Integrating Child Protection and Mental Health Concerns in the Early Childhood Care and Development Program in India

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Adverse childhood experiences and protection risks such as neglect and abuse and family psychosocial and protection vulnerabilities, beginning in early childhood, are linked to negative development and mental health. Child protection is becoming an increasing concern in India, creating new imperatives to address it amongst all children, but particularly among children below the age of 6 years, who due to their age and developmental abilities, are rendered more vulnerable than older child populations. It is therefore imperative, particularly in developing contexts such as India, for early childhood development (ECCD) to integrate child protection and mental health services into their existing intervention package. Although early childhood programs work with multiple sectors, they have limited collaboration with child mental health and child protection systems. This article addresses the question of how to integrate child protection and mental health interventions into existing ECCD programs by describing the experience of a pilot project in the Indian context. It provides the rationale, methodology and content of service delivery for integrating child protection and mental health interventions into the existing ECCD program, the Integrated Child Development Scheme, highlighting emerging concerns and challenges and drawing from the interventions to show how some of these were addressed.

Keywords: *Adverse childhood experiences, Integrated child development services, Intervention, Mental health*.

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The term 'child protection' refers to preventing and responding to violence, exploitation, abuse and neglect of young children. Article 19 of the United Nations Convention of Children's Rights (UNCRC/CRC), 1989 provides children a specific right to protection [1]. About 13.5% of India's population, 16.45 crore children, are in the age group 0-6 years [2]. According to a national study conducted by Ministry of Women and Child Development (MoWCD), on child abuse in India, 66% are reported to be physically abused, 50% have faced one or more forms of sexual abuse and emotional abuse [2,3]. As per the National Crime Records Bureau's 2017 report on crime against children, a total of 129032 cases were recorded, including kidnapping and abduction, sexual offences and murder [4]. A total of 32,608 child sexual abuse cases were recorded in 2017 alone, including for children below 5 years of age [5] and a total of 78,000 orphan and vulnerable children are residing in child care institutions under the Integrated Child Protection Scheme (ICPS) [6]. Child protection is thus becoming an increasing concern in India, creating new imperatives to address it amongst all children, but particularly children below 6 years of age, who due to their age and developmental abilities are rendered more vulnerable than older child populations.

Due to paucity of age-specific data, it is unclear as to what proportion of abused children are between 0 to 6 years of age. Many behaviors such as defiance, anxiety to new situations, which are considered pathological in older children, constitute normal development in young children. Thus, it is difficult to differentiate between normal and pathological behaviors, making mental health diagnosis in young children difficult [7]. Due to their developmental age, and their lower verbal communication skills, they are also hindered from reporting experiences [8], consequently rendering them more vulnerable than older children, to traumatic death and injury caused due to abuse and neglect [9-11].

There is now considerable evidence to show that adverse experiences in early childhood also have a negative impact on young children's overall development and so, if not addressed, may lead to adverse outcomes in later years. For instance, children's exposure to frequent and prolonged abuse, neglect, violence, substance abuse in caregivers, family and economic stressors, and poor attachment relations negatively impacts their mental health, neurodevelopment, psychosocial development and academic functioning [14-17]. Mental health is impacted by increasing the risk of internalizing and externalizing

problems such as anxiety, depression and suicide [18,19], antisocial behavior and psychopathy [20], substance abuse, and legal problems in their adult life [21-23]. The risks of adverse childhood experiences also combine with the disciplinary strategies used with children, including all forms of corporal punishment, to result in increased risk of negative behavioral, cognitive, psychosocial, and emotional outcomes among children [24].

Since critical brain development occurs in the early years of life [25], it is important to note that child protection in early childhood critically involves, but is not restricted to, abuse and neglect. Child protection in early childhood also entails protection from the adverse influences of unmet developmental needs along with the other interventions. According to the Adverse childhood experiences studies, the relationship between adverse childhood experiences and negative health indicators begins early in childhood; child care service providers thus have an opportunity to provide interventions that prevent long-term negative health consequences [26]. Child protection, therefore involves addressing risks relating to neglect, (physical, sexual and emotional) abuse, and absence of opportunities (for learning and development).

