Community Child & Adolescent Mental Health Service Project

4th Quarterly Report (Year 1)
July to September 2015

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Dept. of Child & Adolescent Psychiatry,
NIMHANS

Supported by Dept. of Women & Child Development,
Government of Karnataka

A. Project Objectives

With a view to addressing child and adolescent mental health service needs and gaps, the project aims to extend child and adolescent mental health service coverage, particularly to cover those who are most vulnerable. Project implementation entails a comprehensive plan to provide community-based child and adolescent mental health promotive, preventive, and curative care in urban and later in rural sites through direct service delivery and training and capacity building of child care workers from community-based governmental and non-governmental agencies/institutions and professionals, including schools, NGOs, anganwadis and health workers. The specific objectives of the project include:

i) Establishment of community-based child and adolescent services;

ii) Training and capacity building of childcare workers and staff from various governmental and non-governmental agencies, including schools;

iii) Draw from implementation experiences to develop a comprehensive community child and adolescent mental health service model that may be replicated elsewhere in the country.

B. Project Implementation: Activities and Progress

The first year of the Community Child and Adolescent Mental Health Service Project has ended, and below is a summary of the Project's coverage and achievements. The rest of this document details out the activities completed, including achievements and challenges in the fourth or final quarterly, July to September 2015, for year 1 of the Project.

Table 1: Project Coverage for Year 1 (October 2014 to September 2015)

No. of Institutions/ Agencies Reached	**Government (and Aided) Schools**	56
	Anganwadis	43
	Primary Health Centres	14
	Child Care Institutions	11
Total		**124**

Types of Agencies/ Services	**No. of Children Reached**		
	Individual Services	**Group Services**	**Total**
Schools	504	70	574
PHC	845	0	845[1]
Anganwadi	0	671	671
CCI	94	403	497[2]
Total	**1,443**	**1,144**	**2,587**

Training and Capacity Building	**No. of (Individual) Service Providers Oriented/Trained**	925[3]
	No. of Agencies/ Centres Represented by these Service Providers	311[4]
	No. of Districts	43 (+ 4 countries)[5] other than India)

[1] No. includes children screened and those provided with first level assessments & depth inputs.
[2] No. includes child care agencies serving orphan/ abandoned, street/working/ HIV infected/affected, disabled children.
[3] No. includes half-day/ 1-day orientation/sensitization and 3-day training programs.
[4] No. includes organizing agency and/or centres from which trainees were drawn (eg-PHCs/ ART centres).
[5] 30 districts in Karnataka, 7 from Tamil Nadu, 6 from Maharashtra; countries: Sri Lanka, Ghana, Laos.

During this quarterly, July to September 2015, services were continued in school and primary healthcare centre services, anganwadis, to reach pre-schoolers, and in governmental and non-governmental child care institutions working with children in need of care and protection. Two new initiatives were started during this period: i) remedial education services were implemented by a special educator in 24 government schools erstwhile provided with first level responses to developmental and mental health issues of children; ii) within the child care institution category, work was initiated in agencies serving the needs of children with disability. Further, the Project conducted two large symposiums, one for government schools teachers, on responding to learning difficulties in school children, and the other for anganwadi teachers, on the importance of early stimulation and interventions for pre-school children. 104 school teachers/special educators and 137 anganwadi teachers/special educators attended these symposiums, respectively.

In all, during this quarterly period, the project provided direct services to 1,509 children[6] through individual and group interventions in 14 PHCs, 26 schools, 43 anganwadis and 15 child care institutions. The project also continued its capacity building activities, reaching a total of child care service providers (including parents/ caregivers), from 232 centres/ agencies through orientation and training programs.

1. Mental Health Services in Schools

(i) Services Provided in Collaboration with Rashtriya Bal Swasthya Karyakram (RBSK):

School services continued through this quarterly period, from July to September 2015, in collaboration with the RBSK until 31st August 2015[7], in Bangalore South Zone, in government (and aided) schools served by Teams A, B and C of the RBSK. The NIMHANS team accompanied RBSK teams to schools and demonstrated / assisted the RBSK teams to assess and provide first level responses to children identified by teachers, with emotional/ behaviour/ learning/ disability problems. Responses included basic counselling to children, and inputs to teachers on how to manage children with problems. Mild to moderate problems were managed at school level, while more severe problems (requiring depth work/ medication) were referred to tertiary facilities, namely NIMHANS's Dept. of Child & Adolescent Psychiatry.

The three-month collaboration was completed during this quarterly and a detailed report, containing achievements, challenges and recommendations for ways forward for the RBSK's role in child mental health, was submitted by the Project to RBSK. As highlighted in the previous quarterly report, despite the potential to integration of child mental health services into the RBSK school health team services, the implementation process was fraught with a number of challenges, such as: i) the RBSK teams' inability to participate in mental health services due to the large case load in each school for general/ medical check-ups; ii) their problematic work ethic, including arriving late, poor planning and preparation for school health activities, low motivation due to

[6] This is the number receiving individual services (first level responses) and group session activities; it does NOT include the 285 children screened in the PHCs (because some of these children were received/ served at the PHC and the project data wanted to avoid any double-counting issues).

[7] As mentioned in the previous quarterly report, the RBSK is an important national (central government/ Dept. of Health) initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability. As part of the Project, the objectives of services and support provision to the RBSK school health teams are: i) Early and more accurate identification and referral of children with developmental disabilities and other emotional/ behaviour disorders; ii) The extension of the RBSK school health teams' roles in the area of child mental health issues (including disability) in ways that enable them to provide first-level responses to children with emotional and behaviour problems, including parent and teacher guidance on home-based care and training for children with disability.

dissatisfaction with remuneration and terms and conditions of employment; iii) their relatively poor understanding of the disability-deficit mandate of the RBSK and consequently their inability to identify, assist and advocate for children with developmental and mental health problems. As a result, the project team provided the mental health services alongside the RBSK team but in a manner that is parallel and disconnected, rather than integrated. Consequently, the expected outcome, from the RBSK collaboration, that the RBSK teams would have acquired the learning and skill to continue basic child and adolescent mental health services as part of their health services in schools/ anganwadis and that of (some degree of) integration of child and adolescent mental healthcare into school health services, was achieved to a very limited extent.

Having said that, the above observations and understanding are obtained form a very small group of RBSK functionaries i.e. 3 teams; furthermore, these were all Bangalore urban-based teams. Therefore, the observations and experiences represented in this report are not generalizable to all RBSK teams or at least not to teams in rural areas. In fact, we have a hypothesis that RBSK teams in rural areas may differ markedly in their attitudes and in their motivation levels in ways that are positive because unlike Bangalore city, rural areas have little access to child mental health/ disability services at primary, secondary and tertiary care levels i.e. rural teams may therefore be better motivated to serve their communities in order to increase access to child mental health and disability care.

Thus, despite the relative lack of success during this three-month experiment with select RBSK teams, we still believe that the RBSK school health services have tremendous potential to provide increased access to child and adolescent mental healthcare. Given their coverage and targets i.e. government schools, wherein large numbers of children from low socio-economic backgrounds and therefore at greatest risk of psychosocial and mental health problems, the RBSK school health team is perfectly poised to assist the most vulnerable children in our communities. Furthermore, few government programs have as strong and clear a mandate as the RBSK does, in terms of addressing deficit and disability issues in child health.

In the light of the Project's experiences, the following recommendations, on the ways forward for integrating child mental health into school health services, and strengthening the RBSK teams skills/ role in it, were made to the RBSK officials (as part of the report submission upon completion of the 3- month collaboration):

a) Training for Peri-Urban and Rural RBSK Teams

It is recommended that the focus of training and capacity building be shifted from urban areas such as Bangalore to peri-urban and rural sites and districts of Karnataka. Anecdotal information also has it that the teams located in these areas are eager for more knowledge and skills as the imperative to assist communities that have very poor access to mental health and disability services, appears to be greater than in better served urban areas.

b) Only Medical Officers/ Doctors to be targeted for Training

During the course of our training workshop and our work in the field, with RBSK teams, it was apparent that two cadres of the RBSK were unable to acquire child mental healthcare skills, or therefore, to use them in the field (due to lack of time, interest and ability): nurses and ophthalmologists. We therefore recommend that future training workshops on child and adolescent mental health care include only the medical officers/ doctors from RBSK school health teams.

c) Appointment of Mental Health Professional to RBSK School Health Teams

RBSK's existing plan of staffing District Early Intervention Centres (DEIC) with psychologists may continue but would be inadequate to address the burden of mental health morbidity in schools—since all children referred will not avail of services in DEICs. As documented in sub-section 2.4., for a variety of possible reasons, health seeking behaviour by children identified and referred by the school mental health services has been continually low. Given this scenario, mere identification and assessment (and diagnosis) and referral to tertiary/ specialized healthcare centres is insufficient; most families do not follow up on the referral visit and thus, many children, in fact those with the most severe mental health and/or disability problems, never receive assistance.

In the light of this, providing first level responses i.e. assistance and some inputs at the time of assistance, in school, is critical. Given the existing burden of the school health team personnel, it is recommended that along with the medical officer, nurse and ophthalmologist, a mental health professional is appointed to the school health team. This person, like the others, is part of the mobile health team that moves from school to school and provides assessment, diagnosis, early intervention and first level responses on the spot i.e. in school, to the child and teacher, and the parent/ caregiver when possible. This person needs to have a background of psychology or social work, with specialized training/ experience in child mental health issues.

Of the 26 schools served during this quarterly, 19 were part of the RBSK collaboration, while the remaining 7 formed those who requested the Project to conduct services in their schools following the symposium for school teachers (described in subsequent sections). (*Refer to annex 1 for list of schools).*

In all, 114 children were assessed and provided with first level responses. Amongst these children, a total number of 133 cases of child & adolescent psychiatric problems were identified: 16 (12%) cases of emotional disorder, 44 (34%) cases of behaviour problems, 35 (26%) cases of learning difficulties, 23 (17%) cases of developmental disabilities and the remaining 15 (11%) cases of other issues, namely, serious mental issues, medical problems/ life skills issues and child sexual abuse. *(Refer to tables 2 (a) to (c) for details).*

Of the 114 children, 14 children (12%) were referred to tertiary care facilities for medication and psychotherapy. About half referrals was made for emotional and behavioural disorders as well as other serious mental health issues/ disorders such as psychosis and substance abuse, that required psychotherapy and depth inputs; this is because many children from these schools come from difficult home environments with complex family issues.

Table 2(a): Total No. of Consultations Disaggregated by Age & Sex in Schools, July–September 2015

Age Groups	July		August		September		No. of Children
	Male	Female	Male	Female	Male	Female	
6 to 12 yrs	18	12	16	6	0	0	52
13 to 17 yrs	21	5	15	4	13	4	62
Total	39	17	31	10	13	4	114

Table 2(b): Child & Adolescent Disorders Identified in Schools, July –September 2015

Child & Adolescent Mental Health Issues		No. of Children			Total
		July	August	September	
Emotional Problems	Selective Mutism	0	0	0	0
	Dissociative/Somatic	1	0	0	1
	Bed Wetting	0	0	0	0
	School Refusal	0	0	0	0

	Other Anxiety Issues	4	3	2	9
	Dysphoria/Depression/Adjustment Disorder	5	1	0	6
	Post-Traumatic Stress Disorder	0	0	0	0
Sub-Total		10	4	2	16
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	3	3	3	9
	ODD	0	0	0	0
	Conduct Disorder Symptoms: (Lying and Stealing)	3	0	1	4
	Truancy	2	0	1	3
	Runaway Behaviour	0	0	2	2
	Conduct Disorder (Most Symptoms)	5	0	1	6
	Substance Abuse	0	0	1	1
	Attention Deficit Hyperactivity Disorder	8	9	2	19
Sub-Total		21	12	11	44
Learning Issues	Specific Learning Disability	8	14	1	23
	Other Learning Problems	10	1	1	12
Sub-Total		18	15	2	35
Developmental Disability	Intellectual Disability	4	10	2	16
	Speech Problem	4	3	0	7
	Motor Disability	0	0	0	0
	Autism	0	0	0	0
Sub-Total		8	13	2	23
Other Issues	Life Skill Issues(Sexuality)	4	0	5	9
	Other Health/Medical Problems	2	0	1	3
	Child Sexual Abuse*	1	0	0	1
	Mood Disorder/ Psychotic Symptoms	0	2	1	2
Sub-Total		7	2	7	16
Total		**64**	**46**	**24**	**134**

*Child Sexual Abuse is not a psychiatric disorder. However, it has been coded as it is a major issue of concern needing specialized responses including medical, psychiatric and psychosocial interventions.

Table 2 (c): Referrals to Tertiary Care Mental Healthcare Facility from Schools, July –September 2015

Child & Adolescent Mental Health Disorders		No. of Children			Total
		July	August	September	
Emotional Problems	Other Anxiety Issues	0	0	0	0
	Dysphoria/Depression/Adjustment Disorder	2	0	0	2
	PTSD	0	0	0	0
Sub-Total		2	0	0	2
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	0	0	0	0
	Conduct Symptoms: Lying and Stealing	1	0	0	1
	ODD	0	0	0	0
	Truancy	0	0	1	1
	Conduct Disorder (Most Symptoms)	0	0	1	1
	Attention Deficit Hyperactivity Disorder	1	0	1	2
Sub-Total		2	0	3	5

Developmental Disability	Intellectual Disability	0	2	0	2
	Speech Problem	0	1	0	1
Sub-Total		0	3	0	3
Other Issues (incl. serious mental illness)	Child Sexual Abuse	1	0	0	1
	Substance abuse	0	0	1	1
	Runaway Behaviour	0	0	1	1
	Psychotic Symptoms	0	1	0	1
Sub-Total		1	1	2	4
Total		5	4	5	14

(ii) Remedial Education Services in Government Schools:

As per the Project's observation during counselling services, and teachers' reports, one of the critical issues for schools is learning difficulties in children. Whether due to mild intellectual disability, under-stimulation, poor school attendance or emotional problems, this affects children's academic performance, and consequently their future opportunities and life decisions.

As per the recommendation of the school teachers and children's need for remedial education, the Project appointed a special educator (as resource person), to work with government school children and teachers. Visiting 23 schools, twice a month, the objectives of her services were as follows:

- To provide remedial education to children identified by the project. (These include children with specific learning disability and other learning problems due to causes such as under-stimulation).
- To assess other children as suggested by teachers and include these children also in the remedial education sessions, as required.
- To work with teachers and give them inputs on how to continue/ follow-up remedial work they do with the children.

In all, between July and September 2015, the special educator conducted 97 assessments for children with learning problems, to determine their causes and plan for interventions accordingly. Specific learning disability was the major cause of children's learning difficulties (72%), followed by emotional and behaviour disorders (12%); mild intellectual disability (8%) and other issues such as change in medium of instruction and absenteeism (8%) accounted for the remaining children's learning problems. 154 children were provided with remedial inputs i.e. to those assessed by the special educator (97) as well as others assessed by the Project team as part of the emotional/behaviour/developmental problem identification and response service. Nearly 70% of children receiving remedial inputs showed some form of improvement in academics *(Refer to tables 3(a) to (d) below for details).*

Table 3 (a): Total No. of Children Assessed for Learning Difficulties, July –September 2015

Age	Sex		Total
	Male	Female	
7 to 12 yrs	40	31	**71**
13 to 17 yrs	17	9	**28**
Total	**57**	**40**	**97**

Table 3(b): Causes of Children's Learning Difficulty

Causes	No. of Children (N=157)*
Specific Learning Disability	113 (72%)
Emotional and Behavioural Issues (including ADHD)	19 (12%)
Intellectual Disability (Usually Mild ID)	13 (8%)
Other (Absenteeism/Change in medium of instruction/Under-stimulation)	12 (8%)

*In some instances, a child may have had more than one cause for the learning difficulty.

Table 3(c): No. of Children Receiving Remedial Education Inputs, July –September 2015

Age	Sex		Total
	Male	Female	
7 to 12 yrs	72	36	**108**
13 to 17 yrs	33	13	**46**
Total	**105**	**49**	**154***

*Remedial inputs were provided to those assessed by the special educator (97) as well as others assessed by the Project team as part of the emotional/behaviour/developmental problem identification and response service.

Table 3(d): Impact of Remedial Inputs on Children with Learning Difficulties

No of children with improvement after receiving Remedial inputs	104 (69%)
No of children with no improvement after receiving Remedial inputs	47 (31%)

*N=151. The progress of the remaining 3 children was unavailable at the time of special educator's visit to school.

Inputs to school Authorities and teachers:

As part of the remedial education service, the special educator provided awareness and education to school principals and teachers on:

- What learning difficulties are about and what causes them
- Different types of learning problems in children
- Identifying learning problems in the classroom set-up
- The importance of inclusive education approaches (why children with learning problems should be included in regular classrooms/ how every child has his/her own unique learning needs and styles and that these need to be valued…)
- Role of special educator

The aim was to not only provide remedial inputs to children but also to share these methods with teachers to build their capacities to assist children with learning issues and ensure sustainability of such assistance within the school. While guidance was provided to teachers to continue the remedial activities started by the special educator, these were seldom executed by the teacher—who either stated that they had no time or that they already knew these techniques and were practising them. Although repeated persuasion of teachers was done, to convince them that most remedial methods being advocated were simple enough to be implemented during classroom sessions, and that they did not require much additional time with the child, teachers frequently remained unconvinced. A tiny minority of teachers were, however, receptive to learning remedial methods and took the time to understand individual children's problems and try to tailor their teaching styles to assist them.

Since teachers were often less willing to implement remedial methods, inputs were given, where possible, to children's parents i.e. for those whose parents were literate and motivated. This worked only in one instance, wherein the mother worked with her child, who showed dramatic

improvements in speech, social skills and academics. However, for the most part, parental inputs are not feasible as many parents are daily wage earners and simply have not the time to teach their children (and many are not educated either).

Remedial Work with Children:

Most high school children wanted remedial inputs in English but were confident that they will manage other subjects. They were very keen on receiving remedial inputs. Interventions are provided using different/ creative methods such as use of ice-cream sticks to teach basic concepts of mathematics (addition, subtraction, multiplication, division); other methods such as match the following, fill in the blanks, breaking up sentences were used to teach reading and comprehension; letter sounds, word decoding, word blending, initial and final blends like "sh" 'Ch', 'th' and word lists were used to assist children with reading and writing skills. Techniques such as 'show and tell' using pictures to build stories were used with older children. Basic tasks such as letter recognition, one-to-one correspondence, tracing, joining the dots and sequencing were done with younger children. Concepts such as size, shape and quantity were also taught.

