

An Explorative Study to Assess the Psychosocial Problems and Coping Strategies with a View to Design and Implement a Protocol on Problem Solving Skills Among Children Living in Blind School at Bagalkot

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Abstract:- Childhood is a blissful state of innocence and joy but this is often not for the children, who are disabled, when they play, laugh; they feel isolated, as no one is beside them to hear or bear, as everyday in their life is a big struggle. Disability is proven to be a big hindrance in the normal day-to-day life of a place of negligence, despair and isolation. Visually handicapped children are a highly heterogeneous group they face many problems like behavioral problems, problems of social adjustment, problems in learning, poor intelligence, academic difficulties. Slower speeches etc and sense are gateway of knowledge, the sensory deficit in vision reduces the range and qualities of cognition. **METHOD:-** it deals with defining the problem, formulation of hypothesis, methods adopted for data collection and statistical techniques used for analyzing the data with logical reason behind it. This chapter deals with the description of methodology and different steps, which were under taken for gathering and organizing data for the investigation. It includes description of research approach, research design, setting of the study, population, and sample and sampling technique, development and description of tool, testing of the tools, pilot study, procedure for data collection, plan for data analysis. **RESULTS:-** **INTERPRETATION:-** The data was collected from children. 50 visually impaired. The data collected were grouped and analyzed by using Descriptive Statistics and Informational statistics. The data is analyzed on the basis of the objectives and hypothesis of the study. **CONCLUSION:-** This chapter presents the conclusions drawn, implications, limitations, suggestions and recommendations. The main focus of these studies was to assessment of implementation of protocol on psychosocial problems and coping strategies

among blind children. The data was collected from 50 subjects.

I. INTRODUCTION

As per the persons with disability act 2012, Government provides education, employment, creation of barrier free environment and social security to the disabled.² *Blindness* is a condition ‘‘where a person suffers from visual acuity worse than (3/60) or less in the better eye with correction or a visual field of less than 10 degree’ Blindness imposes sociological, psychological and education limitations on the individual (lowenfeld 2012). Visually handicapped children are a highly heterogeneous group they face many problems like behavioral problems, problems of social adjustment, problems in learning, poor intelligence, academic difficulties. Slower speeches etc and sense are gateway of knowledge, the sensory deficit in vision reduces the range and qualities of cognition. In school age children: congenital and development anomalies, neurological (papillates, papilledema) and trauma.⁷ this is supported by a study conducted by dandona in 2003 on prevalence and causes of blindness in children at Hyderabad. The results of the study show vitamin A deficiency (8.3%), congenital anomalies (25%), retinal degeneration (16.7%) and nystagmus related amblyopia (8.3%). Another study revealed that prenatal factors were the main causes of childhood blindness (52%). Visual impairment is a significant health problem worldwide. The World Health Organization estimates that globally about 314 million people are visually impaired, of whom 45 million are blind in which 1.4 million are children.⁴ Blindness is a devastating physical condition with deep emotional and economical

implications. Various problems that the blind people face are problems in orientation and mobility, personality problems, psychological problems etc. There are certain coping strategies that a visual impaired person adopts, which includes positive strategies and negative strategies:

II. RESEARCH METHODOLOGY

The researcher design selected for the study was cross sectional descriptive survey research design. Socio-demographic variables Age, Gender, Education, cast, Income, Type of family, Frequency of visitors, Disabled sibling in the family, Causes of blindness, Duration of residential in blind school. And study variable include psychosocial problems and coping strategies among blind children. In this study sample size 50 blind children who are in the age group of 12-16 years and above are selected by purposive sampling technique. **Research Approach:** A quantitative evaluative approach was used **Research Design** A researcher's overall plan for obtaining answers to the research question for testing the research hypothesis is referred to as the 'research design'. It spells out the basic strategies that the researcher adopts to develop information that is accurate and interpretable⁴⁶. In the present study research design refers to the plan of a scientific investigation. Research design helps the research in selection of subjects, identification of variables, their manipulation and control, observation to make and types of statistical analysis to interpret the data, among blind children's. **Population:**-The population of the present study comprises on children living in blind school. **Target population:**The target population are blind children residing in Bagalkot district, accessible population are blind children who are received services in shri manic prabhu academy for the blind and assist depth organizer for rehabilitation **Accessible population:**The accessible population includes blind children residing at 52 sectors Navanagar Bagalkot. **Sampling Technique:**Convenient sampling technique was used to select the blind school and sample. From that blind school. **Sample** Sample consist of subjects of units selected from the accessible population in the present study sample includes blind children staying in blind school Navanagar Bagalkot, and amakkalavasati school Navanagar Bagalkot. **Sample size:** Sample size for the present study consists of 50 visually impaired children i.e. 50 children from Sajeeva Andhamakkala Vasati School sector no 52. Academy for the blind and 50 blind children who are receiving services at assess organization for rehabilitation Bagalkot within the age group of 08-14 years. **Method of Data Collection:-** Data Collection is gathering of information relevant to the research problem. The tool was modified by considering the experts suggestions and results of pilot study. Data were collected by self administered structured knowledge closed ended questionnaire. Data was collected in blind school. **Data Collection:-**The data collection was carried out from 01-03-2019 to 14-03-2019. Permission was obtained from the Headmaster

Sajeeva Andhamakkalavasati school sector no 52, Navanagar Bagalkot. **RESULTS:-**The purpose of analysis is to reduce the data to intelligible and interpretable forms so that the relation of problems can be studied and tested. The interpretation of tabulated data can bring to light these real meaning of the finding of the study. Analysis and interpretation of data for present study is based on data collected from 50 blind children's from blind school Navanagar Bagalkot.

The data analysis is described as categorizing, ordering, manipulating and summarizing the data obtain answer to research questions. The purpose of analysis into reduces the data to an intelligible and interpretable form so that the relation of research problems can be studied. The data is analyzed on the basis of the objectives and hypothesis of the study.

