

INFLUENCE OF MENTAL HYGIENE AND HEALTH ON MENTALLY RETARDED CHILDREN ON AGE GROUP (05-20 YEARS)

¹Ishrat Jabeen, ²Dr. Neetee Mehta, ³Dr. Poornima Shrivastava

¹Research Scholar, Deptt. of Psychology, Bhagwant University, Ajmer, Rajasthan

^{1,2}Assistant Professor, Deptt. of Psychology, Bhagwant University, Ajmer, Rajasthan

Abstract: In this paper to assess children's needs with mental retaliation using meeting needs, education, social skills, and problems faced by parents. To find regression with selected demographic variables. (Age, gender, location, socioeconomic status, type of marriage, mode of delivery)) To find linear regression between meetings needs, education, social skills, problems faced by parents. Dependence with demographic variables such as type of marriage and type of distribution. A descriptive study to Influence of Mental Hygiene and Health on Mentally Retarded Children on Age Group (05-20 Years).

Keywords: Mental Hygiene, Retarded Children, Age Group, demographic variables etc.

1. INTRODUCTION

"Health is not primarily an issue of doctors, social services and hospitals. It is also an issue of social justice. "

Health is a common theme in most cultures. In fact, all communities have their concept of health as part of their culture. The earliest meaning of health is "absence of disease". Health and harmony are considered the same in some cultures, with "harmony" being defined as "living at peace with oneself, community, God and the universe". Ancient Indians and Greeks shared this concept and attributed the disease to disturbances in physical balance called "heroes". Modern medicine often accuses the victim of the disease and neglects the study of health and there is no sign of it. Measuring health. Health is recognized as a fundamental human right and a worldwide social goal and is also a major tool for overall socio-economic development and the creation of a new social order.

Health is the overall state of a living organism at a given time. this is Freedom from sound, disease or abnormality of the body and a state of optimal well-being. People want to be healthy, but environmental forces can attack the body or the person may have a genetic defect. The main concerns in health are preventing disease and medical damage caused by injuries and biological attacks. This definition specifies that suboptimal intellectual functioning must be reflected by attenuation in one or more of the following aspects of adaptive behavior: (1) maturity, (2) learning, and (3) social adjustment. These three aspects of adaptation value differently for different age groups as merit conditions of health of mental retardation. The rate of maturity refers to the gradual development of self-help skills of infancy and early childhood such as sitting, crawling, standing, walking, talking, habitual training, and interacting with age peers.

1.1 Defining the Terms Used

Medical care- The availability of clinical care facilities plays an indispensable function in increasing fitness popularity of people and nearby people. Communicable diseases can be eradicated very regularly and infectious and humans can be saved through the good speed of scientific experts.

Ways of living-Ways to live life are influenced to an amazing extent through information about life attitudes, non-public hygiene, attitudes, values and behavior patterns and fitness practices of the individual.

Mental Hygiene- Mental hygiene is an attempt to maintain intellectual fitness through energetic conduct and treatment. Mental fitness is "general psychological well-being." Hygiene refers to the approach to maintain health.

Hygiene- Hygiene is a collection of practices to maintain health. According to the World Health Organization (WHO), "Hygiene refers to practices and practices that help maintain fitness and expose diseases." [2] Personal hygiene skills, maintaining physical hygiene. They are the way they matter to us to keep our environment clean. Hygiene is the ability of mentally retarded adolescents to maintain a healthy environment around them to maintain proper health.

Health- Time period fitness refers solely to emotional and physical well-being. Healthcare exists to help humans to hold this great country of health. The state or condition of a person's health. Health fame about this is the fitness reputation of people with intellectual retardation.

2. LITERATURE REVIEW

This data, in a study by Channababa-Savannah, Bhatti and Prabhu (1985), on parental attitudes towards mentally retarded children, showed that the degree of retardation did not affect attitudes, nor did these Socio-demographic variables of families. The authors hypothesized that in their sample, behaviors were dependent on parents' level of knowledge of disabilities and, therefore, removing misconceptions led to positive changes in them.

In his study of silent-deaf children, Kashyap (1983) found that in 55 percent of families, both parents had little knowledge of disability, and only one mother had good knowledge of disability. The rest had only average knowledge. The majority of parents who had poor knowledge did not see this lack of knowledge affect their ability to cope with a child with a disability. However, the majority of those who had average knowledge felt that lack of information adversely affected their ability to imitate. This implies that when parents have some knowledge of disability, what they find is that lack of complete knowledge affects their communication and interaction with the child with disabilities.

Mehta and Oceanai (1984), Singh and Kaushik (1982) and Kaushik (1984) have evaluated training programs in which parents of mentally challenged children were trained in behavior modification techniques. Kaushik (1984) felt that the important factor of the program was the method of training. Singh and Kaushik (1982) observed that the performance process was very important for teaching behavioral skills. Mehta and Oshanay were of the opinion that the involvement of one or both parents, as a physician, contributes to the success of the program.

Deshmukh and Rawat (1977) used their children to work at home with polio-affected children to teach simple passive practice to rural illiterate mothers. They found that these mothers were able to follow the practice so well, that they were able to prevent complications in their children, such as deformities or contractions. He concludes that rural people can be taught simple physiotherapy methods that achieve the same results at home as in a modern hospital. Mathur, Choksi and Singh (1986) have focused on community-based rehabilitation programs for rural blind persons and have ensured that community-based programs are definitely cost-effective in the home environment and effective in terms of rehabilitation measures.

Varma (1968) studies specifically to explore the prevalence of mental retardation in the community. The study revealed that 1 out of every 8 families studied had a suspected case of mental disability.

2.1 Objective

1. To find out the issues of health problems associated with the perception of mentally retarded children and their parents in Jaipur.
2. To find out the level of awareness of health on mentally retarded children about their health and hygiene.
3. Identifying the value of nutritional foods for mentally retarded children for their better health.
4. Through parents to understand the response of the Doctors in the treatment of mental hygiene and health on mentally retarded children.
5. To analyze the work of help and services of government officials programs in providing better hygiene and health on mentally retarded children.

2.2 Hypothesis

1. There will be no significant correlation between the health of mentally retarded children and the persistent problems associated with them in their lives.
2. There will be no significant difference between the hygiene of the mentally retarded child and their perception and information about environmental hygiene.
3. There will be no significant difference between the mental health status of MRC and their nutritional food.
4. There will be no significant difference between the clinical desire of MRC and the perception of doctors about them.
5. There will be no significant connection between the applications of government officials programs and the not knowing about the welfare of MRC.

3. RESEARCH METHODOLOGY

This chapter includes data related to the effect on mental hygiene and health on age group (05-18 years) psychological examinations. Data related to the impact on mental hygiene and health is included in this chapter detailing the number of tests administered to children.

Research methodology indicates a generalized pattern of streamlining the process to collect valid and reliable data for investigation. It includes strategies used to collect and analyze data to fulfill the research objective and to test the

research hypothesis. It includes a research approach, research design, variables, setting, sampling and sampling techniques, development and description of equipment, data collection and data analysis.

3.1 Research approach

This is a quantitative approach. The aim of this study is to affect mental hygiene and health on mentally retarded children aged 5–18 at the Special School/ Training centers in Rajasthan, India.

3.2 Research Design

This design adopted is a descriptive research design. This study has been taken at the Special School/ Training centers in Rajasthan, India to affect mental hygiene and health on mentally retarded children aged 5–18 years.

3.3 Variable

Dependent Variables: The dependent variables taken in this study are as follows - meeting the needs, education, social skills and problems faced by parents.

Independent variables: The independent variables taken in this study are as follows - age, sex, location, income, marriage etc.

3.4 Study setting

The study has been conducted at the Special School/ Training centers in Rajasthan, India. After studying various articles and research papers on issues related to health and hygiene of MRC in India, Jaipur district of Rajasthan has been selected for the proposed study due to very few studies on the health and hygiene status of MRC and Jaipur district Availability of a large number of specialized schools and training centers.

3.5 Pilot study report

A pilot study has been carried out at Jaipur district of Rajasthan. The descriptive design is adapted to assess mental retaliation between ages 5–18 yrs health and hygiene of MRC in India, Jaipur district of Rajasthan. The total population is selected. After committing to Jaipur district, the study area was visited for MRC to get preliminary information on their overall conditions and issues related to education, health and hygiene. During this study, observation and informal discussions were held with the parents and teachers of MRC. A field visit led to a structured interview schedule and questionnaire.

3.6 Sampling, sampling techniques and selection

The selection of a specimen occupies a very important place in the operation for any research study. The quality of the sample determines the probability of generalization of the results. "Sampling is the process of selecting a subset of the population in which the entire population is represented" (Talbot, 1995). By varying sampling techniques, the investigator selected snowball samples under non-probability sampling to select schools and samples for study. Due to the lack of respondents, the snowball sampling method has been employed. Four hundred mentally challenged children studying in various special schools, and their parents in Jaipur district form the study sample. Regardless of the techniques used in selecting the sample, the first step in sampling is the definition of the population, which is the group in which the investigators want to normalize the results. Population represents the entire group of subjects under study. The population in the present study refers specifically to children with retarded children who are studying in special schools, general schools and training centers in Jaipur district and their parents. In this study the father or mother or both of them are expected to respond to the study together.

The following inclusion and exclusion criteria have been used in sampling, sampling techniques, and selection:

3.6.1 Inclusion Criteria

Children aged 5 to 20 years of chronological age are diagnosed as mentally retarded children by a psychologist who falls under the 70 to 90 IQ educated class.

Mentally retarded children will be provided for children studying in special schools and their parents.

3.6.2 Exclusion Criteria

Mentally retarded children under 5 and above 20 years of age according to chronology.

Did not study in mentally retarded children, special schools and their parents.

Four hundred mentally challenged children and their parents each studying in various special schools in Jaipur District make up the study sample.

The data are categorized according to the various variables studied, mainly age, gender, degree of mental retardation, MRC for religion, health and hygiene practices and education, father and mother's occupation and their annual income.

Table 1.1: Sample Selected for the Study

Sr. No.	Name of Special School/ Training centers	Sample N =400	
		MRC N=400	Parents N=400
1	Ashraya Educ. & Rehab. Centre For Mr Persons	76	76
2	Chetana Special School and	40	40

	Vocational Training Center for Mentally Handicapped		
3	Mentally Retarded Home & Rehabilitation Centre For Women & Children	24	24
4	Rehabilitation Centre For Handicapped Children	56	56
5	Disha (A Resource Centre for Disabled) Disha Path	52	52
6	Sai Nath School Of Disable's	40	40
7	Society for the Rehabilitation of Persons with Differently Abled	32	32
8	Prayas Institute For Special Education & Training	8	8
9	Others	72	72
Total		400	400

Table 1.2: The partitions of the sample of parents and mentally retarded children

Category		N	Percentage
Age of MRC	5-10 years	70	17.5
	11-15 years	250	62.5
	16-20 years	80	40.0
Sex in MRC	Male	364	91.0
	Female	36	9.0
Education in MRC	Pre-primary	50	12.5
	Primary	230	57.5
	Secondary	120	30.0
Parents Sex	Male	172	43.0
	Female	228	57.0
Parents Residence	Rural	72	18.0
	Urban	328	82.0
Parents Religions	Hindu	152	63.0
	Muslim	116	29.0
	Others	32	8.0
Parents Education	12th	26	6.5
	Graduate	120	30.0
	Post Graduate	254	63.5
Parents Occupation	Govt.	232	58.0
	Private	130	32.5
	Others	38	9.5
Parents Income	Low <3lakh	72	18.0
	Mid. <5lakh	212	53.0
	High >5lakh	116	29.0

3.7 Tools Description

Various devices are used to collect anonymous data. The following tools and techniques have been considered the most suitable for studying and for collecting data.