Does this Model of Remedial Education work?

This model of providing schools with monthly sessions by a special educator with direct inputs to children and guidance to teachers has had various challenges, namely that of teacher/ school receptivity. While one acknowledges the difficulties teachers have in terms of the pressures of additional documentation/ administrative work, placed on them by the Dept. of Education, it still does not explain their reluctance to adopt more supportive classroom teaching methods.

Common Teacher Responses to Remedial Education Guidance

- *This is government school .we can't follow things what private schools do. In private school teachers don't have any work. parents will take all the responsibility. Here parents are not bothered about child's future. Some parents they admit their child to school and disappear. they don't even know the child is studying in which std and who is the class teacher.*
- *Leave him... This child is lazy we have tried all the methods with him. He will not learn. He is not motivated… looks as if he has some mental problem. Why do you waste your time by teaching him? Nobody is literate in their home. This boy also will drop out after 9th and do some petty work for his livelihood.*
- *Parents are not taking care of them.*
- *We have lot of documentation work to do, other than teaching. We don't want anything to carry home and do it. Give us clerks to do this clerical job and we will carry out the program which you have given.*
- *We don't have sufficient staff to give extra classes to them.*
- *We can't teach them inside the class room because the other children loose that much time.(wasting time for this child will affect other students future)*
- *We don't want to waste the time of 30+ children who can do something in their life.*
- *We don't have time we have other student who can do better.*
- *we don't have free period to teach or to give extra attention to these children.*
- *You help children who have emotional problem. You cannot solve learning difficulty because 90% of children has it. can you solve their problem?*
- *Basic teaching itself is not proper. Go and give all these guidance to lower primary teacher's who is responsible for these difficulty.*
- *Don't give any program to me. we are giving the T.C. to the child.(sending the child out of school)*
- *I have so many children in my class I can't give attention to him. I will follow if you give something to do with oral in group.*
- *We can't do all this drama here. I will call her mother you give the program to her.*

Secondly, given the large numbers of children with learning problems, the time available (monthly twice for a few hours) is insufficient to provide direct assistance and effective remedial education services to children. The time available to the special educator to obtain more comprehensive understanding of classroom learning and teaching gaps is limited. Despite these challenges, and within the limited time and inputs available to these children, varying degrees of improvement were noted in their academics. This shows that some amount of remedial work, even if it is not extensive in nature, has the potential to help children with learning disabilities.

That said, this model was based on the premise that the direct services to children would serve more as a demonstration for teachers on how to provide remedial education to children with learning problems i.e. it relied on the fact that teachers would build their capacity to assist children, over time, and do so on a regular basis, so that the special educator's inputs to the children could be less frequent. Thus, its effectiveness actually depends on teacher willingness and participation to assist children with learning difficulties, by implementing classroom remediation techniques.

iv) Preparation for Enabling Remedial Education Resources in Government Schools

As will be described elsewhere in this report (under the section on *Training and Capacity Building*), 10 government schools (following the school teachers' symposium on 'Responding to Learning Difficulties in School Children') requested the Project to provide technical support and guidance to enable schools to set up spaces and resources for remedial education so that they could develop in-house capacities to address the needs of children with learning problems. In response to this request, the Project proposes to develop a model for government schools based on i) the needs and resources of the concerned government schools; ii) the experience and practices of other schools that offer remedial education and inclusive education.

a) Observation of Existing Models on Remedial and Inclusive Education

As a first step, the Project special educator spent some weeks at one of the inclusive schools who attended the seminar so as to learn from their practice and experiences in remedial education. The aim was, through classroom observation and discussion with teachers, to learn and understand from their models of work, including challenges and best practices. An inclusive education school was selected because government schools (due to the RTE and other such policies) are essentially, or by de-fault also inclusive education set-ups. Thus, the Project used this observation to suss out what specific (remedial and) inclusive education practices may be applicable in government schools so that we might introduce them in the above-mentioned 10 schools.

Inclusion Model in a Private School – Is this possible in Government schools?

- **Management and Principal Support** – The school Management body and the Principal drive the inclusive practices based on their beliefs that children, irrespective of their learning abilities should be provided with learning opportunities. Thus the admission policy allows for children with learning difficulties due to physical, neurological or socio-emotional behavioral reasons to be a part of the student body. Though this is largely akin to the open admission policy followed in the government schools, there is a critical difference. Insight Academy, as a school is aware of and accepts the presence of learning difficulties in students and thus is prepared to try and cater to the different learning needs of the students. The school, as one of the measures has created a 'customized' section for students with learning difficulties. Both teaching and testing approaches are modified in this section to suit the learning needs of the students.

  On the other hand, the government schools, although to some extent are aware of the presence of learning difficulties in students, do not have the universal support of the Education Department or the HMs to create customized measures to cater to the special learning needs of the students.
- **Parental Support** – Insight Academy relies on parental support as an integral part of their management of students with learning difficulties. Firstly, there's the aware parent group that seeks admission for their children because the children find it difficult to cope in other schools or have been asked to leave due to their learning difficulties. Secondly, there's the parent group that is informed and counseled by the school, about the learning difficulties of their children, based on the observations of the teachers. In either case, the parents cooperate with the school regarding evaluation and assessment of the children and the measures the school suggests. Such measures include those that the school plans and other external help that may be required on a case specific basis. In fact, a few of the shadow teachers in the school are the mothers of the students who need constant supervision. Furthermore, the parent body is educated and economically able to access various sources required for the children.

  The parent community of the government schools, on the other hand is largely illiterate or uneducated. Their financial abilities are very limited, in fact so much so that many of the children have to work to supplement the family income. There is no awareness or understanding of learning difficulties that may be present in the children. It's also important to note in this context that most of the teachers attribute the learning lags in the government school students to home and family issues like poverty, alcoholism, physical and sexual abuse, lack of interest and parental support.
- **Teaching Staff** – Classroom management of students with learning difficulties in Insight Academy that include teaching approaches and testing, are directed by the Principal. All teachers are advised and supported by the Principal and senior coordinators regarding the modification of teaching and testing methods. The teachers are willing followers of the advocated strategies. The school also organizes relevant workshops at the beginning of each academic session as a sensitizing and capacity building measure.

  The teaching staff in the government schools is divided in their opinions about the management of learning difficulties in their students. However, there are some members who are keen to reach out to their students and help them to cope with their learning difficulties. In the absence of a consensus and a defined support from the Education Department, it is left to individual members of the government school teaching community to create measures that will help the students. Moreover, work pressure on the teachers to complete the syllabus and achieve passing grades for the students limits their willingness to put in any effort for individual cases.

b) Ground Work in Government Schools

In the light of our observations of existing models on remedial and inclusive education, we found that many of these models would be largely inapplicable to the government school situations. The wide variation in the socio-economic family backgrounds of the student bodies in a private school and in the government schools is an insurmountable roadblock in the way of applying the private school model to the government schools. The government school authorities are under obligation to adhere strictly to the syllabus and time-table norms laid down by the Education Department in contrast to a comparative autonomy enjoyed in these areas by the private school. However, sensitizing and capacity building measures for the government school teaching staff that introduces them to techniques of managing learning difficulties in students, that are an integral part of their regular teaching activities and not an extra effort, can probably be the beginning of creating a school environment that is more conducive for students with learning difficulties.

Thus, as a next step towards introducing remedial education into government schools, the Project special educator did a round of visits to these 10 schools and gathered some relevant, initial information through semi-structured interviews with the Head Masters/Mistresses and a few teaching staff members of the participant schools. The aim of this preliminary exercise was to understand the schools' contexts, specific needs, the resources available to them, and their willingness and capacities to engage in implementing remedial education spaces/ models within their schools. (Refer to annex 4 for information obtained for each school—some analysis of which has been documented below).

The most critical concerns of the school authorities regarding the student body are about the difficult home and family situations the students largely belong from. Most of them are first generation learners, facing severe physical and emotional abuse, economic hardships and lack of any support from the parents. In the light of such family and home conditions, learning is negatively impacted with the learners displaying lack of interest in academics, as they have no access to any support to aid learning, have to work to contribute to the family income and are continually battling grave socio-emotional difficulties.

On the school front, most of the teachers reported high work pressure that leaves them with no time to address students' learning issues. On one hand the open admission policy guarantees admission to any student on an age parity basis, irrespective of the learning levels of the student, and on the other, there is no existing school practice that helps the student to fill the gaps in the minimum learning levels required for each class. Since Government policy does not allow holding any student back in any class due to the inability to achieve minimum learning levels, the students move from one class to the next with an ever-increasing gap in their learning levels.

Remedial measures as directed by the Education Department are mostly rendered ineffective as they focus more on the current curriculum requirements, which still leaves the issue of gaps in the minimum learning levels unaddressed. Moreover, absenteeism, attributable to some extent for gaps in learning, compounds the problem.

It is necessary for remedial measures to be a regular part of the everyday teaching-learning activity of every class. Such a strategy would provide a continued opportunity for students to fill the gaps in the basic and minimum learning levels. Secondly, it is recommended that bridge courses that are conducted only at the beginning of every academic session be held at the beginning of every term; i.e. three times within one academic session. That, to some degree would offer an opportunity for students to cover some of the gaps in their learning attributable to absenteeism. Varied teaching and revision strategies that help the students to improve initial level reading skills involving

blending and syllabication and writing skills to firmly establish letter name and graphic form association need to be incorporated for all classes.

Remedial teaching models as deemed viable will be designed on the primary conditions of the learning needs of the students and the work load limitations of the teachers. Most of the HMs and teachers felt it was not possible for any teacher to man a resource room and neither was it feasible for them to conduct individual remediation, especially in the high school classes. Moreover, the teachers are extremely wary of any remedial work that would entail an increase in their work hours or correction load. Thus remedial teaching practices need to be incorporated within the regular study periods. That would serve both purposes of addressing students' learning needs as well as being feasible for teachers. Recommendations of effective remedial practices for students with more specific and defined learning needs, as may be revealed through individual assessments, could be offered on a case-specific basis. Resource rooms may be set up for the schools that have available space and willing teaching staff.

Meeting with Director, National Institute of Open Schooling

Students with learning difficulties either diagnosed or otherwise, need support to cope with the academic requirements of the mainstream school system. Such support as is offered is generally restricted to elite private schools and thus not accessible to a major component of the school student community. The national and state education boards also offer some accommodations like extra time, provision of a scribe and subject exemptions to students diagnosed with Specific Learning Disability. While these measures do benefit some students, there's no gainsaying the fact that a significant number of students, who need such support have no access to such measures. In this context, the flexibility of the NIOS system could benefit a large number of students. Firstly, the NIOS allows external candidature, so the students do not need a school enrolment. Secondly, a wider choice of subjects helps students to create combinations according to their interests and abilities. Additionally, students have the option of taking their exams one or two subjects at a time, with the scope of multiple attempts.

Unfortunately, awareness about the NIOS is not very wide spread. Also, learning centres that teach the NIOS syllabus are few and registrations for the courses are perceived as cumbersome. Parents, who do get an assessment for their children, then face the daunting task of finding a suitable school. More often than not, due to the paucity of suitable schooling options, many children drop out. Thus the genesis of the idea to have an NIOS learning centre within NIMHANS premises that will facilitate registration and learning of the prescribed courses. A meeting with the Director, NIOS, Karnataka, was organised to begin discussions on these issues. The salient points of the discussion are as follows –

- NIOS requirements for the setting up of a learning centre:
  1) Physical infrastructure – classrooms, furniture
  2) Teaching staff – B.Ed mandatory
  3) Laboratory mandatory for centres opting for science subjects
- Courses: Vocational / skill-based courses preferred

Some of the barriers in setting up of an accredited centre involve mandatory requirements which may be difficult to fulfil. Alternatively, possibilities of setting up a centre that facilitates access to and the learning of the NIOS syllabus, without the formalities of accreditation could be explored. Further meetings are planned to continue exploring the aforementioned issues and possibilities.

2. Child and Adolescent Mental Health Services in Primary Healthcare Centres

During this quarterly period, 14 PHCs were covered; however, after July 2015, 5 PHCs were dropped due to lack of cooperation and interest by PHC staff, including the medical officers (the same was communicated to the Dept. of Health Officials); and in September 2015, 3 new PHCs were added to our service list. (14 reflects the number of PHCs dropped and those added). 20 visits, for the purposes of child mental health service provision, including screening and depth services, were made. *(Refer to Annex 2for list of PHCs served).*

Community Mobilization: Screening Services

In continuation of the Project's efforts to mobilize families in the communities to avail of mental health services for their children, screening services were provided at the PHC on immunization days. Since the screening is done on immunization mornings, a majority of children, 374 (93%) were between the ages of 0 and 6 years *(Refer to table 4(a) and (b))*. However, often the young children at the PHC for immunization are accompanied by elder siblings, whom also we screen for mental health issues; in addition, the screening process entails discussing the mental health of all her children with the mother—to check whether any of her children, including the older ones not present, have emotional, behaviour, developmental and learning problems. Thus, the Project extends screening activities beyond those young children present at the PHC to others in their families/ near their homes, thus also creating awareness about child mental health issues and service availability.

A total of 401 children were screened. Of those screened, 39 children (10%) were found to emotional/ behavioural/ learning problems or developmental disabilities and referred to return to the PHC for detailed assessment and interventions.

Table 4(a): Screening Services: Demographic Profile, PHC Services, July to September 2015

Age Groups	No. of Children Screened						
	July		August		September		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	81	86	55	45	54	53	374
7 to 12 yrs	7	9	4	1	1	2	24
13 to 17 yrs	0	1	0	0	1	1	3
Total	88	96	59	46	56	56	401

Assessment & First Level Response Services

34 children, between the ages 0 and 17 years, availed of child mental health services at the PHC. These include most of the children identified during the screening services (described above) as well as other children identified and referred by PHC staff. Over half are young children, below 6 years—again because the children screened were mostly younger age groups that avail of immunization services at the PHC. *(Refer to table 4(c))*.

Table 4(b): Screening Services: Referral to PHC for Assessment and Interventions

	No. of Children Screened and Referred to PHC			
	July	August	September	Total
No. of Children Screened	184	105	112	401
No. of Children without Problem	161	96	105	362
No. of Children Referred to PHC	23	9	7	39

Table 4(c): Total No. of Consultations Disaggregated by Age & Sex in PHCs, July to September 2015

Age Groups	July		August		September		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	10	1	2	2	4	1	20
7 to 12 yrs	3	8	0	0	0	0	11
13 to 17 yrs	2	1	0	0	0	0	3
Total	15	10	2	2	4	1	34

The relatively low numbers of children provided with services at the PHC were due to:

i) Absence of community mobilization services in the community, during other times, by community health workers; the introduction of ASHA workers in accordance with the NUHM scheme is still not in place. Thus, child mental health services are reliant solely on community awareness/ mobilization activities provided through the screening services of the Project, which are not adequate.

ii) NUHM constructions and re-modelling work in most PHCs interrupted routine health work in these centres. Sometimes Thursday morning immunizations were not conducted in the PHCs and were done instead in Anganwadis, in ways that were unplanned and impromptu, so that the Project was unable to coordinate with the staff to be part of the services.

Amongst 34 children, 36 cases of child and adolescent disorders were diagnosed and provided with treatment *(refer to Table 4(d))*. At PHC level, treatment included provision of psycho-education and inputs to the child's family, first level responses to the child (where appropriate) and psychiatric medication as required.

Of the 34 children assessed at the PHC, 7 (21%) were referred to tertiary care facilities. As in the case of school mental health services, these were children requiring further in-depth assessments in multiple areas as well as those requiring longer term in-depth psychotherapy (in case of emotional and behavioural disorders) or special inputs for speech and loco-motor disabilities. All children were referred to the Dept. of Child and Adolescent Psychiatry, Dept. of Speech Pathology and/or Dept. of Neurological Rehabilitation (for physiotherapy) as required. *(Refer to table 4(e)).*

Table 4(d): Child & Adolescent Disorders Identified in PHCs, July to September 2015

Child & Adolescent Mental Health Issues		No. of Cases			
		July	August	September	Total
Emotional Problems	Selective Mutism	0	0	0	0
	Dissociative/Somatic	0	0	0	0
	Bed Wetting	0	1	0	1
	Pica	1	1	0	2
	School Refusal	0	0	0	
	Other Anxiety Issues	0	0	0	
	Dysphoria/Depression/Adjustment Disorder	3	0	0	3
	Post-Traumatic Stress Disorder	0	0	0	0
Sub-Total		4	2	0	6
Behaviour Problems	Conduct Symptoms : Anger/ Aggression/Temper Tantrums	1	1	0	2
	ODD	0	0	0	0
	Conduct Disorder Symptoms: (Lying and Stealing)	0	0	0	0

	Truancy	0	0	0	0
	Conduct Disorder (Most Symptoms)	1	0	0	1
	Attention Deficit Hyperactivity Disorders	1	0	1	2
Sub-Total		3	1	1	5
Learning Issues	Specific Learning Disability	1	0	1	2
	Other Learning Problems (incl. under-stimulation)	2	0	1	3
Sub-Total		3	0	2	5
Developmental Disability	Intellectual Disability	5	1	0	6
	Speech Problem	6	1	1	8
	Motor Disability	2	1	1	4
	Autism	0	0	0	0
Sub-Total		13	3	2	18
Life Skill Issues(Sexuality)		0	0	0	0
Other Health/Medical Problems		1	1	0	2
Sub-Total		1	1	0	3
Total		24	7	5	36

Table 4(e): Referrals to Tertiary Care Mental Healthcare Facility from PHCs July to September 2015

Child & Adolescent Mental Health Disorders		No. of Children Referred			
		July	August	September	Total
Emotional Problems	Dysphoria/Depression/Adjustment Disorder	2	0	0	2
Developmental Disability	Speech Problem	4	0	0	4
	Locomotor Disability	1	0	0	1
Total		7	0	0	7

3. Anganwadi Services

i) Direct Services:

During July and August, the Project continued to provide pre-school services in the 24 anganwadis(located within the selected PHC catchments) , randomly selected and targeted in the previous quarterly *(see Annex 3 for list of Anganwadis)*. In September 2015, services to the first group of 24 anganwadis were discontinued as they had received services, including activity demonstrations for a 3 month period. In this month therefore, the next group of 25 anganwadis were taken on for pre-school activities and demonstration/ training activities. Over this quarterly period, 672 children and 62 teachers across 43 anganwadis were reached with pre-school services *(see table 5 for numbers of details)*.

