



ADVANCING CHILD SAFETY IN INDIA

Implementation is the Key



Executive summary

Report by NIMHANS



WHAT WE KNOW?

Every child matters

India is home to 548 million children less than 18 years, distributed over a total geographical area of 3.2 million square kilometers in 29 states and 7 Union territories.⁽¹⁾

Every child is important for the family, society and the nation. The safety and survival of every child matters in India and globally and it is the responsibility of every one to ensure health, survival and safety of children, today and tomorrow.

Apart from bringing immense joy and happiness to everyone, undoubtedly, every child is a national asset.

Child health scenario is changing fast

Due to epidemiological and socio demographic transition, communicable, nutritional and infectious diseases are gradually on the decline and Non-communicable Diseases and Injuries are on the increase. Injuries, which were hitherto neglected and relegated to periphery, are now a major public health problem affecting the growth, development and survival of children.

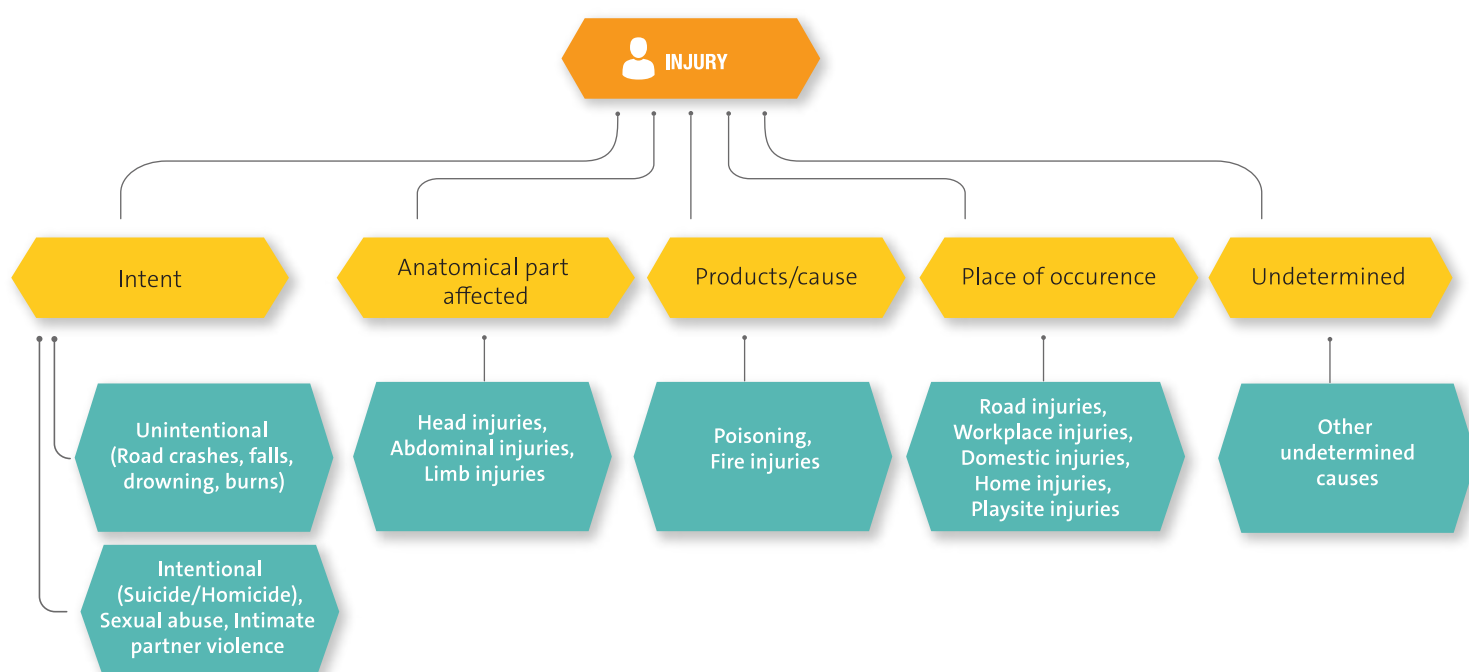
Injuries are a major public health problem

Every day, thousands of children sustain injuries of different nature and varying severity as reported in the media and official agencies. The precise number of child injury deaths, hospitalizations and disabilities along with their determinants and outcomes are not clearly known due to lack of good quality injury reporting systems, injury surveillance, trauma registries, information systems and well-defined research in India.

Injuries can be unintentional, intentional or undetermined

An injury results from a sudden exposure to physical agents such as mechanical energy, heat, electricity, chemicals and ionizing radiation that interact with the body in amounts or at rates that exceed the threshold of human tolerance. In some cases (drowning, frostbite) injuries also result from the sudden lack of essential agents such as oxygen or heat.

WHO classifies injuries as unintentional (Road Traffic Injuries (RTIs), falls, burns, drowning, etc.), intentional (violence, assault, sexual abuse, etc.) and undetermined, based on nature and intent of injury. Injuries are also classified based on external causes (transport injuries, falls, burns etc.), anatomical site of injury (brain injury) or body regions (head injury, limb injury).⁽²⁾ Each of the classification methods have their own importance and are useful for different purposes and programmes.



Existing data sources have major limitations

As injuries are considered medico legal events, the only source of data is from police agencies, published collectively by the National Crime Records Bureau (latest report available for 2015). Apart from underreporting, problems exist in classification methods (age and cause), completeness, coverage, and quality. Comprehensive data from hospitals which provide care for injured children is not available due to absence of good information systems. The NCRB data reveals that children form a significant portion of overall injury deaths. Transport injuries, burns, drowning, poisoning, falls and other intentional injuries are included in NCRB reports; however a comprehensive understanding of burden, pattern and outcomes are not clear.

Child injuries have a huge impact

Any child experiencing any type of injury will have physical and psychological disability (ies) as well as significant psychological trauma (specially with intentional injuries), that remains for the rest of his/her life. It is well acknowledged that childhood injuries are a major cause for many physical and mental health problems of later life. The short, medium and long term impact(s) of injuries and its socioeconomic impact among children are not well understood in India due to lack of research.

Child injuries are predicable and preventable

Globally, experience of many High Income Countries have demonstrated that injuries can be prevented / reduced with implementation of evidence based interventions. Most countries have well established policy (ies), programmes, interventions combined with capacity building, funding, information and evidence, targeted approaches, high level of advocacy, increased public awareness along with highest levels of political commitment. Many children have been saved due to such practices.

WHAT WE DID?

Review of data sources

We focused on only unintentional injuries and reviewed all publicly available sources to delineate child injury burden, distribution, determinants, impact and outcomes in India. Pooled data from previous injury epidemiological studies at NIMHANS ^(5,6,7) was utilized to highlight specific issues.

Safety appraisal of schools

We undertook a safety appraisal of 130 schools (in public and private, aided and unaided schools) in and around Bangalore city (urban) and Kolar district (rural) to examine the current safety scenario through combined methods of primary data gathering, observation of safety situation/implementation practices and interviewed school teachers/management.

Review of ongoing initiatives

We examined existing policies, programmes, directives and legislations at national and state (with a focus on Karnataka state) levels to understand the scope, focus, contents and their components to understand the ongoing initiatives.

