Initiating Community-Based Psychosocial & Protection Services for Early Childhood Care & Development

– A Model for Integrating Child Development, Mental Health and Protection

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By Dept. of Child and Adolescent Psychiatry

NIMHANS, Bangalore

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This document provides a report on A Model for Integrating Child Development, Mental Health and Protection" on a 6-month pilot project that was implemented by the Dept. of Child and Adolescent Psychiatry, NIMHANS, with the support of UNICEF, India. In addition to a descriptive report on the project objectives, activities and methodologies, it also discusses a model for integrating Child Development, Mental health, and protection (a relatively novel approach in the Indian Pre-school health and education context)

Note 1: It is suggested that this document be read in conjunction with the other document which is also developed by this project – Preliminary Understanding and Emerging Issues
Note 2: As part of this project, please also refer to other materials/ documents that have been developed, listed below which are available in the website: https://www.nimhanschildproject.in/

i) **Social Emotional Development Manual for Early Childhood Care and Development - Activities for Anganwadi Children Pre-School Children.**

ii) **"Psychosocial & Protection Issues for Early Childhood Care and Development – Training Manual for Anganwadi/ Pre-School Teachers"**

iii) **Hadutha Nali, Kaliyutha Beli" (Enjoy as you Sing, Grow as you Learn) – A compilation of over 200 songs and poems for early stimulation. Complied by the Anganwadi workers.**
https://www.nimhanschildproject.in/interventions/pre-school-0-to-6-years/early-stimulation-anganwadi-teachers-and-parents-caregivers/

iv) **Translation of "Child Sexual abuse and Personal Safety Module - Activity-Based Awareness & Learning for Pre-Schoolers & Children with Developmental Disabilities" to Kannada. As part of the Module, a Story Series consisting of 3 stories were also translated. (When Somu forgot Stranger Safety rules, Tommy's New Neighbour, Which Secrets to keep?)**
https://www.nimhanschildproject.in/interventions/pre-school-0-to-6-years/i-child-sexual-abuse-prevention-personal-safety-4-6-yrs/

v) **Translation of 3 Stories – Afsa, Tariq and Akbar which are stories on loss and grief issues which can be used with young children. These were**

developed by the Community child and adolescent mental health service project, Department of child and adolescent psychiatry, NIMHANS.
https://www.nimhanschildproject.in/interventions/pre-school-0-to-6-years/iv-stories-for-pre-schoolers/

1. Project Objectives

The objective was to integrate mental health and protection services for young children between the ages of 0 to 6 years. The project implementation included a multi-dimensional approach to provide community based mental health and protection services for promotive, preventive and curative care through direct service delivery as well as training and capacity building of child care service providers for young children in the age group of 0-6 years.

The project was based on the premise that, in the Indian context, there is a vast gap between child mental health and protection needs and resource availability. The few available resources are concentrated in tertiary care health facilities and child welfare committees; and young children, especially those residing in vulnerable communities and/or in difficult circumstances, are at the greatest risk of mental health morbidity, and often have the poorest access to quality psychosocial and mental healthcare and protection services.

The overall goal of the project was to ensure increased access to quality mental health and protection services to young children between the ages of 0 to 6 years, by extending and integrating such services into other agencies and institutions located in the community. More specifically, the objectives are:

1. To examine the mental health problems and socio-emotional vulnerability issues of young children, and provide interventions specific to their contexts of vulnerability by:
    a. Providing mental health assistance and services to vulnerable children residing in institutions and open communities, including those with specific developmental disabilities and psychosocial health issues.

b. Providing direct services to enhance early stimulation and promotive child development programs.

2. To build the capacity of childcare workers and service providers in anganwadis, child care institutions (governmental and non-governmental agencies) and other child protection services, to address the mental health and protection needs of young children.
3. To draw from implementation experiences to develop initial materials for use in community-based early childhood care and protection services for those in vulnerable socio-economic contexts.

2. Location and Target Population

The project implemented its activities and provided services in 31 anganwadis in the vulnerable urban communities in Bangalore city. The direct beneficiaries of the project were children between ages 0 and 6 years— who received direct services by way of individual and group interventions in areas pertaining to child development, mental health and protection; the indirect beneficiaries were parents, caregivers, anganwadi teachers —who received training and capacity building inputs in order to better meet the child development, mental health and protection needs of young children.

Selection of Anganwadis

In order to select anganwadis for services, the project first selected vulnerable communities within Bangalore city i.e. urban slums. This was done because slums represent the vulnerable communities created by rapid urbanization processes; comprised of the urban poor, these communities usually lack water, sanitation, basic housing, health and other essential infrastructural facilities, as well as adequate means of livelihood. As a result of such deprivations, slums are also characterized by high rates of gender disparities, social exclusion and marginalization. Young children living in such situations are therefore most likely to be deprived of developmental needs and opportunities as well as to be exposed to many psychosocial risks.

In the project's initial proposal, the coverage was a total of 27 anganwadis to be provided services. However, after further needs assessment and mapping of the vulnerable communities, five communities from the five Primary health care centres, a total of 32 Anganwadi centres were selected. The rationale for selecting a greater number of anganwadi is to ensure there are at least 27 anganwadi, in case there are any dropouts during the project duration.

Based on the need's assessment and observations, the Project team decided to select those anganwadis which had greater number of children, and anganwadis which had more than one centre in the same location as this would ensure that a greater number of children would be reached through a single visit.

After the initial permissions received from the Department of Women and Child Development (DWCD), the project team met with concerned Child Development Project Officer (CDPO), Supervisors and the anganwadi workers to explain the project's objectives and how the services will be provided. After this, the project implementation and services were initiated.

After the first one month of project implementation, anganwadi workers were asked whether they were willing to continue be part of the project and they were informed that they are free to discontinue. The rationale behind this was to ensure that only interested and willing anganwadi workers would be part of the project. This also enabled the Project team to include other anganwadi workers who were keen and interested to be part of the project. Thus, around 3 anganwadi workers dropped out of the project and, in their place, 3 other anganwadi workers were included. Thus, the project implemented its activities in 31 anganwadis throughout the project duration.

Note: In the initial proposal it was said that the project will also implement its objectives and activities in Anganwadis and also in child care agencies that provide care and protection to 0 to 6-year-olds, including agencies that work with orphan and abandoned children, children with disability and children infected/ affected by HIV/AIDS.

However, the project could not implement the objectives and activities in the child care agencies that provide care and protection to 0 to 6-year-olds due to following reasons:

- Even though the initial proposal was for 27 anganwadis, a total of 31 anganwadis were provided with services.
- A more in-depth and extensive training and capacity building was done for the anganwadi workers.
- Given the short duration of the project, it was extremely difficult to manage and implement the project activities in both anganwadis and child care institutions.

Nevertheless, it is also important to note that much of the project's activities/work done in the anganwadis would be similar to that of the child care institutions (i.e. the developmental, early stimulation work). But the protection related issues of children in the child care institutions would be different from the children in the anganwadi. When compared to the children in anganwadi, most of the children in the child care institution are drawn from vulnerable families and would have experienced loss, trauma and protection issues thereby necessitating more specialised trauma and mental health related interventions.

3. Project Implementation: Activities

In all, during the months of June 2019 - March 2020, the project implemented its activities in 31 anganwadi centres. Individual assessment of 237 children was conducted to examine developmental, mental health, protection issues. Group activities were implemented with children for early stimulation and prevention of child sexual abuse through 276 children over 190 sessions.

Capacity and training programs were conducted for 31 anganwadi workers over four 1-day training workshops and 89 weekly sessions. Around 300 child care service providers from various agencies & organisations were reached through training and dissemination in other forums (i.e. Anganwadi Habba organised by Makkala Jagruthi (NGO), Scientific workshop 'EARLY CHILDHOOD DEVELOPMENT: EARLY MOMENTS MATTER', Training sessions in NIPCCD)

Through the project majorly four activities were implemented as listed below: (Refer Figure1)

- To examine developmental, mental health, protection issues of young children through individual assessments, and provide interventions specific to their contexts of vulnerability.
- Group activity with children to conduct early stimulation activities and implement child sexual abuse prevention and safety module in the anganwadis.
- Capacity building of in anganwadi workers, to address Child development, Mental health & Protection needs of young children.
- To draw from implementation experiences to develop initial materials for use in community-based early childhood care and protection services.

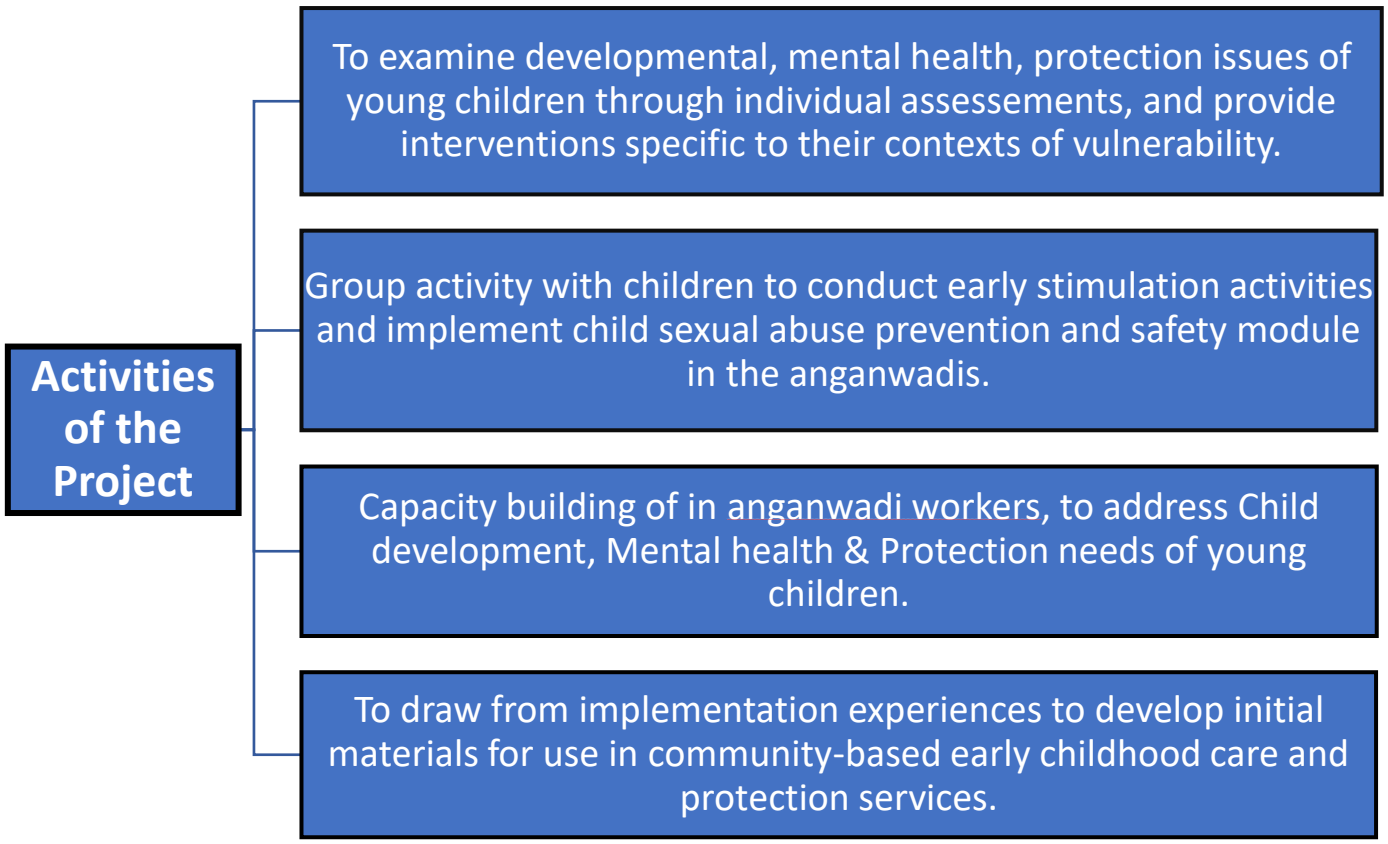


Figure 1: Activities implemented through the project

3.1. Individual Assessment for Mental health, protection and Developmental issues

Assessment of children for developmental, mental health and protection issues among children between the age group of 0-6 years, was developed by upgrading the existing developmental check-list which was developed through the Community Child and adolescent mental health service Project, Department of child and Adolescent Psychiatry, NIMHANS. Based on the age classification and the developmental level of the child three different assessment formats were developed, i.e. 0 to 1 year, 1 to 3 years, 3-6 years. A total of 237 children between the ages of 1-6 years were assessed during the project implementation period. The sections included in the proforma are listed below in Box 1. (The assessment format has been annexed)

Box 1: The proforma included the following sections:

a) **Basic information**: (Name/Age/Sex/Anganwadi name.)
b) **Family History** (living arrangements/parental relationships/Illness in the family/Domestic violence/Family conflicts/Substance use by the parent)
c) **Medical/ Sensory needs and issues identified**
d) **Protection related vulnerabilities**: Physical abuse, Emotional abuse, Sexual abuse, and Neglect.
e) **Developmental functions and skills:** Physical, Speech and language, cognitive, social, and emotional.
f) **Under stimulation concerns**
g) **Emotional and behavioural issues**
h) **Summary & Diagnosis** (Developmental delays/ Under-stimulation/ Emotional and Behavioural problems)
i) **Care plan** (Immediate interventions/ first level responses/ recommendations for further evaluation/ interventions)

Individual assessments were done for only children who had attended the anganwadi for at least three months, the rationale being that children need some time to get used to the anganwadi environment and come out of the initial separation anxiety they have when they

leave their primary caregiver. Along with this, it would also ensure that the anganwadi worker would have an understanding about the child's abilities.