Each Anganwadi received 2 visits per month, by Project staff, who spend about an hour in each centre doing activities with the children and demonstrating the same to the anganwadi teacher. The project has also created some low cost aids (using locally available materials, such as old newspaper and charts freely available in stationary stores) for use in anganwadis. In subsequent visits, the anganwadi teacher was requested to use the materials available in the anganwadi and do the activities erstwhile demonstrated. Thus, the service approach is one of on-the-job training through demonstration and discussion.

Table 5: Anganwadi Service Coverage, July to September 2015

Anganwadi Service Coverage	No. of Children			
	July*	August*	September	Total
No. of Children Participating in Early Stimulation Activities	240	274	397	671
No. of Anganwadi Teachers Reached with Pre-School Inputs	22	23	17	62
No. of Anganwadis Reached	24	24	19**	43

* Since the same anganwadis were reached in July and August 2015, there are over-laps in the children reached. Therefore, the numbers reached in August (the highest numbers of children reached in each centre) are included in the total i.e. the July numbers are not included in order to avoid double-counting.

** Although 25 (new) anganwadis were scheduled to be covered in September 2015, only 19 were reached because there were unexpected holidays/ 'bandhs' during this month, preventing us from completing the visits as planned.

The group activities with children are designed to promote early stimulation and optimum development in the 5 key areas of child development--physical/ social/ speech & language/cognitive/ emotional development—and this conceptual framework is explained to the anganwadi workers.

ii) Completion of Material Development and Distribution

'Arambhikeya Arambha', a book of 35 simple pre-school activities has been developed for the use of anganwadi teachers, was completed, translated into Kannada and made available to anganwadi teachers, as planned, in August 2015 during the anganwadi symposium. Similarly, A flip-chart on home-based stimulation for young children, for anganwadi teachers to use in their education/ awareness sessions with parents of pre-schoolers, was also developed, translated and distributed at the anganwadi symposium.

Despite having the basic activity book, it is observed that many teachers still do not engage the children in early stimulation activities; and many teachers do not appear to have used the early stimulation flip chart in their parents' meetings. The Project therefore plans to conduct a half day workshop, in the next quarterly period, to discuss and demonstrate the use of these books and materials to the teachers.

4. Services in Child Care Agencies

4.1. Interventions in Children's Institutions for Care and Protection

a) Individual Interventions

During this quarterly, the project continued to provide individual services in child care institutions. A total of 41 children were provided with detailed assessments and first-level inputs, including referral to tertiary care facilities/ NIMHANS, as required. Amongst these children, 44 child psychiatric problems were identified[8], 27% (12) of which were emotional problems or internalizing disorders and 48% (21) were behaviour problems or externalizing disorders. Despite this categorization (which is more for convenience), for children in institutions, most behaviour problems actually have a strong emotional basis, also related to their difficult and traumatic experiences in the home/family context. *(Refer to tables 6(a), (b), (c), (d) below).*

[8] A given child may have more than one problem.

Thus, to respond to behaviour problems in child care institutions, the Project team usually adopts a more emotionally-corrective approach over a strongly behaviour management approach. First, much time is spent allowing children to express their emotions and experiences, which are then validated or legitimized, followed by providing the much-needed reassurance. Behavioural methods, are of course useful but at a later stage; particularly in the form of cognitive behaviour therapy (CBT) techniques, such as relaxation techniques, anger/ anxiety control techniques, perspective-taking to help address the consequences (both emotions and behaviours) of the difficult or traumatic experiences for which we do not believe in the use of CBT i.e. although practitioners use CBT techniques in trauma work, from our experience in working with children, we feel that psychodynamic approaches are more appropriate for this (except for relaxation techniques that are borrowed from CBT work, in the initial stages of trauma work).

Table 6(a): Total No. of (New) Consultations Disaggregated by Age & Sex, in Children's Institutions for Care and Protection July- September 2015

Age Groups	No. of Children						
	July		August		September		Total
	Male	Female	Male	Female	Male	Female	
6 to 12 yrs	2	1	0	1	2	4	**10**
13 to 17 yrs	13	1	7	0	7	3	**31**
Sub-Total	**15**	**2**	**7**	**1**	**9**	**7**	
Total	**17**		**8**		**16**		**41**

Table 6(b): Child & Adolescent Disorders Identified in Children's Institutions in Care and Protection, July- September 2015

Child & Adolescent Mental Health Problems/ Disorders		**No. of Cases**			
		July	**August**	**September**	**Total**
Emotional Problems	Dissociative/Somatic	0	0	1	1
	Bed Wetting	0	0	1	1
	Other Anxiety Issues (incl. separation anxiety)	0	0	3	3
	Dysphoria/Depression/Adjustment Disorder	1	1	2	4
	Self-Harm Behaviours	2	1		3
Sub-Total		**3**	**2**	**7**	**12 (27%)**
Behaviour Problems	Oppositional Defiant Disorder	0	0	1	1
	Conduct Symptoms : Anger/Aggression	0	0	3	3
	Conduct Disorder Symptoms: (Lying and Stealing)	0	0	1	1
	Conduct Disorder	1	2	0	3
	Runway Behaviour*	7	4	0	11
	Attention Deficit Hyperactivity Disorder	1	0	0	1
	Substance Abuse	1	0	0	1
Sub-Total		**10**	**6**	**5**	**21 (48%)**
Learning Issues	Other Learning Problems	0	0	1	1
Sub-Total		**0**	**0**	**1**	**1 (2%)**
Developmental Disability	Intellectual Disability	3	1	3	7
Sub-Total		**3**	**1**	**3**	**7**
Other Issues, incl. serious mental health	Life Skill Issues(sexuality, bullying etc)	3	1	1	5
	Other Health/Medical Problems	0	1	0	1
	Psychotic Symptoms	0	0	1	1

issues and life skills issues	Mood Disorder	1	1	1	3
Sub-Total		**4**	**3**	**3**	**10 (23%)**
Total		**17**	**11**	**16**	**44**

*Includes many children from the government boys home who have run away from home due to various difficulties and problems with families.

Table 6(c): Psychosocial Contexts of Emotional/ Behavioural Disorders

Psychosocial Context	No. of Contexts			Total
	July	August	September	
Single Parents/Abandoned	2	2	8	12
Marital Conflict/Domestic Violence	5	2	4	11
Physical Abuse	5	1	5	11
Emotional Abuse	0	0	2	2
Child Sexual Abuse	1	0	0	1
Rescued from Trafficking (incl. Child Labour)	0	0	2	2
Loss & Grief (Death of Parents and/or other Attachment Figures)	2	0	1	3
Alcohol dependency in parents	0	2	3	5
Parent with mental illness/ disability	0	0	1	1
Conflict with law	0	0	1	1

Table 6(d): Referrals to Tertiary Care Mental Healthcare Facility in July, August and September 2015

		Causes of Referral*			
Child & Adolescent Mental Health Issues		July	August	September	Total
	Encopresis/ Eneuresis			1	1
Emotional Problems	Dysphoria/Depression/Adjustment Disorder	0	0	1	1
Sub-Total		**0**	**0**	**1**	**2**
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	0	0	2	2
	Runway Behaviour	2	1	0	3
	Self-Harm Behaviour	1	1	0	2
	Substance Abuse	1	0	0	1
Sub-Total		**4**	**2**	**1**	**8**
Other Problems (including medical issues and serious mental illness)	Other Health/Medical Problems	0	1	0	1
	Mood Disorder	1	2	0	3
	Psychotic symptoms	1	0	1	2
	Life Skills	1	0	0	1
Sub-Total		**3**	**3**	**1**	**7**
Total		**7**	**5**	**3**	**17**

*The table shows causes of referral which is important from a clinical point of view. 9 children were referred, with each having more than one mental health issue.

Further, it is critical to recognize that a majority of institutionalized children's problems stem from attachment issues and neglect. The families and home environments of these children are frequently fraught with marital problems, domestic violence, alcohol dependence or due to single-parenting and lack of time on the part of the parent to care for the child (usually due to financial problems and the need to work long hours outside the home). Therefore, from an early age,

children may have had experiences of neglect, emotional and physical abuse. In other words, the kind of attachment needs a child has i.e. frequent and timely response from caregivers with regard to food, shelter, healthcare and other survival needs as well as emotional needs of love, security and encouragement/ appreciation, have often not been met even during infancy and early childhood.

As a result, the child's early experiences of the world, represented by his/her caregiver are at best, inadequate and at worst, hostile; and so the child's emotional regulation mechanisms are already somewhat dysfunctional, for, a child learns appropriate emotional regulation i.e. the ability and skills to control anger, fear and sadness through responses (usually of love, caring, soothing and reassurance) provided by his/ her caregiver, from babyhood. As these children then continue to grow in these difficult home environments, the mistrust and anxieties are exacerbated by the often difficult, sometimes violent and always unpredictable nature of the home environment—and this worsens their abilities to control and manage difficult emotions. And in later years, when the child comes to the institution, the attachment with the family (whatever the quality of attachment) is severed by physical separation, which may occur in various ways (such as rejection, abandonment, or relinquishment to an institution), the child's anger, resentment and sadness further worsen the already compromised emotional regulation mechanisms.

Multiple changes in institution and changes in care givers due to staff turn-over within these institutions also contribute hugely to children's destabilizing experiences and do not allow them to easily find suitable (substitute) attachment figures as they move through life. The continued lack of stability and predictability in these children's lives serve to maintain their already poor emotional regulation mechanisms.

Finally, there is considerable evidence to suggest that adverse early-life experiences have a profound effect on the developing brain. Neurobiological changes that occur in response to problematic early-life stress can lead to life-long psychiatric issues. Children who are exposed to sexual or physical abuse or the death of a parent are at higher risk for development of depressive and anxiety disorders later in life. Preclinical and clinical studies have shown that repeated early-life stress leads to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress. Clearly, exposure to early-life stressors leads to neurobiological changes that increase the risk of psychopathology in both children and adults[9].

Given that children in institutions have a pre-existing vulnerabilities due to psychosocial events that have led to neurobiological issues, all of which cause them to have poor emotional regulation mechanisms, of which difficult behaviours are a consequence, the paternalistic response of institution staff to problem behaviours is thus often not appropriate or helpful. For instance, the Project team has observed that there is an attitude, also articulated to children, of 'how we have provided you with everything…and you still behave like this'. Inherent in this is an expectation of gratitude and also the implication that: i) children do not actually have the right to access survival needs; ii) that the provision or rather the conferring of these rights are therefore conditional i.e. upon their 'good' behaviour. This attitude is also discriminatory in that it reflects that children in institutions do not enjoy the same rights as those living with their families with regard to survival

[9] Nemeroff CB (2004). Neurobiological consequences of childhood trauma. J Clin Psychiatry. 2004;65 Suppl 1:18-28.

needs—for, the latter are not obligated to express gratitude and behave well (at least not on a continuous basis) in order to avail of care and survival needs.

When children's problems have been discussed with staff, in order to help them understand their predicament and how their behaviours are consequences of their past/ current experiences, staff have also been known to magnanimously say (to the child) 'even if you have nobody else, we accept you, so you should be happy now.' While this may be said with good intent, it is not helpful to children, who require validation of their difficult experiences and their feelings of fear, rejection, isolation, sadness as the case may be. The expectation that children 'should be happy' just because they have apparently been 'removed' from their homes/ hostile environments, is a completely unreasonable one. Inherent in this expectation (and in such statements) is the idea that: i) children should hold the same view as the staff and therefore recognize 'what is good for them' i.e. forget about a family that was largely problematic; ii) children should wipe out the past and be unaffected by past experiences i.e. flip the memory switch in order to be able to forget; iii) they should magically adjust in the new environment, because after all, it offers everything by way of survival needs and also offers better facilities than what they were accustomed to at home.

What is missing in the above described responses and understanding of child care service providers and staff is: i) the recognition that children's past experiences will continue to affect them and that in fact, they can probably never be forgotten; but if acknowledged and discussed/ processed, they can certainly learn to adopt a different, more helpful perspective on them; ii) the understanding that children's identities (as indeed everyone's!) are defined by their families i.e. who they are is also about where they come from, so asking them to disregard their past/ problematic families and seamlessly adopt the culture and way of life in the institution is akin to asking them to disregard the roots of their identity—this creates a dissonance in their minds about where they belong, to whom they belong (all of which they already worry about since leaving home) and what will happen to them in the future.

In the light of the above, the Project team has requested institution staff to incorporate a few simple but specific things in their communication with children, at least to make a start: i) to attempt to understand the emotion behind the behaviour (and indeed the psychosocial events and experiences that lie behind the thoughts and emotions that then cause the behaviour) rather than merely/ superficially focussing on the problem behaviour; ii) to then acknowledge/ legitimize/ validate the emotions of the child so that the child feels heard and valued; iii) to be non-judgemental in their communications with children.

b) Group Interventions

During this quarterly, the Project has reached 163 children through 17 group sessions held in 5 child care agencies. As described in the previous quarterly report, life skills modules have been developed to address issues on emotional development, sex and sexuality, motivation, gender and violence. The Project has started to roll out these sessions on a weekly basis, as per the availability of children in institutions (often a challenge as only Saturday afternoon is available for group work with children since they are at school the rest of the week). Table 6(e) below shows the session content for each institution/ group of children.

Table 6(e): Group Interventions Provided to Institutionalized Children, July to September 2015

Institution	Session Content	No. of Children	Age Group
Makkala Jeevodaya	Understanding & Expressing Anxiety	15	**6 to 12 years**
	Anxiety management	15	
	Anxiety and Identity	15	
	Anger Management	15	
	Story-Telling		
Total No. of Children Reached		**15**	
Total No. of Sessions		**5**	
APSA	Rapport Building	17	**13 to 16 years**
	Identifying and Reporting Feelings	17	
	Talking about difficult and Traumatic Experiences	17	
	Dealing with Traumatic Memories	17	
	Further Reflections on Trauma; Trust Building	17	
Total No. of Children Reached		**17**	
Total No. of Sessions		**5**	
Government Boys' Home	Rapport Building	25	
	Identity	22	
	Trust	25	
	Anger	21	
Total No. of Children Reached		**93**	
Total No. of Sessions		**4**	
Vijayanagar School Residential Facility	Building rapport	19	**6 to 13 years**
	Building rapport; Team participation	23	
	Team participation	22	
Total No. of Children Reached		**23**	
Total No. of Sessions		**3**	
Navajeevana Rainbow School	Rapport Building		
Total No. of Children Reached		**15**	
Total No. of Sessions		**1**	
Grand Total No. of Children Reached		**163**	
Grand Total No. of Sessions		**17**	

Some of our observations from the group work sessions are:

i) Many children erstwhile silent and withdrawn have opened up in group activities; over time, they have been observed to be active participants in the group sessions. One reason for this may be that they have greater opportunity now to express themselves.

ii) Children appear to be reflective about the issues and activities discussed even after the group session is over. One instance of this is when following the session on trauma issues, some children were upset days after the session was conducted. Upon hearing this from the staff, the Project team returned to the agency to conduct an 'emergency' session to enable further processing and perspective-taking on difficult issues, including doing some trust-building activities to help children feel more supported as they processed their difficult feelings.

iii) The groups have provided opportunities for identification of children with needs for individual/ depth work and assistance. (Not all children with individual assistance needs are identified by staff of the institutions).

iv) Group sessions have provided insights into social and peer networks of the children, and how these function within the institution. There are various types of group dynamics such as old inmates versus new comers, and groupism and these dynamics are expressed in various ways. For instance, it is observed in the Government Boys' Home that boys communicate groupism and related dynamics through physical abuse and violence and taking away property (especially that of a new comer amongst them). Indeed the boys acknowledge that 'this is how we communicate'. However, girls, as observed in APSA, have more subtle ways of communicating such dynamics, largely through saying hurtful or insulting things to one another during group sessions or by ganging up with an agreement to simply exclude a particular person/ girl, a directive generally issued by the 'leader', and to be followed by others. That said, it is also observed that children develop some very strong peer networks within the institution: these are very specific in nature, with deep and protective friendships—so much so that in such a close dyad, if the staff reprimands one child, the other may be upset. Such observations provide insights into children's social and emotional worlds i.e. where their responses and behaviours are drawn from.

Given that their peer networks are the only attachment relationships that children struggle to establish, they are indeed all-important to children—for whom, if these networks collapses, the 'world collapses'. This is also evidenced by the fact that in institutions where there is a policy for children to move from one branch/ home to another when a certain age is reached, children are reluctant to do so as they do not wish to leave behind their friend(s); at such times, many children have threatened self-harm and suicide to force the institution to let them stay where they are.

v) Issues emerging from more depth understanding of children through group work are also enabling the Project to address additional and more varied concerns of institutionalized children and to develop methods and materials accordingly. For instance, it is observed (and reported) that most children are 'highly sensitive' to any mention or reference to their families; they tend to react violently if other children were to say (even relatively harmless) things about their family. Consequently, this issue creates many conflicts amongst children within the institution, and is therefore often used by some children then whey purposely want to hurt or insult someone else, knowing that it will provoke them into retaliating. The Project plans to run some sessions on issues relating to family including: what constitutes a family/ is it only biological/ what about the social and geographic family/ feelings of belonging…do they come only from a biological family.

vi) Some of the emerging themes addressed by the Project activities are also unique to the type of institution. For instance, the government boys' home is a transitional shelter where many children come to it because they ran away from (difficult circumstances at) home, or were rescued from child labour and trafficking. While children may be trafficked for labour with the knowledge and complicity of their families, they often find themselves in situations of extreme geographical dislocation. Poor living arrangements, tough working conditions and abuse often compels them to run away from the intended location of trafficking. In many instances, this leads to a cycle of several more personal attempts at relocation, work and run away behaviours. Thus, trafficking for child labour is often variation of the runaway story. Running away is therefore a critical theme in group work sessions held at this home—reasons for running away, developing alternatives to running away, the desire to return home but the unchanged circumstances of home and so on.

From the Field Worker's Diary…

Name of the Institution: Government Boys Home **Date**: 13 September, 2015

Group Composition:

- 22 boys in a transitional home
- 12 years to 16 years

Objectives:

- Rapport Building
- Identity

Methods:

- Conversation
- Game

Materials:

- None

Process:

Session introduction: The children sat in a circle. They had to be calm and absolutely still for a slow count of 20. I asked them if they would like to play a new game with me and that later, if they so wanted we would sit in the circle and talk.

