Awareness in Parents, Teachers and School Children about Mental Retardation: A Community Based Rehabilitation Project in Himachal Pradesh.

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Abstract

This research paper is the outcome of a project on Community Based Rehabilitation which was carried out by the authors to increase awareness of the parents, teachers and students of rural areas of District Kullu in Himachal Pradesh. A Community Based Rehabilitation programme involves measures taken at the community level to use and build on the resources at community level for rehabilitation of the persons with disabilities and provide opportunities for their social inclusion. Community Based Rehabilitation ensures that people with disability are able to maximize their physical and mental ability to access regular services and opportunities up to the level of full social inclusion within their community. The objective to write this paper is to understand that the important aspect of CBR revolves around awareness of people in the community with regard to disability and changing their negative attitudes and behavior towards disability. This project was carried out to increase the level of knowledge of community about Mental Retardation or Intellectual disability and to develop appropriate rehabilitation services for the persons with Intellectual disabilities and also to mobilize the local resources to support them.

Keywords: *Mental retardation, Intellectual Disabilities, Community based Rehabilitation, Home Based Education.*

Introduction

Mental retardation is a condition that not only has medical, educational and psychological implications, but has a major impact on the social system in any given community. Mental retardation since ages was perceived differently by different communities ranging from calling them as devil and evil spirits to good luck and god man carnation. Everybody agrees that whatever is the condition of a person with mental retardation, how the society perceives them definitely has an impact on the way they are treated. The phenomenon of mental retardation has been known for millennia. It has been observed that the phenomenon has a complex nature and is not understood completely by the various sections of the community such as parents, family, professionals, etc., there have been a lot of misconceptions and wrong practices seen across the society. However, in recent decades, serious attention has been paid to it. Considerable scientific information has been built up and published.

In the past, no differentiation was made between mental illness and mental retardation. Mental retardation is a lifelong condition, which cannot be cured. Persons with Mental Retardation possess the ability to be trained to become independent with systematic and planned support. Mental retardation is not a mental illness. Mental illness can be cured. Persons with mental illness have normal development but suffer from psychological disturbance which needs systematic treatment, sometimes even medication whereas mental retardation is a condition where a child's mental development is not matching with his physical development.

There are many superstitions about the mental retardation regarding what causes and there are common to other disabilities also. The concept of comorbidity of mental illness and mental retardation is not only theoretical but also a practical issue. Some of the common questions posed to the therapist are: Are the two conditions different or same? If different, can a person with mental retardation have mental illness?

In recent decades the issue of mental illness in the persons who have also mental retardation has been given increasing attention. This is because firstly the general recognition of the right of a person with mental retardation to appropriate healthcare. Secondly, following the normalization principle, persons with mental retardation are expected to live in the community

and use community facilities. As a result of the recent works in the field, appropriate and convincing answers and explanations have been given to the above-mentioned questions and concepts.

Person with mental retardation due to less I.Q. can have mental illness, which will be manifested in the form of sudden, unpredictable change in the behavior, mood and or thinking. The nature and spectrum of the mental retardation will be similar in the comparison of the general population. However, the incidence and prevalence of mental illness amongst the persons with mental retardation is higher than that of the general population. This is because of the interaction of biological, psychological and social variables resulting in a typical path of development for a person with mental retardation. This may be manifested with the following deficits:

1. Poor integration of self
2. Deficit in self-regulation
3. Lack of confidence
4. Inferiority complex
5. Anxiety
6. Difficulty in living independently.
7. Due to the mentioned deficit, persons with mental retardation are more vulnerable to psychopathology in comparison to the non retarded individuals. Besides the above factors, the stressful and competitive environment due to disparity between the parental/ family expectations to the individual capacity adds to the problem.

In a country like India, most of the people feel that mental retardation and mental illness is one and the same. This is mainly because of the lack of information, existing among the general public regarding the differences between mental illness and mental retardation. Hence it becomes essential to have clear guidance to differentiate these conditions for developing promising management strategies. Mental retardation depending upon I.Q. divided in

Mild 50-70

Moderate 35-49

Severe 20-34

Profound below 20.

Whereas the classification of mental illness can be classified in two basic categories: **Psychosis** (schizophrenia, manic depressive psychosis) and Neuroses (anxiety disorders, phobia, obsessive disorder).

