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Screening of Neonates with Hyperbilirubinemia for Sensorineural Deafness

Basavaraj Patil[1], Aishwarya B.[2], Rudrakshi Itagi[3], Sanjay Goudappa Sangavi[4]

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Abstract

Background and Objectives: Hyperbilirubinemia is associated with hearing impairment. This study was aimed to evaluate the incidence of hearing impairment among the term neonates with hyperbilirubinemia by using otoacostic emission (OAE) and auditory brainstem response (ABR).

Methods: This one year hospital based prospective observational study was conducted from October 2019 to March 2021. A Total of 190 healthy term neonates with hyperbilirubinemia admitted under the department of pediatrics, Mahadevappa Rampure Medical College, Kalaburagi during the study period were studied.

Results: Most of the neonates were boys (60.53%) and boy to girl ratio was 1.53:1. History of consanguineous marriage was noted in 6.32% of the parents. The mean age was 4.73±2.65 days. Majority of the neonates (97.37%) weighed between 2.5 to 3.5 Kg. The mean birth weight was 2.84±0.84 Kg. The mean direct bilirubin levels were 0.88±29 mg/dL and mean total bilirubin levels were 17.3±2.58 mg/dL. During OAE-I, 33.16% of the neonates were advised to refer for second OAE and during OAE-II, 2.63% of the neonates were advised to undergo BERA. The incidence of hearing impairment based on BERA findings was 2.63%. 60.53% of the babies were born by LSCS while 39.47% were born through vaginal route and all the babies with hearing impairment had vaginal delivery while none of the baby with LSCS had hearing impairment (p=0.009). No association was found between hearing impairment in neonate with sex, age at admission and history of consanguineous marriage in parents and total bilirubin levels (p>0.050). Also the mean direct bilirubin, total bilirubin, birth weight, duration of NICU stay and age admission (p>0.050) were similar in babies with and without hearing impairment.

Conclusion and Interpretation: The present study showed incidence of hearing impairment as 33.16% based on OAE examination and 2.63% based on BERA.

Keywords: Auditory brainstem response; Auditory brainstem response; Hearing impairment; Hyperbilirubinemia.

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INTRODUCTION

Hyperbilirubinemia is the most common clinical condition requiring evaluation and management in the newborn. Jaundice is one of the most common problems occurring in newborns. Although most of the jaundiced babies are normal, because of the bilirubin toxicity; high serum bilirubin levels can lead to kernicterus1 (bilirubin encephalopathy).[1]

The incidence of indirect bilirubin levels greater

than 12.9mg/dl in term neonates is 6-7% and less than 3% have bilirubin levels greater than 15mg/dl. Therefore it is very important to identify and evaluate the jaundice early, to prevent the complications like bilirubin encephalopathy, leading to hearing loss. Such early detection is possible only if some form of routine screening is used. However, to screen all neonates would neither be cost-effective nor practical. Hence it becomes necessary to focus on those neonates who are at high risk for this. One of the high risks being Hyperbilirubinemia.[2]

Speech and hearing are interrelated-i.e. a problem with one could mean a problem with the other as speech and language is acquired normally through auditory system.[2]

The prevalence of mild to profound hearing loss is reported to be between 1.1- 6 per 1,000 live-births and with prevalence of hearing loss is estimated to be between 2.5%-10% among high-risk infants4. In most countries, newborn hearing screening programmes that screen only high-risk infants have been in existence for more than 20 years. However, this group of infants with hearing loss comprises only 50% of newborn population with hearing loss. Therefore, hearing screening programs that screened only high-risk neonates missed out 50% of hearing-impaired newborns, who are from among infants without any risks factors. Also as hearing loss is an invisible disability it cannot be passively identified until the child fails to develop speech and language.[3]

Hearing impairment in infants should be identified as early as possible to enable interventions to take full advantage of the plasticity of developing sensory system. Hearing integrity in the first 3-4 years of life, the 'critical period', is essential for acquisition of speech and language. Unfortunately, by the time hearing loss in infancy and early childhood is suspected, audio logically evaluated and appropriately managed two or more of these critical years have elapsed and the child has lost an enormous developmental advantage.[4]

Otoacoustic Emissions (OAE) reflect the status of the cochlea (outer hair cells). OAE's are a byproduct of sensory outer hair cell transduction and are reflected as echoes into the external auditory canal. OAE's are preneural in origin and directly dependant on outer hair cell integrity.[5]

Brainstem Evoked Response Audiometry (BERA) is an objective test of audio logical function which measures activity from the auditory nerve up to the level of brainstem on stimulating with acoustic stimulus. It assesses the neural integrity of auditory pathway up to the brainstem. However it is an indirect measure of hearing acuity.[5]

AIMS AND OBJECTIVES

To evaluate the burden of hearing impairment among the term neonates with hyperbilirubinemia by using otoacostic emission (OAE) and auditory brainstem response (ABR).

