CHAPTER- I

INTRODUCTION
BASIC HUMAN RIGHTS OF CHILDREN

Right to Survival: A child’s right to survival begins before a child is born. According to Government of India, a child life begins after twenty weeks of conception. Hence the right to survival is inclusive of the child rights to be born, right to minimum standards of food, shelter and clothing, and the right to live with dignity.

Right to Protection: A child has the right to be protected from neglect, exploitation and abuse at home, and elsewhere.

Right to Participation: A child has a right to participate in any decision making that involves him/her directly or indirectly. There are varying degrees of participation as per the age and maturity of the child.

Right to Development: Children have the right to all forms of development: Emotional, Mental and Physical. Emotional development is fulfilled by proper care and love of a support system, mental development through education and learning and physical development through recreation, play and nutrition.
65% of girls in India are married by the age of 18 and become mothers soon after.

Out of every 100 children 19 continue to be out of school.

Of every hundred children who enroll, seventy dropout by the time they reach the secondary level.

Of every hundred children who drop out of school, sixty six are girls.

The declining number of girls in the 0 to 6 age group is a cause of concern. For every thousand boys there are only 927 females and even less in some places.

India has the world’s largest number of sexually abused children, with a child below 16 raped every 155th minute, a child below 10 every 13th hour, and at least one in every 10 children sexually abused at any point in time.

With more than one third of its population below 18 years, India has the largest young population in the world.

Only 35% of the births are registered impacting name and nationality.

One out of sixteen children die before they attain the age of one, and one out of eleven die before they are five years old.

35% of the developing world’s low birth babies are born in India.

40% of the child malnutrition in the developing world is in India.

India is home to highest number of child labourers in the world.

India is home to highest number of child labourers in the world.

Status of children in India (2014) (infochangeindia.org)

FIGURE- 1.2- STATE OF CHILDREN IN INDIA
INCEPTION OF THE RESEARCH

TOTAL POPULATION (IN 2011)

- 6,965,944,512

TOTAL POPULATION IN 0 TO 14 YEARS AGE GROUP

- 3,60,79,6626

- 1,210,726,932

- 35,71,64,445

- 19, 95, 81,477

- 6,72,58,958

(SOURCE – WORLD DEVELOPMENT INDICATORS AND CENSUS OF INDIA, 2011)

FIGURE- 1.3- INCEPTION OF THE RESEARCH
CHILDREN IN INDIA

“I have come to realize more and more that the greatest disease and the greatest suffering is to be unwanted, unloved, uncared for, to be shunned by everybody, to be just no body (to no one)”

Mother Teresa

Children are the supremely important asset of a nation. Investment in their childhood not only guarantees a healthy child population but also provides a population which later on contributes to the growth and development of the country. According to 2011 census, India with 1.21 billion people constitute the second most populous country in the world, while children represent 39% of the total population of the country. Uttar Pradesh is the state with the highest child population in the country (19.27%).

Children represent a very big and important section of our population. Children are also considered as the most vulnerable section of the society because of their dependence on others and lack of control over their own lives. Children who are given full opportunities for growth and development and are reared in a safe and protective environment, develop as healthy individuals in terms of physical, mental, emotional, social and spiritual well-being. Contrary to this developing in an insecure environment affects the child’s normal emotional, social and cognitive development.

Constitution of India gives every child some basic rights. Despite these rights and a number of child welfare programs, policies and law initiatives, millions of children today continue to live in difficult circumstances. These children are leading a life of social exclusion. The very survival of these children is an issue of grave concern because even the basic needs of these children are not fulfilled. Insecure attachment patterns and a lack of a stable and secure base make these children even more vulnerable and increase the risk of developing various problems. These children are looking for the attention of policy makers, as well as, of the society. According to Ministry of Women and Child Development, Government of India (2006), children in difficult circumstances include-
Homeless children (pavement dwellers, displaced, evicted etc).
Refugee and migrant children.
Orphaned, abandoned and destitute children.
Children whose parents cannot, or are not able to take care of them.
Street and working children.
Child beggars.
Victims of child marriage.
Trafficked children.
Child prostitutes.
Children of prostitutes.
Children of prisoners.
Children affected by conflict, disaster.
Children affected by substance abuse and HIV/AIDS and other terminal diseases.
Disabled children.
Children belonging to ethnic, religious minorities and other socially marginalized groups.
The girl child.
Children who are victims of crime.
Children in conflict with law.

This is also in parlance with the connotation of children in difficult circumstances given by World Health Organization.

The background of these children is marked with poverty, violence, abuse, neglect, broken or discordant family relationships, unemployment, illiteracy, unfulfilled basic needs etc.

Many of them are abandoned, orphans and runaway children. According to India Country Report on Violence against Children (2005) in India the number of destitute children stands at 44 million. As per UNICEF’s (2008) estimate there were 25 million orphan children in India in 2007 and many of them are in institutional care.
In an attempt to make a living many of them get engaged in hazardous occupations like rag picking, shoe polishing, working in hotels/ restaurants, beggary etc. Census estimated that 12.6 million children were engaged in hazardous occupations in India in 2001. India has the largest number of child labours under the age of 14 years in the world.

In the absence of a secure home, majority of these children become victim of child trafficking, exploitation, substance abuse, crimes etc. It is alarming that in 2011, the crimes against children reported a 24% increase from the previous year with a total of 33,098 cases of crimes against children reported in 2011. Uttar Pradesh accounted for 16.6% of total crimes against children at national level in 2011. A total of 33,887 juveniles were apprehended during 2011, out of which 31,909 were boys and 1,978 were girls (Children in India, 2012 – A statistical appraisal).
Children constitute almost 40% of the India’s population. Vulnerable & dependent upon others for the fulfillment of their needs.

Ten things every child needs:

- Need to interact with others and with their environment.
- Need to be touched
- Stable relations
- Safe environment
- Self esteem
- Quality child care
- Play
- Communication
- Music
- Reading

(McCormick Tribune Foundation, 2004)

Emotionally insecure, inadequate, mental health problems, deviance and vulnerable to exploitation and abuse.

More resilience against all odds, mental health and self esteem

Clinical and social pathology in the child

Mentally healthy child

FIGURE -1.4- A CLOSE UP- WITH PSYCHOSOCIAL SUPPORT AND WITH DEFICIT OF PSYCHOSOCIAL SUPPORT
Health, both physical and mental in children creates the foundation for not only the immune system but also vulnerability for various mental health problems and illnesses. Since the present study focuses on the mental health of children, it becomes imperative to cast a glance on health and mental health in Indian perspective.

HEALTH AND MENTAL HEALTH

“Sama dosha sama agnishcha samadhatu mala kriyaaha,
Prasanna atma mana indriyaha swastha iti abhidheeyate.”

[Sushruta Samhita /3/15/41]

In the above sutra from Sushruta Samhita, *samdosha* refers to the equilibrium of the body humors; *samdhatu* refers to normalcy in body tissues; *mala kriyaaha* means normal process of excretion; and *prasanna atma mana indriyaha* denotes the happy organic functions of soul, mind and senses. Thus, altogether, it means that a state of perfect health occurs when bodily humors and metabolic process are in dynamic equilibrium, all the tissues are functioning in harmony, all the excretory material is expelled out adequately and the soul, the senses and mind is happy. This definition of health focuses on—physical, metabolic, mental, sensory and dietary elements. In other words, it talks about health in a holistic manner.

Meaning of health differs from person to person and from culture to culture. In terms of the traditional Indian view health cannot be viewed as merely a state. It is a dynamic process of striving which ensures stability between the inner, as well as, outer factors which are continuously changing and therefore has no ideal state (Misra, 2005).

Further yogic or vedic scriptures define health as balance at different levels. According to yoga, a living being is considered to be perfectly healthy when he is in a state of balanced functioning of all aspects of existence. Thus, ‘*samatvam’ a state of
balance is synonymous with perfect health according to ancient Indian scriptures. In fact the word ‘samatvam’ is the definition of yoga (Mascaro & Brodbeck, 2003).

Samatvam yoga uchyate //bha gi/2/ 48/

According to Indian health science ayurveda, health is termed as ‘swastha’ meaning ‘establishing in one’s own self’ referring to perfect spiritual health as the highest level in health. This state of health or swastha is maintained by achieving a dynamic state of physiological balance at physical level and blissful existence at mental level (Bhishagratna, 2006).

In the religious perspective, the positive aspect of health is reflected in Arabian proverb “A man who is healthy, has an optimistic view and one who has an optimistic view, has everything” (Husain, 2005).

One of the most widely accepted definition of health was given by World Health Organization. WHO defines health as:

“…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001b)

In accordance with the WHO’s definition, health is seen as well-being and more than absence of disease or illness. According to Sharma and Mishra (2010) well being is the product of a complex interplay of biological, sociocultural, psychological, economic and spiritual factors. In classical Indian conditions health is conceptualized as a state of delight or a feeling of spiritual, physical and mental well-being (Prasannatnmendriyamanah) and this conception is closer to WHO definition of health and well-being (Dalal, 2001; Sinha, 1990).
Further in 1986 WHO Ottawa Charter of Health, health was seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as, physical capacities.

An important and integral component of health is mental health. Even WHO stresses on the fact that there is “No health without mental health”. Since its inception, WHO has included mental well-being in the definition of health. Three ideas central to the improvement of health follows from this definition-

1. Mental health is an integral part of health.
2. Mental health is more than absence of mental illness.
3. Mental health is intimately connected with physical health and behavior.

WHO proposed that mental health is:

“… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001d).