Mental Retardation refers to substantial limitations in the present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas, communication, self-care, home living, social skills community use, self-direction, health and safety, functional academics leisure and work. Mental retardation manifests before age 18 (AAMD1992)

There are three major and important clauses with in the definition:

1. Significantly subaverage intellectual functioning which indicated by IQ which is less than 70
2. Deficit in adaptive behavior which the child/ person exhibits at various stages of development in day to day living.
3. Manifested during the developmental period i.e. from conception of 18 years of age.

Causes of Mental Retardation: Mental Retardation is caused when the brain gets injured or a problem prevents the brain from developing normally. These problems can happen while the baby is growing inside the womb, during birth, or after the baby is born. Many times, even doctors do not know the cause.

Following are some problems that can cause Mental Retardation or intellectual disabilities:

1. Problems in the baby's genes, which are in every cell of the baby and determine how the body will develop, can cause mental retardation. Genes are inherited from both parents and the baby might receive genes that are abnormal or genes might change while the baby is developing.
2. Problems during pregnancy can cause mental retardation. Sometimes, the mother might contract an infection or illness that can harm the baby. Certain medicines used by the mother during pregnancy can cause problems for the baby. Consumption of alcohol or illegal drugs also can damage a baby's developing brain.
3. Insufficient supply of oxygen during childbirth.
4. Premature birth.
5. Serious brain infection soon after birth (Chennat, 2019).

Misconception and Social Practices:

Retarded persons live in the atmosphere created by the attitude held by the people and the professionals they come in to the contact with in addition to those of their families. The person with mental retardation will prosper and improve in the quality of life if these attitudes are positive and supportive. But in reality, by and large all sections of society accept these persons in to the main stream. Especially in a developing country like in India, many misconceptions are wrong practices are seen which are due to their negative attitude, lack of understanding and lack of encouragement.

Misconception:

1) Mental retardation is mental illness.

2) Mental retardation is due to fate and ***karma.***

3) Medicines and vitamins can cure mental retardation

4) Marriage can cure mental retardation.

5) Person with mental retardation becomes normal as he grows.

6) Mental retardation is contagious.

7) Students with mental retardation cannot learn to read.

8) Students with mental retardation can not be successful in the general education setting.

Due to misconceptions, people in general underestimate the capabilities of a person with mental retardation, which in turn hampers the process of rehabilitating them. Hence, there is a need to eliminate these misconceptions mainly through awareness in the society.

Concept of Community Based Rehabilitation (CBR):

All the initiates and programmes established that Community Based Rehabilitation is no more a pilot project work or programme of reaching the unreached but steadily emerging as a movement for prompting comprehensive care and rehabilitation of persons with disabilities. The achievements and efficiency of existing CBR strategies that are the only way of reaching out the unreached person in rural areas is to initiate and implement CBR for persons with disabilities for developing countries. Comprehensive community-based rehabilitation is not a matter of choice but a compulsion. Community Based Rehabilitation involves measures taken at the community level to use and build on the resources of the community for rehabilitation, of opportunities and social integration of all people with disabilities. Following are the important aspects of CBR. It is a greatest approach for the development and rehabilitation program within a community concentrating on need-based services.

CBR ensures that people with disability are able to maximize their physical and mental ability to access a regular services and opportunities up to the level of full social integration within their community. An important aspect of CBR revolves around awareness of people of the community with regard to disability and changing their negative attitudes and behavior towards disability. To increase the level of knowledge of contact people and to develop appropriate rehabilitation services also to mobilize the local resources.

Component of CBR

Person with disability:

It is necessary to educate, empower and rehabilitate them and enable them to integrate as productive and contributing members.

1. Family: Educate them to provide rehabilitation and develop the attitude of acceptance.

2. Community: To provide and promote community responsibility for rehabilitation alone by volunteers with in the community.

3. Rehabilitation Personnel: They act as agents to bring about changes by transforming basic skills and knowledge in the management of disability.

What is Rehabilitation*?*

The process of restoring the handicap individual to the fullest physical, mental emotional and vocational usefulness (for which he/she is capable) and to tap potentials and channelize his/her maximum development so that he or she could live as near normal life. In a successful rehabilitation programme the community, professionals, parents and disabled persons become active partners and also support each other. Any rehabilitation programme will be sustainable if need is articulated and if the community is willing to meet the need. Rehabilitation programmes are successful if community support is available.

