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

– Preliminary Understanding and Emerging Issues

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This document provides a report on "Preliminary Understanding and Emerging Issues" 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 – A Model for Integrating Child Development, Mental Health and Protection
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. Objectives & Activities

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 and 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.

Additionally, further objectives were developed in order to help the Project team to better understand the anganwadi context, so as to develop and design appropriate training and other interventions. The specific objectives in this regard were:

- To examine the available infrastructure and resources in the anganwadis, particularly from a child development and protection perspective.

- To understand the knowledge and skill gaps in the anganwadi workers vis-à-vis child development, mental health and protection, including the workers' barriers to pre-school education service delivery.
- To assess child development, mental health and protection concerns in anganwadi children.

Note: The database created and analysed was for programmatic purposes only i.e. to use the project's routine data for understanding anganwadi children/ workers' needs and concerns, and designing interventions in a more scientific manner. The analysis was NOT for research purposes, and consequently, NOT for publication purposes. Thus, it was used for the following purposes: i) generating an in-depth understanding of anganwadi children's/workers circumstances and concerns; ii) designing responses and interventions in keeping with the daily realities of these children/workers; iii) developing training materials for anganwadi workers/ preschool child care service providers; iv) informing and making recommendations for policy and practice, with regard to ICDS and anganwadi work.

2. Methodology

2.1. Location & 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 are parents, caregivers, anganwadi teachers —who will receive 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, it was said that a total of 27 anganwadis will be provided with services and a list was submitted. However, after further needs assessment and mapping the vulnerable communities, five more communities from the five Primary health care centres i.e 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.

During the needs assessment and mapping vulnerable communities following observations were made:

- Few anganwadis had more than one anganwadi situated in the same centre.
- Same anganwadi worker was in-charge for more than one anganwadi.
- The anganwadis were mostly situated in the slums or near to them.
- There were anganwadis where there were no helpers appointed in the anganwadi.
- Almost all the anganwadis were selected which were within 6-7 km distance from NIMHANS.

Considering these 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 by the Department of Women and Child Development (DWCD), the project team met with the concerned Child Development Project Officer (CDPO), the supervisors as well as the anganwadi workers to explain regarding the

project's objectives and how the services will be provided, after which the project implementation and services were initiated.

At the end of the first month of the project implementation, anganwadi workers were asked whether they were willing to continue to be part of the project and they were informed that they're 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 more anganwadi workers were included. Thus, the project implemented its activities in 31 anganwadis through the project duration.

2.2. Examining Infrastructure

During the project team's visits to the anganwadis, the team observed and also noted various issues pertaining to the infrastructure, location of the anganwadi, availability of resources etc., to see what kind of implications they had on child development, mental health and protection.

The project team had prepared a check-list which included following aspects and issues regarding Building/ Infrastructure, location availability of basic needs, and staffing:

- Building: To understand whether the anganwadi centre is a rented or provided by government/ local MLA.
- Presence of a toilet/bathroom area
- Adequate water and electricity supply
- Presence of sufficient area for the children to perform simple physical activities and play freely
- Presence of sufficient ventilation
- Safe cooking area in the anganwadi: to check whether cooking area which is out of reach from the children
- Anganwadi situated in the high-risk areas: to check whether the anganwadis were situated near a main road and had the risk of children getting hurt, or anganwadis

situated in areas where there are lot of people commuting and there are risks of children being vulnerable, and had safety concerns.

- Sufficient staffing: presence of anganwadi worker and helper exclusive to each anganwadi.

The project team gathered information regarding these aspects through their observations made during the visit and also by interviewing anganwadi workers and the helpers.

2.3. Knowledge & Skill Gaps in Anganwadi Workers

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

To observe how the anganwadi functions in a day and what kind of challenges the anganwadi workers and helpers face, the project team spent one entire day in each of the 30 anganwadis, engaged children in activities, and observed how the teachers plan and implement activities in a day.

In order to better understand the knowledge and skill gaps in anganwadi workers, the project team conducted focus group discussions with the anganwadi workers, supervisors and Child Development Program Officer (CDPO).This was done as to enable the project team to understand the needs and gaps in a more comprehensive and systematic way, and further design and plan the training module for the anganwadi workers. The main objectives of 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 the skills of the anganwadi workers have 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 1.

Box 1: 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 has to 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 most recent 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 the 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 and 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 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-written 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 anganawadi, are more concerned to check whether they have maintained the registers correctly and, at the most, 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. Overall, they report a general shortage of 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 and the types of activities to be done with children, the anganwadi workers reported that they faced many hurdles and problems in the field while trying to implement 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 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.

2.4. Child Development, Mental Health & Protection Assessment of Anganwadi Children

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 age of 1-6 years were assessed during the project implementation period.

To start off, the project team engaged all the children in ice-breaker activities along with group activities to promote early stimulation and optimum development in the 5 key areas of child development--physical/ social/ speech & language/cognitive/ emotional development. This helped to build rapport with the children and ensured incorrect interpretation of the assessment. The information about the child's family context and protection issues was gathered by the anganwadi worker and helper. The developmental assessment was done by observing the child and engaging the child in tasks/activities. The sections included in the proforma are listed below in Box 2. (The assessments formats are annexed)

Individual assessments were done for only children who had attended the anganwadi for at least three months. The rationale behind this was 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 of 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, and 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.

Box 2: 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)

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, the anganwadi worker was informed and referred to the Dept. Child and Adolescent Psychiatry and Dept of Speech Pathology and Audiology, NIMHANS based on the issues.

The assessment of developmental delays and gaps was performed using a developmental checklist. Under each developmental domain, an average of 4-5 indicators are listed. Based on the child's abilities and skills, the child was assessed by - observation, tasking the child with activities and receiving feedback from the teacher. The scoring for this was done based on the following criteria:

- If a given child scored "to a high extent' on a minimum of 3 indicators, it was concluded that the child had overall abilities to a high extent in that domain; similarly, if a child scored "to some extent' on a minimum of 3 indicators, it was concluded that

the child had overall abilities to some extent in that domain; if a child scored “to a low extent/ not at all” on a minimum of 3 indicators, it was concluded that the child had overall abilities to a low extent/ not at all in that domain.

- In some domains, if a child scored equally on the indicators i.e. 2 “some extent” and 2 “low extent”, the benefit of doubt was given to the child and his/her abilities overall were scored at “some extent”, not as “low extent”—this was done because children come from difficult backgrounds and do not receive age appropriate stimulation.

Below in Box 3, operational definitions of various terminologies used in the assessment format is given.

Box 3: Operational Definitions

Primary Caregivers: The term ‘Primary Caregiver’ refers to a parent/ person who has the greatest responsibility for the daily care and rearing of the child. This person can be a parent/ grandparent/ extended family member or an outsider.

Single parent: When a child lives, and is taken care of, by with a single parent either due to death of a parent, separation or divorce.

Death of immediate family member: When the child witnesses death of an immediate family member such as parent, grandparent, siblings or extended family members with whom the child was living and had developed a relationship/ attachment and bonding.

Domestic violence: Domestic violence in India includes any form of violence suffered by a person from a biological relative, but typically is the violence suffered by a woman by male members of her family or relatives.(1)

Conflicts/ fights in the family: In this context, conflicts/ fights in the family refers to the circumstance when the family/ family member is involved in conflict, and fights which have caused some form of disturbance and issues in the family, and has implications on the child’s wellbeing/ mental health and protection.

Chronic illness in parent/primary caregiver: When the primary caregiver or an immediate family member is suffering from a chronic illness such as tuberculosis, HIV/AIDS or cancer.

Disability in parent/primary caregiver: When a primary caregiver or an immediate family member has some form of disability such as locomotor disability, Speech and Hearing issues, blindness etc. it may have implications on the child.

Criminality in the parents/ primary caregiver: Refers to parent/ primary caregiver who is involved in criminal activities such as theft and/or murder, and who are therefore in police custody or prison for their activities.

Definitions of Child Abuse and Maltreatment : Childhood abuse and maltreatment refers to any interaction or lack of interaction by adults, whether families, caregivers or others that results in harm to physical, mental and developmental states of children. Child abuse can be broadly categorized as follows:

a) **Acts of omission:** Consist of things caregivers should do to children but do not do—which amounts to neglect.

- Comprise of psychological neglect, sustained parental non-responsiveness and psychological or physical unavailability.
- For instance, parents/ caregivers who do not respond to children with love, affection and caring; or do not take care of the physical/medical/ nutritional needs of children.
- It also entails depriving children of educational, play and recreational, and other opportunities they require for optimum growth and development.

b) Acts of commission:

- Things caregivers should not do to children but do them, and so, hurt children.
- Involves actual trauma directed toward the child in the form of acts of abuse, whether physical, sexual, or emotional/psychological.

More specifically, child abuse may be of the following types:

Neglect & Physical Abuse

- Entails inadequate parenting or caregiving where there is potential for injury resulting from omissions of caregivers.
- Involves poor hygiene, lack of compliance with medical therapy, malnutrition that occurs due to lack of proper feeding practices by caregivers.
- Any non-accidental physical injury to the child. Can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child.
- Includes corporal punishment—which refers to use of physical punishment, force or threat aimed to decrease the frequency of child misbehaviour, but one that results in (risk of) injury to the child.

