SOCIAL SUPPORT AND QUALITY OF LIFE AMONG CHILDREN WITH DISABILITIES IN MIZORAM

BY

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SUPERVISOR'S CERTIFICATE

This is to certify that the thesis 'Social Support and Quality of Life among Children with Disabilities in Mizoram' submitted by C. Lalmuanpuii for the award of Doctor of Philosophy in Social Work is carried out under my guidance and incorporates the students' bonafide research and that these have not been submitted for award of any degree in this or any other University or Institute of learning.

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DECLARATION

I, C. Lalmuanpuii, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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LIST OF ABBREVIATIONS

AAY	Antyodaya Anna Yojana
ADIP	Assistance of Disabled Persons
AIDS	Acquired Immuno deficiency Syndrome
APL	Above Poverty Line
BPL	Below Poverty Line
CBO	Community Base Organisations
CHASL	Child Health Assessment Leather
CHQ	Child Health Questionnaire
ComQol	Comprehensive Quality of Life
CP	Cerebral Palsy
CwDs	Children with Disabilities
CWSN	Children with Special Needs
DDRC	District Disability Rehabilitation Centre
DPO	District Project Officers
EFCI	Evangelical Free Church of India
FGD	Focus Group Discussion
HIV	Human Immuno deficiency Virus
HRQoL	Health related Quality of Life
IE	Inclusive Education
LC/VC	Local Council/Village Council
MHIP	Mizo Hmeichhe Insuihkhawm Pawl
MUP	Mizoram Upa Pawl
NGOs	Non Government Organizations
NHFDC	National Handicapped Finance and Development Corporation
NILD	National Institute of Locomotors Disability
OBPP	Obstetrical Brachial Plexus Palsy
PedsQL	Pediatric Quality of Life
PRA	Participatory Rural Appraisal

PwDs	Person with Disabilities
PWD Act	Person with Disabilities Act
QoL	Quality if Life
RP	Resource Person
RT	Resource Teacher
RPwD Act	Right of the Persons with Disabilities Act
SCERT	State Council of Educational research and Training
SIPDA	Scheme for Implementation of Person with Disabilities Act
SPSS	Statistical package for the Social Sciences
UNICEF	United Nations Children’s Fund
UPC	United Penticostal Church
US	United States
WHO	World Health Organization
YMA	Young Mizo Association
ZEP	Zoram Entu Pawl

CHAPTER 1

INTRODUCTION

This chapter will discuss a brief introduction of the problem and the scenario at the international, national and regional level. It shall also delve into the concept and definitions.

1.1 International Scenario

Children with Disabilities (CwDs) are one of the most marginalized and excluded groups in society who are facing daily discrimination. In most countries, there is lack of adequate policies and legislation for them. They are presumably hindered from realizing their rights to health care, education, and even for survival (UNICEF, 2017).

According to WHO (2011), there are more than a billion population who are living with disability in the whole world. It is estimated that there are at least 93 million children who are living with one or more disabilities in the whole world. However, the number of children living with disability could be much higher than the estimate. Children with Disabilities are often liable to be among the poorest members of the population. They are less likely to attend school or be enrolled in school, have access to medical and other services, or to the worse, have their voices heard in society. They are in a position of being at a higher risk for physical abuse because of their disability. Children with Disabilities are also likely to be excluded from receiving proper nutrition or humanitarian assistance in emergencies. (UNICEF, 2017)

From the report of WHO (2011), Person with Disabilities are likely to have poor health, lower educational achievements, less economic opportunities and higher rates of poverty than those people living without disability. There is also evidence where people with disabilities face barriers in accessing the health and rehabilitation services in many settings which provide services for Person with Disabilities. One must know that Children with Disabilities too have the same rights to access services and family benefits as all other children (Citizens Information, 2016).

Children with Disabilities experience discrimination and exclusion in the society. Because of discrimination and exclusion, they are likely to feel sad and depressed. Their disability also often restricts them from doing certain body activity and performing certain activity. They are likely to have low academic performance and lacks behind their peers in schools. And because of this, they often have low expectations of achieving higher academic qualifications (Sylvester et.al 2014).

Children with Disability often have lower Quality of Life (Qol) than the other children (Schmidt, 2005). It can be assumed that the Quality of Life of Children with Disabilities tends to be low because there is low availability of social support and services which would meet the needs of Children with Disabilities (Schmidt, 2005). Low Quality of Life of Children with Disabilities can also be related to the fact that child's personal time is considerably limited since children needed time for doctors' appointments, physical therapy, and exercises at home (Akel et.al, 2013).

Children with Disabilities as compared to other children tend to require higher social support. Here, family support is very important because family is the primary source of support which Children with Disabilities could receive. Emotional, social and school supports were also very important for elevating the Quality of Life of Children with Disabilities. Even though the Quality of Life of Children with Disabilities tends to be low, Quality of Life can extensively be increased by the provision or improving social support. Those Children with Disability who are admitted in special schools usually have more access to different kinds of services and receive better quality of care (Szilagyi, 2012; Olsson et.al, 2015).

The disability of a child not only affects the well-being of the child itself but have great impact on the lives of the care givers and the family. Having a disabled child can cause heavy burden to the entire family (Heiman, 2002). It is not easy for parents to easily accept their child's disability and the journey of the parents often begin with disappointment. Physical and pubertal change of the child also adds burden to the parents. And also, having a child with disability tends to create distance from other family members and relatives because the care giver is confined to the disabled child (Park & Chung, 2014). The family also often experience job changes or unemployment for having a disabled child. Having a disabled child adversely resulted to financial loss and also, parents have limited time for self because disabled child require additional time for parental attention and care (Rogers and Hogan, 2003). Parents with a child, or children, with a disability often have more stress placed on their relationship (Disabled world, 2017).

According to First & Curcia (1993), over 43 million Americans suffer from one or more physical or mental disabilities. In order to elevate the living conditions of disabilities, the United States is steadily taking measures to increased inclusionary policies and laws for persons with disabilities. The different laws and policies that pertain to disability include American Disability Act (1990) which protects the right of all disabled persons in a wide range of situations such as private sector employment, availability of services, access to public accommodation, public and private transport services and telecommunication relay services. The Individual with Disabilities education act was another policy which was passed in 1974 that provide federal assistance for identifying and educating Children with Disabilities and to provide Individual education Plan. The act also states that Students with Disabilities should be educated in a least restrictive environment and focus more on inclusion. Another act is the Rehabilitation Act which was passed in 1973 in order address the exclusion of disabled person from participation. The act prohibits discrimination against handicapped persons and also provides free and appropriate public education to all the handicapped students.

1.2 National Scenario

In India, the Ministry of Social Justice & Empowerment is mainly responsible for the welfare and empowerment of Children with Disabilities. However, no single ministry has been established so far for the protection and for the welfare of Children with Disabilities. This leads to varying data of Children with Disabilities for which relevant data of children with Disabilities is not available in India. Due to this absence of relevant data on Children with Disabilities, it is difficult for the government to provide necessary services which meets the needs of Children with Disabilities (Childline, 2010).

As per Census 2011, in India, about 2.68 Cr persons are living with disability, which is 2.21% of the total population. According to Childline (2010), it is estimated that 1.67 per cent of the 0-19 population are living with one or more disability in India, out of which 35.29 per cent of them are children. A total number of 12 million children are estimated to be living with disabilities in India, and out of these, only 1 per cent of them are estimated to have access to school. It is also evident that one third of most disabilities could be prevented. Under-nutrition is a severe problem faced by Children with Disabilities in India and it is predictable that 80 per cent of children with disabilities will not be able to survive over forty years of age.

In India, Children with Disabilities are likely to belong to families having low income and majority of them live in rural areas (Mohisini & Gandhi, 1982). For instance, disability rate is much higher in rural areas than those of urban areas. As compared to other countries, very little has been done for Children with Disabilities in India. Very little rehabilitation programme for Children with Disabilities exist within the country. (Desai,1990).

There is lack of information or publicity of services and schemes for Children with Disabilities in India. In most cases, the application procedure of services for disabled children are quite complicated and consist a number of steps, requirements and involvement of various offices which create great barriers in accessing the scheme and services. And because of lack of information and complicated process, there exist underutilization of services and schemes for Children with Disabilities in India (Mohisini & Gandhi, 1982). Another reason for poor utilization of services for children with disabilities is due to certain barriers in accessing services (Klassing, 2007).

It is notable that disabled children belonging to upper group and those living in urban settings have greater opportunity for accessing welfare services for Children with Disabilities. There also exists gender discrimination in accessing the services where boys have more opportunities than girls (Haider, 1998).

According to the Rights of the Persons with Disabilities (RPwD) Act, 2016, appropriate Government and the local authorities should take measures to ensure that the women and children with disabilities enjoy their rights equally with others. The appropriate Government and local authorities should also ensure that all children with disabilities are enjoying rights on an equal basis to freely express their views on all matters affecting them and providing them appropriate support keeping in view their age and disability. Regarding education, the act states that appropriate Government and the local authorities should make an effort so that all educational institutions funded or recognized by the Government are providing inclusive education to the children with disabilities where, the educational institutions should admit Children with Disabilities without discrimination and provide education and opportunities for sports and recreation activities equally with others. The educational institutions should also provide barrier free environment. Under this act, Children with Disabilities must be provided with books, other learning materials and appropriate assistive devices and also scholarships in appropriate cases. According to this act, suitable modifications must be made in the curriculum and examination system to meet the needs of students with disabilities such as extra time for completion of examination paper, facility of scribe or amanuensis and exemption from second and third language courses.

In India, Children with Disabilities are likely to have lower Quality of Life than their non disabled peers (Moore et.al, 2010). However, Social Support has considerable impact on Quality of Life and could increase the Quality of Life of Children with Disabilities (Sultan et.al, 2016). Therefore, we can say that there is relationship between social support and Quality of Life (Reyhani, 2016).

Child’s disability also has a great impact on the life of the family. It hinders the mothers or care takers from working in a full time Jobs. And to its extent, mothers with disabled child often have to stay unemployed as Children with Disabilities require lot of time and attention (Sandler & Mistretta,1998).

1.3 Regional Scenario

In Mizoram, the Department of Social Welfare is responsible for the welfare of Persons with Disabilities. The state does not have the statistical data of the total number of children with disability. But, the Social Welfare Department (2011) estimates that there are 15,160 persons with disabilities in a total population of 10, 97, 206 people.

According to 2011 census, a total number of 3,748 populations of 0-19 years are living with disability in Mizoram. Out of these, a total number of 541 populations belong to 0-4 years, a total number of 988 populations belong to 5-9 years and a total number of 2219 populations belong to 10-19 years.

There exist very little data on children with disability. The state does not have the exact statistical data of the total number of children with disability. Children with Disability do typically belong to family who live above poverty line. Because of their disability, children with disabilities have low academic performances and to extent, are likely to drop out of school. Mothers of Children with Disabilities are less likely to be employed while most of the Children with Disabilities have working father (Lalmuanpuii, 2016).

The Quality of Life of persons living with disabilities is observed to be low. Social support is one of the important factors for the elevation of children with disabilities in Mizoram. The support agents can be classified into primary, secondary and tertiary supporters. The primary supporters include family, friends and relatives, secondary supporters include various social institutions and non-government organizations such as the Churches, Young Mizo Association (YMA), Mizoram Upa Pawl (MUP), Mizo Hmeichhe Insuihkhawm Pawl (MHIP), Local Council (LC), Zoram Entu Pawl (ZEP), Presbyterian Hospital and Philanthropists and the tertiary supporters include Government agencies (Chhangte, 2017).

Through Social Welfare Department, the Government of Mizoram provides material aid to the disabled persons who are in need. Disabled students are provided with stipends from the Government as a means to encourage them to continue their education. In Mizoram, information of services available for Children with Disabilities tends to be very low because of which care givers are unaware of the services available for their children. In Mizoram, there exist very little amount of services for Children with disability. There is also a wide gap between the availability and accessibility of services for Children with Disability in Mizoram (Lalmuanpuii, 2016).

The report of Mizoram Sarva Shiksha Abhiyan shows that Aizawl District has identified 1819 Children with Special Needs (CWSN). Resource Persons (RP) and Resource Teachers (RT) were recruited at the block level to work at the grassrootS with the CWSN and the teachers in the school. Inclusive Education (IE) staffs are attached at the District Project Office (DPO) to monitor the work of the RPs and RTs at the block. The report also shows that assessment camps were conducted every year in convergence with Non Government Organisations (NGO), State Council of Educational Research and Training (SCERT), Social Welfare Department, National Institute for Locomotor Disability (NILD) and Health Department. Transport Allowance and Escort Allowance were also provided to selected CWSN. World Disabled Day i.e. 3rd December is celebrated every year in convergence with NGO's, SCERT, Social Welfare Department, NILD and Health Department. It can also be known that Training of parents, peers, teachers and professionals are also conducted every year. Material aids like wheel chairs, crutches, hearing aids, spectacles, white canes, large print text book, Braille textbook & Braille paper (Century Board) are provided to CWSN.

According to the report of Social Welfare Department, Mizoram (2015-2016), there are 14 schemes and programmes which were being provided for the welfare of the disabled persons such as:

- Handicapped Student Stipend (State Scheme)
- Handicapped Training Centre (State Scheme), National Programme for Rehabilitation Scheme of Assistance to Disabled Persons for Purchase/Fitting of Aids & Appliances (ADIP Scheme)

- The scheme for Disability Pension
- Economic Rehabilitation Stipend to Educated Unemployed Allowances (State Scheme) of Persons with Disabilities.
- Assessment and Certification Camp
- Loan Scheme under National Handicapped Finance and Development Corporation (NHFDC)
- District Disability Rehabilitation Centre (DDRC)
- Deendayal Disabled Rehabilitation Scheme (DDRS)
- National Trust Office of the State Commissioner for Persons with Disabilities (Pwds)
- Scheme for Implementation of Persons with Disabilities (Pwds) Act, 1995 (SIPDA)

1.4 Definition and Concepts

The United Nations Conventions on the Rights of the child defines children as “a human being below 18 years of age unless under the law applicable to the child, majority is attained earlier”.

According to the Rights of Persons with Disabilities Act, 2016, “person with disability means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others”. The different types of disability as given by the Act are as follows:

i. Locomotor Disability
ii. Leprosy Cured persons
iii. Cerebral Palsy
iv. Dwarfism
v. Muscular Dystrophy

vi. Acid Attack victim
vii. Blindness
viii. Low-vision
ix. Hearing Impairment (deaf and hard of hearing)
x. Speech and Language disability
xi. Intellectual Disability
xii. Specific Learning Disabilities
xiii. Autism Spectrum Disorder
xiv. Mental Illness
xv. Chronic Neurological conditions
xvi. Multiple Sclerosis
xvii. Parkinson's disease
xviii. Hemophilia
xix. Thalassemia
xx. Sickle Cell disease
xxi. Multiple Disabilities including deaf and blindness

According to the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 “person with disability means a person suffering from any of the conditions relating to autism, cerebral palsy, mental retardation or a combination of any two or more of such conditions and includes a person suffering from severe multiple disability”.

According to the PWD Act, 1995, ‘Person with Disability means a person suffering from not less than forty per cent of any disability as certified by a medical authority’.

Disability can be referred to as an umbrella term which covers impairments, activity limitations, and participation restrictions. Here, as defined by WHO, impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action. On the other hand, participation restriction can be referred to as a problem experienced by an individual in involvement of life situations. Thus, it can be said that, “disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives" (WHO, 2011). According to Pankajam (2009), person with disabilities are "those who are born with a disability, who acquire due to micro nutrients deficiencies, become disabled in between due to accidents or trauma or some events in their life".

According to Article 1 of the Convention on the Rights of Persons with Disabilities, the term, 'children with disabilities' is used to refer 'all children up to the age of 18 years who have 'long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

According to Desai (1990), a handicapped child may be defined as, "one who suffers from any continuing disability of body, intellect or personality which is likely to interfere with his normal growth and development or capacity to learn".

In this study, Children with Disability include, those children with the types of disability under Rights of Persons with Disabilities Act, 2016 who are between the ages of 10-17years.

Social Support can be referred to as various types of assistance or help that people receive from others. Social support can broadly be classified into three major categories namely emotional, instrumental and informational. Emotional support frequently takes the form of non-tangible types such as love and care. By contrast, instrumental support refers to the various types of tangible help such as financial assistance, material goods, or services. While informational support refers to the help that others may offer through the provision of information (John and Katherine, 2008).

Social Support can also be defined as "resources provided by others that is used for coping assistance or can be said as exchange of resources". There are several types of social support which include instrumental support (ie. assist with a problem), tangible support (such as donating goods), informational support (such as giving advice) and emotional support (ie. giving reassurance among others) (Schwarze, Knoll & Rieckmann, 2003).

Social support can also be referred as "the provision of physical, emotional, informational, and instrumental assistance that an individual receives from their social network" (Dunst, Trivette, & Cross, 1986).

According to Schaefer et.al (2002), social support can be defined in terms of information or social environmental conditions that in turn enable an individual to feel loved and cared for, affirmed or as belonging to a group of persons with common goals and beliefs.

Cutrona and Suhr (1992) classify social support system into five general categories which include:

- *Informational support* which refers to messages that include knowledge or facts, such as advice or feedback on actions.
- *Emotional support* which is related to the expressions such as caring, concern, empathy, and sympathy.
- *Esteem support* that can be defined as the messages that help to promote one's skills, abilities, and intrinsic value.
- *Social network support* which can be defined as the messages that help to enhance one's sense of belonging to a specific group with similar interests or situations.
- *Tangible support* that includes provision of needed goods and services.

In this study, Social Support includes the support received on the basis of its accessibility, quality and adequacy in seven (7) dimensions such as basic needs support (fooding, shelter, clothing) , emotional support (love, care, concern, empathy, sympathy), physical health support (medical attention, provisions and services) , mental health support (professional counseling, guidance and psychiatric care and services), support in life skills (education and training including vocational training), financial support (sponsorship, donation, aid or help in form of money) and instrumental support (aids, appliances, certificates, goods) (Olsson et.al, 2015;

John and Katherine, 2008; Knoll & Rieckmann 2003; Schwarze, Dunst, Schaefer,Coyne, & Lazarus, 2002; Cutrona and Suhr; 1992; Trivette, & Cross, 1986).

The social support agents includes primary social support agent (Family), Secondary social support agents (schools, peers, church, Mizo Hmeichhe Insuihkhawm Pawl (MHIP), Young Mizo Association (YMA), Mizo Upa Pawl (MUP) and Non-Governemnt Orgasnisations (NGOs) working in the area of disability) and Tertiary social support agents (Local Councils/Village Councils and Government) (Chhangte, 2017; Lalmuanpuii, 2016; Meral and Cavkaytar, 2012; Lifshitz and Glaubman, 2004; Teklu, 2010; Parette et.al, 2010; Mishra & Gupta, 2006).

Quality of Life (QoL) is a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life. Even though health is one of the important domains of overall quality of life, there are other domains as well that include jobs, housing, schools, the neighborhood. Aspects of culture, values, and spirituality can also be the key domains for overall quality of life. All these domains add to the complexity of its measurement (Center for Disease Controll and Prevention, 2018).

The World Health Organization defines quality of life (QoL) as ‘the individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns’ (WHO 1997).

According to Rojas (2013), the term Quality of life refers to “a life which is considered as a good one, well-lived, and being of value and may also refer to the presence of those conditions that favour such a good life”.

WHO (1996) has also developed The WHOQOLBREF have been developed to provide a short form quality of life assessment that looks at four Domain level profiles. The WHOQOL-BREF contains a total of 26 questions. The WHOQOL-BREF is based on a four domain structure such as Physical Health (Activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest, work capacity), Psychological (Bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal belief, thinking, learning, memory and concentration), social relationships (Personal relationships, social support, sexual activity) and environment (Financial resources, freedom, physical safety and security, health and social care, accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment-pollution/noise/traffic/climate and transport) (WHO,1996). In this study, Quality of Life will be understood to be according to this scale of assessment. developed by WHO.

1.5 Statement of the Problem

Children with Disabilities are excluded from the society and often encounter negative attitudes from others (Sylvester et.al, 2014). In India, they are among the poorest members of the society (Mohisini & Gandhi, 1982). In India, there exist gender discrimination in accessing the support and services for Children with Disabilities where preference is given to male child (Haider 1998). There exist poor utilization of services mainly due to lack of information and certain barriers in accessing the services. (Mohisini & Gandhi, 1982; Klassing, 2007). Particularly in Mizoram, very little social supports are available for Children with Disabilities. (Chhangte, 2017; Lalmuanpuii, 2016)

Children with Disabilities because of their vulnerability and their limitations have lower Quality of Life than the other children and as a result of this are subjected to various problems in the home and in society (Schmidt, 2005, Moore et.al, 2010; Chhangte, 2017). The quality of life of Children with Disabilities could extensively be improved by improving the different kinds of social supports for them (Szilagyi, 2012; Olsson et.al, 2015; Sultan et.al, 2016). The child’s disability not only affects the life of the child itself but also has great effects on the lives of the parents and often cause great burden to the family (Heiman, 2002; Sandler & Mistretta, 1998).

With all these in mind, the study shall attempt to highlight information related to the demographic profile of Children with Disabilities (CwDs) in Mizoram, Social support for Children with Disabilities across gender, their quality of life and its relationships with age and gender, the relationship between social support and quality of life and the lived experience of caregivers of Children with Disability and shall also suggest measures for intervention and policy formulation.

1.6 Objectives

1. To highlight the demographic profile of Children with Disabilities (CwDs) in Mizoram.
2. To find out the accessibility, quality and adequacy of social support across the dimensions of social support by primary, secondary and tertiary agents for Children with Disabilities (CwDs) in Mizoram across gender.
3. To find out the quality of life of Children with Disabilities in Mizoram across gender.
4. To find out the relationship between the domains of quality of life of Children with Disabilities (CwDs) in Mizoram
5. To explore the relationship between social support and quality of life of Children with Disabilities (CwDs) in Mizoram.
6. To understand the lived experience of caregivers of Children with Disabilities in Mizoram.
7. To suggest measures for social work intervention and Policy Making.

1.7 Hypothesis

1. Quality of life decreases with increase in age. (Chow et.al, 2005)
2. There is no difference in Quality of Life across Gender. (Moore et.al, 2010; Akel et.al, 2013)

1.8 Rationale of the Study

The study of Children with Disabilities is an integral part of Social work. There exist very little data on Children with Disabilities in the North Eastern part of India, especially Mizoram. Thus, it is very necessary to include Children with Disability in Social Work Research so as to add up to the existing data of Children with Disabilities in Mizoram.

Children with Disabilities are one of the most excluded group who have less voice in the society. Therefore, by studying Children with Disability, Social Work Research would help in advocating Children with Disabilities by providing information about their situation. As for Mizoram, there exist very few services for Children with Disabilities. There also exists wide gap between availability and accessibility or adequacy of services for Children with Disabilities in Mizoram (Lalmuanpuii, 2016) and thus, this study shall help the service providers to identify the gaps that lies between availability and accessibility and also would help them take measures to bridge the existing gaps.

This study shall contribute to elevate the condition of Children with Disabilities by providing reliable data that provide information about Children with Disability which would then help the people to understand the challenges and dynamics related to Children with Disabilities.

On the lights of the different studies, it can be noted that research studies on Children with Disabilities (CWDs) are not adequately conducted in North-East, particularly in Mizoram. Whatever studies that exist, no studies have been made in Mizoram in order to understand the lived experience of care givers of Children with Disabilities in Mizoram.

Therefore, this study will reveal breaking truths about what remains to be known in the area of disability and children in Mizoram.

1.9 Chapter Scheme

Chapter I: Introduction
Chapter II: Review of literature
Chapter III: Methodology
Chapter IV: Results and discussion
Chapter V: Conclusion

CHAPTER 2

REVIEW OF LITERATURE

This chapter will highlight different literature that exist across the world to understand research scenarios as well as help in enriching the content of the study in terms of theory so that gaps can be identified and practice level intervention can be found .

2.1 Demographic profile of Children with Disabilities

The study conducted by Maclnnes (2008) found that disability is more common among male children than female. The study also found that Children with Disabilities are more likely to belong to poorer households. It is then found in the study that raising a child with a disability causes poverty in the family or keeps them to remain in poverty. The study also shows that mothers of Children with Disability are more likely to work at part time jobs that are on a flexible schedule which allows them to have more time to care for their child with disability.

A study conducted by Tran (2014) in Vietnam found that majority of the respondents are from rural areas belonging to low income family.

The study conducted by Reyhan et.al (2016) showed that male children with disabilities are more in number. It is also seen in the study that the educational levels of most parents were elementary levels. The study then finds that most of the fathers were labourers while majority of the mothers were housewives. It can also be known from the study that majority of the children with disabilities belong to middle economic class family.

According to Torres & Vieira (2014), the highest number of respondents are hearing impaired followed by visually impaired and physical disability. Children belonging to age group 15-19 years are more in number than those belonging to the age group 10-14 years. The study also shows that there are more males than females. On studying the reasons for disability, majority of the adolescents developed their disabilities after birth. The studies also found that majority of the respondents are in Elementary School II while very few are in High School. Further, the study shows that those that were enrolled in regular classrooms were more in number than those who were enrolled in special schools.

According to Karger & Rosen (2012), those people living with disabilities tend to be more frequently unemployed and underemployed and therefore often fall below the poverty line. Disability often resulted in poor education and poverty. The study also finds that disability is more common among women than in men. They are less likely to have health insurance and because of their disability, they have to spend more money because they need medical care which adds to their poverty

The study made by Cohen & Prahova in 2006 found that majority of the children diagnosed to have disability were mentally challenged. It is also known from the study that about 20 per cent of the children were suffering from multiple disabilities. In the study, male children were more in number. The study found that less than half of the children are living with married biological parents which mean children with disability are more likely to live in a broken family with a single parent. The study also shows that parents of Children with Dsabilities are less likely to marry and more likely to be divorced.

According to Meral & Cavkaytar (2012), in Turkey, the educational level of mothers of Children with Disabilities are mostly primary level and are mostly non working home makers. The study also shows that the educational level of fathers of Children with Disabilities are mostly primary level and most of them are working as daily wage labourers. The study also found that boys are more in number. It can also be known from the study that most of the Children with Disabilities have learning disability and poor academic performances. It is also known that children belonging to nuclear family consists the highest number and majority belong to low economic class.

According to Muderedzi & Ingstad (2011) there are different components which lead to disability such as poor nutrition, dangerous living conditions, limited access to vaccination programmes, poor health and maternity care, poor hygiene, malnutrition, HIV/AIDS, bad sanitation, inadequate information about the causes of impairments, and natural disasters.

In order to understand the work choices of mothers in families with Children with Disabilities, Porterfield conducted a study in 2002 among mothers of Children below the age of twenty years living with disability. In the study, only mothers of the age 18 to 64 years were included where majority are married. The study revealed that mothers of Children with Disabilities are significantly less likely to work especially in full time basis. In can be known from the study that no single parent mothers were engaged in any kind of work though some of the married mothers were reported to be engaged in part time jobs. From the study, we see that apart from mother's own disability and low educational status, the main factor for mother's not engaged in full time paid works is the presence of a child with disability as taking care of a disabled child consumes a lot of time. The study also show mothers who are post graduate constitute the highest number followed by mothers with high school diploma.

A study conducted by Filmer in 2008 shows that Person with Disabilities do lives in poorer households. The reason for those PWDs to tends to live in poorer households because they have lower educational attainment. It can also be known from the study children between ages 6-17 living with a disability are extensively less likely to start school and are enrolled in schools. It can also be known from the study that disabled children usually have poor academic performances. The results depicts that there will be a worrisome vicious cycle of low schooling attainment and subsequent poverty among people with disabilities.

According to the study conducted by Shumbaa & Abosib (2011) in Botswana, disability is more common among female child than among male child. Those children suffering from visual impairment constitute the highest number followed by those children suffering from hearing impairment. The age distribution shows that the highest number of Children with Disabilities belong to the age group 16 and 20 years. The study also found that Children with Disabilities encounter various forms of abuse by the teachers in the special education schools of Botswana. These forms of abuse may put these Children with Disabilities at high risk to be abused in other ways such as sexual abuse.

From the study made by Shandra, Hogan & Spearin (2008) in US, fathers of children with disabilities are more likely to be working and are more likely to have higher educational qualifications**.** From the study it can be known that the highest number of the fathers are those who completed college degree or higher. Those fathers having high school diploma are lesser than those with higher level.

According to Haider (1998), male children are more in number than those of the girls as more than two third of respondents are male. It can be known from the study that only a few number of the parents are willing to make public about the handicap and disability of their daughters. In the study, the highest number of the fathers of Children with Disabilities were doing salaried job followed by those engaged in business and quite a few were daily wage workers.

According to Mohisini & Gandhi (1982), majority of Children with Disabilities living within the States of Punjab and Haryana and the Union Territories of Delhi and Chandigarh belong to families having low income and majority of them were living in rural areas.

In 2008, CHILDLINE India Foundation conducted a study in Maharashtra which found that only 8 per cent of mentally challenged children attended school in normal schools. There is also evidence that 33 per cent of the parent did not allow their children to interact with other children and hesitate to send their children to schools. This is mainly because they have a fear that their child would be exposed for discrimination and exclusion from their peers and leave emotional scars. They also fear that their child would meet an accident and also that their child would adopt aggressive behavior when exposed to other children.

Singh & Ghaib conducted a study in 2009 among children with mobility ‘impairments’ between the ages of 11–16 years. A purposive sampling method was utilized. From the study, Children with Disabilities do not perceived themselves as different from other children who were called to be normal. On the other hand, there is evidence where children possess a desire to appear the same as everyone else. Children with Disabilities often have a feeling of difference from other children because children often used the terms ‘disabled’ and ‘impaired’ as well as a categorization of ‘like us’/‘like them’. It is clear from the study that ‘disability’ does leave emotional scars and half of the respondents expressed a feeling of dependence and helplessness. There also exist situations where children were aware of other people’s stares and gaze. These staring and gazing have great affects on the children because all these made them feel ‘disabled’ or ‘strange’.

It is found in the study made by Teklu (2010), that children in spite of their disability have a positive perception of themselves. They believe that they have the potential to learn and promote themselves. Because of the positive perception of self, Children with Disabilities develop internal or personal strengths which make them have strong desire and devotion to learn and work, patience, spiritual strength and special ability to communicate with people, accepting limitations and developing an effort not to be a burden to others.

Goodley & Runswick (2015) conducted a study to understand the boundaries, borders and bodies in the lives of disabled children. The study was conducted in Britain among children with disability between the ages of 4-16 years of age. The study reveals that there is existence of social stigma that excludes children with disability. There also exist great discriminatory attitude within the community.

According to Olney& Kim (2010), disabled person usually do not describe their difficulties in clinical terms rather they talked about the problems they encountered as arising due to their disabilities. The study also shows that managing stimulation, poor concentration and focus problems were the common difficulties encountered by them. It is reported that disability cause problem in carrying out various tasks and demands in life. It is also found that person with disability hesitate to disclose themselves to society because there exist stigma and discrimination. We can also know that disabled people thinks that others will never really understand their condition. And even though that is the case, they try to understand themselves as people with both limitations and strengths.

In a study made by Sandler and Mistretta (1998), disability tends to be more common among male children than among female children. The study also states that mothers of children with disabilities are more likely to be financially instable and unmarried. The study found that cerebral palsy is the most common form of disability. It is also found that mothers prefer to work in jobs that allow them to have more and flexible time to take care of their disabled children. This includes working from home, part time jobs or working on flexible schedule. As most of the mothers in this study are working mothers, majority of the children reported that they were financially secure.

From the study made by Lalmuanpuii (2016) in Aizawl, Mizoram, it can be known that female child were more in number than the male child. Those children belonging to the age group 15-17 constitute the highest number and also that majority belong to Lusei tribe. The studies also found that majority of the children are Christians belonging to Presbyterian denomination. The study also shows that most of the Children with Disabilities living in Aizawl belong to nuclear family and stable family. The study also tells that generally Children with Disability belong to family who live above poverty line. Children studying in primary school constitute the highest number. Child’s disability also often causes them to drop out of school. Children who drop out of school mainly drop out in middle school. It is also noted that mothers are less likely to have jobs while most of the Children with Disabilities have working father.

According to Chhangte (2017), on studying social support and quality of life of person with disability, majorities belongs to below poverty line and are unemployed. The study also shows that majority of the respondents are living in nuclear family and also that those belonging to stable family constitute the highest number. The study reveals that majority of the respondents are Christians belonging to Presbyterian denomination. Among the respondents, hearing impaired constitutes the highest number followed by locomotors disability, speech disability and visual impairment. We can also know that more than half of the respondents do not obtained disability certificate because they do not know the process.

2.2 Social support and Children with Disabilities.

The study made by Olsson et.al (2015) found that companion service was the most common type of services in Sweden and in terms of social problem, the most common type of services received were financial assistance. The study then states that help from individual contact was the second most common type of services. Regarding the services received, there is no relation with the child's age or gender. It can also be known from the study that families with children in self contained class received more services than those families with children who are integrated into mainstream classes**.** It can also be noted that there are some families who did not receive any services, which was especially noticeable among integrated children.

According to the Study made by Meral & Cavkaytar (2012), emotional support is the highest form of support received from the family. It was found that social support resources formed by family and friends are the most important predictor of social support perception. The study also found that perception of social support increases with the increace in utilization of social support.

According to the study made by Lifshitz & Glaubman (2004), facilities for Disabilities have already been set up in Israel back in the 1980's, the first facility being school for boys after which more facilities including nursery schools, schools, and special yeshivas for boys with learning disabilities were set up. The funding for all these facilities came from the Ministry of Education or the Ministry of Labour welfare and the staffs of the different institutions includes teachers, medical personnel as well as psychologists, nursing personnel, social workers, counselors, direct care givers and volunteers. It can also be understood from the study that all the institutions for providing service for disabilities operate as public, non-profit organizations that were entrusted with fundraising and supervision. The different activities within the facilities include curricular activities, manifestation of religion within the facility, relations between family and facility and relations between the facility and the community.

The study made by Teklu (2010) found that there are certain limitations in accessing the services provided for Children with Disabilities. These limitations were basically based on attitudes of policy-makers and university officials, the nature of the learning and teaching process, and the type and degree of impairment. The study also found that children with disability encounter different challenges in schools where they were being undermined and ridiculed not only by students, but also by teachers. There is also lack of disability-specific educational support in schools where there exist inaccessibility of instructional materials and other school facilities. Challenges in the school also include misrepresentation of people with a disability as cursed, dependent, special creatures, and incapable of learning . It is known from the study that highest amounts of social support came from family, community, affiliation with a peer group, and advice from successful people with disabilities.

From the study made by Wendelborg & Tossebro (2011), there were more boys than girls living with disability, but there was no significant difference between the gender in regard to social participation with peers. It is also known from the study that the support received from school is high since the use of special education and trained teacher’s assistant provide satisfactory education to children with disability in regular schools and improves academic performances.

The study conducted by Maclnnes (2008), found that children from low-income families often experience more health problems and have more difficulty in recovering from those health problems. Families with fewer resources are more likely to experience more barriers in receiving and accessing to appropriate health and educational services which could play a significant role in building the capacity of the child and family to successfully adapt to overcome the challenges relating to disability.

A study conducted by Lalvani (2015) revealed that negative reactions to children with disabilities exist because of their disability and also because they receive special education. The study also found that stigma tends to be greater when children were removed from general education classrooms for services to be admitted in special schools and be educated in a self-contained classroom.

According to the study conducted by Cardona (2013) there is poor planning or lack of public consideration to meet the needs of disability. From the study it can be known that Participants noted instances when they were perceived as objects of charity. The study then reveals that negative attitudes are not restricted only to the public, yet, they even exist amongst professionals.

The study conducted by Emira & Thompson (2011) found that lack of trust was one of the most considerable issue in accessing leisure services. The service users reported that they experienced abused while they are under the care of the service providers for which the service users find it difficult to trust the service providers. The study also revealed that the staffs and workers of the service centre for disability often show negative attitudes towards service users and also there are untrained staffs that lack certain skills in dealing with the disabled children. This means that there is lack of training for the staff members. The study also shows that there exists lack of availability of leisure services and also lack of flexibility of support in the leisure services. There is lack of information on the availability of services and the process of accessing them. Many of the respondents are not even aware of the services which are available. And even among those who are aware of the service, many of them do not know the process for accessing those services.

According to the study conducted by Tran (2014) in Vietnam there is lack of social assistance for Children with Disabilities. There also exist lack of awareness on different schemes and services available for Children with Disabilities. There is also lack of trained teachers in educational settings and lack of infrastructures which create barriers for the Children with Disabilities in accessing school services.