To conduct the individual assessment an average of 30-45 minutes was spent with each child, along with the anganwadi worker and helper. The information regarding the child's family context & protection related vulnerabilities were gathered by asking the anganwadi worker and helper. To understand the child's developmental functions and skills, children were tasked and engaged in activities.

After each assessment, the anganwadi worker was provided with first level inputs regarding the child's developmental levels and what kind of early stimulation the child requires. Wherever the children needed follow up or referral, anganwadi workers were informed and refereed to Dept. Child and Adolescent Psychiatry and Dept of Speech Pathology and Audiology, NIMHANS.

3.2. Group Activities with Children

As part of the project service provision, the project team conducted group activities with children and demonstrated the same to the anganwadi workers. During the demonstration, the project staff explained the importance of the activities and also encouraged the anganwadi workers to join. Here, on-the-job training through demonstration and discussion was used to train the anganwadi workers.

The group activities conducted with children were to promote early stimulation and optimum development in the 5 key areas of child development - physical/social/speech-and-language/cognitive/emotional development - and this conceptual framework was explained to the anganwadi workers. The activities were taken from the activity book '**Arambhikeya Arambha'** which contains 35 simple pre-school activities which was developed by the Community Child and Adolescent mental health service project, NIMHANS.

The project also implemented specific activities for Socio-emotional Development and in the process developed the **"Social Emotional Development Manual for Early Childhood Care and Development - Activities for Anganwadi Children & Pre-School Children (aged 4 to 6 years)"**.

To implement the "**Child Sexual abuse and Personal Safety Module - Activity-Based Awareness & Learning for Pre-Schoolers & Children with Developmental Disabilities"**, the module was translated to the local language (Kannada) and the anganwadi workers were trained in the basic child sexual abuse concepts and techniques to conduct the activities. Later, the activities were implemented in the anganwadis by the project team and anganwadi workers together. Through these sessions 276 children were reached through 190 sessions in 31 anganwadis. T(he details are given in Table 1).

Table 1: Group activities with Children

Anganwadi	**July2019 to January 2020**
No. of Children Participating in Early Stimulation Activities	**276***
No. of sessions conducted in the anganwadi	**190**
No. of Anganwadis Reached	**31**

* Since the same anganwadis were visited more than twice, there are overlaps in the children reached. Therefore, the highest numbers of children present during a visit was taken as the number of children reached.

3.3. Training and Capacity Building of Anganwadi workers

A. Training Needs Assessment

One major focus of the project was to build capacity of the anganwadi workers in order to ensure that they have the capacity to understand the developmental, mental health and protection needs of children between 0 – 6 years.

The key components of the Integrated Child Development Scheme (ICDS), is provision of pre-school education which is essentially provision of non-formal education to ensure that all children achieve age appropriate development, prepare the children for a smooth transition to school and giving them a head start in life. Before designing and planning the training module for the anganwadi workers a focused group discussion was conducted to understand knowledge and skills the anganwadi workers have and what kind of trainings

they have received so far. The focused group discussions were conducted with anganwadi workers, Supervisors and Child Development Program Officers (CDPO) so as to facilitate and understand needs and gaps in a more comprehensive and systematic way. The main objectives for the focus group discussion were:

- To understand the contents and the curriculum of the various trainings the anganwadi worker has received till now.
- To understand the conceptual knowledge and skills that the anganwadi workers possess regarding early stimulation and managing emotional and behavioural problems among them.
- To understand the Curriculum provided for the early stimulation, standards and materials available.

The details of the focused group discussions are given in Box 2.

Box 2: Focused group Discussion Points

- All anganwadi workers receive a one-month training in the Job Training Course (JTC), wherein they learn regarding early childhood care and development, health and immunization, regarding various programmes and provisions of the Indian government for women and child development and protection, nutrition and health of women and children, and various other management and documentation processes.
- Following the initially one month training every two years once for one week a refresher course must be conducted. However, this has hardly been the case, the gaps between successive trainings has not been consistent, the gap varying from 2 years to 10 years. The latest training received was in the year 2016.
- The Early childhood care and development training is done for 5-days where in they majorly concentrate on activities and early stimulation materials. However, they are not provided with conceptual knowledge regarding five domains of development and how they are linked to each other. They are not provided with an understanding as how child development is impacted by deprivation and how to address children's developmental needs.
- A large component of the training curriculum includes training about data collection and record keeping on anganwadi attendance, pregnant and lactating mothers,

records pertaining to the distribution of food, immunization, growth-monitoring, child malnutrition.

- The importance of social and emotional development hasn't been explained at all.
- The child development component does not cover emotional and behaviour problems in children, and how to recognize and address/ respond to it.
- The training module does not talk about corporal punishment issues nor the laws against it.
- Few of the anganwadi workers have received one random training regarding child sexual abuse, including the POCSO Act. However, when asked regarding the law and its provisions they are not aware and they lack the skills to address these complex issues.
- The anganwadi workers reported more focus in their trainings is given to community development, working with communities, conducting surveys and assisting ASHA workers.
- Anganwadi workers reported that they have a set curriculum and time-table to follow. Each day's schedule includes: health and hygiene session, action songs, pre-writing skill activities, story-time, rest and lunch, games/ physical activities. The same methods are used and each week they have a different theme/ subjects.
- There is no systematic monitoring of the quality of these educational activities; the anganwadi supervisor when they visit the anganwadi are more concerned to check whether they have maintained the registers correctly and may ask one or two questions to one random child.
- Anganwadi workers receive a standard early stimulation kit which includes pictures and charts, wooden puzzles, beads and threads, wooden shapes and coloured cubes, wooden building blocks and so on. teaching. Overall, they report a general shortage in materials available to them to conduct developmental or educational activities.
- Although the Job Training Centre (JTC), responsible for training of anganwadi workers, provides a comprehensive training regarding child development, the types of activities to do with children, the anganwadi workers face many hurdles and problems in the field while implementation of these concepts and activities.

- Among them the 2 major challenges are, limited space to conduct the activities, and lack of time to conduct early stimulation activities. The anganwadi workers report that they are so over-burdened with record-keeping and documentation (a total of 32 registers to be maintained) and other tasks such as attending to the requests of pregnant mothers, providing food (daily meal in the afternoon) for pregnant and lactating mothers through “Mathru Poorna Yojana”. After all this they are left with very little time to interact with the children and actually do activities with them.

B. Training Objectives & Content

The objective of the training anganwadi workers was to develop a set of activities that recognize the limitations of the anganwadi workers’ work environments and to support them to function effectively so that there is an impact in the lives of young children, given the developmental variations and difficult contexts that many children come from. Based on the project staff observations and discussions with the anganwadi workers and supervisors, it was concluded that anganwadi workers need a stronger conceptual framework for understanding child development, identification and address the protection needs of children according their vulnerabilities. Based on the observation, the objectives for the training and capacity building of the anganwadi workers are as follows:

i) To understand basic child development of young children- including 5 domains of development i.e. Physical, speech and language, cognitive, social and emotional.
ii) To learn and develop skills to conduct various activities in five domains of development to promote age-appropriate child development.
iii) To enable anganwadi workers to understand the context of child abuse and neglect, including - Physical, emotional and sexual abuse.
iv) To enable to the anganwadi workers to identify and address the child abuse and neglect, including Physical, emotional and sexual abuse and protection needs of young children at a basic level.
v) To enable the anganwadi workers to use sexual abuse prevention module with children.

vi) To enable the anganwadi workers to use the basic assessment format to identify child developmental, protection and menta health needs and issues.

vii) To enable the anganwadi workers to identify and address basic emotional and behavioural problems among young children in the anganwadi level.

viii) To enable the anganwadi workers to develop and use low cost aids for children's early stimulation.

The following concepts and topics were selected to include in the training Modules as given in Table 2.

Table 2: Concepts and topics included in the training.

Sl. No	Topic
1.	**Introduction** 1.1. Breaking the Ice 1.2. Our objectives and Methods 1.3. The role of an Anganwadi Worker
2.	**Children and Childhood** 2.1. Setting the tone: Re-connecting with Childhood 2.2. Child Development basics 2.3. Power and Rights
3.	**Child Development** 3.1. Physical Development 3.2. Speech and Language Development 3.3. Cognitive Development 3.4. Social Development 3.5. Emotional Development
4.	**Revision/ Re-cap and further work in the field** 4.1. Demonstration of early stimulation activities in five domains of development 4.2. Development of Low-cost early stimulation materials
5.	**Identifying Problems & Contexts: The Child's Experience & Inner Voice** 5.1. Understanding the Child's Experience & Inner voice 5.2. Identifying and understanding Child's behaviour using the Context, Experience and Inner voice framework
6.	**Understanding and Responding to common emotional and behaviour**

	problems in Early Childhood 6.1. Different methods of responding to Emotional and Behavioural Concerns 6.2. Managing the Aggressive and Oppositional Child 6.3. Management of children with temper tantrums 6.4. Identifying and Understanding an ADHD child
7.	**Conceptual understanding of Child protection in Early Childhood** 7.1. Introduction to Child Protection issues specific to Early Childhood 7.2. Introducing Government Systems and Programs available for Child Protection
8.	**Understanding Child Sexual Abuse in Early Childhood** 8.1. Child Sexual Abuse Basics 8.2. First Level Psychosocial Responses for Sexually Abused Children 8.3. Introduction to the Child Sexual Abuse Prevention Module 8.4. Practicing the Child Sexual Abuse Prevention Module
9.	**Assessing Children for Developmental, Mental health and Protection Issues in Early Childhood** 9.1. Assessment of Child Development Issues in Early Childhood 9.2. Assessment of Emotional and Behavioural Problems in Early Childhood 9.3. Assessment of Child Protection Issues in Early Childhood

Note: The above contents have been developed into a training manual titled **"Psychosocial & Protection Issues for Early Childhood Care and Development – Training Manual for Anganwadi/ Pre-School Teachers"** which is also an outcome of this project.

C. Implementation of Training Workshops/ Sessions for Anganwadi Anganwadi workers

During the service provision period, a total of 4 one-day training workshops and 89 weekly training sessions were conducted. (Refer table 3)

After the training needs assessment, the it was decided that the training and capacity building of the anganwadi workers would be done through a mixture of both one-day training workshops and short weekly sessions in the anganwadi. This was devised in order to make it more convenient for the anganwadi workers to travel, enable shorter and more

focused learning. The anganwadi workers also did not feel it as a burden to attend 2 hours per week.

Table 3: Training sessions details

Type of session	Number of sessions
One day training session	**4**
Weekly training sessions	**89**
Total number of anganwadi workers reached	**38***

*While the number of selected anganwadi workers were only 31, during the course of our service provision there were an additional 6 anganwadi workers who voluntarily joined few of the training sessions.

For the weekly sessions the 31 anganwadis were divided in four groups based on the proximity. One session per week were conducted for each group, for about of 2 hours.

D. One-Day Workshops

Workshop 1: Introduction and Basics—Childhood & Child Development

A one-day introductory workshop was conducted on 31st July, 2019 in the Department of Child and Adolescent Psychiatry, NIMHANS, Bangalore. The main objective of the one-day training session was to establish rapport and to provide a basic understanding of the project services. The specific objectives of the workshop were:

- To enable the anganwadi workers to be aware of and alert to young children's experiences and emotions.
- To introduce the anganwadi workers to child rights-oriented thinking.
- To develop a strong conceptual understanding of child development. In particular, the key domains of child development.
- To recognize the importance of early stimulation methods and practice in relation to the key domains of child development.
- To understand the objectives and the services provided by the project.

Table 4: Introductory Workshop Contents

Session	Topic	Duration
Session 1	Introduction to the Aims and objectives of the project	30 mins
Session 2	Re-connecting with children and childhood	45 mins
Session 3	Understand the characteristics/ qualities of a “Best Anganwadi worker”	90 mins
Session 4	Understanding Key Domains of Child Development: (i) Motor Development (ii) Speech & Language Development (iii) Cognitive Development (iv) Social Development (v) Emotional Development	120 mins
Session 5	Power and Rights	30mins
Session 6	Introduction to Early stimulation Kit	60 mins

The details about the sessions are given in Table 4. Each anganwadi worker was provided with an early stimulation kit. This was provided after discussing the importance of each article/toy and to which domain of development it could apply. The same could be used every day with the children. All these toys can be used for sensory stimulation and to aide development of all five domains of development. The kit contained the following items as listed in Table 5.