1. Data sheet
2. Schedule of Health needs
3. Schedule of Hygiene needs
4. Checklist of Health assessment

3.8 Data collection process

Data is collected using the following methods. Which includes primary data, secondary data, interview schedule, field survey, observation and case study etc.

3.8.1 Primary Data

The primary data has been collected from field visits. A careful snowball, non-probability sampling technique is employed to collect the data. A pre-structured and pre-test interview schedule and questionnaire have been used for data collection. Adequate number of open questions are included to get maximum information.

3.8.2 Secondary Data

This data has been collected mainly in the form of informal data and documents. And at the same time it has also collected data collected from various journals, government publications and research articles like journal on special education, disability status in India-2019, census data, etc.

3.8.3 Interview Schedule

The interview is asked by oral question. It is a systematic method that guides a researcher to formulate a set of questions with structured answers. In this study I have covered the area like socio-demographic profile, health issues, hygiene practices and views on government policies, etc.

3.8.4 Field Survey

This field survey has been done in Jaipur district of Rajasthan state. Respondents' homes have been continuously visited to collect data. Special schools have been visited for research and analysis. Results have been obtained by visiting the area related to the actual situation, physical conditions, issues related to female affairs and overall health and hygiene status of children.

3.8.5 Case study

The case study method is used to learn more about the real-life setting of MRC in this study.

3.9 Analysis

Appropriate tools of social science are used in this study to analyze data. The use of graphs or bar diagrams has been added to highlight a graphical representation of the data.

3.9.1 Scoring and Processing of Data

400 sample each for parents and mentally retarded children. Data is analyzed using SPSS. The data obtained using Excel data sheet is categorized on the basis of child related variables such as age of child, gender, severity of retardation. The use of Excel data sheets are categorized based on exposure to parent-related variables such as residence, religion, risk to health information, age, educational status, occupation, and annual income.

3.10 Protection of human rights

Verbal consent has been obtained from the study sample prior to commencing data collection. It has been assured that confidentiality will be maintained. The children participating in this study are explained that they have the right to withdraw from the study at any time. There is a lack of physical and psychological stress for the children participating in this study.

3.11 Reliability and Validity

Evidence regarding the validity of the list lies in the procedures adopted to develop them. The items of the schedule have been carefully prepared after an in-depth review of the literature on related topics. The tools used for the study have been presented to experts in the field of special education, teachers and instructors. The experts have been selected based on their expertise and their interest in the problem being studied. Its relevance, accuracy and suitability have been considered by experts. The modification of the devices has been done on the basis of expert opinion and suggestions. The purpose of item analysis is to select from a pool of items that most effectively seek information, and to eliminate less effective items from the draft scale. The reliability of the tests has been estimated using the method of internal compatibility reliability analysis. Reliability coefficients have been calculated for investigator-constructed tests using samples.

3.12 Problems of Data Collection

Many problems are encountered while doing research. Some problems were encountered due to the limited intellectual capacity of MRC. These were not severe but were sufficient to impede the study.

The researcher had some difficulty in obtaining reliable data because the parents of MRC were hesitant and fearful to disclose information related to their children. Support from some families has been found to be low during the study. The biggest problem was to win the trust of the defendant's family. The respondent has limited intellectual abilities, so the researcher has to spend more time with them, in order to obtain relevant information.

4. RESULT ANALYSIS AND INTERPRETATION

The purpose of this study is to find out the mental hygiene and health status of mentally retarded children in Jaipur district of Rajasthan. Analysis and interpretation of the results are presented under the following heads.

4.1 General Issues Related to Mental Hygiene and Health on Mentally Retarded Children and Parents' Perceptions about the Hygiene and Health Aspects of Mentally Retarded Children (MRC).

People with mental hygiene and health on mentally retarded children are the most insignificant or peripheral groups in our society, as they have extremely limited means of access to education, employment and financial resources. They are

subject to very powerful social determinants of health, poverty and social taboo. Several studies have shown that this group is particularly vulnerable to a range of chronic mental hygiene and health on mentally retarded children in addition to regular mental hygiene in children's problems and the health of mentally retarded children are included as Some types of cancers (particularly stomach and gall-bladder), Mental health problems, Addictions, Menstrual problems, Cardiovascular disease, Type 1 and Type 2 diabetes, Sensory problems (including vision, hearing and tactile), Periodontal problems, Constipation, Thyroid problems, Gastro-Oesophageal reflux disease (GERD), Obesity, Osteoporosis, Epilepsy, Mood swing, Disturbed sleep cycle etc.

Table 4.1: Parental awareness level of parents' health needs

Consciousness	Respondents Number				
	Male	Male %	Female	Female %	Total
Favorable	130	32.5	210	52.5	340
Non Favorable	2	1	4	2	6
Neutral	40	10	14	3.5	54
Total	172		228		400

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Male	3.00	172.00	57.33	4321.33
Female	3.00	228.00	76.00	13492.00

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	522.67	1.00	522.67	0.06	0.82	7.71
Within Groups	35626.67	4.00	8906.67			
Total	36149.33	5.00				

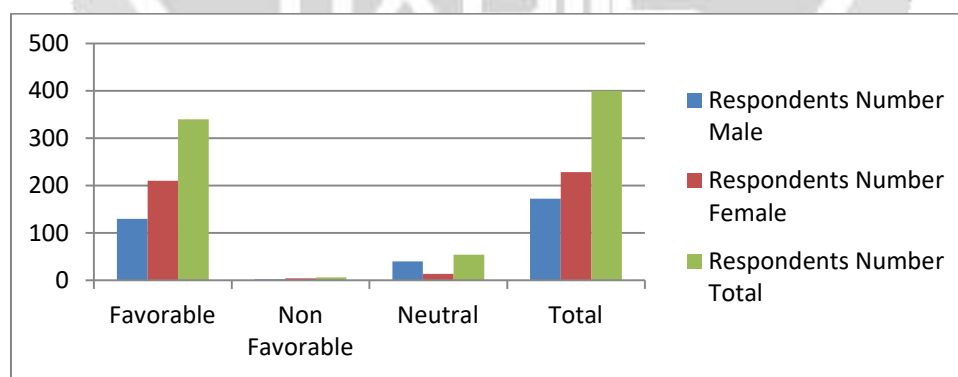


Figure 4.1: Graphical representation of the Respondents

The current table shows that MRC's parental attention stage (health on mentally retarded children). About 32.5% of men scored in the for-profit category, while 10% were in the unbiased category. 52.5% of women have proven profitable reputation, while only 3.5% have proved fair status. This severe version is caused by a woman's more intimate relationship with her male partner.

Table 4.2: Parental frequency and percentage regarding health needs of their MRC

Consciousness	N	Percentage
Favorable	240	85.0

Non Favorable	6	1.5
Neutral	54	13.5
Total	400	100

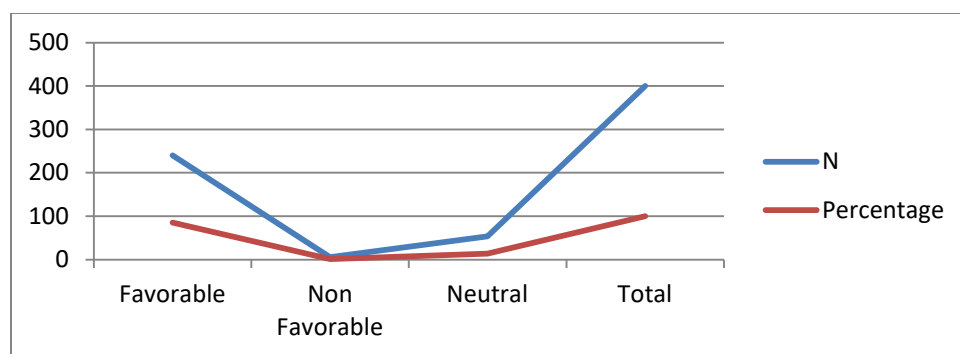


Figure 4.2: Graphical representation of the Parental frequency and percentage

It is clear from the above table that MRC's entire parents state of consciousness (health on intellectual retardation). 85% have scored a for-profit category, while 13.5% are in an unbiased category. Only 1.5% has proved an adverse condition. This huge hole was sometimes due to many elements like poverty, education, monetary level, social environment etc.

Table 4.3: MRC parent awareness on various health Status

Health Status	Level of awareness					
	Favourable		Unfavourable		Neutral	
	N	Percentage	N	Percentage	N	Percentage
Health services	376	94	0	0	24	6
Common diseases	358	89.5	4	2	42	10.5
Infectious diseases	356	89	0	0	44	11
Hygiene	386	96.5	0	0	14	3.5
Nutrition	344	86	0	0	56	14
Human biology	354	88.5	0	0	46	11.5

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Favourable	6.00	2174.00	362.33	242.27
Unfavourable	6.00	4.00	0.67	2.67
Neutral	6.00	226.00	37.67	242.27

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	475160.44	2.00	237580.22	1462.93	0.00	3.68
Within Groups	2436.00	15.00	162.40			
Total	477596.44	17.00				

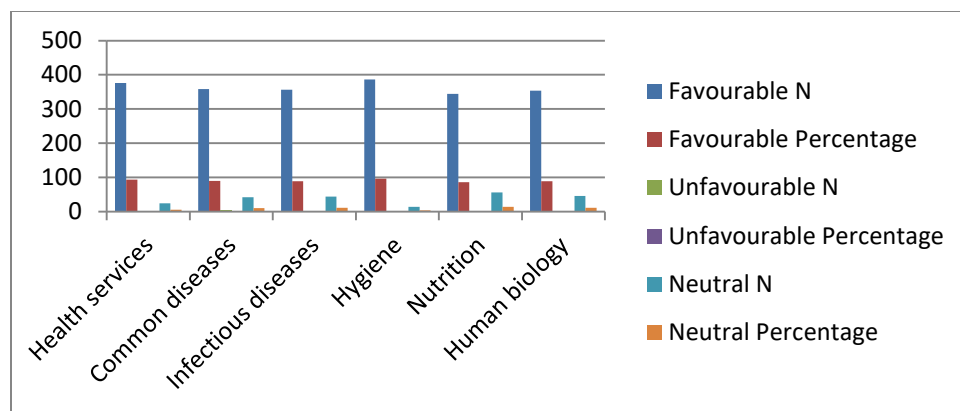


Figure 4.3: Graphical Representation of the level of awareness

The table and graphs shows that fitness limits on sanitation and human biology related to mentally retarded children, nutrition, infectious diseases, persistent diseases and facilities for health services such as fitness. Different regions are proven using extraordinary share numbers, though only 2% have proven a disastrous reputation in the vitamin class, i.e. they hold true to the fact that these teenagers are recognized for their vitamin levels. No more care is required.