Activity1 – The children selected different spots for themselves inside the demarcated space. Each child was asked to consider the particular floor tile he was standing on to be his personal space. At the word 'go' they had to start spot running, but were not to allow their feet to step out of their own tile space. At the word 'stop' they had to be still. Now, at the word 'walk' they had to move around, walk in any direction and stop wherever they were at the word 'stop'. Now this new tile was their own space and they had to do the running now within the boundaries of this tile. The rules – They had to control their movement so that they stay within their own tile space and more importantly, not step into anyone else's tile. While walking they had to take care not to touch anyone else in any way.

Activity 2 – We all sat in a circle. I asked them if they would like to tell me something about themselves and I would tell them something about myself. Each could decide for himself what they would like to share and in case there was anyone who didn't want to say anything, it was perfectly acceptable. I started by telling them about my theatre activities. Then, turn by turn each boy related something about himself. All participated. While one spoke, I helped the rest to remain quiet and give attention to the speaker. After this round, I started the next round. This time I asked them to say any one thing that was 'good' in each and one thing that was 'bad'. I spoke about myself first. There were very few participants in this round. The session ended with many of the boys expressing their feeling that it was 'unfair' that they were caught and were being kept in the home.

Observations:

The children are largely convinced that they are being held unfairly. Almost all of them find it impossible to attribute anything 'good' to themselves. They are intolerant with each other and the quieter ones face constant bullying from the others.

Conclusion:

The children probably could be engaged in an information disseminating discussion about the circumstances of their being apprehended and the protocol that governs their release. Activities that bring in elements of mutual belonging and trust may be tried to generate mutual tolerance within the group.

Name of the Institution: Government Boys Home **Date**: 28 September, 2015

Group Composition:

- 22 boys in a transitional home
- 12 years to 16 years

Objectives:

- Mutual Cooperation

Methods:

- Conversation
- Story-telling
- Game

Materials:

- None

Process:

Session introduction: The children sat in a circle. They had to be calm and absolutely still for a slow count of 20. I asked about some of the children who were supposed to have left. After a conversation about the procedures involved in their release from the home, the children wanted a story.

Activity 1 – The children sat in a circle. I told them a story about a man who had 5 sons and the boys fought amongst themselves all the time. One day the man gave them a stick each and said that they would have to use the sticks to perform the chores their mother gave them but to ensure that the sticks didn't break. Whoever let that happen would get nothing of the father's property. The boys didn't take him seriously but soon they realised that all the sticks had broken. They asked their father for a second chance and this time decided to use the sticks all tied together so that it would be strong and wouldn't break. After the story we discussed some aspects of cooperation, mutual help etc.

Activity 2 – We played the game, 'vish aur amrit'. One child was chosen as the 'den'. As the group scattered and ran around, the 'den' had to chase and catch any one and shout 'vish'. The child caught had to sit down and wait for anyone else from the group to tag him/her and shout 'amrit'. Then he/she would get a new lease and could resume running. The rules – They had to tap gently on the back of the child they caught.

The session ended with the children talking about the problems they faced in the Home.

Observations:

The children seem to be giving some thought to their home and family situations. Some of them referred to their need to come up with viable alternatives to cope with the difficulties once they finally return home. The pre-occupation with returning home still remains a major concern.

Conclusion:

The children are attentive to stories. Thus stories around the themes of escape, challenges of difficult family situations, trust and cooperation etc might help the boys to come up with alternative solutions to the problematic situations in their lives.

Name of the Institution: Vijayanagar School/ Hostel **Date**: 2o September, 2015

Group Composition:

- 23 children of migrant labour
- Mixed Gender
- 5 years to 14 years

Objectives:

- Rapport Building
- Team participation

Methods:

- Story-telling
- Team games

Materials:

- None

Process:

Session Introduction - The children were asked to sit in a circle. I asked them if they remembered my name. Most of them did. I called out the names I remembered and apologised for not remembering all. They were amused and agreed to tell me their names. I asked them to share what all they had been doing through the week. I told them about what all I had been doing also.

Activity 1 - I asked them if they liked to listen to stories. They asked me to tell the story. Some of them said they were hungry. I told them they could get their plates and sit around me for the story. I narrated the story of 'The Thirsty Crow'. Some of them knew it and I asked them to participate in the narration. After the story narration, we talked about how clever the crow was and what else he could have done.

Activity 2 – The children were asked to stand in a large circle. All raise their hands one by one, lift their legs and shake them to a fast count of 5, 4 3, 2 and 1. The children have to call out the numbers loudly and are required to begin and end the activity together. Then the children were asked to make two queues. One child, for each queue, stood at one end of the room facing the queues. They kept their hands held out. On the word go, the first child in the queue had to run up to the team-mate waiting with the hands held out, gently touch the palms and take his place, while the child who had been waiting till then, would run back and join the end of the queue. The moment the children at the waiting position had exchanged places, the child now at the head of the queue would run up and so on till all children had had a turn at being in the waiting position. The rules – the touch had to be gentle, the child at the head of the queue couldn't move the waiting position was occupied, the child running back to join the queue had to join at the end of the queue.

Observations:

Most of the children showed a lot of interest in listening to the story. Their attention is diverted very easily. They are unwilling to adhere to any group behaviour norms and they expect to be disciplined harshly by the adult. Their comment, "We don't listen unless we are beaten." They remain preoccupied protecting personal possessions like marbles, plastic toys etc because each is on the lookout to pick up anything that belongs to anyone. This leads to skirmishes and fights.

Conclusion:

Story-telling can be explored wherein stories based on themes of friendship, mutual help, trust and ownership could be used to introduce these concepts and study how the children respond. Games and activities that involve group collaboration can be used to help the children build dependency on each other and develop a sense of belonging.

Name of the Institution: Vijayanagar School/ Hostel **: Date**: 28 September, 2015

Group Composition:

- 22 children of migrant labour
- Mixed Gender
- 5 years to 14 years

Objectives:

- Team participation

Methods:

- Word games

Materials:

- Chalk and Board

Process:

Session Introduction - The children were asked to sit in a circle. They wanted to know whether the car I had come in was mine. They asked me about my work. I told them and then asked them what they would like to tell me. They wanted to tell me the spellings of their names in English. So turn by turn they spelt out their names and I called out the name as it was spelt. Then they tried to spell my name and some of them could. We then tried to spell the names of the two ladies who live there to look after the children.

Activity 1 - I asked them if they would like to play word games. They were interested. I demonstrated the game. All the children sat in a large circle. I ran around them and gently patted one child. The chosen child was given a letter of the English alphabet. He had to quickly say a word that began with the given letter. I sat in his place and now he ran around and had to choose a child by gently patting him/her on the back. Anyone from the group had to then give that child a letter. Everyone clapped when the word was given.

Activity 2 – The children are divided into 2 groups. I would write a word on the board with a letter missing, for eg, f_n. Turn by turn the teams had to come up with the missing letter and read out the complete word. Everyone clapped for correct responses. I used 3 letter and 4 letter words. The teams had to respect each others' turn. Any response given out of turn would result in that team losing a point. If a child gave an incorrect answer, the team members could correct it. No one could be blamed for an incorrect answer.

Observations:

The children were engaged with the idea of testing their word skills. They found a way of remaining quiet when it wasn't their turn. They reminded each other to be quiet and over the course of the game, instead of slapping they started using gestures like zipping the lips, to get their team mates to be remain quiet. 3 children displayed excellent word skills. All the children were eager to participate.

Conclusion

Team games built around the use of letters and words might be used to develop a sense of belonging within the group. Gentle yet firm rules regarding communication within the group are useful.

4.2. Interventions in HIV/AIDS Infected and Affected Children's Institutions

a) Individual Interventions

During this quarterly, 27 children from 3 child care institutions serving HIV infected/ affected children were assessed and provided with assistance, some with first level inputs to be followed up by staff and others with in-depth support and counselling provided by KHPT staff seconded to the Project. 29 child and adolescent mental health issues were identified in this group of children, of which 8 (nearly 28%) were emotional problems and 16 (nearly 56%) were behaviour problems. As mentioned earlier, the basis on most behaviour problems were also emotional issues. (See Tables 7(a), (b) and (c) for details).

Many of the issues noted for children in institutions in the previous sub-section hold good for HIV infected and affected children, who also come from difficult and traumatic home and family circumstances. The fact of HIV/AIDs and how it impacts/is experienced by the child is a compounding variable. Most children assisted during this quarterly were HIV infected (and therefore also affected) except for a small group who were affected but not infected. Traditional approaches to infected children tends to focus, and understandably so, on basic health, nutrition and ART as indicated, including treatment compliance, and placement for those who are not living in the community. It is only recently that the domain has begun to acknowledge advocacy rights of this group (stigma and discrimination as evidenced by refusal for school admission etc) as well as critical psychosocial issues of mortality, sexuality, loss and grief, and uncertainty about the future. Though this acknowledgement is present, in our interactions with HIV child care institutions, it does not translate into actual psychosocial interventions. In fact, the effort of the Project has been to initiate large-scale sensitization to psychosocial issues as well as training programs in counselling, for care providers. In this quarterly, such training programs have already been initiated (as described elsewhere in this report).

A significant finding from our records in this quarterly is that while children have a range of emotional and behaviour problems, i.e. internalizing and externalizing issues, just like other institutionalized children, in HIV infected/ affected children, the psychosocial contexts these problems is pre-dominantly that of loss and grief due to death and loss of attachment figures. As noted in the previous section, where the psychosocial contexts of institutionalized children range from various forms of abuse, parental marital issues and domestic violence, in HIV infected/ affected children, about 80% of the contextual problems related solely to loss and grief trauma. *(See tables 7(a), (b) and (c) below)*. This is a critical issue to address in staff training as the current capacities do not include skills in trauma work.

Table 7(a): Total No. of (New) Consultations Disaggregated by Age & Sex, July to September2015

Age Groups	No. of Children		Total
	Male	Female	
6 to 12 yrs	2	8	10
13 to 18 yrs	3	14	17
Total	**5**	**22**	**27**

Table 7(b): Child & Adolescent Disorders Identified, July to September2015

Child & Adolescent Mental Health Issues		No. of Children
Emotional Problems	Other Anxiety Issues	6
	Dysphoria/Depression/Adjustment Disorder	1
	Post-Traumatic Stress Disorder	1
Sub-Total		**8 (28%)**
Behavioral Issues	Conduct Symptoms : Anger/ Aggression	13
	Conduct Disorder Symptoms: (Lying and Stealing)	2
	Runaway Behaviour	1
Sub-Total		**16 (56%)**
Developmental Disabilities	Intellectual Disability	1
Sub-Total		**1**
Other Issues	Life Skill Issues(Sexuality and others)	4
Sub -Total		**4 (16%)**
Total		**29**

Table 7(c): Psychosocial Context Identified, July to September2015

Psychosocial Context	No. of Contexts
Child Sexual Abuse	2
Emotional Abuse	1
Loss & Grief (Death of Parents and/or other Attachment Figures)	19
Stigma and Discrimination	2
Single Parents/Abandoned	1

Table 7(d): Referrals to Tertiary Care Mental Healthcare Facility in July, August and September 2015

Child & Adolescent Mental Health Issues		Causes for Referral
Emotional Problems	Other Anxiety Issues	1
	Dysphoria/Depression/Adjustment Disorder	1
Sub-Total		2
Behavioral Issues	Conduct Symptoms : Anger/ Aggression	1
	Attention Deficit Hyperactivity Disorder	2
Sub-Total		3
Total		**5**

b) Group Interventions

In the 2 of the institutions where individual services were provided, group sessions were also initiated with HIV-infected/ affected children, mainly adolescents, as institution staff reported this group to be particularly 'difficult to handle'. *(See table 7(d) below).* Some of the common 'adolescent problems' were reported to be anger, oppositional behaviour and sex and sexuality related issues.

Table 7 (d): Group Interventions with HIV/AIDS Infected and Affected Children

Institution	**No. of Children**	**No. of Groups**	**No. of Sessions**
Snehagram	51 (girls and boys)	6 (3 boys' and 3 girls' groups)	51
Infant Jesus	20 (girls)	1 (girls' group)	6
Total	**71**	**7**	**57**

These children because of their developmental circumstances have lacked the kind of opportunities that other children have for acquisition of 'knowledge' through education, family conversations and processed experiences (of day-to-day lives, television images etc). Thus, they require process-based methodologies that allow them scope and opportunity for reflection that hitherto not been available to them. It also helps for these to be group methodologies as it allows for both solidarity through shared common experiences and learning from different perspectives. These process-based approaches are derived from the life skills model with one major difference. Conventionally, life skills methods follow general skill development based on the ten WHO life skills; however, there is a strategic triangulation between life skills, context and pedagogies. The sessions conducted with HIV infected/ affected children used predominantly experiential pedagogies with significant amounts of process discussions. They also addressed the needs of these children through contextual specificities—for example: loss and grief, anxieties and anger about illness, stigma and discrimination and decisions about sexual behaviour. *(See below for the content of the sessions).* Thus, it was the lived experiences of these children that were addressed.

Effects of Individual and Group Psychosocial Interventions at Snehagram

Adolescents' Feedback:

- They began to think more deeply about their own life.
- Became aware of some of the areas they need to make changes and grow.
- Understand and collaborate with the group better.
- Sharing of negative and painful experiences gave relief to a great extend.
- Gained confidence

Observations of Institutional staff:

- Shouting and fighting among children have come down.
- Some children who were gloomy has started smiling and having friends

Observations by Therapist/ Facilitator:

- After the group sessions children realized the need to work on some of their issues like anger, loss and grief, sexual abuse, thus developing insight on their problems, following which they came forward asking for assistance.
- More than 50% children seen in individual sessions showed signs of improvement in their behavior especially through anger control and improved peer communications.

Sessions Conducted in Snehagram, Krishnagiri	**Sessions Conducted in Infant Jesus, Bangalore**
Getting To Know each other	Getting To Know each other
Feelings wheel	Feelings wheel
talking about difficult &Traumatic experiences	Talking about difficult &Traumatic experiences
Dealing with traumatic memories	
when I get angry	
analysing anger	
Being Assertive	
Good Health: Needs and Pleasures	
Attraction and Love	
Maintaining Privacy and Boundaries	

4.3. Interventions in Agencies Serving Children with Disability

During this quarterly, the Project initiated work in another category of child care agencies, namely those working with children with disability. These agencies are residential and/or non-residential, providing basic care and/or special education and services to children with multiple disabilities. Through our work with three agencies, it is found that agencies have a purely disability-rehabilitation focussed approach to disabled children i.e. focussing on their disabilities and deficits particularly in relation to skills for activities for daily living through loco-motor and (some) cognitive development activities. Undoubtedly, it important to focus on these areas of deficit/ development, but it is also critical, to work on disabled children's social and emotional abilities and skills. Indeed, a rights-based approach entails viewing the child as a person versus a set of disabilities, and therefore addressing issues of identity and personhood are critical to child disability work.

Consequently, we find that care givers, special educators and therapists working with disabled children require skills and inputs therefore, on how to take life skills approaches to children with disability, enabling these children to also evolve as social and emotional beings with self-esteem and self-confidence predicated on a strong concept of self-identity rather than isolated aspects of personality (as is being currently done in many settings). This section first describes the basis of our work i.e. initial observations and discussions with agency staff; experimentation with various types of activities, as might be suitable in each agency, for different groups of children, are on-going.

Nirmala Shishu Bhavan:

- While the high functioning/ normal IQ children have good speech and communication skills in general, they have difficulty expressing their emotions (fears and worries); some tend to be exceedingly shy—they have social skills deficits due to complete lack of exposure to the world outside. The only people who visit the institution are donors/ charitable agencies—who view/ interact with children as 'victims of disability' and adopt attitudes of pity, that seemed to have disempowered the children further—leading them to believe more strongly that they are 'weak' or 'cannot do things'.
- Some of the children have also developed severe social anxiety. While the caregivers are extremely loving and sensitive, they are also very over-protective, frequently concerned that children will be hurt themselves or 'not manage.' Children seemed to have internalized the fears and concerns of caregivers as well, and they tend to reflect the anxiety and protective responses of caregivers. It is observed that caregivers responses to children's anxieties are: either to laugh it off and tease them (gently) about it; or be over-protective and feed into children's fears, agreeing with them. There is no attempt to engage children in a constructive discussion about their fears and how they can overcome them/ reassure them that world is safe place for them to explore.
- While the plan is to use creative methods (as is being done) to work on children's socio-emotional issues, some cognitive work is also necessitated. This is because, despite not having IDD, children with locomotor disabilities are lacking in social exposure; this lack of social exposure limits their development of cognitive skills. Thus, due to somewhat compromised cognitive skills, children also find it difficult to process or express emotional experiences/ content whether in stories or pertaining to their lives.

Dharitree Trust

- The two groups, with different levels of cognitive functioning (one higher and the other lower) within themselves have children with multiple disabilities.
- An assessment was also done on language comprehension and pragmatics with these groups of children. The assessment included questions based on whether the child is able to name and label things, whether the child is able to greet, make requests, answer questions and if turn taking was present. As expected, it was found that the higher functioning group were at a higher level in performing compared to the lower functioning group.
- It has been especially challenging to work with children with speech and hearing impairment. Some children with speech and hearing disabilities also have intellectual disabilities while others do not i.e. they have normal IQ. The ones who have normal IQ and are in the high functioning group have trouble with activities that entail a lot of description whereas if the activities are simplified, due to normal IQ levels, they find these too basic; the ones in the lower functioning group have difficulties because apart from their speech and hearing problems, they also have poor cognitive skills.
- It is also observed that other children are beginning to mimic those with speech and hearing problems, using actions to convey their needs/ thoughts even when they can speak.
- Overall, speech and language skills training appear to be a need for both high and low functioning groups. Even those who can speak have a tendency to do so in monosyllables, but when they are probed into they are able describe the whole event—and this indicates the potential to improve upon their conversational and social skills.

Association for People with Disability:

Integration of Disabled Children into Anganwadis: Schemes such as RTE and Sarva Shiksha Abhayan are already in place at the school level, but inclusive education is not practised in anganwadis, which is where it should start. As per APD's mandate, implementation of this model entails a comprehensive plan to provide community-based preventive, and curative care for disabled children through direct service delivery. It is essential to implement a system at anganwadi level to ensure that all children, those with and those without disability receive early stimulation. APD has been working actively in the community and has been successful in enrolling disabled students into anganwadis. However, during the course of the NIMHANS project visits, it was observed that the "integration" of these children is not happening owing to the fact that, once enrolled, most of these children are not attending the anganwadis at all. Upon delving deeper into the matter, we discovered that the reasons were varied, ranging from the teachers who are hesitant to take them on because they feel they lack the required expertise to manage such children, to the parents of the children who are concerned that the child may find it difficult to fit in or not receive the individual attention and care the child requires.