The study made by Szilagyi (2012) on how health insurance improves access to health care found that Children with Disabilities who are insured are more likely to access the different kinds of supporting services than those who are uninsured. In the study, children who were being insured are likely to have lesser unmet needs and are liable to receive care more quickly than the uninsured ones. The study also shows that insurance improves quality of care since those parents who have their children insured are more satisfied with the primary care, medications, specialty care, and overall health care received by their children.

Kandari conducted a study in 2013 and found that parents, teachers and employees have different perception in prioritizing the services needed for families having a child with disability. From the study, we can know that parents felt great need for receiving information about the services available. Teachers on the other hand gave prior importance to information about how children grow and develop and how to play or talk with the child. Both parents and teachers felt the need to have more time with the child’s teacher or therapist.

The study conducted by Parette et.al (2010) found that computer and the Internet were used to get support as well as to get information on supports available. The study also tells us that internet was one kind of social support used for communication with other parents and with professionals. The study states that majority of the participants were satisfied with the supports which they received using computer and internet some of the participants tells that there are certain limitations regarding the technology based supports and that there are very few support that could meet their needs. From the study, it can be known from the study that the most preference was given to using searchable database and information available by key words and while the least preference was given to using online discussion forum and social networks such as facebook and myspace.

In order to understand the different deprivations suffered by the disabled, Mishra & Gupta (2006) conducted a study and found that the disabled people were excluded from the world of reading and communication. There exists non enrollment of children with disabilities in special schools. There is also lack of pre-school interventions. It can be known from the study that mental disability has not received much attention from the government as illiteracy is highest among the persons suffering from mental problems. The study also shows that there is great educational bias between disabled from the rural and urban areas. It is also known from the study that the education level of the disabled is very low as compared to the general population. There is also lack of occupational skill training as there are very few enrollments of disabled person in vocational training. While the Disability Act has adopted a scheme of 3 per cent reservation for disabled persons in government and public sector open employment, the study reveals that a significant proportion among them still have a non-working status. The poor utilization of these interventions is due to the lack of awareness about the facilities and benefits of the programmes.

Digiacomo et.al (2013) in their study found that there is insufficient or non-existence of services for children with disabilities in India. There is also lack of awareness of services for children with disabilities. The study also revealed that racism is present in accessing services for the disabled within the country. It can also be known that incidents of logistical barriers and cultural and historical issues were present. These issues have great impact on the effectiveness of mainstream services for aboriginal people.

According to Dash (2006) the practice and policies in special needs education is gradually improving and the attitude of society towards children with disabilities has also changed over the centuries. It is evident that the interests of less fortunate children were being damaged by those who claim to serve. At present, the main tendency is to create one education system that values all children and welcomes all irrespective of disability, community background, sexuality, ethnic background, etc. In inclusive classroom, all children are enriched by having the opportunity to learn from one another and grow to care for one another. The study shows that students learn and develop positive attitudes, gain academic and social skills for the preparation of daily living through inclusive education. The study also shows that children enormously gain from socialization with peers in school and develop academic skills, life skills, communication and social skills. It is also seen that through inclusive classrooms, the handicapped children tends to imitate the positive bahaviour of non-handicapped models. Inclusive education also helps children with disabilities to normally function and perform certain task and to interact with their peers in school.

A study conducted by Haider (1998) found that the beneficiaries of services consists more children belonging to the upper caste groups. The study also found that those living in urban settings have greater opportunity of accessing welfare services than those living in rural places. And since male respondents are greater in number, it can also be understood that enough importance is still not being given to the education of blind girls.

Mohisini & Gandhi conducted a study in 1982 within the States of Punjab and Haryana and the Union Territories of Delhi and Chandigarh and found that there have been inadequate education facilities for the disabled children and greatly affects the education level of Children with disabilities. There is also lack of awareness or publicity of services and schemes for Children with disability which results in the underutilization of services and schemes. The study also revealed that the application procedure of services for disabled children is indeed a long process with a number of steps, requirements and involvement of various offices which create great barriers in accessing the scheme and services.

According to a study conducted by Desai (1990), disability rate is much higher in rural areas than those of urban areas. There has also been a wide gap between agency formulation and implementation of services. As compared to other countries, very little has been done for handicapped in India. It is also revealed that there is a very little rehabilitation programme for children with disabilities. There is also lack of statistical data in India.

Klassing (2007) found that there are certain barriers encountered by disables in accessing different services that include medical care, education, employment and barriers in marriages. The main barriers to different services include

- Geographical distances
- Economic constraint
- Lack of Transportation
- Lack of Infrastructure
- Physical accessibility
- Lack of trained teacher
- Lack of disability policy

On studying the challenges faced in accessing social support for Children with Disability, Khanlou et.al (2015) states that availability of services does not mean there is equal access to it. The study found that there exist many barriers in accessing to services and also lack of information regarding available social support for

Children with Disabilities. It can be known from the study that there exist language barriers since all the forms for availing the services were in English which were long and complicated. It can also be known from the study that service users find difficulty in understanding the medical terminologies which were used by the service providers. And also, the support system is really complicated which is difficult to understand and there is also lack of professional help within the service system. The study also found that the service agencies were located in isolated place of the city, which causes difficulty in accessing the services since there is lack of transportation.

According to the study conducted by Shumbaa & Abosib (2011), Children with Disabilities were often sent by their teachers as cheap labourers to do domestic chores. It is also found that Children with Disabilities are at a higher risk of being abused sexually by their teachers. From the study, it can also be understood that that the majority of children were not aware or have knowledge about the rules or regulations that protect them against abuse when they were in primary schools.

According to Pilgrim (2005), most of the people living with mental health problems only receive a primary care response. Though measures were taken for intervention, the most prevalent form of intervention is medication and the availability of psychological interventions lags behind drug treatment. The social treatments were also being individualized because there is under diagnosis of mental illness. In many cases, mental illness are not accurately diagnosed and there is under diagnosis of mental illness. More money is spent on inpatient facility than on service changes to make them more community oriented. Only a few of the psychotic patients receive psycho-social interventions while medication is available in a tremendous amount. And thus, the study suggested that balance should shift from medication to talking treatments.

According to Corker (1998), disabled children are seen as being in a confusing state of personhood. They were also regarded as incompetent to determine their needs and interests. It is also found that burden is discharged by adults because they are the ones who have the power to determine the child’s future identity. Though need based special education and educational environment have been provided, the study found that changes cannot be affective at anything other than local level because everything is reduced to the level of the individual.The study also found that the vulnerability of a disabled child is particularly disposed to social control through oppressive care and that the impairment paradigm.

According to Piskur et.al (2012), in order for their child to perform or engage in meaningful activities, parents of children with Disability provide an enabling environment by changing and making modifications in the social and physical environment of the child. It can also be known that choosing for meaningful activities for their child, advocating for the child, educating the social environment and networking with other people were the most tasks carried out by parents. But there often exist difficulty in finding suitable educational systems and meaningful activities for the child. The study also found that parents often face challenges in the environment where they encounter bad attitudes of other people, insufficient support system and barriers in both the natural and built environments. It is known from the study that negative attitudes towards a child with disability does prevail and has an undesirable effect on children, leading to negative consequences such as low self-esteem and reduction of participation.

According to Chhangte in 2012, from earlier times, in Mizoram, different names were given to Persons with Disability such as piangsual (A person with physical deformity), Ramtuileilo (A person who is not in a position to carry out work), Mianglo (A mentally challenged) and Mi a (A person with mental illness). It can also be known from the study that with emerging awareness of the rights and dignity of persons with disability, more accepted terms like Rualbanlo (A physically challenged) and Vohbik (A special person) were later being used for addressing Persons with Disability. The study also declared that Persons with Disabilities in Mizoram have enjoyed a respected position in the society but adds that the welfare of PWDs still have a long road to go. It can also be known from the study that in some places of Mizoram, Persons with Disabilities are still being teased and stigmatized by the society and were regarded as helpless and useless to a great extent. The study then states that focus must be made for providing barrier free environment for Person with Disability in Mizoram.

Lalmuanpuii (2016) in her study found that the support from family is available, accessible and adequate in Mizoram. Regarding school support, the study shows that there is availability and accessibility but the supports received are not adequate. It can also be known from the study that the availability, accessibility and adequacy of community support were very low. The study also find that there is high availability of Government support for Children with Disability in Aizawl, Mizoram. Though the availability of Government support is high, the accessibility and adequacy of Social support is extremely low.

According to Awia (2005), on tracing the Mizo society states that any person with physical weakness should be excused from doing “hnatlang” (community work).Taking part in “hnatlang” is a must for all individuals of the society to take part. It also affirmed that person who is in need should be helped by the community and this also includes Persons with Disabilities. He also traced back the law of divorce in Mizo society where a spouse should look after the disabled spouse for at least three years before the divorce. And also states that sexual intercourse and making fun of Persons with Disabilities is an offence of which the person doing so should be punished.

According to Chhangte (2017), the primary supporters include family, friends and relatives. From the study, we can see that the highest form of support received from family was emotional support. The financial support received from the primary supporters was also found to be high. There are also respondents who receive instrumental support from primary supporters and very few reported that they do not receive any support from the primary source. The secondary sources include church, YMA, MUP, MHIP, LC, ZEP, Local Cable, Presbyterian Hospital and Philanthropists. It can be known from the study that the highest number of respondents do not receive any kind of support from the secondary supporters. The support received from secondary supporters includes financial and instrumental support but they are accessed by a very small number of respondents. Tertiary supporters include Government agencies and schemes. From the study, we can know that majority of the respondents did not receive any support from tertiary supporters. Less than a tenth received instrumental support and a very few respondents received financial support from tertiary supporters. Gender differences are observed in the primary and secondary support but there are no differences of gender in the tertiary support. In the overall support, respondents who do not receive any form of support constitute the highest. And among the support received, instrumental support is the highest followed by financial support and emotional support.

2.3 Quality of life of Children with Disabilities

Torres & Vieira (2014) conducted a study to understand the Quality of Life of adolescent living with disability. The study administered the short version of WHOQol-BREF for studying the Quality of Life. Adolescent with hearing impairment, visual impairment and physical impairment were included in the study. The study shows that with regards to the domains of Quality of Life, the lowest score of the adolescents with disability on their quality of life was in the environment domain. The quality of life of adolescents in the social relationships domain was high. Those adolescent who have visual impairment also rated their Quality of Life high in the psychological domain. The physically disabled adolescents have a lower quality of life in the physical and environment domain when compared with the adolescent with hearing or visual impairments. The study further shows that adolescents who were enrolled in special schools have lower quality of life than those attending regular class in the psychological, social relationships and environment domains. It can also be known from the study that female respondents have lower quality of life in the psychological and environmental domains. In the overall quality of life, female respondents and those enrolled in special schools have the lowest score.

According to the study made by Migerode (2012), Children with a Disabilities have low quality of life, both subjectively and objectively. Children those who have low adaptive skills significantly have lower Quality of Life. The study also shows the amount of social support received has an impact on the Quality of Life of Children with Disabilities. Though the quantity of social support has an impact on the Quality of Life, only few have direct effects of the Quality of Life. The findings also illustrate the importance of focusing more on positive outcomes such as wellbeing than on the quality and quantity of social support.

According to Law et. al (2014), Children with Disabilities extensively have lower health-related quality-of-life in the physical domain than that of the normative population. The study also shows that the family and environmental supports and barriers have an adverse on the physical health related Quality of Life. It is also found in the study that the environmental barriers have a significant negative association with physical Quality of Life. It can also be known from the study that the disability of a child has a connection with added health or development conditions which leads to lower physical functioning. It is also found that general health, physical functioning and direct support such as funding have positive impact on the Quality of Life of Children with Disabilities.

In order to understand the views of disabled children and young people's views about their Quality of Life, Sylvester et.al conducted a study in the year 2014. The study administered the HRQoL from the child's perspective in terms of physical, mental and social well-being. From the study, it can be known that boys are more in number. Most of the children are living at home with their mothers or stepmothers and/or fathers or stepfathers. It can also be known that most of the children received education. It can be seen from the study that school was the aspect of life where children reported that the support they received in school to be the most satisfaction. It can also be known that majority of the children were positive about their relationships with parents. It is also known that the physical health of the children were satisfactory since the children rated their physical health as good. However, few children reported that they often feel sad and depressed. This feeling of sadness and depression seemed to be linked to the feeling of being excluded from social and sporting opportunities. We can also know that children with disabilities have low expectations of having higher achievements at school since very few of the children have the desire to go to college or universities. We can also understand that respondents were generally pleased with the support they received from school staff. In the study, numbers of children reported that their lives were very enjoyable and often took part in activities with their friends. Children also reported that there are conditions where their disability restricts them from certain bodily activities and behaviour and that there are times when they are unable to do what they want in their free time. Children also reported that they do not have enough time to themselves and lacks sufficient funds to do the same things as their peers.

In 1998, Guillet conducted a study in order to understand the Quality of Life among Children with physical disabilities. Here, Child Health Assessment Ladder (CHASL) was administered. From the study, we can see that the scores of children with disabilities did not differ much from those of children without disabilities. We can also know that school, friends and family have great importance to Quality of Life. Further, the study shows that there were no significant relationships between Quality of life and health status.

The study made by Chow et.al (2005) adopted a QoL tool that was designed for young persons. The study administered a student version of the Comprehensive Quality of Life Scale (ComQoL) in order to study the self-perceived Quality of Life of children and adolescents with physical disabilities in Hong Kong. This instrument contains seven domains: material wellbeing, health, productivity, intimacy, safety, place in community and emotional wellbeing. From the study, we can know that children with physical disability have low place in community. The study also tells that the material wellbeing and health of children with physical disability tends to be low. We can also know from the study that children with physical disability have extensively lower Quality of Life with respect to health, intimacy, and safety. Though the children with physical disabilities tend to have lower Quality of Life in certain domains, the study shows that they have high emotional wellbeing and have high productivity. The study found that the quality of life of children with disabilities tends to decrease with increase in age.

The study made by Janiec et.al (2011) administered a polish version of KIDSCREEN-27 in order to study the health-related quality of life (HRQOL) of children with physical disabilities and the impact of clinical symptoms on HRQOL. KIDSCREEN-27 comprises 27 questions measuring five dimensions: physical well-being, psychological well-being, parents and autonomy, peers and social support, and school environments. The study expose that age had a major influence on the psychological well-being, autonomy and parent relation and school environment by children. There are no statistical differences on the quality of life of children across gender. The study also tell that psychological well-being, autonomy and parent relation, peers and social support, school and environment have direct relations to health related Quality of life. The study revealed lower self-assessment of Quality of Life of children in all investigated dimensions, except for parent and autonomy. From the study, it can be known that younger children have a tendency to rate their quality of life higher. It is clear from the study that this self-evaluation declined in most dimensions after reaching the age of 12 years and this relation was more distinct for girls than boys. In this research, correlation between the higher number and frequency of clinical symptoms prevalence and lower physical wellbeing was found. The study then tells that the hogher self evaluation of the quality of life in children was related to the lower number and occurrence of clinical symptom.

Moore et.al (2010) conducted a study in order to study the Quality of Life and psychosocial needs of children with mild hemiplegic cerebral palsy (CP). The Pediatric Quality of Life (PedsQL) inventory short form was used to assess Quality of Life and psychosocial issues. Here, the questionnaire contains 15 questions in four categories: physical function, social function, emotional function, and school function. Face-to-face interviews were also conducted and the parent interview was conducted during the child’s therapeutic evaluation. It can be known from the study that there was no difference in quality of life across gender in the PedsQL physical and psychosocial subscale scores. The study tells that the similarities in quality of life reported between a sample with CP and a normative sample is controversial. It can be known from the study that adolescents with CP have lower quality of life than their peers. None of the participants mention physical difficulties related to CP that was not activities of daily living. They seemed to have made accommodations to work around physical or other limitations and function in what appears to be normal for them.

Bruil et.al conducted a study in 2004 in order to compare the reported Quality of Life of children themselves and their parents. Here, the study administered Child

Health Questionnaire which has eight domains. It can be known that children rated their Quality of Life better than their parents for behaviour, self-esteem, mental health, family cohesion and worse for physical function. There is great difference between the reported Quality of life of Children and parents.

In order to understand the Health-Related Quality of Life in 8-Year Old Children with Downs Syndrome, Bruile et.al conducted a study in 2003 that aims to evaluate the health, health-related quality of life, school participation, parenting stress and their determinants in a cohort of children with Downs Syndrome. It can be known from the study that most of the children have chronic health problems which include eye abnormalities, chronic airway infections and heart disease. The health problems reported were associated with negative emotional reactions of the child. The study also revealed significant differences on gross motor functioning, autonomy, cognitive functioning and social functioning between children with Downs Syndrome and healthy children. The study shows that half of the participants are enrolled in regular schools. The study also tells that majority of the children participated in regular day care centers or in schools. It can also be recognized from the study that mothers of children with Downs Syndrome significantly have more parenting stress, more chronic health problems and a lower quality of life of their children than mothers of healthy child.

On studying the health-related Quality of Life in children with obstetrical brachial plexus palsy (OBPP), Akel et.al (2013) administered the short parent form of the Child Health Questionnaire (CHQ PF28) for measuring the health related quality of life and active movement scale (AMS) for measuring the functional status.CHQ captures information across 14 domains that measures the child's HRQOL: global health, physical functioning, role/social limitations-emotional/behavioural, role/social limitations-physical, bodily pain/discomfort, behaviour, global behaviour, mental health, self esteem and general health perception. It can be known from the study that Gender or age did not significantly affect scores in any domain. The study then showed that there were significant differences according to the side of injury between groups, especially in the "parental impact-time" and "family activities" domains. It is also revealed that there were no statistically significant differences in CHQ-PF28 scores between groups that had an upper trunk involvement and total injury groups, except in the "bodily pain/discomfort" domain. The study shows that children with OBPP have a poorer HRQL than their healthy peers. In the study, both children and parents have reported worry for future health status. The study showed that the amount of personal time was substantially limited. The study also reveals that early rehabilitation programmes have positive effect on the children’s Quality of Life.

Chhangte conducted a study on the quality of life of person with disability in 2017. The study administered short version of WHOQOL-BREF. The study shows that the overall Quality of Life across the domains of Quality of Life is low. We can know from the study that in the domains of the Quality of Life, environment domain has the highest score followed by physical health, psychological health and social relationship. In the overall quality of life, a few gender differences is obsrved across the domains. The study also shows that there is a significant correlation between overall Quality of Life and environment domain alone. We can also see that there is correlation between social relationships and psychological domains of quality of life. Further, we see that there is correlation between environment and psychological domains of quality of life.

2.4 Social Support and Quality of Life

On studying the effect of social support on Quality of Life among orthopedically disabled students and typical students, a WHO QoL- BREF14 and Multidimensional Scale of Perceived Social Support (comprising 12 items) were administered by Sultan et.al in 2016. The study utilised a purposive convenient sampling. The study revealed that social support positively predicts the Quality of Life which includes physical functioning, psychological functioning, social dimensions and environment. It can be known from the study that peer support also has considerable impact on Quality of Life. It can also be noted that family support also has great effect on physical functioning which then effects the quality of life. Special person support was found to be an important forecaster of psychological functioning. The study then gives an understanding that Quality of Life can extensively be increased by the provision of improved social support.

According to Ignjatović (2019), the Quality of Life of children and their family were affected by poverty. Support and services have an impact on the Quality of Life. The Quality of Life was also improved based on the types of support and services received. It can be assumed that type of service specifically contribute to the different aspects of Quality of Life. However, any kind of proper support has an impact on positive changes on the quality of life in general. The study also confirms that severity of disability has an impact on the Quality of Life.

Reyhani (2016) conducted studies which assessed the status of perceived social support and Quality of Life of hearing-impaired adolescent in Iran. The study adopted a cross-relation study and utilized a multi stage random sampling method. The unit of the study includes hearing impaired adolescents, family members and friends. The study used pediatric quality of life inventory (adolescent form) and perceived social support inventory (from family and friends) for data collection. The pediatric quality of life inventory include four dimensions: physical functioning, emotional functioning, social functioning and school functioning. Likert response scale was utilized across to assess child self-report. From this study, it can be known that most of the adolescents with hearing impaired have moderate Quality of Life. The study also tells that perceived social support from family was moderate while supports which they received from friends were weak. The study also reported that emotional, social and school supports were good. The study then expose that there is relationship between social support and Quality of Life of adolescents.

Schmidt conducted a study in 2005 that focuses on the health care needs and quality of life in children with physical disabilities. The study administered DISABKIDS with a particular emphasis on discrepancy between measures related to health services and to Quality of Life. The results show that the association between different types of measures that might be used for health service research in paediatric care is weak. It can also be known from the study that there is no significant relationship between the type of disability and Quality of Life, however this varied across the type of diagnosis and its severity. The study also tells that unmet needs and satisfaction of health care services showed some specific associations with Quality of Life. It can also be known that Cross-cultural differences tend to be stronger in health services-related measures.

2.5 Caregivers of Children with Disabilities

The study made by Murray (2007) shows that the cost for caring a disabled child is intensively high. The amount of financial support received by the family of disabled child were of dissatisfactory and is not enough to cover the actual costs of the care for many families. It is also found that there exist barriers in transportation since the demand for transportation was really high and invest a lot of money. The costs of transportation, medication and specialized equipment lead to financial problem.

According to the study made by Cuzzocrea (2016), parents of disabled child tends to have more stress than parents of typically developing children where the principal source of stress is related to child's disability. It can be known from the study that family support and support from friends were high as compared to other social support. The study also shows that supported in social context are low. The main coping strategies utilized includes social support, avoidance strategies, positive attitude, problem-solving, and turning to religion.

From the study made by Ceglowski et.al (2009), it is known that parents are unaware of some services available to them. And even if they are aware of it, they are unsure whether they could or should access them. It can be known from the study that child care providers greatly helped the parents in recognizing the child's disability and in encouraging them to seek assessment. Among the many services which were available, parents of children with disabilities needs to be more selective than other parents in choosing a child care provider because there is a chance that parents would just have placed their child with a provider who could not have met their child's needs. Even when the parents find the appropriate service provider for their child, challenges continue for families once their children are enrolled in programs. There are situation where the care provider refused to continue the care since the child was too difficult to care for. The study also revealed that many child care staff lack sufficient preparation to care for Children with Disabilities. It is also known that the service provider lacks training and did not have expertise in dealing with the special child. Placing the disabled child in service programmes has cause great financial problems to the families. And in some cases, service providers charge more cost for children who required more care. Because of the high cost of service use, low-income families are particularly burdened and have to work in job providing health insurance even if preferred to be home to take care of their child.

In order to examine the psychological impact of parenting a child with Disability, Grant et.al conducted a study in 2013. The study shows that parents having a disabled child have high level of stress with anxiety and depression that were greatly affected by the severity of child’s disability and the care giving demands that relates to the physical care of the child. It can also be known that as a child gets older, the challenging behavior of the child increases. The study also shows that parents reduces family outgoings and social visits because of the destructive and aggressive behavior of their child fearing that people will develop negative attitudes towards their child. The challenges faced by parents of children with disability as found in the study includes, lack of time for personal or social matters, constant stress, financial stress related to medical bills, finding suitably qualified child care staff, transportation costs, and education costs. The study also shows that parents have less preferences to plan ahead and be goal oriented because of the disability of their child.

According to the study made by Noojin & Wallander (1997), the stress level of mother of children with disability increases with the severity of their child’s disability. And this stress has an indirect effect on maternal adjustment. In the study, those mothers who have effective problem solving ability were found to have lesser amount of stress. It is also seen in the study that wishful thinking, avoidance and self-blame were most common among mothers of Children with Disabilities.

According to the study made by Maclnnes (2008), it is found that a mother who has a first child with disability tends to have lower risk of giving birth to a second child in order to provide better care to the child. The study shows that having a child with disabilities destabilizes marriage and cause higher rates of divorce. It is found in the study that raising a child with a disability is a difficult task that consumes a lot of time and is emotionally draining. The study also found that parents are very much concerned about their capability to meet the needs of the child and tried their best to help their child to attain his or her fullest achievable potential. The study shows that parents often have a feeling of disappointment thinking that their child would never go to college. Though mothers encounter extensive difficulties that come with raising a disabled child, they also speak of the benefits.

According to the study made by Murray (2007), families with children with severe disabilities are likely to experience lower incomes and have greater expenses for long periods of time. The study also found that most of the caregivers decided not to work so as to have more time to take care of their disabled child. It is also pointed that families often have little time to engage in any form of leisure activities and are often unable to access some community services. The study also shows that most of the support comes from family, friends and support groups. It is also reported in the study that communication between support agencies and professionals was one of the problem since availing information requires a lot of time.

From the study made by Park & Chung (2014) among mothers of Children with Disabilities in Korea, we came to understand that it was not easy for the mothers to easily accept their child’s disability. We can know from the study that the journey of the mothers with a disabled child often begins with disappointment and sorrow. The first diagnosis of their child’s disability was always the most difficult time. The study also tells that mothers usually have a belief that ‘their child’s disability can be cured’ if they tried hard enough when the child was still young regardless of the child’s condition and this tend to add stress to their lives. Mothers also experience increase in physical burdens as their child get older and heavier. Physical and pubertal change of the child also adds burden to the parents. It can also be known that as the children grew older, they started to understand the barriers which they cause to their parents for which they started to have negative perception about themselves and this again adds to the stress of mothers. Mothers always feel thankful and happy on any smallest accomplishment of their children regardless of their disability. The study also revealed that no informal support were received by mothers from the extended family members yet, their child's disability tends to create distance from other family members. Because of this, mothers of Children with Disability developed a community where they share their experiences with other mothers who have a child with disability and receive informal support from each other. The study also states that mothers having a child with disability helps them to grow as a person and become open minded which help them have new expectations and find meaning in life.

In order to understand the impact of child disability on the family, Rogers and Hogan conducted a study in 2003. The study revealed that the family experience job changes for having a disabled child which adversely resulted to financial loss due to low income. Also, the there exist disruption of sleep because children sometimes require night time parental attention. The study also states that parents started lo have limited time for self care since child disability requires more intensive demands on parental time. It is also found that parents do experience situations where they encounter difficulty and limitations in communicating with their disabled child. The study then tells that Rehabilitation services have strong associations with family outcomes.

Heiman (2002) conducted a study on Resilience, Coping, and Future Expectations of Parents of Children With Disabilities in Israel. Most of the parents in the study suspected birth condition was the reason for their child's disability. It can also be known that parents does observe something wrong in their child during early childhood. The study tells us that when the child is diagnosed as having disability, parents started to possess a feeling of depression, anger, shock, denial, fear, self-blame, guilt, sorrow, grief, confusion, despair, hostility or emotional breakdown. It can also be known that parents are likely to share their feelings or thoughts about their child's disability with the people to whom they felt most close, with whom they had the greatest confidence and from whom they expected understanding. In the study, it is known that when mothers told about the disability of their child, most of them reacted in a positive manner that encourage the parents while some were really shock and express deep sorrow or grieving. The study also revealed that parents encounter never-ending emotional and physical fatigue, social isolation, and the feeling of a lack of freedom. Also, the child's disability enormously leads to financial problems and cause heavy burden for the entire family. The study also tells that there is lack accurate information services for which the parents have to seek the services available for their disabled child. The study states that psychological service was the most utilised services available for children with disability. In spite of all the barriers which they encounter, parents in the study turned their negative reactions and feelings positive and optimistic feelings that accompany success in looking after their special child.

Faw & Leustek (2015) conducted a study on the challenges experiences by parent caregivers of Children with Disability in the United States. From the study, it can be known that parents often encounter challenge of isolation where they often "felt cut off from others because of a lack of understanding about their life and their child with disabilities". It is indicated in the study that the isolation of parents usually arose from a lack of crucial community support. Here, parent's isolation not only affects the parent's Quality of Life but also the Quality of Life of children. The study also stated that parents often encounter relationship problem in the family. Since they need to take care of the disabled child in most of their times and that they were too much chained to the disabled child, they do not have time to build relationship with the other family members which includes relationship with spouse and siblings on the disabled child. This also leads to parenting problem. The study also revealed that there exist social stigmas which parents or caregivers of children with disability have to encounter. The study also tells us that parents have to deal with financial problems and complex schedules. It can also be known from the study that even though parents really like to take out their disabled child and get socialized, parents struggled to determine what activities would be suitable for their children in order to avoid situations that might result in behavioural outburst. The study then states that parents are worried about the future of their disabled child and often expressed feeling a deep sadness knowing that their child would never experience key milestones. Parents were also concerned about how their children would survive once they can no longer care for them.

The Study made by Fatima & Suhail (2010) shows that married mothers of Children with Disabilities were less depressed than widows or divorced mom. The study also found that mothers with higher educational level were less depressed and anxious. It is also known from the study that the level of stress of mothers were associated with the number of children. It can also be known from the study that the more the mothers of Children with Disability believed in a personal just world, the more they are satisfied with their life.

According to the study of Muderedzi & Ingstad (2011) child's disability affects the family member's chances of going to school, working for a living, enjoying family life and participation in social life. The study also shows that disability increased isolation and economic strain. It is also known from the study that burden of care often fell on mothers or other female relatives and siblings which often resulted to school dropout of female siblings. It can also be seen that increased workload of caring of a disabled child often results in extreme poverty since valuable time were driven away from the daily struggle and leave the caregivers no time to make a living.

In order to examine the dynamic and complex nature of raising children with disabilities, Lee et.al (2015) conducted a study focusing on the processes that mothers went through as they came to admit their children within their family life context over time. The study administered a purposive sampling method and a snowballing technique. The study reveals that most of the mothers of children with disability possess a painful memory with personal and professionals, where they confront difficult incidents due to pathological perceptions of their child's disability. The study gives an understanding that no matter the severity of their disabled child, mothers continue to focus on the abilities of the child instead of the disabilities. "mothers followed their hearts and moved on with confidence". It can also be known from the study that mothers have the tendency to figure out the different ways to utilize the personal and professional resources for their children. Though mothers understood that there is no permanent cure for their children’s disabilities, yet, they still continue to seek solutions for the ongoing problems. Mothers experience increasing challenges of physical need of the children as they grow older and mothers often need help from others even if they like to be able to do things on their own.

2.6 Research Gaps

- Research studies on Children with Disabilities (CWDs) are not adequately conducted in the North-East, particularly in Mizoram. There is a need to extend the area so as to have a wider perspective of the situation of Children with Disability in Mizoram.
- There is little data on the demographic profile of Children with Disabilities in Mizoram.
- Many of the study found differences on the gender and age in accessing social support. But no studies have been made in Mizoram. So it is necessary to have a study in this field.
- Quality of Life of Children with Disability in Mizoram is also absent.
- Many of the studies that have been reviewed had revealed the differences in age and gender on the quality of life yet no particular studies have been made to explain such relations in Mizoram.
- The different studies reflected that Children with Disabilities with high support have better Quality of life. But no studies have been made in Mizoram. Thus, there is a need understand to the relationship of Social Support and Quality of Life.
- From the studies it can be known that having a disabled child cause great emotional, physical and financial barriers to caregivers, but no studies have been made in Mizoram in order to understand the lived experience of caregivers of Children with Disabilities in Mizoram.

CHAPTER III

METHODOLOGY

Mizoram is one of the states of Northeast India, with Aizawl as its capital city. The name is derived from Mizo (name of the native inhabitants) and Ram (land), and thus Mizoram implies “Land of the Hill People.” The term ‘Mizo’ is an umbrella term to denote the various clans of the region. Mizoram covers an area of approximately 21,087 square kilometers in which 91% is forest. There are 11 districts in the state of Mizoram. The state shares it boundaries with the states of Tripura, Assam, Manipur and with the neighbouring countries of Bangladesh and Burma. Mizo, English and Hindi are the official languages of the state.

According to 2011 Census, the population of Mizoram is 1,091,014. Mizoram is the 2nd least populous state in the country and its population comprises of diverse tribes. The economy of Mizo society was sustained by their agricultural activities. The tribes of Mizoram had gone through several changes and transitions over the years. The advent of Christianity, introduction of formal education, British colonialism, the attainment of statehood in 1987, and growing modernization mark among the major factors contributing to the changes. Majority of the Mizo people are now Christians, which marks 87% of the population as per 2011 Census. This makes it one of three states in India where Christianity is the highest. Mizoram is also known for its high literacy and is the third most literate state in the country with literacy rate of 91.33% as per 2011 population census.

The Mizo people are known to live a simple, honest and peaceful life. The Mizo code of ethics known as “Tlawmngaihna” is deeply embedded in their nature, ‘tlawmngaihna’ simply means on the part of everyone to be hospitable, kind, unselfish and helpful towards one another. The overall morality and social conduct of the people is governed by the prominent CBO’s viz., Y.M.A (Young Mizo Association), M.H.I.P (Women’s Association), M.U.P (Elderly Association) and the churches. The Mizos find deep anchor in their Christian faith thus their community is one which conforms to both the church and the practice of tlawmngaihna, making it one of the most peaceful states in India. Music, singing and traditional dances mark an important element to their culture as well.

Fig. 1: Map of Mizoram

In earlier times, Person with Disabilities were often being downgraded by the Mizo society where they were given unfavorable names and mistreated by the community. But with gradual change in time and with emerging awareness of the rights and dignity of Persons with Disability, Persons with Disabilities in Mizoram have enjoyed a respected position in the society. However, in some places of Mizoram, Persons with Disabilities are still teased and stigmatized by the society and are regarded as helpless and useless to a great extent. Therefore, focus must be made to provide an environment which is free from all kinds of barriers for Person with Disability in Mizoram and for this study, Children with Disabilities.

3.1 Research Design

The Study is descriptive in design and adopted a mixed method. The study was conducted in 4 district of Mizoram. Both qualitative and quantitative methods were utilized for the study.

3.2 Source of Data Collection

Data were collected from both primary and secondary source. Primary sources include data collected from Children with Disability and parents/guardians of Children with Disability. Secondary sources were collected from Government and Non-Governmental records.

3.3 Method of Sampling

The unit of the study is Children with Disabilities in Mizoram. A multi-stage sampling procedure was utilized for the study. In the first stage, a cluster sampling procedure was utilized. Four district representing North, East, West and South Mizoram were purposively selected; Aizawl representing the North, Mamit representing the West, Champhai representing the East and Lunglei representing the South. In the second stage, from each selected District, the District headquarters were selected to identify the respondents through the records of NGOs, government agencies and local leaders across the communities of the selected district headquarters. Apart from this, a snow ball sampling procedure was also utilized in order to identify Children with Disabilities that were not in the records.

Overall, the sample included 140 respondents (132 children with disabilities between the ages of 10-17 years and 8 caregivers) out of which 50 represents Aizawl district, 30 each representing Lunglei and Champhai districts and 22 of the samples represents Mami district. Two (2) case studies of Children with Disability were conducted in each district. Two (2) caregivers from each district were also identified for in-depth interview. Gender and types of disability representativeness could not be maintained because of lack of available data and records of children with disabilities and sporadic cases across the districts.

3.4 Tools of Data Collection

A semi-structured interview schedule formed the tools for data collection for finding the personal profile, family characteristics and suggestions to improve social support. To find out the social support, a 5 point structured scale was constructed to measure 3 items each such as the accessibility, quality and adequacy of social support across various dimensions of social support *viz.* basic needs support, emotional support, physical health support, mental health support, support in life skills, financial support and instrumental support. The different dimensions of social support were constructed based on Olsson et.al (2015), John and Katherine (2008), Knoll & Rieckmann (2003), Schwarze, Dunst, Schaefer, Coyne, & Lazarus (2002), Cutrona and Suhr (1992) and Trivette, & Cross (1986).

The different agent of supporters were constructed based on the study of Chhangte (2017), Lalmuanpuii (2016), Meral and Cavkaytar (2012), Lifshitz and Glaubman (2004), Teklu (2010), Parette et.al (2010) and Mishra & Gupta (2006)

A WHOQOL-BREF structured scale was also used for measuring the quality of life of children with disabilities in Mizoram. The WHOQOL-BREF is a structured tool constructed by the WHO in 1996 to measure the Quality of Life. It is a 26 item, self administered, generic questionnaire. It is the short version of the WHOQOL-100 scale. The options of response range from 1 (very dissatisfied/very poor) to 5 (very satisfied /very good). It consists of four domains *viz.* physical health domain (7 items), psychological domain (6 items), social relations domain (3 items) and environment domain (8 items). The raw scores of the constituent items were summed and transformed into scores that ranged from 4-20, to be in line with the WHOQOL-100 instrument and then the 4-20 scores were converted into a 0-100% scale. The WHOQOL-BREF tool was administered only after receiving permission from the World Health Organizations.

Qualitative methods such as case study, focus group discussion and participatory techniques such as causal tree analysis and daily activities schedule were also conducted. After preparation of the tool, the language was transcribed in Mizo and a pilot study was conducted so as to test the validity and reliability of the tool among Children with Disabilities. Necessary modifications and changes were made after the pilot study.