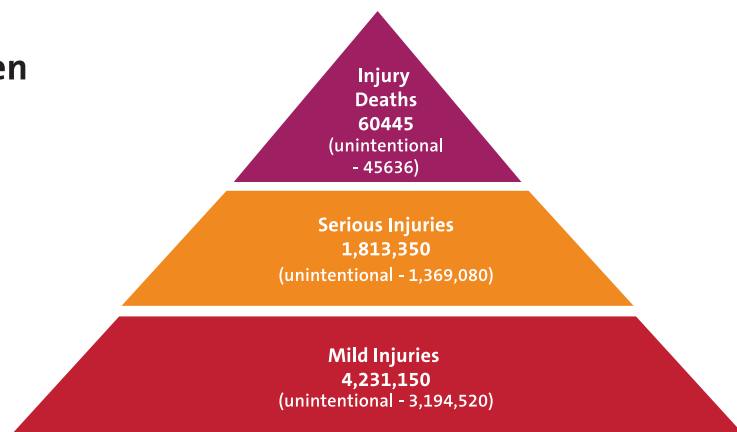


An Android mobile application was developed and used to conduct safety appraisals. Using this application we quantified safety level (%) for each school.

WHAT WE LEARNT?

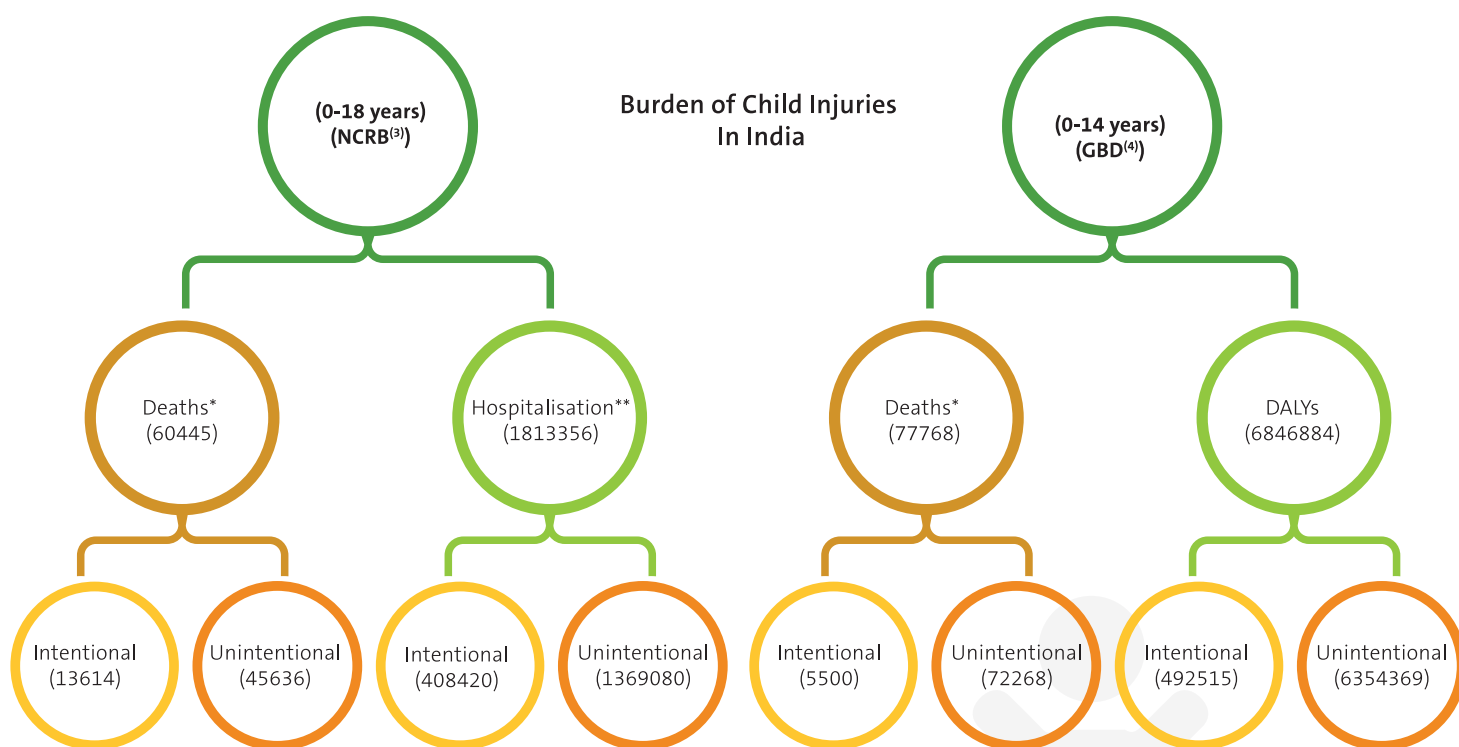
Child injury is an unrecognized and hidden epidemic in India.

Child Injury is extremely common : Over the last 10 years, child injuries are increasing injuries such as transport injuries, falls (at home, schools, workplaces), burns, poisoning, drowning, fall of objects, building collapse, animal bites, sports injuries, physical violence, sexual abuse, (from molestation to rape), bullying, child maltreatment and others are on the increase.



India lost about 5,00,000 children due to injuries in the last decade.

Every day, about 165 children die in India due to an injury: As per official reports, 50371 children aged 0-18 years died in India due to injury causes (natural + unintentional + intentional) in 2015. After adjusting for underreporting (based on Indian observations at 20%), the number of deaths for 2015 is estimated to be 60445. Nearly 45636 deaths were due to unintentional injury due to causes like RTIs, burns, poisoning, drowning etc.



