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A Comparative Study to Assess the Knowledge Regarding Mild and Moderate Mental Retardation of Children Among Primary School Teachers in Selected Urban and Rural Schools, Jalandhar (Punjab) with a View to Develop an Information Booklet

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ABSTRACT

Background and Objectives of the Study: Mental retardation is not a disease but a condition in which the intellectual faculties are never manifested or have developed sufficiently to enable the retarded person to acquire such knowledge. The objective of the study to assess the knowledge score regarding mild and moderate mental retardation of children among the school teacher in urban & rural area, to compare the knowledge score regarding mild and moderate mental retardation of children among the urban and rural school teachers, to find out the association between urban and rural school teacher knowledge score regarding mild and moderate mental retardation and with their demographic variablesandto develop an information booklet regarding mild and moderate mental retardation.

Methodology: A comparative non-experiment is used. The setting is a urban and rural primary schools, Jalandhar. The sample includes 60 primary school teachers selected by purposive sampling technique. The tool consisted: Part 1 demographic variables and Part 2 Self structured knowledge questionnaire. Reliability of the tool was established by using split half method.

Results: The findings of the study show that the mean score and SD of rural primary school on knowledge according to area. Definition and epidemiology the mean score is 3 and SD is 0.5, according to etiology the mean score is 5.6 and SD is 0.5, according to types the mean score is 1.2 and SD is 0.833, according to characteristics the mean score is 2.1 and SD is 0.600, according to sign and symptoms and diagnostic tests the mean score is 0.7 and SD is 0.441, according to prevention the mean score is 2.4 and SD is 0.527 and according to management the mean score is 4.5 and SD is 1.236.

Conclusion: Majority (60%) of urban primary school teachers had satisfactory knowledge regarding mild and moderate mental retardation in children while the majority (83.3%) rural primary school teachers had satisfactory knowledge regarding mild and moderate mental retardation in children.

KEYWORDS: Mild Retardation & Moderate mental retardation, primary school teachers, Urban and Rural Schools, Information Booklet.

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INTRODUCTION

Mental health as the successful performance of mental functions shown by productive activities, fulfilling relationship with other people, the ability to adapt to change and to cope with adversity.[1]

The WHO had declared that the World Health Day theme for the year 2001 is "Mental Health: Stop exclusion -

dare to care". In order to focus global public health attention on this relatively neglected problem. Information regarding the prevalence of mental disorders in India needs to be generated to establish a database for mental health planners to assess the status of mental health in the country. An analysis of the epidemiological studies done in the country would be a rational method of estimating the national prevalence rates for mental disorders.[2]

The definition used most often in the United States is from the American Association on Mental Retardation (AAMR). According to AAMR mental retardation is a disability that occurs before age 18. It is characterized by significant limitations in intellectual functioning and adaptive behaviour expressed in conceptual, social and practical adaptive skills. It is diagnosed through the use of standardized tests of intelligence and adaptive behaviour. AAMR points out that both functioning and adaptive behaviour are affected positively by individualized supports. [3]

According to American association of mental deficiency, mental retardation can be defined "as a significantly sub average general intellectual functioning, resulting or associated with concurrent impairment in adaptive behaviour and is manifested during the developmental period." Here, intellectual functioning is measured by standardized intelligence tests sub average means usually an intelligent quotient (IQ) of below 70 while adaptive behaviour is the person's ability to meet the responsibilities of social, personal, occupational and interpersonal areas of life according to his or her age and socio cultural and educational background. [4]

Globalization and industrialization have in increasing the incidence of mental retardation. Mental handicap is the present term used for mental retardation. Mental handicap has many causes which can be genetic, environmental and includes prenatal as well as postnatal causes. There are possible and easy way to prevent mental retardation. Mental retardation is a condition in which infants and children with a low capacity, poor maturation and inadequate social adjustment exists.[5]

