, especially to those with special health needs.A training package should be developed for those residents who are interested or have the potential to be such Peer Counsellors.

20. Peer Counsellors should, inter alia, be given the responsibility of welcoming new children and helping them to integrate into the SH as well as help settle petty grievances and disputes among the residents.

21. Whenever possible, the Home Manager should may make some arrangements to compensate them in kind or in cash, as an incentive, and as part of a development process. A scheme of tokens as incentive for good behaviour can also be considered,

which can be redeemed at approved rates by the resident at the time of leaving the SH.

22. To ensure that the resident has the opportunity to freely give her feed back or report any negligence, abuse, or any other matter, every SH should maintain a Suggestion Box. The key of the Suggestion Box shall remain in the custody of the Home Manager. It shall be opened every week in the presence of representatives of the residents nominated for this purpose.All suggestions received in this manner,and the actions taken,have to be recorded and placed before the Staff meeting. It should also be recorded in a Children's Suggestion Book to be maintained for this purpose, and the follow up action as proposed by the management, communicated to the General Body meeting of the residents.

Standard 7 Conflict Resolution and Redressal Mechanism

23. An internal grievance/redressal mechanism should be created to deal with all cases of minor disputes, harassment and other such issues among the residents, to ensure that all residents have the right to an impartial process of dispute settlement. Draft protocols for managing conflicts and for addressing abuse by staff of children have been prepared, which are being tested elsewhere on a pilot basis before finalising them. These are provided in Annexes IIand IIIrespectively.

B. Other Services & Benefits for Residents

Expected Outcome: The ambience of the SH is therapeutic in terms of non-judgemental attitude of the staff, along with avenues for relaxation, recreation and spiritual growth.

Standard 8:It is Their Home

24. As in every home, the SH should also have a daily timetable of activities for residents that will bring about a structure and balance in their lives. The residents must be given a clear understanding about the standards of care to be followed within the SH.

25. The daily schedule of activities could include indoors and outdoors sports, physical exercise, cultural activities, workshops, dance, music, meditation, yoga, gardening etc. Study materials and magazines should be made available. Use of computers and TV for recreational purposes should be closely monitored.

Standard 9: Counselling and Other Therapeutic Support

26. There must be facility for individual and group counselling as well as mental health interventions, such as group discussions, individual and group therapy, for every resident in need of such support. A separate counselling room must be available in each SH to ensure total privacy during counselling sessions.

27. A mental health record should be maintained for every child. Every SH shall have the services of trained counsellors who shall help the Home Manager prepare a mental health plan for each inmate of the SH which shall be integrated with therelated Individual Care Plan (Annex IV) Residents showing symptoms of psychiatric disorders should be immediately referred to a professional psychiatrist.

28. There should be both professional and peer counsellors, preferably female, in a SH, who shall provide immediate trauma care and long term counselling for the residents.

Standard 10. Enhancing Life Skills

29. Regular classes for residents should be conducted to enhance awareness of life skills such as grooming, effective communication, and conflict management and stress management through yoga, meditation etc. as well as leadership training. Both formal and informal processes, including mentoring and exposure visits should be used. Modules prepared by SCERT/SSA should be utilized for school going residents.

30. In order to build a sense of well-being and dignity, innovative and creative tools for teaching life skills, such as arts, crafts, experiential workshops etc., should be used. Residents should have access to a variety of reading material in the library- for the mental and social development of children -such as magazines, story books, newspapers, primary education book, weekly magazines, novels. General knowledge books, historical books, autobiographies, spiritual books, dictionary, educational and amusement books etc.

Standard 11. Civic Benefits

31. A requisition on behalf of the resident in the prescribed format should be submitted to the District Collector and to the Director, Social Justice for the allocation of housing, ration card, voters ID, Aadhaar number and other civic benefits entitled as part of the rehabilitation package of the resident. These details should be included in the Handbook for residents. Efforts should be made to ensure that these benefits ideally reach the resident within a stipulated period of 6 months of entry into the SH. It should be further ensured that these benefits do not stigmatize the resident, but instead help mainstream the beneficiary with the family/community. It should also provide benefits for every child of a resident.

32. Each SH has the responsibility to ensure that civic awareness of the residents is developed through a celebration of key days of national importance identified for this purpose. Each SH will ensure the full utilization of the funds allocated for entertainment/recreational purposes (such as visits to places of interest or theatres/exhibitions) The SH must ensure that there is no shortfall in undertaking the above activities.

Standard 12. Standards of Health Care

33. Universal care processes should be established, which enables the SH to provide for all special care needs, including those of HIV positives, the disabled, pregnant and lactating mothers, severely sick residents etc., without any stigma or isolation. This is applicable to all children of residents, who are also entitled to all protection.

34. Where a resident is pregnant as a result of sexualabuse, she must be made aware of her rights. Any decision made by the resident in this regard should be implemented only if it is the best interests of the resident, and after consultation with her parents and the CWC, if she is under 18. When any action is taken, the decision of the resident must be recorded and signed in the presence of two witnesses. As in other cases, confidentiality in all matters must be maintained.

35. A medical record should be maintained for every inmate of the SH. This document must record all aspects of the inmate's health based on a monthly medical check-up, including weight and height record, any sickness and treatment, tests and procedures conducted and other physical or mental problems. The SH should maintain proper documentation regarding the registration of births and deaths.

36. All SHs should have facilities for monthly health care check-ups by a registered medical practitioner, referral to external medical experts for gynaecology, dermatology, dental, ENT and such other medical problems, and, if required, facilities for hospitalization. The SH must have a doctor on call, available on all working days for regular medical check-ups and treatment of the inmates.

37. The Department of Social Justice (DSJ) should arrange for a special provision in the Government Hospitals, Medical colleges, other hospitals, clinical psychologists, psychiatrists and mental institutions for treating the inmates of the SH and for holding periodic health camps within the SH as well as for providing immunisation coverage. They must also ensure that the residents get quality health care and speedy response, by setting up a referral system for cases of deteriorating health or serious cases. Possibility of similar partnerships with private hospitals for provision of facilities that are not available with Government hospitalsneeds to be explored.

38. A person may be admitted to the SH without insisting on a medical certificate at the time of admission. However, there should be a medical examination of the new inmate by the Medical Officer within 24 hours; in special cases or medical emergencies, the medical check must be done immediately.

39. There must also be a thorough physical, psychological and dental check up within one week of arrival of each new resident. HIV test should also be conducted as part of this check up, after taking the necessary consent of the resident, or her guardian if the child is a minor. Similarly no medical procedure or intervention should be performed on a resident without her consent or the consent of her guardian (provided such guardian has not participated in the abuse of the resident).

40. Individual health files should be prepared immediately after the arrival of the resident in the SH, and it should be regularly updated. In cases of transfer of the inmate to another SH, a medical check –up of the inmate should be done within 24 hours of the transfer, and the entire case file, including the medical file, transferred with the inmate to the new SH.

41. In addition to regular check ups for chronic ailments and emergency care, there should be a check up when needed for gynaecology and dental related issues. Once a year, there should be a physical check up, including blood work, given the high risk of infections.

42. The SH should have sufficient medical equipment to handle minor health problems including a First Aid kit with a stock of emergency medicines and consumables. All caregivers in SH should be provided with training in giving First Aid in case of emergencies.There should also be trained caretakers available to provide appropriate care and support for HIV positive residents for early management of symptoms. All staff in the SH must be trained in HIV care and support.

43. The first aid box with basic medicines and equipment should be kept in a secure place not easily accessible to the residents. There should be a standard checklist for the medicines in the First Aid box. It should be replenished on a regular basis, and medicines should be checked regularly for their expiry dates.

44. The SH should coordinate with existing systems and agencies in the provision of care for residents with special needs. Memorandums of Understanding on services to be provided should be signed with government facilities to ensure prompt service. The SH should have referral network with de-addiction centres for those residents who have a problem.The SH should have arrangement for caretakers who will escort residents during hospitalization and also facilities for transportation of sick patients whenever the need arises.

45. The SH should have a Corpus Fund for health related emergencies such as special health conditions, funeral rites, birth of a new child to a resident etc.

Standard 13. Legal Custody, Security, and Movement of Residents

46. Legal custody of residents must be under the Home Manager of the Child Welfare Committee (CWC) (if minors) or any other competent authority dealing with the issues of women and/or children of the area, as the case maybe.

47. The SH should have 24 hour security arrangement. Without appearing custodial in nature, the SH should ensure adequate security for the residents. The security persons should be women, free of any addictions, and have an unbiased approach to issues relating to sexual abuse and related matters.

48. Security guards need to be given suitable training prior to taking up the post in matters such as conflict management, tackling crisis situations and so on. They should be provided with appropriate uniforms, which will help them discharge their responsibilities effectively.

49. All doors (bathrooms, toilets, kitchen, storage, bedrooms) should have provisions for opening from outside in case of emergency.Field Security Plan should be in place with clearly marked fire exits. There should be a regular fire drill. Basements should not be used for residential purposes. All inflammatory or hazardous substances such as kerosene, petrol, pesticides, phenol, acid, bleaching powder, rat poison, medicines and drugs, (especially sedatives etc.) should be kept securely out of reach of the residents. Stock register of all above hazardous substances should be maintained, and monitored through monthly stocktaking by the security staff.

50. For psychologically disturbed residents, any task with sharp, hazardous instruments or substances such as knives, screwdrivers, ropes, and wires should be avoided to the extent possible, and if unavoidable, it should be done under proper supervision.