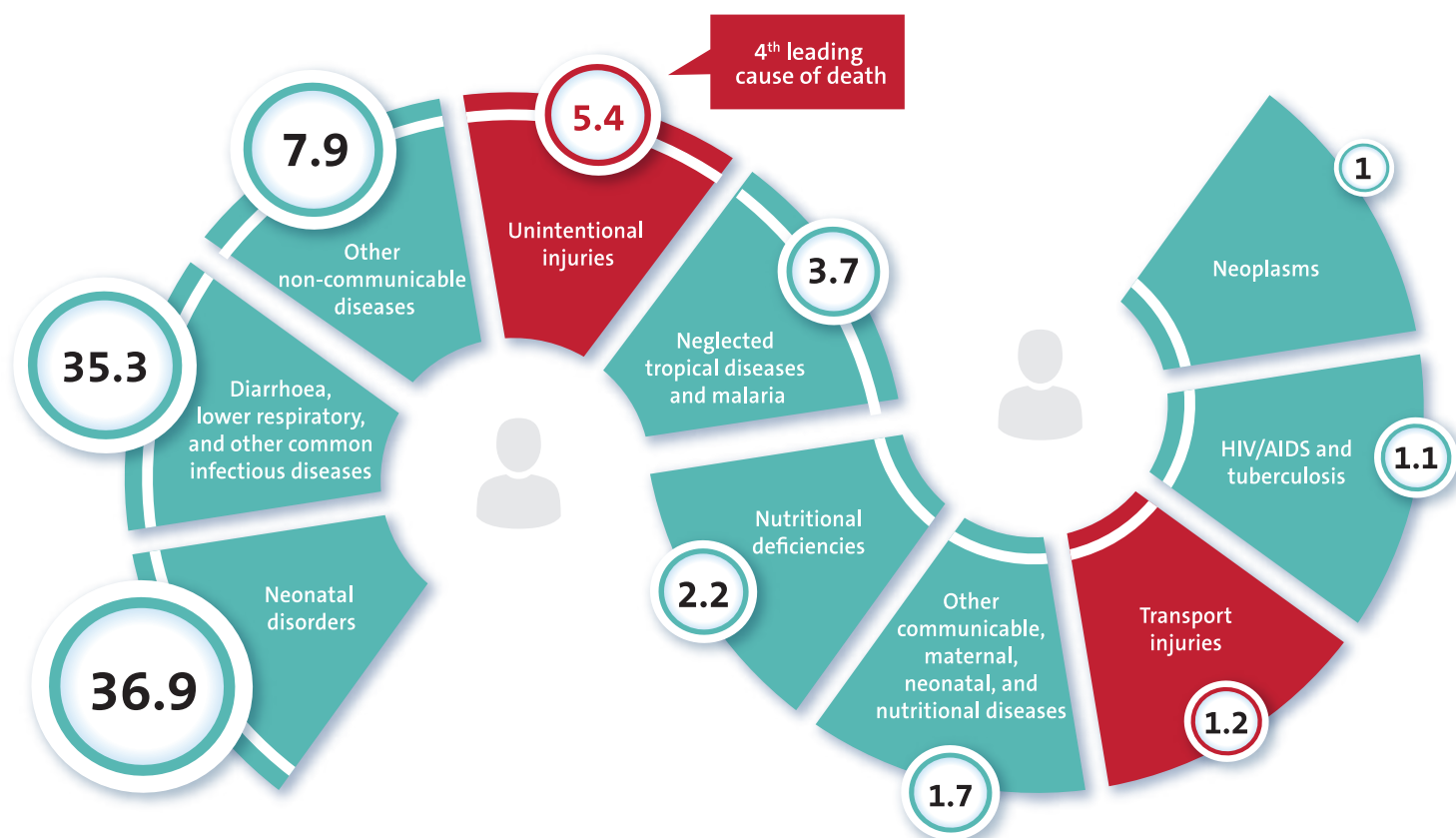
*Includes 1195 deaths due to disasters like lightning, earthquake, floods etc

** Includes 408390 cases hospitalized due to natural causes. Estimates based on a ratio of 1:30 for deaths and serious injuries

As per the recent ICMR-PHFI –IHME report, injuries accounted for 7.2% of all deaths among children aged 0-14 years (20 deaths per 100,000 population) in India. Injuries are the 4th leading cause of death among children <15 years after Diarrheal diseases and neonatal conditions. The same report estimates the number of child deaths to be 86,721 in 2017. At the global level, it is estimated that 479154 children aged 0-14 years succumbed due to unintentional injuries.⁽⁴⁾

The Million Death Study, one of the largest population based surveys in India, estimated that unintentional injury mortality rate among children is 33 per 100,000.⁽⁸⁾

Leading causes of death among children (0-14 years) in India
(% of all deaths, GBD-2017)



Nearly 1,800,000 children would have sustained one or more serious injury (ies) requiring contact with a health care facility for varying periods of time based on an estimate of 1:30 for deaths and serious injuries. This does not include those children who are unlikely to seek care due to stigma from intentional injuries. The GBD report of 2017 estimates the DALYs lost to be 6,354,369 DALYs.⁽⁴⁾

Based on limited population based and hospital based studies, it is recognized that injuries account for ~ 10-12% of deaths, 15 – 20% of hospitalizations and 10-15% of overall disabilities.⁽⁵⁾

Nearly half of the hospitalized children are discharged with varying degrees of physical and psychosocial disabilities which affects their quality of life. This proportion has seen an increase in the last two decades with the decline of communicable, infectious and nutritional disorders.

The ratio of unintentional to intentional injury deaths was 1:3. In 2017, the reported numbers of these two groups was 45636 and 13614, respectively.⁽³⁾ It is well acknowledged that many intentional injuries (rape, child maltreatment, sexual abuse and others) are not reported due to legal and stigma issues.

Child Injuries are on the increase

Trends in NCRB data from 2005-15 indicated that the number of child injury deaths (0-14 years) in India was gradually increasing between 2005-13 (22957 deaths in 2005 to 27670 in year 2013). Post 2014, the trends are not clear due to changes in classification methods.⁽³⁾

Males and older children are affected more

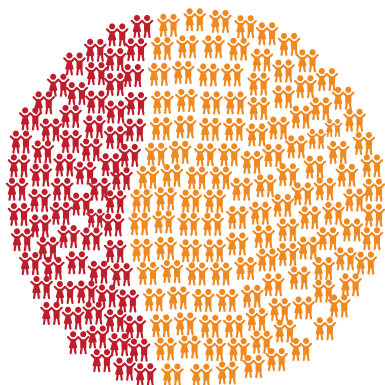
All reports conclusively inform that male children suffer more of unintentional injuries (53-69%), while girls sustain higher number of specific intentional injuries.

Among the 39026 actual reported unintentional child injury deaths, 15549 (40%) and 23477 (60%) were in age groups of 0 – 14 and 15 – 18 years, respectively. (NCRB-2015)

Unintentional Injury in India (NCRB-2015)

 **40%**
0-14 years

 **60%**
15-18 years



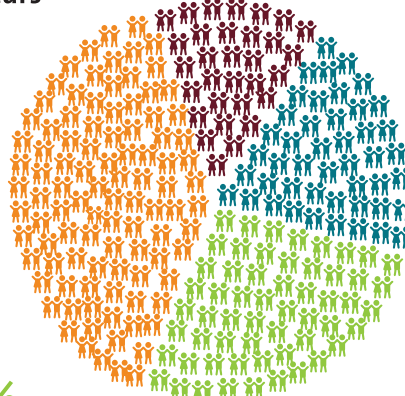
Age distribution of unintentional Injury deaths (%) NIMHANS data (n=629)