Table 4.4: Level of awareness based on educational level of parents of MRC

Educational level	N	%	Good	%	Average	%	Low	%
12th	28	7	14	50	9	32.14	5	17.86
Graduate	130	32.5	88	67.69	35	26.92	7	5.38
Post Graduate	242	60.5	140	57.85	85	35.12	17	7.02

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Good	3.00	242.00	80.67	4009.33
Average	3.00	129.00	43.00	1492.00
Low	3.00	29.00	9.67	41.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	7570.89	2.00	3785.44	2.05	0.21	5.14
Within Groups	11085.33	6.00	1847.56			
Total	18656.22	8.00				

	Total	%
Good	242	60.5
Average	129	32.25
Low	29	7.25

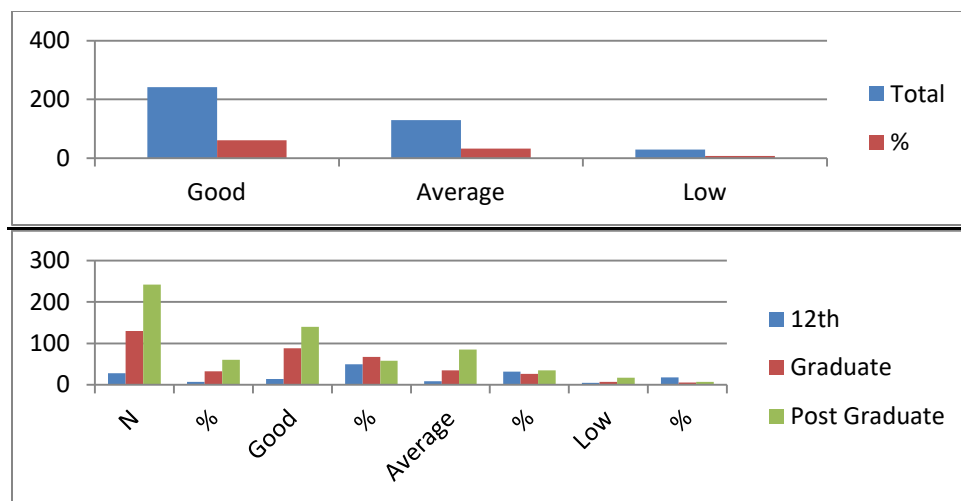


Figure 4.4: Graphical Representation of the educational level of parents

It is indicated from the table above that the parents of MRC (mentally retarded health) focus on their identity status. Overall 60.5% have true expertise while only 7.25% have a low degree of awareness. Graduates have an additional understanding for examining postgraduates. This was once due to his quest for greater understanding of intellectual hygiene and fitness on mentally retarded children.

Table 4.5: MRC's health status according to their age

Age group of MRC	N	%	Good	%	Average	%	Low	%
5-10 years	60	15	8	13.33	34	56.667	18	30
11-15 years	245	61.25	40	16.33	176	71.837	29	11.84
16-20 years	95	23.75	35	36.84	50	52.632	10	10.53

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Good	3.00	83.00	27.67	296.33
Average	3.00	260.00	86.67	6049.33
Low	3.00	57.00	19.00	91.00

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	8134.89	2.00	4067.44	1.90	0.23	5.14
Within Groups	12873.33	6.00	2145.56			
Total	21008.22	8.00				

	Total	%
Good	83	20.75
Average	260	65
Low	57	14.25

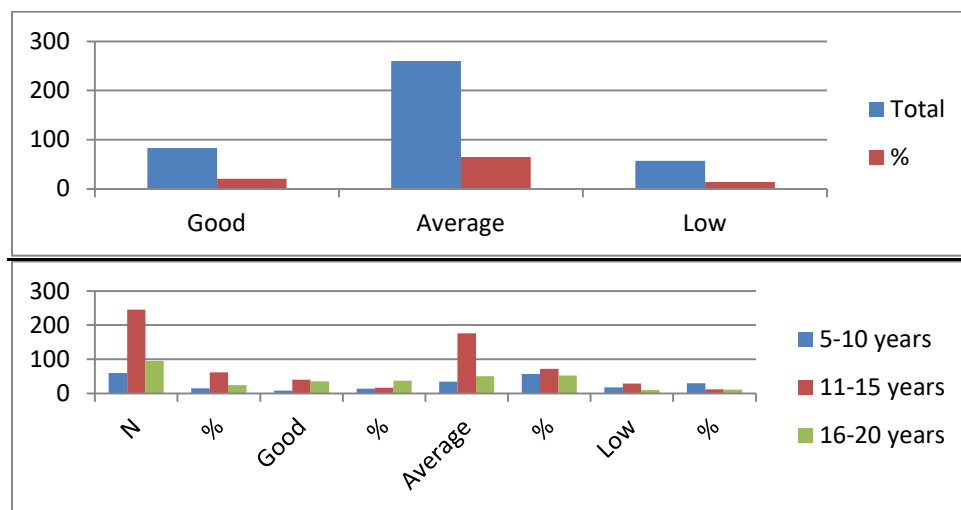


Figure 4.5: Graphical Representation of the health status according to their age

The above table shows that MRC's fitness popularity (health over intellectual retardation) appreciates their chronological age. Overall 65% have a normal fitness profile while only 20.75% have an appropriate stage of their health. 11 to 15 years of age have more beneficial fitness data than others i.e. those aged 5 to 10 and 16 to 20 years old. This was once probably due to his greater socialization and coaching sessions at home and in a one-of-a-kind school.

Table 4.6: Level of awareness of parents of MRC based on their residence

Residence	N	%	Good	%	Average	%	Low	%
Rural	80	20	6	7.50	47	58.75	27	33.75
Urban	320	80	54	16.88	238	74.38	28	8.75

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Good	2.00	60.00	30.00	1152.00
Average	2.00	285.00	142.50	18240.50
Low	2.00	55.00	27.50	0.50

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	17258.33	2.00	8629.17	1.33	0.38	9.55
Within Groups	19393.00	3.00	6464.33			
Total	36651.33	5.00				

	Total	%
Good	60	15
Average	285	71.25
Low	55	13.75

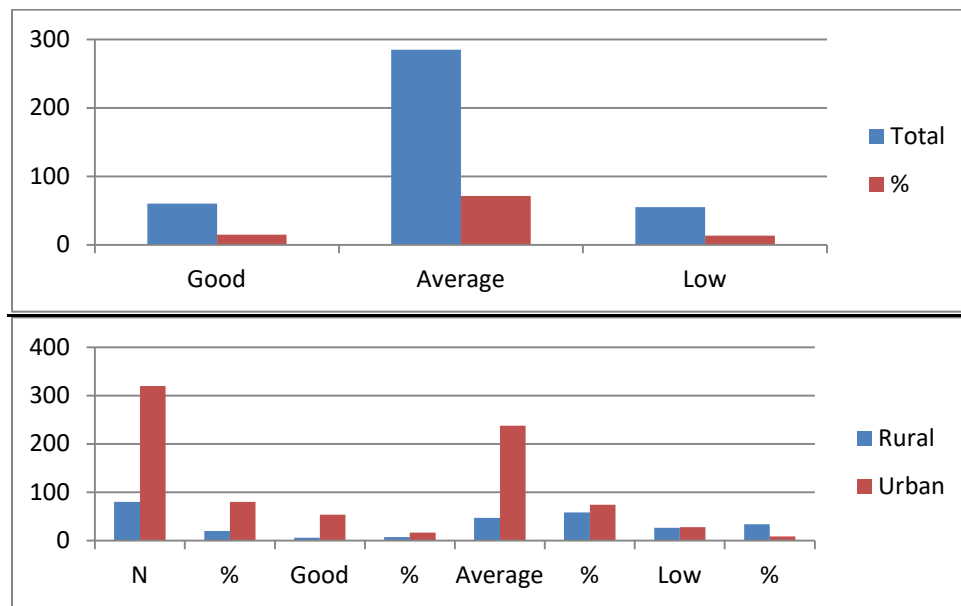


Figure 4.6: Graphical Representation of the awareness of parents of MRC based on their residence. Above table places the clear photograph of mother and father of MRC on the foundation of their house i.e. rural or urban. It is evident from the table that greater respondents are from a city area. People from rural and human beings from the city region have marked distinction in their stage of recognition i.e. 7.50% and 16.88% respectively in the good category. While both, rural and city have 58.75% and 74.38% in the average category. 33.75% rural and 8.75% city has a low stage of awareness; this is due to the fact of the inaccessibility of records related to incapacity and associated services. Overall Average 71.25% have true expertise while only 13.75% have a low degree of awareness.

Table 4.7: Awareness level of MRC parents based on their religion

Religion	N	%	Good	%	Average	%	Low	%
Hindu	244	61	22	9.02	206	84.43	16	6.56
Muslim	112	28	10	8.93	90	80.36	12	10.71
Others	44	11	8	18.18	32	72.73	4	9.09

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Good	3.00	40.00	13.33	57.33
Average	3.00	328.00	109.33	7849.33
Low	3.00	32.00	10.67	37.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	18958.22	2.00	9479.11	3.58	0.09	5.14
Within Groups	15888.00	6.00	2648.00			
Total	34846.22	8.00				

	Total	%
Good	40	10
Average	328	82
Low	32	8

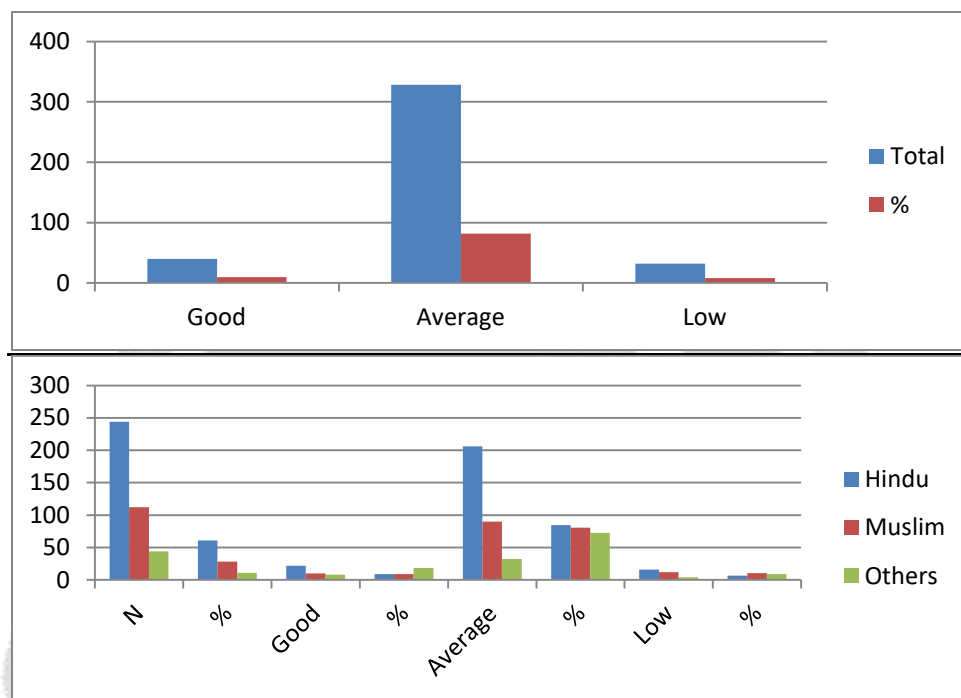


Figure 4.7: Graphical Representation of the MRC parents based on their religion

Above table depicts the image of the fitness and hygiene recognition of parents of MRC concerning their mentally retarded children, with admire to their religion. Here humans from Hindu neighbourhood have good scored 9.02% in suitable and 84.43% in the average category. While human beings from the Muslim neighbourhood have good scored 8.93% and 80.36% in each properly and average category. Peoples from the different neighbourhood have scored most of 18.18% in good category and 9.09% in the low category. This version in the level of consciousness is due to the fact of many elements like education, perception the gravity of disability, disability, positive approach towards disability, financial resources etc. Overall Average 82% have true expertise while only 8% have a low level of awareness.