Table 5: Early stimulation kit provided for the anganwadi workers.

SL. No.	Play Material	Purpose	Uses
1.	**Soft Toy**	To be used as comfort object, transitional object.	To be used with children who are anxious and have separation anxiety.
2.	**Kaleidoscope**	Visual stimulation, eye hand coordination	To teach children turn-taking and as a reward for a child for his/her good behaviour.
3.	**Rubik cube**	Fine motor/ visual stimulation as it has different colours.	To teach children turn-taking and as a reward for a child for his/her good behaviour. Can be used for attention

			enhancing.
4.	**Textured squeeze ball**	Enhance the sense of touch.	For auditory and visual stimulation.
5.	**Hand puppet**	For speech and language, social and emotional development	Can be used to provide instructions and narrate stories.
6.	**Tambourine/ Hand drum**	For auditory, fine motor development	Can be used as a means to draw children's attention, & for providing instructions. Used as a musical instrument for action songs.

During the session, as a motivational strategy, it was announced that, at the end of the project, the three best anganwadi workers would be selected and awarded. It was also informed that the award will be based on their active participation, implementation of their learnings, engaging children and the observations done by the project staff during their visit to their anganwadis.

Workshop 2: Identifying Problems & Contexts: The Child's Experience & Inner Voice

In the month of November 2019, after the completion of 6-7 weekly sessions, a one-day workshop on understanding the context of children's emotional and behavioural problems was conducted. The details about the sessions are given in Table 6. The objectives of the one-day training workshop were as below:

- To enable anganwadi workers to identify psychosocial contexts of young children's problems, and understand & analyse problems in accordance with their context.
- To make the link between context and emotions/behaviours.
- To understand how young children, perceive and internalize their experiences i.e. their inner voices, and how these manifests in emotional and behavioural issues.
- To enable the anganwadi workers to understand basic signs and symptoms of anxiety, depression and anger/aggression behaviours which manifest in young children.

After the sessions, a Kannada movie "Tutturi" was screened for the anganwadi workers with the following objectives:

- To reflect on images of childhood.
- To take perspective on multiple childhoods and emerging psychosocial themes and narratives.

Table 6: Workshop 2 contents.

Session	Topic	Duration
Session 1	Understanding the Child's Experience & Inner voice	60 mins
Session 2	Identifying and understanding Child's behaviour using the Context, Experience and Inner voice framework	120 mins
Session 3	Film Screening: Tutturi	180 mins

Each anganwadi worker was provided with the activity book '**Arambhikeya Arambha'**, which contains 35 simple pre-school activities which was developed by the Community Child and Adolescent mental health service project NIMHANS.

Workshop 3: Understanding and responding to common emotional and behaviour problems in Early Childhood

In the month of December 2019, a one-day training workshop was conducted for anganwadi workers to enable them to identify and understand common emotional and behavioural problems in young children. Following this, different techniques and methods which can be used with young children i.e. by using play and art techniques were explained and demonstrated. These activities were done using role play and other theatrical techniques. The details about the sessions are given in Table 7. Anganwadi workers were provided with two story books with theme of loss and grief in the context of young children, the titles of which are –

1. “Afsa” (about a girl who loses her pet dog)
2. “When spots went away” (about a boy Tariq who loses his pet fish)

These story books were developed by the Community Child and Adolescent mental health service project NIMHANS and translated into Kannada by this project team.

Table 7: Workshop 3 contents.

Session	Topic	Duration
Session 1	Identifying different Emotional and Behavioural Concerns in young children: • Anxious Child • Depressed Child • Angry Child	180 mins
Session 2	Learning Different play and art methods to manage emotional and behavioural problems • Story Telling • Art and craft • Using dolls • Using puppets	180 mins

Workshop 4: Personal Safety Awareness and Child Sexual Abuse Prevention

The one-day training workshop on Personal Safety Awareness and Child Sexual Abuse Prevention was conducted in the month of January 2020. The training workshop was organised for both the anganwadi workers and the supervisors. The objectives of the training workshop were to answer the following questions:

- What is child sexual abuse (CSA)?
- When to suspect CSA in anganwadi children?
- What to do if CSA occurs? (Emergency response)
- How to teach children about personal safety? (Prevention of CSA)

Table 8: Workshop 4 contents.

Session	Topic	Duration
Session 1	Understanding Child Sexual Abuse in Early Childhood	40 mins
Session 2	First Level Psychosocial Responses for Sexually Abused Children	60 mins
Session 3	Introduction to the Child Sexual Abuse Prevention Module	40 mins
Session 4	Practicing the Child Sexual Abuse Prevention Module	180 mins

The details about the sessions are given in Table 8. This workshop was basically focusing to enable the anganwadi workers to understand how CSA occurs, who these perpetrators are, where and when CSA can occur, how they can identify whether CSA has occurred among anganwadi children, and how they should respond if CSA has occurred in their community. The highlights and salient features of the Protection of Children from Sexual Offences (POCSO) Act, 2012 was also explained to the anganwadi workers. The issue of mandatory reporting, aggravated offence was also discussed during the session.

After the workshop the anganwadi workers were provided with the Kannada version of the "**Child Sexual abuse and Personal Safety Module - Activity-Based Awareness & Learning for Pre-Schoolers & Children with Developmental Disabilities"**, which was developed by the Community Child and Adolescent mental health service project NIMHANS, along with the Kannada version of the Tommy and Somu Story Series (which is a part of the CSA and Personal Safety Module) for their use.

E. One-day workshop for Anganwadi Helpers

The project team, during their visits to the anganwadis, noticed that when an anganwadi worker is busy with her work of record keeping and attending various meetings and sessions, the anganwadi helper spends a lot of time with the children. Anganwadi helper is responsible for cooking, cleaning and also for helping children to go to the restroom and providing & feeding them food. Most of the helpers in the anganwadis were very active and engaged children in various activities which they were aware of. Based on this observation, and considering the anganwadi helpers' keen interest to learn and participate, a one-day training workshop was held for them in the month of November, 2019. The details about the sessions are given in Table 9.

The objectives of this training workshop were:

- To enable the anganwadi helpers to connect and relate to young children and childhood experiences.
- To introduce the anganwadi workers to child rights-oriented thinking.
- To introduce the concept of child development, and key domains of child development.
- To enable them to realise the importance of their role in the development of children in the anganwadis.

Table 9: One-day Training Workshop for Anganwadi Helpers contents.

Session	Topic	Duration
Session 1	Re-connecting with children and childhood	40 mins
Session 2	Understanding Key Domains of Child Development:	90 mins
Session 3	Power and Rights	30 mins
Session 4	Understanding the importance of an Anganwadi Helper role in the development of Anganwadi children.	40 mins

F. Weekly Training Sessions for Anganwadi workers

From the months of July 2019 to January 2020, a total of 89 weekly training workshops were conducted in the anganwadi centres by forming four clusters.

Each session was conducted in one of the anganwadi centres which was at a walkable distance for the anganwadi workers. The project staff used to visit these anganwadi centres to conduct the training. These sessions were scheduled between 2:00 pm - 4:00 pm on weekdays so that the anganwadi workers could finish their daily duties in the anganwadi and then attend the sessions. Each session was designed using different methodologies to teach and training materials shared at the end of a few sessions regarding the topics which were discussed. The topics which were covered in these weekly sessions are as follows: (Refer table 10)

Table 10: Training and capacity building weekly session topics

Sl. No	Topics	Duration
1.	Physical development	2 hours/ 1 session
2.	Speech and Language development	2 hours/ 1 session
3.	Cognitive development	2 hours/ 1 session
4.	Social development	2 hours/ 1 session
5.	Emotional development	2 hours/ 1 session
6.	Revision/Re-cap: Demonstration of Activities by anganwadi workers	4-6 hours/ 2-4 sessions
7.	Introduction to developmental checklist	2 hours/ 2 session
8.	Understanding the concept of Corporal punishment and related issues	2 hours/ 1 session
9.	Identifying and Understanding an ADHD child	2 hours/ 1 session
10.	Management of children with temper tantrums	2 hours/ 1 session
11.	Introduction to Child Protection issues specific to Early Childhood	2 hours/ 1 session
12.	Introducing Government Systems and Programs available for Child Protection	2 hours/ 1 session
13.	Development of Low-cost early stimulation materials	2 hours/ 1 session

14.	Assessment of Emotional and Behavioural Problems in Early Childhood	2 hours/ 1 session
15.	Assessment of Child Protection Issues in Early Childhood	2 hours/ 1 session
16.	To demonstrate the implementation of the Child Sexual Abuse and Personal safety Module	8 hours/ 4 sessions

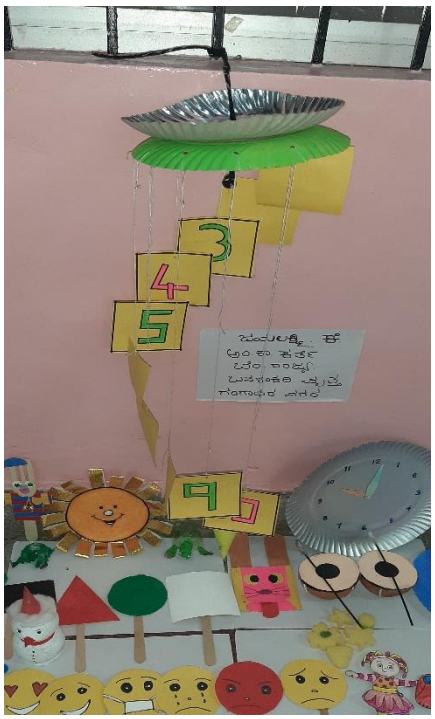
Note: The above contents have been developed into a training manual titled **"Psychosocial & Protection Issues for Early Childhood Care and Development – Training Manual for Anganwadi/ Pre-School Teachers"** which is also an outcome of this project.

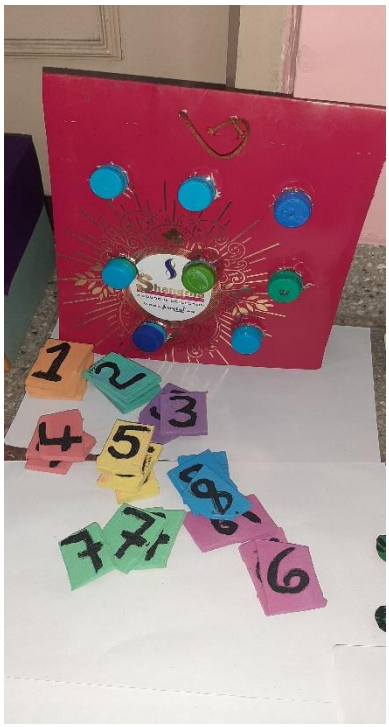
G. Low cost materials for Early Stimulation Competition

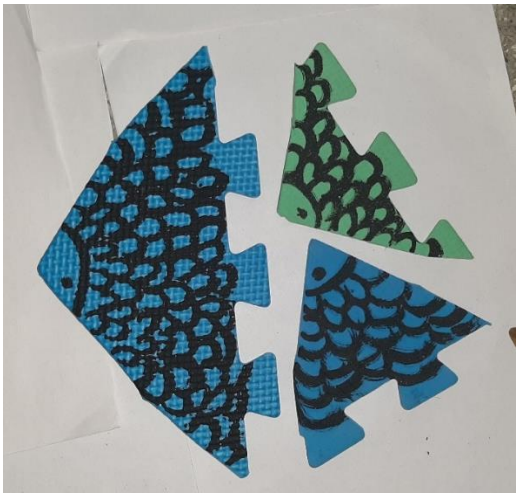
Considering the non-availability/inadequate materials for early stimulation and play in the anganwadi. Through the project, various examples and ideas were discussed with the teachers. They were encouraged to think and come up with these low-cost early stimulation materials. This is more sustainable and they will always have early stimulation materials in the anganwadi.

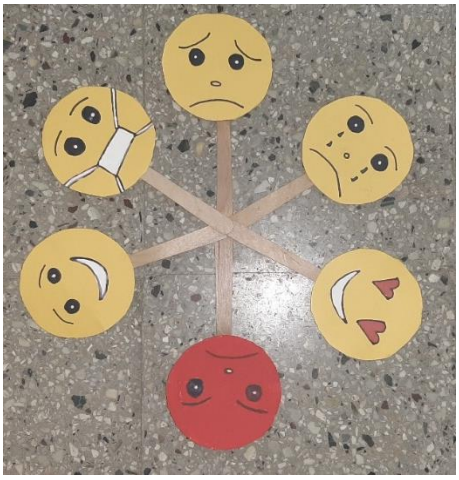
A competition was held where the teachers were given one-month time to come up with at least one early stimulation play material which they have to prepare using waste/ low cost easily available materials.