51. To ensure the security of the residents, the following articles are prohibited from being brought into the SH:

- Any kind of weapon or mobile phone, whether they require a license or not;
- Alcohol and spirit of any description;

- Tobacco, ganja opium or any prohibited other psychotropic drugs or psychotropic substances; and
- Any other article specified in this behalf by the State Government by a general or specific order.

52. Though there is no restriction on the residents receiving letters or writing as many letters as they like at all reasonable times. TheHome Manager may read any of these letters, and may, for reasons that she considers sufficient, refuse to deliver or issue such letters. A record should be kept of the reasons for such refusal in a book maintained for this purpose. The letters should also be preserved for the period of the resident's stay in the SH.

53. The SH should have a Visitor's Policy as well as one for allowing residents to visit their homes. Visitors for residents or to the SH should be allowed only after requisite vetting and permission of the Home Manager or the Director DOSJ. A visitor's room with an external access should be available. Screening and interacting with visitors should be conducted away from the residential area within the campus, to ensure privacy.

54. All visits should be documented in a well-maintained Visitor's Book that will record all details, such as name, designation, name of the organization/institutions, address etc. Proper check by staff at entry and exit points should be maintained. CCTV cameras may be installed in the visitors' room.

55. The telephone for the landline should have a caller ID facility. No resident should possess or have access to a mobile phone, and phone calls should be made only under supervision. A list of all emergency numbers should be prepared and kept readily available.

56. The decision to allow a resident to visit her home or the locality from which she comes on a case-by-case basis. The decision should by the CWC on the recommendation of the Home Manager.

57. No food should be allowed into the Home from the outside. Residents should not be allowed to have in their possessions any cell phones, cameras, or such equipment.

58. While all residents need a companion when they leave the SH, a social worker must accompany those residents, who are at risk of abuse, coercion and exploitation, as determined by the Home Manager. The SH should have specific protocols for different circumstances when any resident leaves the SH unaccompanied by staff. Such protocols should be evolved through risk assessment and by gathering information relating to risk-reduction.

59. Upon the death of a survivor, specific steps need to be taken, consistent with Rule 72 of the Juvenile Justice(JJ) Rules 2013. If a child goes missing while on leave, then steps under Rule 75 (7) & (8) should be followed. If a child is found missing from the Home or from the school, the Home Manager or CWC (if the resident is a child) orDSJ Director must be immediately informed, and steps taken as per their instructions. If no authority can be reached, then the staff must immediately inform the police. A photograph with relevant details shall be sent to the missing person's

bureau and the local police station. On the other hand, if there is a crisis, but the children are all present and safe at the Home (for example, a failed escape), then the Home authorities should be informed and their instructions followed. If the authority cannot be reached, then the Police should be informed immediately if there is any hint of external interference or abettors. If the incident includes a child, then the CWC member must be also informed immediately.

C. Entry, Rehabilitation, and Reintegration

Expected Outcome: A resident always feels welcome and informed in the SH and has access to all avenues, resources, and facilities for her empowerment, rehabilitation and reintegration into society.

Standard 14. Induction of New Residents

60. A new resident should be accepted only as per the direction of the Child Welfare Committee or the court. A person brought through any other entity or an individual should be produced before the CWC or the Court on the next working day. The name and other ID particulars of that individual and a copy of his/ her ID card should be kept on record.

61. On admission into the SH, each resident must be photographed. One photo shall be kept in the case file of the resident, a second one in the index card, a third in an album serially numbered, with the negative in another album, and yet another shall be sent to the CWC and the District or State Child Protection Unit or any other appropriate authority. One copy shall be given for the school photo identity card after admission to a regular school.

62. SH staff should ensure collection of duly completed and signed Handover forms from the police or CWC staff who bring the new residents as part of the induction of the new resident into the SH. When a new resident is brought by persons other than the CWC or court, the SH Staff should first inform the CWC/Police and take all steps necessary for the completion of the medico-legal procedures.

63. The preliminary documentation for each new resident, namely the case file (Annex V) should be completed within a week of arrival of the resident. This form should be duly signed by the Counsellor and reviewed by the Home Manager.In cases where information is not fully available, the SH staff should take all efforts to collect required information within 4 months, with the help of the case worker who is required to submit a report on the background of the resident. The SH must also try to trace A child's antecedents through the *Track a Child* System of the DOSJ.

64. Each resident shall be provided with a welcome kit upon arrival, which will include two pairs of clothes, two sets of school uniforms, a towel, toiletry (tooth brush, tooth paste, soap, sanitary napkins when required, powder, shampoo, hair oil, comb etc.) out of the list of items prescribed for the residents as listed in Annex VI.

65. In the first one hour the new resident should be allowed to take a bath and freshen up, after the medico-legal procedures have been completed. A light snack and water should be provided as soon as the initial formalities are completed. The clothes worn by the resident upon arrival, especially the undergarments in rape cases, should be carefully preserved as possible evidence.

Standard 15. Resident's Individual Care Plan and Other Documentation

66. Each resident, including a resident's child, who is in the SH should have an Individual Care Plan with the ultimate objective of rehabilitating and reintegrating every resident into society once again, as early as possible. This Individual Care Plan should take into consideration the social, economic and educational background as well as the interests, talents and skills of the resident. No Care Plan should be prepared without the active involvement of the resident, whose best interest is paramount when providing care and when implementing the process of reintegration back into society. The Individual Care Plan may be adapted from the one provided in the Juvenile Justice Act and Rules.

67. Every effort must be made to ensure that the Individual Care Plan for a new resident is initiated and ready to the extent possible, no later than one month of the resident being admitted into the SH. Besides the care to be given in the SH, it must include a plan and a road map for the rehabilitation, reintegration, and follow up of the resident.

68. The Care Plan has to be reviewed on a monthly basis by the Home Manager jointly with the counsellors. Every quarter, the CWC or other competent authority must monitor adequacy of, and progress in, the development and rehabilitation, including options for release or reintegration to family, foster care, or adoption. This Care Plan should be updated from time to time for each resident. In case of transfer of the resident to a new SH, continuity of care plan should be ensured.

69. Formation and membership in Self-Help Groups must be encouraged to access microcredit finance and to obtain support for starting small businesses. Tie-ups with entities such as Jana Sikshan Sanstan, Kerala Village Industries Corporation, Kudumbashree, etc. should be explored for developing livelihood training to increase the employability of the resident. Career counselling should also be provided on a regular basis.

70. In collaboration with reputed technical training institutes (continuing education, ITI, Community polytechnics etc.) residents must be allowed to join Certificate or Diploma Courses conducted by Government or reputed certified agencies for improving their opportunities for employment.

Standard16.Rehabilitation and Reintegration

71. Any formalities for the rehabilitation/reintegration process should begin only after getting the informed consent of the resident. All efforts should be made to ensure early rehabilitation and reintegration into society.

72. The option of placing child residents for adoption or under foster care, based on the provisions of the Juvenile Justice Act, should be considered first before institutionalizing them. For this, DSJ should take necessary action, including the preparation of a panel of families that are willing to offer foster care.

73. Reintegration plan for a resident should be undertaken only after complete background investigation is done (Annex VI). The SH investigation should include an assessment of the family, family and community's willingness to accept the girl/woman and the family's environment. Before a resident is reintegrated, a

detailed discussion should be held with the resident and the reintegration team on what explanation should be given to the family on her absence from her village/community.

74. The resident's interest should be paramount. If the Home Manager is of the view that such a return would not in the best interest of the resident (for example, proximity of abuser near the home or continuing fragility of the resident), the final decision must be that of the Director of the NGO, authorized by DSJ, in the case of an adult resident, and the CWC in the case of a child. In taking the final decision, the CWC must explicitly consider the reasons put forward by the Home Manager. Any decision must be recorded in writing, including the views of the Home Manager. Any recourse to challenge a final decision, with which the residents or relatives are not comfortable, must be made to the Director of DSJ.

75. Proper record and documentation (photos, undertaking from parent/guardian) should be maintained for all reintegration undertaken. No resident shall be restored to the family without adequate assessment and without ensuring social acceptance and family support. This shall be undertaken by the CWC in the case of minors in consultation with the Director of the authorized NGO, and by the Home Manager in consultation with the Director of the authorized NGO in the case of an adult child. The Government will ensure that restoration is carried out depending on how safe and nurturing the family environment is for the resident.

76. Government agencies in collaboration with voluntary agencies shall work out the details of the repatriation procedures and structure, and mainstream them in order to facilitate the smooth and efficient repatriation of the residents and their dependent minors, if any. Members of the government/professional and the authorized NGO, who have had some role in interaction with the resident, can be represented in the process of repatriation.

77. A resident from another country/state, who is being repatriated or restored, should be counselled and prepared to return to the country/state of origin, after providing her with adequate medical and psycho-social care. When there is considerable time before the reintegration will take place, efforts should be made to empower her through basic life-skills, so that she can be reintegrated into mainstream life. Even within the state, but for compelling reasons, the resident should be placed in a SH closest to the resident's family or eventual place of rehabilitation. Provision of care and preparation of the Individual Care Plan for such residents should start right away and should not be delayed on the grounds of the impending transfer.

78. Adequate financial assistance from the Corpus Fund should be provided for meeting the needs during travel while repatriating them to their families or institutions. The Government should also make adequate provision for dearness allowance for police escort or any other authorized escort (only female escort is to be provided) during such travel.