III. ORGANISATION OF FINDINGS:

PART- I: Assessment of data related to Socio-Demographic variables.

PART-II. Assessment of level of Psychosocial Problems and coping strategies.

Section A: Assessment of data related to DASS.

- Assessment of data related to depression.
- Assessment of data related to anxiety.
- Assessment of data related to stress.

Section B: Assessment of data related to Social problems.

Section C: Assessment of data related to Coping strategies.

PART-III Assessment of Co relation between psychosocial problems and coping strategies.

Section-A. Co-relation between Psychological Problems with coping strategies.

Section-B. Co-relation between Social Problems with coping strategies.

PART-IV. Association between psychosocial problems with selected socio-demographic variable of blind children.

Section-A. Association between psychological problems with selected socio-demographic variable of blind children.

Section-B. Association between social problems with selected socio-demographic variable of blind children.

PART-V. Association between coping strategies with selected socio-demographic variable of blind children.

PART- I: Assessment of data related to Socio-Demographic variables.

The Socio demographic variables are distributed in terms of Age. Gender. Education. Cast. Income. Type of Family. Disabled Sibling In The Family. Frequency of Visitors. Causes of Blindness. Duration of Residential In Blind School.

Table-2.4

N=50

SOCIO DEMOGRAPHIC VARIABLES	CATEGORY	FREQUENCY	PERCENTAGE
Age	10-11 yrs	18	36%
	12-13 yrs	19	38%
	14-15 yrs	12	24%
	16+ yrs	01	2%
Gendr	Male	26	52%
	Female	24	48%
Education	Primary	37	74%
	High school	13	26%
Cast	Hindu	40	80%
	Christian	07	14%
	Muslim	03	06%
	OTHERS	00	00%
Income	Below 10,000/-	20	40%
	10,001-15,000/-	22	44%
	15,0001-20,000/-	08	16%
	ABOVE 20,001/-	00	00%
Type of family	Nuclear	25	50%
	Joint	25	50%
DISABLED SIBLING IN THE FAMILY	Deaf & dumb	06	12%
	Mental retardation	04	08%
	Physical handicapped	01	02%
	Any other specific	39	78%
FREQUENCY OF VISITORS	Daily	03	06%
	Weekly	13	66%
	Monthly	33	26%
	No visitors	01	02%
CAUSES OF BLINDNESS	Congenital	48	96%
	Trauma	01	02%
	Disease	00	00%
	Others	01	02%
DURATION OF RESIDENTIAL IN BLIND SCHOOL	Below 5 yrs	20	40%
	5-6 yrs	17	34%
	6-7yrs	11	22%
	7-8 yrs above	02	04%

Table1:- Frequency and percentage distribution according to Age.

PART- I: Description of socio-demographic characteristics of sample.

Percentage wise distribution of children's according to their age group reveals that out of 50 subjects, the highest percentage (38%) of the subjects belongs to age group of 12-13 years. Followed by (36%) in the age group of 10-11 years. Average percentage of (24%) in the age of 14-15 years. Last one lowest percentage of (2%) in the age group of 16 years above. (Fig: 6.1). NO=50

AGE	FREQUENCY	PERCENTAGE
10-11 years	18	36%
12-13 years	19	38%
14-15 years	12	24%
16 + years	01	02%

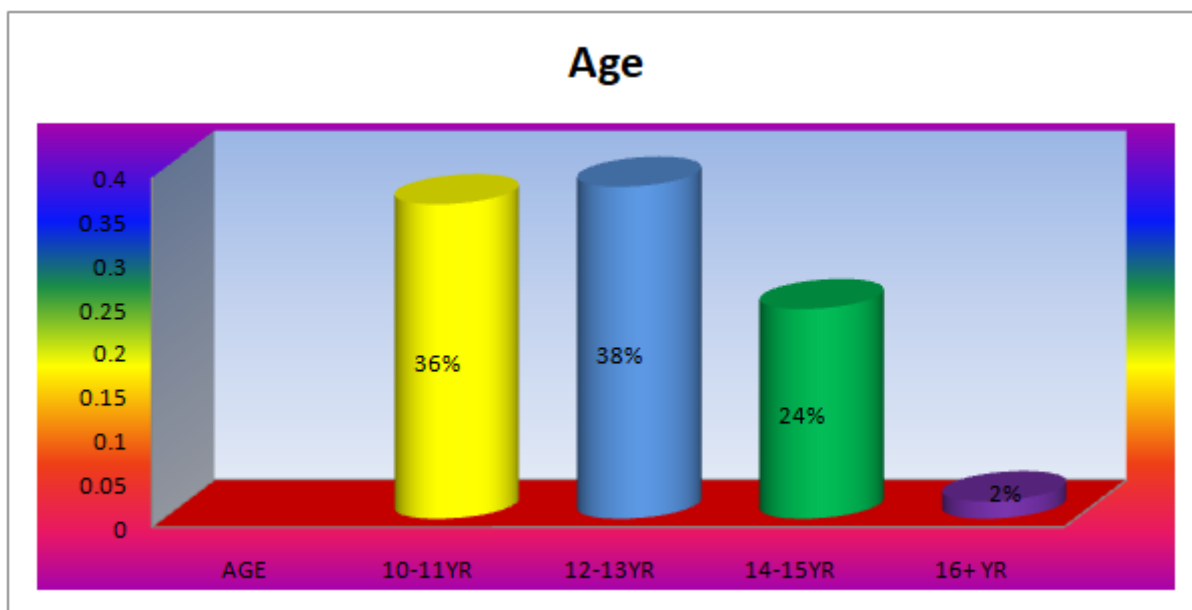


Fig.-1 Frequency and Percentage Distribution According To Gender.

