Participatory Communication Strategies for strengthening Child Care Systems: Care Structure, Procedures, and Concerns in Children's Homes

Dr. Sadguna Karri[1], Dr. T. Tripura Sundari[2]

[1]MCJ, PhD, Assistant News Editor, Doordarshan, Vijayawada

[2]Professor, Department of Communication & Journalism, Sri Padmavati Mahila Visvavidyalayam (Women's University), Tirupati - 517502

Abstract

Participatory communication strategies have become a cornerstone in the development and strengthening of child care systems, especially in children's homes. These strategies involve engaging children, caregivers, staff, and other stakeholders in meaningful dialogue and decision-making processes. This review explores the existing literature on the implementation and impact of participatory communication in the care structure, procedures, and concerns within children's homes.

This literature review explores the role of participatory communication strategies in strengthening child care systems, particularly focusing on the care structure, procedures, and concerns within children's homes. Grounded in theories of participatory development and communication for social change, the review highlights the importance of involving children, caregivers, and other stakeholders in meaningful dialogue and decision-making processes. Key areas examined include the organizational structure of children's homes, the role of caregivers, decision-making procedures, and feedback mechanisms. The review also addresses significant concerns such as power imbalances, cultural sensitivity, and the challenges of measuring the impact of participatory strategies. Findings indicate that participatory communication can lead to more inclusive and responsive care environments, enhancing children's sense of agency and responsibility. However, successful implementation requires addressing existing power dynamics, ensuring cultural appropriateness, and developing effective methods for impact assessment. This review underscores the potential of participatory communication to transform child care systems and improve outcomes for children in care.

Keywords: Participatory Communication; Child Care Systems; Children's Homes; Institutional Care; Vulnerable Children

Introduction:

The resilience and psychosocial wellbeing aspects of vulnerable children in institutional care were kept unaddressed for a long. After ratifying UNCRC in 1992, Indian governments started focusing on the issues of overall wellbeing and development of institutionalized children to concentrate on their social reintegration. The JJ Act laid down provisions for contemplating children's best interests and establishing

child-friendly care systems to assure proper care, protection, development, treatment, and social reintegration. The Juvenile Justice system provides guidelines and procedures for boosting vulnerable children's development needs and wellbeing.

Accordingly, Child Care Institutions (CCIs) strive to provide a categorical safe space enabling the child to heal from trauma, retrieve trust and acquire life skills to manage and assimilate with the external world. The CCIs have to uplift the care standards laid down by the JJ Act, 2015 and JJ Model Rules, 2016 and provide guidelines and capacity building initiatives to all the stakeholders regarding their roles and responsibilities in child care. As per the prescribed care standards, all the homes/CCIs must enable children's safety, security, and dignity on their respective premises. However, homes/CCIs are least desirable for long term or permanent placement. They only serve as a last possible resort for safety and shelter.

Provisions for Institutional Care and Licensing

Children's homes provide care, protection, rehabilitation and social reintegration services to children in need of care and protection in an institutional setting. Initially, the JJ Act 2000 laid down care procedures and guiding legislation for homes/CCIs, further amended and consolidated in JJ Act 2015. The institutes provide age-appropriate interventions to address vulnerable children's developmental needs, including physical, psychological, emotional, social, educational, cultural, economic and moral concerns that are significant for sustaining wellbeing. They also render case management, including preparation and follow up of individual care plans, birth registration and any other required intervention to ensure the wellbeing of the vulnerable child. They work in coordination with the concerned government departments and allied networks. Apart from care services, vulnerable children's rehabilitation and social reintegration are essential for children as they grow up to become adults.

Children's homes (Section 50 & Rule 29 of JJ Act 2015) are established and maintained in every district or group of districts by the government itself or through voluntary or NGOs. The concerned state department issues license to the children's homes to place children in need of care and protection for their shelter, treatment, education, training, development and rehabilitation. Children's homes are to be set up separately for boys and girls. All the homes (run by the government or voluntary organization/ NGO) should be registered as per the sub-section (1) of Section 41 of the Juvenile Justice (Care and Protection of Children) Act, 2015.

The Child Welfare Committee (CWC) issues orders for the placement of a child in a care institution. The committee is a statutory body under the Juvenile Justice (Care and Protection of Children) Act, 2015, to look into the concerns of Children in Need of Care and Protection (CNCP) and disposal of such cases. It possesses the powers of a Metropolitan Magistrate or a Judicial Magistrate of the First Class as a Bench of Magistrates. While entering care, children are offered services such as initial rapport building, familiarity with the institution, staff and other inmates, welcome ceremony, counselling, and peer group interaction.

Children's institutionalization should be considered the last resort as children need a family-like environment for their growth and overall development. The homes should make decisions and actions regarding the rehabilitation of any child in need of care and protection only through the concerned district's CWC. In the case institutionalization is the preferred/only resort available, children should get rehabilitation in institutions in the same geographical area. The CCI should prepare an individual care plan during this period keeping in mind the child's best interest and exploring a more permanent solution. The

individual care plan is a comprehensive plan for a child's development based on age and gender-specific needs and case history, prepared in consultation with the child to restore wellbeing.

The plan addresses health and nutrition needs, including any special needs, emotional/ psychological needs, educational/training needs, leisure, creativity, and play. It provides protection from all kinds of abuse, neglect and maltreatment. The plan offers life skill training, restoration and follow-up services aimed at children's social mainstreaming. The home should develop individual care plans for every child kept in its care. It needs to be reviewed from time to time to ensure appropriate development and rehabilitation.

Care standards include infrastructure, amenities, health and hygiene facilities, security measures, nutrition, medical services, counselling, education, vocational training, recreation aids, record keeping/documentation, and staff recruitment concerns. The management committee of the children's home should initiate and maintain a grievance redressal cell. Care institutions have to generate and follow a child protection policy/protocol specifying the code of conduct to assure the safety and security of children nurtured on their premises. The management should also define disciplinary action against policy offenders or violators.

Concerns for Care and Supervision

Research establishes the harms of institutionalization on vulnerable children's development and wellbeing. However, outright adjuration of institutional care is not possible as it serves vulnerable children's immediate care and protection needs. Their existence is inevitable to meet the temporary placement requirements of children in dire conditions with no other possible/available options. The JJ Act and Rules laid down comprehensive provisions for homes/CCIs regarding care standards and rehabilitation process comprising infrastructure, occupancy, nutrition, staff recruitment, record keeping, and care/protection measures.

The Juvenile Justice System in India grants non-negotiable rights to children in all the matters related to them. Accordingly, child rights should be mediated and realized in all the care institutions in a child-friendly manner considering the child's best interest. The JJ Act emphasizes the rehabilitation and reintegration of children based on care plans. The total presumption of rehabilitation surrounds the quality of care available to the child requiring such service.

Caregivers are significant players in implementing the aims and objectives of the JJ Act and safeguarding vulnerable children. Home management must recruit sufficient caregivers to enable individual care and provide children with an opportunity to bond/attach with a specific caregiver instigating deep-rooted security. It eases monitoring children's daily routines, eliminating risks and ensuring safe living places in the home. All homes must recruit regular and adequate staff as per the specified care standards and monitor the occupancy of children considering the home capacity to assure best care practices.

The Indian constitution directs for child protection where specific child policies and schemes are enforced to realize the law and policy framework. The Juvenile System consents to the core principles of UNCRC, viz. the principle of non-discrimination, the principle of child's best interest, the principle of life, survival, and development, and the principle of inclusion and participation. Accordingly, every child care institution is expected to draft its Child Protection Policy (CPP) and strictly adhere to the procedures and mechanisms specified in the policy.

Such policy reflects the organization's commitment to safeguarding child rights. It administers basic guidelines for institutions for uplifting values and principles in child protection by clearly defining the

rules, regulations and directions for functionality to provide the safety of the inmate children. All the homes/CCIs must draft child policy for the institution and abide by the rules therein. The staff should get adequate training and be capacitated to meet the care concerns. Regular inspection and monitoring by the stakeholders or concerned authorities are also highly recommended to ensure care quality.

Procedures for Psychosocial Care

The homes must create child-friendly spaces enabling therapeutic group intervention with a conducive environment, general ambience and resource availability. They should avail facilitating environments and supporting/sensitive staff for conducting activities and programs. Maintaining confidentiality about a child's details is crucial for building trust and rapport. Caregivers should approach children in a non-critical and proactive manner to ensure their comfort. The homes suggested maintaining and updating the psychosocial profile of every inmate. It is essential to note down the significant observation while updating the psychosocial status of the children and duly complying with the recommendations. The psychosocial profiles should include activity plans aiming at attitudinal change, aptitude development and behavior modification. Encouraging children's involvement in different activities and tasks enhances their wellbeing.