Table 1: Reliability of Scales Constructed and Administered

Sl.No.	Scale	Sample Size	Scales	Cronbach's Alpha	Guttman Split-Half Coefficient
1	Social Support	132	5 point scale; 1= Very Inaccessible/Very Poor/Very Inadequate 2= Inaccessible /Poor /Inadequate 3= Neither accessible nor inaccessible/ Neither good nor poor/ Neither adequate nor inadequate 4= Accessible/ Good/ Adequate 5= Very accessible / Very Good/ Very adequate	.885	.799
2	WHOQOL-BREF	132	5 point scale; 1= Very Dissatisfied/ Not at all/Very Poor/ Never 2=Dissatisfied/Not much/Poor/Seldom/A little 3= Neither satisfied nor dissatisfied/Moderately/ Neither poor nor good/Quite Often 4=Satisfied/ A great deal/ Good/Very Often/Mostly 5=Very satisfied/ Completely/ Very good/ Always	.821	.609

Source: Computed

3.5 Data Processing and Analysis

The quantitative data were analyzed using Microsoft Excel and SPSS package. Descriptive statistics, simple frequency and means were presented to find out the socio demographic profile, family characteristics, disability profile, quality of life and social support across agents as well as across dimensions of Children with Disabilities. Social Support was analyzed based upon the 5 scale tool constructed and

Quality of Life was analyzed based upon WHOQOL-BREF. T-test was used to find out gender differences on primary, secondary and tertiary social support agents of Children with Disabilities. T-test was also used to find out differences in the quality of life of Children with Disabilities across gender and age groups. Pearson's correlation co-efficient was used to find out the relationship among and between domains of quality of life. Pearson's correlation co-efficient was also used for finding out the relationship between social support and quality of life. Qualitative findings using case studies, in-depth interview and focus group discussions are presented accordingly to get an in-depth knowledge about the objectives of the study. The findings of Participatory Rural Appraisal (PRA) using Causal Tree Analysis and Daily Activities Schedule are also presented and analyzed accordingly.

3.6 Ethical Consideration

For ethical reasons, only children who can be interviewed between the ages of 10 to 17 years were identified. Caregivers were also utilized for their support and also to prove a child friendly environment during data collection. Children were included in the sample only after taking consent from them and the caregivers. All names of the respondents are concealed to maintain confidentiality.

3.7 Inclusion and exclusion criteria

In this study, Children with Disabilities include only those children specified under the RPWD Act 2016, who are between the ages of 10-17 years. Only those children who were living in the communities of the district headquarters of Aizawl, Lunglei, Champhai and Mamit were included in the study.

3.8 Limitations

Identification of Children with Disabilities across the District headquarters was a challenge because there were no proper data in each district. Moreover, interviewing the children was also a challenge and was time consuming considering the sensitivity of the case.

CHAPTER IV

RESULTS AND DISCUSSIONS

This chapter shall discuss the findings of the study. The findings shall be divided into 9 sections such as the personal profile, family characteristics, social support, quality of life, social support and quality of life, lived experience of caregivers, case vignettes, focus group discussions and participatory techniques.

4.1 Personal Profile

This section shall include findings related to gender, age-group, sub-tribe, religion, religious denomination, educational status, reason for dropping out of school, educational level of dropping out, reason for never going to school, occupation of working children, district of origin, causes of disability, type of disability, obtainment of disability certificate and reason for not obtaining disability certificate and challenges faced due to disability.

Table 2: Gender

Sl.No.	Gender	Frequency N=132
1	Male	73 (55.3)
2	Female	59 (44.7)

Source : Computed Figures in parenthesis indicates percentages

Table 2 shows the distribution of the children according to their gender. From the table, we see that male respondents (73%) are more in number where than the females (44.7%).

This finding is in consistent with the findings of Maclnnes (2008), Meral & Cavkaytar (2012), Wendelborg & Tossebro (2011), Reyhan et.al (2016) and Cohen & Prahova (2006). However, Shumbaa and Abosib (2011) and Lalmuanpuii (2016) in their studies found that there were more girls than boys.

Table 3: Age-Group

Sl.No.	Group	Gender		Total N=132
		Male n=73	Female N=59	
1	10-13 years	45 (61.6)	35 (59.3)	80 (60.6)
2	14-17 years	28 (38.4)	24 (40.7)	52 (39.4)

Source : Computed Figures in parenthesis indicates percentages

Table 3 shows the distribution of the children according to their age groups i.e.10-13 years and 11-17 years. The table shows that more than half (60.6%) of the children belong to the age group 10-13 years while the rest (39.4%) belongs to the age group 14-17 years. This finding is in contrast with Shumbaa & Abosib (2011) and Lalmuanpuii (2016) who found that there were more children in the older age group than the younger ones.

In the age-group 10-13 years, we find that there are more males (61.6%) than females (59.3%) while in the age-group 14-17 years, we find more females (40.7%) than male children (38.4%).

Table 4: Sub-Tribe

Sl.No.	Sub-Tribe	Gender		Total N=132
		Male n=73	Female n=59	
1	Lusei	63 (86.3)	44 (74.6)	107 (81.0)
2	Hmar	7 (9.6)	8 (13.5)	15 (11.4)
3	Mara	2 (2.7)	3 (5.1)	5 (3.7)
4	Paihte	1 (1.4)	2 (3.4)	3 (2.3)
5	Lai	0 (0.0)	1 (1.7)	1 (0.8)
6	Bru	0 (0.0)	1 (1.7)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 4 demonstrates the distribution of children according to their sub-tribe. The table shows that majority (81%) of the children belong to the Lusei sub tribe. More than a tenth (11.4 %) of the children belong to the Hmar sub-tribe while less than a tenth (3.7%) are Mara and Paihte constitute 2.3 per cent. Children belonging to Lai and Bru constitute 0.8 per cent each. Lalmuanpuii (2016) conducted a study on children with disabilities in Aizawl City and found that majority of the children come from the Lusei sub-tribe.

In the Lusei category, there are more males (86.3%) than females (74.6%) and among the Hmar sub-tribe, there are more females (13.6%) than males (8.2%). In the category of Mara sub-tribe, we also find that there are more females (5%) than males (2.7%) and in the Paihte category, we also find that there are more females (3.4%) than males (1.4%). Further, in the Lai and Bru category, we find only females and no males.

Table 5: Religion

Sl.No.	**Religion**	**Gender**		**Total N=132**
		Male n=73	**Female n=59**	
1	Christianity	71 (97.2)	59 (100)	130 (98.4)
2	Judaism	1 (1.4)	0 (0.0)	1 (0.8)
3	Hindu	1 (1.4)	0 (0.0)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 5 highlights the distribution of children according to their religion. We can see from the table that majority (98.4 %) of the respondents belong to Christianity and very few (0.8% each) belong to the Hindu religion and Judaism. Lalmuanpuii (2016) also revealed similar findings in her study where almost all children with disabilities in Aizawl City were Christians.

Among the Christians, there are more females (100%) than the male children (97.2%) and among the Jews and the Hindus, there are only males.

Table 6: Religious Denomination

Sl.No.	Denomination	Gender		Total N=132
		Male n=73	Female n=59	
1	Presbyterian Church	41 (56.1)	38 (64.5)	79 (59.8)
2	Baptist Church	17 (23.1)	10 (16.9)	27 (20.4)
3	United Pentecostal Church (UPC)	5 (7.0)	3 (5.1)	8 (6.1)
4	Local Mizo Christian Denominations	3 (4.1)	4 (6.7)	7 (5.3)
5	The Salvation Army	0 (0.0)	2 (3.4)	2 (1.5)
6	Roman Catholic Church	2 (2.7)	0 (0.0)	2 (1.5)
7	Methodist Church	1 (1.4)	1 (1.7)	2 (1.5)
8	No denomination	1 (1.4)	1 (1.7)	2 (1.5)
9	Evangelical Free Church of India (EFCI)	1 (1.4)	0 (0.0)	1 (0.8)
10	Hashem	1 (1.4)	0 (0.0)	1 (0.8)
11	Assembly of God	1 (1.4)	0 (0.0)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 6 shows the distribution of children according to their religious denomination. From the table, we find that children who belong to Presbyterian Church constitute the highest number with more than half (59.8%) of the children followed by children (20.4 %) belonging to Baptist Church and children belonging to the United Pentecostal Church (UPC) constitute 6.1 per cent of the children. Those children who belong to the Local Mizo Christian Denomination constitute 5.3 per cent and children who belong to the Salvation Army, Roman Catholic, Methodist Church and those who have no denomination constitute 1.5 per cent each. Very few (0.8% each) belong to Evangelical Free Church of India (EFCI), Hashem and

Assembly of God. In Lalmuanpuii (2016), we also find that more than half of children with disabilities belong to Presbyterian Church.

Among the denominations, we find that there are more males than female children in the Baptist Church and United Pentecostal Church (UPC) while we find only males in Roman Catholic Church, Evangelical Free Church of India (EFCI), Hashem and Assembly of God. There are more females than males in Presbyterian Church, Local Mizo Christian Denominations and Methodist Church while we find only female children in the Salvation Army.

Table 7: Educational Status

Sl.No.	**Status**	**Gender**		**Total N=132**
		Male n=73	**Female n=59**	
1	Primary School Level	23 (31.5)	19 (32.2)	42 (31.8)
2	Dropout	13 (17.8)	15 (25.4)	28 (21.2)
3	Middle School Level	11 (15.1)	10 (16.9)	21 (15.9)
4	Special School	15 (20.5)	2 (3.4)	17 (12.9)
5	Never went to School	8 (11.0)	9 (15.3)	17 (12.9)
6	High School Level	3 (4.1)	3 (5.1)	6 (4.5)
7	Higher Secondary School Level	0 (0.0)	1 (1.7)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 7 shows the distribution of children according to their educational status. From the table, it can be observed that children studying in primary school level constitute the highest number (31.8%) while 21.2 of them are dropouts. Those children from the middle school level constitute 15.9 per cent and children from Special School programmes constitute 19.5 per cent. More than a tenth of the children (12.9%) never went to school while a few (4.5%) were from the high school level while very few (0.8%) of them were from higher secondary level. This reflects the finding of Torres & Vieira (2014) where majority of the respondents were from elementary school while very few were from the higher level of educational status.

In the gender distribution, it can be seen that there are more females than males from the category of primary school, dropouts, middle school, never went to school, high schools and higher secondary while there are more males in special school programmes than females.

Table 8: Reasons for Drop-out

Sl.No.	**Reasons**	**Gender**		**Total N=28**
		Male n=13	**Female n=15**	
1	Loss of interest	4 (30.8)	8 (53.4)	12 (42.8)
2	Mobility Barrier	3 (23.1)	2 (13.3)	5 (17.9)
3	Disability	2 (15.4)	3 (20.0)	5 (17.9)
4	Stigma, Discrimination and Exclusion	3 (23.1)	0 (0.0)	3 (10.7)
5	Difficulty in adjustment	0 (0.0)	2 (13.3)	2 (7.1)
6	Health Problem	1 (7.6)	0 (0.0)	1 (3.6)

Source : Computed Figures in parenthesis indicates percentages

Table 8 shows the distribution of children who drop out according to the reasons for dropping out from schools. Among those children who drop out of school, the highest number (42.8%) of children drop out because of loss of interest while 17.9

per cent reported that they suffered from mobility barrier and other 17.9 per cent attributed it to their disability. A tenth of the children (10.7%) dropped out because of stigma, discrimination and exclusion while less than a tenth (7.1%) dropped out because of difficulty in adjustment in the school environment. Few of the children also dropped out because of health problems. These findings are also consistent with the findings of Lalmuanpuii (2016).

Among the children who drop out of school, we find that there were more males than females who dropped out because of lost of interest, their disability and difficulty in adjustment while there were more females than males who dropped out because of mobility barrier, stigma, discrimination and exclusion and health problems.

Table 9: Educational Level of Dropping Out

Sl.No.	**Level**	**Gender**		**Total N=28**
		Male n=13	**Female n=15**	
1	Primary School Level	7 (53.8)	8 (53.3)	15 (53.6)
2	Special School	4 (30.8)	5 (33.3)	9 (32.1)
3	High School Level	0 (0.0)	2 (13.3)	2 (7.1)
4	Higher Secondary School Level	1 (7.7)	0 (0.0)	1 (3.6)
5	Middle School Level	1 (7.7)	0 (0.0)	1 (3.6)

Source : Computed Figures in parenthesis indicates percentages

Table 9 demonstrates the distribution of children who dropped out according to the educational level at which they dropped out. From the table, it can be observed that children who dropped out at the primary school level constitute 53.6 per cent followed by children (32.1 %) who dropped out from special school programme. Further, those children who dropped in high school level constitute 7.1 per cent and those who dropped out in higher secondary school level and middle school level constitute 3.5 per cent each. Similar trend was also found in the study of Lalmuanpuii (2016).

Among children who dropped out in primary school level and special school, there are more females than males while there were only males who dropped out at higher secondary school level and middle school level. There was no significant gender differences among the children who dropped out in primary school level.

Table 10: Reasons for Never Going to School

Sl.No.	**Reasons**	**Gender**		**Total N=17**
		Male n=8	**Female n=9**	
1	Parents restriction	4 (50.0)	3 (33.3)	7 (41.1)
2	Mobility problem	1 (12.5)	3 (33.3)	4 (23.5)
3	Absence of trained teachers	1 (12.5)	2 (22.2)	3 (17.7)
4	Health issues	2 (25.0)	1 (11.2)	3 (17.7)

Source : Computed Figures in parenthesis indicates percentages

Table 10 depicts the distribution of children who never went to school according to the reasons for never going to school. The table shows that less than half (41.1%) of the children never went to school because of parent’s restriction followed by those children (23.5%) who attributed it to mobility problems. Less than a fifth (17.7%) reported that they never went to school because of absence of trained teachers and another 17.7 per cent reported that health challenges was the main reason for never attending school. Childline (2008) also revealed similar findings where parents restrict their children from going to school.

Among children who never went to school, there are more males than females who never went to school because of parent’s restriction and health challenges while there are more females than males who never went to school because of mobility problem and absence of trained teachers.

Table 11: Occupation of Working Children

Sl.No.	Occupation	Gender		Total N=132
		Male n=73	Female n=59	
1	Unemployed	71 (97.2)	58 (98.3)	129 (97.7)
2	Quarry Work	1 (1.4)	1 (1.7)	2 (1.5)
3	Daily Labour	1 (1.4)	0 (0.0)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 11 indicates the distribution of children according their occupation. It can be seen from the table that while majority (97.8%) were unemployed, 1.5 per cent reported that they work in a quarry and a few (0.7%) work as a daily labourer.

Among the unemployed category, we find that more females remained unemployed than males while among those who work in the quarry, there is very few gender difference. Only males were found to be engaged in daily labour.

Table 12: District of Origin

Sl.No.	District	Gender		Total N=132
		Male n=73	Female n=59	
1	Aizawl	24 (32.9)	26 (44.1)	50 (37.9)
2	Lunglei	21 (28.8)	9 (15.2)	30 (22.7)
3	Champhai	17 (23.2)	13 (22.0)	30 (22.7)
4	Mamit	11 (15.1)	11 (18.7)	22 (16.7)

Source : Computed Figures in parenthesis indicates percentages

Table 12 highlights the distribution of the children according to the Districts they belong to. The table shows that children from Aizawl district constitute the highest (37.9 %) followed by children (22.7% each) from Lunglei and Champhai districts and then children (16.7%) from Mamit district.

As for the gender distribution among the districts, we find that there are more males than females Lunglei and Champhai districts while there are more females than males in Aizawl and Mamit districts.

Table 13: Cause of Disability

Sl.No.	Causes	Gender		Total N=132
		Male n=73	Male n=73	
1	Since Birth	49 (67.2)	46 (63.0)	95 72.0
2	Meningitis during early childhood	5 (7.0)	4 (7.0)	9 (6.8)
3	Accident	7 (9.6)	2 (3.4)	9 (6.8)
4	Epilepsy during childhood	6 (8.4)	2 (3.4)	8 (6.1)
5	Injection side effect	0 (0.0)	2 (3.4)	2 (1.6)
6	Not known	1 (1.3)	1 (1.6)	2 (1.6)
7	Surgical Error	1 (1.3)	0 (0.0)	1 (0.7)
8	Brain Tumor	1 (1.3)	0 (0.0)	1 (0.7)
9	Eye Disease during childhood	1 (1.3)	0 (0.0)	1 (0.7)
10	Septicemia	0 (0.0)	1 (1.6)	1 (0.7)
11	Tuberculosis	1 (1.3)	0 (0.0)	1 (0.7)
12	Dog Bite	0 (0.0)	1 (1.6)	1 (0.7)
13	Ear Infection	1 (1.3)	0 (0.0)	1 (0.7)

Source : Computed Figures in parenthesis indicates percentages

Table 13 highlights the distribution of children according to the causes of disability .The table shows that majority (72.0%) of the children were disabled since birth followed by less than a tenth (6.8% each) who reported that they the cause was due to accident and meningitis during early childhood. There were those children (6.1%) who were disabled because of epilepsy during childhood and few of them (1.6% each) attributed the cause to injection side affect and did not know the cause.

Very few children (0.7% each) reported the cause to surgical error, brain tumor, eye disease during childhood, septicemia, tuberculosis, dog bite and ear infection. This reflects the findings of Muderedzi & Ingstad (2011) while it is in contrast with the findings of Torres & Vieira (2014) where majority of the respondents developed their disabilities after birth.

In the gender distribution, we can see that there are more males whose disabilities were caused since birth, meningitis during early childhood, accident and epilepsy during childhood. We also find only females whose disabilities were caused by injection side effects, septicemia and dog bite. Further, we see that there are only males whose disabilities were caused due to surgical error, brain tumor, eye disease during childhood, tuberculosis and ear infection.

Table 14: Type of Disability

Sl.No.	**Type**	**Gender**		**Total N=132**
		Male n=73	**Female n=59**	
1	Intellectual Disability	38 (52.0)	13 (22.0)	51 (39.0)
2	Muscular Dystrophy	12 (16.4)	8 (13.5)	20 (15.1)
3	Multiple Disability	7 (9.5)	10 (17.0)	17 (13.0)
4	Deaf	4 (6.0)	11 (18.6)	15 (11.3)
5	Blindness	3 (4.1)	5 (8.4)	8 (6.0)
6	Cerebral Palsy	1 (1.3)	7 (12.0)	8 (6.0)
7	Low Vision	3 (4.1)	3 (5.1)	6 (4.5)
8	Speech and Language Disability	2 (2.7)	1 (1.7)	3 (2.2)
9	Hard of Hearing	1 (1.3)	1 (1.7)	2 (1.5)
10	Dwarfism	1 (1.3)	0 (0.0)	1 (0.7)
11	Others (Psoriasis)	1 (1.3)	0 (0.0)	1 (0.7)

Source : Computed Figures in parenthesis indicates percentages

Table 14 displays the distribution of children according to the type of disability. As seen in the table, children with intellectual disability constitute the highest number (39.9%) followed by children with muscular dystrophy (15.1%). The table also shows that 13.0 per cent of the children have multiple disability and more than a tenth (11.3%) of the children are deaf. Further, the table shows that less than a tenth of the children (6.0%) suffer from blindness and cerebral palsy while a few of them (4.5%) suffer from low vision. Children with speech and language disability constitute 2.2 per cent and only 1.5 per cent are hard of hearing. Very few (0.7% each) suffer from dwarfism and others (Psoriasis). Cohen & Prahova (2006) have the same findings in which majority of the children were diagnosed with intellectual disability.

Seeing the gender distribution, there are more male with intellectual disability, muscular dystrophy and speech and language disability. The table also tells that there are more female children with multiple disability, deafness, blindness and cerebral palsy. Among those children having low vision and hard of hearing, we see that both males and females are equal in number. Further, we see that there are only males who suffer from dwarfism and psoriasis.

Table 15: Obtainment of Disability Certificate

Sl.No	**Category**	**Gender**		**Total N=132**
		Male n=73	**Female n=59**	
1	Obtained	47 (64.3)	42 (71.1)	89 (67.4)
2	Not Obtained	26 (35.7)	17 (28.9)	43 (32.6)

Source : Computed Figures in parenthesis indicates percentageS

Table 15 shows the distribution of children according to obtainment of disability certificate. From the table, it can be seen that more than half of the children (67.4%) have obtained disability certificate while a significant rest (32.6%) do not obtain disability certificate. This is in contrast with the findings of Chhangte (2017) where more than half of the respondents do not obtain disability certificate.

Among those children with disabilities who have obtained disability certificate, it can be seen that there are more males than females. And also among those who have not obtained disability certificate, we see that there are more males than females.

Table 16: Reasons for not obtaining Disability Certificate

Sl.No.	Reasons	Gender		Total N=43
		Male n=26	Female n=17	
1	Do not know the process	12 (46.2)	12 (70.5)	24 (55.9)
2	Parent’s Restriction	5 (19.2)	1 (5.9)	6 (14.0)
3	Do not have time	4 (15.4)	1 (5.9)	5 (11.6)
4	Neglegence	2 (7.8)	1 (5.9)	3 (7.0)
5	Not yet being diagnosed by doctor	1 (3.8)	1 (5.9)	2 (4.6)
6	Parent’s aspiration for improvement	1 (3.8)	1 (5.9)	2 (4.6)
7	Mobility Problem	1 (3.8)	0 (0.0)	1 (2.3)

Source : Computed Figures in parenthesis indicates percentages

Table 16 displays the distribution of children who have no disability certificate according to the reasons for not obtaining disability certificate. It can be seen from the table that among those who do have disability certificate, more than half (55.9%) do not know the process of obtaining disability certificate followed by more than a tenth (14.0%) who reported that they did not obtain disability certificate because of parents restriction due to non-acceptance and 11.6 per cent of the children reported that had no certificate because they did not have time to obtain one. Less than tenth (7.0 %) of the children did not obtain disability certificate because of negligence and a few (4.6% each) of the children had no certificate because they were not diagnosed yet and parents still aspired for them to get well. Very few (2.3%) of the children did not have a certificate because of mobility problems. This reflects the findings of Chhangte (2017) where majority did not obtain disability certificate because they do not know the process. It also reflects the findings of Emira & Thompson (2011).

In the distribution of gender, there are more males who did not obtain disability certificate because of not knowing the process, not having time, negligence and parent’s restriction due to non-acceptance. We also see that there are only males who did not obtain disability certificate because of mobility problem. Further, it is seen that there are more females who did not know the process, not yet diagnosed by doctor and parents aspiration for improvement.

Table 17: Challenges faced due to Disability

Sl.No.	Challenges	Gender		Total N=132
		Male n=73	Female n=59	
1	Stigma and Discrimination	40 (54.8)	33 (55.9)	73 (55.3)
2	Low academic performance	37 (50.6)	33 (56.0)	70 (53.0)
3	Lack of information on available services for CwDs.	37 (50.6)	30 (50.8	67 (50.7)
4	Unable to perform certain task	24 (32.9)	28 (47.4)	52 (39.4)
5	Insecurities and low self esteem	23 (31.5)	22 (37.2)	45 (34.0)
6	Dependence	18 (24.6)	23 (38.9)	41 (31.0)
7	Poverty	10 (13.6)	14 (23.7)	24 (18.1)
8	School drop out	7 (9.5)	12 (20.3)	19 (14.3)
9	Never enrolled in school	8 (10.9)	9 (15.2)	17 (12.8)
10	Difficulty in understanding class lectures (in schools and churches)	6 (8.2)	10 (16.9)	16 (12.1)
11	Lack of trained teachers in schools	8 (10.9)	8 (13.5)	16 (12.1)
12	Lack of brail facilities	7 (9.6)	8 (13.5)	15 (11.4)
13	Communication barrier	6 (8.2)	5 (8.4)	11 (8.3)
14	Barriers in accessing services for CwDs	7 (9.5)	3 (5.0)	10 (7.5)
15	Transportation Problem	4 (4.1)	45 (6.8)	10 (7.5)
16	Barrier in accessing disability certificate	1 (1.3)	4 (6.7)	5 (3.7)
17	Health Challenges	2 (2.7)	1 (1.6)	3 (2.3)
18	Physical Abuse	0	1 (1.6)	1 (0.8)
19	Sexual Abuse	0	1 (1.6)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 17 highlights the different challenges faced by children with disabilities. The table shows that more than half (55.3%) of the children report their challenges as being stigma and discrimination followed by those children (53%) whose challenges include low academic performance and another 50.7 per cent whose challenges include lack of information on available services for CwDs. Among the challenges, there were children (39.4%) who reported their challenges as being inability to perform certain task followed by those (34%) who had insecurities and low self esteem. There were those children (31%) who reported that dependence on others was a challenge they face and less than a fifth (18.1%) of the children faced challenges related to poverty. More than a tenth (14.3%) of the children reported that dropping out from school was a challenge they face and 12.1 pee fent of them never enrolled in school. The table also shows that more than a tenth (12.1 % each) of the children reported their challenge as being difficulty in understanding class lectures in schools and churches and lack of trained teachers in schools. Some children (11.4%) reputed that there was lack of brail facilities while less than a tenth (8.3%) faced challenges related to communication barrier. Further, less than a tenth (7.5% each) of the children faced challenges related to barriers in accessing services and transportation problem while few of the children (3.7%) had problems in accessing disability certificate. There were 2.3 per cent of children who had health problems and very few (0.8% each) had experienced physical abuse and sexual abuse. This relates to the findings of Meral & Cavkaytar (2012) and Shumbaa & Abosib (2011).

The table shows that females faced more challenges due to their disability than males. There were more males who faced challenges in the health and barriers in accessing services for CwDs categories.

4.2 Family Characteristics

This section will discuss the findings related to the family of the children with disabilities such as type of family, form of family, educational level of parents, occupation of parents and their monthly income and the socio-economic category of the children’s family.

Table 18: Type of Family

Sl.No.	Type	Gender		Total N=132
		Male n=73	Female n=59	
1	Nuclear Family	48 (65.7)	41 (69.6)	89 (67.4)
2	Joint Family	13 (17.8)	13 (22.0)	26 (19.6)
3	Living with relatives	8 (11.0)	4 (6.7)	12 (9.0)
4	Living in Child Care Institution	4 (5.5)	1 (1.7)	5 (4.0)

Source : Computed Figures in parenthesis indicates percentages

Table 18 shows the distribution of children according to the type of family. The table highlights that children who belong to nuclear family constituts 67.4 per cent of the respondents followed by those children (19.6%) who belong to joint family. There were those children who lived with their relatives who constitute less than a tenth (9%) of the respondents and there were also those (5%) who lived in child care institutions. Lalmuanpuii (2016) also found in her study in Aizawl City that majority of children with disabilities were from a nuclear family. Meral & Cavkaytar (2012) and Chhangte (2017) also found similar conclusion in their study.

Among the children who belong to nuclear family, there are more female children than the males. Similarly, among the children from joint families, we find more females than males. There are more male children living with relatives than the females and among the children living in child care institutions, there are more males than females.

Table 19: Form of Family

Sl.No.	Form	Gender		Total N=132
		Male n=73	Female n=59	
1	Stable Family	49 (67.1)	43 (72.9)	92 (69.7)
2	Broken Family	23 (31.5)	16 (27.1)	39 (29.5)
3	Reconstituted Family	1 (1.4)	0 (0.0)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 19 illustrates the distribution of children according to the form of family. The table indicates that majority (67.7%) of the children belong to a stable family while 29.5 per cent of them belong to broken family. Only a few (0.8%) of the children belong to a reconstituted family. Lalmuanpuii (2016) also found that majority of children with disabilities in Aizawl City belong to a stable family. This also reflects the findings of Chhangte (2017). Cohen & Prahova (2006) also found that children with disabilities are more likely to come from broken families.

Among the children from stable family, we find that there are more females than males. In reconstituted family, we find that there are only males while among those children who belong to broken family, there are more males than females.

Table 20: Educational Level of Father

Sl.No.	**Level**	**Gender**		**Total N=132**
		Male n=73	**Female n=59**	
1	High School Level	18 (25.0)	13 (22.0)	31 (23.4)
2	Do not Know	15 (20.5)	8 (13.6)	23 (17.4)
3	Middle School Level	13 (17.7)	8 (13.6)	21 (16.0)
4	Deceased	7 (9.6)	6 (10.2)	13 (10.0)
5	Primary School Level	4 (5.5)	8 (13.6)	12 (9.0)
6	Graduate Level	7 (9.5)	4 (6.7)	11 (8.3)
7	Higher Secondary Level	5 (6.8)	5 (8.4)	10 (7.5)
8	Illiterate	2 (2.7)	6 (10.2)	8 (6.1)
9	Post Graduate Level	2 (2.7)	1 (1.7)	3 (2.3)

Source : Computed Figures in parenthesis indicates percentages

Table 20 shows the distribution of children according to the educational level of their father. From the table, we see that more than a fifth (23.4%) of the children has fathers who studied till high school level followed by those children (17.4%) who do not know the educational level of their father. Children whose fathers studied till the middle level constitutes 16.0 per cent and 10.0 per cent of the children reported that their fathers had deceased. Less than a tenth (9%) of the children reported that their fathers studied till the primary level and another 8.3 per cent had fathers who studied till the graduate level. Further, less than a tenth, another 6.1 per cent reported that their fathers were illiterate while a few of them (2.3%) had fathers who studied till the post graduate level. Similar trend on educational level of fathers were found in the studies conducted by Maclnnes (2008), Meral & Cavkaytar (2012) and Lalmuanpuii (2016). However, this is in contrast with the findings of Reyhan (2016) where most of the parents were elementary school level only.

Among the children whose fathers studied till the high school level, middle school level, graduate and post graduate level, there were more male children than the female counterpart. However, we find that there were more female children than males who reported that their fathers had studied till primary school level, higher secondary level and illiterate.

Table 21: Educational Level of Mother

Sl.No.	Level	Gender		Total N=132
		Male n=73	Female n=59	
1	High School Level	18 (24.7)	17 (29.0)	35 (26.5)
2	Middle School Level	22 (30.1)	12 (20.3)	34 (25.7)
3	Do not Know	15 (20.5)	8 (13.5)	23 (17.4)
4	Illiterate	3 (4.1)	7 (12.0)	10 (7.6)
5	Primary School Level	4 (5.5)	6 (10.1)	10 (7.6)
6	College Level	4 (5.5)	5 (8.4)	9 (6.8)
7	Higher Secondary Level	4 (5.5)	4 (6.7)	8 (6.1)
8	Deceased	2 (2.7)	0 (0.0)	2 (1.5)
9	Post Graduate Level	1 (1.4)	0 (0.0)	1 (0.8)

Source : Computed Figures in parenthesis indicates percentages

Table 21 depicts the distribution of children according to the educational level of their mothers. From the table, it can be observed that more than a fourth (26.5%) of the children reported that their mothers studied till the high school level followed by those children (25.7%) whose mothers studied till the middle school level. There were 17.4 per cent of them who do not know the educational level of their mothers while 7.6 per cent of the children reported that their mothers were illiterate. Another 7.6 per cent of the children had mothers who studied till the primary level and 6.8 per cent of the children had mothers who studied till the college level. Less than a tenth (6.1%) of the children reported that their mothers studied till the higher secondary level and very few (0.8%) of the mothers were post graduates. Maclnnes (2008), Meral & Cavkaytar (2012), Lalmuanpuii (2016) also revealed similar findings where significant number of mothers had low educational background.

In the gender distribution, we find that among those children whose mothers studied till high school level, were illiterates, studied till primary school level, college level and higher secondary level, there were more females than males while there were more male children than females who reported that their mothers studied till middle school level and only males whose parents studied till the post graduate level.

Table 22: Occupation of Father

Sl.No.	Occupation	Gender		Total N=132
		Male n=73	Female n=59	
1	Daily Labour	25 (34.3)	25 (42.3)	49 (37.2)
2	Government Service	10 (13.5)	15 (25.4)	24 (18.1)
3	Do not know	10 (13.5)	6 (10.2)	18 (13.6)
4	Deceased	7 (10.0)	6 (10.2)	13 (10.0)
5	Business	9 (12.3)	0 (0.0)	9 (6.8)
6	Private employee	4 (5.5)	5 (8.5)	9 (6.8)
7	Agriculture	4 (5.5)	2 (3.4)	6 (4.5)
8	Meat Vending	2 (2.7)	0 (0.0)	2 (1.5)
9	Pension	2 (2.7)	0 (0.0)	2 (1.5)

Source : Computed Figures in parenthesis indicates percentages

Table 22 highlights the distribution of children according to the occupation of their fathers. The table shows that more than a third (37.2%) of the children reported that their fathers worked as daily labourers followed by children (18.1%) whose fathers work in government service. More than a tenth (13.6%) of the children did not know the occupation of their father while a tenth (10%) of the children reported that their fathers have deceased. Less than a tenth (6.8% each) have fathers who are businessmen and private employees while a few (4.5%) have fathers whose occupation was agriculture .Very few (1.5% each) of the children reported that their fathers were meat vendors and pensioners. Maclnnes (2008), Meral, Cavkaytar (2012) & Reyhan (2016) also found similar conclusion in their studies.

Among those children who have fathers working as daily labourers, government servants and private employees, there were more females than males while there are more males than females who reported that the occupation of their father was agriculture. Only male children reported that their fathers were businessmen, meat vendors and pensioners.

Table 23: Occupation of Mother

Sl.No.	Occupation	Gender		Total N=132
		Male n=73	Female n=59	
1	Home Maker	31 (42.5)	30 (51.0)	61 (46.3)
2	Business	14 (19.2)	4 (6.7)	18 (13.6)
3	Daily Labour	10 (13.7)	7 (12.0)	17 (12.8)
4	Do not know	12 (16.4)	5 (8.4)	17 (12.8)
5	Agriculture	1 (1.4)	9 (15.3)	10 (7.5)
6	Government Service	3 (4.1)	2 (3.4)	5 (4.0)
7	Deceased	2 (2.7)	0 (0.0)	2 (1.5)
8	Private employee	0 (0.0)	2 (3.4)	2 (1.5)

Source : Computed Figures in parenthesis indicates percentages

Table 23 shows the distribution of children according to the occupation of their mothers. From the table, we see that children whose mothers are home makers constitute less than half (46.3%) of the respondents followed by children (13.6 %) whose mothers work as businessmen. More than a tenth (12.8%) of the children has mothers who work as daily labourers while another 12.8 per cent do not know the occupation of their mother. Among the children, 7.8 per cent of them reported that the occupation of their mother was agriculture while 4 per cent of the children have mothers who work as government servants. Unfortunately, 1.5 per cent of the children reported that their mothers had deceased and another 1.5 per cent of the mothers were employed in private sector. Porterfield (2002), Reyhan (2016) and Lalmuanpuii (2016) in their studies also found similar trend in the occupation of mothers of children with disabilities.

Among those children who have mothers who were home maker, taking up business, daily wage labourer and government servants, there were more males than females while there are more females than males who reported that the occupation of their mother was agriculture. Only female children reported that their mothers were private employee.

Table 24: Father's Monthly Income

Sl.No.	Income (in Rs)	Gender		Total N=132
		Male n=73	Female n=59	
1	Do not know	50 (68.4)	31 (52.5)	81 (61.4)
2	20000-29999	8 (11.0)	5 (8.4)	13 (9.8)
3	Deceased	7 (9.6)	6 (10.1)	13 (9.8)
4	40000 and above	5 (7.0)	4 (6.7)	9 (7.0)
5	10000-19999	1 (1.3)	7 (12.0)	8 (6.0)
6	1000-9999	2 (2.7)	4 (7.0)	6 (4.5)
7	30000-39999	0	2 (3.3)	2 (1.5)

Source : Computed Figures in parenthesis indicates percentages

Table 24 displays the distribution of children according to the monthly income of their father. It was difficult to acquire information on many of these items because more than half (61.4%) of the children do not know the amount of the monthly income of their fathers. Among the children, 9.8 per cent reported their fathers to be deceased. Another 13 per cent of the children reported their father's income to be Rs. 20000-29999 followed by fathers with an income of Rs.40000 and obeve (7.0%). Six per cent of the children reported their father to have an income of Rs.10000-19999 while 4.5 per cent have fathers with an income of Rs.1000-9999 and only a few (1.5%) reported their father's income to be between Rs.30000-39999.