Table 4.8: Professional Status and Awareness Level of Parents of MRC

Professional status	N	%	Good	%	Average	%	Low	%
Govt.Job	240	60	35	14.58	195	81.25	10	4.17
Pvt.Job	125	31.25	18	14.40	93	74.40	14	11.20
Others	35	8.75	3	8.57	27	77.14	5	14.29

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
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Good	3.00	56.00	18.67	256.33
Average	3.00	315.00	105.00	7164.00
Low	3.00	29.00	9.67	20.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	16622.89	2.00	8311.44	3.35	0.11	5.14
Within Groups	14881.33	6.00	2480.22			
Total	31504.22	8.00				

	Total	%
Good	56	14
Average	315	78.75
Low	29	7.25

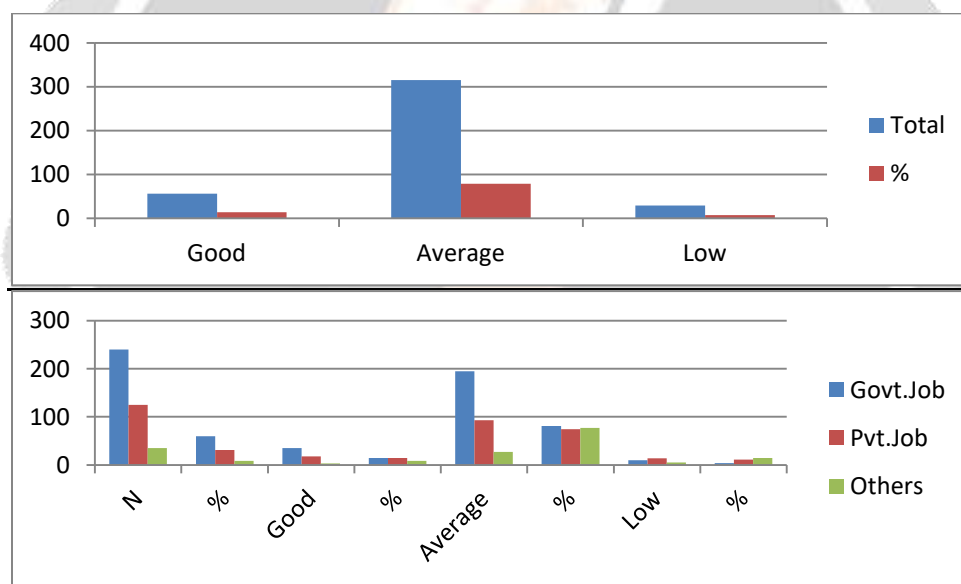


Figure 4.8: Graphical Representation of the Professional Status and Awareness Level of Parents of MRC

This suggests that humans with exceptional occupational reputation have a different phase of awareness, which is related to the health and hygiene needs of MRC. Those in the authority sector have the lowest 4.17% for the focus phase in the lower category, although 81.25% is the average level of awareness in humans. 14.29% of commercial enterprise-class humans have a low level of attention in evaluating any other business situation. Whereas, 14.40% of the people in the individual job category have a good focus and more than different occupational status. Overall the average is true expertise of 78.75% while only 7.25% have a low level of awareness.

Table 4.9: Income status and awareness level of parents of MRC

Income Level	N	%	Good	%	Average	%	Low	%
Low<3Lakh	65	16.25	5	7.69	20	30.77	40	61.54
Mid<5Lakh	217	54.25	14	6.45	193	88.94	10	4.61
High>5Lakh	118	29.5	20	16.95	95	80.51	3	2.54

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Good	3.00	39.00	13.00	57.00
Average	3.00	308.00	102.67	7526.33
Low	3.00	53.00	17.67	386.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	15286.89	2.00	7643.44	2.88	0.13	5.14
Within Groups	15939.33	6.00	2656.56			
Total	31226.22	8.00				

	Total	%
Good	39	9.75
Average	308	77
Low	53	13.25

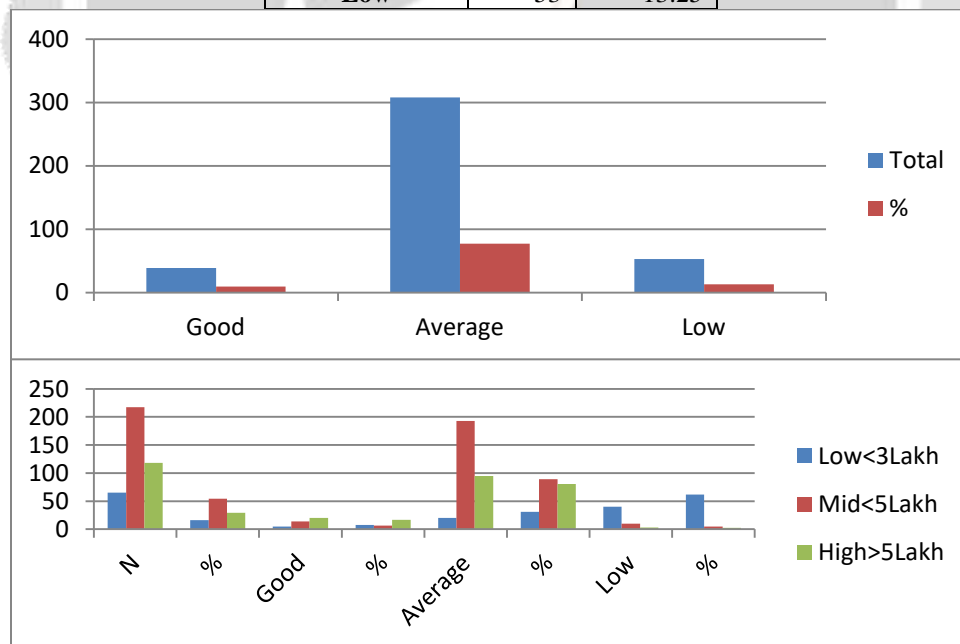


Figure 4.9: Graphical Representation of the Income status

The above table represents the graph of the level of information of the parents of MRC in relation to their benefit group. 88.94% of middle-income group humans have an average level of expertise regarding their MRC's health and hygiene desires. Only 2.54% of the high-income group has low levels of health and hygiene needs of humans. While 16.95% of humans from high income team have an accurate stage of knowledge. Only 7.69% of humans from low-

income groups have a peak stage of knowledge. The proportion of these humans in the low-level understanding category is 61.54%.

4.1 MRC recognizes their health and hygiene

Table 4.10: Knowledge level of MRC with respect to ADL (Activities for Daily Living) N=400

ADL	Can do	Can't do	Needs help
Brushing	336	4	60
Bathing	224	44	132
Eating	324	10	66
Grooming	90	64	246
Sanitation	106	30	264

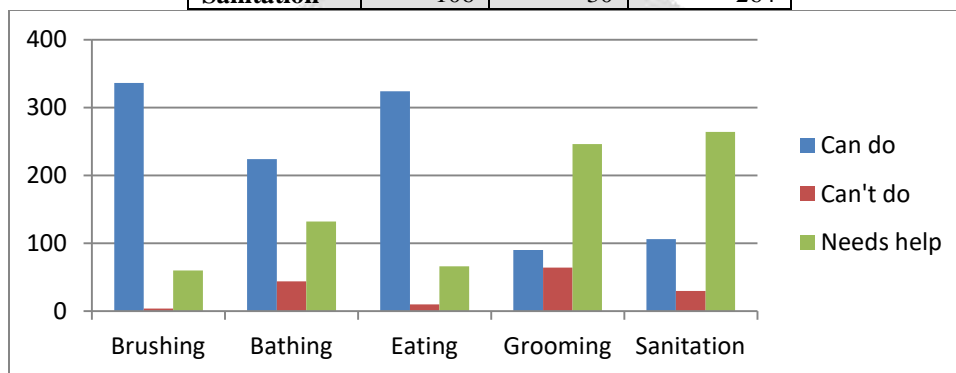


Figure 4.10: Graphical Representation of the MRC with respect to ADL

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Can do	5.00	1080.00	216.00	13526.00
Can't do	5.00	152.00	30.40	606.80
Needs help	5.00	768.00	153.60	9406.80

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	89198.93	2.00	44599.47	5.68	0.02	3.89
Within Groups	94158.40	12.00	7846.53			
Total	183357.33	14.00				

Above table depicts the photo of ADL (activities for the day by day living) of MRC. These activities, which are indispensable for unbiased residing of an individual in their private and social life. Brushing is a quintessential activity, which is efficiently carried out with the aid of 84% of MRC in our pattern size. The recreation of consuming is one of the fundamental want of each individual. 81% of MRC can operate this exercise with extra or much less precision, however, 16.5% wants the assistance of others to function this activity. Grooming is a complicated activity; solely 22.5% of MRC can operate this independently, whilst 61.5% wants to assist to groom

themselves. Sanitation performs a necessary position in wholesome fitness and hygiene practices. It is a complicated endeavour which includes many steps, consequently, 66% MRC wishes to assist and solely 26.5% can do this recreation independently.