In this positive sense, for the individual and the society at large, mental health is the foundation for effective functioning and well-being. Neither the mental nor physical health can exist alone. Mental, physical and social functioning depends on each other.

According to Claringbull (2011) “Mental Health” is a generic term that usually refers to the quality of a person’s general psychological functioning. One way of looking at Mental disturbance (mental health level) is to think of it as lying along an intensity continuum. Just where any particular individual is on that continuum, will vary from time to time during that person’s life, as can be seen from the figure -1.5-
Like health, definition of Mental health also differs from individual to individual. The ancient system of Ayurveda offers a holistic approach to mental health that integrates the mind, body and soul. Ayurveda defines Mental Health as a state of mental, intellectual and spiritual well-being. As per Ayurveda signs of Mental health are as follows-

- Good memory
- Taking right food at right time.
- Awareness of one’s responsibilities.
- Awareness of the self and beyond self.
- Maintaining cleanliness and hygiene.
- Doing things with enthusiasm.
- Cleverness and discrimination.
- Being brave.
- Perseverance
- Fearlessness in facing situation.
- Sharp intellectual functioning.
- Self sufficiency.
- Following a good value system.
- Ability to proceed steadfastly against all odds.

(Prabhat, 2005)
Further different practices, techniques and exercises in Yoga are designed to still the mind. Patanjali defines Yoga as “Controlling the activities of mind”. Yoga practices play a very important role in dealing with various mental disorders.

In addition to this, in the Buddhist tradition, psychology of nirvana considered nirvana to be the goal of mental health. Nirvana is attained as a result of transformation- a transformation is a state of self-fulfillment, realistic self evaluation, freedom from inner conflicts and a stable emotional life. (Srivastava, 2010)

Jahoda (1958), elaborated on mental health by separating mental health into three domains-

1. Mental health involves “self realization” in that individuals are allowed to fully exploit their potentials.
2. Mental Health includes a “sense of mastery” by individual over their environment.
3. Positive Mental health means “autonomy” as in individuals having the ability to identify, confront and solve problems.

Singh (2002) gave the following characteristics of a mentally healthy person-

i. Development of emotionality, creativity, intellect and spirituality.
ii. Maintenance of mutually rewarding social relationships.
iii. Ability to face problems and challenges without losing patience and respond to them with full strength and draw lessons for future.
iv. Possessions of self confidence, assertiveness, sensitivity and sympathy with suffering of others.
v. Prepare constructively for joyful utilization of loneliness and participating in play and fun.
vi. To laugh on the occasions which are really amusing, joyful, wonderful and amazing.
Pandey, Dubey, Rajesh, & Ganeshan. (2004) gave the following signs of a mentally healthy person:

- Should be free from internal conflicts. One should be well adjusted with others.
- Should not get easily upset.
- Should understand the feelings of others.
- Should have good self control, not dominated by fear, anger, worries etc.
- Should face a problem confidently.
- Should solve a problem intelligently.

Shamasundar (2008) in his study of Indian scriptures found that an ideal person is expected to manage one’s life inspite of adversities of any nature. A Mentally healthy person attends to one’s legitimate duties in personal, family, social and occupational areas, fulfilling spiritual, affectional and material needs of self and family in harmony among one’s role functions, one’s abilities and limitations, prevailing circumstances and righteous means with sincerity and honesty, hope and confidence and contentment. He also stated the following four parameters on which different descriptive references to mental health in text books converge:

- **Appropriateness of emotional responses** - This is in reference to prevailing context or circumstances.
- **Adjustment with self and others** –
  a) **Adjustment with self** refers to a state of harmony among all components of one’s psychological apparatus. This requirement is similar if not the same as the Indian concept of “manasa- kaya- vaacha”, which in turn is similar to the meaning of genuinity.
  b) **Adjustment with others** pertain to a state of interactional harmony with other members of the family, social milieu etc.
- **Functional integrity** – This has two dimensions. The first is **cross-sectional integrity** ensuring reliability in all areas of one’s functioning. The second is the **longitudinal consistency** over time under differing circumstances.

- **Self actualization** as described by Maslow which means achieving one’s full potential.

Few corollaries to the integrated definition of mental health were also stated by Shamasundar (2008). These are as follows-

1. a. Mental health is not a passive state. An individual has to actively achieve a state of mental health.
   b. If someone has remained asymptomatic without having been challenged by difficulties or illnesses, there is no guarantee of subsequent mental health.
   c. Therefore, assessment of mental health must be based on the stresses an individual has faced and how he/she has coped with them.
   d. This requires re-orientation and re-organization of methods of assessing the state of mental health.

2. a. Mental health is an evolving, dynamic process that has to be actively achieved in “living-learning” situation of life.
   b. There is always a “price to pay for mental health”: difficulties to face, disappointments, and setbacks to brave, certain distresses to bear with dignity, and keep continuously refining one's coping skills.
   c. Only those individuals who have been challenged by adversities in life and have learnt the coping skills have the potential to remain mentally healthy within the limits of their abilities.
   d. Thus, the state of an individual's mental health has two dimensions to it: (i) The longitudinal, (ii) The cross-sectional.
e. In the same way, an individual's state of mental health potential must necessarily be assessed in respect of how he/she has coped with difficult situations, when “things have went wrong.”

On similar lines in classical Tamil literature more than 2000 years ago, there is a specific mention of the word “mana nalam” which literally means “Mental Health”. In the Tamil literary work Thirukkural, Thiruvalluvar notes “mana nalam man uyir akkam” which means that Mental health is the root source for a better world and better life (Thirunavukarasu, 2011). Thus the various perspective of mental health are being summarized in figure 1.6.
Voluminous literature supports this contention that the care, warmth, security and nurturance given by parents during the early years of development affects the overall development of a person. Ironically these children from difficult circumstances do not have this support system in the form of families. **Their context is marked with neglect, insecurity, lack of warm and affectionate relationships, ignorance etc.** Factors like

### Medical Model
According to medical model mental health refers to the absence of illness. A mentally healthy person is the one who is not ill or does not have any disease.

### Personality Growth
In terms of personality growth mental health is primarily a matter of moving from the self-centered goal of personal superiority to an attitude of construction of the environment and socially useful development. As Adler (1929) stated that the life of the human soul is not a “being” but a “becoming”.

### Religion
‘The mind is restless. To control it is good. A disciplined mind is the road to Nirvana’ (the Dhammapada) (Lal, 1967). In the Buddhist tradition nirvana is considered the goal of mental health which is attained as a result of transformation – a transformation is a state of self-fulfillment, realistic self evaluation, freedom from inner conflicts and a stable emotional life (Srivastava, 2010)

### Yoga
One classic commentary by Vyasa (in Taimni, 1961) on Patanjali’s yoga sutras states that Yoga is illumination. All the various paths and disciplines included in Yoga share fundamental goal of illumination and self realization. It’s outlook on mental health is holistic.

### Indian Medicine
Ayurveda, one of the branch of Indian medicines offers a holistic approach to mental health which is the integration of mind, body and soul. It is a state of mental, intellectual, and spiritual well-being.

### Indian Scriptures
In terms of Indian scriptures a mentally healthy person attends to one’s duties in personal, family, social and occupational areas, fulfilling spiritual, affectional and material needs of self & family in harmony among one’s role functions, one’s abilities and limitations, prevailing circumstances and righteous means with sincerity and honesty, hope and confidence, and contentment.

### Object relations
Object relations theorists hold that it is the satisfaction of relationship needs which determines a person’s mental health.
poverty, lack of basic amenities, ignorance, neglect, marginalization, separation from parents due to death or other reasons, abuse, violence, etc. are bound to affect not only their health but also their mental health.

Mental health is a state of well being in which the child realizes his or her potentials to the fullest, is able to cope with the normal stresses and strains of life, works productively and contributes to his or her community. Wilson (1996) argues: Children in “good enough” mental health are able, in fact, to learn from their difficulties and make the most of their abilities. However, there are significant number of children and adolescent who do find it difficult to deal with the vicissitudes of their lives. Their mental health problems may be mild and short lived or more serious and longer term.

According to Maher and Waters (2005) every child has the right to enjoy the highest attainable standards of health and to have an adequate standard of living for physical, mental, spiritual, moral and social development.

Although it is widely acknowledged that ‘the majority of mental illnesses have childhood antecedents (Royal College of Psychiatrists, 2010) up to 70% of children with diagnosable mental health disorders are undiagnosed and untreated. As a result, this increases vulnerability to Mental health problems in later life (Mc Crone et al., 2008, Department of Health, 2011).

From both demographic and epidemiological perspectives, as well as, from the perspective of burden of disease, mental disorders of children represent a key area of concern.

The lack of attention to mental health of children may lead to mental disorders with lifelong consequences. At this point it becomes imperative to highlight the following-

1. Worldwide up to 20% of children and adolescents suffer from disabling mental illness (WHO World Health Report, 2000).
In 2012, globally the number of deaths of children under 5 years of age was 6.6 million (WHO, Millennium Development Goals, 2013).

In developing countries, percentage of underweight children under 5 years of age was 17% (WHO, Millennium Development goals, 2013).

In India, Indian Council of Medical Research (2001) in its epidemiological study of child and adolescent psychiatric disorders in urban and rural areas found that in the age group 1 to 16 years prevalence of child and adolescent disorders was 12.8%.

Malhotra (2009) while studying the incidence of childhood psychiatric disorders in the community found its rate to be 18/1000 years; the rate could be said to range between 18-37/1000/years.

Shastri (2008) in his paper on promotion and prevention in child mental health stated that 10% of 5 to 15 years old has a diagnosable mental health disorders.

Relationships are detrimental to the healthy development of the child.

