Declaring "Prohibition of Child Marriage Act – 2006 as secular" Land mark judgment by Karnataka High Court

The Childhood of person is precious. On the attaining the age of majority, anything may be given to it like the job, house, husband/wife; but what cannot be got back is its precious childhood. What is therefore of paramount importance is that the child should fully enjoy his/her childhood before entering the wedlock. In whatever form it is, the child marriage is a gross violation of human rights of a girl or boy.

…. Therefore no Indian citizen on the ground of his belonging to a particular religion, can clime immunity from the application of PCM Act.

HON'BLE MR. JUSTICE ASHOK B. HINCHIGERI

(Words from the Judgment of WRIT PETITION NO. 75889 of 2013 (GM-RES) Dated 26th of February 2013. Between 16year old girl from a minority community of Kanakagiri, Koppal District and State of Karnataka)

District Administration (08539-220844),
Zilla Panchayath (220002),
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Unicef-Child Protection Program (225006), Koppal

Situation Of Children and Child Protection Plan of Koppal District

District Administration, Zilla Panchayath,
Department of Women and Child Development,
District Child Protection Unit and
Unicef-Child Protection Program, Koppal

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Situation Of Children and Child Protection Plan of Koppal District

District Administration, Zilla Panchayath,
Department of Women and Child Development,
District Child Protection Unit and
Unicef-Child Protection Program, Koppal

Situation of Children and Child Protection Plan of Koppal District

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FOREWORD

Children have the rights to be protected. The United Nation's Conventions on the rights of the children, Human Rights, Constitution of India, Many legislations such as Juvenile Justice (Care and Protection) Act 2015, The Child Marriage Prohibition Act 2006, Protection of Children from Sexual Offence Act 2012 etc, programmes such as Integrated child Protection Scheme, Sarva Shiksha Abhiyan etc guarantees child protection. Protection of every child from abuse, exploitation, violence, unnecessary separation from the family etc are therefore obligation of all of us.

Protection of every child is one the cherished goal of our country. Problems such as child labour, child marriage, child abuse, beggary, trafficking etc are the challenges for protection. To overcome these challenges in Koppal District, Integrated Child Protection Scheme is implemented. Situational analysis and developing District Child Protection Plan is one of the important strategies of ICPS. District Child Protection Unit with support of UNICEF Child Protection Program has conducted survey to analyse the situation of the children and developed the District Child Protection Plan.

I am sure that this report will be important tool for all child protection functionaries for protection of every child who need care, support and protection in Koppal District.

M. Kanagavalli, IAS
Deputy Commissioner,
Koppal.

MESSAGE

Today's Children are today Citizen and education is paramount important for nurturing of every Children and education is only means for their development. We have the moral obligation and duty bound to fulfill needs of children, getting quality education is right of every child, however because of various limitations we are struggling to provide education to children. Because of this reason children are facing various protection problems. An strategic intervention of various schemes can be measures to overcome the issues. I want every child of Koppal should get minimum of 12 years of education. We all should strive for achieving this vision. Only education can make Koppal a developed District.

I sincerely acknowledge the efforts of the Child Protection team of Koppal for bringing out the Situational Analysis and District Child Protection plan of Koppal District. Let us all have clear understanding of the issues that children are facing and make a collaborative efforts to implement the District Child Protection Plan.

Ramachandran R, IAS.,
Chief Executive Officer
Zilla Panchayath, Koppal.

ABBREVIATIONS

AIDS	:	Acquired Immuno Deficiency Syndrome
ANM	:	Auxiliary Nurse and Midwife
BCM	:	Backward Class and Minority Department
CDPO	:	Child Development Program Officer
CMPO	:	Child Marriage Prohibition Officer
CWC	:	Child Welfare Committee
CWO	:	Child Welfare Officer
DAPCO	:	District AIDS Prevention and Control Society
DCPO	:	District Child Protection Officer
DCPP	:	District Child Protection Plan
DCPU	:	District Child Protection Unit
DD	:	Deputy Director
DWCD	:	Department of Women and Child Development
GP	:	Gram Panchayat
HIV	:	Human Immunodeficiency Virus
ICPS	:	Integrated Child Protection Scheme
IEC	:	Information Education and Communication
IMR	:	Infant Mortality Rate
JJA	:	Juvenile Justice (Care and Protection of Children) Act
JJB	:	Juvenile Justice Board
MR	:	Maternal Mortality Rates
NGO	:	Non Government Organization
NPAC	:	National Plan of Action for Children
PDO	:	Panchayat Development Officer
PNDTP	:	Prenatal Diagnostic Techniques Prevention and Regulation Act
POCSO	:	Protection of Children from Sexual Offences (Act 2012)
SAA	:	Specialized Adoption Agency
SAM	:	Severely Acute Malnourished
SC	:	Schedule Caste
ST	:	Schedule Tribe
SJPU	:	Special Juvenile Police Unit
UN	:	United Nations
UNCRC	:	United Nations Convention on Rights of Children

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INTRODUCTION

1.1. BACKGROUND:

1.1.1. Koppal District: An Overview:

Koppal District was carved out from Raichur District in the year 1997 to improve the administration and increase the pace of development. The District occupies an area of 7,190 sq. kms. It is known to be a backward District among the northern part of the state and situated in the old Hyderabad Karnataka region. Koppal District is surrounded by Bagalkote District in the north, Raichur in the east, Bellary in the south and Gadag District in the West. Koppal District has four taluks namely Koppal, Gangavati, Yalburga and Kushtagi. Recently Koppal District got enrolled in 371 (J) Article which gives special benefits on Education and Government jobs.

Koppal is one of the economically and educationally growing Districts in Karnataka, where drought periodically takes its toll on the agrarian economy and lives of people. Koppal District has partly red sandy and black cotton

soil suitable for agriculture and horticulture crops. Tungabhadra River meets the water requirements of the District to some extent. Climatic conditions are hot throughout the year and average rainfall of the District is 572 mm. District is rich in mineral resources – building stone, Marble and Granite. Gangavathi is famous for paddy cultivation. The main working population is 35% of the total population and majority of them are agricultural labourers. The literacy rate of Koppal is 68.09%. Primary schools in the District are about 1268 and there are 151 high schools in the District.

According to 2011 census Koppal has a population of 13,91,292 (Males- 7,01,479 and Female 6,89,813), of which 16.58% are in urban area and the Majority i.e. 83.42% of the population live in rural area. Koppal District has 983 sex ratio and child sex ratio is 958.

The administrative blocks in the District are as below

1. No. of Talukas : 4
2. No. of Hoblis : 20
3. No. of Inhabited villages : 596
4. No. of Un-Inhabited Villages : 41
5. No. of City & Municipal Corporation/Councils/ Town Panchayaths : 4
6. No. of Gram Panchayaths : 152

1.1.2. Demography Details: According to 2011 census Koppal has a population of 13,91,292 with 264595 families Majority of 83.10 percent of the population of Koppal live in rural area as indicated in the table below.

General information of the District as per 2011 Census				
Name of the Taluka	**No of GPs**	**No, of Villages**	**No. of families**	**Total Population**
Gangavathi	42	157	89885	459905
Koppal	38	151	73149	377781
Kustagi	36	177	51347	284792
Yalaburga	36	144	50214	267442
District Total	**152**	**629**	**264595**	**1389920**

General information of the District as per 2011 Census				
Name of the Taluka	**Urban population**	**Rural population**	**SC Population**	**ST Population**
Gangavathi	114642	345263	88770	64615
Koppal	79370	298411	72533	30205
Kustagi	24878	259914	45266	38445
Yalaburga	14814	252628	52039	29183
District Total	**233704**	**1156216**	**258600**	**162448**

1.1.3. Developmental Indicators: District development indicators showing positive environment for children. The following chart shows that the overall sex ratio of Koppal is 983; whereas child sex ratio is 958. The child sex ratio and women literacy rate are the major areas of concern as depicted in the table below.

Development Indicators of the District				
Name of the Taluka	**Sex ratio**	**Child Sex Ratio (0-6)**	**Literacy Rate**	**Female Literacy**
Gangavathi	988	957	67.30	58.19
Koppal	974	957	70.58	60.48
Kustagi	984	965	66.76	55.08
Yalaburga	982	929	67.32	54.88
District Total	**983**	**958**	**68.09**	**57.55**

Development Indicators of the District				
Name of the Taluka	Density (per Sq.Km)	No. of Angana-wadies	Total Ration BPL Cards	No of Police stations.
Gangavathi	353	731	83312	5
Koppal	276	500	63613	5
Kustagi	208	563	48084	3
Yalaburga	180	483	47111	3
District Total	**250**	**2277**	**242120**	**16**

1.2. UNDERSTANDING CHILD PROTECTION:

1.2.1. Concept of Child Protection

Children are exposed to danger in present times due to various reasons and their Rights are violated and have been subject to abuse and exploitation. Children subjected to violence, exploitation, abuse and neglect are at risk of: shortened lives, poor physical and mental health, educational problems (including dropping out of school), poor parenting skills later in life, homelessness and displacement. Conversely, child protection increases a child's chance to grow up physically and mentally healthy, confident and self-respecting, and less likely to abuse or exploit others, including his or her own children.

‘Child Protection’ refers to preventing and responding to violence, exploitation, abuse and neglect against children[1]. The word “Child Protection” means protecting the children from any perceived or real dangers that affects their childhood. It is about ensuring that no child falls out of the social security and safety net and those who do, receive necessary care, protection and support so as to bring them back into the safety net. Child protection is integrally linked to every other right of the child. The failure to ensure children’s right to protection adversely affects all other rights of the child and the development of the full potential of the child. Thus child protection is building a protective environment for children that will allow children to have access to their rights of survival, protection, development and participation. It must also relate to children’s capacity for self-reliance and self-defense and the roles and responsibilities of family, community, society and the State. While protection is a right of every child, children who are more vulnerable due to circumstances need special attention.

Building a protective environment for children that will help prevent and respond to violence, abuse, neglect and exploitation involves eight essential components[2]. These interconnected elements work individually and collectively to strengthen protection and reduce vulnerability.

1. Strengthening governmental commitment and capacity to fulfill children’s right to protection;

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[1] UNICEF, Child Protection information sheet, 2006. P.1.

[2] Ibid.,p.1

2. Promoting the establishment and enforcement of adequate legislation;
3. Addressing harmful attitudes, customs and practices;
4. Encouraging open discussion of child protection issues that includes media and civil society partners;
5. Developing children's life skills, knowledge and participation;
6. Building capacity of families and communities;
7. Providing essential services for prevention, recovery and reintegration, including basic health, education and protection;
8. Establishing and implementing ongoing and effective monitoring, reporting and oversight.

Child protection issues intersect with all the Sustainable Development Goals (SDGs) – from poverty reduction to getting children into school, from eliminating gender inequality to reducing child mortality. Most of the SDGs simply cannot be achieved if failures to protect children are not addressed. Child labour squanders a nation's human capital and conflicts with eradicating extreme poverty (SDG 1); armed conflict disrupts efforts to efforts to ensure inclusive and equitable quality education and promote life long learning opportunity for all. (SDG 4); child marriage leads to the removal of girls from school and thus prevents gender equality (SDG 5); children separated from their mothers, particularly if they remain in institutional settings, are at greater risk of early death, which hinders efforts to reduce child mortality (SDG 3);

female genital mutilation/ cutting undermines efforts to maternal health (SDG 3); and sexual exploitation and abuse hamper efforts to combat HIV infection (SDG 3). In addition, environmental disasters make children vulnerable to exploitation and abuse, hence the need for environmental sustainability (SDG 6,8,9,11,12 & 17). Overall, protecting children requires close cooperation between different partners, which consolidates the need for a global partnership for development (SDG17).

1.2.1. Legal frame work to Child Protection:

The Constitution of India recognizes the vulnerable position of children and their right to protection. Article 15 of the Constitution guarantees special attention to children through necessary and special laws and policies that safeguard their rights[3]. The Right to equality, protection of life and personal liberty and the right against exploitation is enshrined in Articles 14, 15, 16, 17, 21, 23 and 24. Article 39 and 45 require the state to ensure that the tender age of children is not abused; children are given opportunities and facilities to develop in a healthy manner and under conditions of freedom and dignity.

The child rights and welfare concerns have been addressed in a number of International Conventions, Standards and Declarations, including the UN Convention of the Rights of the Child (UNCRC) 1989. The Government of India ratified the UN Convention on the Rights of the Child (UNCRC) in 1992. The Convention prescribes standards to be adhered to by all State parties in securing the best interest of the child. It emphasizes social re-

[3] Ministry of Women and Child development, ICPS guidelines, New Delhi, p.3

integration of child victims, without resorting to judicial proceedings. The UNCRC outlines the fundamental rights of children, including the right to be protected from economic exploitation and harmful work, from all forms of sexual exploitation and abuse and from physical or mental violence, as well as ensuring that children will not be separated from their family against their will.