Experts recommend facilitating medically prescribed tests during the initial psychological assessment, including detailed case history and cognitive evaluation and personality assessment considering the child's age. Children encountering risk behavior, trauma, mental health concerns, disorders, and addictions need psychological care. The person in charge must document the process, summarize the therapeutic interventions, and plan the follow-up sessions. Home management suggested recruiting trained and experienced counsellors and arranging to enable environments for developing interactive and participatory skills among children needing therapy (individual or group).

The care institutions must adopt a multi-pronged approach to increase awareness about different forms of abuse and facilitate children to cope and regain confidence in life. The management should arrange for safe places of interaction, regular screening of staff, professionals and feedback amongst the children. The counsellor and caregiver should regularly interact with the child individually and in groups to check flag signs of abuse (sexual, physical, emotional, verbal and any other) and signs of self-harm or disruptive behaviors. They should report such incidences as standard procedures, help the child develop coping skills, and initiate therapy and medication.

The homes must arrange for the required infrastructure and facilities for providing individual therapy as a critical mental health intervention. They have to collaborate with child guidance and counselling centers, psychology and psychiatric departments or similar government and non-government agencies for conducting specialized and regular therapeutic interventions. As per the recommendations and consultation with the mental health experts, an individual care plan shall include provisions for mental health. No child shall be administered medication for mental health problems without psychological evaluation and diagnosis by mental health professionals. Medicines should be distributed to the children only by medical staff.

Challenges in Care System

Developmental psychopathology suggests behavioral reactions as the evolving transactions between the child and the environment and the influence of previous adaptations on children's response to their current situations (Cummings et al., 2000). Children exposed to institutional care do not receive the nurturing and

stimulating environment needed for growth and healthy psychological development. Caregivers seldom commence social interactions, replying child's social demands, speedy reaction to emotional distress, or offering warmth and affection (Muhamedrahimov 1999).

The psychosocial deficiencies in institutions continue as the management cannot retain regularity in the caregiving process. Often caregivers are changed or transferred. Frequent staff turnover is a regular phenomenon in institutions. The caregivers are discouraged from forming emotional attachments with inmate children. Generally, caregiving is impersonal and routine rather than warm, affectionate, emotionally supportive, and conditionally responsive (Gunnar 2001). Hence, a low level of caregiver-child social interaction in institutions is maintained.

Inadequate psychosocial care has a severe impact on emotional wellbeing and mental health. Some could have a permanent effect (Rutter et al., 2010). Caregivers may also have unaddressed wellbeing issues such as ill-health, stigma, family loss/separation, work pressure and increased care responsibility resulting in stressful encounters with children. They may not support inmate children adequately at the individual level. Recent studies signified the negative impact of inadequate caregiving on attachment (Cyr et al., 2010).

The JJ Act 2015 ensures child-friendly plans for the care, protection, development, treatment, and social reintegration of vulnerable children. Care providers should be aware that the child-friendly approach can only realize children's psychosocial needs and coping strategies (Tadesse S. et al., 2014).

Strategies for Improving Psychosocial Environments

Care structure adds to the complexities and miseries of environmental vulnerability, influencing wellbeing and quality. Research establishes that the short- and long-term wellbeing of children primarily depends on their living environments and the care they acquire (Biemba et al., 2010). The home environment must have suitable living arrangements to offer better care, or there remains the danger of further victimization of vulnerable children during care. The homes should initiate the best possible ways to ensure the quality of care based on research and strive to offer conducive environments for children's holistic development.

The psychosocial development of children can be alleviated with regularized lifestyle and environmental support where they can identify and attach themselves with the same persons (friends, neighbors, and teachers). In unstable situations, children cannot make reference points for self-identity and belongingness, leading to further vulnerability. Interventions improving psychosocial environments have largely benefited children's development (St. Petersburg–USA Orphanage Research Team, 2008). Such interventions enable children to cherish joyful and fruitful childhood.

Microlevel initiatives may consist of strategies focusing on communication skills and healthy peer relationships. Personalized strategies focus on a child's temperament, strengths and weaknesses at the individual level and tailor interventions such as physical exercise, extra-curricular activities, and promoting benign peer relationships (Hornor, 2017).

Impact of Institutional Care on Resilience and Psychosocial Wellbeing

Vulnerable children in institutional care often suffer delayed and deviant developmental spans. According to Browne (2009), children under "care" for more than three months can be considered institutionalized. In most institutions, the living spaces are arranged with regular activities and routine time schedules. Such impersonal structures discourage forming bonding/parental relationships with caregivers and others, ultimately conditioning the social and emotional attachments of the children. Institutional care is criticized

for its negative consequences considering vulnerable children's psychosocial development. It marks structural neglect where the children could afford only minimum physical resources. In general, institutionalization is only suggested for temporary placement while accounting for care conditions (Munson & McMillen, 2009).

Many children are kept under care for extended periods due to unavoidable reasons. They perceive institutionalization as undesirable, experiencing a sense of loss that would condition their emotional development (Anaut, 2005). Such children may lack the necessary social and cultural skills to negotiate and manage the external world. Besides hampered physical growth, vulnerable children may also confront brain/neuroendocrine issues, delayed cognitive development and deviant/disorder attachment. Goldfarb and Bowlby conducted several studies on institutionalization. They concluded that children raised in institutions develop intellectual, emotional and behavioral deficiencies. Children face difficulties in social and language development, score low on intelligence tests and display limited learning capacities. They even find it challenging to concentrate and form emotional relationships.

Institutional care is a global phenomenon. Research establishes that besides abuse and neglect, socio-economic reasons necessitate children's institutionalization. Most children residing in children's homes have at least one parent/guardian alive. Still, they are compelled to stay in homes only to fulfil shelter and educational needs. Children may not develop a sense of belongingness and emotional satisfaction considering the increasing number of children joining care (Dowdell & Cavanaugh, 2009). Most care institutions operate just as 'hostels' offering food, cloth, shelter, and education. Here, children undergo a very restricted life leading to institutional child syndrome conditions, ultimately affecting the restoration and social reintegration process.

Care Implications on Resilience

Early institutional care is harmful to the development of emotional, behavioral and intellectual domains. Institutional care instigates adverse consequences on children's development (Johnson, Browne and Hamilton-Giachritsis, 2006). At a substantial level, entering institutional care involves complex and unstable relations with primary caregivers, limiting the resilient process further (Masten and Wright, 2010). It also reduces intellectual, social and behavioral abilities compared with those raised in families. In addressing materialistic needs, the psychological needs of children are severely compromised (Skinner D., Davids A., 2006).

In the care system, children face difficulty to lead an everyday life and often cannot afford the significant resilience promoting factors such as the scope to exert agency, parental support and positive educational involvement (Schofield, 2001). Institutional care poses challenges to children as it is a transitional state of adversity. Nevertheless, some adolescents display signs of resilience and can handle difficult situations. Resilience is a positive attitude that enables one to look for possibilities to reorganize and rebuild from rupture. It is essential for adjusting to the institutional environment and other adverse conditions.

Resilience helps survive crises and adversities. It is a dynamic process of absorbing personal strengths, external resources, and practical support systems (Masten & Wright, 2010). The development of resilience processes induces new motivations and enhances adjustment. As Kirk and Day (2011) specified, the development of life skills, self-concept and sense of life contribute to resilience and educational transitions.

Psychosocial Consequences of Institutionalization

Children in institutional care experience severe psychosocial deprivation and exhibit adverse developmental consequences in cognition and psychopathology (Nelson, Fox, & Zeanah, 2014). Children raised in institutions in early childhood are at risk of escalation for internalizing and externalizing disorders at a later developmental stage (Humphreys et al., 2015). Institutionalized children during adolescence face difficulties in acquiring social and emotional competencies. Around 40% of children raised in institutions may have developed symptoms of psychiatric disorders while attaining 12 years (Humphreys et al., 2015). Such vulnerabilities may also alter the evolving capacities of the neuroanatomical systems, such as the amygdala and hippocampus, affecting emotional processing (McEwen, 2004). Institutionalized children's social world is more restricted as their support network is confined to staff (Wekerle et al., 2007) and stakeholders. They hesitate to invest in social relationships and reorganize attachment with alternative figures, limiting the resilient process (Masten & Wright 2010).

Participatory Communication Strategies in Children's Homes

Communication serves the socialization process to a great extent. It paves the way for effective learning and developing cognitive and socialization skills. Individuals and their interactions activate and enrich the participatory process through communication involving planning, designing, and implementing strategic interventions through creative messages and products and identifying effective interpersonal, group and mass-media channels based on the participants' knowledge. Communication facilitates the transfer of ideas, thoughts and words from one another. The main objectives of communication are to persuade, seek information and express emotions. It is a two-way process referring to many forms people keep in touch with one another.

Communication serves more purposes than a mere exchange of information. It is vital to induce desired changes in human behavior and boost participation to achieve predetermined goals. Communication strategies can enhance learning. The primary purpose of communication is to change the person's desired direction who received the communication. Since participatory communication is dialogic, allowing sharing of information, perceptions and opinions among various stakeholders, it provides space for new knowledge to improve situations.