 **43%**
15-18 years

 **16%**
0-4 years

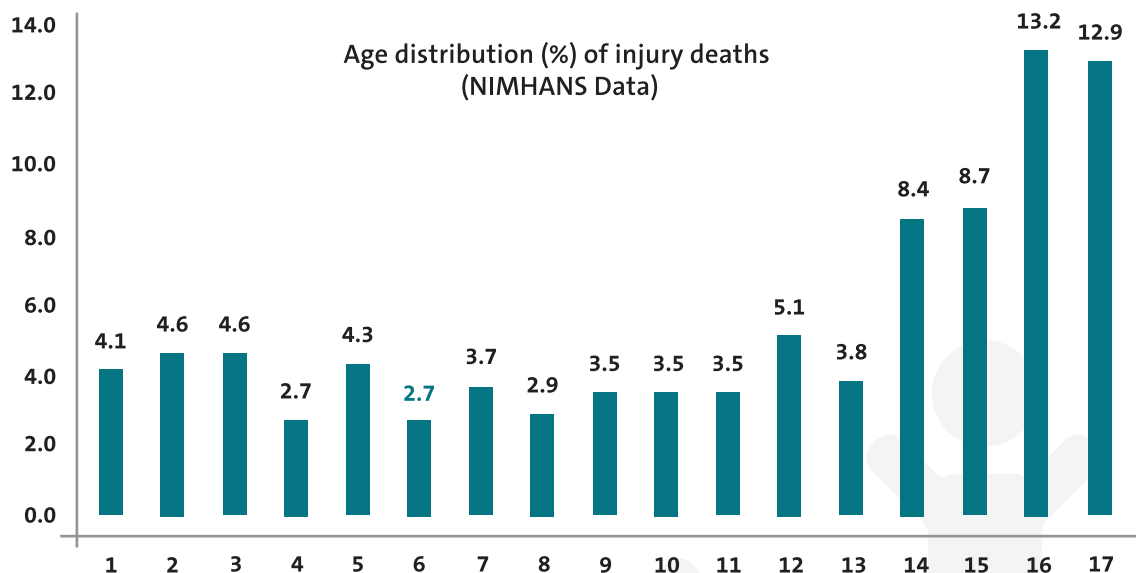
 **24%**
10-14 years

 **17%**
5-9 years



Injury deaths are higher among children aged more than 5 years, compared to those less than 5 years. Injury deaths reach a peak after 10 years of age, correlating with increased mobility and exposure to environment and schooling. Nearly 60% of all unintentional injury deaths in India occurred among children aged between 14-18 years in year 2015.⁽³⁾

Falls, burns and drowning are more prevalent in younger ages, while transport injuries and drowning become a leading cause in later years.



Poor children are affected most

Nearly 2/3rds of all injury deaths are observed in Low and Middle income countries. In India, injury deaths are comparatively higher in middle and poorer sections of society; ⁽²⁾ it is also an unexpected and added burden on the families and the society. Children in low and middle income households sustain more of injuries and also are unable to afford quality trauma care.

Urban – rural differentials exist in injury deaths

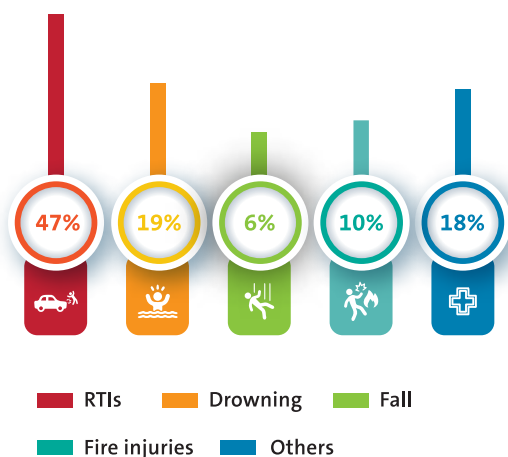
Population based studies indicate that child injury mortality rate per 100,000 persons is higher in rural areas for children aged 0-4 years (3.4 deaths per 100,000) and 5-14 years, respectively (27.32 deaths per 100,000).⁽⁴⁾ Higher mortality in rural areas reflects greater exposure and limited access to quality pre-hospital and hospital level trauma care .

Data from hospitals indicate deaths are more in urban areas (59.7%) as more severe cases are likely to be referred or managed in hospitals in urban areas compared with rural areas.⁽⁵⁾

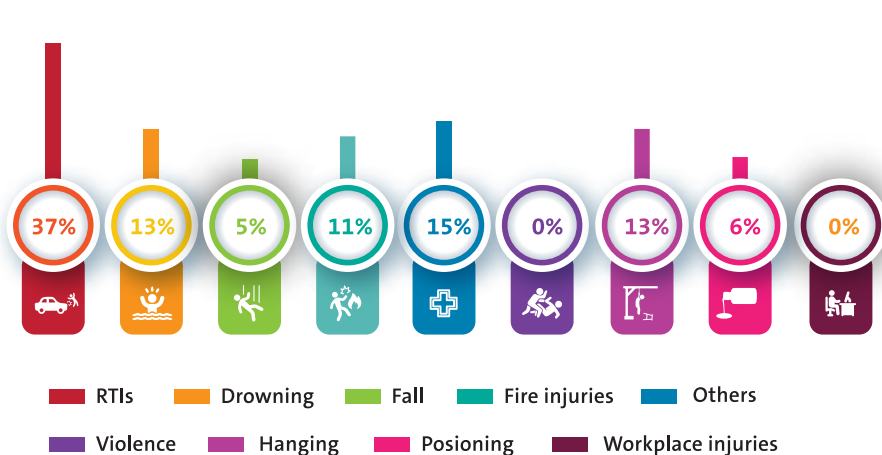
Road Traffic Injury is the biggest contributor for child deaths and injuries

In 2015, nearly 15633 children in 0 – 18 years died due to road crashes as per NCRB report. However, as per MoRTH report of the same year, 12589 children died due to road crashes. With data source being the same for both reports, there is a difference in the reported numbers. The recent 2017 report of MoRTH reveals the number to be 9408 deaths, showing a decline. Adding an underreporting estimate of 20% to these numbers, the number of child deaths due to RTIs in 2019 is estimated to be 11290 deaths. About 2% of injured children are likely to become disabled for their entire life. Road traffic injuries account for nearly 37-38% of deaths among 0-14 years and 62-64% among 14-18 year old children. It accounted for 11% of all trauma admissions and 42% of hospitalizations as per select studies.^(5,6,7)

Causes for child injury deaths
(0-18 years) NCRB-2015

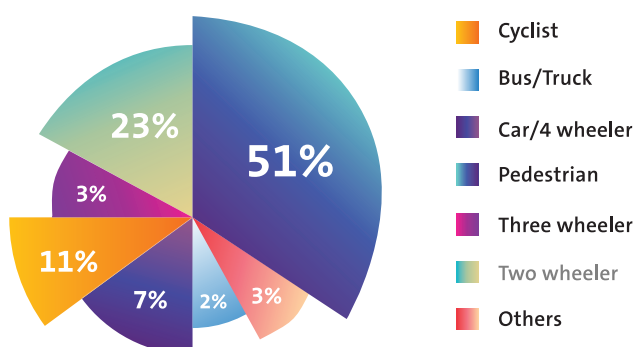


Cause of injury deaths (0-18 years)
NIMHANS Data

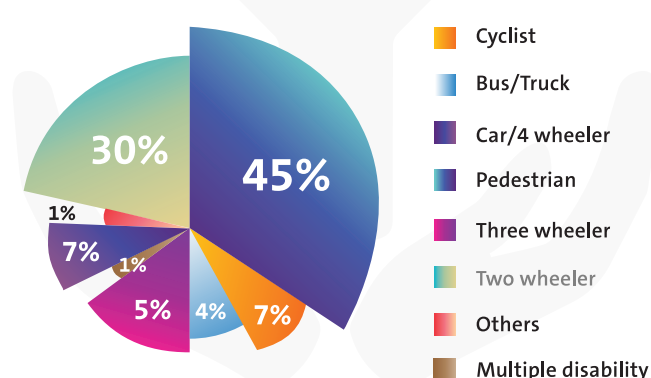


Pooled data from NIMHANS epidemiological studies on RTI informed that children as pedestrians, cyclists and on two-wheelers accounted for 85% of all fatal childhood RTIs in Bangalore.⁽⁵⁾ Hospital based data indicate that nearly half of all fatal (51%) and non-fatal RTIs (45.2%) are reported among child pedestrian road users in Bangalore.⁽⁵⁾ Falls (5-6%), drowning (13-19%) and burns (10-11%) are also common causes for injuries among children aged 0-18 years in India.^(5,6,7)

