



INTERNATIONAL CONFERENCE OF COMHAD & CHPA 2015

(Supported by The Commonwealth Foundation UK)

In association with

UNICEF, MUHS, DMER & IAP Nagpur

Souvenirs 2015

5th & 6th December 2015 * Nagpur, India



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INTERNATIONAL CONFERENCE OF COMHAD & CHPA 2015

(Supported by The Commonwealth Foundation UK)

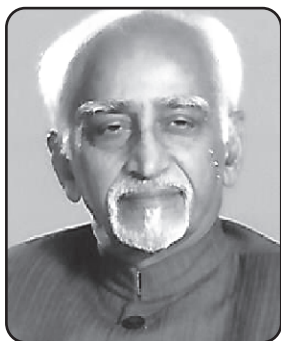
In association with

UNICEF, MUHS, DMER & IAP Nagpur

Souvenir
2015

5th & 6th December 2015 * Nagpur, India





Hon. Mohd. Hameed Ansari



भारत के उप-राष्ट्रपति के विशेष कार्य अधिकारी
**OFFICER ON SPECIAL DUTY
TO THE VICE-PRESIDENT OF INDIA**
नई दिल्ली / NEW DELHI-110011
TEL.: 23016422 / 23016344 FAX : 23012645

Prudent thought

The Hon'ble Vice President of India is happy to learn that under the auspices of Commonwealth Health Professionals Alliance (UK), Indian Academy of Pediatrics Nagpur, UNICEF, DMHR, MUI IS, India & Bangladesh Chapters of COMHAD the International Conference of Commonwealth Association for Health and Disability on the theme 'Global Empowerment and Inclusion of Special Children' is going to be organized on December 5-6, 2015 in Nagpur.

The Vice President extends his greetings and congratulations to the organizers and the participants and wishes the event all success.

(Anshuman Gaur)

**New Delhi
14th October, 2015.**





प्रधान मंत्री कार्यालय
नई दिल्ली-110011
PRIME MINISTER'S OFFICE
New Delhi - 110011

Prudent thought

The Prime Minister is happy to learn that the International Conference of Commonwealth Association for Health and Disability (COMHAD) 2015 is being organised in Nagpur on 5th and 6th December, 2015.

On this occasion, best wishes to the organisers and the participants.

(Chandresh Sona)
Deputy Secretary

18 November, 2015
New Delhi





His Excellency
Shri Kamallesh Sharma
Secretary General of Commonwealth Of Nations

Prudent thought

I am very pleased to introduce the Commonwealth Association for Health and Disability. COMHAD is carrying out vital work in the area of maternal and reproductive health and disability prevention in children, which is so important for the success of future generations.

COMHAD is a Commonwealth organisation and as such forms part of the Commonwealth family, which advances Commonwealth values. In our Commonwealth Charter there is specific recognition of the necessity of all Commonwealth citizens having access to affordable healthcare.

My Best Wishes for the Conference in Nagpur, India.

Commonwealth Secretariat
Marlborough House, Westminster,
London - U.K.



नितिन गडकरी
NITIN GADKARI



मंत्री
सड़क परिवहन, राजमार्ग
एवं पोत परिवहन
भारत सरकार
नई दिल्ली-110001
MINISTER OF ROAD TRANSPORT,
HIGHWAYS AND SHIPPING
GOVERNMENT OF INDIA
NEW DELHI-110 001



Prudent thought

I am happy to know that International Conference of Commonwealth Association for Health and Disability (COMHAD) 2015 is scheduled to be held on 5-6 December, 2015 at Nagpur on the theme "Global Empowerment and Inclusion of Special Children".

Global Empowerment is the need of the hour. A nation cannot develop without empowerment. I am confident that this conference will achieve aims and objectives of the association by providing education and research in health and disability for quality of life by raising awareness for prevention of disease and disabilities and promoting health care for the society at large.

I congratulate and extend my hearty good wishes to the Organisers, all the Members, Participants, Delegates and Audience of this Conference.

I wish the Conference a great success.

(Nitin Gadkari)

Date : 1st October, 2015

Place : New Delhi

Transport Bhawan, 1 Sansad Marg, New Delhi-110 001, Tel.: 23711252, 23710121 (O), 23011027 (R), 23719023 (F)
E-mail : email@nitingadkari.org



डॉ. हर्ष वर्धन
DR. HARSH VARDHAN



मंत्री
विज्ञान और प्रौद्योगिकी एवं पृथ्वी विज्ञान
भारत सरकार
नई दिल्ली-110001

SCIENCE & TECHNOLOGY AND EARTH SCIENCES
GOVERNMENT OF INDIA
NEW DELHI-110001

MESSAGE

I am very glad to know that Commonwealth Association for Health and Disability (COMHAD) 2015 is organizing an International Conference of COMHAD 2015 on 5-6 December, 2015 at Nagpur, Maharashtra.

International Conference of Commonwealth Association for Health and Disability aims to provide education and research in health and disability for quality of life by raising awareness for prevention of disease and disabilities and promoting health care for low and middle income group of the community. It would be a good platform for promoting health development, exchange of technical expertise and inter-country training and education in health in Commonwealth countries all over the world.

I convey my best wishes to Commonwealth Association for Health and Disability on this occasion and wish for its successful completion.


(Dr. Harsh Vardhan)



हंसराज गंगाराम अहिर
HANSRAJ GANGARAM AHIR



राज्य मंत्री
रसायन एवं उर्वरक
भारत सरकार
नई दिल्ली – 110001
Minister of State
Chemicals & Fertilizers
Government of India
New Delhi - 110001

MESSAGE

It is pleasure to know that International Conference of Commonwealth Association for Health and Disability (COMAD) 2015 is being held in association with Commonwealth Health Professions Alliance (CHPA), Indian Academy of Pediatrics, Nagpur, UNICEF, DMER, MUHS, and India and Bangladesh Chapters of COMHAD, is holding on December 5 and 6, 2015, Nagpur. I extend my best wishes to the conference and the souvenir being released to mark the occasion.

The selection of the theme of the conference **Global Empowerment and Inclusion of Special Children** is also appealing and commendable as it can be helpful to find solution on the problems of the special children in the country. Besides this, the new research and trends in the medical field to treat such children can be discussed at length in the conference and the participant pediatrics be appraised with it and benefited with it.

Again, I extend my best wishes to the conference, the souvenir being released and laud Indian Academy of Pediatrics, Nagpur Chapter for its i

With Regards !


Hansraj G. Ahir

Room No 303-A, Shastri Bhawan. New Delhi - 110001 Tel : 23383686, 23382364, 23381768 Fax : 23381713
Address : 8, B D Marg, New Delhi, Tel. : 011-23716855



Ch. Vidyasagar Rao
GOVERNOR OF MAHARASHTRA



RAJ BHAVAN
Malabar Hill
Mumbai 400 035
Tel. : 022-2363 2660
Fax.: 022-2368 0505

12 October 2015



MESSAGE

I am pleased to know that the International Conference of the Commonwealth Association for Health and Disability, COMHAD 2015 is being organized by the Indian Academy of Pediatrics Nagpur in association with the Commonwealth Health Professions Alliance (CHPA), UNICEF, DMER, MUHS and the India and Bangladesh Chapters of COMHAD in Nagpur on December 5th and 6th 2015.

It is gratifying to note that COMHAD established in the United Kingdom in 1983 with support from Commonwealth Foundation, is one of the Commonwealth Professional Associations and Pan- Commonwealth Non-Government Organization (NGO) working in 54 countries, in the field of health and disability. I do hope that COMHAD 2015 will serve as a global forum for dissemination of original research results, new ideas, innovations and practical development experiences on all subjects related to the theme 'Global Empowerment and Inclusion of Special Children'.

As Governor of Maharashtra and Chancellor of universities in the State, I welcome the hosting of this international academic mega event in Maharashtra as I believe that it will bring the problems of special children into sharp focus and bring out suggestions for improving the quality of life of the children. I congratulate the organizers of COMHAD 2015 and wish the participants fruitful deliberations.

(Ch Vidyasagar Rao)



मुख्य मंत्री
महाराष्ट्र



Chief Minister
Maharashtra

10th November 2015



MESSAGE

I am happy to learn that common wealth association for health & disability is organising International Conference of COMHAD on 5th & 6th December 2015 at Nagpur.

It is good to know that this conference is held in association with Commonwealth health Professions Alliance (CHPA). The theme of the conference is a Global empowerment and inclusion of special children.

I wish all the best for the success of the conference and appreciate the efforts of the organisers for conducting international conference on the issue of special children.

I wish good luck for the future endeavours of the Association.

(Devendra Fadnavis)





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email id : guardianminister.officengp@gmail.com

दिनांक :



शुभेच्छापत्र

इंडियन मेडीकल अशोसिएसन, नागपूर व इंटरनॅशनल कॉन्फरन्स ऑफ कोमाड यांचे संयुक्त विद्यमाने ५ डिसेंबर व ६ डिसेंबर २०१५ ला सेंट पॉईंट हॉटेल, नागपूर येथे “ग्लोबल इम्पॉवरमेंट आणि इन्फ्लुशन ऑफ स्पेशन चिल्ड्रेन” या विषयावर आंतरराष्ट्रीय संगोष्ठीचे आयोजन होत आहे. यात ५४ देशाचे एन.जी.ओ. सहभागी होत आहेत. या स्तुत्य उपक्रमास मी मनापासून शुभेच्छा देत आहे.

(चंद्रशेखर बावनकुळे)





Vinod Tawde

Minister

School Education & Sports, Higher & Technical Education, Medical Education,
Marathi Bhasha, Cultural Affairs
Maharashtra State

Date : 30.09.2015

MESSAGE

I was delighted to hear about the International Conference of Commonwealth Association for Health and Disability (COMHAD) 2015 organised by your esteemed organisation, The Indian Academy of Pediatrics Nagpur. The theme of the conference being Global Empowerment and Inclusion of Special Children speaks for the marginalised group and the team is doing an excellent job at highlighting their special issues.

The efforts put in by the members of your institution in organising this event are massive and applause worthy. The ingenuity of thought processes behind creating a joint forces of medical professionals to create awareness about disabilities and related health issues is incredible and it reflects the foresight of the event organisers.

I pray that the conference is a grand success and encourages the members of your institution to come up with many such great events.

Best of Luck for the conference and all future endeavours!

Yours,

(Vinod Tawde)

108, First Floor, Annex Building, Mantraiaaya, Mumbai - 400032.
Telefax : 22027174 / 22029742 E-mail : ministervinodtawde@gmail.com www.vinodtawde.com





**MINISTER FOR
SOCIAL JUSTICE AND
SPECIAL ASSISTANCE**

GOVERNMENT OF MAHARASHTRA
Mantralaya, Mumbai 400 032
www.maharashtra.gov.in

Date : 25.11.2015

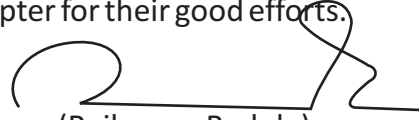
क्र. मंत्री (सा.न्या.व.वि.म.)/नोट/235/2015

I always realise that persons with special needs with appropriate training are gradually proving themselves as useful member and contribution to the society. It is now for the community to open doors for them and make available all possible opportunities to help them to grow and normalise rather than stigmatise them as an incapable that for this we need easy, renewed and advanced knowledge ideas, strategies and research practices.

I am very glad to know that International Conference of Commonwealth Association for Health and Disability (COMAD) 2015 is being held in association with Commonwealth Health Professions Alliance (CHPA), Indian Academy of paediatrics, Nagpur, UNICEF, DMER, MLIHS, and India and Bangladesh Chapters of COMHAD is holding on December 5th and 6th, 2015, Nagpur. On the theme Global Empowerment and Inclusion of special children.

I am very much sure that all the topics, issues to be discussed in the conference will be benefited to all the participator.

I extend my best wishes to the conference, the souvenir being released and congratulate the whole team of the Indian Academy of paediatrics, Nagpur chapter for their good efforts.



(Rajkumar Badole)





मा. डॉ. मिलिंद माने
आमदार
नागपुर-उत्तर
विधानसभा क्षेत्र
भ्र. क्र. 9823044131

कार्यालय : सरस्वती हॉस्पिटल, निर्मल भवन, डॉ. आंबेडकर मार्ग, इंदोरा चौक, नागपूर - 17.



Date : 26/11/2015

MESSAGE

Dear, Iapians and Friends,

I am happy to know that IAP Nagpur in association with commonwealth foundation (U.K), UNICEF, MUHS and DMER organising international conference of COMHAD 2015 at Nagpur.

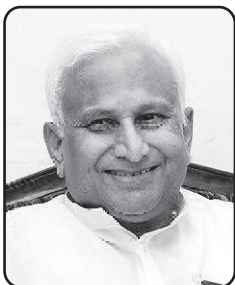
I am sure that this will help the delegates to enrich their knowledge for betterment and empowering the children with any kind of physical and intellectual disability.

My congratulations to organising team and extend my best wishes for success of the conference.

Yours Sincerely

Dr. Milind Mane
M.L.A.
57-Nagpur-North





Dr. GIRISH GANDHI

D.Lit. (HONORIS CAUSA)

RECEPIENT OF INDIRA GANDHI PARYAVARAN PURASKAR (GOVT. OF INDIA)

EDITOR - "GREENHOPE" (ECO-FRIENDLY MONTHLY MAGAZINE) \

TRUSTEE - VANARAI TRUST, PUNE

PRESIDENT - VANARAI FOUNDATION, NAGPUR

PRESIDENT- MARWADI FOUNDATION, NAGPUR

Dear Uday and friends,

Received with thanks your invitation for the **International Conference of Commonwealth Association for Health & Disability on 5th December, 2015.**

The theme of this conference with special focus on children is the need of the hour and will surely address the various important issues in this field.

With Hon'ble Shri. Devendra Fadnavis, Chief Minister, Maharashtra as a patron, the conference will surely be a grandsuccess.

Wishing you and all the member's of COMHAD a very Happy New Year ahead.

With regards

Thanking you.

Your's Sincerely,

(Girish Gandhi)



Dr. (Mrs.) Mrudula A. Phadke

MD. DCH. F1AP, MRCP(UK), FRCP Crt'UK), MNAMS, FNAMS

Visiting Scientist, Haffkine Institute of Training Research & Testing, Mumbai
• Consultant, UNICEF
• Impendent Director, Serum Institute of India Ltd., Pune
• Advisor, Maharashtra state AIDS Control Society
• Adjunct Professor, Maharashtra University of Health Sciences, Nashik

• Ex. Vicc Chancellor, Maharashtra University of Health Sciences, Nashik
• Ex. Director of Medical Education & Research, Govt, of Maharashtra



MESSAGE

Distinguished delegates who have gathered in Nagpur, the orange city of India on this day of 5th of December 2015 to attend one of the prestigious international Conferences of COMHAD

It gives me great pleasure to pen a few lines for the conference which is being jointly organized by various professional bodies like Commonwealth Association for Health and Disability (COMHAD), Commonwealth Health Professions Alliance (CHPA), Indian Academy of Paediatrics (IAP), United Nations International Children's Fund (IJNICEF), Maharashtra University of Health Sciences (MUHS), and Directorate of Medical Education & Research (DMER) on Global empowerment and special children. As we all know, COMHAD was established in the UK in 1983 with an aim to prevent mental handicap, promote advocacy and awareness, establish professional links for education & research and foster political commitment. It is joined today by CIIPA. This august body is formed by an alliance of COMHAD, Commonwealth Association for Paediatric Gastroenterology and Nutrition (CAPGAN), Commonwealth Dental Association (CDA), Commonwealth Medical Association (CMA), Commonwealth Nurses Federation (CNF), Commonwealth HIV And Aids Action Group (CHAG) and Commonwealth Pharmacists Association (CPA), 3 years ago. A united voice is a stronger voice and therefore working together they promote the aims of these organizations, represent and support the members in commonwealth countries. CHPA collaborates on joint projects and therefore the objects of education, advocacy and research are fulfilled through holding of such wonderful conferences.

As one is aware, care for special children begins even before conception. Here comes the role of a Geneticist and an Obstetrician to look after counseling, prevention and prenatal diagnosis of malformations and genetic diseases. Needless to say, gene

manipulation techniques may reach the ambit of a common man In a few years, given that the science is increasing in leaps and bounds. As one prevents these diseases, infections including HIV/AIDS can now be prevented and treated with wonderful combinations of anti retroviral drugs. The next issue especially for the developing countries is the prevention and treatment of severe acute malnutrition which really poses a threat to progress, considering the high morbidity, impaired cognitive development, stunting, leading to decreased productivity and finally lack of national upliftment.

Today's conference deals in detail issues like infant feeding, nutrition, leading to good growth & development of the infant and prevention of malnutrition, i.e. under nutrition in childhood and obesity developing in adults. The role of nursing, pharmacists and general practitioners here is unparalleled.

Such is the expanse of this international conference. I am sure each one of us is playing her / his role in the best possible way to make the conference an academic least, a thought provoking endeavour and providing wonderful forum to share and care!

I congratulate the organizers for their untiring efforts and wish the conference a great success!!

Thank You

Dr. M. A. Phadke
Sr. Adv. NHM
President CHPA

181. Buena Vista Jangannal Bhosale Marg, Near Y. B. Chavan Conter. Mumbai - 400 021

• Telefax -91 22 - 22022654 • Mobile No *91 -9821069353 • E-mail: drmapaa@yahoo.com



MESSAGE

It is heartening to note that the International Conference of Commonwealth Association for Health and Disability (COMHAD) 2015, in association with Commonwealth Health Professions Alliance (CHPA), Indian Academy of Pediatrics Nagpur, UNICEF, DMER, Maharashtra University of Health Sciences (MUHS), Nashik and India and Bangladesh Chapters of COMHAD is scheduled to be held from 5th & 6th December 2015, at Hotel Centre Point, Nagpur.

I am pleased to learn that, the Indian Academy of Pediatrics, Nagpur is hosting and working force on forefront for organizing this mega event, International Conference of COMHAD.

It is noteworthy that COMHAD is carrying out vital work in the area of maternal and reproductive health and disability prevention in children with the support from Commonwealth Foundation and is involved in promoting health development, exchange of technical expertise inter-country training and education in health.

Organizing such conference with an ambitious theme of "Global Empowerment and Inclusion of Special Children" is another sign of showing desire to change with the time. I am sure that this conference will focus on many more issues of area of maternal and reproductive health and disability prevention in children.