Communicating with Vulnerable Children

Vulnerable children's developmental stage determines the appropriateness of a communication strategy. At the same time, establishing rapport and asking understandable questions are also essential. Children's ability to comprehend a message depends on their past experiences. They communicate verbally and nonverbally – more verbal with age, precisely through play, touch, drawings, color, storytelling and music. Children, in general, can respond to positive communication and develop to realize their full potential. As specified by UNCRC, children enjoy specific communication rights such as the right to be heard, free speech and information. The convention firmly establishes the need to listen to children's voices and consider them seriously. It signifies the possibilities for assessing children's opinions and expanding their access to critical information. Communication should regard children's privacy and dignity, forwarding their self-esteem and confidence. While promoting children's voices, the initiation must be more than a mere token attempt to reflect the "child perspective" in the first place, supporting their problem-solving skills and overall development.

Child care professionals can achieve better results by centralizing child perspectives (Maaskant et al., 2016) while seeking needs identification, making important decisions, or selecting a therapy (Akin et al., 2018). Participatory communication strategies improve the institution's psychosocial environments, where children's perspectives, decision-making, and participation are encouraged.

Importance of Child Participation

Participation reflects the core idea of promoting child rights, as specified in the UNCRC (1989). It concerns their 'emerging capacities' to participate, advancing an enabling concept (Lansdown, 2005). Participation is a form of communication to establish a relationship of mutual respect and trust. Beazley and Ennew (2006) suggest that participation relies on employing and testing a method in action.

Children's participation is a prerequisite for ensuring their control over life and its quality. In due course, participatory decision-making empowers one to attain own wellbeing (Honkalaskar et al., 2004). Children should get the space and time to express their opinions and personal needs with people capable of listening and initiating supportive or corrective actions. Accordingly, children could achieve and sustain subjective wellbeing.

Framing of a Communication Strategy

A communication strategy seeks attention to planning, situation analysis, work progress, and explicit goal identification. Framing a communication strategy reduces uncertainties and reiterates planning by involving all the participants/stakeholders. Likewise, while preparing a communication strategy, careful consideration of the essential elements of communication such as source, receiver, message, channel, and language enhances its acceptability.

A communication strategy enunciates, describes and forwards a vision leading to specific goals. It creates continuity and consolidation to 'voice', linking diversified activities and plans to appeal to the audience. Primarily, communication affects people's thinking, beliefs and feelings. A communication strategy realizes a predefined goal by adopting systematically planned activities. It comprises various methods, techniques and tools to attain specific objectives using available resources within a particular time frame. Here, a key role can be ascribed to the public sphere, redefining it as a communicative sphere, which is participative rather than representative (Bentele & Nothhaft, 2010)

Formulating an absolute and workable strategy is complex, mainly when it strategically aims at behavior and social changes. Similarly, identifying and analyzing the short-period impact also remains challenging. The strategic communication indicators should signify changes at the individual and societal levels. Combining strategies can promote an individual's resilience initiative (Masten & Gewirtz, 2006). Every individual is unique, and customizing the strategies considering available resources and limitations is advisable based on the individual's personality construct (Masten & Gewirtz, 2006). Strategic communication is restrictive, but it provides space for dialogue and discussion, offering endless possibilities for consultation.

Communication Interventions as Strategies

Studies reveal that interventions to boost resilience and enhance social and personal competencies and skills are essential to cope with many psychosocial symptoms. Such ailments are due to the inability of children to face life challenges. Interventions support children's resilient skills (Lynch, Geller, & Schmidt, 2004), and emotional functioning (Watson et al., 2014). Other results include coping skills, improved

social and emotional competencies, problem-solving skills, and self-regulation (Lynch, Geller, & Schmidt, 2004).

Experiencing traumatic events in early life cycles increase psychological, developmental and medical challenges (Modi et al., 2016). Communication interventions as strategies help influence peoples' attitudes and behaviors, and as such, children in situations of social vulnerability benefit after intervention (Richaud, 2010). Likewise, vulnerable children could realize life opportunities by providing psychological intervention. Traumatic events in childhood, such as parental death and illness, are interconnected with physical, psychiatric, and psychosocial health problems (Bauman et al., 2006). Without proper intervention, vulnerable children have a probability of encountering problems while attaining adulthood (Luthar & Cicchetti, 2000).

Strengths-based communication portrays and nurtures the strengths and potential rather than deficits or problems. Here the principal goal is to teach and develop resilience and the capacity to cope through channelizing positive thoughts and actions. Such communication can be transformative. Research suggests intervening with vulnerable children to promote resilience and supporting their "identity development" in the best way possible. Stakeholders across countries have implemented several interventions such as cognitive behavioral techniques, therapeutic counselling, and peer-support/kids club (Hjemdal et al., 2011).

Resilience training (Zamirinejad et al., 2014) relieves psychosocial distress among vulnerable children. It is also necessary to consider the child's viewpoint during the design and implementation of strengths-based communication interventions. The interventions decreased behavioral issues and improved mood and peer relationships, leading to positive outcomes during adulthood and family functioning (Watson et al., 2014). Participation enhances social functioning, communication skills, and coping capacities. It reduces socially odd behaviors and stresses while adopting internal and external support mechanisms and improving resilience (Watson et al., 2014). With interventions, children become more available and open up to learning strategies. They facilitate identifying and coping with past traumatic events and memories (Nabors et al., 2016).

"Early intervention" refers to programs aimed at young children, critical in this life cycle. Preadolescence is a sensitive period marked by rapid brain development and instance of genetic factors which significantly influence health and illness issues. Rates of depression remarkably rise while entering adolescence (Maughan et al., 2013). Other mental conditions such as psychosis, obsessive-compulsive disorder and suicidal behavior also surface, which may be reduced with early interventions. Evidence suggests that intervention may be necessary as soon as problems arise in children and young people (Vincent, 2015). Humor is helpful to heal and cope with stress (Brooks & Goldstein, 2001). Implementing activities and interactions to encourage fun and laughter is essential for joyful learning.

Strategies to improve positive emotions are crucial for wellbeing. Incorporating resilience promoting strategies is a practical approach (Roosa, 2000). Interventions such as reinforcement, narration, music, drawing, games, mental and muscular relaxation, cost-benefit analyses, alternative solutions, and auto-referential techniques should be encouraged while addressing socially vulnerable child issues (Oros & Richaud, 2012). Sports activities and physical exercise can also promote relaxation. Due to financial and time constraints in most care set-ups, emphasis is laid on cost-effective psychological services and group therapies. Social skills groups deliver effective treatment interventions (Tynan, 1999).

Stakeholders across countries have implemented several interventions such as memory books (REPSSI, 2005), cognitive behavioral techniques (Tol et al., 2014), therapeutic counselling (Nyawasha & Chipunza,

2012), peer-support/kids club (Hjemdal et al., 2011) and resilience training (Zamirinejad et al., 2014) to relieve psychosocial distress among vulnerable children. Seligman's Penn Program (Seligman, 1995) could develop optimistic thinking in children through involvement in thought awareness, realistic assessment, and generating more accurate explanations. Anyhow, the psychosocial outcome measures differ from study to study.

Based on substantial research, UNICEF advocates life skills education for vulnerable children. Life skills training promotes mental wellbeing and competence in young people. Orphan and vulnerable children benefit from arts-based life skills education. It provides opportunities for children to express, display, and improvise their habits while discovering a hopeful perspective of their surrounding environments. Emotional discomfort is natural during and after exposure to traumatic events, and children should get the space to convey their concerns (Grados & Alvord, 2003). Cognitive restructuring changes the children's judgement of accomplishments (Bandura, 1997).

Children benefit from regular and orderly daily routines and activities. As suggested in the working paper of the World Bank (Tufte & Mefalopulos, 2009), one of the most significant drawbacks of successful communication interventions is the discontinuation of related activities. It is obligatory to generalize change to the natural settings of home, school, and community to instill resilience. Goldstein and Martens (2000) suggest a deliberate generalization program. They assert that the repeated practice of successful attempts enhances generalizability and the fruitful implementation of strategies.

Participatory Communication Strategies and Wellbeing

Participatory communication has evolved as an essential study topic in development communication since the 1970s (Walker, 2007). Even though there are various concepts of participatory communication (Jacobson & Kolluri, 1999), it assumes an unparalleled process of communicative action as it is primarily dialogue-driven. There are several guiding principles for the practical application of participatory communication. It is the means to an end (Bordenave, 1999). In participatory communication, all the stakeholders have free and equal access to the means while expressing their viewpoints, feelings, and experiences. Collective action initiates and promotes interests, problem-solving, and societal transformation.

The core idea of participatory communication is "free and open dialogue" (Tufte & Mefalopulos, 2009). It ensures information exchange, problem identification, communication strategies development, and solutions implementation. Hearing different opinions and ideas brings the desired change in power relations as it provides space for the voices of individuals involved in dialogic communication.