The teachers were asked to bring in the materials which they have developed for one of the one day training workshop held at NIMHANS, and they were judged based on – Creativity, number of developmental domains it covered, number of materials used, and how actively children can use these materials for early stimulation. Some of the materials developed by teachers are given below.







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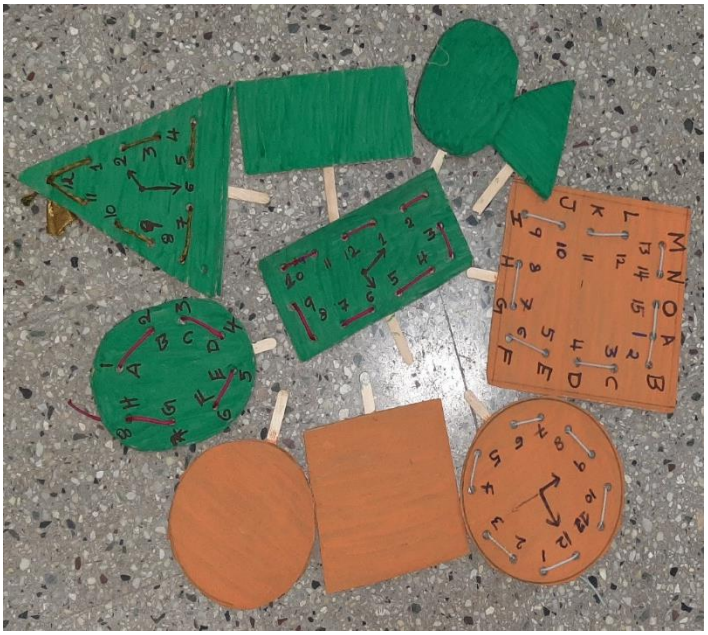


H. Training Observations and Challenges

While conducting the training program and the assessment of children, following observations were made regarding the anganwadi workers and their work with children:

- Firstly, it is important to note that the anganwadi workers were very motivated and enthusiastic to attend these sessions. They were keen and participated actively in all the activities. They also took initiative and came up with ideas and new activities for early stimulation.
- It was observed as most of the children who attend the anganwadi were between 2.5 to 3.5 years, the curriculum and the standard of teaching materials and techniques the anganwadi workers had received were at a much higher level and did not cater to this age group. They needed further simplification.
- They knew more about physical development and cognitive development than they did about the other three areas i.e. speech and language, emotional and social development.
- While they have a basic understanding of the domains of child development, they lack concrete knowledge about the domains. They were not able to delineate a particular domain for a given activity. According to them, all activities are done with a general objective of enabling developmental abilities in children.
- They were able to identify some signs and symptoms of disability or developmental delay, such as children who were unable to speak, withdrawn, hyperactive, or those who have physical disabilities and speech problems. They were able to understand the importance of special attention and more time for children with developmental delays and disabilities. However, they were not able to provide intervention for developmental delays and disabilities.
- They were not able to understand and differentiate developmental delay from under-stimulation. For instance, a child may have developmental delay in cognitive developmental domain, this can be either due to specific developmental delay or may be due to under-stimulation, which the anganwadi workers failed to identify.
- The anganwadi workers did not have an understanding of the context of emotional problems and its impact on the child’s development. For example, a child who is

withdrawn and does not engage with peers might be that way because they have witnessed domestic violence at home or may be due to some extent of intellectual disability.

- It was also observed that the anganwadi workers could not identify emotional problems in young children.
- Anganwadi workers were aware that corporal punishment is unacceptable, and it is against the law. However, they lacked the skills and techniques to practice it. They said “we are aware that we should not punish children, but sometimes we are so frustrated and unable to control them, and end up punishing.” It was observed that they were not using sticks/ rulers to threaten children but resort to mild smacking and shouting at them. It was pointed out to the anganwadi workers that it is inappropriate. However, they were keen to know various techniques which they could use instead of corporal punishment.
- When child protection and safety issues were discussed, the anganwadi workers were aware about the risk of physical abuse. Anganwadi workers had limited knowledge about how young children can be sexually abused and how it can be identified. Anganwadi workers also lacked knowledge and skills to understand the impact and consequences of emotional abuse and neglect on young children.

I. Specific Strategies Adopted for Capacity building of Anganwadi workers (Refer Box 3)

Box 3: Specific Strategies Adopted for Capacity Building of Anganwadi workers

Given the challenges (discussed above) and the context of anganwadi workers, the Project developed several types of strategies, throughout its implementation processes, so as to provide for a more enabling learning and work culture and environment for the workers.

Connection not Correctional Approaches

Listening, recognizing and validating the anganwadi workers’ experiences and concerns related to high workload, including burden of record-keeping, low salaries

(also not received regularly), lack of health insurance, the use of anganwadi workers to collect data and assist with other community initiatives that are not often related to preschool work, their responsibilities relating to maternal health/ nutrition initiatives—these seem to take away a substantial time that could be spent in direct work with children (and imposition of work such as election duty, collection of health-related data at family level etc.). Additionally, in recent months, there has also been a proposal to include LKG and UKG education under anganwadis. While some anganwadi workers were in favour of this (because they thought that this measure may lead to increased number of children in anganwadis and consequently, bring more resources and recognition to anganwadis), others were against it because they felt that they neither had the time nor the expertise to deliver these additional services.

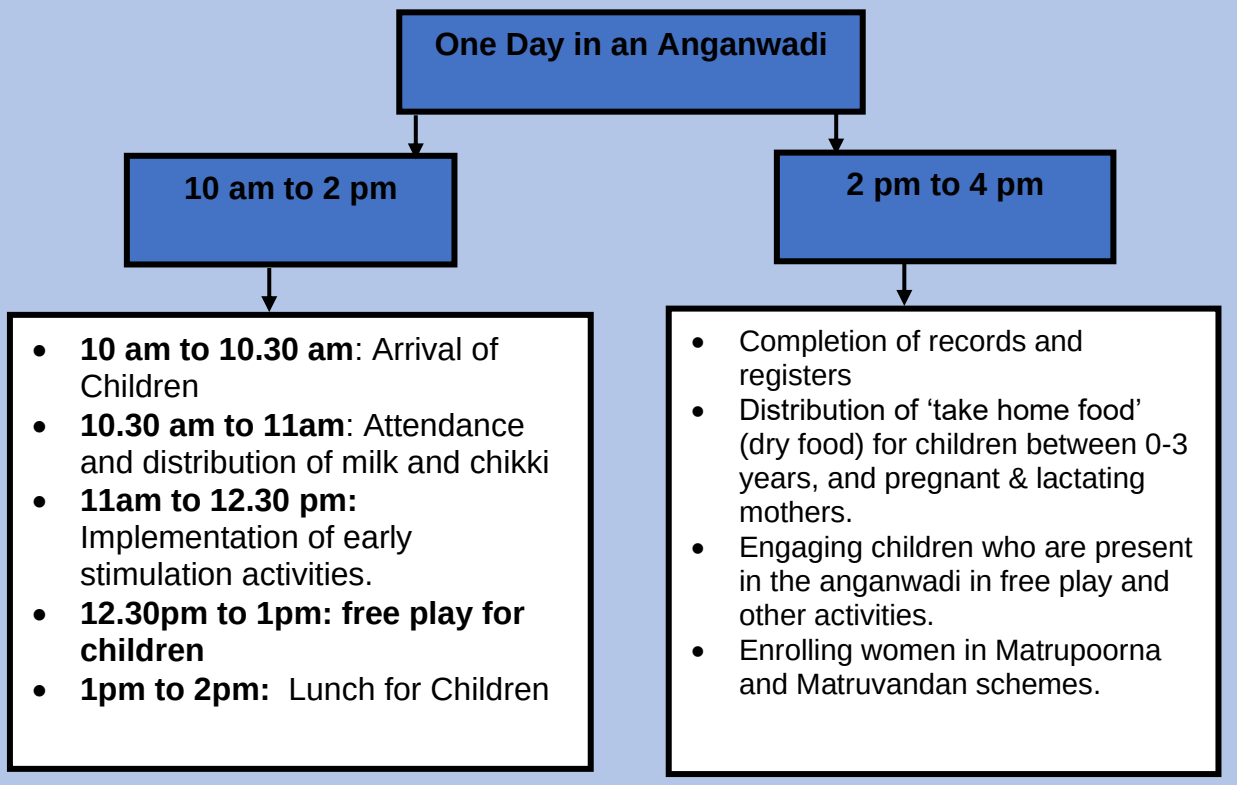
Thus, the NIMHANS team's first strategy was to recognize and validate the concerns of the anganwadi workers and to assure them that the project's intention was to reduce, not increase their work burden, by providing them with methods that would help them plan and manage their direct work with children more efficiently and effectively. Assurances were also provided that the Project's objectives were neither to criticize nor report on work that was not adequately done, but that the objective was to understand and support their work, to enhance what they are already doing, so as to benefit children. Thus, any direction provided by the Project, was in the form of a request or a plea, never as an order or with threat of complaint to the supervisors/CDPOs.

Helping Workers with Time Management

- Asking workers to instruct parents to send the children on time— 'else your children will miss out on activities and critical learning'. [This also addressed parents' complaints that children 'are taught nothing' in the anganwadi].
- Asking workers to instruct pregnant and lactating mothers to come at specific times to collect 'take-home' food (versus coming at random times all day long, thereby interrupting any direct interventions workers are attempting to implement with the children). This suggestion was also taken up at the CDPO level, so that an official notice indicating timings for 'take-home food' (after 2 pm only) could be issued for use to the anganwadi worker—who pasted it on the anganwadi walls for mothers' reference. In

case any mother who came at a different time threatened the worker with action/complaint at higher levels, the worker was advised to maintain a written record and call the supervisor immediately with such information.

➢ Drawing diagrams to show anganwadi workers how they can plan their day's activities for effective and efficient implementation of their work. Further, an entire day was spent in each anganwadi to show the worker that these plans are workable.



Use of Creative Methods in Training

➢ Instead of only one-off workshops that are often convenient to project teams/ facilitators, the bulk of the training was done through weekly sessions of about 2 hours each. This strategy was devised to enable shorter and more focused learning (to allow for detailed discussion on each of the selected topic), with an element of continuity and follow up. The strategy was also tailored to the learning abilities of the anganwadi workers, who we felt would not benefit from long sessions, with multiple concepts taught simultaneously, and information overload that they would find difficult to translate into practice.

- Each of the weekly sessions were held for a cluster of anganwadis, with range of 4 to 12 anganwadi workers, who came from nearby anganwadis. This enabled anganwadi workers to avoid travelling long distances to attend training; and it allowed them to complete their morning tasks comfortably in order to free up their time to attend the session in the afternoon.
- The NIMHANS team created a friendly, informal learning environment, wherein the session would begin with tea and snacks and some sharing of personal and professional stories, on a more light-hearted note. This enabled to establish a deeper emotional and personal connection with the workers, who also then perceived the session as a space to not only learn but to socialize and share their lives—which in turn fed into the learning aspects of the session.
- Lecture methods were used to a minimal extent (no power point slides in the anganwadi!). Each session used different creative and participatory methods, such as role play, case discussions, simulation games, demonstrations, brain-storming, pile sorting/ listing. Such methodologies and approaches served to create a sense of anticipation and enthusiasm amongst the workers, and also gave them a sense of the importance of methodology in child work.
- Each month, the NIMHANS team shared with all anganwadi workers their observations on both positive and negative practices they had observed across the anganwadis—but without naming the worker concerned. Such sharing of observations, with an emphasis on good practices, helped to disseminate new ideas and methods amongst the workers. (For example, the NIMHANS team might say 'We saw how one of the workers dealt with a crying child…she did (such & such) … perhaps others could try that too'.

Motivational Strategies

- A WhatsApp group consisting only of anganwadi workers (not inclusive of supervisors and CDPOs) was created by the NIMHANS team. While the original purpose of this group was to be able to efficiently communicate and disseminate general information on training schedules and venues, it moved on to becoming a platform for anganwadi workers to share the work they were doing with children. They were encouraged to share videos of their activities with children (about 1 to 2 videos per

week) so as to make learning a fun and creative exercise for everyone, and to allow them to learn from each other's efforts, techniques and creativity. While only a few workers posted videos in the initial stages, a gradual increase in posting of videos and ideas was observed over time.

- At the end of each concept or topic taught in a session, the anganwadi workers were requested to spend the following days thinking of an activity they could implement with the children, to help translate the concept/ idea into practice. No criticism or blame was laid on a worker who was unable to do the 'homework' activity; but those workers who did it were appreciated by the NIMHANS team as well as other workers, during the session, with an emphasis on the positive aspects of the activity designed (versus a critical/ correctional approach). Furthermore, the appreciation took the form of 'extra coffee and snacks' for the 'best person's activity'—which the workers participated in, with much laughter and a spirit of comradery. In fact, they almost always judged whose ideas and activities were the best.
- Healthy competition, with care to maintain the spirit of fun and friendship, was also encouraged in other ways. For example, towards the end of the Project, instead of conducting a class on low cost aids for use in child work, a competition was held: a month's time was provided, during which each anganwadi worker had to make/ create at least one low cost aid for early stimulation and child development.