To find the incidence of hearing impairment among term neonates with hyperbilirubinemia

MATERIALS AND METHODS

The present study was conducted in the Department of Pediatrics, Mahadevappa Rampure Medical College, Kalaburagi. The study design was a hospital based prospective observational study. This was conducted for a period from October 2019 to March 2021.

Inborn or Outborn neonates with hyperbilirubinemia admitted under the Department of Pediatrics, Mahadevappa Rampure Medical College, Kalaburagi during the study period were enrolled. Consent was obtained from parents of all children included in study.

Selection criteria

Inclusion criteria

Term neonates with TSB that requires either phototherapy or exchange transfusion according to American Academy of Paediatrics (AAP) guidelines during the first two weeks of postnatal life.

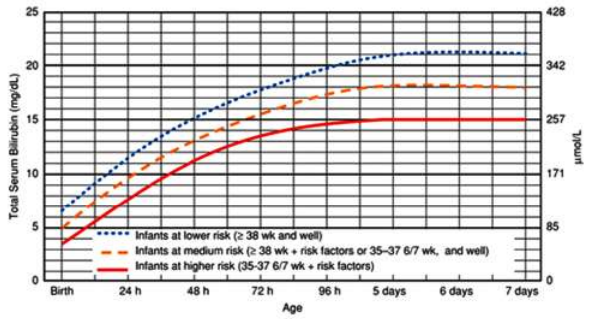

Fig. 1: Guidelines for phototherapy in hospitalized infants of 35 or more weeks gestation 5

Exclusion criteria

Neonates with congenital anomalies, ototoxic drugs consumption, dysmorphic features, syndromic features, chromosomal disorders, family history of

hearing loss or congenital deafness, Torch infection, septicemia, pyogenic meningitis, mechanicaly ventilated, Birth asphyxia.

STATISTICAL METHODS

The data obtained was tabulated on Microsoft Excel spreadsheet. The data was analyzed by SPSS version 20.0 statistical software. The categorical data was expressed as ratios and percentages and continuous data was expressed in terms of mean±standard deviation (SD). The incidence of hearing impairment among term neonates with hyperbilirubinemia was expressed in terms percentages. The association of hearing impairment with risk factors was determined by Chi-square test or Fisher's exact test. Independent sample t test was used to compare means. At 95% confidence interval (CI), a probability value ('p' value) of less than or equal to 0.05 was considered to be statistically significant.

RESULTS

This one year hospital based prospective observational study was conducted from October 2019 to March 2021. A Total of 190 term healthy neonates with hyperbilirubinemia were studied. The data was analysed and the final results were tabulated and interpreted as below. Table 1 depicts the Distribution of babies according to the gender. 60.53% of the babies were boys and 39.47% of the babies were girls. The boy to girl ratio was 1.53:1.

Table 1: Distribution of babies according to the gender

Gender	Distribution (n=190)	
	Number	Percentage
Male	115	60.53
Female	75	39.47
Total	190	100.00

Table 2: Distribution of babies according to the age at phototherapy.

Age group (Days)	Distribution (n=190)	
	Number	Percentage
< 24 hours	0	0.00
>24 hours to 5 days	156	82.11
6 to 10	29	15.26
11 to 15	5	2.63
Total	190	100.00

Table 3: Distribution of babies according to the first OAE examination.

OAE findings	Right ear (n=190)		Left ear (n=190)	
	Number	Percentage	Number	Percentage
Pass	135	71.05	127	66.84
Refer	55	28.95	63	33.16
Total	190	100.00	190	100.00

Table 4: Distribution of babies according to the second OAE examination

OAE findings	Right ear (n=190)		Left ear (n=190)	
	Number	Percentage	Number	Percentage
Pass	186	97.89	185	97.37
Refer	4	2.11	5	2.63
Total	190	100.00	190	100.00

Table 5: Incidence of hearing impairment based on BERA.

Hearing impairment	Distribution (n=190)	
	Number	Percentage
Yes	5	2.63
No	185	97.37
Total	190	100.00

Table 6: Incidence of hearing impairment based on OAE-I, II and BERA.