My wholehearted congratulations for organizing such a wonderful conference! It is remarkable that the COMHAD takes more delight in strengthening and enlarging the institute for better healthcare service to the humanity. MUHS always appreciate and support such kind of activities, which will help strengthening Community Health System.

In the era of modern technology, lectures by eminent International and National speakers and guests from are knowledge boosting platform for participants. I am sure that the scientific programme will help the delegates more to upgrade their knowledge and skills.

Maharashtra University of Health Sciences offers its best wishes to International Conference of Commonwealth Association for Health and Disability (COMHAD) 2015 and congratulates each and every organizing committee member and participants of this magnanimous conference and wishes all success in their present and future endeavours.



Prof. Dr. Arun Jamkar

Dindori Road, Mhasrul, Nashik - 422 004.

Tel.: 0253-2531835 Fax : 0253-2539113

Website : www.muhs.ac.in E-mail: vc@muhs.ac.in, muhsvc@hotmail.com





Message

It gives me immense pleasure and gratification to welcome you all for this mega academic event **"INTERNATIONAL CONFERENCE OF COMHAD, CHPA & IAP 2015"** scheduled on 5th & 6th December 2015 in this famous **Orange City** of INDIA.

The theme of the conference **"Global empowerment & inclusion of special children"** has been chosen to focus on the challenges faced by these specially abled children and their parents in day to day life in leading good quality of life.

Inclusive education and special school concepts are not competitive but complementary to each other; Inclusion in education is an approach to educating students with special educational needs.

Research has shown positive effects for children with disabilities in areas such as reaching Individualized Education Program (IEP) goal, improving communication and social skills, increasing positive peer interactions, many educational outcomes, and post school adjustments.

Positive effects on children without disabilities include the development of positive attitudes and perceptions of persons with disabilities and the enhancement of social status with non-disabled peers.

The overall benefits could be the Directive Principle of Indian Constitution, the National Policy of Education, The RCI Act, the PWD Act, The Sarva Shiksha Abhiyan (SSA 2010) project empowers to ensure admission, retention and education of all children in the age group of 6 to 14 years, including the disabled children. No normal school can deny admission to a disabled child.

Today, with the availability of abundant opportunities across different fields, be it, music, sports, martial arts, art and craft, children, especially the specially challenged children can excel across multiple myriad fields with basic academics and adequate life skills. And this is where we and the current education system of our country need to focus on to empower children with special needs.

Galaxy of experts in the field of childhood disability will enlighten the attending delegates and will finally come out with final guidelines and policies to implement as draft, **"COMHAD NAGPUR declaration 2015."**

We assure you all great academic feast & In addition Vidarbha Hospitality will fetch you all with great cultural feast by specially abled children of ANANDVAN VARORA.

Our ever enthusiastic team of Nagpur under the able academic leadership of Chairman Dr Yashwant Patil, President Dr R G Patil, Organizing Secretary Dr Suchit Bagde, Secretary Dr Girish Charade along with team IAP & COMHAD need special compliments in successfully organizing this mega academic event.

With greetings and best wishes for Happy New Year & Mary Christmas

Dr Uday Bodhankar

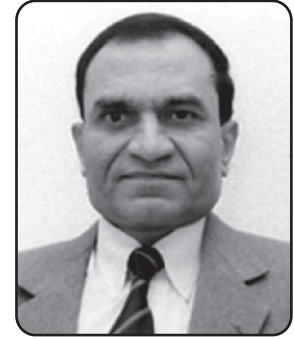
International President Commonwealth Association For Health & Disability

International council Member -ASPR

NAGPUR, MS INDIA 440012

ubodhankar@hotmail.com WWW//COMHAD.COM





Message

Dear Esteemed Delegates,

On behalf of the Organizing Committee with a great sense of pride and privilege, I take this opportunity to invite you to the Orange City of India, to attend this unique convention, INTERNATIONAL CONFERENCE of COMHAD, CHPA & IAP in association with UNICEF, DMER, MUHS and India & Bangladesh Chapters of COMHAD, from 5th to 6th December 2015.

I am extremely thankful to the hardworking, trustworthy and sincere working force on forefront of IAP Nagpur, who has burnt the midnight oil to make the event a memorable one and need to be complimented for their tireless efforts. Indeed we are indebted with their generous and friendly approach towards COMHAD & CHPA.

Renowned experts who are acknowledged authorities in their respective fields are expected to attend this conference. The theme of the Congress is "Global Empowerment and Inclusion of Special Children". Considering the theme every effort is being made with the guidance provided by the seniors to make this conference a valuable learning experience academically, through rich scientific program; and a memorable one socially.

I am sure this Conference is going to give you all, an opportunity to share the knowledge and experience with eminent national and international faculties.

I will fail in my duty if I do not express my sincere thanks to our dynamic President of COMHAD DrUdayBodhankar, Chairperson of CHPA DrMrudulaPhadke&President of IAP Nagpur DrR GPatilfor their untiring efforts&valuable guidance in making this impossible mission to possible with immense support by, DrPrakashSanghavi, DrSuchitBagde, DrJayantUpadhye, DrVasantKhalatkar, DrGirishCharde, DrShaileshPangaonkar, DrUrmilaDahake and all other Committee members of Organizing team.

I look forward to your active participation and assure that you will enjoy Nagpur hospitality and carry home the sweet memories of the conference.

With warm regards and best wishes,

Dr. Yashwant Patil
Jt. Secretary COMHAD UK,
Organizing Chairman
Int. Conf. of COMHAD, CHPA & IAP 2015,
Nagpur





Message

Greetings from Orange city.....

As President of the host association it gives me immense pleasure in welcoming all delegates to the city of oranges. Needless to say organising a conference of this magnitude that too international conference of COMHAD 2015 has its share of omissions and blemishes but I can assure you that these were inadvertent & unintentional. We have put in all efforts to provide best of services and academic feast.

We are happy that primary focus of this conference will be on physically & mentally challenged children. I am confident this conference will bring the best of academic discussions.

I Congratulate Dr Uday Bodhankar, President COMHAD, Patron & always enthusiastic person, helping in nature, Dr Yashwant Patil, Chairman COMHAD, Dr Suchit Bagde, Org Secretary, Dr Girish Charde Secretary IAP, Dr Vasant Khalatkar, EBM & all other office bearers of this conference.

Special thanks to Dr Shailesh Pangaonkar & Dr Shubhada Khirwadkar for taking efforts to publish this Souvenir.

I extend my best wishes for this conference.

**Dr R G Patil,
President IAP, Nagpur**

**Dr Girish Charde,
Secretary IAP, Nagpur**





Message

Dear Colleagues,

IAP Nagpur and COMHAD FOUNDATION (U.K.) with CHPA & MUHS, UNICEF is hosting COMHAD 2015 on 5th and 6th December 2015 at Nagpur. I welcome all Delegates and Speakers and Guests and thank them for their participation and academic contributions to make this event a grand success.

Bringing up the special children and empowering them with skills to excel in life is a big challenge and so also COMHAD 2015 with all odd's and even's under able guidance of Dr Uday Bodhankar and Dr Yashvant Patil we tried to uphold the standards of International Conference COMHAD 2015.

The special efforts by Dr Shailesh Pangaonkar and Dr Urmila Dahake in finalising Scientific Program is worth appreciating. Every member of organising committee put their best to make the conference memorable. I am thankful to President Dr R G Patil and Secretary Dr Girish Charde and E B Member Dr Vasant Khalatkar for their whole hearted support throughout the year.

With Regards

Dr Suchit Bagde
Organising Secretary
COMHAD 2015





Dr Shailesh
Pangaonkar



Dr Shubhada
Khirwadkar

From the Editorial Desk....

Greetings from souvenir committee of International Conference of COMHAD, India & Bangladesh chapters in association with Commonwealth Health Professions Alliance (CHPA) & Academy of Pediatrics, Nagpur, UNICEF, MUHS & DMER.

We are all very excited to host this conference in the heart of India & extend a warm & hearty welcome to you all - the well known faces, the doyens in the field of child health & disability along with the new generation of care givers ! The health & well being of physically & mentally challenged children needs to be looked at with a holistic approach so that they are included as meaningful contributors in the happiness on our planet!

This mega event thus has a vision to connect the National & International experts, not only with pediatricians but also with physiotherapists, special educators, parents, teachers & counselors. Thus, the scientific deliberations which include guest lectures, panel discussions, symposia & workshops including Surgical insights, aim to provide a rich fare of a such a multi pronged approach.

COMHAD along with its associates has been working relentlessly for past several years with a vision for inclusion of the challenged ones with those in the mainstream. Building relationships among all the stakeholders who care for the disabilities, is a dream we all have long cherished ! We hope that this conference provides an opportunity to meeting of such sensitive & knowledgeable minds & holding of caring hands ! This souvenir provides not only a window into the recent advances in management & therapy of disabilities but also opens the door for stimulating thought processes towards an inclusive world!

The organizing committee under the able guidance of Dr Uday Bodhankar & Organizing Chairman Dr. Yashwant Patil have left no stone unturned to make this event a memorable one!

Let us all walk on the path inspired by Helen Keller's words....

"There's no better way to thank God than by giving a helping hand to someone in the dark!"

On behalf of the organizing committee wishing you a professionally fulfilling year ahead!



COMHAD INTRODUCTION



COMHAD was established in the United Kingdom in 1983 with support from the Commonwealth Foundation. COMHAD is one of the Commonwealth Professional Associations and a Pan-Commonwealth Non-Government Organization (NGO) working in the field of health and development focusing on preventive health care. COMHAD is in official relations with WHO since 1990 and is a long standing partner of WHO for collaboration. It is actively involved in promoting health development, exchange of technical expertise and inter-country training and education in health in 53 Commonwealth countries all over the world.

Aims & Objectives :

The aim of the Association shall be to provide education and research in health and disability for quality of life by raising awareness for prevention of disease and disabilities and promoting health care for low and middle income group of the community in urban settings. In the furtherance of this aim the Association will advocate and promote :

- i. Quality health care
- ii. Accessible, acceptable and affordable health care, in particular for differently able people.
- iii. Professional links between workers in health and disability across the Commonwealth.
- iv. The aims and objectives will be achieved through regional and international conferences, workshops and symposiums, publications and communications, demonstration and other projects, training exercises and professional exchange and development programmes.

Membership & Voting Rights :

- i. Membership of COMHAD shall build upon, be continuous with, and transferable from its predecessor CAMHADD.
- ii. Membership shall be open to interested individuals from any commonwealth country.
- iii. Membership of the Executive Committee shall be open only to individuals from Commonwealth countries. However, those having changed citizenship, but originally coming from a Commonwealth country may be elected to the Executive Committee.
- iv. On acceptance, each member will pay such annual subscription as may be determined by the Executive Committee. Subscriptions fall due on 1st January and all members are expected to pay promptly and remain in good standing, which will remain valid till 31st December. The subscription of membership will be the same whenever in the calendar year one is accepted as member of the organization.
- v. All members may vote on matters put before the General Assembly.

Termination of Membership :

Membership may be terminated as follows :

- i. By resignation.
- ii. Through default in the payment of membership subscriptions.
- iii. Where conduct is in any way damaging to the interests and good name of the Association, in which case the Secretary General will notify the member to explain his/her conduct within 30 days. If s/he fails to do so or his/her conduct or his explanation is found to be unsatisfactory, the Executive Committee is empowered to remove such a member.
- iv. Membership of the Executive Committee may be terminated if any member remains absent from three consecutive meetings, or does not respond by post or emails explaining the reasons for such absence.



REPORT OF COMHAD ACTIVITIES :

August 2008-2015



- COMHAD (Commonwealth Association for Health and Disability) met at Puducherry on 15th & 16th August 2008 and reorganized the organization. The theme of the two days workshop was “CAMHADD Vision 2020 : Aids and Child Development”.
- COMHAD was previously known as CAMHADD (Commonwealth Association for Mental Handicap and Developmental Disabilities). However the terminology came under criticism as not being appropriate to address the disabled. Thus during the General body meeting of CAMHADD at Puducherry it was resolved and adopted the change in name of the organization as COMHAD on 15th August 2008.
- Dr. Mark Collins, Director of the Commonwealth Foundation was present during the entire procedure of the two days workshop of COMHAD at Puducherry which also elected the new COMHAD Executive Committee.
- Subsequently the new amended Constitution was given a final shape and adopted by the general members on dated 16th August 2008.
- The EC of COMHAD consists of one President, five Vice presidents from Asia, Africa, Canada / Caribbean, Europe/UK, Pacific, one Secretary General, one Treasurer, and two Joint Secretaries.
- After finalization of the Constitution, COMHAD launched its website as <http://www.comhad.com>. The website consists of the constitution, membership form & publishes activity news and pictures.
- As a part of activity of COMHAD, the Bangladesh Chapter of COMHAD was reorganized and constitution of Bangladesh Chapter was finalized and adopted. Information regarding the Bangladesh Chapter is also available in its website.
- Late Prof. M. S. Akbar, a pediatrician of International repute was the President of the Bangladesh Chapter of COMHAD. He was elected member of the Parliament for four times & was the Chairman of the Bangladesh Red Crescent Society.
- The Bangladesh Chapter of COMHAD is working with Projects on childhood disabilities.
 - a) Development of the Neuroscience & childhood development facilities at BSMMU.
 - b) Childhood Low Vision and Blindness
 - c) Autism
- As a part of COMHAD activity COMHAD India chapter was formed in 2011 at Goa.

The first National Conference of COMHAD India chapter was organised on 30th June 2013 under the leadership of Dr. Prakash Sanghavi President COMHAD India.
- Dr. Uday Bodhankar, Secretary General, COMHAD was also designated as the focal person of COMHAD for all the NGO & WHO contacts. He represented COMHAD on the 60th Anniversary of the Commonwealth Foundation. He met the Director of the Commonwealth Foundation and also visited the Buckingham Palace and met Her Majesty the Queen of England on 28th April 2009 & also H.E. Shri Kamallesh Sharma, Secretary General of Commonwealth Nations.



- Prof. Md. Sirajul Islam, President represented COMHAD at the 63rd World Health Assembly and also the Commonwealth Health Ministers meeting on 16-17 May 2010.
- Dr. Sirajul Islam & Dr. Kathryn Currow, attended debate on “G Goal 2015 achievable or not achievable” organized by CNF. The meeting was addressed by Jill Iliffe, Secretary - CNF, Dr. Mark Collins - Director, CF and Dr. Arulraj, President CMA and others.
- COMHAD organised International Conference at Goa, India on 10 & 11 Sept. 2011. Theme “Women as Agents of Change; Invest in Women & Transform the World”.
- COMHAD had Scientific Session in National IAP Conference (PEDICON 2012) at Gurgaon, India on 20th Jan. 2012. Theme “Save the Women & Child”.
- COMHAD had Scientific Session during 9 National Disability Conference at Nagpur, India on 15th & 16th Sept. 2012. Theme “Challenges to Opportunities Together We can”.
- COMHAD Bangladesh has organised International Conference at Dhaka, Bangladesh, on 20th & 21st Jan. 2013 Theme “Disability Puts no Limit to Ability”.
- New COMHAD Executive Body was elected for three years (2013-2015) by General Body Meeting at Dhaka, Bangladesh on dated 21st Jan. 2013
- National Conference of COMHAD India was organized at Kolhapur, India on 30th June 2013 by President Dr. Prakash Sanghavi. Theme “Create Awareness through Action”.
- Three Days Awareness & Assessment Camp, Training Program for parents & nursing students, Niramay Policy registration camp, on 12th -14th August 2011 at Nagpur, India.
- Free Aids & Appliances Distribution Camp for person under ADIP on 19th Jan. 2013 at Nagpur, India.
- Three Days Continuing Rehabilitation Education Programme (CRE) for Psychologists and Rehabilitation Professionals, on 7th - 9th Oct. 2013 at Nagpur, India.
- Free Aids & Appliances Distribution Camp for person with disability under ADIP on 19th Nov. 2013 at Nagpur, India.
- Continuing Rehabilitation Education Programme (CRE) on “Inclusive Education” on 10th - 12th March 2014 at Nagpur, India.
- Training Programme on “Orientation to International Convention on the Rights of Persons with Disabilities” on 10th May 2014 at Nagpur, India.
- CRE program on “Psychological Intervention for Children with Developmental Delay” on 25th Feb. 2015 at I.M.A. Nagpur, India.
- International Conference of COMHAD, CHPA & IAP 2015 is being organized at Nagpur, MS, India on 5th & 6th Dec. 2015.



FUTURE ROLE OF COMHAD



The new team should evolve new innovations and new ideas and new concepts in view of globalizations, change in global and individual economy, and entry of health insurance and dominance of drug companies.

Taking into consideration of all these factors and the original aims and objectives of COMHAD, following topics are finalized.

- To develop good Governance
- To develop strategies to raise funds
- To develop effective communication through COMHAD Newsletter
- To prepare the second edition of COMHAD Directory
- To appoint one fund raising officer
- To establish & strengthen net work & identify donors
- The team should define the role & responsibilities of each COMHAD Executive Member
- To establish strong COMHAD Chapters in all Regions of Commonwealth Nations

In future there will be two major programmes of COMHAD :

1. Perinatal Health Care including newborn care.
2. Preventive & Promotive Health Care for low and middle income group of the community in urban settings.



COMHAD OFFICE BEARERS (2013 - 2015)



■ **International President**

Dr Uday Bodhankar
NAGPUR, M.S, INDIA

■ **Vice – President (Europe /UK)**

Prof. Sam Lingam
LONDON, UK

■ **President Elect**

Dr. Kathryn Currow
WESTMEAD, Australia

■ **Vice – President (Africa)**

Dr Adenike Grange
NIGERIA, Africa

■ **Imm. Past President COMHAD**

Prof. Md Sirajul Islam
DHAKA, Bangladesh

■ **Joint Secretary**

Dr. Yashwant Patil
NAGPUR, MS, India

■ **Secretary General**

Dr Mesbah Uddin Ahmed
DHAKA, Bangladesh.