79. It should be ensured that all legal formalities are completed for the residents before repatriation.

Standard 17. Follow Up

80. A follow-up plan shall be prepared as part of the individual care plan by the Home Manager, the Child Welfare Officer and the Probation Officer for every child resident. This plan must bemonitored by the Director of the NGO authorized by DSJ, and supervised by the CWC. For the first six months after the reintegration, there should be monthly monitoring of progress. Thereafter, monitoring could be done once a quarter for the next eighteen months.

81. In the case of an adult resident, the follow-up plan should be prepared with the agreement of the resident and recorded in the Individual Care Plan. Monitoring should be undertaken as agreed with the resident, and monitoring reports prepared every quarter, unless otherwise necessary.

82. The monitoring reports shall clearly state the situation of the resident and the steps to be taken by the Government in order to reduce the ex-resident's vulnerability. Monitoringreports should be submitted to the associated NGO and/or the CWC in a timely manner.

83. The follow-up program should ensure:

- Protection against re-trafficking and sexual exploitation.
- Protection against stigma and discrimination.
- Protection against any other exploitation.
- Confidentiality.
- Reorientation/ensuring/exercising of full citizen rights
- Livelihood options
- Mental Health
- Reintegration/ensuring/exercising of rights over parental, ancestral and community property and entitlements.

Standard 18. Social Reintegration

84. Those residents whose families do not accept them and those for whom the family atmosphere does not provide a conducive space for reintegration (for example, when parents/ families are involved in trafficking), special efforts should be made to support the resident to stand on her own feet in a phased manner, and to live in society independently.

85. No resident should be restored to the family without ensuring social acceptance and family support to the resident in order to prevent re-trafficking and further commercial sexual exploitation.

86. Collaborations with government agencies or non-government organizations should be made on priority basis to provide employment services and entrepreneurship development training, which will include skills, knowledge, resources, marketing skills, and microcredit, at the district where the resident is reintegrated.

87. The SH shall conduct outreach/support activities, or shall oversee the delegation of those activities to other organizations or individuals in accordance with the reintegration strategy proposed in the Individual care Plan. Outreach/support activities shall be conducted only with the consent of the resident.

D. Record Keeping and Documentation

Expected Outcome: Transparency and good governance are the hallmarks of the operation of a SH. All decisions related to the residents are recorded clearly and transparently.

Standard 19. Documentation and Recording

88. The separate case files maintained for each resident, should include a profile consisting of personal details, informed consent and referral records, a medical file consisting of medical reports, treatment plan, mental health plan, prescriptions and an Individual Care plan.

89. Simultaneously, she should be provided immediate medical support (check up, treatment for immediate ailments etc.). Paediatric support should be given for accompanying children, and a check by a gynaecologist, if the woman is pregnant. A pregnancy test may be necessary in some cases. Details of all the medical tests undertaken or procedures performed should be kept as part of the medical records.

90. The case file is to be prepared immediately so that the Individual Care Plan can be prepared as soon as possible. However it needs to be ensured that the resident is mentally prepared for responding to the queries. The interviewer needs to be patient with the residents and ensure the authenticity of the information to the extent possible.

91. If the resident is brought during the night she should be allowed to rest and the personal profile and other documentation formalities should be taken only the next day after the resident feels more rested. Preliminary data regarding the resident should be fully filled up in the case file within the first ten days of the resident's arrival to the SH.

92. When preparing the personal profile in the case file, care must be taken to establish the true identity of the resident such as her real name, whereabouts and contact details of family members, community members, relatives, next of kin, address, etc. This information must be carefully crosschecked for veracity. Such verified information must be entered into the DSJ monitoring system within a week of the arrival of the new resident. Updating should be undertaken in a phased manner, as and when more information is received.

93. SHs should maintain all relevant details of the resident after the rescue process (FIR copy, remand diary). Separate registers should be maintained for attendance, visitors, arrival and departure from the SH and for reintegration. (For guidance on the maintenance of various registers, please see Rules 79-81 of the JJ Rules).

94. Profiles of the resident's close associates are also to be secured and maintained. All relevant information should be collected and it should form a part of the initial assessments.

Standard 20. Confidentiality

95. All information relating to the residents of a SH are to be treated as strictly confidential. Confidentiality should be maintained in all cases, and especially so in the case of residents who are HIV positive.

96. Only designated persons shall have access to the case file, Individual Care Plan etc. Under no circumstances should anyone other than the authorised persons have access to these records.

97. No information about a resident shall be given to any outsider without the permission of the DSJ Director or any other person so authorized by such Director and with the informed consent of the resident. Any questions from the media should be directed only to the Director DSJ or any other person so authorized by the Director.

98. The resident should not be exposed to the media, and complete confidentiality should be maintained about the facial features and other personal details about the identity of the resident. This is mandatory at all stages, from the stages of rescue to prosecution, the process of social reintegration and even thereafter. Therefore all case records, especially medical records, should also be maintained with the utmost confidentiality, and the counsellors and the Head of the Home Manager would be responsible to ensure this

E. Accountability and Administration

Expected Outcome: *All stakeholders work together as a team in a collaborative and respectful manner, always keeping in mind the best interests of the resident.*

Standard 21. Accountability

99. All SHs would be directly accountable to the Department of Social Justice (DSJ). The Standards of Care prescribed should be adapted by a SH, irrespective of whether it is government or privately funded. All SHs should have the certification for implementing the Standards of Care.

100. DSJ will lay down the process of ensuring accountability through inspections, visits, through a system of social audit. Every SH shall maintain an Inspection Book which shall have four columns in every page for entering the a) date; b) remark of the inspecting officer; c) action taken by the Home Manager on the remarks of the Inspecting officer and d) remarks of the visiting superior officer. It will be the responsibility of the Home Manager to ensure that effective and timely corrective action is taken to comply with the directions given during these visits, inspections and audits.

101. It is important for the staff members to work together as a team to ensure optimal compliance of the care standards. Except for fiduciary obligations, the team shall jointly perform all other care tasks, which are necessary under this protocol.

Standard 22. Administrative Staff Recruitment/Training

102. Prior to recruiting any staff for the SH, their past record and assessment of their skills and attitude should be specially reviewed. Special care should be taken to ascertain any indications of past criminal record or association, psychological disorders and addictions (alcohol, tobacco, pan parag, drugs, etc.), if any

103. All staff should be made aware that they are individually and jointly accountable for the well-being and security of the residents. All staff, irrespective of the post, from cook to security and cleaning staff, should be given induction training and be adequately sensitized on aspects of trafficking, needs of trafficked residents, trauma care, first aid, medical problems likely to be faced by the victims and counselling. They should also be trained in conflict management and dispute resolution. They also need to be trained in documentation and reporting requirements. This training may be outsourced in consultation with DOSJ.

104. The optimal human resources for a *SH*with an average of 50 residentsshould be as follows:

Managerial and Administrative Staff	• A person with a postgraduate degree, preferably in social work or public health, should be appointed as the Head of the SH, with the overall responsibility of management of all SHs in the state. • 1 fulltime Home Manager, with a graduate degree in a relevant subject, responsible for all day-to-day administrative, reporting, and financial obligations, supported by one accountant who will also be responsible for the documentation needs. • 2 full time resident Wardens (one for every 25 residents), who should be at least graduates, and responsible for all care activities; • 4 caretakers with minimum SSLC education and having at least one with basic nursing skills. Of these at least one person should have training in handling persons with special needs, including HIV/AIDS
Technical Staff	• Two trained, full time Counsellors (one with MSW and other with MA Psychology with special training on trauma care) should be recruited. The Counsellor with experience in providing trauma care has to be resident, and responsible for addressing the in-house problems of the residents, and work as a care worker to support the children in implementing the Individual Care Plans. The other may be a non-resident, who will be responsible for the social integration of the resident and for interfacing with various agencies. Together the Counsellors will be responsible for completing the profile and for developing the Individual care plans. The SH may also choose to use primary level peer Counsellors, who are resident in the SH, to support the secondary level professional Counsellors, as mentioned above. • Medical Services: A special panel of Medical practitioners (both government and private) should be identified to attend to the needs of the residents at any time of requirement, and an appropriate budget should be extended for medical kits, transportation and honorarium.
Legal Assistance	• Such support should be converged with existing free legal aid services. If such services are not easily available, a budget may be provided for legal support and assistance, till such time as mainstream services can be accessed.
Support Staff	• One Cook per twenty-five residents • Two security watch women with reading and writing skills • A driver; and • Two cleaners
In addition to the above, part time staff can be employed for providing tuition, for vocational training, for teaching music, yoga etc.	

Standard 23. Monitoring& Evaluation

105. A monitoring system will be developed based on the profile as well as set of results indicators developed from the Standards of Care. This is different from the profile, which has to be maintained separately. The monitoring system consists of important information, which can help DSJ and other relevant departments to monitor progress at the individual level, at the facility level, and at the State level.

106. The convenor of the District Nirbhaya Committee, assisted by an Empowered Committee, including Nirbhaya Committee members, NGOs and members of government and civil society, should visit and monitor the functioning of the SHs every quarter. This team should have a written authorisation from the District Collector or Director, SJD, and display appropriate ID cards. The monitoring and review report, based on the monitoring format should be submitted to the Chairperson of the District Nirbhaya Committee, the District Collector, and to the Director of DSJ.