3.4. Training and Dissemination in Other Forums

i) Orientation program conducted in National Institute of Public Co-operation and Child Development (NIPCCD)

NIPCCD requested the project to conduct an orientation program in the Government school campus, Avalahalli, Doddaballapur main road, Bangalore-560064 for anganwadi workers and parents on 29th August 2019. A total of 43 anganwadi workers and parents had attended the session.

Objectives and Content of Orientation program were:

- To develop a conceptual understanding of child development. In particular, the key domains of child development.
- To recognize the importance of early stimulation methods and practice in relation to the key domains of child development.
- To understand the importance of child protection issues among young children i.e. neglect, abuse and trauma.

ii) Representation and Presentation at scientific workshop 'EARLY CHILDHOOD DEVELOPMENT: EARLY MOMENTS MATTER'

The project staff represented and presented in Hyderabad on July 30th - 31st 2019. The workshop was organized by the Indian Institute of Public Health, Hyderabad in partnership with UNICEF-Hyderabad office as a part of 'Advanced Collaboration for Early Childhood Development and Empowerment' (ACECD).

During the workshop the project was presented an intervention for addressing 'Child protection: Safety and security in early life', and how integrating Child mental health, development and protection is the way forward. During the presentation, the gaps and challenges in the field of child protection in early life was discussed as follows:

- Lack of specific definition for child protection in young children. It is imperative that we provide a definition which encompasses all aspects of protection including physical, emotional, sexual abuse and neglect.
- Early child development programmes in the country are not inclusive of child protection aspects.
- All the child protection policies, acts and programmes are limited to older children and adolescents.
- The sheer number of children to reach out is, by itself, a huge challenge which is further exacerbated due to lack of skilled professionals to deal with child protection in young children.

- Along with this, young children's limited ability to understand and report abuse & neglect, considering they are still developing, and lack socio-emotional, cognitive and communication abilities.
- Paucity of young-children specific assessment tools, protocols, methodologies to identify, respond and provide intervention.
- There is a lack of awareness and ability to identify and respond to child protection issues in young children.

Along with this, the project's objectives and interventions were shared. The child sexual abuse prevention and personal safety module developed by the Community child and adolescent mental health service project, Department of child and adolescent psychiatry, NIMHANS was shared. The integration of child developmental, mental health and protection services is the way forward for addressing early childhood protection issues.

iii) Participation in the Panel discussion at "Anganwadi Habba" in Dodaballapura

Makkala Jagriti an NGO which works with government schools, children's homes and Anganwadis for the Holistic development of marginalised children. As part of their Early Child Care Education (ECCE) program had organised ECCE Mela—Anganwadi Habba in collaboration with the Department of Women and Child Development on 18th January 2020.

The objective of the Mela was to create awareness about the importance of starting ECCE to the community and also to celebrate and showcase the work of Anganwadis, Anganwadi workers and helpers who were part of the "Makkala Jagriti" team. The Mela had experiential learning stalls, some cultural activities and even a panel discussion. The project team contributed and shared all the materials developed through the project. In the Anganwadi Habba, the project team was part of the panel discussion on the – **Importance of ECCE- Role of all stakeholders in early childhood care, learning and development.** The other panellists were academicians from ECCE background, and Department of Women and Child officials.

Following key points/ questions were discussed during the Panel Discussion:

- What does Early Childhood Care and Development include?
- Importance of Early Stimulation and engaging children in activities.
- Importance and Advantages of ICDS scheme.
- Role of Pre-school teacher/ Anganwadi worker in the ECCE.
- Role of Parents/ Caregivers in the ECCE.
- Examples of activities the parents/caregivers can engage on a day to day basis with their children for early stimulation.

3.5. Material development

As part of the project implementation and through its focused and direct work with young children and anganwadi workers, various materials were developed by the project team. Along with this the project translated a few materials which were developed by the Community child and adolescent mental health service project, Department of child and adolescent psychiatry, NIMHANS. Details of the materials developed are given in the Table 11. These materials are available in the website https://www.nimhanschildproject.in/

Table 11: List of materials developed through the Project

Sl. No	Name/ Type of material	Target Group
1.	Individual Assessment format for Child development, Mental Health and Protection issues: three separate formats based on Child developmental ages were developed, i.e. for 0-1 years, 1-3 years, 3-6 years.	Child care service providers
2.	Social Emotional Development Manual for Early Childhood Care and Development- Activities for Anganwadi Children Pre-School Children	4 to 6 years children
3.	"Psychosocial & Protection Issues for Early Childhood Care and Development – Training Manual for Anganwadi/ Pre-School Teachers"	Anganwadi workers / Pre-school teachers, Child care service providers

4.	"Hadutha Nali, Kaliyutha Beli" (Enjoy as you Sing, Grow as you Learn) – A compilation of over 200 songs and poems for early stimulation. Complied by the Anganwadi workers.	Anganwadi workers / Pre-school teachers, Child care service providers
5.	Translation of "Child Sexual abuse and Personal Safety Module - Activity-Based Awareness & Learning for Pre-Schoolers & Children with Developmental Disabilities" to Kannada. As part of the Module a Story Series of 3 stories were also translated. i) When Somu forgot Stranger Safety rules. ii) Tommy's New Neighbour iii) Which Secrets to keep?	Anganwadi workers / Pre-school teachers, Child care service providers
6.	Translation of 3 Stories which were developed by the Community child and adolescent mental health service project, Department of child and adolescent psychiatry, NIMHANS. i) Afsa: Loss and Grief ii) Tariq: Loss and Grief iii) Akbar: Trauma and Anxiety	Anganwadi workers / Pre-school teachers, Child care service providers

4. Outcomes & Impact

This was a pilot project, implemented over a relatively short duration of 6 months. Despite this, we were able to observe considerable changes in the anganwadi workers attitude to learning and to engaging in direct work with children. Indeed, our learning from this project has also been that motivating anganwadi workers and bringing about attitudinal changes requires a very different approach and methodology from many that have been used so far i.e. that gentle, persuasive ways combined with according of deep respect, development of fun ways to learn through creation of social forums to eat, chat and learn (rather than a formal classroom type of set up with the threat of disciplinary actions in case of poor participation or work not done) are the ways forward.

4.1. Impact on Anganwadi Workers' Work & Learning

The project, through its activities, reached 31 Anganwadis. Conducted individual assessments of 237 children to examine developmental, mental health, protection issues. Implemented group activities with children for early stimulation and prevention of child sexual abuse over 190 sessions and reached 276 children. Conducted Capacity and training programs for 31 anganwadi workers over 4 one-day training workshops and 89 weekly sessions. Around 300 child care service providers from various agencies, organisations were reached through training and dissemination in other forums.

Table 12: Outcomes and targets reached

Sl. No	Outcomes	Frequency
1.	Number of Anganwadi Reached	**31**
2.	Number of Anganwadi Workers reached through intensive training	**30**
3.	Number of Anganwadi helpers reached	**27**
4.	Number of Individual assessments done for examining Developmental, Mental Health and Protection issues	**237**
5.	Number of Group Sessions conducted with the anganwadi children	**190**
6.	Number of Children reached through group activities	**276**
7.	Number of One-day training sessions conducted for anganwadi workers and helpers	**5**
8.	Number of weekly training sessions conducted	**89**
9.	Number of child care service providers from various agencies, organisations were reached through training and dissemination in other forums	**Around 300**

Along with the above outcomes there were also critical qualitative outcomes, mainly in terms of anganwadi workers' attitudes and learning. (See below in Box 4).

Box 4: What anganwadi workers said they learnt, how they viewed the project and their interactions with the NIMHANS team

At the start of the project:

"…Oh, another person, another burden—this is going to be very difficult.
…Why did they select my anganwadi? I wish that they had selected another one for their work!
…Anyway, it is just 6 months…they [NIMHANS team] will come and go…they will just see what is happening and go away…we just have to be there when they come for a 6- month period."

After the Introductory Workshop:

"…When we came to the workshop, the way you greeted us, the way you treated us was different from everywhere else."
…because we are anganwadi workers, we are always considered as the lowest level workers and treated as such.
…we go to many places for meetings and training programs. They never care whether we have eaten and often don't provide us with food.
…here [at NIMHANS], we were given food, travel allowance and a great deal of respect—which made us feel that there is something different about this place/ team."

When the weekly sessions were initiated:

"… we were initially very reluctant to participate in the weekly training sessions. We felt that if we go to the sessions from 2 to 4 pm, we would lose time and not be able to complete our other record keeping work."
…What are they [NIMHANS team] going to teach every week? What is there really, to learn or teach about young children?
…Many people have taught us to do activities with children--we know that already.
…We agree that our job is to teach the children but where is the time, given all the other work/record keeping we must do?
…And now they want us to contribute to a poem book they are developing---Oh no, we have to write 5 poems now!

…But once they [NIMHANS team] started teaching us, we felt that their content and methods were completely different from what we had previously learnt.
…We realized that the techniques and tips that they gave us actually helped us to at least try to do direct work and activities with children—for example, when we had to teach children about vegetables, we used to teach them the names of the vegetables and their colours; but the NIMHANS team taught us how we could use the vegetable activity to touch on all the key domains of child development—how we can ask each child to bring one vegetable from home (if possible) or use those in the anganwadi to then get children to name/identify the vegetable; then to mix all the vegetables and get them to sort/categorize it [cognitive development]; teach the children a song on vegetables and express their likes/dislikes for different vegetables [speech and emotional development]; create a market scene where children are buying and selling vegetables [Pretend play/peer interaction for social development]. This whole activity would take us just an hour to complete—so we would have followed our time table/topic and in the process, even touched the key developmental domains.

…we felt that given the NIMHANS team's time and effort, we should at least attempt to try out some activities with the children; some days we could not but we still tried our best…and found gradually that it was possible to spend some time in doing direct work with the children.
…we had no knowledge as such on concepts of child protection and safety, which we now understand.
…we thought that young children do not understand much, so there is no need to engage in protection issues. But now we realize that there are many risks concerning protection for young children—and that there are also simple ways in which we can teach them about safety awareness."

What anganwadi workers said they learnt… (Cont…)
When the Project was concluded…

"…Before we thought, Oh no! It's Monday and we have a training session in the afternoon…now we feel, it is Monday—Oh no! There is no fun and excitement…the NIMHANS team is not coming anymore!
…We will ensure that we continue to practice what we learnt—and in order to remember, we will try to teach other anganwadi workers in our circle.
…As we look at the poem book now, we feel so proud of ourselves—we are so happy to see our names in it. No one usually gives us any credit for the work we do. In all my 30 years of service, this is the first time someone has given us credit for our work.

A Poem Written by An Anganwadi worker about the Project & NIMHANS's Interventions

ನಿಮ್ಹನ್ಸ ಅವರಿಂದ ಪಡೆದ ತರಬೇತಿ	Training received by the NIMHANS team
ಎಷ್ಟು ತರಹತರಹದ ರೀತಿ	Were about various different themes,
ನಮ್ಮ ಮನಸಿನಲ್ಲಿ ಅಚ್ಚು ಇಳಿಯುವ	The concepts were inscribed in our minds
ತರಬೇತಿಯಲ್ಲಿ ಇತ್ತು ೫ ಬಳವಣಿಗೆಂ	The training had 5 domains of development
ಇದಕ್ಕೆ ಇದೆ ನಮ್ಮೆಲ್ಲರ ಪಾತ್ರ	We play a major role to implement
ಈ ಬಳವಣಿಗೆ ಮಕ್ಕಳಲ್ಲಿ ಮಾತ್ರ	These domains of development are among children,
ಮಕ್ಕಳ ರಕ್ಷಣೆ ನಮ್ಮೆಲ್ಲರ ಕರ್ತವ್ಯ	Protection of children is our Responsibility
ಇದರಿಂದ ಮಕ್ಕಳು ಹೋಗುತ್ತಾರೆ	This enables children to achieve and fly high
ಬಹು ಎತ್ತರ	

Additionally, Anganwadi supervisors and Child Development Program Officers (CDPOs) said that they initially wondered why the NIMHANS team was asking for conducting 'so many' training sessions; however, once the content of the sessions was explained and the supervisors also attended some of the sessions, they said that they understood the importance of the sessions. They also said that often, when the anganwadi workers are requested to go for training, they were reluctant "*but when it is NIMHANS training, the anganwadi workers are excited and happy to go for them…now that I have attended the session, I understand why they are eager to go*." The CDPOs were keen that the project activities and training be extended to other anganwadis in the future. They also pointed out that although the Dept. of Women & Child Development has two components i.e. ICDS and ICPS, the two components often work parallelly, without any integration; they felt that some of the ICPS work, namely protection aspects, need to be integrated into ICDS—as they now realize the importance of child protection (when erstwhile, their entire focus had been nutrition, health and general child development).