■ **Advisors**

Prof Dr Ahrulaj, Past Chairman CPA
Prof Dr B C Chhapparwal, Indore, India
Prof Dr M S Rawat, Nagpur, India

■ **Vice – President (Asia)**

Prof Dr Mrudula Phadke
MUMBAI, MS, India

■ **Hon Legal Advisor**

Adv Mukund Manoharrao Papinwar
High Court, Nagpur, India

■ **Vice – President (Canada / Caribbean)**

Prof. Rajaram Pagadala
MACON, USA

■ **COMHAD News Letter**

Prof. Dr Mrudula Phadke, Chief Editor



COMHAD India Chapter

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Vice Presidents

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Dr K Jayoji Rao

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Dr Arvind D'Almeida

Joint Secretary

Dr Vasant M. Khalatkar

Treasurer

Dr Ramesh M. Nigade

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Mrs Anindita Kishore

Dr Sanil Koyili

Dr Baby Sathish Nayak

Dr Dilip Panikar

Dr H. Paramesh

Mr Abhijit V Raut

Ms G. Anasuya Bai Singh

Dr Prasad Tengshe

Representatives from

Central Executive Committee of COMHAD

Dr Uday Bodhankar

Dr Mesbah Uddin Ahmed

Advisory Committee

Dr Rohit C Agrawal

Dr S. Arulrhaj

Dr Kishore Baya

Dr Vijay Bodhankar

Dr B. C. Chhapparwal

Dr Simin. F. Irani

Dr Sunil D Khaparde

Dr Ajit C. Mehta

Dr Mrs Mrudula A Phadke

Dr M. S. Rawat



COMHAD Bangladesh Chapter

✱ EXECUTIVE COMMITTEE ✱

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Late Prof. M. S. Akbar

Vice Presidents

Prof. T. A. Chowdhury

Prof. A. K. Azad Chowdhury

Secretary

Prof. Md. Sirajul Islam

Joint Secretary

Dr Shaheen Akhter

Treasurer

DrFarid Ahmed

Organizing Secretary

Dr Anisa Jahan

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Dr Md. Laila Arjumand Banu

Dr Mahmuda Hasan

Dr A B M Rafiqul Hoque

Dr Mahbubul Hoque

Dr Md. Shafiqul Islam

Dr Mazharul Mannan (Partho)

Mahbuba Nazneen

Velorie Taylor

Representatives from

Central Executive Committee of COMHAD

Dr Uday Bodhankar

Prof Rajaram Pagadala



International Conference of COMHAD & CHPA 2015

INTERNATIONAL FACULTY



Prof. Md. Sirajul Islam

FCPS (Paed), PhD
Secretary General,
PalliShishu Foundation of Bangladesh



Prof. Rajaram Pagadala

MD (Obs.), DSS (Vienna), PhD (Pop. Studies),
Dip. Hlth. Econ. (WHO, Bangkok)
FIAP, FIMSA, MMAMS (Vienna), FICMCH&FP, FICS
Chancellor & Professor Emeritus
Sri BalajiVidyapeeth University, Puducherry



Prof. Sam Lingam

MD (Hons), FRCPCH, FRCP,
(Glas) Executive Medical Director
Consultant in Paediatrics and
Adolescent Medicine

NATIONAL FACULTY

Dr Azad Sofia

: Principal & Professor Occupational Therapy School & Centre,
GMC Nagpur.

Dr Bhawe Shubhangi

: M.S. (Ophth.), DNB, Consultant Ophthalmologist and Pediatric
Ophthalmologist, Nagpur.

Dr Bodhankar Amol

: MDS (Conservative Dentistry and Endodontics) Endodontist
Bodhankar Dental Clinic, Nagpur, India.

Dr Bodhankar Uday

: International President, Commonwealth Association For Health &
Disability International council Member –ASPR, Nagpur.

Dr Dahake Urmila

: MD Pediatrics, PG Diploma in Developmental Neurology, MA
Counselling Psychology, Developmental Pediatrician, Director,
Vatsalya Child Development Center, Nagpur.

Dr Dalwai Samir

: MD, DCH, DNB, FCPS, LLB, Developmental Pediatrician & Child Rights
Consultant Founder-Director, New Horizons Child Development Centre, Mumbai.

Dr Damke Umanjali

: Principal & Professor Physiotherapy School & Centre, GMC Nagpur.

Dr Disawal Ashish

: MBBS, DLO, DHLS, ENT Consultant, Hearing Language and Speech Therapist,
Director, Digital Diagnostics, Ramdaspath, Nagpur

Dr Deshpande Snehal

: P.T (MIAP), PGDHHM, C/NDT, SI (USC/WPS) Director : Sneh Rehabilitation,
Education & Research Centre- 4 Clinic Chembur, Vashi, Wadala, Mumbai.



Dr Gajre Mona	: Professor, Pediatrics, In Charge, Pediatric Neurodevelopmental Centre Division of Neurology & Developmental Ped., L.T.M.M.C & L.T.M.G.H, Sion, Mumbai.
Dr Gawande Sushil	: Associate Professor Department of Psychiatry NKP Salve Institute of Medical Sciences, Nagpur
Dr Giri Manjusha	: Neurodevelopmental paediatrician, MBBS; DCH; PGDDN; MA (Clinical Psychology), Director Neuron Hospital, Nagpur.
Dr Jain Dipty	: Professor and HOD, Pediatrics, Indira Gandhi Govt. Medical College and Hospital, Nagpur
Dr Kaduskar Prajakta	: M.B.B.S.; D.C.H.; PGD-AP; M.A. (Clinical Psychology) Consultant Child & Adolescent Health Care, 'Blooming Buds' Child & Adolescent Health Care Centre, Nagpur.
Dr Khirwadkar Shubhada	: MD(Ped.) M.A Clinical Psychology, Pediatrician, Counselor & Therapist, Director, 'Tender Buds Child Clinic & Counselling Centre, Nagpur.
Dr Koyili Sanil	: Associate Professor Department of Physiotherapy, NKP Salve Institute of Medical Sciences, Nagpur
Dr Mahadeviah M.	: M.B.B.S, D.A.B.P(USA), FA A C P & D.M Ped. developmental Neurologist, Hon. medical director, Spastics society of Karnataka, Bangalore.
Dr Mallikarajuna H. B.	: Professor of Pediatrics, International course Director and National Trainer IYCF, Professor of Pediatrics, MS Ramaiah Medical College, Bangalore, Karnataka, India.
Dr Meenai Zafar	: MBBS, DCH, PGDDN, Developmental Pediatrician, Consultant Developmental pediatrician and Director Ummeid Group of Child Development Center at Bhopal, Nagpur, Bilaspur. International affairs committee Member FACPD USA. National joint secretary IAP Childhood Disability Group
Dr Mundkur Nandini	: Director - Center for Child Development & Disabilities. Malleshwaram, Bangalore.
Dr Naik Neeta	: Pediatric Neurologist and Epileptologist, Director, EN1 Neuro services, Mumbai, India.
Dr Pangaonkar Shailesh	: MBBS, DPM, DNB, BA, Fellow American Psychiatric Association, Consultant Psychiatrist & Director, Central Institute of Behavioural Sciences, Nagpur.
Dr Paramesh H.	: MD FAAP (USA), FIAP, FIAMS, FIAA, FICAAI Pediatrician-in-Chief, Pediatric Pulmonologist and Environmentalist, Chairman, Medical & Managing Director Lakeside Medical Center and Hospital, Bangalore.
Dr Patil Yashwant	: M.D. (Ped.), D.CH, FIAP, FICMCH, Consulting Pediatrician Jt. Secretary COMHAD UK, Tutor for IPPC/DCH Sydney Uni/MUHS Nashik, Asso. Prof, in Pedi. DMIMS Nagpur, Fellow Guide & Sec. Gen. ICMCH Nagpur.



Dr Shingade Viraj

: MS (Ortho),DNB (Ortho) , Fellowship in Paedi. Ortho. (South- Korea & Royal Ortho.Hosp. UK), Fellowship in Ortho. Oncosurgery (Tata Memorial Hospital, Mumbai, & ROH Birmingham, UK) (Consultant Paed. Ortho. Surgeon Nagpur), Director, Children Orthopaedic Care Institute, Nagpur.

Dr. Shiwalkar Jaya

: MBBS,DCH, MSc..(human development), PG diplomain advanced child/adolescent psychology... EP, Developmental Pediatrician Child/Adolescent Psychologist, Director, CHILD DEVELOPMENT AND ACTIVITY CENTER.

Dr Srivastava Abhishek

: (MBBS, MD, DNB, MNAMS, PhD) Consultant Physiatrist, Specialist in Neurological Rehabilitation Director, Center for Physical Medicine & Rehabilitation KokilabenDhirubhai Ambani Hospital and Medical Research Institute, Mumbai.

Dr Tuteja J. S.

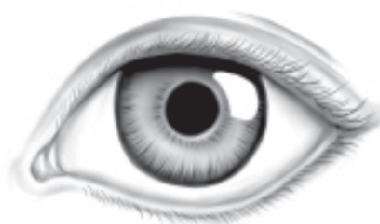
: MD.DCH.PGD-AP.F.I.A.P.Chairperson:Adolescent Health Academy-IAP2012-2013, 2014-2015, MKU 2013

Dr Wankhede Meenakshi

: Pediatric Physiotherapist Director, Sankalp Pediatric Rehab Centre, Wanjari Nagar, Nagpur.



**The worst thing about
disability is that ...**



**it is seen before the
person is seen.**



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Dr Pravin Dahake



INTERNATIONAL CONFERENCE OF COMHAD & CHPA 2015

Scientific Program

1st Day, Saturday 5th December 2015

TIME	SESSION	TOPIC	FACULTY	CHAIRPERSON	MOC/SESSION COORDINATOR
08:00 am – 09:00 am	I	Registration and Breakfast			
09:00 am-10:30 am		UNICEF, MUHS, DMER WORKSHOP			
09:00 am -09:30 am		IYCF	Dr Uday Bodhankar	Prof. Vibhawari Dani Prof.md. Sirajul Islam	
09:30 am - 10:00 am		SAM	Dr Dipty Jain		
10:00 am - 10:30 am		F- IMNCI	Dr Yashwant Patil		
10:30 am - 12:00 noon	II	Perspectives of Childhood Disability			
10.30 am -10.45 am		Global perspective of disability	Dr M Mahadeviah	Dr Suresh Ninawe Dr Prakash Ukey	
10:45 am - 11:00 am		Antenatal risk factors for children with disability	Dr Rajaram Pagadala		
11.00 am – 11.15 am		Early Detection of Disabilities by Parents & Professionals	Prof Dr Sam Lingam		
11:15 am - 11:30 am		Environmental risk factors in children with disability	Dr H Paramesh	Dr Prakash Sanghavi Dr Jayant Upadhye	
11.30 am -11.45 am		Role of Nutrition in prevention of childhood disabilities	Dr Mallikarjun H B		
11.45 am - 12.00 noon		Q & A			

Working Lunch (12 noon to 3 pm) Dr D G Gan Memorial Scientific Session

TIME	SESSION	TOPIC	FACULTY	CHAIRPERSON	MOC/SESSION COORDINATOR
12.00- 2.30		Multidisciplinary approach in child with developmental delay			
12.00 noon - 12.15 pm	A	Follow up of high risk newborn & Early intervention in office practice	Dr Zafar Meenai	Dr K.Jayoji Rao Dr Vasant Khalatkar	
12.15 pm -12.30 pm	B	Orthopedic Interventions	Dr Viraj Shingade		
12.30 pm -12.45 pm	C	Physiotherapy Interventions	D. Snehal Deshpande	Dr Anil Raut Dr Suchit Bagde	
12.45 pm - 01.00 pm	D	Ophthalmic Interventions	Dr Shubhangi Bhawe		
01.00 pm - 01.15 pm	E	Speech-language Issues Management	Dr Ashish Disawal		
01.15 pm - 01.30 pm	F	Psychiatric Interventions	Dr Shailesh Pangaonkar		
01.30 pm - 01.45 pm	G	Oro- Maxillary & Dental Issues - Management	Dr Amol Bodhankar		
01.45 pm - 02.30 pm		Panel Discussion : Multidisciplinary approach in child with developmental delay	Moderator: Dr Jaya Shiwalkar Panelist: DrM. Mahadeviah Dr Rajaram Pagadala Prof. Dr Sam Lingam Dr Zafar Meenai Dr Viraj Shingade		
02:30 pm – 04.00 pm	III	Recent advances in childhood cognitive disability			
02:30 pm - 02:45 pm		ADHD	Dr Neeta Naik	Dr Sanjay Ramteke Dr Meenakshi Girish	
02:45 pm - 03.00 pm		SpLD	Dr Mona Gajre		
03.00 pm – 03.15 pm		ASD	Dr Zafar Meenai		
03.15 pm - 04.00 pm		Panel Discussion : Innovation & Research Cognitive Disability	Moderator : Dr Urmila Dahake Panelist : Dr Neeta Naik Dr Mona Gajre Dr Zafar Meenai		
04:00 pm – 05:00 pm		EB Meeting COMHAD			
05:00 pm – 06:00 pm		GB Meeting COMHAD			
07:00 pm sharp	"SWARANAND"- A Musical Feastby Specially Challenged Children of Anandvan Warora (Venue:IMA Hall, North Ambazari Rd, Nagpur)				



Scientific Program

2nd Day, Sunday 6th December 2015

TIME	SESSION	TOPIC	FACULTY	CHAIRPERSON	MOC/SESSION COORDINATOR
08:00 am – 09:00 am	IV	Registration and Breakfast			
08:00 am – 09:00 am		Paper and Poster presentation			
09:00 am - 10:30 am		Special Symposium : Challenges in Adolescents with Disability			
09:00 am - 09:15 am		Sexuality issues in Adolescents with Disability	Dr J S Tuteja	Dr R G Patil Dr Prashant Bhutada	
09:15 am - 09:30 am		Handling parental stress	Dr Shubhada Khirwadkar		
09:30 am - 09:45 am		Developing self esteem in Adolescents with Disability	Dr Prajakta Kaduskar		
09:45 am -10:00 am		Behavioural Modification for issues in Adolescents with Disability	Dr Manjusha Giri	Dr Nishikant Kotwal Dr Pravin Dahake	
10:00 am -10:15 am		PWD act and carrier options in Adolescents with Disability	Dr Jaya Shiwalkar		
10:15 am -10:30 am		Q & A			
10:30 am - 11:30 am		Inauguration			Dr Rajiv Mohta Dr Smita Desai
11:30 am - 11:45 am	V	Issues in practice of Developmental Pediatrics	Dr Samir Dalwai		
11:45 am – 12:00 noon		Early screening of developmental delay: Free online tool	Dr Nandini Mundkar		

TIME	SESSION	TOPIC	FACULTY	CHAIRPERSON		MOC/SESSION COORDINATOR
12:00 noon – 02.00 pm	VI	Interventions for children with disability	Dr Abhishek Srivastava	Dr Sudhir Bhawe Dr Girish Charde		
12.00 noon - 12:15 pm		"Neuroplasticity" in Cognitive, Speech/language and Motor deficits	Dr Sushil Gawande			
12.15 pm -12.30 pm		Psychopharmacology				
12:30 pm - 12:45 pm		Sensory Integration Therapy	Dr Sofia Azad	Dr Madan Warhade		
12.45 pm - 01.00 pm		Remedial Education	Dr Urmila Dahake	Dr Kush Jhunjhunwala		
01.00 pm - 01.15 pm		Adaptive devices	Dr Meenakshi Wankhede			
01.15 pm - 01.30 pm		Gait analysis	Dr Abhishek Srivastava	Dr Ashish Agrawal		
01.30 pm - 01.45 pm		Sports and Disability	Dr Umanjali Damke	Dr Kishor Vairagade		
01.45 pm - 02.15 pm	VII	Valedictory function			Dr Swati Waghmare Dr Shubhada Khirwadkar	
02.15 pm - 04.00 pm	VIII	Workstations				
		Developmental Assessment Part 1	Dr Manjusha Giri			
		Developmental Assessment Part 2	Dr Prajakta Kaduskar			
		Developmental Therapy- Early intervention programme	Dr Sanil Koyili & Dr Meenakshi Wankhede			
		Remedial Education	Dr Urmila Dahake, Dr Sofia Azad			
		Speech Therapy- Practical aspects	Dr Shubhada Khirwadkar Dr Jaya Shiwalkar			



COMHAD & CHPA

are extremely proud to present
the Scroll of Honour to....

Dr. Vikas Baba Amte

Secretary and Chief Functionary
Maharogi Sewa Samiti, (MSS),
Anandwan, Warora, Dist. Chandrapur (M.S.) India



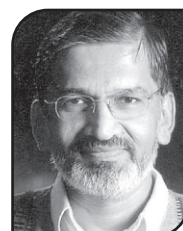
Dr. Vikas Amte is popularly known as a Leprosy Rights Activist and a social entrepreneur changing the lives of millions of people with leprosy and other disabilities.

Dr. Vikas Amte an innovative scientist by knowledge, a create researcher by need, a developed environmental entrepreneur by trade, a liberated management executive by profession, a genuine financier by intelligence, a sincere social worker by roots, and a learned physician by education. He would have liked to become an engineer, but seeing the need for a doctor at Anandwan he studied medicine.

Dr. Vikas heads the organization MSS which is a pioneering institution and an apex nongovernmental referral centre for people afflicted with leprosy. MSS was established in 1949 by his father, Muralidhar Devidas alias Baba Amte with the basic objective of treating and rehabilitating Leprosy Patients and giving them a life with dignity and self-respect through productive work.

Dr. Abhay Bang

Director SEARCH
(Society for Education, Action & Research in Community Health)
"SHODHGRAM", Gadchiroli (M.S.) India



Dr. Bang with his wife Dr. Rani Bang, founded the voluntary organisation, SEARCH 25 years ago in one of the most underdeveloped districts, Gadchiroli, in the state of Maharashtra in India, They have developed village health care program which has now become a nationally and internationally famous model. He showed how the pneumonia in children can be managed in villages & recently, how newborn care can be delivered in villages. Their work has reduced the IMR to 30 in this area. This approach, called the home-based newborn care' has been now replicated in several countries, has become a national poling in India, and resulted in the global guidelines (WHO/UNICEF - 2009). They Have established the famous community health care and research center 'Shodhagram* in the tribal area.

He has received many national & international honors for his work. He and Rani were honoured with the highest honour of the state government 'Maharashtra Bhushan'. The TIME magazine selected him and Rani as the 'Global Health Heros' (2005) He has graced prestigious positions as an expert on various committees of state, national & international level related to Child health & malnutrition.



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Dr. (Mrs) Mrudula A. Phadke

Senior Consultant UNICEF
Director NRHM, Former Vice Chancellor, MUHS
Mumbai (M.S.) India



Dr. Mrudula Phadke has an exemplary academic under graduate and postgraduate Medical Career. She stood first in the University in all the examinations and received over 20 gold medals and prizes including President of India's Medal.