Test modalities	Hearing impairment (n=190)	
	Number	Percentage
OAE- I	63	33.16
OAE-II	5	2.63
BERA	5	2.63

Table 7: Association between total serum bilirubin levels and hearing impairment.

Total bilirubin levels (mg/dL)	Hearing impairment				Total	
	No		Yes			
	No.	%	No.	%	No.	%
< 15.0	39	97.50	1	2.50	40	40.00
15.00 to 19.99	117	97.50	3	2.50	120	120.00
20.00 to 25.00	29	96.67	1	3.33	30	30.00
Total	185	97.37	5	2.63	190	100.00

p=0.966

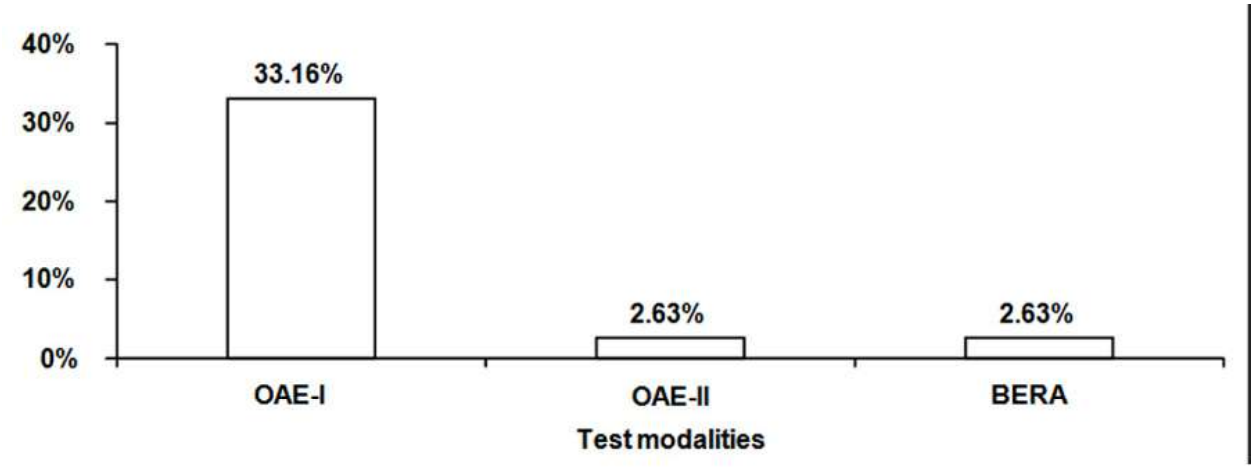

Fig. 2: Incidence of hearing impairment based on OAE-I, II and BERA

In the present study incidence of hearing impairment was slightly high in neonates with total bilirubin levels of 20.00 to 25.00 mg/dL (3.33%) compared to those with 15.00 to 19.99 mg/dL (2.5%) and < 15.00 mg/dL (2.5%). But this difference was statistically not significant (p=0.966).

DISCUSSION

Hearing loss is thus referred to as the silent, overlooked epidemic of developing countries because of its invisible nature which prevents detection through routine clinical procedures. It is referred to as an epidemic because of its high prevalence, being the most frequently occurring birth defect, and even though it is not a life-threatening condition, failure to intervene in time renders it a severe threat to critical quality of life indicators. WHO estimates that globally the number of people with hearing loss, has more than doubled from 120 million in 2005 to at least 278 million in 2015, thus making this condition the most prevalent sensory deficit in the population. In India, it is estimated that 18.49 million persons have disability that equivalents to 1.8 percent of the total population of the country where 10 percent of this figure are likely to have hearing disability of moderate to profound degree. Moreover, this number is likely to go up if we add lower degree of hearing disability.[6]

The adverse affects of hearing loss on language and cognitive development, as well as on psychosocial behavior are widely reported against the established benefits of early intervention. The definition of early identification and intervention has evolved over the years. In the past, early identification was defined as intervention before the age of 18 months. However now early identification is defined as diagnosis as early as 3 months with intervention by 6 months.[8]

Though a battery of tests are available today to detect hearing loss. Screening for hearing loss in infants should be done with a screening test that is simple, cost effective, quick, sensitive, efficient, reliable and effective. In the absence of such objective screening test, hearing loss may not be detected until the child is 2-6 years of age, when intervention outcomes may be suboptima. Because of this reason, this study was undertaken to document the importance of using Distortion Product Otoacoustic Emissions