Table 6.11: Performance level of MRC's ADL activities in relation to their educational status

Classes	N	%	Can do	%	Can't do	%	Needs help	%
Pre-primary	45	11.25	9	20	8	44.44	28	62.22
Primary	240	60	80	33.33	30	13.89	130	54.17
Secondary	115	28.75	53	46.09	12	40.08	50	43.48

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Can do	3.00	142.00	47.33	1284.33
Can't do	3.00	50.00	16.67	137.33
Needs help	3.00	208.00	69.33	2881.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	4198.22	2.00	2099.11	1.46	0.30	5.14
Within Groups	8606.00	6.00	1434.33			
Total	12804.22	8.00				

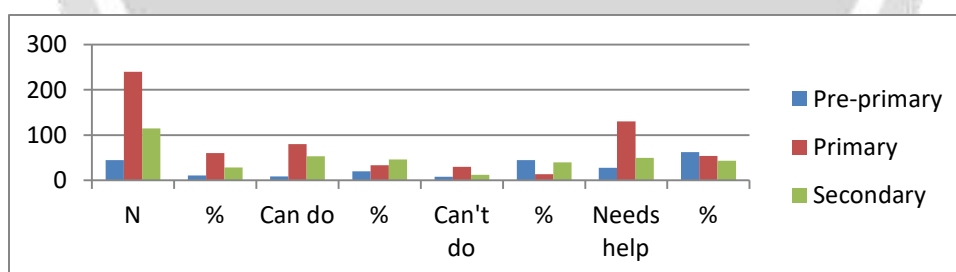


Figure 4.11: Graphical Representation of the MRC's ADL activities in relation to their educational status

The above table gives a picture of the level of ADL activities in relation to their educational status. As is evident in the above table, the progress of MRC's "can" status is steadily increasing in their academic achievement. This is due to two main reasons i.e. the simulation of routine activities and socialization in these children increases with their age and educational achievement. Likewise, a decline can be seen in the other two categories, ie it cannot and needs help. Both categories of MRC excel in regular activities with advancement in their chronological age, so it may have a sharp decline of 44.44% for primary level i.e. 13.89% for primary and 40.08% at secondary level.

Table 4.12: Frequencies and Percentage of Health Aspects of MRC

Health aspect	Health Status	N	%
Appearance	Healthy	235	58.75

	Weak & Tired	130	32.5
	Unhealthy	35	8.75
Posture	Relaxed	320	80
	Bent Posture	80	20
Mental Status	Cooperative	374	93.5
	Withdrawn	26	6.5
Speech	Understandable	300	75
	Not clear	100	25
Skin infection	Absent	350	87.5
	Present	50	12.5
Nails	Clean	370	92.5
	Unclean	12	3
	Brittle	18	4.5
Scalp infection	Present	365	91.25
	Absent	35	8.75
Face	Symmetric	190	47.5
	Facial Dysmorphia	210	52.5
Neck	Normal movements	339	84.75
	Limited movements	61	15.25
Vision	Normal	363	90.75
	Impaired	37	9.25
Ear	Normal	378	94.5
	Low set	22	5.5
Teeth	Normal	340	85
	Caries	60	15
Lips	Normal	190	47.5
	Protruded	200	50
Bowel control	Attained	363	90.75
	Not attained	37	9.25
Bladder Control	Attained	365	91.25
	Not attained	35	8.75
Movements	Coordinated	60	15
	Uncoordinated	340	85
Weight	Normal & above	168	42
	Below normal	232	58
Height	Normal & above	52	13
	Below normal	348	87

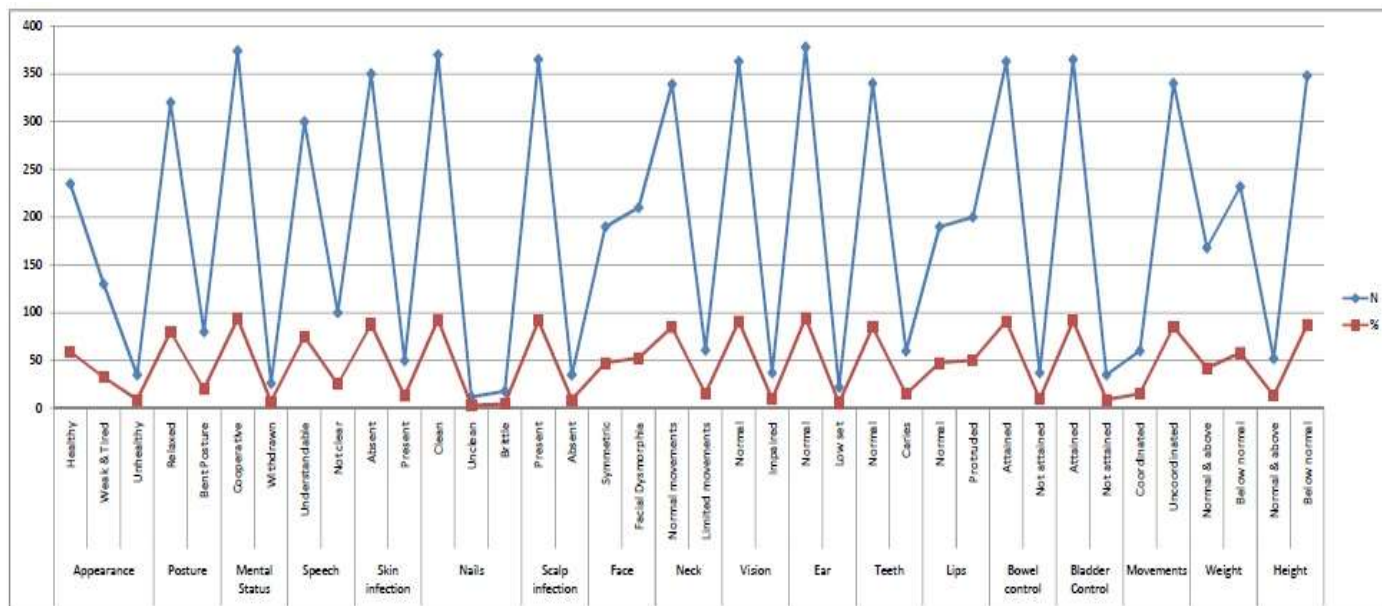


Figure 4.12: Graphical Representation of the Health Aspects of MRC

4.2 Need for nutritional food with respect to their mental hygiene

The parents of MRC have been requested to provide or not provide any precise food in the session to clinical physicians or dieticians for the high uptake of their exceptional children. Parental perceptions are as follows:

Table 4.13: Nutritional Requirement of MRC

Nutrition Level	No. of Respondents					
	Male	%	Female	%	Total	%
Needs special diet	25	15.63	135	84.38	160	40
Don't need	8	66.67	4	33.33	12	3
Can't say	177	77.63	51	22.37	228	57

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Male	3.00	210.00	70.00	8659.00
Female	3.00	190.00	63.33	4404.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	66.67	1.00	66.67	0.01	0.92	7.71
Within Groups	26126.67	4.00	6531.67			
Total	26193.33	5.00				

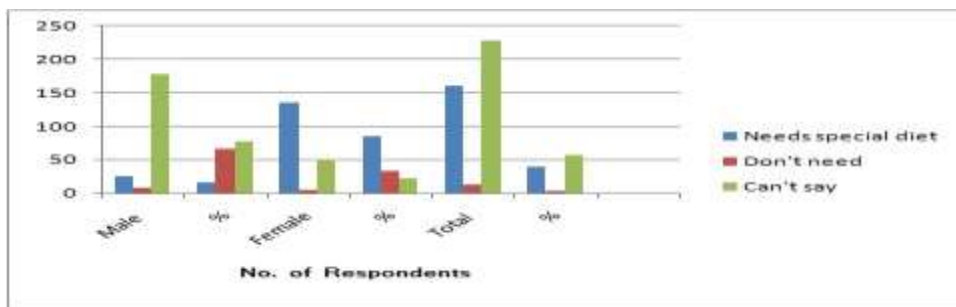


Figure 4.13: Graphical Representation of the Nutritional Requirement of MRC

MRC's parents have been interviewed regarding their consumption of a specific food item in relation to their physical condition. Both mothers and fathers reacted differently, with mother's opinion on their specific childhood milk products, protein-rich weight loss programs for more pulses, meat trading and some folic acid pills for faster recovery supply. 84.38% of mothers and 15.63% of fathers advised to have a specific eating plan, while only 3% directed that there is no desire for a specific diet. 77.63% fathers and 22.37% mothers neither supported nor rejected the unique meal plan format, meaning they were neutral.

Table 4.14: Multiple diet plan for MRC by their parents

Multiple diet	No. of Respondents					
	Male	%	Female	%	Total	%
Yes	3	16.67	15	83.33	18	4.5
No	217	56.81	165	43.19	382	95.5

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Male	2.00	220.00	110.00	22898.00
Female	2.00	180.00	90.00	11250.00

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	400.00	1.00	400.00	0.02	0.89	18.51
Within Groups	34148.00	2.00	17074.00			
Total	34548.00	3.00				

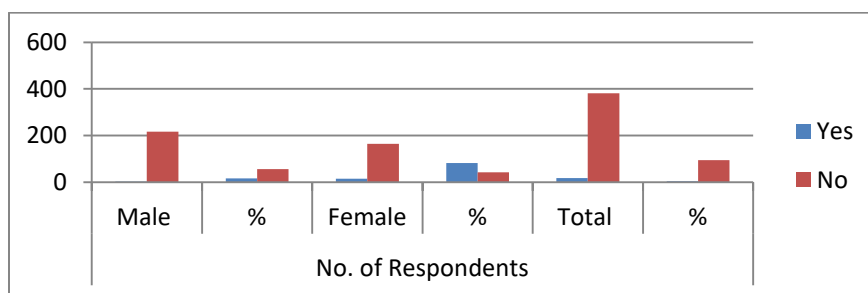


Figure 4.14: Graphical Representation of the multiple diet plans

When parents of MRC were requested whether or not to supply more than one food item to their separated child, 4.5% of the parents responded positively, with 16.67% of the fathers and 83.33% of the mothers. A total of 382 (95.5%) parents said "no" to the provision of a pair of meals. 56.81% fathers are of the opinion that one to two meals are not required. 43.19% of mothers have reacted negatively in addition to the provision of a pair of foods for their specific child.

4.3 Follow MRC's parents' perceptions about doctors

MRC's parents have been interviewed about the doctors' behavior, all in addition to their follow-up visits to their particular young people and the extent of visits in a month.

Table 4.15: Parents 'perception about doctors' follow-up

Educational Level of Parents	Acceptable	%	Non-Acceptable	%	Neutral	%	Total
12th	8	23.53	20	58.82	6	18	34
Graduate	80	74.07	16	14.81	12	11	108
Post Graduate	190	73.64	36	13.95	32	12	258
Total	278		72		50		400

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Acceptable	3.00	278.00	92.67	8401.33
Non- Acceptable	3.00	72.00	24.00	112.00
Neutral	3.00	50.00	16.67	185.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	10544.89	2.00	5272.44	1.82	0.24	5.14
Within Groups	17397.33	6.00	2899.56			
Total	27942.22	8.00				

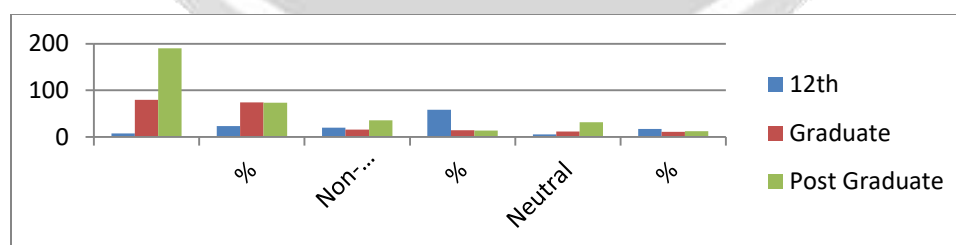


Figure 6.15: Graphical Representation of the Parents 'perception about doctors' follow-up

It is clear from the above tabling that as a whole 278 (69.5%) of the human beings feel, the behavior of doctors was desirable in terms of doctor-patient relationship. A total of 72 (18%) humans experience non-acceptable behavior and 50 (12.5%) uniquely unbiased views. The graduating mother and father are father (7.0% mother%) in the appropriate category and at least 12 (11%) in the non-acceptable category. Postgraduates mother and father are outnumbered and among them, 198 (73.64%) enforce the behavior of doctors at some point of followup. A mother or father who has a twelfth educational qualification has the strongest experience of rejection. 20 (58.82%) feel that the behavior was once unacceptable. However they additionally have a neutral opinion of 18%.