107. Within the SH there should be formal staff meetings every fortnight to discuss the implementation of the Minimum Standards of care. There should also be monthly meetings with the residents to review the Minimum Standards. Based on the feedback received from the staff and residents, improvements must be made which shall be reviewed at these meetings

108. Monitoring should be undertaken in a participatory fashion, seeking feedback not only from the residents and staff but also from the NGOs, and Government officials who visit the SHs and who are in a position to assess compliance by the SHs with the prescribed standards.

109. Half-yearly internal audits and external social audits should be done annually, apart from ensuring total transparency in matters related to receipt of funds and expenditure.

F. Logistics-Related Standards

Expected Outcome: The SH hasoptimal logistical facilities that safeguard the resident's rights and interests but at the same time provides a caring and relaxed environment.

Standard 24. Location of Protection Facility

110. An SH should be located in a residential area and should be maintained and integrated within the local scenario. The name board of the SH should not reveal the purpose of the Home or the service it provides. Each SH should be capable of accommodating a maximum of 50 residents and should not be less than 5500 sq. ft., which includes the different types of spaces, required.

111. A SH shall be resident friendly; it should not have the appearance of a prison or a punitive facility, despite the need to ensure utmost security for the inmates. The location of the SH should minimize any risk to the residents, provide them with privacy, and should have a favourable ambience. Therefore it should not be close to a public facility, liquor shop, slum or shanties, or public places such as auto stands, bus stations, railway stations, roadside stalls, etc. Care should be taken to ensure that

the physical infrastructure does not allow an opportunity for undesirable outside contact.

Standard 5.Basic Infrastructure Facilities

112. There shall be separate sections in the SH for the residents based on age. Classification and segregation according to age group shall preferably be for 5-11 years, 12 -16 years and 16 years and above. Each age group should have separate facilities for bathing and sleeping. In an ideal home, there should be separate facilities for children up to the age of 5, with special facilities for infants.

113. For an institution with 50 inmates the optimal norms of accommodation shall be as stated below:

- 2 dormitories...each of 1000 square feet for 25 inmates i.e. 2000 sq. Ft;
- 2 classrooms.... each of 300 sq. ft for 25 inmates, i.e. 600 sq ft
- Sick room/ First aid room... 75 sq.ft. per inmate for 10 i.e. 750 sq.ft.;
- Kitchen... 250 sq ft
- Store... 250 sq.ft.
- Recreation room... 300sq ft.
- Library ... 500 sq ft
- 5 bathrooms... 25 sq ft each i.e. 125 sq ft
- 8 toilets/latrines... 25 sq ft each i.e. 200 sq ft
- Office rooms...(a) 300 sq ft (b) Home Manager's room... 200 sq ft
- Counselling and guidance room... 120 sq ft
- Structures for differently- abled children
- Residence for Home Manager: (a) 2 rooms of 250 sq ft each; b) kitchen of 75 sq ft; (c) bathroom cum toilet 50 sq ft; (d) a hall of 500 sq ft; and a sit-out of 150 sq ft

114. The SH should be well equipped with amenities that will ensure clean drinking water, electricity, sanitation, clean toilets, approach road, etc. There should be adequate heating and cooling arrangements within the SH. The SH should be well ventilated, with adequate space, and the building should have proper and smooth flooring to prevent accident. No basement should be used for residential purposes. Proper storage space should also be available for the personal effects of the residents.

115. Each SH should be provided with an incinerator for effective waste management. Provision of utilities and waste management should also include green approaches such as rainwater harvesting, use of solar energy, biogas, and wastewater; solid, and organic waste management. There should also be facilities for a kitchen garden, poultry and dairying, wherever possible.

116. Every SH should make provision for first aid kit, fire extinguishers in the kitchen, dormitories and store rooms. There must be periodic review of electric installations and inspection of facilities for storage of articles of food, stand by arrangements for water storage and emergency lighting.

117. The SH should have open spaces for recreation and washing/drying arrangements, (including a covered area for drying clothes during the rainy seasons), although it would be necessary to ensure privacy in such spaces.The residents of the SH should have access to common facilities such as garden,

playground, library, prayer, recreational facilities etc. The SH should be disabled-friendly, with suitable arrangements in toilets, bathrooms, bedrooms, recreations area etc. Wheel chairs and other assistive devices should be provided.

118. The SH should have facilities, either in-house or external or both, for providing skill training and production of goods. Ideally the Home Manager shall live within the premises.

119. Given the sensitive nature of the problems and emergencies faced by the SH, it should be provided with a vehicle for meeting the needs of the residents, preferably with a woman driver.

120. The norms for providing clothing, toiletries and bedding to each resident during her stay in the SH or in the in-house hospital are given in Annex VI.

Annex I:Nutrition and diet scale

Name of the article of diet	Scale per head per day
Rice, wheat, Ragi, Jowar	600gms,(700 gms for 16-18 yrs Of age) of which at least 100 gms To be either wheat or ragi or Jowar
Dal/Rajma/Chana	120 gms
Edible Oil	25 gms
Onion	25 gms
Salt	25 gms
Turmeric	05 gms
Coriander Seed Powder	05 gms
Ginger	05 gms
Garlic	05 gms
Tamarind/mango powder	05 gms
Milk(breakfast)	**150 ml**
Dry chillies	05 gms
Vegetables Leafy	100 gms
Non- leafy	130 gms
Curd or buttermilk	100gms/ml
Chicken once a week or eggs on 4 days	115 gms
Jaggery and ground nut seeds or paneer (vegetarian only)	60 gmseach(or 100 gms for Paneer)once a week
Sugar	40 gms
Following items for 50 children per day	
Pepper	25 gms
Jeera seeds	25 gms
Black gram dal	50 gms
Mustard seeds	50 gms
Ajwain seeds	50 gms
On chicken day, for 10 kg of chicken	
Garam masala	10 gms
Kopra	150 gms
Khaskhas	150 gms
Groundnut oil	500 gms
Bread	500 gms
Milk	500ml
Other Items	
LP gas for Cooking only	

Instructions:

2)Variation in diet

A Three varieties of dal ieToor(Tuvari), Moong (Green gram) and Chana (Bengal Gram) may be issued alternatively

Chicken may be substituted with fish at the discretion of the Superintendant, if there is no extra expenditure to the Government

On non- vegetarian days, vegetarians shall be issued with either 60 gms of jiggery and 60 gms of groundnut seeds per head in the form of laddus or any other sweet dish or100gms paneer

Potatoes can be issued in lieu of vegetables once a week

Leafy vegetables such as fenugreek (methi), spinach (palak), sarson (mustard leaves) and other such leafy vegetables may also be issued once a week. The Superintendant should encourage the cultivation of leafy green vegetables, drumsticks trees, curry leaf trees and coriander leaves to provide greater variety in the vegetables given to the children during the week.

The Superintendent may make temporary alterations in the scale of diet in individual cases when considered necessary by him, or on the advice of the Doctor attached to the SH, subject to the scale prescribed is not exceeded

Meal timings and Menu

Breakfast: after 8 am
Upma or chappatis made of wheat or ragi, or any other dish
Chutneys made of coconut, fresh curry leaves or fresh coriander etc
Dal/vegetable
Milk
Any seasonal fruit in adequate quantity

Lunch at 1.00 pm and Dinner after 7.00pm

Rice/Chappatis or combination of both
Vegetable curry
Sambhar or dal
Butter milk or curd

Others:

Depending on the season, the Superintendent, at his discretion, to alter the meal times
On the advise of the SH's doctor, every sick child may be issued a medical diet as indicated in the diet scale.

Extra diet items like milk, eggs, sugar and fruits may be issued to the children on the advise of the SH's doctor in addition to the regular diet to correct under weight issues or other health reasons. These sick children shall be excluded from the day's strength for the purpose of calculating the daily ration
Sweet dishes may be distributed to all the children on the following national and festival occasions, at the rate fixed by the Superintendent from time to time.

Republic Day
Ambedkar's Birthday
Independence Day
Mahatma Gandhi's Birthday
Children's Day
Child Rights Day
Dussehra
Deepavali
Ramzan
Bakrid
Christmas
Additional festivals may be specified based on local preferences

Annex II:Protocol on Conflict Management[1]

All children have the right to an impartial process of dispute settlement. Non-adversarial and non-intimidating processes such as conciliation and negotiation are being are being utilized.

1. While there is flexibility on the type of dispute resolution mechanism that must be put in place, the process must be speedy and fair. This process should be conducted in a manner to ensure a fair hearing for both parties.

2. Adispute can be reported by a student or staff. It can also be made through the Suggestion Box, which must be opened as prescribed.

3. The process of dispute and the final results should be documented with a fair amount of detail in the daily diaries.

Managing Disputes Between Children

Types of Conflict & Possible Preventive Measures

Typology of Conflict	Selected Examples of Preventive Measures
Violence on new Entrants (Ragging, Stealing their things, forced labour)	When a new child comes in, have a welcoming committee of children who befriend the child until she or he is more at home Try to find a solution through the resident'sredressal committee Pay attention to new child until she or he has settled into the daily routine of the Home Involve NGOs and Community welfare workers
Groupism and Gang fights	Group counselling Use more positive children to influence change, or segregate problematic children Support team work and games for positive use of energy, and tailor the individual care plan to each child
Domination by the strong over the weak:	Examine need for behaviour modification through counselling Increase awareness of rights of children
Homosexuality	Segregate children Advise and counsel both the perpetrator and the victim
Destroying things of others, Stealing	Support team work and games for positive use of energy Try to understand why the children who misbehave are doing so and prepare an ICP Regular discussion at the committee meetings about these issues, without pointing fingers or isolating anyone. Advice children of the consequences of such behaviour if it continues.