Among those children who do not know the income of their father, there are more male than females. Among children who have father with an income of Rs. 20000-29999 and Rs. 40000 and above, there are more male than females. And among children who have father with an income of Rs.10000-19999 and Rs1000-9999 we find that there are more female than males. Further, we find only female child who have father with an income of Rs 30000-39999

Table 25: Mother's Monthly Income

Sl.No.	Income	Gender		Total N=132
		Male n=73	Female n=59	
1	Unemployed	31 (42.4)	30 (51.0)	61 (46.3)
2	Don't know	31 (42.4)	21 (35.6)	52 (39.5)
3	1000-9999	3 (4.1)	5 (8.4)	8 (6.0)
4	40000 and above	3 (4.1)	3 (5.0)	6 (4.5)
5	10000-19999	3 (4.1)	0	3 (2.2)
6	Deceased	2 (2.9)	0	2 (1.5)

Source : Computed Figures in parenthesis indicates percentages

Table 25 shows the distribution of children according to their mother's monthly income. It can be observed from the table unemployed mother constitute the highest number (46.3%) and a quite number of (39.5%) of children are unaware of the income of their mothers. Eight per cent of the mother's have an income of Rs. 1000-9999 (6.0%) followed by mothers with an income of Rs. 40000 and above (4.5%) while 2.2 percent of the mothers have an income of Rs. 10000-19999.among the children, 1.5 per cent reported that their mother have deceased. This reflect the study of Sandler and Mistretta (1998) where they found that mothers of children with disabilities are more likely to be financially instable

In the gender distribution, we find that there are more male than females who have unemployed mother. We can also see that there are more boys than girls who are not aware of their mother's income. Among those children who have mother with an income of Rs1000-9999 there are more girls than boys. Among those children who have mother with income of Rs 40000 and above the number of boys and girls are equal. We only see male children who have mother with an income of Rs 10000-19999.

Table 26: Socio-Economic Category

Sl.No.	Category	Gender		Total N=132
		Male n=73	Female n=59	
1	Below Poverty Line (BPL)	41 (56.2)	22 (37.3)	63 (47.7)
2	Above Poverty Line (APL)	22 (30.1)	29 (49.2)	51 (38.6)
3	Do not know	4 (5.5)	4 (6.7)	8 (6.1)
4	Antyodaya Anna Yojana (AAY)	4 (5.5)	3 (5.1)	7 (5.3)
5	No category	2 (2.7)	1 (1.7)	3 (2.3)

Source : Computed Figures in parenthesis indicates percentages

Table 26 illustrates the socio-economic category of the children's family. The table shows that almost half (47.7%) belong to Below Poverty Line (BPL) family while more than a third (38.7 %) belong to Above Poverty Line (APL) family. There were those children (6.1%) who do not know the socio-economic category of their family and 5.3 per cent of the children reported that they belong to Antyodaya Anna Yojana (AAY) category. A few of the children (2.3%) reported that they did not belong to any category. UNICEF (2006), Tran (2014), Maclnnes (2008) and Meral & Cavkaytar (2012) also revealed in their studies that children with disabilities come from low economic background. It also reflects the finding of Chhangte (2017) where majority belong to below poverty line.

In the distribution of gender, the study revealed that in the category of BPL and AAY, there were more male children than the females while there were more females than males in the category of APL.

4.3 Social Support

This section shall discuss the findings related to social support based upon accessibility, quality and adequacy across the dimensions and social support agents, gender and age distributions and differences across social support systems and suggestions to improve social support systems for Children with Disabilities.

Table 27: Social Support of Family across Dimensions

Sl.No	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	4.44	4.37	4.30
		Female	4.49	4.44	4.42
2	Emotional	Male	4.45	4.36	4.33
		Female	4.63	4.63	4.61
3	Physical Health	Male	4.36	4.22	4.18
		Female	4.37	4.32	4.31
4	Mental Health	Male	4.38	4.30	4.25
		Female	4.25	4.27	4.29
5	Life Skills	Male	4.15	3.92	3.96
		Female	4.14	3.95	3.95
6	Financial	Male	4.23	3.90	3.75
		Female	4.25	4.00	3.88
7	Instrumental	Male	4.05	3.90	3.89
		Female	3.75	3.49	3.51
Total Average Mean			4.28	4.15	4.11

Source : Computed

Table 27 shows the distribution of children according the dimensions of social support given by family based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on a 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate,4 for adequate and 5 for very adequate.

From the table, the overall support from family is high in all dimensions in accessibility (4.28), quality (4.15) and adequacy (4.11), which reflects to the findings of Meral & Cavkaytar (2012), Lalmuanpuii (2016) and Chhangte (2017)

In the basic needs dimension, support received from family was high where accessibility (4.44), availability (4.37) and adequacy (4.30) of support among the males was high and similarly, the accessibility (4.49), availability (4.44) and adequacy (4.42) of support among the females was also high.

In the emotional dimension, support received from family was also high in accessibility (4.45), quality (4.36) and adequacy (4.33) of support among male respondents. Among the female too, accessibility (4.45), quality (4.36) and adequacy (4.33) was also high.

The physical health support received from family was also found to be high in accessibility (4.36), quality (4.22) and adequacy (4.18) among males. Similarly, the accessibility (4.37), quality (4.32) and adequacy (4.31) was also high among females.

Mental health support was also high among boys in accessibility (4.38), quality (4.30) and adequacy (4.25) and the accessibility (4.25), quality (4.27) and adequacy (4.29) of mental health support from family was also high among girls.

The accessibility (4.15), quality (3.92) and adequacy (3.96) of family support on life skill were found to be high among the male children and the accessibility (4.14), quality (3.95) and adequacy (3.95) of family support on life skill was also high among female children.

In the financial dimension of social support from family received by boys, the accessibility (4.23), quality (3.90) and adequacy (3.75) was high and similarly, the accessibility (4.25), quality (4.00) and adequacy (3.88) were also high among the girls.

The instrumental support received by males form their family was high in terms of accessibility (4.05), quality (3.90) and adequacy (3.89) and among females, the support was also high in accessibility(3.75) and adequacy (3.51) while it is moderate in the quality (3.49).

Across the dimensions, there were very few gender variations that exist in social support by family. This relates to the findings of Wendelborg & Tossebro (2011) and Olsson et.al (2015). At the same time, this is in contrast with the findings of (Haider, 1998)

Table 28: Social Support of Peers across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.73	1.56	1.47
		Female	2.12	1.95	1.80
2	Emotional	Male	2.66	2.47	2.45
		Female	3.05	3.03	2.80
3	Physical health	Male	1.36	1.27	1.22
		Female	1.68	1.42	1.37
4	Mental health	Male	1.88	1.73	1.68
		Female	2.20	2.02	1.98
5	Life Skills	Male	1.62	1.47	1.47
		Female	1.80	1.59	1.54
6	Financial	Male	1.32	1.15	1.15
		Female	1.66	1.46	1.39
7	Instrumental	Male	1.25	1.11	1.11
		Female	1.49	1.25	1.27
Total Average Mean			1.83	1.66	1.61

Source : Computed

Table 28 indicates the distribution of children according to the dimensions of social support received from peers based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

From the table, we see that the overall score of social support from peers in all dimensions is low in terms of accessibility (1.83), quality (1.66) and adequacy (1.61). This finding is in contrast with the findings of Teklu (2010), Meral & Cavkaytar (2012) and Reyhan (2016).

The basic need support from peers is low among boys in terms of accessibility (1.73) and quality (1.56) while it is very low (1.47) in the adequacy. We also see that the support in this dimension is low for girls in its accessibility (2.12), quality (1.95) and adequacy (1.80).

The accessibility of emotional support from peers is moderate (2.66) among males while the quality (2.47) and adequacy (2.45) is low. The accessibility (3.05), quality (3.03) and adequacy (2.80) of emotional support from peers is moderate among females. The accessibility, quality and adequacy of basic needs support from peers is higher among females than males.

The physical health support received from peers in the accessibility (1.36), quality (1.27) and adequacy (1.22) is very low among male respondents. The accessibility of physical health support from peers is low among female respondents while it is very low in the quality (1.42) and in adequacy (1.37).

The mental health support provided by peers is low for the boys in the accessibility (1.88), quality (1.73) and adequacy (1.68). Similarly, the accessibility (2.20), quality (2.02) and adequacy (1.98) are low among girls.

The accessibility of peer support on life skill is low (1.62) among male children while the quality and adequacy is very low (1.47). Peer support on life is low among female children in the accessibility (1.80), quality (1.59) and adequacy (1.54).

Financial support from peer is very low among boys in the accessibility (1.32), quality (1.15) and adequacy (1.15). On the other hand, the accessibility of financial support from school is low (1.66) among girls while it is very low in quality (1.46) and adequacy (1.39).

The accessibility (1.25), quality (1.11) and adequacy (1.11) of instrumental support from peers are very low among male respondents. Similarly, the instrumental support from peers in the accessibility (1.49), quality (1.25) and adequacy (1.27) is also very low among female respondents.

Except for the dimension of emotional support (accessibility and quality), there are no significant gender differences, which is in contrast with the study of (Haider, 1998) but relates to the findings of Wendelborg & Tossebro (2011) and Olsson et.al (2015).

Table 29: Social Support of Schools across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	2.82	2.51	2.70
		Female	2.71	2.53	2.58
2	Emotional	Male	3.30	3.16	3.18
		Female	3.39	3.39	3.27
3	Physical health	Male	2.63	2.34	1.97
		Female	2.61	2.41	2.14
4	Mental health	Male	2.93	2.74	2.68
		Female	3.00	3.00	2.85
5	Life Skills	Male	2.32	2.93	2.99
		Female	3.20	3.08	3.00
6	Financial	Male	2.08	1.66	1.42
		Female	1.88	1.61	1.47
7	Instrumental	Male	2.23	2.03	1.89
		Female	2.25	2.08	1.97
Total Average Mean			2.67	2.53	2.44

Source : Computed

Table 29 depicts the distribution of children according to the dimensions of social support provided by schools based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy across the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate,4 for adequate and 5 for very adequate.

Overall, the support from school across the dimensions is moderate in terms of accessibility (2.67) and quality (2.53) while it is low (2.44) in adequacy which is in relation with the findings of Teklu (2010), Wendelborg & Tossebro (2011) and Lalmuanpuii 2016).

From the table, it can be seen that the accessibility (2.82), quality (2.51) and adequacy (2.70) of basic needs support from school is moderate among the male respondents. The accessibility (2.71), quality (2.53) and adequacy (2.58) of basic need support from school is also moderate among the female respondents. The accessibility and adequacy of basic needs support from school is higher among males while the quality of basic needs support from school is higher among females.

The emotional support received from school is also moderate in terms of accessibility (3.30), quality (3.16) and adequacy (3.18) among males and similarly, the frequency of school support is moderate for females in terms of accessibility (3.39), quality (3.39) and adequacy (3.27). The accessibility, quality and adequacy of emotional support from school is higher among female than males.

The accessibility of physical health support received from school is moderate (2.63) among boys while it is low in terms of quality (2.34) and adequacy (1.97). At the same time, the accessibility of physical health support from school is moderate (2.61) for the girls while it is low in terms of quality (2.34) and adequacy (1.97). The accessibility and adequacy of physical health support from school is higher among male while the quality is higher among female.

Mental health support from school is moderate among boys in the accessibility (2.93), quality (2.74) and adequacy (2.68). Likewise, the mental health support receive from school is also moderate for the girls in terms of accessibility (3.00), quality (3.00) and adequacy (2.85). The accessibility, quality and adequacy of mental health support from school is higher among girls than boys.

School support in life skill is low (2.32) for the males in terms of accessibility but is moderate in terms of quality (2.93) and adequacy (2.99). On the other hand, the school support on life skill received by females is moderate in terms of accessibility (3.20), quality (3.08) and adequacy (3.00). School support on life skill is higher among female than male respondents in terms of accessibility, quality and adequacy.

In the financial support of school received by the males, the accessibility (2.08) and quality (1.66) is low while the adequacy is very low (1.42). Financial support received from school is low for the female respondents in the accessibility (1.88) and quality (1.61), but it is very low (1.47) in the adequacy. The accessibility and quality of school financial support is higher among male while adequacy is higher among female than male respondents.

The school instrumental support received by male is low in terms of accessibility (2.23), quality (2.03) and adequacy (1.89). At the same time, the instrumental support from school is also low among female respondents in the accessibility (2.25), quality (2.08) and adequacy (1.95). The accessibility, quality and adequacy of instrumental support is higher among female respondents than the male respondents.

This relates to the findings of (Haider, 1998) and is in contrast with the findings of Wendelborg & Tossebro (2011) and Olsson et.al (2015).

Table 30: Social Support of Church across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.03	1.00	1.00
		Female	1.29	1.17	1.15
2	Emotional	Male	2.21	1.93	1.78
		Female	2.86	2.46	2.22
3	Physical health	Male	1.04	1.05	1.00
		Female	1.17	1.03	1.03
4	Mental health	Male	1.07	1.03	1.01
		Female	1.27	1.10	1.07
5	Life Skills	Male	1.05	1.04	1.00
		Female	1.15	1.05	1.05
6	Financial	Male	2.07	1.68	1.40
		Female	2.80	2.32	1.83
7	Instrumental	Male	1.14	1.07	1.05
		Female	1.19	1.08	1.03
Total Average Mean			1.52	1.36	1.26

Source : Computed

Table 30 highlights the distribution of children according to the dimensions of social support provided by the church based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

From the table, it can be seen that the average score in accessibility of support from church across all dimensions is low while the quality and adequacy is very low across the dimensions. This relates to the findings of Chhangte (2017).

The accessibility (1.03), quality (1.00) and adequacy (1.00) of basic needs support from church is very low among boys. The basic need support from church is also very low among girls in terms of accessibility (1.29), quality (1.17) and adequacy (1.15). The accessibility, quality and adequacy of basic needs support is higher among girls than boys.

The emotional support provided by church is low among the male respondents in terms of accessibility (2.21), quality (1.93) and adequacy (1.78). The accessibility of emotional support provided by church is moderate (2.86) among females while the quality (2.46) and adequacy (2.22) is low. In the accessibility, quality and adequacy of emotional support from church, the amount of support received by female is higher than males.

In the accessibility (1.04), quality (1.05) and adequacy (1.00) of physical health support provided by church, the support received by boys is very low. The physical health support provided by church in terms of accessibility (1.17), quality (1.03) and adequacy (1.03) is also very low among girls. However, girls receive higher physical health support in terms of accessibility while the quality and adequacy of physical health support from church is higher among boys.

The mental health support received from the church is very low among males in terms of accessibility (1.07), quality (1.03) and adequacy (1.01). Similarly, the mental health support received from church in the accessibility (1.27), quality (1.10) and adequacy (1.07) is very low among females. In the mental health support received from church, the accessibility, quality and adequacy is higher among females.

The support in life skill given by the church is very low among males in terms of accessibility (1.05), quality (1.04) and adequacy (1.00). Likewise, the support in life skill from church in the accessibility (1.15), quality (1.05) and adequacy (1.05) is very low among females. However, the life skill support from church in the accessibility, quality and adequacy is higher among females.

The accessibility (2.07) and quality (1.68) of financial support from church are low among the male respondents while it is very low (1.40) in the adequacy. The accessibility (2.80) of financial support from church is moderate for the girls while the quality (2.32) and adequacy (1.83) is low. In the financial support received from church, the accessibility, quality and adequacy is higher among females.

In the accessibility (1.14), quality (1.07) and adequacy (1.05) of instrumental support provided by church, the amount of support received by boys is very low. The amount of instrumental support provided by church in terms of accessibility (1.19), quality (1.36) and adequacy (1.26) is also very low among girls. However, girls receive higher instrumental support from the church in terms of accessibility quality and adequacy.

Table 31: Social Support of YMA across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.07	1.03	1.01
		Female	1.08	1.00	1.00
2	Emotional	Male	1.10	1.07	1.04
		Female	1.27	1.12	1.17
3	Physical health	Male	1.04	1.00	1.00
		Female	1.08	1.00	1.00
4	Mental health	Male	1.04	1.00	1.00
		Female	1.08	1.00	1.00
5	Life Skills	Male	1.07	1.04	1.03
		Female	1.10	1.02	1.02
6	Financial	Male	1.26	1.16	1.10
		Female	1.26	1.15	1.10
7	Instrumental	Male	1.03	1.00	1.00
		Female	1.08	1.00	1.00
Total Average Mean			1.11	1.04	1.03

Source : Computed

Table 31 demonstrates the distribution of children according to the dimensions of social support given by YMA based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

From the table, we see that the average mean score of support from YMA in all dimensions is very low in terms of accessibility (1.11), quality (1.04) and adequacy (1.03), which reflects the findings of Chhangte (2017) where she found that respondents do not receive any kind of support from the secondary supporters

In the basic needs support provided by YMA, we observe that the accessibility (1.07), quality (1.03) and adequacy (1.01) of support is very low among male respondents. The basic need support provided by YMA is also very low among female respondents in terms of accessibility (1.08), quality (1.00) and adequacy (1.00). In the accessibility, quality and adequacy of basic needs support from YMA, the support receive by female respondents is higher than the males.

The emotional support received from YMA is very low among males in the accessibility (1.10), quality (1.07) and adequacy (1.04) of the support. Similarly, the emotional support of YMA among female respondents is very low in terms of accessibility (1.27), quality (1.12) and adequacy (1.17). However, though support is very low, the emotional support from YMA in terms of accessibility, quality and adequacy is higher among females than males..

The accessibility, (1.04), quality (1.00) and adequacy (1.00) of physical health support from YMA is very low among boys. At the same time, the accessibility (1.08), quality (1.00) and adequacy (1.00) of emotional support is also very low among girls. In the table we can see that girls receive higher support in the accessibility while there are no gender differences in the quality and adequacy of emotional support from YMA.

The mental health support from YMA is also very low among male respondents in the accessibility (1.04), quality (1.00) and adequacy (1.00). The mental health support received by female respondents from YMA is also very low in the accessibility (1.04), quality (1.08) and adequacy (1.00). In the accessibility of mental health support from YMA, female respondents receive higher support while there is no gender differences in the quality and adequacy of mental health support from YMA.

The accessibility (1.07), quality (1.04) and adequacy (1.03) of YMA support of life skills are very low for the boys. At the same time, the life skill support provided by YMA among girls is also very low in the accessibility (1.10), quality (1.02) and adequacy (1.02). In the accessibility of life skill support from YMA, girls receive higher support from while boys receive higher support in the quality and adequacy of life skill support from YMA.

The financial support of YMA is very low among boys in the accessibility (1.26), quality (1.16) and adequacy (1.10). The accessibility (1.26), quality (1.15) and adequacy (1.10) is also very low among girls. There are no gender differences in the accessibility and adequacy of financial support from YMA while boys receive higher support in the quality of financial support from YMA.

The accessibility (1.03), quality (1.00) and adequacy (1.00) of instrumental support from YMA are very low among male respondents. Similarly, the instrumental support received from YMA in terms of accessibility (1.08), quality (1.00) and adequacy (1.00) is very low among female respondents. It can be seen that in the accessibility, male receive higher support while no gender difference is seen in the quality and adequacy of instrumental support from YMA.

Table 32: Social Support of MHIP across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.01	1.00	1.00
		Female	1.19	1.10	1.03
2	Emotional	Male	1.18	1.14	1.11
		Female	1.46	1.29	1.24
3	Physical health	Male	1.07	1.07	1.07
		Female	1.08	1.00	1.00
4	Mental health	Male	1.08	1.03	1.05
		Female	1.14	1.05	1.05
5	Life Skills	Male	1.52	1.36	1.29
		Female	1.31	1.20	1.20
6	Financial	Male	1.27	1.15	1.11
		Female	1.42	1.17	1.07
7	Instrumental	Male	1.07	1.05	1.05
		Female	1.14	1.03	1.03
Total Average Mean			1.21	1.12	1.09

Source : Computed

Table 32 displays the distribution of children according to the dimensions of social support based upon accessibility, quality and adequacy of support provided by the MHIP. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate,4 for adequate and 5 for very adequate.

The table shows that the overall mean score of support from MHIP across all dimensions is low in the accessibility (1.21), quality (1.12) and adequacy (1.09). This replicate the findings of Chhangte (2017).

The accessibility (1.01), quality (1.00) and adequacy (1.00) of basic needs support from MHIP is very low among the boys. At the same time, the amount of support received by girls is also very low in terms of accessibility (1.19), quality (1.10) and adequacy (1.03). The table also shows that basic needs support from MHIP is higher among girls than boys.

The accessibility (1.18), quality (1.14) and adequacy (1.11) of emotional support from MHIP are very low among boys. Similarly, the accessibility (1.46), quality (1.29) and adequacy (1.24) of emotional support from MHIP is very low among girls. We can see that the accessibility, quality and adequacy of emotional support from MHIP is higher among girls than boys.

The physical health support provided by MHIP is very low among male respondents in terms of accessibility (1.07), quality (1.07) and adequacy (1.07). The physical heath support provided by MHIP is also very low among female respondents in the accessibility (1.08), quality (1.00) and adequacy (1.00). It can be seen that the accessibility of physical health support from MHIP is higher among female respondents while the quality and adequacy is higher among male respondents.

The accessibility (1.08), quality (1.03) and adequacy (1.05) of mental health support from MHIP among boys are very low. The accessibility (1.14), quality (1.05) and adequacy (1.05) of mental health support from MHIP among girls are also very low. In the accessibility of mental health support from MHIP, female receive higher support in the accessibility and quality while the mental health support from MHIP is equal in adequacy among boys and girls.

The life skill support of MHIP among boys in the accessibility is low (1.52) while it is very low in the quality (1.36) and adequacy (1.29). The accessibility (1.31), quality (1.20) and adequacy (1.20) of MHIP support of life skills among girls are very low. We can see that boys receive higher support on life skills from the MHIP in the accessibility, quality and adequacy.

The financial support received from MHIP is very low among boys in the accessibility (1.27), quality (1.15) and adequacy (1.11). The accessibility (1.42), quality (1.17) and adequacy (1.07) of financial support from MHIP are also very low among girls. The accessibility and quality of financial support from MHIP is higher among females while it is higher among males in the adequacy of financial support from MHIP.

The instrumental support of MHIP received by male respondents is very low in the accessibility (1.07), quality (1.05) and adequacy (1.05). The accessibility (1.14), quality (1.03) and quality (1.03) of instrumental support from MHIP are also very low among female respondents. The instrumental support is more accessible for female respondents while male respondents receive higher support in the quality and adequacy.

Table 33: Social Support of MUP across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
2	Emotional	Male	1.04	1.03	1.03
		Female	1.08	1.00	1.00
3	Physical health	Male	1.01	1.00	1.00
		Female	1.08	1.00	1.00
4	Mental health	Male	1.01	1.00	1.00
		Female	1.08	1.00	1.00
5	Life Skills	Male	1.03	1.00	1.00
		Female	1.08	1.00	1.00
6	Financial	Male	1.10	1.04	1.04
		Female	1.08	1.00	1.00
7	Instrumental	Male	1.03	1.03	1.01
		Female	1.08	1.00	1.00
	Total Average Mean		1.06	1.01	1.01

Source : Computed

Table 33 shows the distribution of children according to the dimensions of social support provided by MUP based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate,4 for adequate and 5 for very adequate.

From the table, the average score of support from MUP is very low across all dimensions in the accessibility (1.06), quality (1.01) and adequacy (1.01). This finding reflects the findings of Chhangte (2017).

We also see that the accessibility (1.01), quality (1.00) and adequacy (1.00) of basic needs support received from MUP are very low for male respondents. The accessibility (1.07), quality (1.00) and adequacy (1.00) of basic needs support received from MUP are also very low for female respondents. It can also be seen that the basic needs support received by females is higher in terms of accessible while the quality and adequacy is equal among male and female respondents.

The emotional support received from MUP is also high in terms of accessibility (1.04), quality (1.03) and adequacy (1.03) for boys. The emotional support from MUP is also very low among girls in the accessibility (1.08), quality (1.00) and adequacy (1.00). The emotional support from MUP is more accessible for girls while the emotional support is higher among boys in the quality and adequacy.

The physical health support received from MUP is very low in the accessibility (1.01), quality (1.00) and adequacy (1.00) among males. The accessibility (1.08), quality (1.00) and adequacy (1.00) of physical health support received from MUP are also very low among females. The physical health support from family is higher among girls while the quality and adequacy are equal between male and female.

Mental health support from MUP is very low for boys in the accessibility (1.01), quality (1.00) and adequacy (1.00). In parallel to the mental support received by boys, the accessibility (1.08), quality (1.00) and adequacy (1.00) is also very low among girls. In the accessibility of mental health support from MUP, girls have higher support while the quality and adequacy is the same for male and female.

MUP support in life skill is very low for male in the accessibility (1.03), quality (1.00) and adequacy (1.00). Likewise, the support of support in life skill provide by MUP is also very low among female in the accessibility (1.08), quality (1.00) and adequacy (1.00). We can see that the MUP support on life skill is higher among male while the quality and adequacy is the same among male and female.

The financial support of MUP received by the males in the accessibility (1.10), quality (1.04) and adequacy (1.04) is very low. Similarly, the financial support of MUP received by the females is also very low in the accessibility (1.08), quality (1.00) and adequacy (1.00). The MUP financial support is higher among males in the accessibility, quality and adequacy.

The instrumental support received from MUP is very low among male in the accessibility (1.03), quality (1.03) and adequacy (1.01). The accessibility (1.08), quality (1.00) and adequacy (1.00) of instrumental support received from MUP is very low among female. The instrumental support from MUP received by female is higher in the accessibility while the quality and adequacy is higher among males.

Table 34: Social Support of Local Councils (L.C)/ Village Council (VC) across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
2	Emotional	Male	1.08	1.05	1.03
		Female	1.12	1.02	1.02
3	Physical health	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
4	Mental health	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
5	Life Skills	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
6	Financial	Male	1.05	1.01	1.01
		Female	1.07	1.00	1.00
7	Instrumental	Male	1.01	1.00	1.00
		Female	1.07	1.00	1.00
	Total Average Mean		1.05	1.01	1.01

Source : Computed

Table 34 illustrates the distribution of children according to the dimensions of social support received from Local Councils (L.C)/ Village Councils (V.C) based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate,4 for adequate and 5 for very adequate.

The table shows that the average score of support from LC/VC across the dimensions is very low in the accessibility (1.05), quality (1.01) and adequacy (1.01). This is in relation with the findings of Lalmuanpuii (2016) and Chhangte (2017).

From the table, it can be seen that the accessibility (1.01), quality (1.00) and adequacy (1.00) of basic needs support from LC/VC is very low among boys. Also, the basic need support from LC/VC is very low among girls in terms of accessibility (1.07), quality (1.00) and adequacy (1.00). The accessibility is higher among female while the quality and adequacy of basic needs support from LC/VC is equal among girls and boys.

In the accessibility (1.08), quality (1.05) and adequacy (1.03) of emotional provided by LC/VC, the amount of support received by boys is very low. Also, the amount of emotional support provided by LC/VC in terms of accessibility (1.12), quality (1.02) and adequacy (1.02) is very low among girls. However, girls receive higher emotional support in terms of accessibility while the quality and adequacy of physical health support from LC/VC is higher among boys.

The physical health support provided by LC/VC is very low among the male respondents in terms of accessibility (1.01), quality (1.00) and adequacy (1.00). The accessibility (1.07), quality (1.00) and adequacy (1.00) of physical health support provided by LC/VC are also very low among female respondents. In the accessibility of physical support received from LC/VC, the support received by female is higher than male respondents while the quality and adequacy is same among male and female.

The mental health support received from the LC/VC is very low among males in terms of accessibility (1.01), quality (1.00) and adequacy (1.00). Similarly, the mental health support received from LC/VC in the accessibility (1.07), quality (1.00) and adequacy (1.00) is also very low among female respondents. In the mental health support received from LC/VC, the accessibility is higher among female while the quality and adequacy is equal among male and female respondents.

The support in life skill from LC/VC is very low among males in terms of accessibility (1.01), quality (1.00) and adequacy (1.00). The support in life skill received from LC/VC in the accessibility (1.107), quality (1.00) and adequacy (1.00) is also very low among female respondents. In the life skill support received from LC/VC, the accessibility is higher among females while the quality and adequacy is equal among male and female.

The accessibility (1.05), quality (1.01) and adequacy (1.01) of financial support from LC/VC are very low among the male respondents. The accessibility (1.07), quality (1.00) and adequacy (1.00) are also very low among female respondents. In the financial support received from LC/VC, the accessibility is higher among female respondents while the quality and adequacy is higher among males.

In the accessibility (1.01), quality (1.00) and adequacy (1.00) of instrumental support provided by LC/VC, the amount of support received by boys is very low. Also, the amount of instrumental support provided by LC/VC in the accessibility (1.07), quality (1.00) and adequacy (1.00) is very low. However, girls receive higher instrumental support from the church in terms of accessibility while quality and adequacy is same among between boys and girls.

Table 35: Social Support of NGOs across Dimensions

Sl.No.	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.01	1.00	1.00
		Female	1.15	1.07	1.05
2	Emotional	Male	1.04	1.03	1.03
		Female	1.22	1.14	1.12
3	Physical health	Male	1.01	1.00	1.00
		Female	1.10	1.02	1.00
4	Mental health	Male	1.01	1.00	1.00
		Female	1.12	1.03	1.03
5	Life Skills	Male	1.01	1.00	1.00
		Female	1.08	1.00	1.00
6	Financial	Male	1.05	1.00	1.00
		Female	1.22	1.14	1.14
7	Instrumental	Male	1.01	1.00	1.00
		Female	1.14	1.05	1.05
	Total Average Mean		1.08	1.03	1.03

Source: Computed

Table 35 demonstrates the distribution of children according to the dimensions of social support provided by NGOs based upon accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

The table indicates that the overall score of support from NGOs in all dimensions is very low in the accessibility (1.08), quality (1.03) and adequacy (1.03), which reflects the findings of Chhangte (2017).

From the table, we observe that the accessibility (1.01), quality (1.00) and adequacy (1.00) of basic needs support provided by NGOs is very low among male respondents. The basic need support provided by NGOs is also very low among female respondents in terms of accessibility (1.15), quality (1.07) and adequacy (1.05). In the accessibility, quality and adequacy of basic needs support from NGOs, the support receive by female respondents is higher than the males.

The emotional support received from NGOs is very low among males in the accessibility (1.04), quality (1.03) and adequacy (1.03) of the support. Similarly, the emotional support of NGOs among female respondents is very low in terms of accessibility (1.22), quality (1.14) and adequacy (1.12). However, though support is very low, females receive higher emotional support from NGOs in terms of accessibility, quality and adequacy.

The accessibility, (1.01), quality (1.00) and adequacy (1.00) of physical health support from NGOs is very low among boys. At the same time, the accessibility (1.10), quality (1.02) and adequacy (1.00) of emotional support is also very low among girls. In the table we can see that girls receive higher support in the accessibility, quality and adequacy of emotional support from NGOs.

The mental health support from NGOs is very low among male respondents in the accessibility (1.01), quality (1.00) and adequacy (1.00). The mental health support received by female respondents from NGOs is also very low in the accessibility (1.12), quality (1.03) and adequacy (1.03). In the accessibility, quality and adequacy of mental health support from NGOs, female respondents receive higher support than males.

The accessibility (1.01), quality (1.00) and adequacy (1.00) of NGOs support on life skill are very low for the boys. At the same time, the life skill support provided by NGOs among girls is also very low in the accessibility (1.08), quality (1.00) and adequacy (1.00). In the accessibility of life skill support from NGOs, girls receive higher support while the quality and adequacy is similar among boys and girls.

The financial support of NGOs is very low among boys in the accessibility (1.05), quality (1.00) and adequacy (1.00). The accessibility (1.22), quality (1.14) and adequacy (1.00) is also very low among girls. The accessibility, quality and adequacy of financial support from NGOs is higher among female respondents than the boys.

The accessibility (1.01), quality (1.00) and adequacy (1.00) of instrumental support from NGOs are very low among male respondents. Similarly, the instrumental support received from NGOs in terms of accessibility (1.14), quality (1.05) and adequacy (1.00) is very low among female respondents. It can be seen that in the accessibility quality and adequacy of instrumental support from NGOs, the score is higher among female respondents than the males.

Table 36: Social Support of Government across Dimesions

Sl.No	Dimensions	Gender	Accessibility	Quality	Adequacy
1	Basic Needs	Male	1.21	1.18	1.21
		Female	1.20	1.12	1.12
2	Emotional	Male	1.30	1.25	1.26
		Female	1.14	1.05	1.05
3	Physical Health	Male	1.26	1.21	1.21
		Female	1.24	1.10	1.12
4	Mental Health	Male	1.23	1.19	1.16
		Female	1.17	1.08	1.08
5	Life Skills	Male	1.58	1.44	1.41
		Female	1.81	1.69	1.69
6	Financial	Male	1.71	1.55	1.32
		Female	2.15	1.80	1.59
7	Instrumental	Male	1.59	1.45	1.41
		Female	2.08	1.76	1.68
	Total Average Mean		1.47	1.35	1.31

Source Computed

Table 36 demonstrates the distribution of children according to the dimensions of support provided by the government based on accessibility, quality and adequacy of support. The accessibility, quality and adequacy of the dimensions of social support were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

The table shows that the average score of support from government across all dimensions is very low in the accessibility (1.47), quality (1.35) and adequacy (1.31).

The accessibility (1.21), quality (1.18) and adequacy (1.21) of basic needs support from government is very low among the male respondents. The accessibility (1.20), quality (1.12) and adequacy (1.12) of basic need support from government is also very low among the female respondents. The accessibility, quality and adequacy of basic need support from government is higher among males. This related to the findings of Lalmuanpuii (2016) and Chhangte (2017).

The emotional support received from government is very low in terms of accessibility (1.30), quality (1.25) and adequacy (1.26) among males. Similarly, the frequency of government support is very low for females in terms of accessibility (1.14), quality (1.05) and adequacy (1.05). The accessibility, quality and adequacy of emotional support from government are higher among male respondents.

The physical health support received from government among boys is very low in the accessibility (1.26), quality (1.21) and adequacy (1.21). Likewise, the accessibility of physical health support from government is also very low for the girls in the accessibility (1.24) quality (1.10) and adequacy (1.12). The accessibility, quality and adequacy of physical health support from government is higher among males.

Mental health support from government is very low among male respondent in the accessibility (1.23), quality (1.19) and adequacy (1.16). The mental health support received from school is also very low among the female respondents in terms of accessibility (1.17), quality (1.08) and adequacy (1.08). The accessibility, quality and adequacy of emotional support from government is higher among male respondents.

Government support on life skill is low among boys in terms of accessibility (1.58) but is very low in terms of quality (1.44) and adequacy (1.41). The government support on life skill among girls is low in the accessibility (1.81), quality (1.69) and adequacy (1.69). The accessibility, quality and adequacy of government support on life skill is higher among girls than boys.

Financial support of government among boys is low in the accessibility (1.71) and quality (1.55) while it is very low in the adequacy (1.32). The financial support received from government is low among girls in the accessibility (2.15), quality (1.80) and adequacy (1.59). The accessibility, quality and adequacy of financial support from government is higher among girls than boys.

The government instrumental support received by male is low in terms of accessibility (1.59) while it is very low in the quality (1.45) and adequacy (1.41). At the same time, the instrumental support from government is low among female respondents in the accessibility (2.08), quality (1.76) and adequacy (1.68). The accessibility, quality and adequacy of instrumental support from government is higher among female respondents than the male respondents.

Table 37: Social Support across Agents

Sl.No	Agents	Accessibility	Quality	Adequacy
1	Family	4.28	4.11	4.10
2	School	2.67	2.53	2.44
3	Peers	1.83	1.66	1.61
4	Church	1.52	1.36	1.26
5	Government	1.47	1.35	1.31
6	MHIP	1.21	1.12	1.09
7	YMA	1.11	1.04	1.03
8	NGOs	1.08	1.03	1.03
9	MUP	1.06	1.01	1.01
10	LC/VC	1.05	1.01	1.01
Overall score		1.73	1.63	1.59

Source : Computed

Table 37 displays the distribution of children according to the social support provided by various agents based on accessibility, quality and adequacy of support. The accessibility, quality and adequacy of social support across different agents were calculated based on 5 point scale. The scale used for scoring accessibility was 1 for very inaccessible, 2 for inaccessible, 3 for neither accessible nor inaccessible, 4 for accessible and 5 for very accessible. The scale used for scoring quality was 1 for very poor, 2 for poor, 3 for neither good nor poor, 4 for good and 5 for very good and the scale used for measuring the adequacy of social support was 1 for very inadequate, 2 for inadequate, 3 for neither adequate nor inadequate, 4 for adequate and 5 for very adequate.

From the table, we see that the overall score of social support in accessibility (1.73), quality (1.63) and adequacy (1.59) across the agents is low.

The table also shows that the accessibility (4.28), quality (4.11) and adequacy (4.10) of support received from family is high which relates to the findings of Teklu (2010) and Lalmuanpuii (2016).

The support received from school is moderate in terms of accessibility (2.67) and quality (2.530 but is low (2.44) in the adequacy. This relates the findings of Teklu (2010)

We also see that peer support is low in the accessibility (1.83), quality (1.66) and adequacy (1.61). This is in contrast with the findings of Chhangte (2017).