Sexual Abuse:

- Is an interaction between a child and an adult where the child is used for sexual stimulation.
- Entails exploration of sexuality between a minor, traditionally understood as below 18 years of age; could be exploitative if the age difference between them is more than 5 years.
- Includes but is not restricted to rape/penetrative genital contact (whether by using the body or any other external object).
- May involve digital handling of the child's genitalia, non-genital forms of sexual touching as well as non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

Emotional Abuse:

- Behaviours, speech, and actions of parents, caregivers, or other significant figures in a child's life that have a negative mental impact on the child or seriously damage the emotional health and development of a child.
- Examples of emotional abuse include: name calling, insulting or humiliating, discriminating against a child based on caste, gender, (lack of) abilities/talents or any other issue, threatening violence (even without carrying out threats), allowing children to witness the physical or emotional abuse of another, and withholding love, support, or guidance
- Children who are neglected, or physically/sexually abused also suffer emotional abuse.

Developmental delay: The condition of a child being less developed mentally or physically than is normal for its age.

Gross Motor Skills: Movements related to large muscles such as legs, arms, etc.

Fine Motor Skills: Movements involving smaller muscle groups such as those in the hand and wrist.

Under-stimulation: Under-stimulation means not receiving age-appropriate early stimulation and learning opportunities for development in key domains of development**.**

Emotional and Behavioural problems: Given that it is difficult to identify and differentiate between behaviours that can be regarded normal for this age (pre-schoolers) and behaviours that can be considered to be pathological, a well-defined mental health diagnosis is not usually made. For instance, many behaviours which could be considered a problematic behaviour in older children such as defiance, anxiety to new situations or lack of emotional and behavioural control may be part of normal development in young children. (2) Thus, during our assessment we have used a basic checklist for common emotional and behavioural problems drawn from our understanding through our work in the Department of Child and Adolescent Psychiatry, NIMAHNS. The following are the emotional and behavioural problems included in the checklist.

1. Interferes with other children's activities (snatching/poking/pinching…)
2. Poor concentration in performing activities (lack of focus/poor sitting tolerance)
3. Difficult to manage the child (does not sit/ does not follow instructions or obey)
4. Not liked by peers, as often doesn't share, and fights/teases them
5. Fights: physically assaults others
6. Withdrawn from peers, doesn't play/participate/engage with peers
7. Total reluctance to speak
8. Withdrawn from staff
9. Fearful and anxious generally.
10. Miserable: always unhappy, cries easily and frequently
11. Habits – Nail biting, thumb sucking, hair pulling, pica, repetitive behavior etc

12. Wets – not toilet trained, doesn't indicate when he/she needs to go to bathroom
13. Soils - doesn't indicate when he/she needs to go to bathroom and dirties their pants, or goes to the toilet in inappropriate places.
14. Temper tantrums- typically involve stamping feet, holding breath, yelling, becoming easily frustrated, falling out, or melting down.
15. Difficult to sooth the child when upset
16. Self-injury: biting hands/lips, scratching, pulling hairs, face slapping, head banging etc
17. Sexualized behaviours: rubbing body against others, touching private parts of others etc

2.5. Limitations of the Work & Reporting

The data was not collected for research purposes, but for record keeping and reporting purposes. As mentioned earlier, the mandate of the Project was provision of access to mental health services to young children between the ages of 0 to 6 years. The assessment provides sufficient information to understand children's development, mental health issues, psycho-social contexts, and protection issues, and to enable the child care service provider to provide relevant assistance for them. Consequently, the assessment proforma was not designed for a research study, in which case it would have needed to incorporate several details that it does not. One of the limitations of the study therefore is that the available data, as extensive as it is, does not provide an understanding of more specific aspects.

Second, while the sample size in itself is not small i.e. 237 is a large enough number to be able to have a preliminary understanding and capture emerging trends and issues of early childhood developmental, mental health and protection issues, as a preliminary study we do have sufficient descriptive data to be able to draw implications and recommendations for intervention, which remains the focus of our project. We feel there is a need to gain much deeper understanding about the same.

Third, the target area and population were only 30 anganwadis in urban slums of Bangalore city. This cannot be generalised and comparable to rural areas.

Finally, the information gathered regarding the protection aspects and psycho-social contexts were only gathered from the anganwadi workers and helpers and it lacks the parents'/family's perspectives. Thus, the information might not be very comprehensive.

3. Trends and Issues

3.1. Anganwadi Infrastructure and Resources

The project team gathered information regarding the infrastructure and the availability of resources in each of the anganwadis. This information was gathered to understand what kind of vulnerability the physical infrastructure and resource availability will have on the child development, mental health and protection issues of young children.

Lack of appropriate anganwadi infrastructure, not only in terms of space, but also non-availability of toilets to pre-schoolers also has implication on the problem of teacher motivation. Learning including, and especially, early childhood learning occurs best in a space that is not restricted and comfortable in terms of basic amenities. Cramped spaces are not nurturing for the age appropriate development of children. They not only limit learning processes but also compromise (because of lack of amenities) the learning potential in specific areas of development, for example, self-care. Information of the anganwadi building, infrastructure and basic needs and facilities available is given in Table 1.

Table 1: Information regarding anganwadi Building/ Infrastructure, availability of basic needs, and staffing issues

Building/ Infrastructure, availability of basic needs, and staffing issues	Number of anganwadis
Rented anganwadi/ no government allotted building or shared anganwadis	**9**
Lack of a toilet/ bathroom area	**8**
Lack of water facility	**18**
Lack of electricity	**7**

Lack of sufficient area for children to play and engage in activities	**6**
Lack of safe cooking area	**12**
Anganwadi situated in a high-risk area	**11**
Lack of Helper	**5**

Consequences and issues which may occur due to anganwadi Building/ Infrastructure, availability of basic needs, and staffing issues are explained below:

- **Rented anganwadi/ no government allotted building or shared anganwadis**: Out of 30 anganwadis, 9 did not have a separate government allotted building; they were either rented or shared the space with another anganwadi. In anganwadis which were rented, the responsibility of finding a space and dealing with the landlord was the anganwadi worker's, and the department did not play any role in it. The issue of finding a decent space for a mere amount of five thousand was very difficult. They were very small, had not ventilation. Quite often, when there was a delay in the release of funds from the department, the anganwadi worker either had to pay the rent out of their own pocket or deal with the landlord and endure their comments and verbal abuse.

The anganwadis which shared spaces with other anganwadis had the issue of managing a large group of children in a small space.

- **Lack of a toilet/ bathroom area:** Among 30 anganwadis, 8 of them did not have a separate bathroom/ toilet for the children's use. The children were asked to go to the bathroom on the street pavements, or neighbours' bathrooms, and children who lived near the anganwadi were sent home. Due to this there were a range of concerns and issues observed such as:
  - ✓ lack of hygiene and cleanliness,
  - ✓ when the children were made to use the street pavements there was a serious privacy violation along with the issue of safety. The chances of children getting hurt was higher.
  - ✓ Inability to toilet train the children.

- ✓ When the children were sent home to use the bathroom/toilet, they often did not come back to the anganwadi, and soon they even started lying, using this as an excuse to go home.

- **Lack of water facility:** 18 out of 30 anganwadis did not have water facility and a separate waterline for the anganwadi. The anganwadi helper had to fetch water from a nearby public tap and wait in line. Many days the helper had to either come early in the morning or stay late to fetch water. When children had to go to the bathroom there was not sufficient water to clean after every use, no sufficient water for washing hands. This caused a serious concern regarding cleanliness and maintaining hygiene in the anganwadi.
- **Lack of electricity:** 7 anganwadis did not have electricity supply, they were not able to use any electrical appliances such as fan, mixer etc. In anganwadis which did not have sufficient ventilation and also lacked electricity, this caused suffocation. An Anganwadi is supposed to be a space for children to grow and nurture, but in this situation, it becomes a very uncomfortable space.
- **Lack of sufficient area for children to play and engage in activities:** Most of the anganwadis did not have sufficient area, none of them had a separate play area for children to engage in play and gross motor activities. Among them, 6 anganwadis did not even have a decent space for children to move around and play simple games such as ‘ringa ringa roses’ or a train game, which is very essential for children’s development. This also had implications for the anganwadi worker who found it a challenge to engage children in various developmental and early stimulation activities.
- **Lack of safe cooking area:** As part of the ICDS scheme, the anganwadi helper has to cook sufficiently large quantity of food in order to provide one meal for children and pregnant/ lactating mothers from the community. In most of the anganwadis there was no separate cooking area. They have managed by using benches and themselves created a platform to form a cooking area inside the anganwadi. This is very risky and may cause fire hazards as they had used wooden tables in many places. If the anganwadi worker or the helper is not cautious, children may reach the stove and get hurt/burnt. Among 30 anganwadis, 12 of them did not have safe cooking areas. This is a serious safety and protection concern.