[1]This protocol covers all minor disputes but does not extend to sexual harassment or other offences, which are covered by existing laws.

Typology of Conflict	Selected Examples of Preventive Measures
	If it is an attention seeking problem, it is important to provide counselling
Possessiveness of small children by big children-	Rotate responsibilities
Use of Bad language and other such behaviour	Imposition and try behaviour changing measures including counselling Staff must be asked to be good mentors

4. Under the guidance of the superintendent or an NGO or other Voluntary worker, a child mentoring committee (CMC) may be established to support and settle disputes between the children. The CMC must consist of senior children, selected by the superintendent from the Children's Committee. The members of the CMC should possess skills and mental aptitude to be able to provide additional care to the junior children, and to contribute to the overall social and emotional welfare of the children.

5. A transparent process of selection based on clear criteria must be established for the selection of CMC members. To the extent possible, the superintendent, in consultation with the caretaker, may make some arrangements to compensate them in kind or in cash as an incentive and as part of a development process. A capacity development module should be developed for those children who are interested or have the potential to be such Peer Counsellors.

Dispute Process

6. When the dispute is between children, the preferred method of dispute resolution is "conciliation", that is a third party must not intervene or take sides but merely facilitate the children to arrive at a solution in a peaceful manner through discussion. The possible steps such a facilitator can take in a conciliation process are as follows:

    - Separate the children and allow them to cool off when upset
    - Encourage them to speak directly to each other
    - Encourage children to speak assertively but honestly and kindly sticking to facts and avoiding opinions and personal attacks
    - Direct children to listen carefully to others and accurately paraphrase their words.

7. The facilitator should ideally not propose solutions but encourage the children to come up with a solution. Where needed, the facilitator can arrange for individual or group counselling. If a child has deviant behaviour, she or he must be sent for counselling or to a psychologist

Appeal Process in Disputes Between Children

8. For minor disputes between children, the CMC leaders, in consultation with the staff may be the final authority.

9. For more serious matter (that is issues which may be considered an offence), the Superintendent is the final authority

Disputes Between Staff and Child

Preventing Conflict between Staff and Child

10. The reasons for conflict between staff and children are various,On the part of the staff, they range from a lack of proper understanding of the child, her or his behaviour and demands, a lack of commitment to the sensitive nature of their responsibilities, holding rigid views, prejudices and actions that leads to friction, making insulting comments etc. On the part of the children, it could be due to lack of role models or their deviant behaviour

11. Open and transparent dialogue between children and staff is essential to ensure cooperation in the Home. Regular staff meetings are also needed for staff to arrive at a consensus on how to handle any conflict issue, keeping always the best interests of the child. It is also essential to encourage children to air their views through the meetings of the residents committee.

12. All staff, particularly the superintendent and the caretaker, must ensure that they are good role models for the children. These include characteristics such as punctuality, use of proper language, proper decorum, absence of any vices or addictions, and so on.

13. Since the children are often scared to report against their superiors, each Home must establish and publicize a process for reporting anonymously.

Process for Settling Disputes Between Staff and Children

14. Mediation is the preferred way for settling disputes between staff and children. The Superintendent must mediate such disputes. He must act in an impartial and fair manner ensuring that the interest of the child is paramount.

15. He may suggest disciplinary action against staff to higher ups (this must be considered an extreme measure in cases such as doing bodily harm to children or where despite a first warning, the staff member continues to act in a way that generates conflict with children.)

Appeal Process

16. Minor disputes – in the case of minor disputes between children and staff, the Superintendent will be the final authority.

17. In the case of more serious matter or in a case where the Superintendent is involved, the Director, Department of Social Justice would be the final authority.

Common requirements

18. Keep Suggestion book and box and follow procedures.

19. The Superintendent must maintain a daily journal so as to be able to recount the details if necessary. If misuse by child is alleged, the Superintendent must dialogue and discuss with the child to better understand the reasons for such an incident, document all facts,

and if no action is proposed to be taken, he shouldprepare a written note to justify why no action was taken. He must send a report to the CWC about the incident within seven working days of being informed of such incident.

Annex III: Protocol to Prevent and Manage Abuse by Staff within Children's Homes/ Shelter Homes

Children are protected from harm, neglect, exploitation, maltreatment, corporal punishment, confinement (solitary or otherwise) and abuse during all the stages that the child remains in contact with Shelter Homes or the Juvenile Justice System

1. This protocol is intended to help staff and residents of Children's Homes and Shelter Homes to work together to prevent abuse of children by staff, and to take action in a timely and transparent manner when necessary. It is also a pilot to make consistent rules for addressing abuse. This protocol is developed based on discussion by a set of staff from Children's Home. Select Children's Homes are expected to revise the Protocol in consultation with their staff, discuss the procedure with the children, and pilot implementation between June and September 30, 2014. It can serve as guidelines for use in Shelter Homes

2. This Protocol illustrates the type of abuse, suggests factors that may help to identify such abuse, measures that could be taken to prevent such abuse, explains who may complain about such abuse, and briefly states the steps that must be taken to address such abuse.

Types of Abuse

3. Abuse can be defined as any act or omission, which results in mental trauma or physical harm. This includes:

- Verbal/Emotional
- Sexual[2]
- Physical
- Neglect
- Maltreatment
- Economic Abuse

Examples of Emotional /Verbal Abuse

- Frequently blames or criticizes you

[2]Sexual abuse is covered in detail by the POSCO Act and is not discussed here.

- Calls you names
- Ridicules your beliefs, religion, race class or sexual preference
- Blames you for "causing" the abuse
- Ridicules/makes bad remarks about your gender
- Criticizes or threatens to hurt your family or friends
- Isolates you from your family and friends
- Tells people you suffer from a mental illness
- Uses phrases like "I'll show you who is the boss," or "I'll put you in line"
- Uses loud or intimidating tone of voice

Examples of Physical Abuse

- Any Physical Abuse intended to hurt
  - Pushes, grabs or shoves you, slaps you, punches you, kicks you, pulls your hair, burns you, ties you up
- Threatens you with a knife, gun or other weapon
- Prevents you from leaving an area/physically restrains you
- Throws objects
- Destroys property or your possessions
- Drives recklessly to frighten you
- Disregards your needs when you are ill, injured or otherwise in a weak situation

Examples of Neglect and Maltreatment

- **Neglect** is the **failure** of a caregiver to provide for a child's basic needs. Neglect may be:
  - Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision)
  - Medical (e.g., failure to provide necessary medical or mental health treatment)2
  - Educational (e.g., failure to educate a child or attend to special education needs)
  - Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)
- Maltreatment may be instances such as making you do the job of the cook or a gardener[3]

Identification of Abuse

4. It is often difficult to identify abuse, but some of the warning factors are indicated below. It is the duty of all staff to be vigilant in monitoring any type of abuse that could occur and so be on the look out for such signals. Such steps should be undertaken in a responsible fashion. Signals can include the following:

- Change in non-verbal behaviour
  - Withdrawal, Gloominess and Crying
- Physical abuse – wound, scratch, complaint of pain
- Sexual abuse
  - Fear of others withdrawal, loss of trust, depression

[3]This is acceptable when it is done as part of a daily routine decided in a transparent and fair fashion by the Home Staff and Children.

- Maltreatment and Neglect
  - Shabby clothes, Unkempt appearances, Low self esteem
- Is reluctant to be around a particular person or does not want to go to the Home or tries to escape
- Child discloses maltreatment
- Suicidal attempts, Insomnia or lack of appetite or over eating

Measures to Prevent Abuse

5. While steps to prevent abuse will depend on the context in the Home, some measures could include:

- Education must be given to children and staff for recognising and responding to bullying behaviour. Children must be involved in discussion and decision-making regarding their own safety and protection, including outside the Home and on-line. Children must be given incentives for good behaviour
- Children must be informed and know how to make a complaint or allegation of abuse. Children must be provided with access to trusted adults outside the Home and know how to contact helpline services.
- Any child or juvenile who has been involved in abuse must be provided with information, support and counselling and involved in the planning of the support programme. Staff and Children must know how they will be supported in the event of an allegation being made
- Train Superintendent and Staff to effectively deal with the issues
- Prepare Safety Plan to prevent abuse
  - Tailored to the type of abuse in the Home – segregate children, remove staff with potential to harm, pay specific attention to children at risk
- Develop alternative mechanisms to corporal punishment to establish discipline
- Implement the concept of Suggestion Box and Book
- Provide adequate training for communication and problem solving to Superintendent

Inspection of staff performance through surprise checks

Who Can Complain?

6. Anybody can complain about abuse of children including staff, children, or others who may be involved in the functioning of the Home.

- Complaint from Child
- Complaint from peers
- Complaint for other staff
- Counsellors and psychologist
- Suggestion Box

Upon Allegation of Abuse

…

7. Sexual, Physical abuse or Neglect
   - Staff or child reports to the superintendent
   - If the superintendent is alleged to be involved, the child or staff member can report to the CWC or other competent authority
8. The Superintendent must then follow the procedure indicated below:

1. Report the matter to the CWC or other competent authority, who in turn shall order a special investigation and also report the matter to the policestation to register a case and conduct necessary enquiries.