Article 4 of UNCRC demands from every State Parties to undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the convention. Complying with the Constitution and UNCRC India has adopted a number of laws and formulated a range of policies to ensure children's protection and improvement in their situation. The Guardian and Wards Act 1890, Hindu Adoption and Maintenance Act 1956, Probation of Offenders Act 1958, Bombay Prevention of Begging Act 1959, Orphanages and Other Charitable Homes (Supervision and Control) Act 1960, National Policy for Children 1974, Bonded Labour System (Abolition) Act 1976, Immoral Trafficking Prevention Act 1986, Child Labour (Prohibition and Regulation) Act 1986, National Policy on Education 1986, National Policy on Child Labour 1987, Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, National Nutrition Policy 1993, Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994, Persons with Disabilities (Equal Protection of Rights and Full Participation) Act 2000, Juvenile Justice (Care and Protection of Children) Act 2015, National Health Policy 2002, National Charter for Children 2004, National Plan of Action for Children 2005, Commissions for Protection

of the Rights of the Child 2005, Child Marriage prohibition Act 2006, Protection of Children from Sexual Offences Act 2012 and National Policy on Children 2013 are some of the legal provisions made to protect the rights of children.

1.2.2. The Juvenile Justice (Care and Protection of Children) Act:

The Juvenile Justice (Care and Protection of Children) Act, 2015 is the key legislation in providing, preventing and addressing protection concerns of children. Juvenile Justice Act is essentially a social legislation, crafted specially to deal with alleged offenders under the age of 18 and aimed at their proper care, protection and treatment through catering to their development needs. It caters to two categories of children – Juveniles in conflict with law and children in need of care and protection.

The Act focuses on Prevention and Protection strategies through a child friendly approach and in the best interest of children. Juvenile Justice System functions through CWC, JJB and SJPU – the statutory bodies set under the Act. Section 4 of the act provides for care, protection, rehabilitation and reintegration of juveniles in conflict with law through the statutory body called Juvenile Justice Board. Children in need of care and protection are provided with similar services through CWC as per section 29 of JJ Act. CWC and JJB are with judicial power to decide on matters relating to children who come under their purview according to the Act. Special Juvenile Police Unit Acts as Gate keeping for both categories of children with a child friendly protection mechanism.

Juvenile Justice Act directs the state to rehabilitate and reintegrate children through Institutional and non-institutional family based services. Considering the best interest of the Child in all matters the Act gives primary importance to family based rehabilitative services and reintegration at the earliest. The act also makes provisions to ensure minimum standard of care for children in institute and ensure maximum protection for children who go into families by providing space for the State governments for detailed rules and guidelines.

Juvenile Justice (Care and Protection of Children) Act 2015, Section 106, makes the provisions to set up Child Protection Units at State and District level to implement the provisions of JJ Act and see to the overall implementation of other legislations for child protection.

1.3. INTEGRATED CHILD PROTECTION SCHEME

In early 2006 the Department of Women and Child Development became a full-fledged Ministry and all child protection matters including implementation of Juvenile Justice (Care and Protection) Act 2015, as well as implementation of various programs for child protection were transferred to this new Ministry. But the glaring gaps in implementing various programmmes through different departments were not producing its desired results. Hence in 2009 a new umbrella scheme – Integrated Child Protection Scheme (ICPS) is brought out by the Government of India to create a system that will efficiently and effectively protect children.

The Integrated Child Protection Scheme is based on the cardinal principles of "protection of child rights" and "best interests of the child". The ICPS aims to promote the

best interests of the child and prevent violations of child rights through appropriate punitive measure against perpetrators of abuse and crimes against children and to ensure rehabilitation for all children in need of care and protection. It aims to create a protective environment by improving regulatory frameworks, strengthening structures and professional capacities at national, state and District levels so as to cover all child protection issues and provide child friendly services at all levels.

1.3.1. Specific Objectives of ICPS:

1. To institutionalize essential services for emergency outreach, institutional care, family and community based care, counselling and support services; and strengthen structures and mechanisms for effective implementation of the scheme at national, regional, state and District levels

2. To enhance capacities of all functionaries at all levels working under the ICPS and sensitize members of allied systems to take responsibility for child protection.

3. To create database and knowledge base for child protection services through child track system, research and documentation.

4. To strengthen child protection at family and community level by building the capacities of families and community in providing care protection and promote preventive measures for child protection.

5. To ensure appropriate inter-sectoral response at all levels

6. To raise public awareness on child rights, situation and vulnerabilities of children and families and available child protection services and structures.

1.3.2. Guiding Principles of ICPS:

1. Child protection, a primary responsibility of family, supported by community, government and civil society.

2. Loving and caring family, the best place for the child therefore institutionalisation of children is the last resort. Hence work for the reduction of vulnerability by strengthening the families.

3. Children's right to privacy and confidentiality should be protected through all the stages of service delivery.

4. Non-stigmatization and non-discrimination of child and treated in a dignified manner.

5. Planning and implementation of child protection policies and service delivery should be child centered at all levels, so as to ensure that the best interest of the child is protected. Customised service delivery is required to respond to local needs. Services for children at all levels and by all providers should be provided by skilled and professional staff.

6. Good governance, accountability and responsibility from all involved in child protection.

1.3.3. Programmes and Activities under ICPS:

1. Mapping needs and services for children and families at risk;

2. Preparing child protection plans at District and state levels; the plan would be gradually extended to block and community levels;

3. Strengthening service delivery mechanisms and programmes including preventive, statutory, care and rehabilitation services;

4. Improving access to and quality of services provided;

5. Promoting and strengthening non-institutional family based care options for children deprived of parental care, including sponsorship to vulnerable families, kinship-care, in-country adoption, foster care and inter-country adoption, in order of preference;

6. Developing capacity of service providers;

7. Strengthening knowledge base, awareness and advocacy;

8. Establishing an integrated, live, web based data base (on children in difficult circumstance, children in care, service providers and services provided), for evidence based monitoring and evaluation and service planning decision making;

9. Monitoring and evaluation;

10. Building partnerships and alliances for child protection at all levels, particularly at the grass-root community and District levels.

11. Strengthening linkages with other bodies and institutions such as the National/State Human Rights Commissions and National/State

Commissions for Protection of Rights of the Child, etc.

1.3.4. Service Delivery Structures of ICPS:

In order to ensure effective service delivery the ICPS is implemented in Mission Mode and set up State and District Child Protection Societies as the fundamental units at State and District levels for the implementation of the scheme. To monitor and evaluate the implementation of the scheme child protection committees are to be formed at District, block and village level.

1.4. NEED FOR SITUATION ANALYSIS OF CHILDREN

The creation of a protective environment for children requires strong knowledge base of information for developing informed and strategic responses. Lack of data adversely affects planning, the provision of appropriate services and allocation of resources. In order to develop effective intervention strategies and implement child protection programmes to reach every child, there is a strong need for availability of comprehensive information base on the situation of children and the available services. Therefore under ICPS provision is made to map the needs and services of children and families at risk by conducting comprehensive studies to assess the causes, nature and extent of specific child protection issues and prepare a child protection plan at District and State level. Hence Karnataka Integrated Child Protection Society in its annual plan of 2012-13 directed all District Child Protection Units to take up need assessment survey in the District through a NGO/University and prepare District Child Protection

Plan for the period 2013-2016. Further to it the plan is made for the period of 3 more years.

1.4.1. Aim and Objectives of the Study:

Aim: To analyse the situation of children in Koppal District and prepare District Child Protection Plan that will prevent and respond to serious service gaps and situations that make children and their families vulnerable.

1.4.2. Objectives:

1) To identify and assess the child protection issues in the District.
2) To strengthen child protection mechanism that exit in the District.
3) To create child friendly environment for children.
4) To assess the support system and service gaps in addressing the situation of children
5) To prepare a District specific Action plan to create a safe environment for children against the existing situation.
6) To facilitate convergence and networking with NGO and aligned department stakeholders.
7) To create model District in the state for child protection.

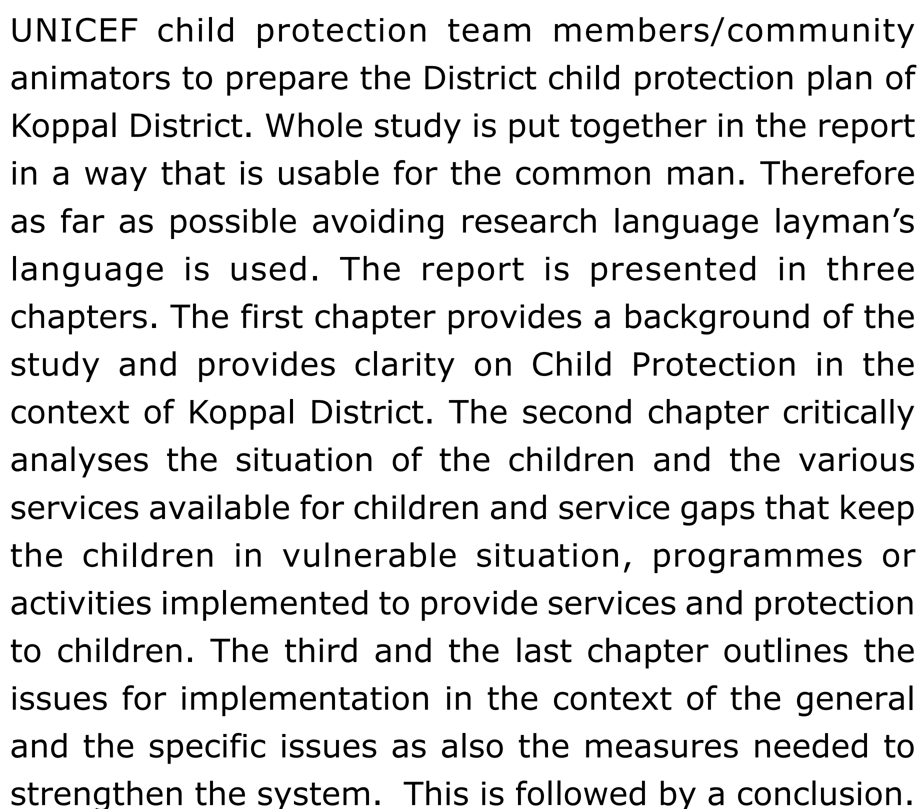
1.4.3. Methodology:

Situation Analysis study was an exploratory in nature. It was carried out in collaboration with UNICEF child Protection project working in the District.

1.4.3.1. Data Collection: State ICPS society prepared the format for data collection from the secondary sources. Data was collected from 152 Grama Panchayats, 4 Talukas and from the District office. The 152 gram panchayth survey was done by the community animators of UNICEF-Child protection program. The municipality area data was collected by the DCPU. Data collection was focused on general information of the District, child specific information and the service delivery systems. In order to compensate for the unavailable data on certain issues Focused Group Discussions were conducted at Hobli level and Municipal wards in 96 groups 4 urban local bodies. The aligned department stakeholders' consultation also conducted to find out realistic data.

1.4.3.2. Data Analysis and Findings: This is the first initiative to find in depth children data of the District on various dimensions. The analysis and findings of data will help to do advocacy to the government on child protection. Quantitative and qualitative data was analyzed focusing only on child protection issues such as Child population and sex ratio; orphan children, Parental care for children and Institutional care for children; harmful social practices like child marriage, devadasi system and child labour; Child trafficking and Street children; children with special need; child malnutrition and school drop-out, migration and the functioning of Juvenile Justice system and service delivery structures in the District. The findings are prioritized and the strategies for action plan are suggested indicating the role of responsible department/stakeholder.

1.4.3.3. Structure of the Report: The enormous effort is put forth by the aligned department stakeholders,



UNICEF child protection team members/community animators to prepare the District child protection plan of Koppal District. Whole study is put together in the report in a way that is usable for the common man. Therefore as far as possible avoiding research language layman’s language is used. The report is presented in three chapters. The first chapter provides a background of the study and provides clarity on Child Protection in the context of Koppal District. The second chapter critically analyses the situation of the children and the various services available for children and service gaps that keep the children in vulnerable situation, programmes or activities implemented to provide services and protection to children. The third and the last chapter outlines the issues for implementation in the context of the general and the specific issues as also the measures needed to strengthen the system. This is followed by a conclusion.

1.5. Excecutive Summary of Key Issues for Intervention and Suggested Stratagies.

Key issues for intervention	Suggested Measures/ Strategies
Increased incidences of Orphan Children & children with single parents	⁕ Study the problem of orphan and single parent children to explore the causes of the problem. ⁕ Extend non-Institutional care programmes of Adoption, Foster Care, and Sponsorship to these children and link the families to other social security schemes. ⁕ Setting up of adoption agency in the District. ⁕ Build linkages with NGOs for effective De-institutionalize possible children and provide family based and community based care. ⁕ Register all Institutions providing care for children.
High number of Special Need Children with disabilities and HIV infected and affected	⁕ Map all children with all kinds of disabilities, plan special programme to meet their needs and implement special rehabilitation programme to these children.