- **Anganwadi situated in a high-risk area:** 11 anganwadis were situated in a high-risk area/ location. Either the anganwadi was situated towards a main road and risked children getting on to the road and getting hurt, or anganwadis were situated in an area where there are lot of unknown people and workers commuting. The chances of children exposed to strangers and risk of abduction was high. This is a major protection issue and concern as the risk of children getting abducted/abused and meeting with accidents are very high.
- **Lack of anganwadi helper:** Initially, when the project implementation had begun, 8 anganwadis did not have a anganwadi helper. However, later, 6 helpers were recruited. Lack of a helper in an anganwadi further enhances the workload and burden of the anganwadi worker as she will be responsible for even the helper's activities in addition to her own in the anganwadi – cooking, cleaning, taking care of children all by herself, engaging children in pre-school activities, miniating records and registers. In anganwadis where there are helpers, when the anganwadi worker has to attend a meeting/training, the anganwadi will be open and the helper takes care of children and provide food, but in places where there are no helpers the anganwadi will be shut and closed for the day.

4.2. Knowledge and Skills of Anganwadi Workers in Child Development, Mental Health and Protection

During the implementation of the project, the project team made some observations regarding knowledge and skills of the anganwadi workers. This was done in order to better evaluate the impact on the overall development of the children. As these skills are required to provide developmental and early stimulation activities, identify mental health, protection concerns among young children and provide appropriate interventions. This also enabled the project team to plan and execute activities and training sessions.

It was observed that 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.

Anganwadi workers had greater understanding and skills regarding physical development and cognitive development than they did about the other three areas i.e. speech and language, emotional and social development. While they had a basic understanding of the domains of child development, they lacked 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 lacked the understanding and were not able to 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 the 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 so 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 get so frustrated and are unable to control them, and end up punishing anyway." 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 this 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 it was observed that, while the anganwadi workers were aware about the risk of physical abuse, they 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.

4.3. Barriers to Preschool Service Delivery

Anganwadi workers also shared several concerns and challenges with regard to implementing preschool education:

- Lack of infrastructure and physical space to conduct developmental and pre-school activities with children.
- Even though each year the anganwadis were provided with some play materials and toys, it was not sufficient. The overused toys and play materials were easily worn out, broken as the children were using it extensively, thus resulting in lack of toys/materials after few months.
- As anganwadi children were usually from deprived backgrounds they were not provided with a lot of toys and play materials even at their homes. Thus, the anganwadis being the only place where children could play with toys, they used it extensively wearing them out soon.
- Lack of sufficient staff – as discussed earlier there were anganwadis where there were no helpers. Similarly, there were anganwadis where one teacher was in-charge of more than one anganwadi. They used to alternate between the anganwadis and were mostly engaged in maintaining records, attending meetings and had no time to engage children in pre-school activities.
- There were no strict timings followed by the children/their parents following quoting various domestic issues such as – lack of sufficient water, presence of guest at home, mother being sick. The anganwadi teachers were not able to impose timings as they had no other option than to comply. Due to this, the anganwadi teacher was not able to implement pre-school activities.

- As the anganwadis were situated in urban slums, there was a lot of noise and disturbance. The attention span of young children in general being very less and limited, all these distractions and noise made it extremely difficult to conduct structured and effective early-stimulation and pre-school activities.
- As anganwadi under the ICDS scheme also implemented Matrupoorna, Matruvandana and other supplementary nutrition schemes. Women from the community (pregnant/ lactating mothers from the community) visited the anganwadi at random times all day long, thereby interrupting any direct interventions workers are attempting to implement with the children.
- As the anganwadi workers maintain around 35 registers and documents they are often seen spending time writing the same. They are always worried and pre-occupied about it and thus, not able to spend time with children and engage them in pre-school activities.
- Parents' understanding of a pre-school is that their children should be able to say rhymes and alphabets. They are not aware of the importance of other skills like categorization, sorting and differentiating capacity, social and emotional development. They insist the anganwadi worker that she teach their children alphabets and rhymes, creating a pressure on the worker.
- Children from the urban slums are usually from migratory population and their mother tongue is different from the Anganwadi teacher's language. The mandate by the department is to teach children in the local language i.e. Kannada. So, it's difficult for children to understand what they are being taught. This poses a problem and causes difficulty to teach and communicate with them.

4.4. Miscellaneous Concerns

There were some additional issues, some observed and noted by the project team, and others by the anganwadi workers—all of which have implications for child protection and mental health.

It was observed that most of the parents do not do any kind of early stimulation activities/work with their children. Even in families who had no problems there was a lack of

stimulation at home. The base-line for this is lack of knowledge and importance among parents and caregiver regarding early stimulation.

Due to lack of structure in the anganwadi most of the time children were left to their own devices, which usually meant they spent their time jumping around, screaming, playing around in an unsafe manner, fighting with each other and generally getting hurt in the process. As the children of this age tend to be full of energy, it would do better to channel the same into productive use. If children's behaviour are not regulated and structured at this age, the probability of children developing behavioural problems and emotional regulation at a later stage greatly increases. This creates an environment which has no structure and regulation. Children's positive engagement with teachers is imperative for children to develop skills in compliance and executive function. Positive engagement of children through tasks help children develop emotional regulation. Research has revealed that engaging children positively with teachers or peers is especially supportive of children's gains in task orientation and reductions in emotional dysregulation. (3)

As stated earlier, due to lack of toilets/ bathrooms in the anganawadi, children were made to go to toilet on the street pavements. When the children asked to go to toilet, their pants were pull down in front of everyone in the anganwadi and asked to go to toilet. This is not appropriate on terms of maintaining basic privacy of children. This is potentially disruptive and does not allow to teach children the concept of privacy, boundary and safety. Teaching children regarding who can touch them, who cannot and so on is very critical to address and prevent child sexual abuse.

Few of the anganwadi workers and helpers raised the concern of children exhibiting sexualized behaviours. This might be due the fact that anganwadi children live in small single room houses. Children and their parents all sleep in the same room. So, the probability of children witnessing parents engaging in sexual activity is high and this might have untoward impact on these young children.

4.5. Assessment of Development, Mental Health & Protection Concerns in Anganwadi Children

A. Age of Children

A total of 237 children between the age group of 1 years to 6 years were assessed where in 2 children were between the age of 1.1 and 2 years, 57 (24.1%) children were between 2.1 to 3 years, 137 (57.8%) were between 3.1 to 4 years, 36 (15.2%) were between 4.1 to 5 years and 5 children were between 5.1 to 6 years. There was no major gender difference observed among the 237 children, both male and female children were equal in number.(Refer table 2)

Table 2: Age categorization of children

Age	Frequency	Percent
1.1 to 2 years	2	0.8
2.1 to 3 years	57	24.1
3.1 to 4 years	137	57.8
4.1 to 5 years	36	15.2
5.1 to 6 years	5	2.1
Total	**237**	**100.0**

Children who attended the anganwadis were all from low socio-economic background and most of their mothers were working women. It was observed that most of the children were between the age of 2.5 years and 3.5 years. This was probably because that the children after 3 years started going to other private schools in the community. It was also observed that the parents in these vulnerable communities prefer to send their children to other private pre-schools even though if it is not recognized or lacks adequate infrastructure. When enquired about it, they reported that they want their children to learn to read and write in English. The parents lack awareness and are not able to understand the importance of early stimulation in all five domains of development. Also, parents did not want to spend money on younger children by sending them to private pre-schools.

The older children (above 3.5 years) who attended the anganwadi were from families who had financial difficulties and could not afford to send the children to schools and didn't have anyone to take care of them at home during daytime.

This has an implication on service provision and training of the anganwadi workers. Maximum thrust of intervention therefore has to cater to children between 2 - 4 years, as they form the biggest group. Accordingly, the anganwadi workers and helpers should be trained so they have the required skills to work with children of this age group. As the existing curriculum and skills, they possess does not cater to children who are below 3 years.

B. Family & Psychosocial Contexts

Each child was assessed for various types of family vulnerabilities, which were mainly in the form of caregivers and/or risks and problems of the caregivers. Each of these factors have been discussed in further detail (below), including the risks they pose for children's development, mental health and protection.

i) Primary Care Giver of Child

To understand who takes care of the child and the level of care the child receives during the assessment, we enquired the regarding the primary care giver of the child. According to Bowlby's attachment theory, early attachment relationships are very critical for child development. Presence of a consistent caregiver at this age is imperative as they provide basic care, affection, nutrition, protection to the child. For instance, a primary caregiver plays a pivotal role in the language development of the child. They create a space and opportunity for the child to interact and connect. They respond to the child's cries, and use simple language in conversations and engage the child, this helps the child learn basic sounds and language to communicate.

Responding to the child in a timely way helps them learn that there is someone to take care, and helps them build trust. Comforting, cuddling, smiling, responding quickly to cries, coos and giggles, playing peek-a-boo and maintaining eye contact all help the child to

develop. These are essential for age appropriate development in all domains of development.

This information also gave us an understanding to gauge what kind of interventions need to be provided and whom should we target it.