(DPOAE) as a screening tool for evaluating hearing loss and cochlear function and to screen for hearing loss in infants especially in high risk infants like hyperbilirubinemia. Because of this reason, this study was undertaken to document the importance of using Distortion Product Otoacoustic Emissions (DPOAE) as a screening tool for evaluating hearing loss and cochlear function and to screen for hearing loss in infants especially in high risk infants like hyperbilirubinemia.[7] Many centers in developed countries have programs for hearing screening both in the neonatal period and infancy and such programs have helped to detect the infants with hearing loss in time to ensure normal language development by appropriate intervention like hearing aids and infant stimulation. Of all the screening programmes for neonates it is screening for deafness which gives the maximum yield and is most cost effective. However unfortunately neonatal screening in india is a neglected field.[10]

With increasing emphasis on neonatal care and the improving survival of high risk neonates the chances of hearing impairments in survivors are likely to be quite high. Hence in this study emphasis was given studying hearing abnormalities in hyperbilirubinemia with OAE and BERA. A feasible system would be one where a hospital like ours would offer facilities like OAE and BERA to neonates referred from peripheries. A high risk register is supposed to be maintained for those children with suspect hearing or proven hearing loss so that follow up and periodic monitoring would be facilitated. This hospital based prospective observational study was conducted from October 2019 to march 2021. A Total of 190 term healthy neonates with hyperbilirubinemia admitted under the Department of Pediatrics, Mahadevappa Rampure Medical College, Kalaburagi during the study period were studied. Neonates were subjected to OAE twice and the neonates who had impaired hearing during OAE-II were evaluated for BERA.

It is universally accepted that screening for hearing loss in neonates is crucial. Recognition and treating hearing loss in its early phase by screening is of critical value.[9] In this study on first OAE, 28.95% of the neonates were advised to refer for second OAE based on right ear examination and 33.16% of the neonates based on left ear examination. But, during second OAE, only 2.11% of the neonates were advised to undergo BERA after second OAE based on right ear examination and 2.63% of the neonates based on left ear examination. Baradaranfar MH, et al.9 (2011) performed OAE on thirty-five neonates with hyperbilirubinemia, thirty cases (85.7%) passed whereas the remaining (14.3%) seemed to be failures. The result of our study showed much high hearing impairment based on OAE. In the present study mean duration of NICU stay in neonates with and without hearing loss was almost similar statistically (4.40±0.89 vs 4.27±1. 05 days; p=0.774).Overall the present study showed decrease in incidence of hearing impairment from 33.16% based on first OAE-I examination to 2.63% based on OAE-II examination and confirmed by BERA at three months interval in term neonates with hyperbilirubinemia. Furthermore, the risk of hearing impairment is high in neonates who were delivered through vaginal route and develop hyperbilirubinemia. However, these findings require careful interpretation due to potential limitations of this study that is, single centre study, relatively smaller sample size, smaller subset of neonates with hearing impairment which limited us to evaluate the other risk factors. Also none of the neonate in our study had family history of deafness.

Among the 5 children with hearing impairment, 2 babies were referred for cochlear implant to higher centre. Remaining 3 babies could not be followed up.

CONCLUSION

The incidence of hearing impairment based on OAE-I was 33.16%. The incidence of hearing impairment based on OAE-II was 2.63% which was confirmed on BERA at three months interval in term neonates with hyperbilirubinemia.

Hence the incidence of hearing impairment in term neonates with hyperbilirubinemia was 2.63%. The risk of hearing impairment is high in neonates who were delivered through vaginal route and develop hyperbilirubinemia.

Hearing impairment in neonates with hyperbilirubinemia was independent of sex, age at admission, history of consanguineous marriage in parents. Strict monitoring, timely diagnosis and treatment of hyperbilirubinemia help not only in the prevention of hyperbilirubinemia but also in prevention of hearing impairment.

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Good Parenting Skills

Sakshi Yadav[1], Prempati Mayanglambam[2], S P Subhashini[3]

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ABSTRACT

Being a Parents there is a lot of responsibility towards a child which helps in their development. good parents have responsibility to teach their children about what is right and wrong and teach them about how to behave in society. Good parenting also helps their child in taking their decisions, self-control, kindness, self-direction, honesty, co-operation and providing them a positive environment so that they can enjoy and feel safe. Good parents give their child proper time and attention so that child doesn't feel alone. Good parenting focusing on developing the independence in children, social skills, building a strong relationship between them.

KEYWORDS: Self-control; Cooperation; Kindness; Honesty; Positive attitude; Social skills; Strong relationship.