4.2. Materials for Use in Anganwadis

In the short duration of 6 months, several materials and manuals have been developed, many for the first time, on issues pertaining to child protection and anganwadi training, with new pedagogies, adapted to the needs and abilities of anganwadi workers; also developed are activities for enhancing social and emotional development in young children (a severely neglected area in India, particularly in pre-schools and anganwadis where there is the greatest emphasis on cognitive aspects of child development though mainly through rote learning). These materials, manuals and activity books can be translated into other languages and used across the country by ICDS programs in different states. The details of the materials are given in the Table 11.

4.3. Development of a Framework to Integrate Child Protection into Early Childhood Development Programs

Child protection in pre-schoolers critically involves but is not restricted to abuse and neglect issues. Adverse childhood experiences in early childhood has a significant impact on the developing child and on the developing brain—and are known to be significantly associated with poor mental health outcomes at a later stage, such as emotional regulation problems and other trauma symptoms. Since critical brain development occurs in the early years of life i.e. 90% of brain development occurs within the first 3 years of our lives, child protection in pre-schoolers also means protection from the adverse influences of their developmental needs not being met. Child protection involves addressing risks relating to neglect, abuse, absence of opportunities (for learning and development); abuse not only includes physical and sexual abuse but also emotional abuse—how experiences of attachment in early childhood are related to the emotional atmosphere in which the child grows. The concept of early childhood development and protection thus encompasses this comprehensive framework (as shown below). Diagrammatic representation of this framework is given in Figure 2.

i) early stimulation and development, including provision for learning opportunities;

ii) providing alternative opportunities for developing healthy attachment, particularly for children who are from compromised or dysfunctional families such as single-parent families/ families in which there is parental discord and domestic violence, where children are witnesses and/or victims of such an environment.

iii) creating awareness in children regarding personal safety and abuse issues to enable early reporting of abuse experiences.

iv) Equipping caregivers (parents and anganwadi workers) with knowledge, skills and methods to identify protection risks in young children, including emotional and behavioural issues, and to address them, depending upon the severity, either at their level or through referral to specialized services and child welfare committee.

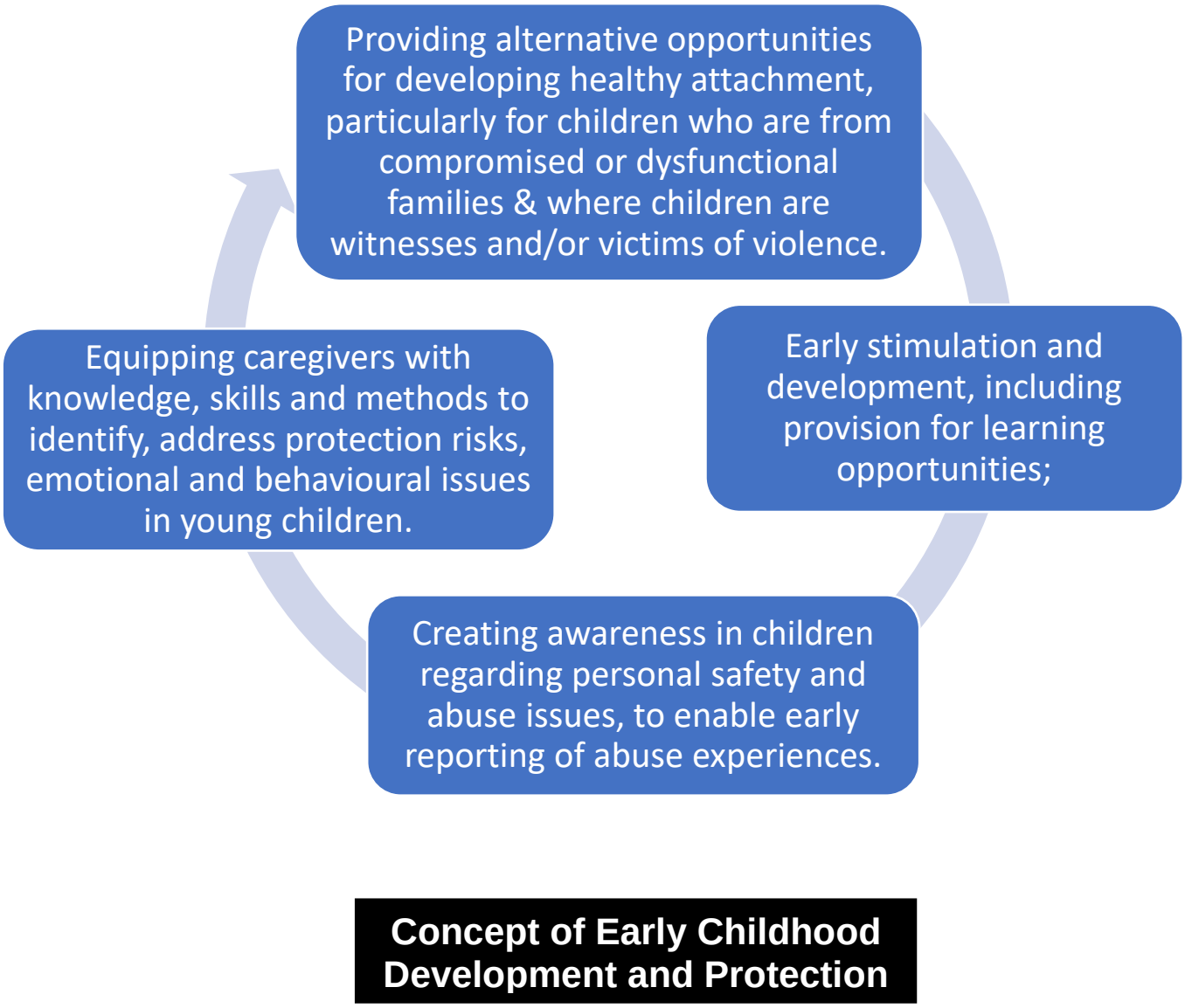
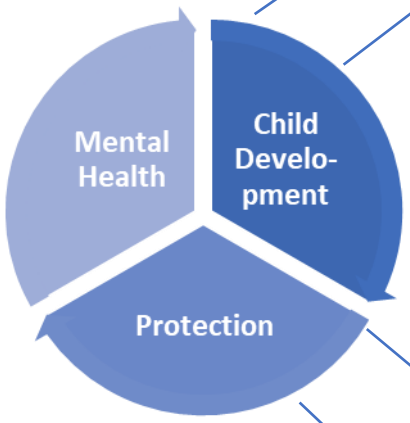


Figure 2: Diagrammatic representation of early childhood development and protection thus encompasses this comprehensive framework.

4.4. Development of a Model for Enhancing the Capacities of Anganwadi Workers in Early Stimulation, Child Development & Protection

Based on our intensive work, through this UNICEF-supported pilot project, we have developed a model where in an integration of early childhood development, mental health and protection is the way forward for the success of ECCD.



To examine developmental, mental health, protection issues of young children through individual assessments, and provide interventions specific to their contexts of vulnerability.

Group activity with children to conduct early stimulation activities and implement child sexual abuse prevention and safety module in the anganwadis.

Capacity building of anganwadi workers, to address Child development, Mental health & Protection needs of young children.

To draw from implementation experiences to develop initial materials for use in community-based early childhood care and protection

Objectives & Activities

- Simple assessment tools to examine Developmental, mental health and protection issues.
- Early stimulation and development, including provision for learning opportunities;
- Creating awareness in children regarding personal safety and abuse issues, to enable early reporting of abuse experiences.
- Providing alternative opportunities for developing healthy attachment.
- Additional care/support for children who are from compromised or dysfunctional families & where children are witnesses and/or victims of violence.
- Using Connection not Correctional Approaches while working with Anganwadi workers.
- Helping Anganwadi Workers with Time Management
- Use of Creative Methods in Training and capacity building
- Using Motivational Strategies with Anganwadi workers and helpers.
- Development of Simple and effective materials in local language.

Strategies

5. Moving Forward…Future Plans

The Dept. of Child & Adolescent Psychiatry, NIMHANS, through its DWCD/ Government of Karnataka-supported Community Child & Adolescent Mental Health Service Project (2014-2019), as well as this UNICEF-supported **"Initiating Community-Based Psychosocial & Protection Services for Early Childhood Care & Development"** has been engaging in training and capacity building initiatives for anganwadi workers on issues of child protection, mental health and psychosocial care.

We plan to continue, consolidate and extend these training and capacity building initiatives in the coming years, through a new initiative "PRATICRIA" - a National Initiative & Integrated Resource for Child Protection, Mental Health, and Psychosocial Care. This initiative will be supported by the Ministry of Women & Child Development, Government of India. Pre-school education, including early childhood development and protection, will form one of the key areas of PRATICRIA's work, and therefore provide technical support to state governments and their ICDS schemes to implement the model and methodologies developed by this pilot project.

6. Annexures

6.2. Annexure 1: List of Anganwadi

Sl no	**ANGANAWADI**
01	DHOBIGHAT 2
02	KALAPPA BLOCK
03	KALIDASA LAYOUT
04	SRINAGARA 2
05	YARAB NAGAR 1
06	PRAGATHIPURA 1
07	PRAGATHIPURA 2
08	PRAGATHIPURA 3
09	SARABANDE PALYA 1
10	JAWAHARLAL NEHRU SLUM
11	BHAVANI NAGAR 2
12	GANGADHAR NAGAR
13	HARI COLONY 2
14	HARI COLONY 1
15	AMBEDKAR NAGAR 1
16	KAVERI NAGAR 2
17	KAVERI NAGAR 4
18	RAMANA GARDEN 1
19	RAMANA GARDEN 2
20	Y M SHALA 1
21	Y M SHALA 2
22	VINOBHA NAGAR 1
23	VINOBHA NAGAR 2
24	HAMEED KHAN GARDEN
25	RAJGOPAL GARDEN
26	N.S. GARDEN
27	KUMBAR GUNDI
28	SOMESHWARA SLUM
29	NARAYANAPURA
30	LAL BHAG SIDDAPURA
31	ARASU COLONY

6.3. Annexure 2: Developmental, mental health and Protection Assessment Formats

Initiating Community-Based Psychosocial & Protection Services for Early Childhood Care & Development
Dept. of Child & Adolescent Psychiatry, NIMHANS
Supported by UNICEF

Developmental, Mental Health and Protection Assessment Format for Children (Aged 0 - 1years)

A. Basic Information

Name of Child: **Date:**
Sex: **Age:** **Name of the Anganwadi/Institution:**

B. Family Context

1. Who is the child's primary caregiver? Parents / Grandparents / Extended Family
2. More than 2 children in the family? Yes/ No
3. Context of the family pertaining to the primary caregiver of the child.

Sl No	Family Context	Yes	No
a.	Single Parent: Separated/ Divorced/ Widowed		
b.	Death of an immediate family member		
c.	Substance use by the parent/ primary care giver		
d.	Domestic Violence in the family		
e.	Conflicts and fights in the family (incl. Physical violence)		
f.	Chronic Illness in the parents/ primary care giver (Tuberculosis, HIV/AIDS, Cancer etc.)		
g.	Mental Illness in the parents/ primary caregiver		
h.	Disability in the parents/ primary caregiver		
i.	Criminality in the parents/ primary caregiver		

3. Any other issues and concerns in the family context.

C.1. Medical Problems/ Sensory Needs & Issues:

Sl No	Medical Problems/ Sensory Needs & Issues	Yes	No
a.	Are there any behavioural indicators to suggest visual impairment? (One or both eyes consistently turn in or out / Persistent tearing, eye drainage, or sensitivity to light and droopy eyelids / Has difficulty calming self, cries for long periods of time / Does not react to new environments and people		

b.	Hearing Impairment? (Does not turn head to locate sounds by 4 months / Does not respond to general sounds / Does not follow instructions given from the back or when the speaker's face is not visible / Asks for repetition of instructions / Turns one side of head towards to the speaker / has running ear or waxy ear)		
c.	Likes to maintain odd postures? (Does not seem very stiff with tight muscles / Seems very floppy, like a rag doll / Head still flops back when body is pulled to sitting position (by 5months, still exhibits head lag / Can't crawl / Drags one side of body while crawling (for over one month) / Cannot stand when supported / Has difficulty getting objects to mouth / Does not sit steadily by 10 months / Doesn't push down with legs when feet are placed on a firm surface by 4 months)		
d.	Has the child been Malnourished and been in treatment for more than 6 months?		

If any of the above problems and issues are present, mention the details.