Mental retardation appears in childhood before the age of 18. It is one of the most globally prevalent neurologic disorders. Survey in developed countries show a prevalence 3 to 5 per 1,000 with mental retardation that is intelligence quotient below 55. Estimates from developing countries however have found prevalence rate from 22 per 1000. Protein- energy malnutrition, dietary micronutrients deficiencies, environment toxins, and lack of early sensory stimulation or ability to profit from it may contribute to neuro developmental disabilities. Tropical disease such as parasites with resultant anaemia, malaria and other infections are major contributory causes of mental retardation and cognitive dysfunction. (Garry, 2008)[6]

In Mangalore, the National Prevalence rates for all mental disorders was observed to be 65.4 per 1000 population. Prevalence rates for schizophrenia, affective disorders, anxiety neurosis, hysteria and mental retardation were 2.3, 31.2, 18.5, 4.1 and 4.2 per 1000 population respectively. The urban morbidity rate was 2 per 1000 higher than the rural rate. The results will be useful to mental health planners and administrators for planning the national mental health programme. [2]

According to latest census 2013 in New Delhi, on disabilities have shown only a marginal increase in the number of differently able people in the country with the figure rising from 21.9 million in 2001 to 26.8 million in 10 years. In percentage terms it has risen from 2.13 per cent to 2.21 per cent as per the Census 2011 released by the Registrar General of India. There are 14.9 million men with disabilities as compared to 11.8 million women in the country with the total number of disabled people over 18 million in the rural areas and just 8.1 million enumerated in the urban settings. The percentage of men with disabilities is 2.41 as against 2.01 in women. [7]

Rehabilitation of the children should be approached by combined and co-ordinated use of medical, social, educational and vocational measures for training and retraining the children to the highest possible level of functional ability. The child needs to be trained for an independent living with special training and education. In India, there are more than 150 schools and institution for the mentally retarded child. These include day care centres, special schools and vocational training centres.[8]

MATERIALS & METHODS

Study Design & Sample Size

In this present study a quantitative non-experimental research approach is used to assess the knowledge regarding mild and moderate mental retardation of children among primary school teachers in selected urban and rural schools, in February 2015 Jalandhar (Punjab)

A comparative descriptive design is used to assess the knowledge regarding mild and moderate mental retardation of children among primary school teachers in selected urban and rural schools, Jalandhar (Punjab) with view to develop an information booklet. the study consists of 60 samples (30 samples from urban schools and 30 samples from rural schools, The primary school teachers between age of 21-58 years) participated in the study.

ETHICAL CONSIDERATION: Institutional Ethical Permission was obtained (letter no. : BINT/PO/IEC/047 DT 05/06/2014). Data was collected after getting formal permission from the concerned authorities.

DATA COLLECTION MEASURES

Purposive sampling technique (non-probability sampling technique) used to collect the sample, which was validated by experts and was found reliable. Data collection tools are the procedures or instruments used by the researcher to observe or measure key variables in the research problem. It is prepared in following section **A**: It consists of demographic data of the participants related to age, religion, professional experience, marital status, do you have children, type of family, type of residence, attended children development training class from any medical agency and source of information**. Section-B**: Self Structured questionnaire to assess the level of knowledge about mild and moderate mental retardation. It consists of 40 questions pertaining to knowledge domain regarding mild and mental moderate retardation. The score was interpreted as Poor = 0-10, Satisfactory = 11-20, Good = 21-30, Excellent = 31-40

STATISTICAL ANALYSIS

Data was analyzed using both descriptive and inferential statistics. Steps taken to analyze the data were, Organized the data in master sheet. Calculated frequency and percentage to show the distribution of subjects according to baseline demographic variables. Analysis of knowledge score of urban and rural primary schools by using frequency and percentage distribution. According to area wise to compare knowledge between the urban and rural schools subjects. Chi-square is used to find out the association between knowledge score and demographic variables