She has had an Intense involvement in patient care, student teaching and research while working as Professor of Pediatrics. Set up & enhanced the Department of Genetics at B.J. Medical college – the only center in Western Maharashtra, started with the help of Govt. of Maharashtra, Dept of Science & technology, Dept. of Biotechnology.

She is only the second pediatrician in India to receive Hon. Fellowship of the Royal College of Pediatricians FRCP (UK 2003). As member of Child Survival Group Planning Commission she was actively involved in Immunization Research, Nutrition and HIV/AIDS Research. She has had a lot of administrative experience while working as Dean B.J. Medical College, Pune, Director Medical Education and Research Govt. of Maharashtra, Mumbai and Vice Chancellor, Maharashtra University of Health Sciences, Nashik, Maharashtra, India. She has helped the Government in Policy-making, Conceptualization and establishment of 3 New Medical Colleges–Govt. Medical College Kolhapur, Latur, Akola.

She has a huge volume of research publications in National & International journals & travels all over the globe for her guest lectures & services as an expert in global policy making related to child health. She has received many national & international awards.



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Dr. Ravindra Kolhe

Social Activist

Tribal Area of Melghat (M.S.) India



Dr Ravindra Kolhe, MD, started nursing the poor tribals here in 1989, the Infant Mortality Rate was 200 per 1,000 infants. Today, it has come down to 60, thanks to the medical awareness spread by Dr Kolhe and his wife Smita, who have made tribal upliftment the motto of their life.

Dr Kolhe has been working here for the past three decades now, and charges just Rs 2 for medical consultation. Kolhe has received help and encouragement throughout his life from his wife Smita, who is a graduate in law and also a paediatrician.

Dr Kolhe has also extended his work to areas like farms, power generation and labour wages. Apart from consultation, the husband and wife team have also been active in creating awareness about women's health and education. Dr Kolhe says that he will not accept any government aid for his work as he believes in self-reliance. He, however, accepted the awards bestowed on him because they make his father proud.

Dr. Ashish Rambhau Satav

President, MAHAN Trust

Mahatma Gandhi Tribal Hospital,
Melghat (M.S.) India



He is working for past 15 years in Tribal area of Melghat, through MAHAN Trust providing modern medical facilities to the underprivileged tribals. His innovative field research projects : Home Based child care to Neonates to reduce the neonatal mortality rate & counselor program to save severely malnourished children have been widely acclaimed & he has presented evidence based research on various health issues of tribal population all over the world. He has received many national & international honours for his distinguished services.



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Bachchu Kadu

MLA & Social Activist
Achalpur, (M.S.), India



Bachchu Kadu is an Independent MLA (Member of the Legislative Assembly) from Achalpur has worked relentlessly for the cause of the disabled through his novel agitations. The lackadaisical attitude of the state government in implementing the 1985 Central Government Act for the rehabilitation of physically challenged persons has resulted in around 40 lakh physically disabled in Maharashtra not getting benefits of the Act.

Even though the state government adopted the said act in 2001, red-tapism has seen that it remains in cold storage. When it could distribute 1,300 crore to physically disabled under various heads, the state distributed only 350 crore. To attract the attention of the government towards the plight of the handicapped Mr Kadu has used his good offices, so that the disabled persons get their due & justice.

Dr. Viral M. Kamdar

Director
Pandit Deendayal Upadhyay Institute of Medical Science Research & HR
Nagpur



Dr. Viral Kamdar is a public health specialist and medical doctor, experienced in public health, mass treatment projects and health awareness. As a general physician & child specialist he has worked in different roles of increasing responsibility, leading fairly large medical teams (both physicians & medical information personnel). responsible at various levels in designing and driving implementation of medical strategy and medico care plans across many therapy areas (tas) incl. diabetes, hypertension, sickle cell, health problems in children. medical lead for launch of many novel compounds in different areas of vidarbha, madhya pradesh & chattisgarh. as medical compliance lead played a key role in putting together a medical governance system.





Abstracts & Articles



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CHILD WITH DISABILITY : ANTENATAL RISK FACTORS

By

Prof. Rajaram Pagadala

MD (Obs.), DSS (Vienna), PhD (Pop. Studies),
Chancellor & Professor Emeritus
Sri Balaji Vidyapeeth University, Puducherry



‘Quality of Life’ is based on the development of human being right from the conception. The aim of the obstetrician is to see that every pregnancy culminates into a healthy mother and healthy baby. Therefore it is the duty of the attending Obstetrician to see the birth of a normal healthy baby takes place by preventing pregnancy wastage, and those born are also not left with physical, intellectual and emotional injuries and allow them to suffer throughout their life.

Developmental disabilities may begin anytime during the evolving period of human life and may last thru the life time. Developmental disabilities may be seen beginning with embryonic life and if preventive measures are not taken can, it can cause socio-economic burden on the family and society. Mother is wrecked for life. Unfortunately it is often missed due to various factors that includes inefficient healthcare services. Therefore the challenge lies in its prevention and detecting in early life; so that affective measures can be initiated to make the growing disabled human into a useful member of the family.

Common causes include usage of certain drugs in the early pregnancy, improper antenatal care, genital tract infections, and birth injuries. Obstetricians, in the field, are either ignorant or have insufficient research experience that can help them take preventive measures. Thus a major burden of the disease and disabilities of the child is passed on to the attending Neonatologist or Pediatrician. When a baby is brought to the pediatrician the child already has multifaceted perplexed problems. Obviously the management becomes a complicated and prolonged one involving various specialists in the field with heavy expenditure.

The most challenging task is to understand and identify the factors that could causes disability. Among the common causes which are not properly tackled are low birth weight, premature birth, multiple pregnancies, genital tract infections, birth asphyxia and genetics besides disability. In addition devastating effects can occur as a result of result poor maternal health and nutrition, smoking, drinking during pregnancy, exposure to high levels of environmental toxins can damage the development of the fetus and new born with permanent ill effects on child. Therefore if simple and appropriate antenatal care is given many problems either can be prevented or disability can be detected early reducing the mortality and morbidity. The burden of disease in the later years will be drastically reduced.



Environmental Risk Factors in Children with Airway Disability

Dr. H Paramesh

MD, FAAP (USA), FIAP, FIAMS, FIAA, FCAAI
Pediatric Pulmonologist and Environmentalist



Environmental hazards are among the health concern globally and locally. There is scant learning and its relation to illness.

Environmental causes of illness may not always be apparent, diagnosis can be missed unless history of exposure is obtained and more so if the illness is atypical or unresponsive to treatment

The biological programming is an accepted reality and contributes Respiratory, Cardiovascular, Cognitive development. The early interventions of mother and fetus might alter the course of development and health in children and adults. Nutritional issues might explain the relationship but needs interventional studies with robust data to make a policy.

The climate change will be the defining issue for health system in the 21st century. Allergic Airway diseases (Asthma) is a global health epidemic respiratory disability and more than 1 billion population is affected and it is anticipated to affect 4 billion population in 2050. Outdoor air pollution causes 3.7 Million deaths and indoor air pollution 4.3 million deaths globally. In addition they are the major socio economic emotional burden to the country. Climate change will widen the health equity gap within and between countries. Adaptations to climate change is essential in primary prevention of health issues

During the talk the issues will be highlighted with global, Indian and local facts and role of nutrition's in prevention

One who knows what to eat, how to eat doesn't get disease. Who ever is the father, under and malnutrition is the mother of the diseases. Indian Adages.

Let food be thy medicine and medicine be thy food. Hippocrates.



DISABILITY

Global Perspective and Global Picture

Dr M Mahadeviah

Pediatric developmental neurologist,
Bangalore

Disability be it childhood or adult is one of the most neglected issue certainly in the developing low and middle income countries as well as the developed country with the improvement in the survival of children in the low and middle income countries because of reduction in mortality and the campaign to eradicate HIV/AIDS, Tuberculosis, malaria and malnutrition. There has been a dramatic improvement in survival of children below five years of age.

The present estimate of survivors in low and middle income countries reaches 200 million who have developmental delays of disability because of the primary condition. There are many children with cerebral pals, intellectual disability and at a later stage educational backwardness.

To significantly reduce the associated co morbidity the health and social service measures have to improve as well as the medical services.

Secondary prevention by early identification of disability and rehabilitation improving the health service, living condition, social environment.

The scenario in developed countries unfortunately even though better is not very rosy. Reports from USA centres for disease control 1997 to 2008 was 13.7% . During this period there has been an increase of 17.1%. In a decade there has been 1.8 million children.

One can gather from these statistics problem of disability in the world is beyond imagination and is never ending. With limited resources, especially in the developing nations there will be millions of children with disabilities.

The current scenario in early diagnosis of developmental disabilities

Low and middle income countries

Priorities are acute illnesses such as infectious diseases, physical growth, immunisation, nutrition and other common childhood diseases as tuberculosis, gastroenteritis etc. Very little is taught about the early identification of developmental delay. Routine developmental screening is not a priority.

Developed countries such as USA

Developmental screening was introduced as part of paediatrics training only in early seventies and is strongly backed by American Academy of Pediatrics. Many of the studies in USA indicate only 20 to 25% of children receive periodic developmental screening.

What is happening in India? Is pathetic childhood disability group in the Indian Academy of Paediatrics was started in early 80's.

A liberal estimate of paediatricians actively involved and interested would be 1000 out of 30000 plus.

It is indeed a great disservice to our children and their parents if we do not provide the best of service by early identification and rehabilitation for the child to attain its full potential.

Early identification provides opportunity for parent education and support. Training the family will have considerable influence on parent child interaction, teaching, carrying, bathing, teaching activities of daily living. Specially in developing countries parents should be made as active partners.



Neuroplasticity, Neurorecovery and Neurorehab



Dr Abhishek Srivastava

MBBS, MD, DNB, PhD

Neurorehabilitation Specialist
Director, Centre for Rehabilitation
Kokilaben Hospital, Mumbai.

Neural plasticity is the ability of the central nervous system (CNS) to change and adapt in response to environmental cues, experience, behavior, injury or disease. Neural plasticity can result from a change in function within a particular neural substrate in the CNS through alterations in synaptic strength, neuronal excitability, neurogenesis or cell death. Changes in the function of a neural substrate can then alter behavior secondary to environmental influences such as experience, learning, development, aging, change in use, injury or response to injury such as unmasking due to the loss of surround inhibition with reduced afferent input. Behavioral changes can also result from compensation, when residual neural substrate(s) are used to perform impaired functions, as may occur at some point during recovery. Neural plasticity may also alter the function of the original neural substrate used to produce a behavior through neuronal sprouting and dendritic growth. The content of the lecture is elucidating how plasticity can be modified to induce functional improvement in patients with CNS lesions.



"No effort that we make to attain something beautiful is ever lost. Sometime, somewhere, somehow we shall find that which we seek. I have so much that I want to do. I hate wasting time."

- Dr. Stephen Hawking



Idiopathic Intellectual Impairment

Dr Chhaya Sambharya Prasad

Developmental & Behavioral Pediatrician,
National Secretary, Childhood Disability Group, IAP
Adolescent Health Expert,
Asha Child Development Clinic, Chandigarh

Idiopathic Intellectual Impairment refers to individuals with low intelligence who show no evidence of gross chromosomal defects or single-gene anomalies. It may also represent the lower end of IQ distribution. This impairment (backwardness) is defined as one which makes less progress than normal. Intellectual impairment means a person with the intellectual capacity that developed at a below average rate during the early developmental years. Several syndromes (such as Downs, Fragile, Rett syndrome, and other well known conditions) can be easily suspected because of their association to specific dysmorphisms, behavioural peculiarities, and multiple congenital abnormalities. However, a consistent percentage of children with genetic intellectual disability do not present a recognizable phenotype which is striking of a well-recognizable syndrome. Determining a specific etiologic diagnosis is central to understand the nature of the problem, providing answers to questions regarding prognosis, recurrence risks, directing specific therapies, and achieving meaningful inclusion of individuals with disability into society.

Intellectual impairment is one of the most frequently diagnosed disabling conditions in our society, and a lifelong disability characterized by impairment of cognitive and adaptive skills. The aetiology is very heterogeneous and, unfortunately, in more than one-half of cases the cause is still unexplained. Anything that damages and interferes with the growth and maturation of the brain can lead to intellectual impairment. This might happen before, during or after the birth of the child (including complications of pregnancy/birth, toxics, malnutrition, trauma, infections, under stimulation). Moreover, genetically determined aetiology (comprising chromosomal aberrations, single-gene disorders, and other genetic conditions) account by itself for 17 to 41% of cases, depending of the different techniques of analysis.

Mental Ability is always more likely to be under estimated than over estimated, especially in case of persons from lower socio economic groups.

India is a vast country with variable social, cultural, geographical and economic background. Communicable diseases and congenital diseases are still a major problem adding to the number of persons with disabilities. Evaluation of intellectual impairment is a big challenge with different social background, economic factors, extended family systems, low literacy rates, and virtually different habits/A.D.L. Intellectual impairment is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior and may present as deficits in conceptual, social, and practical adaptive skills. It is a variable, heterogeneous manifestation of central nervous system dysfunctions, occurring in 1-3% of general population. An estimated 10% of the world's population experiences some form of disability or impairment (WHO Action Plan 2006-2011) Global Prevalence:



4%-10% (Yeo 2001) 4% in developing countries and 7% in industrialized countries (Metts 2000) India and South Asia Prevalence: 1.5-21.3% in WHO South East Asia member countries (<http://www.searo.who.int/>) 8% -2.2% for India (Census 2001, NSSO 2002). Different prevalence rates for disability are available in India. According to the Census 2001, there are 2.19 thousand people with disabilities in India who constitute 2.13 % of the total population (Census 2001). Out of the 21,906,769 people with disabilities, 12,605,635 are males and 9,301,134 females and this includes persons with visual, hearing, speech, locomotor and mental disabilities (Census 2001).

Children with intellectual developmental delay (IDD) may have delayed gross motor milestones, learning to sit up, crawl, or walk later than other children, or they may learn to talk later. Both adults and children with intellectual disability may also exhibit some or all of the following characteristics:

- Delays in speech and language development
- Deficits in memory skills
- Difficulty learning the social rules
- Difficulty with problem solving skills
- Delays in the development of adaptive behaviors such as self-help skills

Children with intellectual disability learn more slowly than a typical child. Children may take longer to learn language, develop social skills, and take care of their personal needs, such as dressing or eating. Learning takes longer time, requires more repetition, and skills may need to be adapted to their learning levels.

In early childhood, a mild intellectual impairment may not be obvious, and may not be identified until the child begins school. Even when poor academic performance is recognized, it may take expert assessment to distinguish mild intellectual impairment from a specific learning disability or an emotional/behavioral disorder. People with mild intellectual impairment are capable of learning reading and mathematics skills to approximately the level of a typical child aged nine to twelve (as published by DK, Ardinger HH, Holmes 2000) They can learn self care and practical skills, such as cooking or using the local mass transit system. As individuals with intellectual disability reach adulthood, many learn to live independently and maintain gainful employment.

According to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), intellectual disability is considered to be approximately two standard deviations or more below the population, which equals an IQ score of about 70 or below. The assessment of intelligence across three domains (conceptual, social, and practical) ensures that clinicians base their diagnosis on the impact of the deficit in general mental abilities on functioning needed for everyday life. This is especially important in the development of a treatment plan. Intellectual disability involves impairments of general mental abilities that impact adaptive functioning (refers to the skills needed to live independently) in below mentioned domains, or areas, which determine how well an individual copes with everyday tasks:

- a) The conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge, and memory.
- b) The social domain refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities.
- c) The practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.



While intellectual impairment does not have a specific age requirement, an individual's symptoms must begin during the developmental period and are diagnosed based on the severity of deficits in adaptive functioning. The disorder is considered chronic and often co-occurs with other mental conditions like depression, attention-deficit/hyperactivity disorder, and autism spectrum disorder.

It is formally diagnosed by professional assessment of intelligence and adaptive behavior. The diagnosis is not based only on IQ scores, but also the adaptive functioning as mentioned above. To assess adaptive behavior, professionals compare the functional abilities of a child to those of other children of similar age. There are many adaptive behavior scales, and accurate assessment of the quality of someone's adaptive behavior requires clinical judgment and experience as well. The following ranges, based on Standard Scores of intelligence tests, reflect the categories of the American Association of Intellectual Developmental Disorders (AAIDD), the Diagnostic and Statistical Manual of Mental Disorders-V, and the International Classification of Diseases-10.

Class IQ

Profound Intellectual Disability Below 20

Severe Intellectual Disability 20–34

Moderate Intellectual Disability 35–49

Mild Intellectual Disability 50–69

Borderline Intellectual Functioning

70–84

A three-generation pedigree helps to find out intellectual impairment in the family, and a detailed pre-, peri- and postnatal history should help to establish a definitive cause. A dysmorphic child may be at risk from the stress of birth, and later delay may be erroneously attributed to birth injury. A careful developmental history, with emphasis on milestones, formal assessments and behaviour, is also a must. Medical records should be sought or requested to validate any diagnosis of malformations. An accurate EEG study and/or brain MRI are sometimes sufficient to suspect several well-known and relatively common disorders (such as Rett's syndrome, Angelman syndrome, neurocutaneous syndromes such as Tuberous Sclerosis, etc.). The degree of Intellectual Impairment is an important indicator: the so called "chromosomal" phenotype, which is well known to accompany larger aberrations, is frequently characterized by moderate-severe Intellectual Impairment associated with one or more of major signs, including congenital malformations. The behavioural phenotype is also distinctive for several well-known syndromic conditions, such as Williams syndrome, Angelman syndrome, Prader-Willi syndrome. Abnormalities in head size, growth parameters, and neurologic signs should also be carefully investigated.