The dictionary meaning of rehabilitation is to return or restore to previous state or condition. According to ILO, “rehabilitation involves the combined and coordinated used medical, social, educational and vocational measures for training or restoring the individuals to the highest

possible level of functional ability. The rural and urban need of rehabilitation programme vary in one or other ways:

Urban Needs:

1. Information about rehabilitation services.
2. Decentralization of services pre- school programme, special school, day care centre and centre for mentally retarded children and counseling services
3. Need of transportation facilities
4. Need for a centre for vocational training, job placement and follow up programmes.
5. Job reservation in public and private sectors.
6. Need of residential institutionNeed of medical therapeutic and care services for severely and profoundly retarded persons in institutional setting or in hospitals.
7. Advocacy and enforcement of laws for protection of rights.
8. Public awareness.
9. Need for appropriate provision of recreation.

Rural Needs

1. Creation of public awareness
2. Provision for prevention, early detection, intervention and management
3. Training programme for village land rehabilitation workers
4. Counseling services
5. Need of anganwadi and balwadis
6. Home based programme/ Home based educational Programme.
7. Training and rehabilitation facilities at community level.
8. Need of developing low cost aids and educational materials
9. Provision for recreational and leisure time activities.

Some landmarks in the rehabilitation of the people with mental retardation:

The advent of sensationalism through the efforts of various philosophers provided a new group of perceiving. American and French revolution encouraged the philosophy of humanism. An awakening (1700-1800) was the result of these historic events which established a new social attitude towards the mentally retarded individuals. This attitude created a positive climate for the young idealistic people to put into practice the philosophy of humanism and the ideas of Locke and Rousseau. The awakening created an attitude of optimism during the first phase of the nineteenth century. The recognized birth of special education and systematic services for the disabled individuals occurred in Europe in the early 1800s. In 1950, formation of National Association for the Mentally Retarded (**NAMR)** children consisting of parents of mentally retarded children was one of the most important events. Over the years, social attitude towards the mentally retarded people has changed from fear and repulsion to tolerance and compassion. President Kennedy, who had a sister with mental retardation, established the President's Panel on Mental Retardation (PPMR) which was to serve as a guide and a source for national policy in the U.S. In 1963, Congress passed the Mental Retardation facilities and Mental Health Center Construction Act, which established sources for the construction of **Mental Retardation Research Centre (MRRC)** in **1964.** Through the 1970s, the field of special education and the provision of services to the mentally retarded persons have made remarkable progress. As the 1980s began, a two-part philosophy enjoyed an eagerness to increase services and to maximize the quality of these services and an understanding that it was necessary to constantly reevaluate all actions. **American Association of Mental Retardation (1983),** had issued the definition of Mental Retardation which is most consistent with the definition put forth by the American Psychiatric Association and World Health Organization. It was again revised in 1992. The **Mental Health Act (1987),** Government Of India, Ministry of Law and Justice, Mentally ill person means a person who needs treatment by reason of any mental disorder other than mental retardation. **Rehabilitation Council of India Act (RCI) (1992)** statutory body under the Ministry of Social Justice and Empowerment to regulate and introduce uniformity in the human resource development in the country. The RCI act is a major move by the Government of India for quality assurance in the education, training and management of persons with disabilities. **World Health Organization (1994)** stated clearly that community based rehabilitation involves measures taken at the community level to use and build on the resources of the community including the impaired, disabled and the handicapped persons themselves, their families and their community as a whole. **Joint position paper ILO, WHO and UNESCO (1994)** reflected that Community based rehabilitation is a strategy within the

community development for the rehabilitation, equalization of opportunities and social integration of all the people with disabilities. **Persons with Disability Act (1995)** has come into force on Feb.1996 as an important land mark and significant step in the direction to ensure the full participation of persons with disabilities in nation building. **National Trust Act (1999)** has made provisions for appointment of guardians for those who have applied, and residential facilities by the organizations who will have to maintain minimum standards prescribed by the Trust in terms of space, staff, furniture, rehabilitation and medical facilities. This is an act to provide for the constitution of a body at the national level for the welfare of persons with autism, cerebral palsy, mental retardation and multiple disabilities. **Annual Report (2001)** as per the report of NSSO, the survey indicated that 3% of the populations have developmental delay including mental retardation. Based on this survey it is estimated that there are more than two crore of children/ person having mental retardation i.e. 2% of population for whom the services are to be extended. **NIMH (2001)** organized a programme for parents in which 67 registered parents' organizations participated. The themes discussed during the meet were the National Trust Act, NHFDC schemes and the role of parents' organizations. **8th National Meet at Secundrabaad (2001)** was held on Dec.2001 which was attended by 92 special employees, with75 escorts from 14 states of India.