CHILDHOOD RELATIONS

Relationships in childhood go a long way in creating the base of positive mental health as is aptly stated in the Object Relations Theory that it is the satisfaction of relationship needs that predisposes a person to mental health. The deficit of the same may lead to mental health problems.

Object relations theory has evolved out of the classical psychoanalytic theory of personality development and psychopathology. In contrast to the Freudian theory, the development of personality and psychopathological behaviour according to the Object Relations Theory (Misra, Kharkwal, Kilroy, & Thapa, 1996) may be stated as follows-

1. The basic need of an infant is not seeking satisfaction of physiological needs but rather satisfaction of relationship needs.
2. The child seeks pleasure/satisfaction through human contacts.
3. For Freud, the term ‘object’ meant persons, events, places, animate objects and inanimate objects. **In Object Relations Theory, the term ‘object’ means only human beings.**

4. The child sees and experiences human beings (‘objects’) around him or her; **gradually, these human beings acquire a place in the mental world (psyche) of the child.** In other words they are internalized by him or her.

5. Thus, **there exists two sets of worlds for the child** (in fact, for all of us). There is the **external world of objects** (mother, father, siblings) and then there is the **internal world of objects** (mother feeds me, sister plays with me).

6. There is yet another very important object in this world of objects- **self.** A very important object relations theorist, **Kohut (1977)** emphasized that self consists of real people, not people in the outside world who are represented in the child’s mind. For Kohut, it is selfobject – ‘**I am me and my significant others**’.

7. **Object relations theorists hold that personality development takes place** not in terms of moving from oral to anal to genital stages, but rather **in terms of changes in structures/patterns/units of object relations.**

8. In the object relations theory, **psychopathology results from lack of separation and/or integration in patterns of object relations, that is, in the lack of differentiation between self and objects.** The boundaries between self and non-self (human beings) are fuzzy, blurred, and foggy.

Thus, **the object relations theory has expanded the unit of study** from the individual in isolation to **individuals in relationships.** It is about internalized relationships with people and their influence on external relationship behavior. Object relations theories are particularly concerned with factors that shape internal representations of relationships and maintain continuity in expectation. Childhood experiences are regarded as especially important because these provide relationship lessons early in life when there is little other contradictory experience. If lessons are particularly painful, they are repressed and made unavailable for conscious inspection even though they continue to influence behavior unconsciously. It is the primacy and unconscious experience of early experience that make it tenacious (Miller, 1993).
CHILDREN IN DIFFICULT CIRCUMSTANCES- A CRY FOR A HELP

Actions Taken

Children of today are the future of tomorrow. They are assets of a nation who contribute to the countries overall growth and development. Thus the future growth of a country is dependent upon the growth and development of children at present. We need to provide them a safe and secure environment in which children can develop freely and enjoy their childhood. Keeping in mind the interest and rights of children, at the international and national level different bodies are working for the protection of children from all kinds of harms.

At the international level there are a number of treaties, plans, policies, programmes and organizations with a committed advocacy for child protection and welfare viz., UNICEF, UNDP, UNIFEM, WHO, UNESCO, Universal Declaration of Human Rights (the first UN document recognizing the need to protect children.) The first UN document focussing on the rights of the child was the Declaration on the Rights of the Child. In 1989, the United Nations Convention on the Rights of the Child was adopted by the global community. These rights are–

- The right to survival.
- The right to develop to the fullest.
- The right to protection from harmful influences, abuse and exploitation.
- The right to participate fully in family, cultural and social life.

The four core principles of the convention were –

- Non – discrimination of the child.
- Devotion to the best interest of the child.
- The right to life, survival and development.
- Respect for the views of the child.
India has the highest number of children in the world. In its efforts for the
development and welfare of children, Government of India acceded to the United
provisions like article 14, 15, 23, 24, 39 (e) & (f) and 45 for the welfare and protection
of children also reiterate the same.

We also get a glimpse of India’s commitment to child welfare and protection in
different Five Year Plans. Efforts made by the Government for the overall growth and
development of children in the various plans have been depicted in the figure- 1.7
Prior to Fifth Five Year Plan- Government’s focus was on child welfare through the promotion of basic minimum services for children. This culminated in the adoption of the National Policy for Children in 1974.

Fifth Five Year Plan- It saw a shift of focus from welfare to development and the integration and coordination of services. A major accomplishment in 1975 was the launching of the Integrated Child Development Scheme.

Sixth Five Year Plan- Plan strengthened child welfare and development. It led to the spatial expansion and enrichment of child development services through a variety of programmes. Programmes were undertaken to improve the health, nutrition and educational status of working children.

Seventh Five Year Plan- It saw the establishment of the Department of Women and Child Development in the Ministry of Human Resource Development. In 1986 the Government of India repealed the Children’s Act and passed the Juvenile Justice Act instead and updated the National Education Policy. In 1987 the National Child Labour Project was started. Internationally this period was witness to the first comprehensive convention for child rights the UNCRC. Lastly in 1990 the government set up CARA.

Eighth Five Year Plan- The focus shifted to human development through advocacy, mobilization, and community empowerment. During this plan India ratified the UNCRC. This plan also paid special focus to the needs of the girl child.

Ninth Five Year Plan- It was in this plan that Government of India declared its commitment to every child. 2000 also saw the adoption of the new Juvenile Justice (Care and Protection of Children) Act. Plan continued to address the plight of the girl child, concentrating on addressing the problem of the declining sex-ratio, as well as, female feticide and infanticide.

Tenth Five Year Plan – It advocated convergent / integrated rights – based approach to ensure the survival, development, protection and participation of children. It set targets for children.

Eleventh Five Year Plan - Development of the child was at the centre of this plan. While continuing with the rights based approach to child development, the plan recognized the importance of holistic approach, focusing both on outcomes and indicators for child development, as well as, macro- perspective trends and governance issues. Plan addressed the following four key areas: ICDS, Early Childhood Education, Girl child and Child Protection. With regard to Girl child the plan reiterates the goals set out in NPAC. Age specific and setting specific interventions are needed for girls. It recognized the need for Child protection programmes and initiatives. Integrated Child Protection Scheme was introduced and adopted.

Twelfth Five Year Plan- The vision of the plan is that “more inclusive growth begins with children” – and that children cannot be merely “put” on the growth agenda because they are integral to it- integral to faster, more inclusive and sustainable economic growth. It represents a new “Child Rights Paradigm” that mandates the fulfillment of children’s rights to survival, development, protection and participation.

Source: Status of Children in India (2014) and Childlineindia

FIGURE-1.7 FOCUS ON CHILDREN IN FIVE YEAR PLANS
In the last few years a number of measures related to children have been undertaken by the Government of India. One of the most important among them is the setting up of a full- fledged Ministry of Women and Child Development as against the Department of Women and Child Development that used to function as part of the Human Resource Development Ministry. Other than this keeping in mind the interest and welfare of children, several policy and law initiatives were also undertaken by the Government of India. These initiatives are depicted in the figure-1.8 and 1.9-
FIGURE 1.8 - GOVERNMENT POLICY AND LEGAL INITIATIVES FOR CARE & PROTECTION OF CHILDREN IN INDIA

THE NATIONAL POLICY FOR CHILDREN (1974)
Policy was declared to ensure that the programs of children were incorporated in the National plans for the development of human resources. It also ensured effective services for children in the areas of health, nutrition, education and recreation with special emphasis on the weaker sections of society. This was envisioned to be achieved through strengthening family ties, so that full potentialities of growth of children are realized within the normal community and family environment.

Three major goals of the plan are as follows:
- Survival and protection of the girl child and safe motherhood.
- Overall development of the girl child.
- Special protection for vulnerable girl children in need of care and protection.

THE NATIONAL PLAN OF ACTION FOR CHILDREN (2005)
It commits to ensure all rights to all children up to the age of eighteen years. The Government shall ensure all measures and an enabling environment for survival, growth, development and protection of all children, so that each child can realize his or her inherent potential and grow up to be a healthy and productive citizen.

NATIONAL COMMISSION FOR PROTECTION OF CHILD RIGHTS (NCPCR) ACT, 2005
Act was amended in 2006 and now it is known as the Commission for Protection of Child Rights (Amendment) Act 2006. The Act provides for Children’s Courts for speedy trial of offences against children or of violation of Child Rights. It examines and reviews the legal safeguards provided by or under any law for the protection of child rights and recommends measures for their effective implementation. It undertakes periodic review of policies, programmes and other activities related to child rights in reference to the treaties and other international instruments. It examines and recommends appropriate remedial measures for all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence/riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution. It inquires into complaints of deprivation and violation of child rights, non-implementation of laws and non-compliance policy decisions, guidelines or instructions.

NATIONAL CHARTER FOR CHILDREN (2003)
It was notified in the Gazette of India on 9th February, 2004. The document emphasizes Government of India’s commitment to children’s rights to survival, health and nutrition, standard of living, play and leisure, early childhood care, education, protection of the girl child, empowering adolescents, equality, life and liberty, name and nationality, freedom of expression, freedom of association and peaceful assembly, the right to a family and the right to be protected from economic exploitation and all forms of abuse. The document also provides for the protection of children in difficult circumstances, children with disabilities, children from marginalized and disadvantaged communities and child victims.
THE JUVENILE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT, 2000

The preamble of the Act states that it is an Act to consolidate the law relating to juveniles in conflict with law and children in need of care and protection by providing for proper care, protection and treatment, by catering to their development needs, and by adopting a child-friendly approach in the settlement and disposition of matters in the best interest of children and for their ultimate rehabilitation through their various established institutions under this Act.