The child's point of view is now regarded as a fundamental requisite for understanding wellbeing (Gorza & Bolter, 2012). Active participation and exchanging dialogue at the individual level are crucial for behavior change communication. Interventions reduced stress and upsetting feelings related to traumatic events and enhanced self-affirmation and self-esteem in children (Nabors, Baker-Phibbs & Woodson, 2016). Studies also reveal higher resilience, emotional comfortability, improved self-control, and decreased impulsive behavior (Folostina et al., 2015).

Unfortunately, in Indian society, child participation had received the least preference. Still, many consider it unimportant and not ready to provide space for child participation. Children are discouraged from expressing their opinions before elders and bound to obey their orders without question. They are considered incapable and not allowed to make their own decisions. The Indian education system also

reflects a similar approach. However, awareness of children's visibility in decision-making processes prioritized in different sectors served as a catalyst for change in recent years.

Participatory communication is more child-friendly than the didactic forms of communication, providing an opportunity for the stakeholders to involve cognitively, physically and emotionally. It can prevent many conflicts and obstacles if addressed quickly (Thomas Tufte, Paolo Mefalopulos, 2009). Participatory approaches involve children's direct experiences offering value and status to their views/perspectives.

Care and Children's Homes

The JJ Act 2015 directs for vulnerable children's care, protection, development, treatment, and social reintegration. It suggests adopting a child-friendly approach in adjudicating matters in children's best interest and enabling their rehabilitation through specified processes and establishing institutions/ bodies. Children's home is one such Child Care Institution (CCI) established for offering care and protection to children in need of such services. As per the provisions, the State Government, either by itself or through a voluntary NGO, establishes or maintains children's homes in every district or group of districts for the care, treatment, education, training, development and rehabilitation of children in need of care and protection. The Collectorate issues licenses to the Children's Homes as per the procedures. The homes have to collaborate with the concerned Government Departments and other allied systems.

The vulnerable child falling under the CNCP category gets placement in a children's home as per the Child Welfare Committee (CWC) orders. After due inquiry, if the CWC opines that the child has no family/guardian and needs protection, it issues such a placement order. The child remains in the home until proper rehabilitation or 18 years of age.

Care communication becomes difficult under such diversified contexts and cultures. It requires keen attention in selecting the appropriate strategies. At this juncture, the literature review is crucial while understanding and addressing the emerging vital aspects of "care" and "wellbeing" in developing effective participatory communication strategies and ensuring active involvement of vulnerable children in decision-making and adopting suitable interventions. The assessment of wellbeing concerns helps to prioritize vulnerability issues through appropriate communication interventions.

The findings of previous studies indicated that orphan children suffered sadness, anger, stress, anxiety, isolation, discrimination, capital punishment, bullying, stigma, attachment disorders, and depression, affecting their overall wellbeing. As the caregivers lack counselling knowledge and skills, they cause challenges. They had limited freedom and knowledge to discipline children displaying misbehaviors. The researchers opined that the provisions for food, clothes and sports alone would not solve psychological problems. The children need to develop a sense of security by attaching to the primary caregivers. The study advocated capital support besides regular visits to the centers offering humor, love and care. It recommends care quality as the determining factor for bringing psychological wellbeing.

The care centers need to improvise counselling services to bring self-awareness and education among inmates. Each center should appoint a counsellor. They should encourage and train the caregivers to adopt best care practices. The researchers advocate for collective social activities to reduce feelings of isolation. Likewise, they also suggest improvements in the recreational services for strengthening emotional support. Such initiations would strengthen the caregiver's role and enable them to develop a social network with the community.

The institutional centers should recruit caregivers who are child friendly and trained in psychology and arrange for counselling sessions. Such measures would address children's psychological problems. The

study also stresses the essential role of communities in building psychosocial wellbeing. Likewise, the governments and stakeholders should ensure social services, psychological support and counselling training for caregivers to reduce children's psychological problems.

Effects of Institutional Care on Wellbeing

Research has confirmed that institutional care in early life leads to intellectual, behavioral and social problems. Young people nurtured in residential care settings are more prone to poor mental health. Even though resilience enhances mental health and promotes wellbeing by reducing the effects of adversities, its conceptualization is complex, considering its multifaceted nature. The evidence signifies that early institutional care is detrimental to all developmental domains of children.

Most under-stimulated children living in care structures have disrupted mind development and delayed language acquisition. Goldfarb (1945) studied speech and language organizing capacities during infancy, 6-8 years, and adolescence. He compared fostered children from these three age groups with children of the same age group residing in institutions and found a clear difference in language development. Brainpower, speech, motor coordination, social maturity, and character were the aspects considered for the study. It emphasized that deprivation in the early phases of development would also curtail psychological development in the later stages. Even after getting placement in other foster care facilities, the effects continued, and some children carried the negative impacts until psychiatric treatment.

Jackson and Martin (1998) studied education and resilience of looked after children thriving in the care system. The study compared a group of "high achievers" (n=38) with low-performing young people where the two groups' pre-care situation was similar. The researchers found that most care environments undervalue education. They reported frequent moves in care patterns, staff discontinuity, and a lack of space to study and do homework. Despite several initiatives, the care children's educational performance remained poor.

The findings noted that children who could do well in their studies had a good relationship with at least one person who could offer the much-needed support and advice. They availed significant study periods outside school, learning to read early and peer groups with an optimistic value of education. It reveals that support for looking after children's educational careers remains a far lower priority in residential and foster care settings.

The typical detrimental characteristic of care structure is the lack of opportunities to bond with a significant parental figure/adult. The institutional practices are primarily concerned with offering physical care and establishing routines rather than emphasizing social interaction and individual care (Giese and Dawes, 1999). A socially rich family environment facilitates infant brain growth, whereas a poor environment affected by parental negligence or institutional care can suppress brain development (Glaser, 2000).

Parental support offers a one-to-one relationship, which significantly encourages an infant's brain development by stimulating the neural pathways and synaptic connections. Studies reveal that early institutional affects all the areas in the cortex. It is observed that metabolic activity in the frontal and temporal lobes is drastically reduced (Chugani et al., 2001). The connections between these regions are also reduced (Eluvanthingal et al., 2006), leading to neural and behavioral deficits in emotions, language and social interactions.

Johnson et al. (2006) investigated 27 studies regarding children raised in care institutions. Out of them, 17 studies discussed the social and behavioral issues that were more common in these children when compared to other children. 16 out of 17 studies (94%) showed negative behavioral and social

consequences for children nurtured in institutional care. The studies emphasized anti-social conduct, social capability, play and peer/sibling connections. One in ten children who spent their early lives in these institutions are living in underprivileged circumstances, often interact less with others and are showing 'quasi-autistic' behaviors like face guarding and conventional 'self-stimulation/ comfort' behaviors, such as body shaking or head hitting (Rutter et al., 2007).

Johnson et al. (2006) reviewed 12 studies that discussed the development of emotional attachments in children raised in child institutions and compared them with other children. Only one study found no supportive evidence for more attachment difficulties in children living in residential care. Nine studies suggest more uncritical friendliness, over-friendliness, and irrational behavior for children in institutions, suggesting 'disorganized attachment disorder' has a more significant occurrence among these children than children with families or children admitted to institutional care after the age of two years (Rutter et al., 2007).

Johnson et al. (2006) concluded that 12 of the 13 studies demonstrated the adverse effects of institutional environment on the development of the mind by discussing the ability of children in institutional care to think and reason (intellectual development) and reported that they deprived cognitive performance having lower I.Q levels when compared to family-based care.

Roy and Rutter (2006) reported deficits in the children's language skills raised in institutions depriving early reading performance. As Tizard and Joseph (1970) mentioned, deficits include poorer vocabulary and less spontaneity. The advances in the neurobiology field enabled the systematic review of child-rearing in institutional care. A child has nearly 100 billion neurons at birth, and in the first two years, each neuron could form up to 15,000 synapses (Balbernie, 2001). The excess of neurons and synapses in the brain helps in environmental adaptation. Early experiences are crucial in determining the neural pathways (Balbernie, 2001).

An infant is genetically structured to interact with others and for optimal brain development interacting with a caregiver is necessary. The caregiver needs to talk, respond, and handle the infant sensitively and consistently. The infants should get repeated new stimuli appropriate to their development stage (Trevarthen and Aitken, 2001). A relationship with the primary caregiver, especially the mother, is essential to instigating an infant's brain development (Perry and Pollard, 1998). Studies suggest that early institutional care damages an infant's holistic development. Apart from staff and care issues, lack of personal possessions, books and play equipment, missing everyday experiences, and immobility outside the institution contribute to developmental delays (Mulheir and Browne, 2007).