INTRODUCTION

Good parenting means rearing or raising a child physically, mentally, psychologically, emotionally, and the overall development of a child from a new born to adulthood. Good parenting includes growing a child with protection and ensuring a child´s healthy development from infancy to adulthood. When a child is born it comes with the responsibilities to the parents not only giving a birth but to nurture a child in a proper way.

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TYPES OF PARENTING

- Permissive Parenting.
- Authoritative Parenting.
- Neglectful.
- Authoritarian.

QUALITIES OF GOOD PARENTS ARE

Role and Responsibilities

Asparents, you have to make a better planning to share the roles and responsible equally. This is a best way to model an equality for your children and sometimes they themselves should take a break from their assigned roles this will enhance their relation with their children and their marriage also.

Practices and Belief

Good parents should discuss about the topics like tradition, belief, caste, religion, gender and politics related issues. This will help to build an effective

communication and healthy relationship. Such matters make difficult for child to have a sense of specification.

Proper Discipline

Parents have to make some rules for appropriate and acceptable behavior which they have to follow consistently. Proper discipline in a family gives a sense of security to a child. Conflict between the parents can disturb parenting experiences.

Economical Security

A family can enjoy the life only when they have proper economical settlement. Couples should plan a baby only when they have financial stability otherwise it will create a dangerous condition for the parents as well as the child.

Plan-do- Review

In this parent implement new rules and regulations according to the time on which they both are agreed. and then they review how it will work, they have to continue it or stop it completely.

STEPS FOR EFFECTIVE PARENTING

- Boosting a child´s self-esteem.
- Proper time management for kids.
- Give them proper attention.
- Be a role model for them.
- Your parenting style should be flexible
- Showing your love to them.
- Acknowledge them about your expectation
- Set them to be as a top priority.
- Set rules and enforces them consistently.
- Always observe good Behavior in child.
- Maintain good relation with time.
- Practice active listening with them.

GUIDELINES FOR PARENT CHILD RELATIONSHIPS

- Set specific time for child to do some activities together.
- Always be consistent about the reward or punishment the behavior in same manner as much as possible.
- Both of them should have share an equal responsibility of discipline.
- Always remember that your behavior affects your child´s behavior because you are role model for them.
- Reward a child´s good behavior by verbal praising, or giving them something like toys, favorite food, or by giving them money.
- Never show disagreement in front of children.

CONCLUSION

The relationship between the child and the parent is the most important thing because it is the foundation for the child´s behavior, overall development, and life choices. Parents teach a child about the situations and how to react to them.

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Review Article

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Bullying:Age and Gender Differences

E Elamathi[1], Rajathi Sakthivel[2], M Hemamalini[3]

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ABSTRACT

Bullying means misuse of force, power, threat and involve in aggressive behaviors towards others. It can occur anywhere in society like school, home, workplace and any social gathering. This bulling act is common for all age groups but most common among children. There are four possible forms of bullying behavior among children like verbal, physical, relational and cyberbully. In worldwide, almost one-third of young teens were experiences bullying. In that, approximately 41% of school going children were remain bullied with age group of 12-18 years at every year. It's necessary, Children need to learn that bullying behavior causes unhealthy environment and promote serious effects on the bullied children's social, emotional and physical well-being. Govt of India have enacted anti-bullying laws to control and prohibit bullying mainly in schools and colleges. Everyone has vital role in prevention of bullying behavior among children, especially parents, teachers and school health nurses to take necessary measures to control it.

KEYWORDS: Bullying; Age; Gender; Behavior and Anti bullying laws.

INTRODUCTION

In 1530, the word "bully" was first used which means of sweetheart applied to address sex. It was borrowed from the word Dutch boel meaning as "lover or brother". In 17th century, the meaning was deteriorated to "fine fellow", blusterer and harasser. It indicates logic in between lover and ruffian. In 1710, first attested the verb "to bully" with meaning of usually one whose claims to strength and courage to another. It is based on the intimidation of those who are weaker.[1] Though there are various types of bullying behavior with different forms and shapes; children are unique in selecting the way to respond it. Subsequently, the teachers and parents were need to know about the significance of bullying behavior among children.[2] In India, only limited researches are available about bullying due to imbalance between population size and their sociocultural factors like religion, caste, gender and color.[3]

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MEANING OF BULLING

The behavior of a person who hurts or frightens someone smaller or less powerful and often forcing that person to do something which they do not want to do - Cambridge Dictionary.[4]