Table 3: Children's Primary caregivers

Primary Caregivers	Frequency	Percent
Parents	**198**	**83.5**
Grand Parents	**31**	**13.1**
Extended Family	**7**	**3.0**
Adopted parents	**1**	**0.4**
Total	**237**	**100.0**

During the assessment it was found that, for 198 (83.5%) of the children, their primary caregiver were their parents (mostly mothers). 31 (13.1%) of the children were taken care of by their grandparents i.e. grandmothers. 7 (3.0%) were taken care of by extended family members like aunt or older cousins of the child. Among all these children, only one child was adopted and was taken care of by the adopted parents.(Refer table 3)

Even, though the mothers are the primary caregivers, they work during daytime when the child is in the anganwadi. They often request the anganwadi teachers to keep the child for longer durations so that they can put in some extra time and earn more. These mothers are always in a hurry and involved in the household work or some family issues. Thus, they are not able to spend quality time with their children. For instance: When the child was upset or was throwing a temper tantrum, they used to often resort to either buying the child sweets/snacks, as this was an easy and quick way for them to calm the child.

Another important observation and understanding gained according to the anganwadi teachers reports is - "Before 5 years or so, we used to see parents discipline the child by hitting and/or threatening the child quite often, but since the past few years things have changed; they rarely even scold the children anymore". All this feedback helps us understand that the parents are not able to help the children to regulate emotions, or help

them to understand what are the consequences of their behaviours. This may cause future behavioural problems and emotional regulation problems in the children.

It was also observed that none of the parents engaged in early stimulation activities with the children. It was understood that the extent of parents' knowledge and training is going to have limitations. Even if we train them, it remains to see how much effect/ impact it is going to have because of lack of time, and their own tension/issues/vulnerabilities. We have to consider what is feasible for parents and accordingly plan and provide training to them. Even with these, it is not guaranteed that the parents will implement the teachings. Thus, Anganwadi is the only opportunity for these children to receive stimulation.

ii) Families with Large Numbers of Children

Among 237 children whose individual assessment was done, 43 (18.1%) children had more than 2 siblings. Having more than 2 children in the family have implications in terms of parent's ability to care, nurture and provide for children. It is also important to note that having large number of children in a family has serious implications on

- Availability of resources
- Availability of care and attachment
- Availability of early stimulation

Having more children creates financial stress of being unable to provide adequate opportunities. For example, parents of larger families are less likely to send them to a well-established/private school and may send them to local government school instead. Parents with more children also have less time to spend with them, and will not be able to provide sufficient resources for all the children.

Even though there was no statistical evidence to corroborate with the child's emotional and behavioural problems with child's family issues, based on descriptive statistics and the understanding gained from interactions with the anganwadi teacher, it can be hypothesized that further depth interview and understanding from the child's parent/primary caregiver might provide further insights in this regard.

iii)Vulnerabilities of Families and Caregivers

An attempt was made to understand the family and psychosocial context of these children and some key variables related to their home environment were noted.

The project team tried to contact the parents and families to obtain this information. But given the short duration of the project, it was exceedingly difficult for a database this size to obtain this information from all parents. Hence, it has not been recorded. Anganwadi workers and helpers were asked but their info on some of these variables are exceedingly sensitive & would not be reliable. Hence, they're not being reported but there are children who come from these contexts. To gather a basic understanding regarding the vulnerabilities that exist among the anganwadi children's families and caregivers, information was gathered by interviewing the anganwadi worker and helper.

During our assessments along with the variables explained below, we have also considered presence of criminality among the parents / primary caregivers of the children as parents' and caregivers' involvement in criminal and illegal activity has serious implications on children's development mental health and protection issues. However, we did not find any such cases.

- **Low socio-economic background:** All the children coming to the anganwadi were from low socio-economic background. The parents and caregivers of these children are daily labourers and wage earners, some with seasonal or irregular incomes; caregivers have low levels of literacy and education (most of them have not completed school), and many children are first generation learners; they live in slum communities wherein they are exposed to conflicts and violence. This also have implications on availability of resources and care/attachment and early stimulation.

Various researches have shown that the socio-economic status of the family has an impact on multiple levels such as health and development of the child, even prior to birth and it continues into adulthood. (7) It is also found that socio-economic factors affect formation of child's personality as parenting styles, quality and quantity of time spent by parents with children, education level of parents, family structure and availability of resources all depend

on the socio-economic status of the family.(8) A study conducted in Japan revealed that factors such as low family income & low parental education level have influence on internalizing, externalizing and behavioural problems in children, and thus indicated that low socio-economic status has an impact on the child's mental health.(9)

- **Single Parent Families**: Among the children, 17 (7.2%) of them either had a single parent either due to separation, divorce or death of a parent. Information was gathered to understand whether there was any kind of marital discord, separation or step-parent. This was to help us understand whether the child had a consistent primary caregiver, as presence of a consistent primary caregiver helps the children develop attachment, bonding and age-appropriate emotional development. Various studies have shown that conflict between parents creates anxiety and stress in the children. This in-turn has an impact on children's development and may cause emotional and behavioural problems. (10) (11)

Table 4: Family Vulnerabilities

Family vulnerabilities	No. of children	Percentage
Single parent: Separated/Divorced/Death	17	7.2
Death/loss of primary caregiver	6	2.5
Substance abuse by primary caregiver	77	32.5
Domestic violence/ Family conflicts	48	20.2
Primary caregiver with illness or disability	8	3.4

Note: A given child may have more than one family vulnerability.

- **Death of a Parent/ Primary Caregiver:** Loss of a primary caregiver or an attachment figure can cause insecurity & anxiety issues in children. Even though these children are very young to understand the context of death/loss, they can still perceive the loss and absence of a person with whom they were attached and spent time with. Thus, to understand the context of loss and death in these children, data was collected. Among the children, 6 (2.5%) of them had experienced loss and death of a primary caregiver.

Studies have shown that death in the 1st year of the child's life has a significant impact on the child's emotional development. Loss of a parent or a primary caregiver has both short

and long term impact on the child's mental health and physical health. (12) Death of a parent has a traumatic impact on the children which is actually more in older children. Studies have shown that when a child loses his/her parent/primary caregiver in the first 3 years of their lives, the impact on the child's mental health and physical health is higher. (13)

- **Substance abuse by parent/primary caregiver:** Among 202 children, 77 (32.5%) children's parents had substance use problem. We have tried to understand the context of substance abuse and its related issues in the family. The information collected is only regarding the substance abuse of the primary caregiver, as they are the ones who interact with and spend time with the child. As most of the anganwadis were situated in urban slums and the parents were daily wage labourers and illiterates, there were a greater number of parents, mostly fathers, who had substance abuse issues. Almost all the parents were using tobacco by either smoking or chewing. Hence, during the assessment the teachers were asked regarding the use of alcohol or ganja by the primary caregivers. As both of these substances may cause serious addiction and cause conflicts and disruption in the family, and inconsistency in parenting, parents/ primary caregivers who use substances are not responsive to the child and unable to provide emotional support and feeling of security for the children.

  Given that the source of data collected was only anganwadi workers and helpers, there might be other parents who use substances that they might not be aware of. Anganwadi workers and helpers tend to be aware of only the parents with severe substance use issues.

  A few studies have shown that fathers who are alcoholic lack warmth and do not engage with the child, thus compromising their relationship with the children. Studies have also shown that parental substance use may create various protection risks to the children i.e. they may be at greater risk of experiencing physical abuse, neglect & violence. Substance abuse by the parent does not provide a nurturing environment for the child to develop.(14)(15)

- **Domestic violence and family conflicts:** Children who are exposed to domestic violence and family conflicts are at risk of developing emotional and behavioural problems, causing an impact on the child's development. Research has shown that this has the possibility of causing problems and issues in various dimensions of the children's lives, having both short term and long-term effects on the children. Children who are exposed to violence and conflicts are at risk of developing aggressive behaviour. As children are often victims of violence in this context, this may cause emotional dysregulation. Children who are often exposed to violence feel that the world is unsafe, feel helpless and develop anxiety and depression.(5) Thus, to understand the children's context and the associated risks, information regarding domestic violence and family conflicts were collected. Among 202 children, it was discovered that 48 (20.2%) of the children had been exposed to either domestic violence or family conflicts. The limitation of the data, however, was that this information was related by anganwadi workers, and they may not be aware of these issues unless they are severe and the entire community is aware of it.
- **Primary caregiver with illness or disability**: A total of 8 (3.4%) children had parents or primary caregivers who were suffering from illness or disability. Given that the information collected was from anganwadi workers, this might not be entirely accurate as, until & unless the parents voluntarily report that they suffer from illness or it is severe and themselves seek help from the anganwadi worker, she will not know about the presence of said illness. It may be also due to stigma or fear of discrimination by the community that the parents won't confide in the anganwadi worker, about their illness.

  When a parent / primary caregiver is suffering from a chronic illness or disability, there is a stressful and anxious environment in the family. Even if the children are young and are not able to perceive the severity / fatality of an illness they can perceive the general anxiety and stress in the family. This eventually precipitates down to the child and cause anxiety and other emotional and behavioural problems. Parents also often do not pay attention or care to explain to the young children, thinking that they are too young to understand, and neglect them. To add to the issue as these children are young and are not able to express their anxiety and the questions they have, they tend to develop behavioural problems. When the illness or the disability is severe, the family focuses majorly on the sick person

and this may have influences on child rearing practices and parent-child relationships. Research has shown that children whose parents suffer from chronic illness have greater risk of developing emotional problems. (16)

C) Developmental Issues and Under-stimulation

To understand the developmental level of children, we have assessed children along five domains of development – Physical, Speech & language, Cognitive, Social and Emotional. To check whether the child has attained age appropriate development we used a set of parameters. (Please refer annexure)

From a programmatic perspective, the developmental delay observed in the children with symptoms to some extent and those with high extent have been clubbed. The rationale is that the implications in terms of interventions for children at this age become the same for both cases (some/high extent). This is because, if we do not do the stimulation at this age, it will only increase/exacerbate.