Children with disability require more intensive stimulation in order to enable them to achieve age-appropriate development to the best of their abilities; other/ 'normal' children require adequate early stimulation interventions in order to prevent them from acquiring developmental delays and disabilities (that result from under-stimulation). Further, the anganwadis provide an excellent opportunity for early identification of children with disability, so that they can be referred for appropriate assistance sooner. Thus, one part of the Project's work is assisting APD with integration of disabled children into anganwadis.

Screening and Early Identification of Disabled Children in the Community through Primary Healthcare System

As part of APD's community-based program of early identification and referral of children with disability, they reach out to PHCs on immunization days to screen young children for disability. A lot of their screening/ identification was heavily focussed on locomotor disabilities. Thus, the Project will input into their screening proformas to ensure that children are screened for disabilities in the five key areas of child development, namely physical/ social/cognitive/emotional/ speech & language domains so their screening tools will be more sensitive and specific in identifying children with disability.

Working with Disabled School Children

In addition to the early intervention services, APD also runs a school for children with multiple disabilities, namely locomotor, speech and hearing and mild intellectual disabilities. Children with disability (whether intellectual or locomotor or sensory or multiple), are at risk of compromised exposure to compared to normal/ non-disabled children. Thus, they start with possible deficits in socio-emotional development. Because their reporting capacities are often compromised (due to speech and language/ hearing deficits and/or intellectual disabilities), their distress often manifests as behaviour problems. On the other hand, behaviour problems are also a medium of expression and communication and are often learnt as a pattern. In these children therefore, complex problems such as physical or sexual abuse are that much more difficult to evaluate and address, for all the above reasons stated. Staff or special education teachers may have skills in the specific domains of deficit but not in addressing emotional and behaviour problems. The approach to emotional and behaviour problems in children with disability tends to be one of containment, using purely behavioural approaches—even this is not often done in a systematic or scientific manner. The Project services has initiated work in APD's school to provide first level assistance to children with emotional and behaviour problems, also providing inputs to teachers on the nature of various problems and how to handle them.

Table 8(a), (b) and (c) provide details on the work initiated in each of the three disability agencies targeted by the Project, including: how the children are grouped according to their (dis)abilities/ skills and/or age and the types of interventions planned/ implemented for each group and for the staff/ caregivers. Table 8 (d) shows our work with in a school run for children with multiple disabilities, wherein first level inputs and interventions were provided to address emotional and behaviour problems in children with disability.

Table 8 (a): Nirmala Shishu Bhavan: 16 sessions/ visits, July to September 2015

Groups	No. of Children	Age Range	Abilities	Disabilities/ Issues for Intervention	Intervention/ Plan
Group 1	4	8 to 15 years	- High Intellectual Functioning - Normal Speech	- Locomotor disability - High social anxiety - Difficulty with emotional expression	Social and emotional development interventions with a focus on identity formation, self-esteem building, development of social skills especially in public spaces (life skills activities and approaches to be used). These will be done through stories, art, role plays and other creative methods and visits/ exposure to public places (outside the home).
Group 2	7	- 2 to 5 years - 6 to 9 years	- Adequate locomotor abilities	- Speech & Language Problems - Intellectual Disability	Early stimulation activities in 5 domains of child development (physical/ speech & language/emotional/social/cognitive)—using pre-school activity book and early stimulation flip chart for ideas/ activities.
Group 3	8	0 to 12 months	Developmental delay		Early (sensory) stimulation activities

Table 8(b): Dharitree Trust Foundation (17 sessions, July to September 2015)

Groups	No. of Children	Age Range	Abilities	Disabilities/ Issues for Intervention	Intervention/ Plan
Group 1 (High Functioning group)	10	10 to 18 years	Basic comprehension and simple analysis of information presented (Higher levels of cognitive skills than group 2)	- Mild intellectual disability - Speech and Hearing issues - Locomotor Disability - Lack of emotional expression	Activities to develop i) speech and cognitive skills such as descriptive abilities and concepts; ii) social and emotional skills, by beginning with identification and reporting of feelings or emotions--through use of pictures ,stories/ narratives, art (lot of visual stimulation used).
Group 2 (Low Functioning Group)	10	8 to 15 years	Adequate speech and hearing	- Locomotor Disability - Mild to moderate intellectual disability - Expressive-communicative problems	Activities to encourage cognitive skills and communication/ expression skills followed by social and emotional skills at a later stage-- through use of pictures and stories)

Table 8 (c): Association for People with Disability: 15 visits/ sessions, July to September 2015

Groups	No. of Children	Age Range	Abilities/ Skills	Intervention/Plan
Early Intervention Centre	15	1-6 years	Multiple disabilities: - Locomotor disability - Intellectual Disability - Speech and Hearing Impaired	- Streamline the existing assessment tools and processes to establish current levels of development/ ability/ skill in each according to the five key domains of child development (physical/ social/ speech & language/emotional / cognitive development). - Based on systematic assessments, enable drafting of individual education plan (IEPs) with clear short-term and long-term goals to meet the developmental needs of the child, with regular monitoring. - Plan developmentally appropriate activities and materials to meet the goals as mentioned in the IEP. - Help the staff understand and implement classroom strategies such as structuring classroom resources and activities, behavior modification techniques, positive behavior supports/ reinforcement, communication for effective implementation of the activities planned for that day. - Sensitize and orient parents/caregivers to be partners in interventions for children with disability through: a) Involving parents in assessment and in planning individual programmes so that they better understand the goals of IEPs. b) Implementing home-based stimulation/ activities to continue teaching and assistance to developmentally disabled children at home. c) Use of low cost and locally available materials to work with children at home/ outside the centre. To draw a comprehensive early intervention model from implementation experiences as described above, so that APD and other agencies running early intervention programs for children with disability agencies can replicate the models and methods developed here.
Community Early Intervention Program	39 Anganwadi children; children in the PHC/community	0 to 6 years	Normal and Children with Multiple Disabilities	Objectives: i) To facilitate integration of disabled children into the anganwadis to further the agenda of inclusive education, starting with pre-school; ii) Enhance the existing screening and identification processes of APD community programs in the primary health centre (PHC); iii) To draw from implementation experiences (in anganwadis and PHCs) to develop a comprehensive model that may be replicated across APDs programs. Activities: - Training and capacity building of APD community services staff and Anganwadi workers on inclusive education in anganwadis incl. using basic screening tools to assess children and identify developmental delays and disabilities and help them to develop activities for disability focused early stimulation; and setting up objectives and planning activities tailored to the specific disability for individual children (IEPs) and developing classroom strategies to implement these in a larger group. - Support to APD's Screening and Identification Processes in PHCs through provision of screening tools and Systematization of data entry formats, including coding of developmental disorders/ disabilities.

Table 8(d) (i): Association for People with Disability: Child & Adolescent Disorders Identified, July-September 2015

Age Groups	No. of Children		Total
	Male	Female	
5 to 12 yrs	6	2	8
Total	**6**	**2**	**8**

Problems/ Disorders		No. of Cases
Emotional Problems	Other Anxiety Issues (incl. separation anxiety)	2
Sub-Total		**2**
Behaviour Problems	Conduct Symptoms : Anger/Aggression(Temper Tantrums)	1
	Attention Deficit Hyperactivity Disorder	3
Sub-Total		**4**
Developmental Disability	Intellectual Disability	2
	Speech and Hearing	2
	Speech Problem	2
Sub-Total		**6**
Other Issues, incl. serious mental health issues and life skills issues	Life Skill Issues(Bullying)	1
	Other Health/Medical Problems	1
Sub-Total		**2**
Total		**14**

Note: *The practice of referring children with additional/ more serious problems continues from all the field sites. However, the section on 'Referrals Received at Tertiary Care Facility' has been removed because: i) Families often do not come on the designated date of the appointment. Sometimes even agencies, due to their own logistical difficulties, bring the child even one or two months after referral and date of appointment have been agreed on. This became a challenge for record keeping; ii) There was an attempt to maintain a register of referrals in the Dept. of Child and Adolescent Psychiatry out-patient clinic. Due to the heavy service load, the clinicians and staff often missed updating the additional records (i.e. apart from the regular hospital data base) as required by the Project; iii) additionally, children are referred from field sites to facilities and services other than the Dept. of Child & Adolescent Psychiatry (such as the Depts. of Speech Pathology/ Neurology/ Rehabilitation); so, it was not possible to make demands of other departments to maintain records on behalf of the Project. For all these reasons, we have only presented the numbers of children referred from each type of field site (as documented in the report) but we do not have the exact number of children who actually availed of tertiary care at NIMHANS or elsewhere.*

5. Training and Capacity Building

5.1. Karnataka Health Promotion Trust (KHPT) Staff Secondment, June to September 2015

With a view to building KHPT's capacity to address psychosocial needs of children infected/affected by HIV, 2 staff were seconded to the Project for a period of 4 months (June to September 2015). Over this period, they underwent intensive classroom and field training in this project. Regular Classroom training has been provided to them (and indeed all project staff participate in in-house learning sessions) on issues such as child development basics, understanding signs and symptoms and intervention methods for internalizing and externalizing problems i.e. the basics of child psychiatry/ child psychiatric disorders and standard methods of

identification and intervention were taught to them. Issues particularly relevant to HIV/ AIDS work such as responding to trauma issues, namely loss, grief and abuse were also covered in theory sessions. Their practical training comprised of daily field visits to schools, anganwadis and child care institutions where they worked alongside the project staff to learn and execute assessments and age-appropriate individual and group activities. Finally, over the last two months of their secondment, the two staff visited 2 to 3 institutions working with HIV/ AIDS infected children, and under the continued guidance of the Project team, using Project materials and methods, provided individual and group (life skills) interventions to children. Their training is now completed and they have returned to KHPT, where they are specifically designated to provide direct support and capacity building services to children/ service providers/ institutions engaged with children infected and affected by HIV/AIDS, across many districts of Karnataka.

With this, the Project concludes its first experience of secondment and based on KHPT's feedback, we believe that it has been a successful one, providing the kind of depth learning in child mental health knowledge and skills, that the Project seeks to promote in child care service providers. Plans are underway for further secondment opportunities in response to requests from KHPT as well as other child care institutions.

5.2. Orientation for District Coordinators, OVC Program, Karnataka Health Promotion Trust (KHPT), July 2015

As part of the Orphan and Vulnerable Children Program, supported by USAID, KHPT requested the Project to conduct an awareness and orientation on the psychosocial care needs of HIV infected and affected children for 23 of KHPT's District Coordinators. The Project provided a detailed framework for working with children in the HIV context: starting with a child development framework and why it is important to understand age-appropriate developmental milestones, their relevance to HIV infected/ affected children who are often neuro-compromised and have developmental delays, the presentation moved on to highlighting common emotional and behaviour problems of children with HIV and how these relate to issues of illness and disclosure, experiences of loss, grief and trauma, stigma and discrimination, uncertainty about the future, and mortality concerns. The discussions generated considerable interest amongst the district coordinators, who were eager to learn more on this issue.

5.3. Parent Orientation, Government High School, Begur, August 2015

Following the school teacher symposium, one of the participant schools requested the Project to conduct an awareness program at Government High School, Begur for a group of 80 parents. The one-hour session covered a brief on various child mental health issues, including learning disabilities, intellectual disability, and common emotional and behavioral problems. The session also focused on contexts of emotional and behavioral issues--how family problems such as marital discord, death in family, alcoholism etc lead to the development of problems such as anxiety and anger, attention and concentration problems, school absenteeism. Inputs were also provided on the importance of parents spending quality time at home—asking children about what they did at school, how the day went will help parents understand their child better and know his/her difficulties at school and outside. The necessity to monitor child's activities in and out of school was emphasized in the light of how children are at risk of developing harmful behaviours such as substance abuse.

At the end, during question and answer time, parents had several questions focussing mainly on academics—namely, concentration problems, intellectual disability, poor academic performance, and lack of interest in studies. Information on alternative schooling (National Institute of Open Schooling), remedial education, disability certification were also provided.

5.4. Learning Symposiums for School & Anganwadi Teachers, NIMHANS, August 2015

A. "Kalikeya Kale" -- Symposium on Responding to Learning Needs and Concerns in School Children

As erstwhile mentioned, during the course of school counselling work, it was found that many children have learning difficulties in the areas of reading, writing and mathematics. The nature and reasons for this are varied:

i) There are children whose problems are due to specific learning disabilities (SLD);

ii) There are those whose learning issues arise from mild (to moderate) intellectual disabilities;

iii) Mild to moderate Attention Deficiency Hyperactive Disorder (ADHD) is common amongst school age children. Some children have a combination of ADHD and SLD while others have only ADHD. In the latter group, inattentiveness and hyperactivity result in hindering children from participating fully in learning processes, thereby creating a context of learning problems.

iv) Many children, due to their difficult home environments, suffer from severe under-stimulation and lack of educational inputs;

v) Children from migratory families have tended to start school late or had intermittent or interruptive schooling opportunities thereby affecting their basic foundations in language and math; these children have also had learning difficulties due to changes in the medium of instruction;

vi) Finally, there is a group of children whose learning difficulties have a basis in emotional problems—children with issues such as anxiety and depression tend to be pre-occupied with family/ social/ individual experiences that have caused these emotional issues; consequently, they are unable to concentrate on academics and participate in learning processes and/or are not motivated to study, thereby creating barriers for learning.

A 2-day symposium, 'Kalikeya Kale' was organized at NIMHANS, on 3rd and 4th August 2015, therefore, for teachers and headmasters from government schools, to help to enable them to them in assist children with special learning needs and concerns, by providing them with awareness on learning issues, including opportunities and techniques to aid their response on the same. *(See annex 5 for list of participants)*. More specifically, the objectives of the symposium were: a) to develop an understanding of learning issues through identification of the nature and type of learning difficulties and disabilities in school age children; b) to enable an awareness of skills, resources and provisions required to assist children with learning issues.

Session Content of 'Kalikeya Kale' School Symposium, August 3rd and 4th 2015

1.	An Introduction to Learning Issues in Children
2.	Assessment & Identification of Children with Learning Difficulties and Disabilities
3.	Classroom Remediation Techniques
4.	Setting Up Resource Rooms
5.	Special Provisions and Alternative Opportunities for Children with Learning Problems: (a) Alternate Schooling (incl. National Institute of Open Schooling) (b) Inclusive Education (c) Vocational Training Opportunities
6.	Management of Emotional and Behavioural Problems in Children with Learning Issues
7.	Working with Families of Children with Learning Difficulties: The Role of School Teachers

Although some sessions were conducted by faculty from Dept. of Child and Adolescent Psychiatry, NIMHANS, most were facilitated by individuals and agencies specializing in providing special education and remedial education services in the city of Bangalore. The aim was to draw professionals practising in the field, to share their methods and techniques with the government school teachers, so that the symposium would be strongly grounded in field reality.

A total of 160 teachers from 80 schools were invited to attend the symposium. Considerable time was spent by the Project obtaining permissions from Block Education Officers and visiting each target school twice to render the invitation and to explain in detail the purpose of the symposium. Despite these efforts, and somewhat disappointingly, only 57 schools (71%) were represented, with only 83 teachers (a little over 50%) participating in the symposium, as shown in Table 9(a). 21 child care institution staff also attended the symposium. In all, there were 104 participants at the symposium. *(Refer to Annex 2 for list of schools and child care agencies attending the symposium).*

Table 9(a): Participation of Schools and Teachers in Symposium, August 2015

Education Zone	No. of Schools Invited	No. of Schools Attendant	No. of Teachers Invited	No. of Teachers Attending
1	20	13	40	18
2	20	15	40	18
3	40	29	80	47
Sub-Total	80	57	160	83
Child Care Agencies	No. of Child Care Agencies Invited	No. of Child Care Agencies Attendant	No. of Staff Invited	No. of Staff Attending
	12	11	22	21

Why the participation was relatively low is somewhat unclear, considering i) The need for awareness and information on remedial education and methods to respond to children with learning difficulties (of whom there are many in government schools), was repeatedly voiced by the teachers, during the course of the Project's school mental health services; ii)The schools/ teachers had been consulted about possible/ convenient dates; iii) Extensive preparations were made by way of visits for invitations. Thus, one may only infer that the motivation levels of the school staff is relatively poor and despite their voicing of many concerns, even complaints about children's learning problems, they find it difficult to respond to/ engage in processes that seek to offer solutions for these problems.

Interestingly enough, it was observed that during the symposium, when the focus of discussion was on learning problems, teachers constantly raised issues of emotional and behaviour problems, claiming that these were the 'main problems'. But during the school services, they had frequently stated the contrary i.e. when project staff had tried to explain how emotional and behavioural problems were in many children the underlying cause of their learning difficulties, the teachers had refused to accept this view, insisting that the major problem was academics and learning! Therefore, while it is difficult to understand these mixed messages and contrary views expressed by school teachers, it does emerge that many of them attempt to 'dodge' the real issue/ children's problems and their role in addressing it. This was evident also in the preliminary work and assessments conducted at the start of the Project, to understand the needs and gaps in the skills of teachers.

That said about the majority of the participants in the symposium, it was heartening to note that there were 10 schools (out of the 57 that attended) that came forward after the symposium, requesting the Project's services in the following ways:
i) To provide mental health services for addressing emotional, behaviour, developmental and learning problems to the children in their schools;
ii) To provide technical support and guidance to enable schools to set up spaces and resources for remedial education so that they could develop in-house capacities to address the needs of children with learning problems.

This was a welcome and an unexpected outcome of the symposium and gave the Project a new direction, to address the need for remedial education in government schools in a manner different from the direct service approach (erstwhile described). The project readily committed to assisting these 10 schools in their objectives, strongly in support of the schools' interest and commitment to children with learning disabilities and difficulties.

In addition to government school teachers, some of the child care institutions that the Project has been supporting, including those working with disabled children, expressed a keen interest to attend the symposium. Thus, 21 child care agency staff from 12 institutions also attended the symposium. (Refer to Annex 2 for list of child care agencies participating in the symposium).