The support provided by the church is low in the accessibility (1.52) while it is very low in the quality (1.36) and adequacy (1.26). This relates the findings of Lalmuanpuii (2016) and Chhangte (2017).

Further, in the accessibility, quality and adequacy, the support received from Government, MHIP, YMA, NGOs, MUP and LC/VC, is very low. This reflects the findings of Lalmuanpuii (2016) and Chhangte (2017).

Table 38: Gender Differences (t-test) across Primary Social Support Agents

Sl.No	Categories	Gender				t
		Male n=73		Female n=59		
		Mean	SD	Mean	SD	
1	Accessibility of Family support	4.30	0.61	4.27	0.58	0.26
2	Quality of Family support	4.12	0.74	4.11	0.77	0.09
3	Adequacy of Family support	4.07	0.74	4.09	0.78	-0.12

Source : Computed

Table 38 highlights the distribution of children according to gender differences in accessibility, quality and adequacy across primary social support agents *i.e.* Family.

From the table, it can be seen that the frequency of family support in terms of accessibility among male respondents (4.30) and female respondents (4.27) is high. The t-test score shows that there is no gender difference in the accessibility of family support.

It can also be seen that frequency of quality of family support among male students is also high (4.12). Similarly, we can also see that the quality of family support among female students is also high (4.27). The t-test score shows that there is no significant gender difference in quality of family support.

The frequency of adequacy of family support is also high among males (4.07) and females (4.09). The t-test score shows that there is no significant gender difference in adequacy of family support.

This finding relates to the findings of Ollson et.al (2015) where he found that there is no gender differences in the support received by CwDs.

Table 39: Gender Differences (t-test) across Secondary Social Support Agents

Sl. No	Social support	Gender				t
		Male		Female		
		Mean	SD	Mean	SD	
1	Accessibility of Peer support	1.68	0.80	2.00	1.01	-2.02
2	Quality of Peer support	0.73	0.93	1.12	1.20	**-2.11**
3	Adequacy of Peer support	1.51	0.65	1.74	0.88	-1.75
4	Accessibility of School support	2.76	1.15	2.72	1.31	0.15
5	Quality of School support	2.49	1.05	2.59	1.22	-0.53
6	Adequacy of School support	2.41	1.00	2.47	1.17	-0.30
7	Accessibility of Church support	1.38	0.47	1.69	0.60	**-3.26**
8	Quality of Church support	1.26	0.33	1.47	0.43	**-3.14**
9	Adequacy of church support	1.18	0.25	1.34	0.37	**-3.09**
10	Accessibility of YMA support	1.09	0.28	1.15	0.35	-1.18
11	Quality of YMA support	1.04	0.15	1.05	0.13	-0.27
12	Adequacy of YMA support	1.02	0.10	1.04	0.13	-0.90
13	Accessibility of MHIP support	1.17	0.40	1.25	0.44	-1.06
14	Quality of MHIP support	1.13	0.33	1.13	0.31	-0.16
15	Adequacy of MHIP support	1.10	0.31	1.09	0.21	0.16
16	Accessibility of MUP support	1.03	0.18	1.08	0.28	-1.33
17	Quality of MUP support	1.01	0.08	1.00	0.00	1.25
18	Adequacy of MUP support	1.01	0.07	1.00	0.00	1.28
19	Accessibility of NGOs support	1.02	0.16	1.15	0.41	**-2.40**
20	Quality of NGOs support	1.00	0.04	1.06	0.22	**-2.27**
21	Adequacy of NGOs support	1.00	0.04	1.06	0.21	**-2.06**

Source : Computed

Table 39 shows the distribution of children according to gender differences in terms of accessibility, quality and adequacy across secondary social support agents *viz.* peers, school, church, YMA, MHIP, MUP and NGOs.

From the table, we can see that there is a low frequency score in the accessibility of peer support among both male (1.68) and female (2.00). It can also be seen that there is no gender differences in the t-test score of accessibility of peer support.

The frequency of quality of peer support is very low (0.73) among males while the frequency if quality of peer support is low (1.12) among females. The t-test score indicates that there is a significant gender differences in the quality of peer support (-**2.11**) as the score of female respondents is higher than the males.

The adequacy of peer support has low frequency among both male respondents (1.51) and female respondents (1.74). It can be seen that there is no gender difference in the t-test score of adequacy of peer support.

Except for quality of peer support, the findings are similar to the study made by Wendeborg and Tosserbo (2011) where they found no gender differences in the support received from peers.

The accessibility of school support shows moderate frequency among both male (2.76) and female (2.72). There is no gender difference in the t-test score of accessibility of school support.

The frequency of quality of school support is low (2.49) among the male respondents while it is found that is moderate among the female respondents (2.59). However, the t-test score does not show any gender differences in the quality of school support.

Further, we see that the accessibility of church support have very low (1.38) frequency among male respondents while the frequency of accessibility of church support is low (1.69) among female respondents. The t-test score shows that there is a gender differences in the accessibility of church support (**-3.26**) as male score higher frequency than the females.

The frequency of quality of church support is very low among both male (1.26) and female (1.47) respondents. The t-test score of quality of church support shows significant gender difference (**-3.14**) where the score of female respondents is higher than male respondents.

The mean score in the adequacy of church support is very low among boys (1.18) and girls (1.34). In the t-test score, we see that there is a gender differences (**-3.09**) as girls score higher frequency than the boys.

In the accessibility of YMA support, there is a very low mean score among male 1.09 and female (1.15) respondents. The t-test score indicates that there are no gender differences in the accessibility of YMA support.

The frequency of quality of YMA support is very low among male respondents (1.04) and female respondents (1.05). Further, the t-test score shows that there is no gender difference in the quality of YMA support.

The frequency of adequacy of YMA support is also very low among both male (1.02) and female respondents (1.04). The score of the t-test demonstrate that there is no gender difference in the quality of YMA support.

The mean score of both male (1.17) and female (1.25) in the accessibility of MHIP support is very low. The t-test score indicates there is no difference in gender in terms of accessibility of MHIP support.

There is a very low frequency in the quality of MHIP support among both male (1.13) and female (1.13) respondents. In the t-test score, it is seen that there is no gender differences in the quality of MHIP support.

The adequacy of MHIP support has a very low mean score among male (1.10) and female (1.09) respondents. We can see that there is no indication of gender difference in the t-test score.

The frequency of accessibility of MUP support is very low among both male (1.03) and female respondents (1.08). The score of the t-test demonstrate that there is no gender difference in the accessibility of MUP support.

The mean score in the quality of MUP support is very low among boys (1.01) and girls (1.00). The t-test score indicates there is no difference in gender in terms of quality of MUP support.

There is a very low frequency in the adequacy of MUP support among both male (1.01) and female (1.00) respondents. In the t-test score, it is seen that there is no gender differences in the adequacy of MUP support.

The frequency of the accessibility of support from NGOs is very low among boys (1.02) and girls (1.15). The t-test score shows that there is a significant gender difference in the accessibility of support from NGO (**-2.40**) where the score of girls is higher than males.

The quality of support from NGOs has a very low frequency among male (1.10) and female (1.06) respondents. We can see that there is a significant gender difference in the t-test score as the score of female is higher than the males.

The frequency of the adequacy of support from NGOs is very low among boys (1.00) and girls (1.06). There is also a significant gender difference in the t-test score where the frequency of adequacy of support from NGOs is higher among females.

Table 40: Gender Differences (t-test) across Tertiary Social Support Agents

Sl.No.	**Social support**	**Gender**				t
		Male		**Female**		
		Mean	**SD**	**Mean**	**SD**	
1	Accessibility of LC/VC support	1.03	0.18	1.08	0.26	-1.23
2	Quality of LC/VC support	1.01	0.08	1.00	0.01	1.03
3	Adequacy of LC/VC support	1.01	0.04	1.00	0.01	0.75
4	Accessibility of Government Support	1.41	0.65	1.54	0.68	-1.14
5	Quality of Government support	1.32	0.57	1.37	0.49	-0.50
6	Adequacy of Government support	1.28	0.58	1.33	0.50	-0.49

Source : Computed

Table 40 shows the distribution of children according to gender differences in terms of accessibility, quality and adequacy across tertiary social support agents *viz.* LC/VC and Government.

From the table, it can be seen that the frequency of support from LC/VC in terms of accessibility is very low among male respondents (1.03) and female respondents (1.08) is high. The t-test score shows that there is no gender difference in the accessibility of support from LC/VC.

It can also be seen that frequency of quality of support from LC/VC among male students is also very low (1.01). Similarly, we can also see that the quality of support from LC/VC among male students is also very low (1.00). The t-test score shows that there is no gender difference in quality of family support.

The frequency of adequacy of support from LC/VC is also very low among males (1.01) and females (1.00). The t-test score shows that there is no gender difference in adequacy of LC/VC.

We can see that there is a very low frequency (1.41) in the accessibility of government support among male respondents. At the same time, the frequency of accessibility of government support is low (1.54) among female respondents. . It can also be seen that there is no gender differences in the t-test score of accessibility of government support.

The frequency of quality of government support is very low among male (1.32) and female (1.37) respondents. The t-test score indicates that there is no gender difference in the quality of government support.

The adequacy of government support has very low frequency among both male respondents (1.28) and female respondents (1.33). It can be seen that there is no gender difference in the t-test score.

This finding reflects the study of Ollson et.al (2015) where there is no gender differences in the support provided for Children with Disabilities.

Table 41: Suggestions to improve Social Support

Sl.No.	Suggestions	Gender		Total N=132
		Male n=73	Female n=59	
1	More awareness on schemes and services for CwDs	28 (38.3)	30 (50.8)	58 (43.9)
2	Recruitment of special educators in all Schools	22 (30.1)	21 (35.5)	43 (32.5)
3	More Awareness about Disability	18 (24.6)	22 (37.2)	40 (30.3)
4	Measures to end stigmatization, discrimination and exclusion	16 (21.9)	17 (28.8)	33 (25.0)
5	Skill training programmes for Disabled	11 (15.0)	12 (20.3)	23 (17.4)
6	More support from NGOs and Church	11 (15.0)	9 (15.2)	20 (15.1)
7	More support from Government	7 (9.5)	13 (22.0)	20 (15.1)
8	Implementation of schemes and programmes for PwDs	5 (6.8)	7 (11.8)	12 (9.1)
9	Establishment of rehabilitation and counseling centers	6 (8.2)	6 (10.1)	12 (9.0)
10	Income generation programme for families of CwDs	8 (10.9)	2 (3.3)	10 (7.5)
11	Barrier Free Environment	4 (5.4)	5 (8.4)	9 (6.8)
12	Brail Facilities in Libraries and in board examination	0 (0.0)	7 (11.8)	7 (5.3)

Source : Computed Figures in parenthesis indicates percentages

Table 41 shows the different suggestions made by the respondents. The suggestions include more awareness on schemes and services for CwDs (43.9%), recruitment of special educators in all Schools (32.5%), more awareness on disability (30.3%), measures to end stigmatization, discrimination and exclusion (25.0%), conducting skill training programmes for disabled (17.4%), more support from NGOs and Church (15.1%), more support from Government (15.1%), implementation of schemes and programmes for disabled (9.1%), establishment of rehabilitation and counseling centers (9.0%), , income generation programme for families with CwDs (7.5%), barrier free environment (6.8%) and Brail facilities in libraries and in board examination (5.3%).

4.4 Quality of Life

This section will discuss the findings related to the quality of life of Children with Disabilities across the domains, quality of life by age and gender and relationships among the various domains of quality of life.

Table 42 Quality of Life across Domains

Sl.No	Domains	Mean	SD
1	Environment	65.5	8.8
2	Psychological	62.5	9.0
3	Physical	53.7	12.1
4	Social Relations	36.7	9.6
	Total Mean	**54.6**	**9.9**

Source : Computed

Table 42 shows the mean score of Quality of Life of children across the domains of Quality of Life.

From the table, we can see that the overall mean score of quality of life is moderate (54.6) not too high, not too low. The table shows that the quality of life of children with disabilities is the highest in the environment domain (65.5) followed by psychological domain (62.5) and physical domain (53.7).

Among the domains of quality of life, the quality of life of children with disabilities is the lowest in the social relationships (36.7). This is in contrast of the findings of Torres & Vieira (2014) and Chhangte (2017).

Table 43: Quality of Life by Age (t-test on dependent variables)

Sl.No	Domain	Age				t
		10-13 years		14-17 years		
		Mean	SD	Mean	SD	
1	Physical health	54.9	11.4	51.8	13.1	1.4
2	Psychological	62.7	8.7	62.3	9.4	0.3
3	Social Relationships	38.2	8.6	34.5	10.6	**2.2**
4	Environment	65.5	8.2	65.6	9.8	-0.1
	Overall Quality of Life	55.3	9.2	53.6	10.7	1.9

Source : Computed

Table 43 shows the distribution of quality of life of children according to age. Here, the age of children with disabilities is divided into two groups *viz.* 10-13 years and 14-17 years. From the table it can be seen that in the domain of physical health, the quality of life is moderate among both the age groups 10 -13 years (54.9) and 14-17 years (51.8). In the Psychological domain, the quality of life of children is high among both the age groups 10-13 years (62.7) and 14-17 years (62.3). The quality of life of children of both the age groups 10-13 years (38.2) and 14-17 years (34.5) is low in the social relationships domain. The quality of life of children is again high in the environment domain among both the age group 10-13 years (65.5) and 14-17 years (65.6).

In the t-test score of relationship between age and Quality of life, it can be seen that there is a significant relationship (**2.2**) between age and quality of life in the domain of social relationships where the quality of life decreases with the increase in age. However, in the t test score of relationship between age and quality of life, there is no relationship between age and quality of life in the domains of physical health (1.4), psychological (0.3) and environment (-0.1).

However, in the overall t-test score (1.9) between quality of life and age, we see that there is no relationship between age and quality of life. *This rejects the hypothesis of the study that was based on (Chow et.al, 2005) where quality of life decreases with increase in age.*

Table 44: Quality of Life by Gender (t-test on dependent variables)

Sl.No	**Domains**	**Gender**				**Total**		**t**
		Male		**Female**				
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	
1	Physical Health	56.2	10.9	50.5	12.9	53.7	12.1	**2.7**
2	Psychological	62.9	8.8	62.0	9.2	62.5	9.0	0.6
3	Social Relationships	36.9	9.5	36.5	9.7	36.7	9.6	0.3
4	Environment	65.9	8.2	65.0	9.6	65.5	8.8	0.6
Overall Quality of Life		55.5	9.4	53.5	10.4	54.6	9.9	**2.2**

Source: Computed

Table 44 highlights the distribution of children according to the quality of life by gender across the domains of quality of life *viz.* psychological, physical health, social relationships and environment.

From the table, we can see that the physical health domain of quality of life, the quality of life of children is moderate (53.7). We see that quality of life is significantly higher among boys (56.2) than girls (50.5) in the physical health domain of quality of life. The t-test score shows that there is a significant gender differences in the physical health domain (**2.7**) of quality of life of the children as the quality of life of boys is significantly higher than girls.

In the psychological domain, the quality of life of children is high (62.5) among male (62.9) and female (62.0). The t-test shows that there are no significant gender differences in the environment domain of quality of life.

The quality of life of children is low (36.9) in the social relationships domain. The mean score of male is 56.2 while the mean score of female is 50.5. The t-test score shows that there are no gender differences in the social relationships domain of quality of life.

The quality of life of children in the environment domain of quality of life is high (65.5) among both boys (65.9) and girls (65.0). The t-test score shows that there are no significant gender differences in the environment domain of quality of life.

However, in the overall score of quality of life, the quality of life of children is moderate (54.6)) It can be seen from the table that the quality of life of boys (55.5) is significantly higher than girls (55.3) in the social relationships domain. The overall t-test score (**2.2**) shows that there is differences in the quality of life of the children across gender. *This also rejects the hypothesis of the study based on Moore et.al (2010) and Akel et.al (2013) where there is no difference in Quality of Life across Gender.*

Table 45: Correlation of the various Domains of Quality of Life

Sl. No	**Domains**	**Physical Health**	**Psychological**	**Social Relationships**	**Environment**	**Overall Quality of Life**
1	Physical health	1	**.234****	.141	.168	**.640****
2	Psychological	**.234****	1	**.334****	**.276****	**.653****
3	Social Relationship	.141	**.334****	1	**.394****	**.485****
4	Environment	.168	**.276****	**.394****	1	**.454****
5	Overall Quality of Life	**.640****	**.653****	**.485****	**.454****	1

Source : Computed

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 45 shows correlation among the Domains of Quality of Life of the children. The *p* values are 0.01 and 0.05 which is tested in two directions (2-tailed). Different domains of quality of life include physical health, psychological, social relationships and environment.

The table shows that there is a significant correlation between physical health domain and psychological domain (.234**) at 0.01 significant level. But, we can see that physical health has no correlation with social relationships (.141) and environment (.168). However, There is a significant correlation between Physical health domain and overall quality of life (.640**) at 0.01 level. This shows that physical health of a child has a significant effect in the quality of life in the psychological domain while it does not have any effects on the quality of life of a child in the domains of social relationships and environment. However, the quality of life of a child in the physical health domain has an effect on the overall quality of life.

The Psychological domain of quality of life have a significant correlation with all domains of psychological (.234**), Social relationships (.334**) and environment (.276**). Therefore, there is a significant correlation between psychological domain and overall quality of life (.653**) at 0.01 level. This shows that the psychological aspect of a child has a significant effect on the overall quality of life of a child.

The social relationships domain has no significant correlation with the physical health domain (.141) while it has a significant correlations with the psychological (.334**) and environment (.394**) domains of quality of life. However, the social relationships domain has a significant correlation with the overall quality of life (.485**) at 0.01 level. This shows that the social relationships of a child does not have an effect of the quality of life of a child in the Physical health domain while it has a significant effect on the quality of life of a child in the domains of social relationships and environment. Therefore, the overall quality of life is determined by the quality of life of a child in the social relationships domain.

There is no significant correlation between the environment and physical health (.168) domains of quality of life. But we can see that the environment domain of quality of life has a significant correlation with the psychological (.276**) and social relationships (.394**) domains of quality of life at 0.01. Thus, a significant correlation is observed between environment domain and overall quality of life (.454**) at 0.01 level. This shows that the environment of a child does not affect the quality of life of a child in the physical health domain while it has significant effects on the quality of life of a child in the psychological and social relationships domain of life at 0.01 significant levels. Therefore, the quality of life in the environment domain has an effect on the overall quality of life.

Thus, we can see that the overall quality of life has a significant correlation with all the domains of Physical health (.640**), psychological (.653**), social relationships (.485**) and environment (.454**) at 0.01 level. This is in contrast with the findings of Chhangte (2017).

4.5 Social Support and Quality of Life

This section will discuss the findings related to the relationship between Social Support and Quality of Life of Children with Disabilities.

Table 46: Correlation of Primary Social Support and Quality of Life

Sl. No	**Social Support**	**Physical health**	**Psychological**	**Social relationships**	**Environment**	**Quality of Life**
1	Accessibility of Family support	.114	.059	**.190***	**.185***	.075
2	Quality of Family support	.081	.039	**.183***	.165	.060
3	Adequacy of Family support	.089	.089	**.201***	**.229****	.114

Source : Computed

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 46 shows the correlation of primary social support and the quality of life. . The *p* values are 0.01 and 0.05 which is tested in two directions (2-tailed). The primary social support include accessibility, quality and adequacy of family support, support from peers and school support. The quality of life includes physical health domain, psychological domain, social relationships domain, environment domain and overall quality of life.

From the table, we can see that the accessibility of family support does not have any correlation with the quality of life at the physical health domain (.114), psychological domain (.059) while it has a significant correlation with the social relationships (.190*) and environment (.185*) domains of quality of life at 0.05 level. However Accessibility of family support does not have a correlation with the overall quality of life (.075). This means that though the accessibility of family support has a significant effect on the quality of life at social relationships and environment domains, it does not have significant effects on the overall quality of life of a child.

The quality of family support does not have a significant correlation with the physical health (.081), Psychological (.039) and environment (.165) while it has a significant correlation with the social relationships domain (.183*) at a 0.05 level. However quality of family support does not have a significant correlation with the overall quality of life (.060). This indicates that though the quality of family support has a significant effect on the quality of life of a child in the social relationships domain, it does not have significant effects of the overall quality of life of a child.

We can see that there is no correlation of family support with physical health (.089) and psychological (.089) domains while we see correlation between adequacy of family support with social relationships domain (.201*) at 0.05 level. We also see a significant correlation between adequacy of family support and environment domain (.229**) at 0.01 level. However, there is no correlation between the adequacy of family support and overall quality of life (.114). This illustrates that though the adequacy of family support has a significant affects on the quality of life of a child in social relationships (at 0.05 level) and environment (at 0.01 level), it does not have a significant effects on the overall quality of life of a child.

This is in contrary with the findings of Sultan et.al in 2016 where he found that family support also has great effects on the quality of life.

Table 47: Correlation of Secondary Social Support and Quality of Life

Sl. No	Social Support	Physical health	Psychological	Social relationships	Environment	Quality of Life
1	Accessibility of Peer support	0.05	-0.002	**.247****	-0.167	0.061
2	Quality of Peer support	0.026	0.056	**.251****	-0.128	0.097
3	Adequacy of Peer support	0.076	0.06	**.253****	-0.086	0.123
4	Accessibility of School support	**.206***	**.232****	**.272****	0.145	**.342****
5	Quality of School support	**.189***	**.240****	**.314****	**.190***	**.362****
6	Adequacy of School support	**.189***	**.281****	**.335****	**.246****	**.404****
7	Accessibility of Church support	**-.233****	-0.12	-0.052	**-.174***	**-.287****
8	Quality of Church support	**-.285****	-0.067	-0.041	-0.165	**-.248****
9	Adequacy of church support	**-.257****	0	-0.006	-0.127	**-.177***
10	Accessibility of YMA support	-0.089	**-.174***	-0.125	**-.320****	**-.227****
11	Quality of YMA support	-0.054	-0.035	-0.076	-0.102	-0.123
12	Adequacy of YMA support	-0.087	-0.055	-0.08	-0.145	-0.148
13	Accessibility of MHIP support	0.023	-0.056	-0.062	-0.119	-0.091
14	Quality of MHIP support	0.025	0.057	0	0.065	0.006
15	Adequacy of MHIP support	0.095	0.065	0.016	0.081	0.039

16	Accessibility of MUP support	0.006	**-.226****	-0.139	**-.418****	**-.193***
17	Quality of MUP support	-0.049	-0.165	-0.149	**-.243****	**-.176***
18	Adequacy of MUP support	-0.038	-0.126	-0.152	**-.212***	-0.148
19	Accessibility of NGOs support	-0.027	**-.227****	-0.055	**-.364****	**-.194***
20	Quality of NGOs support	-0.083	-0.085	0.039	**-.197***	-0.065
21	Adequacy of NGOs support	-0.092	-0.07	0.021	-0.162	-0.058

Source : Computed **Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 47 shows the correlation of secondary social support and the quality of life. . The *p* values are 0.01 and 0.05 which is tested in two directions (2-tailed). The secondary social support includes accessibility, quality and adequacy of support from peers, school, church, YMA, MHIP and NGOs, support from peers and school support. The quality of life includes the physical health domain, psychological domain, social relationships domain, environment domain and overall quality of life.

The table shows that the accessibility of peer support does not have a significant correlation with the physical health (.050), psychological (-.002) and environment (.-167) domains, but it has a significant correlation with social relationships domain (.247**) at a 0.01 level. However, the accessibility of peer support does not have a significant correlation with the overall quality of life. Thos shows that though accessibility of peer support has a significant effect on the quality of life of a child in the social relationships domain, it does not have any affects on the overall quality of life of a child.

There is no correlation between quality of peer support and physical health (.026), psychological (.956) and environment (-.128) while there is a significant correlation between quality of peer support and social relationships domain (.251**)

at 0.01 level. However, there is no significant correlation between quality of peer support and overall quality of life (.097). This illustrates that though quality of peer support effects the quality of life of a child in the social relationships domain, it does not have a significant effect on the overall quality of life of a child.

The adequacy of peer support does not have a significant correlation with the physical (.076), psychological (.060) and environment (-.086) domains of quality of life. At the same time, there is a significant correlation between the adequacy of peer support and social relationships (.253**) domains of quality of life at 0.01. However, we can see that there is no significant correlation between adequacy of peer support ad overall quality of life (.123). This indicates that though adequacy of peer support has a significant effect on the quality of life of a child in the social relationships domain, it does not have a significant effect on the overall quality of life of a child.

We can see that there is a significant correlation between accessibility of peer support and physical health domain (.206*) of quality of life at 0.05 level. We also see that accessibility of school support has a significant correlation with the physical health (.190*) psychological domain (.232**) and social relationships domain (.272**) of quality of life at 0.01 level. But we can see that there is no correlation between accessibility of school support and environment domain (.145) of quality of life. However, we can see that there is a significant correlation between accessibility of school support and overall quality of life (.342**) at 0.01 level. This shows that the accessibility of school support has a significant effect on the quality of life of a child in the physical (at 0.05 level), psychological (at 0.01 level) and social relationships (at 0.01 level) domains. Thus, accessibility of school support has a significant effect on the overall quality of life of a child.

The quality of school support has a significant correlation with all domains of quality of life in which it has a significant correlation with physical health (.189*) and environment (.190*) at 0.05 level. And at the same time, the quality of school support has a significant correlation with psychological (.240**) and social relationships (.314**) at 0.01 level. Therefore, there is a significant correlation between quality of school support and overall quality of life (.362**) at 0.01 level.

This indicates that quality of school support has a significant effect on the quality of life of a child at all domains and thus has an effect on the overall quality of a child.

Further, we see that there is a significant correlation between adequacy of school support and quality of life at all domains where it has a significant correlation with physical health (.189*) at 0.05 level and has a significant correlation with psychological (.281**), social relationships (.335**) and environment (.246**) domains at 0.01 level. Thus, there is a significant between quality of school support and overall quality (.404**) at 0.01 level. This shows that the quality of school support has a significant effect on the quality of life of a child at all domains. Therefore, the quality of school support has a significant effect on the quality of life of a child.

The table also shows that there is a significant correlation between accessibility of church support and physical health domain (-.233**) at 0.01 level. The accessibility of church support has no correlation with psychological domain (-.120) and social relationships domain (-.052) of quality of life. We can also see that there is a significant correlation between accessibility of church support and environment domain (-.174*) at 0.05 level. Therefore we can see that there is a significant correlation between accessibility of church support and the overall quality of life (-.297**) at 0.01level. This means that the accessibility of church support determine the quality of life of a child.

There is a significant correlation between quality of church support and physical health domain (-.285**) at 0.01 level. But, the quality of church support does not have a significant correlation with psychological domain (-.067), social relationships domain (-.041) and environment domain (-.067) of quality of life. However, there is a significant correlation between quality of church support and overall quality of life (-.248**). This means that though the quality of church support do not have a significant effects on the quality of life of a child in the psychological, social relationships and environment domains of life, it has an effect on the overall quality of life of a child.

The adequacy of church support has a significant correlation with thw physical health domain (-.257**) at 0.01 level while it does not have a correlation with the psychological (.000), social relationships (-.006) and environment (-.127) domains. However, there is a significant correlation between adequacy of church support and the overall quality of life (-.177**) at 0.01 level. This means that the adequacy of church support has an effect on the quality of life of a child.

We can see from the table that the accessibility of YMA support does not have a significant correlation with the physical health (-.089) and social relationships (-.125) domains. We can also see that there is a significant correlation between accessibility of YMA support and psychological domain (-.174*) at 0.05 level. The table also depicts that there is a significant correlation between accessibility of YMA support and environment domain (-.320**) at 0.01 level. Consequently, we see that there is a significant correlation between accessibility of YMA support and overall quality of life (-.227**) at 0.01 level. This means that though the accessibility of YMA support does not have an effect on the quality of life of child in the physical health and social relationships domain, it has a considerable effect of the overall quality of life of a child.

The quality of YMA support does not have correlation with all domains of physical health (-.054), psychological (-035), social relationships (-.076) and environment (-.102). Therefore, there is no correlation between the quality of YMA support and overall quality of life (-.123) at 0.01 or 0.05 level. This means that the accessibility of YMA support does not have any effect on the quality of life of a child.

We also see that there is no correlation between adequacy of YMA support and all domains of physical health (-.087), psychological (-055), social relationships (-.080) and environment (-.145). Thus, we can see that there is no correlation between adequacy of YMA support and overall quality of life (-.148). This means that the adequacy of YMA support does not determine the quality of life of a child.

The table indicates that the accessibility of MHIP support does not have a correlation with any of the domains of physical health (-.025), psychological (-.057), social relationships (-.000) and environment (-.065). Hence there is no correlation between accessibility of MHIP support and overall quality of life (-.091). This denotes that the accessibility of life does not have an impact on the quality of life of a child.

It is also observed from the table that there is no correlation between quality of MHIP support and all domains of physical health (-.023), psychological (-.056), social relationships (-.062) and environment (-.119) at 0.01 or 0.05 level. Therefore there is no correlation between the quality of MHIP support and overall quality of life (-.091). This shows that quality of MHIP support does not determine the quality of life of a child.

The adequacy of MHIP support does not have any correlation with all the domains of physical health (.095), psychological (.065), social relationships (.016) and environment (.081). Therefore, no correlation is observed between MHIP support and overall quality of life (.039) neither at 0.01 or 0.05 level. This means that the adequacy of MHIP support doeas not have any effects on the quality of life of a child living with disability.

It can also be seen from the table that the accessibility of MUP support has no correlation with physical health (.006) and social relationships domain (-.139). On the other hand, we can see that the accessibility of MUP support has a correlation with psychological (-.226**) and environment (-.418**) domains of quality of life at 0.01 level. Therefore, we can see that the accessibility of MUP support has a significant correlation with the overall quality of life (-.193*) at 0.05 level. This shows that the accessibility of MUP support has an effect on the quality of life of a child.

It is also observed that there is no correlation between quality of MUP support with the domains of physical health (-.049), psychological (-.165) and social relationships (-.149). But we find a significant correlation between the quality of MUP support and environment domain (-.243**) at 0.01 level. Therefore, we observe a significant correlation between quality of MUP support and overall quality of life (-.176*) at 0.05 level. This means that the quality of MUP support determine the quality of life of a child.

It can also be seen that the adequacy of MUP support has no correlation with the domains of physical health (.038), psychological (-.126), and social relationships (-.152). But we can see that the adequacy of MUP support has a significant correlation with environment (-.212*) at 0.01 level. However, there is no correlation between adequacy of MUP support and the overall quality of life (-.148). This shows that the quality of life of a child is not determined by the adequacy of MUP support.

The accessibility of support from NGOs does not have a significant correlation with the physical health (-.027) and social relationships (-.055) domain while it has a significant correlation with the psychological (-.227**) and environment (-.364**) at 0.01 level. However, we can see that the accessibility of support from NGOs has a significant correlation with the overall quality of life (-.194*) at 0.05 level. This means that though accessibility of support from NGOs does not have an effect on the quality of life in the physical and social relationships domain, it determines the overall quality of life of a child.

The quality of support from NGOs does not have a correlation with the domains of physical health (-.083), psychological (-.085) and social relationships (.039). On the other hand, the quality of support from NGOs has a significant relationship with the environment domain (-.197*) at 0.05 level. However, there is no correlation between quality of support from NGOs with the overall quality of life (-.065). This means that the quality of life of a child is not determined by the quality of support from NGOs.

Further, the adequacy of support from NGOs does not have correlation with all the domains of physical (-.092), psychological (-.070), social relations (-.021) and environment (-.162). Therefore, adequacy of support from NGOs does not have correlation with the overall quality of life (-.058). This means that the adequacy of support from NGOs has no affect on the quality of life of a child.

This finding is in contrary with the findings of Sultan et.al in 2016 in which it was found that peer support has considerable impact on Quality of Life. And at the same time, the findings reflects the findings of Ignjatović (2019) who found that Quality of Life was also improved based on the types of support and services received.

Table 48: Correlation of Tertiary Social Support and Quality of Life

Sl. No	Social Support	Physical health	Psychological	Social relationships	Environment	Quality of Life
1	Accessibility of LC/VC support	.044	**-.221***	-.088	**-.356****	**-.174***
2	Quality of LC/VC support	.064	-.050	-.004	-.061	-.014
3	Adequacy of LC/VC support	.072	-.014	-.004	-.044	.018
4	Accessibility of Government support	-.035	**.229****	.105	.001	**.175***
5	Quality of Government support	-.009	**.301****	.165	.140	**.256****
6	Adequacy of Government support	-.015	**.335****	**.198***	**.173***	**.287****

Source : Computed

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 48 shows the correlation of tertiary social support and the quality of life. The *p* values are 0.01 and 0.05 which is tested in two directions (2-tailed). The tertiary social support includes accessibility, quality and adequacy of support from local council and government. The quality of life includes the physical health domain, psychological domain, social relationships domain, environment domain and overall quality of life.

From the table it can be seen that accessibility of support from LC/VC has no correlation with physical health (.044) and social relationships domain (-.088). We can see that the accessibility of support from LC/VC has a correlation with psychological (-.221*) at 0.05 level and at the same time it has a significant correlation with the environment (.356**) at 0.01 level. Therefore, accessibility of support from LC/VC has a significant correlation with the overall quality of life (-.174*) at 0.05 level. This shows that the accessibility of support from LC/VC has an effect on the quality of life of a child.

It is also observed that there is no correlation between quality of support from LC/VC and all domains of physical health (.064), psychological (-.050) social relations (-.004) and environment (-.061). Therefore, there is no correlation between quality of support from LC/VC and the overall quality of life (-.014). This means that the quality of support from LC/VC does not determine the quality of life of a child.

The quality of support from LC/VC does not have a correlation with any of the domains of physical health (.064), psychological (-.050), social relationships (-.004) and environment (-.061). Therefore, there is no correlation between quality of support from LC/VC and the overall quality of life (.014). This means that the quality of support from LC/VC does not have an effect on the quality of life.

It can also be observed that the adequacy of support from LC/VC has no correlation with all the domains of physical health (.072), psychological (-.014), social relationships (-.004) and environment (-.044). Therefore, there is no correlation between adequacy of support from LC/VC and the overall quality of life (.018) at 0.01 or 0.05 level. This shows that the quality of life of a child is not determined by the adequacy of support from LC/VC.

Accessibility of government support has no correlation with physical health (-.035), social relationships (.105) and environment (.001) domains. However, a significant correlation is observed between accessibility of government support and psychological domain (.220**) at 0.01 level. Hence, a correlation is observed between accessibility of government support and the overall quality of life (.175*) at 0.05 level. This means that though the accessibility of government support does not have an effect on the quality of life of children in the physical health, social relationships and environment domains, it has an effect on the overall quality of children.

Quality of government support has no correlation with physical health (-.009), social relationships (.165) and environment (.140) domains. But, a significant correlation is observed between quality of Government support and psychological (.301**) at 0.01 level. Therefore, a significant correlation is observed between quality of government support and the overall quality of life (.256**). This means that though the quality of government support does not determine the quality of life in the physical health, social relationships and environment domains, it determines the overall quality of life of a child.

No correlation is observed between adequacy of government support and physical health (-.015). On the other hand, a significant correlation is observed between adequacy of government support and psychological domain (.335**) at a 0.01 level. There is also a significant correlation between adequacy of government support with social relationships (.198*) and environment (.173*) at 0.05 level. Therefore, a significant correlation is observed between adequacy of government support and the overall quality of life (.287**) at 0.01 level. This means that the adequacy of government support determine the quality of life of a child.

This finding relates to the finding of Ignjatović (2019) who found that Quality of Life was also improved based on the types of support and services received.

4.6 Lived Experiences of Caregivers

In-depth interviews were conducted among eight (8) caregivers of children with disabilities to understand their lived experiences with regard to disability of their children. The findings are presented as case vignettes.

Case 1

A 43 years old Mawii (fictitious) is a mother of a 12 year old daughter with multiple disability. During her pregnancy, she had no complaints but as fate would have had it, her child was born with a birth condition where the baby had an opening on the upper lip because of cleft palate. At first, when she saw her baby, she did not have the courage to hold the child let alone look at it. She was filled with pain and could not accept her child's condition.

They underwent several surgeries in order to restore the opening of the lip. However, as the child grew, the child experienced developmental delays and could not walk even at the age of two years. This increased her pain and ordeal. In her own words she related, "My world was covered with thick darkness and I could not have a clear mind". They again went for surgery to Imphal and it was at this time when she received prayers from church leaders which helped her accept the condition of her child and began to think positively.