Under-stimulation

Under-stimulation means not receiving age-appropriate early stimulation and learning opportunities for development in key domains of development. We wanted to highlight the issue of under-stimulation because of the danger it poses to the children who come from disadvantaged backgrounds and vulnerable families. A brief note on the importance of Early Stimulation is given in Box 5.

BOX 5: Importance of Early Stimulation

Providing opportunities for children to play, explore and learn is very critical for the overall development of a child. In the Indian context as well as in other parts of the world, children are often exposed to poverty, violence, conflicts, trauma, and challenging social & physical environments.(17) This limits the degree of opportunities that they get to learn and the level of stimulation that they would get at home & by their caregivers. In a study it was estimated that, around the world, over 200 million children under the age of 5 years do not develop to their full cognitive potential. It's also said that in developing countries, children younger than

5 years are often exposed to multiple risks, including poverty, malnutrition, poor health, non-stimulating home environments, lack of parent-child interaction and stable relation/attachment.(18) This has a lifelong impact and implications on the child's education, income, health, fertility rates and delinquency, and jeopardizes the development & well-being of future generations.(19)

During the first five years of life, 90% of the brain development occurs. This is a very important time which comprises of physical, speech & language, social, emotional and cognitive development. This depends on many factors which are interdependent such as genetic inheritance, health & nutrition, social & environmental characteristics and the quality of early stimulation & opportunities the child receives. (20)

Various studies conducted across the world have shown that early intervention and early childhood developmental work is the most effective & promising strategy to ensure reaching at-risk children and have an impact on success & productivity up to adulthood. (21)

In these children, what can easily be categorized as delay, can in reality be due to under-stimulation or lack of opportunity or congenital issues. In some children, it can be one or the other, and in some of the children it can be a combination of both.

Due to failure to receive any kind of early stimulation/developmental activity in the home by the parents / primary caregiver, compounded by their psychosocial vulnerabilities, children find it harder to develop age appropriately as they do not receive early stimulation and opportunities. Add to this the fact that the anganwadi workers do not have sufficient time and skills to spend with children to conduct and engage them in early stimulation activities, and the issue gets exacerbated.

The common assumption that they are still young and they can pick up skills do not apply to children who come from vulnerable backgrounds and disadvantaged backgrounds. For example, a very bright child, even with all the limitations, will be able to pick up and attain age appropriate skills. But when an average child, or a child slightly below average, has experienced trauma or loss/grief or abuse, even with a good and extensive stimulation,

there will be delays and difficulties. A large number of anganwadi children have been exposed to these vulnerabilities and will be starting at a disadvantage of under-stimulation, thus leading to increased and cumulative developmental delays and lags, and at some point, it will appear like a delay. As years go by, it may become cumulative leading to a galloping effect.

It was found that there is a fair amount of under-stimulation among anganwadi children. In fact, we find that most of the children who have delay are actually that way due to under-stimulation. In other words, these children very much have the potential to learn.

Given the life circumstances and psychosocial context of anganwadi children, all children have under-stimulation issues. However, the information here represents the children who have under-stimulation and in need of immediate action and intervention, as it may result in further issues & cause developmental delays.

i) Physical or Locomotor Development

Children tend to develop certain motor skills at specific ages. However, each child reaches these milestones at a different age. If a child has deficits/delays or motor impairments then they will have trouble moving in a controlled, coordinated, and efficient way. Fine motor skills include far superior skills such as being able to grip and manipulate objects, use of both hands to perform a task, and use of fingers to pick up an object, rather than the whole hand.

Gross motor skills are movements that involve large muscle groups and are generally broader. These include walking, kicking, jumping, and climbing stairs. A child develops gross motor skills far more easily & faster than fine motor skills. Development of gross motor skills depends majorly on physical development. There are a lot of nutrition programs that are running to help children with physical development and attain age-appropriate gross motor skills. Whereas fine motor skills is a function not only related to nutrition, but also depends on providing specific stimulation & training.

Table 5: Physical Development

Physical development Delay	Yes	No
Gross Motor Developmental Delay	7	230
	3.0%	97.0%
Fine Motor Developmental Delay	52	185
	22%	78%

Under physical development, children were assessed for their gross motor skills, fine motor skills and self-help skills. 7 children had delay in gross motor development as they were pre-term babies and had a history of traumatic injury. 52 children i.e. 22% had delay in fine motor skills. (Refer table 5)

It was observed that only 2 children had under-stimulation in gross motor development whereas 65 (27.4%) children had under-stimulation in fine motor skills. . (Refer table 6)

Table 6: Under-stimulation in Physical Developmental Domain

Physical development	Yes	No
Gross Motor Developmental Under-stimulation	2	235
	1%	99%
Fine Motor Developmental Under-stimulation	85	152
	35.8%	64%

Most children had self-help skills such as going to the toilet, wearing their pants, eating on their own and washing their hands. Despite not having adequate fine motor skills, many children were able to manage some daily activities because these activities do not entail the use of fine motor skills such as the pencil grip or buttoning. The fine motor skills they were assessed for pertained to more complex skills related to pre-writing or readiness skills - often not involved in their daily activities given the types of clothes these children have to wear.

Most of the children had deficits in fine motor skills as they did not receive opportunities to engage in activities to develop fine motor skills. It was observed that there was a lack of

availability of resources such as crayons/pencils/paper and so on. Other fine motor skill development activities such as beading, buttoning and sorting are not done with the children i.e. there is no daily routine with regard to pre-school activities; children are simply seated in the classroom for a certain number of hours each day, with nothing to occupy them. (The Project staffs have observed this on a regular basis). Below in Box 6, find a brief not on the importance of Fie motor stimulation and its implication.

Box 6: Importance of Fine Motor Skills in Developing Pre-writing skills

Fine motor skills involve skills required to grip and manipulate objects using both hands to perform a task and use fingers to pick something up. Pre-writing skills are the fundamental skills that children need to develop in order to be able to write. For a child to develop pre-writing skills, it first needs to attain hand and finger strength, hand-eye coordination, ability to use both hands together and the ability to manipulate objects & control them before they develop the skills to grasp a pencil and are able to write.

Development of pre-writing skills is very much essential as writing by hand in the early years helps support the development of reading skills. Attaining age-appropriate fine motor skills is important to develop legible handwriting.(22) When children are not trained at pre-school & Anganwadi level, they will have deficits in fine motor skills and are at higher risk of developing learning difficulties in terms of writing etc. Based on our previous work with school children we have gathered that lack of early stimulation and fine motor activities in the pre-school children lead to them developing learning difficulties. Research has also indicated that early fine motor writing skills are essential for school readiness skills associated with later academic success. Studies have also shown that when pre-writing skills are underdeveloped, it can lead to frustration, resistance to writing, low self-esteem and poor academic performance.

During the course of our project we did not see many children with gross motor deficits because children who come to anganwadis are unlikely to have severe disabilities & delays. Usually, children who have severe-to-profound ID (intellectual disability) or locomotor disability are unlikely to even come to anganwadis because –

- As there is a societal stigma associated with the condition, parents are unlikely to even send them
- Parents don't know what kind of disabilities these are or what kind of treatment is available
- As these children need a caregiver and need lot of help, they cannot stay in anganwadi on their own
- Children are not toilet-trained

In fact, such children have not even come under the radar of our project and the Department of Women and Child Development / ICDS need to consider a serious mechanism to be used to track/identify them. Even though ICDs & anganwadis are an inclusive system, these children never avail these services. Thus, a system needs to be put in place wherein, for one day in a week, the anganwadi worker spends time to identify these children in the community and only target them. Or the anganwadi worker helps in screening for these children and referring them to tertiary care, District Early Intervention centers or any other services that these children may require.

ii) Speech & Language Development

It was observed that the method of engaging children in early activities is usually through rote learning and recital of rhymes i.e. they are not geared towards developing an increased fund of words or construction of phrases & sentences or making conversation. Most children have age-appropriate speech and language abilities. They are able to tell their names, provide short narratives of daily events, report and complain about each other's behaviours. As most of the anganwadi children's mother tongue was different from the local language, it was noticed that children found it difficult to understand instruction and the anganwadi workers also found it difficult to teach and communicate with them. This creates serious limitations to be able to do any kind of stimulation activities/developmental work and particularly speech work with children.

Even with all these limitations, importance was given to teach children a word but not its meaning. In other words, the teachers just focus on teaching new words without teaching them their meaning.