The Act is based on the provisions of Indian constitution and the four broad rights of the United Nations Convention on the Rights of the Child (UNCRC), namely- Right to survival, right to protection, right to development and right to participation.

The Act defines ‘juvenile’ or ‘child’ as a person who has not completed his/her eighteenth year of age. Under the Act there are two distinct categories of children-

- ‘Juvenile’ for a child in conflict with the law.
- ‘Child’ for those in need of care and protection

FIGURE- 1.9 CATEGORIES OF CHILDREN UNDER JUVENILE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT, 2000
As the sample in the research falls in the category of children in need of care and protection, it becomes imperative to know who all come in this category. Figure-1.10 shows list of those children who comprise of “Children in need of care and protection”.

“Child in need of care and protection” means a child-

- who is found without any home or settled place or abode and without any ostensible means of subsistence,
- who resides with a person (whether a guardian of the child or not) and such person-
  - has threatened to kill or injure the child and there is a reasonable likelihood of the threat being carried out, or
  - has killed, abused or neglected some other child or children and there is a reasonable likelihood of the child in question being killed, abused or neglected by that person,
- who is mentally or physically challenged or ill children or children suffering from terminal diseases or incurable diseases having no one to support or look after,
- who has a parent or guardian and such parent or guardian is unfit or incapacitated to exercise control over the child,
- who does not have parent and no one is willing to take care of or whose parents have abandoned him or who is missing or run away child and whose parents cannot be found after reasonable inquiry,
- who is being or is likely to be grossly abused, tortured or exploited for the purpose of sexual abuse or illegal acts,
- who is found vulnerable and is likely to be inducted into drug abuse or trafficking,
- who is being or is likely to be abused for unconscionable gains,
- who is victim of any armed conflict, civil commotion or natural calamity;

(Source: Ministry of Law, Justice and Company Affairs, 2000)
This Act provides for the care and protection of children who are vulnerable and are at risk of various harms by adopting a child friendly approach and working in the best interest of the child. Any child, who is in need of care and protection, is brought in the safe environment through a sequence of events, which are illustrated in the figure-1.11 given below.

The State Government may, by notification in the Official Gazette, constitute for every district or group of districts, specified in the notification, one or more Child Welfare Committees for exercising the powers and discharge the duties conferred on such committees in relation to child in need of care and protection under this act.

A child in need of care and protection is produced before the Child Welfare Committee for being placed in safe custody. Committees consists of a chairperson and four other members as the State Government may think fit to appoint, of whom at least one shall be a women and another, an expert on matters concerning children.

Production before Committee- Any child in need of care and protection may be produced before the committee by one of the following persons-

- Any police officer or special juvenile police unit or a designated police officer.
- Any public servant.
- Childline, a registered voluntary organization or by such other voluntary organization or an agency as may be recognized by the State Government.
- Any social worker or a public spirited citizen authorized by the State Government
- By the child himself or herself.

After the completion of the inquiry if the committee is of the opinion that the said child has no family or ostensible support, it may allow the child to remain in the children’s home or shelter home till suitable rehabilitation is found for him or till he attains the age of eighteen years.

FIGURE- 1.11- IMPLEMENTATION OF THE JUVENILE JUSTICE (CARE AND PROTECTION OF CHILDREN) ACT- THE PROCESS
Child in need of care and protection after being produced before the Child Welfare Committee is sent by the committee to the Protective homes (also referred to as Children’s Home) during the pendency of any inquiry. The Juvenile Justice Act empowers the State Government either by itself or in association with the voluntary organizations to set up Children’s Homes in every district or group of districts for the reception of the child in need of care and protection during the pendency of any inquiry and subsequently for their care, treatment, education, training, development and rehabilitation. Figure given below shows the total number of homes and total number of children’s homes in Uttar Pradesh and in Lucknow (Ministry of Women and Child Development, 2013).

**FIGURE- 1.12- CHILD HOMES IN UTTAR PRADESH**
THE PURPOSE OF THESE HOMES

As given in the Act these homes serve the following purpose-

- Safekeeping of children in need of care and protection during the period of inquiry.
- Subsequently for the care, treatment, education, training, development and rehabilitation of these children.

In 2006, the Act was revised with 26 amendments and came into effect from 22nd August, 2006. The Act is now known as Juvenile Justice (Care & Protection of Children) Amendment Act, 2006. The objectives of the Act were –

- To modify the long title of the Juvenile Justice Act (JJA) so as to broaden the scope of rehabilitation of the child in need of care and protection or a juvenile in conflict with law under the Act through not only the institutional but also non-institutional approach.
- To clarify that the JJA shall apply to all cases of detention or criminal prosecution of juveniles under any other law.
- To remove the doubts regarding the relevant date in determining the juvenility of a person and the applicability of JJA.
- Exclusion of the local authority from the provisions authorizing them to discharge or transfer a child in need of care and protection or a juvenile from the children’s home or special home or for sending a juvenile in conflict with law undergoing imprisonment, to a special home or a fit institution.
- To lay down a procedure whereby a claim of juvenility can be raised before any court.
- To have a minimum period of 24 hours, excluding the time needed for the journey from the place where the juvenile in conflict with the law was apprehended, within which he or she should be produced before the board and a similar provision with regard to the production of a child before the Child Welfare Committee (CWC).
To provide for alternatives to detention in the observation home in order to achieve the intensions of the JJA.

To do away with the involvement of any police officer in the inquiry process, for the child in need of care and protection as this work is assigned to the CWC and to cover other cases where the child can remain in a children’s / shelter home after completion of inquiry.

To widen the scope of adoption of a child to childless parents and to limit the same to citizens of India only under the JJA.

To provide for a flexible period of leave that may be given to a child on special occasions like examinations, marriages and death of relatives, accident or serious illness of parent or any similar emergency.

To ensure the applicability of model rules framed by the Central Government in the States / Union Territories who have not yet made their own rules, till rules are framed in this regard by these States / Union Territories. (Mehta, 2008).

UNRESOLVED ISSUES

Despite all legal provisions, policies and initiatives the researcher was intrigued by the gaps in legal provisions and paradoxical state of reality (Figure 1.13).
Article 14 provides that the state shall not deny to any person equality before the law or the equal protection of the laws within the territory of India. 

Reality- In 2011 the crime against children reported a 24% increase from the previous year

Article 15 affirms the right of the state to make special provisions for women and children. 

Reality- The declining number of girls in the 0 to 6 age group is a cause of concern.

Article 23 prohibits trafficking of human beings and forced labour. 

Reality- In 2011 there were 3517 cases of buying of girls for prostitution.

Article 15 provides for free and compulsory education for all children until they complete the age of fourteen. 

Reality- Out of every 100 children 19 continue to be out of school.

Article 24 provides that no child below the age of fourteen shall be employed to work in factories, mines and any other hazardous occupation.

Reality- According to 2001 Census there were 12.66 million child labourers in India in 2001.

Article 39 (f) requires children to be given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity, and that childhood and youth be protected against exploitation and moral and material abandonment.

Reality- According to NFHS – 3 (2005- 2006) half of the country’s children are chronically malnourished.

Article 39 (e) of the directive principle of the state policy provides that children of tender age should not be abused and that they should not be forced by economic necessity to enter vocations unsuited to their age and strength.

Reality- According to NFHS – 3 (2005- 2006) nearly 11.8% of children age 5 to 14 years work either for their own household or somebody else.


FIGURE – 1.13 -UNRESOLVED ISSUES- THE GAPS BETWEEN LEGAL PROVISIONS & REALITY
Thus, the initiatives are there at the planning level, however the implementation of those initiatives seems to draw a blank, which is rather unfortunate. The dismal state of children in India clearly show the child unfriendly and threatening social context, putting children at the helm of marginalization and also raising a question mark on their mental health. Mental health of children especially those living in difficult circumstances being one of the most important area of concern has received minimal attention from policy makers, social workers and from society as well. The neglect of children who are vulnerable or who are at the risk of developing mental health problems, in our policy and financial statements becomes obvious when we cast a glance on the budgetary allocation for children in the total union budget. The Union budget 2012-13 allocates 5.3% in budget for children with an increase of only 0.3% since 2011-12. The increase can be attributed to the increased share in development sector by 66.2% and health by 29.7%. As always the share of protection sector remains the lowest at 0.04%. Better outcomes in any sector not just depends on allocation of funds to that sector but also on the proper utilization of these funds.
REVIEW OF LITERATURE

Empirical operation framework of a research gets its base from the researches done in the area. Since the present research is focused upon the children in difficult circumstances, the literature review also pertains to the researches on children. Nearly 40% of the country’s population comprises of people below 18 years of age and society comprises of both the children who are cared for and protected and also those who are in the need of care and protection. Therefore the literature review takes a gamut of both.

1. DEMOGRAPHIC VARIABLES

Reviewing the researches in terms of demographic or assigned variables like age, gender, locale, socio-economic status etc., help us in gaining an in-depth understanding of the context of these children.

❖ Age-

With reference to age four trends have emerged. The first set of researches focus upon the age group of children and their incidence in homes.

In a study by NIPCCD and Ministry of Women and Child Development (2007) the age structure of inmates in different homes was observed to be young as 57% children were between age groups 6 to 14 years and about one third children were from the age group 14 to 18. In another study on 170 children from four different institutes, it was found that 65.9% and 34.1% were from the age group 6 to 12 years and more than 12 years age group respectively. In addition to this 75.3% were institutionalized between the ages 6 to 12 years (Pasi, Shinde, Kembhavi, & Kadam, 2011).

