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| Physical | | | Domains | Supplementary Table 1. Intervention for community-based family-child-centered care |
| Controlled mobility  : The ability to move within joints and between limbs following the optimal path of instant center of rotation | Stability  : The ability to provide a stable foundation from which to move | Mobility  : A functional range through which to move and the ability to sustain active movement through the range | Purposes |
| (1) Active weight shift training with gym ball  (2) Balance control training with bosu ball | (1) Joint approximation with ‘light’ compression (5-50 ㎐) and ‘heavy’ compression (100-200 ㎐)  (2) Hippotherapy with static and dynamic stability (with 10-80 ㎐ and 0.1-2.0 ㎞/h)  (3) Treadmill training with dynamic stability (with 0.1-2.0 ㎞/h and gradually altered until the subjects self-selected a comfortable speed) | (1) Prolonged stretching with ‘active’ or ‘passive’10 minutes  (2) Rhythmic initiation (RI)  (3) Leg press exercise (with load of 30-40% of the subject’s body weight, 3 sets of 10–15 repetitions) | Techniques |
| Weight shift training: to coordinate the central nervous system both the postural components that stabilize the body and the prime movement components that relate to the particular motor task (Tsaklis, Grooten, and Franzén 2012).  Balance control training: to control the amplitude of muscle activations and to reduce abnormal muscle co-activation (El-Shamy, and Abd El Kafy 2014). | Joint approximation: to stimulate joint receptor, primarily static, mechanoreceptor, facilitate alpha motor neurons, reflex muscle contraction (Wicke, Gainey, and Figueroa 2014).  Hippotherapy: to control using the subconscious feedforward mechanism by which the TrA and multifidus are synergistically co-activated for upright spinal postural stability (Park, and You 2018).  Treadmill training: to promote automatic and rhythmic gait by activating the aCPG of the spinal cord and increase coordination of agonist and antagonist muscle in the lower extremities (Drew, Kalaska, and Krouchev 2008; Grecco et al. 2013). 2013). | Prolonged muscle stretches: to reduce the spasticity by increasing the number of sarcomeres and adjusting the sarcomere length (Hale, Fritz, and Goodman 1995).  RI: to improve coordination and initiation of movement in a desired range of motion and reduce hypertonic muscle (Kim, and Lee 2012).  Muscle strength: to relieve inadequate coactivation of antagonist and agonist muscles, decreased of inadequate motor unit discharge, secondary myopathy, and disturbed muscle physiology (Ozal, Türker, and Korkem 2016). | Rationale |

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| Cognitive | | Physical |
| Hand function | Behavior | Skilled mobility  : The ability to maintain consistency in performing functional tasks with economy of effort, highly coordinated movement |
| Fine motor skill training including academics, play, self-care skills with piano, pegboard, jelly, toys, clothes, and blocks | (1) Behavior modification with positive or negative punishment and reinforcement  (2) Habit formation with motivation, ability, and triggers | (1) Verbal cue for resisted progression, walking, forward and backward, side stepping, stair  (2) RAGT (with body weight support of 30-50%, speed of 1.0- 2.0 ㎞/h, and passive to active mode |
| Fine motor skill training: to inhibit abnormal postural reflex and tone and facilitate normal movement patterns and muscle coordination (Azzam 2012). | Behavior modification: specific responses are performed to occur at different times or that particular reinforcers or punishments may be administered at varying intervals in order to modify behavior (Maurice, Green, and Luce 1996).  Habit formation: to provide motor learning by performing complexity and repetition of individualized tasks through knowledge of performance (KP) and knowledge of results (KR) based on 3 stages of motor learning (Sunaryadi 2016). | Specific task mobility: to alter elementary locomotor variables in the more advanced stage of motor learning (Crenna et al. 2007).  RAGT: to promote automatic and rhythmic gait by activating the aCPG of the spinal cord and increased coordination of agonist and antagonist muscle in the lower extremities (Drew, Kalaska, and Krouchev 2008; Grecco et al. 2013) and decrease spasticity by dynamic muscle stretching and increase dorsiflexor muscle strengthening (Hösl et al. 2018). |

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| Sensory | | | Cognitive |
| Proprioceptive system | Vestibular system | Tactile system | bADL |
| Proprioceptive stimulation with vibrator and swing | Vestibular stimulation with swing, trampoline, gym ball | Tactile stimulation with vibrator, toys, and putty | ADL training including grooming/ personal hygiene, dressing, toileting/ continence, transferring/ ambulating, and eating |
| Proprioceptive system stimulation: to facilitate mechanoreceptors where muscle spindles were stimulated following synovial tissue stimulation by applying passive proprioception stimulus to the whole body stimulating ventral horn cells through afferent fibers and raising the excitability of alpha motor neurons (Abbruzzese et al. 2014). | Vestibular system stimulation: to increase in the dendritic arborization and synapses in the hippocampal pyramidal neurons which improves performance in spatial learning tasks (Sailesh, Manyam, and Jinu 2018). | Tactile system stimulation: to help the mental and physical framework within an individual’s nervous system to properly perceive sensory input, regulate its responses, and understand the significance behind a particular, texture, and movement (Puts et al. 2014). | ADL training: to perform specific daily tasks and control the movement of the different segments of the body and the child’s patterns of movement and posture to help find ways where the function can be optimized with support needs (ÖHRVALL et al. 2010). |

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| aCPG: Central Pattern Generator.  bADL: Activities for Daily Living. | Social integration |
| Emotional, social, school functioning |
| Counselling (5-10 minutes)  FGI (60 minutes once each before and after intervention) |
| Counseling: to help the child achieve his optimal developmental potential by explaining the child's condition and helping the parents to accept it, guiding them regarding proper treatment, addressing concerns about the child and psychosocial stress (Singhi 2004).  FGI: to provide a rich and detailed set of data about perceptions, thoughts, feelings, and impressions of specialist and to find out the people’s understanding and experiences about the issue and reasons behind their particular pattern of thinking (Dilshad, and Latif 2013). |