Nelson et al. (2007) observed children in European residential care homes and found that the children raised in poorer quality institutions displayed stereotypical behavior. After six months of stay in care, they become withdrawn due to failed interactive initiatives. The indifferent care practices made children non-sociable and constrained their efforts to interact with others. The study is primarily relevant to children under three years of age, where a six-month institutional placement consists of a crucial early life experience.

Yang et al. (2007) suggests childhood institutional care as a risk factor for developing an adult personality disorder. It might be related to the risks of abuse and neglect in care. Even the well-established institutions offering good quality care can damage children's natural ability to socialize and form relationships. The absence of a sincere and constant attachment with a sensitive caregiver can lead to attachment disorder. Such condition is rampant in children exposed to early institutional care.

Bakermans-Kranenburg et al. (2011) analyzed six studies conducted on institutionalized children. They considered the quality of attachment with the caregivers. The findings revealed that 73 % of children suffer insecure and disorganized attachment behaviors. They manifested difficulties in establishing friendships and were apprehensive of strangers as the institutional environment lacked sensitivity and responsive interactions. Lability and turnover of caregivers were projected as the main reasons for such problematic behaviors.

Roeber et al. (2012) examined the effects of early institutional experience on motor skills. The sample consisted of 8-15 old children adopted in the United States. Children displayed significant balance and bilateral coordination delays despite an average stay of 6 years in their adoptive homes. They were continuing the delays compared to a sample of family-reared children from the same age group. It emphasizes that an enriched environment alone may not help overcome the harmful effects of institutional care.

Sandhyarani M. C. & Rao C. Usha (2016) studied the perceptions of adjustment among institutionalized adolescent girls in selected districts of Karnataka, India. The universe of the study was 103 adolescent girls between the 13 - 18 age group. The researchers attempted to understand the different dimensions of adjustment, including home, peer, school, teacher, and general adjustment. Most of the girls reported experiencing adjustment problems in the institutions.

Taylor E. et al. (2018) explored the conceptualization, operationalization and measurement of resilience. They studied children and adolescents living in residential care settings experiencing more problems and vulnerability. The findings signify that the higher levels of resilience were related to better developmental outcomes. The study recommends systematic inclusion and evaluation of resilience promoting design and interventions in care settings.

Significance of Participatory Communication Strategies
Fundamentals of a Strategy

A strategy is a plan, course of action, or guideline to cope with a situation. Henry Mintzberg (1987) described plan, ploy, pattern, position, and perspective as five strategy definitions. It helps to understand better and manage accordingly the processes by which strategies form. Strategies have two prominent features, i.e., they are designed well before implementing the actions and developed consciously and purposely. A communication strategy's primary attention is on planning and understanding the situation. It enables carrying out the specific work and identifying its goals.

Framing a communication strategy builds confidence by reducing doubts about the project. It increases visibility, emphasizes planning and increases project participation. A well-defined strategy with a keen understanding of the project goals can ensure participatory development. Need-based assessment and cautiously selecting the source, message, channel, and receiver, and using feedback and local language would improve the acceptability of a communication strategy.

UNICEF (2008) developed a tool (Writing a Communication Strategy for Development Programs: A Guideline for Program Managers and Communication Officers) to guide writing a communication strategy with specific objectives. It disapproved of a top-down approach while developing a strategy and advocated for involving program participants and development partners. It contained two main parts: analyzing and developing the communication strategy. At the outset, it advised on the strategy development analyses. It stressed the need to understand the participants' behavior and identify proper channels to communicate with them.

The second part suggested developing the strategy based on the analyses results and communication objectives. It attempted to enlighten on advocacy, social mobilization and behavior change communication. The UNICEF team provided practical advice for developing, designing and writing the strategy that ensures the primary participants' participation and the community. The guideline also considered the features of available communication channels. It also advised selecting the channels to fit the participants and the communication task.

Paolo Mefalopulos and Chris Kamlongera (2004) developed a handbook on Participatory Communications Strategy Design (PCSD) which was helpful as a training and field guide for developing strategies for field projects. It was helpful for designing, implementing and managing communication. It focused on planning a communication strategy design with participatory elements and at the field level, facilitating the principles and processes of communication planning, message development, multimedia material production, and communication activities. It also explained the basics of the communication strategy plan, participatory designs of messages and themes, communication materials and media issues. The handbook emphasized managing the communication program's planning and implementation.

Communication Interventions and Wellbeing

Seligman (1998) studied the Penn Prevention Program, which was intended to bring changes in children's thinking patterns from pessimism to optimism with the help of cognitive behavioral therapy. The school-based Penn Prevention Program was primarily aiming the general population and not at clinical setups. The strategies involved comic strip characters, role-playing, games, discussions, and videos in a 12-week program. The intervention group displayed a 50% drop in depression levels, and no change was found in the control group. The baseline profiles of both these groups were similar.

Catterall, J. S. (2002) conducted a peer conflict resolution skills program comprising over twenty-four weeks of drama schedules with adolescent students. The groups were encouraged to create and enact the original plays using drama, theatre, writing, and visual arts. They conducted ninety-minute workshops once a week to avail sufficient time for practice. During these interventions, the participants developed expertise, critical thinking skills, and self-motivation.

The study established links between arts and life skills development, associating music with spatial reasoning and the ability to plan. It was evident that drama consistently affected component skills, including character building, reading and writing, and interpersonal skills especially handling conflicts. The results signified art programs for developing cognitive, social, and personal competencies.

Cameron L. et al. (2007) analyzed two studies about the interventions designed on the hypothesis of extended contact and multiple classification skills training to encourage positive intergroup attitudes among children. The researchers considered two stigmatized groups as the sample. The first study analyzed whether these interventions can change the out-group attitudes towards the disabled among 6 to 9 old children. The results revealed that the out-group attitudes were more positive in the extended contact condition when compared to the control group.

The second study consisted of control, extended contact, modified multiple classification skills training, and a blend of interventions. Children between 6 to 11 years who received extended contact and combined interventions developed notably more positive attitudes towards the refugee out-group than the control group. The findings suggested that theoretically derived interventions had reduced prejudice and could be introduced in an educational setting. They brought significant changes in children's stereotyping attitudes towards stigmatized groups.

Chitiyo et al. (2008) ascertained the effectiveness of psychosocial support (PSS) in enhancing schooling outcomes among children orphaned by AIDS. This study involved 20 children between 10 to14 years studying at four primary schools in the rural district of Zimbabwe. Children showed signs of withdrawal, short temper, crying, bullying, and academic underperformance in the initial stages. After exposure to psychosocial support for eight months, the children could improve performance in several areas, including schoolwork. The process involved counselling the children to cope with grief and bereavement. The patrons counselled children at varying intervals considering their need levels.

The counselling process did not follow any predetermined structure as the sessions were primarily based on children's responses. Children were engaged in ball games like netball, soccer, and trust-fall games to socialize them by being part of a team. They were also encouraged to form buddy clubs to assist with household chores and homework rotational. This initiative enhanced their group participation, significantly reducing alone time. As suggested by the patrons, games could yield positive results, where children felt motivated and encouraged after taking part in games. The children could interact more with their peers.

Freeman, Fulton, and Sullivan (2010) studied children in 3rd and 4th grade who had participated in creative drama activities. The project was for eighteen weeks, where children were engaged in dramas one day per week. The sample consisted of 237 participants who were selected and assigned to groups randomly. The researchers used factorial analysis of variance for data analysis. The findings revealed that children improved their self-concept when provided with the opportunities to involve in an uncritical atmosphere. The study reaffirmed the positive effects of creative drama activities on improving self-concept and social skills and reducing problem behavior.

Mueller, Joanne et al. (2010) studied "Make A Difference about Art", a community program in South Africa. The program aimed at reducing psychosocial problems and improving self-esteem, self-efficacy and HIV awareness among children affected by HIV and AIDS. The study was a quasi-experimental cross-sectional post-intervention survey consisted 297 children aged between 8-and 18 years, including 177 program attendees and 120 control group participants. The researchers used standardized and validated psychosocial scales in the inventory to derive measures of depression, emotional and behavioral problems, self-esteem, and self-efficacy. They also considered sociodemographic variables relevant as risk and protective factors.

The findings revealed that children's psychosocial health was severely affected by double parental death, and attending the intervention was significantly anticipated with higher self-efficacy. It waived the alliance related to intervention attendance and degree of self-efficacy. However, the study established an association between deprivation status and intervention attendance on children's self-efficacy. The results suggested intervention programs for reducing orphanhood related psychosocial vulnerabilities by providing opportunities for increasing the self-efficacy of vulnerable children. It also advocated social connection as a vital protective factor.

Miller et al. (2011) conducted a study in Uganda on peer-group intervention involving teachers and health care that could remarkably decrease anxiety and depression, and other psychosocial problems. Likewise, Houck, Darnell and Lussmann (2002) studied a peer-support program and reported reduced stress and distress signs among depressed adolescents. However, early interventions would offer the needed psychosocial support to the vulnerable children enabling them to be more resilient and survive in adverse conditions.