Key issues for intervention	Suggested Measures/ Strategies
	⁕ Ensure that all children avail one or the other benefit designed for such children by the state or central government. ⁕ Ensure coverage of Vishesh Palan Yogan for all HIV infected and affected children. ⁕ Build linkage with NGOs for community based and institutional based rehabilitation of special need children. ⁕ Rehabilitation of children of prisoners and mentally disabled children. ⁕ Nutrition to be supplied to infected/affected children ⁕ Mass awareness to be created to have ART to Needy. ⁕ Map child labour vulnerability area and take up preventive action with campaign
Child Labour	⁕ Database of child labour for proper follow up and rehabilitation.

Key issues for intervention	Suggested Measures/ Strategies
	* Ensure proper rehabilitation and mainstreaming of working children. * More involvement of Sec.17 officers and child welfare officers of all police stations. * Follow-up of school drop-outs and Retention. * Form child rights club, Meena thanda, and village child protection committees
Child Marriage	* Balika Sanga at Anganawadi formed CPP need to be sustained. * Prevent incidence of child marriage specially in certain communities through awareness * Focus on adolescent girls of Balika sanga/Kishori group motivation and sensitization programmes * Monitor mass marriage organization and take up capacity building. Common Protocol to maintain all mass marriage organisors. * Rescue and rehabilitate

Key issues for intervention	Suggested Measures/ Strategies
	effectively the reported cases ⁕ Child marriage rescue protocol to be institutionalized.
Juvenile Justice System	⁕ Organize training to all CWOs and help in maintenance of records ⁕ Increase the number of cases before CWC and make it a single window System for Child Protection ⁕ Follow-up Non-serious cases of children in conflict with law. ⁕ Appointment of vacant positions in children home for boys and girls. ⁕ Full time DCPO to be deputed/ appointed ⁕ The home for girls and home for boys are running in private rented building. There is no senior home for rehabilitation of children. New buildings to be constructed. ⁕ Recognize fit person/fit institution in the District. ⁕ JJB social workers to be appointed.

Key issues for intervention	Suggested Measures/ Strategies
	⁕ Capacity building of SAA in the District.
Devadasi system	⁕ Infrastructure need to be developed in the land which was sectioned for devadasi family. ⁕ Educational opportunity need to be made available to the children of devadasi family and needy adolescent girls linked to various skill Training Institutions. ⁕ In some villages males are not coming forward marry 18+ girls. That myth has to weaken. ⁕ Bringing girl children of devadasi family into the child protection safety net.

2. SITUATION OF CHILDREN IN KOPPAL DISTRICT

Understanding the situation of children is very necessary to plan programmes for protection of child rights. In the following paragraphs an attempt is made to present the situation of children in the District with a focus on realization of child rights. In line with human-rights approach, an effort has been made to highlight the immediate, underlying structure and causes of non-realization of children's rights. It also maps the capacity of various stakeholders' local and state governments to work for the realization of rights of children.

Data is collected, collated and analyzed from different sources to understand the situation of children in the District. As the data was from the secondary sources, few aspects could not be covered; hence focus group discussions were conducted to get the qualitative aspects of the problems the children face. The situation of children covers all children within the age of 18 and children in different set ups. In this study the situation of children is strictly limited to protection issues of children face. Developmental issues related to education; survival issues and participation issues are not dealt extensively to keep the focus.

2.1. CHILD POPULATION

Koppal District has 13.96 percent of 0-6 child population with 201,654 children, and 15.74 percent of 6-14 years child population with 2,19,037 children among 13,91,292 total populations according to 2011 Census of India. Following table gives us a clear picture of the distribution of child population available in 208,795 households covered in the survey of rural area of Koppal district.

Child Population in Koppal District according to 2013 Survey							
	0-6 years		6-14 yrs		14-18 years		
Taluka	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
Gangavathi	10156	9824	11515	11073	4049	3872	50489
Koppal	21721	22135	19433	20225	10397	11069	104980
Kustagi	10711	10492	6547	5834	1262	970	35816
Yalaburga	15976	17479	17842	18995	11780	10995	93067
Total	58564	59930	55337	56127	27488	26906	284352

The above table depicts the largest number of children in Gangavathi Taluk, which is almost 40% of child population of the District. Kustagi Taluk has lowest child population of the District with 12.6% of children. Hence Gangavathi Taluk needs to be the focus of area to work with children as compared to other Talukas.

2.2. CHILD SEX RATIO

Sex Ratio is defined as the number of females per 1,000 males. It is one of the basic demographic characteristics, which is vital for considering inclusive development. The sex ratio in Karnataka has increased from 965 in 2001 to 973 in 2011; Compared to this the sex ratio of Koppal District is above the state average and has remained the same as 983 from 2001 to 2011.

Child sex ratio refers to sex ratio in the age group of 0-6 years. The child sex ratio in the State has registered a nominal increase of 2 points from 946 in 2001 to 948 in 2011. But Koppal District has improved marginally in child sex ratio from 938 in 2001 to 953 in 2011. Though the District is identified as one of the backward District of Karnataka, sex ratio of the District is higher than the State ratio. The following Table indicates the comparison and shows the improved sex ratio in the 1961 to 2011

Child Sex ratio of Koppal District from 1961 - 2011			
Year	Overall Sex ratio	Child sex ratio	Karnataka State overall Child Sex ratio
1961	973	NA	987
1971	979	NA	978
1981	989	NA	974
1991	981	NA	960
2001	983	938	946
2011	983	953	943
Source: Census data of Karnataka table 3.			

It is clear that the sex ratio in the age group 0-6 has decreased at a much faster pace than the overall sex ratio of the State after 1981. Though there is improvement in the Child sex ratio of the district as compared to 2001 census, in reality child sex ratio of the district is a matter of concern.

2.2.1. Efforts in Preventing Female Feticide:

There are 34 scanning and diagnostic centers in the District; of which 4 are cancelled Hence implementation of PNDTP act has been monitored by DHO. Bhagyalaxmi yojana is implemented to address the issue. 59,374 children are covered under Bhagyalaxmi scheme till 2013-14. The purpose of this scheme is to prevent sex selection among children based on gender and motivate the parents towards having girl child.

2.3. PARENTAL CARE FOR CHILDREN:

Loving and caring family is the right of every child. The UNCRC Article 5 acknowledges the primary role of parents and the family in the care and protection of children,

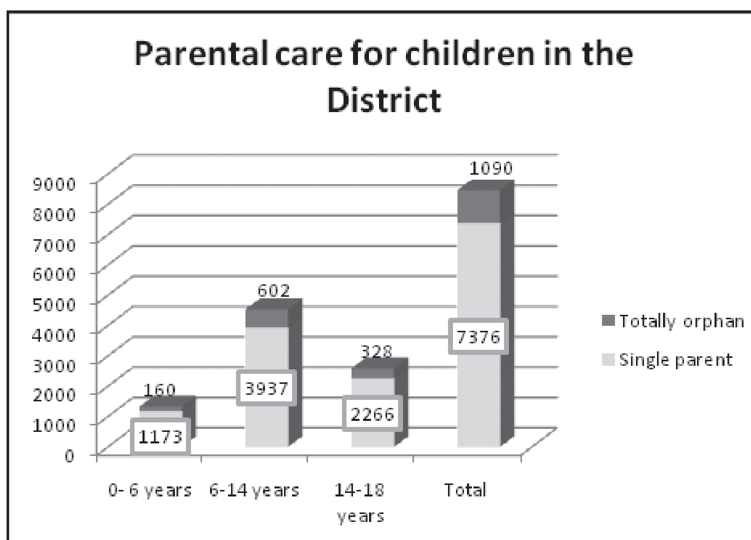
and the obligation of the State to help them in carrying out these duties. A child without parental care has a right for special protection and assistance provided by the State (Art.20).

Koppal District has a large number of children without adequate parental care as depicted in the following chart.

Parental Care for Children in Koppal District				
Totally Orphan				
Taluka	**0- 6 years**	**6-14 years**	**14-18 years**	**Total**
Koppal	12	84	22	118
Gangavathi	82	311	178	571
Kustagi	17	53	25	95
Yalaburga	49	154	103	306
Total	**160**	**602**	**328**	**1090**

Parental Care for Children in Koppal District				
Single Parent				
Taluka	**0- 6 years**	**6-14 years**	**14-18 years**	**Total**
Koppal	325	701	331	**1357**
Gangavathi	4	1938	1142	**3084**
Kustagi	250	369	98	**717**
Yalaburga	594	929	695	**2218**
Total	**1173**	**3937**	**2266**	**7376**

District has 1090 children who are totally orphan and live with alternative care. There are 7376 single parent children. There is no available data about the services offered to these children. This shows the need of effectively administering the alternative care like adoption, foster care and sponsorship specified under Juvenile Justice Act 2015.



It is very clear that 160 orphan children are below the age of 6; and need to be study of the causal factors and care pattern, so that an effective monitoring of adequate protection is done through JJ systems. Newly established specialized adoption agency has a challenge of reaching the large number of orphan children and give focus to attention under juvenile justice system. It was observed that every time the child protection workers get an orphan/abandoned child they have to rush to neighboring District. This problem is resolved by setting up SAA in the district. CWC records reveal that 23 children are declared legally free for adoption 2011 – 2015 June out of 30 children rescued during the period. 603 orphan children in the age group of 6-14 years need to be screened for foster care placement at least kinship or community care. Certain legal provision needs to be done with regard to orphan children below 6 years to prevent abandonment of children.

5110 single parent children below the age of 14 years need to be supported through sponsorship. At least a

study of single parent 1173 children especially below 6 years need to be done. The coverage of sponsorship programme in the District has not even reached 5% of single parent children and it is not adequate intervention for this category of children. The attention need to be focused to present the single parent children before CWC to ensure protection. The reports on HIV/AIDS reveal that one of the causes of lack of parental care is because of the effect of HIV/AIDS and Unnatural death of parent.

There are 313 girls among 727 single parent children in the age group of 14-18. The adolescent period being crucial for the children and especially girls need special intervention for support in personality development. These children are more vulnerable for the problems of child marriage, and early pregnancy.

2.3.1 Institutional Care for Children:

There are 107 institutions providing residential care for children in the District managed both by Government and private administration. Only one institution is registered under Juvenile Justice (Care and Protection of Children) Act 2015 Sec.41 (1). As per 2011-12 data of the District there are 9,075 Children below 16 years of Age are catered in these institutions. Though the number of children in institutions and the children without parental care are almost equal, the data of children in the institution does reveal that children who are without parental care are rarely in institutional care but children with parents are in institutional care. The following table gives clarity on this aspect.

Institutional Care for Children in the age group of 6-18						
	SC/ST Hostels		BCM Hostels		Morarji Desai Residential Schools	
Taluks	No. of Institutions	No. of children	No. of Institutions	No. of children	No. of Institutions	No. of children
Gangavathi	10	850	11	580	2	250
Koppal	9	700	1	650	6	660
Kustagi	11	720	10	570	2	250
yalburgi	9	695	14	1025	6	750
Total	**39**	**2965**	**41**	**2735**	**16**	**1910**

Institutional Care for Children in the age group of 6-18						
	Ashram Schools		Destitute cottages		Ranichennamma Residential Schools	
Taluks	No. of Institutions	No. of children	No. of Institutions	No. of children	No. of Institutions	No. of children
Gangavathi	0	0	0	0	1	250
Koppal	1	125	1	25	1	250
Kustagi	1	75	1	25	1	250
yalburgi	1	125	2	50	1	250
Total	**03**	**325**	**4**	**100**	**04**	**1000**

The linkage of children in need of care and protection to these institutions need to be established to bring these children under the safety net of child protection.

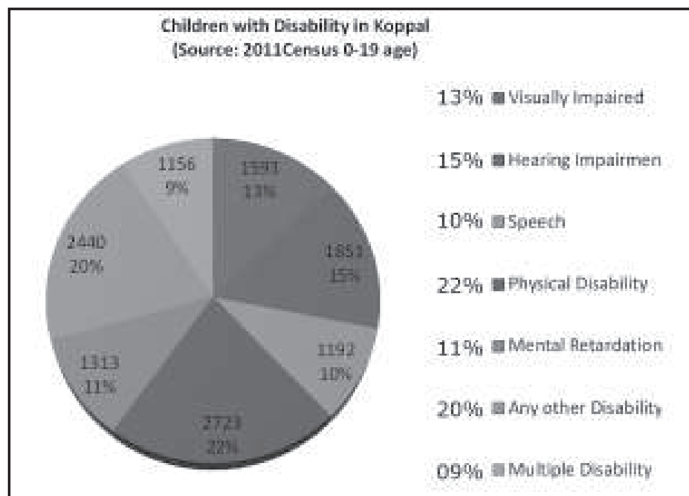
2.3.2. Non-Institutional Family based Services to children: Data collected from Child Welfare Committee and District Child Protection Unit show that the services to children with lack of parental care are not proportionate. During the year 2013-14, 35 children are provided with sponsorship support out of which 11 children are deinstitutionalized; 5 children are single

parent and 6 are orphan and 13 children are in vulnerable families. During 2011-14 CWC has ordered 26 children for sponsorship support and 17 children are declared legally free for adoption. This indicates that the children, who are given sponsorship under Vishesh Palan Yojana benefit, have not gone through Juvenile Justice System and recorded into CWC cases.