National Seminar on Mental Retardation (2002) this seminar gives an opportunity to the rehabilitation professionals to have common platform to share the information about different intervention for mentally retarded people. This year the national annual seminar was held in Dehradoon in collaboration with Karuna Vihar, 277 participants attended the programme and the theme of the seminar was the awareness and networking of the rehabilitation professional. The **SSA & RTE Act 2009** made provisions for their identification, assessment, home based and barrier free access to education for all children with disabilities of the age group 6-18 years. **The Right to Person with Disability act** (RPWD Act-2016) replaced the PWD Act 1995, also act provides preventive and promotional aspects of rehabilitation like education, employment, and vocational training, reservation, research and manpower development, creation of barrier free environment, unemployment allowances, special insurances scheme for disabled employees and establishment oh home for person with severe disabilities.

Rationale of the study:

Mental retardation is basically a social problem. It varies from culture to culture and also among the person with mental retardation. Because of their deviant behavior they are at the great risk of being devalued by the society because of their low mental and physical capability, they fall below the expectation of the society. A need was felt by the investigators to conduct such a project which leads to the successful orientation of the rural population, parents and students about mental retardation. Efforts to improve their ability to adapt to the society, through education and training need and attention, not only from professionals but also from parents. People with mental retardation are different but their needs are the same as that of non-retarded persons. Therefore, they should be perceived and treated as normal.

Majority of the Indian population lives in villages since independence, in India has made considerable progress in bringing quality in the life of special people, but considering the size of the country with its geographic, socio cultural, linguistic variation a lot more needs to be achieved. So, to reach the unreached, community-based rehabilitation is seen as the only way to reach out and develop programmes for prevention, detection, intervention etc.

Objectives of the Study: The objective of the project studied under following main heads:

Objectives of Identification:

1. To verify the information provided by disabled children through investigators by the volunteers and other people.

2. To know the number of disabled persons in the area by using screening tools.

Objectives of Awareness Programme:

1. To create awareness among the parents, teachers and the school children about Mental Retardation.

2. To remove the myth and misconception about mental retardation in the people of concerned Panchayat.

3. To make the students of the community aware of the role of the society, family and neighborhoods towards disability and mental retardation.

4. To design a Community Based Rehabilitation plan for the rehabilitation of MR children.

Method and Procedure:

This project work was basically a Community Based Rehabilitation activity which includes surveys, interviews, observations and implementation of intervention designed to achieve the target of rehabilitation of mentally retarded children. The investigators firstly prepared the plan of the survey. A semi structured interview schedule containing 20 items was prepared for the parents, students, teachers and community members of the concerned panchayat. An observation schedule was also prepared to validate the information collected by the volunteers. A complete one-day awareness programme of four sessions was designed to sensitize the targeted population. The project work was divided in to three main phases:

1. First phase: Initial visit to panchayat and selection of volunteers.
2. Second phase: Survey of selected panchayat
3. Third phase: Organization of awareness programme.

First Phase: Our first action was to visit *Parli* Panchayat**.** It was planned to visit the panchayat on the day of the General House of the Panchayat. Our first visit to "Parli Panchayat" was very successful and we first met the President of Panchayat Mrs. Neelam Chauhan before the general house requested to give us 30 minutes to share our plan, although we had telephonically discussed all our plans with her. Really, it was a very good opportunity to interact with all ward members and many other people together in the Panchayat house. We explained the purpose of our visit to the general house of the Panchayat. Everybody present there was ready to help us. The President of Panchayat introduced some of her colleagues and other members of the community to us. Mr Ghanshyam Chand, Mrs Sunita Devi, Smt. Praveen Kumari, Vimla Devi, Ajay Kumar, Anil Kumar and Tarachand were appointed to help us. All seven were the ward members of this panchayat. We also selected three more persons from the general house of the panchayat. After the general House we held a meeting with all ten volunteers. We noted down the contact numbers of each of these members of Panchayat. We told them about the limitation of the time of our project. We prepared the training schedule and survey schedule on the same day.