Balfour et al. (2013) studied the WhizzKids program conducted by a South African non-profit organization engaging the country's youth in HIV prevention. The organization's primary program, "WhizzKids United", engaged the elementary school children in Pietermaritzburg, South Africa. It was aimed at offering knowledge and life skills vital for HIV prevention. The program addressed large groups in eight sessions over a 12-week duration utilizing soccer as an intervention tool. It strived to change children's attitudes towards HIV and improve self-efficacy for making healthy choices contributing to sexual health.

Folostina, R. et al. (2015) studied resilience issues among at-risk children. The prior understanding was that children were more frightened to witness traumatic events, mainly when such incidents involved significant people in their lives. The study intended to draw inferences on the impact of play and drama sessions on the resilience levels of at-risk children who displayed aggressiveness and underperformance in school tasks/school refusal. The play and drama sessions consisted of basic structure, i.e., warm-up, main event and closure. After participating in these interventions, children felt more self-confident and could reduce disruptive behaviors. Likewise, creative work sessions could offer alternative communication and opportunities for group work.

During art and play activities, children could explore their physical and social environment, which enabled them to address emotional problems. By creating a role, they could achieve a satisfactory state through imaginary events. The creative work sessions showed considerable influence on the teaching staff as well. They were able to realize the unique needs of these problematic children and learned new ways to approach them with care and concern. These sessions could help them understand the importance of availability and attachment while working with at-risk children.

Leventhal, K. S. et al. (2015) conducted a randomized controlled trial in Bihar, India. The sample consisted of 2308 rural adolescent girls studying in 57 government schools on a five-month resilience-based program (Girls First Resilience Curriculum or R.C.). Local women with at least a 10th-grade education participated as group facilitators. The trial revealed that girls exposed to the resilience curriculum could improve emotional resilience, self-efficacy, social-emotional assets, psychological wellbeing, and social wellbeing. The intervention condition girls could reduce symptoms of anxiety and depression and improve social wellbeing. These results suggest that a brief school day program can improve the psychosocial assets and wellbeing of girls in high poverty and studying in rural schools.

Purohit, S. P. et al. (2016) observed and evaluated the effect of perceived wellbeing of orphan adolescents after cognitive Yoga practice, appreciating the loneliness scale for three months. The findings revealed a significant difference (p=0.001) in post scores of self-esteem and self-regulation. The beneficial effect of Yoga in the improving group (19.28 %) had a higher score on concentration, mood, and functioning capacities under pressure. The study showed a decrease in loneliness levels after three months of participation in the Yoga program. The Yoga group displayed better improvement than the control group.

Schiller, U.& de Wet, G. (2018) studied the experiences of adolescents reared in foster care in an indigenous South Africa. It emphasized participatory decision making. The researchers conducted qualitative exploratory research among 29 adolescents in foster care. They also analysed the data collected from 13 adolescents using semi-structured interviews and two focus groups, each of eight adolescent participants. The findings suggest a lack of openness in the foster care system concerning the utility of the communication approach, international covenants, and legislation. The foster family's socio-cultural situation served as a prominent inhibiting factor for adolescents' free and open communication level and their decision-making placement.

Olowokere, A.E. & Okanlawon, F.A (2018) examined sustaining psychosocial wellbeing among vulnerable in-school children in Nigeria. They attempted to compare the impact of resilience-based training and peer support activities using a comparative perspective design. The sample consisted of 339 vulnerable children selected from public high schools. Overall, the study attempted to understand the psychosocial interventions, namely peer support and resilience training and their effects on psychosocial health outcomes, including anxiety, depression, self-esteem and social connection. The findings suggest that resilience training enhances self-esteem apart from reducing anxiety symptoms compared to peer-support interventions. Although the effect size was small, it could be considered significant.

Cie'slik, M.M et al. (2019) studied the prominent predictors of a positive attitude towards life and self during adolescence. The researchers collected data in 2010 from 2562 Polish adolescents aged between 15- and 17-years using Health Behavior in School-Aged Children survey. They employed a 4-item Positive Attitude Scale (PAS) to measure positive attitude. For gender, age and family affluence, univariate analysis of variance and hierarchical linear regression models were adjusted. The mean PAS score was 13.25 (SD = 3.74) on a 0–20 scale.

The final model included eight out of 18 variables to explain 25.1% of PAS variability. The results established that communication in the family and with peers and neighborhoods was crucial as social capital, playing a prominent role in inculcating positive attitudes among adolescents. Physical activity, eating breakfast, and school performance were significant predictors. The study suggests developing interpersonal competencies, promoting physical activity and supporting school performance, in adolescents' mental health promotion programs, particularly for girls.

Conclusion:

In summary, the review of research confirms that participatory communication strategies are vital for strengthening child care systems in children's homes. These strategies ensure that all stakeholders are heard and valued, leading to more effective, compassionate, and child-centered care. The continuous engagement and empowerment of stakeholders foster an environment of trust, transparency, and continuous improvement, ultimately enhancing the well-being and development of children in care.

References:

1. Akin, B. A., Lang, K., Yan, Y., & McDonald, T. P. (2018). Randomized trial of PMTO in foster care: 12-month child well-being, parenting, and caregiver functioning outcomes. *Children and Youth Services Review, 95,* 49–63. https://doi.org/10.1016/j.childyouth.2018.10.018.

2. Anaut, M. (2005). *A resilieˆncia: Ultrapassar os traumatismos* [Resilience: Overcoming trauma]. Lisboa: Climepsi Editores.

3. Bakermans-Kranenburg, M. J., Steele, H., Zeanah, C. H., Muhamedrahimov, R. J., Vorria, P., Dobrova-Krol, N. A., et al. (2011). Attachment and emotional development in institutional care: Characteristics and catch-up. *Monographs of the Society for Research of Child Development, 76*, 62–91. doi:10.1111/j. 1540-5834.2011.00628.x.

4. Balbernie, R. (2001). Circuits and circumstances: The neurobiological consequences of early relationship experiences and how they shape later behaviour. *Journal of Child Psychotherapy, 27*, 237–255.

5. Balfour et al., (2013). HIV Prevention in Action on the Football Field: The Whizzkids United Program in South Africa. *AIDS and behaviour, 17*. 10.1007/s10461-013-0448-6.

6. Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

7. Bauman L. J., Foster G., Johnson Silver E., Berman R., Gamble I., et al. (2006). Children caring for their ill parents with HIV/AIDS. *Vulnerable children and youth studies*, *1*(1), 56-70.

8. Beazley, H., & Ennew, J. (2006). Participatory methods and approaches: Tackling the two tyrannies. In V. Desai & R. B. Potter (Eds.), *Doing development research* (pp. 189–199). London: Sage Publications.

9. Bentele, G., & Nothhaft, H. (2010). Strategic Communication and the Public Sphere from a European Perspective. *International Journal of Strategic Communication, 4*(2), 93-116. Doi: 10.1080/15531181003701954.

10. Biemba, G., Beard, J., Brooks, B., Bresnahan, M., and Flynn, D. (2010). *The Scale, Scope, and Impacts of Alternative Care for OVC in Developing Countries: A Review of Literature.* Center for Global Health & Development, Boston University.

11. Bordenave, J. D. (1999). Participatory communication as a part of building the participative society. In S. A. White, K. S. Nair, & J. Ascroft (Eds.), *Participatory communication: Working for change and development* (pp. 35–48). Los Angeles, CA: Sage.

12. Brooks, R., & Goldstein, S. (2001). *Raising resilient children*. Chicago: Contemporary Books.

13. Browne, K. (2009). *The risk of harm to young children in institutional care*. Fairfield, CT: Save the Children.

14. Cameron, L. et al. (2007). Promoting children's positive intergroup attitudes towards stigmatized groups: Extended contact and multiple classification skills training. *International Journal of Behavioral Development , 31* (5), 454–466. DOI: 10.1177/0165025407081474.

15. Candice C. Watson, Brendan A. Rich, Lisa Sanchez, Kelly O'Brien & Mary K. Alvord. (2014). Preliminary Study of Resilience-Based Group Therapy for Improving the Functioning of Anxious Children. *Child Youth Care Forum, 43*, 269–286. DOI: 10.1007/s10566-013-9238-6

16. Catterall, J. S. (2002). The Arts and the Transfer of Learning. *Critical Links: Learning in the Arts and Student Academic and Social Development* (pp. 151-157). Washington DC: Arts Education Partnership.

17. Chitiyo, M., Changara, D.M., & Chitiyo, G. (2008). Providing psychosocial support to special needs children: A case of orphans and vulnerable children in Zimbabwe. *International Journal of Educational Development, 28*, 384-392. doi:10.1016/j.ijedudev.2007.05.009.

18. Chugani H. T., Behen M. E., Muzik O., Juhasz C., Nagy F. and Chugani D. C. (2001). Local brain functional activity following early deprivation: A study of post-institutionalized Romanian orphans. *Neuroimage, 14*, 1290–1301.