During the developmental assessment of children, it was noticed that 38 (16%) of the children had speech delay. (Refer table 7)

Table 7: Speech and Language

Speech and Language development	Yes	No
Developmental Delay	**38**	**199**
	16%	**84%**

Even though speech delay was present in only 16% of children, it was observed that 45 (19%) children had under-stimulation in the domain of Speech & language development. (Refer table 7 and 8)

The most common reason for under-stimulation in speech and language is mere lack of understanding regarding the components of speech development and engaging children in speech development activities.

Table 8: Under-stimulation in Speech & Language Developmental Domain

Speech and Language development	Yes	No
Under-stimulation	**45**	**192**
	19%	**81%**

It was observed that quite often parents and anganwadi worker feel that if a child is able to say few words like ‘mom’ or ‘dad’ then the child is able to speak. A common belief among parents and caregivers is that it is quite common for some children to have speech delays. And they say that if a child can make a few sounds or is able to say few words, there is no need to worry. They are unaware that a larger fund of words and the ability to understand the meanings of words is also very much important for speech & language development. Based on our observations & understanding, we recommend that the selection & recruitment process of the anganwadi workers has to be matched to the community and the basic language they use. This is a basic systemic issue & this must be addressed/remedied. And without this, no work can be done by the teacher; the child will

not benefit and the teachers do not have the chance to do stimulation & pre-school activities.

iii) Cognitive Development

It was observed that only 23 (9.7%) had cognitive developmental delay (Refer table 9). It is important however, to understand that their cognitive abilities were not assessed using standardized tools. For example, we did not assess whether a child knows the name of the colour/fruit —because we know that children have not been exposed adequately to or taught about such concepts. Therefore, they cannot be assessed on what they have not been taught as this would result in labeling them as having intellectual disabilities, which would be inaccurate.

Table 9: Cognitive Developmental Delay

Cognitive development	Yes	No
Developmental Delay	**23**	**214**
	9.7%	**90.2%**

Instead, what we assessed was the children's ability to differentiate between colour and shape, varying tastes — because the ability to differentiate is the core cognitive function; whereas the ability to name the colour is a learnt one i.e. dependent on teaching. It was observed that the children are able to differentiate between colours, fruits and vegetables. They are also capable of higher levels of cognitive functioning reflected by the fact that they know who is in charge of the anganwadi, to whom they should complain, who cooks the food and who teaches them. It was also observed, when the project team spent time and did early stimulation activities that they proved fast in learning basic things. This is a matter of pedagogy as children have never been taught these things.

Table 10: Under-stimulation in Cognitive Developmental Domain

Cognitive development	Yes	No
Under-stimulation	**62**	**175**
	26.2%	**73.8%**

As already mentioned, most of the children had under-stimulation in cognitive development, however 62 (26.2%) of children had severe under-stimulation which needed immediate interventions to avoid developmental delay. (Refer table 10)

Providing stimulation and opportunities for preschoolers for cognitive development is very essential as this becomes the foundation from which the child starts to develop further fund of information. This further influences the child's future academic success.

iv) Social Development

Children between the age of 2-6 years move from being entirely dependent on their parents to being fairly independent. Children start to understand/learn who they are and how to talk/interact with others, develop relationships, exploring and engaging with their environment.

Table 11: Social Developmental Delay

Social development	Yes	No
Developmental Delay	**38**	**199**
	16%	**84%**

Table 12: Under-stimulation in Social Developmental Domain

Social development	Yes	No
Under-stimulation	**45**	**192**
	19.0%	**81.0%**

Among 237 children, 38 (16%) had development delay and 45 (19%) had under-stimulation in the social developmental domain. (Refer table 11 & 12) Even though we could not find any relation to social factors and the child's behavioural & emotional problems, it is likely from anecdotal information and general observation that these children are exposed to a fair amount of violence, not just physical but also verbal abuse and violence from their parents or adults. Lack of social skills training is missing among these children as parents lack the necessary skills to train and discipline their children. The disciplining methods they use are such that they tend to be more aggressive in nature, and the child will tend to learn

and model this behavior as an adult. This is also by & large a reflection of the child's environment. Thus, the social skills training of these children is a must. As discussed previously, social factors of the family has a great impact on the child's development, social skills development, personality and mental health. (7)

Anganwadi is the place where children come every day. And it provides a great opportunity for them to learn and develop social skills. Thus, appropriate environment, stimulation and activities need to be done with these children by the anganwadi worker to nurture and develop social skills among them.

v) Emotional Development

Emotional development constitutes children discovering a wide range of emotions, developing emotional bond & attachments with their primary caregivers/parents and recognizing & responding to other's emotions. As emotional expression, experiences and understanding emotions take place in the context of social interactions, social & emotional development are tightly coupled with one another.

According to Bowlby's attachment theory, early attachment relationships is very critical for child development. It is said that a child needs to develop a relationship with at least one primary caregiver for the child's successful social & emotional development and in particular, to learn how to effectively regulate their feelings. Bowlby's work on attachment also states that there is a critical period for developing an attachment i.e. 0 to 5 years. If an attachment has not developed during this period (as also discussed above), then the child comes to be at risk of suffering from irreversible developmental problems, such as reduced intelligence, increased aggression and anxiety. (23)

Among the 237 children assessed, 64 (27%) of children had developmental delays and 56 (23.6%) of them had under-stimulation in emotional developmental domain. (Refer table 13 & 14)

Table 13: Emotional Developmental Delay

Emotional development	Yes	No
Developmental Delay	64	173
	27%	73%

Table 14: Under-stimulation in Emotional Developmental Domain

Emotional development	Yes	No
Under-stimulation	56	181
	23.6%	76.4%

During the assessments it was found that many children had temper tantrums issues; they were not easily soothed and comforted. They had difficulty reporting emotions. They were able to recognize only two emotional states—happy and sad. When asked when they feel happy, most of them were unable to state a reason or context. When asked when they feel sad, the only answer received was when they were beaten. When another child is crying, most children make no attempt to soothe or comfort him/her. When they are angry, they pinch and hit other children—this is perhaps what they have observed from each other, and from the response methods used by the family/teacher. Thus, lack of attachment relationships account for a large part of the poor emotional development in the anganwadi children.

It is important to note that as this project was not long enough to look what was happening in the child's home environment, our hypothesis regarding the underlying reason for poor emotional development in children is that they have been continuously exposed to various neglect and abuse issues in their childhood. For example, in early childhood, stresses such as domestic violence cause emotion regulation issues among children. It is early childhood stressors that determine emotional regulation throughout the person's life.

Even though there is no corroborated evidence regarding the presence of emotion regulation and it's correlation with psychosocial issues among anganwadi children, given the nature of the children's vulnerabilities and the psychosocial contexts, we hypothesize

that emotional regulation issues among these children are due to psychosocial issues and vulnerabilities.

Above, we have discussed each developmental domain individually in detail. However, it is important to note that among all the children, 118 children i.e. nearly 50% of them had developmental delay in at least in one developmental domain. Given that these children come from a vulnerable background, the developmental delays are present in almost 50% of the children thus having implications on the importance of early stimulation and pre-school activities in the anganwadi which is the only opportunity for them to receive the same.

D. Mental Health Issues: Common Emotional & Behavioural Problems among Anganwadi Children

As discussed earlier regarding the issue of diagnosing young children with mental health issues, an attempt was made to find emotional and behavioural problems among anganwadi children. The assessment was done based on

- ✓ observations made by the project staff during their visit to the anganwadi.
- ✓ asking the anganwadi worker, helper about the child's behaviour in the anganwadi
- ✓ Whether the child's parents had reported any issues about the child's behaviours to the anganwadi worker/helper.

Young children process, experience and respond to emotional & traumatic events in a very different way than older children. Thus, identification and diagnosing mental health issues among young children is very difficult.

The most common behavioural issues reported was that many children i.e. 43 children (18.1%) of them had temper tantrum issues and it was difficult to sooth and calm them down. Other common issues were - interfering with other children's activities which was reported in 32 children (13.5%), unable to control and manage the child reported in 27 (11.3%) of the children, and 17 (7.2%) of the children being often involved in fights with other children.

During the assessment, the project team also checked for other behavioural issues – whether the child was destructive, not liked by peers and whether they had poor concentration while performing activities. Among the 237 children, only 3 (1.3%) children were found to have destructive behaviour, 6 (2.5%) were not liked by peers and 10 (4.2%) of the children had poor concentration while performing activities. (Refer table 15)

We had also checked for sexualized behaviours and self-injury behaviours among children, but none of the children who were assessed had these behaviours.

Table 15: Common Behavioural Problems

Sl No.	Common Behavioural Problems (Externalizing)	Yes
1.	Interferes with others activities	32
		13.5%
2.	Poor Concentration	10
		4.2%
3.	Difficult to manage the child	27
		11.3%
4.	Not Liked by peers	6
		2.5%
5.	Fights	17
		7.2%
6.	Destructive	3
		1.3%
7.	Temper Tantrums/Difficult to Sooth	43
		18.1%

When compared to behavioural problems it was found that the number of children with emotional problems were lower and the most common among them was children being withdrawn from peers, observed in 18 (7.6%) of children. Other emotional problems observed were - children who were totally reluctant to speak where 11 (4.6%) children had this issue (here the observation was not made by the project staff, it was further corroborated with the anganwadi worker whether the child is reluctant to speak in other

situations also.), 7 (3%) of children were withdrawn form staff, 6 (2.5%) of the children were always miserable and crying, 16 (6.7%) of the children were not toilet trained and they were not able to indicate when he/she needed to go to bathroom and they used to dirty their pants, or go to the toilet in inappropriate places. (Refer table 16)

For the child to form relations/friendships, cope with adversities and achieve success academically, professionally and in their social life, it is very essential that a child while growing up has achieved age appropriate development and has no metal health issues. A pyramid of cards topples even if a single card is disturbed. Similarly, though child's mental health is just one of the many aspects, even a small disturbance in the young child's mental health will have an impact on the overall development of the child and consequently the child's entire future. Thus, early identification and early intervention using appropriate resources is the most effective way to tackle/manage mental health issues at a very young age.