As compared to Idiopathic Intellectual Impairment, the Intellectual Disability per se may occur due to a number of causes such as listed below:

a) Genetic & Chromosomal Abnormalities: One of the first genetic causes of intellectual disability is Down Syndrome. The extra chromosome interferes with the functioning of the brain, mostly leading to interference in intellectual functioning. Other causes such as Fragile X Syndrome, Hunter Syndrome, Hurler syndrome, Rett's syndrome, Tuberous sclerosis, defective chromosomes, chromosome deletions / translocations also interfere with intellectual performance and lead to cognitive impairments.



b) Metabolic Disorders such as Phenylketonuria, endocrinological disturbances as Cretinism, cranial malformations, hydrocephalous, microcephaly, all result in intellectual deficiencies of varying degrees.

c) Nutritional Deficiencies: Nutritional deficiencies are one of the biggest culprits of many a medical condition. A nutritional deficiency during pregnancy can be more disadvantageous to the unborn child than it can be to the mother. A lack of nutrients like vitamin A, iron, iodine, zinc, etc., has been known to cause problems pertaining to mental health for a large population across the world. With a mounting consumption of fast food and junk food, nutritional deficiencies are on the rise like never before. Apart from the above mentioned, famine / conditions causing malnutrition is also one of the largest causes of this mental condition.

d) Environmental Conditions & Exposure to Toxins: The next few highly contributing factors leading to intellectual impairment are those of environmental conditions, as well as exposure to toxins. Environment in a case like such is generally in reference to poverty and cultural deprivation. This idea also refers to the lack of mental stimulus, thus stunting mental growth. Exposure to toxins is an equal culprit leading to it too. One of the more common forms of these toxins would happen to be cigarettes. Expectant mothers who smoke are also a threat.

e) Other conditions leading to intellectual impairment are, traumatic conditions faced during pregnancy, problems at or after birth, including complications of pregnancy and birth, metabolic disorders, infections, as also a multitude of unexplained reasons. Two retrospective studies have found that prenatal exposure to stressful events is associated with increased risk of Autism Spectrum Disorders, Ward (1990) and Beversdorf et al (2005). In both studies mothers reported stressful life events such as loss of job, death of husband or close relative, significant family discordance during pregnancy etc.

Some Probable Etiology for the Idiopathic Intellectual Impairment as understood by varied research across the globe:

a) Microdeletion / Micro duplication syndromes: In the last few years, several emerging clinical entities have been described, due to the advent of newest genetic techniques, such as array Comparative Genomic Hybridization. The detection of cryptic micro-deletion / micro-duplication abnormalities has allowed genotype-phenotype correlations, delineating recognizable syndromic conditions. The presumed channel at the basis of remaining "pure idiopathic" forms of 'Intellectual Disability', highlight possible environmental and epigenetic mechanisms as causes of altered cognition. With the advent of novel genetic techniques, several new cryptic chromosomal aberrations have been discovered in last few years and a consistent number of cases, previously considered "idiopathic" forms, are now classified as syndromic conditions with clinical recognizable phenotypes.

b) Parents with Intellectual Disability: Studies of children raised in homes where both parents were had intellectual impairment, revealed that between 39 to 61% of children tested were intellectually impaired. In studies such as Halperin 1945, and Penrose 1963, non impaired children tended to have borderline intelligence with IQ's varying between 70 & 90 in nearly 16 – 40 percent of cases whereas between 4 to 26 percent of children were of average intelligence. For purposes of general estimate these studies indicated that where both parents were retarded, nearly one half had borderline intelligence and about 1/6th would have an overall average IQ. Average IQ's of 65 and 74 have been noted among children of such parents (Reed & Reed 1965).



The distribution of IQ's in these children, though not lending itself to any judgement as to the role of psychological factors because of the confounding effects of heredity does indicate that intelligence cannot be solely a function of the environment.

c) Home Environment: Yeates et al (1983) conducted a study to investigate maternal IQ and Home environment as determinants of early childhood intellectual competence. Children at risk for socio cultural intellectual disability were studied longitudinally from birth to 4 years of age. Maternal IQ's were assessed before the child's birth and children's IQ and home environment were assessed at regular intervals during 1st 4 years of life. Multiple regression analysis was used to separate the contributions of maternal IQ and home environment to the child's IQ at 24, 36 and 48 months of age. The overall pattern suggested a monotonic increase in the predictability of the child's IQ within the context of a shift in the relative importance of maternal IQ and home environment as predictors.

d) Family Size: Another very important confounding factor has been the family size. Presenting here the various studies by experts across the globe. One of the earliest and most consistently reported findings related to the effects of family size has been a decline in the IQ with an increase in the number of children. The majority of studies conducted in several nations have shown a negative co relation between family size and IQ with some indication, however, that this co relation may be less pronounced in higher socio economic status groups. Attempts to account for this decline in IQ with an increase in family size have generated a variety of hypothesis. All kinds of resources like financial, dietary, spatial, emotional are shared by more members in large families. In the lower socio economic classes, adverse physical conditions may be aggravated when many members of the family have to share a meagre subsistence. The increased size of the family also means that each child receives less attention from his / her parents and learns about life and the outer world more from the siblings who may be just a little older than the child himself. In a large family a child's development may also be affected because of the fact that so many of the role models are children themselves who use speech poorly. The decline in the IQ with increasing size of family in lower socio economic group mostly suggests that children from larger families would on an average be less successful academically. It would appear that compared to their IQ level, their academic achievement is much inferior. Many studies suggest that children from smaller families show higher achievement, motivation and superior performance in academics than those from larger families. Parents with higher educational and occupational aspirations for their children are likely to plan their family to match their resources. They are also likely to set goals for their children and impose standards of excellence beyond those imposed by parents who have fewer ambitions for their children. The primary effect of family size may be seen in respect of the physical development of children from large families which seems more problematic than that of children from smaller families. The probability of intra uterine problems rises with increasing number of child births. Passamanick et al 1956 reported a 10 fold increase in mental backwardness as one moves from the first to the sixth child born to the mother. In general, prematurity and its associated problems and mal development also become more frequent with increasing number of child births. These are all perplexing theories put forth by researchers mystified by the causes of idiopathic intellectual impairment.

e) Effect in Siblings and Relatives: Idiopathic intellectual impairment has been documented in siblings and relatives in few studies. A genetic study of children in Birmingham Coventry has shown a recurrence risk of idiopathic intellectual impairment in siblings lying between 1 in 4 and 1 in 5. There was also a prevalence of intellectual impairment in other relatives that was greater than the population prevalence, and was less for second degree relatives than for first degree, and less still for third degree relatives. Recurrence in siblings was greater if more than one first degree relative was affected. There was no suggestion of a contribution by X linked genes, once the fragile X syndrome had been excluded. The presence of perinatal and other environmental factors in the index children did not alter the recurrence risk for sibs except for very low birth weight.



The results of many studies with pairs of siblings are similar and show that the higher the proportion of genes shared by two relatives, the higher the average correlation between their IQs. There was a low recurrence rate of intellectual impairment in Asian families, suggesting that they had a different distribution of intelligence from non-Asian families. Hereditary factors in the aetiology of idiopathic autism are well established but particular genetic mechanisms have not been identified.

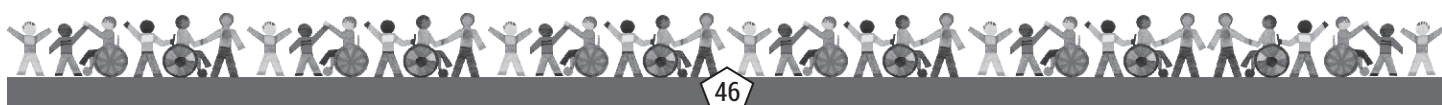
The study by Sarah Bunde et al, 1989 suggested that 60 to 70% of the total variation of intelligence in a population is the result of genetic factors and less than 10% the result of environmental factors outside the family. The genetic component is largely polygenic, that is, composed of many genes individually of little effect. Bouchard and McGue³ considered that there was no evidence of a contribution by X linked genes, because like sex pairings did not differ from unlike sex pairings. However, an X linked gene for spatial ability has been postulated. The relative contributions of genetic and socio cultural factors to the normal range of intelligence have been discussed by many authors.

f) Social Impact: Siblings of cases of ADHD have been documented to exhibit similar symptoms and lower academic performance due to behavioural and social adaptation difficulty. The family of a child with hyperactivity, attention deficits, and cognitive impairment must cope up with frequent and exceptionally high demands of parenting. The family is confronted with serious medical and environmental issues that rarely seemed to be solved.

The primary goal of treatment is to develop the child's potential to the fullest. Mother & child centred, multi disciplinary, comprehensive early Intervention & rehabilitation program should be available under one roof for better compliance so that 'Every Child' may reach his / her maximum potential. Early Intervention Services, special education and training may begin as early as infancy. Importance of home environment, age appropriate toys, social environment, and degree of Parental Responsiveness, amount of warmth and nurturance available, extent of limiting a child's behavior by parents, type of discipline used etc should be reinforced to parents. Importance should be given to dental checkups to look for mal-alignment of teeth which may cause not only improper nutrition intake but may also interfere with speech and language development, phonetic sounds etc. Speech impairment may cause low self esteem and an eventual loss of interest in surroundings in a school going child. Regular growth and development monitoring is of utmost importance in babies born to mothers with pre natal stress and birth complications. It is also important for a specialist to evaluate the person for other affective disorders and treat those disorders. Behavioral approaches are important for people with intellectual impairment.

The outcome and prognosis depends on:

- a) Opportunities provided to the child with respect to his home environment, family support, community support.
- b) Co Morbid conditions and associated psychiatric disorders such as Mood Disorders, Psychotic Disorders, Organic Psychoses etc
- c) Personal motivation
- d) Therapeutic interventions in the form of speech therapy, physio – occupational therapy, special education guidance etc. Many persons can lead productive lives and function on their own; many others may require a structured environment to be most successful.



Paediatricians should be alerted by the presence of Intellectual Impairment of unexplained origin associated with altered auxological parameters, multiple congenital defects, neurological and psychiatric signs, and/or minor dysmorphisms. The implementation of the so called "next generation sequencing" technologies that allow the analysis of whole-genomes, transcriptomes and interactomes could lead to detect single base mutations and structural variations, further broadening the possibility of diagnosis in "idiopathic" cases of ID. Understanding the pathological pathways underlying unexplained forms of ID represent a future challenge to increase both prevention and possible therapies. Because of the high incidence of CNS impairment and low overall interpersonal coping abilities, children / adolescents with Intellectual Impairment have a greater than average risk for developing associated psychiatric disorders. Persons suffering from such a condition require constant care, intervention and custom-made system of education. Resources and services for mental and behavioural disorders are disproportionately low compared to burden caused by these disorders the world over. In most developing countries, care programmes for the individuals with mental and behavioural problems still have a low priority. Provision of care is limited to a small number of institutions usually overcrowded and under staffed. Over past several decades, the model of mental health care is changing and community care approach is setting in. The mental health programmes have played important role in this shifting paradigm. Early Intervention and Early Stimulation programmes are playing a vital role in the Child Development Centres across the country being run by dedicated Developmental Pediatricians. Nevertheless, virtually every child is able to learn, develop and become a participating member of the community at some level.



Paediatric Surgical Services in Remote Areas

DR. RAVINDRA VORA, DR. SUDHAKAR JADHAV, DR. DEEPAK GOEL

COMMUNITY ORIENTED PAEDIATRIC SURGERY CHAPTER OF IAPS

Paediatric Surgery Centre & PG Institute

Sangli, Maharashtra

The scenario in India –

- a) Ignorance & complacency about illness if relief with casual treatment.
- b) Lack of Paediatric Surgical service in the area.
- c) Transportation difficulties , Low income family, not affording costly & at times repeated operations & follow up.
- e) No Health Care insurance or medi-claim cover for cong. anomalies.
- f) Lack of awareness in parents about anomaly & plan of management.
- g) No counseling centers or parents support groups at dist. places.
- h) Information about newer modalities/ equipments to improve the corrections or quality of life and about prevention of cong. anomaly in next offspring does not reach parents

Thereby these patients are deprived of

- a) timely & ideal treatment of primary & associated anomalies.
- b) vigilance for known complications & sequelae and their treatment
- c) alternative treatment or opportunity to avail of new technology & improved modalities of management.

Such deprivations lead to either progression of dysfunction or deformity & chances of complications with morbidity & degradation of life quality.

What are the challenges?

- Does the patient reach us?
 - Timely
 - Safe
 - Distance
 - Cost / Insurance
- Is there service available?
 - Paediatric Surgeons
 - Hospitals
- How to modify Health Care Policy?

Health Insurance for congenital anomalies

Reluctance of companies to cover congenital anomalies

- Not easily available



- Expensive
- Families suffer especially siblings
 - High cost
 - Prolonged treatment.

Health insurance should cover Foetus & Mother

Health Care Policy

- No Provision for Paediatric Surgery
- Lack of incentive to PG's to take up P.S.
- Over 60% Districts have NO Paed. Surgeon
- No Birth Defects Registry
 - Lack of Data for Health care Planning
 - Apathy amongst doctors & Health Dept.
- Poor campaigns for Prevention of Birth Defects
- No Promotion of Foetal Health Insurance

In Summary

- Paediatric & Neonatal Surgery is Safe at District Level
- Needs awareness for early referral
- Needs support from allied specialties
- Recognition of Paed. Surgery as essential
- Greater penetration of dedicated surgeons
- Support from Government and Society

Remedies... 1

- Provide Paediatric Surgical Care at District Level
 - Visiting Paediatric Surgeons from Neighbouring Districts (RBSK/MCH/IAPS)
 - Training of Rural Surgeons / fellowships (IAPS)
 - Incentives (IAPS/NRHM)
 - Infrastructure in Remote Areas PPP (NRHM/RBSK)
 - Periodical Paediatric Surgical Camps (RBSK/IAPS)

Remedies... 2

- Post-graduate Training Programmes (MCI/NBE)
- Department of Paediatric Surgery in Medical Colleges (MCI/Universities) & Govt. Hospitals
- Birth Defects Registry (MoHFW)
- Counselling Centres – Prevention (PHC/NGOs)
- Parent Support Groups (IAPS/NGOs)

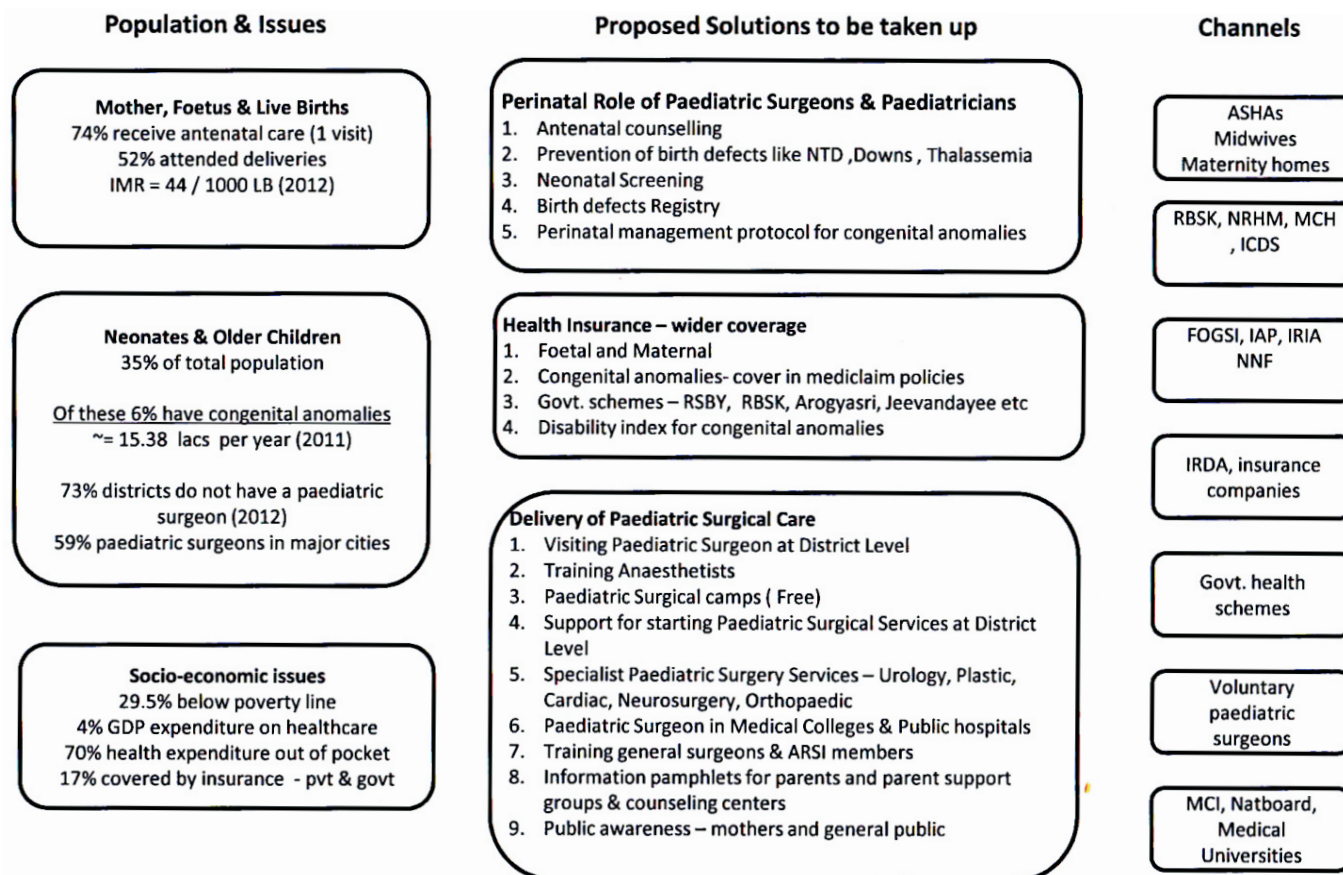


Paediatric Surgical Services Indian Association of Pediatric Surgeons & Role of Healthcare Providers

Ravindra Vora, Convenor, Community Oriented Pediatric Surgery Chapter of India,

Sudhakar Jadhav, Ex-President, Indian Association of Pediatric Surgeons

Deepak Goel, Hon. Secretary, Maharashtra Chapter of Indian Association of Pediatric Surgeons



SPECIFIC LEARNING DISABILITIES

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In Charge, Pediatric Neurodevelopmental Centre

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DEFINITION :

Specific learning disabilities (SLD) refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities despite adequate instruction, cultural difficulties, sensory or emotional problems. Essentially there are four critical components to the definition of SLD:

1. It is a neurobiological condition
2. It is not due to poor instructional practices
3. A demonstrable discrepancy exists between the individual intrinsic ability and the actual academic achievement and
4. The child has at least average cognition abilities.

There are 3 types of SLD :

Dyslexia- difficulties in reading

Dysgraphia - difficulties in writing

Dyscalculia - difficulties in mathematics

CLINICAL EVALUATION :

SLD is a clinical diagnosis, although it has an educational manifestation and pediatricians are often involved due to the associated behavioral problems. The age of presentation varies from as early as preschool or much later in adolescence depending on the educational challenges.