CURRENT STATISTICS

In worldwide, almost one-third of young teens have recently experienced bullying behavior mainly in school. It ranges from high in Samoa (74%) and low in Tajikistan (7%). It also pervasive to across all countries especially Afghanistan (44%), Canada (35%), Tanzania (26%) and Argentina (24%). Globally, in gender wise boys (32%) are slightly more at risk of bullying in schools than girls (28%). some pervasive countries were reported the controversial views about bullying behavior in which slightly high incidence in girls (65%) than boys (62%). It means girls are more extensively impacted from bullying. In developed countries, low socioeconomic status and immigrant youth are main predictors for bullying.[5]

UNESCO Institute for Statistics (UIS - 2018) stated that, almost 1/5 students (20.2%) are bullied. Approximately 41% of school going children bullied with aged 12-18 years in the school every year. In various forms of bullying. 13% of them involved in fun of called names or insulted, 13% rumor's, 5% pushed or spit on, and 5% were excluded from activities on purpose; Apart from this, 35% were involved in traditional and 15% involved in cyberbully in that 14.5% in online. Among them nearly 19,000 bulled children were committing suicide over a year.[6]

Common forms of bullying Among Children

There are two main types of bullying behavior among children. It based on number of children involved which termed as individual and group bullying and also some common forms of bullying like verbal, physical, relational, and cyberbully.[7]

Verbal Bullying

It means use of threat full or cruel words and making disrespectful comments about one's color, appearance, sexual orientation, caste, religion and ethnicity etc. It is also fun of ongoing name calling and criticizes about one's disability.

Ex: When a slim girl says to fatty girl, "You're really looking obese.

Physical bullying

It involves the act of repeated aggressive intimation to others inappropriately. like unwanted touch of others, hitting, pushing, kicking, blocking etc.

Ex: A boy gets his uniform pulled down on the class room during break time

Relational Bullying

It involves with exclusionary tactics (i.e) deliberately preventing someone from joining or being part of a group. It may happen at lunch table, game, sports, or during social gathering. *It is also called social bullying*.

Ex: A group of girls in dance class keeps talking about poor score in examination and treating the one uninvited child as if she were absent.

CYBERBULLY

It is encompassing in cyberspace which cause threats to someone by spreading lies, false rumors through electronic devices. It may be in the form of texts, e-mails and social media posts by some personalities like racist, sexist etc. This type of homophobic messages creates discomfort atmosphere to children when not involve directly.

Ex: Some one posts that Surya is a total loser and mentally unstable in social media.

Fig. 1: Common Forms of Bullying (**Source:** dreams time.com 2020)

BULLYING CYCLE

According to Salmivalli (2014), Bullying is a conceptualized as a group phenomenon with multiple peers taking part other than bully and victim. Bullying cycle shows students' mode of reaction and consist of eight characteristics as follow as in figure 2.[8]

The bully/ bullies are the person who perpetrator in a particular incident first. They are intentionally causing inflicts or injury to someone else.

Followers/Henchmen: They are assistants or henchmen who get involved to help the perpetrator once the episode has begun.

Supporters: They are reinforces who encourage the perpetrator by laughing or showing other signs of approval.

Passive supporters: The person who are present during the bullying event but remain neutral (passive) and helping neither the target nor the perpetrator.

Disengaged onlookers: They are witnessed the whole bulling incident but never take any action to prevent bullying.

Possible defenders: They dislike the bullying act and also thought to help the victim but they do not do.

Defenders of the victim: The persons who were supporting actively to a victim are called as defenders. Less than 20 percent of defenders were supported to the victims who witnessed during bullying episodes/

The victim: The individual who exposed to any forms of bullying behavior.