Percentage wise distribution of children according to gender reveals that out of 50 subjects. Highest percentage (52%) of the subjects were male and lowest percentage (48%) of the subjects were female and lowest percentage. It reveals that majority of blind children under this study were male children (Fig:6.2) NO=50

GENDER	FREQUENCY	PERCENTAGE
MALE	26	52%
FEMALE	24	48%

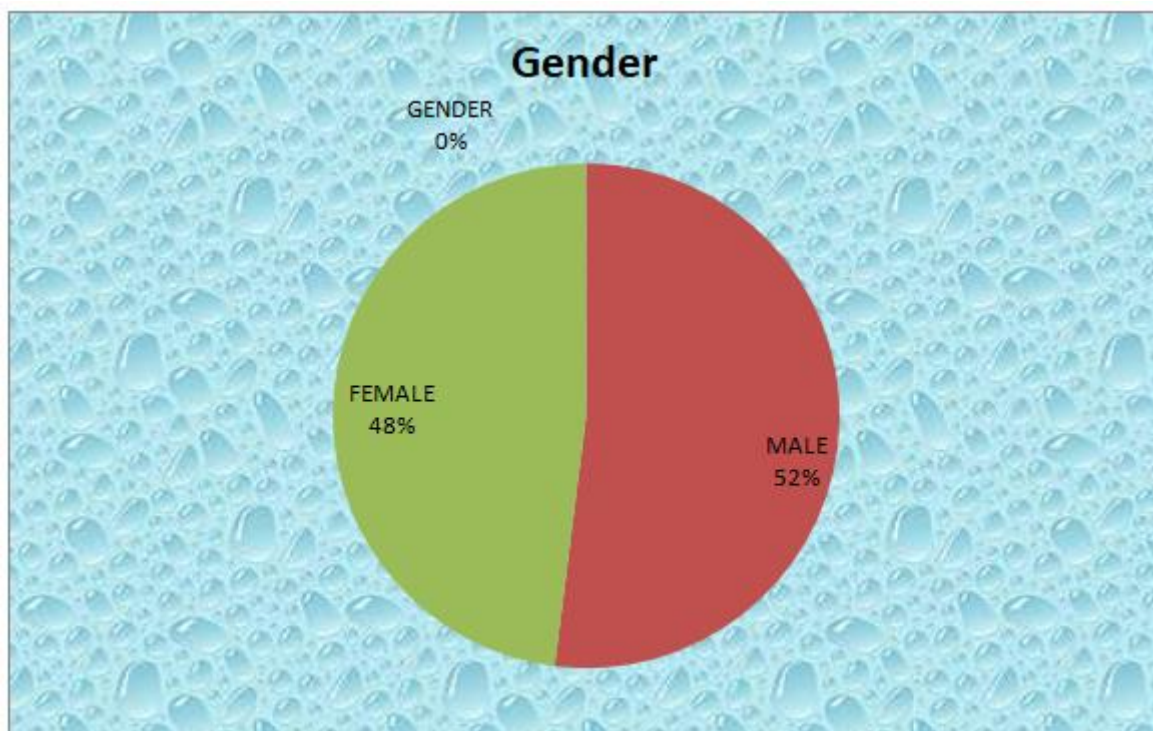


Fig.-2 Frequency and percentage distribution according to Education.

Percentage wise distribution of children according to education reveals that out of 50 subjects. Highest percentages (74%) of the subjects were primary and lowest percentages (13%) of the subjects were high school. It reveals that majority of blind children under this study were primary children (Fig: 6.3) NO=50

EDUCATION	FREQUENCY	PERCENTAGE
PRIMAY	37	74%
HIGH SCHOOL	13	26%

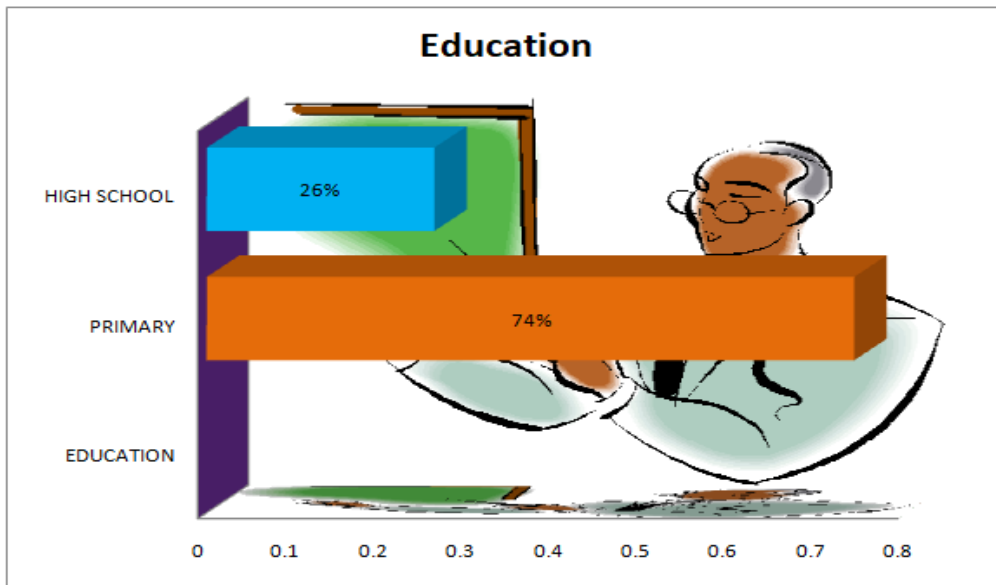


Fig.-3 Frequency and percentage distribution according to Cast.