RESULTS

Table:1 Reveals that according to the age of majority (40%) urban primary school teachers in the age of 26-30 years and (40%) rural primary school teachers in the age of 31-35years. According to religion, most of the urban primary school teachers (80%) were Sikh and (20%) were Hindu and most of the rural primary school teachers (56.7%) were Sikh, (43.3%) were Hindu. Participants total professional experience, highest percentage in urban primary school teachers were 0-10 (80%) and rural primary school teachers were 0-10(100%). Marital status, urban primary school teachers (50%) were unmarried, (50%) were married and rural primary school teachers (96.7%) were married (3.3%) were unmarried. samples that are having children, urban primary school teachers (46.7%) and rural school teachers (96.7%) were having children and those samples that are not having children, urban school teachers (53.3%) and rural primary school teachers (3.3%) were not having children . based on the type of family, most of the urban primary school teachers (63.3%) were nuclear, (36.7%) were joint and rural primary school teachers (63.3%) were joint, (36.7%) were nuclear. participants type of residence, urban primary school teachers (93.3%) were urban, (6.7%) were rural area and rural primary school teachers (90%) were urban, (10%) were rural area. According to attended children development training class from any medical agency, urban primary school teachers (100%) were not attended children development training class from any medical agency and rural primary school teachers (70%) were not attended, (30%) were attended children development training class from any medical agency. According to source of information regarding mental retardation, highest percentage (60%) urban primary school teachers acquired information from books/literature and (40%) rural primary school teachers acquired information from family members/ friends.

Table 2 Depicts that the majority (60%) of urban school teachers were have satisfactory knowledge and 40% of urban school teachers were have good knowledge. Whereas the majority (83.3%) of rural school teachers were have satisfactory knowledge and 16.7% of rural school teachers were have good knowledge.

Table 3 Explains that, the urban primary school teachers had knowledge on etiology of mental retardation shows that the highest mean score 5.8 and SD 1.234. While the sign and symptoms and diagnostic tests of mental retardation shows the lowest mean score 1.1 and SD 0.784.and the coefficient of correlation on knowledge score is 1.352.

Table 4 Depicts etiology of mental retardation shows that the highest mean score 5.6 and SD 0.5. While the sign and symptoms and diagnostic tests of mental retardation shows the lowest mean score 0.7 and SD 0.441 and the coefficient of correlation on knowledge score is 1.352

Table 5 Reveals the association between the knowledge score of urban school teachers regarding mild and moderate retardation in children in selected demographic variables. The table shows that there is no significant association between the demographic variable. No association was found between any other variables and knowledge score. Thus null hypothesis is accepted in all other cases.

Table 6 Explains the association between the knowledge score of rural school teachers regarding mild and moderate retardation of children in selected demographic variables. The chi square test is used to find out the association between demographic variables on knowledge score of rural school teachers. The tabulated chi square value at 0.05 level of significant for 1d.f is 3.84. If the calculated chi square value is greater than the tabulated value, then the null hypothesis will be rejected and will be concluded that there is significant association between the knowledge score of rural school teachers and the particular demographic variable.

The table 6 shows that there is significant association between the attended children development training class from any medical agency and source of information on mild and moderate mental retardation of children and knowledge score with chi square value of 5.50, 6.91 at 0.05 level of significance. Thus it is concluded that the null hypothesis is accepted in the other cases.

DISCUSSION

According to age majority (30%) of urban school teachers were between the age of 20- 25 years, 12% of urban school teachers were between the age of 26-30 years and 20% of urban school teachers were between the age of 31-35 years while 6.7% of urban primary school teachers were between the age of 35-40 years. Only 3.3% of urban school teachers belonged to the age group of 41-45years. Whereas the majority (40%) of rural school teachers were between the age of 31-35 years, 30% of rural school teachers were between the age 35-40 years and 20% of rural school teachers were between the age of 41-45 years while 10% of rural school teachers between the age of 26-30% years.

Another study findings revealed that of the 34 teachers the sex ratio was 1 male and 33 female teachers. The mean age of the sample was 36.00 (SD6.74) and ranged between the 27 to 46 years. Mean duration of primary school teaching 3.60 (SD3.84) and mean duration of working at the current school was 8.20 years (SD 6.22) majority (47%) of the teachers were between 20 to 25 years of age. Ten (29.4%) were in the 25 to 35 years age group. Six (17.6%) were in the 35 to 45 years age group and age two teachers were above 45years age.[38]

The finding of the study showed that maximum urban primary school teachers (60%) had satisfactory knowledge regarding mild and moderate mental retardation, while remaining 40% of urban school teachers had good knowledge on mild and moderate mental of children.