On similar lines for children in difficult circumstances Joshi, Visaria & Bhat (2006) in their study on 153 street children in Ahmedabad observed that more than 50% of the street children were 15 to 17 years old or older; children aged 8 to 10 years were 8% and the rest were between 11 to 14 years. Sharada (2000) studied 100 street children and found that the age of boys and girls approximately ranged between 13 to 15 years. Prayas Institute of Juvenile Justice (2009) in its study on 795 street children...
found that children working on platform were in the age group of 6 to 18 years with 50% in the 12 to 15 years age group. Das (2012) in the survey of 79,306 households in rural areas and 45,374 in urban areas found that the incidence rates of child labour were lower in younger age group than the older ones and also found that gender differentials in employment increased with age.

Children are vulnerable to abuse and exploitation and therefore another set of findings explore the age of children who are most at risk of abuse and exploitation.

Ministry of Women and Child Development (2007) studied 5 to 18 years old children in 13 states of India and found that 5 to 12 years age group was at most risk of abuse and exploitation. Study by Banerjee (2001) on 751, 4 to 15 years old street and slum children of Kolkata showed a lower percentage of physical abuse among children aged 4 to 5 years, but higher and almost equal percentages among 6 to 10 years (39.6%) and 11 to 15 years (41.6%). On the same lines Bureau of Police Research and Development, New Delhi (2009) in their study found that younger children (5 to 12 years) reported higher level of abuse.

The third trend of researches focus upon exploring and identifying the various psychiatric problems which children of different age groups have.

Nagaraja, Parkash & Sitholey (2005) studied children below 16 years attending the child psychiatric outpatient clinic and reported that in the age group 0 to 5 years maximum number of children (33%) had diagnosis of Hyperkinetic syndrome. The common diagnosis in the age group 6 to 11 years were Hysterical neurosis, Hyperkinetic syndrome and conduct disorder and in 12 to 16 years were psychosis, hysterical neurosis and conduct disorders.

In another study by Srinath and Sitholey (2005) found that the prevalence rate of psychiatric disorders in 0 to 16 years was 12.1%. In a similar study by Malhotra (2005) on 873 school children in 4 to 12 years age range the prevalence of overall psychiatric disorders was 9.34%. In addition to this rate of psychiatric disorders were found to be highest in middle childhood with a peak in 6 to 8 years age group.
Problems of anxiety depression and low intelligence along with behavior problems increased with age whereas special symptoms decreased with age.

Margoob, Rather, Khan, Singh, Malik, Firdosi, & Ahmad (2006) examined the DSM-IV psychiatric morbidity of 5 to 12 years old girls in orphanage of Srinagar and found Post Traumatic Stress Disorder as the most common stress disorder (40.62%) among children.

An important component furthering development of children has although been tapped by voluminous number of researches, some statistics is being given here in terms of studies on children in schools in different age groups.

Every Child India, Bangalore (2008) studied 50,666 children, with majority of children belonging to the age group of 6 to 14 years and found that more than half of the children from 3 to 6 years and 6 to 14 years were in schools but more than half of those between 15 to 18 years were out of school. In a sample of 6668 children of mothers dedicated to devdasi system majority of children were aged between 6 to 14 years followed by 15 to 18 years age group.

Jayasree and Chandran (2012) investigated the effect of age of school students on conformity behavior and found that the upper primary students had high conformity behavior when compared to secondary students.

Bansal and Barman (2011) studied 10 to 15 years old 982 students from four schools in a city of North India and recommended that epidemiological studies should be started in early childhood. Katic’ and Bala (2012) studied 162 female school children aged 10 to 14 years and found that the cognitive functioning plays a significant part in the motor efficacy of girls aged 10 to 14 years. 13 to 14 years old children showed significantly superior results in comparison with the 10 to 12 years old in the motor test assessing flexibility, agility, psychomotor speed, explosive strength of throwing type and repetitive strength of the trunk, as well as, in the test assessing cognitive functioning.
Gender-

Two major trends of researches are evident with reference to the variable of Gender-

- Researches which compare male and female children on certain parameters.
- Other researches which concentrate on either of the gender with reference to specific variables.

At the outset researches highlighting the sex ratio need to be considered for understanding the comparative base for gender inequality deeply embedded in the gender script and manifested in various areas of life.

Bhardwaj, Nagargoje, Jadhao, & Khadse (2011) in their study on a population 6344 children found the child sex ratio of 934 females per 1000 males in both slums and elite areas. Further this ratio was significantly lower when the first born child was female and girl child was also found missing from the second and subsequent birth orders, especially when the previous born child is a female. Significantly the missing girl was more evident in the elite areas as compared to slum areas.

Chiddarwar (2000) on a sample of 384 children found that malnutrition was higher among females than among males (59.36% and 40.64% respectively). Even immunization coverage was significantly less among females as compared to males.

Sharada (2000) in a study of 100 street children reported that the girls had higher family life education knowledge score than boys and majority of boys (53.85%) had run away from their families. On the other hand girls were predominantly destitute (77.14%). 29.23% boys were also found destitute. 16.92% of boys and 22.86% of girls were deserted by their families.

In another study by UNESCO (2001) on the enrollment of boys and girls in non formal education, it was found that more boys were enrolled in non formal education
centers run by NGOs but girls were enrolled in a number of government funded non formal education schools.

**Gupta and Sadh (2012)** in a study of 150 students in Himachal Pradesh found no significant difference between boys and girls on adjustment.

**Sood (2012)** found girls to have significantly higher need for achievement than boys.

**Ministry of Women and Child Development (2007)** in a study of 13 states for children 5 to 18 years reported that out of 69% of physically abused children 54.68% were boys.

**Every Child India, Bangalore (2008)** in a study of 50,666 orphans in North Karnataka reported that of all the orphans 55.5% were boys and 44.5% were girls. In addition the number of boys who were out of school and irregular were more than girls.

**Katic’, Bala and Barovic (2012)** in a study of children found that in the 10 to 12 years age group girls were more superior to boys on flexibility whereas boys were higher on strength of trunk, jump and coordination. Further this difference was more pronounced in the 13 to 14 years age group.

**Smt. Jawahar Devi Birla Institute of Home Science, Calcutta (1999)** in the review of various studies on children found mother’s love as a more dominant factor for girls than boys.

**Das (2012)** in their study reported girl children to be less involved in the wage economic activity. Incidence of child labour was more for boys and more boys were employed in hazardous occupations than girls. Further gender differences in employment increased with age and dangers which children faced at work.

**Pasi, Shinde, Kembhavi, & Kadam (2011)** in their study on institutionalized children found that 40% boys and 62.3% girls were from lower socio economic status and 75%
of child labourers were boys in comparison to 25 % girls. Thus, they found more boys engaged in physical labour and girls more involved in other activities.

Bureau of Police Research and Development, New Delhi (2009) in a survey of 13 states found boys and girls at equal risk of abuse, however with reference to physical abuse out of 69% of physically abused children 54.68% were boys.

DuBois and Hirsch (2000) reported that due to gender stereotypes boys reported a higher sense of self worth but feel lonelier and rejected as compared to girls.

Jena (2011) found significant differences in the memory of rural boys and girls.

Srinath and Sitholey (2005) in an epidemiological study of psychiatric disorders found that in Lucknow boys significantly had more psychiatric disorders than girls.

Further Nagaraja, Parkash and Sitholey (2005) also found that psychosis and conduct disorders were significantly more prevalent among boys while hysterical neurosis was more common among girls. On similar lines Malhotra (2005) in a study of 963 school children in Chandigarh and Union territory found more psychiatric disorders in boys than girls.

Stams, Juffer and VanIjzendoon (2002) found adopted girls were better adjusted than boys.

Some studies have concentrated primarily on either of the gender.

Association for Development, New Delhi (2005) in a study of adolescent girls found that 80% of the girls did not have any information about menstruation, HIV and disadvantages of early pregnancy.

Patel (2008) reported that girls who faced gender discrimination had higher prevalence of DSM- IV diagnosis.

Bhat (2009) found that 90.76% of female child labours belong to the age group 11 to 14 years.
In another study by Kackar, Varadan, & Kumar (2007) 70.5% girls reported neglect of one form or the other from family.

Sidhu and Shukla (2002) found behavioural problems in preadolescent boys living in orphanages.

**Socio economic status**

Socio economic status to which a child belongs is detrimental to the fulfillment of his or her basic needs for survival. Researches on socio economic status highlight two major trends -

- Researches which make a **comparison of high and low socio economic status**.
- Other researches, more relevant to the present research explore the socio economic status of children in difficult circumstances.

Association for Development (2002) in its study on 4 to 17 years old children staying at New Delhi, Old Delhi and Hazarat Nizamuddin railway stations found that most of them were from the families belonging to lower income group. Similar results were found by Prayas Institute of Juvenile Justice (2009).

Sharada (2000) studied 100 street children and observed that majority of them were from low income families living below the poverty line.

In another study on 170 children from four different institutes, it was found that 40% of boys and 62.3% of girls were from lower socio-economic status (Pasi, Shinde, Kembhavi, & Kadam, 2011).

Chiddawar (2000) studied 384 children in the age group 0 to 5 years and found that the subjects in the upper social classes had better health and nutritional status than those in lower socio-economic classes. Similar results were found in the study by Kumari (2005).
Jones, Forehand, Brody and Armistead (2002) found that inadequate income was linked to internalizing and externalizing difficulties of the child.

Jaya and Narasimhan (1999) in their study on 121 families of a rural area in Coimbatore found congested housing conditions (55%) to be one of the most common stressful life situation that leads to violence on children in families.