Percentage wise distribution of children according to Hindu, Muslium. Christian, reveals that out of 50 subjects. Highest percentages (80%) of the subjects were Hindu. average percentage (14%) of the subjects were Muslim. And lowest percentage of (6%) of Christian It reveals that majority of blind children under this study children (Fig: 6.4)

NO=50

CAST	FREQUENCY	PERCENTAGE
HINDU	40	80%
MUSLIUM	07	14%
CHRISTIAN	03	06%
OTHERS	00	00%

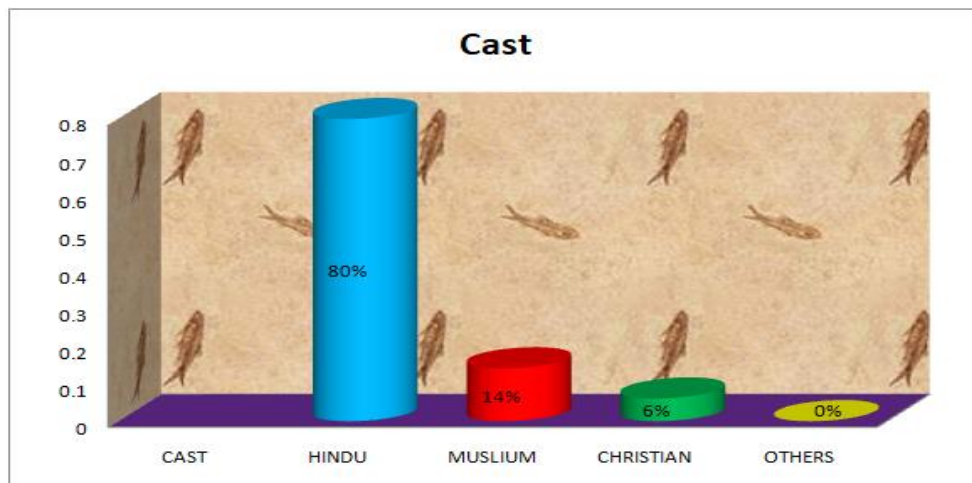


Fig.-4 Frequency and percentage distribution according to Income.

Percentage wise distribution of children according to income, reveals that out of 50 subjects. Highest percentages (44%) of the subjects were 10,000 – 15,000/-. average percentage (40%) of the subjects were below 10,000/-. And lowest percentage of (16%) of 15,001 – 20,000/- It reveals that majority of blind children under this study children (Fig: 6.5)

NO=50

INCOME	FRIQUENCY	PERCENTAGE
BELOW 10,000/-	20	40%
10,000-15,000/-	22	44%
15,001-20,000/-	08	16%
ABOVE 20,000/-	00	00%

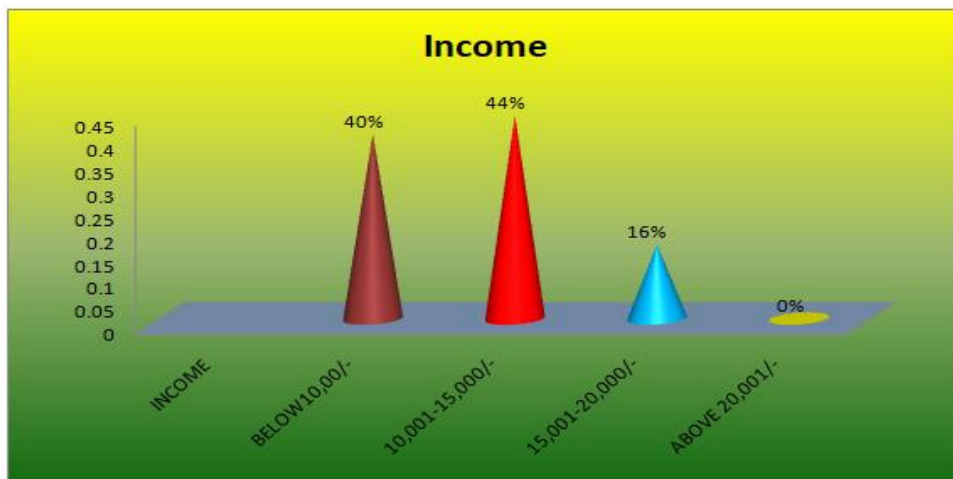


Fig.-5 Frequency and percentage distribution according to Type of family.

Percentage wise distribution of children according to nuclear, joint family. Reveals that out of 50 subjects. Highest percentage (72%) of the Nuclear Family. were Joint family. (28%) (Fig: 6.6) NO=50

FAMILY	FRIQUENCY	PERCENTAGE
NUCLEAR FAMILY	36	72%
JOINT FAMILY	14	28%
EXENDEND FAMILY	00	00%

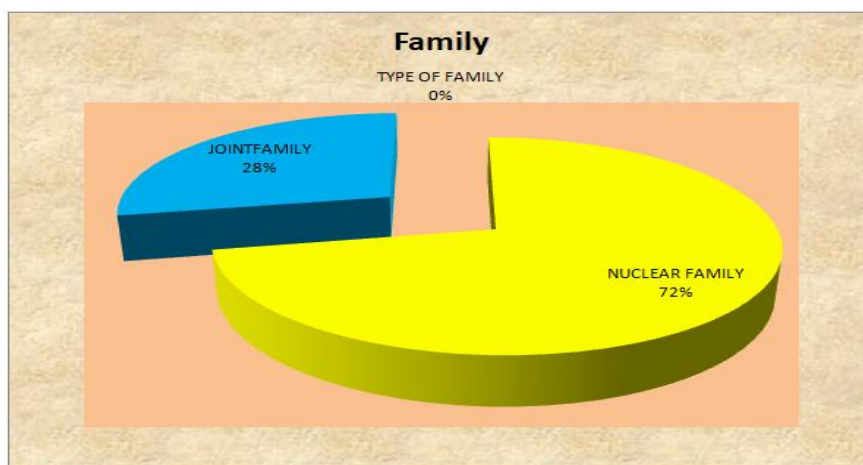


Fig.-6 Frequency and percentage distribution according to sibling in the family.

