

Educating Children With Disabilities - Study Of A Special School In Rural North Kerala

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Abstract: The International classification of Functioning, Disability and Health (ICF) has defined disability as a limitation in functional domain that arises from the interaction between a person's intrinsic capacity and environmental and personal factors. According to the Census of India 2011 there are 2.6 crores disabled people in India.

Education of disabled in India: It is estimated that the number of children of school going age who suffer from disabilities is more than 20 million..

Aims and objectives of the study: To study the academic skills of the students
To study the self help skills of the students.

Materials and Methods: the study was conducted at the Prateeksha Special school in Mukkam Municipality. All the students enrolled in Pratheeksha special school in the year 2016 were included.

Results: out of the 74 students examined 55.4% of the students had mental retardation, 21.6% had Down's syndrome, 6.8% had cerebral palsy and learning disabilities. 40% of the students had behavioural problems.

Discussion: the formation of mentally retarded children's self care skills does not occur spontaneously. Training of such skills is the work of specialists and parents.

Conclusion: the magnitude of disability in India is large. A comprehensive rehabilitation program has to be developed for the welfare of the disabled millions.

Conflict of interest - nil

Key words: children with disability, educating children with disability, special schools

I. Introduction

The International classification of Functioning, Disability and Health (ICF) has defined disability as a limitation in functional domain that arises from the interaction between a person's intrinsic capacity and environmental and personal factors.[1]

Types of disabilities include visual impairment, hearing impairment, speech impairment, impaired mobility, mental retardation.

According to the census of India 2011 there 2.6 crores disabled people in India [2].

Total disabled persons in India 2,68,10,557

Males- 1,49,86,202 Females 1,18,24,355

Rural -1,86,31,921 Urban - 81,78, 636

Type of disability - In seeing - 50,32,463 In hearing -50,71,007 In speech -19,98,535

In movement 54,36,604 Mental retardation- 15,05, 624 Mental illness -7,22,886

Dr. S Meena [3] in her paper on Disability studies and scope for rehabilitation of differentially abled children states that the importance of knowing the disability figures is to integrate the children with special needs and adults more effectively into the community.

Anna Ivanova[4] in her study - **The development of self care skills in mentally retarded children** has stated that there is a large group of children with limited health abilities and special educational needs who cannot be included in the available educational programmes due to the severity and complexity of the developmental disorders or behavioural disturbances resulting in social maladjustments. Children with mental retardation have essential disorders of cognitive processes, and disorders of motor and sensory function. Self-care skills- to dress and undress

look after oneself, use a toilet, take food independently, bathe, wash etc directly influence a child's self evaluation.

Self-care skills formation is an important step in the way to socialisation.

According to Dr Anna Kara [5] children with mental retardation are at risk for difficulties in social and emotional development. These children lack the social and language skills needed to initiate and maintain social relationships.

Udonowa[6] in his study has stated that Self dressing is complex and problematic to mentally retarded children, especially in activities of dressing such as buttoning, zipping, buckling, fastening, appropriate selection of clothes, purchasing, and maintenance.

Overview of Education Of Disabled In India

It is estimated that the number of children of school going age who suffer from disabilities maybe more than 20 million in India[Dr. S Meena]. The situation of Special Schools in India is appalling. The sixth All India Educational survey report, (NCERT) [7] states that of the 6461 towns and cities only 334 or 5.1% towns and cities have the facility of special schools.

The National Sample Survey Organisation (NSSO)[8] estimated that 75% of persons with disabilities live in rural areas .Only 34% of the disabled population is employed.

The Persons With Disabilities Act 1995 [9]

This Act ensures equal opportunities for people with disabilities and their full participation in day to day life. The PWD Act includes that every child with disability has the right to free education till the age of 18 years.

. Sarva Shiksha Abhiyan And The Right To Education Act,2009[10]

The SSA has two major schemes in relation to CWSN [Children with special needs].The educational provisions are fulfilled through the Integrated Education of Disabled Children and assistive requirements are fulfilled through scholarship schemes and the scheme for Assistance to Disabled Persons (AIDP). The Right of Children to Free and Compulsory Education Act (RTE), 2009[11] was amended in 2012 to bring children with disabilities under the consideration of the act.

Trained Teachers in Inclusive Teaching Methods:[12] Training teachers in teaching methods that include students of all ability levels, as well as, spreading awareness to teachers about the importance and benefits of inclusion, because teachers are the people on the ground that are going to accommodate these students.