At the end of the symposium, a written feedback was obtained from all the participants on the content and usefulness of the symposium, mainly focussing on 3 key issues: i) new information they are taking back from the symposium; ii) Sessions they considered most useful; iii) Some techniques they would implement in their classrooms/schools. The feedback, obtained through open questions, is summarized in table 9(b) below.

Table 9(b): Feedback from 'Kalikeya Kale' Symposium Participants

Key Learning and Take Home from Symposium	**No. of Respondents (N=80)**
How to identify children with learning difficulties/ behavioral problems	44 (55%)
How to teach children with learning difficulties	41 (51%)
To have Patience with children , to provide special care support and encouragement to children with problems and a to provide a good positive environment for children to learn	35 (44%)
Inclusive education/remediation techniques	11 (13%)
Setting up Resource rooms	8 (10%)
Vocational training	7 (9%)
National Institute of Open Schooling	7 (9%)
How to work with families of children with learning difficulties	5 (6%)
To understand children better	3 (4%)
Management of adolescent children with special needs	2 (3%)
Most Useful Learning Sessions	**No. of Respondents (N=80)**
Assessment and identification of children with learning Difficulties and disabilities	63 (79%)
Management of emotional and behavioral problems in children with Learning difficulties and disabilities	57 (71%)
Vocational Training	33 (41%)
Working with families of children with learning difficulties and disabilities	32 (40%)
Alternate schooling NIOS	32 (40%)

Inclusive education	30 (38%)
Classroom remediation techniques	29 (36%)
Setting up resource rooms	19 (24%)
Techniques Participants will Implement at School/ Field Settings	**No. of Respondents (N=80)**
To understand child's issues (family issues, developmental, environmental factors) and provide necessary help/support	28 (35%)
Assessment and identification of children with learning difficulties/ behavioral /emotional problems and to provide help and support for the same	21 (26%)
To improve Classroom teaching techniques	15 (19%)
Working with families	10 (12%)
To include counseling techniques	10 (12%)
Resource room	9 (11%)
Positive reinforcement , and to concentrate on Overall Personality Development	6 (8%)
To use different methods in teaching	6 (8%)
Shadow Teaching/inclusive education	6 (8%)
Vocational training and alternate schooling /NIOS	5 (6%)
Patience	4 (5%)

B. Symposium 'Aarambhikeya Arambha' on Re-Orienting Anganwadi Teachers to Pre-School Education

The Integrated Child Development Scheme (ICDS), has clearly delineated components focussing on early childcare and development, namely supplementary nutrition for children, pre-school education, nutrition and health education for mothers, immunization and health check-ups for mothers and children. Of these various areas of work, the one that is least prioritized is pre-school education—essentially non-formal education with the objective of achieving optimum child development, enabling children to make a smooth transition to school and giving them a head start in life.

While the Job Training Centre (JTC), responsible for training of anganwadi workers, covers many areas of child development comprehensively, including the types of activities to do with children, the anganwadi worker faces many problems in the field with regard to implementation of these concepts and activities. One challenge relates to limited space to conduct activities; another is the problem of time-- they are so over-burdened with record-keeping and documentation and other tasks such as attending to the requests of pregnant mothers that they are left with very little time to interact with the children and actually do activities with them. The challenge therefore is, to develop a set of activities that recognize the limitations of their work environments and support them to function effectively i.e. do some beneficial child development and education work so as to make an impact in the lives of young children, given the developmental variations and difficult contexts that many children come from.

Initial assessments by the Project and experiences while working in the anganwadis showed that what might enhance the quality of early childcare education and development is: a stronger conceptual framework for understanding child development i.e. abilities and skills in key domains of child development and activities for acquiring them; early stimulation and its role in assisting children lacking in exposure and opportunities at home/ in the family context; basic concepts of early childhood education and readiness for school; skills in early identification of and response to developmental disabilities.

Thus, the Project organized a one-day symposium, 'Aarambhikeya Arambha' on Re-Orienting Anganwadi Teachers to Pre-School Education on 11th August 2015, seeking to address issues around more practical and effective implementation of developmental activities and pre-school interventions. The specific objectives of the symposium were:

- To develop a strong conceptual understanding of child development, in particular the key domains of child development.
- To recognize the importance of early stimulation methods and practice in relation to the key domains of child development.
- To develop basic skills in early identification and response to common developmental disabilities found in pre-schoolers.

Session Content of 'Arambhikeya Arambha' Anganwadi Symposium, August 11th 2015

Session 1	Introduction: The Importance of Early Stimulation Interventions
Session 2	Understanding Key Domains of Child Development: (i) Motor Development (ii) Speech & Language Development (iii) Cognitive Development (iv) Social Development (v) Emotional Development
Session 3	Early Identification of & Response to Common Developmental Problems: (i) Intellectual Disability (ii) Speech & Communication Problems (iii) Risk of Learning Disability
Session 4	Management of Emotional and Behaviour Problems in Pre-Schoolers

The sessions were facilitated by faculty from Dept. of Child and Adolescent Psychiatry and Dept. of Speech Pathology at NIMHANS and a practitioner of Montessori teaching and training from the Indian Montessori Centre, Bangalore.

A total number of 123 anganwadi teachers (1 per anganwadi) along with 5 supervisors participated in the symposium. Additionally, 9 staff/ caregivers from 4 child care agencies (particularly those focussing on disability) also attended the symposium. *(See annex 6 for list of participants)*In all, 137 teachers/staff or caregivers participated in the symposium. At the end of the day, feedback was obtained on the content and usefulness of the symposium, with a focus on the following: i) main issues learnt from the symposium; ii) most useful sessions/ topics; iii) techniques they will take back to the field. *(Refer to table 9(c) below).*

Table 9(c): Feedback from 'Arambhikeya Arambha' Symposium

Main Issues Learnt	**No. of Responses (N=113)**
Key Domains of Development	31 (28 %)
Speech Issues	11 (10%)
Identification of/ Working with Intellectual Disability	13 (12%)
Learning Problems	5 (5%)
All the Information	65 (58%)
Most Useful Sessions/ Topics	**No. of Responses (N=113)**
Domains of Child Development	62 (55%)
Intellectual Disability	72 (64%)
Speech Problem	67 (59%)
Risk of Learning Disability	65 (58%)
Management of Emotional and Behavior Problems in Pre-Schoolers	57 (50%)

Techniques to Take Back to the Field	No. of Responses (N=113)
To respond to children's needs with love and patience	25 (22%)
Teach children through activities	48 (42%)
Implement activities which focus on domains of development	16 (14%)
Deal with child's emotion	2 (2%)
Implement Activities related to speech	32 (28%)
Referring children with problems to Hospitals	7 (6%)
To deal and identify children with learning difficulties	4 (4%)
Early Identification of children with disability	2 (2%)
To narrate stories to children	9(8%)

All anganwadi teachers were keen that the symposium should be held again, so as to include their colleagues. They also suggested that it be extended so as to include more topics for learning.

5.5. Training Workshop for Pre-School Teachers, Visthaar, August 2015

A training workshop 21 pre-school teachers from post-conflict (north and eastern) regions of Sri Lanka was organized by Visthaar, a Bangalore-based NGO that engages in a range of activities from providing institutionalized care for Devadasi children to training and teaching programs on justice and peace studies. As part of a larger community empowerment program for pre-school teachers, the Project conducted a 3-day workshop on working with pre-school children, providing a mental health and disability perspective to pre-school work. Skill-based training sessions focussed on: Understanding developmental needs of pre-school children; Identifying and assessing key areas for pre-school child development; learning how to identify and respond to common developmental disabilities and early childhood emotional and behaviour problems; Understanding and responding to trauma reactions in young children, including loss and grief as well as child sexual abuse issues.

5.6. Training Session for Parents of Children with Disability, Association for People with Disability (APD), September 2015

Behaviour Problems in Children with Disability

- Temper tantrums/ demanding behaviours
- anger/ aggression
- restlessness/ over-activity
- poor peer relations
- Inappropriate sexual behaviours
- Relationship issues within family (feelings of not being valued/ respected, insecurity, jealousy and anger)

APD, which is one of the agencies where the Project provides weekly services in the school for children with multiple disabilities as well as in the early intervention and community outreach program, requested the Project to conduct a half-day training session for parents of their school children. Thus, a group of 26 parents attended a participatory training session on management of common emotional and behavioral problems in children with disability. Participatory methods of listing and role play were used to discuss children's issues and methods to address disabled children's emotional and behaviour problems were collectively discussed in the group, with all parents offering solutions (those that had worked and not) in addition to the facilitator's making suggestions for behaviour management. Special attention was paid to sexuality issues in children with disability, with a focus on: how they are at greater risk of abuse than other children and therefore the need to maintain open/ non-critical channels of communication allowing for children to freely report their experiences, alertness to changes in emotions and behaviours (in case of children with speech problems), social skills and safety training methods for disabled children.

5.7. Skills Training Workshop for KHPT Partner Organizations, September 2015

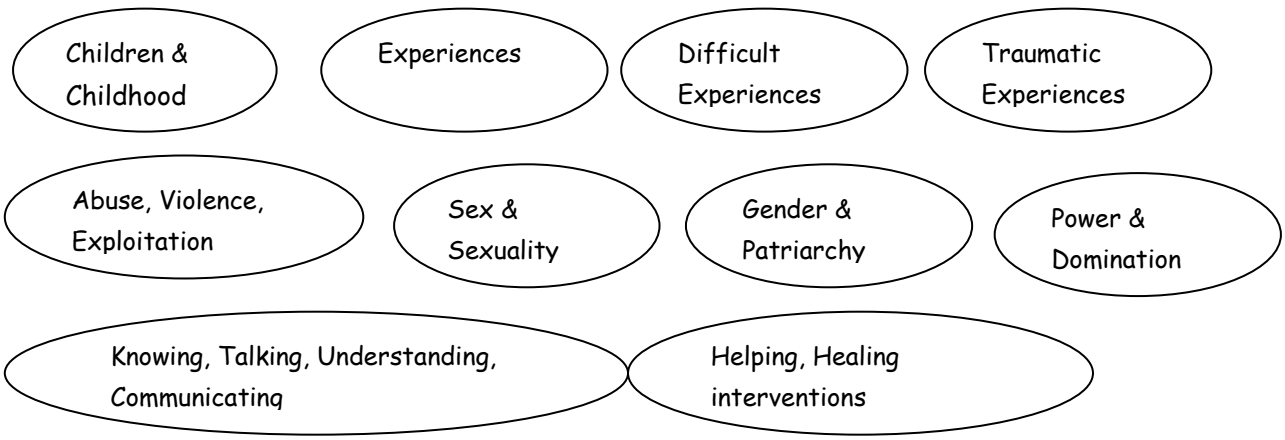
A three-day training workshop was organized for KHPT's Partner Organizations i.e. agencies working with HIV/AIDS infected and affected children, to build first level (basic) knowledge and skills in providing psychosocial assistance to Children Infected and Affected by HIV. 22 participants, appointed as professional counselors by these KHPT partner agencies, working in 20 agencies across Karnataka state (See annex 7) were trained on first level response issues, namely: i) Identifying Child Developmental Needs & How they are Impacted by HIV; ii) Identifying Emotional and Behavioural Problems & Contexts Communication Techniques with HIV Infected/ Affected Children; iii) First Level Responses to specific issues such as Illness & Disclosure, Stigma & Discrimination; iv) Use of Creative Methods including art, stories, dolls & puppets.

This workshop served as a training on dual levels: a) to train the participants erstwhile described; ii) as a training of trainers workshop as the KHPT staff seconded to the Project implemented the training workshop alongside the main facilitators from the Project team, so that the KHPT staff could gain learning and experience in training and capacity building activities.

5.8. Orientation for Institution Staff, Snehagram, September 2015

Following the services rendered by the Project at Snehagram institution (Krishnagiri) for HIV infected/ affected children, and in response to an orientation for 10 institution staff, the Project conducted a one-day orientation workshop for them. It comprised of the following topics: i) Understanding Children and Childhood; ii) Responding to Children's Emotional and Behavioural Issues; iii) Orientation on Issues Relating to Adolescent Sexuality (opinions on sexual behaviour, taking conventional and other positions on sexuality, and a framework for responding to adolescent sexual needs and behaviour). The workshop used experiential methods such as visualization, and participatory methods such as listing, role plays and pile sorting to work through the common challenges and issues that staff have to address in their day-to-day interactions with children.

5.8. (a) Understanding Children and Childhood… Visualization Exercises: What ideas and images come to your mind when I say…



Listing of Common Emotional & Behavioural Problems among Children:

- Stubborn, Non-Responsive, Careless Attitude, Irresponsible
- Sudden Mood Changes (provoked or just moody for no identifiable cause)
- Resentment, Withdrawal
- Low Self-Esteem/ Efficacy
- Insecurity, Poor Receptivity to Feedback

Response and Discussion:

- Relationship of trauma—emotional regulation—insecurity/ self-efficacy
- Unpredictability, lack of stability—emotional dysregulation
- Child's internalization/ inner voices
- Understanding context (illness) ⟶ Experience (death/ loss/ displacement) ⟶ Internalization ("I am not a good person…") ⟶ Emotion (Sad/ angry) ⟶ Behaviour (self-harm/ anger)
- Role of temperament/ personality

Scenarios for Role Play and Discussion Issues Thereof:

i) Child who demands things/ need for immediate gratification/ also feels blamed & rejected by others

- Need for Elaboration & Detailing of child's past and present experiences
- Exploration of context (child's history/ story/circumstances): Allowing for child's perspective/ explanation
- Acknowledgement and validation of emotions
- Where are we on the spectrum of: Order/ Instruction/ Advice/ Suggestion/ Providing Alternatives/ Generation Alternatives with Child (what is the difference and impact of each of these methods on the child?)
- Issue of instant gratification of needs and how this relates to emotional dysregulation
- Legitimize needs and acknowledge deprivation and source of behaviour; generate alternative ways for child to obtain needs

ii) Child who makes inappropriate comments in class; is distracted and disruptive

- Basis of behaviours: impulsive/ADHD? Something to say and needs attention? Plays role of class joker?
- Possible Responses to Child: conversion of child's comment/ use it in the lesson; acknowledge child wants to say something and ask/ find out what his emotions/ problems are (Never involve other children in judging a child's behaviours—creates resentment, anger and difficult peer power dynamics).

iii)Child with anxious behaviours—especially when it is time to do gardening/ activities she does not like.

- Acknowledgement of difficulties and emotions; Explanatory models for aches and pains; Relaxation techniques

Sexuality Issues

- Pile sorting to understand conventional positions on sexuality and what they exclude (example marriage includes pre-marital/ extra-marital sex and adolescent sexuality)
- Opinion cards to examine ideologies on sexual decision-making processes—involving family, future, valence of societal values, relationship context…
- Sexual decision-making as a life skill for adolescents involving: happy/healthy/responsible sexual behaviour; informed choice; open channel of communication (about already happened experience or when contemplating an experience); future orientation; HIV status/plans for disclosure.
- Discussion on window approach to sexual safety/ decision-making in adolescents, using various activities and concepts: good health and pleasure needs; safety; privacy and boundaries; feelings of love/ attraction; relationship contexts (methods modified according to age of child)
- Emerging issues for HIV infected children: disclosure of HIV status by adolescent/ young adult to potential partner and the complexity therof; fatalistic attitude in community boys ('why do I care') resulting in risky behaviours; girls married to old men (abuse)

5.9. Learning Session for Child Care Institution Staff, September 2015

During the course of Project services in child care institutions, one of them, namely APSA, requested us to arrange learning session for their staff as they were facing some particular challenges in dealing with their children. These included certain types of emotional and behavioural problems, namely depression, self-harm and suicidal ideations and attempts, high risk sexual behaviours. In response to their request, the Project conducted a half-day session to enable staff to address these issues. Since we were aware that other child care institution staff face similar challenges, the session was extended to their staff and counsellors too. Thus, 30 counsellors/ child care service providers from 6 agencies/ institutions attended the session.

The aim of this learning session (as opposed to a depth skill training workshop) was to enable child care service providers to understand the context and basis of children's difficult emotions and behaviours and to enable them to provide first-level responses to address them. The learning session was divided into 3 sub-sessions, as detailed below.

Session 1	**Self-Inflicted Harm and Suicidal Tendencies in Children and Adolescents** • Basic understanding of developmental & temperamental changes during adolescence • Effective ways to deal with adolescent behavioural/emotional issues, including: o understanding the context and legitimizing the emotion o Being non-judgmental & establishing confidentiality and trust. o Use of positive reinforcement/ appreciation o Prevent the re-occurrence of the problem by planning and implementing changes one step at a time with constant supervision. • Questions raised: o When children refuse food in order to get demands met o When the child does not wish to be transferred to a different institution, and threatens self-harm if this is forced • Responses and Discussions o Discussing behavioural consequences and examining possibilities with the child and providing alternate solutions o Keeping the child pre-informed about the rules and potential changes which may occur in the institution and providing reassurance regarding the same. o Involving children in meetings with staff so their ideas and views about institutional issues may be considered, and they are part of building a better institutional culture. o Building cohesive relationships inside the institution and creating opportunities for children to think about their future o Issues of emotional regulation and how lack of attachment and early experiences of trauma are underlying causes.
Session 2	**Depression in Children and Adolescents** • Definition of depression & Its characteristics • Basic signs and symptoms of depression • How to identify depression in children and adolescents • How should a child care worker help the child? • Suggested Responses: o Validating emotions o Vigilance and supervision (by staff) o Contracting o Mood diary writing and incl. expression of positive thoughts o Medication/ Referral
Session 3	**Sex and Sexuality Issues in Children and Adolescents** • Physical emotional and behavioural changes that occur in adolescence • What to expect from the adolescent, including the risk factors. • Myths regarding sex and sexuality related to the STDs, pregnancy (as perceived by adolescents) • Response and Discussion: • "Happy Healthy Responsible" sexual behaviour to be discussed with children,

	using the Project's 'Window Approach'—this is a life skills framework that discusses decision-making and choice in sexual behaviour using the following concepts: good health, safety, privacy, boundaries, relationships and abuse. • Non-judgemental attitude; avoid imposition of staff's personal values or beliefs on the child. (Avoid 'moralizing'). • Importance of provision of a framework to children to help them to make their own decisions about sex and sexuality.

A conceptual framework, including some basic theoretical understanding on the issue was provided by the Dept. of Child and Adolescent Psychiatry, NIMHANS staff/ psychiatrists. This was followed by a question-and-answer and discussion session in which agencies shared specific cases and experiences and the Project team suggested ways of response and handling children.