Percentage wise distribution of children according to Sibling of family, reveals that out of 50 subjects. Highest percentages (78%) of the subjects were any othr specify. average percentage (12%) of the subjects were deaf & dumb. Poor percentage of (8%) of mental retardation. And very poor (2%) of physical handicapped. It reveals that majority of blind children under this study children (Fig: 6.7)

NO=50

SIBLING IN THE FAMILY	FRIQUENCY	PERCENTAGE
DEAF & DUMB	06	12%
MENTAL RETARDATION	04	08%
PHUSICAL HANDICAPPED	01	02%
OTHERS	39	78%

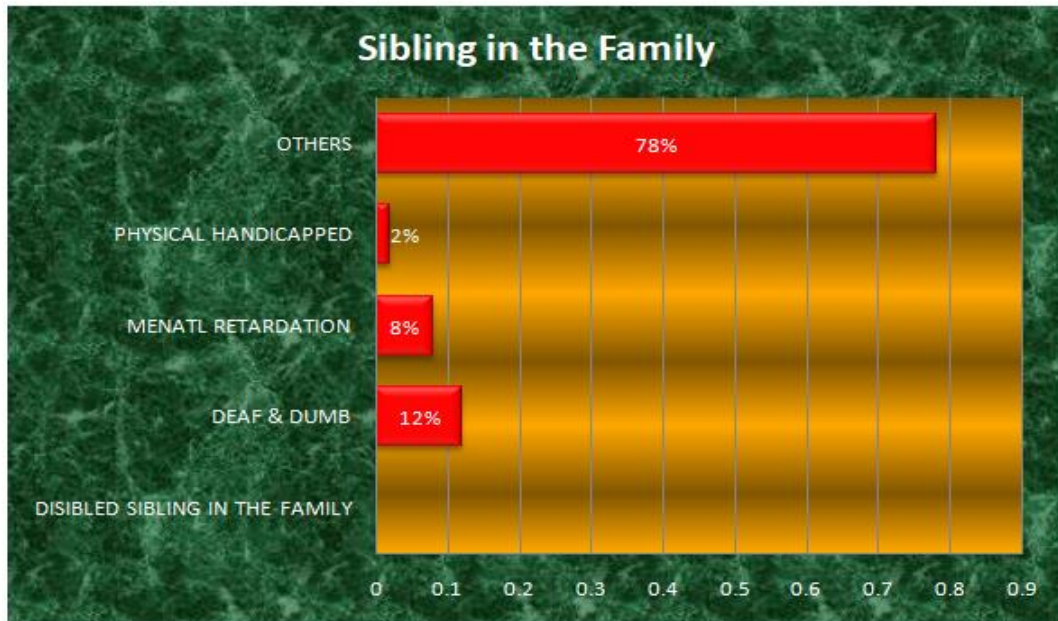


Fig.-7:- Frequency and percentage distribution according to Frequency of visitors.

Percentage wise distribution of children according to frequency of visitors, reveals that out of 50 subjects. Highest percentages (66%) of the subjects were weekly once. average percentage (26%) of the monthly once. Poor percentage of (06%) of daily once. And very poor (2%) of no visitors. It reveals that majority of blind children under these study children (Fig: 6.8) NO=50

Frequency of visitors	Frequency	Percentage
Daily once	03	06%
Weekly once	33	66%
Monthly once	13	26%
No visitors	01	02%

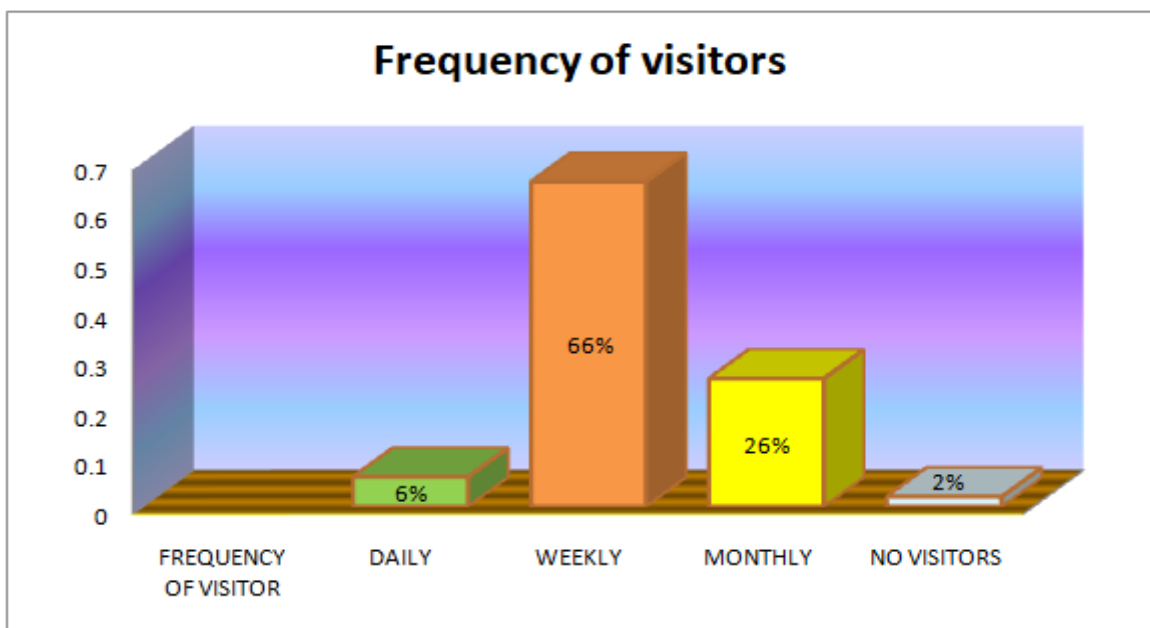


Fig.-8:- frequency and percentage distribution according to causes of blind.