Dyslexics often have slow effortful word reading, difficulty in comprehension of read text, spelling errors. Often writing issues such as poor written expression, multiple grammatical errors, sloppy handwriting skills are seen. Mathematics difficulties such as a poor number sense, finger counting, deficits in mastering mathematical concepts, reasoning skills may be seen.

The common developmental co morbidities linked with SLD have to be screened for and treated simultaneously and these are :

1. Attention Deficit Hyperactivity Disorder (AD/HD)
1. Oppositional defiant disorder (ODD)
2. Conduct disorder (CD)
3. Depressive disorders



4. Anxiety disorders
5. School phobia
6. Sleep disturbances.

A synthesis of reports from the multiple sources such as cognitive abilities, formal and informal educational tests forms the core domains to knowing the child's strengths and weakness and customize the child's IEP at school or resource room.

TREATMENT

A. Educational techniques for SLD's:

1. Remediation:
2. Accommodations:

SLD'S: THE INDIAN CONTEXT

SLD is a disability that is recognized worldwide, but is still culturally unique and has a specific perspective to its identification. India is unique due to her rich diversity in language, teaching styles, curriculum structures across the nation. Hence one of the main issues of concern for India is the correct identification of SLD with culturally appropriate tests.

OUTCOMES:

SLD persist lifelong although their manifestations may evolve with time.



"There are two kinds of 'disabled' persons: Those who dwell on what they have lost and those who concentrate on what they have left."

- Thomas Stephen Szasz



Attention Deficit / Hyperactivity Disorder (ADHD) in Children

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Pediatric Neurologist and Epileptologist, Director,
En1 Neuro services, Mumbai, India



Abstract

Attention Deficit/Hyperactivity Disorder (ADHD) is the commonest behavioral disorder in children. It is characterized by attention deficit, impulsivity, and hyperactivity. ADD is without hyperactivity. ADHD begins in childhood and often persists into adulthood. The exact etiology is unknown; genetics plays a role, but major etiologic contributors could be environmental.

Abnormalities in the front striatal brain circuitry and possible hypo functioning of dopaminergic pathways are apparent in ADHD, and are consistent with the benefits obtained by the use of psychostimulants like methylphenidate.

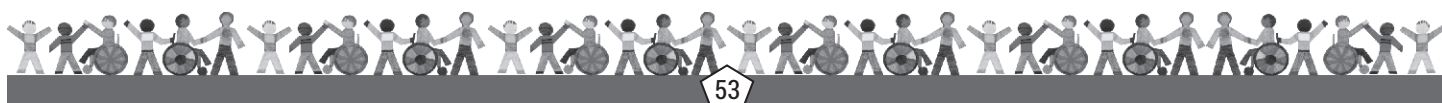
Introduction

Attention Deficit/Hyperactivity Disorder (ADHD) is a combination of neuropsychiatric symptom clusters that emerge in childhood and often persist into adulthood.¹ ADHD is the most prevalent behavioral disorder in children and frequently its symptoms are commingled with learning problems, oppositional conduct, and depression, which altogether compound the family's emotional burden².

A condition in children somewhat resembling ADHD was first described by Still in 1902. He discussed 43 cases of children with aggression, defiance, emotionality, limited sustained attention, and deficient rule-governed behavior. Although his population possessed normal intellectual capacity, he commented, "... the control of activity in conformity with moral consciousness is markedly defective." He suggested, "inhibitory volition," that is, the capacity to exercise good judgment, might be imperfectly developed in these subjects. From 1940 through 1960, the condition was identified with "minimal brain damage or dysfunction," and its etiology was speculated to be insults to the brain such as head injury, infection, and toxic damage.⁶ In the 1960s it became "hyperactivity" or "poor impulse control," reflecting that no underlying organic damage had been identified. By the 1970s-1980s, the "hyperactivity" symptomatology had taken on more diagnostic significance in comparison with the other symptoms. In 1980, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) listed the term "hyperkinetic reaction of childhood," which then evolved through "hyperkinetic syndrome" and "hyper-active child syndrome," to "attention deficit disorder" (ADD), either "with hyperactivity" or "without hyperactivity." By 1987, in the revised DSM-III (DSM-III-R), the earlier focus on hyperactivity had shifted toward inattention and impulsivity.

As the research on ADHD progressed, the balance between the three major diagnostic symptom clusters was subsequently further refined, so that in the 1994 DSM-IV the official term was Attention Deficit / Hyperactivity Disorder, or ADHD, with three subtypes.¹ Inattention and impulse control are now regarded more as the cardinal defects than is hyperactivity. Some professionals continue to reserve the term ADD for children who are only inattentive and ADHD for children who are also hyperactive, but all official reports or other records are required to use ADHD.

ADHD is usually diagnosed in school-age children, and is conservatively estimated to occur in 3-6 percent of this population from diverse cultures and geographical regions.



The adverse social, familial, and personal consequences of ADHD cannot be over-stated. Most ADHD subjects develop emotional, social, and family problems as a consequence of their primary difficulties. ADHD is a major problem both for society and for the child, as it causes friction in school or at the workplace, depresses the academic performance of the student's entire class, interferes with peer relationships, and increases intra-family stress. For the individual afflicted, until ADHD symptomatology can be recognized and brought under medical management, daily existence is likely to be severely compromised along with the lives of those around him (or her, although ADHD is more prevalent in boys by a 3:1 margin). Parents and children express desperation for interventions that will work, but without the adverse effects inflicted by the pharmaceutical management model.

The first report of stimulant use to treat ADHD was in 1937. The current overwhelming reliance on methylphenidate and other stimulants for ADHD treatment belies the ample evidence that ADHD symptomatology can be ameliorated without the use of drugs.

The Diagnosis and Progression of ADHD

ADHD diagnostic guidelines are found in the DSM-IV, which is related to the World Health Organization ICD-9 and ICD-10 categories.

ADHD children have difficulty sitting still, maintaining their attention on the task at hand, and thinking through their answers before they respond to questions. Although ADHD is distinctly different from learning disability per se, the behavioral features that define this disorder, short attention span, distractibility, impulsivity, over activity occur on a continuum across the population, thus the ADHD diagnosis requires thorough consideration of the severity of the symptoms and the relative degree of functional impairment.

ADHD per DSM-IV is diagnosed in five major steps, each with specific criteria. The symptoms must appear before age seven, persist for at least six months, and appear in the school environment as well as the home. The first step is to establish EITHER (a) abnormal and persistent inattention, from at least six symptoms continuing over a minimum six months, OR (b) abnormal and persistent hyperactivity-impulsivity, also from at least six symptoms over six months. The second step is to establish that these symptoms were present before seven years of age. Third, these symptoms must be present in two settings, usually at school (or work, if an adult) and at home. Fourth, there must be clear evidence of "clinically significant impairment in social, academic, or occupational functioning." The fifth criterion is exclusionary—that the symptoms not be secondary to some other disorder. Whereas some of the ADHD symptomatology can be linked to family changes (e.g., divorce) or other life events (e.g., head trauma), ADHD typically begins early in life, is chronic, and is pervasive.

Once the basic ADHD diagnosis is established per the above-described criteria, three subtypes can be differentiated.¹ These are

- (1) ADHD, combined type, applied where both inattention and hyperactivity-impulsivity—(a) and (b) above—are extant for at least 6 months;
- (2) ADHD, predominantly inattentive type, if only the inattention criteria are met; and (3)

ADHD, predominantly hyperactive-impulsive type, if only the hyperactivity-impulsivity criteria are met. There is also a DSM-IV criterion of ADHD in Partial Remission, for individuals (usually adolescents or adults) who exhibit only some of the required symptoms but are otherwise experiencing significant functional impairment. Then come the assessments for the learning disabilities and other neurologically based disorders with which ADHD is often associated.

Between 30-40 percent of ADHD subjects have learning disabilities¹⁸, but the ADHD child is not mentally retarded and can be realigned toward a productive life path. Other neurobiological difficulties encountered



in the ADHD population are motor tic disorder or Tourette's disorder, anxiety disorder, anger control problems, and depression.²² Some children will have two, three, or more of these difficulties without having ADHD, but Biermann studied a large population of ADHD children and found that more than half also had depression, anxiety, and conduct disorder. The clinician must therefore verify, document, and prioritize these various symptom clusters, both to assess their contributions to the child's apparent ADHD patterns and to develop means for their medical management concurrently with ADHD.

To help make this possible the physician and the other professionals involved must work closely with parents and teachers to assess the child as a total individual.

ADHD Medical Management— Current Status

The conventional management of ADHD formally involves a multimodal approach. Currently, this approach includes individual and family education, counseling, behavioral therapy, school remediation, and medication. Close coordination between the subject, the family, the practitioner and the school system ought to be integral to this approach.

Psychostimulant medications are generally the first choice in medication of ADHD. Approximately 70 percent of the children treated show improvement in the primary ADHD symptoms and in co-morbidity such as conduct disorder.

Currently, methylphenidate is the drug of choice, other first-line stimulants include dextroamphetamine. The second-line stimulants include methamphetamine), or pemoline, which causes hepatotoxicity in about three percent of subjects treated and can cause death, so must be closely monitored. The psychostimulants are limited in their applicability, due to their marked and sometimes severe adverse effects. Decreased appetite secondary to anorexia or nausea may occur, leading to weight loss. Insomnia may also occur, as can head-ache. Lowering the dose and changing the timing may eliminate these side-effects. Rarely, psychostimulants may cause tics to develop, and cases of leukopenia and psychosis have been reported.²⁵ Methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and Adderall are all classified as Schedule II agents in the U.S., consonant with their significant abuse potential.^{25,29} As blood levels of the stimulant decrease over time, irritability may manifest as a "rebound" type of withdrawal symptom.

A subgroup with more depression and anxiety may respond better to tricyclic antidepressants (imipramine, desipramine) than to stimulants although both can have major adverse effects, with desipramine linked to sudden death. The antidepressant bupropion can, like the stimulants, exacerbate an underlying tic disorder. This drug is also contraindicated in children with anorexia nervosa, bulimia, or epilepsy.

Certain non-stimulant medications can serve as allopathic alternatives in ADHD when stimulants have failed. Among these are the alpha-adrenergic clonidine and guanfacine. Both are less well validated than the stimulants and not as efficacious. Clonidine can cause sedation and dysphoria, and both of these drugs require blood pressure monitoring because they are also antihypertensive.

The psychological disorders that often coexist with ADHD also require management. The more serious of these include tics or Tourette's syndrome; depression, including the bipolar type which is quite prevalent; anxiety; and obsessive-compulsive disorder. For children who have tic disorders, extreme over activity, oppositional or conduct disorder, ADHD also can be associated with impulse control problems more extreme than the usual ADHD spectrum; sometimes antipsychotics are prescribed, although their risks outweigh their advantages.⁵ In summary, pharmacologic management of ADHD and the coexisting conditions can challenge even the most experienced practitioner, and safer modes of management are urgently indicated for this unfortunate patient population.



Totsguide “Track & Act” – Web based Developmental Screening Tool

Dr. Nandini Mundkur, MD, R M. Sundar Kumar, PT,
Karthik Krishnamoorti, MIT



Early identification of developmental disorders is critical for the well being of children and their families. It is the responsibility of primary care professionals to improve developmental outcomes through early surveillance and appropriate referral of children with developmental delays. However, factors such as limited consultation time in busy office practice, inappropriate methods of screening, high threshold for referral and negligence of parent's concern diminish the effectiveness of early screening. So, it is important to develop a tool that is systematic, easy and convenient for primary care practitioners to improve the effectiveness of Developmental screening and referral patterns.

It is with this objective in mind we have developed a **free web-based developmental screening tool “Totsguide – “Track and Act”** for a long-term monitoring of milestones in children from 4months to 5years.


Login to **“totsguide.com” (parent based child development website)** to access **“Track & Act” Screening tool**. The tool is a cloud-based scalable solution which keeps track of child's development. Using the platform, Professional and caregivers can instantly monitor their child overall development and keep record of milestones till 5 years of age.


Through Online Screening, professionals can create Child's profile with demographic details. The details include automated calculation of corrected age in case of Pre-maturity. The corrected age is taken into account till 2 years of age.

Overview

Edit Account

Sundar






Contact Information
email: @ahoo.com
phone: --

Create a Child's profile

Assess the child profile based on his / her age.

Create a Child's Profile

Children Profile

#	Child Name	Birth Date		Report History	New Assessment
1	Rishi	01-Jun-2014		Report History	New Assessment
2	Aarav	13-Jan-2014		Report History	New Assessment
3	Arun	14-May-2014		Report History	New Assessment

The screening contains structured “Yes or No” questions based on child's age (corrected age in case of prematurity) and across four developmental domains such as Social-Emotional, Communication, Cognitive and Physical.



Track And Act

1 Topic 1 Language/Communication

2 Topic 2 Movement/Physical Development

3 Topic 3 Cognitive

4 Topic 4 Social/Emotional

Language/Communication

Does your child say four or more meaningful words apart from mama & dada

☐ Yes ☐ No

Can your child imitate two word sentences? For example when you say "drink water", "change dress", does your child say the sentence back to you?

☐ Yes ☐ No


Does your child understand and obey simple instructions such as don't touch, give me the toy)

☐ Yes ☐ No

Does your child point to a correct picture or object, when you ask him

☐ Yes ☐ No

The authors recommend the users to test each item with child using Totsguide "Track & Act" screening kit to improve accuracy of responses.

 19 Nov-2015

Child's Name : Arun

Date of Birth: 14-May-2014

Total score obtained by the child: 66

(The score reflects child's performance across developmental domains: Physical, Cognitive, Language and Socio-emotional)

Domain	Score
Language / Communication	60
Movement / Physical	108
Cognitive	108
Socio Emotional	20

Interpretation of the scores

- * If the child's score (either total or domain score) is between 0-40, it is below average. Further monitoring and detailed developmental evaluation may be needed.
- * If the child's score (either total or domain score) is between 41-60, it is borderline. Provide opportunities for learning and monitor development through "Track & Act" next month.
- * If the child's score (either total or domain score) is between 61-100, it is above average. Your child appears to have normal developmental schedule.

Recommendations

- * Share this result with your Paediatrician / Primary care provider. (for all the scores)
- * If you have definite concern about child's development or child scored low in >= 3 consecutive months, meet Developmental Paediatrician for further evaluation. (only for scores between 0-40)

Totsguide Advertisement

On completion of the questionnaire, the program will generate printable report that will have overall and an individual score for each domain. The report will also provide interpretation of scores that will assist primary care practitioners in making appropriate Clinical Decision or to initiate further referral to Developmental clinic.

The screening tool is currently available in English language. However, considerable efforts are made to get Hindi, Tamil, Kannada and other regional versions. The iOS and android version of app will be soon deployed for the professionals to use.

For information about totsguide "Track & Act" contact Dr. Nandini Mundkur at nandinimundkur@gmail.com

Role of Orthopaedic interventions in a child with disability !!

Author : Dr. Viraj U. Shingade

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Children Orthopaedic Care Institute**

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Ph : 0712-3221760, 0712-2252327



Any Orthopaedic or Neurological disorder in a child is sufficient to put any family in lifelong misery. I still remember those days, when I was doing my post graduation in Orthopaedics & we were taught that there is no solution for many Orthopaedic and neurological conditions and we could hardly do anything for a child with disability.

But in last 20 years with advances in Paediatric Orthopaedic specialty, lots of conditions has become treatable, which previously were thought to be non curable.

As we all know, right from history taking, through examination, to diagnosis everything differs in Paediatric branches. Cartilaginous nature of bone, growth potential in bones, recurrence of deformities due to growing bone, delicacy required in surgeons hand while handling soft cartilaginous bone, small structures including neurovascular bundles, smaller or mini incisions, learning new approaches to minimize trauma to normal tissues, minimal scar expectation from parents, and most important the long term, regular follow up at least till skeletal maturity these are the factors which make Paediatric Orthopaedics branch more demanding and challenging.

The incidence of cerebral palsy is rising very high as lots of low birth weight and premature babies are being saved due excellent NICU care at peripheral centers. It is very important to generate awareness amongst parents of spastic children that cerebral palsy is a totally different condition than poliomyelitis and they should not confuse these two conditions. I have seen many surgeons who operate these spastic children in surgical camps for poliomyelitis and which ultimately lead in to disasters.

Many of these spastic children go for camps advertised by spiritual channels on television, and they land-up with trouble. Cerebral palsy is a subject where we need to keep the child under regular follow up; we have to assess the power and spasticity in muscle groups at regular intervals. Before taking the surgical decision, surgeon has to think many times, whether surgery is really going to give benefit to the child or not. By doing the surgery one should not loose the existing power of the muscles. Basically surgeon has to balance the art of deformity correction and maintain the existing power of muscles. Tendon cutting surgeries performed in free surgical camps like in polio, lead in to disasters in cerebral palsy and hence they should be condemned strongly. With recent advances in surgery many non ambulatory children can live independent life; provided they are handled by expert surgeon.



There are many congenital anomalies which can be managed excellently with recent techniques. Club-foot is one of the commonest congenital anomalies seen in day to day life. Previously application of plaster or posteromedial release or bony procedures, these were the only options available to surgeons. Now with better understanding of the pathology of this entity, minimal invasive techniques like Ponsetti methods are available and hence better correction is achieved in majority of the cases without going for extensive release surgeries. It is very important to start the treatment as earliest as possible (day 1 or first 7 days of life), as the results are very good if treatment is started in first few weeks of life. Many neglected late presenting clubfeet and neurogenic foot can be cured now due to recent surgical techniques (Ref. 1 and 2) developed by our Institute.

The conditions like congenital fusion of forearm bones (congenital radioulnar synostosis) which was thought to be incurable can be treated now with surgical technique developed by our Institute (Ref. 3)

Other common congenital anomalies of upper and lower limbs (radial club hand, fibular hemimelias, polydactyly, syndactyly) in which either the bone is missing, or extra or deformed, are getting treated with excellent results, due to availability of newer external stabilization systems and improvement in micro-vascular techniques.

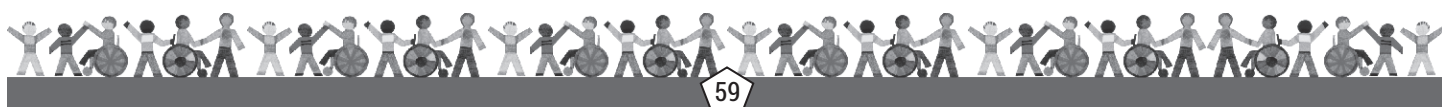
Congenital dislocation of hip lead to severe arthritis of joint and associated lurch while walk. Now, congenital dislocation of hip can be diagnosed in early stages due to advances in USG. The results are excellent, if it is diagnosed, and treated in early age. Many pelvic osteotomies are now available to redirect the acetabulum; they require a skillful approach and technical expertization on part of the surgeon.