Table 4.16: Parents' perception follows doctors according to their income level

Income Level	N	Acceptable	%	Non-Acceptable	%	Neutral	%
Low<3 Lakh	80	28	35.00	44	55.00	8	10
Mid<5 Lakh	208	178	85.58	18	8.65	12	6
High>5 Lakh	112	96	85.71	14	12.50	2	2
Total	400	302	75.5	76	19	22	5.5

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Acceptable	4.00	604.00	151.00	13894.67
Non-Acceptable	4.00	152.00	38.00	818.67
Neutral	4.00	44.00	11.00	70.67

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	44130.67	2.00	22065.33	4.48	0.04	4.26
Within Groups	44352.00	9.00	4928.00			
Total	88482.67	11.00				

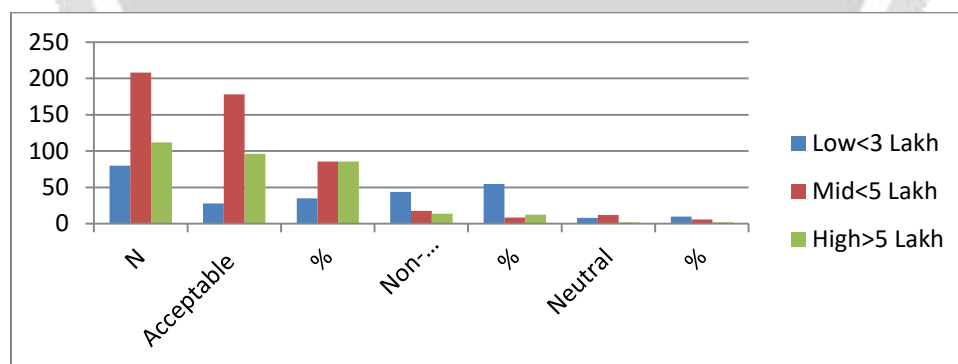


Figure 4.16: Graphical Representation of the Parents' perception follows doctors according to their income level. The parents have been interviewed regarding their follow-up visit to the doctor in terms of their level of earnings. A total of 302 (75.5%) MRC parents perceive that behavior is acceptable at the level of earnings. Only 76 (19%) parents consider it unacceptable, while 22 (5.5%) parents no longer have an opinion i.e. impartial opinion. Equal portrayal of middle-income crew (middle) and high-income crew (high) mothers and fathers in an appropriate class with 85.58 % and 85.71% respectively. Non-acceptable behavior in each category signifies almost equal cost i.e. 10% and 8.65% respectively besides low and middle. Parents from the high income team (high) have the best possible resentment in their individual class with a volume of 14 (12.50%). This is due to the fact of wanting extra for Prasad in relation to their income group. The same decrease is in the case of profitable teams (less), they have the highest volume in the fair class i.e. 44 (55.00%).

Table 4.17: Parental perceptions regarding their service

Service Providers	N	Acceptable	%	Non-Acceptable	%	Neutral	%
Govt.Doctors	280	140	50.00	42	15.00	98	35
Pvt.Doctors	120	70	58.33	10	8.33	40	33
Total	400	210	52.5	52	13	138	34.8

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Acceptable	3.00	420.00	140.00	4900.00
Non-Acceptable	3.00	104.00	34.67	481.33
Neutral	3.00	276.00	92.00	2428.00

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	16686.22	2.00	8343.11	3.21	0.11	5.14
Within Groups	15618.67	6.00	2603.11			
Total	32304.89	8.00				

t-Test: Paired Two Sample for Means

	280.00	120.00
Mean	93.33	40.00
Variance	2417.33	900.00
Observations	3.00	3.00
Pearson Correlation	1.00	
Hypothesized Mean Difference	0.00	
df	2.00	
t Stat	4.76	
P(T<=t) one-tail	0.02	
t Critical one-tail	2.92	
P(T<=t) two-tail	0.04	
t Critical two-tail	4.30	

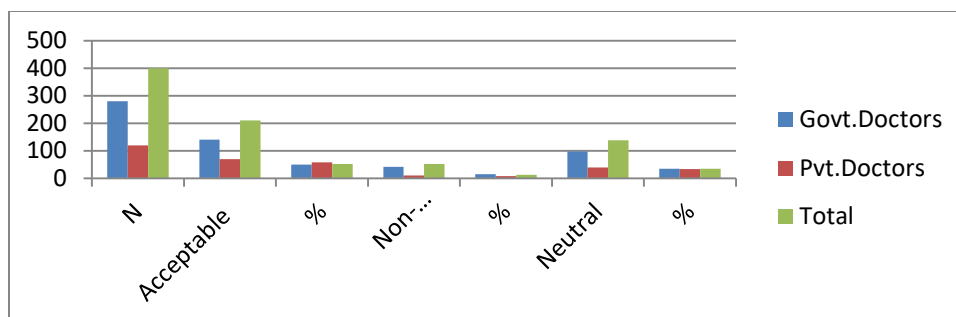


Figure 4.17: Graphical Representation of the Parental perceptions regarding their service

The table above portrays MRC's parents' understanding of Medico follow-up travel from authorities and individual areas. 140 (50%) Dad and Mom are comfortable with the behavior of officers with experience while 70 (58.33%) feel happy with private sector doctors. The unacceptable class represents outstanding differences such as forty-two (15.00%) in executives and 10 (8.33%) in the individual sector, with variations of 98 and 40 respectively. Neutral class matters for almost equal parents i.e. 35% in executives and 33% in personal sector. This extraordinary difference in each completed and non-acceptable category is due to the greater time given to the affected person with the assistance of medical doctors in individual areas as opposed to the officers' areas. But additionally using the respondents it has been acknowledged that integral instances are dealt with on a priority basis through official government doctors.

4.3 Availability of better health and hygiene for government aids and services

This area of goals has once been examined with the help of interviews with parents of MRC on the foundations of the educational reputation of their specific child. The overall pattern was classified into three classes i.e. pre-primary (5–10 years), main (11–15 years), secondary (16–20 years) levels. Parents have been requested to raise questions related to the help and offerings being presented through the State / Central government authorities for the betterment of one type of children.

Table 4.18: Regarding parental perception in government services

Educational Status	Perception about government services						
	N	Satisfied	%	Unsatisfied	%	Neutral	%
Pre-primary	40	2	5.00	34	85.00	4	10
Primary	240	120	50.00	85	35.42	35	15
Secondary	120	30	25.00	80	66.67	10	8
Total	400	152	38	199	49.75	49	12.25

ANOVA: Single Factor

SUMMARY

Groups	Count	Sum	Average	Variance
Satisfied	3.00	152.00	50.67	3801.33
Unsatisfied	3.00	199.00	66.33	790.33
Neutral	3.00	49.00	16.33	270.33

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Between Groups	3924.22	2.00	1962.11	1.21	0.36	5.14
Within Groups	9724.00	6.00	1620.67			
Total	13648.22	8.00				

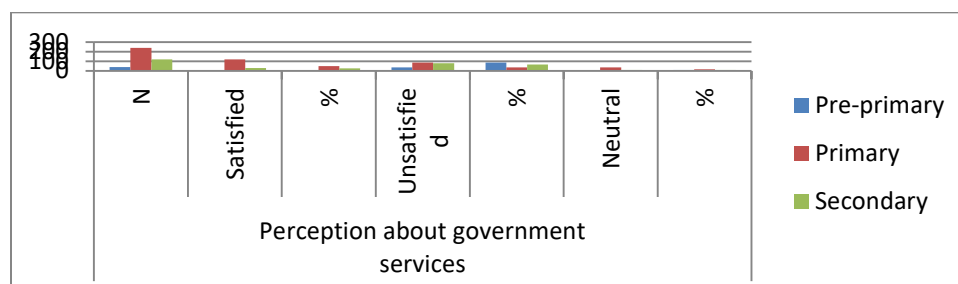


Figure 4.18: Graphical Representation of the parental perception in government services

It is clear from the above table and layout that most of the outrage in the neutral and dissatisfied class is at the pre-primary level. This counts to 34 (85.00%) and four (10%) for the dissatisfied and neutral class respectively. Again the most important level of pride is 120 (50.00%). The neutral class for the secondary degree has at least a percentage of 10 (8%). This edition has several objectives such as non-availability of infrastructural services at pre-primary level, additional support at primary level, non-focus of government schemes and programs and additional possibilities at secondary level.

Table 4.19: Regarding parents' perception about government services living in rural and urban areas.

Residence	Perception about government services						
	N	Satisfied	%	Unsatisfied	%	Neutral	%
Rural	80	10	12.50	52	65.00	18	23
Urban	320	160	50.00	125	39.06	35	11
Total	400	170	42.5	177	44.25	53	13.25

t-Test: Paired Two Sample for Means

	80.00	320.00
Mean	26.67	106.67
Variance	497.33	4158.33
Observations	3.00	3.00
Pearson Correlation	0.07	
Hypothesized Mean Difference	0.00	
df	2.00	
t Stat	-2.08	
P(T<=t) one-tail	0.09	
t Critical one-tail	2.92	
P(T<=t) two-tail	0.17	

t Critical two-tail

4.30

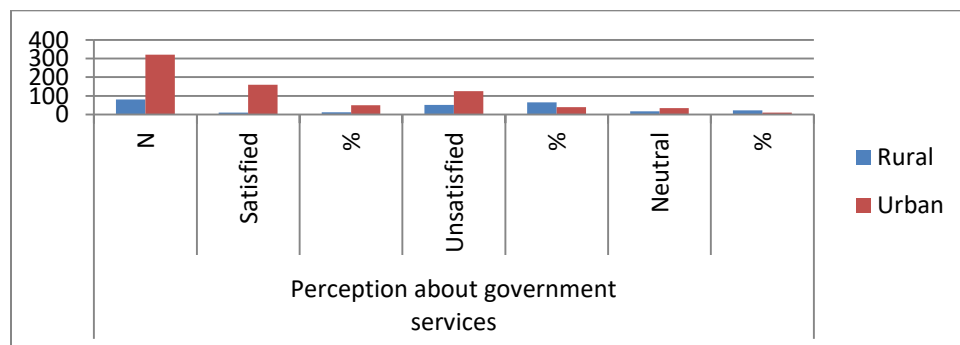


Figure 4.19: Graphical Representation of the parents' perception about government services living in rural and urban areas.