19. Cie´slik, M. M, et al. (2019). Social and Behavioral Predictors of Adolescents' Positive Attitude towards Life and Self. *Int. J. Environ. Res. Public Health, 16*, 1-13. doi:10.3390/ijerph16224404.

20. Cummings, E. M., Davies, P. T., & Campbell, S. B. (2000). *Developmental psychopathology and family process*. New York: Guilford.

21. Cyr, C. A., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment insecurity and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology, 22*, 87–108.

22. Dowdell, E. B. and Cavanaugh, D. J. (2009). Caregivers of victimized children. Differences between biological parents and foster caregivers. *Journal of Psychosocial Nursing, 47*(6), 28-36.

23. Eluvathingal, T. J., Chugani, H. T., Behen, M. E., Juhász, C., Muzik, O., Maqbool, M., Chugani, D. C., and Makki, M. (2006). Abnormal brain connectivity in children after early severe socioemotional deprivation: a diffusion tensor imaging study. *Pediatrics, 117*, 2093–2100.

24. Folostina, Ruxandra & Tudorache, Loredana & Michel, Theodora & Erzsebet, Banga & Agheana, Viorel & Hocaoglu, Hivda. (2015). Using Play And Drama In Developing Resilience In Children At Risk. *Procedia - Social and Behavioral Sciences, 197*.10.1016/j.sbspro.2015.07.283.

25. Freeman, Gregory & Sullivan, Kathleen & Fulton, C.. (2010). Effects of Creative Drama on Self-Concept, Social Skills, and Problem Behavior. *The Journal of Educational Research, 96,* 131-138. DOI: 10.1080/00220670309598801.

26. Giese, S., and Dawes, A. (1999). Child care, developmental delay and institutional practice. *South African Journal of Psychology, 29*, 17–22.

27. Glaser, D. (2000). Child abuse and neglect and the brain: A review. *Journal of Child Psychology and Psychiatry, 41*,97–116.

28. Goldfarb, W. (1945). Effects of psychological deprivation in infancy and subsequent stimulation. *The American Journal of Psychiatry, 102,* 18–33.

29. https://doi.org/10.1176/ajp.102.1.18.

30. Goldstein, A. P., & Martens, B. K. (2000). *Lasting change*. Champaign, IL: Research Press.

31. Gorza, M., & Bolter, F. (2012). Indicateurs de bien-être de l'enfant, une déclinaison en protection de l'enfance est-elle possible ? [Indicators of child well-being, is a child protection declination possible?]. *Journal du Droit Des Jeunes, 312*(2), 26-36. https://doi.org/10.3917/ jdj.312.0026.

32. Grados, J. J., & Alvord, M. K. (2003). Fostering resilience in children. *Behavioral Health Management, 23*, 25–26.

33. Gunnar, M. R. (2001). Effects of early deprivation: Findings from orphanage-reared infants and children. In C. A. Nelson & M. Luciana (Eds.), *Handbook of developmental cognitive neuroscience* (pp. 617–629). Cambridge: MIT.

34. Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship between resilience and levels of anxiety, depression, and obsessive-compulsive symptoms in adolescents. *Clinical Psychology & Psychotherapy, 18*(4), 314–321. https://doi.org/10.1002/cpp.719.

35. Honkalaskar V. H., Sohoni M. and Bhandarkar U. V. (2004). A participatory decision making process for community-level water supply. *Water Policy 16*, 39–61.

36. Hornor, Gail. (2017). Resilience. *Journal of Pediatric Health Care, 31*, 384-390. 10.1016/j.pedhc.2016.09.005.

37. Houck, G. M., Darnell, S., & Lussman, S. (2002). A Support Group Intervention for At-Risk Female High School Students. *The Journal of School Nursing*, *18*(4), 212–218. https://doi.org/10.1177/10598405020180041201

38. Humphreys, K. L., Gleason, M. M., Drury, S. S., Miron, D., Nelson, C. A., 3rd, Fox, N. A., & Zeanah, C. H. (2015). Effects of institutional rearing and foster care on psychopathology at age 12 years in Romania: Follow-up of an open, randomised controlled trial. *The Lancet Psychiatry, 2*(7), 625–634. https://doi.org/10.1016/S2215-0366(15)00095-4.

39. Jackson, S. and Martin, P. (1998). Surviving the care system: education and resilience. *Journal of Adolescence, 21*, 569-83.

40. Jacobson, T. L., & Kolluri, S. (1999). Participatory communication as communicative action. In T. Jacobson & J. Servaes (Eds.), *Theoretical approaches to participatory communication* (pp. 265– 280). Cresskill, NJ: Hampton Press.

41. Johnson R., Browne K. D. and Hamilton-Giachritsis C. E. (2006). Young children in institutional care at risk of harm. *Trauma Violence and Abuse, 7*(1), 1–26.

42. Kirk, R., & Day, A. (2011). Increasing college access for youth aging out of foster care: Evaluation of a summer camp program for foster youth transitioning from high school to college. *Children and Youth Services Review, 33*, 1173–1180. doi:10.1016/j.childyouth.2011.02.018.

43. Lansdown, G. (2005). *The evolving capacities of the child.* Florence: Save the Children, UNICEF Innocenti Research Centre.

44. Leventhal, K. S., et al. (2015). Building psychosocial assets and wellbeing among adolescent girls: A randomized controlled trial. *Journal of Adolescence, 45*, 284-295. https://doi.org/10.1016/j.adolescence.2015.09.011

45. Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: implications for interventions and social policies. *Development and Psychopathology*, *12*(4), 857–885. https://doi.org/10.1017/s0954579400004156.

46. Lynch, K. B., Geller, S. R., & Schmidt, M. G. (2004). Multi-year evaluation of the effectiveness of a resilience-based prevention program for young children. *Journal of Primary Prevention*, *24*(3), 335-353.

47. Maaskant, A. M., van Rooij, F. B., Bos, H. M. W., & Hermanns, J. M. A. (2016). The wellbeing of foster children and their relationship with foster parents and biological parents: A child's perspective. *Journal of Social Work Practice, 30*(4), 379–395. https://doi.org/10.1080/ 02650533.2015.1092952.

48. Masten, A. S., & Gewirtz, A. H. (2006). Vulnerability and Resilience in Early Child Development. In K. McCartney & D. Phillips (Eds.), *Blackwell handbook of early childhood development* (pp. 22–43). Malden: Blackwell Publishing. https://doi.org/10.1002/9780470757703.ch2.

49. Masten, A. S., & Wright, M. O. (2010). Resilience over the life span: developmental perspective on resistance, recovery and transformation. In J.W. Reich, A.J. Zautra, & S. Hall (Ed.), *Handbook of adult resilience* (pp. 213-237). New York, NY: Guilford

50. Maughan, B., Collishaw, S. and Stringaris, A. (2013) 'Depression in Children and Adolescents', *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 22*(1), pp.35-40.

51. McEwen B. S. (2004). Protection and damage from acute and chronic stress: allostasis and allostatic overload and relevance to the pathophysiology of psychiatric disorders. *Annals of the New York Academy of Sciences*, *1032*, 1–7. https://doi.org/10.1196/annals.1314.001.

52. Mefalopulos, P., Kamlongera, C., Southern African Development Community., & Food and Agriculture Organization of the United Nations. (2004). *Participatory communication strategy design: A handbook*. Rome: Food and Agriculture Organization of the United Nations.

53. Miller, G. E., Chen, E., & Parker, K. J. (2011). Psychological stress in childhood and susceptibility to the chronic diseases of aging: moving toward a model of behavioral and biological mechanisms. *Psychological bulletin*, *137*(6), 959–997. https://doi.org/10.1037/a0024768.

54. Mintzberg, H. (1987). The Strategy Concept I: Five Ps for Strategy. *California Management Review, 30*(1), 11–24. https://doi.org/10.2307/41165263.

55. Modi; K.; Nayar-Akhtar; M. C.; Ariely; S.; and Gupta; D. (2016). Addressing challenges of transition from children's home to independence: Udayan Care's UdayanGhars (Sunshin Children's Homes) and Aftercare Program. *Scottish Journal of Residential Child Care, 15* (1). www.udanyancare.org.

56. Mueller, Joanne & Alie, Collin & Jonas, Beatrice & Brown, Elizabeth & Sherr, Lorraine. (2010). A quasi-experimental evaluation of a community-based art therapy intervention exploring the psychosocial health of children affected by HIV in South Africa. *Tropical medicine & international health : TM & IH, 16*, 57-66. Doi:10.1111/j.1365-3156.2010.02682.x.

57. Muhamedrahimov, R. J. (1999). New attitudes: Infant care facilities in St. Petersburg, Russia. In J. D. Osofsky & H. E. Fitzgerald (Eds.), WAIMH handbook of infant mental health. *Perspectives on infant mental health* (Vol. 1, pp. 245–294). New York: Wiley.