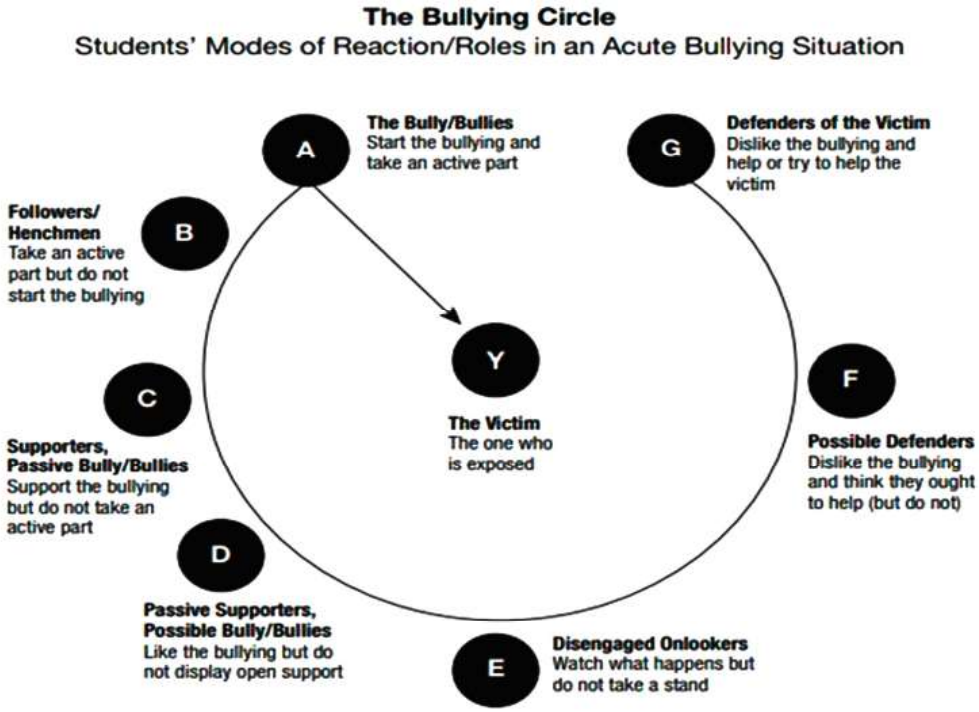

Fig. 2: Eight Characteristics of Bulling Cycle (National Academies Press (US); 2016).

This bullying cycle suggests that children are highly motivated to bully others for purpose of attain high status among their friends. By the way, they are very popular and easily dominate others. Finally, they need spectators to confer their high status and respect.[9]

IMPACT OF BULLYING BEHAVIOUR

Bulling leads to promote serious effects among both bully and bullied children up to their lifetime. Initially it causes negative emotions like sadness, hopelessness, shame, worthlessness and also increases their anxiety level and depression. Simultaneously it affects the children's cognitive functions which lead to low self-esteem, self-doubts, disturbance in daily routines, changes in eating pattern and sleep, academic failures, withdraw from society and involve in antisocial behaviors. Finally, it may lead to risk of suicide. It also affects the bully's mental well-being which causes the persistent mental illness among them.[10]

BULLYING AMONG KIDS (3 TO 5 YRS.)

Kids start to learn about bullying behaviour in home itself like simple fights with siblings and name calling. It occurs due to inability to manage some strong emotions like anger, frustrations or insecurity. The reasons , effects and strategies of kid bullying are depicted in Table 1. Almost 20% of kids were involved in bully like activities but sometime kids torment others by the way they've been treated.

Table1: Reasons, Effects And Strategies of Kids Bullying

Reasons for kids bullying	Effects of kids bullying	Strategies to overcome kids bullying
• Feels insecure • Inability to manage strong emotions • Poor coping behavior • To control others in family • Inadequate development of ego defence	• Poor pear relationships • Academic failures • Anti-social behaviour initially	• Take bullying seriously • Teach kids to treat others with respect and kindness • Learn about children's social life • Encourage good behaviour

Generally, kids may think that aggressive behaviors are normal way of expression of anger because they were observing that their family members got angry with anyone, immediately shouts them in the home. To support this, social media seem to portrait some forms of aggressive behaviors or ridiculous acts are as part of heroism which kids were learned through TV too. Subsequently, parents need to educate their children that bullying is form of harassment to others.[11]

BULLING AMONG CHILDREN & ADOLESCENTS (5 – 19 YRS.)

Bullying transforms the negative acts among children and adolescents which may be in physical or verbal form. It affects the school environment and learning ability which leads to criminal and illegal behaviourin both bullies and victims. The most common forms of bullying among children and adolescent are higher percentage (59%) of them cyberbullies, 42% affected with offensive name calling and other forms of bullying were depicted in Figure 3.[12]

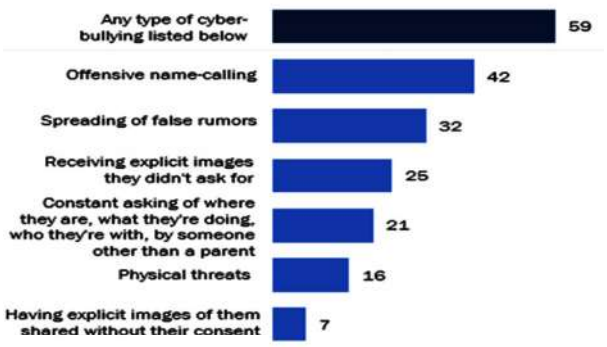

Fig. 3: Different forms of bulling among adolescent (Bishop A et al., 2020)

How to deal bullying behavior among adolescents

- Educatechildren about types of bullying
- Help them to report to an authorityabout bullying incident.
- Explain them how to handle the bullying, help them to learn self-defence and act as brave in any bullyingcircumstances.