Percentage wise distribution of children according to causes of blind, reveals that out of 50 subjects. Highest percentages (96%) of the subjects were congenital. And remaining both same results average percentage (2%) of the trauma and others (02%). It reveals that majority of blind children under this study children (Fig: 6.9) NO=50

Causes of blind	Frequency	Percentage
Congenital	48	96%
Trauma	01	02%
Disease	00	00%
Otheras	01	02%

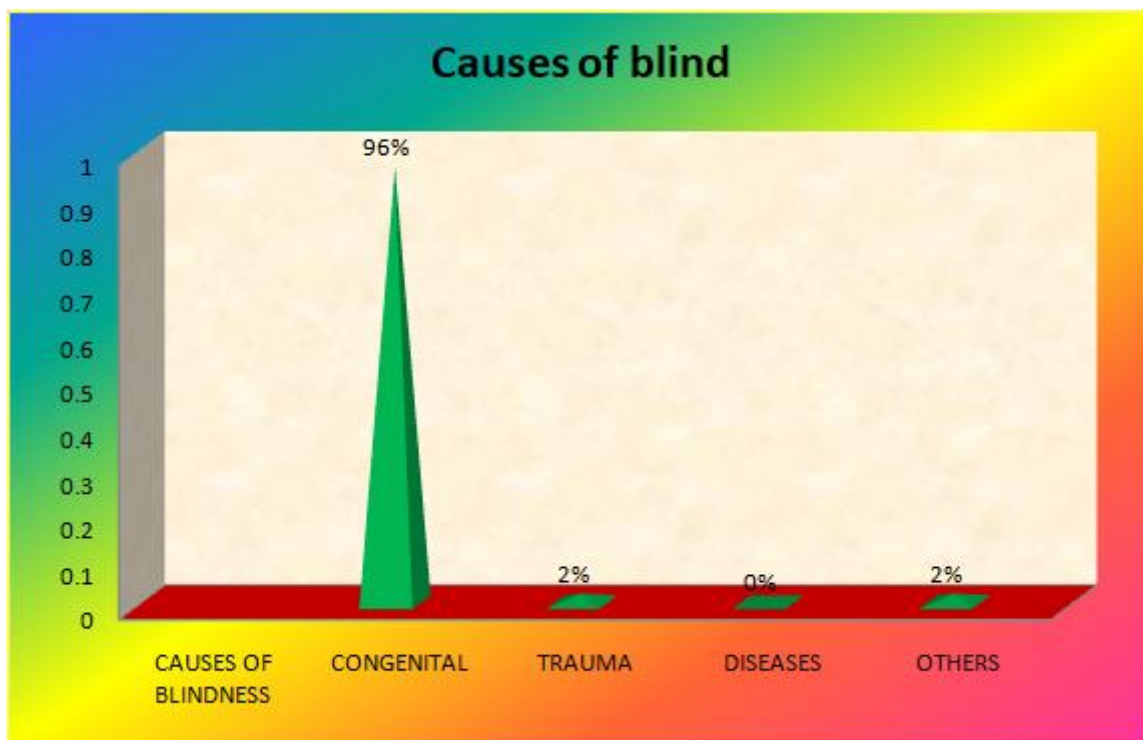


Fig.-9 frequency and percentage distribution according to Residential in blind school .

Percentage wise distribution of children according to Duration of residential in blind school, reveals that out of 50 subjects. Highest percentages (40%) of the subjects were below 5 years. average percentage (34%) of the 5-6 years. Poor percentage of (22%) of 6-7 years. And very poor (4%) of 7-8 years. It reveals that majority of blind children under this study children (Fig: 6.10) NO=50

Residential in blind school	Frequency	Percentage
Below 5 year	20	40%
5-6 year	17	34%
6-7 year	11	22%
7-8 year	02	04%

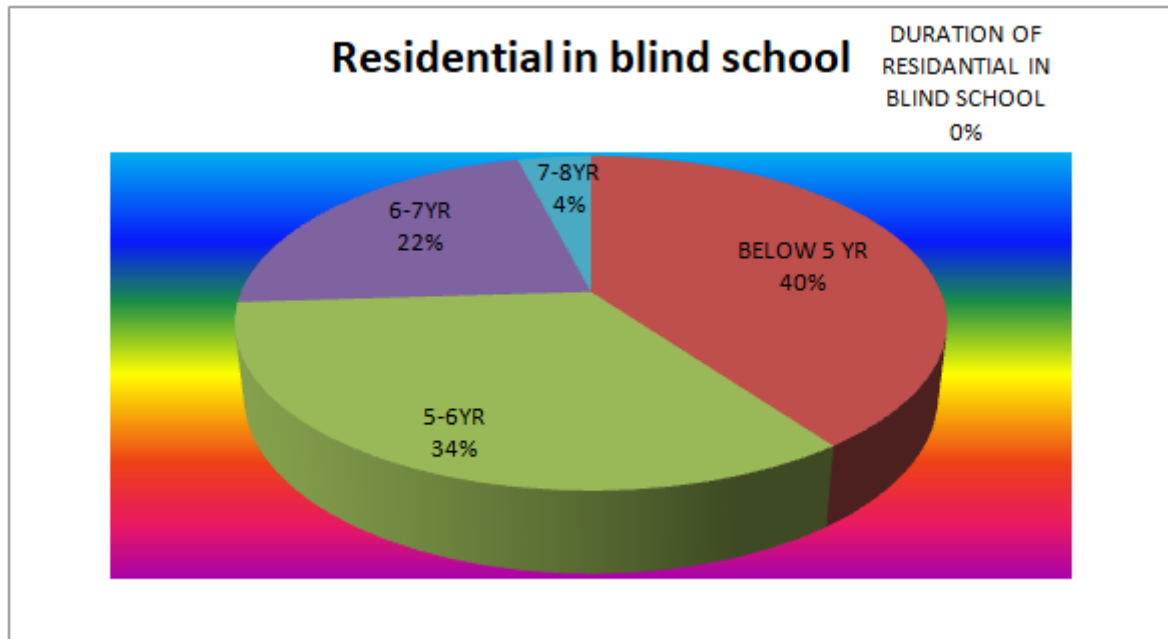


Fig.-10

PART-II. Assessment of level of Psychosocial Problems and coping strategies.