Second Phase: During the second phase, we ourselves conducted the survey with the help of these volunteers and they imparted a lot of information about the different villages of the Panchayat Parli. Our team completed the whole survey in 3 days and interviewed 200 people including the parents, teachers, students and neighbours MR children. The team of volunteers accompanied us to visit all villages, schools and houses of children with disabilities. During the course of the survey, we managed to collect a lot of information about the people and place.

Third Phase: It was the scheduled Awareness programme for the targeted population. This was three hours programme further classified in to three sessions in which first two covering the following topics:

1. First session: **Time 11:00 AM to 12:00 Noon**. Topic of Talk: Causes of MR -Myths and misconception - Prevention of MR -Relationship and attitude of family and neighbors towards MR persons.

2. Second Session: **Time 12:25 PM to 1:25 PM,** Topic of Talk: Schools and NGOs working for MR children, importance of education, social interaction and entertainment for MR, porgrammes and provisions for Mentally Retarded Persons.

3. Third Session: **Time 3:00 PM to 4:00 PM, Group Activity**: Preparation of Plan for the rehabilitation of the MR children in the Panchayat, roles and responsibility of Panchayat Pradhan and Volunteers, Identification of supported services, Role of NGOs and health worker in rehabilitation.

4. Feedback session.

Findings of survey:

1. This Project had been carried out in remote Panchayat Parli of Kullu Block. There were total 17 habitations (group of 17 small villages): Manihar, Jhumi, Baradhal, Rauli, Udsu, Nazan, Ushog, Sadhan, Mathrong, Aisa, Pigrang, Kuin, Kaisudhar, Ukhachin, Khani, Thela and Baga.
2. Out of these seventeen villages, ten villages are remote villages situated at a height of 2940meters above sea level. Most of the houses in the Panchayat were traditional "pahari" "Kathnuma Shaili" constructed with mud, stone and wood.
3. This is the remotest panchayat of Kullu block. The total population of Panchayat was 2196 with 1108 males and 1088 females. The total numbers of families were 356.
4. Majority of the population of Parli Panchayat engaged in agriculture and

horticulture. The crops depend on the rain water. Only a few villages of Panchayats were covered with irrigation facilities.

5. Only 10% people were government employees mostly in class IV jobs. Only 7 villagers were primary teachers and 3 were in class II in government jobs.
6. Only 5% population is high profile families, most of them have apple orchards. Majority of illiterate villagers work as labourers in other fields, shops and in construction works. Majority of the families had a low income profile and very few (only 16) families were under the below poverty line.
7. There were 7 government primary schools, one government middle school and one government high school imparting education in the panchayat. Most of the children were attending the nearby schools in the Panchayat.
8. Majority of the population (70%) of the village had below 10th standard educational qualification whereas 30 % had graduation and Master Degrees.
9. Most of the children attending elementary and primary schools in the Panchayat were anemic as the data shared by the school.
10. 40% of the households in Panchayat had no toilet facilities and they defecated openly in the Panchayat.
11. Most of the water resources get contaminated during the rainy season. There is scarcity of safe water for drinking.
12. Household waste, animal waste and garbage were piled in the open and not disposed off properly.
13. No health facility was available in the Panchayat.
14. Residents of Parli Panchayat were not much aware of the facts regarding disability.
15. Parents and neighbours didn't not know how to handle the situation of disability.
16. The attitude of the family members and the neighbours towards disabled children was found indifferent and ignorant**.**
17. There were no rehabilitation facilities for the children with disabilities.
18. Most of the parents/community members were not aware about the concept and causes of disability specially about mental retardation.
19. There were no agencies working for the disabled in Parli Panchayat.
20. There were 27 cases of major and minor disabilities found in the 17 villages of Parli panchayat.
21. The disability wise cases were : Number of MR/ Intellectually disabled Children-12, Visually Impaired-7, Hearing Impaired-1, Speech Impaired-4, Physical Disabled-3 Only eight cases were identified by the doctor as M Rs and they were medically certified while other 4 cases were identified during the survey however before that their parents never got their children assessed by the doctor or any medical institutes.