Scope of the study - In Kerala there are numerous children with mental retardation. There are several special schools run by voluntary organizations. Mentally retarded children are yet to be integrated into the sociocultural and educational activities of the immediate society basically because they have significant deficits in daily living skills. There is also the problem of misconception/judgement, wrong educational placement, insufficient therapeutic services, inadequate rehabilitative care training, solely because of inadequate knowledge of the differentially abled children. Even though special schools in rural areas remain largely absent, in a community based study (Singal *et.al.*, 2008)[13] it was evident that the presence of a special school in a nearby town/city had a significant impact on the educational journeys of young people with disabilities The Pratheeksha Special School is doing commendable work in educating the differentially abled children.. The school has positively changed the attitude of the society to differentially abled children

II. Aims And Objectives

Aim :- To assess the functioning of Pratheeksha Special School in Mukkom Municipality

Objectives :-

- (i) To study the profile of students in the school
- (ii) To assess the services provided to the students in the school
- 3) To study the academic skills of the students
- 4) To study the self care skills of the students.
- 5] To study the social skills of the students

III. Materials And Methods

- **Type of study:** Community based descriptive study
- **Study area:** Mukkom municipality of Kozhikode district
- **Study population:** All students enrolled in Pratheeksha Special School, in the year 2016.
- **Study period:** Study was carried out in 2016 during Community Medicine posting(03-10-2016 to 15-10-2016)
- **Study setting:** Pratheeksha School for mentally disabled children in Mukkam
- **Sampling technique:** Universal sampling

- **Study tools:** Questionnaire
- **Inclusion criteria:** Those students present on the day of study
- **Exclusion criteria:** Those students absent on the day of study
- **Ethical clearance:** Taken from ethical committee of KMCT Medical College
- **Data collection:** Record based study-baseline data at entry point, prospective case records and interview with teachers
- **Methodology:** Pratheeksha Special School was visited by investigator and MBBS students. Information regarding students' profile was obtained with the use of a predesigned and pretested questionnaire.

Statistical analysis:- data was entered in Microsoft Excel Windows XP - 2013

Data analysis include proportions to determine statistical significance

Essential prerequisites for the study:

Permission from ethical committee and informed consent from school management and beneficiaries.

Pratheeksha Special School

Pratheeksha is a special school located in Mampetta between Mukkom and Kattangal villages of Kozhikode, Kerala. The school is approved for pre-primary, primary and is working under the management of private unaided organization. Pratheeksha Special School is a voluntary organization, established in 1998 with the aim of educating differentially abled children. The inception of the school created a momentum in the locality which has the most number of reported cases of differently-abled children. Primary medium of instruction of the school is Malayalam. It is non-residential. It is a mixed school which started with 22 students and 2 teachers in 1998 and is currently functioning with a total strength of 153 students, 15 teachers and 10 other staff. Admissions are given for children with learning disabilities, speech impairment, Down's syndrome, mental retardation, autism and physical disability. Students are assessed by checking their mental age and physical abilities and are allotted into various classes. Vocational training is given to the students which teach them to do the basic necessities. Their progress is assessed by checklist approved by MDPS. They also train the students in academics, computer and handicraft according to the ability and progress of the child. Special curriculum is adopted for training the autistic children. Physiotherapy and speech therapy are provided for children with requirement. Forenoon session is for vocational training and academics and afternoon session for extracurricular activities and sports. The students participate in various competitions organized at district, state and national levels for the differently-abled. The school boasts 3 gold medal holders from the school at National level for the mentally disabled. The teachers are all graduates and well trained for teaching differentially abled children. They regularly attend teachers' training programs organized by Calicut University. They also participate in workshops for teachers organized by different voluntary organizations. The School is mainly funded by public donation. In 2008, a non recurring grant of 6 Lakhs was allowed for the school by the government. The school is also under midday meal scheme of government from 2006. Future plans of the school include construction of a new building with modern facilities, equipped with vocational training centre, workshop and audiology clinic. The school also plans to provide hostel facility for the students under Gurukulam project.