Gender based bullying

Every bullying experience is unique. It based on not only the type of bully but also the gender involved in the bullying. The bullying approach among boys & girls may vary.[13]

MALE BULLYING

Physical bullying is more common among boys than girls. Boys are forming a group of followers to acknowledge their bullying act. Most of the male can bully both girls and boys and also more open about their bullying behaviour. Bullying episodes are shorter and quicker among boys than girls. (Girls often hold grudges).

Female bullying

Relational or indirect bullying is more common among girls like verbal assaults, spreading rumors and gossip. Girls were experiences more sexual bullying than boys like rumors spread about sexual activity and receiving sexual messages or harassment from male. Most of thefemale bullies do not act alone; they tend to have accomplices or followers who support their behaviors.

Transgender bullying

Transgender teens are being bullied 1.5–2 times more than mainstream teens. 90% transgender was reported being bullied in UK. In India, almost 2% of school going students identify as transgender. Out of them, nearly 27% of them not feeling good

to go to school, 35% of them are bullied in school campus itself and 35% were attempted suicide. Transgender youth are mostly experiences bullying related to their sexual orientation, weight and size. Therefore, necessary actions are recommended to control bulling among gender minority.[14]

MEASURES TO MANAGE AND PREVENT BULLYING[15,16,17]

Anti-bullying Laws

The Government of India has enacted a regulation called "UGC regulations on curbing the menace of ragging in higher education institutions, 2009" which has been applied to all the colleges or higher education institutions to stop bullying among students.

Anti-bullying committee

Human resource development minister formed a committee with teachers and mental health professionals as anti-bullying committee. They have to analyze bullying behaviors in schools and take measures to stop and prevent it.

CBSE School Bullying Protection Law

In order to stop bullying behavior especially cyberbully formulated the CBSE guides to all its affiliated schools to follows,

- ***Form a committee:*** Formed a committee in every school which helps to deal bullying and ragging.
- ***Committee Members:*** Committee members should include the vice- principal, senior teacher, doctor, counselor, parent-teacher representative, school management and legal representatives.

Activities of anti-bullying committee

Rustication: If they found any student is involved in ragging or bullying, they will give written warning and also lead to of the particular student.

- ***School Notice Board:*** Paste a warning notice on a display about bully.
- ***Anti-ragging Laws***

Anti-bullying Laws also enacted to control bulling behavior in worldwide.[17]

- Arresting: India's anti-ragging laws lead to immediate arrests of those who are caught in ragging.
- First Incident Report (FIR): The victim can avail thirteen provisions under Indian Penal Code if he has been ragged or bullied and can register an FIR in the police station under the area where the crime has taken place. The person can apply in various Indian sections of Laws like Section 294 - Obscene acts and songs, Section 339 - Wrongful restraint, Section 506 - Punishment for criminal intimidation

Role of parents[18]

Although school is a right place to deal bullying effectively, parents have key role to empower kids to prevent bullying behaviors.

- Build Trust with your children.
- Talk regularly and specifically with your children about online issues.
- Be a good listener and observing children's aggressive behavior.
- Be friendly with children and gather the information exactly.
- Validate the child's feeling and provide reassurance
- Attend periodical meeting and get feedback of child attitude & academic performance from their teachers.
- Be aware of our child activity in social media.

Nurses Responsibilities to control school-based bullying[19]

- ***School wide interventions***:Student Nurses take a survey / project of bullying problems at school and make in-service training to raise the awareness among children and school staff regarding bullying.
- ***Classroom-level interventions:*** Arrange for periodical meeting along with teachers for establishment of classroom rules against bullying, conduct regular class meetings along with parents to prevent bullying at school.
- ***Individual-level interventions:*** School Health Nurses have discussion with students to identify the bullies & victims and refer to counseling services in person or telephone help lines.

CONCLUSION

Children should learn that bullying behaviors causes serious effects on bullied children's social, emotional and physical well-being. Govt of India have enacted anti bullying laws to prohibit bullying

behavior in school and colleges. All the community members especially school health nurses have vital role in addressing and preventing it. Every year, we are celebrating October month is National bullying prevention month. All school institutions are should take initiation to instruct their students to wear orange color dress and disseminate information about bulling prevention through school magazines, social media post, parent letter and websites aids to promote healthy children in future.

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Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540–7.

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Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone-iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3–9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792–801.

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Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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