Parents are classified into rural and urban at the foundation of their residence. Here, parents in rural areas have proved more resentful about government offerings in their assessment of parents in urban areas. 52 (65.00%) are dissatisfied with parents from rural areas and 125 (39.06%) from urban areas. Whereas the level of satisfaction and non-satisfaction in an urban class is equal i.e. 170 (42.5%) and 177 (44.25%) respectively. Parents are 10 (12.50%) and 53 (13.25%) more satisfied in the rural category.

Table 4.20: Parents' perception about AIDS and services

Service Provider	Perception about aids and services						
	N	Satisfied	%	Unsatisfied	%	Neutral	%
Govt.	140	52	37.14	48	34.29	30	21
Pvt.	260	155	59.62	55	21.15	50	19
Total	400	207	51.75	103	25.75	80	20

t-Test: Paired Two Sample for Means

	140.00	260.00
Mean	43.33	86.67
Variance	137.33	3508.33
Observations	3.00	3.00
Pearson Correlation	0.67	
Hypothesized Mean Difference	0.00	
df	2.00	
t Stat	-1.44	
P(T<=t) one-tail	0.14	
t Critical one-tail	2.92	
P(T<=t) two-tail	0.29	
t Critical two-tail	4.30	

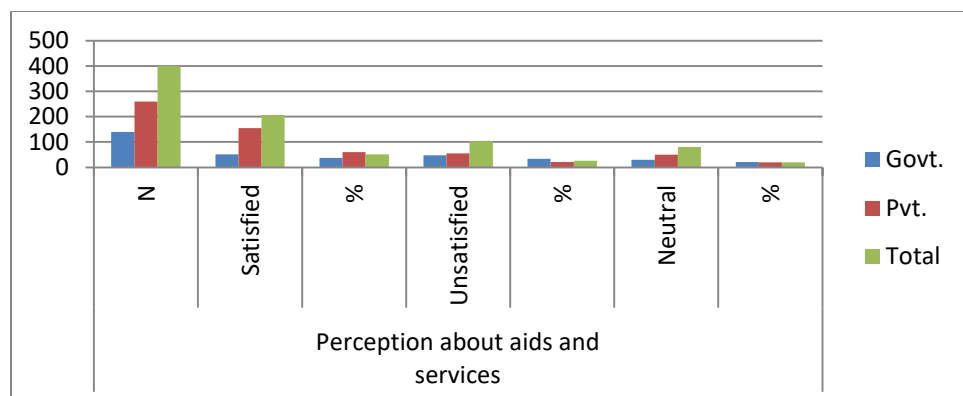


Figure 6.19: Graphical Representation of the Parents' perception about AIDS and services

Using the eyes of MRC's parents, the above desk represents the image of carrier vendors. Parents have been interviewed at the foundation of agencies offering carriers. Government and personal corporations are two essential occupations in the field of disability. More parents are taking offerings from non-public organizations as an alternative to government agencies. Parents with non-public companies are extra comfortable 52 (37.14%), as opposed to government companies 155 (59.62%). This version is due to officials' apathy in shipping assistance and services, time-consuming though cost-effective, more choice in individual agencies, more time span and flexibility, etc.

4.4 Case Study

Suraj is a virtual name born in a joint family and was the third child of that family. Everything was fine for a few years and the whole family was very happy. The 8th birthday of the sun was being celebrated. The whole family was immersed in the celebration. He was playing outside with friends, suddenly opened the Firaj which was kept at his house but when he was getting electrocuted, he got an electric shock and he fainted. Her parents and neighbors immediately took her to a nearby nursing home for treatment. Nothing unusual was seen in the child for a few days but after some time his neighbors noticed that the activities of that child are not normal, then told his family members and his family members did not pay much attention to him but one day the sun mother He also felt that his son's activities were not normal but he was not as active as he was when he was electrocuted. Time passed slowly and they started to pay attention to him, then he was convinced that the child's activities are not normal, then his parents started showing him to the doctor and took advice from many doctors but all of them were in vain. Nearly two years after the accident, someone advised him to show himself to a psychiatric doctor once and consult him. When he was psychologically tested, it was revealed that he was underperforming his peer group. So her parents were told that they were advised to see developmental signs in their child.

Later, it was once revealed that he is mentally retarded and has Attention Deficit Hyperactivity Disorder (ADHD). He has taken many types of medicines. Currently, he is aiming for a goal that is more of a goal scorer. Suraj is the only male child domestically and is much cherished through his mother and father. Suraj's mother and father no longer allow him to play backyard insecurely and given that they each work, he no longer plays in the neighborhood often. Their father and mother have a sensible image towards them, even though they perceive that the behavioral difficulties they experience are usually due to the lack of possibilities to play with different children. In the classroom, Suraj works strictly on his own tasks, however, given that he used to get away from stimulant medication, his focus of time is reduced. He has 20 college students in his class, all with considerable tutorial delays. The lecture hall is designed according to exceptional faculty norms; Instructors and collaborators direct and manipulate all activities; Good reinforcement is infrequent. The course takes extra and focus on instruction to work for a day by day accommodation (ADL). Suraj has typically encountered behavioral difficulties at unstructured times. Suraj's interactions with various college students challenge the staff: He harasses various teenagers who are no longer bothering him. However, the biggest situation is his conduct on leave. When he feels that individual college students have harmed a rule (whether it affects him or not) or violates his rights in some way, he will kick, bite, punch or slap. Suraj can luckily get away with another when suddenly he will get irritated and attack. After an incident, he cries and usually falls apart for about 20 minutes. This conduct sometimes occurs. A conduct expert wrote a layout, although she by no means paid attention to the conduct at leisure. Mom likes Suraj and tries to make him Suraj to "be nice" but has no training. If the sun hurts young people, neighbors are surprised at the desire for an extra restrictor nearby. His mother and father chose him to continue in his contemporary placement. He advised the health practitioner to take Suraj's medicine as an alternative to impulse and attention.

Currently, Suraj is doing analysis at a secondary level in a kind of faculty close to his residence. He is fifteen years historical, with an IQ of seventy-five years. He is of normal peak and weight. He has a bowel movement problem. In addition he complains of enamel sensitivity but no longer has dental caries. His academic stuff is below average level. Although all and diverse are wary of practical academics. In winter, he experiences disturbances in the sleep cycle. His elder sister is pursuing a specialist path in speech and language from Rajasthan. Because of his modern status, the relationship between his father and mother is no longer comfortable. They have discovered all the simple things like brushing, eating, grooming, hygiene etc. He likes drawing with watercolors. Suraj's mother is aware of all welfare schemes and offerings related to a specific child through the Government of India. Still he hopes that a miracle can happen.

5. SUMMARY, CONCLUSION AND RECOMMENDATION

Different techniques have been used for different sampling. Children have been taken from 6 schools of Jaipur district for the study. The snowball sample has been selected under non-probability sampling to select samples. Due to the complacency of the defendants we have employed the snowball sampling method. Four hundred mentally deranged children have been taken from various special schools in Jaipur district, and their parents in Jaipur district of Rajasthan have also been taken for a study sample.

The following tools and techniques have been used to collect data for the present study.

1. General data sheet
2. Health needs schedule
3. Hygiene needs schedule
4. Health assessment checklist

The following statistical techniques have been used to analyze the data.

- a) Computation of frequencies, percentages, statistical values.
- b) Graphs of the above statistical findings.
- c) ANOVA Single Factor
- d) T Test

5.1 Major Finding

It is found that through descriptive studies the mental health of children on retardation is confirmed. According to this study, MRC is at high risk for causing a large number of health problems due to not having suitable health care services available. Many researchers work more than some components of their lives. But the existing information is different about others due to its anthropological method and is completely based on the state of physical health and hygiene.

Health and hygiene is one of the important aspects of everyone's lifestyle whether it is a regular man or a special child. There are many elements that can lead to the improvement of a unique child in a child's life. It can be an accident during pregnancy, genetic causes, repeated miscarriages, cramps, untimely labor etc. A field survey for lookup writing was done once in the year 2018 and 2020 in Jaipur district of Rajasthan. Under the field survey, 9 special schools were selected for research. From there, 400 respondents were periodically interviewed using a simple random sample with 228 female and 172 male defendants. Thus the wide diversity of male contributors is 43 percent while the female diversity is 57 percent. Once there was an additional concern in the care and support of a specific child, the male population decreased compared to the female. It has been learned that the health problems occurring in these children are due to sensory problems, oro-dental problems, obesity, osteoporosis, epilepsy, swelling in nature, respiratory problems, etc., along with proper care, poor and expensive help. Too. Services, unhealthy practices etc. High blood pressure, hypotension, constipation, loss of appetite, pores and skin problems, sleep fluctuations and dizziness / weakness are the main health problems that appear in mentally challenged children in Jaipur district.

Descriptive studies performed at special schools in Jaipur with an interview agenda between MRC and MRC revealed that using these children's negligence compared to two critical elements, such as inappropriate support offerings and various special abilities, led to health risks. Is indicated. happened. Individuals. Although restricted mental capacity is also, according to some individuals, one of the barriers. The Census of India 2011 states that between 2001 and 2011, the most significant amendments occurred in the district Jaipur of Rajasthan. The entire population of paranormal humans in India was 3052887 in 2011, one of a variety of people.

Of the total disabled people in the state, the percentage of people is 34.65%, which is the lowest in the country. This is despite the state government providing 3% reservation in government jobs. Between 0-6 years of age, Rajasthan has 89,791 disabled children. There are 3,850,000 Whole Humans in Jaipur in special categories and 5.23% of which are due to mental disabilities of all levels. Of which 37.88% comes from rural areas and 65.25% comes from urban areas of the city. Work objective of covering 50,000 children and adolescents (5–20 years) in 185 government schools in Jaipur district.

Overall, 2070 (as per 2011 census) mentally challenged persons come in chronological 5 to 20 years. It constitutes 35.54% of the entire population of mentally retarded humans in the district. In the above age group, 59.22% recall for male and 42.78% for female. Census screening shows that 30.29% of the population's most attention comes from the age group of 5 to 20 years. This is due to the increase in strength, vigor and power associated with this age group.

Mental Retardation on Health (MRC) is often bloodless and due to debilitating diseases such as cough, fever, diarrhea, abdominal pain, body aches etc. Apart from the common issues listed above, which can be seen in members of any neighborhood, there is some MRC. Serious issues related to. These problems are listed after MRC has had traditional classes with parents and most of them have been cross-checked with their clinical history. The end result of the entire session is some serious problems like sleep disturbances, well-known mood changes, orodental problems, obesity, constipation etc. Issues related to these children are mainly due to their inappropriate physical and intellectual well-being. The biggest problem is that now we do not have any kind of support gadget for these children as we see for different kind of people. Whether it is government or private systems, the infrastructure is no longer as strong as different disability groups have. And above all, people's perception of parents, especially about health and hygiene, matters most to the well-being of these children.