INTEGRATING CHILD PROTECTION INTO EARLY CHILDHOOD CARE AND DEVELOPMENT PROGRAMS

Early Childhood Care and Development (ECCD) programs across the world majorly focus on nutrition and early stimulation along with other health interventions such as immunization, hygiene, educational and support measures for caregivers to ensure consistent care and support for children. Even though ECCD programs work with multiple departments, they have limited colla-boration with child mental health and child protection systems [27].

While there are child protection programs around the world, those working specifically in the context of early childhood, are relatively limited. For those that do work in the area of early childhood, there are very few that integrate ECCD issues with child protection. Examples of integrated programming include UNICEF's programme guidance for early childhood development [28] and Plan International's development of program models and tools to integrate child protection into ECCD, as reflected in their exploratory studies in Uganda, Bolivia and Timor-Leste [29]. Save the Children, has also attempted, in few of their programs, to integrate child protection into ECCD but while they focus on orphans and vulnerable children, they do not have a mental health component [30].

There are examples of child violence prevention programs, which have been successfully implemented both in developed and developing countries [29,31-35], through parents, nurses or community health worker in the primary health care system. These have focused, and legitimately so, mostly on positive parenting, monitoring for prevention child maltreatment (through home visits by community health care workers), mother–child therapy interventions, provision of primary health care services and safe spaces for children to grow and play. However, these programs have worked largely in family settings–an approach that India could draw upon but that would not be entirely applicable to its context, because the socio-economic situation of many vulnerable children often does not allow for family members to be present for the child. Therein lies the importance, in the Indian context, of the role of the ECCD workers and the need to integrate child protection into the government preschool system.

The key objectives of ECCD and child protection programs are to ensure age-appropriate development, early stimulation and primary prevention. The World Health Organization's Nurturing care framework also recommends providing for the children's physical and emotional needs, protection from harm along with learning and development opportunities as its central tenet [36]. Given that ECCD programs qualify as a universal intervention, their coverage tends to be wide, and ECCD workers and educators are ideally placed to implement protection strategies to assist children at risk of abuse and neglect [37]. Thus, ECCD programs may serve as effective vehicles to protect children from adversities.

Furthermore, as erstwhile described, exacerbated by poverty and other vulnerabilities, mental health needs of children from adverse circumstances are high – placing children at increased risk of continued child protection problems. Thus, it is imperative for integrated ECCD and child protection programs to include child mental health interventions. Effectively addressing emotional and behavioral problems that are consequences of protection issues, would be critical to the successful implementation of early childhood care and protection services and programs [9].

We, herein, address the question of how to integrate child protection and mental health interventions into existing ECCD programs by describing the experience of a pilot project in the Indian context. It provides the rationale, methodology and content of service delivery for integrating child protection and mental health interventions into the existing ECCD program, the Integrated Child Development Scheme (ICDS), highlighting emerging concerns and challenges and drawing from the interventions to show how some of these were addressed. We also discuss how child care service providers, particularly pediatricians, can play a pivotal role in this endeavor.

Experience With a Pilot Project

Prior to this pilot project a large community-based child and adolescent mental health service project, had been implemented by us. The community-based project had executed a resource mapping and needs assessment for community child and adolescent mental health services [4], prior to the start of its activities. With the objective of promoting early stimulation and optimum development in children, activities such as implementation of early stimulation, training and capacity of Anganwadi workers on early stimulation (child protection was not a prominent focus of the program at the time) were conducted. The observations and experiences of our work are available elsewhere (*www.nimhans childproject.in*).

Subsequently this experience was used to develop a pilot project that focused exclusively on ECCD interventions, to include child mental health and protection interventions. In order to obtain a more specific understanding of how ICDS staff view child protection issues, an additional assessment was done prior to this project, and the findings incorporated into the design and content of the interventions.

Context of Intervention

The potential of the integrated child development scheme: The ICDS provides a huge opportunity to incorporate protection components into ECCD because of its universal coverage agenda, particularly in socio-economically deprived communities where some of the most vulnerable children reside. Also, the anganwadi worker, the key worker in the ICDS scheme, conducts non-formal education and early stimulation activities for a given group of children, on a daily basis, over a relatively long time period (such as a year). This provides a perfect platform, not only for early screening and referral for developmental delays, emotional and beha-vioral and protection issues, but also to engage children in personal safety awareness programs.