Observation about awareness programme:

It was a three hours scheduled programme and organized at three different venues for three different days. We had trained 370 participants including students, teachers, parents and anganwadi workers. We were supported by the team of 10 volunteers. Some of observations have been listed below:

1. Date and time were appropriate to hold such a programme because of good attendance.
2. Venues were appropriate/ approachable to everybody.
3. Educational Profile of people was low.
4. We succeeded to remove their myths and misconceptions about MR
5. They were interested to know about the facilities available for their children
6. After the programme these people appeared to have understood the basic aspects of mental retardation.
7. Majority of the participants were able to answer each and every item in the feedback form which was filled by the participants at the end of the programme.
8. Especially after the awareness programme teachers and students were able to reflect their responses regarding their understanding about mental retardation.
9. It has been found that 80 % of the participants wanted a well behave with mentally retarded children, they must be deal with sympathetically by all.
10. It was found that still in a few cases parents and other members of the community did not have a clear cut understanding about the reason and fact behind mental retardation. This reflects that more and more such

awareness programmes are required in the community.

11. Another finding of the study reveals that maximum parents were ready to support their wards and agree for the development of their special children. They also felt the need for special training for their children.
12. Although, many participants came to know the different programme implemented by the government for the welfare of the mentally retarded children but they did not able to answer the items related to different acts and legal provision for the welfare of mentally retarded children.
13. A few parents and teachers were enabled to tell the name of NGOs and field functionaries working in the field of mental retardation. Only 20 % participants were able to answer the last item, about the name of the Department working in the field of disabled children.

Summary:

It was a good learning experience for investigators to avail chance to be a part of this community and to support these strata of the society in whatever little way we could. It was totally a new experience to know about the problem of these people who were leading their life with lots of problems around them. This exercise gave us an opportunity to learn about these people and their lifestyle.

However, in spite of their limited resources money and poor quality of life, inhabitants were content and happy with their lives. The social evils like alcoholism, illiteracy, improper planning of family, lack of health and hygiene facilities, lack of basic needs like: Safe drinking water, road facilities and non-availability of health facilities like health centres and other medical facilities.

Although children were being sent to nearby school but there was no special educator in the school to support mentally retarded children. There was an urgent need of rehabilitation professionals, collaboration of NGOs and resource centers for these children in the community for early intervention programmes. Most of the parents were not aware as to how to cope with their MR children. The young girls and boys of the community need to be trained in this regard so that they can take good care of these children.

The awareness programme which was designed to aware the target population was proved successful in breaking many of their myths and removed many misconceptions about mental retardation.

Major observations of the Project:

Without the help of the panchayat president and volunteers, this community-based rehabilitation project could not have been possible. We realize that no work could get under way till the community is interested. As far as the problem of mental retardation is concerned these people were surrounded by several myths and misconceptions. They were partially ignorant about the issues related to mental retardation. They were not aware of many provisions, early interventions and training facilities available for these children. It was found that when these children reach the age of adolescence, parents become worried about their marriage, academics, employment and social skills. Many parents of children with disabilities become uncertain about their child's future and do not even know where to send their children for education and training.

Recommendations:

For the NGOs:

1. Initial guidance and counselling for the parents, siblings and community should be provided and the community must be provided information about the rehabilitation and early intervention required for Children with mentally retardation.
2. NGOs working in the area of disabilities should come forward to provide support in the process of identification and assessment, education and training needed. These NGOs need to come forward for rehabilitation in terms of employment of persons with mental retardation and also facilitate them to get entered in vocational training institutions.

For schools: Schools should ensure the inclusion of the students with mental retardation/ intellectual disabilities with normal children.

1. These schools should have posts of special educators to support teachers and staff as well in the inclusion of these students. Schools must have well equipped resource rooms to assist the students with disabilities.
2. Flexible rule and regulations in curriculum adaptation and instructional strategies.
3. Schools should decide timely in case of severity to assess the prevocational and vocational training needed to work actively

in this area with support of special educators.

4. Schools should take the outer support like to counselling services, assistive devices, therapy etc. to assist these students.
5. Parents should be counseled and encouraged for sending their children with disabilities to school.

For Administrators:

1. Some grants to be released to improve the toilet facilities in the habitats of Parli Panchayat specifically to the people who are below the poverty line.
2. Health and hygienic conditions should be practiced in the Parli Panchayat in convergence with the rural health mission, a mega project of GOI.
3. Solar lights can be provided with the support of Him Urja Department.
4. More taps for safe drinking water should be installed keeping in mind the cleanliness around the platform of tap.
5. Road conditions should be improved.

For Health Department

1. More awareness needs to be spread among the people of the community regarding cleanliness and hygiene related matters.
2. More awareness related to health and evils like alcoholism, immunization, balanced diet & other work objects is required.

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Web Resources:

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