2.4. CHILDREN WITH SPECIAL NEEDS

Children infected and affected by HIV/AIDS; victims of substance abuse, mentally and physically challenged children, children of Devdasies,; Children of prisoners are more vulnerable as they are least likely to have family care alternatives and hence require specialized care and treatment including medical, nutritional, and psychological support.

2.4.1: Disability among Children: Children with disabilities in other words differently able children are one of the most marginalized and excluded groups in society, facing daily discrimination in the form of negative attitudes, lack of adequate policies and legislation, they are effectively barred from realizing their rights to health care, education and even survival. ICPS considers children with disability as special need children acknowledging their vulnerability for neglect and abuse. It has also been observed that poverty and lack of social security and medical services tend to cause parents to abandon children with physical and mental disability. Such children are also in need of specialized care and services to meet their health, nutrition, educational, etc. needs and emotional well being.



The above chart makes it clear that there are 12268 children who are differently able children. 2723 children are with physical disability, 1313 children are with mental disability and 25% children are with speech and hearing impairment. As compared to the problems of children the services are not adequate. The association for disabled canter and Lions rehabilitation in Gangvathi is functioning for the rehabilitation these children in the District. The collaboration of civil society organisations is required to find out factors responsible for the disability and rehabilitation. Setting up of inclusive education centers may be an suggestive strategy.

2.4.2. Children Infected and affected by HIV (CABA)

The following table shows the list of beneficiaries, who receive sponsorship under Vishesh Palan Yojan; a special scheme for children infected and affected by HIV/AIDS. There are 955 children are given benefit under the scheme out of which 238 children are infected with HIV and 717 children are affected with HIV. There are 54 children who are totally orphan children. There is no rehabilitation

center for CABA children in the District. These children are in the purview of Nutritional needs, parental care. Peer education, counseling opportunity and skill building for extending life span. DAPCU has given the information about the 646 children being infected with HIV for further support, However, the complete data on children infected and affected by HIV/AIDS is lacking in the District which is crucial for planning better programmes for such children.

Identified Children		Infected by HIV	Affected by HIV	On ART
Male	511	126	385	126
Female	444	112	332	112
Total	955	238	717	238

2.4.3. Devadasi System:

The Devadasi practice is known as Basavi or Jogini in Karnataka and Matangi in Maharastra. It is also known as Venkatasani, Nailis, muralis and theradiyan in various other languages. There are 4700 Devdasis in Koppal District. Most children of Devadasis are either drop-outs or do not attend school regularly. As per the Local NGO working in the area of HIV/AIDS in Koppal, they have found that some of the female sex workers they have identified are devadasi women. As per their survey done in 100 villages there are 1142 Female Sex Workers are there. They also note that the children of these women are getting into sex work themselves. While some do get married, they tend to end up in marital conflicts and ultimately in commercial sex work. Many girls also get exploited due to the environment they are found in and

the partners. Most often the girls being formally brought into the devadasi system do not happen now, the stigma of being a child of a devadasi still remains. The study also highlights that some of the children of Devadasis are outside the schooling system.

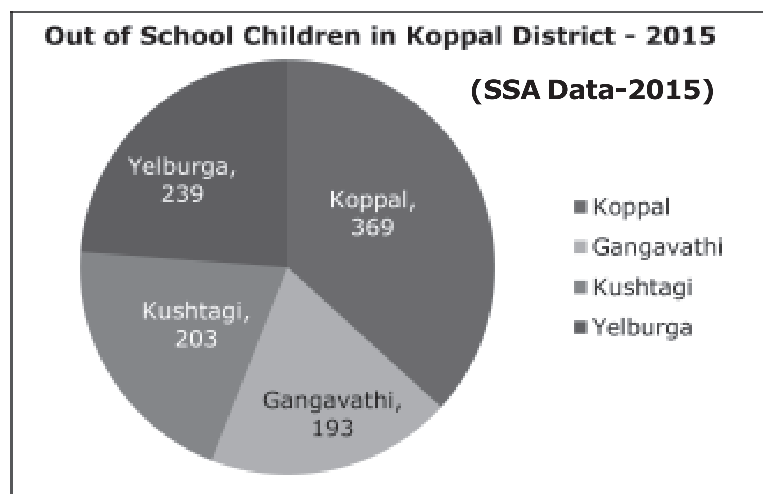
There are various rehabilitation programme for Devadasis to provide care and protection to children of Devdasis. 41% of devadasis availing monthly pension scheme, 25% of Devadasis are beneficiaries of the free home scheme and 28% have availed of the loan/subsidy scheme. Still the problem remains as issue of concern for child protection.

2.4.4. Children of Prisoners: In Koppal District there are two prisons (one is in Koppal and another is in Kustagi). Both of them are under trail Prisons. According to the data obtained from one of the prison there are 10 children identified as children of prisoners. The convicted prisoners are been taken to either to Bellari or Belagaum. The data from these prisons need to be collected for effective implementation of care and protection to children of the prisoners.

2.5. CHILD LABOUR/OUT OF SCHOOL CHILDREN

Child labour is the practice of having children engaged in economic activity, on part or full-time basis. This practice deprives children of their childhood, education and is harmful to their physical and mental development. Child labour prohibition and regulation Act prohibits the employment of children below the age of 14 years in hazardous occupations.

The Right to Education Act guarantees free and compulsory education to all the children of 6-14 years. They are 1,004 children in Koppal who are out of school. The below graph depicts taluk wise number of out of school children.



Karnataka produces cottonseed in an area covering 5,000 acres, mostly in Koppal, Gadag, Chintamani, Bagalkote, and Raichur Districts. It is estimated that approximately 29,500 children below 14 years of age are working in the cottonseed sector in Karnataka, of which 81.2 per cent are girls. Further, around 18,000 adolescents (14–18 years) work in the same sector in the state. Commercial cotton is cultivated on 5,300 acres in Koppal District, which employs seasonal child labour during the sowing and plucking seasons. Cottonseed landowners prefer to hire girls as they are easier to control, are willing to work for longer hours, receive much lower wages than boys, and are more committed to the work. As long as the children are involved in labour, they are denied the opportunity to go to school. It is estimated that 89 percent of children do not attend school and that more than 65 per cent of school-age children in the cotton-growing and cottonseed-producing states are dropouts.

UNICEF is implementing programmes aimed at reducing child labour and promoting protection, preventing exploitation of children in Koppal District. Many children who are involved in cotton seed production typically are from families in debt to agents of cottonseed-producing companies. These agents offer farmers loans of up to INR 40,000 (around US$ 803) an acre to produce cottonseed. Farmers turn to their own children and those of poor landless families to work in cottonseed production. Many deeply indebted families see no way out of their financial crisis but to hand over their children to middlemen as bonded labour. During the project period 13,925 child labour and children outside schools are enrolled into school directly/transit education centers and later the main stream education. Supported SSA in setting up 60 seasonal bridge centers for migrant labourers covering 1600 children. Educational support is provided to 10,202 children to sustain them in schools

In addition to this, large number of children are engaged in grazing of cattle, sheep and goats, paddy farm cleaning, harvesting, sowing, brick manufacturing units, poultry farm, painting , cleaning, rage picking, garage, hotel, chilly pollination, construction work, rice oil mills etc. The village survey in 2013 has indicated 4,706 children are engaged in child labour.

Large numbers of families migrate to various towns and estates for work and they take the children along with them. The children of migrant families either end up in child labour or be vulnerable to various problems that pose a threat to their safety. The village level survey has shown that there are 5,412 families and 13,688 persons migrant every year.

Looking at the large number of children out of school who are probable child labourers, there were 23 Child labour bridge schools functioned under NCLP/SCLP with 701 boys and 269 girls being trained and incorporated into mainstream education. But these bridge centers are closed in August 2014.

2.6. CHILD MARRIAGE:

The Prohibition of Child Marriage Act 2006 Sec.2 (b) defines child marriage as a marriage to which either of the contracting party is a child. Under this law a child or minor is girls below 18 and boys below 21 years of age. Child marriage is an age-old practice that has both social and religious sanction and cuts across all sections of society. Child marriage adversely affect the child individually and nation as a whole. According to Justice Shivraj V. Patil Report on Child marriage, Koppal District records higher than the average child marriages in Karnataka with 41.5% (DLHS-2007-08) child marriage being reported. According to 2007 DLHS survey in Koppal District 44 percent of girls and 18.4 percent of boys get marry before the marriageable age. According to 2012-13 DLHS survey 14.3% of girls and 9.8% of boys get married before the legal marriageable age and moved to 12th position in the state.

The cross analysis of different data collected from various departments reveal the high prevalence of child marriage in the District. Yet possitively 50% of child marriages incidents have reduced in the district. According to UNICEF records there are 847 cases prevented from child marriage.

Prevented Child Marriage Cases in Mass Marriages					
Year	Koppal	Kustagi	Yelburga	Gangavati	Total
2010-11	26	15	06	22	69
2011-12	34	57	22	47	160
2012-13	38	64	62	41	205
2013-14	38	65	08	40	151
2014-15	61	32	08	39	140
2015-16	23	29	19	51	122
Total	220	262	125	240	847

Child Marriage prohibition and prevention is one of the priority of work implemented in convergence with UNICEF, SJPU, CWC, and DWCD. The identified minor children rescued from the field and have been producing to CWC for the necessary action. From 2012 to till the date 12 FIRs are registered and legal proceedings are on under the Prohibition of child Marriage act 2006.

As another strategy to prevent child marriage adoloscent girls collectives are formed in the District. Under UNICEF child protection program with the support of Department of Women and Child Development moe than 900 such groups are formed with more than 34,000 members and oriented on range of child protection issues. Child line and Red Alert are the emergency service available in the district. Child marriage poses many other problems related to health and nutrition such as Maternal Mortality, High Infant Mortality, and Poor Infant Health.

2.6.1. MMR and IMR

Complications like the ones mentioned above have a direct bearing on the maternal mortality rate and the infant mortality rate. There is a likelihood of woman dying during child birth; many women suffer chronic

disabilities after child birth. The chances of girls aged 10-14 dying in pregnancy and childbirth are five times more than that of women's aged 20-24. The maternal mortality rate of Koppal is 54.80 and Infant mortality rate is 18.9. Efforts are made in preventing maternal mortality and infant mortality through a comprehensive programme by the District Administration through active participation of Department of Health, Department of Women and child development and UNICEF Child Protection Programme; wherein institutionalized deliveries are encouraged and nutritional substitutes are provided.

2.6.2. Vulnerable Sexual Health

Another consequence is that child marriage exposes adolescents to higher risk of unwanted pregnancies and sexually transmitted diseases. With absolute absence of premarital counseling, there are very low chances of her being aware of the protection for safe sex, and even if she is, it will be unlikely that she would be able to ever use any form of contraception. Child brides typically experience high rates of unprotected sex and are unable to negotiate safer sex with their older spouses. HIV status of the District makes this point clear.

2.6.3. Malnutrition among Children:

The girls, in spite of not being mature, are required to simultaneously cope with their own and their baby's physiological, emotional and economic needs. Therefore, it is evident that child marriage can have detrimental effects on the physical as well as mental health of the child involved. Early onset of sexual activity after marriage and the persistent pressure on a girl child to conceive can have irreparable and adverse consequences for the

health of both the mother as well as the child. In other words, it can mean the endangering of the health of the adolescent due to early child-bearing, repeated pregnancies, and the risk that the children born will be sick or may even die in infancy.

The following table illustrates that there are 47,218 children in the age group of 0-6 years covered under ICDS programme of them 1579 children severely malnourished and 45,639 children are moderately malnourished.

Status of malnutrition status of children in the District			
Sl. No	Taluk	Severely malnourished	Moderately malnourished
		0-6 years	0-6 years
1	Koppal	183	10,070
2	Gangavathi	396	11,584
3	Kanakagiri	434	6,905
4	Kustagi	283	9,763
5	Yelburga	283	7,317
	Total	**1,579**	**45,639**

Source: DWCD Data - June, 2016.

Efforts made to reduce malnutrition among children. A Special New born children care unit (SNCU) is started to function at District Hospital from February 2014. Around 1300 to 1400 cases get registered for outpatient treatment in every month. Home visit of severely malnourished children is undertaken for counseling the parents to take their children and refer the case to SNCU if there is need. Red Alert help line is set up to report infant deaths, malnutrition and maternal death along with other issues of children in distress. Few of the reasons on high level of malnutrition, infant mortality and maternal mortality could be traced as

- Acute shortage of the Pediatric doctors working for children in government hospital.
- Migration of families and poor care of children.
- Low weight of newly born children
- Severe anemic Pregnant cases

2.7. STREET AND CHILDREN ENGAGED IN BEGGARY:

Six villages/urban area are identified where children of certain communities are pushed into beggary. They are at Benki Nagar and Kalidas Nagaar in Koppal Town, Kudrimothi in Yelburga Taluk, Tavagera and Hanumasagar and Kustagi Town in Kustagi Taluk and Kanakagiri and Karatagi in Gangavathi Taluk. Through some awareness programme and enforcement some children are rescued and rehabilitated through CWC. Children identified as street children are rehabilitated through the open shelter. There is no available data on the exact number of children on the street or engaged in beggary. A survey need to be conducted to trace the children on street and engaged in beggary. This will serve as need assessment to set-up open shelter for the District to rehabilitate the children in distress in fringes of the town.