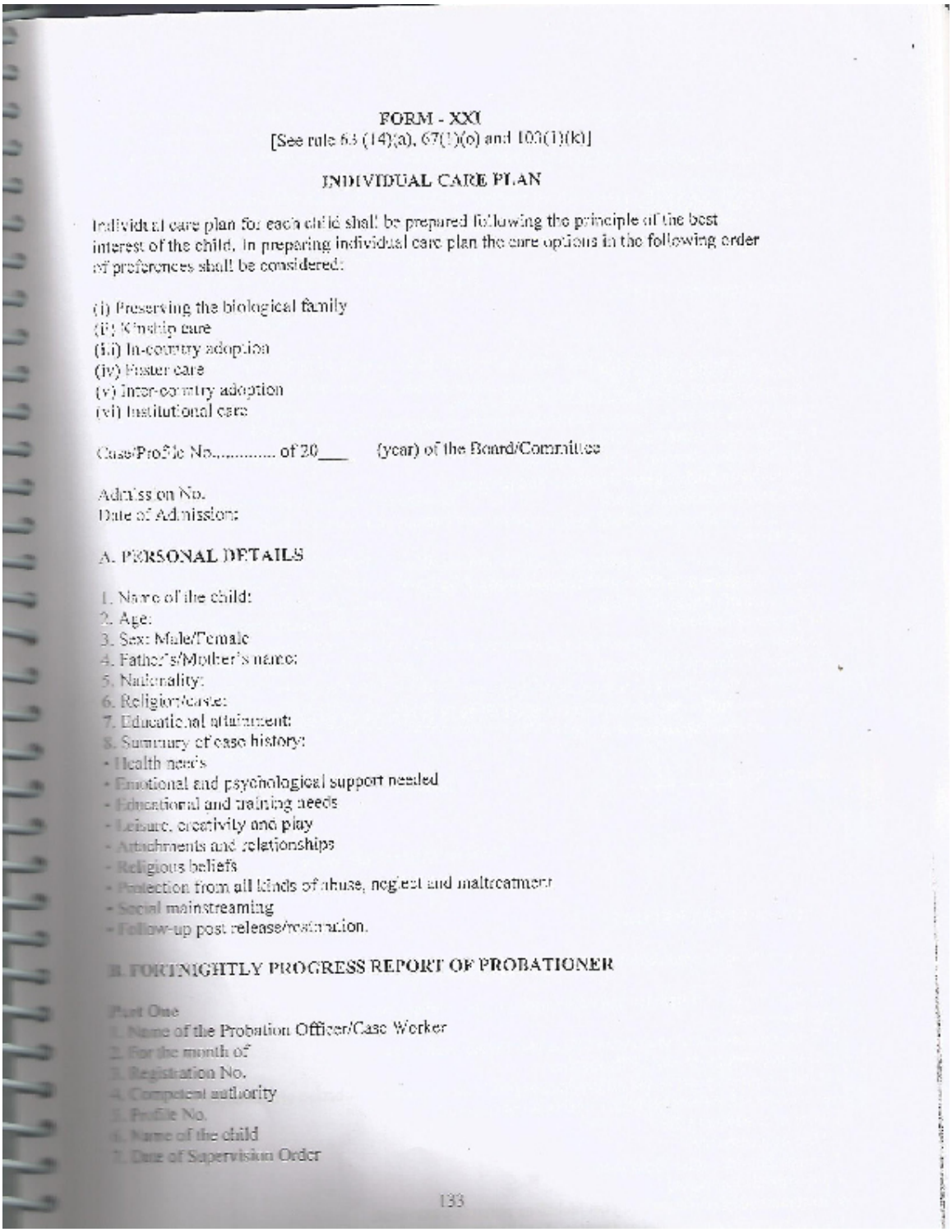
2 Ensure completion of the enquiry, provide legal and counseling support to the resident involved and , if necessary, move the resident to a safer place elsewhere

3Seek the assistance of relevant child rights experts, mental health experts, or Victim AsssistanceCentres to deal with the problem effectively

4The head of the Home or Superintendant shall report the matter to the Director DOSJ and also forward a copy of the report and follow up action taken on it.

. Any child who has been involved in abuse must be provided with information, support and counselling and be involved in the planning of the support programme. Staff and Children must know how they will be supported in the event of an allegation being made.

Annex IV: Individual Care Plan



FORM - XXI
[See rule 63 (14)(a), 67(1)(o) and 100(1)(k)]

INDIVIDUAL CARE PLAN

Individual care plan for each child shall be prepared following the principle of the best interest of the child. In preparing individual care plan the care options in the following order of preferences shall be considered:

(i) Preserving the biological family
(ii) Kinship care
(iii) In-country adoption
(iv) Foster care
(v) Inter-country adoption
(vi) Institutional care

Case/Profile No..... of 20___ (year) of the Board/Committee

Admission No.
Date of Admission:

A. PERSONAL DETAILS

1. Name of the child:
2. Age:
3. Sex: Male/Female
4. Father's/Mother's name:
5. Nationality:
6. Religion/caste:
7. Educational attainment:
8. Summary of case history:
- Health needs
- Emotional and psychological support needed
- Educational and training needs
- Leisure, creativity and play
- Attachments and relationships
- Religious beliefs
- Protection from all kinds of abuse, neglect and maltreatment
- Social mainstreaming
- Follow-up post release/restoration.

B. FORTNIGHTLY PROGRESS REPORT OF PROBATIONER

Part One
1. Name of the Probation Officer/Case Worker
2. For the month of
3. Registration No.
4. Competent authority
5. Profile No.
6. Name of the child
7. Date of Supervision Order

8. Address of the child
9. Period of supervision

Part Two

Places of interview Dates
....
....
....

1.Where the child is residing?
2.Progress made in any educational/training course.
3.What work he/she is doing and his/her monthly average earning, if employed.
4.Savings Kept in the Post Office.
5.Savings Bank Account in his/her name.
6.Remarks on his/her general conduct and progress.
7.Whether properly cared for?

Part Three

1. Any proceedings before the competent authority of or
a)Variation of conditions of bond
b)Change of residence
c)Other matters
2. Period of supervision completed on.....
3. Result of supervision with remarks (if any)
4. Name and Addresses of the parent or guardian or fit person under whose care the juvenile is to live after the supervision is over.

Date of report ___ ___ ___ Signature

Probation Officer/Case Worker___ ___

C. PRE-RELEASE REPORT

(Tick whichever is applicable) Final Release Transfer

1. Details of place of transfer and concerned authority responsible in the place of transfer/release
2. Details placement of the juvenile/child in different institutions
3. Training undergone and skills acquired
4. Final progress report of the officer-in-charge of superintendent/ probation officer/child welfare officer/case worker/social worker (to be attached)
5. Date of release/transfer
6. Date of repatriation
7. Requisition for escort if required
8. Identification of escort
9. Recommended rehabilitation plan including possible placements
10. Sponsorship requirement and report, if applicable

11. Identification of Probation officer/case worker/social worker/non-governmental organisation for post-release follow-up
12. Memorandum of Understanding with non-governmental organisation identified for post-release follow-up
13. Identification of sponsorship agency/individual sponsor for the child post-release, if any
14. Memorandum of Understanding between the sponsoring agency and individual sponsor
15. Details of Savings Account of the child, if any
16. Details of child's earnings and belongings, if any
17. Details of awards/rewards due to the child, if any
18. Opinion of the child
19. Any other information

Note: Pre-release report shall be prepared 6 months prior to the date of release/transfer of juvenile/child and shall take into account the recommendations of the last review report and all other relevant information.

D. POST-RELEASE REPORT

1. Status of Bank Account : Closed / Transferred
2. Earnings and belongings of the child : handed over to the child or his/her parents/guardians – Yes/No
3. First interaction report of the probation officer/child welfare officer/caseworker/social worker/non-governmental organisation identified for follow-up with the child post-release
4. Placement of the juvenile/child if any
5. Family's behaviour towards the child
6. Social milieu of the child, particularly attitude of neighbours/community
7. How is the child using the skills acquired?
8. Whether the child has been admitted to a school or vocation?
9. Give date and name of the school/institute/any other agency
10. Report of second and third follow-up interaction with the child after two months and six months respectively

Annex V: Case File

FORM - XX

[See rule 63 (1) and 67(1)(i)]

CASE HISTORY OF CHILD/JUVENILE IN THE INSTITUTION--

Case/Profile No._____
Date & Time_____

Affix a latest photograph here

A. PERSONAL DATA

1 Name
2 Male / Female (tick the appropriate category)
3 a) age at the time of admission
b) present age:

4 Category:
- Separated from family
- Abandoned/deserted
- Victim of exploitation and violence (give detail)
- Run-away
- Any other

5 Religion Hindu (OC/BC/SC/ST) Muslim/Christian/Other (pl. specify)
6 Location of Residence Urban /Sub-urban/Rural/Slum/Industrial/ Other (Pl. specify)
7 Native District & State:
8 Description of the Housing:
i) Concrete building Tiled House/Hut/On the street/Others (please Specify)
ii) Three bed room/two-bed room/one-bed room/no separate bed room.
iii) Owned/rental
9. By whom the juvenile was brought before the Child Welfare Committee:
i) Police-Local Police/Special Juvenile Police Unit/Railway Police/ Women Police
ii) Probation Officers
iii) Social Welfare Organization
iv) Social Worker
v) Parent(s)/Guardian (s) (please Specify the relationship)
vi) Child himself/herself

10. Reasons for leaving the family
i) Abuse by parent(s)/guardian(s)/step parents(s)
ii) In search of employment.
iii) Peer group influence
iv) Incapacitation of parents
v) Criminal behavior of parents
vi) Separation of parents
vii) Demise of parents
viii) Poverty
ix) Others (please specify)