Protection programs, policies and laws relevant to young children: As a signatory to the UNCRC, the Indian Government established a statutory body, the National Commission for Protection of Child Rights (NCPCR), in 2007, and more importantly, the Ministry of Women and Child Development, launched the Integrated Child Protection Scheme (ICPS) in 2009. The ICPS translates into programs, the vision of a secure environment for all children, as envisaged in the Juvenile Justice (Care and Protection of Children) Act, 2015, which in turn is based on principles of 'protection of child rights' and 'best interest of the child'. It aims at building a protective environment for children in difficult circumstances, as well as other vulnerable children, by bringing together various child protection schemes under one roof and integrating additional interventions for protecting children and preventing harm [39].

India has enacted another key law with regard to child protection – The Protection of Child Sexual Offences (POCSO) Act 2012 which aims to effectively address sexual abuse and sexual exploitation of children. The act defines various forms of sexual abuse, focuses on mandatory reporting issues, stringent punishment graded as per the gravity of the offence, and requisite child-friendly court processes [40].

Despite the existing range of ECCD programs and services, there are gaps and challenges, at knowledge, skill and policy levels, leading to inadequate realization of child protection laws and policies. Some of the challenges observed during the course of our child mental health and protection work in recent years include: limited understanding of child protection and psycho-social issues within child protection system, lack of focus on protection services for young children, inadequate knowledge and skills to identify and address protection concerns, especially in young children and paucity of systematic and standardized materials and protocols for child protection response.

ICDS staff knowledge and skills in child development and protection issues: Based on the needs assessment exercise conducted with anganwadi workers within the ICDS, for a deeper understanding on the staff 's perspectives on young child protection, various issues emerged (which also reflect the general lacunae in the child protection system in the country). Anganwadi workers have not been trained in the use of systematic assessments in child protection, nor in assessment of child mental health and development issues.

Young children in anganwadis: The children in the Anganwadi*s* are drawn from vulnerable homes and communities. Their families were characterized by low socio-economic status, residence in urban slums, substance abuse in caregivers, domestic violence, violence and conflict (extending through neighbor-hoods). The primary caregivers were frequently day laborers, so they were absent for most of the day i.e. as such children's interactions with primary caregivers were limited to a couple of hours a day. Consequently, they spent the maximum number of hours at the anganwadi, with the anganwadi worker serving as a key caregiver.

Conceptual framework: Based on the available literature, a comprehensive framework for integration would entail the following: *i*) early stimulation and development, including provision for learning opportunities; *ii*) providing alternative opportunities for developing healthy attachment, particularly for children who are from

compromised or dysfunctional families; *iii*) creating awareness in children regarding personal safety and abuse issues to enable early reporting of abuse experiences; and *iv*) equipping ECCD workers with knowledge, skills and methods to identify protection risks in young children. Including emotional and behavioural issues, and to address them, depending upon the severity.

The aim of the intervention was to integrate mental health and protection services for young children between the ages of 0 to 6 years into the existing the ICDS program.

Methodology

As shown in **Fig.1**, we used a multi-pronged approach to provide com-munity-based mental health and protection services for promotive, preventive and curative care through direct service delivery for children, and training and capacity-building of anganwadi workers.

The interventions were implemented in anganwadis in which the ICDS is implemented, in vulnerable urban communities the Bangalore. Anganwadis from the five (urban slums) near our center were selected. From amongst these, anganwadis were selected, which had greater number of children, and more than one center in the same location were selected – in order to ensure that a greater number of children would be reached through a single visit.

Results

In all, during the 7 months, the interventions were carried out in 31 Anganwadi centers (**Table I)**. Based on the context of intervention and the conceptual framework, two types of interventions were implemented to integrate child mental health and protection into the ICDS program, through i) direct services for children and ii) capacity building initiatives for ICDS staff.