The Project received very positive feedback on the learning session and there were suggestions to hold more such sessions as child care service providers felt that they were able to obtain useful insights, and that some of their most urgent issues were speedily dealt with in a short time.

Table 10: A Summary of Training & Capacity Building Activities, July to September 2015

Month	Organizing Agency	Topic	No. of Participants	No of agencies Represented	Type/ Profile of Participants	Names/type of Agencies Represented	No. of districts
July	Karnataka Health Promotion Trust	The Need for Psychosocial Assistance to HIV infected and affected Children	23	1	District Coordinators OVC Program	Agencies working with HIV	15
August	NIMHANS (Project)	Kalikeya Kale- Symposium on Responding to learning difficulties in school children	104	68	Teachers and child care service providers	Schools disability/child care agencies	1
	NIMHANS (Project)	Arambhikeya Arambha-reorinting anganwadi teachers to preschool education	137	132	Anganwadi Teachers and child care service providers	Anganwadi disability/child care agencies	1
	Govt. High School Begur	Learning Difficulties/ Emotional and Behavioral Problems in children	80	1	Training for parents	Govt.School	1
	Visthaar	Basics Psychosocial care for Preschool Teachers	21	1	Preschool teachers	Community based post conflict/ (North- East Sri Lanka)	0
September	Association for People with Disability (APD)	Emotional/Behavioral Problems in children with disability	26	1	Training for parents	APD-Parents Children with disabilty	1
	Karnataka Health Promotion Trust	Psychosocial Responses to children affected and infected by HIV (level 1)	20	22	Professional HIV counselors	Agencies working with HIV	17
	NIMHANS (Project)	Emotional/Behavioral Problems in children In institutions	30	7	Childcare Institution staff	Childcare Workers from APSA,Makkala Jeevodaya,Navajeevana,BOSCO,Ananya,Govt Boys Home	1
	Snehagram-Krishnagiri	Responding to common Emotional and Behavioral problems in HIV Infected and affected children	10	1	Childcare Institution staff	Residencial Institution for HIV inffected and affected Children	1
Total No. of Individuals Oriented/ Trained			**451**				

C. Human Resources

Given the wide canvas of the Project, and in order to ensure delivery of quality services, there has been a constant need to increase the staffing. The additional funding requested (and approved) was in part for using the services of resource persons with specific skills in certain areas of child mental health work, so as to provide specialized services to some of the children's groups we serve.

During this quarterly, 5 resource persons were taken onboard the Project on an ad hoc basis, at NO extra cost i.e. the existing human resource budget was used to reimburse them for their services. Their roles and functions on the project were as follows:

- A psychologist to assist with assessments and counselling services, mainly in direct service provision.
- A special educator, to provide early stimulation, early screening and identification of disability as part of anganwadi services.
- A special educator to provide specialized services to child care agencies working with disabled children.
- A special educator to provide daily remedial education services in schools.
- A special educator with skills in drama and other creative arts to work on creating a pilot remedial education model for government schools as well as work in children's institutions, using creative methods to support children in difficult circumstances.

The Project's experience with these 5 resource persons has been mixed. By the end of this quarterly, the services of 2 out of 4 special educators were discontinued (and 1 was unable to continue due to personal reasons) as were the services of the psychologist.

It was observed that the knowledge and skills of the special educators was poor i.e. their understanding of children with disability, especially in relation to socio-emotional problems faced by these children was low; they tended to have a narrow vision of special education, limited largely to acquisition of some basic cognitive skills by children. Their understanding of methodology and ability to create new learning/ teaching methods and to documents was extremely limited. Lastly, coming from a training and experience wherein they are accustomed to primarily doing one-on-one work, they were unable to adapt their individual methods to group work as required by the Project activities, nor were they able to undertake systemic level work (working with service providers and agencies) as mandated by the Project. Likewise, the psychologist's skills and abilities were also not considered a good fit for the contexts in which the Project works.

Consequently, as the needs and services of the Project have grown tremendously, insufficient staff and lack of requisite technical skills continues to be a major roadblock in project implementation. As of now, the Project has only 1 resource person assisting with services, namely the person creating a pilot remedial education model for government schools and using creative methods with institutionalized children. Another resource person has also been identified to implement anganwadi activities—she has a creative arts and drama therapy background and it is hoped that she will be able to focus on social, emotional and expressive skills that pre-schoolers often lack in the current anganwadi methods of teaching.

D. Collaboration with Other Agencies

Following the Project's inputs to the Indira Gandhi Institute of Child Health's (IGICH) paediatric anti-retroviral therapy (ART) centre's telemedicine learning initiative (an orientation session in June 2015 for ART counsellors, on working with HIV infected and affected children) which they use to reach ART

centres/ counsellors across Karnataka State, there were requests from the Centre about providing further training to ART counsellors on child psychosocial issues in the context of HIV/ AIDS .

In order to respond to this request, the Project felt that first-hand knowledge of and experience in an ART centre, through observing and participating in the services would be critical. Therefore, the Project has obtained permission from IGICH to spend two months at the Centre, providing first level responses to mental health care problems that children coming to the ART centre have. The aim is to obtain a clear understanding not only of children's issues but also of counsellor roles and functions, the feasibility and logistics of integrating mental health issues into HIV counselling with children, and the needs and challenges thereof. This experience and understanding will then form the basis of relevant methods/ training for ART counsellors so that we may be in more practical and context-specific in our capacity building approaches. Thus, the Project will extend its support and services to the IGICH paediatric anti-retroviral therapy (ART) centre, thrice a week, over November and December 2015.

E. Operational Challenges

Schools:

- As described elsewhere in this report, despite all preparatory efforts, school teachers' attendance in learning initiatives such as the symposium is low; for those attending, their interest was luke warm and it was observed that they oscillate between apathy to the discussions and complaint about their work. As such, their motivation to assist children is low. Of course, there are exceptions to this rule as the Project does come across schools and teachers who are keen to learn and experiment in ways that will be beneficial to their children—such as the 10 schools that came forward requesting support to assist their children.
- During the course of our school services, it is observed that many schools are very focussed on improving their infrastructure, such as computer labs and other facilities that entail improved technology. While this is certainly important and desirable, it appears that headmasters are using local community resources mainly for these efforts as they are keen for their schools to be seen as the best'. What is somewhat concerning is that children's actual well-being needs, whether they are academic or psychological, are being increasingly ignored (in pursuit of purely infrastructural improvements). In such a situation, the Project also finds it a hard operational environment in which to draw the attention of the school authorities to children's individual academic and psychological problems.

Primary Healthcare Centres:

- The challenges cited in earlier reports continue as the Project is able to garner children/cases for services only in PHCs where the auxiliary nurse mid-wife (ANM) is motivated and takes the initiative to ensure that community children with mental health problems avail of services at the centre.
- Increasingly, the Project observes that medical officers play practically no role in integrating child mental health services into primary healthcare. Scarcely one MO out of the 10 we work with is screening children he/she sees for other medical issues, for mental health and developmental problems.
- Relying purely on the screening services the Project provides on immunization days, as the method to mobilize communities to avail of child mental health services, is not sufficient. A great deal more effort on the part of the PHC, starting with the MO, is required to create

awareness about child mental health issues and services. Further, even the Project's screening efforts on immunization days have often been interrupted due to construction work that is on-going in some of the PHCs—these re-modelling initiatives are part of the NUHM directive and so routine PHC services have also been disrupted.

Anganwadis:

- Anganwadi teachers have voiced that they feel pressured and burdened when asked to conduct early stimulation and non-formal education activities for the children. Despite the Project's efforts to motivate them to do at least 40 minutes of pre-school work each day, using the basic, simple activities outlined in the activity book (also provided by the Project), many anganwadi teachers continue to perceive this as being difficult due to their other nutrition/ health and documentation responsibilities.
- About a third of them still feel that the only objective of the anganwadi is to prevent malnutrition and promote child development through provision of food. As such, despite the symposium and our daily visits/ services, many are unable to understand the importance of early stimulation activities for pre-schoolers.
- They are not able to use the activity books and materials provided during the symposium—either because of lack of motivation or lack of experience/ training in use of teaching aids. The Project plans to hold a half day workshop in the next quarterly period to enable the teachers to use the books and materials provided.

Child Care Agencies and Institutions:

- After about 5 months of the Project's services in select child care institutions, a tremendous amount of credibility and good will have been established towards our team. However, despite the Project's communicating the capacity building and sustainability mandate to agencies, they are not consistent in committing designated persons to be with team while working with individual or groups of children, and to continue the work after. Consequently, since no one at the agency is committed to implementing specific interventions recommended for children with problems, children report that they receive no support, after the visit of the Project team. There is thus no continuity to an intervention process started by the team. As a result, treatment services become less effective. Also, the in-house capacity of the agency is not effectively built.
- The lack of commitment and consistency on the part of agencies is also reflected in that a single agency, having many branches/ institutions function very differently i.e. while children in one institution have access to extracurricular and other activities, those in another, do not. This not only affects the children's well-being but also makes it difficult for the Project to provide uniform interventions within an agency. A lot rides on motivation of individuals within an agency, and as such, there are few systematic processes to ensure some commonalities and uniformity in functioning between various branches of a single agency.
- It is observed that while some agencies are enthusiastic to start new initiatives, they also have a perception and expectation that the NIMHANS Project will spearhead these initiatives and put all systems in place i.e. they are not keen to actively participate and engage actively in the efforts required for their agency to improve in services, technical knowledge and efficiency. This often places the Project in a difficult position of having to (re) motivate and 'manage' other agency staff despite initial agreements and commitments to work in a collaborative manner towards achieving certain goals for children.
- The lack of involvement of persons from the agency when the Project team does individual and group work with children has also hindered capacity building goals and resulted in agency staff continuing to have poor knowledge and skills working with children. For instance, children

requiring individual assistance have sometimes not been identified by agency staff and referred to the Project team—who have later discovered their need for help during group sessions conducted by them. In other instances, this lack of knowledge and experience in children's work has led to unusual difficulties such as in the government boys' home: here, agency staff feel somewhat resentful when children share problems and experiences with the Project team and not with them (the agency staff); they then insist that the children are 'not to be trusted' and thus, when the Project team makes certain recommendations in the best interests of the child or in accordance with the child's desire and right to decide, these interventions and recommendations are not so easily accepted and implemented by the agency staff. As such, it is their lack of experience and understanding of children that serves as an impediment to providing assistance to children in ways that are child-centric or rights-based.

- Faith-based agencies, by virtue of the nature of their guiding principles, provide exemplary care for basic survival and protection of children. However, in the absence of a wider practice covering all the domains of child development, especially in case of agencies caring for children with disability, the children run the risk of compromised social exposure. Sometimes protectiveness can compromise social exposure and cause socio-emotional development to suffer. The challenge for the Project has been how to get agency staff to understand the principles of holistic child development and help the agency to gain some balance between over-protectiveness (some of which is justified by religious and faith-based ideas) and children's development.

Training and Capacity Building

- As the Project provides technical support (by way of trainers and training materials) to capacity building initiatives organized by other agencies, it is observed that for many agencies, training programs are just a matter of completion, as per funding requirements, donor pressures and obtaining numbers of participants. This approach has been in dissonance with that of the Project—which follows a long-term process-oriented approach that looks seriously at skill building through deep pedagogies i.e. meeting the contextual and specific learning needs of a group of trainees or service providers. As a result, there have been some conflicts with agencies regarding training duration and methods of delivery of training. The Project however has remained clear on its learning and teaching ideologies, maintaining a firm stance that if approached for technical assistance in capacity building, the Project team (within reasonable limits and after discussion with the agency concerned on its learning needs) will reserve the right to determine the duration and content of the training program as well as lay out the time-frames and methods of delivery i.e. that it will not bow to agency or donor pressures to merely 'finish', and that quality training requires adequate time and a unequivocal understanding of pedagogy, including how best to implement it.

Logistics and Human Resources

- As this is a community project, working with community-based agencies and institutions, plans and schedules constantly have to be re-worked to accommodate festivals, holidays and other events that go on in the community. At times, this has proven difficult as technical resources, vehicles and other resources have to be re-allocated at short notice i.e. quick shifts in services require to be made in order to implement activities efficiently and meet targets and service needs. There is a yearly calendar, with predictable holidays such as schools have and those for festivals; and then there are '*bandhs*' and less predictable holidays due to unforeseeable events, including sudden changes in plan by agencies and individuals within them. Having

understood these issues, the Project maintains a certain flexibility on a day-to-day basis, including a 'Plan B' to be able to adjust the schedule and deliver services at short notice.

- As already described, obtaining suitable technical skills for this Project is a challenge. Given the ever-growing scope of the project, with increasing requests from the field, to extend our service coverage and capacity building programs, it is imperative to find additional staff. The Project therefore continually searches for suitably skilled staff by way of resource persons and allows a trial period for those whom it finds, to assess their skills and suitability before a longer term arrangement is made.

F. Plans for the Next Quarterly Period, July to September 2015

- **School Services:**

o School mental health services, providing assessment and first level inputs and referral services to children with emotional, behavioural, developmental and learning problems will continue. However, these will be provided in the 10 government schools that took the initiative to ask for these services and start remedial education facilities. (No school services will be provided in October due to festival holidays).

o Likewise, models for remedial education in-house facilities and resources will be created/ piloted in these 10 schools.

- **Primary Healthcare Services:**

o PHC services will continue in 10 centres, to provide screening and depth/ referral services.

- **Anganwadi Services:**

o Pre-school services will continue on a daily basis in the 2nd group of 25 anganwadis, through November and December 2015. (No anganwadi services will be provided in October due to festival holidays).

o Half a day's workshop for anganwadi teachers on how to use the aids and materials provided.

- **Child Care Agencies and Institutions**

o Since children in institutions have holidays in October, and many are not going home, an increased number of life skills sessions will be conducted with children in the 6 care and protection institutions that the Project has been working in over the last five months.

o Material development (already initiated) for use with children having emotional and behaviour problems will be completed.

o Work with agencies providing services to children with disability will also continue more actively, with design and development of life skills activities for this group of children.

o First level response (and referral) services will be provided through November-December 2015, at the Pediatric ART centre at Indira Gandhi Institute for Child Health, to address the mental health care needs of children with HIV/AIDS.

- **Training and Capacity Building**

o A first-level skills training of ICPS staff as well as staff from child care institutions will be conducted in November 2015. This training workshop will focus on child development, advance counselling skills for working with children, and responding to the psychosocial and mental health needs of children in difficult circumstances, particularly the trauma of loss and abuse.

o As part of the MoU with Karnataka Health Promotion Trust, a second level training for professional counsellors, working with HIV/AIDS communities in various districts of Karnataka, will be conducted in December 2015.

Annexe 1

Schools Covered from July to September 2015

Sl. No	School	PHC Catchment Area
1	Govt.High School Sarakki	JP Nagar
2	Govt.High School Sarakki	JP Nagar
3	Govt.High School Sarakki	JP Nagar
4	Govt.High School Sarakki	JP Nagar
5	Govt.Urdu Primary School	Yarabnagar
6	Govt. Kannada Primary School	Adugodi
7	Kamala Nehru Primary School	Nr Colony
8	Kamala Nehru Boys High School	Nr Colony
9	Govt.Lower Primary School	Adugodi
10	Tamil Higher Primary School	Kormangla
11	Tamil Higher Primary School	Kormangla
12	Munichanappa High School	Madiwala
13	Guhps Tank Garden	Wilson Garden Ufwc
14	Guhps Tank Garden	Wilson Garden Ufwc
15	Gmhps-Shiva Talkis Koramangala	Adugodi Phc
16	Bbmp Gkhps Lakkasandra	Wilson Garden Ufwc
17	Bbmp Gkhps Lakkasandra	Wilson Garden Ufwc
18	Bharath Matha Higer Primary School	C.T.Bed Phc
19	Bharath Matha Higer Primary School	C.T.Bed Phc
20	Bharath Matha Higer Primary School	C.T.Bed Phc
21	Hombegowda Govt High School	Wilson Garden Ufwc
22	GHPS-Sunkenahalli	C.T.Bed Phc
23	GHPS-Sunkenahalli	C.T.Bed Phc
24	GHS-Sunkenahalli	C.T.Bed Phc
25	Govt.High School Begur	Begur
26	Govt.High School-Agara	Agara

Annex 2

Primary Health Centres Reached, July to September 2015

Sl.No	Names of the Primary Health Care Centers
1	Bapuji Nagar PHC
2	T.R.Mills PHC
3	Avalahalli PHC
4	Vidyapeeta PHC
5	C.T.Bed PHC
6	Yarabnagar PHC
7	Koramangala PHC
8	N.S.Palya PHC
9	Adugodi PHC
10	Madiwala PHC
11	G.G.Halli PHC
12	Kumarswamy Layout PHC
13	J.P.Nagar PHC
14	Banashankari PHC

Annex 3

Anganwadis Reached, July to September 2015

	PHC	Anganwadi Area/ Location
1	Kumaraswamy Layout	E Stop
2	Banashankari	Kaveri Nagar A.W 1
3		Kaveri Nagar A.W 2
4		Kaveri Nagar A.W 3
5		Kaveri Nagar A.W 4
6		Ambedkar Nagar A.W 1
7		Ambedkar Nagar A.W 2
8	Koramangala	Srinivagilu
9		Ejipura A.W
10		Indragandhi Slum A.W
11	Madiwala	Maduramma Colony
12		Madeena Nagar Masjid A.W
13		Old Madiwala A.W
14		New Madiwala A.W
15	Tavrekere	Bovi Colony S.G.Palya A.W
16		Bismillanagar A.W
17		Gurappana Palya Slum
18	J.P. Nagar	Sarakki
19		Rajarajeshwari Slum
20	Avalhalli	Sanjay Nagar
21		Sanjay Nagar
22	Vidyapeeta	Janashakthi Nagar A.W
23	T.R. Mills	Srinagar I
24		Srinagar II
25	Bapujinagar PHC	Bapujinagar Anganwadi 1
26		Bapujinagar Anganwadi 2
27		Bapuginagar Anganwadi 3
28		Shamannanagar Anganwadi
29		Pantharpalya Anganwadi 1
29		Pantharpalya Anganwadi 2
30		Arundathinagar Anganwadi
31		Chandralayout Anganwadi
32		Ananth Nagar Anganwadi
33		Arfrath Nagar Anganwadi
34		Devagowda Slum Anganwadi
35		Arfath Nagar Anganwadi
36	Avalahalli	Baterayanpura Anganwadi 1
37		Baterayanpura Anganwadi 2
39		Maruthinagar Anganwadi
40	Pantarpalya PHC	Nayan Halli Anganwadi 1
41		Nayan Halli Anganwadi 2
42		Gondanahalli Anganwadi 1
43		Gondanahalli Anganwadi 2