RTI Child deaths by road user type, 0-18 years (n=250)
NIMHANS Data ^(5,6,7)



Non-fatal RTIs by road user type, 0-18 years (n=7020)
NIMHANS Data ^(5,6,7)

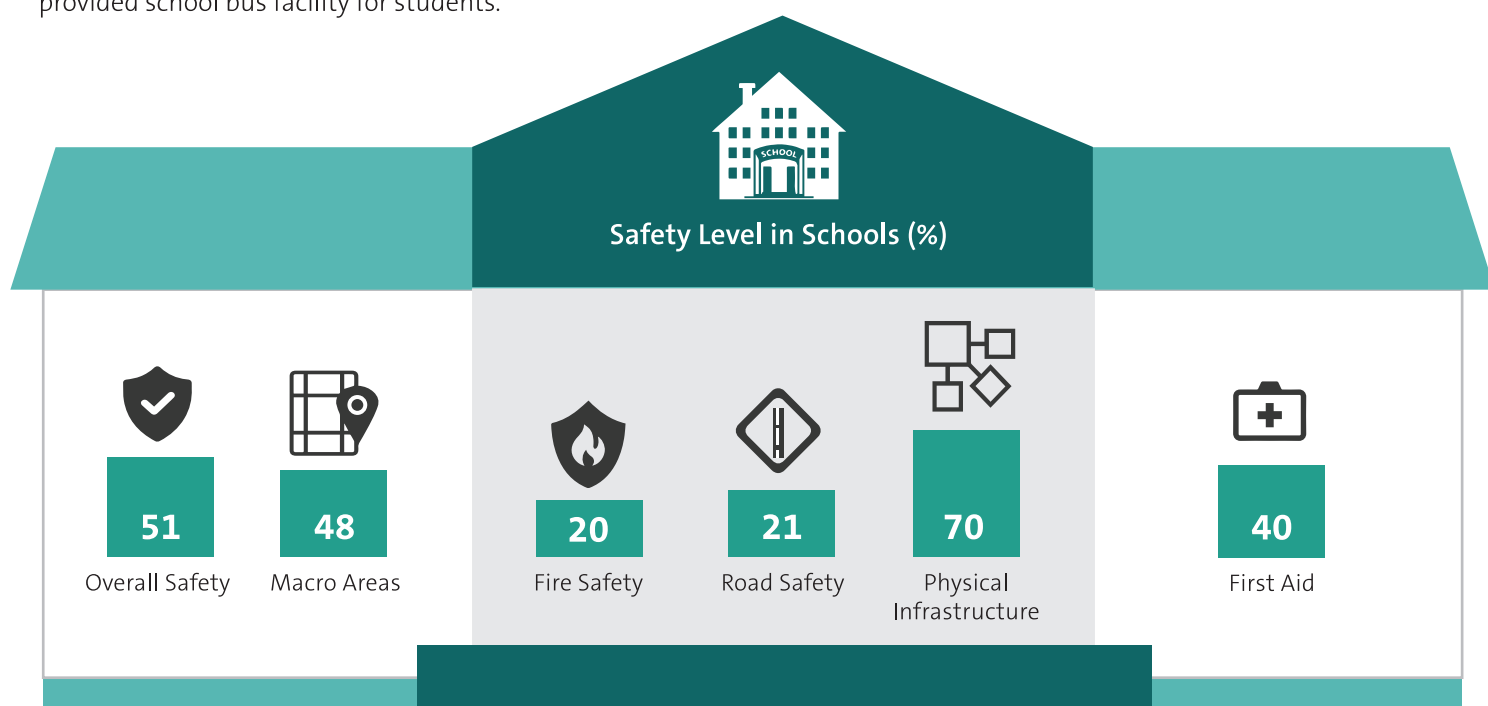


Safe travel to school is a necessity

With RTIs being most common type of injuries, safe transport to school is a serious concern. The most common modes of travel among children are walking, cycling, on two wheelers, in public transport and other modes, while half the children studying in private schools use a dedicated school transport. Studies indicate a strong association between road injuries among children, mode of travel and distance to school. Children who cycled to school were more likely to be injured compared with children who walked (OR 1.5; 95% CI 1.2 to 2.0). Travel by school bus was safer than walking (OR 0.5; 95% CI 0.3 to 0.9).⁽⁹⁾ Our assessment of schools revealed that only 40% of the schools provided school bus facility for students.

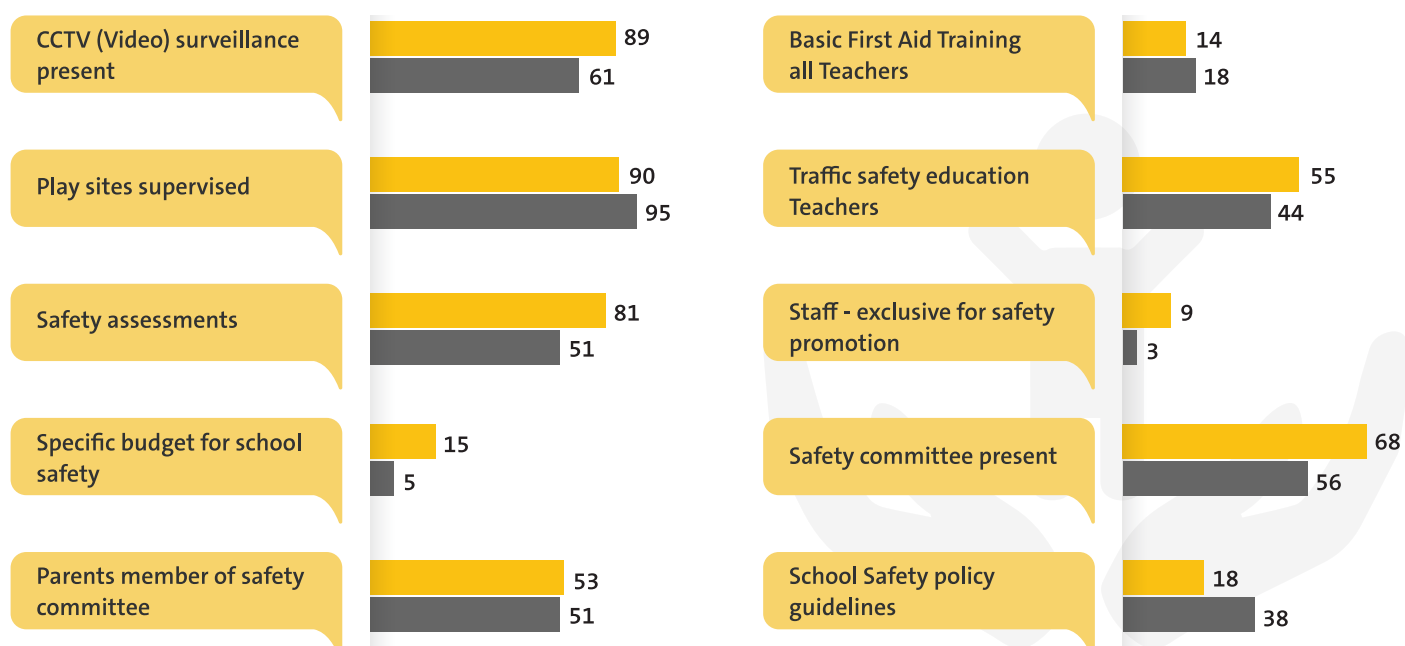
School environment should be safe

Our review indicated that the physical infrastructure of most educational institutions did not confirm to adequate safety standards as noticed by the presence of injury risk enhancing environment interms of physical structure and products. Our school safety appraisal revealed that the overall safety level in schools was 51% with lowest safety observed in roads around the schools (21%) and fire safety in the school (20%). The school management was found to be less equipped to address safety concerns in terms of the overall safety, school building, laboratories, open spaces, stair cases, and playgrounds.