IV. Result

Out of 74 students studied at Pratheeksha Special School 39.2% were of age group 5-14 years ,33.8% of 15-24 years, 7.6% of 25-40 years and 9.4% greater than or equal to 41-60 years. –**Table one**

60.8% were males and 39.2% females. –**Table 2**

55.4% of students had mental retardation, 21.6% Down's syndrome, 6.8% each for cerebral palsy and learning disability. **Table 4**

14.9% students had normal developmental milestones, 81.1% delayed , 4.5% not available.**Table 5**

12.2% had poor fine motor skills , 18.9% average, 68.9% good. 10.8% had poor gross motor skills , 10.8% average, 78.4% good. **Table 6**

In self help skills, 9.55% were poor in self eating, 13.5% average, 77% were good. –table7

20.3% were poor in self dressing, 17.6% average, 62.2% were good – **table7**

21.6% were poor in self toileting, 10.8% average, 67.6% good.**Table 7**

18.9% were poor in self bathing, 17.6% average, 63.5% good.**Table 7**

39.2% of students have verbal communication, 17.6% action only, 43.2% with mixed **Table 8**

.40.5% had behavioural problems and 59% had no behavioural problems. **Table 8**

In academic skills, 71.6% had poor reading comprehension, 18.9% were average, 9.5% good. **Table 8**

18.9% had poor listening comprehension, 27% average, 54.1% good. Table9
48.6% had poor written expression, 36.5% average, 14.9% good. Table10
In extra-curricular activities, 48.6% participate in arts and 51.4% do not participate. Table 11
28.4% participate in sports and 71.6% do not participate. Table 11
18.9% engaged in creative skills, 81.1% not engaged. Table11
31.1% has computer skills, 68.9% doesn't have. Table11
With regard to management plan, 16.2% are receiving behaviour modification therapy, 83.79% are not receiving. Table12
33.8% receive speech therapy, 66.2% does not receive. Table 12
77.02% receive vocational training and 22.98% doesn't receive. Table 12
45.9% receive academic skill and training 54.1% doesn't receive. Table 12
44.6% of students are being taught self help skills, and 85.1% does not require. Table12

V. Discussion

Definition of Mental Retardation

The AAMR Definition

The tri-dimensional definition, developed by the American Association on Mental Retardation, is widely accepted: "Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18"

Mental retardation is a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, social and practical adaptive skills.[5] Kernisan[14] in his Study on The challenges of achieving inclusion for retarded children states that several of the causes of mental retardation are known. But others remain unidentified. Of the known causes of mental retardation there are three main conditions. Down's syndrome Fragile X syndrome Fetal alcohol syndrome. The causes of mental retardation are divided into three according to the time of onset Prenatal PeriNatal and Postnatal.

Prenatal causes include genetic and heredity, toxins taken by the pregnant mother, disease and neural tube defects. Genetics and heredity include conditions as Fragile X syndrome, Down's syndrome and Phenyl Ketouria. Prenatal causes include alcohol, tobacco and drugs. Disease and infections include HIV/AIDS. Neural tube defects as Anencephaly and Spina Bifida also cause mental retardation

Perinatal causes include birth injuries, obstetrical trauma. Low birth weight is also a cause Post natal causes include child abuse and neglect, environmental toxins

Mental retardation is although a condition not a disease but can be improved upon by regular administration of correctional services through the establishment of identification centers at pre natal and post natal stages for early detection

Prevention of mental Retardation

Many cases of mental retardation can be prevented by directly addressing the cause. Because of advances in research over the last 30 years, many cases of mental retardation are prevented. For example, each year 9,000 cases of mental retardation are prevented via the measles and Hib vaccine. 1,250 cases via newborn screening for phenylketonuria (PKU) and congenital hypothyroidism, and 1000 case via the anti-Rh immunoglobulin. In the case of child abuse, teachers now have a legal (and, many believe, a moral) responsibility to report suspected cases so that further damage to the child

Prevention of mental retardation

For Pregnant women- obtain early prenatal care, seek genetic counseling, maintain good health, avoid alcohol, drugs and tobacco, obtain good nutrition, prevent premature births, take precaution against injuries and accidents, prevent or immediately treat infections, avoid sexually transmitted infections.

For Children- guarantee universal infant screening, ensure proper nutrition, provide immunization, prevent or treat infections, have quick and easy access to health care, prevent lead poisoning, provide early intervention programs, eliminate child abuse and neglect.

For Society – eliminate the risk of child poverty, make early intervention programs universally available, provide parent education and support, protect children from abuse and neglect, remove environmental toxins,

In a study by Zinia T Nujum [15] on (A Framework for Healthcare Provision to children with Intellectual Disability) – of the 202 children examined 41.6% were females and 58.4% were males . In our study 39.2% were females and 60.4% were males.