Table-2.4: frequency and percentage distribution of level of psychological problems by using DAS-21 scale.

DASS 21 Score.NO=50

QUESTIONS RELATED TO DEPRESSION	3, 10, 13, 16, 17, 21.
QUESTIONS RELATED TO ANXIETY	2, 4, 7, 6, 9, 15, 19, 20.
QUESTIONS RELATED TO STRESS	1, 5, 8, 11, 12, 14, 18.

Grade	DEPRESSION	Percentage	ANXIETY	Percentage	STRESS	percentage	mean	SD
NORMAL	0-4	18%	0-3	23%	0-7	12%	27.6	5.86
MILD	5-6	24%	4-5	28%	8-9	31%		
MODERATE	7-10	52%	6-7	49%	10-12	56%		
SEVERE	11-13	06%	8-9	00%	13-16	01%		
EXTREMELY SEVERE	14+	00%	10+	00%	17+	00%		

Table.2.5 Frequency Distribution of Depression.

NO=50

Grade	Score	Frequency	Percentage	mean	SD
Normal	0-4	07	14%	15.2	6.1
Mild	5-6	09	18%		
Moderate	7-10	28	56%		
Sever	11-13	05	10%		
Extremely sever	14+	01	02%		

Assessment of the level of **depression** of blind children’s reveals that 50 sample of blind children’s of depression majority moderate (56%) of the blind children’s, (18%) of mild them had normal depression (14%) of them had very severe (10%) depression there were blind children’s who had extremely severe (02%) depression and blind school. And **mean, SD score is 15.2±6.1**

Table.2.6- Frequency Distribution of Anxiety.

NO=50

Grade	score	Frequency	Percentage	Mean	SD
Normal	0-3	02	2%	18.72	6.4
Mild	4-5	02	2%		
Moderate	6-7	14	20%		
Sever	8-9	05	10%		
Extremely sever	10+	28	56%		

Assessment of the level of **Anxiety** of blind children’s reveals that 50 sample of blind children’s of Anxiety Normal 02% of anxiety. Mild rate of 02%. Moderate 14%. Sever 5%. And extremely sever 27%. of anxiety there were blind children’s who had extremely severe depression blind school. And **mean, SD score is 18.2±6.4**.

Table.2.7 Frequency Distribution of stress.

NO=50

Grade	score	Frequency	Percentage	Mean	SD
Normal	0-14	08	12%	21.4	5.35
Mild	15-18	10	14%		
Moderate	19-25	18	56%		
Sever	26-33	14	18%		
Extremely sever	34+	00	00%		

Assessment of the level of **Stress** of blind children’s reveals that 50 sample of blind children’s of Stress Normal 08% of anxiety. Mild rate of 10%. Moderate 18%. Sever 14%. And extremely sever 00%. of anxiety there were blind children’s who had severe depression blind school. And mean, **SD score is 21.4±5.35**.

Table-2.8, Frequency and percentage distribution level of Social Problems.

NO=50

SL NO	Grade	Score	Frequency	Percentage	mean	SD
01	VERY POOR SOCIAL ADJUST	Below 24	26	56%	7.18	1.5
02	POOR SOCIAL ADJUST	25-34	22	41%		
03	GOOD SOCIAL ADJUST	35-45	2	03%		
04	VERY GOOD SOCIAL ADJUST	45-56	00	00%		

Assessment of the level of **Social problems** of blind children reveals that 50 sample of blind children’s of Social problems Mild 01% of social problems. Moderate rate of 48%. Sever 01%. Social problems there were blind children’s who had severe Social problems of blind school. And mean, SD score is 7.18±1.5.

Table-2.9: Frequency and percentage distribution level of coping strategies.

NO=50

SL NO	GRADE	SCORE	Frequency	Percentage	Mean	SD
01	VERY GOOD	34-44	00	00%	20.3	2.76
02	GOOD	23-33	22	13%		
03	POOR	12-22	20	46.66%		
04	VERY POOR	BELOW 11	06	40.34%		

Assessment of the level of **coping strategies** of blind children’s reveals that 50 sample of blind children’s of coping strategies Mild 00% of social problems. Moderate rate of 00%. Sever 50%. Social problems there were blind children’s who had severe Social problems of blind school. And mean, SD score is 20.3±2.76.

PART-VII. Correlation of psychosocial problems with coping strategies.

Section-A. Correlation between psychological problems with coping strategies.

This section deals with the relationship between the psychological problems and coping strategies of blind children. In order to find the relationship the null hypothesis has been formulated

H₃– there will be no significant relationship between psychological problems and coping strategies of blind children at 0.05 level of significance.

Table :- 3.0 NO-50

Variable	Mean	SD	r value	p
Psychological problems	27.6	5.83	0.16	0.0001
Coping strategies	20.3	2.76		

Section-B. Correlation between social problems with coping strategies.

This section deals with the relationship between the social problems and coping strategies of blind children. In order to find the relationship the null hypothesis has been formulated

H₃– there will be no significant relationship between social problems and coping strategies of blind children at 0.05 level of significance.