2.8. MISSING CHILDREN:

The following table shows the missing children information of the Koppal District from 2011 to 2016 June. Though the number seems to be small, this is a high risk factor with regard to the protection of children. Out of 143 children missing 120 Children are ultimately traced and reunited with the family. As compared to the number of cases presented before the CWC, the traced children directly go to the families without any measures to

follow-up of streamlining into Juvenile Justice System. The untraced children give an indication to trafficked cases.

Year	Missing Boys & Girls	Traced	Traced by Police & Parents	Returned to home	Untraced
2011	31	25	23	02	06
2012	37	34	29	05	03
2013	28	22	19	03	06
2014	16	16	10	06	00
2015	24	19	14	05	05
2016 (Upto July)	07	04	04	-	03
Total	**143**	**120**	**99**	**21**	**23**

2.9. CRIMES AGAINST CHILDREN:

Any activity that poses threat to the safety and healthy development of the child could be considered as crime against children. However, using children into child labour, child trafficking, child sexual abuse etc are considered as serious crimes against children. Koppal is also one of the high risk areas with regard to child trafficking.

As indicated by the survey there is 148 instances of making use of children for sexual activities. This may go much higher in the District as the District is in practice of Devdasi system.

POCSO act is effectively used to raise the awareness of general public and deal with the offenders. Till date 124 cases are registered under POCSO in the District.

Substance abuse among children: Koppal District has very high number of children who are victims of substance abuse both in the form of drugs, pan (beetle leaf or

tobacco chewing), alcohol etc. 6461 cases are reported on substance abuse in the survey conducted for situation analysis. Large numbers of boys as compared to girls are prey to substance abuse. 84.32 percent of boys are reported to be using substance in various forms. District child protection unit has referred few cases of substance abuse for rehabilitation Centers.

2.10. JUVENILE JUSTICE SYSTEM:

Juvenile Justice System is fairly functioning well in the District. The Child Welfare Committee, Juvenile Justice Board, Special Juvenile Police Unit, Child Line and District Child Protection Unit are set up and functional in the District.

2.10.1. Child Welfare Committee:

Child Welfare Committee to deal with children in need of care and protection is formulated in the District in the year 2005. All 5 members are appointed and function as bench of magistrate to dispose the cases of children in need of care and protection. On an average 15-20 cases are dealt in a week. The following table shows that there are many children brought before the CWC.

Details of children presented before the CWC

Year	Total	Child labour	Victims of child marriage	Child abuse	Run away	other
2012-13	423	52	40	10	10	311
2013-14	240	42	37	8	14	139
2014-15	447	38	79	29	45	258
2015-16	267	13	50	17	15	172
Total	**1,377**	**145**	**206**	**64**	**84**	**880**

Rehabilitation details

Year	Restoration to family	Institu-tional care	free for adoption	Sponso-rship/ Foster care	Transferred	other
2012-13	248	35	-	-	-	50
2013-14	146	20	09	09	16	45
2014-15	345	28	09	18	08	53
2015-16	142	40	07	18	20	20
Total	**881**	**123**	**25**	**45**	**44**	**168**

During 2012 April to 2016 there are 1377 cases presented before the CWC. The rehabilitation pattern shows that major numbers of children are reunited with family either through transfer or direct integration.

During the 2012-13 the Deputy Director initiated the Taluk level CWC sitting in taluk places. Two taluk level sittings of committee are taken up as special sitting for the convenient sake. However, more clarity needs to be brought with regard to the special sittings of the committee.

The orders passed by the committee are progressive as they have ordered either release to family or Institutionalization. The appropriate orders on child Marriage cases helped the whole child protection mechanism to prevent many child marriage cases in the District. Only during the past four years orders are given for Adoption or transfer to other District/State. Police do provide escort to children for transfer cases both within and outside the state.

There aren't permanent buildings for correctional institutions. The home for boys and home for girls functioning in rented building. This is one of the priority issues to strengthen child protection in the District.

2.10.2. Juvenile Justice Board.

Juvenile Justice Board is set up in the District in the year 2011 to deal with children in conflict with law. Prior to this the cases are heard at Bellary JJB. The record shows the increase of number during the year 2012-14. The analysis of the cases reveals that all the children in conflict with law presented before the JJB are in the age group of 14-18.

Year	No of sittings per year	Cases
2011-12	7	20
2012-13	36	31
2013-14	36	10
2014-15	48	17
2015-16	48	17
2016-17	24	14
Total	**199**	**109**

During the past five years Juvenile Justice Board has dealt with 109 cases and there are 21 pending cases before the board as on June 2016.

2.10.3. Special Juvenile Police Unit:

The Juvenile Justice Act 2015 provides for setting up Special Juvenile Police Units in every District and city to coordinate and upgrade the police interface with children. A well setup SJPU is functional in the District. In every

police station one of the Police officers, designated as juvenile/child welfare officers in the District or city, are members of the SJPU. The database of Missing children, POCSO cases, children in conflict with law case are well maintained in the SJPU. The two police trainers deputed by the state government are moving neighboring Districts to set up SJPUs and facilitate training the police personnel on child protection and gender sensitization issues. The two social workers appointed to support the senior child welfare officers, one social worker is HC and one social worker is constable cadre. The support of DCPU social workers is not yet extended to the SJPU; which need to be enhanced for effective functioning and for available cases follow up.

All Police station staff was trained on child protection issues and gender sensitization and people friendly police. This has enabled them in handling the case very sensitively and referring the Protection required cases to Child welfare committee. Every police station in the District maintains a separate register on issues related to children. UNICEF’s focus in the District on training the police officers and working in convergence has helped in this regard. Outreach programmes are conducted in villages along with a police officer, CWC member, AW supervisor, RP of education department etc to spread awareness on the various institutions and its functions. The SJPU is maintaining records of missing children cases. The exposure visit of the children to the police stations (Open House) enabling harmonized relationship between children and police, from past 5 years more than one lakh children are part of this programme; this activity needs to be continued to create protective environment for children.

2.10.4. District Child Protection Unit:

District Child Protection Unit is established in Koppal District in the year 2012. The staff is recruited and given training on the subject and is functional in the District. DCPO is not appointed by DWCD on regular basis.

UNICEF-GoK DCP programme supported to setup DCPU and gearing its activities in the district. It is functioning well in implementation of child protection measures. However Convergence needs to be achieved through timely network and coordination to protect the best interest of children and all their rights.

Child Line, Red Alert and MCB are working in the District in collaboration with DCPU. The networking and convergence need to be established with the line departments and need fine tuning of enforcement activities.

DISTRICT CHILD PROTECTION PLAN

3.1. FINDINGS

The analysis of available data and the FGDs revealed that the children in general and girl child in particular suffer from various problems and discrimination in the District. The physical and mental challenges, Devadasi system, lack of parental care for children, child labour, Child Marriage, Severely Acute Malnourished children, sexual abuse and exploitation, Children infected and affected by HIV and missing children reflects that protection of child rights and providing a safe environment for their overall growth need to given focus in the District. The findings lead to conclusion that child related legislation and services expeditly need to reach the needy and improve their state of wellbeing. However, the intervention and efforts made by District Administration UNICEF, DCPU, Child Line, NGOs, SJPU, JJB, CWC and various Departments in the past three years has made the District a better place for children.

3.1.1. Child sex Ratio: Koppal District has improved in child sex ratio from 938 in 2001 to 953 in 2011. Though Koppal is one of the backward Districts, sex ratio of the District is static during the decade and improved child sex ratio. Bhagyalaxmi scheme has contributed to a great extent in this regard. However, efforts need to be done to monitor the birth rate of female children.

3.1.2. Lack of parental care: There are 1090 orphan children in the District. An alarming number of 160 children below the age of six and 602 children in the age group of 6-14 are found orphan. Presence of high number of children (7376) living with single parents. It is observed that the Institutions providing alternative care to these children are not yet registered or monitored under Juvenile Justice System. More children with lack of parental care need to be rehabilitated in KGBVs, RMSA residential schools and hostels run by social and minority welfare departments. To prevent their school dropout and reduce the vulnerability.

3.1.3. Special Need Children: It is found that sizable number of children are special need children. There are total of 12,258 children with varied disabilities in the District; out of which 2723 are physically challenged, 1313 are mentally challenged, 1593 are blind children, and 3043 children are deaf and dumb and 115 children are with multiple disabilities. It warrants the need of bridging the gap of services available for these children and create various rehabilitative opportunities for these children. There are more than 600 HIV infected and more than 5000 affected children in the District out of which 955 are enrolled for *vishesh palan yojan* benefit. Hence it reveals that more number of children need to be link to VPY.There are more than 5000 children of Devdasis' who need special focus to protect them from abuse and bring them under the child protection safety net.

3.1.4. Trafficking: "Trafficking in Persons as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other

forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation". Anti Trafficking vigilance committees are formed in all Gram Panchayaths of Koppal District. Members are provided training. Proper monitoring of these committees to be achieved. Migration of families to the metropolitan cities and their returning to the native villages need to be monitored by the committee.

3.1.5. Abandoned children: Neglected children are also found in Koppal. Dumping the new born babies at riverside, bushes, Public Toilets is found in the District. Twelve kids are found abandoned; who are rescued and rehabilitated in adoption centres during the past two years. A Cradle Baby Centre is installed at Hulugi Huligamma temple near Munirabad in the year 2011. In the district 33 orphan children are rescued and referred to CWC. out of 25 children are declared free for adoption. SAA need to be work to provide comphrensive care for orphan and abonded children.

3.1.6. Child Labour: Koppal District has recorded 4706 child labourers with 3022 male and 1684 female children in the year 2012-2013 and 7290 out of school children in 2013-14 and 1004 OOSC in 2014-15. Most of the child laboures are engaged in agricultural field in cotton crossing, chilly crossing, jower and paddy field, poultry farm, and grazing cattle, sheep and goats. Around 30 percent of children engaged in hazardous sectors like garage, building/road construction, stone cutting, and others. There are 2 child labour bridge schools functional

in the District managed by NGOs catering bridge course to these children and mainstream them. But they have been closed in August 2014. Hence it is necessary to open bridge centres soon.

3.1.7. Child Marriage: According to DLHS-RCH surveys 2012-13 reveals that there was 14.3% of Girls marriage before 18 years. In the District there are more than 460 mass marriage organizers who perform mass marriage every year. Marriages with blood relatives rampant in the District with large age gap between the partners. According to UNICEF records 847 child marriages are prevented. 12 FIRs are booked under the Prohibition of child Marriage act 2006 since 2012. Formation of Balika Sanga is used as one of the strategy to prevent child marriage in the District. 900 such groups are formed with more than 34,000 members. These adolescent girls collective need to be sustained. The focus need to be given on girl child education and awareness building process.

3.1.8. Severely Malnourished Children: Malnutrition refers to under nutrition resulting from inadequate consumption, poor absorption, or excessive loss of nutrients. If a child is not provided adequate nutrients for normal growth he/she will be pushed into malnutrition. The malnourished children are less able to perform the task they need to perform. There are 85,589 children in the age group of 0-6 years covered under ICDS programme out of which 1,579 children are severely malnourished and 45,639 children are moderately malnourished. The providing of supplementary food in Anganawadies need to be monitored. Awareness on Parental care and affects of Malnourishment to be

provided. Improving health care facility, sanitation need to achieved.

3.1.9. Missing Children: During the year 2011 to 2016 June 143 children were registered as missing in the District. Out of them 99 Children are ultimately traced and reunited with the family. some children have returned home on their own accord, but 23 children are yet to be traced. The traced children need to be presented before the CWC for effective rehabilitation.

3.1.10. Child Abuse: The District crime record shows till 2016 June 124 cases are registered under POCSO in the District. Hence the sensitization of adolescent children on protective measures is there for very important. School and college level, community level sensitization program need to be organised.

3.1.11. Juvenile Justice System: Juvenile Justice System is fairly functioning well in the District. The Child Welfare Committee, Juvenile Justice Board, Special Juvenile Police Unit, Child Line and District Child Protection Unit are set up and functional in the District.

3.1.11.1. Child Welfare Committee: To deal with children in need of care and protection CWC with full membership is formulated in the District and functional in the district. On an average 15-20 cases are dealt in a week. During 2012 April – 2016 June there are 1,377 cases presented before the CWC. The rehabilitation pattern shows that major numbers of children are reunited with family either through transfer or direct integration. There are 2 children homes for children below 16 years in the District, as there are number of cases of adolescent's boys and girls are referred by child protection

functionaries before CWC, it is necessary to establish the senior homes for both boys and girls in the District.