D. Check list for Physical Signs for Assessing Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and Nutrition

Sl No.	Signs and Symptoms	Yes	No
	Physical Abuse		
a.	Bruises, welts, black eyes or other injuries that can't be explained or don't match with the child's story.		
b.	Burns that cannot be explained.		
c.	Injury marks that have a pattern, like from a hand, belt, or other objects.		
d.	Injuries that are at different stages of healing (bruises change colour over time)		
e.	Fractures and dislocations.		
f.	Wear clothing that doesn't match the weather -- such as long sleeves on hot days -- to cover up bruises.		
	Sexual Abuse (to be asked with the helper/teacher)		
a.	Genital injuries		
b.	Physical injuries		
c.	Pain/burning sensation/ infection/ itching in the genital region		
d.	Urinary tract infections		
	Neglect		
a.	Skin infections and sores		
b.	Appears dirty and has severe body odour		
c.	Has poor dental hygiene		
d.	Lacks sufficient clothing for the weather		
	Signs of Malnutrition		
a.	Respiratory and other infections/ illness		
b.	Skin is thin, dry, inelastic, pale, and cold		
c.	Cheeks appear hollow and the eyes sunken, as fat disappears from the face		
d.	Hair is dry and sparse		
	Emotional & Behavioural Signs		
a.	Sudden unexplained change in behaviour: School refusal, people avoidance		
b.	Sudden onset of bed wetting, aches, pains, general ill health		
c.	Symptoms of depression and Post-Traumatic Stress Disorder		

d.	Appear dull, listless and inactive		
Avoidance of any kind of touch or physical contact			
a.	Fearful appearance always seeming to be on high alert.		
b.	Withdrawal from friends and activities.		
c.	Sexualized behaviour (applicable only to sexual abuse).		

E. Developmental Functions/ Skills Checklist

Sl no		Developmental Functions and Tasks		Ability to Perform Developmental Functions and Tasks		
				To high Extent	To Some Extent	To Low extent /Not at all
	1.PHYSICAL DEVELOPMENT					
	1.1. Motor Skills					
a.	0-3 Months.	Opens and closes hands (folding palm)	o/s			
b.		Able to use hand to hold on to an object	o/s			
c.		Able to bring hands together when lying on his/her back	o/s			
d.		Able to push down on his/her legs when his/her feet are placed on firm surface	o/s			
e.		Stretches legs out when lying on stomach or back	o/s			
f.		Supports upper body with arms when lying on stomach	o/s			
g.		Balances neck for a few minutes while lying or sitting with support	o/s			
h.		Follows moving objects	o/s			
i.		Grasps objects dangling in front of him/her	o/s			
j.	4-7 Months.	Transfers objects from one hand to another, squeezing fingers against palm	o/s			
k		Grasps feet	o/s			
l.		Routinely rolls over from stomach to back and back to stomach	o/s			
m.		Pulls to sitting position with no head lag (with neck control)	o/s			
n.		Sits without support if made to sit	o/s			
o.		Tracks moving objects with ease (visual tracking)	o/s			
p.	8-12 Months.	Crawls forward on belly	o/s			
q		Gets to sitting position without assistance	o/s			
r.		Pulls himself/herself up to standing position using furniture	o/s			
s.		Stands momentarily without support	o/s			
t.		Uses pincer grasp to pick up small objects (grasp using thumb and index finger)	o/s			
u.		Bangs two small objects together	o/s			
v		Puts and takes small objects into and out of container	o/s			

w.		Tries to imitate scribbling	o/s			
2. LANGUAGE DEVELOPMENT						
a.	0-3 Months.	Makes sucking sounds	o/s			
b.		Makes cooing noises; vocal play	o/s			
c.		Attends to sound/ Startles to loud noise	o/s			
d.	4-7 Months.	Laughs and squeals out loud	o/s			
e.		Responds to sound by making sounds	o/s			
f.		Responds to songs and rhythms/rhymes by clapping hands;	o/s			
g.		Uses voice to express joy and displeasure (gurgling vs crying)	o/s			
h.		Distinguishes emotions by tone of voice (recognizes happy/excited tones or angry ones)	o/s			
i.	8-12 Months.	Babbles “da da da....” and “ma ma ma....” (9 months)	o/s			
j.		Says “dada” and “mama” for specific person (11 months)	o/s			
k.		Responds to simple verbal requests, such as “Give me” (12 months)	o/s			
l.		Responds to “no” by briefly stopping activity and noticing adult (10m)	o/s			
m.		Makes simple gestures such as shaking head for “no” (12 months)	o/s			
n.		Uses exclamations such as “oh-oh” (12 months)	o/s			
3. COGNIIVE DEVELOPMENT						
a.	0-3 Months.	Watches face intently when spoken to	o/s			
b.		Responds to voice i.e. turn to, wiggle, reacts	o/s			
c.		Recognize or know the bottle or breast	o/s			
d.	4-7 Months.	Looks for a family member when named	o/s			
e.		Looks for fallen toys	o/s			
f.		Plays peek-a-boo	o/s			
g.	8-12 Months.	Enjoys looking at pictures in books	o/s			
h		Engages in simple games of rhymes, Peek-a-Boo or rolling ball to another	o/s			
i.		Imitates gestures	o/s			
4.SOCIAL DEVELOPMENT						
a.	0-3 Months.	Makes eye contact	o/s			
b.		Smiles at the sound of caregiver’s voice	o/s			
c.	4-7 Months.	Knows faces of family/ caregivers	o/s			
d.		Enjoys playing with others	o/s			
e.	8-12 Months.	Responds to spoken “bye-bye” by waving hands (10 months)	o/s			
f.		Shy/ anxious around strangers	o/s			
g.		Enjoys imitating people in play	o/s			
h		Repeats sounds or gestures for attention	o/s			
5. EMOTIONAL DEVELOPMENT						

a.	0-3 Months	Enjoys playing with other people and may cry when playing stops	o/s			
b.		Becomes more communicative and expressive with face and body	o/s			
c.	4-7 Months.	Able to calm down when soothed or distracted	o/s			
d.		Responds to other people's expression of emotion	o/s			
e.		Cries when mother or father leaves	o/s			
f.	8-12 Months.	Prefers mother and/or regular caregiver over all others	o/s			
g.		Shows specific preferences for certain people and toys	o/s			

Note: o/s stands for observation/staff; T/A stands for Task/ Ask

2. Any other information reported by the parent/ Anganwadi teacher or your own observations of the child with regards to emotional and behavioural problems

F. Service Provider's Interpretations/ Summary (incl. Recommendations & Care Plan)

Initiating Community-Based Psychosocial & Protection Services for Early Childhood Care & Development
Dept. of Child & Adolescent Psychiatry, NIMHANS
Supported by UNICEF

Developmental, Mental Health and Protection Assessment Format for Children (Aged 1 – 3 years)

A. Basic Information

Name of Child: **Date:**
Sex: **Age:** **Name of the Anganwadi/Institution:**

B. Family Context

1. Who is the child's primary caregiver? Parents / Grandparents / Extended Family
2. More than 2 children in the family? Yes/ No
3. Context of the family pertaining to the primary caregiver of the child.

Sl No	Family Context	Yes	No
a.	Single Parent: Separated/ Divorced/ Widowed		
b.	Death of an immediate family member		
c.	Substance use by the parent/ primary care giver		
d.	Domestic Violence in the family		
e.	Conflicts and fights in the family (incl. Physical violence)		
f.	Chronic Illness in the parents/ primary care giver (Tuberculosis, HIV/AIDS, Cancer etc.)		
g.	Mental Illness in the parents/ primary caregiver		
h.	Disability in the parents/ primary caregiver		
i.	Criminality in the parents/ primary caregiver		

3. Any other issues and concerns in the family context.

C.1. Medical Problems/ Sensory Needs & Issues:

Sl No	Medical Problems/ Sensory Needs & Issues	Yes	No
a.	Are there any behavioural indicators to suggest visual impairment? (One or both eyes consistently turn in or out / Persistent tearing, eye drainage, or sensitivity to light and droopy eyelids / Has difficulty calming self, cries for long periods of time / Does not react to new environments and people		
b.	Hearing Impairment? (Does not turn head to locate sounds by 4 months / Does not respond to general sounds / Does not follow instructions given from the back or when the speaker's face is not visible / Asks for repetition of instructions / Turns one side of head towards to the speaker / has running ear or waxy ear)		

c.	Likes to maintain odd postures? (Does not seem very stiff with tight muscles / Seems very floppy, like a rag doll / Head still flops back when body is pulled to sitting position (by 5months, still exhibits head lag / Can't crawl / Drags one side of body while crawling (for over one month) / Cannot stand when supported / Has difficulty getting objects to mouth / Does not sit steadily by 10 months / Doesn't push down with legs when feet are placed on a firm surface by 4 months)		
d.	Has the child been Malnourished and been in treatment for more than 6 months?		

If any of the above problems and issues are present, mention the details.

D. Check list for Physical Signs for Assessing Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and Nutrition

Sl No.	Signs and Symptoms	Yes	No
	Physical Abuse		
a.	Bruises, welts, black eyes or other injuries that can't be explained or don't match with the child's story		
b.	Burns that cannot be explained		
c.	Injury marks that have a pattern, like from a hand, belt, or other objects		
d.	Injuries that are at different stages of healing (bruises change colour over time)		
e.	Fractures and dislocations		
f.	Wears clothing that doesn't match the weather -- such as long sleeves on hot days -- to cover up bruises		
	Sexual Abuse (to be asked with the helper/teacher)		
a.	Genital injuries		
b.	Physical injuries		
c.	Pain/burning sensation/ infection/ itching in the genital region		
d.	Urinary tract infections		
	Neglect		
a.	Skin infections and sores		
b.	Appears dirty and has severe body odour		
c.	Has poor dental hygiene		
d.	Lacks sufficient clothing for the weather		
	Signs of Malnutrition		
a.	Respiratory and other infections/ illness		
b.	Skin is thin, dry, inelastic, pale, and cold		
c.	Cheeks appear hollow and the eyes sunken, as fat disappears from the face		
d.	Hair is dry and sparse		
	Emotional & Behavioural Signs		
a.	Sudden unexplained change in behaviour: School refusal, people avoidance		
b.	Sudden onset of bed wetting, aches, pains, general ill health		
c.	Symptoms of depression and Post-Traumatic Stress Disorder		
d.	Appears dull, listless and inactive		
	Avoidance of any kind of touch or physical contact		
a.	Fearful appearance always seeming to be on high alert.		
b.	Withdrawal from friends and activities.		

c.	Sexualized behaviour (applicable only to sexual abuse).		

E. Developmental Functions/ Skills Checklist

1. Developmental Functions and Tasks Checklist

Sl no		Developmental Functions and Tasks		Ability to Perform Developmental Functions and Tasks		
				To a high Extent	To Some Extent	To Low extent /Not at all
		1.PHYSICAL DEVELOPMENT				
a.	1-2 yrs.	Climbs onto and down from furniture unsupported (16-24 mos.)	T/A			
b.		Pulls toys behind him while walking and Carries large toy or several toys while walking (13-16 mos.)	T/A			
c.		Begins to run stiffly (16-18 mos.)	T/A			
d.		Walks up and down stairs holding on to support (18-24 mos.)	T/A			
e.		Can open doors by turning knobs (18-24 mos.)	T/A			
f.		Can drink from open cup, with some spilling (18-24 mos.)	T/A			
g.		Scribbles spontaneously (14-18 mos.)	T/A			
h.		Turns over container to pour out contents (12-18 mos.)	T/A			
i.		Starts to feed self with spoon, with some spilling (18-24 mos.)	T/A			
j.		Builds tower of four blocks or more (20-24 mos.)	T/A			
k.		Completes simple knobbed wooden puzzles of 3 to 4 pieces (21-24)	T/A			
l.		Goes to toilet during day time with some help (36)	T/A			
m.		Can feed self if mixed and given (3 years)	T/A			
n.	2-3 yrs.	Walks down stairs alone, placing both feet on each step	T/A			
o.		Walks upstairs alternating feet with support (24-30 mos.)	T/A			
p.		Swings leg to kick ball (24-30 mos.)	T/A			
q.		Runs easily (24-26 mos.)	T/A			
r.		Pedals tricycle (30-36 mos.)	T/A			
s.		Bends over easily without falling (18-24 mos.)	T/A			
t.		Makes vertical, horizontal, circular strokes with pencil or crayon (30-36 mos.)	T/A			
u.		Turns book pages one at a time (24-30 mos.)	T/A			
v.		Builds a tower of more than 6 blocks (24-30 mos.)	T/A			
w.		Draws circle or identifiable shapes (30-36 mos.)	T/A			
x.		Can pull pants down with help (24-36 mos.)	T/A			