They do not encounter severe challenge within the society but, when people often stare at her child, she feels pain once. She had placed her child to a special school but due to transportation barrier, she shifted her to a main stream private school in her community. After being in a main stream school and seeing other children walk and run, her daughter started to learn to walk. In school, her daughter was sometimes mistreated and bullied by her classmates. Some parents rather than apologizing for their child's behaviour, showed anger and were protective about their children against her child. Because of this, she shifted her daughter to a government school nearby her house. Her daughter started to have seizure and she felt that the mid day meal provided in school might not be nutritious enough. At the age of 7, she took her daughter to Guwahati for operation. But as the child started to learn walking, the doctor told them to come again by the time she complete 11 years of age.

At present, she has mix feelings about taking her daughter for operation since there was no assurance that her daughter will be able to walk after the operation and more over, she does not want make her daughter to suffer more by going through another operation. She said that there is lack of information on support from government and is difficult to access government support. She feels that there is lack of support for children with disabilities but do not complain because acceptance improves her mental health. The disability of her child also prevents her from working in a regular basis.

Case 2

Liani (fictitious), 38 years old, is a mother of a child with cerebral palsy. The doctor performed a C-section 8 days before her due date; the reason for which she believed resulted in her child's disability. The problem started by the time her child was 3 months old. When consulting a doctor, they could not understand what the doctor wrote on the OPD case sheet. When they asked the nurses who were on duty, they hesitated to respond. They have consulted many doctors but each doctor had a different comment on their child's disability where some said there is nothing to worry about the child's condition while others were cautious about the child's condition.

They were admitted in hospitals several times but no development could be seen. With a hope that their child might be able to walk, they even took her for therapy, but nothing worked. Her daughter is completely dependent on others even for toileting and because of this, Liani could not work or socialize. Even when she had to go out, the child had to be under the care of one family member. Her child's disability restricted the family to participate in social events including church service.

Case 3

Puii (fictitious) is a 32 year old female who has a sister with intellectual disability. Her mother also suffers from a chronic health disease and because of this, she had to look after her sister. Her sister's disability was diagnosed when her sister was 4 years old. At that time, Puii was just 19 years old. Because of her sister's disability, she had to discontinue her studies to look after her. It was just recently that she continued her studies and completed her B.Ed Special Education programme through distance education.

She placed her sister in a special school thinking that she would receive better education. However, she found out that the teachers were not well trained and lacked the required skills. According to her, the special school ran more or less like a day care centre than an educational institution.

Puii feels bad about the stigma her sister faces in the community and because of this, she does not allow her sister to socialize much in public. Her sister's disability also restricts her from participating in social gatherings. She does not have time to socialize and does not even have time to stay in a relationship. She says that she is fine with it because she is happy helping her family.

Case 4

Thani (fictitious), 44 years, is a mother of two disabled children. The first child suffers from multiple disabilities while the second child suffers from intellectual disability. Her husband died soon after their second child was born. Being a single mother, she has to earn her living and at the same time have to look after her children. Her life is full of heavy work load and burden. She is also assisted by her 65 year old mother who lives with them.

She placed both of her children to school though there were no trained teachers. During school time, she has free time to work and earn peacefully without getting worried about her children. She often feels bad for not being able to afford medical treatment for her children and feels that her children's condition might improve if she could get early intervention. She hopes for her children to get treatment at a lower price in the city, but she is not in a condition to even afford transportation cost to reach the city. She often blames herself for not being able to provide the best support to her children. But on the other hand, she feels thankful to God for protecting them and guiding them and for giving her the strength to look after her children. She is not aware of the programmes and services which are available for children with disabilities and does not know where to inquire about the services or whom to approach. She is very much worried about her children in case she dies.

Case 5

Zovi (fictitious) is a single mother of a disabled child. Her daughter had a severe seizure when she was 3 months old, after which the condition of her child worsened. She never thought that she would have a disabled child. And at first, she found it difficult to accept and to add up to her desolation, her husband divorced her and she had to look after her daughter alone. In her own words, she said, “It was really tough for a single mother to take care of a disabled child who requires full time engagement”. Because of the high dependency of her child, she could not get engaged in any work to earn money. Moreover, her daughter has to regularly use diapers which require a lot of money.

They have obtained a disability certificate and because of this, they could receive a small amount of money from government primary school. Though she finds it hard to accept her child’s disability at the beginning, she now accepts their condition and wanted to provide and do the best for her child. She thinks that there is little support for children with disabilities but do not complain about it. This is because she thinks that being happy for everything that happened in life is good for mental health .

Case 6

Sanga (fictitious), 38 years old, is a father of a 5 year old disabled child who suffers from hearing impairment. His son’s disability was diagnosed when the child was 1 year and six months old. Since his son is the first child, he could not accept his situation. He was really hurt when he found out his child’s condition especially when thinking about their economic condition. His wife too felt no different. Knowing that he have to try his best, Sanga consoled his wife saying that everything happens for one’s own good and that God will provide what they needed.

He related that it was really difficult to communicate with their child because the child could not hear or respond to verbal communications. Moreover, there were no schools that had a trained teacher who could teach sign language and it was very difficult to acquire communication skill. There are times when they could not understand what their child was trying to say.

Sanga worries about their child's education because there are no special educators who could teach in sign language in their town. Though there are special schools in the city, he is unsure if he could send his son for education because the cost for education is very high. He fears that he might not afford to send his son for education.

Case 7

Ruata, a 35 years old father has a 5 year old disabled child suffering from intellectual disability. Right from the moment he came to know about his child's disability, he accepted the situation and believed that God had chosen him to be a father of a disabled child and accepted his responsibility to provide his child the best care that he could give. Though he accepted their situation, his wife could not accept the child's disability till today.

They sent their child to a private school but there was no development in their child. They did not seek any support from CBOs, Church and Government because his wife did not allow getting their child registered. His wife feared that their child would be categorised as a disabled by the society if they registered their child in such programmes and services. When he tried to pursue disability certificate, his wife stopped him out of fear of stigmatisation.

Case 8

Chhuani is a 43 year old mother of three. Her youngest male son has multiple disabilities. Not long after birth, her son had seizures and they were asked to take him to the city for treatment. They could not go for better treatment because they do not have money. Because of the seizure, the child acquired multiple disabilities. The expenditure for care and support of their child was expensive since the child has to take medicine and used diapers regularly. Because of their poor background, Chhuani had to work to earn even though her son needed her attention.

As her son requires continuous care and support her eldest daughter had to drop out from school to look after him while she was away for work. The other sister also had very poor attendance in school since there were many time she had to stay home to look after her disabled brother. They did not obtain a disability certificate because they do not know how to pursue it. And since they do not have a disability certificate, they could not get themselves registered in any of the schemes and programmes provided for the disabled by the government. Because of her child's disability, Chhuani has no time to socialize and cannot even attend the church service on Sundays.

Analysis of the Cases

The above cases depict the actual life situations of caregivers of children with disabilities in Mizoram. From the cases, we see the dynamics of poverty as cause of not being able to provide for care and support and also disability increasing the scope of financial difficulties among care givers. We also see evidences of non-acceptance by parents not because of any stigma and discrimination but because of love and emotions that parents have for their children and this hinders the child to participate and socialise with peers in the community. There are evidences of self blame among the caregivers too. However, in some cases, caregivers have hope and accept their situations wilfully and this creates a better environment for their mental health. Religion and spirituality is found as one aspects of coping mechanism for caregivers.

The cases also reveal presence of stigma and discrimination in society and how all these impacts the mental health of caregivers who suffer from stress, anxiety and depression related problems. To add to more burden of caregivers, the cases also reveal that disability disrupts marital relationship and even leads to divorce.

Role conflicts are also evident from the cases as caregivers have to look after their children and work at the same time. Alternative support are sought from schools where children are placed during caregivers occupations for work and besides this, other family members also take part as alternative supporters when the main bread winner has to work. This in some instances lead to dropout of siblings and low attendance in schools. In some cases, we also see that caregivers have no opportunity to work at all putting them at risk to more poverty. Disability also affects the social life of the caregivers.

Caregiver’s effort to educate and train their children is also evident in the cases, however, we also see that lack of facilities, trained manpower in schools and environmental barriers are seen as hindrances for their children to learn or develop at all. The cases also show that there is lack of support in information regarding accessing various kinds of services available for children with disabilities.

4.7 Case Vignettes

In depth interviews were also conducted with the children and also with the help of their caregivers across the districts to understand the lived experiences of the children and the various challenges they face. These finding are presented in case vignettes.

Case 1

A 17 year old intellectually disabled girl Didiki (fictitious) was born to a middle income class family. Right from her childhood, there was a deformity on her chest. Her physical health condition was also very poor. She had difficulty in sleeping and continuously cried. She was taken to a hospital but no diagnosis was given. The doctor at the hospital told them that it was one kind of asthma, which was very common during early childhood and was given medications for asthma. But her problem never really went away and continued to have sleeping disorder. So, they went to a private clinic where no diagnosis was found either. The doctor in the private clinic told the parents that the problem of the child would go away as she grows up if they take good care of her.

Though her parents took care of her as much as they could, the problem never really went away. She was continuously taken for checkups. With a number of medications and treatments, her problem seemed to reduce however, never to the level of being cured. No diagnosis was made even after she attained 4 years of age.

She was then admitted to one of the government schools in her community. She was very poor in studies and lacked far behind her classmates. Since her academic performances were poor, her parents thought that the education system of the school was poor. So, she was shifted to another government primary school. Even here, no improvement or development took place. The parents started to have doubt that their child might have some kind of disability. Even though they had this doubt, they did not gave up hope and made her continue her education in the main stream school till class 3.

A special educator, who knew about her disability visited her parents and asked them to let her join the government school in which she was working. But her mother did not allow sending her to that school because most of the children who were admitted in that school were intellectually disabled. Moreover, there was stigmatization, discrimination and exclusion from the community towards the children who were admitted to that school. But after knowing the importance of their child’s special education, her parents shifted her to the school where a specially trained teacher was available. Here, she began her education by reading in class II with the help of a special educator and she began to show great improvement in her studies. It was the school that even helped her to pursue disability certificate. Didiki started to lose interest in class IV since she was not so good in studies and eventually dropped out.

She loves to take part and participate in church activities especially in Kristian Thalai Pawl (Christian Youth Fellowship). She receives love and care from the fellowship members and she participates in dramas and other activities.

Case 2

Tluanga (fictitious) is a 13 year old boy who suffers from intellectual disability. He comes from a poor economic background. Right from his birth, he suffered from a poor health condition. During his early childhood, he suffered from pneumonia and was admitted to the hospital several times. Because of his illness, he even lost his eyesight during his early childhood but with medical treatment, he recovered. Since has poor physical health condition, he also experienced near death situations many times. During his devastating conditions, he received care and support from the church congregation. The doctors and medical staffs also tried their best to help him survive. And it was only with the help of medical treatment, and prayers that he could overcome these situations.

Though he recovered from his physical illness, he showed some delays in his physical and mental development. He was smaller than his age group and his mental aptitude fell behind peers of his age group. He was admitted to a special school but had to discontinue because of transportation problem. Though the school provided a van which picks up students, the pickup point was really far from his home. Moreover, his parents had to go for work and could not drop him to the pickup point every day.

In spite of his disability, he is a very happy and cheerful boy loves football. Every day, goes out early in the morning and practice the game at A.R ground (Lammual). Here, he meets famous Mizo football players (whom he calls his team mates) and loves to interact with them. The players always manage time to play football with him after their practice. And because of this, he assumes himself as being a member of the team and never wants to miss a match that took place in Aizawl.

At present, a new private special school was established near his home and he is presently enrolled in the school and has obtained a disability certificate.

Case 3

Mawia is a 17 year old boy who suffers from multiple disabilities. He lives with his family who makes ends meet for their livelihood. His problem started when he suffered meningitis when he was 7 months old. He was admitted to hospitals several times, but his condition did not improve. There were signs of delay in mental development and when he was two years old, he was taken to a doctor because he had not started walking. The doctor told his parents that he will not be able to walk because of some damage in his brain.

During his early childhood, he actively went to church and attended sunday schools. But as he grew older, he was mistreated, teased and excluded by his peers. Because of his experience, he started to possess insecurities and hesitated to socialize.

He attended school that had no trained teacher and soon after he was placed in a special school. But in the special school, he started developed anti-social behavior and dropped out soon after. He received a wheelchair from the government, but the quality was poor and there was no security since the wheelchair did not come with a safety belt. Moreover, the size of the wheelchair was big for him. In addition, the roads and infrastructures of buildings were not accessible for a wheelchair.

His disability hinders him from participating in social gatherings especially during Christmas because the church does not have a special provision for the disabled to take part in the Christmas festivals.

Case 4

A 17 year old intellectually disabled boy Zuala (fictitious) was born to a low income family. He was the second child and had one elder step-sister and 3 younger step-brothers. His mother had behavioural problem, roamed around, eloping with different men and was hardly home. Because of this, his grandmother looked after him right from his childhood. At birth, he was born a healthy baby and by the time he was 3 years old, he had high fever and was taken to the hospital immediately. He was admitted in the hospital and from the first night he had seizure. After receiving treatment from the hospital, he was finally discharged. But again, he continued to have fever on the very night of his discharge. He was again admitted to the hospital and had seizure more often than before (four to five times a day).

He was then referred to Guwahati where he received treatment. After coming back from Guwahati, he started to loss his memory and could not even recognize his family members and relatives. Regardless of his health condition, he was admitted to a main stream school but the teachers referred him to a special school saying that the mainstream school was not suitable for him and that there were no special educators who could help him in his studies. Though his grandmother did not totally accept his disability, he was sent to a special school. On going to a special school, he started to have a lot of insecurities and had a feeling of being disabled. He often asked his grandmother why he was sent to a disabled school. He could not adjust himself in the special school for which he had to drop out of school.

They had applied for a disability certificate and the workers said that the certificate will reach them through post. But till now, they have not received the certificate. At present, their main source of income is the pension salary of his deceased grandfather.

Case 5

An 11 year old girl Kimi (fictitious) who suffers from multiple disability was born to a poor family in a rural area. Her parents got divorced when she was very young. She had a poor health condition right from her early childhood. She had been admitted to hospitals several times and was even referred to the city for better treatment. But due to financial problem, they could not afford for such services.

She lacked behind her peers and had severe mental development delays. She was sent to a government primary school but she did not show much progress in her academic performances. It was difficult for her how to read or even write her name. In spite of her disability, she now has a good physical health and shows great physical growth.

At present, she is still reading in class I. She feels insecure and has low self esteem because she was bigger than her classmates. Adding to her suffering, her classmates tease her. She stays isolated from others and her friends because of what she experiences in schools and often hesitates to go to school.

Case 6

Muana (fictitious), an intellectually disabled was born to a poor economic family. His father passed away when he was just 5 years old. Their main source of income is the pension of his diseased father.

During early childhood, his disability was never diagnosed. It was only after going to school that his disability was being diagnosed. In school, he lacks far behind his friends and was sent up to the next class according to his age even though no improvements were made in his academic performances. In school, he was often teased because of his disability. He was often being manipulated and made fun of by his class mates. The situation was not being reported to the teacher because his parents fear that he would be bullied more because of the complaints. He often hesitates to go to school and his attendance in school has become really poor. He does not yet obtain a disability certificate because his parents do not want their child to be categorized as a disabled. They want him to live as normal as possible and function normally in the society.

They have not yet obtained a disability certificate because they do not the how to access it. And since they do not have one, they do not receive any support from the Government.

Case 7

Hlua (fictitious), a 15 year old boy who is suffering from cerebral palsy was born a normal baby. Like any other child he went to school and performed well in class. When he was studying in Class 1, he had high fever that caused several seizures. He was admitted to a hospital and after being hospitalized, he was sent back to school. Here, his mental ability started to decline and could not memorize the things learnt in schools. He even forgot how to read and write. They went for checkups several times and even went to the city for referral. But, no diagnosis was made. Because of his problem, he could not continue education. His condition became worse and he could not function normally any more. The doctors from the city referred him to go out of Mizoram for treatment but because of financial problem, his parents could not afford it.

Because of his disability, his dependency on others increased and a lot of money was invested by his parents. He has not yet obtained a disability certificate. His mother knows the requirements of disability certificate in accessing different schemes, so she inquires about how to obtain disability certificate at the hospital but no one could give her any information.

Case 8

An 11 year old Ziri (fictitious) who suffers from hearing impairment was born to a poor family. Her parents divorced when she was only 6 months old for which she hadto stay with her maternal grandparents. Her disability was not diagnosed until she was 2 years old. Even after completing two years of age, she did not learn to talk nor seem to understand when people speak to her. Therefore, she was taken to the city for check up where she was diagnosed. The doctor told her parents that an operation might cure her impairment but they could not afford the operation. Her grandfather had bought her a hearing aid which was very really expensive. But this hearing aid did not seem to be of much help for her.

She was admitted to a private special school where she studied till class 3. But since the fees were expensive, they were unable to afford the educational expenses for which she had to discontinue her education.

Recently, they has inquired about the RBSK scheme which provide financial assistance for operation of chronic diseases. But they came to learn that the scheme did not cover operation for hearing impairment. They also inquired about the financial assistance in the Social Welfare Department but the scheme here grants only 5 lakhs wile the operaion cost was 15 lakhs. Because of this, they could undergo any operation as yet.

Analysis of the Cases

The above cases reveal that quick diagnoses or detection prevented for early intervention which may have led to more sever implications for children and their disability. Poverty is also seen as one factor that hinders early detection and intervention.

The cases also show that there are high rates of multiple disability, intellectual disability and hearing impairment among children and these are not always genetic or caused by birth but because of other types of health related problems that could be prevented.

The cases also highlight evidences of stigma and discrimination leading to mental health problems among children with disabilities in Mizoram, thus causing them to feel out of place wherever they are and affects their attendances in schools and, in some cases, to the point where they even dropout from schools. Lack of trained teachers in schools also seems to be another challenges faced by the children, a result of which leads parents to admit their children to special schools. This hampers inclusive education.

The cases also reveal high support system from the family and care-givers but, as for support from other stakeholders, there seems to be gaps between the clients as well as the service providers.

4.8 Focus Group Discussion (FGD)

This section will include findings related to the focus group discussion which were conducted during the research. A total number of two (2) FGDs were among children with disabilities between the ages of 10-17 years where one group comprised of visually impaired children and the other comprised of hearing impaired children. The venue, names and other details of participants have been concealed to maintain confidentiality.

Group 1

The first group consists of children who are Visually Impaired. The group was composed of six (6) boys and five (5) girls. The topic of the group discussion was ‘Challenges and Social Support System of Visually Impaired children.’ The findings of the discussion are as follows:

- Visual Impaired children are often seen as objects of charity.
- People assuming that they cannot hear, gossip about them while they are around.
- It is unsafe to go out without a blind stick.
- When exposed to a new environment, it takes time to adjust themselves.
- They suffer from social exclusion.
- They are insecure and suffer from low-self esteem.
- They prefer to be friends with children who suffer from the same type of disability than the normal children.

- There is lack of brail books especially text books.
- There is no brail exam in board examinations.
- It is difficult to find brail books in libraries.
- Family is the main source for emotional support.
- The School provides them with assistive device such as blind stick, phone, brail watch and brail Kits.
- Visual Impaired children have a positive outlook.
- They receive financial support from the church on disabled day and Christmas.
- Some of the children receive financial and instrumental support from YMA, MHIP and MUP.
- Children are not aware of the available support and services.
- There is lack of support in the society and from government.

Group 2

The second group discussion was conducted among Hearing Impaired Children composed of 5 boys and 5 girls. The topic of the group discussion was ‘Challenges and Social Support System of Hearing Impaired children.’ The findings of the discussion are as follows:

- Communication barrier is the main problem because most of the people do not understand sign language
- Hearing Impaired children are often excluded by peers.
- They have difficulty in understanding the sermons in churches and Sunday schools.
- They are at a higher risk of being bullied by others.
- They do not see themselves as a disabled and wanted the people to also accept that they are no different from them.
- Because of their disability, it is difficult to make friends.
- The church provides financial assistance once every year.
- The YMA also sometimes provide them with financial support.

- They prefer to be with hearing impaired children than the normal children.
- Among the participants, two had received hearing aid from the government but for the rest, it was not accessible.

4.9 Participatory Techniques

This section shall include the findings related to participatory research techniques that were utilized during the study in order to enhance participation from the children. These findings enriched the conclusions of the study. Two participatory techniques were conducted such as causal tree analysis and daily activities schedule. The results and findings are as follows:

Fig 2: Causal Tree Analysis I

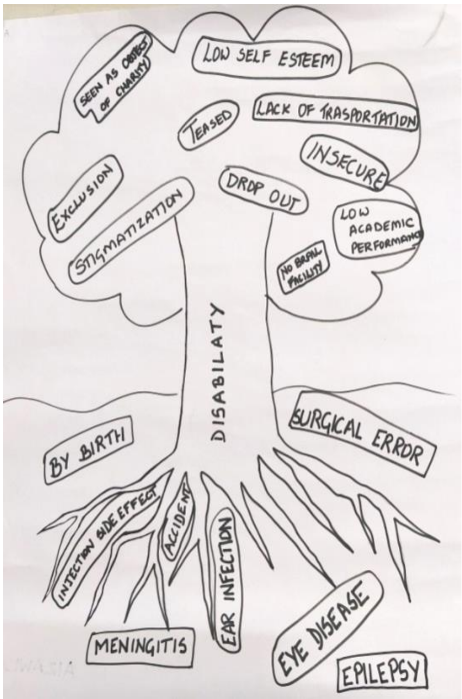

Fig.3: Causal Tree Analysis II

Fig. 4: Causal Tree Analysis III

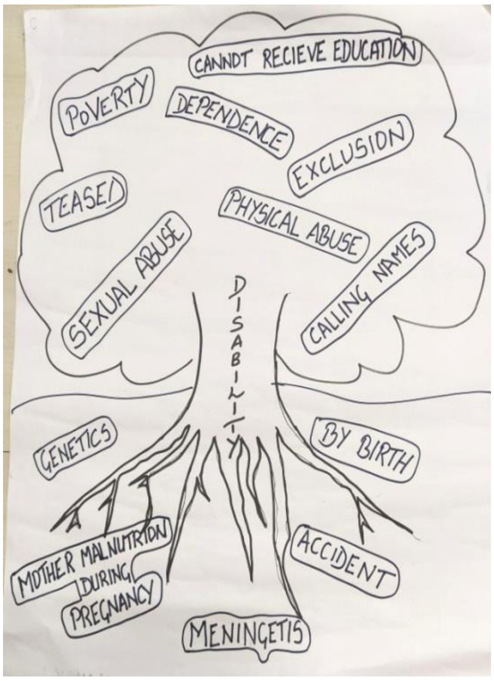

Fig. 5 Causal Tree Analysis IV

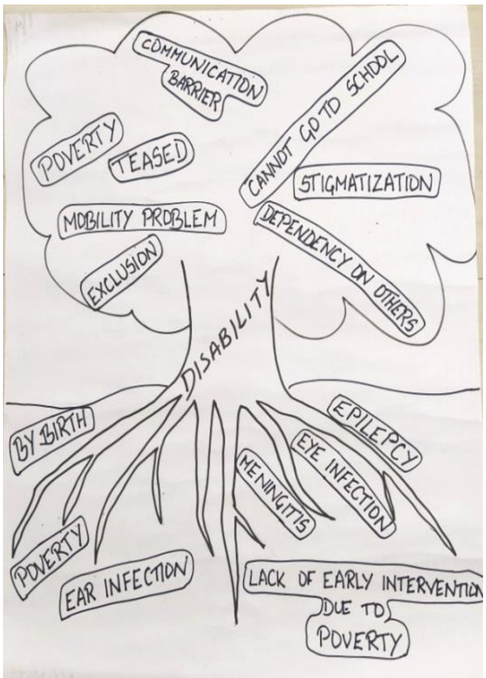

Figure 2, 3, 4 and 5 highlights the findings of the causal tree analysis with children with disabilities. The causal tree analysis depicts the causes and effects of disability.

From the figures, we see that the causes of disability includes those acquired from birth, poverty, lack of early intervention, eye infection, ear infection, meningitis, epilepsy, accident, mother’s health during pregnancy, genetics, injection side effect, surgical error and consumption of marijuana.

The effects of disability on the child include stigma, discrimination, exclusion, teasing, insecurities, low self esteem, school dropout, low academic performances, seen as object of charity, health problems, mobility problem, academic problem, dependency, physical abuse and sexual abuse.

Fig.6: Daily Activities Schedule of School-Going Children

DAILY ACTIVITY SHEDULE OF SCHOOL GOING CwDs

WEEK DAYS

TIME	ACTIVITIES
7:00am	WAKE UP
7:00am-8:00am	WASH UP, DRESS UP FOR SCHOOL
8:00am	BREAKFAST
8:30am	GO TO SCHOOL
9:00am - 2:30 pm	GO TO SCHOOL
2:30pm - 4:00pm	DO HOMEWORK/PLAY
4:00pm - 5:00pm	WASH UP
5:00pm	DINNER
7:00pm - 8:30pm	STUDY
8:30pm - 9:00pm	READY FOR BED
9:00pm	BED TIME

WEEKEND

SATURDAY

TIME	ACTIVITIES
8:00am	Wake up
9:30am	Breakfast
Forenoon	Study and bathing
Afternoon	Recess/Play/Phone game
5:30pm	Dinner
7:00-8:30pm	Study/Church
9:00pm	Bed time

SUNDAY

TIME	ACTIVITIES
7:00am	Wake up
8:00am	Breakfast
10:00am-11:00am	church
11:00am-12:30pm	lunch
1:00pm-3:00pm	church
3:00pm-5:00pm	Rest
5:00pm-5:30pm	Dinner
5:30pm-7:00pm	Dress for church/Rest
7:00pm-8:30pm	Church/Study
9:00pm	Bed time

Fig.7: Daily Activities Schedule of Non-School Going Children

DAILY ACTIVITIES SHEDULE OF NON SCHOOL GOING CwDs

MONDAY - SATURDAY

5:30am	Wake up
5:30am-800am	Doing household chores/ fetching water.
8:00am	Breakfast
9:00am - 12:00pm	Helping parents/help in quarry work/play phone games
12:00pm - 1:00pm	Lunch
1:00pm - 4:00pm	Help prepare dinner/Do household chores/help parents in work/ visit friends.
4:00pm - 5:00pm	Wash up
5:00pm	Dinner
5:00pm - 8:00pm	Church/Play phone games/watch TV on youtube
8:00pm	Bed time

SUNDAY

5:30am - 8:00am	Wake up/Refreshing/Fetching water
8:00am	Dinner
8:00am - 9:00am	Dress for church
9:00am - 11:30am	Church
11:30am - 12:00pm	Lunch
12:00pm-1:00 pm	Rest
1:00pm - 3:00pm	Church
3:00pm - 5:00pm	Play phone games/watching TV on youtube/ play with friends
5:00pm - 6:00pm	Dinner
6:00pm - 8:00pm	Church/Rest
8:00pm	Bed time

Figure 6 shows the daily activities schedule of school going children with disabilities while Figure 7 shows that daily activities schedule non-school going children with disabilities.

From both the figures, we can see that both school going and non-school going children have ample time for leisure activities. The non-school going children wake up earlier than the school going children and non-going school going children are more likely to take part in household activity and in helping the family, while school going children spend more time in school and studies. The daily activities of the school going children is more or less similar because they are influenced by specific timings of the school while the daily activities of non-school going children differs according to the family and the child.

CHAPTER V

CONCLUSION

Children with Disabilities are one of the most underprivileged groups of societies who experience various kinds of discrimination and exclusion. Children with disabilities (CwDs) are presumably hindered from realizing their rights to health care, education, and even for survival. They are less likely to attend school or be enrolled in school, have access to medical and other services, or to the worse, have their voices heard in society (UNICEF, 2017).

They often have lower quality of life than the other children (Schmidt, 2005; Moore et.al, 2010). Even though the Quality of life of Children with Disabilities tends to be low, Quality of Life can extensively be increased by the provision or improving social support (Szilagyi, 2012 & Olsson et.al 2015).

According to Childline (2010), it is estimated that 1.67 per cent of the 0-19 population are living with one or more disability in India, out of which 35.29 per cent of them are children. As compared to other countries, very little has been done for handicapped in India. Children with Disabilities belong to families having low income and majority of them were living in rural areas (Mohisini & Gandhi, 1982).

According to Census 2011, Mizoram has an estimated population of 15,160 persons with disabilities among which 3,748 populations belong to the age group 0-19 years (Census 2011). Because of their disability, children with disabilities have low academic performances and to extent, are likely to drop out of school (Lalmuanpuii, 2016). The quality of life of persons living with disabilities is observed to be low. Social support is one of the important factor for the elevation of children with disabilities in Mizoram (Chhangte, 2017). In Mizoram, there exist very little amount of services for Children with disability. There is also a wide gap between the availability and accessibility of services for Children with Disability in Mizoram (Lalmuanpuii, 2016).

According to the Rights of the Persons with Disabilities (RPwD) Act, 2016, “person with disability means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others”.

According to Article 1 of the Convention on the Rights of the Persons with Disabilities (RPwD) Act, the term, 'children with disabilities' is used to refer 'all children up to the age of 18 years who have 'long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

Social support can be referred to as various types of assistance or help that people receive from others (John and Katherine, 2008). It can can also be defined as "resources provided by others that is used for coping assistance or can be said as exchange of resources" (Schwarze, Knoll & Rieckmann, 2003). The different dimensions of social support include, informational support, emotional support, esteem support, social network support and tangible support (Cutrona and Suhr, 1992)

The World Health Organisation (WHO) defines quality of life (QoL) as 'the individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns' (WHO 1997). The WHO (1996) has given four domains of quality of life *viz.* physical health domain, psychological domain, social relationships domain and environment domain.

The present study is descriptive in design and adopted a mixed method. The study was conducted in 4 district of Mizoram. Data were collected from both primary and secondary source. The unit of the study is Children with Disabilities in Mizoram.

A multi stage sampling procedure was utilized for the study. Both quantitative and qualitative methods were administered in the study. The quantitative methods include semi structured interview schedule and WHOQOL-BREF questionnaires. A semi-structured interview schedule was used for finding the socio demographic profile and the dimensions of social support. A five point scale was constructed to measure the social support across seven (7) dimensions based on items of availability, quality and adequacy of support. A WHOQOL-BREF was administered for measuring the quality of life of Children with Disabilities in Mizoram and measures the quality of life at four domains *viz.* physical health domain, psychological domain, social relationships domain and environment domain. The qualitative method include case study, in depth interview, focus group discussion and participatory techniques.

The quantitative data were analyzed using Microsoft Excel and SPSS package. Descriptive statistics, simple frequency and means were presented to find out the socio demographic profile, family characteristics, disability profile, quality of life and social support across agents as well as across dimensions of Children with Disabilities. Social Support was analyzed based upon the 5 scale tool constructed and Quality of Life was analyzed based upon WHOQOL-BREF. T-Test was used to find out gender differences on primary, secondary and tertiary social support agents of Children with Disabilities. T-test was also used to find out differences in the quality of life of Children with Disabilities across gender and age groups. Pearson's correlation co-efficient was used to find out the relationship among and between domains of quality of life. Pearson's correlation co-efficient was also used for finding out the relationship between social support and quality of life. Qualitative findings using case studies, in-depth interview and focus group discussions are presented accordingly to get an in-depth knowledge about the objectives of the study. The findings of Participatory Rural Appraisal (PRA) using Causal Tree Analysis and Daily Activities Schedule are also presented and analyzed accordingly.

For ethical reasons, only children who can be interviewed between the ages of 10 to 17 years were identified. Caregivers were also utilized for their support during data collection. Children were included in the sample only after taking consent from them or their caregivers. All names of the respondents are concealed to maintain confidentiality.

5.1 Major Findings

The socio-demographic profile of the respondents show that male respondents are more in number and that children belonging to 10-14 years are more than those children belonging to 14- 17 years. Majority of the respondents belong to Lusei tribe and almost all the respondents are Christians belonging to Presbyterian denomination. The highest numbers of children are from Nuclear family. It is also found that majority of children have a stable form of family. The largest number of children are school going who are studying in primary school. There are few children who drop out of school and the most common reason for dropping out is loss of interest in education followed by mobility barrier, disability and difficulty in adjustment, stigmatization, discrimination and exclusion. A very few number of children never went to school and the main reason is because parents do not allow their children to be enrolled in schools. Similar finding is seen in the case study and focus group discussion. There are very few who were employed where the nature of work include quarry work and daily labour.

Among the children, those that have a father who studied till high school constitute the highest and the main occupation of fathers was daily labour. Children who have mothers who studied till high school level constitute the highest. Majority of the mothers are home makers who are unemployed and the same finding is seen in the case studies and focus group discussions. Regarding the socio-economic category, children belonging to BPL family constitute the highest number and the same finding is seen in the case studies.

With regards to the history of disability of the children, majority of the children acquire disability by birth. The other causes of disability includes disability which were caused due to meningitis during early childhood and accident, disability caused due to epilepsy during early childhood, tumor in the brain, eye disease during childhood, septicemia, tuberculosis, dog bight, ear infection, injection side effects and genetics. We have similar finding in the case study and causal tree analysis. A very few of the causes of disability were not known. Children with Intellectual disability constitute the highest number followed by children with muscular dystrophy, multiple disability, hearing impairment, blindness, dwarfism and psoriasis. Among the children, majority have obtained disability certificate while few have not obtained disability certificate due to certain reasons that includes not knowing the process of how to obtain disability certificate, do not have time to pursue disability certificate, negligence, parental denial of child's disability, parental belief for improvement of child and not being able to appear in the medical board due to mobility problem. A similar finding is also drawn in the case studies and focus group discussions.

The respondents reported 19 types of challenges that includes stigma and discrimination, low academic performance, lack of information on available services for CwDs, inability to perform certain task, insecurities, low self esteem and isolation, dependence, poverty, school dropout , never been enrolled in school, difficulty in understanding class lectures, lack of trained teachers, lack of brail facilities, communication barrier, barriers in accessing services for CwDs, health issues, physical abuse and sexual abuse. The similar types of challenges were also being found in the case study, focus group discussions and causal tree analysis.

Family support is the only support which is rated high in terms of accessibility, quality and adequacy. There is no gender differences in the accessibility, quality and adequacy of support from primary agents accept in the quality of peer support. Among the support from secondary supporters, we find gender differences in the accessibility, quality and adequacy of church support and support from NGOs. No gender difference was observed in the accessibility, quality and adequacy of support from tertiary supporters.

The overall quality of life of children with disability is moderate. The quality of life of children with disabilities is highest in the environment domain of quality of life. There are no differences in quality of life across age groups and also it is observed that there are no differences in quality of life across gender. Thus, rejecting the hypothesis of the study. However, this can be because of socio-cultural dynamics and differences in scales used to study the same.

There is correlation between overall quality of life and all the domains of quality of life. Among the primary social support, accessibility, quality and adequacy of school support have a significant correlation with the overall quality of life. Among the secondary social support, it is observed that the accessibility, quality and adequacy of church support and accessibility of YMA support and NGOs support have a significant correlation with the overall quality of life. In the tertiary social support, the accessibility, quality and adequacy of government support and accessibility of support from local council have correlation with the overall quality of life.

Child disability not only has an effect on the child itself but also on the whole family. Parents find it hard to accept their child's disability and the journey often starts with sorrow and disappointment. Avoidance and self-blame were most common among mothers. Child's disability affects the older sibling's chances of going to school, working for a living, enjoying family life and participation in social life. Child's disability also hinders social participation of family and restricts them from attending social gatherings.

5. 2 Suggestions

From the light of the findings, the following suggestions may be made for policy formulation and social work intervention.

- Awareness on children and disability is not adequate. Therefore, more awareness on children and disability must be conducted. The awareness must be conducated at all levels covering individuals, groups and community.

- It is also very important to conduct workshop for care givers and family of Children with Disabilities.

- Measures must be taken to improve early identification and intervention programmes for disability in Mizoram.

- Financial problem was one of the main barrier encountered by children with disabilities. Therefore, poverty alleviation programmes must be implemented for children with disabilities in Mizoram.

- Trained teachers or special educators must be recruited in all the schools of Mizoram so as to improve the educational status of children with disabilities.

- Many of the children do not obtain disability certificate because they do not know the process. Thus, measures must also be taken to provide better information on the process of accessing different kinds of services and benefits available for children with disabilities in Mizoram.

- Infrastructures must also be improved to create barrier free environment for children with disabilities. Improvement in infrastructures shall also increase the accessibility of services for children with disabilities in Mizoram.
- Government and other service providers must monitor the implementation of certain schemes for children with disabilities so that the services reach the right beneficiaries without discrimination.
- Mothers of children with disabilities were hindered from working in full time jobs because of their child's disability and still. Therefore, measures must be taken to implement income generation programmes that are case specific for children with disabilities so that children with disabilities would be able to receive better financial support.
- Skill training programmes for children with disabilities must also be implemented so that children will be able to acquire some skills to be financially stable once they reach maturity.
- As for hearing impaired children, especially those living in rural areas, communication is one of the main challenges encountered by them where they encounter problem to even communicate with their parents. Therefore, measures must be taken so that hearing impaired children and their parents will be able to learn and understand sign language for communication.
- Educational institutions and libraries of Mizoram lacks brail facilities. Therefore, measures must be taken so that brail facilities will be available for visually impaired children in educational institutions and libraries of Mizoram.
- As seen in the Rights of the Persons with Disabilities act (2016), suitable modifications must be made in the curriculum and examination system to

meet the needs of students with disabilities that include brail exams in board examination.