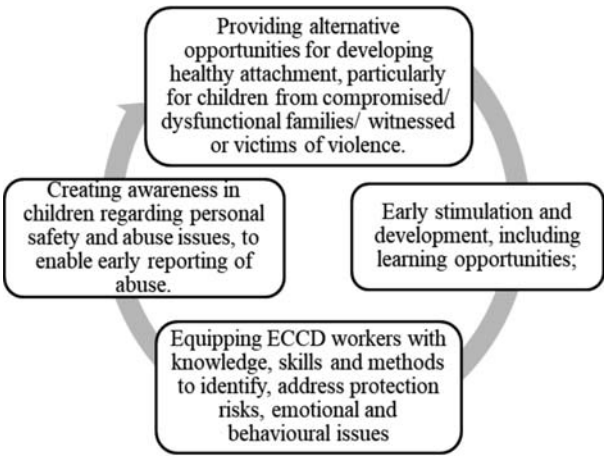

Fig. 1 Conceptual framework for integration of child protection and mental health with early childhood care and development.

Direct services for children: This was carried out in two distinct steps viz., individual assessment of development, mental health and protection issues in anganwadi children, and group activities for children in anganwadis.

An assessment proforma comprising of questions on child development, emotional and behavioral issues and protection concerns was developed (available at: *https://www.nimhanschildproject.in/anganwadis-phcs/).* It was based on existing clinical assessment proformas at the department of child and adolescent psychiatry in a tertiary care facility. The proforma has also drawn from the community-based programs previously executed by the authors, particularly in young child institutions, where children orphan and abandoned children, with serious child protection issues, reside. This assessment was not primarily aimed at arriving at a diagnosis, but mainly geared to help child care service providers to identify and understand children's problems and vulnerabilities, with a view to helping them to access appropriate inter-ventions. Due to the variation in developmental abilities and needs, the proforma was adapted to three sub-groups of children under the age of 6 years: 0 to 1 year, 1 to 3 years and 3 to 6 years.

The assessments were conducted in the anganwadi. An average of 20 minutes was spent engaging with the child and about 15 minutes with the anganwadi worker, for completion of an individual child's assessment. To ensure that the assessments were accurate i.e., that they truly reflected children's developmental abilities, allowing them to respond freely, ice-breakers and group activities were used to build rapport with children Developmental checklists were filled out by observing the child and asking him/her to perform simple tasks and activities that would allow for assessment of develop-mental skills and abilities. Information about the child's family context and related protection issues was gathered by interviewing anganwadi workers and helpers.

Following each assessment, for mild to moderate developmental, mental health and protection issues, the

Table I Interventions and Coverage

Outcomes	*Coverage*
Number of anganwadis and anganwadi workers reached	31
Number of individual assessments done for examining developmental, mental health and protection issues	237
Number of group sessions conducted with the anganwadi children	190
Number of children reached through group activities	276
One day training workshops for anganwadi workers	4
Number of weekly training sessions for anganwadi workers	89

anganwadi worker was provided with first level inputs including what the Anganwadi worker may do to help the child, and how she could counsel the parents. For complex issues (such as developmental disabilities) requiring specialized assistance, the anganwadi worker was assisted to refer the child to the dept. of child and adolescent psychiatry of a tertiary care facility and/or to the concerned child welfare committee.

Group activities were conducted with the anganwadi children along with anganwadi workers (also as part of their capacity building through demonstration and on-the-job training). These group sessions with children, focused on domains of development, mental health and protection, and comprised of the following: Activities for promotion of early stimulation and optimum develop-ment in the five key areas of child development (physical, social, speech and language, cognitive and emotional development). including fine motor activities to develop pre-writing skills; Activities for socio-emotional develop-ment, with a focus on helping children recognize and manage emotions, and develop empathy; and, Activities for child sexual abuse prevention and personal safety.

Capacity building of anganwadi workers: This was done using capacity building workshops and on-the-job training.

One of the key objectives of the intervention was to build the knowledge and skills of the anganwadi workers in the areas of child development, mental health and protection. The specific training objectives included enabling anganwadi workers to: Understand the context of child abuse and neglect, including physical, emotional and sexual abuse; Identify and provide first level and emergency responses and necessary referrals in the context of child abuse and neglect; Administer the assessment proforma to child developmental, protection and mental health needs and issues in individual children; Use personal safety and sexual abuse prevention module with preschoolers; and, identify and manage (including refer) emotional and behavioral problems, develop-mental and protection issues among young children.