y.		Screws and unscrews jar lids, nuts, and bolts (24-30 mos.)				
z.		Turns rotating handles (door knob) (24-30 mos.)	T/A			
2.SPEECH AND LANGUAGE DEVELOPMENT						
a.	1-2 yrs.	Says "no" with meaning (14-18 mos.)	T/A			
b.		Follows simple, one-step instructions (18-24mos.)	T/A			
c.		Says 4-5 meaningful, single words (14-18 mos.)	T/A			
d		Points to object or picture when it's named for them (18-24 mos.)	T/A			
e.		Repeats words overheard in conversations and uses two-word sentences (18-24 mos.)	T/A			
f.	2-3 yrs.	Uses pronouns (I, you, me, we, they) (24-30 mos.)	T/A			
g.		Understands simple sentences (24-40 mos.)	T/A			
h.		Can say name, age, and sex (36 months)	T/A			
i.		Uses words to communicate wants and needs (30-36 mos.	T/A			
j.		Knows simple rhymes and songs (30-36 mos.)	T/A			
k.		Understands prepositions like on, in, under, out, up (24-36 mos)	T/A			
3. COGNITIVE DEVELOPMENT						
a.	1-2 yrs.	Will listen to short story book with pictures (15-20 mos.)	T/A			
b.		Identifies two to three body parts (14-18 mos.)	T/A			
c.		Begins to sort shapes and colours (20-24 mos.)	T/A			
d.		Begins make-believe play (20-24 mos.)	T/A			
e.	2-3 yrs.	Makes mechanical toys work (30-36 mos.)	T/A			
f.		Matches an object in hand or room to a picture in a book (24-30m.)	T/A			
g.		Sorts objects by color (30-36 mos.)	T/A			
h.		Completes puzzles with 3 or 4 pieces (24-36 mos.)	T/A			
i.		Recognizes and identifies common objects and pictures (26-32 mos.)				
j.		Knows several body parts (24-36 mos.)	T/A			
k.		Understands concept of "two" (26-32 mos.)	T/A			
4.SOCIAL DEVELOPMENT						
a.	1-2 yrs.	Imitates behaviour of others, especially adults and older children.	T/A			
b.		Enjoys playing with other children	T/A			
c.	2-3 yrs.	Uses the word "mine" often	T/A			
d.		Begins to follow simple rules of play	T/A			
5. EMOTIONAL DEVELOPMENT						
a.	1-2 yrs.	Demonstrates increasing independence by wanting to do things on their own (18-24 mos.)	T/A			
b.		Begins to separate more easily from parents by 2 years)	T/A			
c.		Begins to show defiant behaviour (18-24 mos.)	T/A			

c.	2-3 yrs	Objects to major changes in routine, but is becoming more compliant	T/A			
d.		Says "no" but will still do what is asked (24-36 mos.)	T/A			
e.		Expresses a wide range of emotions such as joy, sadness, anger	T/A			

2. Under-stimulation in the domains of development

Sl. No	Domain of Development	Yes	No
a.	**Physical Gross Motor Development**		
b.	**Physical Fine Motor Development**		
c.	**Speech and Language Development**		
d.	**Cognitive Development**		
e.	**Social Development**		
f.	**Emotional Development**		

E. Emotional and Behavioural Indicators

Sl. No	Problems	Yes	No
a.	Interferes with other children's activities (snatching/poking/pinching…)		
b.	Poor concentration in performing activities (lack of focus/poor sitting tolerance)		
c.	Unclear speech (speech articulation issues/ stammering)		
d.	Difficult to manage the child (does not sit/ does not follow instructions or obey)		
e.	Not liked by peers, as often doesn't share, and fights and teases with them		
f.	Fights: physical assault		
g.	Withdrawn from peers, doesn't play/participate/ engage with peers		
h.	Total reluctance to speak		
i.	Withdrawn from staff		
j.	Miserable: always unhappy, cries easily and frequently		
k.	Habits – Nail biting, thumb sucking, hair pulling, pica, repetitive behavior etc.		
l.	Wets – not toilet trained, doesn't indicate when he/she needs to go to bathroom		
m.	Soils - dirty their pants, or go to the toilet in inappropriate places.		
n.	Destructive-deliberately breaking toys/furniture		
o.	Temper tantrums- typically involve stamping feet, holding breath, yelling, becoming easily frustrated, falling out, or melting down.		
p.	Fearful		
q.	Difficult to sooth the child when upset		
r.	Self-injury: biting hands/lips, scratching, pulling hairs, face slapping, head banging etc.		
s.	Sexualized behaviours: rubbing body against others, touching private parts of others etc.		
t.	Irregular to preschool		

1. Ask the teacher whether any of these behaviours are present in the child

2. Any other information reported by the parent/ anganwadi teacher or your own observations of the child with regards to emotional and behavioural problems

F. Service Provider's Interpretations/ Summary

Initiating Community-Based Psychosocial & Protection Services for Early Childhood Care & Development
Dept. of Child & Adolescent Psychiatry, NIMHANS
Supported by UNICEF

Developmental, Mental Health and Protection Assessment Format for Children (Aged 3 – 6 years)

A. Basic Information

Name of Child: **Date:**
Sex: **Age:** **Name of the Anganwadi/Institution:**

B. Family Context

1. **Who is the child's primary caregiver? Parents / Grandparents / Extended Family**
2. **More than 2 children in the family? Yes/ No**
3. **Context of the family pertaining to the primary caregiver of the child.**

Sl No	Family Context	Yes	No
a.	Single Parent: Separated/ Divorced/ Widowed		
b.	Death of an immediate family member		
c.	Substance use by the parent/ primary care giver		
d.	Domestic Violence in the family		
e.	Conflicts and fights in the family (incl. Physical violence)		
f.	Chronic Illness in the parents/ primary care giver (Tuberculosis, HIV/AIDS, Cancer etc.)		
g.	Mental Illness in the parents/ primary caregiver		
h.	Disability in the parents/ primary caregiver		
i.	Criminality in the parents/ primary caregiver		

3. Any other issues and concerns in the family context.

C.1. Medical Problems/ Sensory Needs & Issues:

Sl No	Medical Problems/ Sensory Needs & Issues	Yes	No
a.	Are there any behavioural indicators to suggest visual impairment? (One or both eyes consistently turn in or out / Persistent tearing, eye drainage, or sensitivity to light and droopy eyelids / Has difficulty calming self, cries for long periods of time / Does not react to new environments and people		
b.	Hearing Impairment? (Does not turn head to locate sounds by 4 months / Does not respond to general sounds / Does not follow instructions given from the back or when the speaker's face is not visible / Asks for repetition of instructions / Turns one side of head towards to the speaker / has running ear or waxy ear)		
c.	Likes to maintain odd postures? (Does not seem very stiff with tight muscles / Seems very floppy, like a rag doll / Head still flops back when body is pulled to sitting position (by 5months, still exhibits head lag / Can't crawl / Drags one side of body while crawling (for over one month) / Cannot stand when supported / Has difficulty getting objects to mouth / Does not sit steadily by 10 months / Doesn't push down with legs when feet are placed on a firm surface by 4 months)		
d.	Has the child been Malnourished and been in treatment for more than 6 months?		

If any of the above problems and issues are present, mention the details.

D. Check list for Physical Signs for Assessing Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and Nutrition

Sl No.	Signs and Symptoms	Yes	No
	Physical Abuse		
a.	Bruises, welts, black eyes or other injuries that can't be explained or don't match with the child's story		
b.	Burns that cannot be explained		
c.	Injury marks that have a pattern, like from a hand, belt, or other objects		
d.	Injuries that are at different stages of healing (bruises change colour over time)		
e.	Fractures and dislocations		
f.	Wears clothing that doesn't match the weather -- such as long sleeves on hot days -- to cover up bruises		
	Sexual Abuse (to be asked with the helper/teacher)		
a.	Genital injuries		
b.	Physical injuries		
c.	Pain/burning sensation/ infection/ itching in the genital region		
d.	Urinary tract infections		
	Neglect		
a.	Skin infections and sores		
b.	Appears dirty and has severe body odour		
c.	Has poor dental hygiene		
d.	Lacks sufficient clothing for the weather		
	Signs of Malnutrition		
a.	Respiratory and other infections/ illness		

b.	Skin is thin, dry, inelastic, pale, and cold		
c.	Cheeks appear hollow and the eyes sunken, as fat disappears from the face		
d.	Hair is dry and sparse		
	Emotional & Behavioural Signs		
a.	Sudden unexplained change in behaviour: School refusal, people avoidance		
b.	Sudden onset of bed wetting, aches, pains, general ill health		
c.	Symptoms of depression and Post-Traumatic Stress Disorder		
d.	Appears dull, listless and inactive		
	Avoidance of any kind of touch or physical contact		
a.	Fearful appearance always seeming to be on high alert		
b.	Withdrawal from friends and activities		
c.	Sexualized behaviour (applicable only to sexual abuse)		

E. Developmental Functions/ Skills Checklist

1. Developmental Functions and Tasks Checklist

Sl no		Developmental Functions and Tasks		Ability to Perform Developmental Functions and Tasks: To high Extent	To Some Extent	To Low extent/Not at all
		1.Physical Development				
		1.1. Motor Skills				
a.	3- 4 yrs	Able to climb stairs one foot at a time.	T/A			
b.		Stand briefly on one foot	T/A			
c.		Can run	T/A			
d.		Can hop using one foot	T/A			
e.		Kick/ throw and catch a ball	T/A			
f.		Can pick up small objects and place them elsewhere (such as coins, beads)	T/A			
g.						
h.	5-6 yrs	Stands on one foot for longer duration	T/A			
i.		Hops using both the legs	T/A			
j.		Able to colour within the lines.	T/A			
k.		Can copy simple patterns such as circle, square	T/A			
l.		1.2. Self Help skills				
m.	3- 4 yrs	Can eat with a spoon/hand	S			
n.		Can undress themselves (button large buttons on their own)	T/A			
o.		Goes to toilet during day time with some help	S			
p.	5-6 yrs	Can feed self independently	S			
q.		Can dress and undress independently	S			
r.		Can go to toilet independently	S			

2.Speech and Language Development						
a.	3- 4 yrs	Says his/her names	T/A			
b.		Answers simple questions (what did you eat today? what do you like to play?)	T/A			
c.		Can speak complete sentences(3-4 words)	T/A			
d.		Names 3 common objects if pointed to	T/A			
e.		States what action is being performed when a picture is shown	T/A			
f.	5-6 yrs	Able to describe pictures/events/tell small stories	T/A			
g.		Can recite a simple 2-3 line nursery rhyme	T/A			
3. CognitiveDevelopment						
a.	3-4yrs	Comprehends and executes simple instructions (shut the door, brings object as asked)	T/A			
b.		Identifies sizes/ age (big-small, younger-older)	T/A			
c.		Identifies at least 4-5 body parts (can name/ point)	T/A			
d.		Can name/identify some common fruits/vegetables/animals	T/A			
e.	5-6 yrs	Identifies functions of objects (such as telephone, glass of water, vehicle)	T/A			
f.		Able to sort/ differentiate between colour and shapes	T/A			
4.Social Development						
a.	3- 4 yrs	Recognizes family members/ familiar people like teacher	T/A			
b.		Recognizes spaces (kitchen/bathroom/street) and their function	T/A			
c.		Plays cooperatively with other children	S			
d.		Understands rules of simple games (passing a ball or taking turns)	T/A			
e.	5-6 yrs	Is aware of gender	T/A			
f.		Can enumerate routine/ daily activities	T/A			
5. Emotional Development						
a.	3-4yrs	Can recognize common emotions (when pictures of faces are shown)	T/A			
b.		When upset/ frustrated, can be easily comforted	T/A			
c.	5-6 yrs	Able to describe emotions in simple situations and ascribe causalities to emotions	T/A			
d.		Ability to report emotions (when do you cry/when are you happy?)	T/A			
e.		Helpful and caring of other children (shares toys/ comforts others when hurt or crying)	S			

2. Under-stimulation in the domains of development

Sl. No	Domain of Development	Yes	No
a.	Physical Gross Motor Development		
b.	Physical Fine Motor Development		
c.	Speech and Language Development		
d.	Cognitive Development		
e.	Social Development		
f.	Emotional Development		

F. Emotional and Behavioural Indicators

Sl No	Problems	Yes	No
a.	Interferes with other children's activities (snatching/poking/pinching…)		
b.	Poor concentration in performing activities (lack of focus/poor sitting tolerance)		
c.	Unclear speech (speech articulation issues/ stammering)		
d.	Difficult to manage the child (does not sit/ does not follow instructions or obey)		
e.	Not liked by peers, as often doesn't share, and fights and teases them		
f.	Fights: physical assault		
g.	Withdrawn from peers, doesn't play/participate/ engage with peers		
h.	Total reluctance to speak		
i.	Withdrawn from staff		
j.	Miserable: always unhappy, cries easily and frequently		
k.	Habits – Nail biting, thumb sucking, hair pulling, pica, repetitive behavior etc.		
l.	Wets – not toilet trained, doesn't indicate when he/she needs to go to bathroom		
m.	Soils - dirty their pants or go to the toilet in inappropriate places.		
n.	Destructive-deliberately breaking toys/furniture		
o.	Temper tantrums- typically involve stamping feet, holding breath, yelling, becoming easily frustrated, falling out, or melting down.		
p.	Fearful		
q.	Difficult to sooth the child when upset		
r.	Self-injury: biting hands/lips, scratching, pulling hairs, face slapping, head banging etc.		
s.	Sexualized behaviours: rubbing body against others, touching private parts of others etc.		
t.	Irregular to preschool		

1. **Ask the teacher whether any of these behaviours are present in the child**

2. **Any other information reported by the parent/ Anganwadi teacher or your own observations of the child with regards to emotional and behavioural problems**

G. Service Provider's Interpretations/ Summary