Mittal and Bhardwaj (2012) studied 120 adolescents (15 to 17 years) belonging to middle socio economic group and found that perceived parental behavior significantly affected the emotional maturity of adolescents.

In another study Bansal and Barman (2011) on 10 to 15 years old 982 students from four schools in a city of North India, it was found that most of them were from middle income group.

Another study by Malhotra (2005) on 873 school children found that disorders were more in children from low socio – economic status category. In addition to this significantly higher proportion of low IQ children were from the low socio-economic status.

Raju and Reddy (2012) in their study on 14 to 15 years old students from four educational divisions of Chittoor district of Andhra Pradesh found no significant influence of economic position on achievement of class IX students in physical science.

.locale-

The socio economic status is in itself incomplete without considering the bigger context of locale. The place here refers to the place of inhabitants i.e., rural and urban.

In a study on 170 children under institutional care, 80.5% were found to be of urban origin while 19.5% were from rural areas. Thus, showing predominance of urban children in institutional care (Pasi, Shinde, Kembhavi, & Kadam, 2011).
In another study on 300 high school students by Sood (2012) no significant difference in need for achievement was found between rural and urban students. In similar lines Jena (2011) found no significant difference in the memory of rural boys and rural girls. In addition no significant difference in achievement motivation of urban boys and girls, and in rural boys and girls was found.

Patel (2008) found that adolescents from urban areas had higher prevalence of psychiatric disorders than adolescents from rural areas.

Hackett, Hackett, Bakta and Gowers (1999) in their study on 1403 rural children in the age group of 8 to 12 years found prevalence rate of psychiatric disorder to be 9.4%.

Das (2012) in the survey of 79,306 households in rural areas and 45,374 in urban areas found that the incidence of child labour was higher in rural areas and incidence of school dropouts was more pronounced among urban children. Large number of children in rural sector were engaged in agriculture, forestry, fishing and in urban sector in manufacturing and trade. About 10% of male child labourers in rural sector and 21% in urban sector were occupied in hazardous occupations.

2. CHILDREN IN DIFFICULT CIRCUMSTANCES (IN NEED OF CARE AND PROTECTION)

Children who need care and protection are the children who have no one to look after them. They have no home and hence resort to living on streets, railway platforms and in institutions like protective homes, orphanages, destitute homes, day care centers, shelter homes etc. Thus, the review of literature has the four major categories of researches done on children. These are as follows-

- Studies on homeless children living on streets and platforms.
- Studies on institutionalized children.
- Studies on child labour.
- Studies exploring the reasons for runaways, labour and school dropout.
Studies on homeless children living on streets and platforms

Association for Development (2002) in its study on 4 to 17 years old children staying at Delhi railway stations reported that 39% of the children were from Uttar Pradesh, 26% were from Bihar, and significantly 64 out of 100 such children expressed the wish to remain on streets instead of going to some other institution. The reasons given by them were a need for freedom and employment, as well as, physical abuse and lack of facilities at home. Nearly 57% of these children were living on railway stations for the last 1 to 5 years, 11% were there for more than 5 years. The major problems faced in the daily life were harassment by police, lack of shelter and bullying by senior boys. 60% children were involved in rag picking, 74% earned less than rupees 50 and only 30% had some savings.

On similar lines Joshi, Visaria and Bhat (2006) in their study on 153 street children at railway station in Ahmedabad found 50% of such children 15 plus in age. A sense of independence, attractiveness of street life, fear of formal schools and punishment emerged as reasons for being there. 40% were from Gujarat, 13% from Uttar Pradesh and 12% from Bihar. On an average they worked 7.7 hours a day. Their money was spent primarily on food (78.4%), gutkha / smoking (55.6%), cinema (17%), gambling (14.4%), drugs (13.1%) and other things (20.9%). They did all kinds of sundry jobs besides rag picking and begging.

Prayas Institute of Juvenile Justice (2009) in their study on children working on platforms reported 50% of them to be between 12 and 15 years. 52% expressed happiness in staying on the platform while 27% felt scared. 13% of the children begged, 32% did petty jobs and 37% of them did nothing.

Banerjee (2001) in his study on 751 street and slum children of Kolkata found 32% as part time and majority of them as full time workers.

In a pioneer study by UNESCO (2001) to examine the initiative of government, international and voluntary sectors for eradication, rehabilitation and education of
street and working children it was found that there were 2.5 million out-of-school children surveyed and majority of them were from the street category.

On a different note CHILDLINE in a study of street children in distress in terms of the analysis of the CHILDLINE calls reported that the 39% of all calls received for shelter were from children who had left home while 26.9% were from those who had been abandoned by their parents.

- Studies on institutionalized children-

Saraswati, Hunshal and Gaonkar (2009) in their study on 150 children in 10 to 16 years age group from four juvenile institutions and 148 neglected, physically and multiple abused children found that the prevalence of neglect was highest among the institutional children.

In another study on 170 children from four different institutes by Pasi et al. (2011) it was found that 75.3% of the children were institutionalized between the ages 6 to 12 years. 63.5% of the children were Hindus and 34.1% were Muslims, thus showing a predominance of Hindu children in the institutional care. 82.4% were from nuclear families and 17.6% were from joint and extended families. Further 54% of the institutionalized children belonged to medium sized families (4-7), 33.3% belonged to small families and 12.7% belonged to large families.

NIPCCD and Ministry of Women and Child Development (2007) in their study comprising 25 states and 1 Union Territory found that the 57% of children in different homes were between the age groups 6 to 14 years and about one third children were from the age group 14 to 18 years. Maximum number of children were staying up to 3 years as compared to 3 to 5 years and more than 5 years.

Goswami (2013) studied 50 institutionalized children and 50 formal family reared children and found that institutional care because of parental deprivation linked with behavioural and emotional problems subsequently and negatively affects personality development. Further deprived children living in destitute homes have more problems
related to their personality in comparison to the normal children living in their own homes.

Rao (2007) studied 20 adopted children and 20 children of biological parents and found that adopted children had higher internalizing and externalizing scores and more adjustment difficulties as compared to children of biological parents.

- Studies on child labours

UNESCO, New Delhi (2001) in its examination of the initiative of the government, international and voluntary sectors for eradication, rehabilitation and education of street and working children found that the state of Andhra Pradesh (9.98%) had the highest incidence of child labour and Punjab recorded the lowest proportion (3.04%) of child labour.

Narayanaswamy & Sachithanandum (2010) studied 35 boys in agricultural bonded labour and found that by the age 13 or 14 years most of the children totally dropped out of school. 3/4th of the bonded child labourer’s monthly income was one thousand and five hundred rupees. Minimum working hours were found to be 11 hours a day. Children faced violations and atrocities, physical assaults and verbal abuse at their workplace.

In another study investigating the socio clinical profile of 335 working children (in the age group 5 to 15 years) engaged in different sectors in Berhampur, Orissa by Satapathy, Sahu, Behera, & Naraslmham (2005) it was found that 55% of the children were between 13 to 15 years, 44% from rural areas and 61% were from large families. Further 35% of the children did not attend any school, while 51% primary and 14% had secondary level education respectively. Working hours of these children varied from 3.5 hours per day to 12 hours per day.

Bhat (2009) in their study which assessed the nature of exploitation faced by the child labourers found that most of the female child labourers belonged to illiterate
or very little educated families and 90.76% of females were in the age group of 11 to 14 years. All children working in handicraft sector had been to school at one point of time; 49.23% children had studied up to class 5th, 50.76% had studied up to 8th class, 4.61% were still attending school and 95.38% had left school at primary and upper primary levels. 56.92% child labourers earned between rupees 100 to 500 per month and 41.53% earned between rupees 500 to 1000 per month.

Das (2012) in the survey of 79,306 households in rural areas and 45,374 in urban areas found that the incidence of child labour was higher in rural areas and incidence of school dropouts was more pronounced among urban children. Large number of children in rural sector were engaged in agriculture, forestry, fishing and in urban sector in manufacturing and trade. About 10% of male child labourers in rural sector and 21% in urban sector were occupied in hazardous occupations.

- Studies exploring the reasons for runaway, labour and school dropout-
  
  ➢ Reasons for runaway and labour

Study by Every Child India, Bangalore (2008) on 50,666 children reported that death of parents was given as the main reason of orphan hood by majority of orphans and 38.6% of semi orphans.

The main reasons for leaving home reported by street children were abuse and harassment by family members, being orphans, for earning, fight with family member/ teacher/ friend, not wanting to study, family disintegration and other reasons including poverty, lack of facilities and freedom (Joshi, Visaria and Bhat ,2006; Association for Development,2002; Prayas Institute of Juvenile Justice,2009).

Further the main reasons for joining the labour force as given by child labourers were family status of children, big family size, lack of parental care, separation from families, in order to support family income, less or no interest in studies, being
beaten or scolded by the teacher, and out of self interest (Narayanaswamy & Sachithanandam, 2010; Satapathy, Sahu, Behera, & Naraslmham, 2005).

➢ Reasons for school dropout-

Reasons for school dropout as reported by children were being less interested in studies, inability to cope with the classroom teaching, harshness of teachers, humiliation and inadaptable school environment, lack of awareness, poverty, expensive schooling (Narayanaswamy et al., 2010; UNESCO, New Delhi, 2001; Bhat, 2009).