Treatment for upper limb birth injuries and Erb's palsy should be started as earliest as possible; as results are good if treatment is initiated in early stages. Lots of newer techniques of muscle and tendon transfers are available, which give excellent functional hand in long term.

Simple looking problems like flat feet in children can be dangerous, as they might be part of symptom complex, or secondary to many congenital pathologies of foot bones or could be manifestation of neurological pathologies; hence immediate opinion should be sought from a paediatric Orthopaedic Surgeon rather than just neglecting it as an untreatable entity.

Scoliosis (congenital or developmental deformity of back-bone/spine) was previously thought to be untreatable and was neglected by the surgeons due to involved morbidity in surgery, and was accepted by parents as an untreatable entity. These children on follow up used to get decreased vital capacity with increasing severity of spinal curve. Due to availability of allografts (human donated bone) newer instrumentation techniques, and good ventilatory support, the surgery has become very safe with excellent correction of spinal curvature.

Pyogenic infection of bone (osteomyelitis), particularly in neonate is still, a common thing in day to day practice. It requires an emergency management within golden period. If managed urgently with skillful decisions and good new generation antibiotic coverage, many of these patients do well. Some of them results in to dislocation of joint (particularly hip joint) and require reduction either by closed or by open methods. Tuberculosis of bones and joints also require a skillful management to give a good functional joint.



Congenitally or developmentally short limbs and bones are getting lengthened with Ilizarov techniques. Special computerized techniques which guide the progress of limb lengthening and deformity corrections (Taylors frame) are available. Although they are expensive but are accurate and give excellent results.

For malignant tumors in childhood, like Osteogenic Sarcoma, or Ewings sarcoma, amputation of the limb was the only choice in past. With availability of neo-adjuvant chemotherapy (cancer-cell killing toxic drugs) and advances in radiotherapy now there is no need of amputation of the limb. After resection of the bone tumor, the limb reconstruction is done by putting a metal prosthesis (metal joint) in place of previous pathological bone. This, not only preserves the limb, but also gives a functional joint required for locomotion.

With availability of 3-D USG scans, many of the congenital pathologies like club foot, dislocation of hip, scoliosis are getting diagnosed prenatally. Treatment of these conditions in early neonatal period give excellent results on long term follow up.

In nutshell, most of the so called “untreatable orthopaedic and neurological conditions” leading to disability have become treatable now days. And I am sure the day is not far when word “incurable” will vanish from dictionary of disabled child if specialists from all different groups including Paediatricians, Neurologists, Therapists, and Paediatric Orthopaedic Surgeons come together and work for these children hand in hand.

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Topic : Ophthalmic Interventions in children with disability

(Under the section multidisciplinary approach in children with disability)



Dr Shubhangi Bhawe

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Director, Drishti eye clinic & Squint Center, Nagpur

Abstract :

In a disabled child, a visual handicap can have a direct impact on psychosocial status. Ocular abnormalities noted in 86 % of disabled children.

Assessment & management of visual disorders in physically and intellectually impaired children presents a challenge for clinicians. Refractive errors, nystagmus and strabismus often affect quality of vision significantly. Early diagnosis and management help in their learning and psychosocial development.

Intervention :

Method of V/A - Depending upon age and mental status of patient. [Snellens, Kay Picture, Preferential Looking, log MAR, CSM technique]

Ocular motility – Highly interesting colourful objects held in cardinal gazes.

Dolls head tilt test.

Cover test, Hirschberg Test – To see presence of strabismus.

Nystagmus –

- Refraction under cycloplegia (using 1 % cyclopentolate)

Anterior Segment – Examination using slit lamp biomicroscope.

Posterior Segment – Direct / Indirect Ophthalmoscope.

Surgery – To correct Strabismus.



PEDIA RANGE

Vitamin D Supplementation or Booming
IMMUNITY & HEALTH

Caldikind

Sachet

Cholecalciferol 60,000 LU.

As Immunity Booster and for
Improving Muscle Function

RTI in children

Dosage :
1 Sachetweek
for 6-12
weeks

Dosage :
1 Sachetweek
for 6 weeks



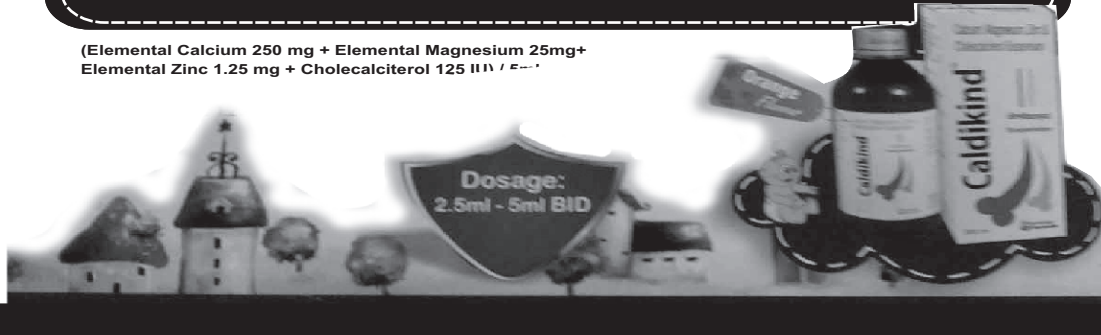
Calcium and Vitamin D Supplementation
in **GROWING** Children

Caldikind

Susp.

(Elemental Calcium 250 mg + Elemental Magnesium 25mg+
Elemental Zinc 1.25 mg + Cholecalciferol 125 IU / 5ml)

Dosage:
2.5ml - 5ml BID



Cope with Recurrent **ALLERGY**

Monticope

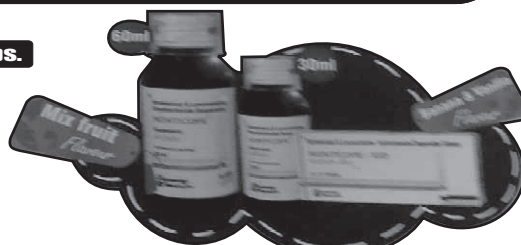
Susp.

KID

(Montelukast 4mg + Levocetirizine 2.5mg) / 5ml

Montelukast 4mg + Levocetirizine 2.5 mg **Disp. Tabs.**

Safe above
6 month
patients



In RTI, Otitis Media & Typhoid Fever



TEACHING STUDENTS WITH LEARNING DISABILITY

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“Learning Disabilities” refer to a number of disorders, which may affect the acquisition, organization, retention, understanding, or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning. As such, learning disabilities are distinct from global intellectual deficiency. Learning disabilities result from impairments in one or more processes related to perceiving, thinking, remembering, or learning. These include, but are not limited to language processing, phonological processing, visual spatial processing, processing speed, memory and attention, and executive functions (e.g., planning and decision making).

Learning disabilities range in severity and may interfere with the acquisition and use of one or more of the following:

- Oral language (e.g., listening, speaking, understanding);
- Reading (e.g., decoding, phonetic knowledge, word recognition, comprehension);
- Written language (e.g., spelling and written expression); and
- Mathematics (e.g., computation, problem solving).

Learning disabilities may also involve difficulties with organizational skill, social perception, social interaction, and perspective taking. Learning disabilities are lifelong. The way in which they are expressed may vary over an individual's lifetime, depending on the interaction between the demands of the environment and the individual's strengths and needs. Learning disabilities are suggested by unexpected academic underachievement or achievement which is maintained only by unusually high levels of effort and support.

Learning disabilities are due to genetic and/or neurobiological factors or injury that alter brain functioning in a manner which affect one or more processes related to learning. These disorders are not due primarily to hearing and/or vision problems, socio-economic factors, cultural or linguistic differences, lack of motivation, or ineffective teaching, although these factors may further complicate the challenges faced by individuals with learning disabilities.

Learning disabilities may co-exist with various conditions including attentional, behavioural and emotional disorders, sensory impairments, or other medical conditions. For success, individuals with learning disabilities require early identification and timely specialized assessments and interventions involving home, school, community, and workplace settings. The interventions need to be appropriate for each individual's learning disability subtype and, at a minimum, include the provision of:

- specific skill instruction;
- accommodations;
- compensatory strategies; and



- self-advocacy skills.

Skill Areas Associated with Learning Disabilities

- Receptive and Expressive Language Skills
- Auditory/Phonological Processing
- Visual Processing
- Visual-Motor Processing
- Attention
- Memory
- Metacognition
- Study and Organizational Skills
- Social Skills

It is important to remember that every student diagnosed with a learning disability will present with his/her own unique learning profile. The degree to which students experience difficulties will vary. The areas of strengths and interests will also vary. It is important to determine and enhance supports for each student based on the individual's strengths and needs.

What is Remedial Teaching?

It is a multifaceted approach, tailoring remedial intervention plans to a child's specific needs. It makes use of one-on-one instruction, small group instruction, written work, verbal work and computer-based work.

- Remedial Therapy focuses on skills rather than on content.
- These skills include visual discrimination, perceptual organization, laterality, sequencing, abstract reasoning, auditory processing, sound recognition, blending, segmenting, phoneme manipulation, mathematical operations, focusing and eye tracking.
- Help is offered to pupils who need (pedagogical/didactic) assistance.
- These are often children who function at a lower than average level because of a certain learning- or behavioural problem/disorder, but it can also be offered to pupils who achieve at a higher than average level, they too can do with the extra attention and care.



Handling Parental Stress

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The parents of an adolescent who is developmentally challenged have often described their plight in handling their growing child as a “nightmare that never ends”!

As it is they have withstood the ordeals of accepting, adjusting & coping positively with the upbringing of their challenged child, when he/she was young. The parents not only mourn the loss of unfulfilled expectations but often face enormous strain on their psychological & economic resources. The chronic disability which is likely to continue indefinitely and is attributable to physical/ mental impairment results in substantial functional limitations in many areas like

Self-care

Receptive & expressive language

Learning

Self-Directions

Mobility&

Capacity to live independently.

With the advent of puberty & adolescence, fresh issues related to sexual maturity, menstruation, abuse, stubbornness, arrogance, mood swings & emotional lability, search for identity & its societal impression, career & financial self-dependence are the multiple issues so suddenly thrown at the family that the coping often becomes very difficult. The parents continuously face the dilemmas in dealing with an adolescent who shows physical growth spurt but suffers from language, cognitive, behavioral or emotional disturbances in addition to the long standing physical or mental disability. Raising a developmentally challenged adolescent is thus far more stressful as there has to be a reorientation of expectations of parents & new & effective coping strategies have to be adopted by them. This leads to the generation of remarkable stress in parents. The sources of stress need to be carefully identified so as to plan actively & positively to tackle the stressors & strengthen the skills of the parents.

The stressors commonly identified are both general & specific. Arrangements regarding vocational education, admission in an appropriate institution to learn pre vocational skills, daily secure transport to & from managing home based learning requires substantial amount of money; hence low socio economic condition adds to the woes of the family.

It is often imperative for both parents to work; therefore a small nuclear family with a developmentally challenged adolescent creates a lot of stressful situations in the day to day management.

The age of parents also is a source of stress if the parents are middle aged or beyond as they feel physically & emotionally incapacitated to deal with an aggressive & stubborn adolescent.



The caring for a challenged adolescent requires healthy interaction within the family with members supporting each other emotionally on a day to day basis. Instead of this, if the communication within the family is spattered with blame games, the resultant stress is more debilitating for everyone.

The normal siblings, elder or younger to the adolescent have to make a lot of social adjustments. They have to deal with the disruptive behavior of their challenged sibling & face embarrassment in public when their friends visit them. This can lead to their social withdrawal. They may develop anxiety, aggression, somatization, depression & behavioral problems therein. The parents then have to face situations ridden with guilt, anger & hopelessness.

Parents adopt various coping strategies in dealing with their peculiar situation. Denial/acceptance of the situation, engagement coping/disengagement coping, distraction coping/ active coping, cognitive reframing & positive planning, empowering strategies versus social withdrawal, rearranging life & relationships, changing expectations, seeking emotional support groups are a variety of modes parents adopt to deal with a disabled in a family. Some of the strategies like denial, disengagement & social withdrawal are harbingers of stress.

The stress that parents & family face is manifested in parents in various ways:

Biological : Fatigue, exhaustion, Cardiovascular strain, GI upsets, reduced appetite & vulnerability to illness

Psychological : Cognitive & emotional effects such as shock, night terror, irritability, anger, helplessness, impaired concentration, confusion, reduced self-esteem, & reduced self-efficacy

Socially : Disruption in family, decrease in social interaction, reduced recreation.

The levels of stress generated depend on a no; of factors which include severity of disability, psychological makeup of parents, self-determination & intellectual functioning of parents, availability & quality of professional services, religious beliefs & attitudes, family size & its socioeconomic status, social support from friends & relatives & good marital interaction. The families which can mobilize internal & external support can adapt better to the situation. How a family adapts to stress is beautifully explained by Hills(1970) model, called ABCX model., where A is the stressor, B denotes family resources, C is family's definition of stressor events X is the crisis situation.

The five domains of quality of life in such families if carefully looked into & tackled with a positive attitude can help parents handle their stress better :

Disability related support

Physical well being

Emotional well being

Healthy interaction within family &

Efficacy of parenting skills.

Adoption of certain coping strategies & principles of behavior help to increase the resilience & reduce the parental stress. Coping is defined as constantly changing cognitive & behavioral efforts to manage specific internal & external demands that are appraised by an individual as "taxing" or exceeding the resources of a person. The different type of coping strategies the family adopts finally determines the efficiency of managing stress. The stress & coping are inversely related to each other. The strategies which are adopted can be internal & external. They are



Problem Oriented coping : the behavior & environmental factors are appropriately changed to deal with the situation.

Emotional regulation coping : Aimed at reducing emotional distress & maintaining a satisfactory internal state.

Task oriented coping : involves conscious efforts taken to reduce stress cognitively & behaviorally.

Sense of coherence coping : It involves coping on three dimensions of comprehensibility, manageability & meaningfulness in life while facing a chronic problem in life.

Purpose in Life coping : involves consideration of individual's experience of having clear & stable goals in life.

Avoidance & Distraction coping : running away from the situation & reasonable solutions to a problem.

Except the last one, the other coping strategies generally help in reducing the stress & bring it down to a level which can be effectively managed.

All in all, if the parental stress is to be managed well, the parents need to do the following things:

- Seek knowledge & awareness & Keep yourself updated on your child's disability
- Locate resources which can help your child
- Communicate your feelings to your family
- Reach out to other parents in similar situations
- Join a support group for emotional well being
- Plan & try to stick to a daily routine
- Take one moment at a time in dealing with precarious situations
- Relax, rest & take good care of yourself
- Involve siblings in care
- Use humor & pursue some hobby
- Practice resilient behavior strategies
- Adopt a positive attitude towards life

If we consider strategies as labels, following labels enrich the life & help reduce the stress:

"Planning & knowledge is Power"

"Share the load"

"Lift the restraining labels"

"Me time"

"Recognize the joys"!



CAREER GUIDANCE FOR PERSONS WITH DISABILITY

By

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Work is an important aspect of adult life. It is believed that each individual is of great capacity and dignity. Hence every person should have equal opportunity to maximize his potential for better employment.

Career, job, work or employment; known as by many names provides not only economic independence, but is also important to develop one's self esteem and self worth. It is a mean for achievement, satisfaction-personal as well as social, and a medium to satisfy creative urge and of course for financial safety and security.

Career development is an ongoing process of gaining knowledge and improving skills that will help an individual to establish a career plan. Same is the case with 'persons with disability (PWD). But, it becomes necessary to provide specialized guidance for career to PWD as they have special needs. Effective and responsible career guidance can significantly impact and empower PWD. If done at various levels of education, vocation and employment, it can provide a very satisfying and rewarding career for PWD.

This is important because, lack of career opportunity will lead to low income dependency on others low self esteem frustration behavioural problems psychiatric problems, etc

In today's world of globalization, industrialization, increasing technology and migration, for PWD it becomes a two way sword. On one hand technology may assist PWD, but on the other hand, if these skills are not mastered, then it will be a major hindrance for employment.

Some of the barriers in employment of PWD are....

Limitation in early life experiences

Difficulty in making decisions

Low/poor self esteem

Lack of opportunity to test their confidence

Limited social experience

Limited sense of self sufficiency

Limited saleable work skills

Low income

Lack of proper information

Transportation facilities and mobility restriction

Public accommodation and services

Classification or labeling based on disability rather than ability

Every individual goes through following career stages

0 to 10 yrs—fantasy

11 to 13 yrs—interest

13 to 14 yrs—capacity building

15 to 17 yrs—exploration

18 to 21 yrs—transition

21 to 24 yrs—trial



25 onwards—career established

Factors to be considered during career guidance of PWD are....

Any type of disability can usually be associated with mild cognitive deficit though not always

Person may have faced problems in acquisition of academic skills like reading/writing or arithmetic

Person may have faced problems in listening skills, comprehension, use of advanced linguistic skills or use of modern technology like computers.

Person may have problems in communication, like following or giving instructions. Communicating instructions in office structure or in understanding and processing of information.

Other important things to be considered are

Lack of vocational or occupational skills

Limited saleable work skills

May have problems in

How to look for job

Finding job opportunities

Writing C.V./other paper work

Managing disability at work place/finding support

High percentage of school dropouts

Failure to develop a consistent, differentiated personality

Career counseling for PWD can be divided in two phases;

Phase 1—

Identification and understanding of disability as well as ability

Assessment of— academic skills

Daily living skills

Personal/social skills

Occupational/vocational skills

Vocational interest

Vocational aptitude

Career maturity

SWOT analysis

Phase 2—

Collecting information

Providing appropriate information

Decision making

Goal setting

Plan of action

Evaluation of complete process

Conclusion — Career development is an ongoing process of gaining knowledge and improving skills that will help an individual to establish his career path. It is important to develop an empowerment approach to career counseling in assisting PWD to achieve their career goals and resolving their career problems

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BEHAVIORAL MODIFICATION FOR ISSUES IN ADOLESCENTS WITH DISABILITY

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Adolescents with chronic illness or disability experience the same developmental transitions as their peers without disabilities, yet their illness or disability places them at risk for certain psycho-social problems as they move into adulthood. The risk is more often related to the degree of fit between the adolescent and his or her environment: family, school, peers, health care services, work, and societal attitude. The fit can lead to optimal integration and development, or it can result in isolation and low self-esteem.