The training content is detailed in **Box I**. It was delivered using creative participatory and experiential methods, such as role play, case discussions, simulation games, demonstrations, brain-storming, pile sorting/ listing – so that the learning was made fun and interesting, but also to enable workers to learn necessary methodologies for use with young children.

Over a 7-month period, training and capacity building activities were conducted through 4 one-day workshops, which were held once in two months, at the tertiary care facility that the project was based out of. Other times, weekly sessions were held on an on-going basis, for clusters of anganwadis (4 to 12 Anganwadi workers) located near each other. This enabled Anganwadi workers to avoid travelling long distances to attend training; and it allowed them to complete their morning tasks com-fortably in order to free up their time for the afternoon session. The training team ensured that a friendly, light-hearted learning environment was created in the Anganwadi and in workshops.

Alongside the training, daily field visits were used by the team, to provide on-the-job support to the anganwadi workers. This included demonstrations on conducting activities for early stimulation and development, and for

Box I Training Content for Integrated Child Development, Mental Health and Protection Programming

Children and childhood

Setting the tone: Re-connecting with childhood
Child development basics
Power and rights

Child development

Physical development
Speech and language development
Cognitive development
Social development
Emotional development (Including demonstration of early stimulation activities in five domains of developmentand development of low-cost early stimulation materials)

Identifying problems and contexts: the child's experience and inner voice

Understanding the child's experience and inner voice
Identifying and understanding child's behavior using the context, experience and inner voice framework

Understanding and responding to common emotional and behavior problems in early childhood

Different methods of responding to emotional and behavioral concerns
Managing the aggressive and oppositional child
Management of children with temper tantrums
Identifying and understanding an ADHD child

Conceptual understanding of child protection in early childhood

Introduction to child protection issues specific to early childhood
Introducing government systems and programs available for child protection

Understanding child sexual abuse in early childhood

Child sexual abuse basics
First level psychosocial responses for sexually abused children
Introduction to the child sexual abuse prevention module
Practicing the child sexual abuse prevention module

Assessing children for developmental, mental health and protection issues in early childhood

Assessment of child development issues in early childhood
Assessment of emotional and behavioral problems in early childhood
Assessment of child protection issues in early childhood

**The content is available as a training manual at: https://www.nimhanschildproject.in/training-and-capacity-building/training-manuals-materials-for-child-care-service-providers/*

personal safety and abuse prevention, administration of the assessment proforma and management of common emotional and behavioral problems in young children. Additionally, revision and recap of some of the training workshops/sessions were also done in one-on-one sessions with anganwadi teachers, to help them link theory and practice issues in the field.

Development of activities and materials for use with children: In order to provide Anganwadi workers with standardized methods in their direct work with children, several materials have been developed for intervention purposes. Some of these materials were also translated into the local language. The materials include the following: activity book for socio-emotional develop-ment in pre-school children; child sexual abuse and personal safety module - activity-based awareness and learning for preschoolers and children with developmental disabilities; early stimulation and development activity books and flip charts (for use with parents, teachers and caregivers); Stories for preschoolers on themes of loss and grief, separation anxiety and attachment, etc. (material available at: *https://www. nimhanschildproject. in/interventions/pre-school-0-to-6-years*/).

Given the contextual challenges of the anganwadi workers, the team developed and adopted several types of strategies, throughout its implementation processes, so as to provide for a more enabling learning and work culture and environment for the workers (**Box II**).

Process outcomes of interventions: Since our interventions were not part of a research study, no measures were used to examine the effectiveness of the interventions we provided. However, based on observations and feedback received from anganwadi workers, some critical qualitative process outcomes, mainly in terms of anganwadi workers' attitudes and learning were found. The anganwadi workers over come their initial reluctance, appreciated learning relevant skills and interventions, and became more aware of the child protections risks and interventions.