3. CHILD ABUSE

“Right to Protection” is one of the basic rights of every child. Despite this rate of crime against children is escalating at an alarming pace. The problem of child abuse is of grave concern and requires urgent and immediate action from policy makers, as well as, from the society. Table -1.1 highlights the researches done on child abuse.
<table>
<thead>
<tr>
<th>S.No.</th>
<th>Perpetrator</th>
<th>Location And Time</th>
<th>Type of Abuse</th>
<th>Victim &amp; their Age</th>
<th>Consequence</th>
<th>Researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Unknown</td>
<td>-At present and earlier observation home, railway stations, and work place. -Late evening/ night</td>
<td>Sexual</td>
<td>Force</td>
<td>6-18 years</td>
<td>In some sexually transmitted disease</td>
</tr>
<tr>
<td>2.</td>
<td>Unknown</td>
<td>Street and slums</td>
<td>Physical</td>
<td>Belts, ropes, hot metal objects, cigarette butts</td>
<td>4-15 years</td>
<td>Internal &amp; external injuries including fractures</td>
</tr>
<tr>
<td></td>
<td>2. Teachers</td>
<td>School</td>
<td>Corporal</td>
<td>Force</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>3. Unknown</td>
<td>Street, work and institution</td>
<td>Sexual</td>
<td>Force</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>1. Unknown</td>
<td>Railway stations</td>
<td>Physical &amp; Sexual</td>
<td>Force</td>
<td>4-17 years</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2. Parent</td>
<td>Home</td>
<td>Physical</td>
<td>Force</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>5.</td>
<td>Father</td>
<td>Home</td>
<td>Physical</td>
<td>Belt, hitting, kicking, burning, twisting the arm, starving, bone breaking &amp; strangling</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

**TABLE- 1.1 STUDIES RELATED TO CHILD ABUSE**
4. AFTER CARE HOMES AND INSTITUTIONS – A REVIEW

Institutions set up by government, private organization and non-governmental organizations cater to the needs of children who are in difficult circumstances. These institutions provide care and protection to these children. Therefore it becomes important to focus on the researches in this area.

**NIPCCD (2001)** in its study on *child care institutions* in Bangalore, Mysore, Gulbarga, and Belgaum in Karnataka found that infrastructure facilities available in children institutions differed significantly from institution to institution. Private institutes had relatively better infrastructure facilities whereas Government run institution had better hostel facilities. Vocational training facilities and counseling and therapeutic services were found to be lacking in majority of institutions, though private institutions seemed to be slightly better. Further many of the staff had not attended any training programme in their service period.

In another study by **NIPCCD and Ministry of Women and Child Development (2007)** on *children homes, observation homes, after care homes and special homes* found that shishu greh and other homes were more crowded in terms of lack of space in dormitories, classrooms, recreational rooms, number of toilets and bathrooms were found to be inadequate and not as per the norms. Maximum number of children were staying there for up to 3 years as compared to 3 to 5 years and more than 5 years.

In another study on **evaluation of institutes** caring for children of prostitutes in Lucknow, it was observed that 33.3% of the children in the centers were 10 years old or below. The main focus was on girl children. The most common course was tailoring (76%) and in few centers embroidery and music was also taught. Further mothers of children advocated that there was a **need to start new courses** such as short hand, typing, computer programming and carpentry. 40% and 46% of the children were highly satisfied with the training and teachers respectively. In addition 50% of the children felt they should be provided financial assistance by the Ministry for them to become self sufficient *(Joshi, Singh & Garia, 2000)*.
UNESCO (2001) conducted a study in 15 cities to examine the initiatives of the government, international and voluntary sectors for eradication, rehabilitation and education of street and working children found that children were unaware of the existence of several agencies providing support to them. The majority of the NGOs surveyed did provide non-formal education to these children but only 25% of these NGOs provided day/night shelters, health care, clothing and vocational skills.

Another set of researches highlight the facilities, services and problems of the inmates. In a study of 61 voluntary organizations by NIPCCD (2006) it was found that most of the centers lacked night shelter facilities and some centers which had night shelter facilities, it was observed that the day activities such as non formal education, coaching etc., were not been conducted. Toilet facilities in 30% of the centers were not available at all whereas on 20% of the centers it was not satisfactory. Some inmates reported that they faced a grave injury or disability or a disease (most common disease among children were tuberculosis and sexually transmitted diseases).

Saraswati, Hunshal and Gaonkar (2009) in their study on 150 children in 10 to 16 years age group from four juvenile institutions and 148 neglected, physically and multiple abused children found that neglect was highest among the institutional children. Neglect was more among girls while physical and multiple abuses were more in cases of boys. Problems of sexual abuse among inmates of observation home was also found by Pagare, Meena, Jiloha, & Singh (2005).

5. MENTAL HEALTH

Childhood experiences create the foundation of later mental health. With the increase in social, environmental and other stresses children are also showing psychiatric symptoms at a much higher pace than couples of decades ago. Researches on mental health therefore focus first and foremost on the prevalence of psychiatric problems in children. Since the society has both the spectrum of general population (with adequate amount of physical and emotional supplies), as well as, those struggling in the gamut of
difficult circumstances, the researcher is giving here both the prevalence and incidence of Mental Health problems in children of general population and children in difficult circumstances.

In a study estimating the incidence of psychiatric disorders in 186 school children, the incidence was found to be $18/1000/year$ (Malhotra, Kohli, Kapoor and Pradhan, 2009). Further in a sample of 982 students aged 10 to 15 years, $20.2\%$ had psychiatric morbidity. Most of them were in the age group of 13 to 14 years from middle income group (Bansal and Barman, 2011). In another study by Reddy, Gupta, Lohiya and Kharya (2013) the burden of mental and behavioural disorders in India was found to range from 9.5 to 102 per 1000 population.

Srinath and Sitholey (2005) in their epidemiological study of child and adolescent psychiatric disorders in rural and urban areas found a prevalence rate of $13.4\%$ in the age group 0 to 16 years at Bangalore center and $12.1\%$ at Lucknow center. It was also found that prevalence rate among urban male children was significantly higher than the males of other areas. In addition to this boys significantly had more psychiatric disorders ($13.72\%$) than girls ($10.69\%$).

Bansal and Barman (2011) in their study on 10 to 15 years old school children found specific phobia, sleep talking, bruxism, tension headache to be the most prevalent disorder followed by sleep terror, hyperkinetic disorder, pica, enuresis. In another study by Nagaraja, Parkash and Sitholey (2005) in 0 to 5 years $33\%$ had diagnosis of hyperkinetic syndrome, in 6 to 11 years hysterical neurosis, hyperkinetic syndrome and conduct disorder were the most common diagnosis whereas in the age group 12 to 16 years psychosis, hysterical neurosis and conduct disorder were most common.

In another epidemiological study to determine the prevalence rate of child and adolescent psychiatric disorders in 2064 children aged 0 to 16 years from urban middle class, urban slum and rural areas in Bangalore, a prevalence rate of $12.5\%$ was found (Srinath, Girimaji, Gururaj, Seshadri and Subbakkishna, 2005). Almost similar results were reported by Srinath and Sitholey (2005).
Another study on general children and children in difficult circumstances, found 14.8% prevalence of psychiatric morbidity among 5 to 14 years old 257 children of a urban slum. The same study also found non organic enuresis, attention deficit hyperactivity disorder, conduct disorder and mental retardation as common mental health problems among children (Patil, Nagaonkar, Shah and Bhat, 2013).

Satapathy, Sahu, Behera, & Naraslmham (2005) in their study investigated the socio clinical profile of 335 working children and found anemia (51.34%), respiratory tract infections (22.08%), helminthic infestations (21.49%), scabies and skin infections (16.41%) and minor injuries (5.67%) as common diseases. Study also observed different grades of malnutrition among 85% boys and 73% girls. Further 68.4% were addicted to chewing tobacco products, 23.4% were bidi smokers and 7.7% consumed alcohol.

In another study based on the electronic databases for studies related to the prevalence of various psychiatric morbidities and associated factors at community level, it was found that the prevalence of mental disorders were high in females, elderly, disaster survivors, industrial workers, children, adolescents and those having chronic medical conditions (Reddy, Gupta, Lohiya and Kharya, 2013).

Study by Khurana, Sharma, Jena, Saha and Ingle (2004) on 10 to 16 years old runaway adolescent boys in Observation homes, revealed that 20.7% were found to have high hopelessness, 8% had depression, 2% revealed that they have attempted suicide at any point of time in life. 8.3% of the depressed children gave history of suicidal attempts, 38% gave history of physical abuse, 14.6% of sexual abuse and a large number of adolescents reported substance abuse. 69.33% were found to have behavioural problems.

In their study on 153 street children Joshi, Visaria and Bhat (2006) found that 85% of the children were addicted to drugs. Similar results were found in the study by Association for Development (2002) and Prayas Institute of Juvenile Justice (2009).

Another set of researches in mental health focus upon factors which contribute to stress and poor mental health of children. Factors like nuclear family, parents not
living together, large family size, positive parental history of psychiatric disorders, familial over involvement, discordant intrafamilial relationships, inadequate and inconsistent parental control and stress in school environment were found to be associated with psychiatric morbidity in children (Patil, Nagaonkar, Shah and Bhat, 2013; Nagaraja, Parkash and Sitholey, 2005).

Patel (2008) found that adolescents from urban areas and girls who faced gender discrimination had higher prevalence of mental disorders. Omigbodum (2004) stated that abuse and corporal punishment are risk factors for mental disorders. Similarly physical abuse and parental mental disorder were found to be significantly associated with psychiatric disorders by Srinath, Girimaji, Gururaj, Seshadri and Subbakrishna (2005).

In another review of studies on children in difficult circumstances conducted by Smt. Jawahar Devi Birla Institute of Home Science, Calcutta (1999) it was found that mother’s love influenced institutionalized adolescent girl’s psychological development and lack of mother’s love led to lonely and neurotic tendency in girls.