Most families experience a loss and undergo a grieving process when they have a child who is born with, or acquires, a disability. No matter what the disability, families find themselves in “unknown emotional territory with no guides to direct them toward ways to express their grief in a culturally acceptable format”. For some families, the chronic care needs of a child with a disability can be overwhelming and never-ending. For those who have a child with a disability, important milestones such as graduation from high school can trigger stress, grief, or fears that impede a vision of normal adulthood.

In addition, the social effects of a disability also impact the parent/child relationship and family dynamics.

It is important for adolescents with disabilities and their families to have information from physicians, teachers, social workers, and other families about adolescent development, and to receive encouragement to create a vision of adulthood. It is also vital that they experience opportunities to share their dreams and hopes, fears and frustrations, and to dialog about their visions for the future. Autonomy, independence, problem-solving, and constructive role-related changes will increase if families can build safety nets amid the fear of life-threatening decisions and risk-taking that are part of the teen experience.

Adolescents with intellectual disabilities may become depressed. They might not have enough language skills to talk about their feelings, and their depression may be shown by new problems, for instance in their behavior, eating and sleeping.

Early diagnosis of psychiatric disorders in children with intellectual disabilities leads to early treatment. Medications can be helpful as one part of overall treatment and management of children with intellectual disabilities.

Periodic consultation with a child and adolescent psychiatrist may help the family in setting appropriate expectations, limits, opportunities to succeed, and other measures which will help their child with intellectual disabilities handle the stresses of growing up.

Behavior Modification is part of a behavioral tradition developed by Pavlov in the early part of the twentieth century. This therapy was adapted by John Watson in 1920 and eventually translated into behavior therapy by researchers and clinicians such as B.F. Skinner and Hans Eysenck in the 1950s. These approaches were later incorporated with cognitive behavior therapy as developed by researchers such as Donald Meichenbaum.

Behavior modification therapy is based on the concepts of

- observable antecedents (events that occur before a behavior is apparent),



- observable behavior, and
- consequences (the events that occur after the behavior occurs).

A behavioral modification program to affect behavioral change consists of a series of stages.

An inappropriate behavior is observed, identified, targeted, and stopped. Meanwhile, a new, appropriate behavior must be identified, developed, strengthened, and maintained.

The key to a successful program of child behavior modification is consistency. And a key piece of behavior modification that parents and teachers can perform is to present their own behavior and reactions in a positive way, so that children can learn and model successful behavior.

The following four points should be incorporated into all three components of behavior modification :

1. Start with goals that the child can achieve in small steps.
2. Be consistent – across different times of the day, different settings, and different people.
3. Implement behavioral interventions over the long period – not just for a few months.
4. Teaching and learning new skills take time, and children's improvement will be gradual.

Positive reinforcement :

Rewarding adolescent with age-appropriate incentives is a valuable way to help his/her change in behavior. This is called positive reinforcement. It involves praising your teen or giving him/her a prize when he/she engages in desirable behaviors. For example, if he/she cleans his/her room without having to be asked several times, reward her with a movie

Negative reinforcement :

Just like with rewards, punishments must be age-appropriate if you want them to change your child's behavior. In addition, they need consistent consequences to help them figure out right from wrong. If he/she chooses to watch television instead of doing homework, he/she isn't allowed to watch her favorite programs for three days. If the same consequence occurs each time a rule is broken, it won't be long before your child starts to change her behavior.

Cognitive Behavior Therapy (CBT)

CBT is usually more focused on the present, more time-limited, and more problem-solving oriented. Indeed, much of what the patient does is solve current problems. In addition, patients learn specific skills that they can use for the rest of their lives. Cognitive behavior therapy helps people to identify their distressing thoughts and to evaluate how realistic the thoughts are. Then they learn to change their distorted thinking. When they think more realistically, they feel better. The emphasis is also consistently on solving problems and initiating behavioral change. Duration of therapy may last from few weeks to many months depending on severity of problem. Childrens visit therapists once a week initially and gradually once every two or three weeks as soon as crisis is over.

Rational Emotive Behavior Therapy (REBT)

As with adults, rational-emotive behavior therapy (REBT) hypothesizes that children's disturbed emotions are largely generated by their beliefs. The Rational Emotive Behavior Therapy framework assumes that humans have both rational and irrational tendencies. Irrational thought/images prevent goal attainment, lead to inner conflict, lead to more conflict with others and poor mental health. Rational thought/images lead to goal attainment and more inner harmony. In other words rational beliefs reduce conflicts with others and improved health. Irrational beliefs and distortions of reality are likely to create anger, anxiety, and depression in children just as they do with adults. In fact, because children are immature, less sophisticated, and less educated—one might expect them to make more cognitive errors than adults and to become upset more easily. Child-oriented REBT practice has always taken into account the child's cognitive-developmental status in selecting appropriate cognitive assessment and intervention procedures. When assessing emotions in children, it is important to normalize and validate their



feelings. It is important for you to explain that everyone gets angry, worried and sad from time to time and that there is nothing wrong with them or bad about them if they get extremely upset. Later on, you will, of course, discuss the negative aspects of getting extremely upset as a way to motivate the child to work on emotional change. The practitioner has the task of (1) helping children to be more aware of their feelings and (2) enabling them to tune into and report their self-talk.

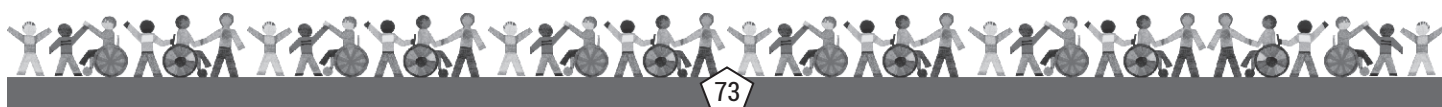
For behavior modification in adolescent with ADHD can be done with the help of parents, teachers. Peers etc.

1. Classroom rules
 - Be respectful of others.
 - Obey elders
 - Work quietly.
 - Stay in assigned seat/area.
 - Use materials appropriately.
 - Raise hand to speak or ask for help.
 - Stay on task and complete assignments.
 - Post the rules and review them before each class until learned.
 - Make rules objective and measurable.
 - Tailor the number of rules to developmental level.
 - Establish a predictable environment.
 - Enhance children's organization (folders/charts for work).
 - Evaluate rule-following and give feedback/consequences consistently.
 - Tailor the frequency of feedback to developmental level.
2. Praise of appropriate behaviors and choosing battles carefully
 - Ignore mild inappropriate behaviors that are not reinforced by peer attention.
 - Use at least five times as many praises as negative comments.
 - Use commands/scolding to cue positive comments for children who are behaving appropriately - that is, find children who can be praised each time a reprimand or command is given to a child who is misbehaving.
3. Appropriate commands and oral punishments
 - Use clear, specific commands.
 - Give private scolding at the child's desk as much as possible.
 - Scolding should be brief, clear, neutral in tone, and as immediate as possible.
4. Individual accommodations and structure for the child
 - Structure the classroom to maximize the child's success.
 - Place the student's desk near the teacher to facilitate monitoring.
 - Enlist a peer to help the student copy assignments from the board.
 - Break assignments into small chunks.
 - Give frequent and immediate feedback.
 - Require corrections before new work is given.
5. Proactive interventions to increase academic performance—Such interventions can prevent problematic behavior from occurring and can be implemented by individuals other than the classroom teacher, such as peers or a classroom aide. When disruptive behavior is not the primary problem, these academic interventions can improve behavior significantly.



- Focus on increasing completion and accuracy of work.
 - Offer task choices.
 - Provide peer tutoring.
 - Consider computer-assisted instruction.
6. “When-then” contingencies (withdrawing rewards or privileges in response to inappropriate behavior) – Examples include recess time contingent upon completion of work, staying after school to complete work, assigning less desirable work prior to more desirable assignments, and requiring assignment completion in study hall before allowing free time.
7. Daily school-home report card – This tool allows parents and teacher to communicate regularly, identifying, monitoring and changing classroom problems. It is inexpensive and minimal teacher time is required.
- Teachers determine the individualized target behaviors.
 - Teachers evaluate targets at school and send the report card home with the child.
 - Parents provide home-based rewards; more rewards for better performance and fewer for lesser performance.
 - Teachers continually monitor and make adjustments to targets and criteria as behavior improves or new problems develop.
 - Use the report card with other behavioral components such as commands, praise, rules, and academic programs.
8. Behavior chart and/or reward and consequence program (point or token system)
- Establish target behaviors and ensure that the child knows the behaviors and goals (e.g., list on index card taped to desk).
 - Establish rewards for exhibiting target behaviors.
 - Monitor the child and give feedback.
 - Reward young children immediately.
 - Use points, tokens or stars that can later be exchanged for rewards.
9. Classwide interventions and group contingencies –
- Establish goals for the class as well as the individual.
 - Establish rewards for appropriate behavior that any student can earn
 - Establish a class reward system in which the entire class (or subset of the class) earns rewards based on class functioning as a whole (e.g, Good Behavior Game) or the functioning of the student with ADHD.
 - Tailor frequency of rewards and consequences to developmental level.
10. Time out – The child is removed, either in the classroom or to the office, from the ongoing activity for a few minutes (less for younger children and more for older) when he or she misbehaves.
11. Schoolwide programs – Such programs, which include schoolwide discipline plans, can be structured to minimize the problems experienced by children with ADHD, while at the same time help manage the behavior of all students in a school.

Adolescent counseling touches many significant developmental , gender related, career related and health as well as mental health related issues. Helping teenagers to develop healthy coping mechanisms and contributing to their overall personality development.



DEVELOPING SELF ESTEEM IN ADOLESCENTS WITH DISABILITY

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Self-esteem is a major key to success in life. The development of a positive self-concept or healthy self-esteem is extremely important to achieve the happiness and success. Self-esteem is how we feel about ourselves, and our behaviour clearly reflects those feelings.

People with high self-esteem will be able to :

- act independently
- assume responsibility
- take pride in their accomplishments
- tolerate frustration
- attempt new tasks and challenges
- handle positive and negative emotions
- offer assistance to others

On the other hand, a person with low self-esteem will:

- avoid trying new things
- feel unloved and unwanted
- blame others for his own shortcomings
- feel, or pretend to feel, emotionally indifferent
- be unable to tolerate a normal level of frustration
- put down his own talents and abilities
- be easily influenced

Adolescence being a vulnerable state of body & mind but still supposed to be one of the 'Life Changer' phases in everyone's life and if this state is accompanied by any disability may it be physical or mental has great impact on developing Self Esteem of that individual. Contrary to popular opinion, adolescence is not a time of turmoil and strife for most individuals when the environment meets the psychological needs of adolescents, who are asserting their independence in all ways (physically, socially, cognitively, and emotionally), adolescence can be a relatively "smooth" period of transition between childhood and adulthood. During late adolescence, most young people with average cognitive ability start careers or begin higher education, move away from home, develop their personal relationships, and consolidate their identities. These developments ultimately influence their quality of life, happiness and success in life. Hence developing self esteem in adolescents is an important issue in itself.



Adolescents with disabilities have the same desires and aspirations as other adolescents. Most adolescents with disabilities want what all adolescents generally want in life - happiness, meaningful occupation, fulfilling relationships, independence, being believed in, and being accepted by others. However, they will have difficulty in attaining these goals due to prejudice, lack of skills, and their current weak economic conditions.

Following are the factors which may be considered to influence development of self esteem-

- The external sphere (i.e., employment, education, and independent living)
- The interpersonal sphere (i.e., marriage and relationships)
- The personal sphere (i.e., self-esteem and self-concept, social isolation)

External and interpersonal spheres : Compared with adolescents without disabilities, those with disabilities are less likely to have social networks and friends, participate in recreational activities, attend college and live independently. Various studies of adults indicate that only 30 to 50 percent of adults with physical disabilities are engaged in paid employment and no more than 40 to 45 percent live apart from their parents. Thus, adults with physical disabilities face both social and economic disadvantage tell us about what adolescents may face in the future.

Personal sphere : On the personal level, research clearly shows that adolescents who have disabilities are at risk for social isolation. Their leisure pursuits tend to be passive and solitary. In a number of studies, females with physical disabilities have rated themselves as particularly low in social acceptance which may lead to social isolation and feelings of loneliness.

The basics for helping teens with disability to improve their self-esteem start in the family as acceptance of that disability as different ability by their parents as well as themselves. Whenever necessary they should seek help of the health professional to improve self-esteem. Disabilities are only limiting to the extent that constraints are imposed in the physical and social environments. We need to apply this philosophy to all the rehabilitation services we provide. Thus we need to work in partnership with adolescents and listen to their concerns and needs as well as provide specific types of services in a style i.e. family-centered or client-centered

Two of the key principles of family-centered service are that teens should :

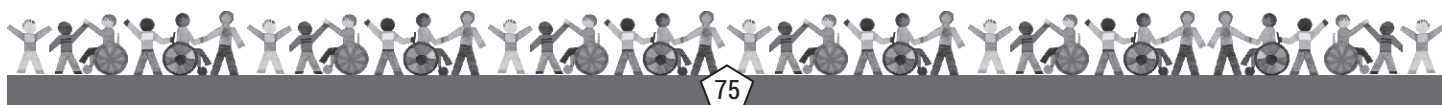
- (1) lead the decision-making process concerning the type and amount of support and services they receive, and
- (2) be treated with respect.

Rather than trying to “fix” adolescents so that they can meet the expectations of society, we should focus on eliminating barriers in the physical, social, and institutional environments. This involves activities such as educating others and working to change attitudes so that individuals with disabilities are believed in and are accepted by others, as well as advocating for physical accessibility and progressive employment criteria and practices.

Thus, we should accommodate their abilities and needs by working to change disabling environments. Partnerships need to be fostered between rehabilitation professionals and community groups as well (such as attendant care, supportive volunteer groups, transportation services) to address these issues.

Some useful tips for adolescents to improve self-esteem may be

- **Maximize the positive and minimize the negative :** Focus on your abilities more than your limitations. Everyone has both abilities and limitations. This is not to say that you don't acknowledge that you have a disability, but rather, by focusing on and developing your abilities you can feel good about all the things you can do.
- **Avoid unrealistic comparisons :** Don't get caught up in comparing apples to oranges. Everyone has both strengths and limitations.



e.g. A person with a locomotor disability may not be able to compete in Olympic hockey, but he or she can compete in Paralympic hockey.

- **Set realistic goals for yourself :** Since everyone has limitations, it is not fair to expect yourself to be able to do something unrealistic. This may mean allowing yourself to take the extra time needed to read material and rewarding yourself for persevering. It may not be realistic to expect yourself to read something in the same amount of time as someone without a reading disability.
- **Do not over-generalize:** If there is something that you cannot do as a result of your disability, it is not fair to conclude that you are an overall failure. There are many things that you can do. Don't tie all of your self-worth to any one attribute or event. Just because you might be a lousy cook does not mean that you are a lousy person in general.
- **Avoid getting caught using "should" statements:** For example, a student with ADHD says, "I should be able to finish this exam in 50 minutes like everyone else in the class." This is an example of a "should" statement that may not be accurate. Accommodations like extra time on tests are an important tool to create equal opportunities for students to show what they know.
- **Appreciate yourself - all of yourself:** This means appreciating your disability too. There may be times when you believe that it is more annoying than appreciable, but focus on the positive aspects of your disability. One way to do this is making a list of your strengths including how your disability, or your methods of coping with it, can be an asset.

Similarly the "Three Fs" of positive parenting (Discipline should be fair, firm and friendly) need to be practiced.

- **Helping the child clarify the problem** by asking him questions that pinpoint how he sees, hears, and feels about the problematic situation and what decision needs to be taken to modify the situation.
- **Brainstorming the possible solutions.** Usually there is more than one solution or choice to a given dilemma, and the parent can make an important contribution by pointing out this fact and by suggesting alternatives if the child has none.
- **Allowing the child to choose one of the solutions only after fully considering the consequences.** The best solution will be one that solves the problem and simultaneously makes the child feel good about himself or herself.
- **Later joining the child in evaluating the results of that particular solution.** Did it work out well? Or did it fail? if so, why? Reviewing the tactics will equip the child to make a better decision the next time around.

After all we need to remember that adolescents with disabilities are adolescents first. Like everyone, adolescents want to be happy. Adolescents with disabilities may not attain all their goals in life, but it is important for them to try, and for them to understand the obstacles they face. As health professionals we can help to provide this knowledge and guidance to make their life from miserable to pleasurable.



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Hearing Language and Speech Therapist,
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Childhood Hearing Disorders. (Importance of early diagnosis and management)... Most of us hearing people learn our mother tongue without any conscious efforts in early childhood days. We don't realize the complexities involved in the process of listening & talking.

It is the ability to hear, comprehend & communicate in spoken language that sets human race apart from the rest of the animal world. The key component of this ability is hearing. Hence early diagnosis and management of hearing disorders is important. We have to USE IT OR LOSE IT.



“ However difficult life may seem, there is always something you can do and succeed at ”

- Helen Keller



Adaptive Devices {used In Children With Disability}

Dr Meenakshi Wankhede

Pediatric Physiotherapist

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Adaptive Devices Means Any Device That Can Help A Individual With An Impairment To Perform Tasks Of Daily Living .there Is A Wide Range Of Types Of Devices In Assistive Technology From Low Cost Tech ,homemade Aids To Computers And Sophisticated Electronic Equipments.

Adaptive Devices Are Tools,equipments Or Services Designed To Compensate Or Enhance The Function Of Certain Ability That Is Impaired.

Adaptive Devices Used In Disability Are Used To Make Child More Independnt,to Achive His/her Level Of Competancy.thiese Devices Can Be Considered As An Enabling For More And Better Participation Of The Child In All Activities.

While Treating The Cp Children Physio ,occupational And Speech Therapist Frequently Come Across The Problem Of Childs Inability To Maintain Proper Posture .an Appropriate Positioning /seating Device Can Help The Child To Maintain Proper Posture.such Devices Are Necessary For Effective Management If Children With Disability.

Different Devices Relevant To The Practice Of Physio And Occupational Therapist Will Be Viewed. .

This Presentation Is Aimed At Discussing The Application Of Adaptive Devices Used In Children With Disability.





Organizing Committee of the Conference



18
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