Table :- 3.1 NO-50

Variable	Mean	SD	r value	p
Social problems	7.18	1.5	0.19	0.0001
Coping strategies	20.3	2.76		

PART-VIII. Association between psychosocial problems with selected socio-demographic variable of blind children.

Table-3.3. Association between psychological problems with selected socio-demographic variable of blind children.
NO=50

Sl No	Socio Demographic variable	Df	Chi-Square value	Table value	Levels of significance	Association
01	Age	01	2.21	3.84	0.05	Not significant
02	Gender	01	0.56	3.84	0.05	Not significant
03	Education	01	4.01	3.84	0.05	significant
04	Cast	01	0.40	3.84	0.05	Not significant
05	Income	01	1.76	3.84	0.05	Not significant
06	Type of family	01	1.49	3.84	0.05	Not significant
07	Disabled sibling in the family	01	0.34	3.84	0.05	Not significant
08	Frequency of visitors	01	0.01	3.84	0.05	Not significant
09	Causes of blind	01	1.36	3.84	0.05	Not significant
10	Duration of residential	01	4.35	3.84	0.05	significant

chi-square value 2.21, 0.56, 0.40, 1.76, 1.49, 0.34, 0.01, 1.36, were lesser than the table values (3.84) which indicates there was no significant association found between results demographic variable (age, gender, cast, income, type of family, disabled sibling in the family, frequency of visitors, causes of blind, with psychological problems p<0.05

chi-squared value (4.01, 4.35,) which indicates there was significant association found between resolved demographic variable (education, duration of residential in blind school. $P < 0.05$

Table-3.4; Association between social problems with selected socio-demographic variable of blind children. NO=50

SI No	Socio Demographic variable	Df	Chi-Square value	Table value	Levels of significance	Association
01	Age	01	2.21	3.84	0.05	Not significant
02	Gender	01	0.56	3.84	0.05	Not significant
03	Education	01	3.01	3.84	0.05	Not significant
04	Cast	01	0.40	3.84	0.05	Not significant
05	Income	01	4.76	3.84	0.05	significant
06	Type of family	01	2.49	3.84	0.05	Not significant
07	Disabled sibling in the family	01	0.34	3.84	0.05	Not significant
08	Frequency of visitors	01	5.01	3.84	0.05	significant
09	Causes of blind	01	1.56	3.84	0.05	Not significant
10	Duration of residential	01	1.35	3.84	0.05	Not significant

chi-square value 2.21, 0.56, 3.01, 0.40, 2.49, 0.34, 1.56, 1.36, were lesser than the table values (3.84) which indicates there was no significant association found between results demographic variable (age, gender, cast, type of family, disabled sibling in the family, causes of blind, duration of residential, with social problems $p < 0.05$

chi-squared value (4.76, 5.01,) which indicates there was significant association found between resolved demographic variable (income, Frequency of visitors. $P < 0.05$

Table. 3.5. Association between coping strategies with selected socio-demographic variable of blind children. NO=50

SI No	Socio Demographic variable	Df	Chi-Square value	Table value	Levels of significance	Association
01	Age	01	2.21	3.84	0.05	Not significant
02	Gender	01	4.56	3.84	0.05	significant
03	Education	01	2.01	3.84	0.05	Not significant
04	Cast	01	0.40	3.84	0.05	Not significant
05	Income	01	2.76	3.84	0.05	Not significant
06	Type of family	01	2.49	3.84	0.05	Not significant
07	Disabled sibling in the family	01	4.34	3.84	0.05	significant
08	Frequency of visitors	01	4.01	3.84	0.05	significant
09	Causes of blind	01	1.56	3.84	0.05	Not significant
10	Duration of residential	01	0.35	3.84	0.05	Not significant

chi-square value 2.21, 2.01, 0.40, 2.76, 2.49, 1.56, and 0.35. were lesser than the table values (3.84) which indicates there was no significant association found between results demographic variable (age, education, cast, income type of family, causes of blind, Duration of residential. with social problems $p < 0.05$

chi-squared value (4.56, 4.34, 4.01.) which indicates there was significant association found between resolved demographic variable of Gender, Disabled sibling in the family, Frequency of visitors. $P < 0.05$

REFERENCES

- [1]. Chintamani kar. Exceptional Children. 1st Ed. New Delhi: Sterling publishers’ private limited; 1992.81-83.
- [2]. M.thomas Kishore. National policy for Persons with Disabilities. NIMH News Letter 2006 June; 1991); 23-33.
- [3]. N. K. Jangira, M.N.G.Mani. Integrated Education for Visually Handicapped. 1st ed. Haryana: The Academic Press; 1990.
- [4]. Michael E. Monbeck. The Meaning of Blindness – Attitude toward Blindness and Blind People. 3rd ed. USA; Indian University Press; 1975. 22-26

- [5]. Samar k. Basak . Essentials of Ophthalmology. 3rd Ed. New delgi : Current Books International ;2005.361
- [6]. Dandona , I Dandona . Childhood Blindness in India. British JI of Ophthalmology 2003; 87:20-23.
- [7]. RahiJS ,Sripathi S , Gilbert CE, Foster A. The impoetance of prenatal factors in childhood blindness in India . ji OF DEV Med child Neuroll 1997 Jul;39(7):449- 55.
- [8]. Sankara eye hospital. Bangalore and sight savers International mull over common eye problems faced by children. 2010. Available from [URL:http://www.indiprwire.com/peersselfcare/healthcare/20100203](http://www.indiprwire.com/peersselfcare/healthcare/20100203).
- [9]. C.S Mohapatra . Disability Management in India challenges and commitments .1STed .secunderabad; Sree Raman Process Ltd; 2000.26-31.
- [10]. J.S Grewal .Educational Perspective on Visual Impairment –Nature of Visual Impaired Children. M.P Bhoj University . Bhopal ;;2006