LESSONS LEARNT

As evidenced by the gaps in literature, there is little data on young child protection and mental health issues in developing contexts, including in India. It is critical therefore for research and intervention studies to be undertaken in non-clinical, community settings to better understand health, protection and developmental issues in some of the most vulnerable children in our country i.e. those who are least likely to access protection and mental health services. Whether for action research or programmatic interventions, the existing ECCD program, namely the ICDS, with its coverage and reach, provides the best chance that a low resource country such as India has, to protect its most vulnerable children.

Box II Specific Strategies Adopted for Capacity Building of Anganwadi Workers

Use of creative methods in training, also to understand importance of child-friendly methods

- Shorter and more focused learning with an element of continuity and follow up.
- Contents were tailored to the learning abilities of the Anganwadi workers.
- Minimal use of lecture methods; increased use of experiential, creative and participatory methods,
- Creation of a sense of anticipation and enthusiasm amongst the workers, and also gave them a sense of the importance of methodology in child work.

Connection, not correctional approaches

- Listening, recognizing and validating the Anganwadi workers' experiences and concerns.
- Assurance that the intent was to reduce, not increase their work burden.
- Assurance that the objectives were neither to criticize nor report but to understand and support their work, to enhance what they are already doing, so as to benefit children.

Helping workers with time management

- Helping with time management and enabling balance between administrative responsibilities and child work.
- Enabling daily schedules to allow time for direct work and non-formal education activities with children.

Motivational strategies

- Creation of WhatsApp group as a shared learning platform to allow for peer learning and appreciation of new techniques and creativity.
- Encouragement of posting of videos for visual (peer) learning.
- Creation of a book of children's songs for early stimulation (with the names of the Anganwadi workers who contributed).

Revision and review

- Encouragement to initiate new activities that help translate theory into concept.
- Competitions wherein Anganwadi workers were asked to create and share low cost aids for early stimulation (with prizes/rewards for some of the most creative efforts–but in a spirit of fun and friendship).
- No criticism or blame was laid on a worker who was unable to do 'homework' activities.
- Appreciation for workers who implemented 'homework' activities', with an emphasis on the positive aspects of the activity designed.

While a great many systemic measures and changes are required to enable the ICDS to gear itself to integrated programming that straddles child development, pro-tection and mental health, child health experts, who are already available within the secondary and tertiary levels of healthcare, can initiate transformations through the approaches they bring to child services. Pediatricians usually see children and families regularly and over a long period, thus having the advantage of trust and a personal relationship that allows them to gain a deeper knowledge of the child's background, including family systems and dynamics. The relationship pediatricians have with the children and parents is devoid of the stigma usually associated with mental health and child protection professionals, thus causing parents and caregivers to be more open and receptive to their suggestions and inputs [41]. Consequently, they are well-placed to pick up on child protection concerns and provide recommendations and/or referrals to child protection systems [42]. Pediatricians can also lead the way in child protection in India, including to provide capacity building support to the ICDS.

The training courses conducted by job training centers who provide capacity building programs to anganwadi workers require major re-examination and over-hauls, so that they develop integrated conceptual frameworks and interventions that cater to the critical domains of early childhood development, protection and mental health, and use pedagogies that are appropriate to those who work with young children–the use of creative and participatory methodologies in training programs are more likely to be translated into practice at field level, in direct work with children.

It is true that anganwadi workers experience a great many challenges and thus work under extraordinarily difficult conditions. It is understandable that high workloads, and lack of health insurance, to serve as demotivating factors for them. This is why methodology is as critical as the content – more so perhaps in this context. The challenge is not so much about the potential opportunities these programs and systems provide for the integration of protection services for young children, rather how best to plan an intervention through which the capacities of the service providers could be developed by navigating through their many challenges.

We have begun work with state departments on sharing the models and methods described in this paper. In conclusion, experiences from our pilot project suggest that an empathic approach, that acknowledges the anganwadi workers challenges and limitations, and takes them into consideration in program design, would be the way forward. The use of less conventional approaches that are built into local traditions and cultures, creating community-based forums that workers are keen to be a part of, is a key strategy for making space and time for their capacity building and for their work with children. We have begun work with state departments on sharing the models and methods described in this paper. In addition to the commitment of the ICDS scheme and its functionaries, further work, research and experiences across the country will determine the scalability of these methods.

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