11. Types of abuse met by the child

i) Verbal abuse – parents/siblings/ employers/others (pl. specify)
ii) Physical abuse
iii)Sexual abuse parents/siblings/
Employers/others (Pl. specify)
iv)Others – parents/siblings/employers/others (pl. specify)

12. Types of ill-treatment met by the child.
i) Denial of food – parents/siblings/employers/other (pl. specify)
ii) Beaten mercilessly – parents/siblings/employers/other (pl. specify)
iii) Causing injury – parents/siblings/employers/other (pl. specify)
iv) Other (pl. specify) – parents/siblings/ employers/others (pl. specify)

13. Exploitation faced by the child
i) Extracted work without payment
ii) Little (low) wages with longer duration of work
iii) Others (pl. specify)

14. Health status of the child before admission.
i) Respiratory disorders - present / not known / absent
ii) Hearing impairment - present / not known / absent
iii) Eye diseases - present / not known / absent
iv) Dental disease - present / not known / absent
v) Cardiac diseases - present / not known / absent
vi) Skin disease - present / not known / absent
vii) Sexually transmitted diseases - present / not known / absent
viii)Neurological disorders - present / not known / absent
ix) Mental handicap - present / not known / absent
x) Physical handicap - present / not known / absent
xi) Others (pl. specify) - present / not known / absent

15. With whom the child was staying prior to admission
i) Parent(s) – Mother / Father / Both
ii) Guardian(s) – Relationship
iii) Friends
iv) On the street
v) Night shelter
vi) Orphanages / Hostels/ Similar Homes
vii)Other (pl. specify)

16. Visit of the parents to meet the child
i) Prior to institutionalization –
Frequently / Occasionally / Rarely / Never
ii) After institutionalization -
Frequently / Occasionally / Rarely / Never

17. Visit of the child to his family

i) Prior to institutionalization
Frequently / Occasionally / Rarely / During festival times / During summer holidays /Whenever fallen sick / Never
ii) After institutionalization –
Frequently / Occasionally / Rarely / During festival times / During summer holidays /Whenever fallen sick / Never

18. Correspondence with parents -
i) Prior to institutionalization –
Frequently / Occasionally / Rarely / During festival times / During summer holidays /Whenever fallen sick / Never
ii) After institutionalization –
Frequently / Occasionally / Rarely / During festival times / During summer holidays /Whenever fallen sick / Never

B CHILDHOOD HISTORY (up to the age of 12 years)

19. Diet of mother during pregnancy:
i) Taken nutritious diet
ii) Ordinary diet
iii) Inadequate food intake

20. Health during pregnancy
i) Mother infected with contagious diseases
ii) Mother consumed/ used contraceptives
iv) Intake of antibiotics
v) No such details available

21. Birth details
i) Normal delivery/ prolonged delivery/ caesarian
ii) Under weight/ normal weight/ over weight

22. Details of immunization provided

23. Details of handicap
i) Hearing impairment By birth/ After accident/ diseases
ii) Speech impairment By birth/ After accident/ diseases
iii) Physical handicap By birth/ After accident/ diseases
iv) Mental handicap By birth/ After accident/ diseases
v) Others (please specify)

C. FAMILY DETAILS:

S. No.	Name &Relationship	Age	Sex	Education	Occupation	Income
1	2	3	4	5	6	7

Health	History of Mental Illness	Handicap	Habit	Socialization
8	9	10	11	12

25. Type of family:
Nuclear family / joint family/ broken family

26. Relationship among the family members:
i) Father &mother Cordial/ Non cordial/ Not known
ii) Father &child Cordial/ Non cordial/ Not known
iii) Mother &child Cordial/ Non cordial/ Not known
iv) Father &siblings Cordial/ Non cordial/ Not known
v) Mother &siblings Cordial/ Non cordial/ Not known
vi) Juvenile &siblings Cordial/ Non cordial/ Not known

27. History of crime committed by family members:

Sl. No.	Relationship	Nature of crime	Arrest if any made	Period of confinement	Punishment awarded

1. Father
2. Step father
3. Mother
4. Step mother
5. Brother
(a)
(b)
(c)
(d)
6. Sister
(a)
(b)
(c)
(d)
7) Child
8) Others (Uncle/aunty/grandparents)

28. Properties owned by the family:
i) Landed properties (pl. specify the area)
ii) Household articles- Cows/ Cattle/ Bull
iii) Vehicles- two wheeler/ three wheeler/ four wheeler (lorry/ bus/ car/ tractor/ jeep)
iv) Others (please specify)

29. Marriage details of family members:

i) Parents Arranged/ Special Marriage/ Local Union

ii) Brothers Arranged/ Special Marriage/ Local Union

v) Sisters Arranged/ Special Marriage/ Local Union

30. Social activities of family members:
i) Participate in social and religious functions
ii) Participate in cultural activities
iii) Does not participate in social and religious functions
iv) Not known

31. Parental care towards juvenile before admission:
i) Over protection
ii) Affectionate
iii) Attentive
iv) Not affectionate
v) Not attentive
vi) Rejection

D. ADOLESCENCE HISTORY (Between 12 and 18 years)

32. Puberty
Early/Middle age/Late

33. Details of delinquent behavior if any
i) Stealing
ii) Pick pocketing
iii) Arms selling
iv) Drug pedaling
v) Petty offences
vi) Violent crime
vii) Rape
viii) None of the above
ix) Others (please specify)

34. Reason for delinquent behavior
i) Parental neglect
ii) Parental overprotection
iii) Parents criminal behavior
vi) Parents influence (negative)
vii)Peer group influence
viii) To buy drugs/alcohol
ix) Others (pl. specify).

35. Habits
i) Smoking

ii) Alcohol consumption
iii) Playing indoor/outdoor games
iv) Drug use (specify)
v) Reading books
vi) Gambling
vii) Religious activities
viii) Begging
ix) Drawing/painting/acting/singing
x) Watching TV/movies
x i) Any other

E. EMPLOYMENT DETAILS

Employment details of the juveniles prior to entry into the home:
Sl.No. Details of employment duration wages earned
i) Coolie
ii) Rag picking
iii) Mechanic
iv) Hotel work
v) Tea shop work
vi) Shoe polish
vii) Household works
viii) Others (pl specify).

36. Details of income utilization:
i) Sent to family to meet family need
ii) For dress materials
iii) For gambling
iv) For prostitution
v) For alcohol
vi) For drug
vii) For smoking
viii) Savings

37. Details of savings
i) With employers
ii) With friends
vi) Bank/Post Office
vii)Others (pl. specify)

38. Duration of working hours
i) Less than six hours
ii) Between six and eight hours
iii) More than eight hours

F. EDUCATIONAL DETAILS

39. The details of education of the juvenile prior to the admission to children's home
i) Illiterate

ii) Studied up to V Standard
iii) Studied above V Std but below VIII Standard
iv) Studied above VIII Std but below X Standard
v) Studied above X Standard

40. The reason for leaving the School
i) Failure in the class last studied
ii) Lack of interest in the school activities
iii) Indifferent attitude of the teachers
iv) Peer group influence
v) To earn and support the family
vi) Sudden demise of parents
vii) Rigid school atmosphere
viii) Absenteeism followed by running away from school

41. The details of the school in which studied last:
i) Corporation/Municipal/Panchayat Union
ii) Government/SC Welfare School/BC Welfare School
iv) Private management
v) Convents

42. Medium instruction;
Hindi/English/Urdu/Tamil/Malayalam/Kannada/ Telugu
Other language (please specify)

43. After admission to children's home, the educational attainment from the date of admission till date;
No. of years Class studied Promoted /detained

44. Vocational training undergone form the date of admission into children's home till date.
No. of years Name of Vocational Trade Proficiency Attained

45. Extra curricular activities developed form the date of admission into the children's home till date
i) Scout
ii) Sports (please specify)
iii) Athletics (please specify)
iv) Drawing
v) Painting
vi) Others (pl. specify).

G. MEDICAL HISTORY

46. Height and weight at the time of admission:
47. Physical condition:
48. Medical history of child (gist):
49. Medical history of parent/guardian (gist):
50. Present health status of the child:

Sl. No.	Annual Observation	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1.	Date of review				
2.	Height				
3.	Weight				
4.	Nutritious diet given				
5.	Stress disease				
6.	Dental				
7.	ENT- Tonsils				
8.	External eye problem: vision/Left/ Right				

51. Height and Weight Chart:

Date, Month & Year	Height Admissible	Actual weight

H. SOCIAL HISTORY

52. Details of friendship prior to admission into children's home:
i. Co-workers
ii. School/Classmate
iii. Neighbors
iv. Others (pl. specify)

53. Majority of the friends are
i. Educated
ii. Illiterate
iii. The same age group
iv. Older in age
v. Younger in age
vi. Same sex
vii. Opposite sex.

54. Details of membership in group (please specify details)
i. Associated with cine fans association
ii. Association with religious group
iii. Associated with arts and sports club
iv. Associated with gangs
v. Associated with voluntary social service league
vi. Others (please specify).

55. The position of the child in the groups/league
i. Leader
ii. Second level leader
iii. Middle level functionary
iv. Ordinary member

56. Purpose of taking membership in the group:
i. For social service activities
ii. For leisure time spending
iii. For pleasure seeking activities
iv. For deviant activities
v. Others (please specify)

57. Attitude of the group / league
i. Respect the social norms and follow the rules
ii. Interested in violating the norms
iii. Impulsive in violating the rules

58. The location/meeting point of the groups
i. Usually at fixed place
ii. Places are changed frequently
iii. No specific places
iv. Meeting point is fixed conveniently.