Macro-environment for school safety - Urban v/s Rural schools (%)

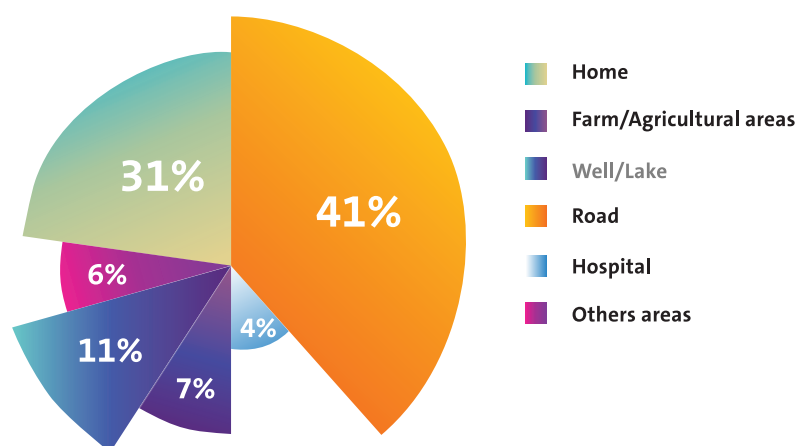
Urban (n=92) Rural (n=39)



Home should always be a safer place

Our data indicate that variety of injuries like burns, poisoning, falls and in some instances drowning (based on geographical location) were common injuries at homes with variation between urban and rural areas. Nearly 41% of all fatal injuries among children were observed on roads followed by 31% at home. Deaths in younger age children (0-5 years) were more common at home and mostly due to falls, drowning, poisoning and burns. Nearly 34% of fatal injuries in rural areas occurred in homes ^(5,6,7).

Place of injury among children (<18 years) (%) - NIMHANS data



Fire safety should be given importance

Nearly 3527 children less than 18 years died due to fire accidents in India in year 2015.⁽³⁾ Fire-related injuries account for 10-11% of all fatal injuries among children in India (0-18 years). Safety appraisal revealed that majority of schools (94%) had fire-extinguishers in schools. However, only 32% (1/3rd) of the schools had fire safety certificate. Evacuation plans, fire log books, fire detectors and fire alarms were present in less than 8% of the schools.

Fire Safety Facilities In Schools (n=131)



Drowning deaths should not occur

Nearly 8701 children less than 18 years died due to drowning in India in year 2015.⁽³⁾ Drowning among 0-14 years and 0-18 years accounted for 41% and 16.8% of all injury deaths in the respective age groups.⁽³⁾ Nearly 1.6 million DALYs were lost due to child (0-14years) drowning deaths in India.⁽⁴⁾

Poisoning can be avoided among children

NCRB reported that 2516 children aged 0-14 years died due to poisoning in India in year 2013.⁽³⁾ Reports indicate that 66% of poisoning deaths among children occurred among children < 5 year.⁽⁴⁾ Most poisoning cases occur within home environment, with detergents, cleaners (28%), medicinal drugs (17%), kerosene (14%) and mosquito repellents/pesticides (17%) being common agents implicated in poisoning.^(3,5,6)

Recreation places needs to be safer

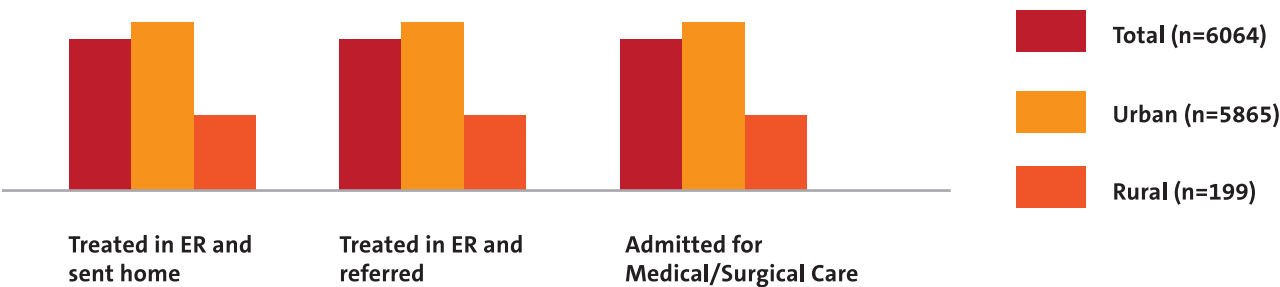
Children spend significant amount of time in play sites, parks, swimming pools and even on roads to engage in variety of sports activities. Our review indicated that plays site injuries, though small in number (48 per 1000 hours of school time), are on the increase. ⁽¹⁰⁾

Early trauma care reduces deaths and disabilities

Data collected from hospitals in Bangalore indicates that Traumatic brain injuries are the most prominent type of injury (53%) experienced by children, while 34% of injuries occurred in the lower limbs.⁽⁵⁾ Nearly 50% of deaths occur either in-transit or in hospitals. It is well known that functioning and responsive trauma care systems reduce mortality by 25-30%.⁽⁵⁾

Most trauma care systems (pre-hospital and hospital level) are not specifically oriented to children. Early first aid, good samaritans, safe transportation, appropriate referrals, triage systems, trained professionals, good management practices and appropriate referrals working in a well defined trauma systems can reduce deaths and injuries. Assessment of trauma care systems reveal a need for great improvement in macro issues of establishing infrastructure, SOPs, budgetary allocation and training. With pediatric trauma care beginning to be recognized as a specialty discipline, there is need for augmenting efforts in this direction

Outcome of management in ER (<18 years)



Disabilities are a major concern

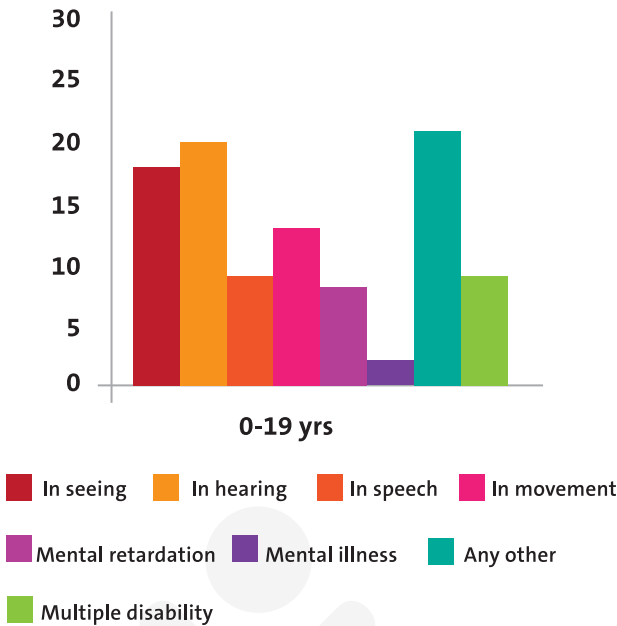
With the decline in disabilities due to communicable diseases like polio and others, contribution of injury related disability is on the increase. Injuries can lead to physical damage to various body organs and in the absence of appropriate rehabilitation services, children live with disabilities for the rest of their life. Intentional injuries, on the other hand, leave a child totally traumatized and have to live with severe psychosocial disabilities affecting their entire life. Any child experiencing any type of injury will have physical and psychological disability (ies) as well as significant psychological trauma (specially with intentional injuries), that remains for the rest of his/her life.