In the study by Zinia the youngest child was 4 years old and 57.9% were in the age group 10-20 years. In our study 35.1% were in the age group 15-24 years.

In the study by Dr Nidhi Singha [12 pg6] on Education of children with disabilities in India 35% of the people with disabilities are in the age group 10 -29 years.

In the study by Zinia of Buds school no vocational training was imparted to the students. In our study 77% students received vocational training. In the study by Zinia 61.4% had intellectual disability. In our study 55.4% had mental retardation

In the study by Anna Ivanowa [4] she states that the formation of mentally retarded children's self care skills does not occur spontaneously. Training of such skills is the work of specialists and parents. In this study 77% had good self eating skills, 67% had good self dressing skills, This is because of the training given to them. The common characteristics of mentally retarded children are that they exhibit almost no adaptive behaviours (Abang, 2005[16].

In an assessment carried out by Harrison, Hanson, and Johnson (2006)[17] in Bloomfield Town among school children with difficulties in bowel elimination, 69% of the population were discovered to be mentally retarded, 15% constituted autistic children, cerebral palsy 13%, etc

In the study by Udonowa[5] on Mentally retarded children and deficits in daily living skills, it was discovered that mentally retarded children can be deficit in daily living skills, but they can live a normal life just like other children through effective training, counselling, motivation and close supervision. The level of deficits in daily living skills was as follows toileting skills -33.91%, self dressing skills- 32.84 % , self eating skills – 32.16%, personal hygiene skills -37.59%. Poor personal hygiene is the most expressed by mentally retarded children. In our study 77% were good in self eating, 62% were good in self dressing, 67% were good in self toileting,

In the study by Dr Arun Kara [6] on Social skills of children with Intellectual disability, children in special schools have achieved higher social skills compared to home based programmes. This is due to the positive environment in special schools. In these schools children interact with each other. Children learn social skills better when they are in groups.

In the study by DrYashpal Singh and Anju Agarwal [18] it was found that technology as a teaching tool immediately, profoundly, and positively improved the education of children with mental retardation. The use of assistive technology devices for individuals with mental retardation was shown by Wehmeyer (1998)[17] to increase self determination, independence, and integration skill. In addition, assistive devices allowed for "positive changes in inter- and intrapersonal relationships, sensory abilities and cognitive Capabilities , communication skills, motor performance, self-maintenance, leisure, and productivity.

In the study by Pavel Zikl [19]] on Gross motor skills of children with mild intellectual disabilities he has stated that If we want to enable children with mild intellectual disabilities to participate in all activities and support their inclusion in society then supporting the development of motor skills should be a part of comprehensive care., because they also need a higher level of support in this area.

In the study by Amit Nagarka[20]on the Clinical profile of mentally retarded children in India

The mean age of the patient in the sample was 11.6 years. They had received an average of 2.42 years of schooling. 67% belonged to the poor section. . More than 58% of the patients had mild MR while 30% had moderate MR. Severe retardation was evident in 12% of patients. . Delay in speech development was the most universal finding seen in 96.7% patients. 86.7% patients had a delay in achieving sensory milestones 76.6% patients reported delay in achieving motor milestones. The percentage of syndromes and medical conditions diagnosed in the study population are: Cerebral Palsy(45%), Down's syndrome(8.33%), Laurence moon Biedlbardest syndrome(3.33%), Microcephaly(3.33%).:

Study by PJ Paul - Academic Inclusion of Children with Learning disabilities [21] In India, the difference between school attendance for children with and without disabilities is even greater, with close to 40% of children with disabilities not enrolled in schools. Study mainly examines the performance of SSA in ensuring social and academic inclusion of children with special needs, CWSN in general and LD in particular. In this study 48% children had mental disability only.

In the Global status report on Disability [22]

It is stated Children with disabilities are often not registered at birth. They are often put in institutions, where they cannot grow in a family environment and are often faced with neglect. They often face barriers in accessing education as well as health services and are often victims of exploitation and abuse. To improve the situation of children with disabilities, awareness raising has to be undertaken at multiple levels, with families and parent groups, service providers, policy makers and legislators. Public awareness and advocacy campaigns need to be targeted at changing mind-sets and social norms directed at children with disabilities – emphasising an understanding of their rights and capacities as well as the challenges they face. More inclusive media is also critical to this. In addition, stigma and prejudice is most effectively addressed through contact – and children learning and playing together helps break down many social stereotypes and establishes norms of inclusion for life.