3.1.11.2. Juvenile Justice Board: Juvenile Justice Board is set up in the District in the year 2011 to deal with children in conflict with law. The records reveal increase of cases before JJB during the year 2012-14. Most of the children in conflict with law are in the age group of 14-18. During the past five years Juvenile Justice Board has dealt with 199 cases and there are 21 pending cases before the board as on June 2016. There is no observation home in Koppal for the rehabilitation of JJB case. JJB have been referring the cases to Bellary for the rehabilitation. Hence observation home need to be set up in the district.

3.1.11.3. Special Juvenile Police Unit: A well setup SJPU is functional in the District. In every police station one of the Police officers, designated as juvenile/child welfare officers in the District or city, are members of the SJPU. The database of Missing children, POCSO cases, children in conflict with law case are well maintained in the SJPU. The two police trainers deputed by the state government are moving neighboring Districts to set up SJPUs and facilitate training the police personnel on child protection and gender sensitization issues. Outreach programmes are conducted in villages and exposure visit of the children to the police stations (Open House) is enabling harmonized relationship between children and police. Regular social workers need to be appointed for the follow-up of Cases brought before SJPU.

3.1.11.4. Child Line, Red Alert & Missing Child Bureau: Child Line, Red Alert and MCB are working in the District in collaboration with DCPU. The networking

and convergence need to be established with the line departments. The enforcement activities need fine tuning.

3.1.11.5. District Child Protection Unit: District Child Protection Unit is established in Koppal District in the year 2012. The staff has been recruited and functional in the District without a regular appointed DCPO. Timely review of the implementation of District ICPS and JJ Unit need to be ensured.

B. DISTRICT CHILD PROTECTION PLAN

Issue: 1. Special need children: Children with disability, HIV infected and affected children.

Action Plan: Strategy - Rehabilitation and Linkage.

1. Map all children with special needs, prioritize children for service delivery target.
2. Assess the accessibility of social security schemes/ benefits from Government and Non-government agencies.
3. Link 50% of the children to social security schemes and non-institutional care such as Sponsorship and Vishesh Palan Yojan and Foster care programme to these children.
4. Organize community based Group home Care and institutional based rehabilitation for mentally challenged children, children of Devadasies and children of prisoners.
5. Identify the need of counseling services and vocational training and provide referral services.
6. Conduct follow-up for Children infected and affected by HIV and keep track of their progress
7. Linkage to infected children for ART and counseling on positive living.

Strategy - Preventive Measures to reduce the incidence of Disability

1. Conduct a vulnerable mapping activity for physical and mental disability.
2. Build link with CSR groups and provide schools with Fluoride purifier units for drinking water.
3. Conduct sensitization and awareness programmes for people to reduce marriage within blood relatives to reduce the incidence of mental retardation among children.

Responsibility: DCPU in collaboration with Department of Women and Child Development, Education, Health Dept, NGOs and Privet Companies.

Time Frame: Long term (3 to 5 years)

Issue- 2: Lack of Parental Care

Action Plan – Strategy: De-institutionalization

1. Map all children in institutions and find the possibility of de-institutionalization
2. Provide Sponsorship support to children who are de-institutionalized

Strategy: Rehabilitation

1. Identify children who lack parental care or need support as family strengthening measure and enroll them to sponsorship programme.
2. Identify children who are orphan and link them to foster care programme with first priority to Kinship Care.
3. Identify the Child Care Institution as Fit Institution to rehabilitate children.
4. Organise training on Minimum standard of care to the staff that provides institutional care for children.

Strategy: Regulative

1. Register all child Care Institutions under Juvenile Justice Act Sec.41(1) within 6 months
2. Conduct Annual Inspection of the Institutions to ensure minimum standard and present all orphan children before CWC.
3. Monitor care and protection provided to orphan children especially for children below 14 years even in the family. Receive undertaking by the relative on care to the orphan and follow up the same. Enrollment of these children in hostels and residential schools.

Responsibility: DCPU in collaboration with DWCD, Social Wlfare and BCM Department.

Time Frame: Long term (3 to 5 years)

Issue – 3: Child labour/OOSC

Action Plan; Strategy: Prevention of the incidence of Child Labour

1. Map child labour/OOSC prevalent Grama Panchayats and take up awareness campaign to the public and children.
2. Panchayathwise, village specific plan to be developed and prioritized.
3. Identify school drop-outs and long absentees and follow them up to retain in schools
4. Map migrating families and prevent migration of children through seasonal rehabilitation programme.
5. Formulate and train Village Child Protection committee and organize advocacy on child labour prevention. Regular meeting of GP child protection committee to be organized once in by month.

Strategy: Rehabilitation Strategy

1. Identify all child labours in the district and map the services of NCLP/SCLP units
2. Conduct a child labour mapping of rag pickers, poultry workers, cotton seed workers community and organize rehabilitative measures.
3. Make advocacy for the functioning and continuation of Child labour Project Units in all Taluks.
4. Conduct rescue of Child labourers and prepare a individual care plan for them and rehabilitate them accordingly.

Responsibility: District Child Labour Rehabilitation Society in collaboration with Labour and education department, RDPR, Sec.17 inspectors, NGOs and other line departments.

Time Frame: Long Term (3 to 5 years)

Issue - 4: Child Marriage

Action Plan: Strategy – Prevention

1. Identify child marriage practice community and conduct village level awareness programme for adults.
2. Take up campaign to prevent child marriage through IEC – sensitization, posters, pamphlets, stickers and letter writing
3. Map and train all 460 mass marriage organizers about the regulatory aspects and protocols to be followed in mass marriages.
4. Form child protection team in the schools to report child marriage, child abuse, and child labour cases.
5. Setting up child red-boxes in schools and other places.
6. Sustain the Adolescent Girls Collectives (Balika Sangha)

Strategy – Rehabilitation

1. Rescue the children when there is child marriage reported and present them to CWC for further rehabilitation plan
2. Inspect records of couples in mass marriages.
3. Register FIR against perpetrators so that people realize the prohibition aspect of child marriage
4. Conduct training to Village level CMPOs on rescue and rehabilitation.

Responsibility: DCPU, DWCD, CMPO's and NGOs

Time Frame: Long term (3 to 5 years)

Issue - 5: Malnutrition

***Action Plan: Strategy: Preventive measures to reduce Malnutrition and effective implementation of ICDS program*.**

1. Focus on educating men, women and adolescents on nutrition and parenting skills.
2. Pediatric doctors to be appointed for first referral units and convergence with Anganawadies to be made.
3. Mass awareness to reduce unhealthy food practices.
4. Improve the sanitation and toilet facilities in the Villages.

Responsibility: DCPU, DWCD in collaboration with Department of Health, RDPR

Time Frame: Long term (3 to 5 years)

Issue - 6: Missing and Street Children

Action Plan: Strategy Prevention and Immediate FIR filing at Police stations.

1. Awareness to be created through village level, Gram Panchayath Level CPCs, ATCs, Balika Sangas, Open House and in Outreach programs on the consequences of Missing children.
2. The awareness to be created on the existence mechanisms of the district.
3. Traced children are produced before CWC for follow up and Rehabilitation
4. Identify children involved in beggary and street children.
5. Evolve special programme for street children involved with begging.

Responsibility: DCPU, SJPU, Police Department, MCB and Child Line.

Time Frame: Long term (3 to 5 years)

Issue - 7: Child Abuse

Action Plan: Strategy - Prevention and Rehabilitative measures

1. Awareness on dynamics of child abuse and provisions of POCSO
2. Training the Police, Doctors and counselors on identifying child abuse and management
3. Training school teachers on educating children about personal safety
4. Referral services and victim compensation for affected children.
5. Awerness Programmes in schools and collages.
6. Organizing 'open house' programme.

Responsibility: DCPU along with Police Department, Doctors, Education Department, District Legal Services Authority.

Time Frame: Long term (3 to 5 years)

Issue - 8: Devadasi women and children

Action Plan: Strategy - Rehabilitation and Linkage.

1. Retention of girls in schools and colleges Devadasi colony.
2. Linkages to skill training program to dropout children.
3. Need tackle government schemes –housing, old age pension etc.
4. Mainstreaming children in Hostels –SW, BCM .
5. Awareness creation and enforcement of POCSO act 2012

Responsibility: DCPU along with Devadasi Rehabilitation Project, Police, DWCD and NGOs.

Time Frame: Long term (3 to 5 years)

Issue - 9: Strengthening Juvenile Justice system

Action Plan: Strategy – Operational

1. Maintain all cases and records regarding crimes against children and children in conflict with law
2. Organizing open house program in all police stations.
3. Strengthening beat system and involvement of police in CPC, CRC, and Balika sanga meetings.
4. Conduct refresh training and review programme to all child welfare officers on legislations regarding children and child friendly police.
5. Conduct outreach programme in schools and villages to encourage children report abuse and crime.

Strategy: Strengthening of SJPU

1. Maintain record of non-serious cases of children in conflict with law and presented to Juvenile Justice Board for effective follow-up
2. Developing Trainers on child protection issues
3. Developing reference materials: The reference materials to be developed and documented. The case studies, the orders issued by JJB on Children in conflict with law, POCSO to be documented as ready to reference material.

Strategy: Strengthening of CWC

1. The cases produced to CWC need to be followed once in quarter. The order to be issued to follow up the CINOCAP cases.
2. Simple Database to track children.
3. Sponsorship programs for released children to be strengthened.

Strategy: Single window system

1. Present all cases of children in need of care and protection specially the issues mentioned above before CWC and increase the cases before CWC by 50%.
2. All children in Institutional care, Sponsorship, foster care, and Vishesh Palan Yojan are to be produced to CWC at least in records and order need be signed by CWC.
3. Follow-up children committing Non-Serious cases and refer them for sponsorship or other rehabilitative measures.
4. Individual care plan of CWC cases maintained at both the homes for follow-up.

Responsibility: DCPU in Collaboration with DWCD, Police, Education and other line departments.

Time Frame: Long term (3 to 5 years)

Annexure 1:- District Level Household and Facility survey -4

Koppal - Key Indicators

Indicators	DLHS-4 (2012-13) TOTAL	DLHS-4 (2012-13) RURAL	DLHS-3 (2007-08) TOTAL	DLHS-3 (2007-08) RURAL
Sample Size				
Households surveyed	1302	662	1270	1064
Ever married women age15-49 years	1424	782	1342	1136
Currently married women age 15-49 years interviewed	1238	689	1197	1019
Population and household profile				
Percentage of population literate age 7+ years	72.2	66.8	63.6	60.8
Percentage of population below age 15 years	31.3	34.4	35.7	36.6
Mean household size	5.8	6.3	6.3	6.4
Sex ratio at birth (Male per 100 Female)	99.3	98.8	101.1	100.5
Percentage of households				
Having electricity	95.5	96.8	88.4	87.4
Improved source of drinking water[1]	98.9	98.0	92.2	90.8
Having access to improved toilet facility	40.8	16.4	13.6	5.9
Use clean fuel for cooking[2]	27.2	9.4	7.0	2.5
Marriage				
Mean age at marriage for girls (marriages that occurred during the reference period)	19.8	18.9	18.7	18.6
Mean age at marriage for boys (marriages that occurred during the reference period)	25.7	24.7	25.4	25.3
Percentage of currently married women married below age 18 years (marriages that occurred during the reference period)	14.3	21.3	41.5	44.9
Percentage of currently married men married below age 21 years (marriages that occurred during the reference period)	9.8	10.7	18.7	19.9
Characteristics of women (%)				
Currently married women who are illiterate	44.4	53.1	60.1	66.2
Currently married women with 10 or more years of schooling	23.4	14.9	10.4	6.4
Fertility (%)				
Births to women aged 15-19 years out of total births[3]	6.4	5.5	25.4	27.9
Women aged 20-24 years reporting birth order of 2 & above	60.7	60.2	79.6	80.4
Women aged 15-49 years who reported birth order of 3 & above	32.9	35.5	41.2	40.0
Women with two children wanting no more children	38.5	26.9	26.6	23.3
Mean no. of children ever born to women age 40-49 years	3.9	4.5	5.8	5.9
Current use of Family Planning Methods (%)				
Any method	55.4	56.2	52.6	52.9
Any modern method	55.3	56.2	52.5	53.1
Female sterilization	54.2	54.6	51.7	53.0
Male sterilization	0.1	0.1	0.2	0.2
Pill	0.2	0.3	0.1	0.0
IUD	0.1	0.1	0.2	0.0
Condom	0.5	0.6	0.3	0.0
Unmet Need for Family Planning (%)				
Total unmet need[4]	14.5	15.2	19.6	19.6
Unmet Need for spacing	10.2	10.7	13.6	14.6
Unmet Need for limiting	4.3	4.5	6.0	5.0

[1] Includes pipe water into dwelling, piped to yard/plot, public tap/standpipe/hand pump/tube well/bore well/well covered/protected spring, tanker/truck, cart with small tank/drum and packaged/bottled water. [2] LPG/PNG/Electricity/Biogas. [3] DLHS-4 reference period is from 1-1-2008 to survey date; DLHS-3 reference period is from 1-1-2004 to survey date.
Unmet need for spacing includes fecund women who are neither pregnant nor amenorrhea, who are not using any method of family planning, and say they want to wait two or more years for their next birth. It also includes fecund women who are not using any method of family planning, and say they are unsure whether they want another child or who want another child but are unsure when to have the birth.
Unmet need for limiting includes fecund women who are neither pregnant nor amenorrhea, who are not using any method of family planning, and who want no more children (These definitions are similar to NFHS-3).
[4] Total unmet need refers to unmet need for limiting and spacing.