The finding of the study showed that the maximum rural primary school teachers (83.3%) had satisfactory knowledge regarding mild and moderate mental retardation, while 16.7% of rural school teachers had good knowledge regarding mild and moderate mental retardation in children.

The study showed that the urban primary school teachers had knowledge on etiology of mental retardation shows that the highest mean score 5.8 and SD 1.234. While the sign and symptoms and diagnostic tests of mental retardation shows the lowest mean score 1.1 and SD 0.784 and the coefficient of correlation on knowledge score is 1.352.

The study showed that the rural school teachers had knowledge on etiology of mental retardation shows that the highest mean score 5.6 and SD 0.5. While the sign and symptoms and diagnostic tests of mental retardation shows the lowest mean score 0.7 and SD 0.441 and the coefficient of correlation on knowledge score is 1.352

The study finding shows that there is no significant association between the demographic variable. No association was found between any other variables and knowledge score.

The study finding showed that there is significant association between the attended children development training class from any medical agency and source of information on mild and moderatemental retardation of children and knowledge score

CONCLUSION

Majority (60%) of urban primary school teachers had satisfactory knowledge regarding mild and moderate retardation in children while the majority (83.3 primary school teachers had satisfactory knowledge regarding mild and moderate mental retardation in children. And According to urban primary school teachers the Age, Religion, Professional experience, No. of children, Type of family, Type of residence, Attended children development class, Source of information regarding mild and moderate mental retardation had no impact on knowledge regarding mild and moderate mental retardation. According to rural primary school teachers the Age, Religion, Professional experience, No. of children, Type of family, Type of residence had no impact on knowledge but Attended children development class, Source of information regarding mild and moderate mental retardation had impact on knowledge regarding mild and moderate mental retardation.

RECOMMONDATIONS

On the basis of the findings of the present study, A similar type of study can be done by taking large sample size so that generalization can be made & A self-instructional module on prevention of mild and moderate mental retardation can be developed with pictorials and can be made available free of cost to enhance the knowledge and awareness.

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Table – 1 Frequency and Percentage Distribution of demographic variables of primary school teachers.
N=60

S. No.	Demographic variables	Urban School N=30		Rural School N=30	
		F	%	F	%
1.	**Age in years**				
	a. 20-25	9	30%	0	0%

S. No.	Demographic variables	Urban School N=30		Rural School N=30	
		F	%	F	%
	b. 26-30	12	40%	3	10%
	c. 31-35	6	20%	12	40%
	d. 35-40	2	6.7%	9	30%
	e. 41-45	1	3.3%	6	20%
2.	**Religion**				
	a. Hindu	6	20%	13	43.3%
	b. Sikh	24	80%	17	56.7%
	c. Muslim	0	0%	0%	0%
	d. Christian	0	0%	0%	0%
	e. Others	0	0%	0%	0%
3.	**Professional experience**				
	a. 0-10	24	80%	30	100%
	b. 11-20	3	10%	0	0%
	c. 21-30	3	10%	0	0%
	d. 31-40	0	0%	0	0%
4.	**Marital Status**				
	a. Unmarried	15	50%	1	3.3%
	b. Married	15	50%	29	96.7%
	c. Divorced/ Separated	0	0%	0	0%
	d. Widow	0	0%	0	0%
5.	**No. of Children**				
	a. None	14	46.7%	1	3.3%
	b. One or more	16	53.3%	29	96.7%
6.	**Type of Family**				
	a. Nuclear	19	63.3%	11	36.7%
	b. Joint	11	36.7%	19	63.3%
7.	**Type of Residence**				
	a. Rural	2	6.7%	3	10%
	b. Urban	28	93.3%	27	90%
	c. Semi urban	0	0%	0	0%
8.	**Attended development class from any agency**				
	a. Yes	0	0%	9	30%
	b. No	30	100%	21	70%
9.	**Source of information**				
	a. Books/ literature	18	60%	11	36.7%
	b. Family members/ friends	10	33.3%	12	40%
	c. Health professionals	0	0%	0	0%
	d. Mass media	2	6.7%	7	23.3%