59. The reaction of the society when the child first came out of the family
i. Supportive
ii. Rejection
iii. Abuse
iv. Ill-treatment
v. Exploitation.

60. The reaction of the police towards children
i. Passionate
ii. Cruel
iii. Abuse
iv. Exploitation
v. Ill-treatment
61. The response of the general public towards the child (HISTORY OF THE CHILD (GIST)
i. Education
ii. Health
iii. Vocational training
iv. Extracurricular activities
v. Others.

Suggestion of Child Welfare Officer/ Probation Officer after orientation to juvenile/child and the response towards orientation.

Follow up by Child Welfare Officer/ Probation Officer/ Case Worker/ Social Worker.

Quarterly Review of Case History by Management Committee.

SUPERINTENDENT/SOCIAL WORKER/

WELFARE OFFICER/PROBATION OFFICER

Annex VI: Clothing Details

1 Skirts and Blouse or Salwarkameez or half sari with blouses and petticoat.....5 sets per year, depending on age and regional preferences
Banyans (1 meter).....6 per year for younger girls
Brassiers.....6 per year for older girls
Panties(1meter cloth each).....6 per year
Sanitary Towels.....12 packs per year for older girls
Woollen sweaters.....2 in 2 years(in cold regions)
Woollen shawls.....1 in 2 years (in cold regions)
Miscellaneous Articles:
Slippers.....1 per year
Shoes.....1 per year
School uniform.....2 sets per year for those attending external school
School shoes.....1 pair per year for those attending external school
School bag and stationery.....1set per year for children attending external school
Handkerchiefs.....6 per year
1 white half sari or one salwarkameez or one white skirt and blouse, a pair of white canvas shoes and a blazer.....once in 3 years (in cold regions)
Bedding:
Towels.....4 per year
Cotton Bed Sheets.....2 per 2 year
Pillow(cotton).....1 per 2 year
Pillow covers.....2 per 2 years
Woollen blankets.....2 per 2 years
Cotton durrie.....2 per 2 years
Cotton filled quilt.....1 per 2 years (in cold regions)
Mattress.....1 per 2 years
Mosquito nets.....1 per 2 years

Every SH should have an hospital attached to it where in- patient treatment facility is available. This hospital should be equipped with the following minimal bedding and clothing for the in- patients:

Mattress.....1 per bed per 3 years
Cotton bed sheets.....4 per bed per 3 years
Pillows.....1 per bed per 2 years
Pillow covers.....4 per bed per year
Woollen blankets.....1 per bed per 2 years
Skirts and blouses or salwarkameezes..... 3 pairs per child per year*
Cotton Durrie.....1 per bed per 3 years
Beds..... 2 tier beds may also be provided depending on need
Locker or kit box.....1 per child, as per convenience and necessity

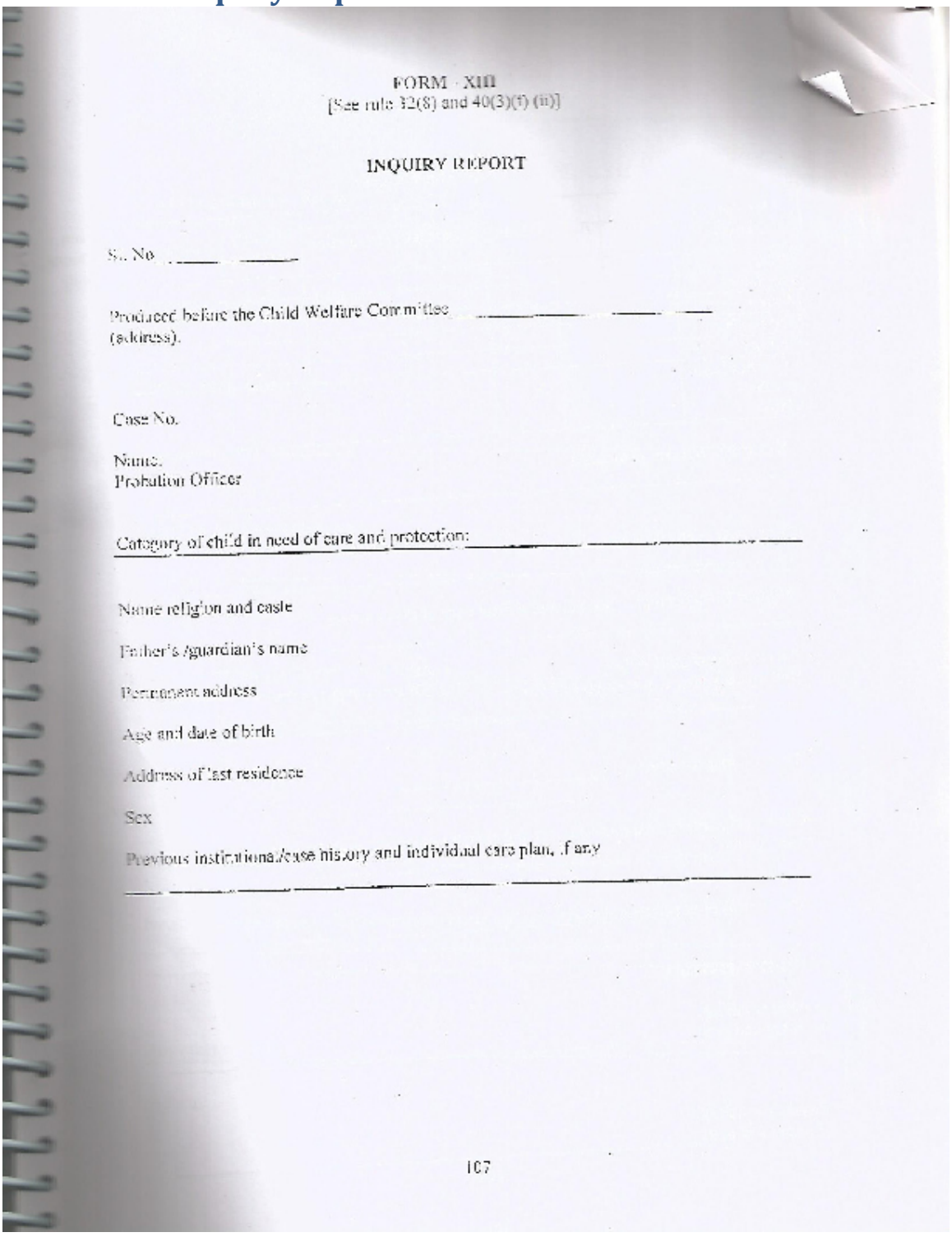
*These clothes should be issued when the patient is admitted and retained with the hospital, when the patient is discharged. The patient's own clothes should be washed, and returned to her when discharged

Toiletry;
Hair oil.....100 mg per month per child
Toilet or carbolic soap.....1 large bar per month
Tooth brush ..... 1 per 3 months
Tooth paste.....50 gms per month
Comb.....1 per year
Washing soap.....1 per month(125 gms), for washing clothes, towels, bed sheets etc except hospital clothes. (An addl soap of 100 gms for children attending outside schools)
Whitening/ bleaching powder....as per need for white coloured clothes

Cleaning items for the SH:

Broom stick.....25 to 40 per month, depending on the area of the SH
DDT spray.....as per the doctor's advise
Bugs killing agent.....as required
Phenyl and cleaning acid(daily).....depending on the area involved and as per the doctor's advise.

Annex VII: Inquiry Report



FORM - XIII
[See rule 32(8) and 40(3)(f) (ii)]

INQUIRY REPORT

Sl. No. _____

Produced before the Child Welfare Committee _____
(address).

Case No.

Name:
Probation Officer

Category of child in need of care and protection: _____

Name religion and caste

Father's /guardian's name

Permanent address

Age and date of birth

Address of last residence

Sex

Previous institutional/case history and individual care plan, if any

_____

FAMILY DETAILS

Members of family	Name	Age	Health	Education	Occupation	Monthly earnings	Disabilities	Any other e.g. social habits
Father								
Step father								
Mother								
Step mother								
Siblings								
Any other legal guardian/ relative								

If married, relevant particulars

Other near relatives or agencies interested

Attitude towards religion normal and ethical code of the home etc.

Social and economic status

Delinquency record of members of family

Present living conditions

Relationship between parents / parents and children especially with the juvenile under investigation

Other factors of importance if any

CHILD'S HISTORY

Mental condition
(Present and past)

Physical condition
(Present and past)

Habits, interests (moral, recreational etc.)_____

Outstanding characteristics and personality traits _____

Companions and their influence_____

Truancy from home, if any

_____

School (attitude towards school, teachers, class mates and vice-versa)

_____

Work record (jobs held, reasons for leaving, vocational interests, attitude towards job or employers) _____

Neighbourhood and neighbours report_____

Parent's attitude towards discipline in the home and child's reaction

_____

Any other remarks _____

RESULT OF INQUIRY

Emotional factors

Physical condition

Intelligence

Social and economic factors

Religious factors

Reasons for child's need for care and protection

Opinion of experts consulted

Recommendation of Child Welfare Officer/Case Worker/Social Worker regarding psychological support, rehabilitation and reintegration of the child and suggested care plan.

Signature of the Probation Officer/Child Welfare Officer/Case Worker