Table 16: Common Emotional Problems

Sl No.	Common Emotional Problems (Internalizing)	Yes
1.	Withdrawn from peers	18 7.6%
2.	Total Reluctance to speak	11 4.6%
3.	Withdrawn from staff	7 3.0%
4.	Miserable	6 2.5%
5.	Wets/ Soils clothes	16 6.7%
6.	Fearful and anxious	6 2.5%

Further, if early identification and intervention of mental health problems among young children is done then there is hope that the intervention provided will have better prognosis

and will have a long-term impact on the child. There are researches done which show that young children in their formative years may show even greater benefits/results from intervention than adolescents and adults as the mental health problems among them would have established more firmly. (24) There is a large amount of evidence that some behaviour problems seen in young children do persist and are predictive of later disturbance. Thus, early diagnosis could result in these children receiving early intervention and in turn reducing the likelihood of later disturbance.(25)

Identifying and addressing these emotional and behavioural problems in anganwadi children is very essential as it will have a lifelong impact on the overall development of the child.

E) Context of Protection

To understand the context and issues related to the children's protection needs, information regarding children's exposure to physical abuse, emotional abuse, sexual abuse, neglect and presence of emotional and behavioural signs of trauma and abuse were all enquired with the anganwadi teacher and helpers.

However, as anganwadi teachers lacked a basic understanding that young children are at risk of physical, sexual and emotional abuse, they had limited knowledge and lacked conceptual understanding as to how these young children can be abused, who can abuse, and what all does the term 'abuse' encompass. Furthermore, Anganwadi teachers were not aware about the issue of neglect and how it can have a serious impact on the child's development even though it is the most common protection related issue. Thus, we were not able to find much children with neglect and abuse issues.

However, based on the general observations & anecdotal information, it is evident that these children have indeed experienced or witnessed neglect and abuse. The probability of these children being exposed to family conflicts, domestic violence and conflicts in the neighborhood is very high. Even though the child's parents themselves are not involved in these issues, they live in communities i.e. urban slums which are comprised of people from

low socio-economic backgrounds and who have various issues such as substance abuse, domestic violence, conflicts, being engaged in illegal & criminal activities and so on.

It was also found that unless these teachers were trained in the concepts and the issue of neglect abuse, they will not be able to understand the importance, identify children with neglect and abuse issues nor will they be able to report and provide appropriate support and interventions.

Even though the project did train the teachers regarding protection related issues, due to the short duration of the project we were not able to conduct a second round of assessment of these children after the training. Further, in order to provide an accurate understanding of the protection related vulnerabilities it is essential to take the parents' perspective, which was also not possible.

Thus, it is suggested that training and capacity building of child care service providers such as – anganwadi worker, anganwadi helpers, Asha workers, ANMs, medical officers, child care institution's staffs and care givers must all be done to better understand the importance/impact of child abuse and neglect, identifying children who would have experienced abuse and neglect, and then providing first level responses to them and referring them to further interventions. They should also be taught about all the facilities and services available where they can refer the child.

5. Conclusions and Recommendations

In all, through this project we were able to understand various issues & trends in child development, mental health and protection issues among young children (0-6 years) in anganwadis situated in 5 urban slums of Bangalore city.

It was found that basic facilities such as – water, electricity and toilets were not present in many anganwadis. Due to lack of sufficient resources and staff, all the activities that an anganwadi worker needs to carry out are not being implemented, thus affecting the children and the success of the ICDS program.

Thus, we recommend that the ICDS program and the Women & Child Development Ministry need to concentrate on developing and upgrading the already present anganwadis rather than opening new anganwadis. We also recommend that basic facilities such as providing water, electricity, toilets and bathrooms must be prioritized which will increase the efficiency of the anganwadi worker/helper and provide children a safe & positive environment for them to learn and grow.

Based on our observation, the anganwadi workers' show a deficit of knowledge and skills pertaining to child development, mental health and protection related issues which occur in early childhood. Thus, extensive on the job training of anganwadi workers which provides them with a stronger conceptual framework for understanding child development, identification and addresses the protection needs of children according their vulnerabilities needs to be provided. To address this, the project has developed 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.

At a minimum, as the anganwadi and the ICDS program are the universal programs for Early Child Care Development in our country, even if it does not provide/address severe development delays because of various other systemic limitations, it should be able to at least identify and cater to developmental delays at a basic level and then refer severe developmental delays/disability cases to other institutions/care centers. Even if a targeted intervention is not possible, a universal intervention approach should be possible. Like a blanket feeding program, the essence of an anganwadi non-formal education program is to provide educational and developmental inputs to all children. At a bare minimum, the anganwadi worker should be able to identify developmental delays and refer them to tertiary care centres or District Early Intervention Centres, under the Rastriya Bala Swasthya Karyakram (RBSK).

These activities which are essential for universal coverage of Early Childhood Care and Development needs to be implemented in four levels by the service providers. A diagrammatic representation of the same is give in figure 1.

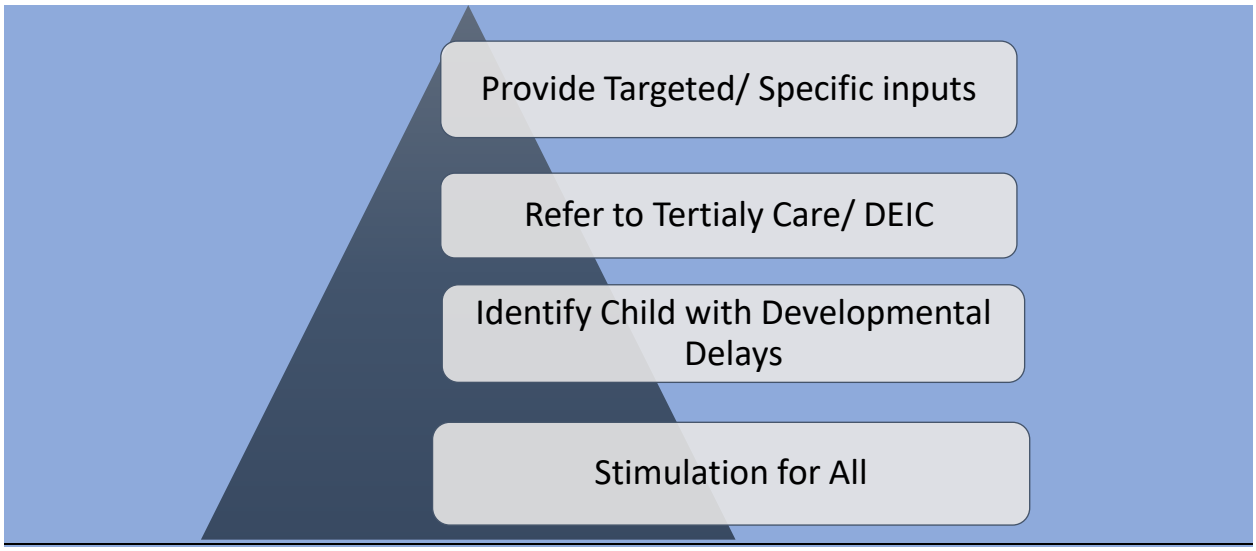


Figure 1. Activities Essential for Universal Coverage of Early Childhood Care and Development Program

Through this project, a total of 237 children between the age group of 1 - 6 years were assessed, the majority of who were between the age group of 2.5 to 3.5 years. It was found that all the children coming to the anganwadi were from low socio-economic background, their parents and caregivers were daily labourers and wage earners with low levels of literacy and education and many children were first generation learners; they lived in slum communities wherein they were exposed to conflicts and violence. This has implications on availability of resources and care/ attachment and early stimulation.

During the assessment, it was found that parents/primary care givers are not able to spend quality time with their children and not able to help the children regulate emotions, or engaged the children in early stimulation activities with the children. This may cause future behavioural problems and emotional regulation problems in the children. The extent of parents' knowledge and training is going to have limitations, hence a comprehensive and feasible plan/program to educate and train them needs to be developed.

237 children were assessed for developmental delays and under-stimulation in 5 domains of development. Among them, 118 i.e. nearly 50% of the children had developmental delay in at least in one developmental domain. This is a serious concern and it has implications on the importance of early stimulation and pre-school activities in anganwadis, which is the only opportunity for them to receive it. Specifically, under-stimulation in fine motor development, cognitive speech & language, and emotional development was more significant and needed immediate intervention to avoid developmental delays.