Table-2. Frequency and Percentage distribution of overall knowledge scores of subjects in urban and rural school N= 60

Level of knowledge	Score	Knowledge score			
		Urban (N =30)		Rural (N =30)	
		N	%	N	%
Poor(less than 25%)	Below 10	0	0%	0	0%
Satisfactory (27.5% - 50%)	11-20	18	60%	25	83.3%

Good (52.5% -75%)	21-30	12	40%	5	16.7%
Excellent (77.5% - 100%)	31-40	0	0%	0	0%

Table – 3

Area	Total no. of questions	Range	Mean	SD
Definition and epidemiology	6	1-6	3.1	1.093
Etiology	11	3-8	5.8	1.234
Types	3	0-3	1.2	0.897
Characteristics	4	0-4	2.0	1.080
Sign and symptoms and diagnostic tests	2	0-2	1.1	0.784
Prevention	5	0-5	2.4	1.162
Management	9	3-7	4.7	1.087
Coefficient of correlation knowledge on score = 1. 352				

Maximum Score = 40
Minimum Score = 0

Table –4

Area	Total no. of questions	Range	Mean	SD
Definition and epidemiology	6	2-4	3	0.5
Etiology	11	4-6	5.6	0.5
Types	3	0-3	1.2	0.833
Characteristics	4	0-4	2.1	0.600
Sign and symptoms and diagnostic tests	2	0-2	0.7	0.441
Prevention	5	1-4	2.4	0.527
Management	9	2-7	4.5	1.236
Coefficient of correlation on knowledge score = 1. 352				

Maximum Score = 40
Minimum Score = 0

Table – 5: Association between knowledge score of urban school teachers and selected demographic variables
N= 30

S. No.	Demographic variables	≥Median	<Median	Chi square result	Inference
1.	**Age**				
	a. 20-25	9	3	0.13	NS
	b. 26 and above	15	3		
2.	**Religion**				
	a. Hindu	4	2	0.83	NS
	b. Sikh	20	4		
3.	**Professional experience**				
	a. 0-10 years	21	6	0.74	NS
	b. Above 10 years	3	0		
4.	**Marital status**				
	a. Nuclear	13	2	0.83	NS
	b. Joint	11	4		
5.	**No. of Children**				
	a. None	11	3	0.02	NS

S. No.	Demographic variables	≥Median	<Median	Chi square result	Inference
	b. More than one	13	3		
6.	**Type of Family**				
	a. Nuclear	15	4	1.26	NS
	b. Joint	10	1		
7.	**Type of Residence**				
	a. Rural	2	0	0.53	NS
	b. Urban	22	6		
8.	**Attended children development class from any medical agency**				
	a. No	0	0	0.006	NS
	b. Yes	24	6		
9.	**Source of Information**				
	a. Books, mass media	18	2	3.75	NS
	b. Health Personnel	6	4		

S = Significant
NS = Not Significant

Table–6: Association between knowledge score of rural school teachers and selected demographic variables
N= 30

S.No.	Demographic variables	≥Median	<Median	Chi square result	Inference
1.	**Age**				
	a. 20-25	10	5	0.14	NS
	b. 26 and above	9	6		
2.	**Religion**				
	a. Hindu	10	3	1.82	NS
	b. Sikh	9	8		
3.	**Professional experience**				
	a. 0-10 years	19	11	0.004	NS
	b. Above 10 years	0	0		
4.	**Marital status**				
	a. Nuclear	1	0	0.59	NS
	b. Joint	18	11		
5.	**No. of Children**				
	a. None	18	11	0.59	NS
	b. More than one	1	0		
6.	**Type of Family**				
	a. Nuclear	8	3	1.09	NS
	b. Joint	11	8		
7.	**Type of Residence**				
	a. Rural	3	0	1.92	NS
	b. Urban	16	11		
8.	**Attended children development class from any medical agency**				
	a. No	3	6	5.50	S
	b. Yes	16	5		
9.	**Source of Information**				
	a. Books and mass media	8	10	6.91	S
	b. Health Personals	11	1		

S = Significant
NS = Not Significant