- As it goes away from family, the accessibility, the quality and the adequacy of support decreases. Therefore measures must be taken to improve the social support across secondary and tertiary group for children with disabilities in Mizoram at all dimensions.

- The accessibility, quality and adequacy of school support have an impact quality of life of children with disabilities. Therefore measures must be taken to improve the social support provided by the school so as to increase the quality of life of CwDs.

- Measures must also be taken so that the church provide better support for children with disabilities in Mizoram because the study shows that the quality of life of children with disabilities is determined by the support of church.

- YMA and NGO's must also take initiatives to provide support for children with disabilities because the support of YMA and NGO's was found to have an effect on the quality of life of children with disabilities in Mizoram.

- Since all the domains of quality of life have an impact on the overall quality of life, we cannot neglect any of the domains of the quality. Measures should also be taken to increase the quality of life at all domains.

Apendices

Interview Schedule (Engish Version)

Social Support and Quality of Life among Children with Disabilities in Mizoram

Interview Schedule
(Confidential and for Research Purpose only)

Research Scholar **Ms. C. Lalmuanpuii,** **Ph.D Scholar** **Department of Social Work,** **Mizoram University**	**Supervisor** **Dr. Henry ZodinlianaPachuau** **Asst. Professor** **Department of Social Work,** **Mizoram University**
Schedule Number:	Date:

I.	**PERSONAL CHARACTERISTICS**		
1.	Name	:	
2.	Age	:	
3.	Gender(Tick)	:	Male/Female
4.	Sub Tribe(Tick)	:	Lusei/Paihte/Hmar/Mara/Lai/Others (________________)
5.	Religion(Tick)	:	Christianity/ Hindu/Mosolman/ Bhuddist/ Others (____________)
6.	Religious Denomination	:	
7.	Present Address	:	
8.	Permanent Address	:	
9.	Type of Family(Tick)	:	Nuclear Family/Joint Family/Staying with relatives
10.	Form of Family(Tick)	:	Stable/Broken /Reconstituted/ Others(_____)
11.	Educational Status(Tick)	:	Never went to School/ School Going/ Drop Out
12.	If never gone to school, indicate reason	:	
13.	If school going, indicate class	:	
14	If Drop out, reason for drop out	:	
15	Drop out at what class	:	
16.	Father's Educational Status(Tick)	:	Illiterate/Primary/Middle/High School/Higher/College/PG
17.	Moher's Educational Status(Tick)	:	Illiterate/Primary/Middle/High School/Higher/College/PG
18.	Socio -Economic Category of family(Tick)	:	AAY/BPL/APL /No catagory
19.	Father's Occupation(Tick)	:	Govt.Servant/ Business/ Daily Wage Labourer/ Cultivator/Others (_____________)
20.	Mother's Occupation(Tick)	:	Govt.Servant/ Business/ Daily Wage Labourer/ Cultivator/Others (_____________)
21	Father's monthly Income	:	
22	Mother's Monthly Income	:	
23.	Are you employed (Tick)	:	Yes / No
24.	If yes, specify occupation	:	
25.	Monthly Income	:	

26.	Type of disability (Tick)	:	i. Physical Disability a) Locomotor Disability Leprosy Cured/ Cerebral Palsy/ Dwarfism/ Muscular Dystrophy/ Acid Attack Victims b) Visual Impairment Blindness / Low vision c) Hearing Impaired Deaf / Hard of hearing d) Speech and Language Disability ii. Intellectual Disability a) Learning Disability b) Autistic Spectrum Disorder iii. Mental Behaviour a) Mental Illness iv. Disability caused due to a) Chronic Neurological condition Multiple Selerosis/Parkinson's Disease b) Blood Disorder Haemopholia / Thalassemia / Sickle Cell Disease v. Multiple Disability vi. Any Other (Specify)
27.	Reason for Disability	:	
28.	Disability certificate	:	Obtained / Not obtained
29.	If not, Reason?	:	
30.	Challenges faced as a result of disability	:	
II	**DIMENSIONS OF SOCIAL SUPPORT**		
31	**Family Support**		

Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 3; AC:Accessible2; NACI;Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

32 Support from Peers

Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

33 Support from School

Sl. No	**Form of Support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

34	**Support from Church**															
Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

35 Support from YMA

Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

36	**Support from MHIP**															
Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

37	**Support from MUP**															
Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional counseling, guidance and															

	psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

38 **Support from Local Council/Village Councils**

Sl. No	**Form of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support (professional															

	counseling, guidance and psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

39 **Support from NGOs**

Sl. No	**Kinds of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health Support															

	(professional counseling, guidance and psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

40 **Support from Government**

Sl. No	**Kinds of support**	**Accessibility**					**Quality**					**Adequacy**				
		VAC 5	**AC 4**	**NACI 3**	**IAC 2**	**VIAC 1**	**VG 5**	**G 4**	**NGP 3**	**P 2**	**VP 1**	**VA 5**	**A 4**	**NAI 3**	**IA 2**	**VIA 1**
i	Provisions for basic needs (Food, shelter and clothing)															
ii	Emotional Support (Love, care, concern,empathy, sympathy)															
iii	Physical Health Support (medical attention, provisions and services)															
iv	Mental Health															

	Support (professional counseling, guidance and psychiatric care and services)															
v	Support in Life Skills (Education and training including vocational training)															
vi	Financial Support (sponsorship, donation, aid or help in form of money)															
vii	Instrumental Support (Aids, Appliances, Certificates and goods)															
viii	Others (Specify)															

VAC: Very Accessible 5; AC:Accessible4; NACI; Neither accessible nor inaccessible3;IAC: Inaccessible2; VIAC: Very Inaccessible 1
VG: Very Good5; G:Good 4; NGP: Neither Good nor poor3;P: Poor 2; VP: Very Poor 1
VA: Very Adequate 5; A: Adequate 4;NAI:Neither Adequate nor inadequate3; IA:Inadequate2; VIA: Very Inadequate 1

41	**Any other suggessions or comments regarding Social Support for disability?**

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last four weeks.**

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5

17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Do you have any comments about the assessment?

Interview Schedule (Mizo Version)

Mizorama Naupang Rualbanlote Puihdan leh an Nun atana Hamthatna Zirna Zawhna Lehkha

(Engkim thup a ni anga Zirna atan chiah a hman tur ani)

Zirchiangtu **Ms. C. Lalmuanpuii,** **Ph.D Scholar** **Department of Social Work,** **Mizoram University**		**Kaihruaitu** **Dr. Henry ZodinlianaPachuau** **Asst. Professor** **Department of Social Work,** **Mizoram University**
Lehkha Number:		Ni :

I.	**MIMAL CHANCHIN**		
1.	Hming	:	
2.	Kum zat	:	
3.	Mipa nge Hmeichhia	:	
4.	Hnam	:	Lusei/Paihte/Hmar/Mara/Lai/ A dang (________________)
5.	Sakhua	:	Kristian/ Hindu/Mosolman/ Bhuddist/ A dang (___________)
6.	Kohhran	:	
7.	Chenna hmun diktak (Veng/Khua)	:	
8.	Tuna chenna hmun (Veng/Awmna Hmun Hming)	:	
9.	Chhungkaw khawsak dan	:	Hringtu te leh unau diktak te nena chengho / Hringtu te leh unau diktak te bakah pi leh pute leh chhung dangte nena chengho/ Lainate bula cheng
10.	Chhungkaw ziarang	:	Chhungkaw nghet/ Chhungkaw kehdarh /Chhungkaw inzawmhkawm leh/ adang (_____)
11.	Zirna lam	:	Sikul kal lo hrim hrim/ Sikul kal/ Sikul chawlhsan
12.	Sikul la kal lo hrim hrim a nih chuan engnge a chhan?	:	
13.	Sikul kal nih chuan pawl engzat nge?	:	
14	Sikul chawkhsan nih chuan, engnge chawlhsan chhan?	:	
15	Sikul chawkhsan nih chuan pawl engzat thleng nge sikul I kal?	:	
16.	Pa zirna dinhmun	:	Ziak leh chhiar thiamlo/Primary/Middle/High School/Higher/College/PG
17.	Nu zirna dinhmun	:	Ziak leh chhiar thiamlo/Primary/Middle/High School/Higher/College/PG
18.	Ei leh bar chungchanga chhungkaw dinhmun	:	AAY/BPL/APL /Nihna neilo
19.	Pa/ enkawltu eizawnna	:	Sorkar hnathawk/ Sumdawnna/ Inhlawhfa/ Lo nei/ A dang (____________)
20.	Nu/enkawltu eizawnna	:	Sorkar hnathawk/ Sumdawnna/ Inhlawhfa/ Lo nei/ A dang (____________)

21	Pa/enkawltu sum lakluh zat (Thla khat ah)	:	
22	Nu/emkawltu sum lakluh zat (Thla khat ah)	:	
23.	Hnatawh lai nei em	:	Aw/ Aih
24.	Neih chuan, eng hna nge thawh	:	
25.	Hna thawh neih chuan thla khat a lakluh zat	:	
26.	Rualbanlohna	:	i. Taksa lampang rualbanlohna a) Chetna harsatna Phar dam/ Thluak harsatna/ Mi te/ Thalam harsatna/ Acid leih tuartu b) Hmuhtheihna lampang harsatna Del / Hmu thalo c) Hriatna lampang harsatna Bengngawngh / Hre tha theilo d) Tawng leh thusawi lampang harsatna ii. Thiamtheihna lampang harsatna a) Zirna lampanga harsatna b) Autistic Spectrum Disorder iii. Rilru Zia a) Rilru lampanga harsatna iv. A hnuaite vanga rualbanlohna siam a) Thluak lampanga diklohna/ Multiple Selerosis/Parkinson’s natna b) Thisen lampang diklohna Haemopholia / Thalassemia / Sickle Cell Disease v. Pakhat ai tam rualbanlohna A Dang awm chuan ziak rawh:
27.	Rualbnaloh Chhan	:	
28.	Rualbanlo certificate	:	Nei/Neilo
29.	Nei lo a nih chuan a chhan?	:	
30.	Rualbanloh vanga harsatna tawn te	:	
II	PUIHNA LEH ENKAWLNA DAWN DAN CHUNGCHANG		
31	Chhungkua atangin		

Sl. No	Puihna/ enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel															

	tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

32 Thiante atangin

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance															

	(Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															
5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk 5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk 5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk																
33	Sikul atangin															
Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseli															

	ng and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

34 **Kohhran atangin**

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama															

	enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

35 **YMA atangin**

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															

iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

36 MHIP atangin

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangai															

	hna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

37 **MUP atangin**

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh															

	fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

38	**Local Council/Village Councils atangin**															
Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1

i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															

5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk
5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk
5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk

39	**NGO atangin**			
Sl.	Puihna/e	I tan a awm remchang em?	A tha tawk em?	A tam tawk em?

No	nkawlna dawn	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															
5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk 5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk 5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk																
40	**Sorkar atangin**															

Sl. No	Puihna/enkawlna dawn	I tan a awm remchang em?					A tha tawk em?					A tam tawk em?				
		5	4	3	2	1	5	4	3	2	1	5	4	3	2	1
i	Ei leh in, silh leh fen															
ii	Hmangaihna leh enkawlna															
iii	Hriselna lama enkawlna															
iv	Counseling and Guidance (Fuihna, chhel tura zirtirna, leh adangte.)															
v	Zirtirna (Ziak leh chhiar, Thiamthil, thil ti thei ve tura zirtirna,leh adangte)															
vi	Sum leh pai															
vii	Ka hman tangkai tur hmanrua (Disability certificate, wheelchair, hearing aid, blind stick, zirna pui thei tur hmanrua, leh a dangte)															
viii	A dang? :															
5 Awm Lutuk; 4 Awm; 3 Ka hrelo le; 2 Awmlo; 1 Awmlo Lutuk 5 Tha Lutuk; 4 Tha; 3 Ka hre lo le ; 2 Tha lo; 1 Tha lo Lutuk 5 Tam lutuk; 4 Tam; 3 Ka hre lo le ; 2 Tam lo ; 1 Tam lo Lutuk																

41. Puihna leh enkawlna chungchangah sawi belh duh emaw rawtna I nei em?

WHOQOL-BREF

A hnuaia zawhna te hian I nunphung chungchang te, I hriselna chungchang te leh I nun a thil thleng hrang hrang te a zawt dawn che a ni. Heng zawhna te hi i chhanna tur options te nen ka chhiar sak che a nga, I tawn hriat nen a inmil dan berin I chhang dawn nia. Chhan dan tur ber I chianglo palh anih chuan, I rilru a chhanna lo lang hmasa berk ha a dik ber fo tih I lo hre dawn nia. Nangma nun, tawn hriat leh ngaihdan hmang ngeiin chhan I tum dawn nia. Heng zawhna te hian thla khat kalta chhunga i nuna thil thleng te a huam ang.

		Lungawi lo lutuk	Lungawi lo	Pangngai	Lungawi	Lungawi lutuk
1.	I nunah I lungawi em?	1	2	3	4	5
2.	I hriselna chungchangah I lungawi tawk em?	1	2	3	4	5
		Engtiangmahin	Tlema zawngin	Pangngai	Nasa pangngaiin	Nasa lutukin
3	Engtianga nasa in nge I rualbanlohna hian a tih thuanawp che?	1	2	3	4	5
4	Nitin pangngai taka khawsa turin damdawia inenkawlna engzat nge I mamawh?	1	2	3	4	5
5	Nun hi en gang taka nuamin nge I hman?	1	2	3	4	5
6	Engtiang chenin nge I nun hian awmzia nei tura I duh?	1	2	3	4	5
7	Engtianga tha in nge I rilru I sawrbing theih?	1	2	3	4	5
8	I nitin nunah him tak leh thlamuang takin I awm thin em?	1	2	3	4	5
9	Nitina I chetna leh I chhehvelte hi nangma tan a tha in a hrisel tawk I ti em?	1	2	3	4	5
		Tha lo lutuk	Tha lo	Pangngai	Tha	Tha lutuk
10	I nitin nunah chakna tha hrui I nei tha tawkin I hria em?	1	2	3	4	5
11	I taksa nihphung leh landan I pawm tha thei em?	1	2	3	4	5
12	I mamawhte leina tur sum I nei tha tawkin I hria em?	1	2	3	4	5
13	I nitin nuna I thil mamawh chungchangah hriattirna I dawng tha em?	1	2	3	4	5

14	I duhzawng tih nan hunawl I nei tha em?	1	2	3	4	5
		Harsa lutuk	Harsa	Pangngai (Harsa chuang lo, harsa lo chuang lo)	Awlsam	Awlsam lutuk
15	Chetvelna ah harsatna I nei em?	1	2	3	4	5
		Lungawi lo lutuk	Lungawi lo	Pangngai	Lungawi	Lungawi lutuk
16	I mut that theih danah I lungawi em?	1	2	3	4	5
17	I nitin nun kawng leh khawsak dan I hlenchhuah kawngah I lungawi tawk em?	1	2	3	4	5
18	Hna I thawh theih danah I lungawi em?	1	2	3	4	5
19	I nihna leh awmdan ah I lungawi em?	1	2	3	4	5
20	Midang nena in inkungkaina ah I lungawi tawk m?	1	2	3	4	5
21	Mipat hmeichhiatna hman kawngah I lungawi tawk m?	1	2	3	4	5
22	I thiante atanga tanpuina I dawnah I lungawi tawk em?	1	2	3	4	5
23	Tuna I chenna hmunah hian I lungawi tawk em?	1	2	3	4	5
24	Hriselna lama enkawlna leh tanpuina I dawnah I lungawi em?	1	2	3	4	5
25	I vahkual leh I len vel nana I hman transportationah I lungawi em??	1	2	3	4	5
		Vawi khat mah nei ngai lo	Nei ngai vak lo	Nei ve zeuh zeuh	Nei ve fo	Englaipawhin Nei reng
26	Rilru hnualna te, hrehawm tihna te, mal ngawih ngawiha inhriatna te, nun awmze neilo ni a inhriatna te leh beidawn chang te I nei ngai em?	5	4	3	2	1

A chunga zawhna chungchangah hian sawi belh duh i nei em?

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Bibliography

Akel, B.S. , Öksüz, C. , Oskay, D. , Fırat, T. , Tarakcı, E. and Leblebicioğlu, G. (2013). Health-related quality of life in children with obstetrical brachial plexus palsy. *Quality of Life Research*, 22 (9), 2617-2624. Retrieved from http://www.jstor.org/stable/24725481

Awia, M.C. (2009). *Mizo Hnam Dan*. Mizoram. Mualchin Publications.

Bruil, J. , Fekkes, M. , Wouwe, K.V. and Verrips, E.(2004). Effects of Early Intervention on Development and Health-Related Quality of Life of Children with down's Syndrome. *Quality of Life Research*, 13 (9), 51–63. Retrieved from http://www.jstor.org/stable/4039249

Cardona, G.C. (2013). Overcoming disabling barriers: disability and attitudes to disability within the Maltese context: an insider's perspective .*Disability & Society*, 28 (2), 279–284. doi: 10.1080/09687599.2012.753186

Ceglowski, D. A. , Logue, M. E. , Ullrich , A. & Gilbert J. (2009). Parents' Perceptions of Child Care for Children with Disabilities. *Early Childhood Education Journal*, 36, 497–504. Doi: 10.1007/s10643-009-0309-0

Center for Disease control and Prevention (2016). *Health – Related Quality of Life (HQRL)*.Retrieved from https://www.cdc.gov/hrqol/concept.htm

Chhangte, L. (2012). Status of Persons with Disability in Mizo Society. *Contemporary Social Scientist*, 3(1), 107–111. ISSN No. 2230-956X

Chhangte L. (2017). *Social Support and Quality of Life across Gender among Persons with physical disabilities in Aizawl, Mizoram* (Ph.D Thesis). Department of Social Work, Mizoram University.

Childline India Foundation (2010).*Child Protection & Child Rights.* Retrieved from http://www.childlineindia.org.in/children-issues.htm

Children's Rights Alliance (2017).*The United Nations Convention on the Rights of the Child.* Retrieved form http://childrensrights.ie/childrens-rights-ireland/un-convention-rights-child

Chow, S.M.K. , Lo, S.K. and Cummins, R.A. (2005) Self-Perceived Quality of Life of Children and Adolescents with Physical Disabilities in Hong Kong. *Quality of Life Research*, 14 (2). 415-423. Retrieved from http://www.jstor.org/stable/4038774

Citizens Information(2016). *Caring for a child with a disability.* Retrieved from http://www.citizensinformation.ie/en/health/health_services/children_s_health/caring for_a_child_with_a_disability.html

Cohen, P. & Prahova, M.P. (2006). Gendered Living Arrangements among Children with Disabilities. Journal of Marriage and Family, 68 (3), 630-638. Retrieved from http://www.jstor.org/stable/3838881

Cutrona CE. Suhr JA. Controllability of stressful events and satisfaction with spouse support behaviors. Communication Research. 1992;19:154–174.

Corker,M. (1998). *Disability Human Rghts and Society.* Buckingham: Open University Press.

Cuzzocrea, F. , Murdaca , A.M. , Costa , S. , Filippello, P. & Larcan , R. (2016). Parental stress, coping strategies and social support in families of children with a disability. *Child Care in Practice*, 22 (1), 3-19, DOI:10.1080/13575279.2015.1064357

Dash, N. (2006). *Inclusive Education: For Children with Special needs.* New Delhi: Publishers and Distributors Ltd.

Department of Social Welfare (2016). *Report of Disability Commissioner*.

Desai, A. N. (1990). Helping the Handicapped: Problems and Prospects. Delhi: New Prints.

DiGiacomo, M., Delaney, P., Abbott, P., Davidson, P.M., Delaney, J. & Vincent, F. (2013).Doing the hard yards: Carer and provider focus group perspectives of accessing Aboriginal childhood disability services. *BMC Health Services Research*, 13, 1-12. Retrieved from http://www.biomedcentral.com/1472-6963/13/326

Disabled world(2017).*Children with Disabilities: Health, Education & Information*. Retrieved from https://www.disabled-world.com/disability/children/

Dunst, C. J., Trivette, C. M., & Cross, A. H. (1986). Mediating influences of social support: Personal, family and child outcomes. *American Journal of Mental Deficiency*,90, 403–417

Ellison, T. (2006). *Perceptions of Social Support and Childhood Disability among Families of Children with Disablities*. Ph.D Dissertation, University of North Carolina.

Emiraa, M. .& Thompson, D. (2011). In the quest for their trust: the perceptions of families on accessing leisure services for disabled children. *Leisure Studies*, 30(1), 33–48.doi: 10.1080/02614367.2010.506648

Fatima, I. & Suhail, K. (2010). Belief in a just world and subjective well-being: Mothers of normal and Down syndrome children. *International Journal of Psychology*, 45 (6), 461–468. Doi: 10.1080/00207591003774519

Faw, M. H. & Leustek J. (2015). Sharing the Load: An Exploratory Analysis of the Challenges Experienced by Parent Caregivers of Children With Disabilities. *Southern Communication Journal*, 80 (5), 404–415. Doi: 10.1080/1041794X.2015.1081978

Filmer, D. (2008).Disability, Poverty, and Schooling in Developing Countries: Results from 14 HouseholdSurveys.*The World Bank Economic Review*, 22(1), 141-163. Retrieved from http://www.jstor.org/stable/40282267

First, F. & Curcio, J.L. (1993). *Individuals with Disabilities: Implementing the newest laws.* Sage Publications.

Goodley, D. & Cole, K.R. (2015).Critical psychologies of disability: boundaries, borders and bodies in the lives of disabled children.*Emotional and Behavioural Difficulties*, 20(1), 51–63.doi: 10.1080/13632752.2014.947096

Government of India (2011).*Census*. Retrieved from https://pwds.mizoram.gov.in/.

Grant , S. , Cross, E. , Wraith, J.E, Jones, E. , Mahon, L. , Lomax, M. ,Bigger, B. & Hare,D. (2013). Parental social support, coping strategies, resilience factors, stress, anxiety and depression levels in parents of children with MPS III (Sanfilippo syndrome) or children with intellectual disabilities (ID). *Inherit Metab Dis*, 36, 281–291, DOI 10.1007/s10545-012-9558-y

Guillett, S. (1998) Quality of Life among Children with Physical Disabilities between the Ages of 8 and 15. *Quality of Life Research*, 7 (7), 603.Retrieved from http://www.jstor.org/stable/4035915

Haider, S.I. (1998). *Visually Handicapped Children: Study of their Psychological Characteristics and Academic Achievement*.Jaipur: Rawat Publications.

Heiman, T. (2002). Parents of Children With Disabilities: Resilience, Coping, and Future Expectations. *Journal of Developmental and Physical Disabilities*, 14 (2), 159-171.

Ignjatović T.J. (2019). Services for Children with Disabilities and Their Families: The Impact on the Family’s Life Quality. *Open access peer-reviewed chapter - ONLINE FIRST.* DOI: 10.5772/intechopen.86750. Retrieved from https://www.intechopen.com/online-first/services-for-children-with-disabilities-and-their-families-the-impact-on-the-family-s-life-quality

Janiec, I. , Werner, B. , Sieminska, J. and Sieberer, U.R. (2011) Quality of life of children with mitral valve prolapsed. *Quality of Life Research*, 20 (4). 537-541. Retrieved from http://www.jstor.org/stable/41488105

John D.and Katherine T. (2008). *Research Network on SES and Health*. University of California: California

Karger and Rosen (2012). From, *Controversies and Disputes in Disability and Rehabilitation (edited).* Routledge: USA

Kandari, K. (2013). Parents' and Professionals' Perceptions of the Services of Families of Children with Intellectual Developmental Disabilities . *Child Adolesc Soc Work,* 31, 119–142.doi: 10.1007/s10560-013-0314-4

Khanlou, N. , Haque, N. , Sheehan S. & Jones, G. (2014). ''It is an Issue of not Knowing `Where to Go'': Service Providers' Perspectives on Challenges in Accessing Social Support and Services by Immigrant Mothers of Children with Disabilities. *Immigrant Minority Health*, :1840–1847 DOI 10.1007/s10903-014-0122-8

Klassing, I. (2007). *Disability and Social Exclusions in India*. Jaipur: Rawat Publications.

Lalmuanpuii, C. (2016). *Children with Disabilities in Aizawl: A Situational Analysis*. M.Phil Dissertation, Mizoram University.

Lalvani, P.(2015).Disability, Stigma and Otherness*:* Perspectives of Parents and Teachers. *International Journal of Disability, Development and Education*, 62(4), 379–393. doi: 10.1080/1034912X.2015.1029877

Law, M. , Hanna, S. , Anaby, D. , Kertoy , M. , King , G. & Xu, L. (2014). Health-related quality of life of children with physical disabilities: a longitudinal study . *BMC Pediatrics,* 14, 16, Retrieved form http://www.biomedcentral.com/1471-2431/14/26

Lee, Y.J , Park, H. J. & Recchia S. L. (2015). Embracing Each Other and Growing Together: Redefining the Meaning of Caregiving a Child with Disabilities. *Original Paper,* 24, 3662–3675. Doi: 10.1007/s10826-015-0175-x

Lewis, V.*(2002). Development and Disability.* Oxford,UK*:* Blackwell Publishers.

Lifshitz, H. and Glaubman, R. (2004). Caring for people with disabilities in the Haredi community: adjustment mechanism in action. *Disability & Society,* 19 (5), 469-486. doi: 10.1080/0968759042000235316

Mishra,A. K. &Gupta, R. (2006).Disability Index: A Measure of Deprivation among Disabled.*Economic and Political Weekly,* 41(38), 4026-4029. Retrieved from http://www.jstor.org/stable/4418722

Meral, B.F. , & Cavkaytar, A. (2012). A study on social support perception of parents who have children with autism. *International Journal on New Trends in Education and Their Implications,* 3(3) , 1-12. ISSN 1309-6249

Migerode, F. M. , Maes, B. , Byusse, A. & Brondeel, R. (2012). Quality of Life in Adolescents with a Disability and Their Parents: The Mediating Role of Social Support and Resilience. *Dec Phys Disabil,* 24, 487–503, DOI 10.1007/s10882-012-9285-1

Ministry of Law, Justic and Company Affairs (1999). *The National Trust fot the Welfare of Persons with Autism, Cerebral palsy, mental retardation and Multiple disabilities Act, 1999.* Government of India- No 44 of 1999, New Delhi.

MacInnes, M.D.(2008). One's Enough for Now: Children, Disability, and the Subsequent Childbearing of Mothers. *Journal of Marriage and Family,* 7(3), 758-771, Retrieved form http://www.jstor.org/stable/40056365

Muderedzi, J. & Ingstad, B. (2011).D *Disability and Poverty Book Subtitle: Disability and social suffering in Zimbabwe.* Polocy Press, University of Bristol. Retrieved from http://www.jstor.org/stable/j.ctt9qgths.14

Murray, S. (2007). Families’ Care of Their Children With Severe Disabilities In Australia. Community, Work & Family, 10(2), 215-230, DOI: 10.1080/13668800701270141

Ministry of Law and Justice (Legislative Department) (2016). *The Rights of Persons With Disabilities Act, 2016*. New Delhi: The Controller of Publications.

Ministry of Law, Justice and Company Affairs, Legislative Department (1999). *The National Trust for The Welfare of Persons With Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999*. New Delhi: Govt. of India.

Mohisini, S.R.& Gandhi, P.K (1982). *The Physically Handicapped and the Government*.New Delhi: Light and Life Publishers.

Moore, L. , Allegrante, J. P , Palma, M. , Lewin, J. & Carlson, M.J (2010). Assessment of Quality of Life Needs of Children With Mild Hemiplegic Cerebral Palsy. *Children's Health Care,* 39(2), 51–63.doi: 10.1080/02739611003679980

Noojin, A. B., & Wallander, J. L. (1996). Development and evaluation of a measure of concern related to raising a child with a physical disability. *Journal of Pediatric Psychology,* 2(4), 483-498.

Olsson, L. M. , Andersson, E. ,Granlund, M. & Huus, K. (2015). Social service utilisation patterns among children with mild intellectual disability – differences between children integrated into mainstream classes and children in self-contained classes. *European Journal of Special Needs Education,* 30 (2), 220-236.doi: 10.1080/08856257.2014.986920

Olney, M. F. & Kim, A. (2010). Beyond Adjustment: Integration of cognitive disability into identity. *Disability&Society*, 16 (4), 563–583. Doi: 10.1080/09687590120059540

Pilgrim, D. (2005). *Key concept in mental health.* London: Sage Publications.

Piškur, B. , Beurskens, A.J. , Jongmans M.J. , Ketelaar , M. , Norton , M. , Frings, C., Frings , H. & Smeets, R.J., G. (2012). ‘‘Parents’ actions, challenges, and needs while enabling participation of children with a physical disability: a scoping review . *BMC Pediatrics*, 12, 177, Retrieved form http://www.biomedcentral.com/1471-2431/12/177

Parette, H. P. , Meadan, H. , Doubet, S. & Hess J. (2010). Supporting Families of Young Children with Disabilities Using Technology. *Education and Training in Autism and Developmental Disabilities*, 45 (4), 552-565. Retrieved from http://www.jstor.org/stable/23879760

Park, H. J. & Chung G. H. (2014). A Multifaceted Model of Changes and adaptation among Korean Mothers of Children with Disabilities. *Original Paper*, 24, 915–929. Doi: 10.1007/s10826-014-9902-y

Porterfield, S.L. (2002). Work Choices of Mothers in Families with Children with Disabilities. Journal of Marriage and Family, 64 (4) , 972-981. Retrieved from http://www.jstor.org/stable/3599996

PWDA. (2010). *The Social Model of Disability* .Retrieved from http://www.pwd.org.au/student-section/the-social-model-of-disability.html

Pnkajam, G. (2009). *Care and Education of Differently Abled*. New Delhi: Concept Publishing company.

Reyhani, T. , Mohammadpour, V. , Aemmi, S.Z. , Mazlom, S.R. and Nekah, S.M.A(2016). Status of Perceived Social Support and Quality of Life among Hearing-Impaired Adolescents. *Original Article*, 20 (4). 1381-1386. Retrieved from http:// ijp.mums.ac.ir

Rogers M. L. & Hogan, D. P. (2003). Family Life with Children with Disabilities: The Key Role of Rehabilitation. *Journal of Marriage and Family*, 65(4), 818-833. Retrieved from http://www.jstor.org/stable/3599893

Rojas, M. *The Measurement of Quality of Life: Conceptualization Comes First ; A Four Qualities-of-Life Conceptual Framework and an Illustration to Latin America*. Retrieved from http://www.iadb.org/res/laresnetwork/files/pr308finaldraft.pdf

Rubin, A. & Babbie.E.(2010). *Methods for Social Work Research*. New Delhi: Cangage Learning India Private Limited.

Sandler, A. G. & Mistretta L. A. (1998). Sharing the Load: Positive Adaptation in Parents of Adults with Disabilities. *Education and Training in Mental Retardation and Developmental Disabilities*, 33 (2), 123-130. Retrieved from http://www.jstor.org/stable/23879160

Sarva Shiksha Abhiyan (2016). *Record of Children with Special Needs.*

Shandra, C.L., Hogan, D.P. &Spearin, C.E. (2008). Parenting a Child with a Disability: an Examination of Resident and Non-Resident Fathers. Journal of Population Research, 25 (3), 630-638. Retrieved from http://www.jstor.org/stable/41110917

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (2002). The health-related functions of social support. *Journal of Behavioral Medicine*, 4, 4381-406.

Schmidt, S. (2005). Health Care Needs and Quality of Life in Children with Physical Disabilities: Cross-Cultural Results of the Disabkids Study. *Quality of Life Research*, 14 (9), 51–63. Retrieved from http://www.jstor.org/stable/4039423

Schwarzer, R, Knoll, N. & Rieckmann, N. (2003). Social Support. *Introduction to health psychology,* 1-23. Oxford, England Blackwell. Retrieved from http://userpage.fu-berlin.de/~schuez/folien/social_support_2.pdf

Shumba, A. &Abosi, O. C. (2011).The Nature, Extent and Causes of Abuse of Children with Disabilities in Schools in Botswana. *International Journal of Disability,* 58 (4), 373–388. doi: 10.1080/1034912X.2011.626664

Singh, V. &Ghai, A (2009). Notions of self: lived realities of children with disabilities.*Disability & Society,* 24 (2), 129–145.doi: 10.1080/09687590802652363

Sultan, B. , Malik,N. And Atta,M. (2016). Effect of Social Support on Quality of Life among Orthopedically Disabled Students and Typical Students . *Original Article*. Retrieved from najmamalik@gmail.com

Sylvester, J. , Donnell, N. , Gray, S. , Higgins, K. , & Stalker, K. (2014) . A survey of disabled children and young people's views about their quality of life. *Disability & Society,* 29 (5), 763-777.doi: 10.1080/09687599.2013.848782

Szilagyi, P.G (2012). Health Insurance and Children with Disabilities. *The Future of Children*, 22 (1), 123-148. Retrieved from http://www.jstor.org/stable/41475649

Teklu, A.A. (2010). We Cannot Clap with One Hand: Global Socio–Political Differences in Social Support for People with Visual Impairment. *International Journal of Ethiopian Studies*, 5(1), 93-105 Retrieved from http://www.jstor.org/stable/41757575 Accessed: 29-11-2017 09:07 UTC

Torres V.M.F and Vieira S.C.M (2014). Quality of life in adolescents with *disabilities.* Revista Cefac*:* On-line version, 16 (6) *ISSN 1982-0216. Retrieved from* https://doi.org/10.1590/1982-0216201416213

Tran, K.V. (2014) .Exploring the experience of children with disabilities at school settings in Vietnam Context.*Tran Springer Plus*, 3, 1-11. Retrieved from http://www.springerplus.com/content/3/1/103

UNICEF (2017).*Disabilities.*Retrieved from http://www.unicef.org/disabilities/

Wendelborg, C. & Tøssebro , J. (2011). Educational arrangements and social participation with peers amongst children with disabilities in regular schools. *International Journal of Inclusive Education*, 15(5), 497-512, DOI: 10.1080/13603110903131739

WHO (2011).*World Report on disability*. Retrieved from http://www.who.int/disabilities/world_report/2011/report

World Health Organisation (1996). *WHOQOL-BREF: Introduction, Administration, Scoring and Generic version of the Assessment (Field Trial Version).* Programme on Mental Health, Geneva.

World Health Organisation (1997). *Measuring Quality of Life.* Retrieved from http://www.who.int/mental_health/media/68.pdf

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Other Relevant Information

List of Papers Presented in Seminars / Conferences:

Sl.No	Year	Title of Paper	Title of Seminar / Conference	Organizers and Place
1	2019	Children with Disabilities in Aizawl: A situational Analysis	Two days Seminar on Early Identification and Intervention of Childhood (0-6 years) Disabilities in North Eastern States (Aizawl)	National Institute of Locomotor Disability; Mizoram
2	2019	Right to Person with Disabilities Guidelines on Employment of Persons with Disabilities; Challenges and the way forward	Zonal Conference on 'Rights of Persons with Disabilities Act 2016 and its implication for persons with Disabilities.	National Institute for empowerment of Persons with Multiple Disabilities (NIEPMD), Chennai in collaboration with Department of Social Work, Mizoram university; Mizoram
3	2019	Activities of Daily Living: Conceot and Dimensions	One day Workshop on Activities of Daily Living (ADL) for Parents of Children with Disabilities	National Institute for empowerment of Persons with Multiple Disabilities (NIEPMD), Chennai in collaboration with Department of Social Work, Mizoram university; Mizoram
4	2020	Government Support and Children with Disabilities in Mizoram	National Seminar on Rehabilitation of Disabled and Inclusive Development with Specific Reference to North east India.	Department of Sociology, Mizoram University; Mizoram

Published Work:

Sl.No	Year	Title of Chapter / Research Paper	Name of Book / Journal	Publication Details (place/publishers with ISBN/ISSN)
1	2020	Challenges and Coping Strategies of Children with Disabilities in Aizawl, Mizoram	Mizo Studies (A Quarterly Referred Journal)	Department of Mizo, Mizoram University ISSN: 2219-6041
2	2020	Socio-Economic Characteristics of Children with Disabilities in Northeast India: The Case of Mizoram	Studies in Indian Place Names (UGC Care Journal)	Studies in Indian Place Names (UGC Care Journal) ISSN: 2394-3114

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SOCIAL SUPPORT AND QUALITY OF LIFE AMONG CHILDREN WITH DISABILITIES IN MIZORAM

BY

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Submitted
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1. Introduction

Children with Disabilities (CwDs) are one of the most marginalized and excluded groups in society who are facing daily discrimination. In most countries, there is lack of adequate policies and legislation for them. They are presumably hindered from realizing their rights to health care, education, and even for survival (UNICEF, 2017).