Study on 20 adopted children (8 to 16 years) and 20 children of biological parents found that the group did not differ in terms of self-esteem. Further adopted children had higher internalizing and externalizing scores and more adjustment difficulty as compared to biological children (Rao, 2007). On the same lines Goswami (2013) stated that institutional care because of parental deprivation linked with behavioural and emotional problems negatively affects personality development. Deprived children living in destitute homes have more problems related to their personality than normal children living in their own homes.

Cognitions play a very important role in mental health of a person. Katic’ and Bala (2012) studied 162 female school children aged 10 to 14 years and found 13 to 14 year old group to be superior in comparison to 10 to 12 year olds in flexibility, agility, psychomotor speed, as well as, cognitive functioning. In another study by Jena (2011) on 400 urban and rural senior secondary students of Sikkim, significant difference in their memory was found. There was significant difference in the memory of rural boys
and rural girls. In urban boys and urban girls and in rural boys and rural girls no significant difference was found in achievement motivation. Study by Umadevi (2013) on 200 adolescents found that the **majority of them came under average and above average category of emotional intelligence**. Adolescents hailing from joint families were highly emotionally intelligent and those from large families were good at adaptability and stress management in comparison to adolescents from small families.

Some studies have also been done to explore the **effect of abuse and violence on the mental health of children**.

**Abused and neglected children are more likely to have mental health concerns** (suicide attempts and Post Traumatic Stress Disorder), **educational problems** (extremely low IQ scores and reading ability), **occupational difficulties and public health and safety issues** (prostitution, alcohol problems) (Widom and Maxfield, 2001). Similarly children who are exposed to violence in their homes are left emotionally scared and traumatized and also have a negative impact on neuro cognitive development, leading to lower intelligence scores in young children (Koenen, Moffitt and Caspi et al., 2003).

In another study on the **effects of violence on children who witnessed abuse of their mothers by their fathers**, it was observed that ‘being caught in the middle of domestic violence can affect the child adversely’ (Sengupta, 2001).

With 36 % of the population living below poverty line a number of children in difficult circumstances also witness times of poverty and hunger. So another set of research focuses on **hunger found in low socio – economic status and below poverty line group and their effect on child’s mental health**. Weinreb, Wehler, Perloff, Scott, Hosmer, Sagor and Gundersen (2002) in their study examining the effect of hunger on child’s physical and mental health and academic functioning found that **for school aged children severe hunger was a significant predictor of chronic illness and for preschoolers moderate hunger was a significant predictor of health conditions**. For both groups of children severe hunger was associated with higher levels of
internalizing behavior problems. Malhotra (2005) in her study observed that disorders were more in boys and in children in low socio-economic status category.

6. RELATIONAL WORLD

“People create their lives within a web of connections to others. The cast of character in a life and nuances of interconnections provide the richness, intricacy, the abrasion and much of the interest in living. Life unfolds as a kaleidoscope of relationships, with varying pieces in shifting arrangements.”

Josselson (1996)

Relationship is the oxygen we breathe. The first and foremost relationship of a person is with his or her own self. The way a person relates with his own self determines the way he would relate with others. Therefore, literature review highlights the researches done in the area of relationships.

Goswami (2013) in a comparative study of deprived institutionalized children in the age range of 8 to 18 years and normal family reared children from five government secondary schools and found that institutional care because of parental deprivation linked with behavioural and emotional problems negatively affects personality development. Further deprived children living in destitute homes have more problems related to their personality in comparison to the normal children living in their own homes.

On the same note Buri, Murphy, Richtsmeier and Komar (1992) reported a positive correlation between perceived parental nurturance and self esteem.

In another study by Dhal, Bhatia, Sharma and Gupta (2007) on 110 adolescents it was found that adolescents with high self – esteem were securely attached while those with low self esteem had preoccupied and fearful attachment. On similar lines Blankman (2002) found that the quality of childhood attachment was significantly related to the quality of adult attachment. Securely attached individuals scored higher in social interaction than anxiously attached individuals.
Smt. Jawahar Devi Birla Institute of Home Science, Calcutta (1999) in their review of various studies on children in difficult circumstances stated that mother’s love is an important factor which influenced institutionalized adolescent girl’s psychological development with mothers playing a very important part in the lives of girls than fathers. Further parenting was found to be an important factor contributing to good outcomes.

Mittal and Bhardwaj (2012) studied 120 adolescents (15 to 17 years) belonging to middle socio economic group and found that perceived parental behavior significantly affected the emotional maturity of adolescents. They also reported positive relationship between perceived parental care behavior and emotional maturity.

In a study on 2048 adolescents from six urban wards and four rural communities by Patel (2008) it was found that having one’s family as a primary source of social support was associated with lower prevalence of mental disorders.

Stein (2002) found unhealthy development of children who had lost their parents.

Narayanaswamy & Sachithanandam (2010) studied 35 boys in agricultural bonded labour and found that deprivation of proper parental care and separation from the families pushed children to bonded system.

Jaya and Narasimhan (1999) in their study on 121 families of a rural area in Coimbatore reported that poor interpersonal relationships with family and relatives (50%) was one of the most common stressful situation that lead to violence on children in families. Children also expressed a strong desire to have parents who do not treat children violently (29%), getting rid of parents (26%), and to be born in some other loving family (20%).

Another set of researches on male orphans, female orphans and delinquents found that the most important area of conflict in the life of orphans and delinquents was interpersonal relations (Shukla, 2007; Shukla, 2006; Singh, 2000).
RECOMMENDATIONS MADE BY SOME RESEARCHES

Recommendations not only help in taking immediate actions but also reinforce the implementation of various plans, policies and intervention programmes. This section deals with the recommendations made by some researches.

Study by Bansal and Barman (2011) on 982 school children recommends that epidemiological studies should be started early in childhood and carried longitudinally for the development of preventive, promotional and curative programmes in the community.

Patel, Flisher, Nikapota and Malhotra (2008) in their review titled ‘Promoting Child and Adolescent Mental Health in low and middle income countries stressed that the capacity needs to be built across the health system with particular foci on low cost, universally available and accessible resources, and on empowerment of families and children. They also considered the role of formal teaching and training programmes, and the role of specialists child and adolescent mental health promotion.

CINI ASHA – UNESCO (2000) in its analysis of the UNESCO supported project on street children, working children and children of sex workers, started by CINI ASHA in Calcutta suggested introduction of programmes like Balwadis, Integrated Child Development Scheme and counseling of parents of preschool children. For school going children it suggested improvements in the educational system, to provide basic amenities in schools, to promote group activities and to provide school uniform, stationary etc. It further recommended strong networking among non-governmental organizations, government departments, police and schools to deal with the problems of street children.

In a study on 189 boys aged 6 to 18 years from observation homes in Delhi Pagare et al. (2005) suggested that problem of sexual abuse among inmates of the observation homes is grave and requires urgent remedial actions.

UNESCO, New Delhi (2001) in its examination of the initiative of the government, international and voluntary sectors for eradication, rehabilitation and
education of street and working children suggested that preventive measures like supporting families in poverty, creating broad based awareness among parents and society, addressing the factors underlying family disintegration, providing employment for adults, and support in times of crisis, strong child care programmes, relevant schooling, psychological support to children and efforts to address the roots of domestic violence to keep families intact are urgently required. Further the ultimate goal should be mainstreaming of all children in formal education system. Accountability of non–governmental organizations and regular monitoring of activities must be an integral component of government funded educational programmes.

Thus the review of literature clearly shows the dearth of empirical researches on children in difficult circumstances. Studies done have largely focused on the homeless street and working children, institutionalized children and children in labour. However most of the studies, be it studies on street children or institutionalized children, focus upon the incidence rates or the demographic variables like age, gender, locale, socio economic status etc. Few of them focus upon the risk of and actual vulnerability to abuse of children on streets. Some other studies explore the reasons for their being on streets, runaway and their habits. Therefore it becomes more imperative to state here that Mental Health from the phenomenological perspective is showing huge gaps in researches.

Another important highlight of the review shows that studies in the context of after care homes, observation homes and other such institutions have predominantly focused upon the physical and infrastructural facilities in these homes and institutions. Their health and mental health status has not been assessed.

Further review also shows paucity of researches on children in difficult circumstances in Uttar Pradesh despite having the highest child population in the country. Most of the studies have been done in other states like Gujarat, Karnataka, Himachal Pradesh, Kolkata and Delhi.

Children are born with a basic need to be touched. Stable, warm and affectionate relationships in childhood help in developing security and trust in the child. Children
from difficult circumstances lack this secure base. Literature review shows that the relational world of these children has been explored in orphanages and some institutionalized girls in Kolkata. Further studies done have largely focused on the variables like self esteem, attachment and emotional maturity. Huge gaps are seen with reference to other psychological variables like – personality characteristics, emotional health, self – image, motivation, self- other relatedness, cognitions, adjustment etc. Researches on children taking into account the relational world of children from phenomenological perspective are almost missing. The questions that intrigued the researcher were-

- What is the children’s perception of themselves, as well as, others?
- How do they handle their emotional traumas?
- What is the effect of neglect, abuse, violence and ignorance on their Mental Health?
- What are their desires and wishes?
- What is their perception of reality?
- How early childhood traumas has affected their self image and their relationship with others?
- How deprivation of cognitive and affective stimulation has affected their intellectual functioning?
- Keeping in mind the Object – Relations perspective, how negative experiences and broken relationship ties has affected their adjustment?
- How do these children cope with the stresses of life?

As all the issues cannot be taken up in a single research, therefore the present research attempts to answer some of these questions.