58. Mulheir, G. and Browne, K. (2007). *De-Institutionalising And Transforming Children's Services: A Guide To Good Practice.* Birmingham: University of Birmingham Press (in collaboration with EU, WHO, CHLG and Hope and Homes for Children)

59. Munson, M. R., & McMillen, J. C. (2009). Natural mentoring and psychosocial outcomes among older youth transitioning from foster care. *Children and Youth Services Review, 31*, 104–111. doi:10.1016/j.childyouth.2008.06.003.

60. Nabors, Laura & Baker-Phibbs, Christina & Woodson, Jr, Kenneth. (2016). Community-based counselors interventions for elementary school-Age children coping with trauma. *Journal of Prevention & Intervention in the Community, 44, 79-91*. 10.1080/10852352.2016.1132820.

61. Nelson, C., Zeanah, C., Fox, N., Marshall, P., Smyke, A., Guthery, D., (2007). Cognitive recovery in socially deprived young children: The Bucharest early intervention project. *Science, 318*, 1937–1940.

62. Nelson, C. A., Fox, N. A., & Zeanah, C. H. (2014). *Romania's abandoned children: Deprivation, brain development, and the struggle for recovery.* Cambridge, MA: Harvard University Press.

63. Nyawasha, T. S., & Chipunza, C. (2012). An assessment of psychosocial and empowerment support interventions for Orphans and Vulnerable Children in Zimbabwe. *Journal of Human Ecology (Delhi, India), 40*(1), 9–16. Retrieved from https://pdfs.semanticscholar.org/9058/ 1a4a9159058b122c18df15df40f69 7cb3ece.pdf.

64. Olowokere, A. E., & Okanlawon, F. A. (2018). Improving vulnerable school children's psychosocial health outcomes through resilience-based training and peer-support activities: a comparative prospective study. *Vulnerable Children and Youth Studies, 13* (4), 291–304. https://doi.org/10.1080/17450128. 2018.1499988.

65. Oros, L. B., & Richaud, M. C. (2012). La promoción de emociones positivas en la escuela. Propuestas para integrar el desarrollo afectivo al curri culo escolar. Manual para docentes de Nivel Inicial y 1,2y3 grado [The promotion of positive emotions at school. Proposals for incorporating the emotional development in the school curriculum]. Entre Ríos, Argentina: Universidad Adventista del Plata.

66. Perry, B., and Pollard, R. (1998). Homeostasis, stress, trauma and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Clinics of North America, 7*, 33–51.

67. Purohit, S.P., et al. (2016). Yoga as a preventive therapy for loneliness in orphan adolescents. *Indian Journal of Health and Wellbeing, 7*(1), 169-172.

68. REPSSI. (2005). Enhancing psychosocial support of children affected by HIV/AIDS: A special focus on memory work. *MMS Bulletin*, *95*. Retrieved from http://www.medicusmundi.ch/de/bulletin/mms-bulletin/memory-work/etappen /enhancing-psychosocial-support-of-chil dren-affected-by-hiv-aids-a-special-focus-on-memory-work.

69. Richaud, M. C. (2010). Different factors affecting psychological development of children at risk due to poverty. Possibilities of intervention. In A. Fiedler & I. Kuester (Eds.), *Child development and child poverty* (pp. 223–248). Hauppauge, NY: Nova Science.

70. Roeber B. J., Tober C. T., Bolt D. M., Pollak S. D. (2012). Gross motor development in children adopted from orphanage settings. *Dev Med Child Neurol, 54*, 527–31.

71. Roosa, M.W. (2000). Some thoughts about resilience versus positive development, main effects versus interactions, and the value of resilience, *Child Development, 71*(3), 567-69.

72. Roy, P. and Rutter, M. (2006). IC: associations between inattention and early reading performance. *Journal of Child Psychology and Psychiatry, 47*, 480–487.

73. Rutter, M., Colvert, E., Kreppner, J., Beckett, C., J., Groothues, C., Hawkins, A., O'Connor, T., Stevens, S., Sonuga-Burke, E. (2007). Early adolescent outcomes for institutionally-deprived and nondeprived adoptees I: Disinhibited attachment. *Journal of Child Psychology and Psychiatry, 48*(1), 17–30.

74. Rutter, M. et al. (2010). *Deprivation-Specific Psychological Patterns: Effects of Institutional Deprivation.* London: Wiley-Blackwell.

75. Sandhyarani M. C., and Rao C. Usha. (2016). Perception of adjustment among institutionalized adolescent girls in selected districts of Karnataka.. *International Journal of Advanced Multidisciplinary Research, 3*, 23-30. 10.22192/ijamr.2016.03.12.005.

76. Schiller, U.& de Wet, G. (2018). Communication, indigenous culture and participatory decision making amongst foster adolescents. *Qualitative Social Work, 17*(2), 236–25. DOI: 10.1177/1473325016662329.

77. Schofield, G. (2001). Resilience and family placement: a lifespan perspective. *Adoption and Fostering, 25*(3), 6-19.

78. Seligman, M. E. P., Reivich, K., Jaycox, L., & Gillham, J. (1995). *The optimistic child*. New York: Houghton Mifflin.

79. Seligman, M. (1998). *Learned Optimism*. New York: Pocket Books.

80. Skinner D., Davids A. (Eds). (2006). *Multiple vulnerabilities: Qualitative data for the study of orphans and vulnerable children in South Africa*. Cape Town: Human Sciences Research Council Press.

81. St. Petersburg–USA Orphanage Research Team. (2008). The effects of early social-emotional and relationship experience on the development of young orphanage children. *Monograph of the Society for Research in Child Development, 73*, Serial No. 291(3).

82. Tadesse S., Dereje F., Belay M. (2014). Psychosocial wellbeing of orphan and vulnerable children at orphanages in Gondar Town, North West Ethiopia. *J Public Health Epidemiol, 6*(10), 293–301.

83. Taylor, E., Di Folco, S. & Lou, Y. (2018). Resilience and resilience factors in children in residential care: A systematic review. *Children and youth services review, 89*, 83-92. https://doi.org/10.1016/j.childyouth.2018.04.010.

84. Tizard, B., and Joseph, A. (1970). Cognitive development of young children in residential care: A study of children aged 24 months. *Journal of Child Psychology & Psychiatry, 11*, 177–186.

85. Tol, W. A., Komproe, I. H., Jordans, M. J. D., Ndayisaba, A., Ntamutumba, P., Sipsma, H., & de Jong, T. V. M. (2014). School-based mental health intervention for children in war-affected Burundi: A cluster randomized trial. *BMC Medicine, 12*, 56.

86. Trevarthen, C., and Aitken, K. J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry, 42,* 3–48.

87. Tufte, T., & Mefalopulos, P. (2009). *Participatory Communication: A Practical Guide.* Washington DC: World Bank.

88. Tynan, W. D. (1999). Concurrent parent and child therapy groups for externalizing disorders: From the laboratory to the world of managed care. *Cognitive and Behavioral Practice, 6*, 3–9.

89. UNICEF. (2008). *Writing a Communication Strategy for Development Programmes: A Guideline for Programme Managers and Communication Officers.* Bangladesh: UNICEF.

90. United Nations. (1989). *Convention on the Rights of the Child.* Geneva: United Nations.

91. Vincent, S. (2015). Introduction in Vincent, S. (ed.) *Early Intervention: Supporting and Strengthening Families.* Edinburgh: Dunedin.

92. Walker, G. B. (2007). Public participation as participatory communication in environmental policy decision-making: From concepts to structured conversations. *Environmental Communication, 1*, 99–110. doi:10.1080/ 17524030701334342.

93. Wekerle, C., Waechter, R., Leung, E., & Leonard, M. (2007). Adolescence: A window of opportunity for positive change in mental health. *First Peoples Child & Family Review, 3*, 8–16.

94. Yang, M., Ullrich, S., Roberts, A. and Coid, J. (2007). Childhood IC and personality disorder traits in adulthood: Findings from the British National Surveys of psychiatric morbidity. *American Journal of Orthopsychiatry, 77*, 67–75.

95. Zamirinejad, S., Hojjat, S. K., Golzari, M., Borjali, A., & Akaberi, A. (2014). Effectiveness of resilience training versus cognitive therapy on reduction of depression in female Iranian college students. *Issues in Mental Health Nursing, 35*(6), 480–488. https://doi.org/10.3109/01612840.2013.879628.

Web Sources:

1. https://wcd.nic.in/juvenile-justice-care-and-protection-children-act-2000-56-2000

2. https://wcd.nic.in/sites/default/files/JJAct2015-1.pdf

3. https://upload.indiacode.nic.in/showfile?actid=AC_CEN_13_14_000010_201602_1517807328168&type=rule&filename=english%20model%20rule.pdf

4. https://nhrc.nic.in/sites/default/files/UNCRC_2020.pdf