Studies report that nearly 10% of injured children have temporary functional limitation varying from one week to several months.⁽¹¹⁾ Seriously injured children are unable to walk, move and perform daily activities for longer periods and need support. Brain injured children have cognitive impairments, memory problems, information processing deficits, speech -language problem and can be crippled for their life.

GBD (2017) estimates indicate that among children aged 0-14 years, nearly 917226 DALYs were lost due to RTIs in India in year 2016, accounting for 10% of all DALYs lost worldwide. NSSO survey of disabilities in India revealed that there were nearly 26.8 million disabled individuals (2.1%) in India in year 2011, of which 7.87 million(29%) were children aged 0-19 years. Nearly 9% of children with disabilities had multiple disabilities and 13% had disabilities in movement, which are expected to occur as a result of injuries.⁽¹²⁾

Data from the Global Childhood Unintentional Injury Surveillance study informed that 2% of children under the age of 12 years who had suffered an unintentional injury severe enough to warrant presentation to an emergency department were left with permanent disability and 12% were left with long term (>6 weeks) temporary disability. Permanent disability was more among children with drowning (10%) burns (8%) and RTIs (3%).⁽¹³⁾

Distribution of disabled persons by age group and type of disability in India (%) - Census, 2011



Economic impact is huge and unmeasured

The economic impact of injuries in India is significant. RTIs alone are estimated to cost nearly 3% of GDP every year and the cumulative cost due to all injuries might be around 5% of GDP.⁽¹³⁾ The impact is greater among children as those who survive have to live for the rest of their life with minimum or no participation in activities of life.

There has been increasing concern, but very little action to address the problem

There has been an increasing concern in recent years for safety of children. This is limited to print and visual media due to greater reporting, debates, discussions, scientific deliberations and the overall concern of the society; however, much more needs to be done. There is a strong need to move beyond knee jerk reactions, ad-hoc approaches, crisis mediated solutions to more scientific and systematic actions. Actions are required on several fronts – government level, community level and in all settings like schools, homes, play areas, water bodies and other areas.

ACTIONS TO ENSURE SAFETY OF CHILDREN

Implementing a framework for action is vital.

Injury prevention and safety promotion should be on the national agenda

India does not have a national injury prevention policy/programme or an action plan. It is a prerequisite that child injury prevention needs to be on the public health agenda at both national and state levels and should be given highest importance.

Integrate child injury prevention in all national policies/programmes

National policies/programmes addressing child health Reproductive and Child Health programme, Rashtriya Kishor Swasthya Karyakram (RKSK), Integrated Child Development Services, Sarva Shiksha Abhiyan, National health Policy, etc. need to integrate child injury prevention components in their respective activities. This will enhance coverage of injury prevention interventions.

The existing guidelines like safety of school children in school bus as per CBSC guidelines (2017), fire and life safety guidelines as per national building code (2016), National Disaster Management Authority School Safety Policy Guidelines (2016), Guidelines for School Infrastructure and Strengthening (2014), Manual on Safety and Security of Children by National Council for Protection of Child Rights, POSCO act (2012) and the recently amended Motor vehicles amendment bill (2019) needs strict implementation for safety of children.

Data systems needs strengthening

The existing data systems in India within police and transport sector needs to be strengthened to obtain good quality data and to be used for child injury prevention programmes. Both police and hospital sources have serious limitations and injuries are highly under-reported.

Specific and focused child injury epidemiological research based on surveillance, registries, risk factor studies, product safety studies and other areas along with its integration in the existing health management information system needs to be implemented.

Promote favourable (policy) environments for manufacturing, sales and easy access to standard and good quality safety equipment (for children)

Good quality safety products to be used in houses, schools, play grounds, vehicles, roads and communities are resource intensive at times, thereby limiting their widespread use. Compliance among all sections of the society can be enhanced by promoting policy, taxation changes to facilitate financial access to technologies. Social marketing can be adopted to facilitate community use of the technologies.

Dedicated programmes are required

Considering the fact that transport injuries, falls, burns, poisoning, drowning and intentional injuries like child sexual abuse are on the increase, dedicated programmes in each of these areas developed on a combination of engineering, safer products, enforcement, education and emergency care needs to be developed and implemented by the individual states of India.

Setting-based approaches need to be piloted to deliver targeted interventions for children in school, workplaces and in less resourced communities.

Strengthen capacity of implementing agencies

The implementation of several existing guidelines/regulations/standards requires capacity strengthening of concerned authorities for visible-uniform-random-people friendly mechanisms.

Choosing the right interventions

The larger goals of injury prevention and safety promotion are to see that injuries do not occur in the first place; even if it occurs, injuries should not lead to serious injuries, hospitalizations and disabilities. Furthermore, it is important to see that the injured child is rehabilitated to return him/her back to his/her optimum level of functioning.

Children live in a world that is largely designed by adults for adults. The needs, vulnerabilities, susceptibilities and capabilities of children are largely ignored or paid lesser importance in development of products and creation of environments. Expecting children to behave safely on their own is considered unrealistic as it is dependent on their age, understanding and perceptions of safety. The experience of many high income countries has revealed that child injuries, like injuries in other age groups, are predictable and preventable.



The approaches to child injury prevention are based on making safer products which children use, creating safer environments that are less injurious where children live and by informing/educating parents/caregivers and all others to take adequate actions for the safety of children – all towards keeping children safe. A combination of approaches based on education, enforcement, engineering and emergency care should be employed in this process.

The safe system approach in recent years builds on these approaches by considering the childhood characteristics, vulnerability and susceptibility of children and responsibility of all stakeholders at different levels towards making children safe and to prevent injuries. Policies, programmes, regulations, legislations, setting and enforcing standards, awareness building programmes at different levels and others, are several tools employed in this process.

A child normally spends its day at home, on road, in vehicle, in school, in play area and others. In all these places, children come in contact with variety of products that can lead to an injury or unsafe environments that can enhance the occurrence of injuries. While it is important to make every product safe and less injurious, the larger environments where children spend time can be made safer.

Road safety

Key Transport Guidelines:

Issued by the Honorable Supreme Court of India with regard to safety of school buses

1. Painted yellow with the school name and telephone number written on it.
2. School Bus - written on the back and front of the bus.
3. Presence of First Aid Box and a fire extinguisher.
4. Fitted with speed governor of specified standard.
5. Fitted with horizontal grills and doors should be fitted with reliable locks
6. Space fitted under the seats to keep school bags
7. Qualified attendant in the Bus to attend to Children.
8. Parent /teacher may also travel to ensure these safety norms.
9. Driver should have at least 05 years of experience of driving heavy vehicles.
10. Driver who has been challenged (Fined) more than twice in a year cannot be employed.