Annexe 4

Preliminary Information on 10 Government Schools Requesting Remedial Education Support

School Name	Student Strength	Teacher Strength	Issues & Needs	School Measures	Viable Model	Comments
1. Government Urdu High School, Tank Garden	Classes 8 to 10	8	Academic problems; Help with Reading, Writing and Comprehension, learning assessments.	Bridge course, Extra classes 1 hour each in the mornings and evenings for all students	1/2 hour reading skills and ½ hour writing skills group remedial in the morning extra class, individual remedial sessions in the afternoon extra class.	Teaching staff willing, HM supportive, lack of space and difficulty in manning resource room
2. Sarakki Senior School	Classes 8 to 10, 560 students	20	Academic problems; Help to improve basic academic skills	Bridge course, Extra classes 1.5 hours in the evenings only for class 10.	10 minutes of reading skills remediation in every period, 3 days a week in classes 8 and 9. 10 minutes of writing skills remediation in every period, 3 days a week in classes 8 and 9.	Teaching staff unwilling, HM supportive, work pressure high, difficulty in manning resource room.
3. Government School, Begur	Classes 8 to 10, 350 students	14	Social and Academic Problems; Help to manage behaviour like smoking, fighting, interaction of boys with girls, improve basic academic skills, assessments.	Bridge course, Extra classes 1 hour each in the mornings and afternoons only for class 10, extra classes 1 hour in the afternoons for class 9.	Group sessions with students, every 3 months, to address issues of smoking, aggression and inter-gender dynamics. 10 minutes of reading skills remediation in every period, 3 days a week and 10 minutes of writing skills remediation in every period, 3 days a week in class 8. 20 minutes of reading skill remediation, 3 days a week and 20 minutes of writing skill remediation, 3 days a week, within the extra class hour for class 9.	Teaching staff mostly unwilling, HM supportive, work pressure high, space available but difficulty in manning resource room.
4. Government High School, Agara	Classes 8 to 10, 858 students	18	Psychosocial issues; Help to manage behaviour like smoking, fighting, and interaction of boys with girls. Counselling/Therapy, both group and individual to manage socio-emotional issues.	Bridge course, Extra classes 1 hour each in the afternoons for classes 9 and 10	Group sessions with students, every 3 months, to address issues of smoking, aggression and inter-gender dynamics. Individual counselling on case-specific basis. 10 minutes of reading skills remediation in every period, 3 days a week and 10 minutes of writing skills remediation in every period, 3 days a week in class 8 may be recommended	Teaching staff interested in help with students' socio-emotional issues, HM supportive
5. New Fort Government	Classes 8 to 10, 119	10	Psychosocial & Academic Issues; Help	Bridge course, Extra classes 1 hour each in	Group sessions with students, every 3 months, to address issues of smoking,	• Teaching staff

High School, Chamrajpet	students		to manage behaviour like smoking, fighting, absenteeism and serious lack of attention. Counselling/Therapy, both group and individual to manage socio-emotional issues. Improve basic academic skills.	the mornings for class 10 and afternoons for classes 8 and 9.	aggression and irregularity. Individual counselling on case-specific basis. 10 minutes of reading skills remediation in every period, 3 days a week and 10 minutes of writing skills remediation in every period, 3 days a week in class 8 may be recommended.	interested in help with students' socio-emotional issues, HM supportive.
6. Higher Primary, Chamrajpet	Classes 1 to 7, 138 students	6	Psychosocial & Academic Issues; Help to create interest, regulate attentiveness and everyday work, improve basic academic skills, treatment for 2 children with physical disability, assessments	Bridge course, home visits.	Group sessions with students, every 3 months, to address issues of attentiveness and work regularity. 10 minutes of reading skills remediation in every period 3 days a week and 10 minutes of writing skills remediation in every period 3 days a week for all classes.	Teaching staff mostly unwilling, HM supportive, work pressure high, space not available.
7. Urdu Higher Primary School, Arundhati Nagar	Classes 1 to 7, 201 students	7	Psychosocial & Academic Issues; Help to improve basic academic skills, create awareness in parents and assessments.	Bridge course, home visits, Remedial teacher appointed by the Minority Welfare Board takes classes of English, Maths and Science for classes 6 and 7, every Sunday.	10 minutes of reading skills remediation in every period 3 days a week and 10 minutes of writing skills remediation in every period 3 days a week for all classes.	Teacher strength less, high work pressure, space possible for resource room, difficulty in manning resource room.
8. Sahakari Vidya Kendra, Padmanabha Nagar (Aided High School)	Classes 8 to 10, 250 students	11	Psychosocial & Academic Issues; Help to improve basic academic skills, comprehension and interest, assessments.	Bridge course only for class 8, extra class of 1 hour each in the morning and afternoon only for class 10.	10 minutes of reading skills remediation in every period 3 days a week and 10 minutes of writing skills remediation in every period 3 days a week for class 8 and 9. Setting up of resource room possible.	HM supportive, some staff members interested, the Primary school may also be open to a remediation programme.
9. Government High School, Baratena Agrahara	Classes 8 to 10, 600 students	16	Psychosocial Issues; Help to counsel students to deal with issues like smoking,	Home visits, strict school environment	Group therapy sessions to help the students cope with socio-emotional issues.	Teachers feel that learning problems are due, only to social issues. Remedial programme may be

			stealing, watching pornography, absenteeism and dropouts. Academic help not required. Assessments.			introduced after initially addressing the socio-emotional problems.
10. Netaji Government High School, Wilson Garden	Classes 8 to 10, 190 students	11	Psychosocial & Academic Issues; Help to counsel students to deal with issues like aggression, absenteeism and lack of interest, improve basic academic skills, assessments.	Bridge course, extra classes of 1 hour each in the morning and afternoons for class10, extra class of 1 hour in the afternoons for classes 8 and 9, home visits.	Group therapy sessions to help the students cope with socio-emotional issues. 20 minutes of reading skill remediation, 3 days a week and 20 minutes of writing skill remediation, 3 days a week, within the extra class hour for classes 8 and 9. Individual remedial sessions can be conducted during the afternoon extra class hour.	• Supportive staff and HM, space available for Resource room, Teachers willing and enterprising.

Annex 5

Schools & Child Care Agencies Participating in 'Kalikeya Kale' Symposium

South/ Block Education Officer 1		
SL No	School Name	Present(P)/Absent (A)
1	Govt. Vidyakendra (Padmanabnagar)	P
2	Govt. Urdu Primary School (Sarbandepalya)	P
3	Govt. Higher primary School (Kumarswamy Layout)	A
4	Govt. Lower Primary School (Gowdenpalya)	A
5	Govt. Higher Primary School (Kadrenhalli)	P
6	Govt. Higher Primary School (Marenhalli)	P
7	Govt. High School (Sarakki)	P
8	Govt. Lower primary school (Sarakki)	P
9	New Vani Vilas Government School	P
10	Govt. Lower Primary School (Gavipuram)	P
11	Govt. Higher Primary School (Sunkenhalli)	A
12	Govt. Tin School (Basvangudi)	A
13	Govt. High School (VV Puram)	A
15	Kamala Nehru School (Thyagrajnagar)	P
16	Govt. Lower Primary School (Itmadu)	P
17	Govt. Higher Primary School (Hoskerhalli)	A
18	Govt. Urdu Primary School (Yarabnagar)	P
19	Govt. Tamil Higher Primary School (Bhavinagar, Banshankari)	P
Block Education Officer 2		
1	Govt. Urdu Higher Primary School (Haleguddada Halli)	P
2	Govt. Urdu Model Primary School (Shamanna Garden)	P
3	Govt. Urdu Lower Primary School (Rasool Nagar)	A
4	Govt. Higher Primary School (Gangondanahalli)	P
5	Govt. High School (Byatarayanpura)	P
6	Govt. Higher Primary School (Byatarayanpura)	P
7	Govt. High School (Hallekote)	P
8	Govt. Model primary school (Chamrajpete)	P
9	Govt. Model primary school (Athiguppe)	A
10	Govt. Higher Primary School (Arundathi	P

	Nagar)	
11	Govt. Higher Primary School (Marenhalli)	P
12	Govt. Higher Primary School (Pantharpalya)	P
13	Govt. Model Primary Scool (Nayandhalli)	A
14	Govt. Higher Primary School (Nagarbhavi)	A
15	Govt. Urdu Higher Primary School (Padrayanpura)	P
16	Govt. Urdu Higher Primary School (Arundathi Nagar)	P
17	Govt. High School (Goripalya)	P
18	Govt. High School (Govindraj Nagar)	A
19	Govt. High School (Chikpet)	P
20	Govt. High School (Athiguppe)	P
Total Schools		20
Total Teachers Present		15

South/ Block Education Officer 1

SL No	School Name	Present/Absent
1	Govt. Model primary School (Adugodi)	P
2	Govt. Model primary School(MARP Lane)	A
3	Govt. Model primary School(Konnankunte)	P
4	Govt. Model Primary School (Puttenhalli)	P
5	Govt. Urdu Model Primary School (Tank Garden)	P
6	Govt. Urdu Model Primary School (Chineyanpalya)	A
7	Govt. Model Primary School (Wilson Garden)	P
8	Govt. Higher Primary school (Lalbagh Siddapura)	P
9	Govt. Higher Primary School (Byarsandra)	P
10	Govt. Higher Primary School (Dairy Colony)	P
11	Govt. Lower Primary School (Mastripalya)	P
12	Govt. Model Primary School (Madiwala)	P
13	Govt. Urdu Higher Primary School (Tavrekere)	A
14	Govt. Urdu Model Primary School (Gurrapan Palya)	P
	JANARDHAN SCHOOL(Gurrapan Palya)	P
15	Govt. Higher Primary School (Sudgunte Palya)	P
16	Govt. Lower Primary School (Itmadu)	P
17	MEWA High School (East End)	A
18	Christa Vidyalaya (SG Palya)	P
19	Hombegowda Boys High School (Wilson Garden)	P
20	Gangamma Hombegowda Girls High School	A
21	Govt. Higher Primary School (Yadyur)	A
22	Govt. Higher Primary School (Gulbarga Colony)	P
23	Govt. Higher Primary School (Eiji Pura)	A
24	Govt. Higher Primary School (Adugodi)	A
25	Govt. High School (Madiwala)	P

26	Govt. High School (Domlur)	P
27	Govt. High School (Yadyur)	P
28	Govt. High School (Konnapan Agrahara)	P
29	Govt. High School (Berten Agrahara)	P
30	Govt. High School (Agara)	P
31	Govt. High School (Begur)	P
32	Govt. High School (Jaynagar 9th Block)	A
33	Govt. Urdu High School (Tank garden)	P
34	Govt. Urdu High School (Yalgondhalli)	P
35	Govt. High School (Hombegowda Nagar)	P
36	Govt. High School (Adugodi)	P
37	Govt. High School (Gottigere)	A
38	Govt. Telgu High School (Vivek Nagar)	P
39	Govt. High School (Eijipura)	P
40	Govt. High School (Puttenhalli)	P
Total Schools		40
Total number of Teachers present		30

Sl No	Child Care Institutions
1	APD
2	Shri Kumaran School
3	Nele Foundation
4	Roopa learning centre
5	Navajeevana
6	Dharithree Trust
7	APSA
8	Brindhavan School
9	Aarohan Foundation
10	Nirmala shishu bhavan
11	Insight Academy
	Total number of Institutions-11

Annex 6

Anganwadis & Child Care Agencies Participating in 'Arambhikeya Arambha' Symposium

	PHC Catchment	Anganwadi
1	C.T.Bed Phc	Bhuvneshwari Nagar 1
2		Vinayak Nagar
3		Vidyapeeta
4		Ittamadu
5		Manjunatha Colony 1
6		Manjunatha Colony 2
7		Bhuvneshwari Nagar 2
8	Kathriguppe Phc	Srinivasnagar Anganwadi 1
9		Srinivasnagar Anganwadi 2
10	T.R.Mill Phc	Dhobighat 1
11		Dhobighat 2
12		Kalappa Block
13		Kalidasa Layout
14		T R Shamanna Nagar 1
15		T R Shamanna Nagar 2
16	Vidyapeeta Phc	Venkatappa Layout A.W
17		Kalidasa Nagar
18		Ganapathi Nagar
19		Dwarkanagar
20	Lions Club Ufwc	Harijana Seva Sangha
21		LIONS CLUB 2nd AW
22	Pantarpalaya Phc	Avalahalli 1
23		Avalahalli 2
24		Ganapathi Nagar
25		Girinagar 1
26	Singsandra	Mangana Palya 1
27		Mangana Palya 2
28	N.S.Palya Phc	N.S.Palya 1
29		N.S.Palya 2
30		N.S.Palya 3
31		Old Madiwala 1
32		Old Madiwala 2
33	Madiwala Phc	Maduramma Colony
34		Madeena Masjid
35		New Madiwala 1
36		New Madiwala 2
37		New Madiwala 4
38		Ksrp Quarters
39	Adugodi Phc	Jyothi Nivas Slum
40		Jaibheema Nagar
41	Kumar Swamy Layout Phc	E-Stop
42		F-Stop

43	Yarab Nagar Phc	Yarab Nagar 1
44		Pragathipura 1
45		Pragathipura 2
46		Sarabande Palya 1
47		Sarabande Palya 2
48		Jawaharlal Neheru Slum
49		Umarbhag
50		Bhavani Nagar 1
51		Bhavani Nagar 2
52		Gangadhar Nagar
53		Hari Colony 1
54		Hari Colony 2
56	Bsk Ufwc	Ambedkar Nagar 1
57		Ambedkar Nagar 2
58		Kaveri Nagar 1
59		Kaveri Nagar 2
60		Kaveri Nagar 4
61	Elchenahalli Phc	Vinayaka Nagar 1
63		Vinayaka Nagar 2
64		Vinayaka Nagar 3
65	J.P.Nagar Phc	Rajarajeshwari Slum
66	Jayanagar Phc	Marenahalli
67		Gundappa Colony
68		J.P.Nagar
69		B.T.B Area
70		Gulberga Colony
71	Wilson Garden Ufwc	Lal Bhag Siddapura
72		Hombegowda Slum
73		Anjaneya Slum
74		J.K.Pura
75		Corporation Slum
76		Laksandra
77		Bismilla Nagar
78		Arasu Colony
79		Someshwara Slum
80		Dayanda Slum
81	Tavarekere Phc	Mukrum Masjid
82		Gurappana Palya
83	Siddaiha Hospital	Ramana Garden 1
84		Ramana Garden 2
85		Appajappa Garden
86		Ramana Garden
87		Hameed Khan Garden
88		Rajgopal Garden
89		N.S.Garden
90		Vinobha Nagar

91	N.S.Palya Phc	Hale Madiwala
92	Dasappa Hospital	S.R.Nagar
93		Kumbar Gundi
94		Kalasipalya
95		Dharmaraya Devasthana
96		Sampangi Ram Nagar
97	Wilson Garden Ufwc	Bada Makhan 1
98		Bada Makhan 2
99		Chikka Mavahalli
100		Souharda Vrutha
101	Azad Nagar	Kasthuriba Nagar 1
102		Kasthuriba Nagar 2
103	Bangarappa Nagar	Panthar Palya 2
104	Nayandhalli	Roshan Nagar
105	Avalahalli	Maruthi Nagar
106		Batarayana Pura
107		New Timber Layout
108		Sanjay Nagar 1
109		Sanjay Nagar 2
110	Panthar Palya	Nayandhalli 1
111		Gangondana Halli 1
112		Gangondana Halli 2
113	Gangondana Halli	Bendre Layout
114		Arundthathi Nagar
115		Jyothi Nagar
116	Bapuji Nagar	Shamanna Nagar
117		Anath Nagar
118		Bapuji Nagar 1
119		Bapuji Nagar 2
120		Bapuji Nagar 3
121		F.A.Nagar 1
122		F.A.Nagar 2
123		Arfath Nagar 2

Annex 7

KHPT Partner Agencies Participating in First Level Training Workshop on Psychosocial Care for Children Infected and Affected by HIV/AIDS

	HIV/AIDS Institutions	District
1	Nithyajeevana Network	Bellary
2	Suchethana Network	Chitradurga
3	Sanjeevini Davanagere Net Work	Davanagere
4	Vimukthi	Hospet
5	Abhayadhama HIV Sonkithra Bembala Sangha Shimoga	Shimoga
6	Bandhavya Network	Chikmagalur
7	Deepajyothi Network Of Positive People	Udupi
8	Jeevanashraya Network	Hassan
9	Jeevan Jyothi Network, Bagalkot	Bagalkot
10	Spandana Network	Belgavi
11	Svym, Chikkodi	Belgavi
12	Spad, Dharwad	Dharwad
13	Rakshitha Network, Haveri	Haveri
14	Navachetan Network	Gadag
14	Aids Jagruthi Mahila Sangha(Ajms)	Sindagi
15	Knp+	Bangalore
16	Ashakiran	Mysore
17	Jevadan	Mysore
18	Khpt	Bangalore
19	Khpt	Bangalore
20	Daya Bhavan	Tumkur

Annex 8

Child Care Institutions Reached, July to September 2015

	Name of the Institution	Type of children targeted / focus of services
1	Govt. Boys Home (Bangalore)	Transitional home for runaway/Rescued Children
2	Govt. Shishu Mandir	Orphan/Abandoned Children
3	Rainbow School- Navajeevana Chamrajpete (Bangalore)	Orphan/Abandoned/Street Children in need of care and protection
4	BOSCO -Vatsalya Bhavan Chamrajpete (Bangalore)	
5	Rainbow School- Wilson Garden (Bangalore)	
6	Makkala Jeevodaya (Bangalore)	
7	APSA	
8	Ananya Trust	Children with low/problematic socio-economic family groups
9	Vijayanagar Govt School	Children of Migrant Labor
10	Infant Jesus	HIV Infected and affected Children
11	Aradhana Home(Kolar)	
12	Snehagram (Krishnagiri)	
13	Nirmala Shishu Bhavan	Children with Disability
14	Dhatritree Trust	
15	Association for People with Disability	