Koppal - Key Indicators

Indicators	DLHS-4 (2012-13) TOTAL	DLHS-4 (2012-13) RURAL	DLHS-3 (2007-08) TOTAL	DLHS-3 (2007-08) RURAL
Quality of Family Planning Services (%)				
Non-users ever advised by health personnel to adopt any family planning method	15.1	19.8	8.2	8.2
Current users told about side effects of method	4.2	5.7	9.9	9.0
Users who received follow-up services for sterilization and IUD within 48 hours	95.2	94.4	90.8	91.0
Post-partum adoption of Family Planning for sterilization	91.0	90.2	94.4	94.8
Antenatal Care[4] (Women who had last live/still birth during reference period) (%)				
Pregnant women who received any antenatal check-up	93.6	90.9	80.8	80.9
Pregnant women who had antenatal check-up in first trimester	82.0	79.0	52.7	50.9
Pregnant women who had three or more ANC visits	88.7	84.5	65.7	64.4
64.4Pregnant women who had at least one tetanus toxoid injection	96.1	96.3	74.0	73.2
Pregnant women whose Blood Pressure (BP) taken	90.3	90.1	77.1	76.6
Pregnant women who had blood tested (Hb)	75.7	73.6	76.3	75.9
Pregnant women whose abdomen examined	60.5	59.5	72.4	72.5
Pregnant women who consumed 100 or more IFA Tablets/Syrup equivalent	21.4	18.2	37.1	36.2
Pregnant women who had full antenatal care[5]	20.3	16.7	16.7	15.8
Delivery Care (women who had live/still birth during reference period) (%)				
Institutional delivery	71.3	68.5	24.7	20.2
Delivery at government health institutions	43.6	49.0	11.8	11.2
Delivery at private health institutions	27.7	19.5	13.1	9.2
Delivery by Caesarean section at government health institutions	3.5	2.7	1.5	1.3
Delivery by Caesarean section at private health institutions	11.0	7.0	4.3	2.8
Delivery at home	28.2	30.7	74.9	79.6
Delivery at home conducted by skilled health personnel[6] (Out of total Deliveries)	12.6	10.1	12.6	12.5
Mothers who received post-natal care within 48 hours of Institutional delivery	73.9	72.8	44.2	41.2
Mothers who received post-natal care within two weeks of Institutional delivery	80.9	80.2	49.2	45.8
Delivery attended by skilled health personnel	83.9	78.6	37.3	32.7
Discharge of mothers from institution after minimum stay of 48 hours	55.9	51.7	NA	NA
Out of pocket expenditure per institutional delivery in Public health facility(Rs. in 000's)	2.71	2.16	NA	NA
Percentage of women who received JSY benefits				
Home delivery	7.4	6.3	9.6	10.7
Institutional delivery	27.1	30.7	10.6	15.2
Percentage of Women who had				
Any Pregnancy complication[7]	29.8	28.4	47.1	46.6
Any Delivery complication[7]	16.3	15.2	45.0	44.0
Any Post-delivery complication[7]	15.9	15.6	34.3	34.4
Problem of vaginal discharge during last three months	11.2	11.4	17.5	17.9
Menstrual related problems during last three months	11.2	11.6	19.7	19.5
Percentage of pregnancy resulted in				
Live Birth	93.8	95.5	93.9	93.6
Still Birth	2.2	2.3	2.5	2.8
Induced abortion	0.3	0.5	0.6	0.6
Spontaneous abortion	3.7	1.8	2.9	3.1
Child Immunization (%) (Children age 12-23 months)				
Number of children	124	73	128	103
Received full vaccination[8]	74.8	75.8	66.4	63.8
Received BCG vaccine	98.2	98.5	96.1	95.2
Received 3 doses of DPT vaccine	83.8	86.4	79.4	78.1
Received 3 doses of polio vaccine	88.3	86.4	84.0	83.8
Received measles vaccine	92.0	92.4	78.5	77.1
Children (age 9-35 months) received at least one dose of vitamin A supplement in last 6 Months	82.7	81.2	57.1	57.3

[5]Full ANC: At least three visits for antenatal check-up, one TT injection received and 100 IFA tablets or adequate amount of syrup consumed. [6]Doctor/ANM/Nurse/midwife/LHV/Other health personnel. [7] Women who had their last live/still birth since 1-1-2008. [8] BCG, 3-injection of DPT, 3 doses of Polio (excluding polio zero) and Measles

Koppal - Key Indicators

Indicators	DLHS-4 (2012-13)		DLHS-3 (2007-08)	
	TOTAL	RURAL	TOTAL	RURAL
Child feeding practices (based on last-born child in the reference period) (%)				
Children age 0-5 months exclusively breastfed[9]	73.5	82.9	NA	NA
Children age 6-9 months receiving solid/semi-solid food and breast milk	69.2	62.5	57.1	54.2
Children age 12-23 months receiving breast feeding along with complementary feeding	83.6	80.0	NA	NA
Children age 6-35 months exclusively breastfed for at least 6 months	32.2	34.4	48.5	51.9
Children under 3 years breastfed within one hour of birth	71.7	68.2	65.5	66.1
Birth Weight (%) (age below 36 months)				
Percentage of Children weighed at birth	79.5	80.0	NA	NA
Percentage of Children with low birth weight (out of those who weighted) (below 2.5 kg)	6.3	7.3	NA	NA
Awareness about Diarrhoea (%)				
Women know about what to do when a child gets diarrhoea	48.0	48.6	90.7	91.4
Awareness about ARI (%)				
Women aware about danger signs of ARI[10]	36.0	30.0	34.2	37.6
Treatment of childhood diseases (based on last two surviving children born during the reference period) (%)				
Prevalence of diarrhoea in last 2 weeks for under 5 years old children	6.6	6.1	14.3	15.0
Children with diarrhoea in the last 2 weeks and received ORS[11]	55.3	66.7	34.9	34.7
Children with diarrhoea in the last 2 weeks and sought advice/treatment	71.8	63.6	73.9	71.4
Prevalence of ARI in last 2 weeks for under 5 years old children	9.2	8.9	7.2	7.4
Children with acute respiratory infection or fever in last 2 weeks and sought advice/treatment	88.9	87.5	91.4	90.3
Children with diarrhoea in the last 2 weeks given Zinc along with ORS	39.5	38.1	NA	NA
Awareness of RTI/STI and HIV/AIDS (%)				
Women who have heard of RTI/STI	8.5	7.0	36.2	32.8
Women who have heard of HIV/AIDS	37.7	31.9	62.0	59.6
Women who have any symptoms of RTI/STI	7.9	8.4	18.8	18.4
Women who know the place to go for testing of HIV/AIDS[12]	56.9	64.7	49.0	43.9
Women underwent test for detecting HIV/AIDS[12]	37.8	44.6	16.1	12.4
Utilization of Government Health Services (%)				
Antenatal care	68.5	78.4	52.2	54.6
Treatment for pregnancy complications	43.4	51.8	43.3	45.6
Treatment for post-delivery complications	45.8	44.1	32.5	36.6
Treatment for children with diarrhoea[13]	37.0	53.8	NA	NA
Treatment for children with ARI[13]	16.7	21.4	NA	NA
Birth Registration (%)				
Children below age 5 years having birth registration done	88.8	84.9	NA	NA
Children below age 5 years who received birth certificate (out of those registered)	86.0	85.7	NA	NA
Personal Habits (age 15 years and above) (%)				
Men who use any kind of smokeless tobacco	46.0	49.5	NA	NA
Women who use any kind of smokeless tobacco	30.7	33.5	NA	NA
Men who smoke	22.0	21.8	NA	NA
Women who smoke	0.2	0.1	NA	NA
Men who consume alcohol	24.9	27.1	NA	NA
Women who consume alcohol	0.7	0.8	NA	NA

[9] Children Who were given nothing but breast milk till the survey date [10] Acute Respiratory Infections [11] Oral Rehydration Solutions/Salts [12] Based on the women who have heard of HIV/AIDS. [13] Last two weeks

Koppal - Key Indicators

Indicators	DLHS-4 (2012-13) TOTAL	DLHS-4 (2012-13) RURAL	DLHS-3 (2007-08) TOTAL	DLHS-3 (2007-08) RURAL
Reported Prevalence of Morbidity				
Any Injury	3.0	2.9	NA	NA
Acute Illness	2.2	2.1	NA	NA
Chronic Illness	1.8	2.1	NA	NA
Reported Prevalence of Chronic Illness during last one year (%)				
Disease of respiratory system	9.4	9.1	NA	NA
Disease of cardiovascular system	17.5	15.9	NA	NA
Persons suffering from tuberculosis	2.2	1.1	NA	NA
Anaemia Status by Haemoglobin Level[14] (%)				
Children (6-59 months) having anaemia	74.5	72.8	NA	NA
Children (6-59 months) having severe anaemia	11.0	10.9	NA	NA
Children (6-9 Years) having anaemia - Male	55.0	53.2	NA	NA
Children (6-9 Years) having severe anaemia - Male	4.2	4.7	NA	NA
Children (6-9 Years) having anaemia - Female	51.9	45.5	NA	NA
Children (6-9 Years) having severe anaemia - Female	3.4	3.5	NA	NA
Children (6-14 years) having anaemia - Male	47.9	47.0	NA	NA
Children (6-14 years) having severe anaemia - Male	2.8	3.0	NA	NA
Children (6-14 years) having anaemia - Female	46.0	40.5	NA	NA
Children (6-14 years) having severe anaemia - Female	2.4	2.5	NA	NA
Children (10-19 Years[15]) having anaemia - Male	35.2	34.8	NA	NA
Children (10-19 Years[15]) having severe anaemia - Male	1.4	1.7	NA	NA
Children (10-19 Years[15]) having anaemia - Female	46.8	42.9	NA	NA
Children (10-19 Years[15]) having severe anaemia - Female	2.4	2.4	NA	NA
Adolescents (15-19 years) having anaemia	40.9	40.9	NA	NA
Adolescents (15-19 years) having severe anaemia	3.5	3.8	NA	NA
Pregnant women (15-49 aged) having anaemia	57.5	53.2	NA	NA
Pregnant women (15-49 aged) having severe anaemia	4.4	4.4	NA	NA
Women (15-49 aged) having anaemia	50.8	48.7	NA	NA
Women (15-49 aged) having severe anaemia	4.3	3.6	NA	NA
Persons (20 years and above) having anaemia	38.3	36.1	NA	NA
Persons (20 years and above) having Severe anaemia	2.7	2.5	NA	NA
Blood Sugar Level (age 18 years and above) (%)				
Blood Sugar Level >140 mg/dl (high)	6.8	5.2	NA	NA
Blood Sugar Level >160 mg/dl (very high)	3.5	2.6	NA	NA
Hypertension (age 18 years and above) (%)				
Above Normal Range (Systolic >140 mm of Hg & Diastolic >90 mm of Hg)	23.0	20.4	NA	NA
Moderately High (Systolic >160 mm of Hg & Diastolic >100 mm of Hg)	8.7	7.4	NA	NA
Very High (Systolic >180 mm of Hg & Diastolic >110 mm of Hg)	3.4	2.4	NA	NA
Iodized salt in Households (%)				
Households using iodized salt (15+ppm)	34.0	17.2	NA	NA

[14] Any anaemia below 11g/dl, severe anaemia below 7g/dl. [15] Excluding age group 19 years

Chronic Illness : Any person with symptoms persisting for longer than one month is defined as suffering from chronic illness