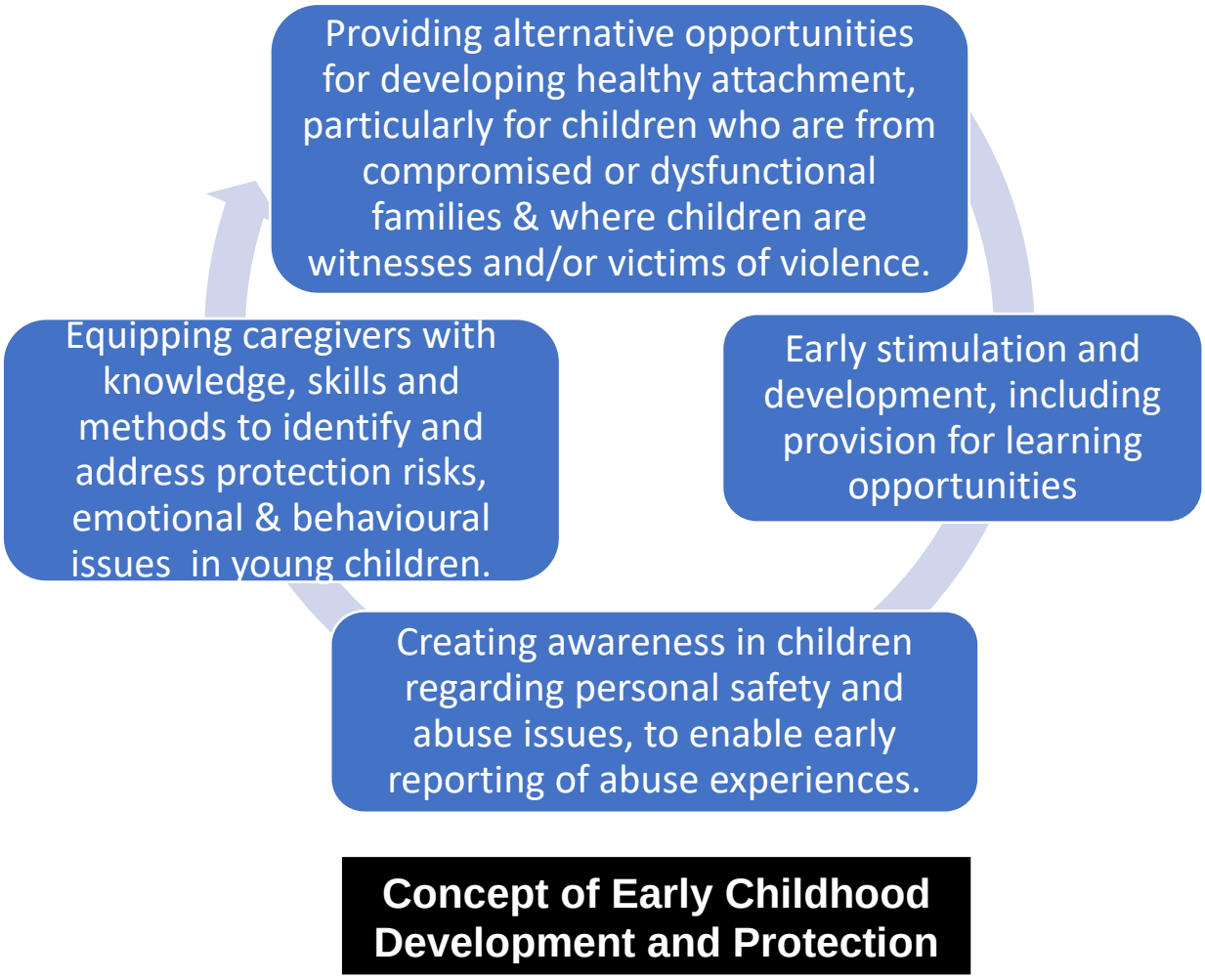
Based on observations and anecdotal information it is evident that these children have experienced or witnessed neglect and abuse (Physical, Emotional and Sexual abuse). These children are at risk and have various protection related issues either directly or indirectly, which need to be addressed.

For the child to form relations/friendships, cope with adversities and achieve success academically, professionally and in their social life, it is very essential that a child while growing up has achieved age appropriate development and has no metal health issues. To address issues of early childhood care and development a multi-sectoral coordinated service which focuses on the child's environment, relationships including parents, extended family members, providers of early care and education, mental health and child rights protection should be initiated. A preventive promotive approach to prevent problems and remediate early difficulties should be developed to ensure they do not destabilize the developmental process.

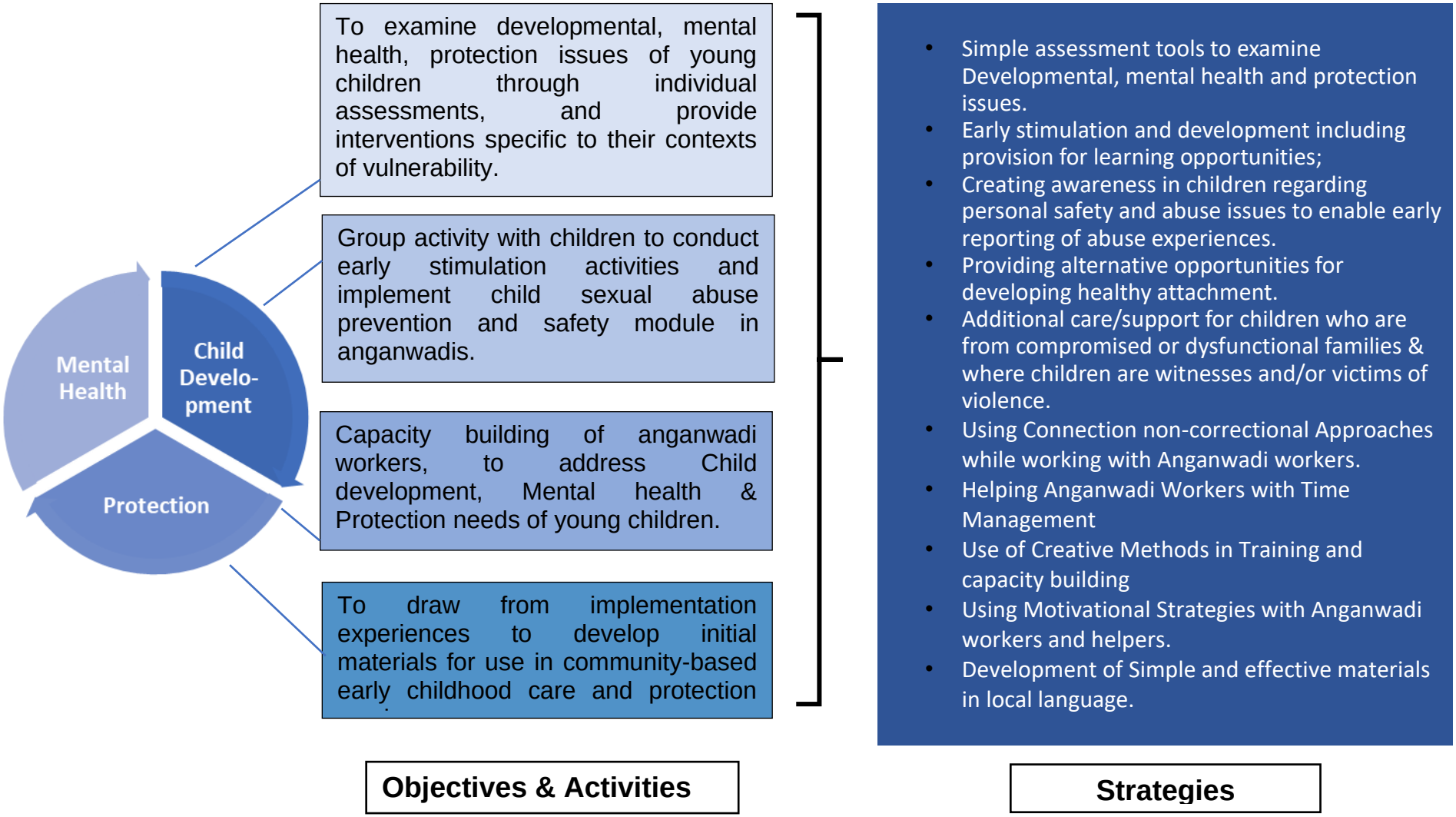
Based on our intensive work through this UNICEF-supported pilot project, we have developed numerous materials, the details of which have been presented and described in the report – "A Model for Integrating Child Development, Mental Health and Protection". Which provides a way forward for successful Early Childhood Care and Development program.

Please find below the diagrammatic representation of the same.

i) **Figure 2: A Framework to Integrate Child Protection into Early Childhood Development Programs.**



ii) **Figure 3: A model wherein an integration of early childhood development, mental health and protection is the way forward for the success of ECCD.**



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Annexures

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

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

Developmental Functions and Tasks				Ability to Perform Developmental Functions and Tasks		
				To high Extent	To Some Extent	To Low extent /Not at all
Sl no	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

Developmental Functions and Tasks				Ability to Perform Developmental Functions and Tasks		
				To high Extent	To Some Extent	To Low extent/Not at all
Sl no	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