Safer roads

Adopt safe road design around school premises that accounts for needs and requirements of children.

Inform and work with local administrative bodies to implement speed reduction strategies like setting speed limits to less than 30 kms, appropriate display of signages, enforcement of speed limits, erecting speed bumps at frequent intervals, elevated pedestrian crossings as well as education of parents, caregivers and drivers to be implemented in areas near schools.

Roads should be free of potholes, manholes, unsafe roads around schools and should have safer footpaths, pedestrian crossing facilities, increased visibility and supervised road crossing facilities.

Safer vehicles

Inform parents and encourage children to travel in school buses or public transport vehicles (arrangements to be made).
Ensure complete compliance of school buses to the Supreme Court guidelines;

Towards making children as safe road users



Inform parents about use of child restraints, encourage them to use and follow legislations; educate parents about dangers of carrying children in front seat of cars.

Inform local civic agencies to provide footpaths, safe crossing zones, pot-hole free roads, speed limit signages and safe roads.

Inform local police authorities to enforce laws on helmets, seat belts, child restraints, in your areas, speeding, drink driving, use of cell phones in your areas and near to schools



Increase awareness among parents and care givers on road safety

Parents/ care givers/school vehicle drivers to be aware of dangers of speed and to follow legislations on speed related matters

Encourage children to use visibility enhancing materials on roads

Encourage all adults to be good role models for children on road safety issues



Educate students (above 12 years) about use of helmets - seat belts , excessive speeding, driving under the influence of alcohol and drugs, mobile phone use, being safe pedestrians, benefits of using day time running lights (it is automatic in many vehicles now), having a proper license and others on a regular basis. Inform them about existing laws, penalties and educate them to be compliant on these aspects.

Conduct school based driver education programmes for school bus drivers, autorickshaw drivers and others

Increase compliance to traffic rules among children

Child specific protective and safety equipment's (helmets, restraints, visibility clothing etc) to be made available in schools and enforced to use as per existing legislations



Steps for safer home environment to prevent child injuries

- All residential dwellings should be built with safety in mind and should adhere to safety standards.
- All young children should be supervised at all times and in all places by parents and caregivers.
- All products made specifically for children like toys, play materials, cycles, and others should be made safer and certified by safety authorities.
- Standards with regard to balconies, terraces, staircases with railings and grills should be strictly enforced.
- Encourage use of anti-skid resistant flooring materials.
- All electrical products should be made safer and not to be within easy reach of children in homes.
- All dangerous products like unused medicines, detergents, kerosene, stoves, lamps, inflammable substances, hazardous chemicals, cleaning agents, rat poison/mosquito repellents, cockroach repellents, insecticides and pesticides and other products should be kept out of reach of children.
- Restricting use of injury producing products and replacing with energy absorbing materials.
- Parents and caregivers should be informed of potential dangers at home and to be encouraged to take proactive measures.



Steps to prevent drowning among children

- Parents/caregivers/public and security personnel should be informed about the potential dangers of children entering watery bodies.

- Parents and caregivers should continuously supervise their children as long as children are in water.
- All public watery bodies like swimming pools should be supervised at all times. Similarly, all places like swimming pools, play sites, play areas in and around homes should conform to requisite safety standards.
- All watery places like sumps, wells, open watery drains to be covered at all times.
- Children should be encouraged to learn swimming from an early age so that they can protect themselves and help others at times of need.
- Display messages/warnings/instructions should be put up near all watery bodies to alert the public.
- Safety devices like life vests and other floatation devices should be available at all times when children enter water.
- Special precautions as informed by disaster management authorities should be followed at times of natural disasters like cyclones, floods, etc.



Steps to prevent playsite / recreational injuries among children

- Parents/caregivers/public and security personnel should be informed about the possibilities of children sustaining injuries and to be constantly vigilant.
- Parents and caregivers should continuously supervise their children as long as children are playing in recreational areas.
- All public recreational places like parks, playgrounds, open fields should be supervised at all times.
- Notification about the type of play site materials should be prominently displayed. The timings and type of activities, do's and don't's should be prominently displayed in these places.
- Energy absorbing materials should be used in all play sites to minimize the impact of an injury.

Advocacy and awareness are highly essential

A wide variety of professionals including public health experts, pediatricians, trauma care professionals, social scientists, legal experts, child psychologists and others need to strongly advocate for child safety to facilitate the development of child injury prevention policies and programmes. Furthermore, professionals need to get engaged on a regular basis to increase awareness among politicians, policy makers, professionals, media, judiciary, parents and caregivers and other stakeholders to adopt safety programme and activities.

Dedicated funding is vital

With no specific ring fenced budgeting for road safety or for prevention of child injuries in India, there is limited concerted action. In the year 2018-19, 3,150 million rupees were allocated for road transport and safety which is 0.4% of budget of MoRTH. There is a need to increase specific funding and spending on safety.

Inter-sectoral coordination is the need of the hour

Injury prevention is a cross-cutting issue involving departments of home, transport, education, health, social justice, youth empowerment and others. There is a need for creating mechanisms and institutional approaches between the different ministries/departments to realize cost-effective outcomes and reduction in deaths and disabilities.

Policies, law, Safety standards and guidelines need innovative enforcement and implementation

Over time, the response to the increasing problem of injuries has been fragmented and piecemeal that has resulted in the enactment of legislations/regulations/guidelines by the government and the judiciary to safeguard the interest and safety of children. However, enforcement and implementation

Child safety and injury prevention needs a serious consideration from all policy makers and professionals along with highest political support. Needless to say, children should not die or become disabled nor seek care in health care institutions for conditions that are predictable and preventable. It is time to act. It has been a challenge. Innovative, comprehensive technology based and acceptable strategies for enforcement and implementation of existing laws, policies and programmes is very much required.

Existing guidelines need better implementation..... Implementation is the KEY



Strengthen trauma care systems to provide quality paediatric trauma care services

Trauma care systems in hospitals need strengthening as per WHO essential guidelines for trauma care. Triage systems, human and physical resources, treatment protocols, guidelines specific to child trauma care needs to be established across level 2 and 3 trauma care facilities across the country.

Early first aid, safe transportation, appropriate referrals, triage systems, trained professionals, good management practices and appropriate referrals needs to be established in all ER rooms in India.

Rehabilitation programmes need strengthening

Rehabilitation services for children affected by trauma needs to be strengthened by establishing continuous and coordinated activities between departments of social justice, education and health, across the country. Data regarding disabilities among children with injuries and outcomes of rehabilitation services needs to be strengthened at all levels to implement evidence based programmes including Community Based Rehabilitation (CBR).

School based rehabilitation programmes should be encouraged in all schools to the possible extent.

Monitoring and evaluation are central to measure programmes

All programmes and activities should be systematically monitored using good quality data to measure progress. These activities should not just count on programmes but focus on quality and actual reduction in deaths and injuries.

Child safety and injury prevention needs a serious consideration from all policy makers and professionals along with highest political support. Needless to say, children should not die or become disabled nor seek care in health care institutions for conditions that are predictable and preventable. It is time to act.

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