VI. Conclusions

There are various special programmes run by government organisations and Non Governmental Organisations for children with special needs. The disabled children continue to be neglected and marginalized with the burden of care on the family rather than on the community. India needs to shift focus from the medical model of intervention to community rehabilitation of the disabled. We need to change the education system to make it accessible to all children and prepare the society-the parents, friends and employers to provide support to the disabled child. The disabled, the family, the community must corporate in our plight towards the independence of the disabled. The society, voluntary organization, local, national and international, government at the state and central level must co-operate and collaborate in this noble venture. By this, we can dream of a society where the disabled will have employment, financial security, setup their own family and lead an independent life by using appropriate assistive technology. And disability studies play a crucial role towards this development by creating awareness and helps in implementing policies for differently-abled people. And finally, it is concluded that a disabled person can function as well as anybody else provided he/she is given appropriate training alternative techniques and assistive devices. A human mind is a terrible thing to waste, so is the body. Let us maintain it in the best way we can. Let us not allow anybody to be imprisoned in his/her body. Liberate the human spirit, restore the human body and finally let us liberate the disabled and open the world for them .

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Tables TABLE one Age category n=74

Age	number	percentage
5-14	29	39.2%
15-24	25	33.8%
25-40	13	17.6%
Above 41	7	9.4%

Table 2 -gender n=74

Gender	No.	%
Male	45	60.8%
female	29	39.2%

Table -3 Socioeconomic status

Socio economic status		
APL	8	10.8%
BPL	66	89.2%

Table4-Type of Disability -n=74

Disability	No.	%
Mental retardation	41	55.4%
Down's syndrome	16	21.6%
Learning disability	9	12.2%
Cerebral palsy	8	10.8%

Table -5- Developmental milestones – n=74

Developmental milestones	No.	%
Normal	11	15%
Delayed	60	80.9%
Not available	3	4.1%

Table 6-Motor skills -n=74

Motor skills	No .	
Fine motor skills -poor	9	12.2%
Fine motor skills-average	14	19%
Fine motor skills-good	51	68.8%
Gross motor skills – poor	8	10.8%
Gross motor skills- average	8	10.8%
Gross motor skills –good	58	78.4%

Table 7 self help skills

Self eating	poor	7	9.5%
Self eating	average	10	13.5%
Self eating	good	57	77%
Self dressing	poor	15	20.3%
Self dressing	average	13	17.6%
Self dressing	good	46	62.1%
Self toileting	good	50	67.6%
Self bathing	poor	14	18.9%
Self bathing	average	13	17.6%
Self bathing	good	47	63.5%
Care for belongings	poor	16	21.6%
Care for belongings	average	11	14.9%
Care for belongings	good	47	63.5%

Table- 8- social communication

Social communication		
Verbal	30	40.5%
Action	13	17.6%
Mixed	32	43.2%

Table -9-Behavioural problems

Behavioural problems		
Present	30	40.5%
Absent	44	59.5%

Table- 10

Reading comprehension-poor	53	71.6%
Reading comprehension- average	14	18.9%
Reading comprehension -good	7	9.5%
Listening comprehension -poor	14	18.9%
Listening comprehension- average	20	27%
Listening comprehension -good	40	54.1%
Written expression- poor	36	48.6%
Written expression- average	27	36.5%
Written expression -good	11	14.9%
Mathematical skills- poor	47	63.5%
Mathematical skills- average	21	28.4%
Mathematical skills-good	6	8.1%

Table- 11

Extra curricular activities		
Arts -participates	36	48.6%
Arts- no participation	38	51.4%
Sports – participates	21	28.4%
Sports –no participation	53	71.6%
Creative skills-present	14	18.9%
No creative skills	60	81.1%
Computer skills- present	23	31.1%
No computer skills	41	68.9%

Table 12- Management plans

Behavior modification therapy -	yes	12	16.2%
	no	62	83.8%
Speech therapy	-yes	49	66.2%
	no	25	33.8%
Vocational training	yes	57	77.02%
	no	17	22.98%
Self help skills training	yes	33	44.6%
	no	41	55.4%
Academic skills training	yes	33	45.9%
	no	41	54.1%

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Self help skills training	yes	33	44.6%
	no	41	55.4%
Academic skills training	yes	33	45.9%
	no	41	54.1%