According to WHO (2011), there are more than a billion population who are living with disability in the whole world. It is estimated that there are at least 93 million children who are living with one or more disabilities in the whole world. However, the number of children living with disability could be much higher than the estimate. Children with Disabilities are often liable to be among the poorest members of the population. Children with Disabilities are also likely to be excluded them from receiving proper nutrition or humanitarian assistance in emergencies. (UNICEF, 2017)

There is also evidence where people with disabilities face barriers in accessing the health and rehabilitation services in many settings which provide services for Person with Disabilities. One must know that Children with Disabilities too have the same rights to access services and family benefits as all other children (Citizens Information, 2016).

Children with Disability often have lower Quality of Life (Qol) than the other children (Moore et.al, 2010). It can be assumed that the Quality of Life of Children with Disabilities tends to be low because there is low availability of social support and services which would meet the needs of Children with Disabilities (Schmidt, 2005). Therefore, the Quality of Life of Children with Disabilities can extensively be increased by the provision or improving social support (Szilagyi, 2012; Olsson et.al 2015).

The disability of a child not only affects the well-being of the child itself but have great impact on the lives of the care givers and the family. Having a disabled child can cause heavy burden to the entire family (Heiman, 2002).

In India, the Ministry of Social Justice & Empowerment is mainly responsible for the welfare and empowerment of Children with Disabilities. However, no single ministry has been established so far for the protection and for the welfare of Children with Disabilities. This leads to varying data of Children with Disabilities for which relevant data of children with Disabilities is not available in India (Childline, 2010).

According to Childline (2010), a total number of 12 million children are estimated to be living with disabilities in India, and out of these, only 1 per cent of them are estimated to have access to school. In India, disability rate is much higher in rural areas than those of urban areas. As compared to other countries, very little has been done for Children with Disabilities in India (Desai,1990). There is lack of information or publicity of services and schemes for Children with Disabilities in India. And because of this, there exist underutilization of services and schemes for Children with Disabilities (Mohisini & Gandhi, 1982).

In India, Children with Disabilities are likely to have lower Quality of Life than their non disabled peers (Moore et.al, 2010). However, Social Support has considerable impact on Quality of Life and could increase the Quality of Life of Children with Disabilities (Sultan et.al, 2016).

Child’s disability also has a great impact on the life of the family. It hinders the mothers or care takers from working in a full time Jobs. And to its extent, mothers with disabled child often have to stay unemployed as Children with Disabilities require lot of time and attention (Sandler & Mistretta,1998).

In Mizoram, the Department of Social Welfare is responsible for the welfare of Persons with Disabilities. According to 2011 census, a total number of 3,748 populations of 0-19 years are living with disability in Mizoram. Out of these, a total number of 541 populations belong to 0-4 years, a total number of 988 populations belong to 5-9 years and a total number of 2219 populations belong to 10-19 years.

Children with Disability do typically belong to family who live above poverty line. Because of their disability, children with disabilities have low academic performances and to extent, are likely to drop out of school. Mothers of Children with Disabilities are less likely to be employed while most of the Children with Disabilities have working father (Lalmuanpuii, 2016).

In Mizoram, information of services available for Children with Disabilities tends to be very low because of which care givers are unaware of the services available for their children. In Mizoram, there exist very little amount of services for Children with disability. There is also a wide gap between the availability and accessibility of services for Children with Disability in Mizoram (Lalmuanpuii, 2016).

1.2 Definition and Concepts

According to the Rights of Persons with Disabilities Act, 2016, "person with disability means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others". The act gave twenty one types of Disability.

According to Article 1 of the Convention on the Rights of Persons with Disabilities, the term, 'children with disabilities' is used to refer 'all children up to the age of 18 years who have 'long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.

In this study, Children with Disability include, if identified, those children with the types of disability under Rights of Persons with Disabilities Act, 2016 who are between the ages of 10-17years.

Social Support can be referred to as various types of assistance or help that people receive from others. Social support can broadly be classified into three major categories namely emotional, instrumental and informational (John and Katherine, 2008).

Social support can also be referred as “the provision of physical, emotional, informational, and instrumental assistance that an individual receives from their social network” (Dunst, Trivette, & Cross, 1986).

Cutrona and Suhr (1992) classify social support system into five general categories which include Informational support, Emotional support, Esteem support Social network support and Tangible support.

In this study, Social Support includes the support received on the basis of its accessibility, quality and adequacy in seven (7) dimensions such as basic needs support (fooding, shelter, clothing) , emotional support (love, care, concern, empathy, sympathy), physical health support (medical attention, provisions and services) , mental health support (professional counseling, guidance and psychiatric care and services), support in life skills (education and training including vocational training), financial support (sponsorship, donation, aid or help in form of money) and instrumental support (aids, appliances, certificates, goods) (Olsson et.al, 2015; John and Katherine, 2008; Knoll & Rieckmann 2003; Schwarze, Dunst, Schaefer,Coyne, & Lazarus, 2002; Cutrona and Suhr; 1992; Trivette, & Cross, 1986)..

The social support agents includes primary social support agent (Family), Secondary social support agents (schools, peers, church, Mizo Hmeichhe Insuihkhawm Pawl (MHIP), Young Mizo Association (YMA), Mizo Upa Pawl (MUP) and Non-Governemnt Orgasnisations (NGOs) working in the area of disability) and Tertiary social support agents (Local Councils/Village Councils and Government) (Chhangte, 2017; Lalmuanpuii, 2016; Meral and Cavkaytar, 2012; Lifshitz and Glaubman, 2004; Teklu, 2010; Parette et.al, 2010; Mishra & Gupta, 2006).

The World Health Organization defines quality of life (QoL) as ‘the individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns’ (WHO 1997).

According to Rojas (2013), the term Quality of life refers to “a life which is considered as a good one, well-lived, and being of value and may also refer to the presence of those conditions that favour such a good life”.

WHO has also developed The WHOQOLBREF have been developed to provide a short form quality of life assessment that looks at four Domain level profiles. The WHOQOL-BREF contains a total of 26 questions. The WHOQOL-BREF is based on a four domain structure such as Physical Health (Activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest, work capacity), Psychological (Bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal belief, thinking, learning, memory and concentration), social relationships (Personal relationships, social support, sexual activity) and environment (Financial resources, freedom, physical safety and security, health and social care, accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment-pollution/noise/traffic/climate and transport) (WHO 1996). In this study, Quality of Life will be understood to be according to this scale of assessment. developed by WHO.

1.5 Statement of the Problem

Children with Disabilities are excluded from the society and often encounter negative attitudes. In India, they are among the poorest members of the society and very little social supports are available for them. There also exist wide gaps between the existence of policies and programmes and the actual implementation of services for Children with Disabilities.

Children with Disabilities because of their vulnerability and their limitations have lower Quality of Life than the other children and as a result of this are subjected to various problems in the home and in society. The child’s disability not only affects the life of the child itself but also has great effects on the lives of the parents and often cause great burden to the family. The quality of life of Children with

Disabilities could extensively be improved by improving the different kinds of social supports for them.

With all these in mind, the study shall attempt to highlight information related to the social support for Children with Disabilities across gender, their quality of life and its relationships with age and gender, the relationship between social support and quality of life and the lived experience of caregivers of Children with Disability and shall also suggest measures for intervention and policy formulation.

1.6 Objectives

1. To highlight the demographic profile of Children with Disabilities (CwDs) in Mizoram.
2. To find out the accessibility, quality and adequacy of social support across the dimensions of social support by primary, secondary and tertiary agents for Children with Disabilities (CwDs) in Mizoram across gender.
3. To find out the quality of life of Children with Disabilities in Mizoram across gender.
4. To find out the relationship between the domains of quality of life of Children with Disabilities (CwDs) in Mizoram
5. To explore the relationship between social support and quality of life of Children with Disabilities (CwDs) in Mizoram.
6. To understand the lived experience of caregivers of Children with Disabilities in Mizoram.
7. To suggest measures for social work intervention and Policy Making.

1.7 Hypothesis

1. Quality of life decreases with increase in age. (Chow et.al, 2005)
2. There is no difference in Quality of Life across Gender. (Moore et.al, 2010; Akel et.al, 2013)

2. Overview of Literature

The study conducted by Maclnnes (2008) found that disability is more common among male children than female. The study also found that Children with Disabilities are more likely to belong to poorer households.

The study conducted by Reyhan et.al (2016) found that the educational levels of most parents were elementary levels. The study then finds that most of the fathers were labourers while majority of the mothers were housewives.

According to Torres & Vieira (2014), the highest number of respondents are hearing impaired followed by visually impaired and physical disability. Children belonging to age group 15-19 years are more in number than those belonging to the age group 10-14 and that majority developed their disabilities after birth.

The study made by Cohen & Prahova in 2006 found that children with disability are more likely to live in a broken family with a single parent.

According to Meral & Cavkaytar (2012), in Turkey, the educational level of mothers of Children with Disabilities are mostly primary level and are mostly non working home makers. The study also shows that the educational level of fathers of Children with Disabilities are mostly primary level and most of them are working as daily wage labourers.

From the study made by Lalmuanpuii (2016) in Aizawl, Mizoram, it can be known that female child were more in number than the male child. Those children belonging to the age group 15-17 constitute the highest number and also that majority belong to Lusei tribe. The studies also found that majority of the children are Christians belonging to Presbyterian denomination. The study also shows that most of the Children with Disabilities living in Aizawl belong to nuclear family and stable family. The study also tells that generally Children with Disability belong to family who live above poverty line. Children studying in primary school constitute the highest number. Child’s disability also often causes them to drop out of school. Children who drop out of school mainly drop out in middle school. It is also noted that mothers are less likely to have jobs while most of the Children with Disabilities have working father.

According to Chhangte (2017), on studying social support and quality of life of person with disability, majorities belongs to below poverty line and are unemployed. The study also shows that majority of the respondents are living in nuclear family and also that those belonging to stable family constitute the highest number. The study reveals that majority of the respondents are Christians belonging to Presbyterian denomination. Among the respondents, hearing impaired constitutes the highest number followed by locomotors disability, speech disability and visual impairment. We can also know that more than half of the respondents do not obtained disability certificate because they do not know the process.

The study made by Olsson et.al (2015) found that the most common type of services received were financial assistance. The study then states that help from individual contact was the second most common type of services.

According to the Study made by Meral & Cavkaytar (2012), emotional support is the highest form of support received from the family. It was found that social support resources formed by family and friends are the most important predictor of social support perception.

From the study made by Wendelborg & Tossebro (2011), there is no significant difference between the gender in regard to social participation with peers. It is also known from the study that the support received from school is high since the use of special education and trained teacher’s assistant provide satisfactory education to children with disability in regular schools and improves academic performances.

According to the study conducted by Tran (2014) in Vietnam there is lack of social assistance for Children with Disabilities. There also exist lack of awareness on different schemes and services available for Children with Disabilities. There is also lack of trained teachers in educational settings and lack of infrastructures which create barriers for the Children with Disabilities in accessing school services.

Digiacomo et.al (2013) in their study found that there is insufficient or non-existence of services for children with disabilities in India. There is also lack of awareness of services available for children with disabilities.

A study conducted by Haider (1998) found that those living in urban settings have greater opportunity of accessing welfare services than those living in rural places.

Lalmuanpuii (2016) in her study found that the support from family is available, accessible and adequate in Mizoram. Regarding school support, the study shows that there is availability and accessibility but the supports received are not adequate. It can also be known from the study that the availability, accessibility and adequacy of community support were very low. The study also find that there is high availability of Government support for Children with Disability in Aizawl, Mizoram. Though the availability of Government support is high, the accessibility and adequacy of Social support is extremely low.

According to Chhangte (2017), the highest form of support received from family was emotional support. The financial support received from the primary supporters was also found to be high. There are also respondents who receive instrumental support from primary supporters and very few reported that they do not receive any support from the primary source. It can be known from the study that the highest number of respondents do not receive any kind of support from the secondary supporters. The support received from secondary supporters includes financial and instrumental support but they are accessed by a very small number of respondents. We can also know that majority of the respondents did not receive any support from tertiary supporters. Less than a tenth received instrumental support and a very few respondents received financial support from tertiary supporters. Gender differences are observed in the primary and secondary support but there are no differences of gender in the tertiary support. In the overall support, respondents who do not receive any form of support constitute the highest. And among the support received, instrumental support is the highest followed by financial support and emotional support.

Torres & Vieira (2014) found that the lowest score on their quality of life was in the environment domain. The quality of life in the social relationships domain was high. It can also be known from the study that female respondents have lower quality of life in the psychological and environmental domains. In the overall quality of life, female respondents have the lowest score.

According to the study made by Migerode (2012), Children with a Disabilities have low quality of life, both subjectively and objectively. The study also shows the amount of social support received has an impact on the Quality of Life of Children with Disabilities.

According to Law et. al (2014), Children with Disabilities extensively have lower health-related quality-of-life in the physical domain than that of the normative population. The study also shows that the family and environmental supports and barriers have an adverse effect on the physical health related Quality of Life. It is also found in the study that the environmental barriers have a significant negative association with physical Quality of Life. It is also found that general health, physical functioning and direct support such as funding have positive impact on the Quality of Life of Children with Disabilities.

The study made by Chow et.al (2005) found that the material wellbeing and health of children with physical disability tends to be low. We can also know from the study that children with physical disability have extensively lower Quality of Life with respect to health, intimacy, and safety. Though the children with physical disabilities tend to have lower Quality of Life in certain domains, the study shows that they have high emotional wellbeing and have high productivity. The study found that the quality of life of children with disabilities tends to decrease with increase in age.

Moore et.al (2010) found that there was no difference in quality of life across gender. The study tells that there are similarities in quality of life reported between a sample with CP and a normative sample is controversial. It can be known from the study that adolescents with CP have lower quality of life than their peers. None of the participants mention physical difficulties related to CP that was not activities of daily living. They seemed to have made accommodations to work around physical or other limitations and function in what appears to be normal for them.

Akel et.al (2013) administered the short parent form of the Child Health Questionnaire (CHQ PF28) found that Gender or age did not significantly affect scores in any domain. The study also reveals that early rehabilitation programmes have positive effect on the children’s Quality of Life.

According to Chhangte (2017), in the domains of the Quality of Life, environment domain has the highest score followed by physical health, psychological health and social relationship. In the overall quality of life, a few gender differences is obsrved across the domains. The study also shows that there is a significant correlation between overall Quality of Life and environment domain alone at 0.01 significant level. We can also see that there is correlation between social relationships and psychological domains of quality of life. Further, we see that there is correlation between environment and psychological domains of quality of life.

Sultan et.al (2016). found that social support positively predicts the Quality of Life which includes physical functioning, psychological functioning, social dimensions and environment. It can be known from the study that peer support also has considerable impact on Quality of Life. It can also be noted that family support also has great effect on physical functioning which then effects the quality of life. Special person support was found to be an important forecaster of psychological functioning. The study then gives an understanding that Quality of Life can extensively be increased by the provision of improved social support.

The study made by Murray (2007) shows that the cost for caring a disabled child is intensively high. The amount of financial support received by the family of disabled child were of dissatisfactory.

According to the study made by Cuzzocrea (2016), parents of disabled child tends to have more stress than parents of typically developing children where the principal source of stress is related to child’s disability.

According to the study made by Murray (2007), families with children with severe disabilities are likely to experience lower incomes and have greater expenses for long periods of time. The study also found that most of the caregivers decided not to work so as to have more time to take care of their disabled child. It is also pointed that families often have little time to engage in any form of leisure activities and are often unable to access some community services.

According to the study of Muderedzi & Ingstad (2011) child's disability affects the family member's chances of going to school, working for a living, enjoying family life and participation in social life. The study also shows that disability increased isolation and economic strain. It is also known from the study that burden of care often fell on mothers or other female relatives and siblings which often resulted to school dropout of female siblings. It can also be seen that increased workload of caring of a disabled child often results in extreme poverty since valuable time were driven away from the daily struggle and leave the caregivers no time to make a living.

2.1 Research Gaps

- Research studies on Children with Disabilities (CWDs) are not adequately conducted in the North-East, particularly in Mizoram. There is a need to extend the area so as to have a wider perspective of the situation of Children with Disability in Mizoram.
- There is little data on the demographic profile of Children with Disabilities in Mizoram.
- Many of the study found differences on the gender and age in accessing social support. But no studies have been made in Mizoram. So it is necessary to have a study in this field.
- Quality of Life of Children with Disability in Mizoram is also absent.
- Many of the studies that have been reviewed had revealed the differences in age and gender on the quality of life yet no particular studies have been made to explain such relations in Mizoram.
- The different studies reflected that Children with Disabilities with high support have better Quality of life. But no studies have been made in

Mizoram. Thus, there is a need understand to the relationship of Social Support and Quality of Life.

- From the studies it can be known that having a disabled child cause great emotional, physical and financial barriers to caregivers, but no studies have been made in Mizoram in order to understand the lived experience of caregivers of Children with Disabilities in Mizoram.

3. Methodology

The Study is descriptive in design and adopted a mixed method. The study was conducted in 4 district of Mizoram. Both qualitative and quantitative methods were utilized for the study.

3.1 Source of Data Collection

Data were collected from both primary and secondary source. Primary sources include data collected from Children with Disability and parents/guardians of Children with Disability. Secondary sources were collected from Government and Non-Governmental records.

3.2 Method of Sampling

The unit of the study is Children with Disabilities in Mizoram. A multi-stage sampling procedure was utilized for the study. In the first stage, a cluster sampling procedure was utilized. Four district representing North, East, West and South Mizoram were purposively selected; Aizawl representing the North, Mamit representing the West, Champhai representing the East and Lunglei representing the South. In the second stage, from each selected District, the District headquarters were selected to identify the respondents through the records of NGOs, government agencies and local leaders across the communities of the selected district headquarters. Apart from this, a snow ball sampling procedure was also utilized in order to identify Children with Disabilities that were not in the records.

Overall, the sample included 140 respondents (132 children with disabilities between the ages of 10-17 years and 8 caregivers) out of which 50 represents Aizawl district, 30 each representing Lunglei and Champhai districts and 22 of the samples represents Mami districtt. Two (2) case studies of Children with Disability were conducted in each district. Two (2) caregivers from each district were also identified for in-depth interview. Gender and types of disability representativeness could not be maintained because of lack of available data and records of children with disabilities and sporadic cases across the districts.

3.3 Tools of Data Collection

A semi-structured interview schedule formed the tools for data collection for finding the personal profile, family characteristics and suggestions to improve social support. To find out the social support, a 5 point structured scale was constructed to measure 3 items each such as the accessibility, quality and adequacy of social support across various dimensions of social support *viz.* basic needs support, emotional support, physical health support, mental health support, support in life skills, financial support and instrumental support. The different dimensions of social support were constructed based on John and Katherine (2008), Schwarze, Knoll & Rieckmann (2003), Dunst, Trivette, & Cross (1986), Schaefer,Coyne, & Lazarus (2002), Olsson et.al (2015) and Cutrona and Suhr (1992). The different agent of supporters were constructed based on the study of Chhangte (2017), Meral and Cavkaytar (2012), Lifshitz and Glaubman (2004), Teklu (2010), Parette et.al (2010), Mishra & Gupta (2006) and Lalmuanpuii (2016).

A WHOQOL-BREF structured scale was also used for measuring the quality of life of children with disabilities in Mizoram. The WHOQOL-BREF is a structured tool constructed by the WHO in 1996 to measure the Quality of Life. It is a 26 item, self administered, generic questionnaire. It is the short version of the WHOQOL-100 scale. The options of response range from 1 (very dissatisfied/very poor) to 5 (very satisfied /very good). It consists of four domains *viz.* physical health domain (7 items), psychological domain (6 items), social relations domain (3 items) and environment domain (8 items). The raw scores of the constituent items were summed and transformed into scores that ranged from 4-20, to be in line with the WHOQOL-100 instrument and then the 4-20 scores were converted into a 0-100% scale. The WHOQOL-BREF tool was administered only after receiving permission from the World Health Organizations.

Qualitative methods such as case study, focus group discussion and participatory techniques such as causal tree analysis and daily activities schedule were also conducted. After preparation of the tool, the language was transcribed in Mizo and a pilot study was conducted so as to test the validity and reliability of the tool among Children with Disabilities. Necessary modifications and changes were made after the pilot study.

3.4 Data Processing and Analysis

The quantitative data were analyzed using Microsoft Excel and SPSS package. Descriptive statistics, simple frequency and means were presented to find out the socio demographic profile, family characteristics, disability profile, quality of life and social support across agents as well as across dimensions of Children with Disabilities. Social Support was analyzed based upon the 5 scale tool constructed and Quality of Life was analyzed based upon WHOQOL-BREF. T-test was used to find out gender differences on primary, secondary and tertiary social support agents of Children with Disabilities. T-test was also used to find out differences in the quality of life of Children with Disabilities across gender and age groups. Pearson’s correlation co-efficient was used to find out the relationship among and between domains of quality of life. Pearson’s correlation co-efficient was also used for finding out the relationship between social support and quality of life. Qualitative findings using case studies, in-depth interview and focus group discussions are presented accordingly to get an in-depth knowledge about the objectives of the study. The findings of Participatory Rural Appraisal (PRA) using Causal Tree Analysis and Daily Activities Schedule are also presented and analyzed accordingly.

3.5 Ethical Consideration

For ethical reasons, only children who can be interviewed between the ages of 10 to 17 years were identified. Caregivers were also utilized for their support and also to prove a child friendly environment during data collection. Children were included in the sample only after taking consent from them and the caregivers. All names of the respondents are concealed to maintain confidentiality.

3.6 Inclusion and exclusion criteria

In this study, Children with Disabilities include only those children specified under the RPWD Act 2016, who are between the ages of 10-17 years. Only those children who were living in the communities of the district headquarters of Aizawl, Lunglei, Champhai and Mamit were included in the study.

3.7 Limitations

Identification of Children with Disabilities across the District headquarters was a challenge because there were no proper data in each district. Moreover, interviewing the children was also a challenge and was time consuming considering the sensitivity of the case.

4. Major Findings

The socio-demographic profile of the respondents show that male respondents are more in number and that children belonging to 10-14 years are more than those children belonging to 14- 17 years. Majority of the respondents belong to Lusei tribe and almost all the respondents are Christians belonging to Presbyterian denomination. The highest numbers of children are from Nuclear family. It is also found that majority of children have a stable form of family. The largest number of children are school going who are studying in primary school. There are few children who drop out of school and the most common reason for dropping out is loss of interest in education followed by mobility barrier, disability and difficulty in adjustment, stigmatization, discrimination and exclusion. A very few number of children never went to school and the main reason is because parents do not allow their children to be enrolled in schools. Similar finding is seen in the case study and focus group discussion. There are very few who were employed where the nature of work include quarry work and daily labour.

Among the children, those that have a father who studied till high school constitute the highest and the main occupation of fathers was daily labour. Children who have mothers who studied till high school level constitute the highest. Majority of the mothers are home makers who are unemployed and the same finding is seen in the case studies and focus group discussions. Regarding the socio-economic category, children belonging to BPL family constitute the highest number and the same finding is seen in the case studies.

With regards to the history of disability of the children, majority of the children acquire disability by birth. The other causes of disability includes disability which were caused due to meningitis during early childhood and accident, disability caused due to epilepsy during early childhood, tumor in the brain, eye disease during childhood, septicemia, tuberculosis, dog bight, ear infection, injection side effects and genetics. We have similar finding in the case study and causal tree analysis. A very few of the causes of disability were not known. Children with Intellectual disability constitute the highest number followed by children with muscular dystrophy, multiple disability, hearing impairment, blindness, dwarfism and psoriasis. Among the children, majority have obtained disability certificate while few have not obtained disability certificate due to certain reasons that includes not knowing the process of how to obtain disability certificate, do not have time to pursue disability certificate, negligence, parental denial of child’s disability, parental belief for improvement of child and not being able to appear in the medical board due to mobility problem. A similar finding is also drawn in the case studies and focus group discussions.

The respondents reported 19 types of challenges that includes stigma and discrimination, low academic performance, lack of information on available services for CwDs, inability to perform certain task, insecurities, low self esteem and isolation, dependence, poverty, school dropout , never been enrolled in school, difficulty in understanding class lectures, lack of trained teachers, lack of brail facilities, communication barrier, barriers in accessing services for CwDs, health issues, physical abuse and sexual abuse. The similar types of challenges were also being found in the case study, focus group discussions and causal tree analysis.

Family support is the only support which is rated high in terms of accessibility, quality and adequacy. There is no gender differences in the accessibility, quality and adequacy of support from primary agents accept in the quality of peer support. Among the support from secondary supporters, we find gender differences in the accessibility, quality and adequacy of church support and support from NGOs. No gender difference was observed in the accessibility, quality and adequacy of support from tertiary supporters.

The overall quality of life of children with disability is moderate. The quality of life of children with disabilities is highest in the environment domain of quality of life. There is no relationship between age groups and quality of life and also it is observed that there are no differences in quality of life across gender. Thus, rejects the hypothesis of the study. However, this can be because of socio-cultural dynamics and differences in scales used to study the same.

There is correlation between overall quality of life and all the domains of quality of life. Among the primary social support, accessibility, quality and adequacy of school support have a significant correlation with the overall quality of life. Among the secondary social support, it is observed that the accessibility, quality and adequacy of church support and accessibility of YMA support and NGOs support have a significant correlation with the overall quality of life. In the tertiary social support, the accessibility, quality and adequacy of government support and accessibility of support from local council have correlation with the overall quality of life.

Child disability not only has an effect on the child itself but also on the whole family. Parents find it hard to accept their child’s disability and the journey often starts with sorrow and disappointment. Avoidance and self-blame were most common among mothers. Child’s disability affects the older sibling’s chances of going to school, working for a living, enjoying family life and participation in social life. Child’s disability also hinders social participation of family and restricts them from attending social gatherings.

5. Conclusion and Suggestions

From the lights of the findings, the following suggestions may be made for policy formulation and social work intervention.

- Awareness on children and disability is not adequate. Therefore, more awareness on children and disability must be conducted. The awareness must be conducated at all levels covering individuals, groups and community.

- It is also very important to conduct workshop for care givers and family of Children with Disabilities.

- Measures must be taken to improve early identification and intervention programmes for disability in Mizoram.

- Financial problem was one of the main barrier encountered by children with disabilities. Therefore, poverty alleviation programmes must be implemented for children with disabilities in Mizoram.

- Trained teachers or special educators must be recruited in all the schools of Mizoram so as to improve the educational status of children with disabilities.

- Many of the children do not obtain disability certificate because they do not know the process. Thus, measures must also be taken to provide better information on the process of accessing different kinds of services and benefits available for children with disabilities in Mizoram.

- Infrastructures must also be improved to create barrier free environment for children with disabilities. Improvement in infrastructures shall also increase the accessibility of services for children with disabilities in Mizoram.

- Government and other service providers must monitor the implementation of certain schemes for children with disabilities so that the services reach the right beneficiaries without discrimination.

- Mothers of children with disabilities were hindered from working in full time jobs because of their child's disability and still. Therefore, measures must be taken to implement income generation programmes that are case specific for children with disabilities so that children with disabilities would be able to receive better financial support.

- Skill training programmes for children with disabilities must also be implemented so that children will be able to acquire some skills to be financially stable once they reach maturity.

- As for hearing impaired children, especially those living in rural areas, communication is one of the main challenges encountered by them where they encounter problem to even communicate with their parents. Therefore, measures must be taken so that hearing impaired children and their parents will be able to learn and understand sign language for communication.

- Educational institutions and libraries of Mizoram lacks brail facilities. Therefore, measures must be taken so that brail facilities will be available for visually impaired children in educational institutions and libraries of Mizoram.

- As seen in the Rights of the Persons with Disabilities act (2016), suitable modifications must be made in the curriculum and examination system to meet the needs of students with disabilities that include brail exams in board examination.

- As it goes away from family, the accessibility, the quality and the adequacy of support decreases. Therefore measures must be taken to improve the social support across secondary and tertiary group for children with disabilities in Mizoram at all dimensions.

- The accessibility, quality and adequacy of school support have an impact quality of life of children with disabilities. Therefore measures must be taken to improve the social support provided by the school so as to increase the quality of life of CwDs.
- Measures must also be taken so that the church provide better support for children with disabilities in Mizoram because the study shows that the quality of life of children with disabilities is determined by the support of church.
- YMA and NGO's must also take initiatives to provide support for children with disabilities because the support of YMA and NGO's was found to have an effect on the quality of life of children with disabilities in Mizoram.
- Since all the domains of quality of life have an impact on the overall quality of life, we cannot neglect any of the domains of the quality. Measures should also be taken to increase the quality of life at all domains.

References:

Akel, B.S. , Öksüz, C. , Oskay, D. , Fırat, T. , Tarakcı, E. and Leblebicioğlu, G. (2013). Health-related quality of life in children with obstetrical brachial plexus palsy. *Quality of Life Research*, 22 (9), 2617-2624. Retrieved from http://www.jstor.org/stable/24725481

Chow, S.M.K. , Lo, S.K. and Cummins, R.A. (2005) Self-Perceived Quality of Life of Children and Adolescents with Physical Disabilities in Hong Kong. *Quality of Life Research*, 14 (2). 415-423. Retrieved from http://www.jstor.org/stable/4038774

Citizens Information(2016). *Caring for a child with a disability.* Retrieved from http://www.citizensinformation.ie/en/health/health_services/children_s_health/caring for_a_child_with_a_disability.html

Cohen, P. & Prahova, M.P. (2006). Gendered Living Arrangements among Children with Disabilities. Journal of Marriage and Family, 68 (3), 630-638. Retrieved from http://www.jstor.org/stable/3838881

Cutrona CE. Suhr JA. Controllability of stressful events and satisfaction with spouse support behaviors. Communication Research. 1992;19:154–174.

Cuzzocrea, F. , Murdaca , A.M. , Costa , S. , Filippello, P. & Larcan , R. (2016). Parental stress, coping strategies and social support in families of children with a disability. *Child Care in Practice*, 22 (1), 3-19, DOI:10.1080/13575279.2015.1064357

Chhangte, L. (2012). Status of Persons with Disability in Mizo Society. *Contemporary Social Scientist*, 3(1), 107–111. ISSN No. 2230-956X

Childline India Foundation (2010).*Child Protection & Child Rights.*Retrieved from http://www.childlineindia.org.in/children-issues.htm

Desai, A. N. (1990). Helping the Handicapped: Problems and Prospects. Delhi: New Prints.

DiGiacomo, M., Delaney, P., Abbott, P., Davidson, P.M., Delaney, J. & Vincent, F. (2013).Doing the hard yards: Carer and provider focus group perspectives of accessing Aboriginal childhood disability services. *BMC Health Services Research*, 13, 1-12. Retrieved from http://www.biomedcentral.com/1472-6963/13/326

Dunst, C. J., Trivette, C. M., & Cross, A. H. (1986). Mediating influences of social support: Personal, family and child outcomes. *American Journal of Mental Deficiency*,90, 403–417

Government of India (2011).*Census*. Retrieved from https://pwds.mizoram.gov.in/.

Haider, S.I. (1998). *Visually Handicapped Children: Study of their Psychological Characteristics and Academic Achievement*.Jaipur: Rawat Publications.

Heiman, T. (2002). Parents of Children With Disabilities: Resilience, Coping, and Future Expectations. *Journal of Developmental and Physical Disabilities*, 14 (2), 159-171.

John D.and Katherine T. (2008). *Research Network on SES and Health*. University of California: California

Lalmuanpuii, C. (2016). *Children with Disabilities in Aizawl: A Situational Analysis*. M.Phil Dissertation, Mizoram University.

Law, M. , Hanna, S. , Anaby, D. , Kertoy , M. , King , G. & Xu, L. (2014). Health-related quality of life of children with physical disabilities: a longitudinal study . *BMC Pediatrics*, 14, 16, Retrieved form http://www.biomedcentral.com/1471-2431/14/26

Meral, B.F. , & Cavkaytar, A. (2012). A study on social support perception of parents who have children with autism. *International Journal on New Trends in Education and Their Implications*, 3(3) , 1-12. ISSN 1309-6249

Migerode, F. M. , Maes, B. , Byusse, A. & Brondeel, R. (2012). Quality of Life in Adolescents with a Disability and Their Parents: The Mediating Role of Social Support and Resilience. *Dec Phys Disabil*, 24, 487–503, DOI 10.1007/s10882-012-9285-1

MacInnes, M.D.(2008). One's Enough for Now: Children, Disability, and the Subsequent Childbearing of Mothers. *Journal of Marriage and Family,* 7(3), 758-771, Retrieved form http://www.jstor.org/stable/40056365

Murray, S. (2007). Families' Care of Their Children With Severe Disabilities In Australia. Community, Work & Family, 10(2), 215-230, DOI: 10.1080/13668800701270141

Ministry of Law and Justice (Legislative Department) (2016). *The Rights of Persons With Disabilities Act, 2016*. New Delhi: The Controller of Publications.

Mohisini, S.R.& Gandhi, P.K (1982). *The Physically Handicapped and the Government*.New Delhi: Light and Life Publishers.

Moore, L. , Allegrante, J. P , Palma, M. , Lewin, J. & Carlson, M.J (2010). Assessment of Quality of Life Needs of Children With Mild Hemiplegic Cerebral Palsy. *Children's Health Care,* 39(2), 51–63.doi: 10.1080/02739611003679980

Muderedzi, J. & Ingstad, B. (2011).D *Disability and Poverty Book Subtitle: Disability and social suffering in Zimbabwe.* Polocy Press, University of Bristol. Retrieved from http://www.jstor.org/stable/j.ctt9qgths.14

Olsson, L. M. , Andersson, E. ,Granlund, M. & Huus, K. (2015). Social service utilisation patterns among children with mild intellectual disability – differences between children integrated into mainstream classes and children in self-contained classes. *European Journal of Special Needs Education,* 30 (2), 220-236.doi: 10.1080/08856257.2014.986920

Reyhani, T. , Mohammadpour, V. , Aemmi, S.Z. , Mazlom, S.R. and Nekah, S.M.A(2016). Status of Perceived Social Support and Quality of Life among Hearing-Impaired Adolescents. *Original Article*, 20 (4). 1381-1386. Retrieved from http:// ijp.mums.ac.ir

Rojas, M. *The Measurement of Quality of Life: Conceptualization Comes First ; A Four Qualities-of-Life Conceptual Framework and an Illustration to Latin America*. Retrieved from http://www.iadb.org/res/laresnetwork/files/pr308finaldraft.pdf

Sandler, A. G. & Mistretta L. A. (1998). Sharing the Load: Positive Adaptation in Parents of Adults with Disabilities. *Education and Training in Mental Retardation and Developmental Disabilities*, 33 (2), 123-130. Retrieved from http://www.jstor.org/stable/23879160

Sultan, B. , Malik,N. And Atta,M. (2016). Effect of Social Support on Quality of Life among Orthopedically Disabled Students and Typical Students . *Original Article*. Retrieved from najmamalik@gmail.com

Szilagyi, P.G (2012). Health Insurance and Children with Disabilities. *The Future of Children*, 22 (1), 123-148. Retrieved from http://www.jstor.org/stable/41475649

Torres V.M.F and Vieira S.C.M (2014). Quality of life in adolescents with *disabilities.* Revista Cefac*:* On-line version, 16 (6) *ISSN 1982-0216. Retrieved from* https://doi.org/10.1590/1982-0216201416213

Tran, K.V. (2014) .Exploring the experience of children with disabilities at school settings in Vietnam Context.*Tran Springer Plus*, 3, 1-11. Retrieved from http://www.springerplus.com/content/3/1/103

UNICEF (2017).*Disabilities.*Retrieved from http://www.unicef.org/disabilities/

Wendelborg, C. & Tøssebro , J. (2011). Educational arrangements and social participation with peers amongst children with disabilities in regular schools. *International Journal of Inclusive Education*, 15(5), 497-512, DOI: 10.1080/13603110903131739

WHO (2011).*World Report on disability*. Retrieved from http://www.who.int/disabilities/world_report/2011/report

World Health Organisation (1996). *WHOQOL-BREF: Introduction, Administration, Scoring and Generic version of the Assessment (Field Trial Version).* Programme on Mental Health, Geneva.

World Health Organisation (1997). *Measuring Quality of Life.* Retrieved from http://www.who.int/mental_health/media/68.pdf