Indicators	Number/Percentage DLHS-4	DLHS-3
Villages covered		
Number of villages	25	42
Health Facilities covered		
Number of Sub-Health Centres	23	33
Number of Primary Health Centres (PHC)	15	21
Number of Community Health Centres (CHC) including Block PHC	9	9
Number of Sub-Divisional Hospitals (SDH)	3	NA
Number of District Hospitals (DH)	1	1
Health programmes at village level		
Percentage of villages having ASHA	84.0	19.1
Percentage of Villages having Village Health Nutrition and Sanitation Committee (VHNSC)	76.0	33.3
Accessibility of health facility (%)		
Villages with Sub-Health Centre within 3 km	76.0	45.2
Villages with PHC within 10 km	80.0	85.7
Availability of Health Infrastructure, Staff and Services at (%)		
Sub-Health Centre		
Sub-Health Centre located in government building	65.2	54.6
Sub-Health Centre with ANM	100.0	93.9
Sub-Health Centre with male health worker	43.5	45.5
Sub-Health Centre with ANM residing in Sub-Health Centre quarter where facility is available	84.6	94.1
Sub-Health Centre with additional ANM	0.0	3.0
Primary Health Centre (PHC)		
PHCs functioning on 24 X 7 hours basis	100.0	81.0
PHCs having Lady Medical Officer	14.3	19.1
PHCs with at least 4 beds	100.0	81.0
PHCs with AYUSH doctor	64.3	61.9
PHCs having residential quarter for Medical Officer	46.7	52.4
PHCs having new born care services on 24 X 7 hours basis	100.0	NA
PHCs having referral services for pregnancies/delivery on 24 X 7 hours basis	73.3	NA
PHCs conducted at least 10 deliveries during last one month on 24 X 7 hours basis	80.0	38.1
Community Health Centre (CHC)		
CHCs having 24 X 7 hours normal delivery services	9	9
CHCs having Obstetrician/Gynaecologist	NA	0
CHCs having Anesthetist	2	NA
CHCs having functional Operation Theatre	7	0
CHCs designated as FRUs	5	3
CHCs designated as FRUs offering caesarean section	1	0
CHCs having new born care services on 24 X 7 hours basis	9	1
Sub Divisional Hospital (SDH)		
SDHs having Paediatrician	0	NA
SDHs having regular radiographer	0	NA
SDHs having 2D Echo facility	0	NA
SDHs having Ultrasound facility	1	NA
SDHs having three phase connection	3	NA
SDHs having critical care area	0	NA
SDHs having suggestion and complaint box	0	NA

Annexure 2: National Family Health Survey – 4 2015 -16

Indicators	NFHS-4 (2015-16)	
Population and Household Profile	**Rural**	**Total**
1. Population (female) age 6 years and above who ever attended school (%)	60.8	63.8
2. Population below age 15 years (%)	29.6	29.5
3. Sex ratio of the total population (females per 1,000 males)	961	980
4. Sex ratio at birth for children born in the last five years (females per 1,000 males)	932	997
5. Children under age 5 years whose birth was registered (%)	90.9	92.3
6. Households with electricity (%)	98.7	98.2
7. Households with an improved drinking-water source[1] (%)	92.0	92.6
8. Households using improved sanitation facility[2] (%)	41.5	48.9
9. Households using clean fuel for cooking[3] (%)	22.0	33.6
10. Households using iodized salt (%)	82.2	84.1
11. Households with any usual member covered by a health scheme or health insurance (%)	36.5	34.9
Characteristics of Adults (age 15-49)		
12. Women who are literate (%)	50.8	56.2
13. Men who are literate (%)	78.0	81.3
14. Women with 10 or more years of schooling (%)	23.5	28.1
Marriage and Fertility		
15. Women age 20-24 years married before age 18 years (%)	36.0	35.9
16. Men age 25-29 years married before age 21 years (%)	(8.2)	(11.8)
17. Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	8.7	9.7
Current Use of Family Planning Methods (currently married women age 15–49 years)		
18. Any method[4] (%)	44.6	44.5
19. Any modern method[4] (%)	44.6	44.5
20. Female sterilization (%)	44.4	44.3
21. Male sterilization (%)	0.0	0.0
22. IUD/PPIUD (%)	0.0	0.0
23. Pill (%)	0.2	0.1
24. Condom (%)	0.0	0.0
Unmet Need for Family Planning (currently married women age 15–49 years)[5]		
25. Total unmet need (%)	11.8	10.4
26. Unmet need for spacing (%)	8.9	7.7
Quality of Family Planning Services		
27. Health worker ever talked to female non-users about family planning (%)	17.0	17.4
28. Current users ever told about side effects of current method[6] (%)	33.4	42.4

[1] Piped water into dwelling/yard/plot, public tap/standpipe, tube well or borehole, protected dug well, protected spring, rainwater, community RO plant.

[2] Flush to piped sewer system, flush to septic tank, flush to pit latrine, ventilated improved pit (VIP)/biogas latrine, pit latrine with slab, twin pit/composting toilet,
which is not shared with any other household. [3] Electricity, LPG/natural gas, biogas. [4] Includes other methods that are not shown separately

[5] Unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting). Specifically, women are considered to have unmet need for spacing if they are:

- At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next two years, or are unsure if or when they want to become pregnant.
- Pregnant with a mistimed pregnancy.
- Postpartum amenorrheic for up to two years following a mistimed birth and not using contraception.

Women are considered to have unmet need for limiting if they are:

- At risk of becoming pregnant, not using contraception, and want no (more) children.
- Pregnant with an unwanted pregnancy.
- Postpartum amenorrheic for up to two years following an unwanted birth and not using contraception.

Women who are classified as infecund have no unmet need because they are not at risk of becoming pregnant. Unmet need for family planning is the sum of unmet need for spacing plus unmet need for limiting.

[6] Based on current users of female sterilization, IUD/PPIUD, injectables and pill who started using that method in the past 5 years.

( ) Based on 25-49 unweighted cases

* Percentage not shown; based on fewer than 25 unweighted cases

Koppal, Karnataka - Key Indicators

Indicators	NFHS-4 (2015-16)	
Maternal and Child Health	**Rural**	**Total**
Maternity Care (for last birth in the 5 years before the survey)		
29. Mothers who had antenatal check-up in the first trimester (%)	59.2	62.8
30. Mothers who had at least 4 antenatal care visits (%)	56.4	60.5
31. Mothers whose last birth was protected against neonatal tetanus[7] (%)	86.1	87.3
32. Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	19.6	23.8
33. Mothers who had full antenatal care[8] (%)	11.9	17.2
34. Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	97.2	97.2
35. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	52.8	54.3
36. Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution (%)	26.4	23.6
37. Average out of pocket expenditure per delivery in public health facility (Rs.)	1,725	1,681
38. Children born at home who were taken to a health facility for check-up within 24 hours of birth (%)	(6.2)	(5.5)
39. Children who received a health check after birth from a doctor/nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	27.0	29.7
Delivery Care (for births in the 5 years before the survey)		
40. Institutional births (%)	83.9	84.8
41. Institutional births in public facility (%)	71.8	72.6
42. Home delivery conducted by skilled health personnel (out of total deliveries) (%)	10.0	9.9
43. Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	91.1	91.1
44. Births delivered by caesarean section (%)	10.4	10.0
45. Births in a private health facility delivered by caesarean section (%)	(48.1)	(47.9)
46. Births in a public health facility delivered by caesarean section (%)	6.4	5.7
Child Immunizations and Vitamin A Supplementation		
47. Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	75.3	72.8
48. Children age 12-23 months who have received BCG (%)	96.6	97.1
49. Children age 12-23 months who have received 3 doses of polio vaccine (%)	87.0	82.9
50. Children age 12-23 months who have received 3 doses of DPT vaccine (%)	86.5	87.0
51. Children age 12-23 months who have received measles vaccine (%)	90.0	91.3
52. Children age 12-23 months who have received 3 doses of Hepatitis B vaccine (%)	65.1	64.0
53. Children age 9-59 months who received a vitamin A dose in last 6 months (%)	92.5	91.5
54. Children age 12-23 months who received most of the vaccinations in public health facility (%)	100.0	98.6
55. Children age 12-23 months who received most of the vaccinations in private health facility (%)	0.0	1.4
Treatment of Childhood Diseases (children under age 5 years)		
56. Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey (%)	3.9	4.3
57. Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%)	*	*
58. Children with diarrhoea in the last 2 weeks who received zinc (%)	*	*
59. Children with diarrhoea in the last 2 weeks taken to a health facility (%)	*	*
60. Prevalence of symptoms of acute respiratory infection (ARI) in the last 2 weeks preceding the survey (%)	0.5	0.4
61. Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility (%)	*	*
Child Feeding Practices and Nutritional Status of Children		
62. Children under age 3 years breastfed within one hour of birth[9] (%)	63.9	68.0
63. Children under age 6 months exclusively breastfed[10] (%)	*	*
64. Children age 6-8 months receiving solid or semi-solid food and breastmilk[10] (%)	*	*
65. Breastfeeding children age 6-23 months receiving an adequate diet[10,11] (%)	0.0	1.9
66. Non-breastfeeding children age 6-23 months receiving an adequate diet[10,11] (%)	*	*
67. Total children age 6-23 months receiving an adequate diet[10,11] (%)	2.4	6.3
68. Children under 5 years who are stunted (height-for-age)[12] (%)	59.7	55.8
69. Children under 5 years who are wasted (weight-for-height)[12] (%)	26.4	26.4
70. Children under 5 years who are severely wasted (weight-for-height)[13] (%)	11.2	10.8
71. Children under 5 years who are underweight (weight-for-age)[12] (%)	52.9	49.9

[7] Includes mothers with two injections during the pregnancy of her last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth. [8] Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for 100 or more days. [9] Based on the last child born in the 5 years before the survey. [10] Based on the youngest child living with the mother. [11] Breastfed children receiving 4 or more food groups and a minimum meal frequency, non-breastfed children fed with a minimum of 3 Infant and Young Child Feeding Practices (fed with other milk or milk products at least twice a day, a minimum meal frequency that is receiving solid or semi-solid food at least twice a day for breastfed infants 6-8 months and at least three times a day for breastfed children 9-23 months, and solid or semi-solid foods from at least four food groups not including the milk or milk products food group). [12] Below -2 standard deviations, based on the WHO standard. [13] Below -3 standard deviations, based on the WHO standard.

Koppal, Karnataka - Key Indicators

Indicators	NFHS-4 (2015-16)	
Nutritional Status of Adults (age 15-49 years)	**Rural**	**Total**
72. Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m^2)[14] (%)	26.9	26.9
73. Men whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m^2) (%)	24.4	21.4
74. Women who are overweight or obese (BMI ≥ 25.0 kg/m^2)[14] (%)	10.5	12.0
75. Men who are overweight or obese (BMI ≥ 25.0 kg/m^2) (%)	15.0	20.2
Anaemia among Children and Adults[15]		
76. Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	67.1	68.1
77. Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%)	47.4	45.7
78. Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%)	(42.1)	(43.3)
79. All women age 15-49 years who are anaemic (%)	47.1	45.6
80. Men age 15-49 years who are anaemic (<13.0 g/dl) (%)	18.0	16.2
Blood Sugar Level among Adults (age 15-49 years)[16]		
Women		
81. Blood sugar level - high (>140 mg/dl) (%)	6.5	5.4
82. Blood sugar level - very high (>160 mg/dl) (%)	2.3	1.9
Men		
83. Blood sugar level - high (>140 mg/dl) (%)	9.4	9.3
84. Blood sugar level - very high (>160 mg/dl) (%)	5.2	5.1
Hypertension among Adults (age 15-49 years)		
Women		
85. Slightly above normal (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	4.9	5.1
86. Moderately high (Systolic 160-179 mm of Hg and/or Diastolic 100-109 mm of Hg) (%)	1.0	1.1
87. Very high (Systolic ≥180 mm of Hg and/or Diastolic ≥110 mm of Hg) (%)	0.6	0.8
Men		
88. Slightly above normal (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	12.7	12.0
89. Moderately high (Systolic 160-179 mm of Hg and/or Diastolic 100-109 mm of Hg) (%)	1.9	1.5
90. Very high (Systolic ≥180 mm of Hg and/or Diastolic ≥110 mm of Hg) (%)	0.8	0.6
Women Age 15-49 Years Who Have Ever Undergone Examinations of:		
91. Cervix (%)	17.0	20.5
92. Breast (%)	12.7	16.6
93. Oral cavity (%)	11.6	10.0

[14] Excludes pregnant women and women with a birth in the preceding 2 months. [15] Haemoglobin in grams per decilitre (g/dl). Among children, prevalence is adjusted for altitude. Among adults, prevalence is adjusted for altitude and for smoking status. [16] Random blood sugar measurement (including those under medication).

Conclusion

No violence against children is justifiable; all violence against children is preventable. Children should never receive less protection than adults. Therefore States must invest in evidence-based policies and programmes to address factors of violence against children. States have the primary responsibility to uphold children's rights to protection and access to services, and to support families' capacity to provide children with care in a safe environment. States have the obligation to ensure accountability in every case of violence. The vulnerability of children to violence is linked to their age and evolving capacity. Some children, because of gender, race, ethnic origin, disability, or social status, are more vulnerable. Children have the right to express their views, and to have these views taken into account in the implementation of plans polices and programmes.

Koppal District Child Protection Plan ensures that no child falls out of the safety net and those who do, receive necessary care, protection, and support. Koppal District Child Protection Plan focuses on the major issues of Devadasi children special need children such as children with disability, HIV infected and affected children and Children, Children who lack parent and children in Institutions; Child labourers and child marriage victims, child abuse cases and strengthening of Juvenile Justice System.

Protection is right of every child and Government of India is committed to creating a protective environment for Children. In this direction it is very important that all the stakeholders from all aligned departments and civil

society organization need to work together in coordination and bring to convergence all efforts to meet the best interest of children.

If District Child Protection Plan is implemented in its real spirit Integrated Child Protection Scheme will produce positive results and children of Koppal will experience protection in all aspects. Involvement of NGOs and experts in the field of child rights and protection will enhance the quality of service to children. Timely Action, sensitive intervention and coordinated effort will sure to bring expected result.

"No violence against children is justifiable; all violence against children is preventable"