When respondents were requested about their children's health and hygiene desires and its usefulness in one life, they answered 85% favorably and only 1.5% unfavorably. This variation in Table 6.2 indicates that parents of MRC experience that their unique infant needs additional care and support in terms of their high health and health status. 13.5% of humans have been neutral, although further investigations indicate that they take pains to take friendly care of one type of child. The frequency and percentage of parents' understanding of wanting to understand on several health factors in their MRC suggest that most parents feel that these children are more needed than everyday children. Parents have been requested about many components such as human biology, nutrition, hygiene, infectious diseases, persistent diseases and healthcare providers. As proven in Table 6.3, 89.5% and 96.5% of parents felt that infectious diseases and personal hygiene are more important than different aspects of nutritional health, respectively. Only 1% are of the opinion that no additional nutrition is required for these children. Health care providers in the neutral category had at least 6%. This was due to the lack of information about special health field services between the mother and father themselves. The entire discussion above suggests that most parents and fathers desire more care and help for their child and that the place where they voted unfavorably is no longer conscious of this information.

The parents of MRC are of exceptional academic background. They were classified in 12th, undergraduate, post-graduation well known and responses recorded accordingly. In Table 6.4, 60.5% and 32.14% of the mother and father completed are accurate and average levels of health and hygiene wishes, respectively. Only 7.5% have a low level of knowledge. Here we can say that the mother and father of middle academic history ie more and more know initially and there is a decrease in rating in the deficiency grade. Parents with low and extreme educational backgrounds have similar views and percentage scores. There may also be different purposes for this version which we will try to address in later discussions. The MRC's health status is analyzed through a structured schedule. Their health status data is listed in Table 6.5. MRC was once classified into three chronological intervals such as 5–10 years, 10–15 years and 16–20 years. Overall, 20.5% of youth are in good health, 65% on average and 14.25% in low levels of health. But in the age group, we see that the phase of good health is always increasing. It starts at 13.33% to 36.84% for chronological ages of 6-10 and 16-18 years respectively. The maximum increase in average age of 11-15 years in 1.3 % of while at the age of 6–10 years the lowest level is 30% listed. This suggests that as these children get older in their chronological age, their fitness issues regularly diminish to some extent. One of the most important factors of this growth is the socialization of a specific child.

Healths on Children mental retardation are classified on the basis of their area of home i.e. rural and urban and on the basis of their religion Table 6.6 and 6.7 respectively. Parents in rural areas are far less familiar with applied facts than mothers and fathers in urban areas. The level of awareness among Muslim neighborhood parents is reasonable when compared to different communities. Others here include Christians, minorities, reserved classes etc. The Muslim neighborhood has a low percentage of 10.71%. This is due to educational differences between families. Parents following MRC are categorized into tables 6.8 and 6.9, respectively, primarily based on their occupation and annual income. Parents in non-public sector business have a better awareness level than mothers and fathers involved in government and commercial enterprise activities. The investigation revealed the reality that government sector mothers and fathers have services to identify their specific child, making it difficult for them to do more research. While most parents in the non-public sector no longer have any such service and this puts more pressure on them that they are demanding extra in your medium programs for your specific child. A comparable version can be considered in Table 6.9 based primarily on their annual income. High-income groups and middle-income parties have higher levels of awareness than lower-income groups. The income constraint is the only factor, which is the

barrier to leverage and the use of the offerings needed for the specific child. Local taboos are additionally responsible for this.

To find out the level of awareness of health on mentally retarded children about their health and hygiene.

Disability (MRC) on children's mental health is rated for their general health and hygiene aspect. Activities for each day of living (ADL) are additionally evaluated as an incomplete sample size. ADLs are things that are often and usually done through a person. It is necessary for a person to live a fair life. These things include brushing, bathing, cleaning, grooming, eating, etc. These ADLs are evaluated in Table 6.10 and classified into CWMR Co-Can-Do. It cannot help and does not want help. Most of the school going children is skilled in essential activities like brush, bath and eating. But they want to help with grooming and cleanliness. The investigation revealed the reality that things that are complex in nature require time for study and efficiency. These children are taught in pieces to do this and there is no longer the whole way. For example, hygiene requires countless steps such as opening clothes, which is a top motor skill and then going to the toilet, which is a gross motor activity. Then cleaning emphasizes great motor activity and later discovers the button of clothes. The whole process needs to be done in secret at a certain place.

ADL is mostly taught by instructors and specialized teachers. Typically, parents are also taught how to train their child, so he can learn things easily and efficiently. The National Institute for Intellectual Disability, Secunderabad has produced some leaflets about the pictures and all the necessary steps with these ADLs. Table 6.11 was created based on the educational status of MRC in three categories i.e. pre-primary, primary and secondary. It is clear from the table that children become more efficient as their educational level progresses. Two things come to light here, for the first time they gradually learn the process of socialization and with the passage of time all these processes become regular for them. Various health aspects were listed for the assessment of MRC in table 6.12. These are general features which can be seen in any individual of good health and hygiene. These features are appearance, posture, mental status, speech, movements, face, skin, nails, teeth, bladder movements, bowel movements etc. while deciding these factors, advice of some medical practitioners are also sought. Due to the limited intellectual capacity of these children, such factors are decided which don't involve the use of any equipment. As most parents of these children feel themselves stigmatized and cautious they generally don't allow the use of any equipment on them. It is found that most children are in an average range of health and hygiene.

Identifying the value of nutritional foods for mentally retarded children for their better health

Nutrition is one of the most important levels in a person's everyday life. We can say that nutrition is the constructing block of one's life. Because except perfect nutrition we can't think about a wholesome life. Therefore, MRC's parents had been requested whether or not they felt that a special food plan used to be wished or regular diet is enough for these children. Table 6.13 and 6.14 discuss the want for a specific food plan design and quite a few diets, respectively. 83.33% of woman parents oppose a special diet prosperous in protein and carbohydrates in contrast to 16.67% of male parents. A whole of 95.5% of the parents voted neutral. Further investigation suggests that there is no medical foundation for over-voting for a specific diet, it is simply a pretext for her child that her consumption of a wealthy protein diet might also be normal. Although some docs have suggested for a special diet plan prosperous in protein and carbohydrates, however now not below normal circumstances. These diet plans are solely for these who have some associated problem with mental retardation.

Through parents to understand the response of the Doctors in the treatment of mental hygiene and health on mentally retarded children.

It is clear from the table 5.15 that as a whole 278 (69.5%) of the human beings feel, the behavior of doctors was desirable in terms of doctor-patient relationship. A total of 72 (18%) humans experience non-acceptable behavior and 50 (12.5%) uniquely unbiased views. The graduating mother and father are father (% 7.0 mother%) in the appropriate category and at least 12 (11%) in the non-acceptable category. Postgraduates mother and father are outnumbered and among them, 198 (73.64%) enforce the behavior of doctors at some point of followup. A mother or father who has a twelfth educational qualification has the strongest experience of rejection. 20 (58.82%) feel that the behavior was once unacceptable. However they additionally have a neutral opinion of 18%. Doctors are an important agent in the wellness industry and they play an important role in keeping members of society physically and mentally healthy. If a doctor shows symptoms related to Ting, the patient feels half-treated. With this idea in mind, parents were asked about their experience with doctors for their particular child. Parents were classified in Table 6.15 based on their educational status. 69.5 parents have found that doctors' behaviors were acceptable, while 18% felt unacceptable and 12.5% were neutral. Although the majority felt that the behavior was acceptable, it was found that parents with a low educational background, who mostly visited government hospitals, primary health centers, and community health centers, were provided with a facility for their particular child by doctors available there Has experienced a kind of rejection. Table 6.16 and 6.17 were created based on the level and nature of the income provider, respectively. The low-income group has more resentment than the middle and upper income

groups. The middle and high income group found the behavior of doctors to be more satisfactory than the low income group. The doctors in the private sector were more appreciated than the doctors in the government sector. It was found that private doctors have given more time to the patient and listens to their complaint properly but government doctors usually do not give enough time for the patient and their complaints. This may be due to the greater number of patients in government centers. Parents also believed that the treatment of serious diseases is usually treated efficiently by government doctors at a reasonable price.

To analyze the work of help and services of government officials programs in providing better hygiene and health on mentally retarded children.

It is clear from the above table and layout that most of the outrage in the neutral and dissatisfied class is at the pre-primary level. This counts to 34 (85.00%) and four (10%) for the dissatisfied and neutral class respectively. Again the most important level of pride is 120 (50.00%). The neutral class for the secondary degree has at least a percentage of 10 (8%). This edition has several objectives such as non-availability of infrastructural services at pre-primary level, additional support at primary level, non-focus of government schemes and programs and additional possibilities at secondary level.

The process of support system provided by government or private agencies is also evaluated by interviewing the parents of MRC. Here services are classified on the basis of educational achievement MRC in Table 6.18 i.e. pre-primary, primary and secondary. 85% of parents with children at the pre-primary level feel dissatisfied, while 50% of parents feel satisfied with the services provided by government and private agencies. Services include specialized teaching kits, specialized schools, physiotherapy centers, psychological centers, vocational centers, etc. It was found that the services listed above are frequent at private centers but on an expensive package. Government services are not efficient, but at a reasonable price package. Parents in rural areas are more dissatisfied due to non-availability of their services. Parents in urban areas have almost the same views about satisfaction and un-satisfaction. It was found that rural parents are mostly unaware of the services and delivery of the center. Similar is the situation with government and private agencies. Parents found that private agencies are more skilled in the delivery of specialized services, which are required by their particular child.

5.2 Recommendation and Further Research of the Study

5.2.1 Recommendation

Research studies are to be done on various fields related to mentally challenged children such as education, education, vocational training, employment opportunities and their contribution to society etc. Measures should be taken to instill sensitivity among community members amid the need to educate children with mental retardation on general health aspects. As parents' knowledge about health and mental hygiene aspects is only moderate, increasing their knowledge of health and mental hygiene aspects for the prevention of common and infectious diseases and preparing them for the use of available health services and A concerted effort is required to train. Knowledge of parents will increase their confidence and in turn, it will be beneficial for MRC. Steps should be taken to allow children with mental retardation and their parents to produce more reading material and other audio-visual material on general health and hygiene aspects in their native language. The health and hygiene status of children with mental retardation should be evaluated periodically with the participation of their parents in all special schools. This will facilitate early intervention programs for them. Both the government and private sector should focus on specialized training centers for these children and also for their parents. Therefore, parents can prevent themselves from practicing in vain to correct the mental caliber of their loved ones.

5.2.2 Further Research

The current study was conducted on a mental disability covering 400 mental hygiene and health samples, which are attended by special classes of educated class and their parents in Rajasthan's district Jaipur. The same study can be conducted with a large sample drawn from all districts of the state; So that more general conclusions can be drawn. Mental hygiene and health on mental retardation children may attempt to identify mental hygiene and other health needs. The effectiveness of parent-teacher association on mental hygiene and mental retardation can be studied on children health. Follow-up studies may be conducted to ascertain the effects of inclusion, zero rejection and generalization of these children in society in general. The effectiveness of health and sanitation programs and welfare schemes of the government and the needs of these children can be studied. A similar study would be worthwhile in terms of their socio-cultural profile with different methods of data collection such as anthropometric measurements and for conducting medical camps. A comparative study of the health and hygiene needs of children with mental retardation and not attending special schools in all categories can be studied.

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